TRANSNATIONAL INSTITUTE

TOWARDS A HEALTHIER LEGAL ENVIRONMENT

A REVIEW OF MYANMAR'S DRUG LAWS

The 1917 Burma Excise Act

The 1993 Narcotic Drugs and Psychotropic Substances Law

The 1995 Rules relating to Narcotic Drugs and Psychotropic Substances

February 2015

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Introduction

This report reviews Myanmar's drug laws and related policies, including the 1917 Burma Excise Act; the 1993 Narcotic Drugs and Psychotropic Substances Law; and the 1995 Rules relating to Narcotic Drugs and Psychotropic Substances. Since these laws were enacted several important changes have taken place inside and outside of Myanmar. The decision of the Myanmar Government to review the law is not only timely but also offers a prospect to improve the drugs legislation and to ensure that the laws address drug-related problems in the country more effectively. It is an opportunity to ensure that affected populations have access to health care and development, taking into account both national conditions and international developments and best practices.

This review paper will first give an overview of Myanmar's current legal and policy framework related to drugs, followed by an overall analysis. After that it will make specific comments on a number of key articles. In addition, the review will outline some international obligations and best practices. Finally, the paper will make some overall conclusions and recommendations

Drug-Related Problems in Myanmar

Drug production and consumption trends have changed over the years and Myanmar faces several serious drug-related challenges. Myanmar is currently the second largest producer of raw opium in the world, after Afghanistan. After a period of initial decline, poppy cultivation in the country has tripled again since 2006.[1] Most of the poppy is cultivated by impoverished ethnic minority communities in the country's uplands, who grow opium as a cash crop to meet their basic needs, including food, medicines, clothing and access to education. Opium is also used as a painkiller and against diarrhea in areas where there is no access to essential medicines. Opium has traditional, cultural and religious use. In short, for such communities, opium is a solution it helps to solve their main problems and allows them to live a life in dignity. Myanmar is also a major producer of heroin and amphetamine-type stimulants (ATS)[2], and large quantities of these substances are smuggled to neighbouring

countries. Precursors to make heroin and ATS are not produced in Myanmar; these originate mainly from neighboring India and China.

Myanmar has some serious drug use related problems. There are no reliable data available on number of drug users, drug consumption trends, drug use patterns, and drug use related health problems, as there has not been any national drug use survey. However, available evidence from case studies in selected areas suggests a significant number of injecting heroin users, with high concentrations in the northern part of the country (especially Kachin and Shan States). Many of them have serious health problems related to their drug use, including HIV/AIDS and Hepatitis C. Injecting drug use has been one of the key drivers of the spread of HIV/AIDS in Myanmar. There also is a large and growing number of ATS users in the country. In most areas where opium cultivation is present, traditional opium uses also take place, but these are less problematic. Since the current drug laws were promulgated, important developments have taken place. The most serious of these is the large number of injecting drug users that have been infected by HIV by sharing unclean needle syringes.

Drugs production and trafficking have fuelled conflict in Myanmar, which has experienced decades of civil war. It has stimulated corruption and contributed to lack of rule of law. The drug trade is a highly profitable business, and has attracted international criminal syndicates who have aligned themselves with conflict actors in Myanmar.

Current Legal and Policy Framework Related to Drugs

There are several laws and regulations in Myanmar's legal framework that are relevant for drug related issues. Among them the most relevant are:

- The 1917 Burma Excise Act
- The 1993 Narcotic Drugs and Psychotropic Substances Law
- The 1995 Rules relating to Narcotic Drugs and Psychotropic Substances

There are also two important national strategies related to drugs:

- 15-year Drug Eradication Plan (1999-2014)
- National Strategic Plan on HIV/AIDS (2011-2015)

The 1917 Burma Excise Act

The '1917 Burma Excise Act' deals with alcohol and 'intoxicating drugs'. The latter includes cannabis – hemp plant, leaves, small stalks and flowering or fruiting tops (*Bhang, Sidhi and Ganja*), resin (*Charas*) and any drink containing these (Section 2(l)) Importantly, cultivation of cannabis is permissible under a special license (section 11).

The 1917 Burma Excise Act is relevant as Section 33 prohibits the use, making, possession, sale or distribution of hypodermic needles or other syringes suitable for injection without a license. As this Act was promulgated when the country was still under British colonial rule, the fine for failure to comply with the law is stipulated in rupees.

The 1993 Narcotic Drugs and Psychotropic Substances Law

The most important drug law in the country is the 'Narcotic Drugs and Psychotropic Substances Law' adopted on 27 January 1993 by the State Law and Order Restoration Council (SLORC), the then military government of Myanmar. This law brought Myanmar's legal system in line with the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, to which Myanmar acceded on 11 June 1991. The 1993 Narcotic Drugs and Psychotropic Substances Law replaced the 1974 Narcotic and Dangerous Drugs Law. The 1974 law was adopted to bring Myanmar's legal framework in line with the 1971 UN Convention on Psychotropic Substances. The Myanmar Government has made some reservations to both the 1961 Single Convention on Narcotic Drugs[3] as well as 1971 UN Convention on Psychotropic Substances.[4]

The 1995 Rules relating to Narcotic Drugs and Psychotropic Substances

The 1995 Rules relating to Narcotic Drugs and Psychotropic Substances were issued by the Ministry of Home Affairs of the Government of the Union of Myanmar on 17 July 1995. These rules give more specific details on how the 1993 law should be implemented, especially in relation to arrest, search and seizure of drugs as well as registration and treatment of drug users.

15-year Drug Eradication Plan (1999-2014)

In 2008, at the ASEAN Ministerial Meeting, the regional grouping pledged to achieve a drug-free ASEAN by 2020. Two years later the target date was brought forward to 2015, and all member states developed national plans to meet the deadline, although they did not agree on a common strategy on how to do so.[5] In 1999, the Myanmar government adopted a 15-year plan to make the country drug-free by 2014.

In mid-2013 the national deadline was postponed to 2019 (synchronising it with the new UN target date) because of the threat posed by amphetamines and the increase in opium cultivation in the country since 2006.[6] The government announced that it would extend the 15-year drug elimination plan with an additional five years and would focus on eradicating poppy in 51 townships in major opium growing areas in Shan, Kachin, Kayah and Chin States.[7]

National Strategic Plan on HIV/AIDS (2011-2015)

The National Strategic Plan (NSP) on HIV/AIDS is a guiding document issued by the National AIDS Program of Myanmar. The aim of NSP is to prevent HIV transmission among most vulnerable populations and reduce morbidity and mortality related to the infection. The target of NSP (2011-2015) is also to achieve the Millennium Development Goals of HIV by 2015. The guiding principles of NSP facilitate to cut down the new infections by half of the estimated rate of 2010, and to increase availability of Anti-Retroviral Therapy (ART) to those who are in need.

The NSP highlights the necessity to develop an appropriate policy and legal framework to protect the basic human rights of affected communities when addressing HIV/AIDS issues. Fundamentally, the strategic plan has three main priorities and among them, the first one is to prevent transmission of HIV via unsafe sexual contacts and injecting drug use. In addition the new NSP emphasizes accessibility of health services by people who are in prison and rehabilitation units.

Analysis of the Current Legal Framework

The focus of the current laws and policies is mainly on law enforcement and compulsory 'treatment' of drug users, and there is very limited legal space to address the health and other needs of people who use drugs. The current legal framework is on occasion contradicting the rights acquired in the 2008 Myanmar Constitution.

The mandatory registration and compulsory treatment for drug users is problematic. Failure to enroll or comply with directives of the health ministry results in a prison sentence ranging from 3 to 5 years. Punishing drug users for undergoing treatment at a facility which is different from the user registration centre not only violates their right to health but is detrimental to their life and personal freedom, which is protected under Article 353 of the Constitution, 2008.

