CHAPTER 13

Incorporating Child Rights into Scheduling Decisions at the UN Commission on Narcotic Drugs

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Abstract

This chapter focuses on the child rights implications of bringing new substances into the global drug control regime. Focusing on the examples of ketamine and khat, which in turn highlight the issues of access to medicines (SDG 3) and child labour (SDG 8), it outlines the process for placing substances under international control and the child rights implications of such decisions. To date, however, child rights law has not been featured in this procedure. While child rights law may not be determinative in terms of outcome, the chapter focuses on an important process in global drug policy governance. If decisions to place substances under international control within the drug control architecture of the United Nations engage the obligations of child rights treaties, then there is a strong case for formally taking the obligations arising under those treaties into account.

1 Introduction

Children are at the centre of drug policy debates, but aside from prevention, and rhetorical statements of concern about future generations, substantive policy discussions remain limited. This is especially noticeable in relation to supply-side controls (e.g. crop eradication, interdiction) and their development aspects. Similarly, child rights discussions have become more prevalent in drug policy discussions as the silos between human rights and drug policy within the UN have been broken down over time. Mention of child rights remains, however, fairly superficial, usually a mere reference to the Convention on the Rights of the Child in a preambular resolution paragraph. Less visible are substantive aspects relating to state obligations under international child rights law across the supply chain. This chapter focuses on the child rights implications of placing substances under international control, the legal and administrative effects of such decisions, and their relevance for development. Building on commitments made in the Sustainable Development Goals (SDGs), it
focuses on access to essential medicines (SDG 3.8) and addressing the worst forms of child labour (SDG 8.7). Its central argument is straightforward.

If decisions to place substances under international control within the drug control architecture of the UN engage the obligations of child rights treaties, then there is a strong case for formally taking the obligations arising under those treaties into account. The examples of ketamine (an essential medicine, used for anaesthesia) and khat (a stimulant plant), both not yet under international control, illustrate the relevance of the scheduling process for child rights and development, and make the case for the routine inclusion of child rights obligations in that process. Our argument is therefore procedural, rather than one of outcome. But in aiming to mainstream child rights in an important aspect of global drug policy governance, it speaks directly to SDG 16.6—accountable institutions.

2 The International Drug Control System: Two Imbalances

Three multilateral treaties form the core legal framework for international drug control. Each enjoys near universal ratification or accession: the Single Convention on Narcotic Drugs 1961, as amended by its 1972 Protocol (UN, 1961. Hereafter: ‘Single Convention’), the Convention on Psychotropic Substances 1971 (UN, 1971. Hereafter: ‘1971 Convention’), and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 (UN, 1988. Hereafter: ‘Trafficking Convention’). The Single Convention replaced multiple prior treaties, creating one ‘single’ treaty, and primarily controls plant-based substances and their derivatives—in particular coca, opium poppy and cannabis. The 1971 Convention controls synthetic substances that had been omitted from the Single Convention. These include, for example, amphetamines, LSD, and ecstasy (MDMA). The Trafficking Convention, on the other hand, is primarily an instrument of transnational criminal law, bolstering the weak penal provisions of the earlier treaties, and was adopted in response to the growing illicit drug trade. Critically, the entire system builds upon the ‘general obligation’, set out in Article 4(c) of the Single Convention, ‘[...] to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs’. That obligation recognises that many of the substances controlled under the drugs conventions have important medical uses (e.g. morphine). However, any other uses, such as for recreational, cultural or religious purposes, fall outside of this definition and are therefore proscribed by international law (see Article 49(2)(d)-(g), Single Convention).
Beyond debates about the ethics of the above distinctions (e.g. the effects on indigenous communities or cultural minorities of controlling traditional plants), there are at least two imbalances in the system that are of relevance to development, and that the cases of ketamine and khat exemplify. The first is the administration of the licit market for medical and scientific purposes. Under the *Single Convention*, a system of import/export authorisation is established as an ‘estimates’ and ‘statistical returns’ system (Articles 12 and 13). This is intended to ensure adequate supply of controlled medicines and to verify that imports and exports are for such purposes. There is no such system for the *1971 Convention*, the preamble of which states merely that access for medical purposes should not be ‘unduly restricted’. The system has not been working. For example, an estimated 83 per cent of the world’s population lives in countries, overwhelmingly in the developing world, with low to non-existent access to opiates for moderate to severe pain (Seya et al., 2011). Paediatric access brings additional challenges (Marston, 2011). While non-medical use of certain substances is a serious problem, national and international scheduling leads to reduced availability and accessibility of medicines, may negatively affect perceptions of the medicine, creating a ‘chilling effect’ on prescribing (*HRW*, 2009, 2011, 2013, 2015, 2016 and 2017), and may drive up cost (De Lima, 2018). These concerns go to the heart of controversies surrounding ketamine, to which we return below.

