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STRATEGY FOR SUBSTANCE ABUSE REDUCTION

Introduction

1. This document proposes a regional public health strategy to respond to the health problems associated with the use of psychoactive substances¹ in the Americas. A public health approach to substance use disorders focuses on prevention, early intervention, reduction of health and social harms, treatment, rehabilitation, and health systems management. It also takes into account the epidemiology of substance use in populations in which it is both epidemic and endemic. By reducing the demand for psychoactive substances through universal, selective, and indicated prevention measures (1), the public health approach complements supply-control efforts and related criminal justice interventions.

2. The strategy comprises five areas of action: development of national policies and resource allocation; promotion of universal prevention; early intervention, care and treatment systems; research, monitoring, and evaluation; and development of strategic partnerships. The strategy complements the PAHO Strategy and Plan of Action on Mental Health (Document CD49/11),² adopted by the Directing Council in 2009 (Resolution CD49.R17).³

¹ Psychoactive substances, more commonly known as psychoactive drugs, are substances that have the ability to alter an individual's consciousness, mood, or thinking processes. Psychoactive substances act on mechanisms in the brain that normally regulate the functions of mood, thought, and motivation. In this document, the emphasis will be on hypnotics and sedatives, opioids, cannabis, cocaine, amphetamines and other stimulants, hallucinogens, and psychoactive inhalants. Alcohol and nicotine (in tobacco products) are not included because there are covered by other strategies.

² Available at:

http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=2623&Itemid=

³ Available at:

http://new.paho.org/hq/index.php?option=com_content&task=view&id=1640&Itemid=1425&lang=en

Background

3. In response to the growing burden of illness attributable to substance use in the Region, Member States have supported several resolutions and strategies aimed at reducing the impact of individual substances (such as tobacco) and have recognized the need to address broader health concerns, such as HIV/AIDS (Documents CD45/11 [2004], and CD46/20 [2005]), adolescent health (Document CD48/8 [2008]), road safety (Document CD48/20 [2008]), mental health (Document CD49/11 [2009]), and human security (proposed resolution, 2010). PAHO recently published a regional report on drug use epidemiology in the Latin American countries (2). Babor et al. (3) conducted an international review of the scientific evidence on policy approaches to supply control and demand reduction in relation to illicit substances. Illicit substance use information is included in the global school-based student health survey (GSHS) conducted in several countries of the Region.⁴ (See Table 1 in Annex A). The Strengthening Families Program (*Programa Familias Fuertes*)⁵ promotes substance use prevention through the strengthening of communication between youth and parents and prevention of risk behaviors among youth.

4. Substance use and related disorders are part of the Health Agenda for the Americas 2008-2017 and the Strategic Plan 2008-2012, which guide collective action by national, regional, and international actors. In 2009, WHO and the United Nations Office on Drugs and Crime (UNODC) launched a Joint Program on Drug Dependence Treatment, and Care, designed to scale up the application of ethical, evidence-based policies, strategies, and interventions for drug dependence treatment and care in low- and middle-income countries. WHO launched the Mental Health Gap Action Program (mhGAP) in October 2008 to build capacity in middle- and low-income countries as a priority to reduce the burden of mental, neurological, and substance use disorders worldwide. The program is based on Cochrane reviews of the literature on the effectiveness of interventions for alcohol and drug use disorders. The Inter-American Drugs Abuse Control Commission (CICAD) has recently approved (May 2010) a new hemispheric drug strategy. PAHO is well-positioned to provide the health sector with the necessary tools and methodologies to effectively understand and address the causes and consequences of substance use, by integrating and promoting the best practices described in various documents and programs across several organizations.

⁴ See <http://www.who.int/chp/gshs/en/index.html> for more information.

⁵ See http://www.paho.org/spanish/ad/fch/ca/sa-familias_fuertes.htm for more information.

Situation Analysis

5. Although substance use disorders are more prevalent in the developed countries of the Americas, the health burden of such disorders, especially in terms of disability-adjusted life years, is felt disproportionately in low- and middle-income countries. The prevalence of drug use among youth varies greatly, but in general it is concentrated in urban areas in countries undergoing rapid transition, such as Brazil, Colombia, and Mexico. In addition to alcohol and tobacco, the substances mostly widely used in the Region are cannabis, cocaine, and volatile solvents (4).

6. As to demand reduction strategies, the evidence suggests that there are a variety of treatment and early intervention options to address harmful drug use and drug dependence (3, 9). Substantial investments in evidence-based early-intervention and treatment services can reduce drug-related problems. The strongest supporting evidence is for services for opiate-dependent individuals. Such services are also effective in reducing drug-related crime and the spread of HIV infection. Needle exchange programs have also been evaluated favorably because they promote safe injection practices and engage injection drug users in treatment and other health services. School-based drug education and community prevention programs have a very modest impact collectively. Broad-based universal prevention programs that target all aspects of a teenager's life are more promising than purely didactic ones delivered through the classroom, the mass media, or the community. Early intervention programs have shown even more promise (10), especially when screening and brief interventions are conducted systematically in primary care and other health care settings.

7. Substantial evidence supports a range of demand reduction strategies, including those aimed at reducing the risks related to injecting drug use. The challenge is to disseminate these strategies and to organize and offer prevention and treatment services through national or subnational public health systems that will meet the needs of particular populations. These services must have the appropriate allocation of human and financial resources and the political commitment to include a health dimension in all substance-related policies and to broaden access to treatment and care for substance-related health problems.

