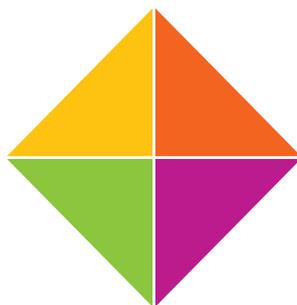


Post-2015 Negotiation Briefs #2: Drug Related Harm Reduction



Prevalence of Drug Use and Addiction and the Global Burden of Disease (GBD)

Estimates calculate that amongst 3.6 and 6.9% of the world's population habitually uses illicit drugs.^{1,2} In 2011, it was projected that between 167 and 315 million people aged 15–64 had used an illicit substance the year before.³ This represents an 18% increase from the same measure in 2008,⁴ which is a reflection of both an increase in the global population and an increase in the prevalence of illicit drug use. From this, it is expected that between 30 and 40% are young people.^{5,6}

Out of this usage, UNODC estimates that 12% develop dependence or addiction every year.^{7,8} However, not enough data is collected on frequency and quantity of use, which is basic to estimate increased health risks. For instance, people who use drugs only once or twice have, at most, a very small increase in mortality, which is difficult to detect in epidemiological studies. On the other hand, problematic drug use most clearly harms the health of users. Because of this, no global estimates of the prevalence of specific forms of drug dependence exist.⁹

While it is difficult to accurately measure the burden of disease attributable to illicit drug use, some indicators suggest that global illicit drug consumption (and its related burden) has significantly increased since 1990.¹⁰ Injecting drug use,

for example, is now reported in more countries,¹¹ and HIV amongst Injectable Drug Users (IDU) is more prevalent in Eastern Europe, and Asia.¹² In 2002, a comparative risk assessment exercise estimated that the median number of deaths attributed to illicit drugs was about 200,000.¹³

In all, current policies have been unsuccessful in deterring drug use, and prevalence of illicit drug use continues to grow today, particularly amongst young people. In fact, the WHO estimates amphetamine, cocaine, or opioid use in 2004 accounted for 0.9% of global DALYs,¹⁴ varying widely across regions.¹⁵ Drug dependence (excluding cannabis) was the largest of the four causes of global illicit drug burden assessed (68%), followed by HIV/AIDS (18%).¹⁶

According to Degenhardt, these estimates indicate that illicit drug use is a substantial global cause of premature mortality and morbidity.¹⁷ Even more, these are acknowledged to be underestimates, as they do not include cannabis and MDMA, or the burden attributable to hepatitis B, hepatitis C, or drug-related violence.¹⁸

To respond to the harms associated to drug use, health professionals came up with the concept of 'harm reduction', defined as the *"policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption"*.¹⁹ These interventions include:

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counselling (T&C)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for IDUs and their sexual partners
7. Targeted information, education and communication (IEC) for IDUs and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis (TB).

Health professionals are not alone in recognize the necessity for harm reduction, the UN General Assembly has also endorsed harm reduction as an essential HIV prevention measure in its Declaration of Commitment on AIDS in 2001 and in the Political Declaration on AIDS in 2006.

Drug Use in the Post-2015 Agenda

If the world is to achieve our universal target of ending the AIDS epidemic by 2030, explicit mention of drug-related harm reduction services is required in the post 2015 framework. More importantly, drug use must be understood from a public health approach where the objective is to lessen health-harms and maximise health interventions.

From the output document of the OWG, we know there is one established Goal²⁰ relevant to the subject: **“Goal 3. Ensure healthy lives and promote well-being for all at all ages”**.

Within Goal 3, there are three relevant targets currently suggested:

- 3.4** by 2030 reduce by one-third pre-mature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and wellbeing;
- 3.5** strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol, and
- 3.a** strengthen implementation of the Framework Convention on Tobacco Control in all countries as appropriate.

