

Submission to the Committee on Economic, Social and Cultural Rights – 66th Session (March 2020)

ITALY

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Reporting Organisations:

**forum
droghe**

Forum Droghe is a no profit association, working in the field of drug research and drug policies. Since it was established in 1995, Forum Droghe has acquired a large amount of knowledge and expertise, particularly in the field of drug legislation and harm reduction policies. Forum Droghe promotes research about the evaluation of the impact of drug legislation on the prison and justice systems, and publishes a yearly “White Book” dedicated to these issues. In 2012, it has promoted a coalition of NGOs working in drug policies, justice and human rights advocating a shift towards a less punitive drug legislation, more respectful of drug users’ human rights. Its website, www.fuoriluogo.it, provides reliable information and documentation on a wide variety of topics and issues (international trends in drug legislation, innovative drug policies and drug addiction interventions at European level, models and experiences of drug use decriminalization, medical cannabis etc.). The association also publishes *Quaderni di Fuoriluogo*, a series of thematic papers.

Forum Droghe is partner member of International Drug Policy Consortium (IDPC), member of the Civil Society Forum on Drug of the EC and of Vienna NGO Committee on Drugs (VNGOC).

www.fuoriluogo.it



LILA - Italian League for the Fight against AIDS - is a non-profit organization founded in 1987. It is a federation of 12 associations (local units) of both HIV positive and HIV negative community health workers, volunteers and professionals, which operates in many Italian regions through its local units. The national coordination team has implemented a structure organized in the following areas: information; prevention; community based counseling and testing services for HIV, hepatitis C and STIs; harm reduction strategies targeted to key populations (drug users, sex workers, prisoners); defense of human rights.

LILA’s national coordination team supports the development of social and health policies and coordinates the activities of its units at regional, provincial and municipal level. It works in partnership with other Italian and European NGOs and participates to relevant European networks; it is actively engaged also with Italian institutions, by participating to Health Technical Committee within the Ministry of Health and to other commissions related to health issues, drug policies and infectious diseases.

<https://www.lila.it>



Società della Ragione is a non profit organization, founded in 2008, which aims at promoting a reductionist approach on the penal system in order to narrow the scope of application of the criminal law towards use of the least restrictive sanction in full compliance with human, social, and civil rights. Hence, Società della Ragione's main objective is raising awareness on penal systems' issues. Specifically, the association is keen to foster a positive confrontation with EU Member States' best practices with the purpose of guaranteeing the social and work integration of offenders. Moreover, Società della Ragione engages in research on torture, life sentence, and alternative measures to detention and drug policies. According with the Società della Ragione's statute, the association carries out its aims through the promotion and coordination of action research activities. Indeed, Società della Ragione has been conducting relevant researches and analyses at local and national levels, with the involvement of a wide range of institutions and stakeholders. Furthermore, Società della Ragione offers significant support in the elaboration of legislative provisions and/or amendments in order to reach parliamentary consensus on legislative acts. Results and outcomes of the activities of the association are diffused through the publications of books, reports, and papers. Moreover, seminars and conferences to publicly discuss the results are organized.

www.societadellaragione.it



ItaNPUD is a network of people who use drugs fighting for the rights of all people who use drugs in Italy. ItaNPUD is part of the broader European network of people who use drugs, and arises from the urgency to react to the oppression and violence we face every day, and to the systematic attack on our rights and dignity and the dignity.

ItaNPUD believes this is a direct result of prohibitionist and punitive policies, which we reject, based both on scientific evidence and human rights and that the wealth of experience and knowledge that people who use drugs can bring to the table is a collective asset to be always taken into account while developing policies and interventions that affect our lives. For this reason, we reclaim the right of people who use drugs to be at the core of every decision or policy on drugs, as crucial and non-negotiable.



Harm Reduction International (HRI) is a leading NGO dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies.

The organisation is in Special Consultative Status with the Economic and Social Council of the United Nations.

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Introduction

Forum Droghe, LILA, La Società della Ragione, ItaNPUD and Harm Reduction International (HRI) welcome the opportunity to submit information to the UN Committee on Economic, Social and Cultural Rights (CESCR) ahead of its review of the periodic report of Italy and the adoption of the List of Issues Prior to Reporting at its 66th session (9th-13th March 2020). Focusing on the right to health, this submission will assess the compatibility of key drug control policies and practices pursued by Italy with its obligations under the International Covenant on Economic, Social, and Cultural Rights (ICESCR), with particular attention to:

- Harm reduction as a fundamental component of the right to health, including availability and accessibility of quality harm reduction services;
- Discrimination in enjoyment of the right to health against vulnerable populations, including prisoners, migrants, refugees, and asylum seekers;
- The right of people who use drugs to access health services;
- The criminalisation of people who use drugs;
- The right of civil society and of people who use drugs to participate in the developing, monitoring, and evaluating of drug policies;

Suggestions for issues to be submitted to the country are included at the end of each paragraph.

1. Background

1.1) Harm reduction as a fundamental component of the right to health

Harm reduction has been recognised as a fundamental component of the right to health, as well as of the right of everyone to enjoy the benefits of scientific progress.¹ Harm reduction has been explicitly endorsed as an essential measure for people who use drugs on numerous occasions by this Committee,² as well as by the UN General Assembly,³ the Human Rights Council,⁴ the Committee on the Rights of the Child,⁵ the Committee on the Elimination of Discrimination against Women,⁶ the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,⁷ and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment.⁸ The World Health Organization (WHO), UNAIDS and UNODC recognise Needle and Syringe Programs (NSPs) and Opioid Substitution Therapy (OST) as key components of an effective HIV and viral hepatitis response for injecting drug use.⁹ These interventions have also been endorsed by the UN General Assembly,¹⁰ the Economic and Social Council,¹¹ and the Commission on Narcotic Drugs (CND). The CND has highlighted the importance of these interventions to meet SDG targets to end AIDS and tuberculosis, and combat hepatitis by 2030.¹²

