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

Human rights challenges in addressing and countering all aspects of the world drug problem, in particular on the impact of drug policies on the rights of women and girls

Report of the Office of the United Nations High Commissioner for Human Rights*

Summary

In the present report, submitted pursuant to Human Rights Council resolution 60/26 on "Human Rights Implications of Drug Policy", the Office of the United Nations High Commissioner for Human Rights (OHCHR) outlines human rights challenges in addressing and countering the world drug problem, in particular focusing on the impact of drug policies on women and girls.

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I. Introduction and methodology

1. The present report is submitted pursuant to Human Rights Council resolution 60/26 on "Human Rights Implications of Drug Policy" that requested OHCHR to prepare a report on human rights challenges in addressing and countering all aspects of the world drug problem, in particular on the impact of drug policies on the rights of women and girls. In preparing the report, OHCHR issued a call for submissions, addressed to States and other stakeholders. The report is based on the analysis carried out by OHCHR of inputs received, [1] and a review of publicly available material.

2. The world drug problem has a major impact on the enjoyment of human rights, and public policies aiming to respond to this problem have significant human rights implications. In 2023, in its report A/HRC/54/53, OHCHR identified the main human rights challenges in relation to efforts to address the world drug problem, highlighting in particular: the human rights consequences of the 'war on drugs' and the militarization of drug control; overincarceration and prison overcrowding resulting from punitive drug policies; the continued use of the death penalty for drug-related offences; the lack of and unequal access to treatment and harm reduction services; and, the disproportionate impact of drug policies on children and youth, people of African descent, Indigenous peoples and women. The current report builds on the 2023 report, with a focus on the impact of drug policies on the rights of women and girls.

II. International legal and policy framework

3. The international drug control system is governed by three drug conventions.[2] The 1988 United Nations Convention against Illicit Traffic in Narcotics Drugs and Psychotropic Substances contains provisions regarding the protection of children, reflecting that, in many parts of the world, children are exploited both as a market for illicit drug consumption and for the illicit production, distribution, and trafficking of narcotic drugs and psychotropic substances.

4. International human rights law applies fully in the context of drug policy, including to protect the rights of women and girls. Under the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), relevant protections include the rights to equality and non-discrimination, life, liberty and security of person, privacy, health, an adequate standard of living and access to justice.

5. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) obliges States to eliminate discrimination against women in law and practice and to ensure equality in all areas of life. The Convention on the Rights of the Child requires States to take appropriate measures to protect children from the illicit use of narcotic drugs and to prevent the use of children in the illicit production and trafficking of such substances (article 33). These protections apply especially to women and girls affected by drug-related activities and enforcement measures.

6. Over the past decade, United Nations organs and bodies have increasingly affirmed that drug policies should be implemented in conformity with human rights obligations. General Assembly, Human Rights Council and Commission on Narcotic Drugs (CND) resolutions and the 2016 UNGASS Outcome Document and subsequent declarations, call for human rights-based, gender-responsive and non-discriminatory approaches to drug policy. Human Rights Council resolution 60/26, as well as other resolutions, has specifically urged States to integrate a gender perspective into drug policies and ensure the participation of women in their design, implementation and evaluation. CND resolutions have similarly

[1] See https://www.ohchr.org/en/calls-for-input/2026/call-inputs-ohchr-report-human-rights-implication-drug-policy.

[2] 1961 Single Convention on Narcotic Drugs, 1971 Convention on Psychotropic Substances, 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

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promoted gender mainstreaming, sex-disaggregated data collection and access to gender-responsive services.[3]

7. The International Guidelines on Human Rights and Drug Policy[4] provide guidance on the application of international human rights law to drug policy. They affirm that drug control efforts must be consistent with human rights obligations and call on States to address the specific forms of discrimination and disadvantage experienced by women and girls, including women who use drugs and those involved in drug-related economies, through gender-responsive laws, policies and services.

8. The United Nations System Common Position on Drug Related Matters commits UN agencies to supporting Member States in developing balanced, human rights-based, non-discriminatory drug policies aligned with the 2030 Agenda for Sustainable Development.[5]

III. The impact of drug policies on the rights of women and girls

A. Punitive drug policies

9. While the international drug control system is designed inter alia to protect public health and welfare, drug control policies have frequently been characterized by punitive and repressive approaches with significant negative consequences for human rights in many parts of the world.[6] The so-called "war on drugs" has led to strategies that criminalize – often with severe penalties - and stigmatize individuals related to drug production, distribution and, especially, consumption or living in areas where these activities are carried out.[7]

10. In particular, military, military police or specialized security forces are engaged by some countries to counter drug-related organized crime and illicit drug cultivation and trafficking in place of, or alongside, civilian policing.[8] Such approaches have been associated with increased rates of excessive use of force, extrajudicial killings and impunity.[9] Punitive drug policies can also have specific impacts on the rights of women and girls, as outlined below.

1. Liberty and security of person

11. The criminalization of drug use and possession has exposed people who use drugs to police harassment during arrests. This affects women and girls in specific ways, including as a result of verbal and sexual harassment during raids; racial profiling and gendered profiling for gender-diverse persons; and even sexual extortion.[10] Reportedly, law enforcement officials in some States target women who use drugs, demanding money or sexual favours in exchange for not arresting them.[11]

12. Although women and girls represent a minority of the global prison population, accounting for around 7 percent in 2019, the number of women in prison has increased faster than the number of men in prison in recent years, as the female prison population increased by 33 percent between 2000 and 2019, compared with 25 percent for men[12]. The available

[3] Resolution 63/2 Resolution 63/5 Resolution 63/4 Resolution 64/2; Resolution 64/3, Resolution 64/5, Resolution 66/4, Resolution 67/2; Resolution 67/3; Resolution 67/4; Resolution 61/4; Resolution 69/4.

