

Response to the 2009 Annual Report of the International Narcotics Control Board

May 2010



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The International Drug Policy Consortium (IDPC) is a global network of NGOs and professional networks that specialise in issues related to illegal drug production and use. The Consortium aims to promote 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. It produces occasional briefing papers, disseminates the reports of its member organizations about particular drug-related matters, and offers expert consultancy services to policymakers and officials around the world.

Introduction

Published as it was under the Presidency of Sevil Atasoy, this year's Annual Report was anticipated for what it might reveal about the attitude of the Board under fresh leadership. Appointed as President of the Board in 2009, Atasoy broke the revolving door arrangement operating consistently between Hamid Ghodse and Philip Emafo for the previous nine years. As is always the case, the *Report* contains an impressive array of technical information on the operation of the international drug control system; a system constructed with the aim of managing the global licit market for narcotic and psychotropic substances for medical and research uses while simultaneously suppressing the illicit market. Such operational descriptions are interspersed with references and discussions on certain policy issues. These, as is the norm, are primarily observations on what the Board perceives to be the strengths and weaknesses of the system and are in the main a welcome contribution to the policy process. However, despite what has turned out to be only a hiatus in the Ghodse-Emafo dynasty (Hamid Ghodse re-assumed the Chairmanship in May 2010), the *Report* also displays a certain continuity of approach in terms of its more worrying content. Although at points perhaps more conciliatory in tone than in previous years, the document reveals the Board as a body that maintains a very narrow and selective interpretation of the

drug control conventions. Within this context it remains keen to censure what it regards as moves towards the liberalization of policy practice, yet stays silent on other areas that are worthy of attention; particularly those relating to the non-punitive aspects of the conventions. As policy debates around the world grow richer and more diverse, the INCB is in danger of being left behind.

The INCB is the "independent and quasi-judicial" control organ for the implementation of the drug control treaties. The Board was created under the 1961 Single Convention and became operational in 1968. It is technically independent of Governments, as well as of the UN, with its 13 individual members serving in their personal capacities. The WHO nominates a list of candidates from which three members of the INCB are chosen, with the remaining 10 selected from a list proposed by Member governments. They are elected by ECOSOC and can call upon the expert advice of the WHO. In addition to producing a stream of correspondence and technical assessments arising from its programme of country visits (all of which, like the minutes of INCB meetings, are never made publicly available), the INCB produces an annual report summarising its activities and views. This response to the *Annual Report for 2009* (INCB Annual

Reports are usually published in the spring of the following year) focuses on four issues - the INCB's position on drug use prevention, its ongoing proclivity for exceeding its mandate, the Board's systemically contradictory attitude towards access to controlled medicines and, for different reasons, its problematic positions on harm reduction, the coca leaf and human rights.

Drug use prevention in a globalising world

“International drug control efforts cannot be successful in the long term without continuous efforts to reduce illicit drug demand.”¹ So begins the Foreword to the 2009 *Report*, and continues a discussion for several paragraphs, anticipating one of the Board's key emphases this year. The *Report's* opening chapter is devoted to a discussion of one of the major strategies for demand reduction, *primary prevention*. The concept of prevention is broken down into three sub-categories; *tertiary prevention*, aimed at treating and ameliorating already-existing drug use (this is the category in which the Board has previously placed harm reduction²); *secondary prevention*, measures aimed at diverting those already ‘seriously’ involved with drugs away from dependence; and *primary prevention*, which aims to stop or reduce the use of drugs by populations either not using or using only very occasionally. In the words of the *Report*, primary prevention “promotes the non-use of drugs and is aimed at preventing or delaying the first use of drugs and the transition to more serious use of drugs among occasional users.” (Para 5)