¹ Among others, see: Paul Hunt, 'Human rights, health, and harm reduction', 8; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover(2010) A/65/255, para. 55; CESCR, Concluding Observations on the combined initial and second periodic reports of Thailand, UN Doc. E/C.12/THA/CO/1-2; CEDAW, Concluding Observations on the combined fourth and fifth periodic reports of Georgia (2014), UN Doc. CEDAW/C/GEO/CO/4-5, para. 31(e); Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, Mission to Poland (2010) A/HRC/14/20/Add.3, para. 86; CESCR, 2016, Concluding Observations on the sixth periodic report of Sweden. UN Doc. E/C.12/SWE/CO/6. For more information, see: International Centre on Human Rights and Drug Policy/UNDP, International Guidelines on Human Rights and Drug Policy

² In E/C.12/RUS/CO/5, E/C.12/LTU/CO/2, E/C.12/EST/CO/2 and E/C.12/UKR/CO/5.

³ In its resolution 65/277.

⁴ In its resolution 12/27.

⁵ See the Committee's general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health.

⁶ In CEDAW/C/GEO/CO/4-5 and CEDAW/C/CAN/CO/8-9.

⁷ In A/65/255.

⁸ In A/HRC/22/53.

⁹ WHO, UNODC and UNAIDS, WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users: 2012 Revision (Geneva, WHO, 2012).

¹⁰ Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS (General Assembly resolution 65/277, annex).

¹¹ Economic and Social Council resolution 2009/6.

¹² CND Resolution 60/8; Promoting measures to prevent HIV and other blood-borne diseases associated with the use of drugs, and increasing financing for the global HIV/AIDS response and for drug use prevention and other drug demand reduction measures (2017)

Other key harm reduction interventions include:

- a. Drug Consumption Rooms (also known as Safe Injecting Sites), healthcare facilities supervised by medical staff, where individuals can safely consume drugs in a non-judgmental environment;¹³
- b. Overdose prevention and reversal.¹⁴ A key instrument is naloxone, an opioid reversal medication proved to be safe, cost-effective, and life-saving.¹⁵ WHO recommends that people likely to witness an opioid overdose (such as peers and family members) have access to naloxone and be instructed in its administration.¹⁶ Take-home naloxone programmes can thus prove essential in reducing overdose-related deaths.

1.2) Drug use in Italy: key trends and developments

There are an estimated 235,000 (223,000-247,000) people who inject drugs in Italy,¹⁷ with an HIV prevalence of 27.7% and a Hepatitis C prevalence of 64.3%.¹⁸ In 2019, The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reported that “a third of the Italian population aged 15-64 years had used a psychoactive substance at least once in their lifetime and 1 in 10 had done so in the last year.”¹⁹

In the past 30 years there has been a significant decrease in opioid overdose-related deaths in the country: from 470 recorded deaths in 1999, to 280 in 2005, to 154 cases in 2010 (a 34.7% decrease from the previous year), to 101 recorded cases in 2015. Among the key reasons for this positive trend were availability of OST and the best practice of take-home naloxone programmes; which have been carried out by harm reduction services since 1995, as part of a comprehensive package of interventions including information, counselling, and peer-support trainings.²⁰

In the past two years, the trend has been reversing, with fatal overdoses increasing both for “unknown substances” and for opioids.²¹ One key reason is the spread of new psychoactive substances, and the growing number of young users, who are less informed on and experienced in how to safely regulate their use, thus being more exposed to risks. According to the Ministry of Interior the number of people deceased for “unknown drugs” increased by 3% in 2018 compared to 2017 (94/334 drug related death in 2018 vs 74/294 in 2017).²²

2) The right to health and harm reduction in Italy

2.1) Institutional framework and implementation

Article 32 of the Italian Constitution acknowledges the right to health of every individual:

“The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent. No one may be obliged to undergo any given health treatment except under the provisions of the law. The law cannot under any circumstances violate the limits imposed by respect for the human person.”

¹³Stone K, Shirley-Beavan S (2018) Global State of Harm Reduction 2018. Harm Reduction International:London, 21

¹⁴<https://harmreduction.org/issues/overdose-prevention/>

¹⁵<https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio>

¹⁶WHO community management of opioid overdose (Recomm 1, pag 9)

¹⁷http://www.emcdda.europa.eu/countries/drug-reports/2019/italy_en

¹⁸EMCDDA Drug Report 2019, http://www.emcdda.europa.eu/edr2019_en,

¹⁹http://www.emcdda.europa.eu/countries/drug-reports/2019/italy/drug-use_en

²⁰ Ronconi S. (eds) (2016), *Preventing opioid overdose deaths. A research on the Italian naloxone distribution model*<https://www.fuoriluogo.it/ricerca/naloxone/naloxone-abstract#.Xd0FNPKjIU>

²¹Relazione annuale al Parlamento sul fenomeno delle tossicodipendenze in Italia anno 2018, <http://www.politicheantidroga.gov.it/it/attivita-e-progetti/relazioni-annuali-al-parlamento/relazione-annuale-al-parlamento-sul-fenomeno-delle-tossicodipendenze-in-italia-anno-2018-dati-2017/>

²²<https://antidroga.interno.gov.it/wp-content/uploads/2019/07/relazione-annuale-2019.pdf>

Law n. 833 of 1978 established the Nation Health System (Servizio Sanitario Nazionale, SSN). This is managed by the Regions, which shall guarantee the right to health as envisioned in the Constitution through a system of healthcare services, totally free or subsidized, all over the country. Each of the 20 Italian Regions – which are responsible for the local health system - can decide and organize their own health systems, provided that these comply with national guidelines and Essential Levels of Assistance (Livelli Essenziali di Assistenza, LEA) defined by the Central Government. LEA are the basic, standard, free treatments and services that must be mandatorily guaranteed to all.²³

Under the SSN, drug services and treatments are guaranteed by National and Regional Public Health Systems (Law n.309/1990), sometimes in agreement with civil society organizations acting as providers. The 600 Public Drug Units present on the Italian territory are responsible for providing OST, Anti-Retroviral Treatment, psychological and social support, and HIV/HCV tests - which are to be guaranteed for free to all people who use drugs (including migrants without regular permission) on a voluntary basis (except for treatment programs as an alternative to prison).

