propaganda about our good doctors ,,calling them,"the candy man,"' or ,"candy land",,which is actually a Veterans Hospital in Tomah Wisconsin,,the good doctor there,, Dr,Houlihan resigned in protest,,stating he was helping veterans with lost limbs,who had chronic physical pain from war,,The consequence of this witch hunt has now reached our VETERANS,who can't even get MEDICINES,,to help relieve their physical pain!!..Another casualty of this ,"war on legitimate pain medicine," was a Dr,name Dr,Ibsen....he was helping what he called ,"narcotic refugee's,",,,because sooo many Dr.s were dropping all their chronic pain patients,,he was picking a lot of them up,,,they all had legitimate causes for the physical pain,,but as you can imagine his quantities of medicines went up..The D.E.A,, pounced on him,arrested him and he is now fighting for his ability to ever feed his family again,,,This is just 2 examples of 100's of Doctors who are targeted by the D.E.A. every year...These are GOOD MEN,,there our doctors,,,No other country in the world prosecutes Doctors for doing their job of helping people in physical pain,,,No other country prosecuted Dr.s,,who has 1 patient who is an ADULT,,who chooses on his/her own to not obey their Doctors orders,and chooses to sell their prescription for money,,,here in the U.S.A...they blame the Doctors for this Adults wrongful behaviour,,,they don't blame the stupid Adult who chooses to use his medicine illegally,,,,they blame the Doctor,,,no other country does this,,,not 1!!!Its not the Doctors fault for an ADULT humanbeing to use their medicine illegally,,but again,,that 1 person out of 1000's who those 1000 use their medicine correctly,,,but we are being blamed and hurt physically for that 1 idiot who uses his medicine illegally,That is like blaming a car manufacturer for a drunk driver..The D.E.A, will twist anything as an excuse to demonize our medicines and anyone who treats us.,,,,Please keep in mind,,not 1 patient of these good doctors ever complained about their Doctors,,not 1....It was a disgruntled employee's who claimed some sorta wrong doing,,,not any patient..This is the reality here in the U.S.A.,,but the terrible consequences of this D.E.A, witch hunt is 1000's of us chronic pain humanbeings are being forced to endure pain,suffering,imprisonment and death,and our government does not care to actually stop the witch hunt.The D.E.A. will claim its not there fault,but it is there fault,,None of this was happening until the D.E.A. started arresting legitimate Doctors,,By the D.E.A. living in this illusion,thus denial,that its not there fault,the assault continues every day here.If you ask ANY pain management Doctor here,,they will tell you ,they fear the assault from the D.E.A...

The documents included in this complaint hopefully will help all of you understand how bad it has become here.You can further look for yourselves on the internet..As far as some of the documents I got off the internet,,,its not the media article I copied them for,,,I copied them for the ,"comments," by humanbeings with chronic pain,,Their comments are heartbreaking,,,,if you don't shed some tears reading them,,then u have no business being in humane rights,,,,there aweful,their heartbreaking and their the cruel reality that has come to all chronic pain people,,,, in America,,Hopefully with your superior understanding of human rights, you will be able to speak to those who participated in theD.E.A. Governments meetings,and ask the 90% of people who voted against any ,"new" laws against our medicines,,but again the D.E.A. did not honor the 90% and put their own ,"new" laws against chronic pain patients,,,this document is included in our complaint,and theD,E.A. will not give these names out to the public.Despite being governed by the people.Now anyone on opiate medicines now

have to see their doctors every 90 days,some have to see their doctors every 30 days,,,its seems minor,,but those of them living at the poverty line, cannot afford 3 visits,or 12 visits,,at 2,000 a piece,,,when your deductibles for insurance is 7,000,,,its money we don't have,,,now we can opt out,,but we have to give all our private medical history to the D.E.A,,,90% of all chronic pain patients voted against this ,"new" law,,,but our government did not care,,and passed it anyways,,,now we will be with-out our medicines again,because if we don't comply,no medicine,,It use to be 1nce a year,,,that we can barely afford,,,This is just 1 of 100's new ideas put into law the D.E.A,,,has come up with..The huge elephant in the room here,,is the D.E.A,,,are NOT doctors,,,,yet they are now controlling all aspects of our medicines,with propaganda,our doctors, with fear of imprisonment,our pharmacies with prison,ie fear,,,,,,In the state of Florida certain pharmacies will not fill any opiate medicines,,This is why,when it comes to MEDICINES,only DOCTORS not government agencies,,only doctors should make decisions on medical issues.
The bottom line here are people,good people are dying,suffering,enduring physical pain cruelly,which is conscidered torturous,,,,when there are medicines that have worked for 100's of years,,,Medicines,,, not terrible street drugs,,,,Medicines designed to help people stop cruel suffering from the physical pain,,,but this is no-longer happening in America!!What the D.E.A,, under Michele Leonhart lacks in compassion she makes up with cruelty and torture.She brings only suffering and death.She is totally unworthy of this position in a civilized world..We the good people of America have attempted to reason w/the Michele Leonhart to no avail..just more tortuous physical pain..The D.E.A's ideology of ,"war on drugs," has created a long line of human abuses from this agency,and we,the good people in chronic pain are the ;latest victims of this D.E,A. ideology,,,they have abused human rights before,,and they will continue to do so,,unless they are stopped,,The D.E.A is writing all kinds of ,"new" rules against the use of pain management MEDICINES,but no-one is writing laws to protect those of us who need those MEDICINES,nor are there laws protecting the doctors who help us..Laws like no Doctor can be held legally responsible for what their ADULT patient does illegally w/those medicine,,or a law stating we chronic pain people have a legal right to no forced pain and suffering and the legal right to opiate MEDICINES without infringements .If u put such restriction on insulin for diabetics they too would be dying.This is the D.E.A'S fault,100 %%and that is where this needs to start..Please help us,,before 1 more good person has to choose death,as their only means of stopping their physical pain,,

Joint Submission on Controlled Medicines Policy and Human Rights

Office of the High Commissioner for Human Rights

May 2015

In response to your letter of April 16, 2015, we are pleased to make the following submission to the Office of the High Commissioner of Human Rights (OHCHR) for consideration in the preparation of the study mentioned in Resolution A/HRC/28/L.22 for the UN General Assembly Special Session on the World Drug Problem.