Following its introduction of the topic, the chapter goes on to give a short overview of the estimated extent of global drug use, quoting *the World Drug Report* for 2009³ to the effect that between 172 and 250 million people had used an illegal drug in the past year. The Board notes that this total conceals wide variation in concentration and types of usage, while stating

that rates of use tend to be higher amongst adolescents and young adults. It observes that, “the question of why some young people begin to use drugs and others do not is complex.” (Para. 9.) In its ensuing discussion of the factors involved in influencing some to use drugs and others not, which it divides into “risk factors” and “protective factors” respectively, the Board reveals its unspoken assumptions about both the use of drugs and what constitutes a good society; these assumptions then go on to structure its strategies for prevention. The fact that the discussion is couched in the language of health will be a welcome development to many of those in government and civil society who wish to move international drug policy framework away from a preoccupation with crime and law enforcement. However, the Board's discourse of health, as our analysis will seek to show, articulates a moral and socio-political belief system, translating as ‘healthy’ attitudes and behaviours those of which the Board approves, and vice versa. To examine this tendency at work, we will critically interrogate the Report's account of the factors involved in moving individuals towards or away from the use of drugs.

Before doing so, it may be helpful to briefly consider the *context* for prevention. This involves providing a brief account of the social world in which drugs are used and prevention efforts must be grounded. All of the most significant sociological analysis of the last few decades has been concerned with that set of rapid and far-reaching changes which the global community has undergone over the final quarter of the twentieth century. The increasingly inter-connected world which we inhabit is often understood in the large-scale terms of *globalisation*—economic inter-dependence, global connectivity via the internet and other technologies of communication, transnational and regional politics, and so on. These changes are clearly of immense importance. But it is also essential to keep in mind that this process of change is also transforming the lives of individual human beings and the most

intimate regions of our personal experiences and relationships; it has meant the erosion of many traditional types of marriage and family structure, a plurality of new forms of identity, the mixing of ethnicities and cultures, new gender roles and styles of sexuality, different ways of working and playing—it is an extensive list. The INCB, however, often appears to be at best dimly aware of this state of affairs; the section on prevention does mention social change and upheaval, but only in a very limited sense. In general, and to put it in colloquial language, it is as if the Board’s vision of the society in which drug prevention takes place remains locked in some eternal 1950s. In order to demonstrate this point, we will examine further the factors listed as important in terms of prevention. These factors are divided into six areas.

1. Personal factors. A number of factors are listed in this section, focused on individual biography and genetic predisposition. However, the territory quickly becomes rather cloudy as reference is made to “an easy-going temperament (which) is a protective factor that buffers the influence of risk factors” (Para. 11); this only so in early childhood, as later on, apparently, “a cautious temperament is a protective factor.” Aside from these remarks, which are easy targets owing to their vagueness, the *Report* states that “a well formed sense of identity” (Para. 11) also has prophylactic powers. This statement is problematic for two reasons: firstly because in childhood and adolescence the sense of identity is continually being shaped and it is difficult to know in quite sense it could be ‘well-formed’; secondly, and more importantly in terms of the scenario outlined above, present social and historical circumstances tend to make most of our identities increasingly provisional, fluid and contingent. This does not just apply to children; adults are required to continually reinvent themselves to meet social, economic, technological and cultural change.

2. Family factors. This section opens by stating that, “The quality of family life is a large factor affecting health and behaviour throughout childhood and adolescence.” (Para. 12) Few would take issue with this, but the way the argument unfolds raises some more contentious points; for example, “Transitions or significant changes in family life (such as parental separation, loss of a close family member or moving to a new neighbourhood or school) can place any young person at risk.” (Para.12) Such phenomena are, however, increasingly familiar in contemporary social life, where personal relationships are often provisional and divorce and second marriages common, and few can expect the ‘job-for-life’ which was a normal expectation for their grandparents. As a result of rapid economic and technological changes, moving house to follow employment opportunities is increasingly ‘normal.’ More contentious is the Board’s support for parents who “model healthy behaviours”. The example given of a “healthy behaviour” is the parents relation to use of medication—but what else is a “healthy behaviour”? One suspects it is behaviour of which the INCB would approve, particularly since “deviant peers” are contrasted with “more conventional peers”⁴, revealing the underlying assumptions that pattern the Board’s notion of health (“healthy” stands for conventional, while “deviance” and “unhealthiness” often refer to the unconventional).

