



MODULE 1

The Global Drug Control System



Aim of Module 1

To describe and understand global drug policies, and to discuss how current drug policies across West Africa reflect these.



Learning objectives

Participants will gain an understanding of:

- the international framework that underpins drug control policies, the ideology behind these, and the history of the development of international drug control;
- the UN drug control system – the treaties and drug control bodies
- the tensions between drug control and human rights (health, development and legal issues);



Introduction

The roots of our current international drug control regime can be traced back more than 100 years, and are underpinned by the belief that a punitive approach would deter any involvement in the illicit drug market. This Module will provide a description and analysis of the global drug control system, as well as describe its consequences.

SESSION 1.1:

Activity: Setting the scene – what do we mean by drug policy

SESSION 1.2:

Activity: Overview of dominant drug control approaches

SESSION 1.3:

Presentation: Background to international drug policy

SESSION 1.4:

Presentation: United Nations drug control architecture

SESSION 1.5:

Activity: Impact & consequences of dominant approaches

SESSION 1.6:

Film clip: West Africa has a drug problem

MODULE 1

Session 1.1

Activity: Setting the scene - what do we mean by drug policy?

 20 min

Facilitators' note

In case of time constraints, the facilitator may decide to present all definitions used in the training toolkit in this session (i.e. advocacy, harm reduction, etc.) This would mean reworking the sequence of sessions later on in the training and merely referring to the already agreed definitions rather than having participants come up with their own definitions.

Aim – To come to a shared understanding of the term “drug policy” and agree on a working definition to use during this training

1. Introduce the aim of the session.
2. Ask participants to brainstorm the key points for defining policy / drug policy.
3. Present the policy definitions below and ask participants if they know of other good policy definitions.
4. Depending on participants' knowledge, understanding and time available, you could also explore the term “controlled” – i.e. how much “control” does prohibition actually provide over certain drugs?

Examples of definitions

Policy

Policies can be defined as how societies and their institutions deal with issues. Policies may be formal and written (such as laws) or informal and/or unwritten (e.g. social etiquette or practice).

Controlled drugs

Psychoactive substances that are controlled under the three UN drug control conventions, and/or under national laws and regulations. These are widely referred to as “illicit drugs”.

Drug policy

The formal or informal policies that aim to affect the supply of drugs, the demand for drugs and/or the harms caused by drug use and/or drug markets. In practice, the term “drug policy” is most commonly used to describe laws and practices that target controlled drugs (rather than uncontrolled or pharmaceutical drugs).

Drug control

Drug control is a term used to indicate the overall system of laws, regulations, practices and institutions that focus on controlled drugs – at local, national, regional and international level.

War on drugs

The term “war on drugs” was made famous by US President Nixon in the 1970s, and has come to refer to the more punitive, repressive drug policies and a “zero tolerance” approach to drug use and people who use drugs.

Session 1.2

Activity: Overview of current drug control approaches



20 min



Aim – To review the dominant approaches taken by most governments to control drugs

1. Introduce the aim of the session.
2. Ask participants to brainstorm (without evaluating at this stage) the interventions used by governments to control the supply of, harms from, and demand for, controlled drugs. If they mention broader terms such as the “war on drugs”, ask them to break these down into the specific interventions that formed part of these approaches.
3. Note responses on a flip chart under three columns – **demand reduction**, **harm reduction** and **supply reduction** and control. The interventions that come under harm reduction will be discussed further in [Module 4](#).
4. Ask participants, based on their experience, how successful or not these interventions have been.



Examples of what participants may come up

Demand reduction

- School based educational programmes – ‘Just say no!’
- Schools based drug-testing
- Pragmatic drug user education
- Abstinence -based programmes
- Prevention programmes
- Incarceration of drug users
- Crackdowns on drug offenders
- Etc.

Supply reduction

- Crop eradication
- Crop substitution / alternative development programmes
- Efforts to stop the sale of drugs, including arrest & punishment of low level dealers engaged in the drug trade to fund their drug use
- Interventions against money laundering
- Interventions against diversion of chemical precursors
- Imprisonment and fines for producers and traffickers
- Seizure of drugs
- Etc.

Harm reduction

- NSP
- Peer outreach
- OST
- Heroin assisted treatment (HAT)
- Drug Consumption Rooms
- Overdose prevention / management
- Etc.

5. Put the flipchart up on a wall and explain that we will return to it at different points in the training.
6. Summarise by noting that the dominant strategy of reducing the scale of drug markets and use has been based on the **principle of deterrence** and focused on implementing **tough laws prohibiting** the production, distribution and use of drugs – referred to as **prohibition-led / prohibitionist / punitive** approaches. It was believed that this strategy, which seeks to deter any involvement in the illicit drug market with the threat of **punishment**, would reduce, and eventually eliminate, the global drug market and its associated health and social harms – it would lead to “a drug-free world” (which was the United Nations target for 2008!). These drug policies are underpinned by the international drug control system, which we will describe in the next session(s).



Retrieved from: <http://www.humanrightsanddrugs.org/category/images/>

Session 1.3

Presentation: Background to international drug policy



20 min



Aim – To provide participants with an overview of the international drug control system (which their governments have signed up to, and which informs drug policies at the national level)

1. Introduce the aim of the session.
2. Before starting the presentation, ask the participants what they know about when and why the international community first came together to discuss setting up a global system for drug control.
3. Present slides. The facilitator can refer to [handout “The UN drug control conventions”](#) for more information.



Facilitators' note

Depending on time available, the facilitator has a choice of either combining the presentations of Sessions 1.3 and 1.4 in one presentation, or to keep them in separate sessions.



Information to cover in this presentation:

The roots of the present global drug control system can be traced back 100 years, and therefore pre-dates the United Nations system itself. It was inspired by the realisation that no country could regulate drug use in isolation, since these commodities were so readily bought and sold across borders and jurisdictions. Control would require states to work together.

