# Media information resource pack

## The UN and global drug policy

**This pack has been compiled by the International Drug Policy Consortium (IDPC), a global network of NGOs and professional networks that specialise in issues related to illegal and legal drug use. This pack provides information and easily accessible background resources on the key issues relating to the UN drug control system. The articles in this pack have been written by experts in the field of drug policy to highlight and raise awareness of the failings of the current global system of drug control.**

### Contents

## The International Drug Policy Consortium

The International Drug Policy Consortium (IDPC) is a global network of 69 national and international NGOs and professional networks that specialise in issues related to illicit drugs. IDPC promotes objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. Based on the findings of its members' research and publications, IDPC engages with officials and politicians in national governments and international agencies – through correspondence, face-to-face meetings and involvement in conferences, seminars and workshops – to promote effective policies, thereby making the most up-to-date research and practice knowledge available to decision makers.

The Consortium plays a key role in the development of global drug policy when international agencies meet in Vienna every year. Our task consists of co-ordinating the work of our membership and other partners and help to bring its collective energies to bear in an accurately and timely way. Our hope is that civil society, working in partnership with the many progressive governments who will be present, will be able to steer drug policy in a new direction, which is both more humane and more effective.

For more information, please visit our website: www.idpc.net, or contact us: contact@idpc.net.

## The UN drug control system – Happy anniversaries?

2011 marks the 50th anniversary of the United Nations Single Convention on Narcotic Drugs, the international treaty that requires all national governments to control the production, distribution, and possession of a wide range of psychoactive substances – including heroin, cocaine, and cannabis – for any non-medical purpose. The international community have been faithfully implementing this system for five decades.

2011 also marks the 40th anniversary of the launch, by President Richard Nixon, of the US Federal Government's 'war on drugs' that he, and all his successors in the White House, have stated will ultimately succeed in stifling drug markets, and eradicating drug use. For four decades, the US has poured trillions of dollars into this policy, mostly financing military and law enforcement efforts in source and transit countries, and the mass arrest and incarceration of American drug users.

In 2012, the 1912 Hague International Opium Convention will celebrate its 100th anniversary. The convention was the first international agreement that enshrined the principles of worldwide prohibition of a wide range of psychoactive substances. Therefore, some form of international drug control system has been in place for a century.

Approaching all of these anniversaries, we need to ask ourselves whether our chosen policies are working – what have we achieved, at what cost, and with what collateral damage?

The last time the international community got together to review progress was in 2009 (i). Ostensibly, this 'High Level Meeting' was held in Vienna to review progress against the agreements made by the international community 10 years earlier (ii). Under the slogan 'A drug free world – We can do it', the more functional objective was 'the elimination or significant reduction of the illicit market for psychoactive substances, such as cannabis, heroin, cocaine and synthetic drugs primarily through enforcement action against growers, traffickers and users'. Despite clear evidence that this objective had nowhere near been reached (iii), the gathering of international leaders declared 'satisfying progress', and committed themselves to a broad continuation of the same set of policies for another ten years (iv).

The diplomatic exchanges around the 2009 meeting, however, showed that there were growing cracks in the global consensus, with many countries pushing for clearer recognition of the limited success of the current system, and for more tolerant policies focusing on health and human rights. These cracks have widened in the last two years, with expert opinion and government positions increasingly at odds with one another. There are increasing calls for new models of drug control to be tried, and many countries are pushing the boundaries of the flexibility of the current regime.

Countries are beginning to divide broadly into two camps on the issue – those who want to defend the 1961 Convention as sacrosanct and oppose even the slightest attempt to amend or modernise it, and those who feel that the time has come to address some of the weaknesses and inconsistencies in the system. The main battleground for these opposing views in early 2011 was the proposal by Bolivia to remove the practice of coca leaf chewing from the prohibition provisions of the Convention (v). Seventeen countries have objected to this amendment (vi), most of whom have not tried to articulate a substantive argument for the objection, simply referring to the 'integrity of the conventions', the implication being that any amendment, however sensible or trivial, would undermine the sanctity of a document drafted in the 1950s, when drug markets and patterns of use were very different than today.

The following sections of this guide give background information on specific aspects of the control regime and link to resources for further research and contacts.

**ENDS**

## Endnotes

(i) International Drug Policy Consortium (2009), *The 2009 Commission on Narcotic Drugs and its High Level Segment- Report of Proceedings*,
http://www.idpc.net/php-bin/documents.pl?ID=1000241

(ii) In March 2008, the international community began a process to evaluate the action plan set out at the UN General Assembly Special Session (UNGASS) on Drugs in 1998 (see note 3). A year-long 'period of global reflection' was followed in 2009 by a High Level Meeting (HLM) at the Commission on Narcotic Drugs (CND), the central UN policy-making body on drugs, in Vienna. The HLM took place, in Vienna, on 11 and 12 March 2009. Senior ministers representing the member countries of the Commission on Narcotic Drugs (CND) attended and agreed upon a Political Declaration mapping the direction of drug policy over the next ten years.

(iii) European Commission, Trimbos Instituut & Rand Europe (2009), *A report on the global illicit drugs markets 1998-2007*,
http://ec.europa.eu/justice/doc_centre/drugs/studies/doc/report_short_10_03_09_en.pdf

(vi) United Nations Office on Drugs and Crime (2009), *Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem,* http://www.unodc.org/unodc/en/commissions/CND/session/52-HLS.html
For a critical discussion of the process by which the 'consensus' was achieved, see: International Drug Policy Consortium (2009), *Why is the outcome of the United Nations Drug Policy Review so weak and inconclusive?* http://www.idpc.net/php-bin/documents.pl?ID=1000235
For an account of the content of the Political Declaration that emerged from the 2009 meeting, see: International Drug Policy Consortium (2009), *The High Level Segment of the 2009 Commission on Narcotic Drugs: The Political Declaration – A Missed Opportunity*, http://www.idpc.net/php-bin/documents.pl?ID=1000231

(v) International Drug Policy Consortium (January 2011), *IDPC Advocacy Note - Correcting a historical error: IDPC calls on countries to abstain from submitting objections to the Bolivian proposal to remove the ban on the chewing of the coca leaf*,
http://idpc.net/sites/default/files/library/IDPC%20Advocacy%20note%20-%20Support%20Bolivia%20Proposal%20on%20coca%20leaf_0.pdf

(vi) Transnational Institute Weblog (February 2011), *Seventeen objections to abolish coca chewing*,
http://www.druglawreform.info/en/weblog/item/1131-seventeen-objections-to-abolish-coca-chewing

## Background information

For more information on the 1998 *UN General Assembly Special Session on The World Drug Problem*, see: http://www.un.org/ga/20special/

International Drug Policy Consortium. (2008). *The United Nation's review of global policy on illegal drugs: an advocacy guide for civil society.* (London, UK: Author).
http://idpc.net/sites/default/files/library/IDPC_AdvocacyGuide_June08_EN.pdf

(vi) United Nations Office on Drugs and Crime (2009), *Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem,*
http://www.unodc.org/unodc/en/commissions/CND/session/52-HLS.html

UNGASS. (1998). *Political Declaration from the 1998 UN General Assembly Special Session on The World Drug Problem.* (A/S-20/4, chapter V, section A) Vienna, Austria: Author.
http://www.un.org/ga/20special/poldecla.htm

# The death penalty for drug offences: a violation of international human rights law

***Rick Lines, Executive Director of the International Harm Reduction Association, examines whether the use of the death penalty for drug-related offences is legitimate under international human rights law.***

58 countries around the world continue to use capital punishment. A little more than half of these nations have legislation that allows for the use of the death penalty for drug-related offences (i).

Over the past 25 years, there has been a remarkable international trend towards the abolition of capital punishment, a trend that culminated with UN General Assembly resolutions in 2007 and 2008 calling for a worldwide moratorium on executions (ii).

Despite this trend, the number of countries expanding the use of the death penalty to include drug offences *increased* through most of this period. Only in the past decade has this figure started to decline.

It is difficult to estimate the number of people put to death for drugs each year since many countries classify their death penalty figures as a state secret or simply do not make such numbers available. However, it is clear that a significant number of executions for drug offences take place each year.

In Iran, 172 people are believed to have been executed for drug-related crimes in 2009 (iii) and Saudi Arabia is believed to have killed more than 60 people between 2007 and 2008 for drug offences (i). Although Viet Nam does not report figures on executions, of 201 people sentenced to die between 2007 and 2009, at least 109 were drug offenders (iv). Similarly in Malaysia, at least 22 people in 2008 and at least 50 in 2009 were sentenced to death for drug related offences (i).

Based on these and other figures, it can be safely estimated that the number of people executed every year is in the hundreds and very likely reaches a thousand when those countries that do not release death penalty figures are included.

The application of the death penalty for drug offences continues to be used despite the authoritative findings of various UN human rights bodies and monitors that such executions take place in violation of international human rights law.

Although capital punishment is not prohibited under international law, article 6(2) of the *International Covenant on Civil and Political Rights* states that the penalty of death may only be lawfully applied to the 'most serious crimes'. While many retentionist governments argue that drug offences fall under this umbrella, this is not the assessment of international human rights monitors, treaty bodies and the UN drug control agencies.

Both the UN Human Rights Committee (the body responsible for monitoring and interpreting the terms of the *Covenant*) and the UN Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions have authoritatively stated that drug offences do not constitute 'most serious crimes' and that executions for such offences are in violation of international human rights law. In a letter written to delegates to the 2008 session of the Commission on Narcotic Drugs, both the UN Special Rapporteur on Torture and the UN Special Rapporteur on the Right to Health stated that 'the weight of opinion indicates clearly that drug offences do not meet the threshold of "most serious crimes" for which the death penalty may be lawfully applied' (v).

In 2010, the Executive Director of the United Nations Office on Drugs and Crime wrote, 'As an entity of the United Nations system, UNODC advocates the abolition of the death penalty and calls upon Member States to follow international standards concerning prohibition of the death penalty for offences of a drug-related or purely economic nature' (vi).

