



THE WORLD DRUG REPORT 2018: **HEALTH CONSEQUENCES OF DRUG USE, THE SUSTAINABLE DEVELOPMENT GOALS AND SYSTEM-WIDE COHERENCE**

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Key points

- The *World Drug Report 2018* incorporates some of the Sustainable Development Goals in its analysis and recommendations, a progressive development that goes some way toward achieving the UN system-wide coherence that the drug control regime needs, and without which it will remain largely ineffective.
- The *Report* acknowledges that people who inject drugs are among the most marginalised and stigmatised people who use drugs.
- The *Report* also acknowledges the severe lack of access to harm reduction services, and implies that the consequences of the shortfall in these and other scientifically supported interventions for health is catastrophic.
- On the negative side of the balance, the *Report* has failed to seize the opportunity to comprehensively examine the results of the policies and measures adopted in the 2009 Political Declaration and Plan of Action, leaving civil society to take on this important task.
- The *Report* does not acknowledge the impact of the drug control regime itself on the health of people who use drugs; stigmatisation and marginalisation are deeply associated with criminalisation, and drive people away from health and social support services and directly impact on their mental and emotional health.
- Owing to the compounded stigma and violence women face, they are more prone than men to HIV and hepatitis C infection. It is encouraging to see the *Report* point this out.
- While the United Nations Office on Drugs and Crime can influence the terms of drug policy debates through the production of documents such as the *World Drug Report*, it is up to states to engage with, and act upon, the evidence and narratives being presented. In terms of the development

of coherent health- and rights-based drug policies, it is with states that the ultimate responsibilities reside.

Introduction

Almost a decade ago, the international community agreed upon a *Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem*.¹ The Declaration included the decision to establish 2019 as the target date for the goals set within it, specifically for states to ‘eliminate or reduce significantly and measurably’ the illicit cultivation, production, trafficking and use of internationally controlled substances, the diversion of precursors and money laundering. Consequently, despite the conclusion of a series of additional soft law instruments since 2009 – including the Outcome Document² from the UN General Assembly Special Session on the ‘World Drug Problem’ in 2016 – we are fast approaching a critical juncture for the UN-based international drug control regime.

Having agreed the process at its 60th session,³ March 2019 will see the Commission on Narcotic Drugs (CND) convene a two-day Ministerial Segment⁴ to take stock of progress made and define a global drug strategy for the next ten years or so. While always important in helping to set the narrative for debates within the Commission, the publication of the *World Drug Report 2018* comes at a particularly important moment, representing as it does the last major publication to come out of the United Nations Office on Drugs and Crime (UNODC or Office) before the high-level meeting. It is difficult to ignore the fact there remains no UN produced comprehensive review⁵ of the impacts of drug policies worldwide over the past decade to help inform the forthcoming discussion in Vienna, the home of the UN’s drug control apparatus. Moreover, that the *Report* fails to explicitly examine market trends since 2009 also appears to be a missed opportunity.

Nonetheless, as has been the case in recent years, the flagship publication remains rigorous in its analysis and provides an impressive

overview of the latest developments and trends in the world's illicit drug markets. Surely of significance for deliberations at the Ministerial Segment, the consistently high-quality research reveals a similar, if not more challenging, picture to previous years. Amidst the ongoing theme of uncertainty and issues around reliable and comprehensive data, readers learn of the increasing complexity and scale of the global drug market. As the UNODC's Executive Director, Mr. Yury Fedotov, remarks in his preface, 'Both the range of drugs and drug markets are expanding and diversifying as never before' (1. p. 1).⁶ This view is echoed in the Report's 'Conclusions and Policy Implications' section. Here the Office notes how 'The information presented in the *World Drug Report 2018* illustrates the unprecedented magnitude and complexity of the global drug markets'. 'The adverse health consequences caused by drug use remains significant', it continues, 'drug related deaths are on the rise...' (1, p. 23). And it is the adverse health consequences of drug use, particularly, although not exclusively those relating to injecting drug use, as well as policies and interventions designed and implemented to mitigate them, that will be the focus of this analysis.

Departing from the well-tried format of previous IDPC responses to, and analyses of, the *World Drug Report*, a series of publications dating back to 2006,⁷ our intention this year is to narrow our focus and explore just a few of the many facets of the 'World Drug Problem' to be found within the Office's latest offering. Intending to supplement – in the absence of any UN level analysis – IDPC's recent report, *Taking stock: A decade of drug policy – A civil society shadow report*⁸ (see Box 1), the pages that follow contain a discussion of not only the alarming scale of the negative health impacts of drug use described in the *Report*, but also the woefully inadequate provision of a range of scientifically proven interventions; interventions that operate comfortably within the existing confines of the three UN drug control treaties. Mindful of member states' apparently increasing commitment to the 2030 Sustainable Development Agenda⁹ within the context of drug policy, a perspective

Box 1 The civil society Shadow Report: The recording of failure

In October 2018, IDPC launched 'Taking stock: A decade of drug policy'¹¹ which evaluates the progress made against the commitments agreed by the international community in the 2009 Political Declaration and Plan of Action on drugs. Using data from the UN, academic research and civil society reports, the report provides an analysis of whether the 'drug-free world' targets set out in article 36 of the Political Declaration were achieved, and tracks progress towards specific actions agreed in 2009 against the broader UN priorities of protecting human rights, promoting peace and security and advancing development.