The beginnings of the international drug control system

At the instigation of the United States, a group of those countries most concerned about the drugs issue came to together in Shanghai in 1909 to devise an international system for controlling drugs. At the time, the widespread use of opium in China was the main concern. Although the drug control system is often presented in terms of humanitarian and health concerns, the movement was equally driven by economic and political forces. Although it had no legal powers, the Shanghai commission devised a system which was an early blueprint for today's international drug control regime.

Countries present in Shanghai met again at the Hague in the Netherlands, where they devised the 1912 International Opium Convention, a legally binding treaty that began the process of restricting the production, distribution and use of drugs to scientific and medical purposes. However, it was very difficult to persuade the major producing countries to sign up – Turkey and Germany for instance, leading producers of opium and cocaine respectively, were reluctant to enter into this agreement. They were, essentially, forced to do so when the Opium Convention was incorporated into the Treaty of Versailles which ended the First World War in 1919, which all the formerly warring nations had to sign in order to end hostilities. The system developed throughout the twentieth century, becoming gradually more restrictive.

Facilitators' note

'Illicit' drugs?

None of the drugs controlled in the international drug conventions were ever made 'illicit' in and of themselves – their production and trade were placed under tight control to limit use to medical and scientific purposes. It is therefore a behaviour (i.e. production, trade and consumption for non-medical purposes) that is illicit, rather than the substance itself. We therefore use the term 'controlled substances' or 'controlled drugs' in this training.

Today, three conventions with near universal ratification make up the **instruments of international drug control** that guide contemporary national drug laws and policies:

- **The 1961 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol)** – It formally established the current international drug control system that brought together and replaced all previous international agreements on drug control that had been signed since the 1912 Hague Convention. It established a universal system for limiting the cultivation, production, distribution, trade, use and possession of narcotic substances strictly to medical and scientific purposes, with special attention on substances derived from plants: opium/heroin, coca/cocaine and cannabis.
- **The 1971 Convention on Psychotropic Substances** – This convention extended international control to cover over a hundred synthetic psychotropic substances, but because of international pressure from European and North American pharmaceutical companies, the controls were much weaker than those imposed by the 1961 Single Convention.

NB – The preambles of the 1961 and 1971 Conventions state that the fundamental objective of these conventions is to protect the **“health and welfare of mankind”**.

- **The 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances** – This last convention was negotiated in response to massive increases in both demand and supply of cannabis, cocaine and heroin for non-medical use. The rapid growth of illicit trafficking fuelled a criminal black market worth billions. The 1988 convention provides special enforcement measures to reduce illicit cultivation, production and trafficking of drugs, and the diversion of chemical precursors. The Convention significantly reinforced the obligation of countries to apply criminal sanctions domestically. However, there is some flexibility in this convention which enables governments to implement national policies. We will explore those flexibilities in **Module 2**.

Summary Points

Controls in the UN drug control conventions apply to a variety of substances such as cocaine, methadone, oxycodone, diazepam (market name Valium), morphine and codeine, but these substances are placed in different schedules, each of which requires different control systems. Each of the treaties encourages, and in some instances requires, **criminal sanctions** to be put in place at the **national level** for certain types of drug-related offences. There are **two main aims to the drug control treaties**:

- to **prohibit the supply** of and **demand** for controlled substances for non-scientific or recreational/non-medical purposes, and
- to ensure **adequate access** to those substances for scientific and medical purposes.
- Traditionally the **overwhelming focus** has been placed **on the former, restrictive aspect**¹ – the various approaches which we will further review later on in this Module.

In addition, collectively, in more than 110 articles covering many areas that impact upon **human rights**, such as extradition, crop eradication and penalties, there is scarcely any reference to human rights, except in the preamble of the 1961 and 1971 conventions, which highlights that the conventions are concerned with the “health and welfare of mankind”. We will also look at this in more detail later on in the training.

1. For more information, please read: International Centre on Human Rights and Drug Policy, *International drug control law*, <http://www.humanrightsanddrugs.org/international-law/international-drug-control-law/>.

Session 1.4

Presentation: United Nations drug control architecture



30 min



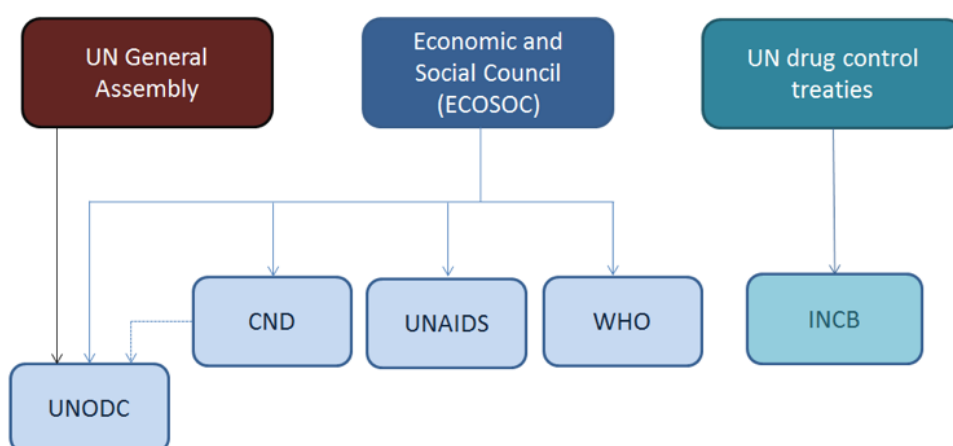
Aim – To provide an overview of the UN bodies that are responsible for overseeing the functioning of the international drug control system

1. Introduce the aim of the session.
2. Before starting the presentation, check with participants what they know about which UN bodies are involved in international drug control, what their mandates are and whether there is scope for civil society engagement. The facilitator can refer to handout [“The UN drug control bodies and how to influence them”](#) for more information.
3. Present slides.



Information to cover in this presentation:

The United Nations drug control bodies¹



Economic and Social Council (ECOSOC)

The Economic and Social Council is the central forum for discussing international economic and social issues, and for formulating policy recommendations addressed to Member States and the UN system. The UN Charter² (the organisation’s founding document) entrusts ECOSOC with international economic, social, cultural, educational, health and related matters. In order to perform these functions, the Council established various functional commissions, including the Commission on Narcotic Drugs.