[4] https://www.humanrights-drugpolicy.org/site/assets/files/1640/hrdp_guidelines_2020_english.pdf

[5] CEB/2018/2.

[6] A/HRC/54/53. Para.3.

[7] A/HRC/56/52, para. 5; A/HRC/54/53, paras. 19-22.

[8] A/HRC/54/69, paras. 33 and 48; A/HRC/54/53, paras. 19–22; A/HRC/39/39, para. 29-31; Dejusticia, 'Voces desde el cocal', pages 81-86; Contribution by Black Initiative for a New Drug Policy, A/HRC/57/19, paras 23-2.

[9] A/HRC/39/39, para. 27-33; A/HRC/47/40, para. 8; A/HRC/54/53, para. 17.

[10] E/C.12/EST/CO/3 (2019), paras. 44(f), 45(f); A/HRC/47/40, paras 8 and 61; A/HRC/59/49: A/HRC/54/69, para 33; A/HRC/56/52, para.40.

[11] A/HRC/47/40, para. 61.

[12] United Nations Office on Drugs and Crime (UNODC), Data Matters No. 1: Nearly Twelve Million People Imprisoned Globally (2021), p. 2.

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data estimates that 35 percent of women in prison are imprisoned for drug-related offences, compared with 19 percent of men. [13]

13. Contributions highlighted the systematic overuse of pretrial detention[14] or mandatory or near-automatic pretrial detention for drug-related crimes[15] without individualised assessments of, necessity or proportionality.[16] As a consequence, women accused of such offences may spend prolonged periods in detention awaiting trial. In many States the number of women held in pretrial detention equals or outnumbers convicted female prisoners and they are held in detention for long periods.[17] Moreover, women have reportedly been arrested and held in pre-trial detention as co-defendants of a partner or spouse irrespective of their level of involvement in an offence. In some instances, they have remained in detention after being acquitted, without any certainty as to the reasons for their detention.[18]

2. Right to a fair trial

14. Failure to consider the particular situation of women and girls during judicial proceedings can affect the right to a fair trial. Justice systems do not always acknowledge mitigating factors affecting women's participation in drug offences, including coercion, violence, abuse, poverty, dependence on partners, or other forms of vulnerability[19]. While not all women are coerced into drug-related offences, this gap can mean that women defendants may receive an unfair assessment of their criminal liability or an inappropriate sentence. On the other hand, judges and juries may allow gender stereotypes affect their assessment of issues such as knowledge or intent.[20] This can affect the presumption of innocence and other aspects of fair trial.

15. Mandatory minimum sentencing for drug-related offences, including mandatory death sentencing,[21] can be especially harmful for women and girls as it removes judicial discretion thereby rendering it impossible to account the specific vulnerable situations and contexts of discrimination and violence, or even instances of coercion, that can influence acts and decisions leading to the commission of drug related offences.[22]

16. Further, codification of offences that blur the distinction between personal possession and trafficking, gender-blind adjudication that ignores the power dynamics that may have affected women, and use of gender stereotypes defining the image of how a vulnerable woman or a caring mother should act can also lead to women in low-level roles or women who have been coerced receiving sentences with similar severity as drug traffickers and persons in leading roles.[23]

17. According to information received, in certain States sentencing of women incarcerated for drug offences - often first-time, non-violent, or low-level roles such as drug mules or coerced co-defendants - can fail to account for relevant mitigating factors relevant such as caregiving responsibilities, coercion or socio-economic inequality, resulting in sentences disproportionate to their actual level of involvement and cascading harms for the families and children who depend on them.[24]

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[13] UNODC, Data Matters No. 1: Nearly Twelve Million People Imprisoned Globally; Contribution by CEDA; UN Women; HRI, WHRIN, IDPC.

[14] Contribution by UN Women; HRI, WHRIN and IDPC; Hemp Hub Japan; Corporación Humanas; Mexico Annex 1, page. 6; See also Women Mobilizing for Change.

[15] Contribution by CAT; JPP.

[16] International Guidelines , II 7 (ii).

[17] A/HRC/31/57, para. 20.

[18] Contribution by Mexico Annex 3, pp. 251–252; JPP; ADPAN, Eleos Justice,Monash University and CPJP.

[19] A/HRC/41/33, para. 69; Contribution by INCB, Pos Foundation.

[20] Contribution by HRI, ESOHR, KHRC and WHRIN; GAATW, JPP, and ZCLDN.

[21] Contribution by HRI, ESOHR, KHRC and WHRIN; Monash University, Eleos Justice, ADAN, CPJP; and JPP

[22] A/HRC/57/44, paras. 43, 45, 47 and 51; Contribution by CEDAW.

[23] Contribution by GCDP; JPP; Mexico, Annex3, pp. 249 and 252; ADPAN, Eleos, CPJP; HRI, ESOHR, KHRC and WHRIN; Grupo de Trabajo (GT) "Mujeres, Políticas de Drogas y Encarcelamiento".