3. Social factors. “In some societies, the media have contributed to a normalization of drug use.” (Para 13). This is a familiar theme for the Board, having provided the first chapter in the 1997 *Report*, in which the Board advocated recourse to legal measures by governments to stop what it sees as pro-drug incitement. While there is no doubt that the popular media (television, movies, newspapers, magazines, CDs etc) do influence social life, they also reflect it.⁵

In certain parts of the world, certain kinds of drug use have become normalized, and the media may therefore be regarded as articulating a libertarian strand of popular culture in which drug use is celebrated.⁶ This too, like it or not, is part of our current social landscape. The Board advocates “Spiritual engagement, active involvement in healthy recreational activities and service to a community” as protective factors, though all of these can and do co-exist with some forms of drug use.

4. Gender factors. The Board is surely correct when it says that, “It is important to consider gender differences for protective and risk factors in relation to drug use.” Once more, however, the vision of gender differences invoked seems curiously remote from present day experience. Boys are alleged to have earlier contact with “deviant peers” and earlier initiation into drug use, while girls are affected more by issues of appearance: “self-image” and “weight concerns”. While the latter are traditionally associated with feminine identity, the old gender roles are undergoing profound changes, certainly in the developed world, and the traditional male and female roles assigned by the INCB are somewhat anachronistic.⁷ As a result, prevention measures built around its vision of these categories are increasingly liable to be problematic and ineffective.

5. School factors. According to the *Report*, “The opportunity to attend school is an important protective factor.” This is likely to be the case, as is the quality of relationships in the institution. The claim that students “are less likely to use drugs when the norms of the school reflect a clear disapproval of drug use” requires some nuancing. Much of the evidence for the urine testing of school children for drugs (which reflects a clear disapproval) is highly ambiguous or poorly constructed. It has been observed by researchers that the introduction of testing can in fact *reduce*

protective capacity by disrupting the trust and sense of connectedness which helps to prevent the development of problematic drug use.⁸

6. Community and societal factors. The *Report* rightly acknowledges that “Many of the above-mentioned factors...arise from community conditions and other broad social factors...” (Para 16), and shares common ground with the IDPC when it points to factors such as poverty, poor housing and monotonous employment as being important in this respect. However, again it seems lacking in a global historical and sociological perspective to provide an integrative framework for analysis and policy. The text acknowledges the corrosive effect that can stem from “migrating from a rural setting to an urban one...a sense of uprooting, loss of traditional family values and relationships, loss of social structure with respect to the community of origin, difficult cultural adaptation of a feeling of alienation.” (Para. 16.) However, these experiences are not confined to the setting of the Board’s example, but rather tend to characterize the life-world of millions of ordinary people all over the planet.⁹

The analysis in the *Report* appears to be insufficiently aware of the degree to which the changes associated with globalisation have eroded traditional norms, bringing with it new opportunities and risks. As the British sociologist Anthony Giddens has observed, “Where tradition has retreated, we are forced to live in a more open and reflective way...A society living on the other side of nature and tradition—as nearly all Western countries now do—is one that calls for decision making, in everyday life as elsewhere. The dark side of decision making is the rise of addictions and compulsions.”¹⁰ The individualism and consumerism of the developed world is highly resistant to the vision of prevention exemplified in the *Report*, which essentially appeals to traditional mechanisms and modes of authority. While the *Report* does

acknowledge that approaches will need to be tailored toward different target populations, there is little in this chapter that will be of help in effectively managing the drug situation in developed nations.

In addition, the Report's recommendations, based as they are on the analysis described above, do little to encourage governments to address prevention in a targeted and structured way.