The Shadow Report finds that there has been no reduction in the illicit demand and supply for drugs – in fact, both have increased since 2009. Access to controlled drugs for medical and scientific research purposes remains far short of appropriate levels: 75% of the world's people lack access to proper pain relief treatment. Findings also highlight the many severe impacts of repressive drug policies worldwide on human rights, peace and security and development. The final section of the report outlines new indicators for assessing drug policy progress and impacts, in line with the SDGs and the protection of human rights.



notably incorporated within the 2016 UNGASS Outcome Document,¹⁰ we also make deliberate reference to the Sustainable Development Goals (SDGs) and the potential of the Agenda to improve progress towards the long sought-after goal of UN system-wide coherence around drugs. A focus on the Report's discussion of the complexities surrounding drug use patterns and treatment needs of specific groups – women, young people and old people – also reveals how conceptualisation of the intersection between the Goals and the issue of drug use can still be broadened. Indeed, as we suggest, in order to appropriately heed Mr. Fedotov's call for the international community to 'step up its responses to cope with' the myriad 'challenges' explored in the *Report*, (1, p. 1), member states must resist the temptation of remaining in a Vienna bubble and connect drug policy more effectively to the broader goals of the UN system of which it is one small part.

The extent of drug use and related health consequences

The extent of drug use and dependence

In setting the scene for the data and related analysis that follows, we are informed at the very beginning of the Report's Executive Summary that 'About 275 million people worldwide', equating to 'roughly' 5.6% of global population aged 15-64 years old, used drugs at least once during 2016. Within this figure, the *Report* stresses, 31 million people suffer from 'drug use disorders' (representing around 11% of the total number of people who use drugs) – i.e. use that is 'harmful to the point that they may need treatment' (2, p. 6). Although a complex set of factors underlie what triggers presentation and a perceived need for treatment,¹² that the issue is dominant within the publication is clearly positive. A key message to be taken from the 2018 *Report* is that at a global level there remains a significant gap between the number of people who need treatment and those that receive it. In 2016, an estimated one in six people suffering from 'drug use

disorders' received treatment, which, as the *Report* notes in a somewhat understated fashion 'is a relatively low proportion that has remained constant in recent years' (1 p. 16). Of particular relevance to our discussion is the fact that women with 'drug use disorders' are underrepresented in treatment: although representing one in three people who use drugs, women continue to count for only one in five people in treatment (2, p. 14).

The health consequences of drug use

As has been the case in recent editions of the publication, the *World Drug Report 2018* certainly retains a welcome focus on various aspects of the health implications of drug use, particularly what the UNODC refers to at different points as 'adverse health consequences' and 'negative health' impacts (2, p. 12, pp. 14-28) as well as the inadequate provision of 'drug treatment and health services to reduce the harm caused by drugs' (1, p. 16). Highlighting the unavoidable fact that drug use is 'associated with significant adverse health consequences', Booklet 2, *Global Overview of Drug Demand and Supply. Latest Trends, Cross-cutting issues*, contains detailed analysis of a range of related data, including the harms caused by opioids and a sophisticated discussion of drug overdoses that incorporates the effects on non-fatal overdoses as well as being a witness to an overdose event. Unsurprisingly in this regard, it is noted how overdose deaths associated with the non-medical use of pharmaceutical opioids, including fentanyl and fentanyl analogues, have now reached epidemic proportions' in North America (2, p6). Within the context of a worryingly high number of deaths associated with drug use – according to figures by the World Health Organization (WHO) approximately 450,000 in 2015 – data show that 167,750 were directly associated with 'drug use disorders' (primarily overdoses). While the reader is left to do the calculation, this means that 282,250 deaths were indirectly attributable to drug use, including those relating to HIV and hepatitis C acquired through 'unsafe injecting practices' (1, p. 7 & 2, p. 6).

Indeed, the *Report* once again points out

that ‘Some of the most adverse health consequences of drug use are experienced’ by people who inject drugs and that ‘unsafe injecting practices’ are responsible for the greatest burden of disease, in terms of mortality and disability, associated with the use of drugs. Opioids remain the chief drug type of concern, but as with so many aspects of the contemporary global drug market, the picture is becoming more complex. In this case this is due in part to the use via injecting of other drugs including cocaine and NPS. The magnitude of the problem is presented in data taken from joint work by the UNODC, WHO, UNAIDS and the World Bank. This estimates that the number of people who inject drugs in 2016 was 10.6 million (range 8.3 -14.7 million), a figure corresponding to 0.22% (range 0.17 to 0.30) of the global population aged 15-64 years. As is so often the case regarding various aspects of this issue area, levels of uncertainty remain high in some regions with available data suggesting variation across different regions. That said, the regions and subregions where the largest numbers of people who inject drugs reside are identified, as in previous years, as East and South East Europe. At national level, almost half of all people who inject drugs worldwide in 2016 were estimated to reside in just three countries: China, the Russian Federation and the United States. Combined these nations represent only 27% of the global population (aged 15-64 years), yet they are home to 45% of the world’s people who inject drugs, an estimated 4.8 million people (2, p. 15). As the referenced research from a 2017 study in *The Lancet Global Health* demonstrates through its examination of disaggregated data, the issue is complex and multifaceted (2, pp. 18-9).

