

Appendix 2b: Comments on indicators

		Indicator			Data		
		Relevance of indicator (why)	Source(s) for relevance	Interpretations and limits	Source(s) of data	Difficulties	Limits of source
1. Public Health	1.1 Number of syringes distributed (per client and year, 2007-2018)	Needle and Syringe Programs (NSP) are a measure of harm reduction services that governments or NGOs implement. The objective is mainly to reduce the spread of diseases such as HIV or Hepatitis B and C which can be transferred by people sharing needles/syringes while injecting drugs. The more syringes that are distributed per client, the more importance the State can be said to give to preventive health measures addressing risky forms of drug use. We expect this indicator to reveal the level of harm reduction efforts in a particular country.	WHO, UNODC, UNAIDS, <i>Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users</i> , 2009.	We acknowledge that just because more syringes are distributed, doesn't necessarily mean that coverage is effective. Nonetheless, if more syringes are distributed per client (on average), it can safely be considered a positive indicator of action taken by the State to prevent negative health problems related to particular forms of drug use. If the number is low, it could either mean that generally speaking, PWID are not able to have access to enough syringes (meaning low average), or that there are too few PWID who receive enough syringes compared to the total number of PWID (also meaning low average). The best information/indicator would no doubt be the level of access to these programs for the entire "PWID population" (and not only on "clients"), but this data is only available in networks with very precise data collection systems (such as the EMCDDA).	UNAIDS has data on the number of syringes distributed per person, per year, but the data or data sources are incomplete concerning PWID. Indeed, when looking at their dataset, either data is missing (around 50%), sources are not always specified, or the data is old (e.g. Switzerland has data from before 2000). The data used in their latest report (UNAIDS Data report 2019) can be viewed under the Key Population Atlas . We therefore looked for academic research papers on this precise question and selected the most comprehensive datasets possible. UNAIDS refers to Harm Reduction International in their additional data sources. HRI, the EMCDDA and regional studies provided us with the most complete data.	No meta-analysis or source having gathered general data on all countries was found. The idea was to use the aggregated data presented in the HRI Global State of Harm Reduction report, which mentions "at least one NSP operational". This provided a dichotomous answer (yes/no). Then, we searched for a more precise indicator and decided to look at the distribution of needles and syringes.	The limit of our data's quality is the fact that it comes from multiple sources, with potential differences in the process of data collection. Plus, we don't have any information on the number of people actually receiving these distributed syringes, which could constitute a bias in the data identified.

<p style="text-align: center;">1. Public Health</p>	<p style="text-align: center;">1.2 Number of people in OST programs (per 100'000 inhab., 2008-2017)</p>	<p>Opioid Substitution Therapy (OST) programs are another harm reduction measure a country or NGOs can implement. Its objective is mainly to reduce risky heroin consumption and to assist those depending on heroin-like substances to overcome their addiction, typically by using fewer addictive opioids like methadone. We expect it to reflect the will of governments to include harm reduction measures into their drug policies. It can be interpreted as the more people entering OST programs, the more importance the State gives to preventive health measures focused on drug use. We expect this indicator to show the harm reduction efforts in the country.</p>	<p>WHO, UNODC, UNAIDS, <i>Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users</i>, 2009.</p>	<p>The original idea (to calculate ratios with the number of PWID) encountered 2 problems. First, even if one could say that injection is still the most popular method to consume opioids around the world (see Degenhardt et al.), it would be wrong to suppose that all opioid consumers inject drugs (so the number of PWID wouldn't be valuable). Plus, they would need to access these OST programs. Second, even if we wanted to go for the previous method, we wouldn't be able to find good data of the number of PWID for the years where we had the number of people entering OST programs. Therefore, it was concluded that it would be easier to use the 15-64 years old population for each country, at the specified year for which we have data, to calculate a ratio. The best data would be the coverage rate that these treatments for problematic opioid users represent out of the whole population that would need it, instead of building the ratio with the active population (15-64 years old). For that we would need very good data collection systems for all analyzed countries.</p>	<p>UNAIDS has data on OST coverage but only for less than 50% of our countries. Therefore, we decided to gather data from multiple sources, such as EMCDDA, Harm Reduction International or national studies.</p>	<p>Again, no general meta-analysis including all countries could be found. The original idea was to use the HRI Global State Report data only, meaning the "at least one OST program operational" variable, which made it dichotomous. A more precise scale to compare countries such as the number of persons entering/being treated in OST programs would be more relevant and precise.</p>	