[24] Contribution by GCDP; JPP; Mexico, Annex3, pp. 249 and 252; REDSAI Nigeria

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18. Several States have adopted gender-sensitive measures to reduce incarceration and address structural inequalities. Colombia introduced non-custodial sentencing options for marginalized women with caregiving responsibilities. Brazil expanded the use of house arrest in lieu of pre-trial detention to pregnant women and mothers of young children. Mexico adopted an amnesty law recognizing the role of poverty, discrimination, and coercion in drug-related convictions. Collectively, these measures seek to reduce women's exposure to imprisonment and mitigate the gendered consequences of drug control policies.[25]

3. Torture and ill treatment

19. Strongly punitive drug policies can heighten the risk of torture and ill-treatment, including through violence, both prior to and during detention. In the context of militarized responses to drug offences — torture, gender-based violence, including sexual violence against women and girls are prevalent.[26] Gender based violence is rooted in unequal gender relations and broader patterns of discrimination. Militarized responses to drug related activities can reinforce these dynamics by normalizing the unwarranted use of force and exacerbating power imbalances, thereby increasing the risk of violence against women and girls.[27]

20. Risk of sexual violence is often higher during the phases of arrest, transfer and initial custody, where separation of male and female detainees does not occur, or where women are transported by male personnel.[28] Body searches may constitute a particularly acute form of gendered ill-treatment for women detained on drug charges. Vaginal examinations, especially by male guards, are common and often disproportionate or unnecessary, with the potential in certain circumstances to amount to torture.[29] Personal searches should be conducted only by trained female staff, alternative screening methods should be developed, and strip and internal body cavity searches should be used only when absolutely and legally necessary, never routinely.[30]

21. Contributions highlighted that women convicted for drug-related offences face a risk of torture and ill-treatment.[31] For example, women with drug dependency face compounded risks arising from the systematic failure of prison health systems to respond to their needs. There are instances of discriminatory access to services including harm-reduction programmes; failures in diagnosis and medical neglect; and denial of medicines, including for chronic conditions.[32] In some States there are either no dedicated prisons for women or no services for drug dependence or harm-reduction measures.[33]

22. Disclosing drug dependence can sometimes result in harsher detention conditions rather than access to adequate evidence-based health care, leaving those concerned to face severe withdrawal symptoms without appropriate care.[34] The illicit circulation of controlled substances and medication in detention facilities has been reported as a vector for sexual exploitation. Untreated drug dependency in prison has also been linked to a higher likelihood of re-offending.[35]

23. Section III.3 of the International Guidelines on Human Rights and Drug Policy recalls that States should ensure equivalent, voluntary, evidence-based health care for people in detention, including harm reduction, drug treatment, essential medicines, HIV and hepatitis C services. The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) require individualized, gender-sensitive, trauma-informed mental health care and specialized treatment programmes

[25] Law in Brief ISSNe: 2745-1879, No. 24, January 2026, Bogotá D.C., pp. 5–7; Contributions by Colombia - Defensoría del Pueblo y de la Naturaleza, Brazil, Grupo de Trabajo Mujeres Políticas de Drogas y Encarcelamiento,

[26] A/HRC/54/53, para 22; see also Dejusticia, 'Voces desde el cocal', pages 81-86.

[27] A/HRC/4/34, para. 65; see also CEDAW/C/GC/30, paras. 4, 34 and 35.

[28] A/HRC/31/57, paras. 19–20.

[29] A/HRC/31/57, para.23

[30] UNODC Commentary on Bangkok rules, pp. 32-33

[31] A/HRC/31/57, para. 20. Contribution by Mexico Annex 3, p. 219; and GCDP.

[32] A/HRC/31/57, paras. 25–26.

[33] A/HRC/47/40, para. 60.

[34] CEDAW/C/84/D/129/2018, para. 7.7; Contribution by INFIW.

[35] UNODC commentary on Bangkok Rules, page 30; Contribution by Mexico, Annex 3, pp. 224

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for women with substance use disorders, taking into account prior victimization, pregnancy, caregiving responsibilities and cultural background.[36] These measures can contribute to the prevention of torture and ill treatment.

24. The Subcommittee on Prevention of Torture has identified complementary safeguards, including applying a gender perspective to drug-related offences, expanding alternatives to incarceration and ensuring regular access to female doctors and specialist medical care for women detainees.[37]

4. Death penalty and the right to life

25. Thirty-six countries or territories maintain the death penalty for drug-related offences. International human rights law provides that the death penalty may be imposed only for the "most serious crimes", that is, crimes of extreme gravity involving intentional killing. drug-related offences do not meet this threshold States must abolish the death penalty for such offences and revoke death sentences issued for these crimes and pursue the necessary legal procedures to resentence those convicted for such crimes.[38]

26. While women are a minority of those sentenced to death, drug-related offences are the main reason for which women are sentenced to death in several countries, according to available information. Imposition of the death penalty is mandatory in 15 States for some drug-related offences. Mandatory imposition of the death penalty denies judicial capacity to consider mitigating circumstances at the time of sentencing, including those related to gender.[39]

5. Right to health

27. Punitive drug policies, compounded by mandatory drug testing, can form structural obstacles to the right to health, with surveillance and potential coercive interventions that can discourage treatment-seeking.[40] Fear of punitive consequences can deter women and girls, especially pregnant women and mothers who use drugs, from seeking health care.[41]

28. Disproportionate protection measures such as removing a child from the mother's care or preventing reunification with her child based solely on her drug use or dependency, and restrictions on sexual and reproductive rights are still widespread against women who use drugs, have used drugs, or have been convicted of drug-related offences, causing women to avoid seeking related healthcare, information and treatment.[42] In some States, pregnant women who use drugs risk confinement, forced medical treatment, or imprisonment. There are also cases were women are faced with charges for attempted abortion, miscarriage, child abuse or perceived harm to the foetus based solely on their drug use[43].

