VISITING FELLOW WORKING PAPER NO. 1 | 2015

UNGASS 2016 ON THE WORLD DRUG PROBLEM

Khalid Tinasti

THE GRADUATE INSTITUTE GENEVA

GLOBAL HEALTH PROGRAMME

VISITING FELLOW WORKING PAPER NO. 1 | 2015

Global Health Programme
Graduate Institute of International and Development Studies
Chemin Eugène-Rigot 2 | Case Postale 136
1211 Geneva 21 – Switzerland
Tel + 41 908 4558
Fax + 41 908 4594
Email globalhealth@graduateinstitute.ch

graduateinstitute.ch/globalhealth

The Visiting Fellow Working Paper Series of the Global Health Programme provides a platform for young researchers and visiting fellows to publish and circulate their research findings and ideas. In this way, new thinking can be introduced and visiting fellows may benefit from the Global Health Programme's outreach and receive feedback on their work.

UNGASS 2016 ON THE WORLD DRUG PROBLEM: INVOLVING THE GENEVA-BASED INTERNATIONAL ORGANISATIONS IN THE GLOBAL DRUG POLICIES DEBATE

Khalid Tinasti [1]

The United Nations General Assembly (UNGA) will convene a Special Session (UNGASS) on the world drug problem in April 2016, three years ahead of its regular review of the ten-year plan of action to 'counter' drugs planned in 2019. Convening this Special Session illustrates the need for new approaches to respond to drug use, for a review of international drug policies and an open dialogue on all aspects relating to drug use. Though the General Assembly named the Commission on Narcotic Drugs as the leading entity for the preparatory process of the UNGASS 2016, it also introduced an innovation in the process by calling for input from all other UN entities.

As the UNGASS approaches, the Geneva-based organisations with mandates on human rights and health have a major role to play in the global debate on drug policies. This working paper reviews how the mandate of the major UN entities and international organisations based in Geneva covers drug policy, their current contribution to the UNGASS process, and suggests pathways to strengthen their involvement in the debate on drugs. The paper focuses on the impact of the current drug control approaches on the work of the World Health Organisation, the Joint United Nations Programme on HIV/AIDS, the Office of the High Commissioner for Human Rights and the Human Rights Council, the International Labour Organisation, the Office of the High Commissioner for Refugees and the Global Fund to fight AIDS, Tuberculosis and Malaria. With the identification and acknowledgement of the shortcomings of the current drug control system on health and human rights, the involvement of the Geneva-based organisations should positively influence the course of the debate around UNGASS 2016 and beyond.

Keywords

Drug control; public health; essential medicines; HIV; harm reduction; human rights; refugees; workplace.

LIST OF ABBREVIATIONS

CND	United Nations Commission on Narcotic Drugs
ECDD	WHO Expert Committee on Drug Dependence
ECOSOC	United Nations Economic and Social Council
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HRC	Human Rights Council
ILO	International Labour Organization
INCB	International Narcotics Control Board
OHCHR	Office of the United Nations High Commissioner for Human Rights
PCB	UNAIDS Programme Coordinating Board
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNHCR	Office of the United Nations High Commissioner for Refugees
UNODC	United Nations Office on Drugs and Crime
UNTF	United Nations Task Force on Transnational Organized Crime and Drug Trafficking
WHA	World Health Assembly
WHO	World Health Organization

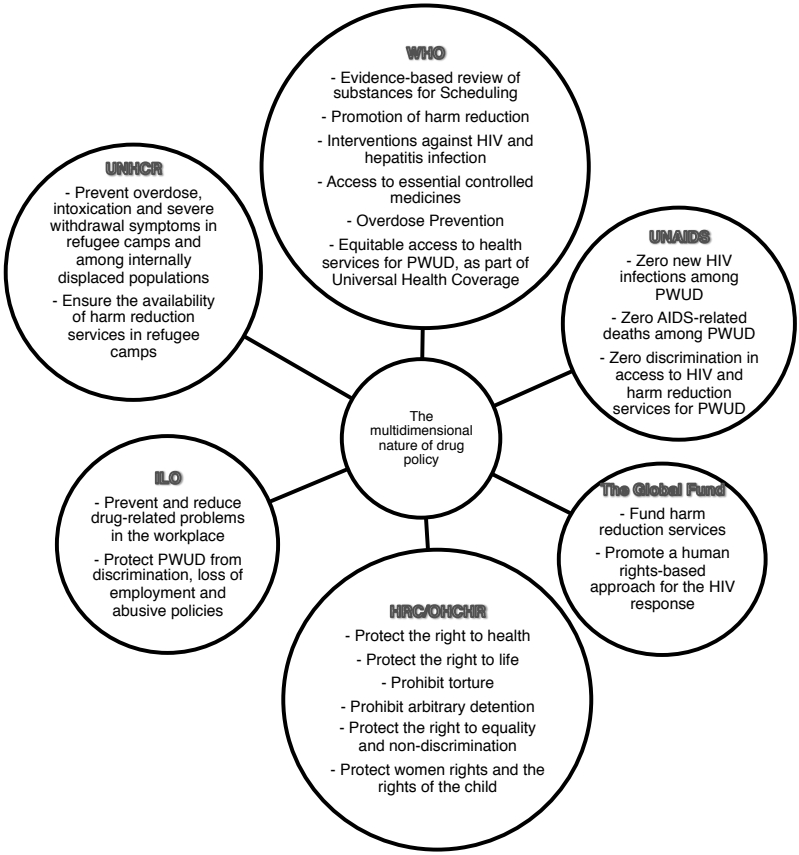
INTRODUCTION

The 1961 Single Convention on Narcotic Drugs gives four international UN entities the mandate to respond to the world drug problem [2]: the Commission on Narcotic Drugs (CND) representing the Economic and Social Council, the United Nations Secretary-General, the International Narcotics Control Board (INCB) and the World Health Organization (WHO). CND member states have the task of drafting and negotiating an international strategy to 'counter' the world drug problem. The latest strategy, adopted in 2009 [3], delineates the work of stakeholders at the international level around three approaches: demand reduction [4], supply reduction, and enhancement of international cooperation around money laundering [5]. These approaches guide member states in the implementation of the 2009 Political Declaration, of which the stated goal was to "significantly reduce the use and production of illicit substances" within a decade. These same approaches guided the objective of a 'drug-free world' by 2008, articulated at the 1998 United Nations General Assembly Special Session (UNGASS) on the World Drug Problem.

In recent years, multiple voices including member states, civil society and international organisations have raised concerns about the failure of the prohibition-based approach to achieve drug-free societies, which fuels violence, undermines human rights and negatively impacts on public health. In 2012, the United Nations General Assembly approved a resolution to convene a UNGASS on the world drug problem [6]. The governments of Mexico, Colombia and Guatemala proposed the resolution, which was supported by 95 member states [7]. Such a request for a Special Session was evidence of the pressing need to discuss new approaches, to review international drug policies, and for a comprehensive dialogue on the multidimensional impact of drugs. The General Assembly confirmed the CND as the leading entity for the preparatory process, both on substance and organisation, of the UNGASS 2016. It nevertheless introduced an innovation in the process by inviting all other UN entities and multilateral member states' assemblies to provide their input and participate in the preparation of the UNGASS and during the Special Session itself, as stated in the following: "the special session of the General Assembly on the world drug problem in 2016 shall have an inclusive preparatory process that includes extensive substantive consultations, allowing organs, entities and specialised agencies of the United Nations system, relevant international and regional organisations, civil society and other relevant stakeholders to fully contribute to the process in accordance with the relevant rules of procedure and established practice" [8].