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1. Public Health	1.3 Criminal sanctions for personal cannabis possession	<p>We wanted to differentiate countries from a legal point-of-view, with regard to the possible sanction a person may receive as a consumer with a certain level of cannabis possession. This is representative of the stigmatization people who use drugs experience because of certain drug policies. It is a matter of public health to bring drug consumption into its realm, and to distance people who use drugs from penal responses that fuel stigma and therefore, endanger health.</p>	<p>Global Commission on Drug Policy, <i>Advancing Drug Policy Reform: a new approach to decriminalization, 2016</i></p> <p>Csete et al, <i>Public Health and International Drug Policy, Lancet Commission on Drug Policy and Health, 2016.</i></p> <p>EMCDDA, <i>Perspectives on Drugs, Models for the legal supply of cannabis: recent developments, 2016.</i></p>	<p>The indicator presents how countries treat a person who uses drugs with a minor drug possession. We chose to investigate the legal sanctions that countries impose on minor drug possession cases. The case used for this indicator is a consumer found with 5g of cannabis in his possession, with no intent to sell. Cannabis is the world's most consumed drug prohibited by UN Drug Control Conventions, and cannabis is therefore the most inclusive indicator for drug use stigmatization. In our case, the user/possessor has no specific position, like a medical or governmental position. Looking at this indicator can show the potential legal severity towards a person who uses drugs in a specific country, and therefore shows how minor drug possession is stigmatized by the State.</p>	<p>Our primary sources of data were drug monitoring institutions (e.g. EMCDDA, UNODC, and other national institutes), national laws, national health institutes, academic research studies, NGOs specialized in drug policies and international newspapers.</p>	<p>It was the hardest indicator to gather information for, because of the diversity of national (sometimes even regional) laws across all analyzed countries. To find the laws, and to be able to read them (either French, Spanish, English or German could be read, but for the other countries, translated versions had to be found) was a challenge. Still, it was the only way to aggregate this data.</p>	<p>Legality and penal sanctions are complex subjects, especially with many different legal systems. We read the main articles of the relevant laws concerning drug possession and had to make our own conclusions based on the presented articles. A limit of this indicator is the possibility that some parts of legislation that weren't known to us may be relevant for such a case and could potentially change the outcome.</p>
2. Law enforcement	2.1 Incarceration rate for drug-related offences (per million inhab., 2012-2014)	<p>This indicator presents the ratio between the number of persons held in prison for drug-related offences. We expect this to reveal the degree of harshness and level of investment of governments in combatting drug offences. Indeed, since incarceration is a costly sanction for governments, imprisoning more drug offenders is a sign that a State is more willing to engage in harsh sentencing for such illicit behavior.</p>	<p>United Nations Surveys on Crime Trends and the Operations Criminal Justice Systems; UNODC; PRI, <i>Global Prison Trends, 2015.</i></p>	<p>It should be noted that this indicator primarily shows the activity of the judiciary system (police, state attorneys and courts) and more generally a country's investment in penal responses for drug-related cases. We can consider that higher rates of drug-related detentions reflect a harsher judiciary system for drug-related offences.</p>	<p>UNODC has a dataset of incarcerated persons for drug-related offences: the UNODC Special Data Collections on Persons held in Prisons (2010-2014), which, to the best of our knowledge, is the most complete collection of data on the matter.</p>	<p>Only 19 out of the 33 countries that were analyzed shared data with UNODC on their prison population for this survey. Generally speaking, it was difficult to find UN datasets on prison populations related to drug offences. No academic studies could be found with such datasets.</p>	<p>The first limit is the important lack of information on this subject (no information for 14 countries on our list). Another important limit, as stated by UNODC itself, is that cross-national comparisons might be tricky considering the legal definition of drug offences, and the different statistical counting systems. Another limit we could add here is whether or not the number of pre-trial detention cases should be included (they are not included in the UNODC's dataset).</p>