**ENDS**

**Media Notes**

**About the author**

Rick Lines is the Executive Director of the International Harm Reduction Association (www.ihra.net) based in London. He is a leading international authority on human rights and drug policy, and is the author of *The Death Penalty for Drug Offences: A Violation of International Human Rights Law* (IHRA, 2007), and co-author of *The Death Penalty for Drug Offences: Global Overview 2010* (IHRA, 2010), http://www.ihra.net/files/2010/06/16/IHRA_DeathPenaltyReport_Web.pdf.

**End notes**

(i) Gallahue, P. & Lines, R. (June 2010), *The Death Penalty for Drug Offences: Global Overview 2010*, International Harm Reduction Association: There are 32 countries or areas that apply the death penalty for drugs including China, Iran, Saudi Arabia, Viet Nam, Singapore, Malaysia, Indonesia, Kuwait, Thailand, Pakistan, Egypt, Syria, Yemen, Bangladesh, Lao People's Democratic Republic, Cuba, Taiwan, Oman, United Arab Emirates, Bahrain, India, Qatar, Gaza (Occupied Palestinian Territories), Myanmar, South Korea, Sri Lanka Brunei-Darussalam, United States of America, North Korea, Iraq, Sudan, Libya. In late 2010, the Gambian National Assembly passed a law prescribing the death penalty for drug offences, however, at the time of this writing it was unclear if this law had been approved by the president.

(ii) Two UN General Assembly resolutions calling for a worldwide moratorium on the death penalty have been passed, one in 2007 and the other in 2008. The 2008 resolution was adopted by 106 votes in favour, compared with 104 votes in favour in 2007. Votes against totalled 46 in 2008, compared with 54 in 2007. Abstentions increased to 34, five more than in 2007. The results of the resolution simply confirm the continued progression towards abolition of capital punishment worldwide. According to Amnesty International, 137 of the 192 United Nations Member States may be considered abolitionist, either in law or in practice. Approximately two to three States abolish the death penalty each year, a trend that has existed for more than twenty years. If this continues, the death penalty will disappear in twenty-two years, that is, by 2030.

(iii) Dutch Ministry of Foreign Affairs, Human Rights Department (n.d.), *Overview executions 2009: Iran*. This estimate, however, is in contrast to Iran Human Rights' calculation of 140 in its annual report for 2009.

(iv) Amnesty International (2009), *Communication*. However, due to secrecy around the death penalty, these numbers cannot be considered comprehensive.

(v) The letter is available online at: http://www.ihra.net/contents/329

(vi) UNODC (2010) *Drug control, crime prevention and criminal justice: A human rights perspective*. Note by the Executive Director (Commission on Narcotic Drugs, Fifty-third session, Vienna, 8–12 March), UN Doc. E/CN.7/2010/CRP.6*–E/CN.15/2010/CRP.1*.

**Background information**

Alston, P. (2007), *2007 Report of the UN Special Rapporteur on extrajudicial, summary or arbitrary execution* (New York: United Nations), http://www2.ohchr.org/english/issues/executions/annual.htm

Amnesty International. (2007), *Death Sentences for drug crimes rise in the Asia Pacific*. (AI Index No: ASA 01/002/2007) (Hong Kong: Anti-death Penalty Asia Network - ADPAN), http://www.amnesty.org/en/library/asset/ASA01/002/2007/en/dom-ASA010022007en.pdf

Lines, R. (2007),*The Death Penalty for Drug Offences: A Violation of International Human Rights Law* (London, UK: International Harm Reduction Association), http://www.ihra.net/files/2010/07/01/DeathPenaltyReport2007.pdf

Gallahue, P. & Lines, R. (2010), *The Death Penalty for Drug Offences: Global Overview 2010* (London, UK: International Harm Reduction Association), http://www.ihra.net/files/2010/06/16/IHRA_DeathPenaltyReport_Web.pdf

# Failed policies: the impact of misguided drug policies on the spread of HIV/AIDS

***As HIV continues to spread through injecting drug use, many countries let ideology trump proven HIV prevention measures. Daniel Wolfe, Director of the Open Society Institute's International Harm Reduction Development Programme investigates.***

Despite clear evidence that the provision of sterile injection equipment and prescription of medications such as buprenorphine and methadone can reduce HIV risk and rates of HIV infection (i), epidemics among injecting drug users in many regions, including Eastern Europe, Central Asia, and other parts of Asia, continue largely unchecked.

Drug control policies that contradict public health approaches, such as the arrest of those carrying injecting equipment, mass incarceration and addition of the names of those with a history of drug use to government registries shared with police are among the causes for this failure in HIV prevention.

There has been an explosive spread of HIV through contaminated needles (ii). An estimated three million people who inject drugs are HIV positive. Excluding Sub-Saharan Africa, nearly one in three new HIV infections worldwide are caused by contaminated injecting equipment. Injecting drug users (IDUs) account for the largest share of cumulative HIV infections in Russia, China, Ukraine, Indonesia, Malaysia, Vietnam, all the Central Asian Republics, Baltic states, as well as parts of Latin America.

The spread of the HIV infection through contaminated injecting equipment can be much faster than infection caused by sexual transmission. In cities in China, Russia, India, and Thailand, among others, studies have documented levels of HIV infection among IDUs increasing from 1% to more than 40% in a single year (ii).

Multiple studies have found that the provision of sterile injection equipment reduces needle sharing without encouraging drug use (iii). Prescription of legal medications such as methadone and buprenorphine decrease the incidence of injection among drug users as well as reduce their participation in criminal activity. Positive benefits of these interventions include better relationships with family, the take up of productive employment and improved adherence to HIV treatment.

Where harm reduction initiatives are long established, such as Australia, New Zealand and much of Western Europe, HIV prevalence among people who inject drugs remains low. Yet despite evidence of the effectiveness of these approaches, which have been endorsed by the World Health Organisation, UNAIDS and UNODC (iv), drug users in many countries have no access to these life saving measures.

According to the UN Secretary General, in 2008 only 34% of countries with a concentrated or low HIV epidemic had implemented programmes to reduce risks among IDUs (v). In 2010, coverage remained low. In Latin America, the Middle East, North and Sub-Saharan Africa, for example, programmes provided less than a single syringe per injecting drug user. In the five countries that account for nearly half of all IDUs living with HIV (vi), 98% of IDUs, estimated at more than 4.5 million people, had no access to methadone and buprenorphine (vii).

Drug control approaches pose a major obstacle to effective HIV prevention. Although the International Narcotics Control Board has clearly stated that provision of sterile injecting equipment

and prescription of methadone and buprenorphine are in line with international drug control conventions, harm reduction groups in countries as varied as Bangladesh, China, Kazakhstan, India, Ukraine and the Unites States report that the police harass outreach workers at needle exchange sites and arrest drug users attempting to access clean syringes. Policing, pre-trial detention and incarceration of IDUs are associated with multiple health risks, including hurried injection, sharing of injection equipment, failure to see health services, and treatment interruption (viii, ix).

Even efforts to promote health can be undermined by drug control and institutionalised prejudice. Although the Chinese and Malaysian governments endorse the use of methadone, patients undergoing treatment have their names added to government registries and often face police harassment, forced urine testing, or arrest during raids on clinics (viii). IDUs are disproportionately less likely to receive HIV treatment in the low- and middle-income countries where they are the majority of those infected (vii). Some 400,000 drug users in East and Southeast Asia are detained for the purposes of "rehabilitation" in centres that offer no judicial process, right of appeal, or treatment for HIV or TB infections. In some countries, such as China and Vietnam, detainees are forced to labour for years in the service of private companies, and subjected to beatings, starvation, and cruel, inhuman or degrading abuses that sometimes rise to the level of torture (x).

Overly restrictive policies on the prescription of opioids also limit drug dependence and pain treatment. In Russia, for example, which has the fastest-growing HIV epidemic in the world, and more than 70% of infections related to drug injecting, methadone and buprenorphine are illegal for drug dependence treatment. In multiple countries, regulation of opiates reduces the availability of pain relief through requirements such as limits on the dose of medication dispensed, requirements that prescriptions be renewed every few weeks, and demands for special licenses or permits for physicians and patients alike (xi).

In order to curb the HIV epidemic, countries must not only institute and expand proven prevention and treatment approaches, including needle exchange and treatment with methadone and buprenorphine, they must also ensure that drug users are able to access these programmes. This will mean training the police on the legality of such approaches, and working with drug users themselves to ensure that programmes are tailored to their needs. Until that happens, drug users will miss out on vital health programmes, and HIV will continue unchecked.

**ENDS**

**Media Notes**

**About the author**

Daniel Wolfe is the Director of the International Harm Reduction Development (IHRD) programme at the Open Society Institute (http://www.soros.org/). Mr. Wolfe has been a community scholar at Columbia University's Center for History and Ethics of Public Health, the recipient of the Revson Fellowship awarded to individuals who have made a substantial contribution to the city of New York. Mr. Wolfe is a core member of the United Nations Reference Group on Injecting Drug Use and HIV, and the author of several books, book chapters and multiple articles in publications including AIDS, New York Times Book Review, the International Herald Tribune, the Journal of the American Medical Association, the Lancet, and the International Journal of Drug Policy.