As the UNGASS approaches, and considering the current drug control system - based on prohibition and control measures - negatively affects human rights and public health, the Geneva-based organisations have a major role to play in the global debate on drug policies. This working paper reviews how the mandate of the major UN entities and international organisations based in Geneva covers drug policy, examines their current contribution to the process, and suggests pathways to strengthen their involvement in the debate on drugs. It aims at emphasising the horizontal nature of the drugs issue given that prohibition-based drug policies directly and negatively affect the ability of these organisations to achieve their objectives. The paper focuses on the effects of the current drug control approaches on the work of the World Health Organisation (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Office of the High Commissioner for Human Rights (OHCHR) and the Human Rights Council (HRC), the International Labour Organisation (ILO), and the Office of the High Commissioner for Refugees (UNHCR) and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFTAM). The General Assembly and the United Nations System Task Force on Transnational Organised Crime and Drug Trafficking (UNTF) have both invited all of these organisations to engage in the 2016 UNGASS (see Figure 1).

The availability and quality of illicit drugs are increasing, while the drug control system still focuses on prohibitionist approaches to eliminate drugs. Drug control, through its legal obligations, the fear environment it induces, and the use of harsh policies against drugs have contributed to a world where access to essential medicines is almost impossible in 75% of the world; where HIV and hepatitis have spread among people who inject drugs; where harm reduction is not consensual while it is scientifically proven to protect drug users and the larger community; where funding is concentrated on law-enforcement and not on health or community-strengthening; where the right to health, the right to life and many others are often not granted; and where drug users do not access the labour market and, when employed, are not protected. The involvement of the Geneva-based organisations in the UNGASS and beyond will be critical to address the health, employment, and human rights dimensions related to drug use.



1. The World Health Organisation

Figure 1: The roles of the Geneva-based International organisations in drug policies

1. The World Health Organisation

The health-related issues of drug use combined with the mandate of WHO to evaluate and recommend the scheduling of substances - based on assessments of harm to public health - gives WHO a leading role in drug policy. WHO, as the entity charged with protecting health across the entire UN system, is responsible for the health and well-being of people who use drugs (PWUD), as it is for the health of the general population. The WHO Constitution [9] states that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", yet the punitive approaches and prohibition-based policies of the drug control regime have negatively impacted the health of people who use drugs [10]. The international drug control regime is also tasked with ensuring that substances scheduled under the drug Conventions are available and accessible in all countries for medical and scientific purposes while not diverted for recreational use – a task far from being achieved.

WHO represents a privileged organisation to support the international community's work to address the drugs phenomenon. The Single Convention directs WHO to nominate five members with "medical, pharmacological or pharmaceutical experience" to the International Narcotics Control Board (INCB), the UN entity mandated to administer the estimates system and other aspects of international drug control. ECOSOC then elects three of the five members suggested by WHO into the INCB for a renewable five-year term [11].

Prohibitionist drug policies impact the work and objectives of several WHO departments, from prevention of infectious and blood-borne diseases, to mental health, access to pain relief, and health of specific demographic groups including children, women or older persons. The last time the World Health Assembly (WHA) raised the drugs issue was in 1990, in a resolution on demand reduction following the UNGASS 1990 on drugs [12].

Given its mandate, WHO should contribute to the UNGASS by leading the process with the CND and UNODC. UN member states should consider requesting through the WHA, WHO's governing body, that WHO play its assigned role in responding to the world drug problem.

1.1. Classifying drugs and ensuring access to controlled medicines

Article 3 of the 1961 Single Convention on Narcotic Drugs and Article 2 of the Convention on Psychotropic Substances of 1971 [13] both direct WHO to engage in an evidence-based evaluation of the harms and benefits of psychotropic substances prior to recommending whether CND should place them in the schedules of the drug control treaties. The WHO Expert Committee on Drug Dependence (ECDD) meets every second year (or more often if requested) to review the substances member states consider for scheduling. Member states or WHO itself can request such reviews, and ECOSOC can approve or reject the subsequent CND decision on scheduling.

The ECDD applies the conventions' mandates to protect public health articulated in the preambles, ensuring that controlled medicines are available and accessible for clinical and scientific use. The ECDD has reviewed more than 400 substances since 1949 and the establishment of WHO. The expert body bases its reviews on evidence, within the mandate given to it by the conventions and resolutions [14]. Between 1948, when WHO was created, and 1999, the number of internationally scheduled narcotic drugs rose to 118 and psychotropic substances to 111 [15]. The current structure and procedures of the ECDD are under extreme pressure at the present time, given that one new psychoactive substance appears in the drug market every week.

While WHO reviews the substances to guide their scheduling decision, it also has to ensure that these substances are available for medical and scientific use. Together with the INCB, WHO estimates that 5.5 billion people live in countries with low or no access to the opioid analgesics listed in the schedules of the drug control conventions, meaning that they will not receive adequate treatment to their pain and suffering if needed [16]. Lack of access to medicines used to treat moderate to severe pain particularly affects people living in low and middle income countries. WHO estimates that lack of access to controlled essential medicines affects "1 million end-stage HIV/AIDS patients, 5.5 million terminal cancer patients, 0.8 million patients suffering injuries caused by accidents and violence, patients with chronic illnesses, patients recovering from surgery, women in labour (110 million births each year) as well as paediatric patients" [17]. According to the INCB, the majority of the world's population has no access to medical opioids for pain relief; only 7.5% of the world lives in countries that report adequate consumption and 66% that report none at all. Ten percent of countries report very low consumption, 3% low, and 4% moderate consumption [18].

WHO has developed a Model List of Essential Medicines that should also be of good quality, available in sufficient amounts, and at an affordable price [19]. This list guides member states in the development of their national lists. Essential medicines include controlled opioids such as morphine and methadone [20].

The WHA has passed several resolutions in response to the situation of inadequate access to medicines controlled under the drug conventions, including a resolution on cancer prevention and control, which calls for the improved availability of opioid analgesics for cancer management[21]. The resolution on access to essential medicines requested member states to design and implement policies to ensure reliable procurement, stable pricing, and rational regulation to ensure access. In 2014, the resolution on integrating palliative care within national health systems called on member states to ensure access to essential medicines for palliative care, to avoid stock-outs, and to change policies to ensure pain management[22].

In 2015, the WHA passed a global surgery resolution urging member states "to promote access to essential medicines, including controlled medicines, antibiotics, medical devices and diagnostics used in anaesthesiology and surgery that are of good quality, safe, efficacious and affordable". The resolution also called on the WHO Director-General to "work with the INCB, UNODC, health ministries and other relevant authorities at global, regional and national levels, to promote the availability and balanced control of controlled medicines for essential and emergency surgical care and anaesthesia" [23].

