Roundtable 1
Demand reduction and related measures, including prevention and treatment, as well as health-related issues; and ensuring the availability of controlled substances for medical and scientific purposes, while preventing their diversion ("drugs and health")

Introduction

The international drug control conventions are explicitly concerned with the health and welfare of people and provide for protective measures from risks linked to drug use for non-medical purposes (hereinafter referred to as 'drug use') and drug use disorders through drug use prevention, as well as through treatment, care, rehabilitation and social reintegration for people with drug use disorders or in need of services to prevent related health problems.

Drug use and drug use disorders continue to create an unacceptable burden on individuals, families, communities and societies. It is estimated that a total of 246 million people, or 1 out of 20 people between the ages of 15 and 64 years, used drugs for non-medical or non-scientific purposes in 2013. Of these, 27 million people (or 1 in 10 people who use drugs) suffer from drug use disorders, whilst 187,100 people who use drugs lost their lives prematurely, including from drug overdose. Almost half of the people with drug use disorders also suffer from other co-occurring mental health disorders. Member States have recently recognised the powerful connection between substance use, drug use, health and development by adopting Sustainable Development Goal (SDG) 3.5, thus committing themselves to strengthening drug prevention and treatment. This development should

This document has been prepared with the assistance of UNODC; in accordance with resolution 57/5, UNODC was requested to provide substantive expertise and technical support to the preparatory process for the special session;

be a call for joint action by the international community, national Governments, civil society and the private sector.

Injecting drug use has been documented in at least 158 countries, and unsafe injecting drug use continues to drive the HIV epidemics in many of them. UNODC, UNAIDS, WHO and the World Bank estimate[i] that there are 12.2 million people who inject drugs. Among them, 13.5 per cent or 1.7 million people are living with HIV. In addition, high risk sexual practices linked to the use of stimulant drugs (e.g. amphetamine type substances, cocaine and new psychoactive substances) among sub-groups of key populations are also contributing to the spread of HIV. Under Sustainable Development Goal 3.3, countries committed themselves to ending AIDS as a public health problem by 2030. To help achieve that end, the recently adopted UNAIDS Fast Track Strategy 2016-2021 calls for a 75% reduction in new HIV infections by 2020 among key populations, including people who inject drugs.

Concurrently, the aim of the three international drug control conventions is to guarantee the availability and access to controlled drugs for medical use for the treatment of a variety of medical conditions, particularly pain and many psychiatric and neurological conditions. All of these have recently been re-affirmed in the new adopted framework of the Sustainable Development Goals and this background document provides an overview of the situation and proposes action to achieve the objectives mentioned.

(i) Demand reduction and related measures, including prevention and treatment, as well as health-related issues, including HIV/AIDS prevention, treatment and care

Stocktaking: what works and what does not work

Only one in six persons suffering from drug use disorders has access to treatment services and this data masks profound differences amongst regions and between gender (only one out of five drug users in treatment is a woman even though one out of three drug users is a woman[ii]). This low coverage is typically concentrated in the urban and peri-urban areas of the capitals and major towns. At least a third of the reporting Member States have not established a budget for their drug prevention and treatment strategies[iii], whilst fewer than half of the countries surveyed by WHO reported having a specific budget line allocated for the treatment of substance use disorders[iv]. Finally, too often, drug prevention and treatment services are not provided as part of the normal provision of health services under the national health system.

Low coverage is compounded by stigma and discrimination, as well as low quality services. Drug prevention strategies rely on isolated efforts to raise awareness about the danger of drugs among youth and the general public[v]. They are rarely based on a scientific understanding of the factors that increase the vulnerability of children and youth when they start drug use or progress into drug use disorders. These vulnerabilities are largely beyond the control of the individual and can be addressed by drug prevention based on scientific evidence which can start at a very young age and in a variety of settings. An indication of quality drug prevention is the presence of an evaluation component. In this context, Member States report that they assess the impact or the outcome of only 1 in 5 prevention strategies at best, with the consequence that the effectiveness of these strategies is simply not known[vi].

