

Strengthening the role of the World Health Organization in global drug policy

Introduction

Health should be at the centre of the global drug policy debate. After all, the primary reason for the creation of the UN drug control regime is the protection of the ‘health and welfare of mankind’, as the preambles of the 1961, 1971 and 1988 UN drug conventions put it.¹ As the lead entity on health matters within the UN system, the World Health Organization (WHO) is uniquely placed to fulfil a broad mandate in articulating a more progressive approach that truly puts people’s health, wellbeing and human rights at the centre of drug policies.

Yet, the role of the WHO in global drug policy has been surprisingly limited. This may be the result of a number of factors, including the minimal role that the UN drug control conventions assign the WHO, political obstruction by UN member states that prefer to perpetuate Vienna’s monopoly² on drug-related issues, and a reluctance in recent decades of the WHO’s leadership and its governing bodies to proactively claim a role that reflects the centrality of health in drug policy. The WHO’s mandate on drugs issues, however, does not only derive from the UN drug conventions, but also from its role as the lead agency of the UN on health, and its own Constitution.³

The 2016 UN General Assembly Special Session (UN-GASS) on the ‘world drug problem’ opened up space for the WHO to claim a greater role, an opportunity that the Organization seized, in part. A new timeline for global drug policy for 2019-2029⁴ was agreed at the Ministerial Segment of the 62nd session of the Commission on Narcotic Drugs (CND), while the first ever ‘UN System Common Position on international drug control policy through effective inter-agency collaboration’⁵ (see Box 1) was adopted by UN leadership in November 2018. As both documents are implemented, it is critical that the WHO strengthen its

political and technical leadership to ensure that the global response to drugs is focused on producing favourable health outcomes and is based on evidence and public health principles, rather than ideology and politics.

In this advocacy note, the International Drug Policy Consortium (IDPC) discusses the WHO’s strategic role in drug policy, including progress made and ongoing gaps and challenges, and calls on the WHO and its governing bodies to engage in a more progressive and systematic way in various aspects of global drug policy to ensure more coherence with the UN system on drug policy, health, human rights, and the achievement of the Sustainable Development Goals.

Background

In the 1960s, the international community began putting in place the treaties that constitute today’s legal framework for international drug control. While protecting health and wellbeing was the rationale given for these international agreements, the 1961 Single Convention on Narcotic Drugs established the CND as the policy-making body on drug-related issues. The Single Convention created the International Narcotics Control Board (INCB) as a quasi-judicial body charged with monitoring the implementation of the treaty.⁶ The UN General Assembly subsequently established the UN International Drug Control Programme and its successor, the UNODC, as the UN agency with a field presence, a coordinating role and a mandate to ‘assist Member States in their struggle against illicit drugs, crime and terrorism’.⁷ Despite lacking adequate health expertise or mandate, the CND, the INCB and the UNODC have dominated the global drug policy debate for decades.

The UN drug control treaties also entrusted the WHO with limited but critical technical functions at the

Box 1 The UN System Common Position on international drug control

In November 2018, the UN System Chief Executives Board for Coordination (CEB) – the main instrument for supporting and reinforcing coordination between UN bodies on social, economic and related matters, of which the WHO is a member – adopted the ‘United Nations system Common Position supporting the implementation of the international drug control policy through effective inter-agency collaboration’.⁸

The Common Position recognises that ‘the concern for the health and welfare of humankind underpins the three international drug control conventions’, and promotes drug policies that are ‘balanced, comprehensive, integrated, evidence-based, human rights-based, development-oriented... within the framework of the 2030 Agenda for Sustainable Development’. In so doing, it supports drug policies ‘that put people, health and human rights at the centre, by providing a scientific evidence-based, available, accessible and affordable recovery-oriented continuum of care based upon prevention, treatment and support, and to promote a rebalancing of drug policies and interventions towards public health approaches’ – issues which are within the mandate of the WHO.

The Common Position more specifically promotes harm reduction services; universal health coverage for and the decriminalisation of people who use drugs; as well as enhanced access to controlled medicines, including for the relief of pain and treatment of drug dependence.

To ensure the implementation of the UN common position, the CEB established the ‘UN system coordination task team on the implementation of the UN system common position on drug-related matters’, led by the United Nations Office on Drugs and Crime (UNODC), within the framework of the UN Secretary General’s Executive Committee. The task team is responsible for translating the Common Position into practice by guiding approaches across the UN system and stepping up efforts to ensure that no one is left behind; identifying joint inter-agency activities; and speaking with one voice and raising awareness of the multifaceted nature of drug policy.