- Targeted, in the sense of shaping prevention efforts toward those substances and modes of use that carry the greatest risk of harm.
- Structured, in the sense that evidence indicates that the problematic use of drugs is closely linked to poverty, inequality and marginalisation in societies. The *Report* argues for capacity-building in terms of prevention, including recommendations that governments collaborate across relevant departments and ministries, and with civil society organisations; however, primary prevention is viewed as a matter of using advice and instructions rather than directing resources toward the structural inequalities and exclusions which generate the most important risk factors.¹¹

The Continuation of “Mission Creep.”

In previous years, the IDPC has noted its concern regarding the INCB's encroachment into areas beyond its mandate as laid out in the international drug control conventions; a phenomenon that we have referred to as “Mission Creep.”¹² Despite repeated criticisms on this point, from us and others, this year's *Report* displays a worrying continuation of this trend. It can be identified in relation to a number of issues:

Medical Marijuana

In this instance, the *Report* notes that while it

welcomes research within the field, “The Board is concerned that, without having appropriate scientific confirmation of its efficacy, a few Governments authorized the use of cannabis for medical purposes.” (Para 62.) In fact, a rapidly increasing number of national governments and local authorities have moved to make various cannabis derivatives available for medical purposes, basing these decisions on their understanding of the evidence (itself a fast-moving field). As we have noted after similar comments in a previous report, it is not up to Board members to pass judgement on the evidence base. Such a position is “neither within their mandate nor their competence.”¹³ It is appropriate for the INCB to express interest in the arrangements that the authorities are making to prevent diversion of marijuana from medical distribution mechanisms to recreational use, but it is for the WHO and the research community to assess the strength of the evidence for the medical use of the substance.

Ketamine

It should be recalled that the Board's mandate for advising on rescheduling is restricted to precursor chemicals listed in the Tables of the 1988 Convention, a task for which the INCB convenes an Advisory Expert Group. The Board consequently has no mandate in relation to scheduling procedures for the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances. According to Article 2 of the Single Convention and Article 3 of the 1971 Convention, it is the WHO that makes recommendations to the Commission on Narcotic Drugs on scheduling a new substance, rescheduling a substance or deleting a substance from schedules altogether. During this process the WHO's Expert Committee on Drug Dependency (ECDD) is responsible for formulating recommendations. The body works to a “critical review procedure” and instructs experts to consider substances according to the “WHO Guidelines on the Evaluation of Dependence Producing Drugs for International Control” and to draft a “Critical Review Report” on the substance. The

ECDD makes a recommendation to the WHO Director-General, who then makes the formal recommendation to the CND as to whether a substance should be controlled internationally, and if yes, under which schedule.¹⁴ Although INCB has observer status in meetings of the ECDD, authority clearly lies with the WHO. The Board, however, continues to seek to influence the classification of substances beyond its purview, both in its publications and at the CND meetings. The attention given to ketamine in this year's *Report* thus represents not only another example of the INCB operating beyond its remit, but also the ongoing marginalization of the WHO; an important treaty body in its own right.

Ketamine is not subject to the restrictions of the international control regime and is listed as an essential medicine by the WHO.¹⁵ It is widely regarded as "a particularly important medicine in resource limited settings where it enables surgery where conventional anaesthesia is otherwise unavailable."¹⁶ Indeed, it was the only widely available anaesthetic following the Haitian earthquake in January 2010.¹⁷ However, the substance has also become increasingly popular as a recreational drug due to its hallucinatory effects. Because of growing concerns about recreational use, ketamine was subject to critical review by the ECDD in March 2006. According to the 34th Report of the ECDD, with regard to dependence potential, actual abuse and/or evidence of likelihood of abuse and therapeutic usefulness, "The Committee reviewed the information contained in the critical review document and concluded that this information was not sufficient to warrant scheduling."¹⁸ Crucially, however, even before the expert opinion of the ECDD was published, a resolution was tabled at the CND that called upon countries to place ketamine on the list of substances controlled under the 1971 Convention on Psychotropic Substances.¹⁹ As the 34th Report notes, in the course of the meeting, "the Committee was informed that the United Nations Commission for Narcotic Drugs at its 49th session, held in March 2006,