Commission on Narcotic Drugs (CND)

The CND is the central policy-making body for the UN drug control system. It meets every year for a week in March in Vienna, Austria, to discuss drug policy issues and adopt resolutions on the direction of international drug control for the coming year. It comprises 53 UN member States elected by ECOSOC, with a geographical distribution of seats. The Commission is mandated by the UN drug control conventions to consider all issues relating to the objectives of the conventions. Under resolution [1991/38](#) of the Economic and Social Council, the Commission was requested to give policy guidance to and to monitor the activities of the United Nations Office on Drugs and Crime (UNODC).³ The secretariat of the CND resides within the Division of Treaty Affairs of UNODC. The CND is the final decision maker on proposals by the World Health Organisation (WHO) to schedule, de-schedule or re-schedule a psychoactive substance (although it can only accept or reject the WHO proposal – see more information below on the description of WHO).

International Narcotics Control Board (INCB)

The INCB was created by the 1961 Convention (Article 9) to oversee the implementation of the drug control conventions. The second function of the INCB, of equal importance, is to ensure the availability of controlled drugs for medical and scientific research purposes. The INCB is made up of 13 members elected by ECOSOC, who serve 5-year terms, and is based in Vienna, Austria. The INCB has a secretariat that assists it in its functions. The INCB is the guardian of the treaties. As such, it monitors member states' compliance with the drug control treaties, and can raise the matter with individual governments if it judges them to be in contravention with the conventions. It is, however, supposed to approach such countries in a spirit of cooperation. It can also raise the matter with the CND and ECOSOC. In practice, the INCB has been one of the most conservative UN drug control bodies and has regularly criticised countries that sought to develop more progressive drug policies based on human rights and public health.

United Nations Office on Drug Control (UNODC)

UNODC is responsible for coordinating international drug control activities and is the public face of the drug control system. It assists member states in their responses to the challenges of illicit drug use and related crime. It was established in Vienna in 1997 through a merger between the UN Drug Control Programme and the Centre for International Crime Prevention. UNODC operates in all regions of the world through a broad network of field offices. In addition to drug control, UNODC is mandated to deal with security threats in the form of organised crime and terrorism. It has a three-pillar work programme:

1. Research and analytical work to increase knowledge and understanding of drugs and crime issues. This includes the production of documents such as the World Drug Report.
2. Normative work to assist States in the ratification and implementation of the international treaties.
3. Field-based technical cooperation projects to enhance the capacity of Member States to counteract illicit drugs, crime and terrorism.

World Health Organisation

WHO is the UN specialised agency for health, established in 1948. Its objective is the attainment by all peoples of the highest possible standard of health. Health is defined as a state of complete physical, mental and social wellbeing — not merely the absence of disease or infirmity. The WHO is the only treaty mandated body to conduct medical and scientific assessments of psychoactive substances and advise on their scheduling, and the WHO expert committee can recommend to upgrade or downgrade the classification of a substance between the four schedules of the 1961 and 1971 conventions, or recommend to remove a substance from the lists altogether. The CND can adopt or reject the WHO recommendation by vote

(simple majority for substances under the 1961 convention, two-third majority for substances under the 1971 convention) but not take another decision. However, lack of funding prevents the WHO expert committee from meeting on a regular basis, which results in some assessments being long overdue. For instance, cocaine, morphine and opium have never been reviewed by the WHO or any other entity since 1912, while cannabis and the coca leaf have not been reviewed since 1965.

UNAIDS

While UNAIDS is not a drug control body, it has a key relationship with the global drugs issue. UNODC and WHO are among the co-sponsors of UNAIDS, with UNODC taking the lead role in UNAIDS' response to HIV amongst people who use drugs and in prisons. To achieve the system-coherence needed by the UN as a whole, and to effectively and realistically address the HIV/AIDS epidemic, it is vital that the drug control policies are in line with the objectives and work of UNAIDS.

1. A full organisation chart of the UN bodies is available here: http://www.un.org/en/aboutun/structure/org_chart.shtml
2. Charter of the United Nations, <http://www.un.org/en/documents/charter/index.shtml>
3. For more information, please read: <http://www.unodc.org/unodc/en/commissions/CND/index.html?ref=me-nuside>

MODULE 1

Session 1.5

Activity: Impact & consequences of dominant approaches: The “tree of prohibition-led drug policy”

 90 min

Facilitators' note

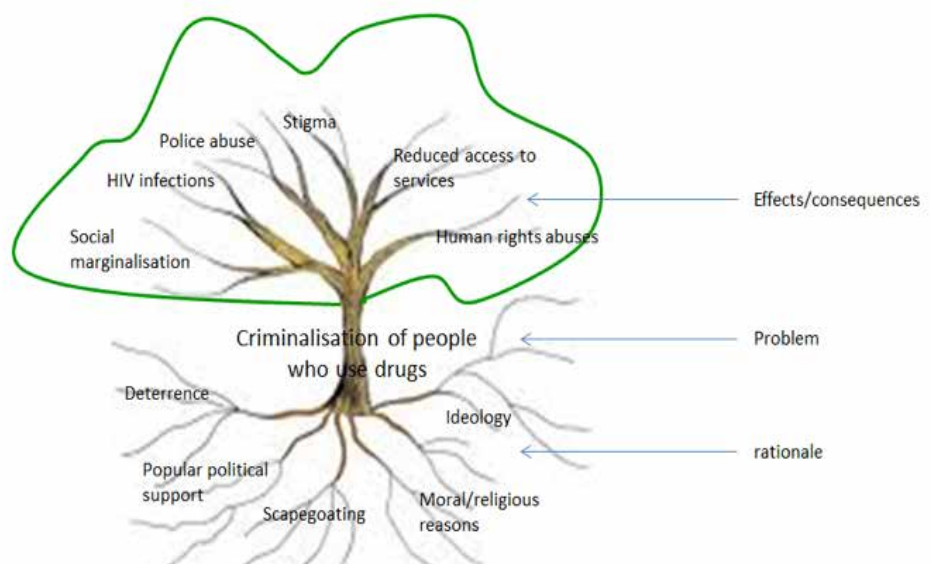
In case of time constraints, it is possible to conduct this activity at the same time as [activity 2.2](#) (the “Tree of good drug policy”) in Module 2, by splitting the participants into four groups and ask two groups to work on the tree of bad drug policy while the two other groups work on the tree of good drug policy. The discussions can then focus on comparing the findings of all groups on what they consider good and bad policies.

