

**Contribution from the Civil Society Forum on Drugs
to the 3rd intersessional meeting of the 63rd session of the Commission
on Narcotic Drugs – 19 to 21 October 2020**

**Topic: Accessibility and availability of internationally controlled
substances for medical and scientific purposes**

October 2020

The Civil Society Forum on Drugs in the EU (the ‘CSFD’) welcomes the opportunity to contribute with this submission to the forthcoming 3rd intersessional meeting of the 63rd session of the Commission on Narcotic Drugs (CND), which will take place from 19 to 21 October 2020. This contribution will focus on Thematic session 3, namely on the availability of internationally controlled substances for medical and scientific purposes. This paper refers mainly to opioids and not to other essential and non-essential controlled substances.

1. Summary

People with serious health-related suffering across the world lack of accessibility and availability of opioids for the management of pain, treatment of opioid dependence and other symptoms – especially in low-income countries. Despite the fact that the objective to ensure access to medicines is included in the preamble to the 1961 Convention, there are barriers at many levels – governmental, health care professionals and the public. The International Narcotic Control Board has raised this issue and has criticized member states for failing to provide access. There is a disproportionate emphasis on control while neglecting availability, thus fuelling the current scarcity in access to pain relief. This is especially striking, as at its inception the scheduling system was justified as a mechanism to increase access to medicine.

Clear national guidelines, increased public awareness and the increasing education of health care professionals are necessary for the safe and effective medical use of opioids for people in pain, resulting in a reduction in suffering, whilst minimising the risks of opioid diversion. A human rights perspective that regards access to medicines as an integral part of the right to health, and the right to be free from torture and other forms of cruel, inhuman and degrading treatment, needs to be integrated, highlighting that restrictions must be based on evidence, and strictly proportionate.

2. Introduction: A global overview

Evidence for the use and efficacy of potent opioids, such as morphine, for the management of moderate to severe pain is well-documented and evaluated. Many people develop pain, particularly towards the end of life. Over 70% of patients with advanced cancer will experience severe pain at some time in the progression of the disease, but pain is also very

common in other diseases, such as heart disease, respiratory disease and neurological disease.

Furthermore, there is a geographical component to the distribution of opioid use: especially in low-income countries people with serious health-related suffering across the world lack of accessibility and availability of opioids for the management of pain, treatment of opioid dependence and other symptoms.

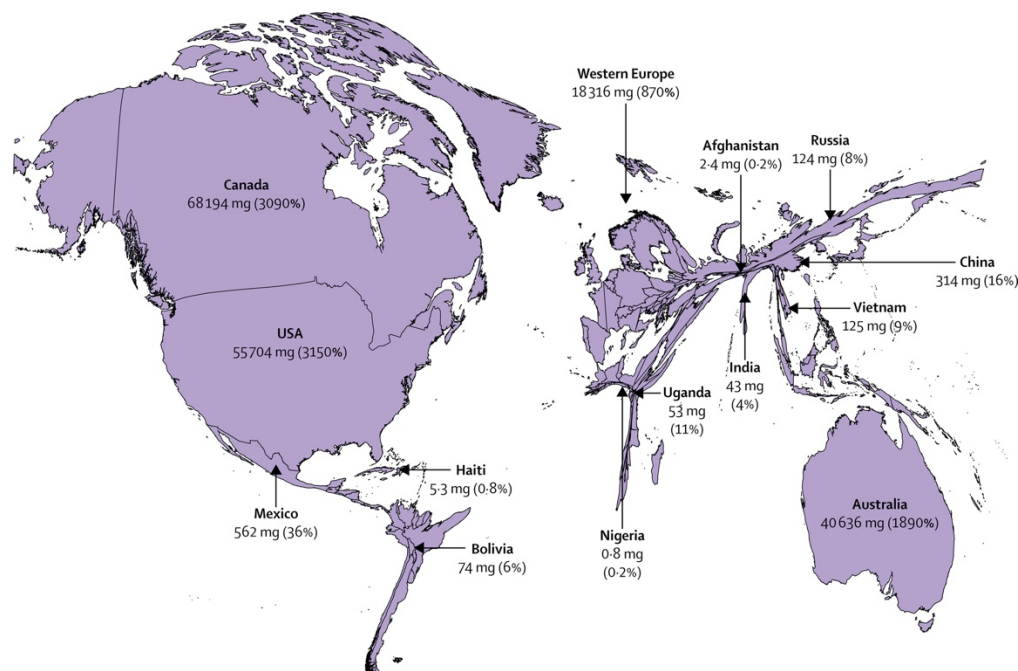


Figure: Distributed opioid morphine-equivalent (morphine in mg/patient in need of palliative care, average 2010–13), and estimated percentage of need that is met for the health conditions most associated with serious health-related suffering. Source; Knaul FM, Farmer PE, Krakauer EI, et al (2017)