Strategic Framework

8. The proposed regional public health strategy calls for an expanded role for PAHO in coordinating and implementing a multilateral public health approach to substance use problems in the Region. The promotion of public health measures is designed to complement rather than to supplant exclusive supply control and law enforcement measures to drug use. It also will address the need for the public health sector to devote more attention to vulnerable population groups.

Principles and values

9. The strategy emphasizes the following principles and values:
 - (a) Respect for the right to the enjoyment of the highest attainable standard of health (“right to health”) and other related human rights of persons affected by substance use disorders.⁶
 - (b) Community participation in the design and implementation of drug control policies at the local and national levels, based on the best available scientific evidence.
 - (c) In the context of national budgets, recognition of the social determinants of health as critical factors to be addressed in prevention efforts (e.g., quality education, meaningful employment, alternative livelihoods, access to information and social participation).
10. Several cross-cutting themes cover all strategic areas, including gender equality, equity, health promotion, ethnic/racial sensitivity, and human rights. PAHO will adopt an integrated approach to the implementation of this strategy, working in collaboration with other organizations, particularly UNODC and CICAD.
11. *Vision:* PAHO coordinates collaborative efforts of Member States to implement public health measures designed to reduce the burden of substance use in the Americas.
12. *Aim:* To promote the strengthening of an integrated public health response of the health sector and other related sectors through the implementation of appropriate plans of action for prevention, treatment and rehabilitation of individuals suffering from substance use disorders.

⁶ See Strategic Plan 2008-2012 for the PASB, Strategic Objective 7, adopted by the 27th Pan American Sanitary Conference in October 2007, and amended in September 2009. Available at: http://intranet.paho.org/DPM/PPS/0_OD_328_post-PASC_strat_Plan_eng_0908.pdf. See also document CD47/15 and Resolution CD47.R1 on “Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Health and other Related Rights,” p. 10-16, adopted by the 47th Directing Council, September 2006. Available at: <http://www.paho.org/English/gov/cd/CD47-15-e.pdf>.

Strategic Areas

Strategic Area 1: Development and implementation of national public health policies, plans, laws, and resource allocation compatible with the magnitude of the substance use problem

13. Member States should develop or revise existing national plans to be consistent with national needs and resources. The national plan should strengthen prevention, health promotion, treatment, social reintegration, and harm reduction activities, particularly among high-risk groups in the population. Such demand reduction activities have been neglected in prior approaches to drug policy or have been implemented without evaluation or evidence of effectiveness. The current strategy provides a vision for integrating substance abuse services within general health care and public health systems. Policies are also needed to implement or revise current legal frameworks and to guide the prioritization of resource allocation between supply control and demand reduction, which will depend in part on the needs identified from epidemiological data and projected trends in drug use. High-risk groups deserving special attention are the homeless, prisoners, sex workers, children and adolescents (particularly those with mental disorders and those who have been victims of violence), injection drug users, and pregnant women (see Annex A).⁷

14. Multisectoral coordination, advocacy, and social mobilization are essential components of a comprehensive health promotion approach. A framework to guide the formulation of a national drug policy has been developed by CICAD (11). It includes a series of logical steps designed to identify a country's basic needs, bring the right stakeholders to the policy-making table, evaluate the evidence supporting effective strategies, and implement performance measurement to evaluate progress and provide feedback. The proposed PAHO strategy is designed to complement the CICAD hemispheric strategy by developing or strengthening the public health aspects of demand reduction that are most likely to be implemented within the health sector of Member States.

⁷ PAHO's Member States have stressed that international human rights conventions and standards offer a unifying conceptual and legal framework for strategies to improve services for the most vulnerable populations (including the homeless, prisoners, sex workers, children, adolescents, injection drug users and pregnant women) as well as measures to ensure accountability and clarify the responsibilities of the various actors involved. It is therefore important to incorporate the provisions of the conventions, declarations, and recommendations of the United Nations and inter-American systems into policies, plans, and laws relating to substance abuse reduction. A list of human rights conventions and recommendations may be found in PAHO's Regional Strategy and Plan of Action on Mental Health (Document CD49/11), available at: http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=2623&Itemid.

Objectives

- 1.1 To have national substance use policies and plans in all countries as part of general health policies, plans, and laws. Such policies and plans should ensure: that they complement and coordinate with the overall national drug policy, that they support public health goals, and that they adhere to human rights conventions, declarations, and recommendations of the inter-American and United Nations systems.
- 1.2 To strengthen prevention, health promotion, treatment, harm reduction, and social reintegration, particularly among high-risk groups in the population.
- 1.3 To mobilize the financial and human resources necessary for the implementation of planned activities and to ensure that such resources are used primarily in community-based outpatient services linked with primary health care and integrated into the general health care system.

Strategic Area 2: Promotion of universal prevention of substance use, emphasizing the psychosocial development of children and young people

15. Efforts must account for the diversity of youth. The most effective measures share two characteristics: they focus on early intervention within the proximal social environment—generally the classroom or the family—and they address issues other than drug use by focusing on social and behavioral development (what is meant here by universal prevention). It is important for Member States to review their prevention activities to make sure that the best evidence-based practices are identified and disseminated and that ineffective programs are discontinued if not improved, as not to squander scarce resources.

Objective

- 2.1 To promote evidence-based universal prevention models and best practices that will support the social and economic development of women and young people in particular, reduce poverty, increase access to quality education and meaningful employment, encourage alternative livelihoods in rural agricultural areas and poor urban communities where drugs are distributed, and enhance access to appropriate and evidence-based health information and services.