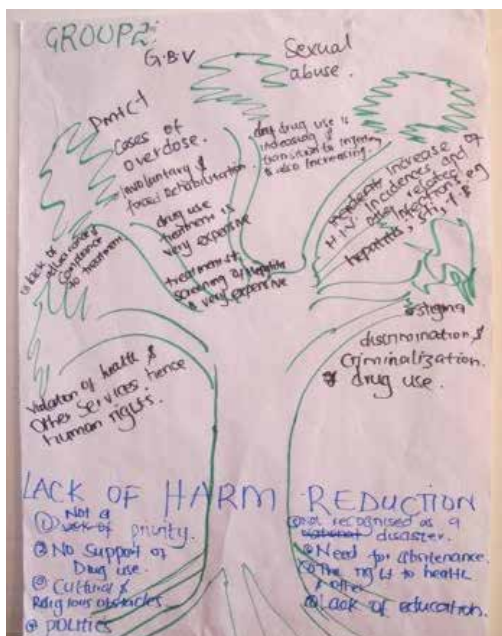
Please also note that Sessions 1.5, 2.2 and 3.9 include a similar activity (the “tree” exercise”). To avoid repetitions, we advise the facilitator to use this exercise only once during the training.

Aim – To explore the efficacy and consequences of prohibition-led policy and practice

1. Introduce the aim of the session.
2. Ask participants to work in small groups (three to five people) and to select one of the prohibition-led interventions or policies identified in the previous session that is relevant in their context – e.g. incarceration / criminalisation of people who use drugs, abstinence-based approach to drug use, compulsory detention, death penalty, disproportionate sentencing, inappropriate and badly sequenced alternative livelihoods, crop eradication, etc.
3. Give each group flipchart paper and coloured marker pens.
4. Ask each group to produce a large drawing of the trunk of a tree and write their chosen intervention on the trunk.
5. Encourage participants to identify the **rationale/justifications behind the intervention**. Draw these along the roots of the tree.
6. Next, encourage participants to identify the **main effects and consequences of the intervention** (both desired and undesired). Ask them to write each effect as a branch of the tree. Ask participants to pay particular attention to the consequences of the chosen intervention on the lives of people who use/transport/grow drugs (i.e. in terms of stigma, discrimination, social marginalisation or status, service uptake, livelihood and self-esteem).
7. When completed, ask each group to present and discuss what their tree shows. For example, how do the reasons for and the effects of the intervention relate to each other? Does the intervention have the desired effect as stipulated by the drug strategy rationale? What are the benefits of the policy? Are there harmful consequences? Can these be grouped – e.g. harms to public health, human rights, development?

Example of “tree of prohibition-led drug policy”





Example of “tree of prohibition-led drug policy” made during civil society advocacy workshop in Nairobi, Kenya, November 2012

8. In plenary, ask participants to consider why these traditional prohibitionist approaches to drugs have remained so predominant over the years.
9. For each of the approaches listed, ask what the rationale for governments pursuing this approach is – i.e. what are the perceived advantages? Add these in a column headed “advantages” to the right of the approach.
10. Next, ask participants to consider the negative consequences or disadvantages of each approach. Add these next to the advantages in a second column headed “disadvantages”.
11. Provide a brief summary presentation (which will pave the way for subsequent sessions) along the following lines (present slides):



Example of what participants may come up with

Advantages

- Easily measured (e.g. numbers of arrests made, individuals incarcerated, narcotics seized)
- Offer images that are media friendly and ease public concerns
- Present a visible response to a complex, often hidden problem
- Assumption that not following such a hard line will invite criticism from other nations and organisations such as the United Nations

Disadvantages

- High costs of custody
- Breaking international human rights commitments, such as...
- Lack of evidence of effectiveness for drug education programmes
- Corruption
- Difficulties in border policing
- Environmental impact
- Increases in blood borne virus transmission
- Increased global organised crime

✓ Information to cover in summary presentation:

There are two fundamental problems related to the current international drug control system. Firstly, when the 1961 Convention came into being over 50 years ago, and when President Nixon launched the US government's war on drugs more than 40 years ago, policy makers believed that harsh law enforcement action against those involved in drug production, distribution and use would lead to an ever-diminishing market in drugs such as heroin, cocaine and cannabis, and the eventual achievement of a "drug free world".

In practice, the **global scale of illicit drug markets** – largely controlled by organised crime – **has grown dramatically** over this period. While accurate estimates of global consumption across the entire 50-year period are not available, an analysis of the last 10 years alone shows a large and growing market.¹

Secondly, the current regime has led to a **number of serious negative consequences**. There is mounting recognition that the "war of drugs" approach has failed. This is a position now supported by many commentators, not least the Global Commission on Drug Policy² and the West Africa Commission on Drugs.³ The West Africa Commission's 2014 report – "Not Just in Transit" states:

We have concluded that drug use must be regarded primarily as a public health problem. Drug users need help, not punishment.

We believe that the consumption and possession for personal use of drugs should not be criminalised. Experience shows that criminalisation of drug use worsens health and social problems, puts huge pressures on the criminal justice system and incites corruption.

We abhor the traffickers and their accomplices, who must face the full force of the law. But the law should not be applied disproportionately to the poor, the uneducated and the vulnerable, while the powerful and well-connected slip through the enforcement net.