As organizations active in the field of palliative care, our submission focuses on the need for countries to ensure people have access to controlled substances for medical purposes. As you may know, controlled substances play a critical role in the provision of healthcare around the world. At present, 12 medicines that are made of or contain controlled substances are on the World Health Organization (WHO) Model List of Essential Medicines which are used such diverse fields of medicine as analgesia, anesthesia, drug dependence, maternal health, mental health, neurology, and palliative care. In this submission we focus on access to opioid analgesics for pain management and palliative care.

The Human Rights Council (HRC) resolution recalls the international drug control conventions and notes the "need to promote adequate availability of internationally controlled narcotic drugs and psychotropic substances for medical and scientific purposes," echoing a core objective of the UN drug conventions. Under both the international drug control conventions and international human rights law, countries have a legal obligation to ensure patients with a medical need for these medicines have access to them.

A wealth of research from countries around the world, however, suggests that controlled substance regulations often interfere with the availability and accessibility of this group of medicines, especially strong analgesics. Regulations are frequently far more restrictive than required by the UN drug conventions, deterring their use. These kinds of regulations raise important questions about the fulfillment by countries of their obligations under the right to health as well as the obligation to protect individuals from exposure to cruel, inhuman, or degrading treatment.

Background

With life expectancy increasing worldwide, the prevalence of non-communicable diseases (NCDs), such as cancer, lung, and heart disease, is rising rapidly.[1] These and other chronic illnesses are often accompanied by pain and other distressing symptoms.[2] Palliative care focuses on relieving these symptoms and ensuring that people with life-limiting illnesses and their loved-ones can enjoy the best possible quality of life throughout the course of their disease up until their last moments.

An important aspect of palliative care is addressing chronic, severe pain. Pain has a profound impact on quality of life and can have physical, psychological, and social consequences. It can lead to reduced mobility and consequent loss of strength; compromise the immune system; and interfere with a person's ability to eat, concentrate, sleep, or interact with others.[3]

Most pain in palliative care patients can be controlled well.[4] The mainstay medication for the treatment of moderate to severe pain is morphine, an inexpensive opioid that is made of an extract of the poppy plant. For moderate to severe pain, the WHO has recognized that strong opioids, such as morphine, are "absolutely necessary".[5]

Human Rights Standards

The obligation of states to respect, protect, and fulfill the right to health includes an obligation to ensure access to pain medicines and palliative care.[6] Notably, the United Nations Committee on Economic, Social and Cultural Rights has identified providing essential medicines, as defined by the WHO, as a core obligation under the right to health.[7] The WHO has included morphine in its Model List of Essential Medicines, a list of the medications that should be available to all persons who need them, since it was first established.[8] The right to be free from torture, cruel, inhuman, or degrading treatment or punishment also creates a positive obligation for states to protect persons in their jurisdiction from unnecessary pain related to a health condition.[9]

In 2008, the U.N. Special Rapporteur on The Right to the Highest Attainable Standard of Health and the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment jointly recognized that a failure to address barriers to palliative care and pain treatment can be a violation of human rights:

> The failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to protection against cruel, inhuman and degrading treatment. International human rights law requires that governments must provide essential medicines—which include, among others, opioid analgesics—as part of their minimum core obligations under the right to health.[10]

Since 2008, there has been an increasing body of statements supporting the right to pain treatment and palliative care, including statements by the Committee on Economic, Social and Cultural Rights,[11] the Committee on the Elimination of all Forms of Discrimination Against Women,[12] and the Committee on the Rights of the Child.[13]

In 2011, in her opening statements at the Human Rights Council Panel on the Right to Health of Older Persons, Navi Pillay, the UN High Commissioner on Human Rights stated: "Adequate access to palliative care is essential to ensure that these people can live and—ultimately—die with dignity."[14] In that same year, in the Report of the Secretary General on the rights of older persons, the Secretary General noted: "The challenges to Member States, particularly low- and middle-income countries, include: ... [a] lack of specific measures to avoid pain and provide palliative care that allow the terminally ill to die with dignity."[15]

Impact of Controlled Substance Regulations on Access to Palliative Care and Pain Treatment

Opioid pain medicines are subject to control under the 1961 Single Convention on Narcotic Drugs.[16] Under the system set up by the Single Convention, states must monitor and regulate their distribution and use.[17]

Under international human rights law and drug control treaties, however, countries have a dual obligation with respect to these medicines: They must ensure their adequate availability for medical and scientific use while preventing their misuse and diversion.[18] The 1961 Convention specifically declares the medical use of narcotic drugs indispensable for the relief of pain and requires their adequate availability.[19]

As noted, however, despite the obligations outlined above, many states fail to properly ensure the availability of opioid pain medicines. According to the International Narcotics Control Board (INCB)—the body responsible for monitoring the 1961 Convention— "approximately 5.5 billion people, or three quarters of the world's population, live in countries with... inadequate access to treatment for moderate to severe pain...."[20] Due to limited access to essential medicines, the WHO estimates that tens of millions of people around the world, including around 5.5 million end-stage cancer patients and one million people with AIDS, suffer from moderate to severe pain each year without treatment.[21]

One reason for the limited availability of opioid pain medicines is the failure of countries to strike a balance between ensuring the availability of controlled medicines for legitimate purposes and preventing their abuse and diversion. Indeed, many states severely restrict access through onerous regulations.[22] In a 2011 discussion paper, the UN Office on Drugs and Crime enumerated the following examples of regulations that, among others, may impede medicines availability and are not required by international drug conventions:

> (a) Limitations on the number of days' supply that may be provided in a single prescription (with too short a period of time allowed);
> (b) Limitations on doses that may be prescribed in a single prescription (with allowed doses being too low);
> (c) Excessive limitations on prescription authority, such as only to some categories of medical doctors;
> (d) Special prescription procedures for opioids, for example, the use of specific prescription forms, which may be difficult to obtain....[23]

These unduly strict regulations frequently create complex procedures for procuring, stocking, and dispensing opioid pain medicines. The result is that pharmacies and health facilities do not procure or stock opioid pain medicines; doctors are deterred from prescribing them; and obtaining opioids is so impractical that patients cannot realistically hope to obtain a sufficient, continuous supply. Where these regulations unnecessarily impede the procurement and dispensing of these medications for medical purposes, they are incompatible with the right to health.