The second imbalance is its supply-side focus. While there are general provisions relating to the prevention of drug use and the treatment of dependence, the three treaties are overwhelmingly geared towards cutting off drugs at source, and interrupting illicit flows (see Barrett, 2020, Annex II). As part of this, the production of certain crops (coca, cannabis and opium poppy) is to be made a crime (Article 3, *Trafficking Convention*), and the eradication of those crops is a specific obligation of States Parties (Article 22, *Single Convention*; Article 14, *Trafficking Convention*). These measures are known to complicate development policy in producer regions (*UNDP*, 2015). If placed under international control, khat would be subject to the same requirements. A further complication discussed below, however, is the role of children in the farming of such crops once they are rendered illicit. On that, the drugs conventions are silent.

### 3 Placing Substances under International Control

However bland it may seem on the surface, the process for deciding which substances enter into international control in the first place, often referred to
as ‘scheduling’, is critical. The process involves both a technical review by the World Health Organization (WHO) and a political vote by the United Nations Commission on Narcotic Drugs (UN CND). Made up of fifty-three member states, the UN CND is the main policy-making body within the UN system for drug control, and has the mandate under the drug treaties to place substances under international control, which it can do via a majority vote, following the review by the WHO.

Under the treaties, controlled substances are listed according to their risk profile. Each ‘schedule’ carries specific international obligations in relation to the substances it contains (see Hallam, Bewley-Taylor and Jelsma, 2014). Substances seen as particularly risky, with little or no therapeutic value, are placed in the schedules carrying the most stringent controls (Article 2, Single Convention; Article 2, 1971, Convention; Article 12, Trafficking Convention). Thus, for example, all of the substances in schedule I of the Single or 1971 Conventions are subject to all of the obligations under the relevant treaty, while substances in schedule III of each treaty are only subject to some of them. Importantly, without a decision to ‘schedule’ a substance, the treaties do not apply to that substance at all. For example, as alcohol is not under international control, despite being a harmful substance, these treaties do not apply to it. Similarly, they do not currently apply to ketamine or khat.

Under the Single Convention’s system, a state party to the conventions, or the WHO, may notify the UN Secretary-General of the need for a change to the schedules—that is to say, the inclusion of a substance, its removal, or moving it from one schedule to another (Article 3(1) Single Convention; see also UN, 1973, 80). The Secretary-General then brings this to the attention of the UN CND, or to the WHO if the issue was raised by a State Party. A technical review of the substance, weighing the risk of abuse versus its therapeutic potential, is then carried out by the WHO’s Expert Committee on Drug Dependence (ECDD). Based on this review, the WHO may recommend not scheduling the substance or that it be placed on a specific schedule, or, if the substance is already on a schedule, it may recommend moving it to another, or removing it entirely. The process under the 1971 Convention is similar, but the role of the WHO is explicitly ‘determinative as to medical and scientific matters’. Moreover, states are expressly allowed to take into account other relevant ‘economic, social, legal, administrative and other factors’ (Article 2(5), 1971 Convention). This is not stated clearly under the Single Convention process.