Strategic Area 3: Promotion of early intervention in primary care settings and development of treatment systems linked to primary health care and related services

16. As part of the mhGAP program, WHO is preparing a package of interventions related to the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) (10). The value of integrating early identification of substance use into alcohol and tobacco use screening activities is that health care providers are more likely to support early intervention programs when they are linked to similar screening that is already occurring.

17. Experience from large-scale demonstration programs suggests early intervention programs are effective.

18. An effective community based service delivery model includes the delivery of specialized treatment, outreach, and services to reduce harms and risks related to substance use that are culturally appropriate, equitable, and free from discrimination on the basis of gender, ethnicity, and the type of substance use.

19. National policy must prioritize interventions and modalities. There is good evidence to support a variety of treatment and services both in the community and in prison settings, including opioid substitution therapy, self-help groups, psychotherapy, behavior therapy, needle exchange programs, and therapeutic communities.

20. Interventions should prioritize pregnant women to protect the fetus. These same mothers will be ill prepared for parenthood. Their well being can affect the current and future development of their children and may serve to prevent risk behaviors ultimately linked to substance use in their offspring.

21. High-quality services require adequately trained human resources. High quality services include networks of mutual-help organizations to provide community support to persons after they have undergone appropriate therapeutic interventions. Building the substance use prevention and treatment competencies of primary health care workers is critical to the improvement of service delivery. Because many Member States have only the rudimentary elements of a comprehensive drug treatment system, there is a need for expanded curricula both at the graduate and post-graduate levels, continuing education programs, and other training opportunities for those working outside the health system, such as NGOs and social services agencies.

22. The United Nations has a mandate to ensure the availability of psychotropic drugs for medical purposes and WHO has included them on its Essential Drug List. Training of

medical doctors in good prescribing practices is needed in order to ensure that these substances are prescribed at appropriate levels to patients who need them.

Objectives

- 3.1 To provide a package of essential, evidence-based interventions at the various levels of the health care system that can be adapted by Member States, emphasizing primary health care.
- 3.2 To provide tools for training the health work force to deal with substance use and related problems, including good prescribing practices.
- 3.3 To review and update curricula of health care professionals at graduate and post-graduate levels and in continuing education programs on topics related to substance use.
- 3.4 To promote adequate availability of internationally controlled psychoactive drugs for medical and scientific purposes while preventing their diversion and use for non-medical purposes.

Strategic Area 4: Research, monitoring, and evaluation

23. Research on illicit drug use is disproportionately concentrated in developed countries, where most funding supports epidemiology, basic science, clinical interventions, and prevention programs. Research on supply control, policy implementation, drug diversion, the organization of treatment and prevention services, decriminalization measures, criminal sanctions, and early intervention programs needs to be strengthened throughout the Region. PAHO can provide technical cooperation by facilitating urgently the strengthening of epidemiological surveillance, including by establishing rapid assessment procedures, sentinel sites, and systems designed to monitor substance use indicators. In view of the limitations of the existing data/information systems throughout the Region, PAHO can also strengthen its information dissemination role, facilitate the standardization of substance-related health information, and focus more on knowledge management activities. Evaluating and disseminating information on the impact of policies should be a PAHO priority.

Objectives

- 4.1 To comprehensively assess substance use prevention, treatment, and services aimed at reducing specific harms related to drug use in the countries, establishing baselines, and monitoring the situation.
- 4.2 To improve the data on substance use in national information systems, ensuring regular collection and analysis of core data relevant for decision-making and for monitoring changes over time.
- 4.3 To promote research and surveillance in Member States and through PAHO/WHO Collaborating Centers in order to create an evidence base for effective intervention strategies and to monitor substance abuse trends in the Region.
- 4.4 To compile and disseminate evidence-based information and materials on substance use issues, such as evaluations of policies and programs at national and local levels, that can expand the knowledge base and support decision-making with regard to policies, programs, and other activities.

Strategic Area 5: Strategic Partnerships

24. Strategic partnerships are required to ensure that there is an appropriate division of responsibility and inter-organizational collaboration. Ultimately, the aim is to improve collaboration and prevent duplication of functions in the use of scarce resources. Nongovernmental organizations devoted to health promotion, social services, human rights, and public policy are also of critical importance in such strategic partnerships at national and international levels.

25. Recent initiatives by CICAD, UNODC, UNAIDS, and WHO make it timely to direct more attention to regional collaboration in demand reduction activities and to the coordination of drug control policies with policies related to public health.

Objective

- 5.1 To create and strengthen partnerships with other stakeholders for the development and implementation of national drug plans and policies, including CICAD, UNODC, WHO, other intergovernmental Organizations, NGOs, civil society, among others.

Action by the Executive Committee

26. The Executive Committee is requested to identify prevention, care, and treatment of substance use disorders and associated problems as a public health priority and support measures designed to strengthen the health sector's response to the problem. The Committee is furthermore requested to review the information in this document and consider adopting the proposed resolution in Annex D.

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Annexes

SUPPLEMENTARY SITUATION ANALYSIS

1. Survey data compiled by PAHO (1) indicate that lifetime prevalence in Latin America varies significantly by country and level of urbanization. As reported in Table 1, prevalence of drug use among adolescents aged 13-15 ranges from 3% to 22% of the school population. The rates are universally higher among boys than girls (average lifetime prevalence during early adolescence: 13.5% for boys, 8.1% for girls). Cannabis is the drug most often used, but in some countries (e.g., Barbados, Brazil, Jamaica, Trinidad and Tobago) inhalants are used by more than 10% of students. In general, the use of cannabis and inhalants is concentrated in the school-age population, while the use of cocaine, coca paste, opiates, amphetamines, and 3,4-methylenedioxymethamphetamine (MDMA or “ecstasy”) is more prevalent among young adults and marginalized populations. It is known that coca cultivation and use in the Andean countries has been closely linked to the traditional agricultural practices of the rural indigenous minority (2). Very little information is available about the prevalence and problems of drug use among indigenous populations or other ethnic groups.