Since 2010, Italy does not have a National Strategy nor a National Action Plan on Drugs. The most recent strategy was developed by the National Drug Agency (Dipartimento Politiche Antidroga, DPA) in 2010, but it was never implemented, as Regions did not agree with the Plan and thus never rolled it out.

In January 2017, also thanks to concerted civil society efforts, harm reduction services and interventions were included in the LEA. In spite of this important progress, as of December 2019 no steps have been taken by the government, the Ministry of Health, or the DPA to guarantee the implementation of these harm reduction-related LEA. Only a few Regions (Piemonte, Toscana, and Emilia Romagna) adopted regional harm reduction LEA, also thanks to the involvement of civil society, organisations of people who use drugs, and health professionals²⁴.

The state is thus failing its institutional duty to ensure that essential health services are implemented on an equitable basis at the national level, which has led to systemic discrimination in the enjoyment of the right to health among people who use drugs living in different Regions (more details below).

Suggestions for List of Issues Prior to Reporting:

- How does the central government plan to respond to the increase in drug-related deaths, both caused by opioids and by unknown/unspecified drugs?
- Which steps is the government taking to adopt a national plan on drugs, to ensure the enjoyment of the right to health is consistent throughout the Italian territory?
- Which steps is the government taking to ensure that harm reduction-related LEA are implemented at the regional and local level?

2.2) Availability and accessibility of harm reduction services

This Committee has identified the availability, accessibility, affordability, and quality of health goods and services as core components of the right to health.²⁵ Accessibility must be ensured on several levels, and it implies a prohibition of discrimination. As clarified by this Committee, “health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.”

Because of institutional failures and practical limitations, the availability and accessibility of drug prevention, drug treatment, and harm reduction services are not equally guaranteed to all people who use drugs in Italy, leading to inequality and discrimination. In particular:

²³ As for migrant people see 2.2

²⁴ The most comprehensive Harm Reduction LEA guidelines have been developed by Regione Piemonte, <https://www.fuoriluogo.it/oltrelacarta/lea-della-rdd-in-piemonte/#.Xd0J2vIKjIU>

²⁵ UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) (11 August 2000), para. 12. UN Doc. E/C.12/2000/4

- *OST and NSPs* have been implemented in Italy since the early 1990s, in response to an ongoing HIV and overdose crisis. Implementation differs by region, with some recording more significant developments than others. According to the latest available data there are 66 needle and syringe programmes in Italy.²⁶ OST, which in Italy is regulated as a form of drug treatment, should be broadly guaranteed, however the EMCDDA reports that OST is only accessed by 30% of potential clients.²⁷ This is below the WHO recommended target of OST coverage which is fixed at 40% of people dependent on opioids.²⁸
- *Drug consumption rooms* (DCR) currently do not exist in Italy– despite sustained advocacy by civil society and a wealth of scientific literature demonstrating their effectiveness²⁹ - as the 2010 Action Plan explicitly excluded any possibility for a DCR experimental protocol.
- *Drug checking* is instrumental in promoting the health, safety, and life of people who use drugs, as it allows them to be informed about the substance they are going to consume. Although drug checking is not explicitly prohibited under Italian law, its implementation remains controversial. After many years of pioneering interventions by civil society and associations of people who use drugs, it is now a stable, legal, and publicly available service, but it is only part of the intervention package in few Regions.³⁰
- *Early Warning System for New Psychoactive Substances (NPS)*³¹ are information-sharing systems whereby information on new substances is collected in real time and shared with relevant entities through a system of alerts.³² This is particularly important as it allows health professionals and people who use drugs to be aware of the composition of new drugs and related harms – thus it is instrumental in preventing drug-related deaths. Although this system exists in Italy, its effectiveness is limited. Harm reduction professionals and people who use drugs report a slow and inaccessible system of information exchange, which limits its potential to protect people who use drugs. This is particularly problematic in a context where overdose-related deaths are now driven by deaths linked to “unspecified drugs.”
- *Take-home naloxone (THN)*: The above-mentioned delay in implementing harm reduction-related LEA is obstructing the implementation of take-home naloxone programmes in the country, thus weakening the potential impact of this strategy in preventing opioid overdose-related deaths.³³

Suggestions for List of Issues Prior to Reporting:

- Which steps is the government taking to ensure availability and accessibility of quality harm reduction services throughout the Italian territory on an equitable basis?
- Which steps is the government taking to develop the harm reduction services system on the basis of the so called “combination intervention” (all available harm reduction services and intervention in an integrated strategy) to guarantee the most effective results in the perspective of safer models of drug use?
- Which steps is the government taking to increase the effectiveness of the Early Warning System on NPS currently in place, with an eye to preventing overdose-related deaths, thus protecting the right to life of people who use drugs?