Nonetheless, key messages are clear. The *Report* highlights, ‘PWID are among the most marginalized and stigmatized people who use drugs. They are exposed to specific risk behaviours and risky environments and experience a broad spectrum of adverse social and health consequences’. It goes on to note that ‘Homelessness and incarceration are common as is engagement in risk behaviours such as casual unprotected sex, using a

needle-syringe after use by someone else and involvement in sex work’. (2, p. 16). The authors reiterate the now widely acknowledged fact that unsafe injecting practices are a ‘major route for the transmission on both HIV and HCV among PWID’. More specifically, data within the *Report* show that, although there is variation across regions, more than half of people who inject drugs live with hepatitis C with one in eight is living with HIV (1, p. 7). Moreover, and an often overlooked facet of the issue, data show that the estimated probability of transmission of hepatitis C virus (HCV) per exposure to a contaminated syringe is between five and 20 times higher than for transmission of HIV, with the findings of the joint work of UNODC, WHO, UNAIDS and World Bank also producing estimates that in 2016 the prevalence of hepatitis B virus (HBV) among people who inject drugs was 7.5%; equating to an estimated 0.8 million people who inject drugs living with the virus (2, pp. 16-17).

Availability of harm reduction services

Taking into consideration the patchy nature of the data, the picture presented is clearly alarming. What is probably more concerning, however, is the information contained within it regarding the poor availability of measures proven to be effective in improving the situation and reducing these prevalence figures, particularly in relation to the spread via injecting drug use of HIV, HCV and HBV. These findings are reinforced by other research, prominent amongst them Harm Reduction International’s *Global State of Harm Reduction 2018*.¹³ Aware of the largely depoliticised character of the *World Drug Report* in recent years, it is unreasonable to expect the publication to explicitly judge nations’ policy choices; a dynamic that, as Helco described in 1972, can be understood as a governing authority’s inaction as well as action in relation to a specific issue area.¹⁴ As such, the *Report*’s implicit comment on what might be referred to as the ‘adverse consequences’ of a lack of engagement with several scientifically proven interventions designed to reduce the harm of drug use is certainly welcome.

Mindful of the many years of experience and a solid underpinning evidence base for the effectiveness of a range of interventions, it remains alarming to read at various points in the *Report*, including significantly in the high-profile Executive Director's Preface (1, p. 1), that coverage of core interventions to prevent the spread of HIV and HCV among people who inject drugs 'remain poor and insufficient' (2, p. 19), 'in most countries' interventions remain 'too low to be effective' (2, p. 21) and that 'Many countries still fail to provide adequate drug treatment and health services to reduce the harm caused by drugs' (1, p. 16 & 2, p. 6). As the *Report* notes, the core 'science-based interventions' for the prevention of HIV are, in order of priority, needle and syringe programmes (NSPs), opioid substitution therapy (OST), and HIV testing and counselling. Further, as is explained, for effective HCV prevention, the key interventions are NSP and OST coupled with HCV treatment to substantially reduce the ongoing transmission in the community. In particular, the *Report* highlights, NSP and OST 'can be especially effective for both HIV and HCV prevention when they are implemented together with high levels of coverage among PWIDs' (2, p. 21).

Yet, as is stressed, these core interventions are not available in all countries where there is evidence of injecting drug use. The extent of these shortfalls is explored by using the categorisations laid out in the 2012 version of the *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.¹⁵ Here coverage is classified as low, moderate or high (2, p. 21). Within this framework, as the Office notes, a global review of the availability of these interventions assessed that the coverage of NSP and OST among people who inject drugs was at low levels 'with an estimated 33 (range 21-50) needle-syringes distributed per PWIDs per year, and 16 (range 10-24) clients of opioid substitution therapy per 100 PWID'. While acknowledging some complications in relation to old data, it was shown that in subregions with the largest numbers of people who inject

drugs (East and South East Asia, Eastern Europe and North America there were low levels of service coverage for both NPS and OST, with the 'single exception of moderate coverage of OST in North America' (2, p. 21).

At national level, the *Report* shows that of the 179 countries where there was evidence of injecting drug use (although not necessarily a population size estimate of people who inject drugs) NSPs were known to be available in 93 countries (52%) and confirmed to be absent in 83 (46%). There was evidence of implementation of OST in 86 countries (48%), but it was absent in 92 (46%). In terms of the implementation of the most effective combination of approaches, 79 countries (44%) were found to be implementing both NSP and OST. High levels of NSP and OST were available, however, only in 5% and 11%, respectively, of the 179 countries where there was evidence of injecting drug use. Of the 79 countries implementing both NSP and OST, only 4 countries (three in Western Europe and one in Oceania) were classified as having high levels of coverage for both interventions (1, p. 16 & 2, p. 21).

Once again highlighting the problems surrounding adequate data capture, while information is available for some states – for example evidence of its availability in 34 countries but its absence in 17– the *Report* notes an inability to produce global coverage estimates for HIV testing and counselling. The situation is shown to be worse for antiretroviral therapy (ART), with the information described as 'sparse' and a commensurate lack of data revealed in 162 countries (1, p. 16). That evidence of the very existence of such interventions is difficult to capture and collate perhaps explains the *Report's* relative lack of nuance on this issue, with coverage (the extent to which an intervention is delivered to the target population)¹⁶ being the main variable under consideration. As the *Technical Guide* itself outlines, this is only one of several important indicators to be considered during any assessment process. Key among the others is 'quality'. This is defined as encompassing 'the