We caution that West Africa must not become a new front line in the failed "war on drugs," which has neither reduced drug consumption nor put traffickers out of business.⁴

According to the United Nations itself, the "unintended" consequences of the international drug control system include:

- A huge criminal black market that thrives.
- Funds and attention being drawn away from public health and into law enforcement.
- A "balloon effect" where tighter controls in one place produces increased drug production, trafficking or use in another place.
- "Substance displacement", whereby drug controls may encourage individuals to move from one drug to another – potentially more harmful – substance.
- The widespread perceptions of people who use drugs as criminals, and the associated social exclusion, human rights violations and marginalisation that they suffer.⁵

In addition drug policies have made drugs an explicitly political issue, which has resulted in organised crime exerting an undue influence in the political arena – resulting in the corruption of public servants, in particular those in the criminal justice system.

Thirdly, the regime is alarmingly **outdated**. The 1961 convention is now more than 50 years old, pre-dating the HIV epidemic, the internet and many of the characteristics of modern drug markets. Over the years, the system has not been able to adapt to new health and social realities.

The Global Commission, the West Africa Commission and a number of international advocates are now calling for:

- An open debate which acknowledges the failure of past policies, and looks for alternatives which differentiate between the harms caused by different drugs and acknowledge the human rights of those that take them
- A reduction of the harms caused by prohibitionist strategies
- The development of a new paradigm which treats drug use as a public health issue; reduces consumption through better information, education and prevention; and focuses repression on organised crime rather than drug users and subsistence farmers.
- Open up a larger public debate, through engagement of civil society, which considers previous policy shortfalls and considers alternatives.

The global drug control system is also being seriously questioned by a number of government officials, in particular in Latin America, where a call for reform from Mexico, Guatemala and Colombia has led to a UN General Assembly Special Session (UNGASS) on drugs in 2016 to review current strategies.

1. See, for instance: European Commission, Trimbos Instituut & RAND Europe (2009), *A report of global illicit drugs markets 1998-2007*, https://dl.dropboxusercontent.com/u/64663568/library/EU_Markets_Study_EN0409.pdf
2. To access the reports of the Global Commission on Drug Policy, please visit: <http://www.globalcommissionondrugs.org/>
3. To access the reports of the West Africa Commission on Drugs, please visit: <http://www.wacommissionondrugs.org/>
4. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
5. Costa, Antonio Maria (7 May 2008), *Making drug control 'fit for purpose': Building on the UNGASS decade – Report by the Executive Director of the United Nations Office on Drugs and Crime as a contribution to the review of the twentieth special session of the General Assembly*, E/CN.7/2008/CRP.17, http://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_51/1_CRPs/E-CN7-2008-CRP17_E.pdf

MODULE 1

Session 1.6

Film clip: West Africa has a drug problem

 20 min

Facilitators' note

The film is just over one minute long, and can be shown earlier in this module, or later on during the training, according to the facilitator's preference.

Facilitators' note

If time allows, there are several other films that could be shown to participants, including:

- West Africa Commission on Drugs – “West Africa Has a Drug Problem” (Longer Film) (https://www.youtube.com/watch?v=gMPqm3IE_GE)
- Open Society Foundations – “International Drug Policy: Animated Report 2009” (<http://www.youtube.com/watch?v=Do-RCrOrkpY>)



Aim – To showcase an animated film from the West Africa Commission on Drugs from 2014, which summarises the drug problem in the region and the need to review and reassess drug policies.

1. Introduce the aim of the session, and explain that this film was produced by the West Africa Commission on Drugs in 2014 to highlight some of the disastrous effects of drug policy in recent years and propose solutions for a way forward.
2. Provide the participants with some questions to consider while watching the film, in order to guide the discussions afterwards. For example, you could ask the participants to think about what the “stand out” point they take from the film – which of the facts or arguments was most impactful in their opinion, and why.
3. Allow some time for discussion (including of any issues raised in the film not previously explored), but contain discussions about the proposed solutions, explaining that these will be explored in the sessions that follow.
4. The film clip can be accessed online:

<https://www.youtube.com/watch?v=c5dz9d22NGw> (English)

<https://www.youtube.com/watch?v=hZXaB0m6a20> (French)

In areas where the internet is slow or intermittent, it is highly recommended that the facilitator streams the film prior to the session so that it is loaded on the computer.

Alternatively, the video can be downloaded from <http://vimeopro.com/afpservices/b-rolls-wacd/video/97953664>, and then played from a hard drive without the need for internet access.



Handout: The United Nations drug control treaties

The 1961 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol)

This convention formally established the current international drug control system that brought together and replaced all previous international agreements on drug control which had been signed since the 1912 Hague Convention. It established a universal system for limiting the cultivation, production, distribution, trade and use of narcotic substances strictly to medical and scientific purposes, with special attention on substances derived from plants: opium/heroin, coca/cocaine and cannabis. Importantly, “medical and scientific purposes” were not defined, though the implication is that only the modern western system is real medicine.

This convention contained new provisions that established the following:

- A harsher, prohibition-based system for the control of drugs
- Extended controls to include the cultivation of plants from which narcotic drugs are derived (this impacted directly on countries that traditionally produced plants such as opium¹ poppies, cannabis and coca)
- A ban on traditional practices that included traditional medicinal use of all three plants. Such use was defined as “quasi-medical” practices that had to be terminated within set time-frames. Opium was to be eliminated over a 15-year period, and coca and cannabis within 25 years
- The classification of more than a hundred substances under varying levels of control in four schedules according to their alleged level of dangerousness. Controversially, cannabis appears under the list of the most dangerous substances.

The 1971 Convention on Psychotropic Substances

This treaty extended international control to cover over a hundred synthetic psychotropic substances, such as amphetamines, barbiturates, benzodiazepines and psychedelics under four schedules. However, due to pressure from European and North American pharmaceutical companies the controls were much weaker than those imposed on plant-based drugs in the 1961 Convention.

