

Non-paper on Part I of the Plan of Action: Demand reduction and related measures*

Introduction

At the high-level segment of the fifty-second session of the Commission on Narcotic Drugs, held in March 2009, heads of States, ministers and government representatives from 132 States adopted the Political Declaration and Plan of Action on International Cooperation towards an integrated and Balanced Strategy to Counter the World Drug Problem.² Part I of the Plan of Action focuses on Demand reduction and related measures.

In the Plan of Action, Member States committed themselves to reducing drug abuse and dependence through a comprehensive approach by enhancing international cooperation; developing a comprehensive approach to drug demand reduction; ensuring human rights, dignity and fundamental freedoms in the context of drug demand reduction; applying measures based on scientific evidence; increasing the availability of and accessibility to drug demand reduction services; mainstreaming community involvement and participation; targeting vulnerable groups and conditions; addressing drug use and dependence care in the criminal justice system; developing and adopting quality standards and training of staff; and increasing data collection, monitoring and evaluation.

General information

In 2011, between 167 and 315 million people aged 15–64 were estimated to have used an illicit substance in the last 12 months. This corresponds to between 3.6 and 6.9 per cent of the adult population. The prevalence of illicit drug use and the numbers of people suffering from drug use disorders or dependence have remained stable since 2009, although the quality of available data varies widely and there are significantly differing trends in terms of different regions and different substances³.

The limited available data suggest that opioid use (opium, heroin, prescription opioids) has gone up in parts of Asia (East and South-East Asia, as well as Central and West Asia) and Africa since 2009. Overall, the use of opiates (heroin and opium) remains stable (around 16.5 million people, or 0.4 per cent of the population aged 15-64), with a high prevalence for opiate use reported from South-West and Central Asia, Eastern and South-Eastern Europe and North America. In Europe, while non-medical use of prescription opioids continues to be reported from some parts, there are indications that heroin use is declining.⁴

While, earlier, North America and Central/Western Europe dominated the demand for cocaine, today they account for approximately one half of users globally, a reflection of the fact that use seems to have stabilized in Europe and declined in North America. Significant increases have been noted in Asia, Oceania and Central and South America and the Caribbean.⁵

The use of amphetamine-type stimulants (ATS), excluding “ecstasy”, remains widespread globally, and appears to be increasing in most regions. In 2011, an estimated 0.7 per cent of

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¹ See *Official Records of the Economic and Social Council, 2009, Supplement No. 8 (E/2009/28)*, chap. I, sect. C.

³ UNODC (2013), *World Drug Report*, United Nations Office on Drugs and Crime, Vienna, Austria.

⁴ *Ibid.*

⁵ *Ibid.*

the global population aged 15-64, or 33.8 million people, had used ATS in the last 12 months. The prevalence of “ecstasy” use in 2011 (19.4 million, or 0.4 per cent of the population) was lower than in 2009. While use is steady in the traditional markets of North America and Oceania, there seems to be an increase in the market in Asia’s developed economies, notably in East and South-East Asia, and there is also an emerging market in Africa.⁶

Cannabis remains the most widely used illicit substance. There was a minor increase in the prevalence of cannabis users (180.6 million or 3.9 per cent of the population aged 15-64) as compared with previous estimates in 2009.

The number of new-psychoactive substances (NPS) reported by Member States to UNODC rose from 166 at the end of 2009 to 251 by mid-2012, an increase of more than 50 per cent. For the first time, the number of NPS actually exceeded the total number of substances under international control (234).⁷

Of those identified as problem users suffering from drug use disorders or dependence, approximately one in six globally receives treatment each year. However, there is a greater than six fold variation between the regions and much variety exists in terms of the form and quality of available treatment.⁸

UNODC estimates that there were between 102,000 and 247,000 drug-related deaths in 2011, corresponding to a mortality rate of between 22.3 and 54.0 deaths per million population aged 15-64. This represents between 0.54 per cent and 1.3 per cent of mortality from all causes globally among those aged 15-64. The extent of drug-related deaths has essentially remained unchanged globally and within regions. It should be noted, however, that drug-related deaths are generally under-reported. These deaths occur at a relatively younger age (e.g. the mean age for drug related deaths for countries in Europe varies from 26 to 44 years), and such deaths can largely be prevented⁹.