scope, completeness, effectiveness and safety of interventions.¹⁷ Further, as is mentioned at various points within the *Report*, appropriate approaches require an awareness of the needs of different affected populations. For example, in demonstrating an ongoing focus on incarcerated individuals, the UNODC notes how people in prisons and closed settings are at a ‘much greater risk of contracting infections such as tuberculosis, HIV, hepatitis C than the general population’, but that ‘access to treatment and prevention programmes is often lacking’ (2, p. 7). Relating directly to the issue of quality of provision, the *Report* goes on to note that even where they are available ‘they are not necessarily of the same standard as those provided in the community’ and that ‘the lack of access to prevention measures in many prisons can result in the rapid spread of HIV and other infections’ (1, p. 21). Similarly, as well as ‘telescoping’ – initiating drug use later than men but then increasing the rate of consumption more rapidly – towards ‘drug use disorders’ and, as noted earlier, being under-represented in treatment, women also have a range of different and complex requirements when engaging with different interventions designed to reduce the ‘adverse health consequences’ of drug use. The same can be said for both young and older people.

Taking stock, looking forward for policies around drug use

The increasing prominence within the *World Drug Report 2018* of the intersections between gender, age, drug markets and – certainly within the Executive Director’s Preface – human rights implications more broadly, provides an example of just a few aspects of the ‘world drug problem’ where many member states are required to dramatically shift their policy approaches if they are to fulfil the commitments made within both the Outcome Document and, at a system-wide level, the 2030 Sustainable Development Agenda. Political debates rumble on within the Commission on Narcotic Drugs (CND) concerning the primacy of the UNGASS Outcome Document over earlier soft law instruments adopted in 2009 and

2014.¹⁸ Nonetheless, the fact that the most recent significant product of international deliberation includes a series of explicit Operational Recommendations concerning, among others, the issues discussed here highlights an ongoing disconnect between what many member states are willing to agree to in the rarified atmosphere of UN conference rooms and what is implemented on the ground.¹⁹

As things stand, it appears that without a considerable change in outlook and operational approach the international community is once again destined to miss its own targets. In light of the discussion above, this seems particularly so concerning the reiteration of the ‘commitment to ending, by 2030, the epidemics of AIDS and tuberculosis, as well as combatting viral hepatitis and other communicable diseases, inter alia, among people who use drugs, including people who inject drugs’, as expressed in the UNGASS Outcome Document.²⁰ It should be recalled how recent analysis presented in *Taking Stock: A Decade of Drug Policy* assesses the targets set in the 2009 Political Declaration and Action Plan against recent available data and finds shortfalls across almost all categories, including against the broader priorities of the United Nations: protecting human rights, promoting peace and security and advancing development (see Box 1).

While avoiding any explicit evaluation of the previous ten years, the need for member states to improve future performance is given prominence in the Report’s ‘Conclusions and Policy Recommendations’. Here, for example and acknowledging the ‘unprecedented magnitude and complexity of the global drug markets’ and the ongoing significance of the ‘adverse health consequences caused by drug use’ (1, p. 23), it is stressed that ‘This situation calls for renewed efforts to support the prevention and treatment of drug use and the delivery of services aimed at reducing the adverse consequences of drug use’ (1, p. 23). In this regard, the UNODC highlights the need, among other things, to provide people who use drugs with the necessary knowledge and skills to prevent overdoses, providing



a continuity of health-care services for those in prison and upon their release and crucially in relation to our discussion, ‘scaling up core interventions’ as outlined in the *Technical Guide*, to help ‘prevent the spread of HIV and hepatitis C among PWID’ (1, p. 23). All of which, the *Report* emphasizes, should be pursued in line with targets 3.3 and 3.5 of the Sustainable Development Goals. It will be recalled that SDG 3 aims to ‘ensure healthy lives and promote well-being for all and all ages’, with target 3.5 committing states to ‘strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol’ and 3.3 stating that by ‘2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and other communicable diseases.’²¹ Mindful of the prominence given to the Sustainable Development Agenda in discussions across a range of UN activities and commensurate references to the SDGs within the Outcome Document, the emphasis on SDG 3 is clearly important. Nonetheless, as a growing body of research reveals,²² intersections between sustainable development, drug markets and policy responses to those markets, goes well beyond a single Goal. This was an issue discussed in some detail within the thematic chapter of the *World Drug Report 2016*²³ and is picked up to varying degrees at various points in this year’s publica-

tion, including within the thematic booklets. Indeed, as we discuss below, with the increasing and welcome disaggregation of data on people who use drugs and an accompanying improvement in understanding of the specificities of different ‘sets’ of people who use drugs comes the identification of a range of linkages to the SDGs and an increased appreciation of the potential utility of the Sustainable Development Agenda to improve UN system-wide coherence on the multifaceted issue of drugs.

Drugs, age and system-wide coherence

Demonstrating the increasing granularity of analysis, the fourth Booklet of the package making up the *World Drug Report 2018* contains a thematic focus that breaks down the population of people who use drugs into two key demographic components: youth and older people and subjects each population to a specific analysis. The former of these two categories has already received considerable attention from academics and civil society researchers, drug consumption often being associated with young people and their trends, fashions, and subcultures.²⁴ The illicit use of substances by older people, by contrast, has been the object of relatively little investigation,

and will consequently form the major element of analysis in this section. Examination of the phenomenon will be pursued here through two specific conceptual lenses: while continuing our focus on health, we will also explore further the issue of UN system-wide coherence and drug policy. As noted above, the integration of drug policy into the UN's broader project can largely be achieved through linkage with the SDGs.