<p style="text-align: center;">2. Law enforcement</p>	<p style="text-align: center;">2.2 Police intervention rate for drug-related offences (per 100'000 inhab., 2008-2016)</p>	<p>The number of police interventions for drug-related issues represents the activity and work of law enforcement officers related to drug “offences” (at the time of interventions, unsure violations of the law). We expect this to represent the importance of police activity and the government’s investment in addressing drug offences. This is a direct State activity, since the police is generally a public service under the Ministry of Interior Department.</p>	<p>The United Nations Rule of Law Indicators, United Nations Department of Peacekeeping Operations (DPKO) and the Office of the United Nations High Commissioner for Human Rights (OHCHR), 2011.</p>	<p>It can be hypothesized that more police interventions (in terms of higher rates) represent a more “punitive” approach against drug use, production and trafficking. Still, the number of interventions could also vary depending on whether the procedures awaiting the criminal justice system are lighter, often because its penal response is lighter and hence could be misleading.</p>	<p>The UNODC World Drug Reports have the most complete and aggregated datasets on police interventions for drug-related offences. Therefore, we selected the data contained in the UNODC World Drug Reports 2018 and 2014 (the latter for completion when countries lacked data in the 2018 report).</p>	<p>The main difficulty was finding a report containing standardized statistics on drug-related offences. UNODC’s Drug Related Crime Report 2012-2016 is the most recent data that countries completed through reporting of the “number of people brought into formal contact”. There were older UNODC surveys (at the end of 1990’s-early 2000’s) but often, the problem was the lack of data for our selected countries or the lack of per year data (some countries don’t always have corresponding data in the analyzed report, but in a previous version of it). Therefore, we focused on the UNODC World Drug Report 2018 (which includes this Drug Related Crime Report 2012-2016), combined with the 2014 WDR Report data for the countries that still had figures missing from the just-mentioned reports.</p>	<p>This type of data poses the difficulty of comparison, since the expression “brought into formal contact” with the national legislation can mean different things in different countries (as stated by UNODC). Indeed, since the laws and police “traditions” are different, if the wording used is different, it makes it more complex to compare police activity across countries. The phrasing can also be different while in practice it is the same. Actually, it depends directly on the police’s statistics policies, rather than the police activity. If a country doesn’t record its activities as precisely as others, it will affect the comparison between them. A new statistics procedure policy (or counting procedure) may also affect police statistics. Still, if looked at from a more general (not purely legal) perspective, most of the countries seem to count the number of cases handled by police forces. The wording may vary between ‘apprehensions’, ‘arrested persons’, ‘suspected persons’ and ‘offences’.</p>
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2. Law enforcement	2.3 Drug seizures economic value (in % of GDP PPP, 2016)	<p>This indicator represents police activity as an economic indicator of the drug market problematic. First, the idea is to count how much of each drug category (exclusively cocaine, heroin, opium, marijuana, hashish, cannabis oil, amphetamine, methamphetamine and ecstasy) each country has seized. Then, we combined this information with the wholesale value to provide an economic dimension to the result. Finally, we calculated a ratio per capita, and combined it with the GDP (in Purchasing Power Parity, or PPP) per capita. While an idea could be to divide by the total population, this makes more sense because it includes the wealth of countries. The result is a ratio between Total drug seizures value (Wholesale) and GDP (PPP), meaning the economic proportion of those seizures compared to the GDP (PPP). We expect this indicator to represent the importance of police work conducted against drug trafficking, and the relative economic importance of these seizures compared to the country's GDP (PPP).