29. Women who use drugs can confront restricted access to sexual and reproductive rights, including access to contraception, because of negative stereotyping about drug users.[44] In addition, instances of coerced or forced sterilization, abortion or contraception and obstetric violence have been reported against women who use drugs.[45]

30. Punitive drug policies hinder HIV and other blood borne diseases prevention policies. Women who use drugs face heightened risks of HIV and hepatitis C due to gender inequalities, violence, discrimination in health care, and punitive laws that discourage access

[36] A/RES/65/229, rules 12–13. See also NHRC Oman.
[37] Contribution by SPT, Morocco.
[38] CCPR/C/GC/36, para 35.
[39] Contributions by HRI, ESOHR, KHRC and WHRIN and Maldives Human Rights Commission
[40] Contributions by HIV Legal Network and DPA; Reason Foundation, Commentary
[41] Contributions by Portugal; HRI WHRIN/IDPC and
[42] Y.I. v. Russia 25.2.2020 (no. 68868/14), paras. 85-90; The War on Drugs Meets Child Welfare; DPA; Uzbekistan; WHRIN and the International Network of Women who Use Drugs ; WHRIN and ICW, Joint briefing paper,
[43] A/HRC/41/33, paras. 38–39; Pregnancy justice; Contribution by OSF.
[44] UNODC, "Addressing Gender-Based Violence against Women and People of Diverse Gender Identity and Expression who Use Drugs"
[45] A/HRC/41/33, para. 39; WHRIN and ICW, Joint briefing paper, page 3 and 6; UNODC, "Addressing Gender-Based Violence against Women and People of Diverse Gender Identity and Expression who Use Drugs", page 6-7; Building Black Feminist Visions to End the Drug War, pp. 21–22.

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to prevention, testing, and treatment services.[46] Criminalization, including drug-related activities such as possession of needles and syringes can further aggravate risk of exposure.[47]

31. Women who use drugs continue to face stigma and stereotypes portraying them as unfit mothers which can impact their access to reliable health care. Mothers who use drugs often face loss of parental rights solely based on drug use, which acts yet as another deterrent from seeking healthcare[48].

32. Several States have adopted specific measures to address the health needs of pregnant women who use drugs and to reduce barriers to accessing care. Switzerland allows pregnant women access to supervised consumption facilities and related reproductive health support. Portugal has integrated sexual and reproductive health services into drug treatment networks, including maternal and child health consultations and programmes enabling children to remain with incarcerated mothers.[49] Canada's approach is primarily health-based, harm-reduction oriented, and non-punitive, emphasizing access to care rather than criminalization.[50]

B. Health-centred drug policies

1. Drug-dependency treatment

33. While drug-dependency treatment policies are essential for the realization of the right to health, women and girls continue to face disproportionate barriers in accessing such services. For example, only one in seven men compared with one in 18 women with drug use disorders are estimated to be in treatment.[51] This gap reflects treatment systems historically designed around male patters of drug use, often failing to address the specific pathways, experience and needs of women.[52]

34. Stigma and discrimination constitute a major barrier for women accessing treatment, as they are stigmatized both for drug use and for perceived failures relating to their role as mothers and caregivers.[53] Caregiving responsibilities, which continue to fall disproportionately on women, can create practical barriers to accessing and remaining in treatment.[54]

35. In addition, the design of drug-dependency treatments can lead to disproportionate impacts on some women and girls. In particular, women who have experienced gender-based violence and high-levels of trauma may not benefit from psychosocial and sexual and reproductive health responses that are trauma-informed and survivor centred.[55]

36. Several States have adopted gender-responsive approaches to drug dependency treatment for women and girls. Chile's residential programmes allow women to enter treatment together with their children. Norway has established specialized services for women affected by gender-based violence who have concurrent substance use disorders, recognising the need for integrated and gender-responsive care. Sri Lanka strengthened its community-based treatment models that allow women to continue living with their families and maintain caregiving roles while receiving rehabilitation support.[56] Morocco adopted laws

[46] World Drug Report 2018, booklet 5; A/HRC/56/52. See also contributions of Armenia and NHRC Zambia.
[47] A/65/255, para 21; UNODC, Practical Guide for Service Providers on Gender-Responsive HIV Services, p. 5; Contribution by SWAN
[48] UNODC, "Addressing Gender-Based Violence against Women and People of Diverse Gender Identity and Expression who Use Drugs", page 6-7; WHRIN and ICW, Joint briefing paper, page 6.
[49] Contribution by Switzerland and Portugal.
[50] https://www.canada.ca/en/public-health/services/pregnancy/substance-use-pregnancy.html
[51] World Drug Report 2025, pages 60-61.
[52] Contribution by Ghana, ZONTA; Elementa and Provencasa; see also UNODC Guidelines on Drug Prevention and Treatment for Girls and Women 2016, page 36.
[53] Contribution by WFAD., NHRC Nigeria, NHRC Oman, NHRC Qatar, Corporación viviendo; EHRA and HFHR.
[54] Contribution by Instituto RIA and Romania.
[55] Contributions by Portugal; HRI, WHRIN, IDPC; Albania-People`s Advocate.
[56] Contribution by Sri Lanka.