The SDGs: An opportunity for more system-wide coherence

Unlike the discussion on gender in Booklet 5 (see below), there is little explicit reference to the SDGs in Booklet 4. Nonetheless, in relation to age – as well as wide range of other domains – they must be seen as more than simply an important adjunct to the drug control regime. Rather, the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals²⁵ provide an opportunity to integrate the drug control nexus and its spread of policies within the UN's broader project of system-wide coherence. Drug control has in the past tended rather toward being an incoherent facet of the UN, with the Vienna-based bodies arguably operating in a 'parallel universe' or silo outside the normative field that the United Nations attempts to configure around its core priorities of conflict resolution, human security, human rights and sustainable development.²⁶

In order to be effective, drug control must be situated within a much wider field of analysis than has historically been the case. The problems that have accrued around some forms of the consumption of drugs – not all – arise in a complex and thoroughly interwoven domain in which all the areas covered by the SDGs have an impact. To be sure, drug control is the epitome of the 'cross-cutting issue' and, although long recognised as such, has been problematic to address. A previous attempt in the 1990s to introduce the beginnings of a system-wide action plan for drug policy ended with the Vienna structure more solidly entrenched than ever; one civil society commentator described

Vienna as 'the perfect burial ground for UN system-wide coherence on drug policy'.²⁷ By 2016 the situation had changed somewhat, rhetorically at least, with the Outcome Document containing some promising elements in this regard. The Document is, among other things, foregrounded with the statement that 'efforts to achieve the Sustainable Development Goals and to effectively address the world drug problem are complementary and mutually reinforcing' and that states 'welcome continued efforts to enhance coherence within the United Nations system at all levels'.²⁸

Drug use among young people

It is interesting to note that Booklet 4 does at times go further than many of the previous World Drug Reports in shifting its analysis beyond the narrow conceptual confines of the drug control treaties. For example, with regard to poverty, the point is made that: '...poverty, lack of opportunities, isolation, lack of parental involvement and social support, negative peer influences and poorly equipped schools are more common amongst those who develop substance use than amongst those who do not' (4, p. 6). Indeed, a full conception of poverty that is not restricted to the purely economic sphere might include all of these areas within it: emotional poverty, cultural poverty, social poverty (loneliness), etc. The Booklet also mentions poverty in the context of the drug use among street children, in recruitment of young people into organised trafficking groups, and their employment in the intensive labour involved in producing drug crops (4, p. 7, 18, 41, *passim*). It is widely understood in social scientific research that poverty and inequality are intimately associated with drug use that is visibly problematic.²⁹ It is somewhat surprising, therefore, that SDG 1, 'An end to Poverty', is not listed here or elsewhere in the *Report* by UNODC as one of the Goals that merits attention.³⁰

Drug use among older people

As noted, the SDG with which the UNODC has most publicly aligned itself is Goal 3 and this, in a largely positive sense, links to the promise of

the drug control regime to shift its focus from a predominantly punitive, enforcement-led project to one oriented toward public health and human rights. It is clearly a welcome development. Yet drug control and the policies pursued by member states need to go further if the commitments set by the 2016 UNGASS Outcome Document and the goals of the 2030 Agenda for Sustainable Development are to be met. Moreover, bearing in mind the fact the SDG 3 speaks of ensuring 'healthy lives' and the promotion of 'well-being for all ages' there should be increased attention towards the needs of specific subsets of people who use drugs. This includes what the UNODC refers to as 'older people'; a group that is becoming more noticeable within recent data analysis.

'There is evidence from some countries,' the *Report* tells us, 'that the use of drugs among older people, although starting from a low prevalence, has been increasing over the last decade and at a faster rate than among younger age groups' (4, p. 47). It gives the example of the United States, where drug use in the over-50s is alleged to have risen from 1.3% to 9.8% between 1996 and 2016, representing a sevenfold increase (4, p. 47). Booklet 4 offers some tentative explanations for this increase, which include: changing perceptions of risk associated with drug use; increased availability of drugs; increased social acceptance of drugs and self-medication; challenges linked to retirement, and higher rates of depression and other mental health problems.

One of the most intriguing intersections of drugs and health in Booklet 4 lies in the ageing cohort of people who use heroin and other opioids in Europe. There have been several waves of heroin use, with major increases in the 1970s, 1980s and 1990s. Younger people presenting to treatment services tend not to be people who inject drugs – injection being the most risky form of opioid administration in terms of exposure to HIV and HCV infection, and of liability of overdose – with injectors tending to be concentrated in ageing populations. The authors inform us that the overall numbers of those in treatment is declining, but the proportion of clients aged

over 40 entering treatment has increased from 20% in 2006 to 33% in 2013. According to the text: 'The evidence points to a large ageing cohort of opioid users who started injecting during the opioid "epidemics" of the 1980s and 1990s and who have shaped and characterised current European specialist and low-threshold treatment systems' (4, p. 54).