</p>	<p>Beau Kilmer and Rosalie Liccardo Pacula, <i>Estimating the size of the global drug market</i>, 2009;</p> <p>UNODC, <i>Economic and Social Consequences of Drug Abuse and Illicit Trafficking</i>, Technical Series, 1998;</p> <p>UNODC, World Drug Report, 2019.</p>	<p>Since not all seizures were included, it is important to note that it is an underestimation based on the main drugs where the seizure's unit was the same as the price unit. All other seizures were not included. Also, speaking of the indicator's nature, seizures are already an underestimation of the real total amount of drugs circulating.</p> <p>Even if the main drug trafficking flows are well known, it is interesting to see at the wholesale level where drugs were seized, and then to look at the seizure's economic worth (in the country of seizure). A high value could be interpreted as high economic attractiveness, for different possible (and non-exclusive) reasons: - there are high drug prices in the country; - it is an interesting transit point from production sites to well-known high profitable markets (countries; - there are many potential consumers in the country itself; - the country itself is a big producer of drugs; - there isn't a strict control on drug traffic flows from the government (meaning low police activity). A better indicator for police activity on drugs could for example be the allocated budgets for drug police interventions, which are generally not available.</p>	<p>UNODC's World Drug Report (2018) is the source of data used for this indicator.</p> <p>For the GDP, our data source is the World Bank.</p>	<p>UNODC is the only global dataset on the topic of drug seizures. Choosing the appropriate seizures wasn't easy at first: indeed, different units of seizures' quantity measures were used (sometimes unstandardized like "bottle" or "unit", while prices were per kg). Sometimes, the problem was reversed with the drug's price (price was per "pill" while seizures are in kg). If a match could be found between "seizure-unit" and "price-unit", then it was included in the final value.</p> <p>For GDP data, we looked at the World Bank datasets, since it is a well-known and respected financial institution with comprehensive and complete datasets.</p>	<p>The difficult part in analyzing drug seizures in a country is that it does not provide us with information about where the drugs were meant to go: are they for national consumption or for transit only? Sometimes it could be for both. Plus, there is also the question of standardized seizure data: the UNODC seizures data could be incomplete because of countries' potential lack of rigorous centralized seizure reporting. Indeed, it is already visible that countries sometimes report seizures with many different measurement units (bottle, ml, kg, unit, etc.), making it impossible to compare them with their price units.</p>
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3. Human Rights	3.1 Human Rights at UN (2018-2019)	<p>Evaluating human rights related to drug policies through indicators is a hard task. To our knowledge, there are no tools or indicators directly collected and archived by UN agencies. That is why we instead chose to consider the positions of member States on this particular issue, in order to understand the political factors behind States' inclusion (or refusal) of human rights in drug policies. We expect this indicator to reflect the countries' position with regard to human rights in drug policies.</p>	<p>The specific role of the Human Rights Council is detailed here: https://www.ohchr.org/EN/HRBodies/HRC/Pages/AboutCouncil.aspx</p>	<p>This indicator is highly significant, since it forces the countries to "take a side" on a UN level, with regard to human rights in drug policies. This indicator is a direct political demonstration of the importance of human rights in the drug policy debate. If the country couldn't vote, the country's statement at the last CND (March 2019) session was read and analyzed to see if human rights were mentioned in a positive or negative way, or not at all. We believe that the presence/absence of references to human rights principles, such as the prohibition of the death penalty, is enough to categorize countries into "positive", "neutral" or "negative" support for human rights. Still, it is clear that this vote is not the only representation of a country's stance on human rights in drug policy, since voting and implementing solutions on the ground are two different political actions.</p>	<p>Our data comes from the vote at the United Nations Human Rights Council (2018), 37th session (A/HRC/RES/37/42) of the Human Rights Council. If a country wasn't present at this session, we selected the statements made at the last CND session (the 62nd, in March 2019) to look for support for human rights, either on the CND's official website, or on the CNDBlog's website (which is managed by IDPC, the largest consortium of drug-related NGOs).</p>	<p>There are no sources of "human rights" indicators to our knowledge. Therefore, we selected a voting session at the UN Human Rights Council as our main data source. To understand some of the statements (e.g. in Russian or Arabic), we had to use translation tools to evaluate the wording.</p>	<p>UN votes can also be a political matter so other motivations might be at play at the moment of the vote. Also, statements can be politicized so the real motivation behind them may be wrongly interpreted as well.</p>