Under the treaty, “street drug” hallucinogens are most tightly controlled while pharmaceutical products have much weaker controls, reflecting the interests of those countries with powerful pharmaceutical interests (such as the United States, United Kingdom, Canada, Federal Republic of Germany, Switzerland, The Netherlands, Belgium, Austria and Denmark).

Note: The preambles of the 1961 and 1971 Conventions states that the fundamental objective of these conventions is to protect the “health and welfare of mankind”.

The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic substances

This last convention was negotiated in response to massive increases in both demand and supply of cannabis, cocaine and heroin for non-medical (therefore illicit) use. Demand had dramatically increased for these substances in Western countries during the 1970s

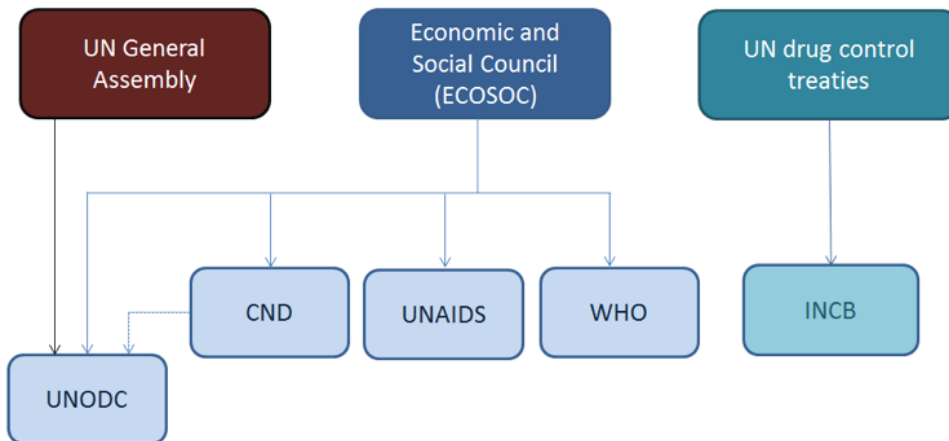
and 1980s, and large-scale illicit production took place in the traditional producer countries to meet that demand. Prior to the 1961 Convention, this demand for non-medical use had been met partly through leakage from licit production, and partly through illicit cultivation and production. However, by the 1980s, globalised organised crime groups had established an international industry to handle illicit supply.

The rapid growth of illicit trafficking of these drugs fuelled a criminal black market worth billions. This development led the international community to negotiate the 1988 convention to provide special enforcement measures focused on reducing illicit cultivation, production and trafficking of drugs, and the diversion of chemical precursors. The treaty also made provisions for mutual legal assistance including extradition for such offences, mechanisms to combat money-laundering, and so on.

The important point about the 1988 Convention is that it significantly reinforced the obligation of countries to apply criminal sanctions domestically to combat all the aspects of illicit production, possession and trafficking of drugs. It is arguably the most prescriptive and punitive of the three conventions. However, there is some flexibility in this convention which enables governments to implement national policies, such as decriminalisation and alternatives to imprisonment.

1. "If in those days the opium-producing countries had been as concerned about alcohol as Western countries were concerned about opium, we might have had an international convention on alcohol", remarked the former head of the WHO Section on Addiction Producing Drugs.

Handout: The UN drug control bodies and how to influence them



Economic and Social Council (ECOSOC)

ECOSOC serves as the central forum for discussing international economic and social issues¹, and for formulating policy recommendations addressed to Member States and the United Nations system. The UN Charter entrusts ECOSOC with international economic, social, cultural, educational, health and related matters. In order to perform these functions, the Council established various functional commissions, including the Commission on Narcotic Drugs

Scope for CSO engagement – ECOSOC can grant what is called “consultative status” to NGOs working on drug-related issues, which enables them to obtain access to certain institutions and events relevant to the international drug control system, some of which are illustrated below.

Commission on Narcotic Drugs (CND)

The CND is the central policy-making body for the UN drug control system. It meets every year for a week in March in Vienna, Austria, to discuss drug policy issues and adopt resolutions on the direction of international drug control for the coming year. It comprises 53 UN member States elected by ECOSOC, with a geographical distribution of seats. The Commission is mandated by the UN drug control conventions to consider all issues relating to the objectives of the conventions. Under resolution [1991/38](#) of the Economic and Social Council, the Commission was requested to give policy guidance to and to monitor the activities of the United Nations Office on Drugs and Crime (UNODC).² The CND is the final decision maker on proposals by the World Health Organisation (WHO) to schedule, de-schedule or re-schedule a psychoactive substance (although it can only accept or reject the WHO proposal – see more information below on the description of WHO).

Scope for CSO engagement – The CND is mandated by the UN Charter (article 71) to facilitate NGO and civil society participation in its work. There are formal provisions for NGOs which have ECOSOC consultative status to attend the CND as observers; and a small number of NGO representatives have been able to deliver statements at the CND’s Plenary session. More importantly, the informal sessions at which member states meet to negotiate disputed draft resolutions are closed to civil society.

A more efficient channel of influence consists of NGOs liaising directly with their own government's delegation at the CND in the "corridors" of the meeting. In some cases, NGO representatives can even be included in government delegations, but this will of course depend on the governments' willingness to do so. In any case, as member states are best placed to achieve policy changes at the CND, advocacy directed at national delegates constitutes an effective tool for promoting drug policy reform

International Narcotics Control Board (INCB)

The INCB oversees the implementation of the drug control conventions. It is made up of thirteen members elected by ECOSOC, who serve 5-year terms, and is based in Vienna. The INCB was created by the drug controls treaties (Article 9 of the Single Convention) 1- to be the guardian of the treaties and 2- to ensure the availability of controlled drugs for medical and scientific research purposes. As "guardian of the treaties", the INCB monitors member states' compliance with the drug control treaties, and can raise the matter with individual governments, the CND and ECOSOC when it judges some governments to be in contravention with the conventions. In practice, the INCB remains one of the most conservative UN drug control bodies and has regularly criticised countries that seek to develop more humane and progressive drug policies.