Nevertheless, fears of diversion of opioid-based essential medicines impede the vast majority of the world's countries to ensure the availability of these medicines. Such an obligation exists in the preamble of the drug conventions but also as a binding obligation under the "right to health". The unavailability of medicines - that are essential to treat pain, for palliative care, for anaesthesia in surgery, and for substitution therapy – is in contradiction to the work programme of WHO, which promotes availability and affordability of these medicines.

1.2. Infectious and blood-borne diseases

The current drug control system hinders an effective response to HIV transmission. HIV prevalence is twenty-eight times higher among people who inject drugs (PWID) than in the general population, making it one of the most vulnerable populations to HIV, hepatitis and tuberculosis infection[24]. Around 1 in 10 new HIV infections globally is associated with unsafe drug injection; this infection rate reaches 80% in some countries in Eastern Europe[25]. Also, of the estimated 16 million PWID, approximately 10 million are living with Hepatitis C (HCV), out of a total of 130-150 million people living with Hepatitis C globally. HCV infection can reach 90% of PWID in Eastern Europe and South-East Asia, regions that enforce some of the harshest drug policies in the world[26]. Hepatitis C is the most common infection among PWID worldwide.

WHO has provided normative guidance on HIV, HCV and injecting drug use, and attempted to define harm reduction in a technical guide produced jointly with UNODC and UNAIDS[27]. The nine interventions recommended by the three international organisations include the provision of needle and syringe programmes (NSPs), opioid substitution treatment (OST), HIV testing and counselling, and antiretroviral therapy. The General Assembly, ECOSOC, the CND and the UNAIDS Programme Coordinating Board (PCB) approved these interventions based on evidence and on consensus among member states about the need for an effective HIV response to the heavy health burden borne by PWID. These interventions on harm reduction include vaccination, diagnosis, and treatment of viral hepatitis[28]. The vaccination rates for hepatitis B are lower among PWID than in the general population, although the need is much higher[29]. WHO has issued a set of recommendations that include the provision of a Hepatitis B vaccine that is cheap, available, and safe, as well as the provision of low dead-space syringes that prevent infection with Hepatitis C and HIV, and the development of peer interventions[30].

In 2014, WHO published guidelines for HIV key populations and revised the nine interventions that attempt to define a harm reduction package. The guidelines promote drug policies that support harm reduction, decriminalisation of drug use and NSP, the legalisation of OST, the ban of compulsory treatment of PWID, community empowerment, and policies to address discrimination, stigma and violence, and reduce incarceration[31].

Although effective treatment for Hepatitis C is now available, cost and discrimination-related barriers prevent PWID from achieving universal access. Barriers include the view that PWID are at high risk for reinfection, as well as doubts about their ability to adhere to treatment. PWID are also excluded from government-funded Hepatitis C treatments in many parts of the world[32]. WHO's guidelines on Hepatitis C reiterate, nevertheless, that treatment of PWID helps prevent transmission and reduces the prevalence of the virus among this key population[33]. In May 2014, the WHA passed its first resolution on hepatitis, which called on member states to implement the WHO, UNODC and UNAIDS harm reduction interventions, to ensure equity in access to health services for vulnerable groups, and to review the policies that discriminate against people living with hepatitis[34].

As HIV has been linked to drug injection since "the first AIDS-related illnesses"[35], HIV/Hepatitis C co-infection threatens the survival of PWID because of the high prevalence of HCV; 50 to 90% of PWID living with HIV are co-infected with Hepatitis C[36]. PWID should have access to HIV, Hepatitis C and addiction treatment all at once, and WHO should strongly recommend lifting the discrimination barriers and fears of PWID inability to adhere to treatment. The technical tools and treatments are available to avoid preventable morbidity and mortality related to HIV, Hepatitis C, and their co-infection.

1.3. Illicit drugs abuse

WHO estimates that illicit drug use accounts for one percent of all disability-adjusted life years (DALYs)[37], attributing morbidity primarily to suicide, overdose, AIDS, and hepatitis. Problematic drug users, who represent 10% of all drug users according to UNODC, suffer from higher mortality rates than the general population. DALYs are a measure that combines premature mortality, years of life lost (YLL), with morbidity due to disability, years of life lived with disability (YLD). An estimated 183,000 (95,000-226,000) drug-related deaths were reported in 2012[38].

However, there are inexpensive and effective ways to prevent adverse health outcomes among people who use drugs, whether for overdoses, HIV, hepatitis or other infections. Naloxone is a proven, low cost, effective medicine that reverses opioid overdose. In 2012, the CND passed a resolution calling on member states to include Naloxone provision in their drug policies to prevent death from opioid overdose[39]. WHO estimates that there are 69,000 opioid overdoses each year[40] and, along with UNODC, called for better availability and use of Naloxone, which has unique agonist effects, is only effective with opioids, and is unlikely to be diverted[41].

WHO has also developed guidelines on psychosocially assisted pharmacological treatment for opioid dependence syndrome. WHO stated that of all the maintenance programmes researched, opioid agonist maintenance treatment has been the most effective when combined with psychosocial assistance. Methadone and Buprenorphine for substitution and maintenance therapy significantly reduces heroin use and injection practices, overdose risk, drug-related criminal offences, and HIV transmission rates while promoting treatment adherence. WHO guidelines cite poor results from opioid abstinence treatment compared to maintenance, stating that abstinence should be pursued only when it is the informed choice of drug users. Finally, WHO has said that substitution and maintenance services should respect human rights standards and provide equitable access to the treatment best adapted to the user[42].

In line with the UNTF request to all its members to produce reports to inform the UNGASS preparation process, in December 2014 WHO produced a report titled "WHO's role, mandate and activities to counter the world drug problem: a public health perspective"[43]. The report describes the work WHO undertakes in the drugs field, the guidelines it produces, the resolutions the WHA has passed, and the role given to the organisation by the drug treaties. Nevertheless, the interest in such a report is limited, as it misses a central element on how drug policies challenge public health and increase the burden of disease among people who use drugs.

Recommendations for WHO

→ In the coming months, member states need to bring the debate on drugs to WHO's Executive Board and then to the WHA, and request a comprehensive review of the effect of drugs on health. Such a review should compile and compare both the harms of drugs as substances, but also drug policies as political choices. If it might be too late for WHO to be effectively involved in the UNGASS 2016, the latter should at least be a trigger to WHO's action in the field of drugs, strengthening its response capacity and fully integrating it in the wider drug policy debates.

2.The Office of the High Commissioner for Human Rights and the Human Rights Council

In September 2015, at its 30th session, the High Commissioner for Human Rights launched a report on the impact of drug control policies on the enjoyment of human rights and their protection [44] and the Human Rights Council (HRC) held a panel discussion on the impact of drug control on human rights. The report and the panel were requested to contribute to UNGASS 2016 [45] by a resolution adopted at the 28th session. This resolution was the product of a long history of advocacy around human rights violations associated with drug control policies reported by member states, the office of the High Commissioner for Human Rights, as well as the HRC Special Procedures.