Services for the early intervention, treatment, care, recovery, rehabilitation and social reintegration of people with drug use disorders are too often not based on a scientific understanding of drug dependence as a complex, multifactorial health disorder characterized by a chronic and relapsing nature. Compulsory treatment is still widespread, as are other approaches that sanction drug use and relapse through the criminal justice system or end in the withdrawal of health and support services. In addition to the paucity of services to prevent overdose and transmission of HIV, viral hepatitis and other blood-borne diseases associated with drug use, the scarcity of services to address the high prevalence of co-occurring mental health disorders is particularly worrying, as well as of services in prison settings.

This situation contrasts sharply with what could be afforded by the systematic implementation of drug prevention and treatment services that are based on scientific evidence and human rights, as described in the International Standard on Drug Use Prevention and the UNODC-WHO International Standards on the Treatment of Drug Use Disorders. Quality drug prevention that is based on scientific evidence can prevent the initiation of drug use and many other risky behaviours (including truancy, aggressiveness, delinquency and violence, etc.), thus ensuring that children and youth grow healthy and safe[vii]. Treatment, care, rehabilitation and social reintegration services that are based on scientific evidence and on the respect of the rights and dignity of the individuals who use drugs and suffer from drug use disorders can protect health, by preventing overdose, HIV, Hepatitis C and other health co-morbidities (consequences) and can lead individuals to regain control over their lives and initiate full and productive lives in recovery[viii]. In both cases, services have proven to be effective and cost effective[ix].

A comprehensive package of nine evidence-based HIV prevention, treatment and care interventions, also known as 'harm reduction'[x], has been outlined in a technical guide, issued jointly by WHO, UNODC and UNAIDS in 2009 and revised in 2012, and referred to by the Commission on Narcotic Drugs[xi], UNAIDS Programme Coordinating Board, UN ECOSOC and the UN General Assembly. In countries with substantial epidemics among people who inject drugs, analyses have

consistently shown that investment in an optimal mix of evidence based interventions for HIV among people who inject drugs minimizes new HIV infections and deaths[xii]. For example, by prioritizing needle and syringe programmes, opioid substitution therapy and anti-retroviral therapy, countries could improve coverage and achieve fewer new HIV infections and deaths among people who inject drugs. This will also reduce new HIV infections among sexual partners of people who inject drugs and the wider population. These programmes also serve as an entry point to other services and engage clients on a regular basis, providing opportunities to facilitate access to other health services.

However, access to these essential evidence-based and cost effective services for HIV prevention and treatment for people who inject drugs is disproportionately low to have an impact at an individual level as well as at the public health level. Globally, fewer than 8 in 100 people who inject drugs have access to opioid substitution therapy, only 2 sterile needles are distributed per month per person who injects drugs and only 4 in every 100 eligible people who inject drugs are receiving antiretroviral therapy[xiii]. HIV services are often not responsive to the specific needs of particularly vulnerable groups of people who use drugs such as women, young people, and those living in prisons and other closed settings. As a result, the global community failed to achieve the global target of halving the transmission of HIV among people who inject drugs by 2015.[xiv] UNAIDS estimates that between 2010 and 2014, there was a mere 10% reduction in new HIV infections among people who inject drugs.[xv] On the other hand, countries having implemented and facilitated the access for people who inject drugs to needle-syringe programmes and opioid substitution therapy, have reduced the number of new HIV infections among people who inject drugs to almost zero.

A growing body of evidence suggests that the main factors behind the disproportionately low access to HIV services include: lack of adequate legislation and supporting national drug control policies; over-reliance on sanctions; incarceration of people who use drugs; compulsory detention for drug use; lack of gender and age responsive services; stigma and discrimination and related violence against people who use drugs; and lack of predictable and sustainable funding including domestic investment[xvi].