had adopted a draft resolution for transmission to ECOSOC, on the listing of ketamine as a controlled substance."²⁰ Consequently, the ECDD report continues, the "Committee requested the Secretariat to produce an updated version of the critical review and present it to the next meeting of the Expert Committee on Drug Dependence." To this date, the Expert Committee has not made a recommendation on Ketamine. Indeed, the ECDD's 35th meeting remains postponed.²¹

Such a situation clearly fits well with the INCB's position on ketamine. To be sure, since 2004, the Board has used its *Annual Report* to draw the attention of governments to "the abuse of, and trafficking in ketamine."²² Furthermore, the proximity of the ECDD's 34th meeting to the 46th session of the CND raises the suspicion that the Board may have been seeking to circumvent the forthcoming scheduling procedures by encouraging member states to pass a resolution on the substance.²³ Indeed, although the final version of resolution 49/6 did not contain language urging the scheduling of ketamine under 1971 Convention, among other things, "Listing Ketamine as a controlled substance" called upon Member States "to consider controlling the use of ketamine, by placing it on the list of substances controlled under their national legislation, where the domestic situation so require."²⁴ It is noteworthy that among the preambular paragraphs, the resolution recognized that Board's ongoing concern with regard to the "widespread abuse of substances not scheduled under the international drug control treaties, in particular ketamine" and its "abuse" of the substance in various parts of the world.

While it is of course within the mandate of the Board to highlight such concerns, and hence be cited within related resolutions, the INCB's pronouncements on ketamine arguably did much to generate an air of expectancy among CND members. In this way, it can be argued that the Board exploited its position within the international drug control system to move

regime members in a preferred direction. Such a process of circumventing the well established WHO procedures regarding scheduling was complemented in 2006 by a more direct challenge to the WHO's authority. In a move that clearly exceeded its mandate, the Board used its *Report* to not only welcome the adoption of resolution 49/6, but also to encourage "all Governments concerned to take steps to determine the size of the population abusing ketamine and, wherever warranted, *to place ketamine under their national control legislation.*"²⁵ (Italics added.)

It is within this context that the IDPC notes its unease in relation to the Board's position on ketamine as a Special Topic within its most recent *Report*. As in previous years, the INCB notes its concern about abuse, "particularly among youth, in East and South-East Asia and of trafficking in ketamine in that region and in other regions; including the Americas." (Para. 249) and encourages states to report to both itself and the WHO information on the abuse of the substance. (Paras. 253-259.) While repeating its very direct and illegitimate 2006 call for national governments to place ketamine under their national legislation, the Board's encouragement to states, as well as INTERPOL and the World Customs Union (See Recommendation 48), to provide information about abuse and trafficking, arguably continues to generate momentum towards the international control of ketamine. Thus, despite the ECDD's reluctance as a mandated body to schedule ketamine and presumably risk a reduction in its availability for medical purposes, the Board privileges its familiar concern for abuse above all other considerations and continues to work beyond its remit to achieve its goals. The adoption of positions that run counter to those held by the WHO not only generate tensions concerning scheduling but also confuse the Board's relationship with the WHO on the Access to Controlled Medications Programme (ACMP); the framework of which was prepared by the WHO in cooperation with the Board (See para. 83.) It is difficult to see how the two bodies can work in harmony when the

Board consistently circumvents the WHO's authority regarding the legal status of particular substances.