Ahead of the 2019 Ministerial Segment, the task team drafted a report summarising key learning points on UN drug policy over the past ten years – with the health aspects of drug policy featuring prominently in its analysis and ‘Summary of key messages’ at the end of the document.⁹ This includes ensuring access to healthcare and universal health coverage; promoting prevention, treatment, rehabilitation and harm reduction for people who use drugs; reducing stigma and discrimination in access to healthcare; changing laws, policies and practices that threaten health and human rights; and improving the availability of controlled medicines, among others.

Both the Common Position and the task team are critical tools to ensure more coherence within the UN system – and the WHO has a key role to play for its effective implementation.

core of the drug control system: conducting scientific assessments of substances and making recommendations about scheduling (see below for more detail), and nominating candidates for three of the 13 seats on the INCB.¹⁰ The WHO also has a mandate with respect to drugs based on its broader status as the UN’s lead agency on health, which includes setting norms and standards on drug-related health matters.

However, the CND (where member states are mostly represented by diplomats and law enforcement officials) having been designated as the primary policy-making body on drugs, the WHO’s role in UN political debates about drug policy has often been limited. In the 1990s, the WHO sought a bigger role in international debates on drugs, openly questioning war-

on-drugs rhetoric and advocating in favour of a harm reduction, rather than a punitive, approach to drugs. However, the effort was promptly suppressed by the United States.¹¹

For many years since, WHO leadership has seemed to accept this marginalised role on a key global health issue. Symptomatic of this marginalisation, for years WHO representatives wishing to address the CND could only do so after the UNODC, the INCB and all UN member states had had their say, and even then only from the back of the room, as if their views were barely relevant to the discussion. This practice changed only in 2015.¹²

Dynamics have begun to change in recent years as UN member states increasingly started to recognise the

limitations and harms of a law enforcement-driven approach to drugs and to favour a more holistic approach that emphasises health, development and human rights. In the preparations for the 2016 UNGASS, a concerted effort was made to bring all relevant UN agencies into the process, including the WHO. Like other UN agencies, the WHO was actively engaged in the preparations for UNGASS. Top WHO officials participated in preparatory meetings, the Secretariat prepared a report on the public health dimensions of the world drug problem for UNGASS at the request of the Executive Board,¹³ and the Executive Board and World Health Assembly (the WHO's governing bodies) debated the WHO's contributions to the Special Session.

Following the 2016 UNGASS, the WHO Secretariat has continued its stronger engagement with global drug policy. In a follow-up report, it informed its governing bodies that it had an 'important role to play in promoting a public health approach to counter the world drug problem, strengthening the role of health systems in reducing the disease burden due to psychoactive drug use and improving the well-being of populations at all levels'.¹⁴ It committed to intensifying its efforts to 'ensure the coherence of public health-oriented drug-related policies...' and to international co-operation.¹⁵

Political leadership on drugs and health

Despite greater involvement, the WHO's executive and governing bodies continue to fall short of truly claiming a leadership role in the global drug policy debate – unlike the position it has claimed with respect to alcohol and tobacco. For example, the WHO's Executive Board rejected the proposal to schedule an agenda item on drugs issues for its meeting in January 2019 and the World Health Assembly in May 2019,¹⁶ despite the fact that the international community was making important strategic decisions about the next 10 years of UN drug policy at the Ministerial Segment of the 62nd CND session. This continued unwillingness by the WHO to claim a greater role in drug policy may be due, at least in part, to some member states' reluctance for the agency to take on such a role and to move the focus from criminal justice to health and human rights.