Proposals for addressing the issues and way forward

The international community should take concerted and immediate action to strengthen the quality and drastically increase the coverage of drug prevention, treatment, care and rehabilitation services that are based on scientific evidence and human rights in order to meet Sustainable Development Goal 3.5 and to ensure the present and future wellbeing of children, youth, families and communities by reducing the health and social burden of drug abuse and drug use disorders, particularly on the vulnerable populations such as children, women, people suffering from co-

occurring mental health disorders and people in prison settings as well as the marginalised in the context of a comprehensive, integrated and balanced approach based on public health.

Substantively, drug prevention and treatment services should be based on a scientific understanding of the aetiology and nature of drug use and drug use disorders, as well as the scientific evidence of what is effective and cost-effective. In particular, prevention of drug use should support children and youth throughout their development from infancy and early childhood through childhood and adolescence; programme and policies should target the population at large (universal prevention), but also support groups (selective prevention) and individuals (indicated prevention) that are particularly at risk; both individual and environmental factors of vulnerability and resilience should be addressed in multiple settings (e.g. families, schools, communities, the workplace, etc.)[xvii] With regard to treatment, a range of evidence-based voluntary pharmacological and psychosocial treatment services should be available, accessible and affordable through a network of settings (community-based outreach, screening, brief interventions and referral to treatment, short-term residential treatment, outpatient treatment, long-term residential treatment, recovery management) together with health care and social protection[xviii].

From an infrastructure point of view, evidence-based interventions should be supported by the balanced allocation of adequate and sustained financing in the context of the national health system and in coordination with a number of other sectors, most notably, law enforcement and justice, education, social welfare and labour, as well as civil society, universities and the private sector. The quality of the services should be ensured by data collection, national standards based on international scientific evidence, accreditation and continuous training, monitoring and evaluation. New options for the treatment of disorders, particularly arising from the use of stimulants and new psychoactive substances, need to be scientifically developed.

To achieve the SDG target 3.3, countries need to fast track the HIV response among people who inject drugs to reach, by 2020, 90% of people who inject drugs with needle and syringe programmes, 40% with opioid substitution treatment and 90% with anti-retroviral therapy.[xix]

However, the HIV epidemic among people who use drugs cannot be ended without addressing the determinants of vulnerability. Specifically, key sectors such as health, drug control, law enforcement and justice must work together and align their respective policies, strategies and practices based on international evidence and human rights considerations, taking into account gender and age dimensions. Equally important, affected communities, civil society organizations and the scientific community must collaborate in policy and programme development and implementation, in order to make sure that interventions targeting HIV are effective. Further, a significant ramp up in international and domestic investments is required to scale up prioritized evidence-based interventions, which will substantially reduce future health care cost, recognizing that every new HIV infection implies future cost for life-long treatment of HIV and opportunistic infections. To

maximize the return on investment, it is, therefore, important for countries to review spending to ensure that resources can be reallocated to evidence-based interventions.

Questions for discussion

- **What concrete measures could be taken at the national, regional and global levels to substantially improve the coverage and quality of drug prevention interventions?**
- **What concrete measures could be taken at the national, regional and global levels to substantially improve the coverage and quality of drug treatment, care and rehabilitation services?**
- **What can the international community do to ensure and scale-up access to life saving, evidence based comprehensive HIV services for people who use drugs, towards reaching the SDG 3.3 target of ending AIDS as a public health problem by 2030?**

(ii) Ensuring the availability of controlled substances for medical and scientific purposes, while preventing their diversion

Stocktaking: what works and what does not work

The need to ensure the availability of controlled drugs for medical and scientific purposes, along with the need to prevent their diversion and abuse, has been first established by the international drug control conventions and has been supported by numerous recommendations of the international drug control bodies (including both the International Narcotics Control Board (INCB) and the Commission on Narcotic Drugs), as well as other international law instruments related to health and human rights[xx]. Most recently, in the UN framework of the Sustainable Development Goals, target 3.8.b aiming to provide access to affordable essential medicines and vaccines and 3.8.c aiming to substantially increase health financing and strengthen the health workforce in developing countries are closely aligned to the efforts to increase access to controlled drugs for medical purposes.