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<p>3. Human Rights</p>	<p>3.2 Operational OST in prisons (2018)</p>	<p>Another human rights indicator related to drug use that we selected was OST (opioid substitution therapy) programs in prisons. Denial of medical care during forced withdrawal may constitute torture, according to the UN Special Rapporteur on Torture (see Nowak, Report to the Human Rights Council, 2009). The countries where OST programs are in place are in accordance with human rights, because the programs mostly focus on the suffering of the user who is no longer using the drugs that he or she was previously taking. While, in many countries, OST programs can be found in the community, OST programs in prisons focus on the rights of prisoners, which are often more neglected by societies. We expect this indicator to show a state's respect for the human rights of prisoners using drugs.</p>	<p>WHO, UNAIDS, UNODC, ILO, UNDP, <i>Policy Brief, HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions</i>; 2013.</p> <p>WHO, UNAIDS, UNODC, <i>Evidence for action Technical papers: effectiveness of Interventions to address HIV in prisons</i>, 2007; WHO, UNAIDS, UNODC, <i>Policy Brief, Reduction of HIV transmission in prisons</i>, 2004.</p> <p>Nowak, <i>Report to the Human Rights Council</i> (2009), M. Nowak, Interim Report of the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, UN General Assembly, 64th Session, UN Doc. A/63/176 (3 August 2009).</p> <p>Open Society Foundations, <i>Treatment or Torture? Applying international human rights standards to drug detention centres</i>, June 2011.</p>	<p>This indicator might seem less robust given that other similar indicators (general OST, NSP) were more precise as they used continuous data (such as the needles/PWID ratio for example). Indeed, this indicator is dichotomous (absence/presence of OST in prisons). The reason for this is that prison data is very hard to obtain, and especially for OST in prisons. Concerning the interpretation of this indicator, it is meant to show whether countries are willing to prevent the suffering of detainees. It is well known that people who use drugs go through a great deal of pain and suffering when their consumption is suddenly interrupted (withdrawal symptoms) and therefore it can be considered as a pro-human rights measure to implement OST programs in prisons.</p>	<p>Harm Reduction International Global State 2018 contains tables of presence (or absence) of OST systems in prisons for most of the countries selected for this study.</p>	<p>The data could not be found on any international organisation's official database. UNAIDS cites Harm Reduction International as their source of information on this topic. To our knowledge, HRI has the most comprehensive dataset on this specific topic, even if the data only concerns the presence and absence of OSTs in prisons.</p>	<p>The limit of this source is that, like for NSPs and OSTs in civil society, it would have been interesting to have more precise data concerning the number of prisoners accessing OST services, which would indicate the number of detainees benefiting from such measures. Indeed, data on coverage would be more relevant than just the presence or absence of such measures. Still, the indicator serves its purpose of indicating a basic differentiation between countries on this matter.</p>
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3- Human rights	3.3 Abolition of the death penalty for drug-related offences (2018)	<p>The death penalty has long been criticized as an inhumane sanction, and illegal for non-violent offences according to UN conventions. Still, some countries use it to punish drug-related offenders. We expect this indicator to differentiate between countries respecting basic human rights in drug policies, and others violating these human rights.</p>	<p>UN General Assembly Res 44/128, The Second Optional Protocol to the International Covenant on Civil and Political Rights, December 1989</p> <p>Council of Europe, Protocol No. 6 to the European Convention on Human Rights, 1983.</p> <p>Council of Europe, Protocol No. 13 to the European Convention on Human Rights, 2002.</p> <p>General Assembly of the Organization of American States, Protocol to the American Convention on Human Rights to Abolish the Death Penalty, 1990.</p>	<p>It identifies countries that have various implementations of capital punishment schemes for drug-related offences.