Scope for CSO engagement – The INCB has traditionally not been receptive to engagement with civil society, citing the "need for security of information" as a justification. However, in the face of extensive criticism from NGOs working in the drugs field and subsequent negotiations between the INCB and the Vienna NGO Committee on Drugs (VNGOC – see below for more information), it has recently made some concessions, in particular the possibility for NGO participation during the INCB country missions. As a result, it is now possible for NGOs to apply³ to meet INCB representatives when they undertake visits in member states to examine the drug control situation (a number of these visits are made in various countries each year). At the international level, the INCB chair now meets every year with NGOs at the informal dialogue organised at the CND.

United Nations Office on Drug Control (UNODC)

UNODC is the UN agency responsible for coordinating international drug control activities, and is the public face of the drug control system. It was established in Vienna in 1997 through a merger between the UN Drug Control Programme and the Centre for International Crime Prevention. UNODC operates in all regions of the world through a broad network of field offices. The UNODC is also mandated to deal with security threats posed by organised crime and terrorism. It has a three-pillar work programme:

1. Research and analytical work to increase knowledge and understanding of drugs and crime issues. This includes the production of documents such as the World Drug Report
2. Normative work to assist States in the ratification and implementation of the treaties
3. Field-based technical cooperation projects to enhance the capacity of member states to tackle controlled drugs, crime and terrorism.

Scope for CSO engagement – The primary mechanism for civil society involvement with UNODC and the other international drug control bodies is the Vienna NGO Committee on Drugs (VNGOC). Formed in 1983, the VNGOC has a Board of 7 officers, and is made up of international, national and local NGOs. The Vienna NGO Committee works to provide information about NGO activities, draw attention to areas of concern, build partnerships between governmental and non-governmental organisations, and enhance civil society involvement in the formation and development of international drug policies. Beyond 2008, an initiative of the VNGOC in partnership with UNODC, provided a platform for civil society to contribute to the review of the 1998-2008 United Nations General Assembly Special Session on Illicit Drugs. NGOs can apply for membership of the VNGOC through its website⁴. UNODC has established a "Civil Society Team" which is coordinating collaboration with NGOs. In addition, the UNODC is directly engaged in informal consultations with a number of NGOs, including IDPC.

World Health Organisation (WHO)

WHO is the UN specialised agency for health, established in 1948. Its objective is the attainment by all peoples of the highest possible standard of health. Health is defined as a state of complete physical, mental and social wellbeing — not merely the absence of disease or infirmity. The WHO is the only treaty mandated body to conduct medical and scientific assessments of psychoactive substances and advise on their scheduling, and the WHO expert committee can recommend to upgrade or downgrade the classification of a substance between the four schedules of the 1961 and 1971 conventions, or recommend to remove a substance from the lists altogether. The CND can adopt or reject the WHO recommendation by vote (simple majority for substances under the 1961 convention, two-third majority for substances under the 1971 convention) but not take another decision.

Scope for CSO engagement – The importance of civil society engagement is embedded in the WHO constitution. A number of public health NGOs have formal relationships with the WHO and are permitted to speak at governmental meetings. While no drug policy NGOs presently enjoy such relations, numerous NGOs involved in harm reduction, for example, are engaged in informal dialogue with the WHO. In 2001, the Civil Society Initiative was set up to examine the state of civil society participation in the body. The initiative concluded that a new policy was necessary to guide WHO's relationships with civil society. This has yet to be approved by the WHO governing body.

1. For more information, please visit: <http://csonet.org/>
2. For more information, please read: <http://www.unodc.org/unodc/en/commissions/CND/index.html?ref=me-nuside>
3. For more information, please visit the INCB Watch page: <http://idpc.net/incb-watch>
4. For more information, please visit the website of the Vienna NGO Committee on Drugs: http://www.vngoc.org/details.php?id_cat=7&id_cnt=26

MODULE 1

Handout: Drug control and human rights violations

The tables below, adapted from the [IDPC Drug Policy Guide](#), 2nd Edition, highlights examples of international human rights violations caused by current drug control efforts. If you would like to learn more about drug policy and human rights advocacy, please read:

- Harm Reduction International (2011), *The UN human rights system and harm reduction advocacy: A training package for civil society organisations*, http://www.ihra.net/files/2011/03/29/IHRA_Training_Pack_Final.pdf
- Kaplan, K. (2009), *Human rights documentation and advocacy: A guide for organizations of people who use drugs* (New York: Open Society Institute Public Health Program), http://www.opensocietyfoundations.org/sites/default/files/hr-doc_20090218.pdf

Human right	International human rights convention	Violations in the name of drug control
Right to life	<ul style="list-style-type: none"> • Article 4 of the Universal Declaration of Human Rights, 1948 • Article 6 of the International Covenant on Civil and Political Rights, 1966 	<ul style="list-style-type: none"> • Use of the death penalty for drug offences¹ • Extra-judicial killings by law-enforcement agencies²
Right to be free from torture, cruel and inhuman punishment	<ul style="list-style-type: none"> • Article 5 of the Universal Declaration of Human Rights, 1948 • Article 7 of the International Covenant on Civil and Political Rights, 1966 • Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1975 • Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984 	<ul style="list-style-type: none"> • Arbitrary detention of people who use drugs • Abuses in compulsory centres for drug users³
Right to be free from slavery	<ul style="list-style-type: none"> • Article 4 of the Universal Declaration of Human Rights, 1948 • Article 8 of the International Covenant on Civil and Political Rights, 1966 	<ul style="list-style-type: none"> • Use of forced labour in the name of drug treatment⁴
Right to health	<ul style="list-style-type: none"> • Constitution of the World Health Organisation (WHO), 1944 • Article 25 of the Universal Declaration of Human Rights, 1948 • Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966 	<ul style="list-style-type: none"> • Restricted access to essential medicines for pain relief⁵ • Restricted access to the means to prevent disease transmission and restricted access to appropriate forms of humane drug dependence treatment programmes
Social and economic rights	<ul style="list-style-type: none"> • Article 22 (and next) of the Universal Declaration of Human Rights, 1948 • Articles 6 and 7 (and next) of the International Covenant on Economic, Social and Cultural Rights, 1966 	<ul style="list-style-type: none"> • Implementation of forced crop-eradication campaigns, leaving many farmers with no means of subsistence⁶