Over the past 20 years, the global consumption of opioids for medical purposes has more than tripled[xxi]. However, the data collected and analysed by INCB show that the consumption of drugs for pain relief and other medical purposes is still low in most countries. Access to these drugs is uneven, with consumption concentrated primarily in more developed countries. This imbalance is worrying as the latest data show that many of the conditions requiring pain management are increasing in low- and middle-income countries. At the same time, there has been an increase in the abuse of prescription drugs and related overdose deaths in countries with a high per capita consumption of opioid analgesics in recent years[xxii].

The most recent INCB special report on the Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes, showed increased access to opioids, including codeine, dextropropoxyphene, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, ketobemidone, morphine, oxycodone, pethidine, tilidine and trimeperidine, in Latin America and the Middle East. However, the situation across the continents of Africa and Asia has seen little improvement with a majority of the population still under 100 defined daily doses for statistical purposes (S-DDD) per million inhabitants per day. In comparison, the United States, Canada and Australia report greater than 10,000 S-DDD per million inhabitants per day[xxiii].

A number of controlled substances under the three conventions, including morphine along with several other opioids for pain control and palliative care as well as buprenorphine and methadone for the treatment of opioid dependence, are on WHO's Model List of Essential Medicines[xxiv]. In spite of this, over 80% of the world's population have low to non-existent access to controlled medicines with inadequate access to treatment for moderate to severe pain[xxv]; including an estimated 1.5 million people dying of AIDS-related causes[xxvi], including people who use drugs, without adequate pain control; while less than 8% of people who inject opioid drugs have access to opioid substitution therapy. Even where pain control and palliative care services are available, people who use drugs often face additional access barriers, including adequate pain management being withheld on account of regulations concerning people who have had opioid dependence syndrome[xxvii].

Additionally, the International Agency for Research on Cancer, the specialized cancer research agency of WHO, report that the global burden of cancer has risen to 14.1 million new cases and 8.2 million cancer deaths in 2012, with a predicted increase in new cancer cases to be almost 20 million by 2025 due to an ageing global population[xxviii]. The implication being that with this level of medical demand for pain management and palliative care, it is critical to support a system of drug control that provides increased access to essential medicines for all patients, including in developing countries, while preventing diversion, misuse and abuse. This can be accomplished through a collaborative approach when regulatory impediments are reduced, attitude and knowledge barriers to procurement are addressed, advocacy efforts are made in communities, the capacity of

healthcare professionals to implement a comprehensive approach is increased and policies are in place to ensure safe delivery, while preventing their abuse and diversion.

Proposals for addressing the issues and way forward

The international drug control conventions provide a framework upon which to build a system that ensures access to controlled drugs for medical purposes while simultaneously preventing diversion, misuse and abuse. Access to controlled drugs for medical purposes, including most notably for the treatment of pain, should be guaranteed as an essential component of the right to health in the context of a health-based drug control system. Member States should enhance international cooperation and share lessons learned and best practices to address identified barriers to availability of controlled substances for medical and scientific purposes such as, attitudes and knowledge of the provisions of the international drug conventions; capacity of health care workers; national legislation and regulatory frameworks; and economic and procurement related issues.

Questions for discussion

- **Within the framework of the existing conventions and international law instruments, how can Member States increase access for medical purposes without creating an environment of overuse and misuse?**