**End notes**

(i) These are treatment options for people who are dependent on opiates and are referred to as opiate substitution therapy (OST). They can be taken in tablet or liquid form and are usually

prescribed in conjunction with a support programme to help patients manage their opiate dependence. It has been established that opiate substitution therapy reduces the incidence of injecting behaviour and associated risks. See this link for studies on the effectiveness of OST: http://international.drugabuse.gov/collaboration/guide_methadone/partb_question3.html

(ii) Studies that document the explosive increase in HIV transmission among injecting drug users include:
Burack, J.H., & D. Bangsberg (1998), 'Epidemiology and transmission of HIV among injection drug users. In *The AIDS Knowledge Base*. Ed. P.T. Cohen, M.A. Sande, and P.A. Volberding. (USA: Lippincott, Williams & Wilkins), http://hivinsite.ucsf.edu/InSite?page=kb-07-04-01
Rhodes. T., Lowndes, C., Judd, A., *et al.* (2002), 'Explosive spread and high prevalence of HIV infection among injecting drug users in Togliatti City, Russia'. *AIDS*. **16**(13): F25-F31 (31 ref.), http://www.ncbi.nlm.nih.gov/pubmed/12218407

(iii) Studies providing evidence that needle and syringe programmes reduce HIV risk behaviours without encouraging drug use include:
Watters, J.K., Estilo, M.J., *et al.* (1994). 'Syringe and needle exchange as HIV/AIDS prevention for injection drug users'. *Journal of the American Medical Association* **271**:115–120, http://jama.ama-assn.org/content/271/2/115.full.pdf+html
Institute of Medicine (2007), *Preventing HIV infection among injecting drug users in high-risk countries : an assessment of the evidence*. (Washington, D.C.: National Academies Press)

(iv) UNAIDS, UNODC and WHO have all endorsed harm reduction measures. There are various documents from each of these bodies that endorse individual harm reduction interventions. The following document outlines a "comprehensive package of prevention, treatment, and care of HIV in injecting drug users," which includes harm reduction measures. *In* World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV and AIDS (2009), *WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*.
http://www.who.int/hiv/pub/idu/OMSTargetSettingGuide.pdf.
See also the following journal article where the package is articulated: Donoghoe, M., Verster, A., Pervilhac, C., Williams & P. (2008) 'Setting targets for universal access to HIV prevention, treatment and care for injecting drug users (IDUs): Toward consensus and improved guidance'. *International Journal of Drug Policy,* **19S**: S5-S14, http://www.ncbi.nlm.nih.gov/pubmed/18243681

(v) In 2008, the UN Secretary General stated that only about 34% of countries with a concentrated or low HIV epidemic had implemented programmes to reduce risk among injecting drug users. See: *Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals*. Report of the Secretary-General (2008).
http://www.ua2010.org/en/UNGASS/UNGASS-2008/Secretary-General-s-Report-released

(vi) Mathers, B.M., Degenhardt, L., Ali, H., *et al.* (2010), 'HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage'. *The Lancet,* **375**(9719): 1014-1028,
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60232-2/abstract

(vii) Wolfe, D., Carrieri, M.P. & Shepard, D. (2010) 'Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward'. *The Lancet,* **376**(9738): 355-366, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2960832-X/abstract

(viii) Wolfe, D. & Cohen, J. (2010), 'Human Rights and HIV Prevention, Treatment, and Care for People Who Inject Drugs: Key Principles and Research Needs'. *Journal of Acquirred Immune Deficiency Syndromes*, **55 (**Suppl 1): S56-62, http://www.ncbi.nlm.nih.gov/pubmed/21045602

(ix) Grover A. (2010), *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report in accordance with Human Rights Council resolution 6/29*. 65th Session of the United Nations General Assembly; Document A/65/255. (New York: United Nations General Assembly), http://idpc.net/sites/default/files/library/Right%20to%20highest%20standard%20of%20health.pdf

(x) Wolfe, D. & Saucier, R. (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.idpc.net/publications/in-rehabilitations-name

(xi) Cherny, N.I., Baselga, J., de Conno, F. & Radbruch, L. (2010), 'Formulary availability and regulatory barriers to accessibility of opioids for cancer pain in Europe: a report from the ESMO/EAPC Opioid Policy Initiative'. Annals of Oncology, **21**(3): 615-626, http://annonc.oxfordjournals.org/content/21/3/615.full

**Background information**

Barrett, D., *et al.* (2008), *Recalibrating the regime*: *The need for a human rights-based approach to international drug policy.* (Report 13). UK: The Beckley Foundation. http://www.idpc.net/sites/default/files/library/Recalibrating%20the%20regime.pdf

Cook, C. & Kanaef, N. (2010), *The global state of harm reduction: Key issues for broadening the response* (London, UK: International Harm Reduction Association), http://www.ihra.net/contents/245

Open Society Institute (2009), *At what cost? HIV and human rights consequences of the global war on drugs* (New York: Author), www.soros.org/health/drugwar

Open Society Institute. (2009). *Fact Sheet: Abuses in the Name of Drug Treatment.* (New York), www.soros.org/health/drugwar

Wolfe, D. & Malinowska-Sempruch, K. (2009), *Illicit Drug Policies and the Global HIV Epidemic. (*New York: Open Society Institute) http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/cnd_20040316/Illicit%20Drug%20Policy%20for%20web%20FINAL.pdf

# The failure of punishment as a tool of drug policy

***It costs the taxpayer millions, ensures an ever-expanding prison population and contributes to public health harms. But does punishing drug users actually work? Mike Trace, chairman of the International Drug Policy Consortium and former deputy UK drugs tsar, thinks not.***

One of the basic assumptions of the international drug control system is that demand for illicit drugs is reduced by the threat of penal sanctions against potential users. This, in turn, lowers the amount of users and therefore the potential for profits for traffickers.

For many years, UN bodies, national governments and local authorities have put their faith in the principle of deterrence, by enacting strict laws against drug possession and use, sending tough messages on the unacceptability of drug use and investing huge amounts in the arrest and punishment of users.

In practice, the enthusiasm with which countries have pursued this line has varied widely around the world, and over time. The USA has led the way in articulating and implementing the belief in deterrence through punishment. Around 1.6 million Americans are arrested each year for drug possession offences (i), this is 13% of the total number of all arrests. Approximately a quarter of the current total of over 2 million prisoners in the USA are incarcerated for drug offences. Russia, Thailand, the UK and Japan also have relatively high arrest and imprisonment rates for drug offences.

Conversely, countries such as the Netherlands, Spain, Portugal and Australia have consciously moved away from harsh laws and penalties, responding to drug possession and use primarily through civil procedures. Many other countries, particularly in the developing world, rarely use the harsh penalties that exist in their legislation, with vigorous rhetoric hiding very low arrest rates (ii).

Strong drug law enforcement and the use of imprisonment as a deterrent have led to serious abuses and harms around the world.

Arrests and punishments in many countries are concentrated amongst poor or minority groups. In the USA, although African-Americans and whites use and sell drugs at similar rates, African-Americans are more likely to be imprisoned for drugs offenses. In 2005, of the 253,300 incarcerated in state prison for drug offenses, 44.8% were black and 28.5% were white (iii).

Prison terms can be longer for drug use than for crimes involving serious violence (including rapes and kidnappings), while crackdowns on drug users have led to multiple human rights abuses. In Thailand in 2003, thousands of extrajudicial killings resulted from a government-driven anti-drug campaign (iv).

The concentration of large numbers of drug users in prisons around the world, where HIV prevention measures such as sterile injection equipment are frequently unavailable, can lead to greater health and social problems. HIV epidemics in several countries, including Russia, Canada, Brazil, Iran and Thailand have been traced back to unsanitary conditions in jail. In Russia in 2002, 4% of the prison population was registered as HIV positive, some 36,000 prisoners, representing 20% of the total of known cases in the whole of the country (v), Syringes are shared between large numbers of users, re-sharpened and passed from wing to wing within the prison (vi). Studies report up to 86% of imprisoned drug users had shared injecting equipment in the past month (vii).

In terms of police, prosecution and prison budgets, the policy of deterrence results in a heavy burden for the taxpayer. Several US states spent nearly twice as much on corrections (US$ 42.89 billion) as they did on public assistance (US$ 24.69 billion) (viii).

Moreover, the threat of prison has been an almost complete failure in terms of its main objective – to reduce demand and thus supply. Successive research studies (ix) find little correlation between the severity and extent of drug law enforcement, and trends in demand for illicit drugs. Some of the toughest countries, the prime example being the United States, have some of the highest rates of drug use, while some of the most lenient, such as the Netherlands, have low rates. Analysts have been unable to draw a link between clampdowns on drug users and significant and sustained reductions in demand.

At the 10-year review of current global drug strategy in March 2008, Antonio Maria Costa, the executive director of the UN Office on Drugs and Crime, acknowledged that enforcement-centred drug policies like those on which the international community had relied for much of the last century had produced a range of "unintended consequences". The routine resort to imprisonment for non-violent drug users illustrates these graphically. Aside from the research evidence that tells us that incarceration falls far short of meeting its intended objectives, the marginalised populations condemned to cycles of crime and incarceration, poverty and poor health are a dramatic symbol of the failure of the policy. It is high time that our national and international leaders have the courage to face the reality of this failure, and to change direction.

**ENDS**

**Media Notes**

**About the author**

Mike Trace has a wide range of experience in the field of drug treatment and policy, from direct work with problematic drug users, to senior positions in national government and international agencies. He is the former UK deputy drug tsar and has chaired the European Union drugs agency, the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA). He worked for a short time at the United Nations Office on Drugs and Crime in Vienna before returning to the UK to work in the non-governmental sector. He is currently the Chief Executive of RAPT, one of the biggest providers of drug treatment services in the UK prison system. Mr. Trace continues to engage in policy issues as chairman of the International Drug Policy Consortium, a global network of NGOs promoting objective and evidence-based drug policy.

**End notes**

(i) http://www2.fbi.gov/ucr/cius2009/arrests/index.html

(ii) For further discussion see Bewley-Taylor, D., Trace, M. & Stevens, A. (2005), *Incarceration of Drug Offenders: Costs and Impacts*, Briefing Paper 7 (Beckley Foundation Drug Policy Programme), http://beckleyfoundation.org/pdf/paper_07.pdf

(iii) Sabol, W.J., PhD & West, H.C., Bureau of Justice Statistics, *Prisoners in 2007* (Washington, DC: US Department of Justice, December 2008), NCJ224280, p. 21, Appendix Table 10.

(iv) Thailand's 'War on Drugs' in 2003 has become notorious for the extrajudicial killings and abuses that it entailed. According to an unpublished report commissioned by the Thai government and seen by Human Rights Watch, 2,819 people were killed between February and April of that year.

