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Implementation of the international drug control treaties: International cooperation to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes while preventing their diversion

Statement submitted by the International Association for Hospice and Palliative Care, Inc. (IAHPC), a non-governmental organization in special consultative status with the Economic and Social Council**

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 36 and 37 of Economic and Social Council resolution 1996/31.

* E/CN.7/2023/1.
** Issued without formal editing.

The International Association for Hospice and Palliative Care, IAHPC commends the Board of the 65th Commission, particularly the Chair, His Excellency Ambassador Ghislain d'Hoop of Belgium, for the #NoPatientLeftBehind Initiative undertaken with the INCB and the World Health Organization. The sort of inter-agency multilateral cooperation it represents has served as a boost for our global, national, and regional advocacy to improve availability of, and access to, internationally controlled essential medicines on the WHO Model List, Chapter 2. The heads of multilateral agencies involved in drug policy, and even the Office of the High Commissioner for Human Rights, have done their utmost to raise the profile of this issue within the confines of their mandates. It is now up to CND member States to take the political and policy initiatives necessary to implement the recommendations listed in Chapter Two of the Outcome Document of the UN General Assembly Special Session on the World Drug Problem.

The North-American opioid crisis of *excess* opioid availability and overdose – a *regional* public health problem – has dominated political attention and media coverage in recent years, while the media and policymakers overlook the *global* crisis of *availability,* affecting people in more than 80 per cent of the world according to the United Nations agencies. This attention imbalance intimidates national authorities afraid of igniting a public health catastrophe like the one plaguing certain communities in North America. Unaware of best practice supply chain governance for controlled medicines and lacking expert consultation from medical professionals practicing under internationally approved guidelines, decisionmakers have delayed taking the necessary steps to improve availability.

Yet as state Parties to the drug control treaties and to the Vienna Convention on Law of Treaties (1969), which stipulates that "every treaty in force is binding upon the parties to it and must be performed by them in good faith," (Article 26) all CND member States have committed to ensuring that their populations have adequate access to controlled medicines for the relief of suffering. (Single Convention on Narcotic Drugs, 1961 as amended 1972] Fortunately, examples of best practice supply chain governance do exist and expert consultation from councils of medical professionals can assist policymakers to take the necessary steps to improve availability of controlled medicines while avoiding a public health crisis of non-medical use.

Treaty obligations evolve with science and international law. Palliative and addiction medicine – undeveloped when the Single Convention was approved – now allow governments to ensure that their health systems ensure availability of controlled medicines to relieve suffering while preventing diversion and non-medical use. Some best practices available in national and sub-national jurisdictions of countries of all income levels have achieved this balance of legal obligations.

While availability may have improved marginally in a few regions of the world in the last few years, and in a few subnational districts fortunate enough to have health professionals trained in the safe handling and prescription of controlled medicines, much remains to be done to ensure equitable availability. Serious, preventable, health related suffering afflicts more than 80 per cent of the world's people with surgical, obstetric, substance use disorder, and palliative care needs who still lack affordable access.

Affordability of controlled medicines in low-and-middle income countries

A colleague in a small, war-torn Central African country recently told me that morphine tablets, although they only cost 50c each, are unaffordable to most patients experiencing severe pain, either from traumatic wounds or advanced cancer, in his country. Ten 10 mg tablets, or 100 mg, perhaps adequate for a day or two's pain relief for an advanced cancer patient, costs $5 from the pharmacy. This cost is prohibitive for most salaried workers, let alone those in the informal sector, or those who are unemployed. Yet in a high-income country, properly registered prescribers can order

up to 450 mg in a 24-hour period for their patients, paid for by insurance. One patient's suffering was relieved, the other's was not.

The IAHPC recommends the Uganda, Kerala, and Colombia models based on public/civil society partnerships to estimate needs for, and then procure and manage distribution of generic opioids. These are subsidized by the government, which distributes them at no cost to approved palliative care providers and medical facilities for patient use in the public sector. Pharmacists and providers who follow strict safety and stewardship protocols to prevent diversion and non-medical use report no diversion into the illicit market. Moreover, just as production and marketing of generic oral morphine, which relieves pain but does not produce a euphoric high, is unprofitable (and therefore unattractive) to the pharmaceutical industry, it is likewise unattractive to traffickers, whose more lucrative pickings can be found in expensive designer drugs and synthetic fentanyl.

The IAHPC Opioid Price Watch project tracks availability and affordability of morphine in many countries, finding that patients in LMICs and LICs have limited access to generic opioids, although and there are subsidies in place for more expensive medications and formulations.[1] Public pooled procurement by regional organizations such as PAHO Strategic Fund provides another useful model.[2] Pooled public procurement is a key strategy to offset poorly regulated marketing of expensive patented medications by the global pharmaceutical industry.

Recommendations

Responsible authorities in all relevant ministries seeking to improve availability to alleviate preventable suffering can avoid ending up in the North-American cul-de-sac that led to the crisis of excess by:

(1) Including all affected populations, including patients, providers, pharmacists, public servants, academics, and policymakers at all levels of governance in consultations to enact and implement balanced national drug policies that make availability of, and access to, affordable medical opioids for normal clinical practice, research, and treatment of substance use disorder an *obligation* of health systems. The Access to Opioid Medications in Europe (ATOME project) is a useful model for consultations.[3]

(2) Promoting, supporting, and where possible mandating, clinical training of relevant healthcare and law enforcement professionals in the public sector – including pharmacists, regulators, narcotics police, and administrators – in supply chain management and therapeutic benefits of rational opioid use. The model for this is the multistakeholder group convened by the Government of Uganda in partnership with the Palliative Care Association of Uganda and allied professionals.

(3) Instructing drug regulators and relevant health ministry officials at all levels of governance (national and sub-national) to participate in the INCB Learning Programme modules on improving availability under the drug control conventions.

(4) Engaging in cost-effective local manufacturing of generic oral morphine and, where appropriate, cultivation of opium per the limitations of the Single Convention on Narcotic drugs, which allows national production up to five (5) tons of national production per year.

[1] https://hospicecare.com/opioids/reports/map/.
[2] https://www.paho.org/en/paho-strategic-fund.
[3] https://cordis.europa.eu/project/id/222994.