Injecting drug use continues to drive the expansion of the HIV epidemic in many countries around the world. In 2013, UNODC estimates that there are 14.0 million (range: 11.2 million to 22.0 million) people who inject drugs worldwide, and of these, 1.6 million (range: 1.2 million to 3.9 million) are living with HIV, representing a global prevalence of HIV of 11.5 per cent among people who inject drugs¹⁰. These estimates are lower than the previous global estimates reported in 2008 by Mathers et al¹¹ - unfortunately, not necessarily representing a decrease in the epidemic itself, but rather the improved availability of more reliable data. There is an urgent need for intensified efforts and particularly domestic investments in monitoring and research among this key population.

Very high prevalence of injecting drug use is found in Eastern and South-Eastern Europe and in Central Asia - 1.3 per cent of the population aged 15-64 (i.e. four times greater than the global average). HIV is also concentrated among people who inject drugs in Eastern Europe and Central Asia, as well as East and South-East Asia. While HIV in sub-Saharan Africa is transmitted mainly via heterosexual contact, injecting drug use and HIV transmission have emerged as major concerns in East Africa, and is reported in multiple other African countries¹².

⁶ *Ibid.*

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⁸ *Ibid.*

⁹ UNODC/WHO (2013), Opioid overdose: preventing and reducing opioid overdose mortality, Discussion Paper, United Nations Office on Drugs and Crime, Vienna, Austria.

¹⁰ UNODC (2013), World Drug Report, United Nations Office on Drugs and Crime, Vienna, Austria.

¹¹ Bradley M. Mathers and others, “Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review”, *The Lancet*, vol. 372, No. 9651 (2008), pp. 1733-1745.

¹² UNODC (2013), World Drug Report, United Nations Office on Drugs and Crime, Vienna, Austria.

The use of ATS and "ecstasy" remain widespread globally with over 53 million people having used these substances over the past 12 months in 2011¹³. The most common HIV risk faced by people who use ATS and/or "ecstasy" involves unprotected sexual behaviours with partners from groups with high HIV prevalence and incidence, defining this is major issue to consider with regard to eliminating HIV transmission in this group. People who inject ATS and do not use a clean needle every time face HIV transmission risks similar to those faced by people who inject opiates who use non-sterile injection equipment.

Hepatitis C, also transmitted through contaminated injection equipment, represents another major health challenge for people who inject drugs. Globally, approximately 150 million people are infected with hepatitis C¹⁴.

HIV and hepatitis C transmission are further fuelled by incarceration. Globally each year at least 30 million men, women and children go through prison systems, where high-risk behaviours and HIV transmission are highly prevalent. The prevalence of HIV, sexually transmitted infections, hepatitis B and C and tuberculosis (TB) is 2 to 20 times - and up to 50 times - higher in prison populations than in the general population. The proportion of people who use and inject drugs in prisons can reach half the incarcerated population, especially among women in closed settings. In some countries up to 50 per cent of people who inject drugs go through prison and pre-trial detention once or several times in their life, and a large proportion of the people who inject drugs and living with HIV are found in prisons and closed settings^{15,16}. Access to health services, and in particular drug and HIV services, is largely absent.

Specific information

I. Achievements

More and more countries recognize drug use as a health issue and drug dependence as a multi-factorial health disorder which needs to be treated and not punished.

Many countries have reported adopting written national strategies that covers components of drug prevention, treatment, care and rehabilitation, including prevention of health and social consequences (or 'harm reduction')^{17,18} as part of a balanced response alongside supply reduction. These strategies were reported to cover prevention, treatment, rehabilitation and social reintegration services, services to prevent the health and social consequences of drug use and drug monitoring and research.

¹³ UNODC (2013), World Drug Report, United Nations Office on Drugs and Crime, Vienna, Austria.

¹⁴ WHO Fact sheet N°164 (2013)

¹⁵ UNODC/ILO/UNDP/WHO/UNAIDS (2013) Policy Brief on "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions" http://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf

¹⁶ UNODC (2007) Drug dependence treatment: interventions for drug users in prisons http://www.unodc.org/docs/treatment/111_PRISON.pdf

¹⁷ In this document the term 'harm reduction' refers to the set of nine interventions for HIV prevention, treatment and care for people who inject drugs, as initially 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, 2009), namely: 1 Needle and syringe programmes (NSPs); 2 Opioid substitution therapy (OST) and other evidence-based drug dependence treatment; 3 HIV testing and counselling (HTC); 4 Antiretroviral therapy (ART); 5 Prevention and treatment of sexually transmitted infections (STIs); 6 Condom programmes for people who inject drugs and their sexual partners; 7 Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners; 8 Prevention, vaccination, diagnosis and treatment for viral hepatitis; 9 Prevention, diagnosis and treatment of tuberculosis (TB).