In our organizations' work, we routinely see the impact of these regulatory restrictions on patients. Human Rights Watch, for example, has found that people with untreated severe pain often describe their pain in exactly same terms as victims of torture—that is, as so intense that they would do anything to make it stop. These individuals often want to commit suicide to end the pain, pray for death, or tell doctors or relatives that they want to die.[24]

***

We respectfully urge OHCHR to include access to opioid analgesics for pain management and palliative care in its study, giving voice to the millions of people who require controlled medicines for the relief of pain and suffering.

African Palliative Care Association
Asia Pacific Hospice Palliative Care Network
European Association for Palliative Care
Hospice Palliative Care Association of South Africa
Human Rights Watch
International Association for Hospice and Palliative Care
International Children's Palliative Care Network
Kenya Hospice and Palliative Care Association
Latin American Palliative Care Association
Pallium India
Union for International Cancer Control
Worldwide Hospice and Palliative Care Alliance

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[1] UNDESA Population Division, "World Population Prospects: The 2012 Revision," 2013, p. 4 http://esa.un.org/wpp/Documentation/pdf/WPP2012_%20KEY%20FINDINGS.pdf (accessed March 31, 2015).

[2] Katrien Moens, MSC, et al., "Are There Differences in the Prevalence of Palliative Care-Related Problems in People Living With Advanced Cancer and Eight Non-Cancer Conditions? A Systematic Review," *Journal of Pain and Symptom Management*, vol. 48, No. 4, (2014), pp. 667-669.

[3] F. Brennan, D.B. Carr, and M.J. Cousins, "Pain Management: A Fundamental Human Right," *Anesthesia & Analgesia*, vol. 105, no. 1 (2007), pp. 205-221.

[4] WHO, "Achieving Balance in Opioid Control Policy: Guidelines for Assessment," 2000, p. 1, http://whqlibdoc.who.int/hq/2000/who_edm_qsm_2000.4.pdf (accessed April 28, 2014).

[5] Ibid.

[6] International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993; Convention on the Rights of the Child, adopted Nov. 20, 1989, G.A. Res. 44/25, Annex, 44 U.N. GAOR, Supp. No. 49, U.N. Doc. A/44/49, at 167 (Sept. 2, 1990); Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, G.A. Res. 34/180, 34 U.N. GAOR, Supp. No. 46, U.N. Doc. A/34/46, at 193 (Sept. 3, 1981); International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, G.A. Res. 61/106, Annex, U.N. GAOR, 61st Sess., Supp. No. 49, U.N. Doc. A/61/49, at 65, entered into force May 3, 2008.

[7] UN Committee on Economic, Social and Cultural Rights, "Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights," General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000), para. 43, http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument (accessed April 28, 2014).

[8] WHO, "WHO Model List of Essential Medicines: 18th list," April 2013, http://apps.who.int/iris/bitstream/10665/93142/1/EML_18_eng.pdf?ua=1 (accessed March 31, 2015).

[9] Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, A/HRC/22/53, February 1, 2013, para. 54, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf (accessed April 28, 2015); International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, art. 7; Universal Declaration of Human Rights (UDHR), adopted December 10, 1948, G.A. Res. 217A(III), U.N. Doc. A/810 at 71 (1948); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, art. 16.

[10] United Nations Special Rapporteur on the Prevention of Torture and Cruel, Inhuman, or Degrading Treatment or Punishment & Special Rapporteur on Right of Everyone to the Highest Attainable Standard of Physical and Mental Health, "Letter to Chairperson of the Commission on Narcotic Drugs," U.N. Doc. G/SO 214 (52-21) (Dec. 10, 2008), p. 4, http://www.hrw.org/sites/default/files/related_material/12.10.2008%20Letter%20to%20CND%20fromSpecial%20Rapporteurs.pdf (accessed April 28, 2015).

[11] UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, November 8, 2000, para. 34.

[12] UN Committee on the Elimination of Discrimination Against Women (CEDAW), General recommendation No. 27 on older women and protection of their human rights, CEDAW/C/GC/27, December 16, 2010, para. 45, http://www2.ohchr.org/english/bodies/cedaw/docs/CEDAW-C-2010-47-GC1.pdf (accessed April 28, 2015).

[13] UN Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), CRC/C/GC/15, April 17, 2013, para. 25, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f15&Lang=en (accessed April 28, 2015).

[14] UN Office of the High Commissioner for Human Rights (OHCHR), Opening Statement by Ms. Navi Pillay United Nations High Commissioner for Human Rights : Geneva (September 13, 2011), http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=11531&LangID=E (accessed April 28, 2015).

[15] Report of the Secretary General, Social development: follow-up to the International Year of Older Persons: Second World Assembly on Ageing, A/66/173, July 22, 2011, http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/428/83/PDF/N1142883.pdf?OpenElement (accessed April 28, 2015).

[16] United Nations Economic and Social Council (ECOSOC), "Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961," https://www.unodc.org/documents/commissions/CND/Int_Drug_Control_Conventions/Ebook/The_International_Drug_Control_Conventions_E.pdf (accessed March 31, 2015).

[17] Ibid.

[18] INCB, "Report of the International Narcotics Control Board on the Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes," 2011, http://www.incb.org/documents/Publications/AnnualReports/AR2010/Supplement-AR10_availability_English.pdf (access July 11, 2014); INCB, "Availability of Opiates for Medical Needs: Report of the International Narcotics Control Board for 1995," http://www.incb.org/pdf/e/ar/1995/suppl1en.pdf (accessed June 28, 2014), p. 1.

[19] ECOSOC, "Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961," preamble.

[20] INCB, "Report 2014," March 3, 2015, p. 3, https://www.incb.org/documents/Publications/AnnualReports/AR2014/English/AR_2014.pdf (accessed March 23, 2015).

[21] WHO Briefing Note, "Access to Controlled Medications Programme," April 2012, http://www.who.int/medicines/areas/quality_safety/ACMP_BrNote_Genrl_EN_Apr2012.pdf?ua=1 (accessed March 31, 2015).

[22] WHO and World Hospice and Palliative Care Association, "Global Atlas of Palliative Care at the End of Life," p. 28, http://www.who.int/nmh/Global_Atlas_of_Palliative_Care.pdf (accessed April 28, 2015); Pain and Policy Studies Group, University of Wisconsin School of Medicine and Public Health, "Improving Global Opioid Availability for Pain & Palliative Care: A Guide to a Pilot Evaluation of National Policy," http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/Global%20evaluation%202013.pdf (accessed April 28, 2015).