Moreover, 1,400 of the victims had no links to the drugs trade; little investigation and no prosecutions followed these events. For more information see:
http://www.hrw.org/en/reports/2004/07/07/not-enough-graves-0 and
http://www.hrw.org/en/news/2004/07/07/thailand-drug-war-darkens-aids-success

(v) Jurgens, R., Ball, A. & Verster, A. (2009), 'Interventions to reduce HIV transmissions related to injecting drug use in prison'. *Lancet Infectious Diseases,* **9**: 57-66,
http://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2808%2970305-0/abstract

(vi) Scott, R., Dolan, K., Wodak, A., Hall, W., Maher, L. & Dixon, D., *Is Syringe Exchange Feasible in a Prison Setting? An exploratory study of the issues,*
http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/TR_27/$file/TR.025.pdf

(vii) UNDP HIV/AIDS in Eastern Europe and the CIS (2004), *Reversing the Epidemic – Facts and Policy Options,* http://europeandcis.undp.org/hiv/

(viii) National Association of State Budget Officers (2006), *2005 State Expenditure Report* (Washington, DC: NASBO), p. 35, Table 18, and p. 58, Table 32.

(ix) There are many research studies that demonstrate the lack of fit between the toughness of a country's or a city's drug laws and the prevalence of its drug use. These are some examples:
King, R.S., & Mauer, M., (2005), *The War on Marijuana: The Transformation of the War on Drugs in the 1990s* (Washington DC: The Sentencing Project),
http://www.sentencingproject.org/doc/publications/dp_waronmarijuana.pdf
Reinarman, C., Cohen, P.D.A., & Kaal, H.L. (2004), 'The Limited Relevance of Drug Policy: Cannabis in Amsterdam and San Francisco'. *American Journal of Public Health*, **94**(5): 836-842, http://www.ncbi.nlm.nih.gov/pubmed/15117709
Reuter, P. & Stevens, A. (2007), *An Analysis of UK Drug Policy* (London: UKDPC), http://www.ukdpc.org.uk/docs/UKDPC%20drug%20policy%20review.pdf
Stern, V. (1998), *A sin against the future: Imprisonment in the world* (London: Penguin Books)

**Background information**

Bewley-Taylor, D., *et al.* (2005), *Incarceration of drug offenders: costs and impacts* Briefing Paper 7 (Oxford: The Beckley Foundation), http://www.beckleyfoundation.org/pdf/paper_07.pdf

International Drug Policy Consortium (2010), 'Chapter 2: Criminal justice' *In: IDPC Drug Policy Guide*. http://idpc.net/sites/default/files/library/IDPC%20Drug%20Policy%20Guide_Version%201.pdf

King, R. (2008), *Disparity By Geography: The War on Drugs in America's Cities*. (Washington, DC: The Sentencing Project).
http://www.sentencingproject.org/Admin%5CDocuments%5Cpublications%5Cdp_drugarrestreport.pdf

## An obstacle to access essential medicines

***Diederik Lohman, Senior Researcher of Human Rights Watch's Health and Human Rights Division, explores how the implementation of the international drug conventions has left millions of people, many with terminal illnesses, with untreated chronic pain or untreated drug dependence.***

UN drug conventions recognise the importance of controlled substances for medical and scientific purposes. The 1961 Single Convention on Narcotic Drugs states that "narcotic drugs are indispensable for the relief of pain and suffering" and must be made available for that purpose (i).

Yet, almost 50 years after the convention was adopted, the availability of controlled medications for the relief of pain and suffering remains very poor in many parts of the world. Dozens of countries in Africa, Asia and elsewhere use almost no morphine, the mainstay drug for the treatment of chronic pain. The failure to offer that treatment leaves tens of millions of people, including cancer patients and people living with HIV/AIDS, suffering from severe pain without treatment.

In September 2008, the mother of a cancer patient in Colombia was driven to such desperation by her inability to obtain morphine for her daughter that she placed a classified ad in a local paper stating: "Cancer is killing us. Pain is killing me because for several days I have been unable to find injectable morphine in any place. Please Mr. Secretary of Health, do not make us suffer any more" (ii).

In many countries, people with opioid dependence caused by to illicit drug use cannot get methadone substitution treatment because it is either banned or not readily available, despite its proven effectiveness. In 2007 a 25-year old female heroin user in Russia, where substitution treatment is outlawed, expressed her deep anguish about the inadequate drug treatment services in her country. She told Human Rights Watch, "I'm not going back there [the drug treatment clinic]. There's no point, they don't cure you. I would go to the detoxification clinic if they actually helped [me] there. I'm sick and tired of injecting. But I can't [withdraw] at home. I would like to live to 30 at least..." (iii).

Many countries see prevention of the misuse of controlled substances, rather than their availability for legitimate purposes, as the primary objective of the UN drug conventions, even though the World Health Organisation and the International Narcotics Control Board have repeatedly reminded them of their obligation to ensure availability of controlled substances for medical use.

As a result, this obligation has been widely neglected or marginalised. By adopting a resolution on the promotion of safe availability of controlled medications, the 53rd session of the Commission on Narcotic Drugs took an important step toward ensuring that the poor availability of controlled medications takes its rightful place in international drug policy discussions (iv).

"The Commission on Narcotic Drugs resolution on controlled medications is a welcome first step," said Lohman. "Now the UN needs to ensure that countries implement the resolution so that millions of people are spared the needless suffering from chronic, debilitating pain or other health conditions they currently face."

A clear and ambitious plan of action is needed to improve availability of controlled medications. Access to controlled substances should be elevated to the same level of priority as prevention of drug abuse.

**ENDS**

**Media Notes**

**About the author**

Diederik Lohman is a senior researcher with the Health and Human Rights Division of Human Rights Watch (www.hrw.org). He has conducted extensive research and advocacy on various health issues, including drug dependence treatment in Russia, HIV testing policies in Lesotho, and palliative care and pain treatment services in India, and access to controlled medicines globally.

**End notes**

(i) The Single Convention codified all previously existing multilateral treaties on drug control. It established the modern-day international system for the prevention of abuse of controlled substances and mechanisms for ensuring their availability for medical and scientific purposes.

(ii) Human Rights Watch (2009), *"Please, do not make us suffer more..." Access to Pain Treatment as a Human Right,* http://www.hrw.org/en/reports/2009/03/02/please-do-not-make-us-suffer-any-more

(iii) Human Rights Watch (2007), *Rehabilitation Required: Russia's Human Rights Obligation to Provide Evidence-Based Drug Dependence Treatment*, http://www.hrw.org/en/reports/2007/11/07/rehabilitation-required

(iv) Commission on Narcotic Drugs (2010), *Resolution 53/4: Promoting adequate availability of internationally controlled licit drugs for medical and scientific purposes while preventing their diversion and abuse.* http://www.unodc.org/documents/commissions/CND-Res-2000-until-present/CND53_4e.pdf

**Background information**

Human Rights Watch (2009), *Unbearable Pain-India's Obligation to Ensure Palliative Care,* http://www.hrw.org/en/reports/2009/10/28/unbearable-pain-0;

Human Rights Watch (2010), *Needless Pain-Government Failure to Provide Palliative Care for Children in Kenya,* http://www.hrw.org/en/reports/2010/09/09/needless-pain-0

McNeil, Jr., D.G. (2007). 'In India, a quest to ease the pain of the dying'. *The New York Times Magazine*, 1-3, http://www.iht.com/articles/2007/09/11/healthscience/11pain.php

Wilson, R. (Director & Executive Producer) and Sitaram, A. (Director & Executive Producer) (2008), *The Two Faces of Opium.* [Motion picture] (London: Rockhopper), http://www.rockhopper.tv/programmes/138/

World Health Organisation (2007), *Access to Controlled Medications Programme*, Briefing Note (Geneva). http://www.who.int/medicines/areas/quality_safety/AccessControlledMedicationsBrNote.pdf

## Human rights abuses in the name of drug treatment

***Thousands of people around the world are forced or coerced into various forms of treatment for drug use every year. Human Rights Watch advocate, Rebecca Schleifer, takes a look at this harsh treatment.***

In some countries, people identified as – or suspected to be – drug users can be detained in locked facilities and consigned to 'treatment' for months, or even years at a time without trial or any semblance of due process.

Compulsory treatment facilities are often run by military or public security services and staffed by people who are untrained in medical care or drug dependence treatment. The treatment provided often consists of forced labour, psychological and moral re-education, military exercises and in some cases, being chained, caged, or caned. Poor conditions of detention pose additional risks to the health and lives of detainees. Former detainees frequently report physical and sexual assault at the hands of guards (i).

In many countries, people who seek treatment voluntarily are subjected to similar abuses. Regardless of whether residential treatment is voluntary or forced, evidence-based medical care to manage drug dependence, as well as HIV prevention and treatment, is frequently limited or unavailable.

International human rights law protects the right of every person, including those who use illicit drugs, to the highest attainable standard of health and freedom from torture and other forms of ill treatment. These and other rights are frequently violated in the name of treatment of drug dependence.

Since 2003, thousands of people in Thailand have been coerced into 'drug treatment' centres run by security forces, without a clinical assessment that they are indeed drug dependent. Many are subjected to 'rehabilitation' provided by security personnel, with military drills a mainstay of the so-called treatment. Thailand's coerced treatment and rehabilitation policy has had long-term consequences on the health and human rights of drug users, as many continue to avoid drug treatment or any government-sponsored health services out of fear of arrest or police action (ii).

In China, as many as 350,000 people are interned in mandatory drug detoxification centres throughout the country, where they can be detained without trial or due process for up to three years on suspicion of drug use (iii). Detainees are required to work without pay to produce goods such as trinkets for the tourist trade (iv). Treatment in these centres consists of little more than repetition of slogans like "drug use is bad, I am bad" and military-style drills. Methadone is not provided. As a doctor at one drug detention centre stated, "The purpose of the detox. centre is really just disciplinary, it's not to give people medical care".