</p>	<p>There is no UN data on this topic to our knowledge. Instead, we chose the Harm Reduction International 2018 Report on the subject: “The Death Penalty for Drugs Offences: Global Overview 2018”, which specifically analyses the situation for drug-related offences and cover countries around the world.</p>	<p>When looking at the number of executions a country has carried out, the exact statistic can be difficult to find. Some countries don’t publish their data on executions, which makes it hard to estimate the number of people actually executed. Nevertheless, this more precise information was not used to categorize countries.</p>	<p>While we also collected the number of executions (when possible), the number of people sentenced to death (meaning: the judiciary decision) would be more precise in showing a country’s intention to use the death penalty. Still, the result, on a macroscopic level (which country includes death penalty as a sanction for drug offences), would be the same.</p>
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4. Market regulation	4.1 Adequacy of Consumption Measure - in morphine equivalents (in %, 2010)	<p>The idea of evaluating access to essential medicines is to indicate the right to have access to basic health services such as painkillers, provided by the pharmaceutical industry as set out in the UN Drug control conventions. We expect this indicator to show the “coverage” of (or access to) essential opioid-based medicines, and in a sense to show if countries can provide the highest attainable standards of health and well-being, set out in the WHO Constitution and protected in other human rights treaties.</p>	<p>WHO, Global Health Observatory, Universal Health Coverage.</p> <p>WHO, Monitoring the components and predictors of access to medicines, February 2019.</p> <p>ICF, Towards a fairer and more effective measurement of access to healthcare across the EU, Final report, 28 November 2018</p>	<p>This topic is of importance in drug policy and is often mentioned in UNODC or CND statements. We interpret the results as follows: countries with low access to “pharmaceutical” opioids (countries that don’t have an adequate coverage of opioid-based painkillers) are not prioritizing or investing in the need to increase their access to the painkiller market.</p>	<p>Two scholars, Duthey and Scholtern from the WHO, published a report in 2013 on the adequacy of consumption of opioid analgesic (in morphine equivalents). We have a full dataset (only data from one country on our list is missing). INCB has very detailed reports on access to essential medicines (see 2015 Report http://www.incb.org/documents/Publications/AnnualReports/AR2015/English/Supplement-AR15_availability_English.pdf). But their estimates strictly concern consumption, whereas Duthey and Scholtern’s study focuses on the “coverage” (or: adequacy) of consumption. This presents the advantage of gaining insight into the “ratio” between what is consumed/provided and what would be needed.</p>	<p>It wasn’t easy to find public statistics including data from all selected countries, since the UN and WHO don’t have such datasets. INCB’s data could have been interesting to use but Duthey and Scholtern’s concept of Adequacy of consumption seemed more informative than the sole number of painkillers consumed per capita.</p>	<p>This report is a good data source because it not only presents consumption, but also estimates the percentage of “adequacy” between consumption and need with relevant methodological tools. An interesting statistic would be to view the distribution of consumption in the population, to see if there are small populations that consume a lot of medical opioids. This way, high-consuming countries would maybe not fall in the “adequate” category. Indeed, overly high consumption/coverage is noted as “adequate”, while this is debatable.</p>
4. Market regulation	4.2 Cannabis for medical use (2018)	<p>Cannabis-based products for medical reasons is an example of drug market access for health reasons, as distinct from the pharmaceutical industry. We expect this indicator to provide a better understanding of current medicinal cannabis legislations, and more precisely to better differentiate between countries with a progressive agenda concerning medicinal use of drugs and others that have not moved in that direction.</p>	<p>EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2018), <i>Medical use of cannabis and cannabinoids: questions and answers for policymaking</i>, Questions and answers for policymaking, December 2018.</p> <p>Transform International, <i>Ending the war on drugs, How to win the global drug policy debate</i>, 2016.</p>	<p>The main interpretation is that with the legalization of cannabis for medical use, countries go forward to a “health and human rights”-oriented policy, instead of keeping a prohibitionist policy. The exclusion of pharmaceutical products is important because we wanted to present the access to other markets than the traditional pharmaceutical one when it comes to drugs.