To help collect additional input about post-2015 global goals from people working to end the HIV epidemic, International Civil Society Support (ICSS)²¹ sponsored a webinar series, a global e-survey, and an in-person meeting during December 2012 and January 2013. Six webinars were held with over 100 participants. From the output document it was identified that:²²

“The fight against HIV, tuberculosis, and malaria is a driver of improved health systems, including scale up of quality maternal and child healthcare, sexual and reproductive health, harm reduction services, management of chronic health issues, and affordable treatment access and treatment adherence. [...]

“Global goals should focus on the leading causes of premature death and disability. These should include specific time-bound targets against HIV, tuberculosis and malaria and also targets against other diseases (including NCDs and vaccine-preventable infections) and for indicators of sexual and reproductive health, maternal and child health, mental health, harm reduction and prevention of deaths and disability due to substance use.”

Target 3.5: Room for Improvement According to Science

Within the language currently used under Goal 3, we urge member States to substitute target 3.5 for the following: “**3.5 Reduce by x% the burden of health harm and premature death associated with unhealthy foods and alcohol, tobacco and other drugs**”. This language suggestion responds to the following concerns:

1. The current wording is lacking in clarity as it mixes definitions that are not clear (e.g. ‘Substance abuse’, ‘harmful use of’ and ‘narcotic drug abuse’). Language should aim to be consistent with definitions of the ICD (e.g. ‘Harmful use’ and ‘dependence’) and avoid ill-defined concepts such as ‘substance abuse’.
2. The language used at the moment is not a target, and allows a lot of room for interpretation. The focus should be on the health issues to be addressed, not on (ill-defined) interventions. The suggested wording focuses on health harm and acknowledges the variety of approaches for addressing them.
3. A lot of ineffective ‘prevention and treatment’ happens today, and to call for it to be strengthened without any note as to its quality is not helpful.
4. Tobacco is missing from the current wording, and while there is language on FCTC in **3.a**, that does not fit as it is not a target. The focus should be on reducing health-harms, so the target should relate to that. Our suggested wording achieves this.

Resources

- × *Taking Control: Pathways to Drug Policies that Work*, Global Commission on Drug Policy. www.gcdpsummary2014.com/#foreword-from-the-chair
- × *The Vienna Declaration: We Cannot End AIDS Until We End The War on Drugs*. www.viennadeclaration.com
- × ‘Count the costs of the war on drugs’ Global Campaign. www.countthecosts.org
- × Speech by Michel Kazatchkine, UN Special Envoy for HIV/AIDS in Eastern Europe and Central Asia: *Arresting Drug Users Increases HIV*. www.youtube.com/watch?v=-e4nrF18gQo

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Footnotes

1. UNODC / WHO. "Principles of Drug Dependence Treatment". UNODC / WHO. 2008. www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf
2. This calculation includes all non-medical use of a variety of drugs that are prohibited by international law. Because of data uncertainty mentioned earlier, the UN and UNODC in particular tend to show wide ranges of prevalence.
3. UNODC. "World Drug Report 2013". UNODC. 2013. www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_Report_2013.pdf
4. UNODC. "World Drug Report 2008". UNODC. 2008. www.unodc.org/documents/wdr/WDR_2008/WDR_2008_eng_web.pdf
5. There is no disaggregated data available at a global level, partly because many countries do not disaggregate age groups when reporting to the UNODC. However, based on national surveys from Australia, the United States, Greece, Nigeria and Seychelles, a range was drawn. See more: Lynskey, M., White, V., Hill, D., Letcher, T. and Hall, W. (1999), "Prevalence of illicit drug use among youth: results from the Australian School Students" Alcohol and Drugs Survey. *Australian and New Zealand Journal of Public Health*, 23: 519–524; Vega, W. A., Alderete, E., Kolody, B. and Aguilar-Gaxiola, S. (1998), "Illicit drug use among Mexicans and Mexican Americans in California: the effects of gender and acculturation". *Addiction*, 93: 1839–1850.; D Kandel, E Single, and R C Kessler. "The epidemiology of drug use among New York State high school students: Distribution, trends, and change in rates of use." *American Journal of Public Health* 1976 66, 1, 43-53; A Kokkevi and C Stefanis. "The epidemiology of licit and illicit substance use among high school students in Greece." *American Journal of Public Health* 1991 81, 1, 48-52; OY Oshodi, OF Aina, AT Onajole. "Substance use among secondary school students in an urban setting in Nigeria: prevalence and associated factors". Vol 13, No 1 (2010). *African Journal of Psychiatry*; David Faeh, Bharathi Viswanathan, Arnaud Chiolerio, Wick Warren and Pascal Bovet. "Clustering of smoking, alcohol drinking and cannabis use in adolescents in a rapidly developing country". *BMC Public Health* 2006, 6:169.
6. It is expected that most surveys under-report prevalence of use. Barbara S. Mensch and Denise B. Kandel. "Undereporting of substance abuse in national longitudinal youth cohort: Individual and interviewer effects". *Public Opinion Quarterly* (1988) 52 (1): 100-124
7. *Op. Cit.* UNODC / WHO, 2008.
8. The International Classification of Diseases defines addiction as "harmful use [...] a pattern of psychoactive substance use that is causing damage to health" and "dependence [...] a cluster of behavioural, cognitive, and physiological