Decriminalization

Within the context of a series of legislative reforms in a number of states in the Western Hemisphere, the Report devotes significant attention to the issue of "decriminalization" and is openly critical towards policy shifts or discussions thereof in Mexico (Para 408) Argentina and Brazil, and to a lesser extent Colombia (Para 453). Last year Mexico decriminalized possession of cannabis, heroin, cocaine, and other drugs found in small amounts. Argentina followed with a Supreme Court ruling (the Arriola ruling¹) in August 2009. This ruled on the unconstitutionality of the arrest of five youths carrying a small amount of cannabis.²⁶ Brazil adopted legislation to replace jail sentences with educational measures in 2006. Meanwhile, in Colombia debate continues regarding the decriminalization of the possession of controlled drugs for personal use. That Country's Constitutional Court decriminalized the personal consumption of marijuana and cocaine in 1994 and since he came into office in 2002, President Alvaro Uribe has made repeated attempts to overturn the ruling. Events within the region are thus clearly an area of acute concern for the Board. Not only is the Board displeased with regard to "a growing movement to decriminalize the possession of controlled drugs, particularly cannabis, for personal use" within countries in South and North America, including Mexico" it is also alarmed by state level liberalizing trends in the United States (Para 400.)²⁷ It should be recalled that fifteen US states have now decriminalized the possession of cannabis for personal use to varying degrees and fourteen now allow medical marijuana in one form or another. Adoption of, support for and trends towards decriminalization, the Board contends, "may give the wrong signal" (Paras 400& 408) and "send the wrong message to the general public" (Para 453). Although, as in previous INCB reports, the precise mechanisms behind

the process of sending “signals” and giving “messages” remain unexplored and problematic, the Board’s hostile stance raises two particular and inter-related issues of concern.

The first of these relates directly to the body’s proclivity to exceed its mandate, stray into the sensitive area of national sovereignty and openly criticize the policy choices of member states that deem themselves to be operating within the bounds of the international drug control conventions. In assessing this issue, it is necessary to refer back to Article 9 of the Single Convention. This refers to “*All measures taken by the Board*” (Emphasis added) taking place in terms of “co-operation with Governments” and via mechanisms for “continuing dialogue.” And it is an issue that the Board ostensibly refers to at various points throughout this year’s *Report* (E.g. Paras 147 & 154.) The only exception to this spirit of cooperation relates to specific conditions laid out in the 1961 and 1971 Conventions. Article 14 of the Single Convention notably refers to circumstances where “the Board has objective reasons to believe that the aims of this Convention are being *seriously endangered* by reason of the failure of any party, country or territory to carry out the provisions of the Convention” (Emphasis added). Within this context, the general mandate established for the Board under the Single Convention, especially after the 1972 Protocol, is quite broad. In fact, the Board “may raise with any Government... any question related to the aims of the Single Convention.” But, this broad mandate is restricted to suggesting consultations and asking for explanations. The aim is dialogue with governments, who are, even then, not legally bound to engage in such consultations. As the 1976 *Commentary* on the Protocol Amending the Single Convention points out, the INCB is not allowed to give advice to any government unless that government requests the Board to do so, let alone cast judgement or recommend governments to change their policy. Such conduct is outside its remit, unless and until the Board has objective reasons – which it needs to substantiate – to argue that certain

countries are undermining the aims of the conventions in such a serious way that it may affect other parties to the treaty. In such cases the Board needs to invoke explicitly Article 14 of the 1961 Convention or the similar Article 19 of the 1971 Convention for which special rules apply. Those rules include that any Party shall be invited to be represented at a meeting of the Board at which a question of direct interest to it is considered under these articles and that the report includes an account of the explanations given by governments. In addition, if a decision reached by the Board under these articles is not unanimous, the views of the minority shall be stated. Furthermore, while it is true that Article 15 of the Single Convention does not impose restrictions on the Board concerning the kind of observations and recommendations that its reports may contain, Annual Reports must still be formulated in accordance with Article 9.