The law stipulates very long sentences for relatively small drug-related offences, especially compared to other countries in the world. The minimum sentence for simple possession of drugs is 5 years imprisonment, which is excessive and disproportionate. Importantly, the 'Basic Principles of the Union' articulated in the Constitution, 2008 to guide the enactment of laws prohibits penalty that violates human dignity (Article 44).

The mandatory registration and the criminalization of drug users have prevented users from accessing services provided by the government and other relevant local and international organisations. The law also provides the extreme penalty of death for the offence of production, distribution or sale of a narcotic drug or psychotropic substance.

Clearly the focus of the legal and policy framework is on punitive action, with little attention for more positive policy outcomes. Most indicators for 'success' are enforcement oriented, including number of drug-related arrests, hectares of poppy fields eradicated, rather than social and health oriented indicators such as number of drug users having access to services, number of overdoses prevented, and more livelihood opportunities for poppy cultivating communities to reduce their dependency on opium for their basic needs.

Implications

Like other countries which have criminalized drug use, Myanmar's prison and judicial system is under great pressure by the large number of people incarcerated with long jail sentences for relatively small drug-related offences. This includes failure to register as drug user, possession of needle syringe, and possession of drug for personal use. Although exact figures are not available, government officials estimate that up to 70% of Myanmar's estimated 60,000 prison population is convicted for drug-related charges. The large majority of them are poor drug users and/or small drug traders.[8] Very few large-scale drug traffickers have been targeted and arrested.

This punitive approach has further contributed to a lack of access to health and other services, as drug users are criminalized and go underground to avoid arrest and/or extortion by law enforcement officers. At the same time there has been little investment in health and other services for drug users.

The focus on law enforcement and the official policy to make the country drug free by 2014 – later postponed to 2019 - has also put great strains on already resource-strained government departments responsible to reach these targets. These departments have been forced to develop strategies and implement policies based on unachievable objectives. In 2008, the ASEAN status report to review its strategy to become drug-free by 2015 reported "an overall rising trend in the abuse of drugs" and acknowledged that "a target date of zero drugs for production, trafficking and consumption of illicit drugs in the region by 2015 is obviously unattainable".[9]

Opportunities for Reform

On the political level, the country has seen some important changes in recent years. Since 2011, the Thein Sein government has initiated a reform process in Myanmar. This process includes the review of many of the country's laws to bring these up to date with existing realities on the ground in Myanmar as well as with international obligations, standards and best practices. One of the laws currently being under review is the 1993 Narcotic Drugs and Psychotropic Substances Law.

At the international level, several important drug policy developments have taken place, moving away from the 'war on drugs' and repressive drug policies towards prioritizing health and development based approaches. At the UNGASS review in 2008, UNODC Executive Director Costa warned about 'unintended consequences' of drug control framework and its implementation. These negative aspects include the existence of a thriving criminal black market; policy displacement (from a focus on public health to a focus on security); geographic displacement (shift in cultivation from one area to another, or 'balloon effect'); substance displacement (shifts from controlled to less controlled drugs); and the stigmatisation of drug users.[10]

In Latin America, many countries have had political debates on drug law reform, leading to legislative changes in several countries, including Colombia, Argentina, Ecuador and Mexico with regard to decriminalization of possession of drugs for personal use and proportionality in sentencing for low-level trading offences. In December 2013, Uruguay approved the legal regulation of the production, distribution and sale of cannabis, the first country in the world to do so.

The Global Commission on Drug Policy - a body of retired world leaders[11] - in 2011 publicly condemned the drug war as a failure and recommended major reforms of the global drug prohibition regime. In a 2014 report, the Commission called for "decriminalization, alternatives to incarceration, and greater emphasis on public health approaches".

In 2012 two U.S. states, Colorado and Washington, legalized and regulated the production, distribution, possession, and use of recreational marijuana after a referendum. In 2014 they were joined by Alaska and Oregon, and it is likely more States may follow their example in 2016. The Obama administration has conditionally accepted these state-level policy reforms, even though they conflict with the federal drug control legislation as well as with the international drug control treaties. In an attempt to avoid that this might open a discussion about the UN Conventions, the backbone of the current international drug control system, the U.S. State Department has invented a legally dubious narrative about the flexibility and prosecutorial discretion allowed under the treaties for these policies.[12]

There are also some positive examples of drug policy reform in the region. For instance, there has been an acknowledgement of the ineffectiveness of compulsory centres for drug users and the need to consider transition in China (although the status of this is unsure now given new crackdown on drugs last year), the Philippines, Cambodia and Vietnam. The latter has already passed new laws and is working on implementing a policy transition, but without committing to eliminate all the compulsory centres for drug users.

Thailand is currently reviewing measures to reduce its levels of incarceration, where the majority of those in prison are sentenced for drug offences, many of them for relatively small cases. This is especially relevant for women, as 80-90 percent of the female prison population is incarcerated for drug offences. Thailand is also undergoing a review of its drug laws, but the outcomes are not clear yet.

Indonesia passed a multi-agency regulation in 2014 to implement diversion for people who use drugs away from prison into treatment. However, there are several problems with its implementation, for example the national police have not committed to this policy change yet, and there are still compulsory centres for drug users in place, creating uncertainty about whether people can only be sent to these centres if they are not sent to prison. UN agencies are working at provincial level to train police on approaches to people who use drugs and to promote alternatives to incarceration.

Clearly, there are several important national and international developments that support the arguments for a review of Myanmar's legal drug policy framework. This legal review of Myanmar's drug related laws by TNI will focus mostly on the Myanmar 1993 Narcotic Drugs and Psychotropic Substances Law.

Comments on Specific Articles of the 1917 Burma Excise Act

Chapter IV Manufacture, possession and sale

Section 13

No person shall make, sell, possess or use--

(i) any hypodermic syringe, or

(ii) any other apparatus suitable for injecting any intoxicating drug, except under and in accordance with the conditions of a license granted under this Act :

Provided that this prohibition shall not apply to

(a) a medical practitioner,

(b) a veterinary practitioner,

(c) a person who possesses or uses any such syringe or apparatus on the prescription of a medical practitioner.

Chapter VII Offences and penalties

Section 33

Whoever, in contravention of section 13, makes, sells, possesses or uses

(a) any hypodermic syringe, or

(b) any other apparatus suitable for injecting any intoxicating drug,

shall be punishable with imprisonment for a term which may extend to six months, or

with fine which may extend to one thousand rupees, or with both.

Comment

This colonial act, which is still in force today, prohibits the possession, sale or distribution of hypodermic needles without a license. Section 33 prohibits the making, selling, possessing or use of hypodermic syringes or any other apparatus suitable for injecting any intoxicating drugs without license. Failure to comply is punishable with six

months' imprisonment and/or a fine of 1,000 rupees (the currency used when the country was under colonial rule by the British).

Drug users are often searched and arrested for possession of either new or used needles and syringes. Because of the police crackdowns drug users are afraid to return used needles and syringes and discard them in places like bushes or rivers which is a threat to the community. The National Strategic Plan (NSP) for HIV/AIDS places harm reduction and HIV prevention among injecting drug users in top priority. The Excise Act is contravening important harm reduction interventions such as needle and syringe programmes. When a drug user is found with a syringe, it is also sent to laboratory for chemical test for trace amount of drugs. As a consequence, the user is also liable for punishment for possession and use of drugs and can be sentenced from five to ten years under the 1993 Law.

In fact the Excise Act was set up initially to protect the role of medical and veterinary practitioners and to prevent the emergence of questionable medical practices. However the law has been hindering drug users to access HIV prevention services such as needle and syringe exchange programs.