[23] Commission on Narcotic Drugs, Discussion Paper, Ensuring availability of controlled medications for the relief of pain and preventing diversion and abuse: Striking the right balance to achieve the optimal public health outcome, E/CN.7/2011/CRP.3, March 17, 2011, para. 37, http://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_54/4_CRPs/E-CN7-2011-CRP3_V1181366_E.pdf (accessed April 28, 2015).

[24] Human Rights Watch Report, "Please, Don't Make Us Suffer Anymore...," (New York: Human Rights Watch, 2009), http://www.hrw.org/sites/default/files/reports/health0309webwcover_1.pdf

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Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez

Summary

The present report focuses on certain forms of abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment. It identifies the policies that promote these practices and existing protection gaps.

By illustrating some of these abusive practices in health-care settings, the report sheds light on often undetected forms of abusive practices that occur under the auspices of health-care policies, and emphasizes how certain treatments run afoul of the prohibition on torture and ill-treatment. It identifies the scope of State's obligations to regulate, control and supervise health-care practices with a view to preventing mistreatment under any pretext.

The Special Rapporteur examines a number of the abusive practices commonly reported in health-care settings and describes how the torture and ill-treatment framework applies in this context. The examples of torture and ill-treatment in health settings discussed likely represent a small fraction of this global problem.

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I. Introduction

1. The present report is submitted to the Human Rights Council in accordance with Council resolution 16/23.

2. Reports of country visits to Tajikistan and Morocco are contained in documents A/HRC/22/53/Add.1 and Add.2, respectively. A/HRC/22/53/Add.3 contains an update on follow-up measures and A/HRC/22/53/Add.4 contains observations made by the Special Rapporteur on some of the cases reflected in the communication reports A/HRC/20/30, A/HRC/21/49 and A/HRC/22/67.

II. Activities of the Special Rapporteur

A. Upcoming country visits and pending requests

3. The Special Rapporteur plans to visit Bahrain in May 2013 and Guatemala in the second half of 2013 and is engaged with the respective Governments to find mutually agreeable dates. The Special Rapporteur has accepted an invitation to visit Thailand in February 2014. He also notes with appreciation an outstanding invitation to visit Iraq.

4. The Special Rapporteur has reiterated his interest to conduct country visits to a number of States where there are pending requests for invitations: Cuba; Ethiopia; Ghana; Kenya; United States of America; Uzbekistan; Venezuela (Bolivarian Republic of) and Zimbabwe. The Special Rapporteur has also recently requested to visit Chad, Côte d'Ivoire, Dominican Republic, Georgia, Mexico and Viet Nam.

B. Highlights of key presentations and consultations

5. On 10 September 2012, the Special Rapporteur participated in a Chatham House event in London hosted by REDRESS on "Enforcing the absolute prohibition against torture".

6. On 26 September 2012, the Special Rapporteur met the Director General of the National Human Rights Commission of the Republic of Korea, who was visiting Washington D.C.

7. Between 22 and 24 October 2012, the Special Rapporteur presented his interim report (A/67/279) to the General Assembly and participated in two side events: one, held at the Permanent Mission of Denmark to the United Nations in New York, on "Reprisals against victims of torture and other ill-treatment" and the other organized jointly with the World Organisation Against Torture, Penal Reform International, the Centre for Constitutional Rights and Human Rights Watch on "The death penalty and human rights: the way forward". He also met with representatives of the Permanent Missions of Guatemala and Uruguay.

8. On 17 November 2012, the Special Rapporteur participated in a symposium organized by New York University on the practice of solitary confinement, entitled "Solitary: wry fancies and stark realities".

9. From 2 to 6 December 2012, the Special Rapporteur conducted a follow-up visit to Uruguay (A/HRC/22/53/Add.3), at the invitation of the Government, to assess improvements and identify remaining challenges regarding torture and other cruel, inhuman or degrading treatment or punishment.

10. From 13 to 14 December 2012, the Special Rapporteur convened an expert meeting on "Torture and ill-treatment in healthcare settings" at the Center for Human Rights and Humanitarian Law, American University in Washington, DC.

III. Applying the torture and ill-treatment protection framework in health-care settings

11. Mistreatment in health-care settings[1] has received little specific attention by the mandate of the Special Rapporteur, as the denial of health-care has often been understood as essentially interfering with the "right to health".

12. While different aspects of torture and ill-treatment in health-care settings have been previously explored by the rapporteurship and other United Nations mechanisms, the Special Rapporteur feels that there is a need to highlight the specific dimension and intensity of the problem, which often goes undetected; identify abuses that exceed the scope of violations of the right to health and could amount to torture and ill-treatment; and strengthen accountability and redress mechanisms.

13. The Special Rapporteur recognizes that there are unique challenges to stopping torture and ill-treatment in health-care settings due, among other things, to a perception that, while never justified, certain practices in health-care may be defended by the authorities on grounds of administrative efficiency, behaviour modification or medical necessity. The intention of the present report is to analyse all forms of mistreatment premised on or attempted to be justified on the basis of health-care policies, under the common rubric of their purported justification as "health-care treatment", and to find cross-cutting issues that apply to all or most of these practices.

A. Evolving interpretation of the definition of torture and ill-treatment

14. Both the European Court of Human Rights (ECHR) and the Inter-American Court of Human Rights have stated that the definition of torture is subject to ongoing reassessment in light of present-day conditions and the changing values of democratic societies.[2]

15. The conceptualization of abuses in health-care settings as torture or ill-treatment is a relatively recent phenomenon. In the present section, the Special Rapporteur embraces this ongoing paradigm shift, which increasingly encompasses various forms of abuse in health-care settings within the discourse on torture. He demonstrates that, while the prohibition of torture may have originally applied primarily in the context of interrogation, punishment or intimidation of a detainee, the international community has begun to recognize that torture may also occur in other contexts.

16. The analysis of abuse in health-care settings through the lens of torture and ill-treatment is based on the definition of these violations provided by the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its authoritative interpretations. In order to demonstrate how abusive practices in health-care

[1] Health-care settings refers to hospitals, public and private clinics, hospices and institutions where health-care is delivered.