[i] UNODC (2015), World Drug Report, United Nations Office on Drugs and Crime, Vienna, Austria.
[ii] United Nations Office on Drugs and Crime, "World Drug Report 2015," 2015, pages xi, xii. Highlighted also in UN Women (2014), A gender perspective on the impact of drug use, the drug trade, and drug control regimes, UN Women Policy Brief.
[iii] Report of the Executive Director on Actions taken by Member States to implement the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, E.CN.7/2016/6.
[iv] WHO (2010), ATLAS on substance use (2010), Resources for the prevention and treatment of substance use disorders, World Health Organisation.
[v] Report of the Executive Director on Action taken by Member States to implement the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. E/CN.7/2016/6.
[vi] Report of the Executive Director on Action taken by Member States to implement the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. E/CN.7/2016/6.
[vii] UNODC (2013), International Standards on Drug Use Prevention.
[viii] UNODC/WHO (2016), International Standards on the Treatment of Drug Use Disorders, UNODC (2009), Principles of Drug Dependence Treatment - UNODC/WHO Discussion Paper; UNODC (2009) Reducing the adverse health and social consequences of drug abuse: a comprehensive approach; UNODC (2010) From Coercion to Cohesion: Treating Drug Dependence Through Health Care, Not Punishment.
[ix] UNODC (2013), International Standards on Drug Use Prevention, WHO (2016), Public health dimension of the world drug problem including in the context of the Special Session of the United Nations General Assembly on the World Drug Problem, to be held in 2016, Report by the Secretariat to the Executive Board 138th session, EB138/11.
[x] Set of nine interventions for HIV prevention, treatment and care for people who inject drugs, as set out in the WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users World Health Organization, Geneva, rev. 2012.
[xi] Bradley M. Mathers and others, "HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage", The Lancet, vol. 375, No. 9719 (2010), pp. 1014-1028 and highlighted in UNAIDS 2015 | REFERENCE: A Public Health and Rights Approach to Drugs
[xii] Wilson D, Benedikt C, Wilson P D, Kelly Allocative and implementation efficiency in HIV prevention and treatment for people who inject drugs, (to be published in 2016).
[xiii] Bradley M. Mathers and others, "HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage", *The Lancet*, vol. 375, No. 9719 (2010), pp. 1014-1028 and highlighted in UNAIDS 2015 REFERENCE: A Public Health and Rights Approach to Drugs.
[xiv] See the General Assembly Resolution 65/277. Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (General Assembly resolution 65/277, annex).
[xv] UNAIDS Programme Coordinating Board, "Halving HIV transmission among people who inject drugs: background note", UNAIDS/PCB (35)/14.27, 25 November 2014.
[xvi] WHO (2014) Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations; Public health dimension of the world drug problem including in the context of the Special Session of the United Nations General Assembly on the World Drug Problem, to be held in 2016. WHO EB138/11 15 January 2016.
[xvii] UNODC (2013), International Standards of Drug Use Prevention, United Nations Office on Drugs and Crime.
[xviii] UNODC/ WHO (2016), International Standards for the Treatment of Drug Use Disorders, United Nations Office on Drugs and Crime.
[xix] UNAIDS 2015 Reference, A public Health and Rights Approach to Drugs.
[xx] See for example: CND resolutions 53/4 in 2010 and 54/6 in 2011; resolution B134/7 of the Executive Board of the World Health Assembly; art. 25 of the Universal Declaration of Human Rights; INCB (2011), Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes; INCB (2016), Report of the International Narcotics Control Board on the availability of internationally controlled drugs: ensuring adequate access for medical and scientific purposes'.
[xxi] INCB (2015), Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes, International Narcotics Control Board.
[xxii] Ibid.
[xxiii] Ibid.
[xxiv] World Health Organization. Essential Medicines. http://www.who.int/topics/essential_medicines/en/
[xxv] Duthey B., Scholten W. (2014). Adequacy of Opioid Analgesic Consumption at Country, Global and Regional Levels in 2010, Its Relationship With Development Level, and Changes Compared With 2006. Journal of Pain and Symptom Management 47 (2) February 2014. pp.283-297, available online at: http://apps.who.int/medicinedocs/documents/s21500en/s21500en.pdf
[xxvi] UNAIDS Spectrum Estimates 2013.
[xxvii] WHO (2011). Ensuring balance in national policies on controlled substances. Guidance for availability and accessibility of controlled medicines, available online at http://www.who.int/medicines/areas/quality_safety/guide_nocp_sanend/en/
[xxviii] IARC (2013), Latest world cancer statistics, World Health Organization Press Release no. 223, International Agency for Research on Cancer of the World Health Organization.