In 2010, the UN Special Rapporteur on Torture shared his concern that many governments are violating the prohibition against torture in the name of security exceptions that include drug offences [46]. Similarly, the UN Special Rapporteur on the Right to Health stated that the international drug control system has failed because its aim at achieving a drug-free world through prohibition has resulted in human rights violations, does not acknowledge the nature of drug use and addiction, and has aggravated public health outcomes for people who use drugs [47]. The report also details the effects of criminalisation and incarceration of drug users that deter them from using or accessing health services, the negative effects of compulsory treatment, and the excessive barriers in many countries that impede access to controlled essential medicines for pain relief and substitution therapy. In 2013, two other special procedures included drug control policies in their work. The UN Special Rapporteur on Torture stated in his report that compulsory treatment centres funded by international donors continue to operate despite the international community's denouncement. He reported that controlled substances, including those recognised as essential for "the relief of pain and suffering" [48] are not available in 150 countries in the world for people who need them, although human rights law requires states to provide them. He reported that people who use drugs are criminalised and highly stigmatised, often victims of humiliation and cruelty [49]. The UN Special Rapporteur on Violence Against Women also reported drug policy violations of women's rights. Many women are coerced into smuggling drugs or are incarcerated for drug offences related to intimate relationships - the so-called "girlfriend problem" - which makes women particularly vulnerable under current international and national drug control policies. The Special Rapporteur stated that "many new minimum sentencing regulations have resulted in harsher sentences for drug-related offences than for crimes such as rape and murder" [50]. Such regulations expose women with low-level offences to incarceration more than men. The HRC

special procedures have produced an extensive set of conclusions and recommendations regarding the need for states to implement drug policies in full respect of their human rights obligations.

In the 27th session of the HRC, sixteen member states delivered the first-ever cross-regional statement on drugs and human rights[51]. This statement called on the HRC to guide the adoption of human rights based approaches to drugs, under its mandate as the human rights coordinating body of the UN system. Member states saw this approach as a crucial step to prevent human rights violations resulting from traditional drug control approaches based on demand and supply reduction that emphasise law-enforcement and criminal justice. They also clearly stated that the prohibitionist approach to drugs has a negative impact on the enjoyment of human rights.

The former High Commissioner for Human Rights, Navi Pillay, continued to defend the protection of human rights in the context of drug control, while recalling the ongoing egregious violations. At the 57th session of the CND[52] and the 26th session of the HRC, she recalled that "Violations of the right to life; the right to health; the prohibition of torture and other forms of ill treatment; the prohibition of arbitrary detention; the right to equality and non-discrimination; the rights of indigenous peoples; and the rights of children, are all sources of serious concern. Unintended consequences of drug control policies are also concerning, since the focus on repression may actually contribute to excessively high levels of violence in some communities"[53]. Moreover, the High Commissioner for Human Rights, Zeid Ra'ad Al Hussein, stated that the death penalty for drug offences contradicts provisions of the International Covenant on Civil and Political Rights, which states it may be imposed only for the "most serious crimes." The Human Rights Committee has determined that the concept of "most serious crimes" applies only to the intentional taking of another life[54]. Nevertheless, thirty-three countries still impose the death penalty for drug offences[55]. He also called for decriminalising drug use and possession.

The right to health is a key human right that is negatively impacted by current approaches to combatting drug use, with important implications for a number of Geneva-based international organisations including HRC, WHO and UNAIDS (Figure 2).

Recommendations for the HRC and OHCHR

- → The High Commissioner for Human Rights must be a vocal presence at the UNGASS 2016 if future drug policies are to meet the standards enshrined in the Universal Declaration of Human Rights and other human rights treaties.
- → The Special Procedures should consider producing a common report on the impact of drug control policies on their respective mandates.
- → Member States at the HRC should consider delivering recommendations on national drug policies during the Universal Periodic Reviews; they should also commission the Human Rights treaty bodies to review the current international and national drug policies.

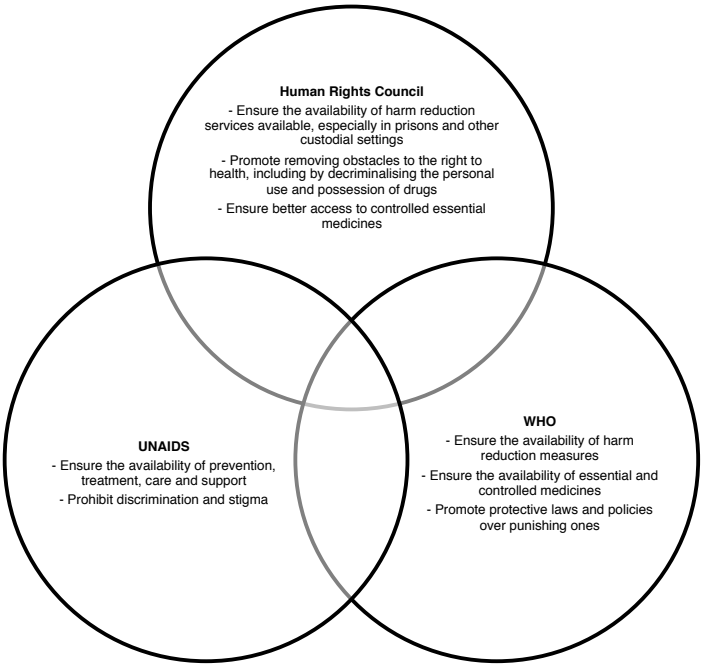


Figure 2: The right to health, drug use and the role of the Geneva-based international organisations:

3. The Joint United Nations Programme on HIV/AIDS

The 2011 Political Declaration on HIV/AIDS, which committed to reducing HIV transmission by 50% among PWID by 2015, noted that many national HIV strategies do not focus on people who inject drugs, although they represent a most-at-risk population for infection[56]. Four years later, the UNAIDS PCB thematic session on HIV among PWID stated that the reduction in HIV transmission in 2013 had reached only ten percent[57], far from the 50% objective of the political declaration. Moreover, UNAIDS reported that some member states were making no significant investments in effective and cost-effective harm reduction services that could enable the objectives to be met.

Given that the current drug control policies have a negative impact on the objectives of UNAIDS, the joint programme should play a major role in UNGASS 2016. UNAIDS has recognised that punitive policies hinder the HIV response and that criminalisation of PWID discourages them from accessing health, prevention and treatment services[58]. People who use drugs avoid these services because they often involve compulsory treatment, which has been condemned by the UN and other international donors[59,60]. Immediately following the 2016 UNGASS on the world drug problem, the United Nations General Assembly will hold a High-Level meeting on HIV/AIDS[61], which is of utmost importance for drug policy stakeholders because it will discuss the implementation of HIV programmes for PWID.

WHO, UNODC and UNAIDS jointly developed a set of recommendations and a package of nine comprehensive interventions attempting to define harm reduction. These interventions include needle and syringe programmes, opioid substitution therapy, provision of anti-retroviral treatment for PWID living with HIV[62], as well as the needed synergy between all of these interventions. Although member states in ECOSOC, the CND and the PCB have approved these recommendations, of the 158 countries that report illicit drug use, only 91 have integrated harm reduction policies[63]. UNAIDS estimated that an effective response to HIV among PWID will require USD 2.3 billion in 2015, and USD 1.5 billion in 2020[64]. Yet only seven percent of the global needs are covered, representing an investment in harm reduction of USD 160 million, contrasting with the USD 100 billion spent on anti-drug enforcement[65].