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for the protection of women exposed to violence and exploitation in the context of drug use.[57] Switzerland and Czechia have treatment services that accept children, although services may remain insufficient to meet current needs.[58] In Austria, a women-led outpatient treatment centre operates with a feminist approach, providing a safe space for women.[59] Iraq and Kuwait promote voluntary treatment and rehabilitation in place of incarceration.[60]At the European level, policy guidelines have been developed to identify and reduce barriers to treatment for women who use drugs.[61]

2. Harm reduction services

37. Harm reduction services - such as needle and syringe programmes, overdose-reversal medication, supervised consumption sites, mobile harm reduction units, peer support programmes and education - are important policies that are effective ways to realise the right to health. However, harm reduction services remain limited in many countries.[62] In many jurisdictions, access to essential harm reduction tools remains restricted or criminalized.[63]

38. Where available, Gender-responsive, rights-based, and harm reduction approaches have proven effective. For example, Australia reduced mother-to-child HIV transmission from 17.5 per cent to 1.5 per cent, Estonia achieved a 61 per cent reduction in HIV infections nationally and a 97 per cent reduction among people who inject drugs, and Portugal's decriminalization of drug use and public health-based policies contributed to a significant decline in blood-borne disease infections.[64]

39. It is critical that the design of such approaches consider the specific needs of women and girls. Key barriers for women in accessing harm reduction services include distance to services, economic limitations, limited autonomy, caregiving responsibilities, and control exerted by male partners.[65]

40. Harm reduction education for young people, and in particular education aimed at young women and adolescent girls, remains very limited. In many countries, girls who use drugs cannot access harm reduction services, including HIV testing, without the consent of a parent or guardian.[66] Confidential, age-appropriate, gender-responsive harm reduction services without parental or guardian consent should be ensured when it is in the best interest of the individual.[67]

41. Access to opioid substitution therapy also remains inadequate and uneven. Coverage for high-risk opioid users can be very low, and those seeking care, including women and gender-diverse people, frequently encounter practical obstacles such as waiting lists, restrictive opening hours, burdensome administrative requirements, mandatory daily attendance, and stigmatizing treatment by service providers. In some contexts, punitive measures in the provision of opioid substitutes, including frequent drug testing, threats of expulsion, or dose reductions following positive test results, further undermine access to treatment.[68]

[57] Contribution by Morocco.
[58] Contributions by Norway; Switzerland; Czechia; and Chile.
[59] Contribution by ZONTA;
[60] Contribution by Iraq and Kuwait.
[61] Contributions by EUDA and European Union.
[62] WHRIN, “Global Mapping of Harm Reduction Services for Women and Gender Diverse People who use Drugs”.
[63] Contribution by Release; UNODC, UN Women, WHO, INPUD Policy Brief: Women who inject drugs and HIV, p. 3; Position Paper by Youth RISE and WHRIN, page. 5. See also contribution by AfricaNPUD, Côte d’Ivoire example as a good practice on protective harm reduction law.
[64] Contributions of Australia, Estonia; WHO, “Portugal on fast track to achieve HIV targets ahead of 2020 deadline”.
[65] UNODC, Practical Guide for Service Providers on Gender-Responsive HIV Services, p. 5.
[66] Contribution by Youth Rise.
[67] See International Guidelines, p.16
[68] Contribution by EuroNPUD.

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42. Women and girls may also avoid harm reduction, HIV testing, and sexual and reproductive health services due to fears of stigma, criminalization, judgment, or losing custody of their children.[69]

3. Access to controlled substance for medical and scientific purposes

43. Despite the fact that controlled medicines are essential for management of moderate to severe pain, including palliative care, emergency obstetric situations, and the management of epilepsy, [70] people who use drugs might face restrictions in accessing controlled substances due to stigmatized assumptions about persons who use drugs. This can affect women who use or have used drugs, particularly where they are denied access to opioid substitution therapy and anaesthesia during childbirth.[71] Furthermore, countries with the lowest morphine availability[72] are those where women face the greatest risk of inadequately managed pain during childbirth and related obstetric emergencies.

C. Drug cultivation eradication policies, alternative development and women

1. Rights to health, and to a clean, healthy and sustainable environment

44. The use of pesticides and other chemicals for crop eradication, in particular aerial spraying – as part of policies targeting illicit drug economies - has led to deforestation, monocultures, and water and soil pollution.[73] Women and girls are particularly vulnerable to the adverse health effects of toxic substances with exposure to pesticides and other pollutants linked to infertility, fibroids, miscarriage, stillbirth, premature birth, low birth weight and birth defects.[74]

45. Bolivia's community-based coca-leaf social control model - which institutionalizes rural women's organizations in monitoring cultivation levels through negotiation rather than forced eradication[75] - avoids the health risks associated with aerial or manual eradication campaigns. Colombia suspended in 2015 the use of aerial glyphosate, although this practice was renewed in late 2025.[76]

46. The Human Rights Council has encouraged States to ensure that measures to prevent illicit cultivation of and eradicate plants containing narcotic and psychotropic substances respect human rights, and of the protection of the environment, in accordance with international law. It has further recalled that the United Nations Declaration on the Rights of Indigenous Peoples, which states that Indigenous People have the right to their traditional medicines and to maintain their health practices.[77] The International Guidelines on Human Rights and Drug Policy call on States to ensure women's equal right to participate in and benefit from alternative livelihood efforts in rural communities dependent on illicit drug crops, including equal rights to agrarian reform, land ownership, natural resources, and financial services, credit and markets, irrespective of civil or marital status.[78]

2. Right to an adequate standard of living

47. Women coca or opium poppy growers, and in particular indigenous women, often need to combine work in coca cultivation with unpaid domestic labour, care, support work and face limitations in their access to legal titles to land.[79] In places such as Colombia, coca