As a result, in the above-mentioned UNGASS follow-up report, the WHO Secretariat explicitly recognised the UNODC as the 'leading entity in the United Nations system for countering the world drug problem' and set out an agenda that, as in the past, focused strongly on technical questions and shied away from politically controversial questions that are fundamental to

its mandate.¹⁷ For instance, the report discussed extensively the 'public health problems caused by psychoactive substance use' but it remained silent on the devastating public health impacts of the *response* to drugs, such as the health harms caused by the criminalisation of drug use. Likewise, the WHO submission to the UNGASS process did not challenge the fact that many states continue to implement approaches to drugs that are informed by ideology rather than evidence. To its credit, the WHO did explicitly address the lack of health-related targets and indicators in the 2009 Political Declaration and Plan of Action on drugs, observing that 'Rebalancing drug policy towards public health objectives requires appropriate monitoring and evaluation systems to be developed and strengthened at the national, regional and global levels'. It recommended that monitoring should cover not just population drug use and the drug-attributable disease burden but also the 'public health impact of measures taken to counter the drug problem'. Moreover, in his video message to the 2019 Ministerial Segment of the 62nd session of CND, the WHO Director General Tedros Adhanom Ghebreyesus called for new approaches based on public health, human rights and scientific evidence, as his predecessor had done at the 2016 UNGASS.¹⁸

Nonetheless, the WHO's 13th General Programme of Work for 2019 to 2023 makes no reference to the question of drugs, despite its explicit commitments to ensuring health for all people and serving the vulnerable.¹⁹ This is particularly concerning considering that the WHO itself estimated that 450,000 people had died in 2015 alone as a result of drug use – a third to half of which from mainly preventable overdose deaths, and the rest associated with complications arising from HIV, hepatitis C and tuberculosis.²⁰ The fact that the Programme of Work for 2019-2023 fails to mention this issue is therefore a major oversight.

It is essential that the WHO provides not just technical guidance on drugs and health but also assumes the political role of addressing head-on some of the most problematic doctrines of global drug policy that, for decades, have structurally undermined and harmed public health, and that stand in the way of an approach to drugs that is truly based on health considerations. This is especially important given the direction towards repressive 'war on drugs' approaches taken by some countries to respond to the overdose crisis in North America and elsewhere.²¹ Moreover, the 2019 Ministerial Declaration and the UN System Common Position on drug policy (see Box 1) clearly invite greater leadership from the WHO to enhance coherence within the UN system and ensure that drug policies put 'people, health and human rights at the centre'.²²

In particular, IDPC calls on the WHO, its governing bodies and member states to:

- Participate in regular sessions of the CND at the highest level to convey the importance that the WHO attaches to global drug policy and ensure the WHO's involvement in setting the global drug policy agenda going forward.
- Actively participate in the 'UN system coordination task team on the implementation of the UN system common position on drug-related matters' to translate the health-focused recommendations of the UN System Common Position on the ground.
- Lead a process to develop and adopt health-specific targets and indicators, including on HIV and viral hepatitis transmission, drug-related overdose deaths, and the prevalence of problematic drug use. In the coming months, the WHO should actively engage in the UNODC's Annual Report Questionnaire review process to ensure that key data on drugs and health is routinely collected from member states, and to strengthen the WHO's collaboration with other UN agencies on drug-related data collection.
- Consistently express concern about the failure of many countries to implement evidence-based approaches to drugs in favour of ideologically-driven repressive responses that lack an evidence base and often undermine health.
- Call strongly and unambiguously for the decriminalisation of drug use and possession for personal use, as endorsed in the UN System Common Position on drug policy and WHO technical guidance,²³ and work with other UN agencies and member states to end criminalisation worldwide.
- Improve coherence within the WHO across various teams working on drug-related issues, especially on harm reduction and decriminalisation. Formalise the inter-departmental working group that includes the Substance Abuse Team, the HIV Department and Global Hepatitis Programme, the Access to Medicines team and other relevant units to ensure coherent language and messaging across the agency – including at headquarters in Geneva as well as in regional and country offices.
- Seek voluntary contributions from member states or other sources to enhance the WHO's capacity to provide technical assistance on drug policy issues, in particular on a health-based approach to drug use and on access to controlled medicines.

A health-based approach to drug use

There is a growing consensus internationally that a health-based approach to drug use is essential. Yet, as the WHO recognised in its UNGASS submission, 'actions to reduce drug use through enforcement...and related law enforcement strategies have largely dominated the implementation of national drug control strategies to date'.²⁴

The WHO plays an essential role in providing member states with technical guidance on health-based interventions on drugs, including around primary prevention, harm reduction, and treatment. This is an area where WHO has made significant progress (see Box 2). Over the years, it has developed important guidance that sets out best practices related to, among others, HIV prevention, treatment and care for people who inject drugs in the community²⁵ and in prisons and other closed settings,²⁶ the use of substitution therapy in the management of opioid dependence²⁷ and on overdose prevention.²⁸ The WHO has issued a good practice recommendation for countries to review their laws and work towards the decriminalisation of drug use and possession for personal use, presenting evidence of the health harms of criminalisation and stigma.²⁹ Likewise, the WHO has issued important public statements, sometimes jointly with other UN agencies, setting out key ethical principles related to drug policy. These include, for example, joint statements on compulsory drug detention and rehabilitation centres³⁰ and on ending discrimination in healthcare settings.³¹