The situation is very unequal regionally, as some regions like Western Europe have introduced comprehensive harm reduction services and significantly reduced the HIV transmission rates to approximately one percent. Switzerland, like other Western European countries, has gone from a high point of over 900 individual cases of infection in the late 1980's to fewer than fifty in 2012[66]

Moreover, there is no evidence that harm reduction increases rates of drug injection or diverts governments from strategies of demand and supply reduction. On the contrary, opioid substitution therapy and methadone programmes have proven "effective in reducing opioid dependence, reducing risk behaviours related to injection drug use, preventing HIV transmission and improving PWID adherence to anti-retroviral therapy" [67]. Other approaches to prevent HIV transmission, such as pre-exposure prophylaxis (PrEP) or treatment as prevention (TasP) have not been evaluated in the trial phase among drug users [68].

Effective and cost-effective interventions that have been available for over twenty years could have reduced the global burden of HIV/AIDS among HIV key populations of PWID. Stigma and discrimination, poor health services and punitive drug control policies, however, have made what could have been a success story into a significant failure.

Recommendations for UNAIDS

- → In order to achieve its post-2015 strategy on ending AIDS [69], to defend its commitment to key populations and to implement its PCB decision points on PWID, UNAIDS should engage strongly in the UNGASS process. With its structure as a joint UN programme, UNAIDS has the capacity to convene UN interagency national and regional consultations, along with UNODC and other UN agencies, on ending HIV transmission among injecting and non-injecting drug users.
- → UNAIDS should produce a strong report in which it assesses the national, regional and international policies on HIV and drug use; where it would publish data on the last twenty years linking drug policy choices and trends in HIV transmission among PWID; and call for the decriminalisation of drug use to lower the HIV burden on drug users.

The United Nations System Task Force on Transnational Organized Crime and Drug Trafficking

Established in March 2011 by the Secretary-General, the UN Task Force on Transnational Organized Crime and Drug Trafficking (UNTF) is co-chaired by UNODC and the UN Department of Political Affairs. The Task Force ensures a coherent and effective response to drugs and crime from the UN system.

The UNTF is comprised of UNODC, the Department of Political Affairs, the Department of Peacekeeping Operations, the Department of Public Information, the United Nations Environment Programme, the Office for Disarmament Affairs, the Peace Building Support Office, the United Nations Children's Fund, the United Nations Development Programme, UN Women and the World Bank. The Geneva-based agencies in the UNTF are WHO, UNAIDS and OHCHR.

The Secretary-General's Policy Committee has called upon the Task Force to provide input into the process leading to UNGASS 2016. The UNTF has been setting objectives encouraging increased participation by the wider UN System and drafting a "One-UN" approach to drugs[70]. The UNTF has called for the application of drug control policies in full conformity with the human rights standards, for the implementation of harm reduction and for the rebalancing of drug control with a stronger focus on human rights, public health and social aspects of the drug issue. The UNTF also requested its members to draft and publish reports on their mandates and the world drug problem.

4. The Global Fund to fight AIDS, Tuberculosis and Malaria

Created in 2002, The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) quickly became the biggest international donor for harm reduction programmes [71]. GFATM is a public-private partnership comprising governments, civil society, international organisations, and private philanthropists. Its governing system is an innovation in global health, as it ensures donors and beneficiaries have equal rights in discussing funds and requires that country demand drives funding.

The global investment in harm reduction services represents USD 160 million, although UNAIDS calculated the need to be USD 2.3 billion in 2015, reducible to USD 1.5 billion in 2020, in order to cover all those who need services [72]. Between 2002 and 2009, GFATM invested USD 430 million in services for harm reduction and in 2010 approved a funding reserve for HIV key populations and an additional fund of USD 152 million for PWID [73]. Eleven percent of the total funding of HIV programmes during the tenth funding round was dedicated to the response among PWID [74].

Nevertheless, in 2013, after GFATM had received USD 12 billion from donor countries and other partners, it announced that it would focus its investments on the countries with the lowest revenues and the highest burden of diseases, in order to have the highest impact as part of its New Funding Model [75]. This new funding model still focuses on key populations and bases the HIV response on human rights; however, its focus on national income and funding low-income countries according to the World Bank's ranking undermines the HIV response to PWID and endangers harm reduction programmes where they are most needed. The fact is that approximately 70% of the world's poorest people live in middle-income countries, which are home to the concentrated HIV epidemic among PWID [76]. Low- income countries will account for only 13% of people living with HIV in 2020.

GFATM continues to promote harm reduction as an effective and necessary tool for the HIV response [77]. It calls on the beneficiaries of its funds to implement the nine harm reduction interventions developed by WHO, UNODC and UNAIDS [78].

Recommendations for GFATM

- → Donor states, recipients and global policy-makers should support the mandate of GFATM, sustain its funding, recognise the need for evidence-based harm reduction services and lift the punitive policies faced by service providers who implement harm-reduction.
- → GFATM's vision of country ownership and shared responsibility[79] must continue to sustain the programmes it has successfully helped to build. It should also join the UNGASS debate to remind member states of the negative impact of the current drug policies on its work, on the funding of harm reduction, and on the response to HIV, Tuberculosis and Hepatitis.

5. The International Labour Organization

The International Labour Organization (ILO) should play a prominent role in the debate on drug policy reform as the use of psychotropic substances may affect work performance, and cause accidents and injuries in the workplace, resulting in worker suffering and economic losses. In 2009, the global workforce (aged 15 and beyond), represented over 3 billion people [80] including employed (76.1%) and unemployed persons [81]. It is also estimated that between 3.5% and 7% (162 million-324 million) of the same global demographic, had used an illicit drug in 2012 [82].

The preamble to ILO's Constitution declares that states parties should protect "the worker against sickness, disease and injury arising out of his employment" [83]. In fact, ILO's Conference has ratified several binding and non-binding mechanisms to ensure the protection of people who use drugs from discriminatory policies within their workplace. Resolutions have stated that all workers should receive information about substance use and that employers should provide counselling and treatment to all in need. Among the binding mechanisms is the 1981 Convention concerning Occupational Safety and Health and the Working Environment, which states that health in work includes "the physical and mental elements affecting health which are directly related to safety and hygiene at work" [84]. The Convention is supported by the non-binding 1981 Recommendation concerning Occupational Safety and Health and the Working Environment [85].

The 1985 Convention concerning Occupational Health Services states that employers, workers and their representatives should "establish and maintain a safe and healthy working environment which will facilitate optimal physical and mental health in relation to work" as well as the "adaptation of work to the capabilities of workers in the light of their state of physical and mental health" [86]. This statement relates directly to the role of all stakeholders in the workplace not only to ensure prevention, treatment and support for people who use drugs, but also to provide opioid maintenance therapy and harm reduction. In fact, it mandates the provision of substitution therapy for problematic drug users to stabilise their condition and consumption levels. This allows them to fulfil their professional duties while in treatment, avoiding the risk of adverse health consequences that have direct consequences on productivity.