That said, this year’s *Report* provides another example of the Board, apparently without the necessary consultation, openly criticizing the policy choices of states that deviate from its own specific (and highly selective) interpretations of the conventions, yet by any measure do not come under the provisions of Article 14 of the Single Convention. Such a position led the authors of a Washington Office on Latin America (WOLA) and Transnational Institute critique of the *Report* to note that in this instance the Board had overstepped its mandate and that its position on constitutional frameworks and national decisions to liberalize policies on drug possession represented “unwarranted intrusions into these countries’ sovereign decision-making.”²⁸ On a related point, it can be argued that, despite reference to states’ commitments to the 1969 Vienna Convention on the Law of Treaties, the Board is also venturing into uncertain legal terrain with its comments on the primacy of the international drug control conventions over domestic legislation throughout national jurisdictions. This is a response to the continuation of a range of policies and harm reduction interventions, namely the use of “safer crack kits’, the

'medical use of cannabis,' 'coffee shops' and the establishment of so-called 'drug injection rooms,' which contravene the international drug control treaties." (Para 278). Under Special Topics 7, "Treaty Obligations applicable in the entire territory of a State party," attention is devoted to multilevel governance structures, such as the Federal model, and what is regarded as the inability of central governments' compel state or provisional authorities to conform to what the Board regards as policies that are in line with the conventions. (See paras. 278-286 and Recommendation 2 para. 786) Noting that the issue may be "controversial," the Board asserts that "treaty obligations are applicable to the entire territory of each State Party, including its federated states and/or provinces." (Para 283.) Regardless of the legal complexities of such a position, it is highly debatable whether or not it is the Board's place to question the constitutional arrangements within sovereign states. Such a habit, however, is not new. Reflecting upon the INCB's criticism of the Canadian Supreme Court to allow the medicinal use of cannabis in 2002, Professor Cindy Fazey noted "...it is not the place of the INCB to question a decision of the Supreme Court of any country, nor to interfere with the separation of the policy and the judiciary."²⁹

In specific reference to the Board's position on the ruling of its own Supreme Court, the Argentine delegation observed at this year's CND session that the *Report* had generated "surprise and frustration" throughout the country.³⁰ The lack of dialogue between Buenos Aires and Vienna was certainly a key factor behind the strong Argentinean protest, expressing "concern and aggravation" about the INCB's disrespect over the country's sovereignty and constitutional order. The Argentinean statement put forward the view that the INCB offered "insufficient explication and substantiation" and announced that there would be an official reply later this year demanding that the INCB should "reconsider" its remarks.³¹

The issue of insufficient explication brings us to the second point of concern in this area. Not only can a strong case be made that the Board is exceeding its mandate in criticizing the process of decriminalization in some states, the *Report* also displays its rigidly absolutist, incomplete and in many ways disingenuous reading of the 1988 Convention. In justifying its calls to "resolutely counter" the decriminalization trend in the states mentioned, the Board reminds "governments of provisions in the 1988 Convention." In arguing against the liberalization of policies concerning drug possession for personal use, the *Report* claims on several occasions that the 1988 Convention requires the criminalization of drug possession. For example paragraph 408 states "The Board would like to remind the Government that article 3, paragraph 2, of the 1988 Convention requires each party to that Convention to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended by the 1972 Protocol or the 1971 Convention." (Also see para. 477.) However, as John Walsh, Senior WOLA Associate, points out "Not only does the INCB lack the mandate to raise such issues" it also "misreads the 1988 Convention itself, asserting an absolute obligation to criminalize drug possession when the Convention explicitly affords some flexibility."³² At no point in the *Report* is it mentioned that article 3 (2) of the 1988 Convention also explicitly states that that measures to criminalize possession for personal consumption are subject to each country's "constitutional principles and the basic concepts of its legal system." Consequently, the Board can itself be soundly accused of "sending the wrong message" by giving the impression that the 1988 Convention obliges the criminalization of possession for personal consumption when that is not in conflict with a nation's constitutional and legal principles. Governments do in fact have a certain degree of latitude within the Conventions when pursuing legislative reform.