The need for palliative care and pain management is increasing globally, as more people are living longer, and are diagnosed with non-communicable diseases, such as cancer, heart disease, and diabetes among others. The need for pain management will increase as at present there are 14.1 million new cases of cancer worldwide annually in 2012, with 8.2 million deaths, and this is expected to increase to 20 million new cancer cases by 2025 (International Agency for Research on Cancer 2014). In the EU in 2018 there were 3.9 million new cases of cancer annually with 1.9 million deaths. Other people who require access to adequate pain management include older persons, children, those suffering from traumatic injuries and violence, post-surgical pain, and obstetrical complications (WHO 2011) as well as people with mental health problems (posttraumatic stress disorders, depression).

Similarly, there is decades of evidence to support the efficacy of opioid substitution therapy (OST), such as methadone, for the treatment of drug dependence. Globally, there is significant unmet need for opioids for treatment of drug dependence, with opioid substitution therapy available in just 84 countries around the world, notwithstanding the fact that 179 countries report evidence of injection drug use. UNODC estimates there are 11.3 million people who

inject drugs globally and the World Health Organization recommends that 40 in every 100 people who inject opioids are offered opioid substitution therapy. A systematic review in 2017 concluded that there is low coverage of OST globally; with an average of only 19 OST recipients per 100 people who inject opioids.

The availability of opioid medication varies greatly across the world. Of the 298.5 million tonnes of opioids produced every year, only 0.1% are available in low-income countries. 90.5% of the morphine consumption in 2013 was from Europe, USA, Canada, Australia, New Zealand and Japan, although these countries account for only 18.9% of the population (Human Rights Watch 2015). WHO estimates that 5 billion people live in countries with low or no access to controlled medication, and there is insufficient access to treatment for severe or moderate pain in over 150 countries. For instance, in Haiti the use is 5mg morphine equivalent/ patient in need / year (1% of the need), whereas in Canada the use is 68,000mg/patient in need /year (3090% of the need) (Knaul et al, 2018).

Even in Europe, the ATOME study found that opioid consumption is low or very low in 12 countries, with many restricting the use by legislation (Linge-Dahl et al 2015). There was evidence of lack of education of the public and health care professionals, lack of knowledge about opioids, a reduced recognition of pain assessment, problems in reimbursement and limitations in the availability of opioids (Linge-Dahl et al 2015). The Adequacy of Consumption Index allows the comparison of opioid consumption across Europe. The baseline of 100% was calculated from the average consumption of the top 20 countries in Europe in 2013. The ACM for the top 3 European countries is 127% but there is a large variation with Denmark at 189% whereas the levels in other countries are very low – Cyprus 4%, Estonia 6%, Lithuania 12% (Vraken et al 2018). Other studies estimated that opioid underuse in long care facilities – the estimated prevalence of deceased residents in the last week of life without an opioid prescription - and found that this again was very variable with an estimated level of 19% for Netherlands but 79% in Poland (Tanghe et al 2020).

Availability of OST is even more critically limited in prisons (and other detention settings). This is despite the significant number of people who inject drugs who are incarcerated, and the fact that OST is recognized by UNODC and WHO as an essential intervention for HIV prevention, treatment and care in prisons. As of 2020, OST is only available in at least one prison in 59 countries worldwide – and even where available its accessibility and quality are often substandard (for example, OST may be available only in some prisons or prison sections, and/or only accessible to individuals who were on OST prior to incarceration).

3. International commitments on the availability of controlled substances

The preambles of the drug treaties underscore that the medical use of most substances is “indispensable”, and that their availability should not be unduly restricted. Indeed, facilitating access to controlled substances is one of the two core goals of the international drug system, even though the UN system and Member States have so far failed at securing this goal (International Drug Policy Consortium, 2016).

In recent years, UN Member States and international bodies have addressed the lack of accessibility and availability of controlled substances in a number of documents:

- At the 2016 UNGASS, **UN Member States** committed to addressing the existing barriers to the availability and accessibility to controlled substances for medical and scientific use, *“including those related to legislation, regulatory systems, health-care systems, affordability, the training of health-care professionals, education, awareness-raising, estimates, assessment and reporting”*, amongst others. (UNGASS 2016).
- The **UNODC** has pushed for improving accessibility, within the framework of the human right to access pain relief. The resulting report included recommendations on integration of systems, increased awareness and education and management of the supply chain to improve access (UNODC 2018).
- The **World Health Organisation** at the 71st World Assembly on Health in 2018 stressed the need for availability of all medication, as part of Universal Health Coverage (WHO 2018) reinforcing the earlier WHO Access to Controlled Medications Programme in 2007, which outlines the need for an Essential Model of medications, including opioids (WHO 2007).
- The **International Narcotics Control Board** have reported that there has been a global increase in the use of opioids but there is still a great disparity and there has been a reduction in the availability within low-income countries (INCB 2019). 92 countries had less than 20% of their pain treatment needs met by morphine that was available for use.
- The **European Union** has been issuing clear statements in support of greater availability and accessibility of controlled substances for medicinal purposes. At a CND intersessional meeting in September 2018, it made clear that it fully appreciated the importance of the topic, and suggested projects to provide access without inadvertently aiding or abetting their diversion (EU 2018). At the 63rd session of the CND, Croatia, togated with Australia, presented a resolution to the Commission on Narcotic Drugs (E/CN.7/2020/L.4) at the CND meeting in March 2020, to promote the awareness-raising, education and training to ensure access to availability of controlled substances for medical and scientific purposes. The resolution was later adopted at the CND.
- In 2019, the UN Chief Executives Board for Coordination agreed upon a UN Common Position on Drug Policy (‘United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration’). The Common Position provides that relevant UN agencies should enhance access to controlled medicines for legitimate medical and scientific purposes,

including the relief of pain and treatment of drug dependence’; and highlights important human rights considerations.

Thus, there is increasing awareness across many regional and global institutions that there is need to increase the availability and accessibility to controlled medicines pain and symptom management.

4. The availability of controlled substances for medical use, from a human rights perspective

In recent years, a number of UN human rights bodies have approached the issue of availability of controlled medicines under the light of international human rights law. These include:

- In 2015, the UN Independent Expert on the enjoyment of all human rights by older persons made clear that the failure to ensure access to controlled medicines for the relief of pain and suffering is a threat to the fundamental right to health, and to the right to be free from cruel, inhuman and degrading treatment (UN Human Rights Council 2015, para. 87).
- In 2020, the UN Special Rapporteur on the right to health urged Member States to safeguard the availability and accessibility of controlled medicines for the treatment of drug dependence, palliative care, and other treatment. In the COVID-19 context, it warned that complex procedural requirements could create unnecessary barriers, and it urged states to simplify control procedures for the export, transportation, storage and provision of medicines containing controlled substances. (UN Special Rapporteur on the right to health, 2020).
- The UN Committee on Economic, Social and Cultural Rights has noted the “effectiveness [of OST] in improving the health and living conditions of persons experiencing drug dependence”; expressed concerns at the lack of OST both in the community and in prisons; and recommended to increase its availability.
- The UN Human Rights Committee has urged states to comply with their “obligation to effectively protect [...] against the pain and suffering associated with the withdrawal syndrome” and to ensure that timely, adequate and scientifically based medical assistance to counter withdrawal symptoms is available in practice. Similarly, the Committee has clarified that a human rights approach to drug use requires a focus on healthcare, including opioid substitution therapy for people with a drug dependence.

We call on the EU and its Member States to refer to these documents in their statements in the thematic session on availability of controlled medicines, and to consistently integrate a

human rights perspective in discussions regarding the availability of controlled substances for medical use (see next section for an example).

5. Concerns over Opioid Use Disorder and the Opioid Crisis

Restrictive policies on the prescription of medicines can operate as a major barrier to availability. In many cases they are based on the concern that patients might develop drug dependence or overdose (UNODC 2011), with such worries voiced by many stakeholders. At the same time, in certain countries such as the USA, there has been a large increase in opioid use together with a growth in opioid dependence which has led to restrictions. Additionally, the effectiveness of opioids for managing chronic non-cancer pain has also been questioned, and some health authorities are considering advising against the dispensation of opioids for chronic primary pain.

A balance must be struck to address these concerns, balancing between ensuring that restrictions do not lead to patients with pain not receiving the medication they require, resulting also in distress for their families and carers and preventing opioid related harm.

A human rights approach should also be integrated in these debates. Under international human rights law, States have an obligation to safeguard the availability and accessibility of controlled medicines for the treatment of drug dependence, palliative care, and other treatment; restrictions to access can constitute a violation of the right to health, if they are disproportionate, or unnecessary. (See Global Commission on Drug Policy, 2015). Therefore, all restrictions should be clearly based on evidence.

6. Need for training

The use of opioid medication for medical use is complex, as part of the wider assessment and management of pain and other symptoms. In many countries there is little education of health care professionals in the assessment and management of pain, and other symptoms. In a 2018 survey, the International Narcotics Control Board found that only 71 countries (62% of those who answered) reported that palliative care was in the curriculum; continued education on palliative care and training on the rational use of controlled drugs were only found in only 72 (63%) of countries (INCB 2019).