Booklet 4 goes on to say that numerous health problems arise in the context of drug use by older people who use drugs, especially in cases where people have a long history of dependence. Concurrent physical and mental health issues complicate the delivery of drug treatment for this population. There is, in addition, a lack of extensive evidence as to what forms of treatment are most effective for older people who use drugs. A relatively new phenomenon, the health needs of this ageing group do not have an appropriate infrastructure in place to meet them. The issue has, historically, not been viewed as a priority; the Booklet suggests that this was because there was a low prevalence of older people seeking drug treatment (4, p. 54). It may also be the case that both popular and expert understandings of drug use see it as associated with youth. The European Monitoring Centre on Drugs and Drug Addiction states that, 'HCV is more prevalent among older people who inject drugs than among their younger counterparts, highlighting the accumulation of risk over the years, and the high burden of infection among the older groups.'³¹

The most severe of the 'adverse health consequences' mentioned in Booklet 4 is, clearly, death. While the majority of those whose deaths are caused by the use of drugs are younger people, 'those aged 50 and over still constitute a sizeable proportion' (4, p. 54). The text gives a figure of 39% of deaths amongst global 'drug-use disorders' for those of 50 years and above. During the period from 2000 to 2015, there was, according to Booklet 4, 'a rapid increase globally in the numbers of deaths resulting from drug-use disorders among those aged 50 and over' (4, p. 54), with numbers more than doubling. Numbers in the Western Pacific and the Americas rose more

than threefold during this period. There was a 'sharp rise' in these deaths in the UK after 2012. Booklet 4 speculates that, 'An ageing cohort of heroin users, increased purity and availability of the drug and changes in the specific drugs taken alongside heroin and/or morphine have contributed to this rise' (4, p. 55).

The *World Drug Report 2018* consequently recommends that 'increasing drug use among older people requires new responses' (1, p. 25). It continues – 'treatment and care will need to incorporate specialised drug treatment programmes with mainstream healthcare and social support services. Novel, integrated and multidisciplinary approaches to care are required to address the health and social needs of older drug users' (1, p. 25).

Prominence of such a nuanced understanding of the different needs of people who use drugs is welcome and provides another example of the increased level of sophistication of the *Report*. Nonetheless, it is difficult to ignore the fact that there is little or no recognition of the impact of the drug control system itself, its theories and practices, on people who use drugs, regardless of age. The criminalisation of non-medical drug use is undoubtedly part of the stigmatising culture that fastens upon people who use drugs and impacts their lives in negative and harmful ways.³² These impacts occur most powerfully on health and well-being; a dynamic that, despite the UNODC's previously awkward relationship with the topic of decriminalisation, perhaps could be more explicitly framed within the context of the Sustainable Development Agenda. While controversy surrounded the premature release of a UNODC document in 2015 calling for the decriminalisation of people who use drugs,³³ the Office does recommend this course of action.³⁴ This is a position shared several other UN agencies and related entities including the WHO, UNFPA, UNHCR, the World Bank, UNDP, UNESCO, UNAIDS, the ILO and UNICEF; an important array of actors in terms of system-wide coherence.³⁵

Women and drugs

It is promising, in the light of the goal of achieving system-wide coherence, to note that Booklet 5, *Women and drugs: Drug use, drug supply and their consequences*,³⁶ is introduced by reference to the SDGs as they relate to women and drugs (5, p. 9). The text once again mentions Goal 3, but this is supplemented by reference to Goal 5 on gender equality. Goal 8 (decent work and economic growth) and Goal 10 (reduced inequalities) also receive a mention, as does Goal 16 (peace, justice and strong institutions). It is curious, however, that the Office does not mention SDG 1, the 'Ending of Poverty' goal. However, this more inclusive understanding and linkage with the SDGs is encouraging.

Women who use drugs

The Booklet begins by stressing that there are significant differences between drug use among men and women: 'Overall, men are more likely than women to use cannabis, cocaine and opiates, whereas the prevalence of the non-medical use of opioids and tranquillizers is comparable between men and women, if not actually higher among women' (5, p. 11). Most research on gender and drug consumption, however, is carried out in the developed world, and it is consequently necessary to treat such claims with caution.

The *Report's* analysis also includes some reasons for women's drug use. It is suggested that women are likely to attribute their drug consumption to emotional issues such as post-traumatic stress, problems with relationships, and the consequences of childhood adversity. Women may also use drugs in order to self-medicate and alleviate pain, which, according to this section of the *Report*, is more acute, severe and more anatomically diffuse than pain in male experience (5, p. 15). The Booklet also mentions the influence of neurobiological systems in women, who may have 'diminished regulation of emotions' as a result (5, p. 15). This latter form of analysis has, however, been the object of widespread critique by social scientists and historians,³⁷ and it is notable

that the terminology deployed in this form of analysis contains numerous formulations linked to the cultural stereotyping of women. To mention a few: 'impaired coping mechanism', 'weakened neuroendocrine stress response', 'mood and anxiety disorders', as well as the 'diminished regulation of emotions' mentioned above (5, p. 15). All of these terms carry connotations of weakness and moodiness associated with women in patriarchal culture.³⁸

Booklet 5 also claims that women are more likely to experience violence and coercion when they use drugs. In particular, sex workers who use drugs are exposed to violence and coercion from clients, pimps, drug dealers and police officers. Women sex workers who inject drugs are liable to be displaced onto the street, where they have less protection and safety, and may encounter blood-borne viruses through being pressured into unprotected sex. As the *Report* observes, 'Such inequities that result from gendered social relations further contribute to women's compounded adverse health effects' (5, p. 19). This is one of the factors involved in the greater risks faced by women who use drugs. In addition to the difficulties associated with negotiating condom use, women are more often compelled to use injecting equipment after a male intimate partner has already used it. The *Report* estimates that 20% of the global total of people who inject drugs are women; despite this lower proportion of usage as compared to that of men, women possess a greater vulnerability to contracting HIV and other blood-borne infections.