Nonetheless, there is a clear need for the WHO to provide greater leadership on harm reduction. At present, this public health intervention is defined narrowly as prevention for HIV and viral hepatitis for people who inject drugs, mainly for opioids. However, harm reduction has far broader benefits that pertain to all types of drugs and methods of drug use. This includes preventing drug-related overdoses, reducing the risk of people taking contaminated or high-potency drugs through drug checking, and linking people to health and social services. Despite an impressive and growing body of research showing the public health benefits of drug consumption rooms³² and drug checking services, the WHO has neither provided guidance on these important harm reduction interventions nor included them in their 'comprehensive package' of services.³³ Moreover, the WHO has yet to issue adequate guidance to states on the collection of better data on key drug-related issues, including on harm reduction for stimulants. Finally, the newly agreed term 'medication assisted treatment', adopted at the

Box 2 Selected technical guidance, policy briefs and position

Access to hepatitis C testing and treatment for people who inject drugs and people in prisons — a global perspective³⁴ (2019)

International guidelines on human rights and drug policy³⁵ (2019)

International standards on drug use prevention³⁶ (2018)

Treatment and care for people with drug use disorders in contact with the criminal justice system: alternatives to conviction or punishment³⁷ (2018)

Joint United Nations statement on ending discrimination in health care settings³⁸ (2017)

Biobehavioural survey guidelines for populations at risk for HIV³⁹ (2017)

Serving the needs of key populations: case examples of innovation and good practice in HIV prevention, diagnosis, treatment and care⁴⁰ (2017)

Implementing comprehensive HIV and HCV programmes with people who inject drugs: Practical Guidance for collaborative interventions (the “IDUIT”)⁴¹ (2017)

International Standards for the Treatment of Drug Use Disorders⁴² (2017)

Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs⁴³ (2016)

Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations⁴⁴ (2014, updated in 2016)

Guidelines for the screening, care and treatment of persons with chronic hepatitis C infection⁴⁵ (2016)

Consolidated guidelines on HIV testing services⁴⁶ (2015)

Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations⁴⁷ (2015)

HIV and young people who inject drugs⁴⁸ (2015)

Community management of opioid overdose⁴⁹ (2014)

Women who inject drugs and HIV: Addressing specific needs⁵⁰ (2014)

Guidelines for identification and management of substance use and substance use disorders in pregnancy⁵¹ (2014)

WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users⁵² (2009, updated in 2012)

Joint statement: Compulsory drug detention and rehabilitation centres⁵³ (2012)

Guidance on prevention of viral hepatitis B and C among people who inject drugs⁵⁴ (2012)

Therapeutic interventions for users of amphetamine-type stimulants⁵⁵ (2011)

Principles of prevention and treatment for the use of amphetamine-type stimulants⁵⁶ (2011)

Harm reduction and brief interventions for ATS users⁵⁷ (2011)

Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence⁵⁸ (2009)

Principles of Drug Dependence Treatment⁵⁹ (2008)

Effectiveness of interventions to address HIV in prisons: Evidence for action technical papers⁶⁰ (2007)

Guide to starting and managing needle and syringe programmes⁶¹ (2007)

Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention⁶² (2004)

UNGASS⁶³ instead of the standard ‘opioid substitution therapy’ and reiterated since in various CND resolutions,⁶⁴ raises concerns that this might open the door to interventions that lack a solid evidence base, such as forced detoxification with mild pain or sickness relief or naltrexone implants. A clear definition by the WHO of what is, and what is not, evidence-based ‘medically assisted treatment’ is therefore essential.

Furthermore, a lack of consistency in messaging across WHO headquarters, regional and country offices on technical guidance on drug-related issues – likely, in part, as a result of the WHO’s highly complicated structure, with six regional offices that each have their own governing bodies – is an ongoing problem, as is the lack of capacity to assist countries with the implementation of available guidance. Moreover, technical guidance is often not translated into all relevant languages, making it less accessible for policy makers, healthcare providers and civil society organisations working in the field of drugs. Finally, although the WHO has made significant efforts in meaningfully involving people who use drugs when drafting its technical guidance, peer involvement in designing and implementing health-based drug policies at national level remains an issue which would benefit from guidance from the WHO.