[69] Position Paper by Youth RISE and WHRIN, p. 1 and 3
[70] A/HRC/30/65, para. 32
[71] A/65/255, para. 42 and 44; UNODC, Addressing Gender-Based Violence against Women and People of Diverse Gender Identity and Expression who Use Drugs; contribution by Dream.org.
[72] A/65/255, para. 42; A/HRC/56/52, para. 49.
[73] A/HRC/54/53, para. 52.
[74] A/HRC/52/33, paras. 29 and 31.
[75] Contribution by Bolivia.
[76] Contribution by Dejusticia and Elementa.
[77] A/HRC/RES/60/26, paras. 4 and 7.
[78] Chapter III, 2.3
[79] GIZ and OSF “Raising voices”, pp. 2-3

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cultivation has been one of the few avenues for economic independence for women in remote areas. Forced eradication without real alternatives can push women into extreme poverty.[80]

48. Bearing in mind cultural and gendered relationships to land, eradication can also disproportionately displace women from the land and agricultural livelihoods.[81]

49. Alternative development policies[82], aimed at providing lawful, viable and sustainable alternatives to the illicit cultivation of drug crops, have had positive outcomes on local development.[83] However, gender-blind alternative development programmes can have gendered effects if they require beneficiaries to have formal title to the land or natural resources, whilst women's role is often unpaid or informal.[84]. In designing alternative development policies, States should take into account such factors, which can hinder women benefiting from such policies.[85]

50. In Albania, a pilot project supported by Germany's development cooperation supported the creation by a group of women of a cooperative producing traditional foodstuffs, creating licit livelihoods and reducing the economic pressures that can drive women towards illicit drug economies.[86]

D. Prevention policies

51. The WHO/UNODC 'International Standards on Drug-Use Prevention' consider the primary objective of prevention as being 'to help people – especially, but not only, young people – to avoid or delay the initiative of the use of psychoactive substances, or, if they have already initiated use, to avert the development of substance use disorders'.[87] The International Guidelines on Human Rights and Drug Policies emphasize that preventive measures should be evidence-based, human rights-compliant and gender sensitive. [88]

52. Through their contributions, some States highlighted gender-sensitive prevention policies. For example, Brazil introduced a comprehensive prevention policy addressing prevention of harmful drug use and associated violence.[89] Nigeria has drug misuse prevention initiatives that include targeted activities for women and girls.[90]

53. States reported the prioritization of children and young persons within prevention policies, responding to increased drug use among young persons, with higher increases in drug use among young girls compared to young boys in some countries. However, submissions indicated children-focused prevention strategies sometimes omit a gender perspective as well as active participation from young persons in strategy conception.

54. The International Narcotic Control Board's programme "Operation Knockout" enhanced cooperation among law enforcement agencies on the prevention of trafficking of so-called "date rape drugs" increasingly used in gender-based sexual violence.

55. Contributions from some civil society and other stakeholders highlighted the importance of early prevention in line with human rights standards, referring to measures to protect children from the illicit use of narcotic drugs and psychotropic substances and to prevent the use of children in the illicit production and trafficking of such substances. Contributions also emphasized that preventive measures should be evidence-based and compliant with human rights norms.[91]

[80] Contribution by Dejusticia and Elementa.
[81] Coalition for Drug Policy Reform and Environmental Justice.
[82] A/HRC/39/39, para.77
[83] UNDP Development dimensions of drug policy, p. 22. See also UNDP submission.
[84] Dejusticia and Elementa, page. 3.
[85] Coalition for Drug Policy Reform and Environmental Justice
[86] Contribution by Germany.
[87] WHO/UNODC 'International Standards on Drug Use Prevention', Second Updated Edition.
[88] See International Guidelines on Human Rights and Drug Policies, pages 7, 11, 16 and 17
[89] Contributions by Brazil.
[90] Contribution by Africa Center for Health law and Development.
[91] Convention on the Rights of the Child, art. 33; Contributions by San Patrignano, Drug Free Australia, DFAF, SCF; NHRC India and Uzbekistan; NPC

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56. Prevention measures should respect human rights standards, yet this has not always been the case. In some instances, prevention strategies have comprised mandatory drug testing, including in educational and healthcare settings, in particular pregnancy and neonatal healthcare; drug test without knowledge or consent raises human rights concerns.[92] In this context, women of African descent and racialised women are particularly affected.[93]

E. Social services and assistance for persons who use drugs policies

57. Women who use drugs often face significant social and economic vulnerability. Many States have adopted programmes to provide social services to women who use drugs, including housing, academic and professional training and health services, either as part of harm-reduction policies, as part of drug dependence programmes, or indirectly by supporting community-based support services.[94]

58. However, denying access to social service programmes based solely on their drug dependence, for example conditioning assistance on participation in treatment programmes or drug testing, can constitute impermissible discrimination.[95]

F. Social reintegration of women and girls incarcerated for drug offences

59. Contact with the criminal system disrupts access to education, employment and housing, creating cycles of economic instability that compound the obstacles women already face in many societies. [96] Upon release from prison, women often face further barriers, such as restrictions on social services and difficulties to access the labour market, which particularly affect those with caregiving responsibilities.[97] Furthermore, they face barriers related to structural stigma-based exclusions in relation to public assistance and social services or may avoid applying for benefits for fear of punitive consequences.[98]

60. Given the significant proportion of women incarcerated for drug offences, it is important that social reintegration programmes[99] take into account the specific needs of women who use drugs and should not restrict access to housing, social security, education or employment on the basis of drug use or drug-related criminal records, particularly given the connection between homelessness and drug use.