Women who use drugs also face greater stigma than their male counterparts, partly because gender stereotypes hold women to different behavioural standards. Additionally, women who use drugs are more prone to becoming entrenched within drug using networks. All of these factors impact upon the health and wellbeing of women. Their children are, moreover, liable to suffer as a result of the criminalisation, stigma and marginalisation that surround the use of drugs (5, p. 20).

Treatment for women who use drugs is also problematic, as the specificity of their patterns

of usage is still not widely recognised, and the forms of treatment are often inadequate to meet the diverse needs involved. This is particularly the case, notes the *Report*, in countries with scarce resources, where evidence-based treatment is uncommon, and treatment shaped around women's needs even more so. Women regularly refrain from approaching treatment services where punitive attitudes prevail, adding further to the barriers preventing their access to healthcare and social support. The widespread problem for women of obtaining good quality and affordable childcare is exacerbated for women who use drugs, owing to a lack of resources and, especially in the developing world, the requirement to travel long distances to obtain drug treatment, a necessity that impinges on the time, labour and income of women. The additional burdens of stigma and hostility faced by women who use drugs contribute to their being still more of a hidden population than men who use drugs. This is picked up and given emphasis in the 'Conclusions and Policy Implications' of the *Report*. Here, in reference to SDG 5, it is noted how, to achieve this goal, 'strategies to counter the world drug problem need to consider the special needs of women and the great stigma that they endure. Prevention programmes, treatment interventions for drug use disorders and alternative development programmes, as well as the criminal justice response to drug related offences, need to be gender sensitive' (1, p. 25).

In order to address this set of challenges, it is necessary to fully involve women, including women who use drugs, in the design and delivery of the services that they will use. In the words of the 2016 Outcome Document, the drug control regime must: 'Mainstream a gender perspective into and ensure the involvement of women in all stages of the development, implementation, monitoring and evaluation of drug policies and programmes, develop and disseminate gender-sensitive and age-appropriate measures that take into account the specific needs and circumstances faced by women and girls with regard to the world drug problem and, as States parties, implement the Convention on

the Elimination of All Forms of Discrimination against Women'.³⁹

Women's involvement in illicit supply-side activities

Booklet 5 also provides some interesting consideration of the place of women in the supply-side of drugs markets. Recognising that little research has been conducted in this area, it sets out to examine the role of women in illicit crop cultivation and drug production; in drug trafficking, and women's contact with the criminal justice system. The analysis of illicit crop cultivation notes that this often takes place in areas where the rule of law is frail and there is often conflict between armed groups. Citizens in such regions have little access to education, sanitation and healthcare. The authors state that: 'Women living in such areas suffer the worst consequences of poverty, are paid low wages or not paid at all, and lack other opportunities for self-reliance and access to education and healthcare services' (5, p. 24). The linkage between drugs, health and poverty is again readily apparent here; in addition to its reference to SDGs 3 and 5, therefore, a coherent system would also take SDG 1 into account; the eradication of poverty. Members states should also be aware that drug-linked crops provide basic subsistence for farmers and labourers, in an ecosystem eminently suited to the growth of opium poppy, such as that of Afghanistan. Without the poppy crop, many poor farmers and their families face hunger and disease.

This section of the *Report* notes that in South Asia poppy is grown in the poorest villages where the local culture is hostile to discourses of equality between men and women, and that women have little role in family decision-making regarding the cultivation or otherwise of poppy. It is possible, though the publication does not speculate, that this culture of inequality prevails in the opium economy partly because much of the crop is cultivated in areas controlled by the Taleban insurgency, whose form of Islam is highly patriarchal. The Booklet informs us that in Latin America, women enjoy a more active role in the decision-making processes around the cultivation of drug-linked

crops (5, p. 24). Nonetheless, it is important to recall that women in Latin America face huge issues of gender equality, violence and 'macho' culture, and must continually negotiate these challenges in their involvement in the drug trade.

In terms of trafficking, we learn that the proportion of women entering the criminal justice system for drug trafficking offences was 10% of total offences. The majority of those involved in the upper echelons of trafficking are men, though there are exceptions. And while there are no reliable global data for the numbers of women involved in trafficking, Booklet 5 claims that there is a 'widespread perception' that the number of women arrested for involvement in the illicit drug trade is rising worldwide. There have been a number of studies exploring the role of women as drug couriers, a lowly role in the drug trade involving carrying illicit substances across borders. Many women carry out this role as a way of obtaining money in situations lacking other, licit opportunities for income, though the major profits naturally accrue to the upper echelons of the trafficking organisation, most of whom are men. Some women are coerced and intimidated into acting as drug couriers, though the majority resort to such work because of situations of poverty and the lack of decent, well-paid employment opportunities.⁴⁰

These women can be easy targets for the law enforcement agencies, who are able to achieve more immediate results by concentrating on the lower and most visible echelons of the illicit drug trade. Research presented estimates that women make up around 7% of the global prison population, some 714,000 women and girls, and that between 2010 and 2014, 35% of them were in prison for drugs offences (the equivalent figure for men was 19%). (5, p. 32).

Again, when reading this situation across the commitments made within the UNGASS Outcome Document, it should be recalled how the international community must: 'Continue to identify and address protective and risk factors, as well as the conditions that continue to make women and girls vulnerable to exploitation

and participation in drug trafficking, including as couriers, with a view to preventing their involvement in drug-related crime.⁴¹The Outcome Document also encourages member states to take 'into account of the specific needs and possible multiple vulnerabilities of women drug offenders when imprisoned, in line with the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules).'⁴² This includes access to adequate drug services while incarcerated.