In India, treatment in private centres can involve drug users being physically isolated, chained, denied meals and forced to work. Some are caged, beaten and in some cases given dangerous medication.

Drug users in some facilities in Russia have been subjected to 'flogging therapy', handcuffed to beds during detoxification and denied medication to alleviate painful withdrawal symptoms. Those who enter treatment voluntarily are consigned to locked wards, in some cases with fatal consequences. In 2006, 46 young women died in a fire in a Moscow substance abuse hospital,

where staff had abandoned residents to struggle against locked windows and doors. Government officials acknowledge that opioid dependence is a serious problem, but methadone and buprenorphine, the most effective treatments, are banned (v).

In Vietnam, drug users who test positive in periodic compulsory urine tests are forced into rehabilitation through labour centres. Even those who enter voluntarily, expecting stays of six months, are often kept longer against their will, including two years of 'rehabilitation' and two to three years of 'post-rehabilitation'.

In Cambodia, more than 2,000 people are arbitrarily detained in 11 government drug detention centers. The centers, while mandated to treat and "rehabilitate'" people who use drugs, instead subject detainees to sadistic violence (including electric shocks and whippings with electrical wire) as well as forced labour and harsh military-style drills. Children, as well as people with mental illnesses, make up a large number of detainees. In December 2009, 21 drug users were illegally detained in one centre and forced to participate in the trial of an unregistered Vietnamese herbal formula purported to "cure" drug dependence (vi).

For a long time, UN agencies have provided little guidance to countries to address human rights abuses carried out in the name of 'drug treatment.' In practice, UN drug control agencies have paid little attention to whether drug treatment is conducted consistent with human rights protections. UN human rights bodies have likewise paid scant attention to human rights abuses in the name of drug policy.

However, in March 2010, former Executive Director of UNODC, Antonio Maria Costs, declared: "With respect to drug treatment, in line with the right to informed consent to medical treatment (and its 'logical corollary', the right to refuse treatment), drug dependence treatment should not be forced on patients" (vii).

Torture and ill-treatment occur as a consequence of drug control efforts throughout the world. The Commission on Narcotic Drugs and the Human Rights Council must make sure that human rights are not sacrificed in the name of zero tolerance anti-narcotics policies and unproven and ineffective approaches to 'drug treatment.'

**ENDS**

**Media Notes**

**About the author**

Rebecca Schleifer is the advocate for the Health and Human Rights Division at Human Rights Watch. She has authored numerous reports and advocacy documents on HIV and AIDS in Africa, Asia, Central and Eastern Europe, and North America, focusing on the human rights of people living with and at highest risk of HIV and AIDS. Her research and advocacy have covered the role of criminal law in addressing (or impeding) the response to HIV/AIDS; government restrictions on harm reduction services to injection drug users and on HIV/AIDS information and services to youth, people who use drugs, and sex workers; access to HIV prevention and other post-rape services to survivors of sexual violence; and abuses against people living with and at high risk of HIV/AIDS in the United States, Bangladesh, South Africa, Jamaica, Ukraine, India, and Thailand. Rebecca has a JD and an MPH from the University of California, Berkeley, and an AB from Harvard-Radcliffe College.

**Endnotes**

(i) Open Society Institute, (November 2008), *Abuses in the name of drug treatment: Reports from the field*. In several countries – including Malaysia, Thailand, Vietnam, China, Nepal, Cambodia, and Russia – people who use drugs are subjected to unscientific methods to "treat" drug dependence that violate fundamental rights to health and are in fact cruel, inhuman, degrading, and sometimes rise to the level of torture. www.soros.org/health/drugwar

(ii) Human Rights Watch (November 2007), *Deadly denial: Barriers to HIV/AIDS treatment for people who use drugs in Thailand,* http://www.hrw.org/en/reports/2007/11/28/deadly-denial

(iii) Human Rights Watch (December 2008), *An unbreakable cycle: Drug dependency treatment, mandatory confinement, and HIV/AIDS in China's Guangxi province,* http://www.hrw.org/en/reports/2008/12/09/unbreakable-cycle-0

(iv) Human Rights Watch (January 2010), *"Where darkness knows no limits" - Incarceration, ill-treatment and forced labor as drug rehabilitation in China*, http://www.idpc.net/sites/default/files/library/hrw_china_darkness%20knows%20no%20limits.pdf

(v) Human Rights Watch (November 2007), *Rehabilitation required: Russia's human rights obligation to provide evidence-based drug dependence treatment,* http://www.hrw.org/en/reports/2007/11/07/rehabilitation-required

(vi) Human Rights Watch (January 2010), *"Skin on the cable" – The illegal arrest, arbitrary detention and torture of people who use drugs in Cambodia,* http://www.hrw.org/node/87692

(ii) Antonio Maria Costa, UNODC Executive Director (3 March 2010), *Drug Control, Crime Prevention, and Criminal Justice: A Human Rights Perspective*, E/CN.7/2010/CRP.6*–E/CN.15/2010/CRP.1, http://www.unodc.org/documents/commissions/CND-Uploads/CND-53-RelatedFiles/ECN152010_CRP1-6eV1051605.pdf

**Background information**

Nowak, M. (2009), *Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 7th Session, Agenda Item* (Geneva: OHCHR): This report calls for a human rights-based approach to drug policy, denounces forced drug treatment, and recommends that during the UNGASS review, States and UN agencies reassess drug policies to ensure that legal frameworks governing drug dependence treatment and rehabilitation services are in full compliance with international human rights norms**.** http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.44AEV.pdf

Open Society Institute (November 2008), *Abuses in the Name of Drug Treatment: Reports from the Field*. In several countries – including Malaysia, Thailand, Vietnam, China, Nepal, Cambodia, and Russia – people who use drugs are subjected to unscientific methods to "treat" drug dependence that violate fundamental rights to health and are in fact cruel, inhuman, degrading, and sometimes rise to the level of torture. See: www.soros.org/health/drugwar

UNODC (2010), *From coercion to cohesion: Treating drug dependence through healthcare, not punishment. Discussion paper*, http://www.idpc.net/sites/default/files/library/Coercion%20FULL%20doc%20(2).pdf

Human Rights Watch has documented human rights abuses in the name of drug dependence treatment in China, Thailand, and Russia and has called on Governments around the world to adopt

and expand needle and syringe exchange programmes and effective drug dependency treatment as part of their efforts to address HIV among people who use drugs: http://www.hrw.org/en/node/80747

## Drugs and development: a missing link

***Martina Melis, Associate of the New Zealand Drug Foundation and former UN staff, highlights how the failure of the development world to recognise the role and impacts of illicit drug policies on broader development goals and strategies has resulted in missed opportunities and negative consequences.***

The nexus between illicit drugs and development, and the identification of opportunities for comprehensive approaches to illicit drugs *and* development, have received little attention. This is despite the fact that illicit drugs and illicit drug policies impact on development in many ways.

Drug use, particularly non traditional use, contributes to diminished health, leading to higher health care costs and decreased earnings. This is most noticeable in the area of HIV/AIDS where the sharing of needles not only spreads HIV infection among people who inject drugs but also serves to fuel the broader spread of the epidemic. Involvement in the illicit drug market diverts people and resources from licit economic activities. The huge profits associated with the drug market foster organised crime and corruption, which in turn inhibit the development of good governance. Environmental degradation resulting from the cultivation and refinement of naturally derived drugs is also being increasingly documented.

To date, most policies and strategies designed to address the drugs problem have been narrow in their focus, and have operated largely in isolation from other development strategies. In the absence of systematic reviews and assessments of the effects and consequences of these policies from a broader development perspective, punitive and repressive approaches have led most national and international responses to illicit drugs.

Seen from a broader development angle, the high costs of repressive operations have diverted huge resources from other priority areas, yet have achieved limited impact on reducing the drug problem. Conversely, these interventions have led to a wide range of negative consequences. These relate not only to the huge costs of finding and destroying drugs but also to the economic, health and social costs to societies across the world resulting from the marginalisation, discrimination, criminalisation and incarceration of people involved with illicit drugs.

Health, development, socio-economic, human rights and environmental issues have paid the price of these narrow-focused and repressive policy choices. For example:

- Opium bans and forced eradication policies in South East Asia, Afghanistan and Latin America have been linked with increasing levels of poverty among poppy (i) and coca farmers. Many of these communities register extreme poverty, high infant mortality rates and widespread malnutrition, have limited access to water, health and social services, and viable alternative income opportunities are limited. In some countries, eradication campaigns have also exacerbated armed conflicts;

- In the face of the resources allocated to drug law enforcement, many countries have reported increasing rates of drug-related crime, often facilitated by corruption (ii). Law enforcement has not prevented the emergence of strong organised crime syndicates, and of a culture of violence with destabilising political, social and economic effects.

- Many national laws impose disproportionately long prison terms for minor drug offences (iii). These laws overcrowd the prisons of many developed and developing countries - with a high

human cost - but have not curbed the production, trafficking, or use of drugs. Worryingly, the imposition of excessive penalties for minor drug offences result in incapacitated or distorted criminal justice systems, where the use of limited crime fighting resources is diverted from more serious crimes. The overall notion of proportionality (iv) and fairness of the law is also undermined. These negative consequences are particularly felt in those countries where the justice systems are weak and the administration of justice often arbitrary.

- The impact of drug control is often unduly focussed on vulnerable and marginalised individuals and communities. Drug users are most often socially excluded individuals and their social exclusion can itself have a major economic impact for societies. It can lead to a higher social security bill, increases in crime and low productivity resulting from poor skills and wasted talent.

- Drug control policies disproportionately affect women. In some countries, women are subject to ill-conceived penalties (v) that intensify their vulnerability, marginalisation, discrimination and disempowerment. Within programmes and policies that address drug production, gender components are often relegated to the range of 'special considerations'. While women are punished as harshly as men for their drug trafficking crimes, policies aimed at offering assistance and treatment to drug users have largely ignored the needs of women. Overall, the causes and nature of women's involvement – particularly in their role as mothers and wives – in drug production, trafficking and use has been largely disregarded in the formulation and implementation of responses.