[2] World Organization Against Torture (OMCT), *The Prohibition of Torture and Ill-treatment in the Inter-American Human Rights System: A Handbook for Victims and Their Advocates* (2006), p. 107, citing Inter-American Court of Human Rights, *Cantoral-Benavides* v. *Peru*, Series C, No. 69 (2000) para. 99; ECHR, *Selmouni* v. *France*, Application No. 25803/94 (1999), para. 101.

settings meet the definition of torture, the following section provides an overview of the main elements of the definition of torture.

B. Applicability of the torture and ill-treatment framework in health-care settings

1. Overview of key elements of the definition of torture and ill-treatment

17. At least four essential elements are reflected in the definition of torture provided in article 1, paragraph 1, of the Convention against Torture: an act inflicting severe pain or suffering, whether physical or mental; the element of intent; the specific purpose; and the involvement of a State official, at least by acquiescence (A/HRC/13/39/Add.5, para. 30). Acts falling short of this definition may constitute cruel, inhuman or degrading treatment or punishment under article 16 of the Convention (A/63/175, para. 46). The previous Special Rapporteurs have covered in great detail the main components of the definition of torture. Nevertheless, there are a few salient points worth elaborating for the purpose of the present report.

18. The jurisprudence and authoritative interpretations of international human rights bodies provide useful guidance on how the four criteria of the definition of torture apply in the context of health-care settings. ECHR has noted that a violation of article 3 may occur where the purpose or intention of the State's action or inaction was not to degrade, humiliate or punish the victim, but where this nevertheless was the result.[3]

19. The application of the criteria of severe pain or suffering, intent, and involvement of a public official or other person acting in an official capacity, by consent or acquiescence to abuses in health-care settings, is relatively straightforward. The criterion of the specific purpose warrants some analysis.[4]

20. The mandate has stated previously that intent, required in article 1 of the Convention, can be effectively implied where a person has been discriminated against on the basis of disability. This is particularly relevant in the context of medical treatment, where serious violations and discrimination against persons with disabilities may be defended as "well intended" on the part of health-care professionals. Purely negligent conduct lacks the intent required under article 1, but may constitute ill-treatment if it leads to severe pain and suffering (A/63/175, para. 49).

21. Furthermore, article 1 explicitly names several purposes for which torture can be inflicted: extraction of a confession; obtaining information from a victim or a third person; punishment, intimidation and coercion; and discrimination. However, there is a general acceptance that these stated purposes are only of an indicative nature and not exhaustive. At the same time, only purposes which have "something in common with the purposes expressly listed" are sufficient (A/HRC/13/39/Add.5, para. 35).

22. Although it may be challenging to satisfy the required purpose of discrimination in some cases, as most likely it will be claimed that the treatment is intended to benefit the "patient", this may be met in a number of ways.[5] Specifically, the description of abuses

[3] See *Peers v. Greece*, Application No. 28524/95 (2001), paras. 68, 74; *Grori v. Albania*, Application No. 25336/04 (2009), para. 125.

[4] Open Society Foundations, *Treatment or Torture? Applying International Human Rights Standards to Drug Detention Centers* (2011), p. 10.

[5] Ibid., p. 12.

outlined below demonstrates that the explicit or implicit aim of inflicting punishment, or the objective of intimidation, often exist alongside ostensibly therapeutic aims.

2. The scope of State core obligations under the prohibition of torture and ill-treatment

23. The Committee against Torture interprets State obligations to prevent torture as indivisible, interrelated, and interdependent with the obligation to prevent cruel, inhuman, or degrading treatment or punishment (ill-treatment) because "conditions that give rise to ill-treatment frequently facilitate torture".[6] It has established that "each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm".[7]

24. Indeed, the State's obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, health-care professionals and social workers, including those working in private hospitals, other institutions and detention centres (A/63/175, para. 51). As underlined by the Committee against Torture, the prohibition of torture must be enforced in all types of institutions and States must exercise due diligence to prevent, investigate, prosecute and punish violations by non-State officials or private actors.[8]

25. In *da Silva Pimentel* v. *Brazil*, the Committee on the Elimination of Discrimination against Women observed that "the State is directly responsible for the action of private institutions when it outsources its medical services" and "always maintains the duty to regulate and monitor private health-care institutions".[9] The Inter-American Court of Human Rights addressed State responsibility for actions of private actors in the context of health-care delivery in *Ximenes Lopes* v. *Brazil*.[10]

26. Ensuring special protection of minority and marginalized groups and individuals is a critical component of the obligation to prevent torture and ill-treatment. Both the Committee against Torture and the Inter-American Court of Human Rights have confirmed that States have a heightened obligation to protect vulnerable and/or marginalized individuals from torture, as such individuals are generally more at risk of experiencing torture and ill-treatment.[11]

C. Interpretative and guiding principles

1. Legal capacity and informed consent

27. In all legal systems, capacity is a condition assigned to agents that exercise free will and choice and whose actions are attributed legal effects. Capacity is a rebuttable

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[6] General comment No. 2 (2007), para. 3.

[7] Ibid., para. 15.

[8] General comment No. 2, paras. 15, 17 and 18. See also Committee against Torture, communication No. 161/2000, *Dzemajl et al.* v. *Serbia and Montenegro*, para. 9.2; Human Rights Committee, general comment No. 20 (1992), para. 2.

[9] Communication No. 17/2008, para. 7.5.

[10] Inter-American Court of Human Rights. (Series C) No. 149 (2006), paras. 103, 150; see also Committee on the Elimination of Discrimination against Women, general recommendation No. 19 (1992), para. 9.

[11] Committee against Torture, general comment No. 2, para. 21; *Ximenes Lopes* v. *Brazil*, para. 103.

presumption; therefore, "incapacity" has to be proven before a person can be designated as incapable of making decisions. Once a determination of incapacity is made, the person's expressed choices cease to be treated meaningfully. One of the core principles of the Convention on the Rights of Persons with Disabilities is "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons" (art. 3 (a)). The Committee on the Rights of Persons with Disabilities has interpreted the core requirement of article 12 to be the replacement of substituted decision-making regimes by supported decision-making, which respects the person's autonomy, will and preferences.[12]

28. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health observed that informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision. Guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services (A/64/272, para. 18).

29. As the Special Rapporteur on the right to health observed, while informed consent is commonly enshrined in the legal framework at the national level, it is frequently compromised in the health-care setting. Structural inequalities, such as the power imbalance between doctors and patients, exacerbated by stigma and discrimination, result in individuals from certain groups being disproportionately vulnerable to having informed consent compromised (ibid., para. 92).