¹⁸ UNODC (2009) Reducing the adverse health and social consequences of drug abuse: a comprehensive approach - Discussion paper. http://www.unodc.org/docs/treatment/Reducing_the_Adverse_Health_and_Social_Consequences_of_Abuse.pdf

A wide range of drug prevention interventions are reported to be implemented by Member States and a majority of Member States report the implementation evidence-based interventions such as: life skills education in schools, family and parenting skills training, screening and brief interventions and workplace prevention programmes,¹⁹ although this is often on a pilot basis.

A relatively wide range of drug dependence treatment, care and rehabilitation services as described in the UNODC/WHO Discussion Paper “Principles of drug dependence treatment” are reported to be implemented by Member States, including both residential and outpatient²⁰.

HIV prevention, treatment, care and support services, including needle-syringe programme, opioid substitution therapy and anti-retroviral therapy, for people who inject drugs and people in prisons and other closed settings have been scaled up in countries which have adequately invested in these services.

Significant progress has been made in several countries in improving gender responsive drug dependence and HIV services, including the prevention of mother-to-child transmission of HIV (PMTCT) and the provision of gender-specific treatment facilities for female drug users, as well as programs for women living in prisons and other closed settings, for example in Afghanistan, Pakistan and Nepal.

Civil society organizations (CSOs) have been more closely engaged in different aspects of the response with regard to drug dependence treatment, drug use prevention, HIV and drug use, and HIV in prison settings.

In countries, where adequate investments in research, monitoring and evaluation have been made, and related human resources and systems of government and civil society enhanced, more strategic, effective and efficient responses to HIV among people who inject drugs have been put in place.

Some countries are considering reducing or ending compulsory treatment for drug users.

II. Challenges

A health-centred approach to drug use and dependence is still not sufficiently implemented: A variety of sources suggest^{21,22,23,24,25} that several national drug control systems over-rely on sanctions and imprisonment, not health care; that compulsory treatment and punitive practices in the name of treatment are still applied; and that stigma, discrimination and violation of human rights towards people using drugs, people dependent on drugs and living with HIV/AIDS are common.

The coverage and quality of drug prevention interventions and policies implemented by Member States is not known, many interventions and policies that are not based on

¹⁹ The reference for these statements is E/CN.7/2012/14, 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. Report of the Executive Director.

²⁰ E/CN.7/2012/14

²¹ E/CN.7/2012/14

²² Joint UN Statement - Compulsory drug detention and rehabilitation centres (March, 2012)

²³ WHO (2010), Atlas on substance use (2010): resources for the prevention and treatment of substance use disorders, World Health Organization, Geneva.

²⁴ UNODC (2010) From coercion to cohesion: Treating drug dependence through health care, not punishment, United Nations, New York.

²⁵ UNAIDS report on the global AIDS epidemic 2012, UNAIDS, Geneva.

scientific evidence are still being implemented, and very limited evaluation of the impact of interventions and policies is undertaken²⁶.

The coverage of drug dependence treatment, care and rehabilitation services as described in the UNODC/WHO Discussion Paper “Principles of Drug Dependence Treatment” is of great concern. The vast majority of patients are not reached and, where services exist, they are not appealing and there remain multiple barriers to access. In particular, the availability of outpatient services in the community is very limited in some regions²⁷; on average, one-third of Member States did not offer treatment as an alternative to criminal justice sanctions, with percentages much higher in some regions²⁸; and, services in prison settings are not as available in the community²⁹.

There exist few evidence-based drug prevention, treatment, care and rehabilitation interventions and services that reach some of the most vulnerable groups³⁰, including young people, children and youth exposed to drugs at a very young age, women, sex workers, street children, women with children, pregnant women, Lesbian, Gay, Bisexual and Transgender (LGBT) populations, refugees and displaced populations, and people living in post-conflict or fragile countries.

Some countries do not appear to have a comprehensive and detailed overview of drug use and dependence, including of vulnerabilities, to allow for or data-driven planning of the development of drug prevention, treatment, care and rehabilitation services, including the prevention of health and social consequences, especially HIV/AIDS.