2. Occasional use of drugs may increase the risk of accidents, injuries, and interpersonal problems because of acute intoxication. Although frequent and regular use is reported by relatively small proportions of the population, the risks associated with this type of use are significant from a public health perspective. Over 40 million people (6.9% of the population aged 15-64) were estimated to have used cannabis in the Americas in 2006 (3). The figures for cocaine (10 million), amphetamine-type stimulants (5.7 million), and heroin (2.2 million) are lower, but the burden of disease and mortality risk increases significantly with frequent use of these substances, especially when they are injected. Across the Region, the use of amphetamine-type drugs is increasing, a trend associated with the growing diversion of prescription stimulants in recent years (3). In South America, use of cannabis and cocaine is increasing, according to recent reports (3). Table and Figure 2 show the extent of problem use of illegal drugs in three WHO subregions in the Americas.

3. Drug use contributes to the burden of disease in two ways: it causes premature death and produces significant health consequences, some attributable directly to drug use per se and others to the mode of drug administration (e.g., intravenous injection). Possible health consequences include HIV/AIDS, hepatitis B and C, other infections, drug dependence, non-lethal overdose, attempted suicide, and injuries. Drug-use disorders among males were ranked eighth among the top 20 contributors to disability-adjusted life years (DALYs) in Latin America in 2002 (4). The extent of drug use in the Region, especially among young persons, and the wide variety of health consequences associated with it, suggest that illicit drugs contribute significantly to preventable death and disability in the Americas.

4. The growing evidence of increased drug use in the Region, and PAHO's increasing interest in the public health response to substance use problems, have drawn attention to the two dominant approaches to drug control policy: supply control and demand reduction. The lack of systematic research on the most common policy options for controlling drug supply (e.g., enforcement, interdiction, incarceration) poses a major barrier to the effective application of these measures (5).

5. A limited amount of research indicates that efforts by developed countries to curtail the cultivation of drug-producing plants in developing countries have not reduced aggregate drug supply or use in downstream markets (6). One reason is that these activities shift production to another area within the country or to another nation. Interdiction of drug exports from producer nations may disrupt the drug market and supply chain, and thus increase the cost to drug users, but the cost of implementing and sustaining interdiction programs is extremely high. Similarly, aggressive enforcement and severe penalties against drug users produce diminishing returns because incarcerating large numbers of people does not result in price declines or decreased prevalence of use beyond what would occur with routine enforcement of drug laws.

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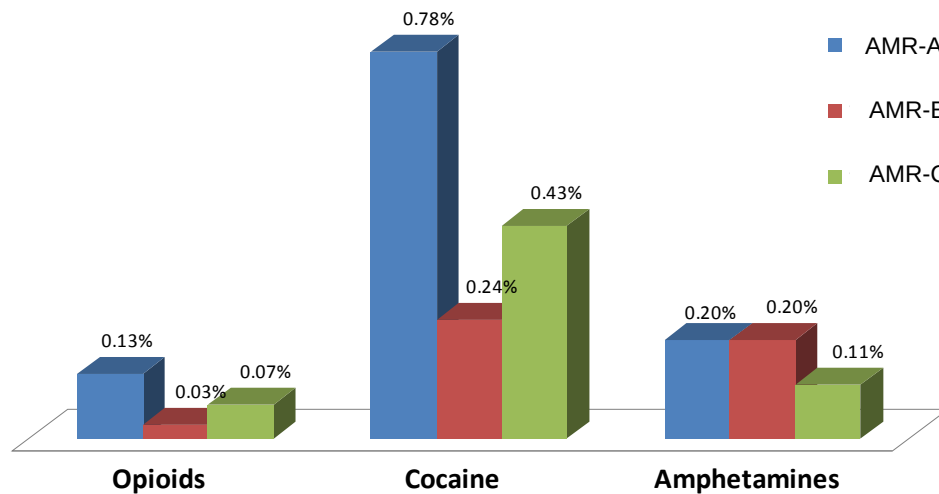
Table 1: Lifetime Prevalence of any Illegal Drug Use among Students Aged 13-15, by Sex and Country