²⁶Stone K, Shirley-Beavan S (2018) Global State of Harm Reduction 2018. Harm Reduction International: London,

²⁷http://www.emcdda.europa.eu/media-library/infographic-coverage-opioid-substitution-treatment-percent-estimated-high-risk-opioid-users-receiving-intervention-2017-or-most-recent-year-and-20078_en

²⁸https://apps.who.int/iris/bitstream/handle/10665/77969/9789241504379_eng.pdf?sequence=1, 63

²⁹ EMCDDA (2018), *Drug Consumption Rooms. An overview of provision and evidence*, http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms_en

³⁰ Regione Piemonte, <http://baonps.coopalice.net/>

³¹ SNAP <https://ofad.iss.it/2019/07/04/snap-sistema-nazionale-di-allerta-precoce-contro-la-droga/>

³²<http://www.emcdda.europa.eu/thematic-papers/ews>

³³ A national Campaign “Mai senza naloxone (Never without Naloxone) has been organized by a network of CSOs, <http://maisenzanaloxone.fuoriluogo.it>

2.2.a) *Discrimination against migrants, refugees and asylum-seekers who use drugs*

In Italy, registered migrants have the right to access all services provided under the SSN, while migrants without a legal permit have a right to access primary care,³⁴ irrespective of whether they have identification documents.³⁵

As harm reduction and drug treatment are recognised as “primary care”, both legal immigrants and migrants without a legal permit should be able to access Public Drug Units for testing, harm reduction services, and residential treatments. In practice, however, service users and civil society report that many Public Drug Units’ professionals obstruct migrants’ access to services citing bureaucratic reasons;³⁶ and that many residential treatments discriminate against migrants without a regular permit, prioritising Italians or legal immigrants.

The impact of the country’s new immigration policy

Recent amendments to the national immigration and asylum policy (the so-called “Decreti sicurezza”, Safety Laws³⁷) have had a negative impact on the right to health of asylum-seekers and refugees. These laws introduce a more repressive and restrictive regime which is causing, or is expected to cause, many asylum-seekers to lose their temporary regular permit, making them ‘illegal’. As a consequence, they risk expulsion and imprisonment. Service providers believe that the combination of their illegal status and the stigma associated with it will prevent them from accessing essential harm reduction and treatment services because of perceived safety risks.

In addition, as a consequence of the new immigration laws, Municipalities can – and according to anecdotal evidence often do - reject migrants’ requests for registration in the city registry office, which is the bureaucratic condition for accessing most social and health services.

2.2.b) *Discrimination on the basis on regional residence*

Because of the above-mentioned discrepancies in the availability and quality of harm reduction and treatment services between regions, access to these fundamental health services is not guaranteed on an equal basis across the country. The result is a very heterogeneous map and a “harm reduction lottery”, whereby access to a harm reduction service is dependent on the region where one lives. In addition, even among regions where harm reduction systems are in place there is a significant difference with regards to the number of available services, their quality, and their budget.

Notably, harm reduction services were among the first casualties of austerity-related cuts to health and social budgets (which started in 2008 and are ongoing). For example, between 2012 to 2014 the number of NSPs available in the country decreased from 106 to 72, and their coverage decreased from 24% to 15%.³⁸ With regard to funding, by 2014 only 29% of all harm reduction services were considered “stable”, 22% had an estimated ‘life’ of two years, and for 11% this was less than 11 months.

On this point, we wish to recall that that Article 2.1 ICESCR significantly restricts the discretion of states to adopt retrogressive measures impacting on the enjoyment of social, economic and cultural rights, and that “there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible.”³⁹ Human rights mechanisms have conceded that in times of economic crisis austerity measures that impact on the enjoyment of

³⁴Stranieri temporaneamente presenti. Law DLvo 286/98, art. 35.3 (so-called STP Code)

³⁵In case, they can go to a special service (ISI) to receive the STP code to access to hospitals and health services.

³⁶In case of a migrant without an identity document, the STP paper released by the ISI centre doesn’t show the migrant’s photo, and, in some professionals’ opinion, this would be a risk for identification: methadone treatment could be required to more than one service

³⁷<https://www.altalex.com/documents/news/2019/08/06/decreto-sicurezza-bis-ok-conversione>

³⁸ HRI (2017), *Harm reduction investment in the European Union Current spending, challenges and successes. Italy*, https://www.hri.global/files/2017/04/25/HRWreportApril2017_web_1.pdf

³⁹UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) (11 August 2000), para. 32. UN Doc. E/C.12/2000/4

fundamental rights could be inevitable, but clarified that such measures should be temporary, legitimate, necessary, reasonable, and proportionate.⁴⁰

In 2015, 12 out of 20 regions had harm reduction services in place, but only in six were these considered stable. Six regions had no harm reduction services (with the exception of OST, which are available all over the Country) while two regions did not provide data.⁴¹

The main reasons for this alarming disparity is the lack of political commitment and responsibility on drug policies by the national government. Three key factors contributing to this situation are:

- a) The failure to adopt a National Strategy and a National Action Plan on Drugs, discussed in paragraph 2.1;
- b) The failure to carry out an evaluation of outcomes and impact of the national drug policies for the last 19 years, since the last effective National Conference on Drugs was held in 2000.⁴² The lack of an evaluation process deprives decision-makers of evidence-based assessment and contributes to making the political debate on drugs an ideological one, with an increasing shift towards criminalisation and repression instead of human rights and health.
- c) The lack of clear guidelines and standards at the national level on health issues, such as HIV/HCV testing or harm reduction interventions.

As a consequence, there are significant and unjustified differences between local and regional drug services systems and related critical differences in the enjoyment of the right to health by people who use drugs. In addition, the lack of national guidelines on harm reduction interventions increases the risk of overdose deaths and other drug-related harms.

Suggestions for List of Issues Prior to Reporting:

- Which steps is the government taking to carry out an in-depth, evidence-based evaluation of outcomes and impact of the national drug legislation, as well as an analysis of its compliance with Constitutional principles and international human rights obligations?
- Is the government planning to organize a national Conference on Drugs by 2020, according to the national law n.309/90, and guarantee the active participation of all stakeholders and social actors, including professionals, CSOs and organisations of people who use drugs?
- Is the government planning to adopt national standards on harm reduction and health services for people who use drugs? If so, what is the expected timeline for this?
- Please report on budgetary allocations for treatment and harm reduction services at the regional and national level, and on actions undertaken to ensure the protection and promotion of the right to health in compliance with the principles of maximum available resources and prohibition of retrogressive measures;
- Please report on access to essential harm reduction and treatment services by migrants, refugees, asylum seekers and homeless people, and on the actions undertaken to ensure that national immigration policies do not negatively impact on the right to health of these groups.