Some countries do not appear to have adopted standards with regard to drug prevention, treatment, care and rehabilitation interventions and services, including the prevention of health and social consequences, especially HIV/AIDS, as well as to the competencies of the policy makers, practitioners, and researchers involved. Training is not institutionalised on an on-going basis.

The role of the CSOs, including those representing affected populations (people using drugs, people who used to use drugs, parents, partners, etc.), in the development of policy and in accessing funding mechanisms remains limited, in spite of their substantial involvement in the delivery of drug prevention, treatment, care and rehabilitation interventions.

There is a grave need to increase domestic investments in HIV services for people who inject drugs. Globally, fewer than 8 in 100 people who inject drugs have access to opioid substitution therapy (OST), and only 2 clean needles are distributed per month to people who inject drugs. Only 4 in every 100 eligible people who inject drugs are receiving antiretroviral therapy (ART)³¹.

HIV services are often not responsive to the specific needs of particularly vulnerable groups of drug users, in particular women and young people.

In many countries, there is an overuse of incarceration of people instead of putting in place alternative measures that are more effective. Prisoners and ex-prisoners who are drug users and/or are living with HIV continue to face multiple stigmas, and their rights to health care, education, employment, social integration, food and decent living conditions are often

²⁶ E/CN.7/2012/14

²⁷ E/CN.7/2012/14

²⁸ E/CN.7/2012/14

²⁹ E/CN.7/2012/14

³⁰ UNODC (2013), International Standards on Drug Use Prevention.

³¹ 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.

denied. Drug dependence treatment, care and rehabilitation services are scarce in prisons and other closed settings. Access to condoms, needle and syringe programmes (NSP), OST, HIV testing and counselling (HTC), ART and PMTCT remains limited in prisons and other closed settings. Globally, NSP is only available in some prisons in 7 countries and OST in prisons in only 20 countries. Screening and treatment for TB, hepatitis and sexually transmitted infections (STIs) are often unavailable. The absence or interruption of services has serious implications for treatment outcomes and risks for HIV/TB transmission.

New risks of HIV associated with injecting drug use are emerging in regions with already high rates of HIV infection, particularly in Africa.

Globally, the use of stimulant drugs is on the rise, particularly in South-East Asia, Latin America and Caribbean. Its link to HIV transmission among certain key population groups, through both sexual and injecting routes, is of great concern.

Many countries lack reliable data required for evidence-informed, comprehensive policy and programmatic response to the HIV epidemic among people living in prisons and other closed settings.

Availability of opioid agonist/antagonist maintenance treatment and naloxone remain very limited despite being recommended approaches to reduce overdose among people who use opioids³².

Access to controlled drugs for medical purposes is severely limited, particularly in low- and middle-income countries, in spite of clear input from the three drug Conventions³³.

III. Priorities

A health and human rights centred drug control system promoting a society where illicit drug use is not accepted as a way of life and where those needing services receive them. People using drugs should not be stigmatized and punished but receive support for recovery, social cohesion and integration.

Drug prevention, treatment, and rehabilitation interventions, including the prevention of health and social consequences and services that are based on scientific evidence and human rights, including an understanding of drug disorders as multi-factorial disease caused by a complex interplay of neurobiological, psychological and environmental vulnerabilities need to be expanded.

The coverage and quality of drug prevention systems, interventions and policies based on scientific evidence as described in the International Standards on Drug Use Prevention should be expanded, with particular attention to a scientific-based monitoring and evaluation component.

Basic drug dependence treatment, and rehabilitation services, including the prevention of health and social consequences, as described in the UNODC/WHO Discussion Paper “Principles of Drug Dependence Treatment ” should become accessible and appealing.

The coverage and quality of drug dependence treatment, and rehabilitation services, including the prevention of health and social consequences, that are voluntary and based on scientific evidence and medical standards of respect for the patient should be expanded, in particular outpatient treatment widely distributed in the territory and accessible in the community and treatment as an alternative to criminal justice sanctions. Multiple pathways

³² UNODC (2013), Opioid overdose: preventing and reducing opioid overdose mortality, UNODC/WHO discussion paper, United Nations Office on Drugs and Crime, Vienna, Austria.

³³ E.g., see the Preamble of the 1961 Single Convention.

to recovery are essential to support the rehabilitation and reintegration of people suffering from drug disorders and dependence.