The frequent politicisation of drug policy questions makes it particularly important for the WHO to publish and distribute clear, unambiguous technical guidance on key issues. Such guidance – and support for its implementation – would help reduce the current abyss between interventions which have shown to improve health outcomes, and the policies and practices that are actually implemented in many countries. IDPC therefore makes the following recommendations:

- Develop clear scientific technical guidance on key issues such as decriminalisation; drug consumption rooms; drug checking; the meaningful involvement of people who use drugs in the design and implementation of national drug policies and programmes; and on drug dependence treatment, with a clear definition of ‘medication assisted treatment’ and treatment methods that protect patients’ rights and are in line with ethical medical practice. Ensure their wide circulation in accessible formats and in relevant languages.
- Develop technical or policy briefings on harm reduction for different types of drugs and methods of use, and promote harm reduction as a proven drug policy approach grounded in the principles of public health, human rights and social inclusion. Ensure that guidance addresses the legal and policy barriers that are critical to the successful application of technical recommendations.

- Ensure that the development of normative technical guidance, especially on politically controversial issues such as decriminalisation or drug consumption rooms, is based exclusively on scientific evidence and is protected from political interference.
- Ensure that affected communities are systematically involved in the development of technical guidance. Champion community mobilisation in all its forms as a model of best practice in healthcare and incorporate this as a key principle in future guidelines regarding interventions targeted at people who use drugs.
- Ensure appropriate coordination across WHO departments and offices regarding the WHO’s positions on evidence-based interventions related to drugs, especially around harm reduction and decriminalisation.
- Prioritise and allocate more funding to increasing the capacity of WHO country and regional offices to assist countries with the implementation of technical guidance.

Ensuring access to controlled substances for medical and scientific purposes

The UN drug control conventions establish a dual obligation for member states: to ensure the adequate availability of controlled substances for medical and scientific purposes, while preventing their diversion and non-medical use.⁶⁵ Despite this dual obligation, the availability of controlled medicines remains severely limited in numerous countries, causing unnecessary suffering to hundreds of millions of people each year, often as a result of excessively restrictive drug control regulations or practices.⁶⁶ Until around 2010, UN drug control bodies such as the CND and the UNODC largely ignored this duty of balance in their work.

While the UN drug control conventions do not explicitly assign any responsibility to the WHO for monitoring this treaty obligation, such responsibility flows from its own mandate to promote the highest standard of health for all people.⁶⁷ Indeed, the WHO has worked to promote access to controlled medicines for decades, collaborates with the INCB (which does have a treaty-mandated role), and collaborates with the UNODC and the Union for International Cancer Control to implement small programmes in Ghana and Timor-Leste.⁶⁸

The WHO has issued important technical guidance for member states on controlled medicines, including 2011 guidance on ensuring balance in national

policies on controlled substances (please note that in June 2019 the WHO withdrew this policy guidance),⁶⁹ clinical guidelines on persistent pain in children⁷⁰ and on management of cancer pain in adults and adolescents.⁷¹ In 2014, the World Health Assembly adopted a resolution on palliative care which called on all states to review and revise, as needed, national and local legislation and policies for controlled medicines, a call reinforced by a 2015 World Health Assembly resolution on anaesthesia.⁷²

As a result of efforts of the WHO, several member states and civil society, the 2016 UNGASS Outcome Document for the first time recognises access to controlled medicines as a major drug control priority, dedicating a full thematic chapter to the issue.⁷³ Furthermore, the 2019 Ministerial Declaration reiterates the international community's 'resolve' to 'ensure access to and the availability of controlled substances for medical and scientific purposes, including for the relief of pain and suffering, and address existing barriers in this regard, including affordability'.⁷⁴

Yet, the WHO's capacity to assist member states in improving access to controlled medicines is very limited, despite a major need in many countries. Moreover, the recently announced initiative to restructure the WHO⁷⁵ means that the future of this work is uncertain.