30. The intimate link between forced medical interventions based on discrimination and the deprivation of legal capacity has been emphasized both by the Committee on the Rights of Persons with Disabilities and the previous Special Rapporteur on the question of torture.[13]

2. Powerlessness and the doctrine of "medical necessity"

31. Patients in health-care settings are reliant on health-care workers who provide them services. As the previous Special Rapporteur stated: "Torture, as the most serious violation of the human right to personal integrity and dignity, presupposes a situation of powerlessness, whereby the victim is under the total control of another person."[14] Deprivation of legal capacity, when a person's exercise of decision-making is taken away and given to others, is one such circumstance, along with deprivation of liberty in prisons or other places (A/63/175, para. 50).

32. The mandate has recognized that medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned (ibid., paras. 40, 47). This is particularly the case when intrusive and irreversible, non-consensual treatments are performed on patients from marginalized groups, such as persons with disabilities, notwithstanding claims of good intentions or medical necessity. For example, the mandate has held that the discriminatory character of forced psychiatric interventions, when committed against persons with psychosocial disabilities, satisfies both intent and purpose required under the article 1 of the Convention against Torture, notwithstanding claims of "good intentions" by medical professionals (ibid., paras. 47, 48). In other examples, the administration of non-consensual medication or involuntary

[12] See CRPD/C/ESP/CO/1.

[13] Convention on the Rights of Persons with Disabilities, art. 25 (d); see also CRPD/C/CHN/CO/1 and Corr.1, para. 38; A/63/175, paras. 47, 74.

[14] A/63/175, para. 50.

sterilization is often claimed as being a necessary treatment for the so-called best interest of the person concerned.

33. However, in response to reports of sterilizations of women in 2011, the International Federation of Gynecology and Obstetrics emphasized that "sterilization for prevention of future pregnancy cannot be ethically justified on grounds of medical emergency. Even if a future pregnancy may endanger a woman's life or health, she ... must be given the time and support she needs to consider her choice. Her informed decision must be respected, even if it is considered liable to be harmful to her health."[15]

34. In those cases, dubious grounds of medical necessity were used to justify intrusive and irreversible procedures performed on patients without full free and informed consent. In this light, it is therefore appropriate to question the doctrine of "medical necessity" established by the ECHR in the case of *Herczegfalvy* v. *Austria* (1992),[16] where the Court held that continuously sedating and administering forcible feeding to a patient who was physically restrained by being tied to a bed for a period of two weeks was nonetheless consistent with article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms because the treatment in question was medically necessary and in line with accepted psychiatric practice at that time.

35. The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings. It is therefore important to clarify that treatment provided in violation of the terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine.

3. Stigmatized identities

36. In a 2011 report (A/HRC/19/41), the United Nations High Commissioner for Human Rights examined discriminatory laws and practices and acts of violence against individuals based on sexual orientation and gender identity in health-care settings. She observed that a pattern of human rights violations emerged that demanded a response. With the adoption in June 2011 of resolution 17/19, the Human Rights Council formally expressed its "grave concern" regarding violence and discrimination based on sexual orientation and gender identity.

37. Many policies and practices that lead to abuse in health-care settings are due to discrimination targeted at persons who are marginalized. Discrimination plays a prominent role in an analysis of reproductive rights violations as forms of torture or ill-treatment because sex and gender bias commonly underlie such violations. The mandate has stated, with regard to a gender-sensitive definition of torture, that the purpose element is always fulfilled when it comes to gender-specific violence against women, in that such violence is inherently discriminatory and one of the possible purposes enumerated in the Convention is discrimination (A/HRC/7/3, para. 68).

38. In the context of prioritizing informed consent as a critical element of a voluntary counselling, testing and treatment continuum, the Special Rapporteur on the right to health has also observed that special attention should be paid to vulnerable groups. Principles 17 and 18 of the Yogyakarta Principles, for instance, highlight the importance of safeguarding informed consent of sexual minorities. Health-care providers must be cognizant of, and adapt to, the specific needs of lesbian, gay, bisexual, transgender and intersex persons (A/64/272, para. 46). The Committee on Economic, Social and Cultural Rights has

[15] *Ethical Issues in Obstetrics and Gynecology* (2012), pp. 123–124.

[16] Application No. 10533/83, paras. 27, 83.

indicated that the International Covenant on Economic, Social and Cultural Rights proscribes any discrimination in access to health-care and the underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of sexual orientation and gender identity.[17]

IV. Emerging recognition of different forms of abuses in health-care settings

39. Numerous reports have documented a wide range of abuses against patients and individuals under medical supervision. Health providers allegedly withhold care or perform treatments that intentionally or negligently inflict severe pain or suffering for no legitimate medical purpose. Medical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or punishment, and if there is State involvement and specific intent, it is torture.

A. Compulsory detention for medical conditions

40. Compulsory detention for drug users is common in so-called rehabilitation centres. Sometimes referred to as drug treatment centres or "reeducation through labor" centres or camps, these are institutions commonly run by military or paramilitary, police or security forces, or private companies. Persons who use, or are suspected of using, drugs and who do not voluntarily opt for drug treatment and rehabilitation are confined in such centres and compelled to undergo diverse interventions.[18] In some countries, a wide range of other marginalized groups, including street children, persons with psychosocial disabilities, sex workers, homeless individuals and tuberculosis patients, are reportedly detained in these centres.[19]

41. Numerous reports document that users of illicit drugs who are detained in such centres undergo painful withdrawal from drug dependence without medical assistance, administration of unknown or experimental medications, State-sanctioned beatings, caning or whipping, forced labour, sexual abuse and intentional humiliation.[20] Other reported abuses included "flogging therapy", "bread and water therapy", and electroshock resulting in seizures, all in the guise of rehabilitation. In such settings, medical professionals trained to manage drug dependence disorders as medical illnesses[21] are often unavailable.

42. Compulsory treatment programmes that consist primarily of physical disciplinary exercises, often including military-style drills, disregard medical evidence (A/65/255, paras. 31, 34). According to the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC), "neither detention nor forced labour have been recognized by science as treatment for drug use disorders".[22] Such detention – frequently

[17] General comment No. 14 (2000), para. 18.

[18] See World Health Organization (WHO), *Assessment of Compulsory Treatment of People Who Use Drugs in Cambodia, China, Malaysia and Viet Nam* (2009).