In 2001, the Myanmar Police Force Headquarters issued a directive not to arrest drug users for possession of needles and syringes. This directive was meant to ensure drug users to get better access to harm reduction services and change the enforcement practices at the level of township police, but currently seems to be largely ignored by local authorities.

Comments on Specific Articles of the Myanmar 1993 Narcotic Drugs and Psychotropic Substances Law

Chapter I Title and definition

2. *(a)* narcotic drugs

(1) poppy plant, coca plant, cannabis plant or any kind of plant which the Ministry of Health has, by notification declared to be a narcotic drug, substances and drugs derived or extracted from any such plant

(2) drugs, which the Ministry of Health has by notification, declared to be a narcotic drug, and substances containing any type of such drug

(b) psychotropic substances *means drugs which the Ministry of Health has, by notification, declared to be a psychotropic substance*.

Comment

> There is no guidance in the law as to the basis on which the Ministry of Health may notify a particular drug as a narcotic drug or a psychotropic substance. This may result in arbitrary decisions, including notification of substances that do not require control under international conventions or those that do not carry a significant health risk or potential for causing dependence.
>
> The drafters of the new law may consider adding a reference to international drug conventions, particularly the schedules under the 1961 and 1971 Conventions, in order to clarify to what extent national controls of specific drugs are consistent with international treaty provisions.

Chapter II Aims

3. The aims of this law are as follows:

(a) to prevent the danger of narcotics drugs and psychotropic substances, which can cause degeneration of mankind, as a national responsibility;

(b) to implement the provisions of the United Nations Convention Against Illicit Traffic in Narcotics Drugs and Psychotropic Substances [the 1988 Convention];

(c) to carry out more effectively measures for imparting knowledge and education on the danger of narcotics drugs and psychotropic substances and for medical treatment and rehabilitation of drug users;

(d) to impose more effectively penalties on offenders in respect of offences relating to narcotic drugs and psychotropic substances;

(e) to cooperate with the State Parties to the United Nations Convention, international and regional organisations in respect of the prevention of the danger if narcotics drugs and psychotropic substances.

Comment

The drafters of the law may consider adding another aim to the existing list to reflect the principle of 'balance' between availability and control of narcotic drugs and psychotropic substances as contained in international drug conventions.

The proposed objective could read: "*to ensure availability and use of narcotic drugs and psychotropic substances for medical and scientific purposes.*"

Chapter III Formation of the Central Committee and the Functions and Duties of the Central Committee

5. In forming the Central Committee:

(a) it shall consist of the Minister of Ministry of Home Affairs as Chairman and persons from the relevant ministries, Government departments and organizations as members

(b) the vice chairman, secretary and joint secretary of the Central Committee shall be determined

Comment

The drafters may consider specifically providing for the Minister of Health to be a member of the Central Committee, given the significant role that the health ministry plays in drug control and treatment.

The drafters may also consider civil society participation in the Committee and insert the following provision:-

"(c) Representatives from affected groups – farmers, drug users and community organizations"

Such participation also finds support in the 'Basic Principles of the Union' enshrined in Articles 23 and 28 of the Constitution of the Republic of Myanmar (2008). Inputs from affected representatives will help the Central Committee make practical and informed decisions on drug control.

6. The functions and duties of the Central Committee are as follows:

(a)laying down the policies in respect of the prevention of the danger of narcotic drugs and psychotropic substances and coordinating with the relevant boards of authority, Ministers and non-Governmental organizations; (...)

(o) carrying out the functions and duties as are assigned by the Government from time to time.

Comment

To strengthen the health and treatment aspects, the drafters of the law may consider adding a provision that would entrust the Central Committee with formulating guidelines for treatment. The proposed provision could read: *"laying down evidence-based norms for medical treatment of drug users"*

In keeping with the commitment to health and harm reduction, the drafters may also consider adding the following function for the Central Committee:-*"outlining measures to reduce harms associated with narcotic drugs and psychotropic substances on individuals, community and society"*

Chapter V Registration Medical Treatment and Deregistration of a Drug User

Section 9: *(a) "A drug user shall register at the place prescribed by the Ministry of Health or at a medical centre recognized by the Government for this purpose, to take medical treatment".*

(b) The Ministry of Health shall lay down and carry out programmes as may be necessary in respect of medical treatment for a registered drug user;

(c) A registered drug user undergoing medical treatment shall abide by the directives issued by the Ministry of Health.

Comment

Not all drug users need treatment, UNODC estimates that only between 10-15 per cent of drug users develop problematic patterns of use that may require psychological or medical attention, not dissimilar to the proportion of alcohol abuse and dependence. The Special Rapporteur on the right to health has noted that the lack of distinction between

occasional drug users and those dependent on drugs may result in forcing people to undergo unnecessary medical interference, which violates the right to health. (See United Nations General Assembly, Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, dated 6 August 2010, A/65/255, para 37).

The World Health Organisation (WHO) has develop diagnostic guidelines to define drug dependence:

"A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:

- A strong desire or sense of compulsion to take the substance;
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
- A physiological withdrawal state when substance use has ceased or have been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill non-tolerant users);
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
- Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm."[13]

For those who need treatment, different kinds of drug use as well as different drug use patterns require different kinds of treatment. Not all 'treatment' is medical – some drug users require other services and/or responses.

Drug users should be able to choose (or have a say in) which treatment, if required and necessary, is the most appropriate for them. Informed consent for treatment is a part of the right to health, which is not only recognised under international law but also under Article 367 of the Constitution, 2008.

Chapter VII Search, arrests and seizure of exhibits

Section 13: Action taken under this law in respect of the following matters shall be done in accordance with the rules:

See comments on the relevant rules under the section "Comments on Specific Articles of the 1995 Rules relating to Narcotic Drugs and Psychotropic Substances" later in this report.

Chapter VIII Offences and Penalties

Section 15: "*A drug user who fails to register at the place prescribed by the Ministry of Health at a medical center recognized by the Government for this purpose or who fails to abide by the directives issued by the Ministry of Health for medical treatment shall be punished with imprisonment for a term which may extend from a minimum of 3 years to a maximum of 5 years*".

Comment

This section forces a drug user to go through a mandatory registration system to receive treatment concerning his/her drug use and related consequences. Many users are reluctant to register, worrying that the information they provide may not be used for treatment purpose only and, as mentioned above, the far majority of drug users do not need any assistance. Problems associated with drug dependence among a

minority of drug users, should be seen as a chronic relapsing disease and treated similarly to other addictive behaviours, psychosis, or medical conditions like diabetes and hypertension. Incarcerating people for using drugs is contradictory to international human rights measures, and drug treatment should be provided only on a voluntary basis.

Compulsory drug treatment constitutes cruel, inhuman and degrading treatment, which is unacceptable. (See United Nations General Assembly, Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Mendez, dated 1 February 2013, A/HRC/22/53, paras 40 and 42)

Drug user registries have been criticized by the Special Rapporteurs on Health and Torture (See A/65/255, para 20 and A/HRC/22/53, para 72). Punishing patients for failing to attend a clinic or visit a health facility would also violate fundamental human rights.

Moreover, when the 1993 law was adopted there were limited treatment options in the country: hospitalization and detoxification were the only two. Nowadays there are evidence based treatment programs, including methadone maintenance therapy and community based harm reduction services. Drug users could get access to these services and receive appropriate medical care if the law would not enforce punishment for not being registered.

Section 16: "*Whoever is guilty of any of the following acts shall, on conviction be punished with imprisonment for a term which may extend from a minimum of 5 years to a maximum of 10 years and may also be liable to a fine:*

(a) cultivation of poppy plant, coca plant, cannabis plant or any kind of plant which the Ministry of Health has, by notification declared to be a narcotic drug".

Comment

Opium cultivation in Myanmar and the region is strongly linked to poverty. Most households involved in opium cultivation are impoverished subsistence farmers from various ethnic minorities in the remote mountains of northern Myanmar. They grow opium as a cash crop to address food insecurity and buy access to health and education.