In light of these considerations, IDPC calls on the WHO to:

- Advocate for controlled medicines as a pillar of future drug strategies and debates, along the lines of the 2016 UNGASS Outcome Document, and include clear indicators, timed benchmarks and objectives to track progress towards improved access.
- Work closely in very low consumption countries with WHO country offices, the INCB and the UNODC to address barriers that impede access to controlled substances for medical purposes for those in need, and regularly report to the WHO's governing bodies and the CND about progress.
- Ensure that the restructuring process of the WHO results in increased capacity to assist countries to ensure the adequate availability of controlled medicines, especially in regional and national offices, including on estimating need for controlled medicines, reforming restrictive regulations, and training healthcare professionals on the safe and effective use of these medicines.

Scientific reviews of substances and scheduling

A central feature of the UN drug control system is its mechanism to place substances that pose significant risks to public health under international control. Any substance added to a schedule may be used only for medical and scientific purposes and its legal manufacture, trade and use are subject to restrictions under both international and national law.

Under the UN drug control treaties, the WHO is entrusted with the responsibility of reviewing and assessing substances to determine whether they should be internationally controlled in the 1961 or the 1971 drug control treaties.⁷⁶ Ultimate decision-making power on scheduling, however, rests with the 53 member states that comprise the CND. The Commission makes such decisions by vote by either accepting or rejecting the WHO recommendation.

To conduct scientific reviews of the public health risks and benefits of substances, the WHO created the Expert Committee on Drug Dependence (ECDD), a body of independent experts in the field of drugs and medicines which conducts its assessments based on literature reviews and other relevant documentation prepared by the WHO Secretariat.⁷⁷ Since 1949, the Committee has reviewed more than 400 substances, bringing the number of substances under international control from 50 in 1948 to 229 in 1999.⁷⁸ In the past 10 years, ECDD has met seven times reviewing dozens of substances.

While the scheduling process is supposed to be apolitical and informed only by scientific considerations, it has become increasingly politicised in recent years. In 2015, China sought a vote at the CND to schedule ketamine despite the WHO's repeated recommendation not to schedule it.⁷⁹ This led to confusion over whether the CND can schedule substances against the WHO's advice.⁸⁰ In 2019, Egypt, Nigeria and other countries criticised the WHO for recommending against the scheduling of tramadol, following multiple reviews of the substance.⁸¹ The INCB and the UNODC have also repeatedly implied that ketamine and tramadol should be scheduled internationally, although stopping short of explicitly criticising the WHO.⁸² The WHO's own recommendation on the scheduling of cannabis in January 2019 also raised concerns about the integrity of the process. In its recommendation, the WHO recognised that cannabis has medical uses – and recommended removing it from Schedule IV, which contains substances with no known medical applications. However, it also recommended keeping cannabis in Schedule I, which contains substances

considered as being the most harmful (including heroin, cocaine and morphine), because of its widespread use, rather than moving it to another schedule or deleting it altogether, despite finding that it was not associated with the same level of risk as other substances included in Schedule I.⁸³ This is despite the fact that the conventions do not provide for the option of keeping a substance in a stricter schedule solely based on the prevalence of its use.

More generally, there are various concerns regarding the functioning of the scheduling system. One such concern relates to the scope of the ECDD's review which is too narrowly defined and excludes questions of critical importance.⁸⁴ These include, for example: the likely impact of scheduling on a substance's medical availability, a consideration of less far-reaching measures than international scheduling to limit the public health harms, the probability that international scheduling is effective to limit the harms associated with the substance, and the social and health harms resulting from the criminalisation of unauthorised possession and use of substances that are scheduled internationally.⁸⁵ Moreover, the WHO does not provide clear guidance to the ECDD on how to weigh the level of public health risks of a substance and the importance of its therapeutic uses, which leads to a decision-making process that lacks transparency.

IDPC is likewise concerned that the composition of ECDD is too narrow, often including only experts in pharmacology, drug dependence and toxicology whereas the impact of scheduling extends far beyond those fields.⁸⁶ The ECDD that reviewed tramadol in November 2018, for example, did not include a single palliative care expert, even though scheduling of the substance would have had major implications for that field. Similarly, the ECDD does not typically have members with broad public health or human rights expertise, nor any mechanism for representation of directly affected populations, despite clear implications for the right to health.

More broadly, IDPC is worried about the feasibility, in today's world, of a scheduling and review system created more than 50 years ago when new substances emerged infrequently. According to the UNODC, 803 new psychoactive substances have emerged in the last ten years, more than twice the number of substances reviewed since 1949.⁸⁷ This new trend raises questions as to the efficiency of the current scheduling process.