61. The UN Model Strategies on Reducing Reoffending (the Kyoto Model Strategies) recall that reducing reoffending requires gender-sensitive approaches accounting for different pathways to crime, prior victimization, and reintegration challenges.[100] Access to social services for women and girls who have been incarcerated for drug-related offences or who use drugs should be treated as a right.[101]

G. Policies addressing drug-related organized crime

62. One of the major challenges that State face when addressing the world's drug problem is countering organized crime. The activities of organized criminal groups can affect women and girls in distinct ways. Policies aimed at combating drug-related organized crime should

[92] A/HRC/39/39, para. 8.
[93] Lusero et al, Mobilizing the Office for Civil Rights' Authority to Address Obstetric Violence and Obstetric Racism, pages 59-66.
[94] See inter alia, Contributions by Albania, Algeria, Australia, Brazil, Chile, Czechia, Ecuador, Egypt, Germany, Ghana, Italy, Mexico, Norway, Portugal, Singapore, Spain, Switzerland, Uzbekistan,.
[95] A/HRC/47/40 ; See also International Standards for the Treatment of Drug Use Disorders, principle 2; Contribution by Forum Droghe and others; E/C.12/GC/19, para. 24, see also International Guidelines, p. 4.
[96] Contribution by Mexico Annex 3, pp. 229; Corporation Mujeres Libres; Law in Brief ISSNe: 2745-1879, No. 24, January 2026, Bogotá D.C., pp. 11, 22–23, 26–28, 32–34; INFIW, p. 3.
[97] A/HRC/30/65, para. 50. Also contribution by; Mexico Annex 3, pp. 229; and Uzbekistan, .
[98] A/HRC/56/52 para. 2; Position Paper by Youth RISE and WHRIN, Page 5.
[99] A/HRC/60/55
[100] A/RES/80/226, para 5 and 25.
[101] A/HRC/60/55, para 55.

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take these gendered impacts into account to avoid exacerbating existing inequalities and exposing women and girls to further harm, and to ensure an effective response to forms of crime and violence that disproportionately affect them.[102]

63. Some drug-related organized crime groups use armed violence to exercise territorial control, imposing a climate of silence through fear of reprisal.[103] Femicide and sexual violence against women, girls and LGBTIQ+ persons feature prominently in such violence.[104]

64. Gender stereotypes can mean that women and girls are thought to be less suspicious or threatening, making them attractive to criminal gangs as couriers, lookouts, extortion collectors or sellers, often combined with sexual exploitation.[105]

65. In Southeast Asia, transnational drug syndicates exploit cross-border movements of female labour, particularly migrant domestic workers, recruiting or forcing them into serving as drug couriers, at times exposing them to severe law enforcement responses.[106] ASEAN's 2025 Guidelines on the Non-Punishment Principle for the Protection of Victims of Trafficking in Persons recognize that persons who have been coerced into drug-related offences should not be punished.[107]

IV. Multiple forms of discrimination and intersectionality

66. Gender often interacts with other grounds of discrimination such as race, ethnicity and age, resulting in distinct and compounded harms in law enforcement, detention and access to health care and social services.

67. Women from racial minorities, including Afro-descendant women, are overrepresented in prisons for low-level, non-violent drug-related offences and more often stopped for policing checks.[108] Age can intersect with gender, ethnic and racial origin leading to higher instances of police checks, including in relation to possession of drugs, for children and young adults, including women and girls, from ethnic minorities.[109]

68. Gender-based violence particularly affects people of diverse gender identity and expression who use drugs, yet they are often excluded from mainstream gender-based violence prevention or response measures.[110] In many countries, trans women also specifically face criminalization, elevated rates of sexual abuse and violence during arrest and detention, placement in facilities according to sex assigned at birth, denial of gender-affirming care, and disproportionate exposure to HIV, estimated at twelve times that of the general female population.[111]

69. Indigenous women may experience intersecting forms of discrimination based on both gender and indigenous status. Criminalization of drug crop cultivation can have particular consequences for indigenous women, including economic marginalization, family disruption and barriers to accessing justice.[112]

[102] See contribution by Council of Europe's Pompidou Group.
[103] A/HRC/59/46, paras. 54, 57, 63; A/HRC/59/39, paras. 25–28 and A/HRC/20/16, para. 70
[104] Berenice Fernandez Niet et al, Weaponisation of Female Bodies: Violence Against Women by Cartels and Gangs; Inter-American Commission on Human Rights, Northern Central America Impact of Organized Crime on Women and Girls, para. 4; International Crisis Group, "Exploiting Prejudice" Briefing N°54, 3 December 2025 (updated 18 February 2026), section II–III; Human Rights Watch, 'Interview: LGBT People Flee Violence'.
[105] Contribution by GAATW; see also UNODC World Drug Report 2018 Booklet 5, pages. 7 and 28-31 and 35; contribution by Youth rise: Joint contribution by ADPAN, Eleos Justice (Monash University) and CPJP,
[106] Contribution by GAATW.
[107] Pp. 23-24; ADPAN et al, p. 3.
[108] A/HRC/41/33, para 27.
[109] A/HRC/41/33, para. 27; A/HRC/63/72.
[110] UNODC, 'Addressing Gender-Based Violence against Women and People of Diverse Gender Identity and Expression who use Drugs', 2023, page. 5
[111] Frontline AIDS, 'A Guide for programmes', page. 9; Building Black Feminist Visions to End the Drug War, pp. 14, 25. See also contribution by SOGIESC.
[112] A/HRC/54/53, para. 42

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V. Conclusions and recommendations