Opium is also traditionally used as a painkiller and against diarrhea in areas lacking access to essential medicines. As mentioned previously, the law needs to carefully balance the control measures required by the UN drug conventions between preventing their diversion and abuse while assuring their adequate availability for medicinal purposes.

Cultivating the cannabis plant is made punishable with a minimum sentence of five years imprisonment. However, the Burma Excise Act, 1917 permits cultivation of cannabis under a special license [see section 11, Burma Excise Act, 1917] and the punishment for growing cannabis without a license is imprisonment up to six months or a fine or both [see section 30(g), Burma Excise Act, 1917]. This is contradictory. In addition, the penalty prescribed for cultivation of cannabis under the NDPS law is excessive by any standard and diverging more and more from international trends.

(b) possession, transportation, distribution and sale without permission under this Law of materials, implements and chemicals which the relevant Ministry has, by notification declared to be materials used in the production of a narcotic drug or psychotic substance".

(c) possession, transportation, transmission and transfer of a narcotic drug or psychotropic substance"

Comment

Many drug users are punished for possession of even a small amount of drugs according to Section 16 C. The law does not make specific exemptions for personal use, it only mentions that if a person is found with possession of 3 grams of heroin, 3 grams of opium, or twenty-five grams of cannabis, he or she should be sentenced to imprisonment considering that the possession is for the purpose of sale. The police often search and physically harass drug users, and force them to undergo a mandatory urine analysis, which is not in accordance with international human rights principles. These enforcement practices prevent drug users from seeking appropriate treatment services and lead them to go underground if there is a police crackdown.

Section 19: "*Whoever is guilty of any of the following acts shall, on conviction be punished with imprisonment for a term which may extend from a minimum of 10 years to a maximum of an unlimited period:-*

(a) possessing, transporting, transmitting and transferring a narcotic drug or psychotropic substance for the purpose of sale

(b) offering for sale, agreeing thereto of communicating to market a narcotic drug or psychotropic substance;

(c) (...).

Comment

> Punishing persons who possess drugs 'intended for sale' is problematic. Section 19, read in conjunction with section 26 (any quantity over the specified amount shall be deemed to be for sale) means that any person in possession of more than 3 grams of heroin/morphine or cocaine is presumed to intend to offer the drug for sale. There is no need for the prosecution to prove that the drug was meant to be sold. This casts a very wide net and criminalises drug users and other small time vendors with an extremely disproportionate sentence of 10 years imprisonment or longer.
>
> The drafters of the new drug law may consider lowering the punishment scale, introducing principles of proportionality and reviewing the use of quantity thresholds. They may consider removing the presumption of the intent of trading under section 26 above a certain quantity and make the prosecution responsible for establishing, through production of evidence, that the drug was intended for sale. The quantity threshold would rather be indicative among other indicators, and lose its current determinative nature. Possession of a quantity below the threshold would be assumed to be for personal use, but additional evidence would be required to prove that a higher amount would be intended for sale.

Section 20: "*Whoever is guilty of any of the following acts shall, on conviction be punished with imprisonment for a term which may extend from a minimum of 15 years to a maximum of an unlimited period or with death:*

(a) production, distribution and sale of a narcotics drug of psychotropic substance

(b) importing and exporting a narcotic drug or psychotropic substance; communicating to effect such import and export."

Comment

Proportionality of sentences

Persons accused of distribution or sale, especially of small amounts, are mostly on the lower end of the drug trafficking chain and unconnected with the profits made by big players. It is not uncommon for people who use drugs to engage in distribution or sale of small amounts of drugs to peers as a means to support their own use. But also, many of those involved in harvesting, processing, transporting, street dealing and micro-trafficking (mules/couriers) are caught up in the illicit drugs market for basic survival reasons.

The drafters may consider that the current 15 year sentence of imprisonment is way too harsh for such cases, also in comparison to sentences for other types of criminal offences such as sexual assault, rape, violent robbery or murder, and that prison sentences for this category of drug law offenders involved in the illicit trade for subsistence reasons, should be the exception rather than the rule.

There is no justification for the death penalty, which, under the International Covenant on Civil and Political Rights, can be invoked only for the 'most serious crime', that is, a crime that involves intentional killing. Production, distribution or sale of drugs does not meet this threshold. (See UN General Assembly, Report of the Secretary-General on the Question of the death penalty, dated 30 June 2014, A HRC/27/23 at paras 28, 29, 30, 31). The drafters of the law are strongly urged to repeal the death penalty from the Myanmar drug law.

Chapter IX Miscellaneous

Section 26: defines possession for sale (as opposed to personal consumption) on the following criteria:

(a) in the case of heroin (three grammes)

(b) in the case of morphine (three grammes)

(c) in the case of mono-acetyl morphine (three grammes)

(d) total of the narcotic drugs contained in subsection (a), (b) and (c) (three grammes) or total of two types out of the said three (three grammes)

(e) in the case of crude opium or processed opium or total of the two (one hundred grammes)

(f) in the case of cannabis or essence of cannabis or total of the two (twenty-five grammes)

(g) in the case of [coca] leaf (one hundred grammes)

(h) in the case of cocaine (three grammes)

Comment

A law that rests on a presumption that the possession of drugs in excess of a specified amount is always intended for sale, without actually looking into the background and circumstances is highly problematic and undermines the fundamental legal principle of the presumption of innocence. Quantity should not be the sole indicator of what the drug was meant for. Quantity based determination of culpability has many unintended consequences.

First, it casts a very wide net to incriminate people who may be in possession for personal use or use in social contexts such as among peers and friends that does not involve sale or commercial distribution.

Second, it may cause enforcement to overlook other factors that would ordinarily distinguish minor wrongdoers from serious offenders and innocuous acts from conduct that is harmful to society.

Third, it results in 'standardized' sentencing that does not take into account the individual's role and circumstances. A truck driver, on the scale of culpability and punishment, must be treated differently from the person who organized the shipment, even though the quantity of drugs involved is the same in both cases.

In many countries, penalties that are disproportionately graver than the harm caused by the offence are outlawed for being 'cruel and inhuman'. Importantly, the 'Basic Principles of the Union' articulated in the Constitution, 2008 to guide the enactment of laws prohibits penalty that violates human dignity (Article 44).

28. The provisions of this law shall not apply to the following cases:-

(a) (...).

(b) use, possession, transportation, transmission, transfer, sale, import, export and external dealing in respect of narcotic drugs or psychotropic substance in the manner prescribed for the purpose of production, work of research of medical treatment, with the consent of the relevant ministry

(c) use, possession, transportation of a narcotic drug or psychotropic substance permitted by the Ministry of Health under the direction of any registered medical practitioner, in accordance with the stipulations

Comment

> These provisions must be used liberally by the Ministry of Health to allow harm reduction measures including oral substitution, prescription and maintenance, especially for opiates. As the Health Ministry officially recognizes and carry out Methadone programmes, then its use, possession and transportation should not amount to an offence under the law.

Comments on Specific Articles of the 1995 Rules relating to Narcotic Drugs and Psychotropic Substances

Chapter II Registration, Medical Treatment and Deregistration of Drug Users

4. *The drug user shall, if he has attained the age of 18 years appear personally or if he has not attained the age of 18 years, appear together with his parent or guardian at the drug user registration centre near to him and register thereat.*

Comment

> Drug user registries are ineffective in protecting the health of people who use drugs and violate their right to health. As stated in the report of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: "Use of drug registries — where people who use drugs are identified and listed, and their civil rights curtailed — also may deter individuals from seeking treatment, as violations of patient confidentiality are documented frequently in such jurisdictions."[14]

Rule 6. *Obligation of the drug user to report in advance if s/he is shifting residence and to register in the Centre at the new place (...)*

Comment

> Constitutes undue surveillance and breach of privacy especially as drug use and dependence is not a 'communicable' disease.