However, as pointed out by the civil society organisation Penal Reform International (PRI), 'in practice, many prisoners receive healthcare of a far inferior standard to that available outside in the community, if they receive treatment at all.'⁴³ PRI go on to say that: 'Women in prison are disproportionately likely to be victims of domestic or sexual abuse, to experience poor mental health, and to have alcohol and drug dependency problems... Women are also more likely to develop mental health problems while in prison and are more likely to self-harm or attempt suicide than male prisoners. Women prisoners surveyed by PRI in Central Asia and the South Caucasus (2014) said that what they needed most to help them build a new life on release was health treatment.'⁴⁴

To tackle the specific vulnerabilities and needs of women engaged in the illicit drug trade and to deliver on the promise of equivalent quality medical treatment in carceral spaces such as prisons, and specifically for women, as well as providing alternatives to prison, especially for women with children, several of the SDGs should be invoked: in addition to Goals 3 and 5, there are roles for Goal 10 (reducing inequality and discrimination), Goal 16 (peaceful and inclusive societies, access to justice and accountable institutions) and Goal 1 (an end to poverty). All of these are necessary to situate the drug control project within a coherent framework of policies, increase effectiveness and ultimately assist in the achievement of the SDGs.

Conclusion

When referring to the forthcoming Ministerial Segment in his preface to the *Report*, Mr. Fedotov urges 'the international community to reinforce cooperation and agree upon effective solutions' (1, p. 2). Putting aside the problematic nature of seeking solutions to a complex 'wicked problem'⁴⁵ like 'the world drug problem', the Executive Director's sentiment hits the right note, but could go further. It is true that he notes how the UNODC continues to work closely 'with its United Nations partners to assist countries' in implementing the recommendations within the Outcome Documents 'in line with the drug control conventions and the 2030 Agenda for Sustainable Development' (1, p. 1). Yet, mindful of a growing awareness of the connections between the drug markets and the Sustainable Development Agenda, including those relating to health and disaggregated groups of people who use drugs as discussed within the body of the *Report*, one wonders if the Executive Director could have given the SDGs more prominence. Indeed, as we mentioned above, the 'Conclusions and Policy Implications' section includes specific reference to the complementarity and mutually reinforcing nature of 'countering the world drug problem and efforts to achieve the Sustainable Development Goals' (1, p. 25). And within this context and the increasingly sophisticated evidence base and growing awareness of the importance of gender and age sensitive drug policies presented by the UNODC, it is becoming harder to ignore how any genuine effort to achieve the SDGs can be successful without a serious review of current policy approaches; approaches that include the implementation of interventions like NSP and OST that are evidence based, rights affirming, cost effective and operate within the confines of the existing treaty framework.⁴⁶

As the Rt Hon. Helen Clarke, Member of the Global Commission on Drug Policy, former Prime Minister of New Zealand (1999-2008) and former administrator of the United Nations Development Programme (2009-2017) recently pointed out, 'As the situation stands today, the

major Sustainable Development Goals that concern gender equality, the protection of the environment, socioeconomic development and the reduction of violence and corruption will not be achieved for an important part of the population because of current drug policies.⁴⁷

Where these factors intersect with health, adequate funding clearly remains an issue, with what might be referred to as the funding gap illustrative of the commitment gap between high order language within soft law instruments like the Outcome Document and implementation within member states. As work by Harm Reduction International reveals, funding for harm reduction services in low- and middle-income countries is just 13% of what is required. Moreover, this figure is restricted to the HIV response among people who use drugs, not the full spectrum of harm reduction interventions. Although financial constraints are increasing issues of concern across a range of public policy domains, cost effectiveness within this area is proven. This reality has led UNAIDS to recommend a rebalancing of drug control expenditure to ensure that the resources needed for public health services are fully funded.⁴⁹

To be sure, an approach to drug control that engages the entire UN system and specialist agencies like UNAIDS acting as a coherent whole represents the best opportunity for effective policies in the future. As former UN Secretary General Ban Ki-moon has said: 'We must consider alternatives to criminalization and incarceration of people who use drugs and focus criminal justice efforts on those involved in supply. We should increase the focus on public health, prevention, treatment and care, as well as on economic, social and cultural strategies.'⁵⁰ The policies emerging from the Vienna drug control nexus – despite some welcome transformation in its public and internal discourse that includes regular statements on public health and human rights – still fall far short of the systemic coherence imagined in the erstwhile Secretary General's foregoing statement. While the UNODC can, through a publication like the *World Drug Report*, help determine the narrative for debates, it remains the responsibility of member states to engage with, and act upon, the evidence being presented.

Endnotes

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In this report, IDPC provides an analysis of key points from the UNODC *World Drug Report for 2018*, in particular issues related to drug use and its related health consequences, a discussion of the Report's focus on youth, older people and women, and the welcome links with the Sustainable Development Goals and system-wide coherence. This analysis should be read alongside IDPC's 'Taking stock: A decade of drug policy', published in October 2018.

The International Drug Policy Consortium (IDPC) is a global network of NGOs that promotes objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harms. IDPC members have a wide range of experience and expertise in the analysis of drug problems and policies, and contribute to national and international policy debates. IDPC offers specialist advice through the dissemination of written materials, presentations at conferences, meetings with key policy makers and study tours. IDPC also provides capacity building and advocacy training for civil society organisations.