2.3) Right to health of people who use drugs in prison

According to the Constitution and to national legislation, prisoners retain their right to health while incarcerated, which includes the right to treatment, harm reduction, and preventive health services.

⁴⁰ A/HRC/37/54

⁴¹ *Relazione annuale al Parlamento sul fenomeno delle tossicodipendenze in Italia anno 2016* <http://www.politicheantidroga.gov.it/media/1095/1-relazione-annuale-al-parlamento-2016-sullo-stato-delle-tossicodipendenze-in-italia.pdf>

⁴² For a critical overview of the limits in current Italian drug policies see *Decimo Libro Bianco sulle droghe 2019* (White Book on Drugs Policies), https://www.fuoriluogo.it/pubblicazioni/libro-bianco-droghe/2019-lb/#.Xd0R7_IKIUU

At the international level, it is widely accepted that providing harm reduction services to the general public but not to prisoners is a flagrant violation of international human rights law. This stems from the core obligation to “ensure the right of access to health facilities, goods and services, on a non-discriminatory basis, especially for vulnerable and marginalised groups” and, closely related, the obligation to provide a standard of care that is at least equivalent to that available in the broader community, commonly known as “principle of equivalence.” Denial of these services in prison settings has also been found to contribute to, or even constitute, conditions that meet the threshold of ill-treatment.⁴³

In Italy in 2008, the reform of the Prison Health System abolished the separate health system governed by the Ministry of Justice and established that all health services in prison form part of the National Health System.⁴⁴ This reform aimed to ensure a more effective and equitable implementation of the right to health, as well as consistent standards of quality.

Regrettably, systemic issues remain in practice. Ten years after the reform, the enjoyment of right to health in prison is limited because of: absence of key harm reduction interventions, such as NSPs; significant differences in the standards of quality between prisons; failure to respect the right to privacy and the principle of free and informed consent;⁴⁵ failure to guarantee continuity of care; and often, delays in interventions.⁴⁶

A more general issue is that of overcrowding and poor conditions of detention: in the “pathogen context” of prisons, poor living conditions (in terms of lack of space, adequate food, water and sanitation) increase the risk of contracting diseases.⁴⁷

As mentioned above, people who use drugs in prison should have access to the same services and interventions available in the community, and UN agencies identified a comprehensive package of 15 interventions essential for HIV prevention, treatment and care in closed settings. These include OST, NSP, anti-retroviral treatment, and condom programmes.

In contrast with this, the only harm reduction service currently available to prisoners in Italy is OST, which is provided to those identified as “drug dependent”. Even with regards to OST, civil society reports several issues. Among others:

- a) In the event of withdrawal symptoms, provision of OST is often not timely;
- b) The continuity of care from outside to within the prison and vice versa – or in case of a prison transfer - is often not ensured, or delayed. This is particularly problematic considering that the risk of drug-related death in the first weeks after release from prison is significantly higher than average.⁴⁸
- c) Maintaining the same prescription as outside the prison is not always possible, and maintenance therapy is often lacking in prison. This is problematic for people who have been in a maintenance programme for a long time.

⁴³ Among others, see ^[1] World Health Organization, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* (2009). Human Rights Council. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez (1 February 2013), para. 54. UN Doc A/HRC/22/53; Human Rights Committee. Concluding observations on the seventh periodic report of the Russian Federation (28 April 2015), para. 16. UN Doc. CCPR/C/RUS/CO/7; Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development, U.N. Doc. A/HRC/10/44 (Jan. 14, 2009) (by Manfred Nowak). Para 74; European Court of Human Rights *Wenner v. Germany* App. 62303/13 (1 September 2016).

⁴⁴ Modalità e criteri per il trasferimento al Servizio sanitario nazionale delle funzioni sanitarie, dei rapporti di lavoro, delle risorse finanziarie e delle attrezzature e beni strumentali in materia di sanita' penitenziaria. (GU Serie Generale n.126 del 30-05-2008) <https://www.gazzettaufficiale.it/eli/id/2008/05/30/08A03777/sg>

⁴⁵ A critical issue is the lack of information and consensus on drug tests. See the case of the female prison of Florence, in 2015, where prisoners have been tested in a compulsory way for repressive, not health reasons; the privacy Guarantor denounced the prison department, and won the case, https://www.fuoriluogo.it/rubriche/la-rubrica-di-fuoriluogo-sul-manifesto/solleciano-il-diritto-alla-privacy-vale-anche-in-carcere/#.Xd1Ji_IK1IU

⁴⁶ Rapporto Antigone (2018), La riforma della sanità penitenziaria compie 10 anni: più ombre che luci, <https://www.antigone.it/quattordicesimo-rapporto-sulle-condizioni-di-detenzione/wp-content/uploads/2018/06/XIVrapporto-sulle-condizioni-di-detenzione-riforma-sanita%CC%80-penitenziaria.pdf>

⁴⁷ In 2013 CEDU, European Court of Human Rights condemned Italy for the prisons overcrowding and its consequences on inmates conditions of life and health, Sentenza della Corte Europea dei Diritti dell'Uomo dell'8 gennaio 2013 - Ricorsi nn. 43517/09, 46882/09, 55400/09, 57875/09, 61535/09, 35315/10 e 37818/10 - Torreggiani e altri c. Italia, [https://www.giustizia.it/giustizia/it/mg_1_20_1.wp?facetNode_1=1_2\(2013\)&facetNode_2=0_8_1_85&previousPage=mg_1_20&contentId=SDU810042](https://www.giustizia.it/giustizia/it/mg_1_20_1.wp?facetNode_1=1_2(2013)&facetNode_2=0_8_1_85&previousPage=mg_1_20&contentId=SDU810042)

⁴⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2955973/>

Suggestions for List of Issues Prior to Reporting:

- Please report on the availability, accessibility, and quality of harm reduction services available in detention settings;
- Which steps is the government undertaking to implement the UN comprehensive package of 15 interventions essential for HIV prevention, treatment and care in closed settings? Please provide detailed information on a timeframe and budgetary implications for the implementation of NSPs, anti-retroviral treatment, and condom programmes in prisons;
- Which steps is the government undertaking to ensure continuity of care for people who use drugs, when they enter and leave prison, and when they are transferred from one prison to another?
- Which steps is the government undertaking to combat systemic prison overcrowding?