Rule 8. *Allows private centres to offer treatment but only with the permission of the Ministry of Health after fulfilling stipulated conditions.*

Comment

> This is a useful provision and an important safeguard against unregulated drug treatment centres that operate in other countries in the region. But its effective implementation does require the establishment of a clear set of norms and standards for treatment centres.

Rule 13 prescribes that:

(a) all medical providers at hospitals, dispensaries, clinics are under an obligation to report if an unregistered drug user comes to them for treatment

(b) any drug user who undergoes treatment at a place other than a drug user treatment centre is liable for punishment under section 15 of the law

(c) any person who gives medical treatment without permission or allows the use of drugs knowing the person to be a drug user is liable for abetment

Comment

> This provision is severely damaging for health and violates human rights. Obligation on doctors to report drug users who seek treatment without registration will dissuade people who use drugs from seeking help. Punishing drug users for undergoing treatment at a facility which is different from the user registration centre not only violates their right to health but is detrimental to their life and personal freedom, which is protected under Article 353 of the Constitution, 2008. It also makes for bad public health policy as it inhibits provision of emergency and urgent medical care, especially in case of overdose. Sub clause (c) of Rule 13 puts harm reduction service providers at risk of prosecution.

Chapter IV Search, Arrest, Seizure of Exhibits, Attachment and Sealing

20. *Whoever sees an offence being committed in his presence at a public place, may arrest the offender and seize the exhibits without a search warrant, and after such arrest shall hand over systematically to any member of the Myanmar Police Force without delay. If there is no member of the Myanmar Police Force, such offender will be handed over to the nearest police station systematically and immediately together with the exhibits.*

Comment

> This provision appears to confer powers of arrest in public places to anyone present in the public place. This is very serious as drug-related searches and arrests require the greatest possible safeguards for the simple reason that drugs can easily be planted on a person, particularly during the course of a personal search or frisking operation.

23. *Execution of search warrant*

Comment

> The drafters may include the following safeguards in executing a search under the law. I) Require the presence of at least two witnesses, preferably from the local area and, ii) that the searching officer must, before proceeding to search the person or the premises, present his credentials to the said person, in the presence of the witnesses.

Chapter IX Use, Possession, Storage, Sale, Transportation, Transmission and Transfer

48. *Lists out persons and entities that have a 'right to use and possess' drugs for medical purposes. These include government hospitals, private hospitals, medical practitioners, medicine shops and patients with prescription.*

Comment

> This is a useful provision and must be applied liberally to support various medical uses of narcotic and psychotropic drugs including for pain relief and drug dependence treatment.

International Obligations and Best Practices

The UN Drug Control Conventions

The three major international drug control treaties are mutually supportive and complementary. An important purpose of the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances is to codify internationally applicable control measures in order to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes, and to prevent their diversion into illicit channels and include general provisions on trafficking and drug use. The 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances significantly reinforced the obligation of countries to apply criminal sanctions to combat all the aspects of illicit production, possession and trafficking of drugs. All three start with preambles expressing concern for the health and welfare of mankind.

In the context of drug laws and sentencing, the drug-control conventions generally require parties to establish a wide range of drug-related activities as criminal offences under their domestic law. Nonetheless, they permit parties to respond to them proportionally, including through alternatives to conviction or punishment for offences of a minor nature.

According to the drug-control conventions, serious offences, such as trafficking in illicit drugs, must be dealt with more severely and extensively than offences such as possession of drugs for personal use. In this respect, it is clear that the treaties do not require parties to establish any punishment for drug use and that parties are allowed to decriminalise the possession of drugs for personal use. Also the use of non-custodial measures for trafficking offences of a minor nature or the option of treatment instead of punishment when such offences are committed by 'drug abusers' offer a more proportionate response and the more effective administration of justice.

Decriminalisation

In many countries personal consumption is not an offence. The UN conventions do not oblige any penalty (penal or administrative) to be imposed for consumption *per se*, as is clearly stated in the official Commentary to the 1988 Convention: "It will be noted that, as with the 1961 and 1971 Conventions, paragraph 2 does not require drug consumption as such to be established as a punishable offence".[15] The Commentary suggests determining a strategy regarding the range of offences relating to personal use, similar to that practiced by many states, in which such offences are distinguished from those of a more serious nature by a threshold in terms, for example, of weight.[16] There are some countries in which possession of a quantity of drugs for personal use is completely decriminalised, and there are many where this is no longer a priority for law enforcement, or where sentences have been reduced. These changes in the law or jurisprudence can have a positive effect on the overburdened penal system and prison overcrowding. The prison population throughout most of the world has exploded these last twenty years, partly due to the tightening of anti-drug laws, under the influence of the 1988 Convention.

The Convention makes it mandatory for the signatory countries to *"adopt such measures as may be necessary to establish as criminal offences under its domestic law*" (art. 3, §1) all the activities related to the production, sale, transport, distribution, etc. of the substances included in the most restricted lists of the 1961 and 1971 conventions. Criminalization also applies to the "cultivation of opium poppy, coca bush or cannabis plants for the purpose of the production of narcotic drugs". The text distinguishes between the intent to traffic and personal consumption, stating that the latter should also be considered a criminal offence, but "subject to the constitutional principles and the basic concepts of [the state's] legal system" (art. 3, §2).

Parties to the Convention could – but are not requested to do so – adopt stricter measures than those mandated, such as the criminalization of use. In the US, Russia and China, massive imprisonment is practiced, and the majority of European and Latin American countries have also seen a major increase of the prison population past decades. The resultant prison crisis and lack of positive impact have prompted various de-penalisation

and decriminalization reforms. The removal of criminal sanctions for the possession of drugs does not lead to a significant increase in drug use or drug-related harm. Criminalizing users pushes them away from health services out of fear of arrest, drives them into the shadows, and locks them up in prisons, which serve as schools for crime. This cycle derails lives even more than drug dependence itself and diminishes chances of recovery.

This also applies to the way drug users are treated when committing nonviolent property crimes to sustain their habit. The 1961 Convention, the backbone of the global drug control model, already endorsed the principle that "*when abusers of drugs have committed... offences, the Parties may provide... as an alternative to conviction or punishment ...that such abusers shall undergo measures of treatment, education, aftercare, rehabilitation and social reintegration...*" (Art. 36.1b).

Harm Reduction

By now, there is a convincing body of evidence to support the effective implementation of harm reduction services and policies from project and programme evaluations. Indeed, harm reduction efforts have been shown to be critical in HIV prevention, in reducing overdose deaths, in improving health conditions, in reducing drug-related crime, and increasing participation and engagement of affected communities. The low-threshold approach associated with harm reduction also significantly contributes to attracting problematic users in touch with treatment options they would otherwise not have access to. Effective implementation of harm reduction services, however, is only possible within a legal environment in which drug users are not prosecuted, allowing them to enter services without fear of arrest.