ILO has not been involved in the ongoing international debate around UNGASS. Nevertheless, it produced a set of recommendations in the late 1990s to manage issues related to illicit use of substances in the workplace [87]. These recommendations could have an impact if they are updated and shared widely, as they recognised the difficulty of attaining the objective of a drug-free workplace. Realistic policies to reduce the adverse consequences of illicit use produce the highest

results for employers and employees alike. The code of practice, intended for all workplaces, private and public alike, stated that workplace drug policies should aim to prevent and reduce drug related-problems, and that drug issues are health issues and not a matter for the criminal justice system. The ILO takes the position that workplace drug policies should be drafted in consultation with workers' and employers' unions, that workplace drug testing involves moral, ethical and legal components and should be used in extremely limited cases, and that employers should not discriminate against individuals based on previous or current drug use.

Within its mandate and mission to promote social justice and protect human and labour rights, ILO should play an active role in the UNGASS 2016. Within its global strategy on occupational safety and health[88], the organisation has the responsibility of protecting workers who use drugs from discrimination, loss of employment, and abusive policies.

Recommendations for ILO

- → ILO should reiterate its call to end the criminalisation of drug use, as well as its recommendation that drug-related problems should be addressed as health issues and covered by the health insurance schemes.
- → The involvement of ILO in the UNGASS 2016 process should take the form of a strong report, endorsed by employer and labour unions through the ILO Conference, highlighting how drug policy and workplaces interact, examining the best pathways to manage drug use in workplaces and identifying the necessary reforms to protect the health and rights of drug users in their workplace.

6. The Office of the High Commissioner for Refugees

People who use drugs face specific social challenges in refugee camps, which are both causal and consequential of drug use, but are largely triggered by their extreme vulnerability. Moreover, drug related harms among refugees who use drugs are more related to lack of services than to the harms of the substances themselves[89]. This does not mean that illicit substance use is a direct result of the specific situation in each refugee camp, because use is common across different camps and in the larger society, but that most of them provide inadequate services for people who use drugs.

The United Nations Office of the High Commissioner for Refugees (UNHCR) covers 13 million displaced people according to 2014 data, whether in camps, in urban settings, or in other forms of shelter. Over five million people live in refugee camps in the Middle East, run by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)[90]. Among these displaced populations, the most vulnerable are even more stigmatised and discriminated against. People who use drugs increase their consumption to cope with displacement's social, physical and psychological challenges, while many others are initiated into drug use[91]. In emergency situations and in refugee camps, drug-dependent persons who were in harm reduction programmes suffer from disruption of substitution treatment, which could endanger their lives and have certain consequences on the rest of the population. UNHCR should engage in the debate around UNGASS 2016 to give input on the challenges posed by drug use and by drug policies in refugee settings, as the following examples show.

A UNODC study in the North-West Frontier Province of Pakistan, which covered eighteen Afghan refugee camps, revealed that the prevalence of drug use was 2.6%. Moreover, the study insisted that this number was actually much higher, as women and children might use opium orally without admitting it. Customary and cultural use of illicit substances makes collection of accurate data a challenge. Overall, drug use and non-medical use of prescription drugs exceeded 15% in those eighteen camps[92]. Moreover, in the neighbouring urban centre of Peshawar, eight percent of PWID were Afghan refugees[93].

In the Palestinian refugee camps in Lebanon, home to 50% of the 470,000 Palestinian refugees[94], recent reports have cited the use of diverted prescription medicines as party drugs. Prescription drugs are readily available in unregulated camp pharmacies because the refugee camps are not governed by the Lebanese authorities. Tramadol and Xanax are frequently the most diverted medications, but the unstable situation in the camps makes collection of accurate data a challenge[95].

UNHCR looked into the social and health issues related to drug use by developing tools to assess illicit use of controlled substances among refugees. Its joint assessment guide with WHO recognised that the biggest health issues related to drug use are overdose, intoxication, severe withdrawal symptoms in case of interrupted opiate supplies, as well as the increase in infectious and blood-borne diseases due to unsafe injecting and the unavailability of harm reduction services[96]. Its joint guide with UNAIDS provides the tools to assess HIV vulnerabilities among PWID within internally displaced populations[97].

Recommendations for UNHCR

- The Refugee agency needs to recognise the negative social, security and public health impacts of the drug control regime on its work. UNHCR, through the 1951 Convention Relating to the Status of Refugees[98], bases its mandate on the Universal Declaration of Human Rights and should therefore use the UNGASS as a platform to call for more humane and effective drug policies among refugees, internally displaced populations and in emergency or post-conflict situations.
- UNHCR should monitor and assess the social and health harms resulting from drug policies; It should publish these results; and convene along with the INCB and UNODC a global consultation on drug control and the availability of controlled medicines in refugee camps, in order to identify the best policies in response to the vulnerabilities refugees face.

Concluding comments

The UNGASS is a member state-led process. Member states rely on the UN entities, other regional and international organisations, the scientific community and civil society for technical expertise and consultation. Many CND member states claim that, since CND's mandate is drug control, discussions around public health, the use of death penalty for drug-related offences, torture, discrimination and related topics belong to other fora. This paper has argued that, given that drug control impacts all of these issues, the UNGASS must provide a dialogue platform for all affected entities, be it UN agencies or other stakeholders.

The Geneva-based organisations are best-placed to provide the evidence to ground arguments for humane drug policies based on public health and human rights. UNAIDS, GFATM, ILO and UNHCR should all produce position papers on the real impact of punitive drug laws on their mandates and discuss how these impact implementation of their policies on the ground. Some UN agencies already produced reports to inform the UNGASS process, like the United Nations Development Programme[99], WHO or UN Women[100]. Such position papers can trigger a process of periodic assessment that will provide indicators to measure the effectiveness of drug policies and their results in achieving safer, healthier and protective environments for all.

Member states must also improve coordination efforts in different multilateral fora, by presenting and adopting resolutions in the WHA and the International Labour Conference, just as they did at the HRC. A comprehensive and coordinated member state approach in all multilateral fora is essential if UNGASS is to be a platform for shared experiences, where member states can design drug policies based on human rights and to allow international organisations to effectively collaborate to address the world drug problem.