Scheduling decisions are ultimately made by a majority vote at the UN CND. Under the Single Convention system decisions are made through a simple majority vote. Under the 1971 Convention it requires a two-thirds majority. Thus, following a vote in which only twenty-seven states under the Single Convention,
or thirty-six states under the 1971 Convention, explicitly agree to schedule a substance, international legal obligations for all states parties are engaged. This is a rare power for such a commission, as it effectively changes the scope of the relevant treaty without the need for a plenipotentiary conference. There is no possibility for states to opt out of their treaty obligations with regard to a specific substance. States must ‘carry out the onerous decisions of the Commission as expeditiously as practicable’ (UN, 1973, 98). Rarely discussed, however, is that the above decisions, made by majority vote, not only affect drug treaty obligations, but also have consequences for broad child rights obligations of universal application.

4 Scheduling Decisions: Delimiting the Scope of Child Rights Treaties

The Convention on the Rights of the Child (UN, 1989. Hereafter: ‘crc’) is the only core UN human rights treaty to refer to drugs. Article 33 reads:

States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances (emphasis added).

There are two clauses here, or essentially two rights of direct relevance to the examples of ketamine and khat: protection from the illicit use of drugs, and prevention from involvement in the illicit drug trade. The key word is ‘illicit’. The reference to the ‘relevant international treaties’ establishes how ‘illicit use’ is ‘defined’, but also indicates which substances Article 33 covers. The drafting history of the crc demonstrates that the reference to the ‘relevant international treaties’ was intended to delimit the scope of Article 33. In the technical review phase of drafting, the wording of the drugs conventions then in force (the Single and 1971 Conventions) was adopted, limiting Article 33 to the substances under international control, and thereby excluding alcohol and tobacco from this provision (WHO, 1988).

Substances ‘defined by the relevant international treaties’, of course, is not a closed list. The scheduling process can change it, thereby changing the scope of application of the crc. In practice, it has been an ever-expanding list with many more substances now controlled than were at the time when the crc
was adopted. As substances enter onto international drug treaty schedules, all states party to the CRC must, because of Article 33, take ‘all appropriate measures’ to protect children from using them illicitly, and prevent the use of children in illicit production and trafficking. This in turn affects the remaining articles of the CRC, which must be read as a whole when considering what an ‘appropriate measure’ may be (Barrett and Tobin, 2019). As such, scheduling decisions made by the few dozen Commission members in Vienna affect the legal obligations of all 196 states party to the CRC, and may extend beyond the relatively vague wording of Article 33 itself. This includes states that have not yet ratified or acceded to the drug conventions at all,1 or those that may one day denounce them. In other words, if a state were to decide that it no longer wished to be bound by the Single Convention, its child rights obligations would still be engaged by decisions made under a regime to which it is no longer a party. There is no indication from the available drafting documents that the consequences of scheduling decisions for CRC obligations were fully discussed (Barrett, 2020, 50‒53).

A further treaty involved is International Labour Organization (ILO) Convention No 182 on the Worst Forms of Child Labour (ILO, 1999a. Hereafter: ‘ILO 182’; see also ILO, 1999b). One of the ‘fundamental’ ILO treaties, it too enjoys near universal ratification or accession, including by the United States, which is the only state to have not ratified the CRC. Article 1 requires that States Parties ‘[…] take immediate and effective measures to secure the prohibition and elimination of the worst forms of child labour as a matter of urgency’. From there, the definition of the worst forms of child labour includes, at Article 3(c), ‘the use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international treaties’. (emphasis added.)

Article 7(1) further requires the ‘effective implementation of the treaty’, including ‘the provision and application of penal sanctions or, as appropriate, other sanctions’ (See Noguchi, 2016).