It is important to increase space for harm reduction interventions, including needle and syringe programmes (NSPs), methadone maintenance treatment (MMT) and the provision of naloxone for the prevention of overdose deaths. The ASEAN Taskforce on AIDS (ATFOA) monitors the implementation of member state commitments relating to HIV, such as the *ASEAN Declaration of Commitment: Getting to zero new HIV infections, zero discrimination, zero AIDS-related deaths* adopted in 2011,

which includes a commitment to reduce transmission of HIV among people who inject drugs by 50 per cent by 2015.[17] In Indonesia, strong civil society engagement and supporters of harm reduction within the government ministries, including a supportive Health Minister, has helped to enable ongoing monitoring, evaluation and advocacy for expanded and improved harm reduction services, including in prisons.[18]

In his report the former Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak has noted the challenges posed to criminal justice systems by punitive drug policies, both in terms of sheer numbers but also of the special needs of drug users in detention.[19]

Voluntary Treatment

The issue of compulsory detention is a sensitive but important issue for the whole Southeast Asian region. Some countries in the region, including China, Vietnam, Indonesia, Cambodia, Malaysia and Thailand, have adopted the slogan 'drug users are patients not criminals' and corresponding policies diverting people arrested for drug use into 'rehabilitation' programmes instead of prison.[20] While these policy changes appear to be positive steps away from criminalising people who use drugs, serious problems remain with these approaches because of their underlying premise that all forms of drug use may not be tolerated and must be 'treated', reliance on compulsory detention as a means of 'treatment', compulsory requirements for registration of people who use drugs in Indonesia and China. People arrested for drug use are subjected to law enforcement monitoring for several years in Malaysia and China, and police are permitted to detain people arrested for suspected drug use for up to 45 days in Thailand.[21]

The *Right to Health* includes the right to informed consent to medical treatment, and doubts have been documented about the effectiveness of coerced treatment.[22] The drug users who are subject to compulsory centres are usually arrested and sent to the centres automatically, without having been provided a fair trial. In several South East Asian countries, all drug users, dependent or not, are sent to these compulsory centres.

This means that the system does not differentiate between the users who are indeed in need of treatment, and those who are non-problematic users. These centres are often run by law enforcement officials with no medical training. Some centres even reported to use experimental treatment without the consent of the patients. Compulsory drug treatment centres sometimes use forced labour as a 'therapeutic' element, making patients work for hours without remuneration. Many drug users in prisons and compulsory drug treatment centres have reported being subject to beatings, sexual assaults, starvation and humiliation. According to the UNODC-WHO Principles of Drug Dependence Treatment: "As is the case with any other medical procedure, in general conditions drug dependence treatment, be it psychosocial or pharmacological, should not be forced on patients. Only in exceptional crisis situations of high risk to self or others should compulsory treatment be mandated for specific conditions and periods of time as specified by the law."[23]

For at least the past five years in Southeast Asia and China, the issue of compulsory detention centres for drug users has been the subject of major focus by UN agencies and civil society organisations. This attention was likely spurred by reports published in 2010 and 2011 by Human Rights Watch exposing extensive abuses committed in the centres in Laos, Vietnam, Cambodia and China.[24] By establishing voluntary 'Cure and Care' centres providing drug treatment and harm reduction services in 2010, Malaysia has been considered a regional leader and best practice model for transforming detention centres into effective, rights-based treatment centres.[25] However, recently some steps backward seem to have been made, and the laws have not been changed to decriminalise drug use, for which a court may still sentence an individual to a term in compulsory detention (intended as a form of rehabilitation), or imprisonment and/or caning.[26]

In March 2012 a joint statement of several United Nations entities[27] called on States to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community in compliance with human rights. Sustained advocacy by UN agencies, donors and civil society organisations have appeared to help shift policy positions

and more governments (e.g. Vietnam, Cambodia) are now willing to establish voluntary treatment settings and close down some but not all of their compulsory detention centres for drug users.

Proportionality of Sentences

The issue of proportionality of sentences has received little legislative attention to date. In fact, the trend has been to toughen drug laws and sentencing guidelines, setting mandatory minimums, disproportionate prison sentences and even death penalties in several countries. This punitive approach can be interpreted as politically driven as it has made no impact on the availability of drugs or on prevalence figures. A large-scale review of research on imprisonment carried out for the Canadian government found that offenders who were imprisoned were no less likely to re-offend than those given alternative community sentences, and that those given longer prison sentences were more likely to go back to crime after serving their term than those with lower sentences. All studies undertaken in this field reveal the ineffectiveness of long prison sentences, most notably for nonviolent drug law offenders. At the same time the capacity of the judicial system is stretched far beyond its limits, resulting in slow procedures, lengthy pretrial custody and overcrowded prisons. An additional worry is that legislative reforms in favor of decriminalizing drug users are regularly made politically acceptable, in a trade-off, increasing penalty levels for small trafficking, as happened in Mexico, for example.

One of the more positive developments is the growing recognition that greater distinction is required regarding the level of involvement in drug trade. Small-scale cultivation of coca and opium poppy is increasingly seen more as a developmental challenge than one for law enforcement. For trading levels, more jurisdictions acknowledge that 'user-dealers' should be dealt with as a separate category of offenders. Legislation or jurisprudence is more frequently establishing criteria to distinguish between micro-trade, transport/courier, mid-level trading and organized trafficking, taking into account the level of responsibility the offender has in the trafficking chain, earnings and reasons why he/she became involved. Such criteria vary wildly at the moment and inevitably will remain subject to differences in national legal principles.

Two recent examples are more visionary and point to more radical changes in how to deal with lower-level courier trading. At the end of 2008 and early 2009, over 2,000 persons incarcerated in Ecuador for drug trafficking were released. This "pardon for mules" singled out a specific group of prisoners who were victims of the disproportionate laws in effect for many years. The release criteria were: no prior conviction under the drug law; arrest for possession of a maximum of two kilograms of any drug; either ten percent of the sentence or a minimum of one year served. In 2014 a new Penal Code was adopted introducing a scale of sentences for drug trafficking more proportionate to the seriousness of the offence, significantly lowering the sentence levels. Because of its retroactive nature, another 2,500 prisoners are estimated to benefit from the reduced sentences and to be released in 2015. In Thailand the Kamlangjai Project is exploring options for reducing the numbers of women incarcerated for low-level drug smuggling, often involving methamphetamine. At the moment, the Project is concentrating on the judiciary, prosecutors and prison officials as their key target audience. [28]

Threshold Quantities

Legally, what constitutes an amount for personal use differs widely and has been the subject of debate, revision and controversy. In the last 15 years at least seven EU countries (Belgium, Germany, Greece, Italy, Netherlands, Portugal and Finland) have redefined limits for non-prosecution of individuals caught with drugs that appear to be for personal use. In 2000 Portugal, decriminalizing consumption and possession of all drugs, adopted the norm of "the quantity required for an average individual consumption during a period of 10 days." Indications are given for what constitutes an average daily dose, for example 2.5 grams for cannabis or 0.2 grams for cocaine. "These thresholds are presumptive as opposed to be determinative; however, so long as there is no additional evidence implicating the drug user in more serious offences, drug possession is decriminalized, dealt with as an administrative violation, as opposed to being prosecuted as a criminal offence."[29] The Cato Institute recently concluded that "judged by virtually every metric, the Portuguese decriminalization framework has been a resounding success. Within this success lie self-evident lessons that should guide drug policy debates around the world."[30]

Other EU jurisdictions define thresholds in terms of a specific amount in grams or units. In Austria the limit of the "serious offence" (punishable by prison) is 15 grams of cocaine and 3 grams of heroin, while "small amounts" are defined as 1.5 grams of cocaine, 1 gram of ATS and 0.5 grams of heroin. In Finland, by comparison, the law refers to 1 gram of heroin or 1.5 grams of cocaine, although in practice, the lower limit for a prison sentence is 10 grams of ATS, 40 ecstasy pills, 4 grams of cocaine and 2 grams of heroin. All EU countries offer legal or judicial distinction to graduate the severity of the offence. An increasing trend is to divert drug users from the penal system, with either no punishment at all or only administrative measures (including offering treatment instead of punishment). This principle requires determining whether people should be assisted or imprisoned by drawing a line between users and traders. However, this is more easily said than done. Inaccurate distinction may distort the principle of the law: a low threshold separating personal use and traffic might result in users being imprisoned as traffickers, whereas a high threshold could allow dealers to continue working with little interference. According to the EMCDDA, the real emphasis in the EU "seems to be on the intent rather than the amount possessed... The great majority chooses to mention some sort of "small" quantity in the law or guidelines, but leaves it to prosecutorial or judicial discretion, with knowledge of all of the surrounding circumstances, to determine the true intention behind the offence. No country definitively uses the quantity to determine who is a user or a trafficker." [31]

Scheduling criteria

There is growing recognition in the drug policy debate that talking about ¨drugs¨ is too often a not very helpful generalization and that a more refined distinction is required to define appropriate control measures according to the specific characteristics of substances, their health risks, the dynamics of their markets and their user groups. The classification schedules attached to the UN 1961 and 1971 Conventions do not provide sufficient differentiation to enable more targeted policy interventions.