Acknowledgements

The author sincerely thanks Professor Michel Kazatchkine for his valuable guidance in the drafting of this paper. He also thanks Dr Michaela Told for her comments and continuous support.
This paper continues the discussion started during the public event "Time to Revisit Drug Policies-Towards the UNGA Special Session on Drugs" organised by the Global Health Programme on Monday 17 November 2014. More details and analysis can be found in the Policy Brief of the event: http://graduateinstitute.ch/files/live/sites/iheid/files/sites/globalhealth/ghp-new/publications/pb/PB_Drugs_final-4-1.pdf

BIBLIOGRAPHY

1. Visiting Fellow, Global Health Programme, Graduate Institute of International and Development Studies, Geneva
2. Single Convention on Narcotic Drugs. The United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, New York: 1961.
3. Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. Commission on Narcotic Drugs, Vienna: 2009.
4. Declaration on the Guiding Principles of Drug Demand Reduction, resolution S-20/3. United Nations General Assembly, New York: 1998.
5. Measures to enhance international cooperation to counter the world drug problem, resolution S-20/4. United Nations General Assembly, New York: 1998.
6. International cooperation against the world drug problem, resolution A/RES/67/193. United Nations General Assembly, New York: 2012.
7. The UN General Assembly Special Session on Drugs (UNGASS) 2016. International Drug Policy Consortium. http://idpc.net/policy-advocacy/the-un-general-assembly-special-session-on-drugs-un-gass-2016, accessed 4 June 2015.
8. International cooperation against the world drug problem, resolution A/RES/69/201. United Nations General Assembly, New York: 2014.
9. Constitution of the World Health Organization. World Health Organization, http://www.who.int/governance/eb/who_constitution_en.pdf, accessed 9 June 2015.
10. The War on Drugs and HIV/AIDS: How the Criminalization of Drug Users Fuels the Global Pandemic. London: 2012 / The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic. Geneva: 2013 / The Negative Impact of Drug Control on Public Health: The Global Crisis of Avoidable Pain. Kuala Lumpur: 2015. Global Commission on Drug Policy.
11. Single Convention on Narcotic Drugs. The United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, New York: 1961.
12. Reduction of demand for illicit drugs, resolution WHA43/11. World Health Assembly, Geneva: 1990.
13. Convention on Psychotropic Substances. United Nations, Vienna: 1971.
14. Guidance on the WHO review of psychoactive substances for international control. World Health Organization, Geneva: 2010.
15. The Expert Committee on Drug Dependence. World Health Organization, http://www.who.int/medicines/areas/quality_safety/ECDD/en/, accessed 9 June 2015.
16. Seya MJ, Gelders SFAM, Achara OU, Milani B et al. A First Comparison between the Consumption of and the Need for Opioid Analgesics at Country, Regional and Global Level. J Pain & Palliative Care Pharmacother, 2011; 25:6-18.
17. Ibid.

18. Duthey B, Scholten W. Adequacy of opioid analgesic consumption at country, global, and regional levels in 2010, its relationship with development level, and changes compared with 2006. J Pain Symptom Manage. 2014 Feb;47(2):283-97. doi: 10.1016/j.jpainsymman.2013.03.015.
19. Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines. World Health Organization, Geneva: 2011.
20. 19th WHO Model List of Essential Medicines. World Health Organization, Geneva: 2015.
21. Cancer prevention and control, resolution WHA58/22. World Health Assembly, Geneva: 2005.
22. Strengthening of palliative care as a component of comprehensive care throughout the life course, resolution WHA67/19. World Health Assembly, Geneva: 2014.
23. Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage, resolution WHA68/31. World Health Assembly, Geneva: 2015.
24. The Gap Report. Joint United Nations Programme on HIV/AIDS, Geneva: 2014.
25. Injecting drug use, HIV/AIDS. World Health Organization, http://www.who.int/hiv/topics/idu/about/en/, accessed 7 August 2015.
26. The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic. Global Commission on Drug Policy, Geneva: 2013.
27. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS, Geneva: 2009.
28. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS, Geneva: 2009.
29. Prevent Hepatitis: Harm Reduction. World Hepatitis Alliance, London: 2015.
30. Guidance on prevention of viral hepatitis B and C among people who inject drugs. World Health Organization, Geneva: 2012.
31. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. World Health Organization, Geneva: 2014.
32. Perspectives on Drugs: Hepatitis C treatment for injecting drug users. European Monitoring Centre for Drugs and Drug Addiction. Lisbon: 2015.
33. Guidelines for the screening, care and treatment of persons with hepatitis C infection. World Health Organization, Geneva: 2012. World Health Organization, Geneva: 2012.
34. Hepatitis, resolution WHA67/6. World Health Assembly, Geneva: 2014.
35. Taylor LE, Swan T, Matthews GV. Management of Hepatitis C Virus/HIV Coinfection Among People Who Use Drugs in the Era of Direct-Acting Antiviral–Based Therapy. Clin Infect Dis. (2013) 57 (suppl 2): S118-S124. doi: 10.1093/cid/cit326
36. Walsh N, Maher L. HIV and viral hepatitis C coinfection in people who inject drugs: implications of new direct acting antivirals for hepatitis C virus treatment. Curr Opin HIV AIDS. 2012 Jul;7(4):339-44. doi: 10.1097/COH.0b013e328354131e.

37. WHO's role, mandate and activities to counter the world drug problem: a public health perspective. World Health Organization, Geneva: 2014.
38. World Drug Report 2014. United Nations Office on Drugs and Crime, Vienna: 2014.
39. Promoting measures to prevent drug overdose, in particular opioid overdose, resolution 55/7. Commission on Narcotic Drugs, Vienna: 2012.
40. Information sheet on opioid overdose, November 2014. World Health Organization, http://www.who.int/substance_abuse/information-sheet/en/, accessed 10 June 2015.
41. Opioid overdose: preventing and reducing opioid overdose mortality. United Nations Office on Drugs and Crime, World Health Organization, Vienna: 2013.
42. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. World Health Organization, Geneva: 2009.
43. WHO's role, mandate and activities to counter the world drug problem: a public health perspective. World Health Organization, Geneva: 2014.
44. Study on the impact of the world drug problem on the enjoyment of human rights, Report of the United Nations High Commissioner for Human Rights A/HRC/30/65. Human Rights Council, Geneva: 2015.
45. Contribution of the Human Rights Council to the special session of the General Assembly on the world drug problem of 2016, resolution A/HRC/28/L.22. Human Rights Council, Geneva: 2015.
46. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak: Study on the phenomena of torture, cruel, inhuman or degrading treatment or punishment in the world, including an assessment of conditions of detention, report A/HRC/13/39/Add.5. Human Rights Council, Geneva: 2010.
47. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, note by the Secretary-General A/65/255. United Nations General Assembly, New York: 2010.
48. Single Convention on Narcotic Drugs. The United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, New York: 1961.
49. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, report A/HRC/22/53. Human Rights Council, Geneva: 2013.
50. Report of the Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo, note by the Secretary-General A/68/340. United Nations General Assembly, New York: 2013.
51. Quintana Aranguren JJ. Cross-regional statement on Drugs and Human Rights, General Debate, Item 8. Human Rights Council, Geneva: 2014.
52. Statement by Ms. Navi Pillay, High Commissioner for Human Rights, High Level Review of Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. Commission on Narcotic Drugs, Vienna: 2014.
53. Pillay N. Side event: World Drug Problem on Human Rights. Office of the High Commissioner for Human Rights, Geneva: 2014.