</p>	<p>IDPC’s “Medicinal cannabis policies and practices around the world” (2018) is the most complete aggregated source we found on this topic.</p>	<p>No UN or aggregated source of data could be found on this topic. Instead, IDPC published a report in 2018 on the matter: “Medicinal cannabis policies and practices around the world”. This report analyses the medical use of cannabis legislations around the world. It is also important to note that we only looked at non-pharmaceutical medicinal cannabis. This means that products such as “Sativex”, which are produced by the pharmaceutical industry, are excluded.</p>	<p>Since this data is changing rapidly (the selected report was published in April 2018), some countries may have passed laws allowing cannabis for medical reasons, after this period. The selected study includes a lot of details on requirements or restrictions of the legislations and practices. Still, it would be interesting to analyze the different legislation and access procedures, which could then be used to distinguish countries with different progressive approaches: for example, one country could have authorized the medical use of cannabis but have made access very hard.</p>

4. Market regulation	4.3 Non-medical use/personal possession of drugs (prohibited by UN Conventions)	This indicator provides us with a better picture of the countries' situation in terms of prohibition, decriminalization or legalization of their drug markets for non-medical use. We expect this indicator to present a good overview of this market, and its legal status. Also, it distinguishes the countries that have progressive agendas in terms of drug policies moving towards forms of regulated access to drugs.	Global Commission on Drug Policy (GCDP), <i>Regulation: The responsible control of drugs</i> , 2018. EMCDDA, <i>Perspectives on Drugs, Models for the legal supply of cannabis: recent developments</i> , 2016.	This indicator has great value: it shows the level of market regulation for the major prohibited drugs (cocaine, heroin, cannabis, amphetamine-based drugs, etc.) and presents the progressiveness of drug policies from a market point-of-view.	We had to select various types of data sources such as: drug monitoring institutions (e.g. EMCDDA, UNODC, and other national institutes), national laws, academic research studies, NGOs specialized in drug policies and international newspapers.	Finding good and reliable sources for this indicator was hard, and since no aggregate data source could be found, gathering all the information took a long time.	The main limit for this data is that legal systems are complex: each country has its own legal system, laws and implementations. Our understanding depended on the reliability of the resources we found. Indeed, we had to interpret the legal sources by ourselves.
5. Unintended consequences	5.1 Estimated prevalence of PWID among population (in %, 1996-2016)	This is an indirect indicator of a State's drug policy: it shows the number of high-risk drug users. More directly, it presents the context of a country's situation with regard to risky forms of drug use: the number of PWID shows the importance of people with potential problematic drug use, in the sense that their consumption habits may present dangerous health issues. We expect this indicator to show the drug-related burden based on the number of people concerned with risky forms of drug use.	UNODC, <i>World Drug Report</i> , 2017; 2018; 2019. Louisa Degenhardt et al, <i>Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review</i> , 2017.	The main interpretation of this indicator is that high numbers of PWID (more precisely: high % among general population) is related to the prevention of such drug use. A higher number of PWID can lead to a higher number of serious health consequences among the wider population, and therefore the State should provide appropriate services such as harm reduction measures. It does not necessarily mean that a high figure is negative, it simply reveals that there is a bigger risk, or more significant challenges for the State's public health system. Similarly, a lower number isn't necessarily positive, since the indicator is only a statistic: it only presents the relative share of the population with risky forms of drug use in a country.	UNAIDS has data on PWID but the data is far from complete. There was only data for about 60% of the countries in our selection. Therefore, we searched for academic research papers, and selected the study from Degenhardt et al. (2017) which UNAIDS also refers to.	The difficulties of finding relevant data were similar to the challenges encountered for the HIV indicator: UNAIDS has data which is more complete when it comes to general trends regarding HIV, but not specifically with regard to PWID. This is why we selected a scientific study with very broad datasets and data sources.	A limit for this indicator is that the data is spread over a long period of time (20 years), which makes comparisons between countries weaker since situations may have changed over the years.