Human right	International human rights convention	Violations in the name of drug control
Right to be free from discrimination	<ul style="list-style-type: none"> Article 7 of the Universal Declaration of Human Rights, 1948 Article 26 of the International Covenant on Civil and Political Rights, 1966 International Convention on the Elimination of All Forms of Racial Discrimination, 1965 Convention on the Elimination of All Forms of Discrimination Against Women, 1979 	<ul style="list-style-type: none"> Discriminatory application of drug control laws, notably towards minority ethnic people,⁷ indigenous people, young people and women
Right to privacy	<ul style="list-style-type: none"> Article 12 of the Universal Declaration on Human Rights 	<ul style="list-style-type: none"> Practice of stopping and inspecting people, including school children, suspected of carrying drugs Sharing of confidential medical information of a person under drug dependence treatment with the police
Right to be protected from illicit drug use	<ul style="list-style-type: none"> Article 33 of the UN Convention on the Rights of the Child 	<ul style="list-style-type: none"> Denial of harm reduction services targeted at young people⁸

References

- ¹ In 2010, 33 countries retained the death penalty for drug offences: Harm Reduction International (2010), *Complicity or abolition? The death penalty and international support for drug enforcement* (London: Harm Reduction International), http://idpc.net/sites/default/files/library/IHRA_DeathPenaltyReport_2.pdf
- ² Haugaard, L. & Nicholls, K. (December 2010), *Breaking the silence: in search of Colombia's disappeared* (Washington DC: Latin America Working Group Education Fund & US Office on Colombia), <http://lawg.org/storage/documents/Colombia/BreakingTheSilence.pdf>
- ³ Open Society Foundations (June 2011), *Treatment or torture? Applying international human rights standards to drug detention centers* (New York: International Harm Reduction Program, Open Society Foundations), <http://idpc.net/sites/default/files/library/Treatment-or-torture.pdf>; Nowak, M. (February 2010), *Report of the Special Rapporteur on torture and cruel, inhuman or degrading treatment or punishment* (United Nations General Assembly A/HRC/13/39/Add.5), http://idpc.net/sites/default/files/library/A.HRC_13.39.Add_5_en.pdf; Wolfe, D. & Saucier, R. (May 2010), 'In rehabilitation's name? Ending institutionalised cruelty and degrading treatment of people who use drugs', *International Journal of Drug Policy*, 21(3): 145–148, <http://www.ijdp.org/article/PIIS0955395910000095/abstract?rss=yes>
- ⁴ Human Rights Watch (January 2010), *'Where darkness knows no limits' – incarceration, ill-treatment, and forced labor as drug rehabilitation in China* (New York: Human Rights Watch), http://idpc.net/sites/default/files/library/hrw_china_darkness%20knows%20no%20limits.pdf
- ⁵ WHO estimates that approximately 80% of the world's population has either no or insufficient access to treatment for moderate or severe pain: World Health Organization, Access to Controlled Medications Programme (2007), *Improving access to medications controlled under international drug conventions* (Geneva: World Health Organization), http://www.who.int/medicines/areas/quality_safety/access_to_controlled_medications_brnote_english.pdf
- ⁶ Mansfield, D. (2011), *Assessing supply-side policy and practice: Eradication and alternative development* (Geneva: Global Commission on Drug Policy), <http://idpc.net/sites/default/files/library/crop-eradication-and-alternative-development.pdf>
- ⁷ For example, in the USA, African-American individuals are 10 times more likely than whites to enter prison for drug offences: Human Rights Watch (2008), *Targeting blacks: drug law enforcement and race in the United States* (New York: Human Rights Watch), <http://www.hrw.org/en/node/62236/section/1>
- ⁸ Harm Reduction International & Youth RISE. *Drugs, Harm Reduction and the UN Convention on the Rights of the Child: Common themes and universal rights*, <http://www.ihra.net/child-rights>

Handout: Resources / Further reading

Full texts of the three UN Drug Control Treaties

Single Convention on Narcotic Drugs, 1961, as amended by the 1972 protocol, <http://www.unodc.org/unodc/en/treaties/single-convention.html>

Convention on Psychotropic Substances, 1971, <http://www.unodc.org/unodc/en/treaties/psychotropics.html?ref=menu>

United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, <http://www.unodc.org/unodc/en/treaties/illicit-trafficking.html?ref=menu>

Discussion and analysis of the drug control system

West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf

Global Commission on Drug Policy (2014), *Taking Control: Pathways to Drug Policies That Work*, <http://www.globalcommissionondrugs.org/reports/>

Global Commission on Drug Policy (2013), *The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic*, <http://www.globalcommissionondrugs.org/reports/>

International Drug Policy Consortium (2012) *Drug Policy Guide* (2nd Edition), <http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition>

Global Commission on Drug Policy (2012), *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic*, <http://www.globalcommissionondrugs.org/reports/>

Organization of American States (2012), *Scenarios for the drug problem in the Americas 2013 – 2025*, www.oas.org/documents/eng/press/Scenarios_Report.PDF

Bewley Taylor, D. & Jelsma, M. (2012), *The UN drug control conventions: The limits of latitude* (International Drug Policy Consortium & Transnational Institute), <http://idpc.net/publications/2012/03/un-drug-control-conventions-the-limits-of-latitude>

Global Commission on Drug Policy (2011), *War on Drugs: Report of the Global Commission on Drug Policy*, <http://www.globalcommissionondrugs.org/reports/>

Jelsma, M. (2011), *The development of international drug control: Lessons learned and strategic challenges for the future*, <http://www.druglawreform.info/en/publications/legislative-reform-series-/item/1158-the-development-of-international-drug-control>