Country and year	Percent who have used an illicit drug at least once during their lifetime								
	Both sexes			Boys			Girls		
	%	standard deviation		%	standard deviation		%	standard deviation	
Argentina (2007)	9.0	±	3.1	11.6	±	4.1	6.7	±	3.1
Cayman Islands (2007) ^a	15.6			20.3			10.3		
Chile /Metropolitan (2004)	10.1	±	2.4	10.7	±	2.0	9.5	±	3.5
Chile/Region I (2004)	9.0	±	2.9	9.5	±	2.5	8.5	±	4.2
Chile /Region V (2004)	8.3	±	2.5	9.4	±	3.4	7.0	±	2.2
Chile /Region VIII (2004)	7.2	±	2.0	7.8	±	2.5	6.3	±	2.3
Colombia / Bogotá (2007)	10.8	±	2.8	13.7	±	3.3	8.3	±	3.4
Colombia / Bogotá Public schools (2007)	10.4	±	3.7	13.7	±	4.0	8.0	±	4.3
Colombia / Bogotá Private schools (2007)	12.4	±	5.7	17.2	±	7.4	8.9	±	5.6
Colombia /Bucaramanga (2007)	6.8	±	1.5	8.6	±	2.4	5.2	±	2.4
Colombia /Cali (2007)	17.8	±	2.4	21.1	±	4.2	15.1	±	2.6
Colombia /Manizales (2007)	21.0	±	3.0	21.1	±	4.3	20.8	±	2.9
Colombia /Valledupar (2007)	3.5	±	1.1	4.5	±	1.8	2.8	±	1.4
Ecuador /Guayaquil (2007)	7.7	±	2.3	9.9	±	2.9	5.7	±	2.5
Ecuador /Quito (2007)	5.5	±	1.5	7.0	±	1.9	4.1	±	2.1
Ecuador /Zamora (2007) ^a	3.1			4.2			2.0		
Grenada (2008)	13.9	±	2.6	21.9	±	3.9	7.8	±	2.7
Guyana (2004)	11.7	±	2.8	17.7	±	4.5	5.9	±	2.5
St. Lucia (2007)	22.0	±	3.0	29.7	±	4.5	15.8	±	3.6
St. Vincent and the Grenadines (2007)	19.9	±	3.2	26.9	±	4.7	13.4	±	3.6
Trinidad and Tobago (2007)	12.8	±	2.9	15.3	±	4.2	10.1	±	2.7
Trinidad (2007)	12.7	±	3.0	15.1	±	4.3	10.2	±	2.8
Tobago (2007)	14.0	±	3.3	20.0	±	5.0	9.0	±	3.0
Uruguay (2006)	8.4	±	1.7	10.5	±	2.8	6.7	±	1.7
Uruguay /Montevideo (2006)	10.6	±	3.2	13.8	±	4.6	7.6	±	2.7
Uruguay /Rest of country (2006)	6.7	±	1.9	7.4	±	3.2	6.1	±	2.1
Venezuela /Barinas (2003)	3.1	±	1.2	4.7	±	2.2	1.7	±	1.4
Venezuela /Lara (2003)	3.1	±	1.0	4.2	±	1.1	2.2	±	1.2

Source: WHO Global School-based Student Health Survey conducted in the various countries. Available at: <http://www.who.int/chp/gshs/country/en/index.html>.

^a Where no variance in the prevalence rates is shown, the entire universe of schools for the country or city was surveyed, and the percentage reflects overall prevalence.

Figure 1: Problem use of illegal drugs among people aged 15 and older in the previous 12 months in three subregions in the Americas, 2008



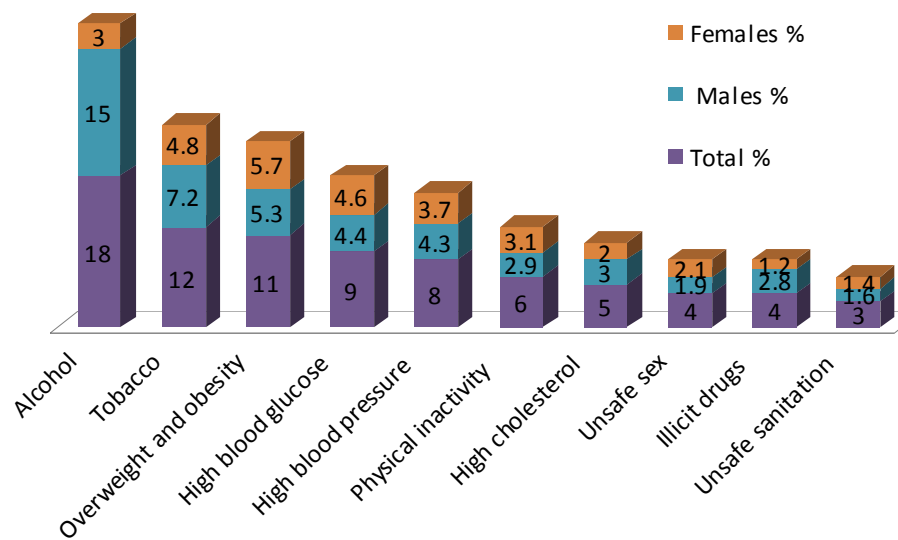
Source: United Nations Office on Drugs and Crime (UNODC). The World Drug Report 2008. Vienna: UNODC; 2008.

Note: Statistics reported by UNODC (2008) are not segregated by sex or age group. Problem drug use was defined as daily use or drug use by injection.

Subgroups of the Region of the Americas (AMR):

- **AMR-A**—Countries in the Americas with very low child and adult mortality (Canada, Cuba, United States of America).
- **AMR-B**—Countries in the Americas with low child and adult mortality (Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Brazil, Chile, Colombia, Costa Rica, Dominica, Dominican Republic, El Salvador, Grenada, Guyana, Honduras, Jamaica, Mexico, Panama, Paraguay, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela).
- **AMR-C**—Countries in the Americas with high child and adult mortality (Bolivia, Ecuador, Guatemala, Haiti, Nicaragua, Peru).

Figure 2: Disability-adjusted life years (DALYs) attributable to 10 leading risk factors, by sex, Region of the Americas, 2004



Source: World Health Organization. Global Health Risks. Geneva: WHO; 2009. Available at: http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf.