Although it is clear that the impacts and effects of illicit drugs and illicit drug policies reach far beyond their specific fields, the development community has thus far paid limited attention to these issues (vi). The most recent manifestation of the 'divide' between illicit drugs and development can be found in the absence of UNODC among the UN partners to the 'Millennium Development Goals' (MDGs). This is despite the crucial importance of illicit drug policies to the aims and objectives of the MDGs.

It is high time to address these inconsistencies and omissions. In 2010, the UN Secretary General Ban Ki Moon made a first step in this direction by calling for the promotion of development in drug-growing regions. He recognised that the advancement and achievement of the MDGs could not be dissociated from actions to address illicit drugs (vii). Likewise, the newly appointed UNODC Executive Director declared his intention to lead UNODC to '[…] make significant contribution to economic and social progress. Illicit drugs, crime and corruption cut lives short and retard prosperity, whereas justice and health spur development. We can play our part in the global fight against poverty and to achieving the UN Millennium Development Goals' (viii).

These calls and intentions need to be translated into action. It is clear that multi-sectoral discussions on these issues are urgently needed to broaden the ownership of the drug control agenda and promote joint and coherent policies and programmes.

**ENDS**

**Media Notes**

**About the author**

Martina Melis has worked on issues related to illicit drugs for more than ten years. She worked as a programme officer with the United Nations Office on Drugs and Crime in East Asia, as Manager of the European Network on Drugs and Infections Prevention in Prison and as Senior Policy Analyst with the New Zealand Drug Foundation before taking an extended maternity leave. She has

authored two books and various articles and reports on issues related to drugs, development and transnational crime.

**Endnotes**

(i) Renard, R. 'The making of a problem: Narcotics in mainland Southeast Asia'. *In* Mc Castill, D. & Kampe, K. (1997), *Development or Domestication?* (Thailand: Silkworm Books)

(ii) Klein, M. Day & Harriott, A. (2004), *Caribbean Drugs – from Criminalization to Harm Reduction* (London: Zed Books)

(iii) Transnational Institute & Washington Office on Latin America (December 2010), *System overload – Drug laws and prisons in Latin America,* http://www.idpc.net/sites/default/files/library/TNI-WOLA-prison-overload-latin-america.pdf

(iv) Even the INCB in its 2007 Annual Report noted that 'some countries still expend disproportionate effort in targeting low level offenders and drug users, as compared to the more pressing issues of identifying, dismantling and punishing those who control or organize major drug trafficking activities'. International Narcotics Control Board (2007), *INCB Annual Report 2007*, http://www.incb.org/pdf/annual-report/2007/en/chapter-01.pdf

(v) Human Rights Watch (2003), *Fanning the flames: How human rights abuses are fuelling the AIDS epidemic in Kazakhstan,* http://www.hrw.org/en/reports/2003/06/29/fanning-flames-0

(vi) One notable exception is a World Bank report written in March 2010, 'Innocent bystanders: developing countries and the war on drugs', which provides an understanding of the economics and logistics of the illicit drug market in relation to development issues: Palgrave MacMillan & World Bank (2010), *Innocent bystanders: developing countries and the war on drugs* (Editors: Philippe Keefer & Norman Loayza), http://idpc.net/publications/world-bank-innocent-bystanders

(vii) United Nations Secretary General (22 June 2010), *Work to achieve Millennium Development Goals, fight illicit drugs 'must go hand in hand', says Secretary General in message on day* (SG/SM/12969 OBV/892 SOC/NAR/940), http://www.un.org/News/Press/docs//2010/sgsm12969.doc.htm

(viii) United Nations Office on Drugs and Crime (13 September 2010), *New UNODC Executive Director sets out immediate priorities,* http://www.unodc.org/unodc/en/frontpage/2010/September/new-unodc-ed-sets-out-immediate-priorities.html?ref=fs3

**Background information**

Byrd, W.A. (2006) *Drugs, Security, and Development*, World Bank PREM Notes number 111

Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH (February 2010), *Briefing note – Development-oriented drug policy (EOD)*

MacMillan, P. & World Bank (2010), *Innocent bystanders: developing countries and the war on drugs* (Editors: Philippe Keefer & Norman Loayza). http://idpc.net/publications/world-bank-innocent-bystanders

Mansfield, D. (2006), *Development in a drugs environment: A strategic approach to alternative*

*development*, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, http://www.davidmansfield.org/data/Alternative_Development/GTZ/strategic_approach.pdf

Melis, M. & Nougier, M. (2010), *IDPC Briefing Paper – Drug policy and development: How action against illicit drugs impacts on the Millennium Development Goals,* http://idpc.net/sites/default/files/library/Drug%20policy%20and%20development%20briefing.pdf

Singer, M. (2008), 'Drugs and development: The global impact of drug use and trafficking on social and economic development', *International Journal of Drug Policy,* **19**: 467–478, http://www.ijdp.org/article/S0955-3959%2806%2900255-6/abstract

## Aerial fumigation: the collateral damage and alternative approaches

***Sanho Tree, Fellow at the Institute for Policy Studies in Washington DC, looks at the impact of forced crop eradication on the Colombian environment and its people.***

The over-reliance on forced illicit crop eradication (i) through measures such as aerial fumigation has failed to reduce the amount of coca being grown in Colombia. Even worse, it has caused tremendous damage, both to the country's diverse and precious environment and to the health of many Colombian people.

The substance used in aerial fumigation is a super-concentrated version of Roundup, a brand of weed killer, the active ingredient of which is a chemical called glyphosate (ii). Against manufacturers' instructions, Roundup is mixed with other chemicals (iii) to make the product more effective at eradicating coca plants. The resulting mixture kills anything green, but is particularly devastating to crops such as corn and yucca. Coca bushes tend to be hearty and resilient plants, so they can resist some of the fumigation if farmers take countermeasures such as dispersing their planting patterns or trimming the fumigated plants back to the stump so that they can resprout faster than new seedlings.

Aerial fumigation takes place across Colombia's conflict zones, meaning spray plane pilots frequently fly at higher than recommended altitudes in order to avoid trees, as well as hostile ground fire from FARC guerrillas. Crosswinds sweep the chemical cloud away from the intended target, causing damage to the jungle, food crops, aquaculture ponds, livestock and humans (iv). Local NGOs have linked fumigation exposure to skin rashes, vomiting, diarrhoea and infant deaths.

Of course, aerial fumigation is not the only consequence of the cocaine trade to impact on the environment in Colombia. The production of cocaine itself is very damaging. When farmers process coca leaves into coca paste, they dump waste chemicals such as gasoline and sulphuric acid into the ecosystem, causing significant damage.

Aerial fumigation only compounds this problem. Fumigation does not deter re-cultivation – many farmers have few viable economic alternatives in rural areas, historically abandoned by the central government. When a coca plantation has been damaged by spraying, farmers often venture deeper into the jungle to replant coca, cutting down more rainforest and introducing their waste products to new areas of this delicate ecosystem. The spray planes follow.

As with so many drug war measures, it is the unintended consequences that are the most alarming. Forced eradication is usually carried out before alternative livelihood programmes are in place. The devastation it wreaks leads many farmers to join the nearly four million internally displaced in Colombia – or worse, to join the ranks of the guerrillas or narco-traffickers.

The folly of policy makers (as evidenced by Plan Colombia) (v) has been to expect coca farmers to grow legal alternative crops without substantial agricultural and infrastructure assistance. The regions in which they live are often remote and undeveloped. A kilo of coca paste is easy to transport and sell. It is much harder to grow hundreds of kilos of fruits and vegetables that must be transported on vehicles farmers do not have, over roads that do not exist, to sell in domestic and international markets to which they do not have access. In addition, they have to compete against cheaper imports from international agribusiness - often subsidised by US taxpayers - against which they do not stand a chance.

Those who implement Washington's policies define success by relatively meaningless targets, such

as the number of hectares eradicated or kilos seized. They fail to take into consideration whether the coca growers have basic food security or realistic economic alternatives – measures that might give eradication 'successes' some sustainability. Thus, measuring success by 'hitting the numbers' is as misleading as 'body count' was to the Vietnam war. Coca farmers – like peasant farmers anywhere else in the world – will do whatever it takes to feed their families, including replanting coca.

There are more humane and effective approaches to coca crop reductions. This includes the promotion of alternative livelihoods, through comprehensive economic and rural development programmes intended to improve the welfare, overall quality of life and income generation opportunities for subsistence farmers.

Forced eradication puts the cart before the horse: once these farmers have basic food security, they can *then* diversify their local economy with different crops and livelihoods. Unfortunately, too many elected officials in the US place a greater emphasis on eradication than on alternative development because they want to look tough, rather than be effective, at election time.

**ENDS**

**Media Notes**

**About the author**

Sanho Tree is a Fellow of the Institute for Policy Studies (IPS), Washington DC (http://www.ips-dc.org/). He directs the Drug Policy Project at the IPS and has made several visits to Colombia over the last decade to monitor US counternarcotics policies.

**End notes**

(i) Crop eradication consists of the destruction of illicit crops through either manual or chemical means. Manual or mechanical means are most common, except in Colombia, which employs aeroplanes to spray herbicides. Occasionally, crop eradication is done voluntarily in exchange for aid, but it is more often carried out by force.

(ii) Roundup is the brand name of a type of systemic herbicide manufactured by Monsanto (www.monsanto.com). Its active ingredient is glyphosate.

(iii) Chemicals that are added to Roundup include a proprietary Colombian additive called Cosmoflux 411. It acts as a surfactant (or soap) to make the product stick to coca leaves more effectively. Monsanto specifically warns against adding surfactants to their product. A study published by the Universidad de Antioquia (Colombia) entitled *Assessment of toxic effects and lethal concentration of surfactant Cosmoflux 411F on juveniles of cachamar blanca (Piaractus brachypomus)*, demonstrated how dangerous, even lethal, this substance is for fish and other aquatic species.