[19] Human Rights Watch (HRW), *Torture in the Name of Treatment: Human Rights Abuses in Vietnam, China, Cambodia, and LAO PDR* (2012), p. 4.

[20] See Daniel Wolfe and Roxanne Saucier, "In rehabilitation's name? Ending institutionalized cruelty and degrading treatment of people who use drugs", *International Journal of Drug Policy*, vol. 21, No. 3 (2010), pp. 145-148.

[21] United Nations Office on Drugs and Crime (UNODC) and WHO, "Principles of drug dependence treatment", discussion paper, 2008.

[22] Ibid., p. 15.

without medical evaluation, judicial review or right of appeal – offers no evidence-based[23] or effective treatment. Detention and forced labour programmes therefore violate international human rights law and are illegitimate substitutes for evidence-based measures, such as substitution therapy, psychological interventions and other forms of treatment given with full, informed consent (A/65/255, para. 31). The evidence shows that this arbitrary and unjustified detention is frequently accompanied by – and is the setting for – egregious physical and mental abuse.

Overview of developments to date

43. The numerous calls by various international and regional organizations to close compulsory drug detention centres,[24] as well as the numerous injunctions and recommendations contained in the recently released guidelines by WHO on pharmacotherapy for opiate dependence,[25] the UNODC policy guidance on the organization's human rights responsibilities in drug detention centres,[26] and resolutions by the Commission on Narcotic Drugs,[27] are routinely ignored.[28] These centres continue to operate often with direct or indirect support and assistance from international donors without any adequate human rights oversight.[29]

44. Notwithstanding the commitment to scale-up methadone treatment and evidence-based treatment as opposed to punitive approaches, those remanded to compulsory treatment in the punitive drug-free centres continue to exceed, exponentially, the number receiving evidence-based treatment for drug dependence.[30]

B. Reproductive rights violations

45. The Special Rapporteur has, on numerous occasions, responded to various initiatives in the area of gender mainstreaming and combating violence against women, by, inter alia, examining gender-specific forms of torture with a view to ensure that the torture protection framework is applied in a gender-inclusive manner.[31] The Special Rapporteur seeks to complement these efforts by identifying the reproductive rights practices in health-care settings that he believes amount to torture or ill-treatment.

46. International and regional human rights bodies have begun to recognize that abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering, inflicted on the basis of gender.[32] Examples of such violations include abusive treatment and humiliation in institutional settings;[33]

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[23] See for example WHO, UNODC, UNAIDS, *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* (WHO, 2009).

[24] World Medical Association, "Call for compulsory drug Detention centers to be closed", press statement, 17 May 2011; United Nations entities, "Compulsory drug detention and rehabilitation centres", joint statement, March 2012.

[25] See Wolfe and Saucier, "In rehabilitation's name".

[26] "UNODC and the promotion and protection of human rights", position paper, 2012, p. 8.

[27] Such as resolutions 55/12 (2012); 55/2 (2012) and 55/10 (2012).

[28] See Wolfe and Saucier, "In rehabilitation's name".

[29] HRW, submission to the Special Rapporteur on the question of torture, 2012.

[30] See Wolfe and Saucier, "In rehabilitation's name".

[31] See A/54/426, A/55/290.

[32] CAT/C/CR/32/5, para. 7 (m); Human Rights Committee general comment No. 28 (2000), para. 11.

[33] See Center for Reproductive Rights, *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis* (2011).

involuntary sterilization; denial of legally available health services[34] such as abortion and post-abortion care; forced abortions and sterilizations;[35] female genital mutilation;[36] violations of medical secrecy and confidentiality in health-care settings, such as denunciations of women by medical personnel when evidence of illegal abortion is found; and the practice of attempting to obtain confessions as a condition of potentially life-saving medical treatment after abortion.[37]

47. In the case of *R.R.* v. *Poland*, for instance, ECHR found a violation of article 3 in the case of a woman who was denied access to prenatal genetic testing when an ultrasound revealed a potential foetal abnormality. The Court recognized "that the applicant was in a situation of great vulnerability"[38] and that R.R.'s access to genetic testing was "marred by procrastination, confusion and lack of proper counselling and information given to the applicant".[39] Access to information about reproductive health is imperative to a woman's ability to exercise reproductive autonomy, and the rights to health and to physical integrity.

48. Some women may experience multiple forms of discrimination on the basis of their sex and other status or identity. Targeting ethnic and racial minorities, women from marginalized communities[40] and women with disabilities[41] for involuntary sterilization[42] because of discriminatory notions that they are "unfit" to bear children[43] is an increasingly global problem. Forced sterilization is an act of violence,[44] a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment.[45] The mandate has asserted that "forced abortions or sterilizations carried out by State officials in accordance with coercive family planning laws or policies may amount to torture".[46]

49. For many rape survivors, access to a safe abortion procedure is made virtually impossible by a maze of administrative hurdles, and by official negligence and obstruction. In the landmark decision of *K.N.L.H.* v. *Peru*, the Human Rights Committee deemed the denial of a therapeutic abortion a violation of the individual's right to be free from ill-treatment.[47] In the case of *P. and S.* v. *Poland*, ECHR stated that "the general stigma attached to abortion and to sexual violence ..., caus[ed] much distress and suffering, both physically and mentally".[48]

50. The Committee against Torture has repeatedly expressed concerns about restrictions on access to abortion and about absolute bans on abortion as violating the prohibition of torture and ill-treatment.[49] On numerous occasions United Nations bodies have expressed

[34] See CAT/C/PER/CO/4, para. 23.
[35] E/CN.4/2005/51, paras. 9, 12.
[36] A/HRC/7/3, paras. 50, 51, 53; CAT/C/IDN/CO/2, para. 16.
[37] CAT/C/CR/32/5, para. 6 (j).
[38] ECHR, *R.R.* v. *Poland*, Application No. 27617/04 (2011), para. 159.
[39] Ibid., para. 153.
[40] See ECHR, *V.C.* v. *Slovakia*, Application No. 18968/07 (2011).
[41] A/67/227, para. 28; A/HRC/7/3, para. 38.
[42] A/64/272, para. 55.
[43] See Open Society Foundations, *Against Her Will: Forced and Coerced Sterilization of Women Worldwide* (2011).
[44] See Committee on the Elimination of Discrimination against Women, general recommendation No. 19, para. 22; Human Rights Committee, general comment No. 28, paras. 11, 20.
[45] A/HRC/7/3, paras. 38, 39.
[46] Ibid., para. 69.
[47] Communication No. 1153/2003 (2005), para. 6.3.
[48] ECHR, Application No. 57375/08 (2012), para. 76.
[49] See CAT/C/PER/CO/4, para. 23.

concern about the denial of or conditional access to post-abortion care.[50] often for the impermissible purposes of punishment or to elicit confession.[51] The Human Rights Committee explicitly stated that breaches of article 7 of the International Covenant on Civil and Political Rights include forced abortion, as well as denial of access to safe abortions to women who have become pregnant as a result of rape[52] and raised concerns about obstacles to abortion where it is legal.