phenomena that develop after repeated substance use". In: World Health Organization. "International Classification of Diseases". 10th revision. apps.who.int/classifications/icd10/browse/2015/en#/F17.2

9. Drug dependence (combined for all illicit drugs and illicit pharmaceutical use) was assessed in WHO's World Mental Health household surveys in 27 countries in five WHO regions. More in: Kessler R, Üstün T. "The WHO World Mental Health Surveys: global perspectives on the epidemiology of mental disorders." Cambridge: Cambridge University Press, 2008.

10. Degenhardt, Louisa and W. Hall, "Extent of illicit drug use and dependence, and their contribution to the global burden of disease". *The Lancet*, Volume 379, Issue 9810, 7–13 January 2012, Pages 55-70.

11. Mathers B, Degenhardt L, Phillips B, et al. "Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review." *Lancet* 2008; 372: 1733–45.

12. *Ibid.*

13. Degenhardt L., Hall W., Lynskey M., Warner-Smith M. "Illicit drug use". In: Ezzati M, Lopez AD, Rodgers A, Murray R, eds. "Comparative quantification of health risks: global and regional burden of disease attributable to selected major risk factors". 2nd edn. Geneva: World Health Organization, 2004: 1109–76.

14. The disability-adjusted life year (DALY) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.

15. WHO. "The global burden of disease: 2004 update". Geneva: World Health Organization, 2008.

16. Four broad types of adverse health effects of illicit drug use exist: the acute toxic effects, including overdose; the acute effects of intoxication, such as accidental injury and violence; development of dependence; and adverse health effects of sustained chronic, regular use, such as chronic disease (eg, cardiovascular disease and cirrhosis), blood-borne bacterial and viral infections, and mental disorders. In: Babor TF, Caulkins J, Edwards G, et al. "Drug policy and the public good". Oxford: Oxford University Press, 2010.

17. *Op. Cit.* Degenhardt, Louisa and W. Hall, 2012.

18. *Ibid.*

19. Definition by Harm Reduction International. www.ihra.net/what-is-harm-reduction

20. Open Working Group. "Open Working Group proposal for Sustainable Development Goals". United Nations Department of Economic and Social Affairs. sustainabledevelopment.un.org/focussdgs.html

21. These ICSS activities were organized with the collaboration and support

of International Council of AIDS Service Organizations (ICASO), STOP AIDS Alliance (SAA), UNAIDS, World Health Organisation (WHO), the HIV Young Leaders Fund (HYLF), Global Action for Trans Equality (GATE), Global Forum on MSM & HIV (MSMGF), Global Network of People Living with HIV/AIDS (GNP+), International Community of Women Living with HIV/AIDS (ICW), Network of People Who Use Drugs (INPUD), and Network of Sex Work Projects (NSWP).

22. Consultation of HIV Advocates about Post-2015 Global Development Goals. Available online: www.worldwewant2015.org/file/311569/download/338668

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