INSTRUMENTS FOR THE PROTECTION OF HUMAN RIGHTS

1. The Member States of WHO adopted important principles in regard to public health that are enshrined in the preamble to its Constitution. Hence, the Constitution establishes as a fundamental international principle that enjoyment of the highest attainable standard of health is not only a state or condition of the individual, but “(...) one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition...” The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946 and signed on 22 July 1946 by representatives of 61 States. The International Covenant on Economic, Social, and Cultural Rights (UN), in turn, protects “(...) the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (...)” (Article 12), and the Protocol of San Salvador (OAS) protects “the right to health” (Article 10). Moreover, health protection as a human right is enshrined in 19 of the 35 Constitutions of the Member States of PAHO (Bolivia, Brazil, Chile, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, and Venezuela).

2. United Nations instruments on the protection of human rights:

- Universal Declaration of Human Rights (1);
- International Covenant on Civil and Political Rights⁸ (2);
- International Covenant on Economic, Social, and Cultural Rights⁹ (3);
- Convention on the Rights of the Child¹⁰ (4);
- Convention on the Rights of Persons with Disabilities¹¹ (5);

⁸ Entered into force on 23 March 1976 and ratified by Argentina, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, the United States of America, Uruguay, and Venezuela.

⁹ Entered into force on 3 January 1976 and ratified by Argentina, Barbados, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

¹⁰ Entered into force on 2 September 1990 and ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

¹¹ Entered into force on 3 May 2008 and ratified by Argentina, Brazil, Chile, Costa Rica, Cuba, Ecuador, El Salvador, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, and Peru.

- Convention on the Elimination of All Forms of Discrimination against Women¹² (6);
 - Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care¹³ (7);
 - Standard Rules on the Equalization of Opportunities for Persons with Disabilities¹⁴ (8).
3. Inter-American system instruments for the protection of human rights:
- American Declaration on the Rights and Duties of Man¹⁵ (9);
 - American Convention on Human Rights¹⁶ (10);
 - Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights “Protocol of San Salvador”¹⁷ (11);
 - Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities¹⁸ (12);
 - Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women¹⁹ (13);

¹² Entered into force on 3 September 1981 and ratified by Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, Uruguay, and Venezuela.

¹³ Include guidelines for establishing national mental health systems and evaluating their practices. They refer to the human rights of persons with mental disabilities, especially in the context of psychiatric institutions.

¹⁴ “The purpose of the Rules is to ensure that girls, boys, women, and men with disabilities, as members of their societies, may exercise the same rights and obligations as others.”

¹⁵ OAS Res. XXX. OEA/Ser.L.V/II.82 doc.6 rev.1 at 17 (1992).

¹⁶ Entered into force on 18 July 1978 and ratified by Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

¹⁷ Entered into force on 16 November 1999 and ratified by Argentina, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, Suriname, and Uruguay.

¹⁸ Entered into force on 14 September 2001 and ratified by Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela.

¹⁹ Entered into force on 5 March 1995 and ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Colombia, Costa Rica, Chile, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

- Recommendation of the Inter-American Commission on Human Rights (OAS) for the Promotion and Protection of the Rights of the Mentally Ill²⁰ (14).

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9. Declaración Americana de los Derechos y Deberes del Hombre, 199 OEA res. XXX. OEA/Ser.L.V/182 doc. 6 rev.1, p.17 (1992).

²⁰ Urges States to “promote and implement through legislation and national mental health plans, the organization of community mental health services to achieve the full integration of the mentally ill into society ...”

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CE146/13, Rev. 1 (Eng.)
Annex C

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. Agenda item: 4.5. Strategy for Substance Abuse Reduction

2. Responsible unit: Sustainable Development and Environmental Health/Mental Health and Consumer's Protection Project

3. Preparing officer: Maristela Monteiro

4. List of collaborating centers and national institutions linked to this agenda item:

National Reference Institutions

- Health Canada, International Affairs Directorate
- National Health Surveillance Agency (ANVISA), Brazil
- National Institute on Drug Abuse, Bethesda, Maryland, USA
- Pacific Institute for Research and Evaluation (PIRE), Calverton, Maryland, USA
- Department of Community Health, University of Connecticut, Storrs, Connecticut, USA
- Mercer University, Atlanta, Georgia, USA
- Fundação Fiocruz, Rio de Janeiro, Brazil

Collaborating Centers

- The College on Problems of Drug Dependence, Scottsdale, Arizona, USA
- Department of Psychobiology, Federal University of São Paulo, Brazil
- National Institute of Psychiatry Ramon de la Fuente Muniz, Mexico
- Centre for Addiction and Mental Health, Toronto, Canada

5. Link between agenda item and Health Agenda for the Americas 2008-2017:

Substance abuse is linked to rapid urbanization, inequalities and inequities, social exclusion, violence, and mental health disorders. It is a health determinant and a health outcome, and tackling substance abuse problems requires increasing social protection and access to quality health services. Building the capacity of health workers is also fundamental to an effective response to substance abuse problems.

6. Link between agenda item and Strategic Plan 2008-2012:

Strategic Objective 3: To prevent and reduce disease, disability and premature death from Chronic non-communicable conditions, mental disorders, violence and injuries.

Strategic Objective 6: To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions.

7. Best practices in this area and examples from countries within the Region of the Americas:

- Expansion of treatment services for drug users in Brazil and the United States of America, as part of these countries' national health systems;
- Integration of screening and brief interventions for early drug problems in primary care or non specialized settings in Brazil and Mexico;
- Considering drug problems as public health problems in the national drug policy in Ecuador;
- Universal access to ART in Brazil for HIV + drug users;
- Needle exchanges programs in Argentina, Brazil, Canada, Mexico, and the United States;
- Psychosocial treatment for substance use disorders, several countries;
- Methadone and buprenorphine maintenance for heroin users in the United States and Canada;
- Alternatives to incarceration for drug users with minor offenses in Argentina, Brazil, and Uruguay;
- Availability of drug treatment services in prisons in the United States;
- Regulatory control of psychotropic medicines for medical use in Brazil, Canada, and the United States;
- Control of chemical precursors for the production of amphetamines in the United States;
- Strengthening family programs in the United States;
- Peer self-help organizations in several countries.