Existing recommended approaches to reduce overdose among people who use opioids (such as opioid agonist/antagonist maintenance treatment and making naloxone available to reverse opioid overdose) should be systematically implemented and additional approaches should be further investigated³⁴.

Planning of the development of drug prevention, treatment, and rehabilitation services, including the prevention of health and social consequences needs to be based on a comprehensive and accurate assessment of drug use and dependence, including of vulnerabilities and of health (especially HIV and hepatitis C) and social status.

Evidence-based drug prevention, treatment and rehabilitation treatment, care and rehabilitation interventions and services that reach some of the most vulnerable groups (including young people, children and youth exposed to drugs at a very young age, women, sex workers, street children, women with children, pregnant women, Lesbian, Gay, Bisexual and Transgender (LGBT) populations, refugees and displaced populations, and people living in post-conflict or fragile countries) should be researched, expanded and implemented.

Detection and identification of new psychoactive substances is the first step in assessing potential health risks, and therefore scientific, epidemiological, forensic and toxicological information on these substances needs to be collected, maintained and disseminated.

Research on the pharmacological treatment of stimulants is a priority, as well as research about the aetiology and treatment of new psychoactive drugs use and dependence.

National standards based on scientific evidence, medical ethics and human rights need to be developed and adopted with regard to drug prevention, treatment and rehabilitation, including the prevention of health and social consequences, interventions and services, as well as to the competencies of the policy makers, practitioners, and researchers involved. Accordingly, training should be institutionalised on an on-going basis.

The role of the CSOs, including those representing affected populations (people using drugs, people who used to use drugs, parents, partners, etc.), in the development of relevant policy and in the delivery of drug prevention, treatment, care and rehabilitation interventions expanded and institutionalised.

National AIDS and drugs policies, strategies and programmes will need to be revised to allow all nine WHO/UNODC/UNAIDS comprehensive package³⁵ interventions for people who inject drugs to be implemented. Programmes should be increased in scale and multiple delivery models should be utilized (including outreach, low threshold drop-in centres, peer education) and barriers to access the services should be identified and removed. The meaningful involvement of CSOs representing and including people who use drugs and to build their capacity should be intensified. Addressing the HIV epidemic driven by injecting drug use in Eastern Europe and Central Asia region is a key priority.

Regarding prisons, people using drugs in prisons should have access to health services including drug dependence treatment and harm reduction measures, at least equivalent to the community, and priority should be given towards implementation of the fifteen interventions as outlined in the UNODC/ILO/UNDP/WHO/UNAIDS Policy Brief on “HIV

³⁴ UNODC (2013), Opioid overdose: preventing and reducing opioid overdose mortality, UNODC/WHO discussion paper, United Nations Office on Drugs and Crime, Vienna, Austria.

³⁵ WHO/UNODC/UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012 revision

prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions”³⁶.

Legislation that prevents the introduction, or inhibits the delivery of the key HIV prevention, treatment and care services to people who inject drugs and people in prisons and other closed settings should be revised to allow for and support these interventions.

It is critical to rapidly increase domestic funding for drug demand reduction and for the essential lifesaving HIV services recommended for people who use drugs and people in prisons and other closed settings.

Scale-up action to ensure access to controlled drugs for medical purposes whilst preventing diversion and abuse.

IV. Further observations for consideration

Member States could consider:

Building on the commitments made in the 1998 Political Declaration³⁷ and Declaration on the Guiding Principles of Drug Demand Reduction³⁸, as well as in the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, adopted at the high-level segment in 2009.

Renewing commitment to a health and human rights centred drug control system promoting a society where illicit drug use is not accepted as a way of life and where those needing services receive them. People using drugs should not be stigmatized and punished but receive support for recovery, social cohesion and integration.

Developing prevention, treatment, and rehabilitation interventions, including the prevention of health and social consequences and services that are based on scientific evidence and human rights, including an understanding of drug disorders as multi-factorial disease as a result of a clinical history of disadvantages caused by a complex interplay of neurobiological, psychological and environmental vulnerabilities.

Expanding the coverage of drug prevention systems, interventions and policies based on scientific evidence as described in the International Standards on Drug Use Prevention, with particular attention to cultural adaptation as well as to a scientific-based monitoring and evaluation component.