The same delimitation ‘as defined in the relevant international treaties’ is there. The drafting history reveals that the wording was intended to mirror Article 33 of the CRC in order to avoid contradiction. There was, however, no discussion of the fact that scheduling decisions by a vote at the UN CND would engage the obligations of all ILO 182 states parties (ILO, 1999c). As with the

1 Currently these are Palau, Papua New Guinea, Equatorial Guinea, Kiribati, the Solomon Islands, South Sudan, the State of Palestine, and Tuvalu.
CRC, then, these explicit obligations under ILO 182 (including applying criminal sanctions) are engaged by decisions of the UN CND.

5  Child Rights Implications of Scheduling Decisions

Article 33 is central to any discussion of child rights and drug policy, but given the scope of the CRC, it is genuinely difficult to find any article that cannot be linked to drug use or the drug trade. For example, the child’s right to health (Article 24) and access to essential controlled medicines; the child’s right to an adequate standard of living (Article 27), and crop eradication campaigns; or protection from economic exploitation (Article 32) and agricultural work. In addition, the ‘general principles’ of the CRC apply to all policies, including the principle of the best interests of the child (relating the wider CRC to Article 33; see Barrett and Tobin, 2019 and Barrett, 2020). Traditionally, this principle has focused on children’s best interests being served by their not using drugs. This is obvious, but does not end the discussion. What of those children affected in other ways by what seem to be arcane procedures in Vienna, including those along the supply chain, or those in need of access to essential medicines?

5.1  Ketamine and the Child’s Right to Health

Ketamine is a synthetic medicine, is included on the WHO model essential medicines list for children (WHO, 2017), is recognised as a ‘safe and effective choice for sedation in children’, and is ‘perhaps the most widely used agent in the world’ for this purpose (WSIA, 2014). The medicine is not currently under international control, but over the years there has been political pressure for ketamine to be controlled internationally due to its recreational use (e.g. UN CND, 2014a). The WHO has, however, recommended against scheduling ketamine at repeated meetings of its Expert Committee on Drug Dependence. This is due to its low risk as a public health concern and its high medical benefit. In the words of the ECDD, it is ‘a widely used anesthetic and analgesic, especially in developing countries, because it is easy to use and has a wide margin of safety when compared with other anesthetic agents’ (WHO, 2016). The WHO’s caution against scheduling ketamine is borne out of the lack of access to controlled medicines already noted above, which is seen as a failing of the system into which ketamine would be drawn. The worry was that ‘if ketamine were placed under international control, this would adversely affect its availability and accessibility. This in turn would limit access to essential and emergency surgery, which would constitute a public health crisis in countries where no affordable alternative anaesthetic is available’ (WHO, 2014).
In 2015, however, China sought to place ketamine on schedule I of the 1971 Convention. According to China, ketamine had become a major public health concern due to recreational use. For China, placing the medication under international control was essential to countering this public health threat (UN CND, 2015a). China’s proposal ran contrary to the WHO recommendation, leading to lengthy debates at the CND as to the legality of acceding to it (UN CND, 2015a; TNI, 2015). Some states supported China, while others disagreed, focusing on the medical benefits of ketamine (UN CND, 2014b). What was not at issue were the international child rights obligations raised by the debate. The importance of the medicine certainly was discussed, but the child rights obligation on CRC states parties to ensure access to such medicines for children in need was not. In particular, the child’s right to health under Article 24 of the CRC would clearly be affected—including, importantly, its ‘core minimum’ standard of access to essential medicines (UN Committee on the Rights of the Child, 2013). This right applies to every state, bar the US, whether voting on the decision at the UN CND or not. These obligations were entirely missing from the UN CND ketamine discussions.

With a WHO review assessing risk versus therapeutic benefit, however, the added value of bringing in a child rights perspective is a valid question. First, the CRC demands a focus on the impact on children and foregrounds their best interests as a legal requirement. This, alone, is an important factor, and brings the challenge of appropriate paediatric access to the forefront. Second, states do not cast off their human rights obligations because they are voting at the UN CND. Bringing in human rights law—in this case child rights law—may help to redress the above imbalances in a system that, rooted in concerns about addiction and the drug trade, has tended towards ever more substances being controlled. Third, and directly related to this, a child rights focus strengthens the access-to-medicines aspect of the drug control system, which is by far its weakest element. Under the drug conventions, there is—strictly speaking—an obligation to ensure adequate stocks. The right to health focuses on ensuring access, locating this in a duty of the state towards everyone within its territory (under the CRC the right to health is not linked to citizenship but to geographical location in the territory).