Considering such diverse substances as coca, cocaine, cannabis, opium and heroin in the same schedule, has hampered the development of more targeted and effective responses that take account of their completely

different properties, harmfulness and the reasons people use them. In a number of countries cannabis is treated differently, with lower sentences, decriminalisation and in a few cases legal regulation of the market. In Myanmar this relates also to the domestic controls imposed on kratom, a tree indigenous to Southeast Asia whose leaves have been traditionally used for recreational and medical purposes. In low dosage, kratom works as a stimulant, and keeps people awake – rather similar to the effect of drinking a few cops of coffee. A higher dosage also has a sedative effect, hence its traditional use as a painkiller. Kratom is attracting increasing attention as a natural alternative to medically supervised opioid substitution therapy (OST) because of its capacity to attenuate potentially severe withdrawal symptoms. In view of the kratom's harmlessness and its potential medicinal value, it should not be criminalised and unhindered access to kratom for scientific research should be facilitated.[32]

Human Rights

Human rights appear explicitly only once in the three treaties – article 14(2) of the 1988 Convention. However, these treaties must be read and interpreted in line with concurrent human rights obligations. Though protecting health and welfare can be considered the core principles of the drugs conventions, in practice the drug control system has resulted in human rights abuses across the globe. Over the past decades, repression has been implemented as the main strategy to address drugs-related problems. Both nationally and internationally, most of the resources have been spent on combating the illicit market. As with responses to other perceived 'threats', such as terrorism, this has resulted in the erosion of civil liberties and innumerable human rights abuses worldwide.

In past years several Charter-based and treaty based human rights mechanisms have expressed concerns about human rights violations in the name of drug control. In 2010 the UN Special Rapporteur on the Right to Health declared that he was "concerned that the current drug control approach creates more harm than the harms it seeks to prevent. Criminalisation of drug use, designed to deter drug use, possession and trafficking, has failed. Instead, it has perpetuated risky forms of drug use, while disproportionately punishing people who use drugs."

The UN High Commissioner for Human Rights reminded the UN member states that "individuals who use drugs do not forfeit their human rights", while the UN Committee on Economic Social and Cultural Rights and the UN Committee on the Rights of the Child have recognised harm-reduction as a component of the right to health. The UN High Commissioner for Human Rights, Navi Pillay, urges States to reconsider drug control from a human rights perspective, speaking at a side event at the Human Rights Council in Geneva, 16 June 2014.

The right to life

Article 3 of the Universal Declaration on Human rights and Article 6 of the International Covenant on Civil and Political Rights

- 33 countries worldwide still retain the death penalty as a possible punishment for drug-related offences in their national laws, Myanmar is one of them. The death penalty for drug offences fails to meet the threshold of 'most serious crimes' to be legal under the International Covenant on Civil and Political Rights and should therefore be abolished for drug offences.

The right to health

Constitution of the World Health Organisation, Article 12 of the International Covenant on Economic, Social and Cultural Rights, article 24 of the Convention on the Rights of the Child (and other sources)

- People who use drugs have the right to available, accessible, acceptable and sufficient quality health services
- Criminal laws banning syringe provision and possession create a climate of fear for drug users, driving them away from life-saving HIV prevention and other health services. This fosters risky behaviour, and therefore facilitates the transmission of blood-borne diseases such as HIV and hepatitis C.
- Access to essential medicines is a recognized core-minimum requirement of the right to health. Because of legal and political

restrictions on essential medicines such as morphine, tens of millions of people suffer moderate to severe pain. Access to methadone and buprenorphine as substitution treatment for dependent opioid users is hampered, or in some countries even illegal. In 2010, the INCB reported highly inadequate levels of consumption of opioid medications, which are essential medicines for the treatment of pain, in most countries in Asia. In East and Southeast Asia, only Japan, South Korea and Hong Kong (China) reported adequate levels of consumption. At the other end of the spectrum, Cambodia, Indonesia, Lao PDR and Myanmar reported the most inadequate levels of consumption (less than 10 S-DDD (defined daily doses for statistical purposes) per million inhabitants per day ; the INCB considers less than 100 S-DDD as being 'very inadequate'). [33] Despite seriously inadequate levels of access to essential medicines, there seems to be very little civil society advocacy and governmental awareness on the issue in Myanmar.

The right to due process and a fair trial

Article 9 of the International Covenant on Civil and Political Rights

- As a result of the large number of drug-related arrests, the criminal justice system is often overloaded and suspects are sometimes kept in pre-trial detention for months.
- The drug users who are subject to compulsory centres are usually arrested and sent to the centres automatically, without having been provided a fair trial. In several South East Asian countries, all drug users, dependent or not, are sent to these compulsory centres. This means that the system does not differentiate between the users who are indeed in need of treatment, and those who are non-problematic users.
- Special courts have been put in place or used to try those suspected of drug trafficking, such as the Iranian Revolutionary Courts.

The right to be free from discrimination

1960 International Convention on the Elimination of All Forms of Racial Discrimination, 1979 Convention for the Elimination of All Forms of Discrimination Against Women 1966 International Convention of Civil and Political Rights

- Because of the high social stigma associated with drug use, drug users are discriminated against in their workplace and within their communities.
- In certain countries, drug control laws are implemented discriminating against minority ethnic groups, indigenous people and women. A particularly high stigma is attached to women and pregnant drug users.

The right to an adequate standard of living, and to progressive realization of economic social and cultural rights

1966 International Covenant on Economic, Social and Cultural Rights

- Illicit drugs are generally produced by farmers from the poorest and most vulnerable communities in the world. Crop eradication campaigns can have a devastating effect on these farmers and their families, leaving them with no alternative means of subsistence.
- Alternative development programmes that are not properly designed and sequenced can also be devastating for these communities.

The economic, social and cultural rights of indigenous people

Article 14(2) of the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1989 Convention No. 169 on Indigenous and Tribal Peoples in Independent Countries and 2007 Universal Declaration on the Rights of Indigenous Peoples (Articles 11, 12, 24, 26, 27), International Covenant on Civil and Political Rights, Article 5, Convention on the Elimination of Racial Discrimination (and other sources)

- Indigenous people are prevented from producing and consuming controlled substances that they have been using for centuries for traditional purposes. This is the case for the coca leaf in Latin America, of kratom in Thailand and Myanmar, and of opium throughout South East Asia

The rights of the child

Article 33 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.

- The current drug control system is not protecting children the way we would hope, drug use among teenagers is higher than ever, and when children start using drugs no treatment and harm reduction services are provided. In most countries drug-using children are criminalized and in many cases they have to carry this burden for the rest of their lives. At the same time, the children of drug-using parents are stigmatized and if their parents are sent to jail or detention centres the children run a high risk of committing crimes and using drugs themselves.
- Children are among those without access to essential controlled medicines for the relief of pain.
- Children have been detained with their mothers who have been convicted of drug offences, as they have nowhere else to go
- Children have been killed and orphaned in drug-related violence
- The UN Committee on the Rights of the Child has called for children who use drugs to not be criminalized; for accurate and objective information on drugs to be made available; for appropriate youth-friendly harm reduction and drug treatment services to be in place
- The Committee has criticised aerial spraying in Colombia and the use of minors in the Mexican military for fighting the drug war. It has also criticized Viet Nam and Cambodia for holding children in drug detention centres.