(iv) The health and environmental impacts of fumigation have been well documented:
'The adverse effects on human health and the environment due to exposure to the spray chemicals may be considerably more severe than has been officially acknowledged'. *In* Washington Office on Latin America (2008), *Chemical Reactions: A WOLA Report on the Failure of Anti-Drug Fumigation in Colombia*, http://www.wola.org/index.php?option=com_content&task=viewp&id=669&Itemid=2
'A number of studies have found that Roundup is far more toxic than glyphosate alone. This is often due to the presence of an 'inert' ingredient called polyethoxylated tallowamine, or POEA. POEA is added to help the herbicide penetrate into the plant leaves. The herbicide mixture used in Colombia

contains POEA'. *In* Latin America Working Group (2005), *New science on roundup: Threats to human health and wildlife*

(v) Plan Colombia was first proposed in 1998 by Colombian president Pastrana as an integrated and balanced development and counternarcotics plan. The Clinton Administration militarised the programme and began fumigation campaigns in 2001.

**Background information**


Latin America Working Group (2002), *Blunt instrument: The United State's punitive fumigation program in Colombia* (Washington, DC: Latin America Working Group), http://www.lawg.org/storage/documents/blunt%20instrument%20(pdf).pdf

Marsh, B. (2004), *Going to extremes: The U.S.-funded aerial eradication program in Colombia* (Washington, DC: Latin America Working group), http://www.lawg.org/storage/documents/going2extremesfinal.pdf

Transnational Institute (2007), *Crop spraying: a déjà vu debate: From the Andean strategy to the Afghan strategy* (Drug Policy Briefing No 25, December 2007), (Amsterdam, Netherlands: Author), http://www.tni.org/detail_page.phtml?&act_id=17711

Washington Office on Latin America (2008), *Chemical reactions: A WOLA teport on the failure of anti-drug fumigation in Colombia* (Washington, DC: Author). http://wwww.wola.org/index.php?option=com_content&task=viewp&id=669&Itemid=2

Transnational Institute (2008), *Crops for illicit use and ecocide*. Germán Andrés Quimbayo Ruiz, author. (Drug Policy Briefing No, 28, December 2008), (Amsterdam, the Netherlands), http://www.idpc.net/sites/default/files/library/TNI_Crops_EN.pdf

Center for International Policy (2009). *After Plan Colombia: Evaluating "Integrated Action," the next phase of US assistance.* (Adam Isacson and Abigail Poe, authors. Washington, DC). http://justf.org/content/after-plan-colombia

Washington Office on Latin America (2010). *Development first: A more humane and promising approach to reducing the cultivation of crops for the illicit market*. (Coletta A. Youngers and John Walsh, authors, Washington, DC). http://www.idpc.net/sites/default/files/library/WOLA%20Development%20First.pdf

## Glossary

| | |
|---|---|
| **Blood borne viruses (BBV)** | BBVs are viruses that some people carry in their blood and which may cause severe disease in certain people and few or no symptoms in others. The virus can spread to another person, whether the carrier of the virus is ill or not.<br><br>The main BBVs of concern are: hepatitis B virus, hepatitis C virus and hepatitis D virus, which all cause hepatitis, a disease of the liver; and human immunodeficiency virus (HIV) which causes acquired immune deficiency syndrome (AIDS), affecting the immune system of the body. |
| **Buprenorphine** | Brand name Subutex, this is a medication used in opiate substitution therapy for people who are dependent on heroin or other illicit opioids. Buprenorphine is a semi-synthetic opioid with partial agonist and antagonist actions. This means it eases withdrawal symptoms and helps to reduce cravings for heroin and other street opioids, but, in proper doses, gives the user no euphoric effect. |
| **CND** | Commission on Narcotic Drugs. The CND was established in 1946 as the central policy-making body of the United Nations in drug-related matters.<br>Read more: www.unodc.org/unodc/en/commissions/CND/index.html |
| **Contaminated needles** | Injecting drug users sometimes share injecting equipment. This puts them at risk of contracting blood borne viruses (BBVs) such as HIV and Hepatitis B or C. Even a tiny amount of blood left on a needle from an infected person can be enough to cause spread to others. Using other used injecting items such as syringes, etc, is sometimes a cause of infection. |
| **Controlled drugs** | A drug or chemical whose manufacture, possession and use are regulated. This may include illegal drugs and prescription medications. |
| **Crop eradication** | The destruction of illicit crops through either manual or chemical means. Manual or mechanical means is most common, except in Colombia where aeroplanes are employed to spray herbicides. Occasionally, farmers undertake crop eradication voluntarily in exchange for aid, but it is more often forced eradication. |
| **Demand reduction** | Demand reduction refers to efforts aimed at reducing public desire for illegal and illicit drugs. This drug policy is in contrast to the reduction of drug supply, but the two policies are often implemented together. |
| **Drug dependence** | Dependency describes a compulsion to continue taking a drug in order to feel good or to avoid feeling bad. When this is done to avoid physical discomfort or withdrawal, it is known as physical dependence; when it has a psychological aspect (the need for stimulation or pleasure, or to escape reality) then it is known as psychological dependence. |
| **Drug detoxification** | Detoxification or detox. describes the way in which a drug such as heroin is eliminated from a drug user's body, often with the help of a doctor and/ or specialist drug worker. This is often a gradual process and may take a number of days or weeks. |

| | |
|---|---|
| **Drug prohibition** | The prohibition (forbidding) of drug use through legislation or religious law is a common means of attempting to control drug use. Prohibition of drugs has existed at various levels of government or other authority, from the Middle Ages to the present.<br><br>While most drugs are legal to possess, many countries regulate the manufacture, distribution, marketing and sale of some drugs, for instance through a prescription system. Only certain drugs are banned with a "blanket prohibition" against all use.<br><br>Many governments do not criminalise the possession of a limited quantity of certain drugs for personal use, while still prohibiting their sale or manufacture, or possession in large quantities. Some laws set a specific volume of a particular drug, above which is considered ipso jure to be evidence of trafficking or sale of the drug. |
| **Drug rehabilitation (rehab)** | An umbrella term for the processes of medical and/or psychotherapeutic treatment, for dependency on psychoactive substances such as alcohol, prescription drugs, and so-called street drugs such as cocaine, heroin or amphetamines. The general intent is to enable the user to cease substance misuse. |
| **Drug use / misuse / abuse** | Drug use is an easy term to understand. Drug misuse and drug abuse are more difficult to pin down as they are highly subjective. In most circles, misuse means using in a socially unacceptable way. However, for many people, misuse is defined as using drugs in a way that results in experience of social, psychological, physical or legal problems related to intoxication and / or regular consumption.<br><br>Many regard the term abuse as too judgemental, as it suggests impropriety regardless of how the drug us being used. As abuse and misuse can be morally loaded terms, many people prefer to talk of drug-taking or of harmful or problematic use instead, where appropriate. |
| **Harm reduction** | Refers to policies and projects that aim to reduce the health, social and economic harms associated with the use of psychoactive substances. Needle exchange programmes, for example, are a key harm reduction intervention.<br><br>Harm reduction is an evidence-based and cost-effective approach. Harm reduction recognises that society is unlikely to ever be drug-, drink- or nicotine-free. Harm reduction does not exclude abstinence as a goal for individuals who are dependent but, rather, provides people with more pragmatic choices such as limiting their intake or using drugs more safely. |
| **Injecting drug user (IDU)** | Someone who uses drugs by injecting them, intravenously (directly into their bloodstream), intramuscularly, or subcutaneously (under the skin). |
| **Methadone** | This is a medication used in opiate substitution therapy for people who are dependent on heroin or other illicit opioids. Methadone is a long-acting synthetic opioid. This means it eases withdrawal symptoms and reduces cravings for heroin or street opioids, but, in appropriate doses, gives no euphoric effect. |
| **Narcotic** | Commonly used to mean any illicit drug, especially in the US. However, the term technically refers to chemicals that induce stupor, coma or insensibility to pain, such as opiates or opioids. |

| | |
|---|---|
| **Needle exchange programmes** | A key harm reduction intervention that was borne out of the rise in blood borne viruses such as HIV and hepatitis B/C. Injecting drug users hand in used needles and syringes in return for sterile injecting equipment. |
| **Opiate substitution therapy (OST)** | A key harm reduction intervention. OST refers to the medical procedure of treating people dependent on illegal opiates such as heroin, by prescribing a longer acting opioid, usually methadone or buprenorphine, that is taken under medical supervision.<br><br>The driving principle behind OST is that someone dependent on opiates will be able to regain a normal life while being treated with a substance that stops him/her from experiencing withdrawal symptoms and cravings, but does not provide strong euphoria. It also reduces the risk of transmitting blood borne viruses through contaminated needles or other injecting equipment. |
| **Opiates** | Drugs derived from the opium poppy. Includes morphine, codeine and heroin. |
| **Opioids** | This term includes both opiates and their synthetic analogues, such as methadone and buprenorphine. |
| **Paraphernalia** | Equipment used for drug taking e.g. silver foil, spoon, syringe, needle. |
| **Problem drug use** | Tends to refer to drug use that could be either dependent or recreational. In other words, it is not necessarily the frequency of drug use that is the primary problem, but the effects that the drug-taking have on the user's life (they may, for example, experience social, financial, psychological, physical or legal problems as a result of their drug use). |
| **Psychedelic** | This term was coined in 1956 by LSD researcher Humphrey Osmond and literally means 'soul manifesting' - an activation of consciousness. Although virtually synonymous with hallucinogenic, psychedelic implies that the drug or experience acts as a catalyst to further feelings and thoughts and is not merely hallucinatory. |
| **Psychoactive / psychotropic** | Perhaps the most all-encompassing ways of describing mood-altering drugs in general, although they are more often used to describe LSD and similar hallucinogenic drugs. |
| **Recreational drug use** | The use of drugs for pleasure or leisure. |
| **Residential rehabilitation, residential services** | Residential treatment programmes are usually used by heavily dependent users who experience ongoing social and psychological problems as a result of their drug use. Usually residents must be drug free on admission, which usually entails that the entrant has undergone detoxification before entry. Programmes most commonly last for between three and six months (although some last up to a year). |
| **Supply reduction** | Supply reduction means using various strategies to disrupt the production and supply of illicit drugs, for example, crop eradication or interrupting the trafficking of drugs. Supply reduction has been used for decades but the evidence is that it is extremely expensive and not cost-effective. |
| **Tolerance** | Refers to the way the body gets used to the repeated presence of as drug, meaning that higher or more frequent doses are needed to maintain the same effect. |