Finally, states party to the CRC must give reasons for limiting the child’s right to health. As ketamine is an existing, widely used essential medicine, placing it under international control would (as the ECDD noted) have the effect of limiting its current availability. While states may limit rights in certain circumstances, such limitations must be justified with respect to the goal being pursued, necessity, and proportionality. These factors are currently missing from UN CND decision-making (Lohman and Barrett, 2020). Incorporating child rights into the process may help to fill this gap, at least with regard to the child rights obligations directly engaged by the process.
5.2 **Khat, Child Labour, and Prevention from Involvement in the Illicit Drug Trade**

Turning to a very different example, khat is a stimulant plant with a long history of use, especially in East Africa and the Arabian Peninsula, as well as among immigrants from these regions (Beckerleg, 2008). It is primarily used socially and in some cases for traditional medicine (EMCDDA, undated). It is a major export commodity for some countries. Its active components, cathinone and cathine, are controlled under the 1971 Convention, but unlike coca, opium poppy, and cannabis—which each have traditional, cultural, or religious uses—that itself was not placed under international control when the treaties were drafted.

While khat has been discussed at the UN CND for decades, concerns about excessive use, in particular among men from diaspora communities in European countries, have increased recently. The International Narcotics Control Board (INCB), which oversees the implementation of the drug conventions, has recommended that states place plants containing psychoactive substances under international control (a recommendation aimed at khat), while many states have banned the plant (Hallam, Bewley-Taylor and Jelsma, 2014). In 2006, however, the ECDD reviewed khat and recommended against scheduling the plant itself, stating, 'The level of abuse and threat to public health is not significant enough to warrant international control [...] The Committee recognized that social and some health problems result from the excessive use of khat and suggested that national educational campaigns should be adopted to discourage use that may lead to these adverse consequences' (WHO, 2006, 11).

To date, khat remains outside of international controls, but the debate remains active. Here, however, we see a limitation of the ECDD technical review, which focuses on pharmacology and on the health risk versus benefits. What the ECDD does not look into are the potential negative effects on traditional practices or the economies of developing countries, not to mention the risk of adding to the criminal market in drugs or potential damage to relations between the authorities and immigrant communities (GDPO, 2014). Children may, of course, be affected by all of these aspects, and many rights within the CRC are applicable. The UN CND decision-making process does not, however, currently provide official space for such consequences to be foregrounded. The fact that child rights treaties are explicitly affected by scheduling decisions may assist in opening up this space. Children’s involvement in khat production is a clear example of why this is needed.

There are many ways in which children are involved in the khat industry, including picking, trimming and bundling; selecting good quality plants; transport to market; and assistance with sales. As a 2017 study from Ethiopia found, the average age of child involvement is 14 (with children as young as 8
involved), and with the work varying from family smallholdings to larger commercial operations in the context of a growing industry (Negash, 2017, 25–31).

While there are important concerns about child labour in this context (i.e. work that harms the child’s physical or mental well-being, or deprives children of a childhood), placing khat under international control would result in a very specific legal distinction, which is why attention to process matters. By a vote of the UN CND, khat would become illicit ‘as defined by the relevant international treaties’, thereby engaging Article 3 of ILO 182. By the decision of the UN CND, then, children’s involvement in khat production would automatically become a ‘worst form of child labour’, even though no working conditions will have changed. This would be a profound difference, brought about by a diplomatic process rather than attention to the realities on the ground. Instead of being a qualitative assessment of child labour conditions and standards relating to agriculture (e.g. type of work, hours, access to rest and leisure, access to education), the UN CND vote would in effect result in an absolute ban under a fundamental ILO treaty and, indeed, the CRC. Children’s involvement would automatically become illegal exploitation, thereby proscribing any and all of the above types of activities. Indeed, the word ‘use’ was an intentionally broad formulation used in drafting the CRC and the Trafficking Convention, mirrored in ILO 182, and intended to capture even very minor roles in the drug trade (Barrett 2020, 45–46 and 50–56). Recalling the wording of Article 7(1) of ILO 182, then, states would have obligations to ‘[…] take immediate and effective measures to secure the prohibition and elimination of the worst forms of child labour as a matter of urgency’, including the ‘application of penal sanctions or, as appropriate, other sanctions’.