C. Denial of pain treatment

51. In 2012, WHO estimated that 5.5 billion people live in countries with low or no access to controlled medicines and have no or insufficient access to treatment for moderate to severe pain.[53] Despite the repeated reminders made by the Commission on Narcotic Drugs to States of their obligations,[54] 83 per cent of the world population has either no or inadequate access to treatment for moderate to severe pain. Tens of millions of people, including around 5.5 million terminal cancer patients and 1 million end-stage HIV/AIDS patients, suffer from moderate to severe pain each year without treatment.[55]

52. Many countries fail to make adequate arrangements for the supply of these medications.[56] Low- and middle-income countries account for 6 per cent of morphine use worldwide while having about half of all cancer patients and 95 per cent of all new HIV infections.[57] Thirty-two countries in Africa have almost no morphine available at all.[58] In the United States, over a third of patients are not adequately treated for pain.[59] In France, a study found that doctors underestimated pain in over half of their AIDS patients.[60] In India, more than half of the country's regional cancer centres do not have morphine or doctors trained in using it. This is despite the fact that 70 per cent or more of their patients have advanced cancer and are likely to require pain treatment.[61]

53. Although relatively inexpensive and highly effective medications such as morphine and other narcotic drugs have proven essential "for the relief of pain and suffering"[62], these types of medications are virtually unavailable in more than 150 countries.[63] Obstacles that unnecessarily impede access to morphine and adversely affect its availability include overly restrictive drug control regulations[64] and, more frequently, misinterpretation of otherwise appropriate regulations;[65] deficiency in drug supply management; inadequate infrastructure;[66] lack of prioritization of palliative care[67]; ingrained prejudices about using

[50] See CAT/C/CR/32/5, para. 7 (m); A/66/254, para. 30.
[51] CAT/C/CR/32/5, para. 7 (m).
[52] General comment No. 28, para. 11; see also CCPR/CO.70/ARG, para. 14.
[53] WHO, "Access to Controlled Medicines Programme", briefing note (2012), p. 1.
[54] Resolutions 53/4 (2010) and 54/6 (2011).
[55] WHO, "Access", p. 1.
[56] See HRW, *"Please Do Not Make Us Suffer Any More...": Access to Pain Treatment as a Human Right* (2009).
[57] Open Society Foundations, "Palliative care as a human right", Public Health Fact Sheet, 2012.
[58] Ibid.
[59] Ibid.
[60] Ibid.
[61] HRW, *Unbearable Pain: India's Obligation to Ensure Palliative Care* (2009), p. 3.
[62] Single Convention on Narcotic Drugs, 1961, preamble.
[63] Joseph Amon and Diederik Lohman, "Denial of pain treatment and the prohibition of torture, cruel, inhuman or degrading treatment or punishment", *INTERIGHTS Bulletin*, vol. 16, No. 4 (2011), p. 172.
[64] See HRW, *"Please Do Not Make Us Suffer"*.
[65] E/INCB/1999/1, p. 7.
[66] A/65/255, para. 40.

opioids for medical purposes;[68] and the absence of pain management policies or guidelines for practitioners.[69]

Applicability of torture and ill-treatment framework

54. Generally, denial of pain treatment involves acts of omission rather than commission,[70] and results from neglect and poor Government policies, rather than from an intention to inflict suffering. However, not every case where a person suffers from severe pain but has no access to appropriate treatment will constitute cruel, inhuman, or degrading treatment or punishment. This will only be the case when the suffering is severe and meets the minimum threshold under the prohibition against torture and ill-treatment: when the State is, or should be, aware of the suffering, including when no appropriate treatment was offered; and when the Government failed to take all reasonable steps[71] to protect individuals' physical and mental integrity.[72]

55. Ensuring the availability and accessibility of medications included in the WHO Model List of Essential Medicines is not just a reasonable step but a legal obligation under the Single Convention on Narcotic Drugs, 1961. When the failure of States to take positive steps, or to refrain from interfering with health-care services, condemns patients to unnecessary suffering from pain, States not only fall foul of the right to health but may also violate an affirmative obligation under the prohibition of torture and ill-treatment (A/HRC/10/44 and Corr.1, para. 72).

56. In a statement issued jointly with the Special Rapporteur on the right to health, the Special Rapporteur on the question of torture reaffirmed that the failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to protection against cruel, inhuman and degrading treatment. Governments must guarantee essential medicines – which include, among others, opioid analgesics – as part of their minimum core obligations under the right to health, and take measures to protect people under their jurisdiction from inhuman and degrading treatment.[73]

D. Persons with psychosocial disabilities

57. Under article 1 of the Convention on the Rights of Persons with Disabilities, persons with disabilities include those who have long-term intellectual or sensory impairments, which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. These are individuals who have been either neglected or detained in psychiatric and social care institutions, psychiatric wards, prayer

[67] Palliative care is an approach that seeks to improve the quality of life of patients diagnosed with life-threatening illnesses, through prevention and relief of suffering. WHO Definition of Palliative Care (see www.who.int/cancer/palliative/definition/en/).

[68] E/INCB/1999/1, p. 7.

[69] HRW, *"Please Do Not Make Us Suffer"*, p. 2.

[70] Amon and Lohman, "Denial", p. 172.

[71] See for example ECHR, *Osman* v. *United Kingdom*, Application No. 23452/94 (1998), paras. 115-122; Committee on Economic, Social and Cultural Rights, general comment No. 14.

[72] Amon and Lohman, "Denial", p. 172.

[73] Joint letter to the Chairperson of the fifty-second session of the Commission on Narcotic Drugs, 2008, p. 4.