75. **Women and girls are affected by drug policies in distinct ways that often reflect and reinforce existing patterns of discrimination and inequality. Punitive drug policies can have distinct consequences for women and girls, including through overincarceration, barriers to health care, exposure to violence, stigma and discrimination, and obstacles to social and economic reintegration. These impacts are often compounded by intersecting forms of discrimination. At the same time, the report identifies gaps in access to gender-responsive services, with fear of criminalization, loss of child custody and social stigma frequently deterring women from seeking support.**

76. **All drug policies must be implemented in accordance with international human rights law, informed by scientific evidence and responsive to the specific experiences and needs of women and girls. A human rights-based, gender-responsive approach to drug policy based on scientific evidence is not only consistent with States' existing international obligations, but essential to reducing the disproportionate harms drug policies can inflict on women and girls.**

77. **OHCHR reiterates the recommendations issued in previous reports to develop effective drug policies grounded in human rights and, in the context of protecting and promoting the rights of women and girls, and further recommends States:**

(a) **Implement effective, practical and evidence-based prevention measures to protect people, particularly children and young people, from the harms of drug use, and ensure that such measures are gender-sensitive and compliant with international human rights law;**

(b) **Consider decriminalization of possession of drugs for personal use and consider responsible regulation to eliminate profits from trafficking, criminality and violence[113] , while ensuring that any reforms are evidence-based and designed and implemented in a manner that promotes gender equality, reduces stigma and discrimination, and protects the rights of women and girls;**

(c) **Review drug laws, policies and practices to identify and eliminate discriminatory impacts on women and girls, including women who use drugs, women involved in low-level drug offences, Indigenous women, women of African descent and other marginalised racial and ethnic groups, young women and girls, and women facing intersecting forms of discrimination;**

(d) **Reduce reliance on punitive responses to drug-related offences and expand alternatives to arrest, prosecution, detention and incarceration, particularly for women involved in minor drug-related activities, taking into account caregiving responsibilities, histories of violence, coercion, poverty and other relevant circumstances and repeal any mandatory minimum sentencing solely on the basis of offences being drug-related;**

(e) **Ensure that law enforcement in drug control efforts is fully consistent with States' human rights obligations and is primarily reserved for civilian law enforcement agencies. Only deploy military forces in drug control operations on an exceptional basis, where permitted by domestic law and consistent with the principles of legality, necessity, proportionality and accountability, and subject to civilian oversight;**

[113] Decriminalisation, accompanied by increase investment of resources and means in harm reduction, prevention and other drug policies, can reduce stigma and improve access to treatment. At the same time, responsible regulation can reduce organised crime's influence and eliminate profits from trafficking and violence, whilst generating public revenue, provided regulatory frameworks prioritize public health, remove profit incentives to expand markets, heavily restrict marketing, ensure that policies are implemented cautiously and incrementally subject to careful monitoring and evaluation, and remains rights-based and evidence-based. See Statement by the High Commissioner to Dealing with Drugs II Conference; Contribution by UNDP, page 4: See also A/HRC/56/52, para 85(f), AHRC/63/72 para. 65; UNDP, Development Dimensions of Drug Policy, https://www.undp.org/sites/g/files/zskgke326/files/2025-09/undp-development-dimensions-of-drug-policy.pdf.

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Universally abolish the death penalty for all crimes, including for drug related offences;

(f) **Ensure that women deprived of liberty for drug-related offences are treated in accordance with international human rights law and standards, including the Bangkok Rules, and have access to gender-responsive health care, drug dependence treatment, harm reduction services, mental health support and sexual and reproductive health services equivalent to those available in the community;**

(g) **Ensure that measures to address drug-related organized crime are gender-responsive and human rights-based. States should take steps to prevent the recruitment, coercion, trafficking and exploitation of women and girls in drug-related activities; apply the non-punishment principle to victims of trafficking and other forms of coercion; guarantee access to protection, justice and reparations, and effectively prevent, investigate and prosecute gender-based violence perpetrated by organized criminal groups, including in territories where such groups exercise *de facto* control;**

(h) **Guarantee access to voluntary, evidence-based and gender-responsive drug dependence treatment, harm reduction services and health care, including HIV and hepatitis prevention and treatment, sexual and reproductive health services and childcare, and access to controlled medicines for medical purposes; including through safe spaces for women and people of diverse gender identity;**

(i) **Remove legal, administrative and social barriers that deter women and girls from accessing health and support services, including stigma, discrimination, fear of criminalization, loss of child custody and any other measures inconsistent with human rights and informed consent;**

(j) **Ensure that prevention programmes are evidence-based, gender-responsive and consistent with international human rights standards, and address the specific needs and realities of girls, young women and women in marginalised situations;**

(k) **Strengthen social protection, housing, education, employment and social reintegration programmes for women affected by drug use, drug dependence or drug-related convictions, and ensure that access to such services is not made conditional on abstinence, compulsory treatment or mandatory drug testing in a manner incompatible with applicable human rights law;**

(l) **Design and implement alternative development and rural livelihood programmes that promote women's economic empowerment, ensure equal access to land, financial services and productive resources, and enable the meaningful participation of women, including Indigenous women and women from affected communities;**

(m) **Ensure the meaningful participation of women and girls, including women who use drugs and women with lived experience of drug-related criminal justice systems, women human rights defenders- in the design, implementation, monitoring and evaluation of drug policies and programmes; and they are working in safe and enabling environments;**

(n) **Collect, analyse and publish data disaggregated by sex, age and other relevant characteristics, in order to identify and address the distinct and intersecting impacts of drug policies on women and girls.**

78. **International human rights mechanisms are encouraged to strengthen their focus on drug policies and provide recommendations to assist States in meeting their human rights obligations and in addressing the impact of drug policies in the enjoyment of their human rights by women and girls.**

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