This is not to say that khat farming is without problems. All agricultural work carries child rights implications, and there is much harm, as the above-mentioned Ethiopian study identified, including access to education and uptake of khat chewing. But to legally define all involvement in khat production as a ‘worst form of child labour’ would be a significant legal difference demanding direct attention in UN CND decision-making. Currently, however, these child rights questions rooted in treaties outside of the drug control regime are not accounted for in the scheduling process.

6 Conclusion: from Discretion to the Routine Inclusion of Child Rights Considerations in Scheduling

The drug conventions do not preclude taking CRC and ILO obligations into account. Article 2(5) of the 1971 Convention provides more explicitly for the
ability of the UN CND to take into account other relevant ‘economic, social, legal, administrative and other factors’ in making its decisions. No such aspects are set out explicitly in the Single Convention, though the element of discretion is retained. In drafting, it was agreed that ‘administrative’ and ‘social’ considerations may guide the decision (UN, 1973, 90). As such, child rights law and child rights effects ‘may’ be brought to bear based on the terms of the drug conventions themselves.

Such discretion, however, necessarily entails the discretion not to include child rights considerations. This chapter has proposed instead that there is a legal imperative to do so. As we have discussed, there is a clear linkage between UN CND scheduling decisions and child rights treaties. There is a range of child rights—beyond those specific to drugs—that may be engaged, and certain decisions (as exemplified by khat) that can change the legal status of something as serious as child labour. Every time the Commission adds a substance to international control it extends the obligations of child rights treaties to that substance. Every time it removes one, it removes those obligations.

To move child rights considerations from ad hoc discretion to a routine aspect of such decisions, however, would require a formal process of some sort. One way to do this would be to adopt a form of child rights impact assessment relating to the substances in question. This could be done in isolation, or as part of a wider human rights impact assessment of such decisions (e.g. based on the right to health; see Lohman and Barrett, 2020). Such a system could be set up via a resolution of the UN CND, requesting child rights assessments from its secretariat, the UN Office on Drugs and Crime (UNODC). As politically unlikely as this may seem, UN CND resolutions have called for the need to bear in mind CRC obligations, including those sponsored by some of the most conservative governments (e.g. UN CND, 2018). Even without a resolution, the UNODC could still produce a Conference Room Paper for each substance in question, advising states of the child rights implications of their decisions, perhaps seeking assistance from UNICEF and the WHO in this regard. In many cases there may be little to add, such as a new compound very similar to a substance already controlled. In some important cases, however, as ketamine and khat demonstrate, there may well be important legal and practical child rights considerations to address. A rights-based analysis, rooted in treaty obligations, would place the relevant child rights implications before the entire Commission, and could also be distributed to the more than 140 non-members of the UN CND that are parties to the CRC and ILO 182, but would not have a scheduling vote. This would allow those states to engage diplomatically on issues that would affect their legal obligations within and beyond the drug control system. Moreover, should this transpire, such information should be shared
with the monitoring bodies of the child rights treaties—the UN Committee on the Rights of the Child and the ILO Committee of Experts on Standards and Recommendations—given that the scope of those treaties would be expanded by each new substance placed under international control.

In this way, accountability for child rights could be strengthened within the scheduling process, and the silos between human rights and drug control within the UN system could be further broken down.

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