Conclusion and Recommendations

A review of the Myanmar's drug laws is timely and offers a prospect to improve the drugs legislation and to ensure a sound legal base for health and development-oriented drug policies and to address drug-related problems in the country more effectively. The focus of Myanmar's current legal drug framework is on punitive action, with little attention for more positive policy outcomes. Most indicators for 'success' are enforcement oriented, such as number of drug-related arrests and hectares of poppy fields eradicated, rather than social and health oriented indicators such as number of drug users with access to services, number of overdoses prevented, or more livelihood opportunities for poppy cultivating communities to reduce their dependency on opium for their basic needs.

Like other countries which have criminalized drug use, Myanmar's prison and judicial system is under great pressure by the large number of people incarcerated with long jail sentences for relatively small drug-related offences. The punitive approach has further contributed to a lack of access to health and other services, as drug users are criminalized and go underground to avoid arrest and/or extortion by law enforcement officers. At the same time there has been little investment in health and other services for drug users. The focus on law enforcement and the official policy to make the country drug-free by 2014 – later postponed to 2019 - has also put great strains on the already resource-strained government departments responsible to reach these targets, which are unachievable. In some instances the drug law is even in contradiction with the Myanmar Constitution (articles 44 and 353).

The reform process initiated by the Thein Sein government in 2011, and trends at the international level to move away from the 'war on drugs' and repressive drug policies towards prioritizing health and development based approaches present good opportunities to reform Myanmar's drug laws.

This report makes the following key recommendations:

Amend sections 15 and 16 of the Myanmar 1993 Narcotic Drugs and Psychotropic Substances Law (1993 NDPS Law) and decriminalise drug use and possession for personal use and remove compulsory registration of drug users from the law. In many countries personal consumption is not an offence. The UN conventions do not oblige any penalty (penal or administrative) to be imposed for consumption *per se*, as is clearly stated in the official Commentary to the 1988 Convention. There are some countries in which possession of a quantity of drugs for personal use is completely decriminalised, and there are many where this is no longer a priority for law enforcement, or where sentences have been reduced. These changes in the law will have a positive effect on the overburdened penal system and prison overcrowding. Decriminalisation of use makes health services more accessible to drug users since they no longer have to fear arrest when in need of support and health care.

Create a legal framework that supports key harm reduction interventions to fight the spread of HIV/AIDS, hepatitis C and prevent the harms associated with drug use as much as possible. These interventions should include Needle and Syringe Programmes (NSP), Methadone Maintenance Therapy (MMT), Peer Education and Overdose Prevention. Experiences have shown much can be gained through a harm reduction approach, and this should be firmly based in the Myanmar legal framework. The law should ensure that harm-reduction measures and drug-dependence treatment services are available to all who need them, including in prison settings. At the moment section 33 of the Burma Excise Law is severely hampering access to clean needles, sections 15 and 16 of the 1993 Narcotic Drugs and Psychotropic Substances Law and Rule 13 of the 1995 Rules relating Narcotic Drugs and Psychotropic Substances are also hampering access to harm reduction services.

Sentences should be proportional to their crime. Greater distinction is required regarding the level of involvement in the drug trade. Small-scale opium cultivators should not be criminalized and targeted with legal action.

'User-dealers' should be dealt with as a separate category of offenders, and criteria should be established to separate between micro-trade, transport/courier, mid-level trading and organized trafficking, taking into account the level of responsibility the offender has in the trafficking chain, earnings and reasons why he/she became involved Especially sections 15 (Failure to register) and 16 (possession, transportation, distribution of drugs) are often resulting in excessively long prison sentences for relatively small drug-related offences. The minimum sentence for simple possession of drugs is five years imprisonment, which is excessive and disproportionate, compared to many other countries in the world.

Increase threshold quantities defining possession for personal use and include additional criteria to distinguish between personal use and trading (sections 19 and 26). In the last 15 years at least seven EU countries have redefined limits for non-prosecution of individuals caught with drugs that appear to be for personal use. An increasing trend is to divert drug users from the penal system, with either no punishment at all or only administrative measures (including offering treatment instead of punishment). This principle requires determining whether people should be assisted or imprisoned by drawing a line between users and traders. However, this is more easily said than done. Inaccurate distinction may distort the principle of the law: a low threshold separating personal use and traffic might result in users being imprisoned as traffickers, whereas a high threshold could allow dealers to continue working with little interference. The emphasis should be on the intent rather than the amount possessed. Therefore many European countries mention some sort of "small" quantity in the law or guidelines, and leave it to prosecutorial or judicial discretion, with knowledge of all of the surrounding circumstances, to determine the true intention behind the offence.

Amend section 20 of the 1993 Narcotic Drugs and Psychotropic Substances Law to abolish the death penalty for drug offences. According to the law production, distribution and sale of narcotic drugs and psychotropic substances can still be punished with capital punishment. This is in breach with the International Convenant on Civil and

Political Rights since drug offences fail to meet the threshold of 'most serious crimes' and therefore the death penalty must be abolished.

Allow for only voluntary treatment services for drug users, and abstain from any kind of compulsory drug detention and rehabilitation centres. It has to be taken into account that only a small minority of the drug users is developing problematic drug use. Among those who need treatment only very few need residential care as most can be better treated at home, with the support of their family and community. Compulsory treatment is in breach with human rights and has proven to be very ineffective. The mandatory registration (Sections 9a, and 15) and the criminalization of drug users have prevented users from accessing services provided by the government and other relevant local and international organisations.

Re-evaluate scheduling criteria. In Myanmar this relates also to the domestic controls imposed on kratom, a tree indigenous to Southeast Asia whose leaves have been traditionally used for recreational and medical purposes. In view of kratom's harmlessness and its potential medicinal value, it should not be criminalised and unhindered access to kratom for scientific research should be facilitated

Amend section 16a of the 1993 Narcotic Drugs and Psychotropic Substances Law and allow the cultivation of opium in the transition period to new alternative livelihoods. Myanmar is currently the second largest producer of raw opium in the world, most of which is cultivated by impoverished ethnic minority communities in the country's uplands, who grow opium as a cash crop to meet their basic needs, including food, medicines, clothing and access to education. In these communities opium has traditional, cultural and religious use. In short, for such communities, opium is a solution, it helps to solve their main problems and allows them to live a life in dignity.

Amend the law to increase access to controlled essential medicines and allow the medicinal use of opium in remote areas. Opium is also used as a painkiller and against diarrhea by ethnic communities in isolated and mountainous in areas where there is no access to essential medicines.

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"Reservation made upon signature and confirmed upon ratification:

"Subject to the understanding that the Shan State is being allowed to have reservation of the right:

"(1) To allow addicts in the Shan State to smoke opium for a transitory period of 20 years with effect from the date of coming into force of this Single Convention;

"(2) To produce and manufacture opium for the above purpose;

"(3) To furnish a list of opium consumers in the Shan State after the Shan State Government has completed the taking of such list on the 31st December, 1963."

4 Myanmar had made some reservations to the 1971 Convention:

"The Government of the Union of Myanmar will not consider itself bound by the provisions of article 19, paragraphs 1 and 2.

The Government wishes to express reservation on article 22, paragraph 2(b) relating to extradition and does not consider itself bound by the same.

The Government of the Union of Myanmar further wishes to express that it does not consider itself bound by the provisions of article 31, paragraph of the Convention concerning the referral to the International Court of Justice of a dispute relating to the interpretation or application of the Convention."

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