| | |
|---|---|
| **UNAIDS** | Joint United Nations Programme on HIV/AIDS. This is a joint venture of the United Nations, bringing together the efforts and resources of ten UN agencies to help prevent new HIV infections, care for people living with HIV, and mitigate the impact of the HIV/AIDS epidemic.<br>Read more: http://www.unaids.org/en/ |
| **UNGASS** | United Nations General Assembly Special Session. Established in 1945, the UN General Assembly occupies a central position as the chief deliberative, policy-making and representative organ of the United Nations. It also plays a significant role in the process of standard-setting and the codification of international law.<br><br>The Assembly meets in regular session intensively from September to December each year but reconvenes for Special Sessions when necessary. In 1998 there was an UNGASS on Illicit Drugs. That meeting concluded by adopting a political declaration where actions for the next decade were outlined. As part of a UN review of the success of these measures, another UNGASS is being held on drug policy in New York in 2009. |
| **UNODC** | United Nations Office on Drugs And Crime. This UN agency was established in 1997 to assist the UN in better addressing a coordinated, comprehensive response to the interrelated issues of illicit trafficking in and misuse of drugs, crime prevention and criminal justice, international terrorism, and corruption. It was originally named the Office for Drug Control and Crime Prevention but was renamed as the UNODC in 2002.<br>Read more: www.unodc.org/ |
| **WHO** | World Health Organisation. This is the directing and coordinating authority for health within the United Nations system.<br>Read more: http://www.who.int/en/ |
| **Withdrawal** | The body's reaction to the sudden absence of a drug to which it has adapted. A range of physical and psychological symptoms may manifest themselves during the period of withdrawal. The effects can be stopped either by taking more of the drug, by managed detoxification or by 'cold turkey' - which may last up to a week. |

# Background on UN Drug Control Treaties

| The 1961 Single Convention on Narcotic Drugs (as amended by the 1972 protocol) |
|---|
| The Single Convention replaces previous international drug controls enacted in the 20th century. Its objective is to restrict the use of narcotic drugs to medical and scientific purposes, and it is focused on plant-based drugs (opiates, cannabis and cocaine).<br><br>There are two strands to this objective: to suppress illicit drugs and to ensure supplies for medical and scientific purposes.<br><br>Full text available at: http://www.unodc.org/unodc/en/treaties/single-convention.html |

| The 1971 Convention on Psychotropic Drugs |
|---|
| The 1971 Convention is concerned with manufactured drugs such as amphetamines, barbiturates, hallucinogens and minor tranquillisers. It aims to restrict use of these substances to medical and scientific purposes, to suppress illicit production, supply and use while facilitating supplies for medical and research objectives.<br><br>Full text available at: http://www.unodc.org/unodc/en/treaties/psychotropics.html |

| The 1988 Convention against the Illicit Trafficking in Narcotic Drugs and Psychotropic Substances |
|---|
| The 1988 Convention was brought into being to combat the dynamic and flexible trafficking networks that had grown up over the 1970s and 80s.<br><br>Its objective is to harmonise drug laws and enforcement measures around the world; it obliges signatories to enact specific legislation to criminalise all supply-related activities, and includes measures for judicial co-operation, extradition, seizure of assets, cross-border actions against money-laundering and so on. It also establishes a control regime for precursor chemical used to produce illegal drugs.<br><br>Full text available at: http://www.unodc.org/unodc/en/treaties/illicit-trafficking.html |

# List of IDPC member organisations

| Organisation | Country | Website |
|---|---|---|
| Agência Piaget para o Desenvolvimento (APDES) | Portugal | http://www.apdes.net/ |
| AIDS Foundation East West (AFEW) | Netherlands | www.afew.org |
| Aksion Plus | Albania | www.aksionplus.net |
| AKZEPT | Germany | www.akzept.org |
| Alcohol and Other Drugs Council of Australia (ADCA) | Australia | www.adca.org.au |
| Alternative Georgia | Georgia | www.altgeorgia.ge |
| Andean Information Network (AIN) | Bolivia | www.ain-bolivia.org |
| Andreas Papandreou Foundation (APF) | Greece | www.agp.gr |
| Andrey Rylkov Foundation for Health and Social Justice | Russia | http://rylkov-fond.ru |
| Asian Harm Reduction Network (AHRN) | Thailand | www.ahrn.net |
| Asian Network of People Who Use Drugs (ANPUD) | Thailand | www.anpud.info |
| Asia-Pacific Committee on Drug Issues (APDIC) | Australia | http://www.ancd.org.au/committees/asia-pacific-drug-issues-committee.html |
| Association Française de Réduction des Risques | France | www.a-f-r.org |
| Association Nationale des Intervenants en Toxicomanie et Addictologie (ANITEA) | France | www.anitea.fr |
| Association Prevent | Serbia | www.prevent.org.rs |
| Association Terra Croatia | Croatia | http://www.udrugaterra.hr/ |
| Australian Drug Foundation (ADF) | Australia | www.adf.org.au |
| Beckley Foundation | UK | www.beckleyfoundation.org |
| Canadian Foundation for Drug Policy (CFDP) | Canada | www.cfdp.ca |
| Canadian HIV/AIDS Legal Network | Canada | www.aidslaw.ca |
| Caribbean Drug Abuse Research Institute (CDARI) | Saint Lucia | www.cdari.org |
| Centro de Estudios de Derecho, Justicia y Sociedad (DeJuSticia) | Colombia | www.dejusticia.org/ |
| Centro de Investigación Drogas y Derechos Humanos (CIDDH) | Peru | http://www.ciddh.com/es/# |
| Centro de Respuestas Educativas y Comunitarias A.C (CRECE) | Mexico | |
| Colectivo por Una Política Integral Hacia las Drogas (CUPIHD) | Mexico | www.cupihd.org |
| Connections | Belgium | www.connectionsproject.eu |
| Correlation European Network on Social Inclusion and Health | Netherlands | www.correlation-net.org |
| Diogenis, Drug Policy Dialogue in South East Europe | Greece | www.diogenis.info |
| Drug Policy Action Group (DPAG) | Ireland | www.drugpolicy.ie |
| Drug Policy Alliance (DPA) | USA | www.drugpolicy.org |
| DrugScope | UK | www.drugscope.org.uk |
| Espolea | Mexico | www.espolea.org |
| Eurasian Harm Reduction Network (EHRN) | Lithuania | www.harm-reduction.org |
| Federation of European Professional Associations Working in the Field of Drug | UK | www.erit.org.uk |

| | | |
|---|---|---|
| Abuse (ERIT) | | |
| Forum Droghe | Italy | www.fuoriluogo.it/home/forum_droghe |
| Groupement Roman d'Etudes des Addictions (GREA) | Switzerland | www.grea.ch |
| Harm Reduction Coalition | USA | www.harmreduction.org |
| Health Connections international | Netherlands | www.myhci.org |
| Healthy Options Project Skopje (HOPS) | Former Yugoslav Republic Macedonia | http://www.hops.org.mk/info_en.htm |
| Hungarian Civil Liberties Union (HCLU) | Hungary | www.tasz.hu |
| Illicit Drug Market Institute (IDM) | Italy | http://idminstitute.org/ |
| Initiative for Health Foundation (IHF) | Bulgaria | www.initiativeforhealth.org |
| Institute for Policy Studies (IPS) | USA | www.ips-dc.org |
| Intercambios | Argentina | www.intercambios.org.ar |
| International AIDS Society | International | www.iasociety.org |
| International Harm Reduction Development Program (IHRD) | International | www.soros.org/initiatives/health/focus/ihrd |
| International Network of People Who Use Drugs (INPUD) | International | http://www.inpud.net/ |
| Juventas | Montenegro | |
| Lawyers Collective | India | www.lawyerscollective.org |
| Malaysian AIDS Council (MAC) | Malaysia | www.mac.org.my |
| National Rehabilitation Centre (NRC) | United Arab Emirates | www.nrc.ae |
| New Zealand Drug Foundation | New Zealand | www.nzdf.org.nz |
| NGO Veza | Serbia | http://www.ngoveza.org.rs/lang/en/activities |
| Psicotropicus | Brazil | www.psicotropicus.org |
| Puente, Investigación y Enlace (P.I.E) | Bolivia | www.piebolivia.org.bo |
| Red Americana de Intervención en Situaciones de Sufrimiento Social (RAISSS) | Chile | www.raisss.cl |
| Red Chilena de Reducción de Daños | Chile | http://www.reduccion dedanos.cl/wp/ |
| Release | UK | www.release.org.uk |
| Romanian Harm Reduction Network | Romania | http://rhrn.ro/index.php?l=en |
| Society for Promotion of Youth and Masses (SPYM | India | www.spym.org |
| South Eastern European Adriatic Addiction Treatment Network (SEEAN) | Slovenia | www.seea.net |
| Thai AIDS Treatment Action Group (TTAG) | Thailand | www.ttag.info |
| Transform Drug Policy Foundation | UK | www.tdpf.org.uk |
| Transnational Institute (TNI) | Netherlands | www.tni.org |
| Trimbos Institute | Netherlands | www.trimbos.nl |
| Viva Rio | Brazil | www.vivario.org.br |
| Washington Office on Latin America (WOLA) | USA | www.wola.org |
| World AIDS Campaign | International | www.worldaidscampaign.org |
| Youth RISE | International | www.youthrise.org |