8. Financial implications of Agenda this item: N/A.



PAN AMERICAN HEALTH ORGANIZATION
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146th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 21-25 June 2010

CE146/13, Rev. 1 (Eng.)
Annex D
ORIGINAL: ENGLISH

PROPOSED RESOLUTION

STRATEGY ON SUBSTANCE ABUSE REDUCTION

THE 146th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the document “Strategy for Substance Abuse Reduction”
(Document CE146/13, Rev. 1),

RESOLVES:

To recommend that the 50th Directing Council adopt a resolution along the following lines:

STRATEGY ON SUBSTANCE ABUSE REDUCTION

THE 50th DIRECTING COUNCIL,

Having reviewed the document “Strategy for Substance Abuse Reduction”
(Document CE50/___);

Recognizing the burden of morbidity, mortality, and disability associated with substance use disorders in the world and in the Region of the Americas, as well as the existing gap in treatment and care for persons affected by such disorders;

Understanding that while supply reduction strategies are needed, such strategies have had limited impact on substance use problems in the Region, and that from a public health perspective the expansion of evidence-based demand reduction approaches has the

potential to fill a critical need for prevention, treatment, rehabilitation, and harm reduction;

Considering the context and framework for action offered by the Health Agenda for the Americas, the PAHO Strategic Plan 2008–2012, and the World Health Organization (WHO) Mental Health Gap Action Program: Scaling up care for mental, neurological, and substance use disorders (mhGAP), which reflect the importance of the issue of substance use and establish strategic objectives for addressing it; and

Observing that the Strategy for Substance Abuse Reduction proposed in Document CD50/___ sets out the principal areas of work to be addressed and identifies areas for technical cooperation to address the varying needs of Member States with regard to substance use,

RESOLVES:

1. To endorse the provisions of the Strategy for Substance Abuse Reduction and support its implementation within the context of the specific conditions of each country in order to respond appropriately to current and future needs in relation to substance use.
2. To urge Member States to:
 - (a) identify substance use as a public health priority and implement plans to tackle substance use problems that are consonant with their specific problems and priorities, especially with regard to reducing existing treatment gaps;
 - (b) recognize that substance-related problems are a result of an interplay between health and social determinants and outcomes, and that tackling substance use problems requires increasing social protection and sustainable development, including alternatives to drug use production and distribution in both rural and poor urban areas, and access to quality health services;
 - (c) promote universal, equitable access to care for substance use disorder treatment and early intervention for the entire population through strengthening of services within the framework of primary health care-based systems and integrated service delivery networks and ongoing efforts to eliminate the residential hospital-centered model of the past;
 - (d) continue working to strengthen their legal frameworks with a view to protecting the human rights of people with substance use disorders and effectively enforcing laws without having a negative impact on public health;

- (e) promote intersectoral initiatives to prevent the initiation of substance use, with particular attention to children and adolescents, and to reduce stigmatization of and discrimination against people with harmful substance use or dependence problems;
 - (f) encourage the effective involvement of the community, former substance users, and family members on policy, prevention and treatment activities through support for mutual help organizations;
 - (g) recognize human resources development in the area of substance use prevention, care and treatment as a key component in the improvement of national health plans and services and develop and implement systematic training programs and curriculum changes;
 - (h) bridge the existing substance use information gap through improvements in the production, analysis, and use of information, as well as through research, with an intercultural and gender equality approach;
 - (i) strengthen partnerships between the public sector and other sectors, including nongovernmental organizations, academic institutions, and key social actors, emphasizing their involvement in the development of substance use related policies and plans; and
 - (j) allocate sufficient financial resources to achieve a more equitable balance between supply control and demand reduction activities.
3. To request the Director to:
- (a) prepare a 5 year plan of action in close collaboration with Member States, NGOs, research institutions, PAHO/WHO Collaborating Center, and other international organizations, to be presented at the Directing Council in 2011;
 - (b) support Member States in the preparation and implementation of national plans on substance use within the framework of their public health and social policies, taking into account the Strategy for Substance Abuse Reduction, endeavoring to correct inequities, and giving priority to care for vulnerable and special-needs groups;
 - (c) collaborate in the assessment of substance use problems and services in countries with a view to ensuring that appropriate, evidence-based corrective measures are taken;

- (d) facilitate the dissemination of information and the sharing of positive, innovative experiences and promote technical cooperation among Member States;
- (e) promote partnerships with governmental and nongovernmental organizations, as well as with international organizations and other regional actors in support of the multisectoral response required in order to implement this Strategy; and
- (f) coordinate the implementation of the Strategy with Inter-American Drug Abuse Control Commission (CICAD) and with national drug commissions, where applicable.