Significantly improving the coverage and quality of drug dependence treatment, care and rehabilitation services and prevention of health and social consequences (‘harm reduction’)^{39,40} that are voluntary and based on scientific evidence and medical standards of

³⁶ UNODC/ILO/UNDP/WHO/UNAIDS (2013) Policy Brief on “HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions”

³⁷ A/RES/S-20/2

³⁸ A/RES/S-20/3

³⁹ In this document the term ‘harm reduction’ refers to the set of nine interventions for HIV prevention, treatment and care for people who inject drugs, as initially 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, 2009), namely: 1 Needle and syringe programmes (NSPs); 2 Opioid substitution therapy (OST) and other evidence-based drug dependence treatment; 3 HIV testing and counselling (HTC); 4 Antiretroviral therapy (ART); 5 Prevention and treatment of sexually transmitted infections (STIs); 6 Condom programmes for people who inject drugs and their sexual partners; 7 Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners; 8 Prevention, vaccination, diagnosis and treatment for viral hepatitis; 9 Prevention, diagnosis and treatment of tuberculosis (TB).

⁴⁰ UNODC (2009) Reducing the adverse health and social consequences of drug abuse: a comprehensive approach - Discussion paper.

http://www.unodc.org/docs/treatment/Reducing_the_Adverse_Health_and_Social_Consequences_of_Abuse.pdf

respect for the patient, including as outpatient treatment in the community and treatment as an alternative to criminal justice sanctions. Services should become accessible and appealing. Multiple pathways to recovery are essential to support the rehabilitation and reintegration of people suffering from drug disorders and dependence.

Eliminating all compulsory drug treatment that is without judicial process, medical evaluation, or ability to leave voluntarily.

Expanding evidence-based drug prevention, treatment and rehabilitation treatment, care and rehabilitation interventions and services that reach some of the most vulnerable groups, including young people, children and youth exposed to drugs at a very young age, women, sex workers, street children, women with children, pregnant women, Lesbian, Gay, Bisexual and Transgender (LGBT) populations, refugees and displaced populations, and people living in post-conflict or fragile countries.

Developing drug prevention, drug dependence treatment, care and rehabilitation services, including the prevention of health and social consequences, on the basis of a comprehensive and detailed overview of drug use and dependence, including of vulnerabilities.

Investing in developing additional evidence-based treatment, care and rehabilitation and HIV prevention approaches for people who use stimulant drugs.

Developing, adopting and implementing national standards based on scientific evidence and human rights with regard to drug prevention, treatment, care and rehabilitation interventions and services, including the prevention of health and social consequences, as well as to the competencies of the policy makers, practitioners, and researchers involved. Institutionalise training accordingly on an on-going basis.

Expanding the role of the CSOs, including those representing affected populations (people using drugs, people who used to use drugs, parents, partners, etc.), in the development of relevant policy and in the delivery of drug prevention, treatment, care and rehabilitation interventions.

In order to achieve maximal impact, national HIV and drugs strategies should include implementation of all the nine interventions outlined in the WHO/UNODC/UNAIDS comprehensive package for people who inject drugs. In countries, where HIV epidemic is driven by injecting drug use, implementation of needle and syringe programmes and long-acting opioid maintenance therapy should be a priority. National drug control agencies, law enforcement agencies, ministries of justice, interior and health, and CSOs should work together. Increased resources, in particular domestic investments, to scale-up essential HIV interventions for people who inject drugs are urgently required.

Regarding prisons and HIV, countries should work towards implementation and scaling-up of drug dependence treatment and the interventions outlined in the UNODC/ILO/UNDP/WHO/UNAIDS Policy Brief on “HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions”. The interventions in prisons should be integrated into national drugs, AIDS and tuberculosis-related plans and programmes, and resources should be allocated for their implementation. National coordination mechanisms, involving prison authorities, ministries of health and labour, national AIDS committees, national tuberculosis programmes and CSOs should be established.

The global community needs to continue to build on the current gains to ensure that the countries receive adequate support to enable them to lead, manage and establish accountability for their HIV response, not only in the community, but also in prisons and other closed settings.

Scaling-up action to ensure access to controlled drugs for medical purposes whilst preventing diversion and abuse.

Share information on the potential adverse impacts and risks to public health and safety of new psychoactive substances through tailored prevention strategies, including awareness-raising to counter the public perception that new psychoactive substances not subject to drug controls are safe.