2.4) Right to access to health services for people who use drugs

From the right to health also descends a right to access quality, evidence-based drug dependence treatment on a voluntary basis. As clarified by the International Guidelines on Human Rights and Drug Policy, such services should be “adequately funded; appropriate for particular vulnerable or marginalised groups; compliant with fundamental rights (such as to privacy, bodily integrity, due process, and freedom from arbitrary detention), and respectful of human dignity.”⁴⁹

2.4.a) Access to HIV and Hepatitis C Virus (HCV) testing and treatment

An early HIV or HCV test is essential from a prevention and treatment perspective. In Italy there are still barriers in accessing HIV and HCV tests for all residents, and especially for people who use drugs and other key populations.

In some cases, patients have to pay a ticket for the tests. Public Drug Units offer tests for free, but the percentage of tested clients is very low, as shown by the data published in the *DPA 2018 Annual Report to the Parliament on Drugs and Drug addiction* (data from 2017): only 38.5% of all Public Drug Units clients are tested for HIV, 19.6% for HBV and 18.8% for HCV.⁵⁰ The 2019 EMCDDA report shows an increase in the percentage of late diagnosis among people who inject drugs, and confirms that Italy is one of EU member states with the highest rates of HIV and HCV among people who inject drugs.⁵¹

More cogent guidelines and efforts by the Health and the Drug systems are thus needed to guarantee people who use drugs access early tests.

Data on access to HCV treatment is not available. While 185,000 people have been treated with the new Directly Acting Antivirals since 2016, the percentage of people who use drugs who have access to treatment is very low compared to the general population (according to anecdotal evidence gathered by health professional and service users, as no official data is available). In the past, people who use drugs were excluded from treatment because of a false belief – driven by stigma – about their problematic compliance, and the fear that they would become re-infected.

The number of people who use drugs accessing HCV treatment has only recently increased, and only in certain regions. The lack of data on HCV transmissions routes among people on DAA treatment in the AIFA National Register (Italian

⁴⁹See 1.2

⁵⁰<http://www.politicheantidroga.gov.it/media/2445/339911.pdf>

⁵¹http://www.emcdda.europa.eu/countries/drug-reports/2019/italy/drug-related-infectious-diseases_en

Drug Agency) however makes it impossible to assess access to therapies by people who use drugs. Moreover, no national program or HCV screening plan aimed at people who use drugs has been implemented.⁵²

2.4.b) Access to liver transplants

Transplants are often essential to save the lives of people with liver pathologies. Although a high percentage of people who use drugs suffer from liver pathologies, they experience discrimination in accessing liver transplants. In particular, local civil society reports that in many (if not most) hospitals, being in methadone treatment represents a serious barrier to accessing a liver transplant.⁵³ Not only is this approach discriminatory, but is also unsupported by the scientific literature, which suggests a case-by-case assessment⁵⁴.

Suggestions for List of Issues Prior to Reporting:

- How is the state planning to confront the rates of HIV and HCV among people who use drugs, which are currently among the highest in Europe?
- Which steps is the government undertaking to increase access to HCV tests and treatment among people who use drugs?
- Which steps is the government undertaking to ensure that access to liver transplants is determined on a case-by-case basis, and that people who use drugs are not discriminated against when accessing this essential treatment?
- Please provide updated, comprehensive and disaggregated data on access to HCV treatment.

2.5) Medical cannabis

The Italian legislation recognizes the therapeutic qualities of cannabis, and regulates the circumstances in which doctors can prescribe it as a form of treatment.⁵⁵

When the therapeutic use of cannabis was first regulated, in 2007, cannabinoids could be prescribed by any physician for virtually any condition if the patient was considered to be resistant to “traditional” medicines. Since 2015, medicinal cannabis can be prescribed to treat specific health conditions, and only when standard therapies appear not to be working. In December 2017, new laws were adopted on medical cannabis, training of health professionals, the reimbursement by the National Health System, among others.⁵⁶

2.5.a) Discrimination in accessibility to and availability of medical cannabis

Because of a lack of clear guidelines at the national level and because the competence for implementation sits with the Regions, access to medical cannabis, and the very health conditions for which this can be prescribed, differ significantly between Regions. This gives rise to a discrimination in access to what is effectively recognized at the domestic level as a treatment/medicine, in violation of accessibility as a central tenet of the right to health.

⁵²http://www.agenziafarmaco.gov.it/sites/default/files/Aggiornamento_dati_Registri_AIFA_DAAs-15-07-2019.pdf

⁵³ AIFS, Italian Association for Liver Studies (a scientific body) on one side recognizes that “studies show that results and compliance are similar” between people on methadone maintenance and the other patients; while also prescribing extraordinary criteria for admission, such as “in depth psychiatric examination which can exclude any personality disorder” and “a very strict control over the methadone therapy”. Such a “special” control is a barrier de facto, which forces physicians towards exclusion of people on methadone maintenance as a “defensive attitude” not to risk a failure, and bring them to privilege other kind of patients https://appaisf.it/wp-content/uploads/2019/01/commissione_trapianto_fegato.pdf

⁵⁴<https://www.nadironlus.org/download/NADIRPOINT2.pdf>; <https://www.sciencedirect.com/science/article/abs/pii/S1527646502000357>

⁵⁵ Decree 98 of 28/04/2007, available at: <http://www.trovanorme.salute.gov.it/norme/detta?id=23064>