54. Study on the impact of the world drug problem on the enjoyment of human rights, Report of the United Nations High Commissioner for Human Rights A/HRC/30/65. Human Rights Council, Geneva: 2015.
55. The Global State of Harm Reduction 2014. Harm Reduction International, London: 2014.
56. Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, resolution A/RES/65/277. United Nations General Assembly, New York: 2011.
57. Agenda item 11: Halving HIV transmission among people who inject drugs, background note. Joint United Nations Programme on HIV/AIDS, Geneva: 2014.
58. The Gap Report. Joint United Nations Programme on HIV/AIDS, Geneva: 2014.
59. Joint Statement: Compulsory drug detention and rehabilitation centres. Joint United Nations Programme on HIV/AIDS, Geneva: 2012.
60. Amon JJ, Pearshouse R, Cohen JE, Schleifer R. Compulsory drug detention in East and Southeast Asia: evolving government, UN and donor responses. Int J Drug Policy. 2014 Jan;25(1):13-20. doi: 10.1016/j.drugpo.2013.05.019.
61. Global Partnerships, document A/68/L.51. United Nations General Assembly, New York: 2014.
62. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS, Geneva: 2009.
63. The Global State of Harm Reduction 2014. Harm Reduction International, London: 2014.
64. Schwartländer B, Stover J, Hallett T, Atun R et al. Towards an improved investment approach for an effective response to HIV/AIDS. Lancet, 2011. DOI: http://dx.doi.org/10.1016/S0140-6736(11)60702-2
65. The Global State of Harm Reduction 2014. Harm Reduction International, London: 2014.
66. HIV and AIDS in Switzerland: Charts. Federal Office of Public Health. http://www.bag.admin.ch/hiv_aids/05464/12908/12909/12915/index.html?lang=en accessed 2 June 2015.
67. Dutta A, Wirtz A, Stanciole A, Oelrichs R, et al. The Global Epidemics among People Who Inject Drugs. World Bank. Washington, DC: 2013.
68. Shoptaw S, Montgomery B, Williams CT, El-Bassel N et al. Not Just the Needle: The State of HIV Prevention Science among Substance Users and Future Directions. J Acquir Immune Defic Syndr. 2013 July ; 63(0 2): S174–S178. doi:10.1097/QAI.0b013e3182987028.
69. 90–90–90 - An ambitious treatment target to help end the AIDS epidemic. Joint United Nations Programme on HIV/AIDS. Geneva: 2014.
70. UN System Task Force on Transnational Organized Crime and Drug Trafficking. Special Session of the United Nations General Assembly on the World Drug Problem. https://www.unodc.org/ungass2016/en/un-system-task-force.html (accessed 21 August 2015)
71. Cook C, Bridge J, McLean S, Phelan M et al. The funding crisis for harm reduction: Donor retreat, government neglect and the way forward. Harm Reduction International, International Drug Policy Consortium, International HIV/AIDS Alliance, London: 2014.
72. Schwartländer B, Stover J, Hallett T, Atun R et al. Towards an improved investment approach for an effective response to HIV/AIDS. Lancet, 2011. DOI: http://dx.doi.org/10.1016/S0140-6736(11)60702-2

73. Statement by Dr Mark Dybul, Executive Director of the Global Fund to fight AIDS, Tuberculosis and Malaria. Harm Reduction Requires Strong Political Commitment. International Harm Reduction Conference, Vilnius: 2013.
74. Cook C, Bridge J, McLean S, Phelan M et al. The funding crisis for harm reduction: Donor retreat, government neglect and the way forward. Harm Reduction International, International Drug Policy Consortium, International HIV/AIDS Alliance, London: 2014.
75. Funding Model. Global Fund to fight AIDS, Tuberculosis and Malaria. http://www.theglobalfund.org/en/fundingmodel/, accessed 8 June 2015.
76. Undermining the Global Fight, The Disconnect between the Global Fund's Strategy and the Real-life Implications of the New Funding Model. Open Society Foundations, New York: 2015.
77. Information Note: Harm Reduction for People Who Use Drugs. The Global Fund to fight AIDS Tuberculosis and Malaria, Geneva: 2015.
78. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS, Geneva: 2009.
79. Panel 1: Shared responsibility– a new global compact for HIV, 2011 High Level Meeting on AIDS. United Nations General Assembly, New York: 2011.
80. Data. The World Bank. http://data.worldbank.org/indicator/SL.TLF.TOTL.IN/countries?display=graph, accessed 2 June 2015.
81. Jobs data. The World Bank. http://datatopics.worldbank.org/jobs/#, accessed 2 June 2015.
82. World Drug Report 2014. United Nations Office on Drugs and Crime, Vienna: 2014.
83. ILO Constitution. International Labour Organization, Versailles: 1919.
84. Occupational Safety and Health Convention, 1981 (No. 155). International Labour Organization, Geneva: 1981.
85. Occupational Safety and Health Recommendation, 1981 (No. 164). International Labour Organization, Geneva: 1981.
86. Occupational Health Services Convention, 1985 (No. 161). International Labour Organization, Geneva: 1981.
87. Management of alcohol and drug-related issues in the workplace, an ILO code of practice. International Labour Organization, Geneva: 1996.
88. Global strategy on occupational safety and health. International Labour Organization, Geneva: 2003.
89. Streel E, Schilperoord M. Perspectives on alcohol and substance abuse in refugee settings: lessons from the field. Intervention 2010, 8(3), 268-275.
90. Refugee figures. The United Nations Refugee Agency. http://www.unhcr.org/pages/49c3646c1d.html, accessed 8 June 2015.
91. People Who Inject Drugs. HIV in Humanitarian Emergencies, http://his.unhcr.org/aae/?page_id=426#_ftn1, accessed 8 June 2015.

92. Hussain H, Qayum A. Situational Analysis of Drug Users in Afghan Refugees Camps of NWFP, Pakistan. United Nations Office on Drugs and Crime, Vienna: 2005-2006.
93. Addressing HIV amongst Most-at-Risk Populations in Humanitarian Settings: Afghan Refugee Drug Users in Peshawar, Pakistan. United Nations High Commissioner for Refugees, Geneva: 2010.
94. Hussain H, Qayum A. Refugees in the Near East, http://www.unrwa.org/activity/health-lebanon, accessed 8 June 2015.
95. Nashed M. Palestinian refugees struggle with drugs. Aljazeera, http://www.aljazeera.com/news/middleeast/2014/03/palestinian-refugees-20143411657852453.html, accessed 8 June 2015.
96. Rapid Assessment of Alcohol and Other Substance Use in Conflict-affected and Displaced Populations: A Field Guide. United Nations High Commissioner for Refugees, World Health Organization, Geneva: 2008.
97. HIV-related Needs in Internally Displaced Persons and Other Conflict-affected Populations: A Rapid Situation Assessment Tool. United Nations High Commissioner for Refugees, Joint United Nations Programme on HIV/AIDS, Geneva: 2007.
98. 1951 Convention Relating to the Status of Refugees. United Nations Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons, Geneva: 1951.
99. Schleifer R, Sagredo J, Avafia T. Addressing the Development Dimensions of Drug Policy. United Nations Development Programme, New York: 2015.
100. A Gender Perspective on the Impact of Drug Use, the Drug Trade, and Drug Control Regimes. United Nations Entity for Gender Equality and the Empowerment of Women, New York: 2014.

THE GRADUATE INSTITUTE GENEVA

INSTITUT DE HAUTES ÉTUDES INTERNATIONALES ET DU DÉVELOPPEMENT

GRADUATE INSTITUTE OF INTERNATIONAL AND DEVELOPMENT STUDIES

graduateinstitute.ch/globalhealth