In light of the above, IDPC makes the following recommendations:

- The WHO and member states should vigorously re-

sist any political interference with the scheduling process.

- The WHO should make a number of structural changes to its process for reviewing substances by amending its 2010 guidance on review of psychoactive substances to ensure: 1- That it encompasses additional factors relevant to scheduling, such as an assessment of potential alternatives to, and the impact of, scheduling on medical availability as well as health and social harms; 2- That ECDD membership includes experts not just in pharmacology and drug dependence but also people with other relevant expertise, including on health and human rights.
- The ECDD should maintain and expand its recent practice of holding open segments at its meetings, and allowing for inputs and engagement from civil society and affected groups into its review process.
- The WHO should proactively initiate the review of substances that are scheduled internationally but have never been subjected to a critical review (e.g. for coca). It should also assess how to continue its critical role in scientifically reviewing substances in the face of a growing number of new psychoactive substances coming onto the market each year.

Conclusion

In 2015, there were an estimated 450,000 drug-related deaths, with many more suffering from health and social harms related to drug use. The vast majority of that mortality and morbidity is preventable with basic interventions that should be readily available everywhere and which, in reality, are limited to non-existent. In 2015 also, it was estimated that 75% of the world's population had little to no access to controlled medicines for pain relief.

Instead of addressing these harms, responses to drugs based on criminalisation, stigma and discrimination further jeopardise the health of people who use drugs, and people suffering from moderate to severe pain. As the UN's lead agency on health, it is imperative that the WHO play a leading role in reducing these health harms, by promoting drug policies that truly put 'people, health and human rights at the centre', as promoted by the UN System Common Position.⁸⁸ As part of its commitments to ensuring health for all and universal health coverage in its Global Programme of Work 2019-2023, the WHO Secretariat and its governing bodies should strengthen their leadership on drug policy issues, both politically and technically.

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Endnotes

1. 1961 Single Convention on Narcotic Drugs, 1971 Convention on Psychotropic Substances, and 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, available here: <https://www.unodc.org/unodc/en/treaties/index.html?ref=menu#Drugrelated>
2. The term ‘Vienna Monopoly’ refers to the fact that the UN drug control bodies (the CND, the UNODC and the INCB) based in Vienna make global drug policy decisions with minimal input from other parts of the UN family such as the WHO, the UN Development Programme, UNICEF, the UN Office of the High Commissioner on Human Rights and others
3. The WHO Constitution states that: ‘The objective of the World Health Organization (hereinafter called the Organization) shall be the attainment by all peoples of the highest possible level of health’ (emphasis added). See: https://www.who.int/governance/eb/who_constitution_en.pdf
4. Commission on Narcotic Drugs (March 2019), *Ministerial declaration on strengthening our actions at the national, regional and international levels to accelerate the implementation of our joint commitments to address and counter the world drug problem*, https://www.unodc.org/documents/commissions/CND/2019/Ministerial_Declaration.pdf
5. United Nations System Chief Executives Board for Coordination (January 2019), ‘Annex I: United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration’, *Summary of deliberations, second regular session of 2018, Manhasset, New York, 7 and 8 November 2018*, CEB/2018/2, <https://www.unsceb.org/CEBPublicFiles/CEB-2018-2-SoD.pdf>
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10. Articles 3 and 9 of the 1961 Single Convention on Narcotic Drugs; articles 2 and 3 of the 1971 Convention on Psychotropic Substances
11. Jelsma, M. (2003), ‘Drugs in the UN system: The unwritten history of the 1998 United Nations General Assembly Special Session on drugs’, *International Journal of Drug Policy*, **14**(2): 181, 195
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About this advocacy note

In this advocacy note, IDPC discusses the WHO's strategic role in drug policy, including progress made and ongoing gaps and challenges, and calls on the WHO and its governing bodies to engage in a more progressive and systematic way in various aspects of global drug policy to ensure more coherence with the UN system on drug policy, health, human rights, and the achievement of the Sustainable Development Goals.

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About IDPC

The International Drug Policy Consortium is a global network of non-government organisations that specialise in issues related to illegal drug production and use. The Consortium aims to promote 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 harm. It produces briefing papers, disseminates the reports of its member organisations, and offers expert advice to policy makers and officials around the world.

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