⁵⁶ Law. 04/12/2017 nr. 172, art 18 quater

Availability is also impacted by state failures, in a way that negatively affects the enjoyment of the right to health. In the last five years, the use of medical cannabis increased tenfold, from 58.59 Kg in 2014 to 578.46 kg in 2018.⁵⁷ As the Health Minister and the Regions did not plan for such an increase, the national production is currently insufficient. Since 2017, this situation has been creating serious problems for patients, many of which have been forced to stop therapies, sometimes with serious consequences (formal complaints were lodged against the Health System⁵⁸, supported by CSO and patients' organizations.)⁵⁹

2.5.b) Limitations to the research on medical cannabis

The right to health and the right to benefit from scientific progress imply that states should “take legislative and other appropriate measures to ensure that scientific knowledge and technologies and their applications [...] are physically available and financially accessible without discrimination.”⁶⁰ States should also refrain from imposing heavy and unjustified administrative and bureaucratic requirements that unnecessarily hinder or impede research.⁶¹

Since 2015 and after a 12-month pilot project launched by the Ministries of Health, Defence and Agriculture in September 2014, Italy produces CBD-rich inflorescences at a Military Pharmaceutical Institution in laboratories that have received all the necessary certification concerning Good Manufacturing Practice and Active Pharmaceutical Ingredients under the name of FM2 and, more recently, FM1.

On 9 July 2019, the Superior Council on Health recommended that the Minister of Health launch research and clinical trials to demonstrate the effectiveness of cannabis use for therapeutic purposes, and to potentially register it as a medicine. The Minister has not formally responded yet. Research is ongoing in a few University departments, but researchers that have asked to study FM1 have met unjustified bureaucratic hurdles to obtain the material.

Suggestions for List of Issues Prior to Reporting:

- Which steps is the government undertaking to ensure medical cannabis is accessible without discrimination throughout the country?
- Which steps is the government undertaking to ensure availability of medical cannabis to every patient that has been prescribed this treatment in accordance with the law?
- Please provide detailed information on the administrative and bureaucratic requirements in place for conducting scientific research on the therapeutic use of cannabis, and on how these comply with state obligations under the right to benefit from scientific progress.

3) Criminal justice responses to drugs

Proportionality of sentencing is a key tenet of any fair justice system, from which descends that any deprivation of liberty must be lawful, imposed as a measure of last resort, and reasonable. In contrast, the application of punitive laws (criminal or administrative) for drug possession for personal use and non-commercial drug distribution in small quantities among fellow drug users, is disproportionate and discriminatory. Indeed, using punitive laws with respect to drugs unnecessarily infringes upon multiple human rights, including social and economic rights, in a way that undermines objectives of public health and public safety.

In addition, punitive laws are discriminatory because they contribute to the marginalization and discrimination of people who use drugs — a group that historically suffers from social and often state-sanctioned stigma.

⁵⁷http://www.salute.gov.it/portale/temi/p2_6.jsp?lingua=italiano&id=5066&area=sostanzeStupefacenti&menu=organismo

⁵⁸https://www.fuoriluogo.it/forum_droghe/azioni/cannabis-terapeutica-modello-diffida-al-ministero

⁵⁹<https://www.fuoriluogo.it/mappamondo/cannabis-terapeutica-le-associazioni-si-appellano-al-governo>

⁶⁰Guidelines, 2.i

⁶¹HRI submission to CESCR on right to science

In line with this, several human rights mechanisms – including this Committee - have recommended review of drug legislation and decriminalisation of drug use and other minor offences, also with an eye to improve health outcomes.⁶²

3.1) Disproportionate sentencing

The Italian drug law (DPR n. 309/90) envisages harsh penalties for drug-related offences, which appear to be in breach of the principle of proportionality in criminal law. Among others, the punishment for dealing drugs classified as “hard”⁶³ is imprisonment for six to 20 years (Article 73.1, DPR 309/90). The previous minimum punishment for such an offence - eight years’ imprisonment - was recently declared unconstitutional; as a result, the minimum penalty has been reduced. Nevertheless, the maximum penalty remains exceedingly high, taking into account that such penalties are the same established for murder and other violent crimes.⁶⁴

Penalties for minor drug crimes (Article 73.5, DPR n. 309/90) also appear to be disproportionate to the offence, ranging from six months’ to four years’ imprisonment.

As a consequence, Italian prisons are overcrowded with individuals convicted of minor, non-violent crimes and experiencing health problems. In 2018, out of 21,070 persons in prison for drug offences (over 30% of the total prison population), only 940 had been condemned for a violation of Article 74 (dealing at high level), while 14,579 were imprisoned for minor crimes (Article 73), and 16,669 are registered as drug dependent (for more on this refer back to para. 2.3).⁶⁵

3.2) Administrative sanctions

Harsh and disproportionate administrative sanctions are established for drug possession for personal use, such as the suspension of driving licenses and passports. The number of people found guilty of possession for personal use and impacted by these sanctions is enormous (about 40,000 in 2018), and increasing (they were 38,600 in 2017, 32,700 in 2016).⁶⁶ The administrative sanctions can have an extremely negative – and disproportionate – impact on the person’s personal, family, and social life.

⁶²Among others, see: States should stop arbitrary detentions for drug offences, say UN rights experts’ (Statement by the UN Working Group on Arbitrary Detention, 20 March 2019). <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24369&LangID=E>; A/HRC/41/27, para 5; CESCR, Concluding Observations, Philippines, E/C.12/PHL/CO/5-6 (2016), para. 54; A/65/255; Report to the General Assembly by UN Special Rapporteur on the right to health, Anand Grover (2010), A/65/255, para. 72; Report of the United Nations High Commissioner for Human Rights: Study on the impact of the world drug problem on the enjoyment of human rights, 4 September 2015, A/HRC/30/65.

UNAIDS/UNHCR/UNICEF/WFP/UNDP/UNFPA/UN Women/ILO/UNESCO/WHO/IOM/OHCHR, *Joint United Nations Statement on ending discrimination in health care*, 27 June 2017; A/HRC/39/39, paras. 14–17.