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Annex E

Report on the Financial and Administrative Implications for the Secretariat of the Proposed Resolution

1. Agenda item: 4.5 Strategy for Substance Abuse Reduction

2. Linkage to Program Budget 2008-2009:

(a) Area of work: Sustainable Developmental and Environmental Health

(b) Expected result:

- RER 6.4: Member States supported through technical cooperation to develop evidence-based and ethical policies, strategies, programs and guidelines for preventing and reducing alcohol, drugs and other psycho-active substance use and related problems.
- RER 3.1: Member States supported through technical cooperation to increase political, financial and technical commitment to address chronic non-communicable conditions, mental and behavioral disorders, violence, road safety, and disabilities.
- RER 3.2: Member States supported through technical cooperation for the development and implementation of policies, strategies and regulations regarding chronic non-communicable conditions, mental and behavioral disorders, violence, road safety, disabilities, and oral diseases.
- RER 3.3: Member States supported through technical cooperation to improve capacity to collect, analyze, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions, mental and behavioral disorders, violence, road traffic injuries and disabilities.
- RER 3.4: Improved evidence compiled by the Bureau on the cost-effectiveness of interventions to address chronic non-communicable conditions, mental and behavioral disorders, violence, road traffic injuries, disabilities, and oral health.
- RER 3.5: Member States supported through technical cooperation for the preparation and implementation of multisectoral, population-wide programs to promote mental health and road safety and prevent chronic non-communicable conditions, mental and behavioral disorders, violence, and injuries, as well as hearing and visual impairment, including blindness.
- RER 3.6: Member States supported through technical cooperation to strengthen their health and social systems for the integrated prevention and management of chronic non-communicable conditions, mental and behavioral disorders,

	violence, road traffic injuries, and disabilities.
RER 4.6:	Member States supported through technical cooperation for the implementation of policies and strategies on adolescent health and development.
RER 6.1:	Member States supported through technical cooperation to strengthen their capacity for health promotion across all relevant programs; and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.
RER 6.2:	Member States supported through technical cooperation to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination.
RER 7.1:	Significance of determinants of health and social policies recognized throughout the Organization and incorporated into normative work and technical cooperation with Member States and other partners.
RER 7.2:	Initiative taken by PAHO/WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty-reduction and sustainable development.
RER 7.3:	Social and economic data relevant to health collated and analyzed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).
RER 7.4:	Ethics- and human rights-based approaches to health promoted within PAHO/WHO and at national, regional and global levels.
RER 7.5:	Gender analysis and responsive actions incorporated into PAHO/WHO's normative work and technical cooperation provided to Member States for formulation of gender sensitive policies and programs.
RER 7.6:	Member States supported through technical cooperation to develop policies, plans and programs that apply an intercultural approach based on primary health care and that seek to establish strategic alliances with relevant stakeholders and partners to improve the health and well-being of indigenous peoples and racial/ethnic groups.
RER 8.3:	Member States supported through technical cooperation to strengthen occupational and environmental health policy-making, planning of preventive interventions, service delivery and surveillance.
RER 8.4:	Guidance, tools, and initiatives created to support the health sector to influence policies in priority sectors (e.g. energy, transport, agriculture), assess health impacts, determine costs and benefits of policy alternatives in those sectors, and harness non-health sector investments to improve health.
RER 8.5:	Health sector leadership enhanced to promote a healthier environment and influence public policies in all sectors to address the root causes of environmental threats to health, by responding to emerging and re-emerging environmental health concerns from development, evolving technologies, other global environmental changes, and consumption and production patterns.
RER 10.1:	Member States supported through technical cooperation to strengthen

	health systems based on Primary Health Care, promoting equitable access to health services of good quality, with priority given to vulnerable population groups.
RER 10.2:	Member States supported through technical cooperation to strengthen organizational and managerial practices in health services' institutions and networks, to improve performance and to achieve collaboration and synergy between public and private providers.
RER 10.3:	Member States supported through technical cooperation to strengthen programs for the improvement of quality of care and patient safety.
RER 11.1:	Member States supported through technical cooperation to strengthen the capacity of the national health authority to perform its steering role; improving policy analysis, formulation, regulation, strategic planning, implementation of health system changes; and enhancing intersectoral and inter-institutional coordination at the national and local levels.
RER 11.2:	Member States supported through technical cooperation for improving health information systems at regional and national levels.
RER 11.3:	Member States supported through technical cooperation to increase equitable access to, and dissemination and utilization of, health-relevant information, knowledge and scientific evidence for decision-making.
RER 11.4:	Member States supported through technical cooperation for facilitating the generation and transfer of knowledge in priority areas, including public health and health systems research, and ensuring that the products meet WHO ethical standards.
RER 13.1:	Member States supported through technical cooperation to develop human resources plans and policies to improve the performance of health systems based on primary health care and the achievement of the Millennium Development Goals (MDGs).
RER 13.3:	Member States supported through technical cooperation to formulate and implement strategies and incentives to recruit and retain health personnel in order to attend to the needs of health systems based on renewed primary health care.
RER 13.4:	Member States supported through technical cooperation to strengthen education systems and strategies at the national level, with a view to develop and maintain health workers' competencies, centered on Primary Health Care.
3. Financial implications: The strategy has financial implications for the Organization.	
(a) Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US\$ 10,000, including staff and activities): US\$ 450,000 per year for 5 years, totalizing \$2,250,000.	
(b) Estimated cost for the biennium 2010-2011 (estimated to the nearest US\$ 10,000, including staff and activities): US\$ 650,000.	

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 410,000.

4. Administrative implications

- (a) Indicate the levels of the Organization at which the work will be undertaken:** Regional, subregional, and country levels.
- (b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):** A professional-level post (requiring a Master in Public Health) to provide technical support and coordinate and monitor the implementation of country-specific projects.
- (c) Time frames (indicate broad time frames for implementation and evaluation):** 2011-2021.

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