5. Unintended consequences	5.2 Drug-related deaths (per million inhab., 2009-2016)	We expect this indicator to show the burden, in terms of the number of lives lost, which could be prevented with harm reduction measures and better access to treatment. It is expected that with well-implemented public health measures, the number of deaths related to drug use should be lower.	European Monitoring Centre for Drugs and Drug Addiction, <i>An overview of the drug-related deaths and mortality among drug users (DRD) key indicator</i> , 2017.	More deaths caused by drug-related activities would be interpreted as a heavier burden on society. Also, it would indicate that the State isn't able (or willing) to invest in reducing this kind of mortality, by for example implementing harm reduction measures or establishing better treatment coverage.	UNODC World Drug Report 2018 was our only source of data.	UNODC has collected and aggregated data for this indicator since 2012. Therefore, we selected the latest World Drug Report data (2018), given that no other source of aggregated data could be found for the countries included in our review.	First, data was lacking for several of the countries in our list (12 out of 33). Second, the definition of "drug-related death" may vary for each country (as stated by UNODC). A further limit is that deaths caused by other non-medical reasons, such as extrajudicial killings related to a country's drug policy, are not included in the counting, which is debatable.
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5. Unintended consequences	5.3 Estimated HIV prevalence among PWID (in %, 2004-2014)	<p>The transmission of HIV infection may occur when PWID exchange their needles/syringes (it should be noted that is isn't the only infection vector). The hypothesis is that HIV infection rates among people who inject drugs are an indirect result of drug policies in place (of repression and harm reduction measures). If harm reduction measures (such as NSPs or OSTs) are widely available, and stigmatization and repression is low, we expect to see a lower HIV prevalence.</p>	<p>UNODC, <i>World Drug Report</i>, 2019;</p> <p>The World Bank, <i>The Global HIV Epidemics among People Who Inject Drugs</i>, 2013.</p> <p>UNAIDS, <i>The Gap Report</i>, 2014;</p> <p>Louisa Degenhardt et al, <i>Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review</i>, 2017.</p>	<p>There are multiple interpretations of the results. The research group, which assembled more than a thousand research papers, points out that they are only estimates and sometimes only focus on specific locations such as cities. While biases may occur while generalizing these figures to entire countries, the research group was careful in their estimations and sometimes gathered many different estimates for only one country (for example: 32 times for Australia or 29 for Myanmar). HIV infection rates among people who inject drugs do not necessarily represent the needles/syringes exchange infection vector only but may have other origins (typically: unprotected sexual relations). To be able to conduct better analyses, data of new HIV infections over time would be needed, instead of only having a prevalence at a certain time (which can be influenced by public health measures of the past).</p>	<p>UNAIDS has data on the HIV infection rate among PWID, but a few countries are missing. The data used in their latest report (UNAIDS Data report 2019 - https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf) can be viewed in their Key Population Atlas (http://aidsinfo.unaids.org/). Sometimes data is included for a country without presenting a data source. Hence, we looked for academic research papers and selected the most comprehensive datasets possible. The most inclusive study we found was the one conducted by Degenhardt et al. (2017), which includes data from research papers and from UN agencies. Their research focuses specifically on PWID, while UNAIDS focuses on infectious diseases, and depends on Member States reporting reliable data. Also, it follows the Guidelines for Accurate and Transparent Health Estimates Reporting (GATHER, see http://gather-statement.org/), which was developed by a WHO mandated group of experts, establishing best practices for calculating health estimates. This kind of systematic review of evidence is not adopted by UN agencies and explains why Degenhardt's study was selected.</p>	<p>Given the arguments presented in the column immediately to the left of this one, we selected Degenhardt et al. (2017)'s study. The main difficulty was to determine which source of data was most relevant to us.</p>	<p>The main limitation for this indicator was that in some cases, the data was included in regional statistics rather than national ones.</p>
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Note: Population Data used to calculate rates were taken from the World Bank.