Good education and training of healthcare professionals will ensure the safe and timely administration of opioid medication. The concerns surrounding the use of opioids may result in practitioners underestimating patients' pain and subsequently result in the underuse of pain medication. This may be from the concerns of diversion and illegal use, the side-effects of opioids, particularly opioid dependence, or legal investigations. Legislation that restricts the use of opioids may further discourage their use in pain control.

The development of palliative care was endorsed by the World Health Assembly Resolution on Palliative Care in 2014, which urged the global development of an integrated approach to palliative care. The resolution encourages palliative care education and training to include basic, intermediate and advanced training. Importantly, the resolution also suggests that in order to improve access to controlled medicines, opioids and other medication should be included in national essential medicines list, following recent updated to the WHO Model List of Essential Medicines and the WHO Model List of Essential Medicines for Children the WHO Model list of Essential Medicines (World Health Assembly 2014; WHO 2007).

7. Recommended actions

The CSFD would suggest the following actions:

- Pressure at national and international levels for all countries to improve the accessibility and availability of controlled substances for medical and scientific use
- The need to develop National Plans for Pain Management and Palliative Care, including ensuring accessibility and availability of medication and palliative care, as part of Universal Health Coverage
- Education of health professionals, at all levels -as students and postgraduates and as continuing medical education – on the safe and effective use of medication containing controlled substances
- Increased education and awareness of all – governments, health care professionals, legislators, general public - on the effective use of controlled medicines for pain and symptom management
- Ensuring the accessibility and availability of controlled substances for medical and scientific use, when planning other measures relating to safety, harm reduction, drug management and control.
- Need to invest in better evidence and priority settings to adequately measure the global need for palliative care, implement policies and programmes and monitor progress towards alleviating the burden of pain and other types of serious health - related suffering.

The Civil Society Forum on Drugs (CSFD) is an [expert group of the European Commission](#) that was created in 2007 on the basis of the [Commission Green Paper](#) on the role of civil society in drugs policy in the EU. Its purpose is to provide a broad platform for a structured dialogue between the Commission and European civil society which supports drug policy formulation and implementation through practical advice. The CSFD is consistent with the [EU Strategy on Drugs 2013-2020](#) and the new [Action Plan on Drugs 2017-2020](#) both of which require the active and meaningful participation and involvement of civil society in the development and implementation of drug policies at national, EU and international level. Its membership comprises 45 CSOs from across Europe and representing a variety of fields of drug policy, and a variety of stances within those fields. Below is the list of CSFD members for the period 2018-2020:

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| 1. ABD - Associació Benestar i Desenvolupament | 23. Forum Droghe |
| 2. AFEW International | 24. FUNDACIÓN ATENEA |
| 3. AIDES | 25. GAT - Grupo de Ativistas em Tratamentos |
| 4. Ana Liffey Drug Project | 26. HRI - Harm Reduction International |
| 5. APDES - Agência Piaget para o Desenvolvimento | 27. IDPC - International Drug Policy Consortium |
| 6. APH - Association Proyecto Hombre | 28. INPUD - International Network of People who use Drugs |
| 7. ARAS - Romanian Association Against AIDS | 29. IREFREA - Instituto Europeo de Estudios en Prevención |
| 8. Citywide Drugs Crisis Campaign | 30. MAT - Magyar Addiktológiai Társaság |
| 9. De Regenboog Groep | 31. Médicos del Mundo España |
| 10. Dianova International | 32. PARSEC Consortium |
| 11. Diogenis Drug Policy Dialogue | 33. Polish Drug Policy Network |
| 12. EAPC - European Association for Palliative Care | 34. Prekursor Foundation for Social Policy |
| 13. EATG - European AIDS Treatment Group | 35. Proslavi Oporavak |
| 14. ECAD - European Cities Network for Drug Free Societies | 36. Romanian Harm Reduction Network |
| 15. EFSU - European Forum for Urban Security | 37. Rights Reporter Foundation |
| 16. ENLACE | 38. San Patrignano |
| 17. EURAD | 39. SANANIM |
| 18. EuroTC - European Treatment Centres for Drug Addiction | 40. SDF - Scottish Drugs Forum |
| 19. EUSPR - European Society for Prevention Research | 41. UNAD |
| 20. FAD - Fundación de Ayuda contra la Drogadicción | 42. UTRIP |
| 21. Federation Addiction | 43. WFAD - World Federation Against Drugs |
| 22. FEDITO BXL | 44. WOCAD |
| | 45. YODA - Youth Organisations for Drug Action |

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