⁶³Footnote on distinction between soft and hard and reference legislation

⁶⁴For an in-depth analysis of this issue, see: Series on Legislative Reform of Drug Policies nr.15, August 2011. (How to determine personal use in drug legislation, by GraziaZuffa, <https://www.tni.org/files/download/dlr15.pdf>

⁶⁵*Decimo Libro Bianco sulle droghe 2019* (White Book on Drugs Policies), https://www.fuoriluogo.it/pubblicazioni/libro-bianco-droghe/2019-lb/#.Xd0R7_IKjIU

⁶⁶Ibidem

Suggestions for List of Issues Prior to Reporting:

- Please elaborate on how the current punishments for drug-related offences meet the fundamental principles of fairness and proportionality;
- Is the government planning to adopt and develop scientific evaluation studies on the impact of the criminalization of minor drug use behaviours in terms of social inclusion, human rights respect and social and economic costs/benefits outcomes?
- Please elaborate on how the current administrative sanctions for drug possession for personal use meet the fundamental principles of proportionality and necessity; and on the safeguards put in place by the State to ensure such sanctions do not have a disproportionate impact on the individual's personal and family life, as well as on their socio-economic rights.

3.3) Right to alternatives to imprisonment for people who use drugs

The Italian drug law provides for access to a therapeutic programme as an alternative to imprisonment for persons with a drug dependence if certain conditions are met. In 2018 this possibility, aimed at protecting the right to health of people who use drugs (although problematic in its potential lack of voluntariness), has been offered to 28,000 people.⁶⁷ According to local civil society, access to this alternative is often obstructed by:

- Limitations in the resources available for alternative treatments;
- Excessive delays and slowness of the legal and bureaucratic process (it is not uncommon for prisoners to be released before receiving a response);
- Biases within the judicial process: in case of relapse in drug use, judges often revoke the alternative treatment (almost considering relapse a “new crime”) and rule for imprisonment, thus also preventing the person from continuing the treatment.

Suggestions for List of Issues Prior to Reporting:

- Which steps has the government undertaken, or plans to undertake, to ensure that individuals have access to alternatives to imprisonment as guaranteed by domestic law?
- Provide detailed information and evaluation on the compliance of this form of treatment as an alternative to punishment with the principle of free and informed consent when accessing health services and interventions.

4) The right to participation of communities and civil society

General Comment no. 14 of this Committee stresses that the right to health also requires “the participation of the population in all health-related decision-making at the community, national and international levels”⁶⁸ as well as in the provision of health services.⁶⁹ The International Guidelines on Human Rights and Drug Policy clarify that everyone – and particularly those directly affected – has a right to meaningful participation in the design, implementation, and assessment of drug laws, policies, and practices.⁷⁰ The same recommendation is in the European Strategy on Drugs⁷¹.

⁶⁷ Ibidem

⁶⁸ UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) (11 August 2000), para. 11 and 54. UN Doc. E/C.12/2000/4

⁶⁹ Ibid., Para 17

⁷⁰: International Centre on Human Rights and Drug Policy/UNDP, International Guidelines on Human Rights and Drug Policy (March 2019), General Principle 4

⁷¹<https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A52012XG1229%2801%29>

Italian drug law establishes a National Conference on Drugs which must be organised by the government every three years, with the specific goal of evaluating and, if necessary, reforming the national drug legislation and policies, through a participative process which should engage all relevant stakeholders, including civil society organisations (CSO).

Until 2008 the Health and Social Affairs Ministries organized an annual national Board of Professionals and CSOs, which allowed for CSO participation.

Since 2009, when the DPA was created, the Italian Government has failed to organize this Conference, in spite of its obligation under the law. In 2017 a group of CSOs – including Forum Droghe - presented a formal complaint against the government for failing to convene the Conference.⁷² In 2018, the DPA, in the framework of the reform to the national Observatory on Drugs, introduced the possibility for some CSO to participate (on an ad hoc, not ‘consistent’, basis) in the activities of the Observatory, reserving the right to decide on the rules for CSO selection and involvement. As of December 2019, no dialogue with CSO has been initiated, nor have any decisions been taken about selection and participation criteria. As a consequence, at this stage CSO have no possibility to participate.

The result is that the level of CSO participation in drug policy in Italy is one of the worst in Europe.⁷³ There are exceptions in some Regions, but these are usually limited as CSO are involved only if they are services providers.

With regards to the participation of people who use drugs in drug policy decision-making and evaluation processes, this is almost non-existent.⁷⁴ This is mostly due to (a) the failure to ensure CSO involvement in decision-making processes described above, and (b) stigmatizing attitudes linked to the mainstream drug policy approach based on a repressive and pathologising paradigm. Even when the law clearly allows for a participatory process (such as in the case of National and Regional Health System services, which must be evaluated by the clients/patients⁷⁵), this usually does not involve Public Drug Units clients.

Suggestions for List of Issues Prior to Reporting:

- Which steps is the government undertaking to organize a National Conference on Drugs, in compliance with the national legislation?
- Please elaborate on how the government ensures the meaningful participation of people who use drugs and civil society organizations in the design, implementation, monitoring and evaluation of drug policies and programmes; including in the activities of the national Observatory on drugs.

⁷² <https://ungass2016.fuoriluogo.it/2017/07/31/conferenza-nazionale-sulle-droghe-le-associazioni-diffidano-governo/>

⁷³ A study by the University of Hamburg, in the framework of the European project *Civil Society Involvement in Drug Policy*, *CSI-DP*, evaluated the level of CSOs participation, <https://csidp.eu/assessment/>

⁷⁴ Only in Regione Piemonte (North Italy) a PWUD organization participate at the Harm reduction regional working group.

⁷⁵ Carta dei servizi sanitari pubblici, <http://www.compartosanita.it/cose-la-carta-dei-servizi/>