Such a selective reading of the convention certainly does little to build confidence in the ability of the Board to engage in constructive dialogue with member states. It is difficult to disagree with the views of the Argentine delegation at this year's CND. Reflecting upon the contents of the *Annual Report for 2009*, it noted, "A truly efficient international system should have, as a guide, criteria for dialogue and partnerships. Judgments without foundation will only contribute to the deterioration of the functionality of this Organization."³³

A Question of Imbalance: the INCB and Access to Controlled Medicines

The problem of increasing the availability of pain medications controlled under national and international law has become more pressing in recent years. The urgency of the issue lies in a growing awareness of the fact that, for millions of people around the world suffering from the pain associated with conditions such as cancer and HIV/AIDS, relief through recourse to analgesic medicines is inadequate or entirely absent. The World Health Organisation (WHO) has estimated that "5 billion people live in countries with low or no access to controlled medicines".³⁴ The INCB discusses measures to increase access to medicines in its 2009 *Report*, and the IDPC is pleased to once again note this support. At the same time, we believe that problems of balance and coherence remain with the Board's approach to the question.

It is important, firstly, to acknowledge the *Report's* calls for governments to devote attention to ensuring the adequate provision of pain relief to their citizens. Its recommendations to governments include three items that explicitly support the expansion of access to controlled drugs for medical purposes. For example, recommendation 40 calls on governments to, "identify the impediments in their countries to access to and adequate use of opioid analgesics for the treatment of pain

and to take steps to improve the availability of those narcotic drugs for medical purposes..." The Board also notes the enduring inequalities which mark access to pain medicines, with the developed countries of Europe, North America and Australasia consuming well over 90% of all the major powerful analgesics.

In the final paragraph of the Foreword, the *Report* makes the following claim: "The Board has been the leading advocate of increasing the licit use of opioid-based medications. The consumption of those substances for medical purposes is regularly reviewed in the reports of the Board."³⁵ The *Report* lists the Board's involvement with the WHO in developing the framework for the latter's ACMP, and other recent and welcome contributions to addressing the problem of inadequate access to pain relief. The Board goes on to make the important observation that, "overly restrictive policies are contrary to one of the principles enshrined in the international drug control conventions: that the medical use of narcotic drugs is indispensable for the relief of pain and suffering and that adequate provisions must be made to ensure their availability for such purposes." The problem of excessively stringent regulation is widely acknowledged as a major barrier to the availability of adequate pain medication. The Board regards the problem as deriving from the provisions of national legislation; the international regime (comprising the drug control conventions and their associated agencies) is not acknowledged as partly accountable. The IDPC believes this position to be somewhat disingenuous. Indeed, to a large degree the national policies and procedures that have been implemented to ensure tight control, and that now inhibit wider access, were created by national authorities to comply with their obligations under the drug control conventions. In recommendation 40, therefore, the international system should really be included in any listing of those 'impediments' to rational and adequate access, since its 100 year regime has been characterised by an emphasis on the harmful characteristics of drugs, with insufficient attention directed

to their benefits, and to the fact that millions of patients use opiate medicines safely and without problems of addiction. Consequently, while the INCB identifies inadequate training of healthcare professionals and administrative barriers as factors interfering with the adequate provision of analgesics, a powerful case can be made that the attitudes underpinning these factors derive partly from the discourse and practice of the international control system—no least the INCB itself.

It is of course true that the drug control conventions recognise the utility of drugs in medical practice, and permit a licit international trade in controlled medications to continue; indeed, the responsibility for overseeing this trade (ensuring that scientific and medical requirements are met, and preventing the diversion of controlled substances into the illicit market) lies with the INCB. In the words of its website, the Board, “Administers a system of estimates for narcotic drugs and a voluntary assessment system for psychotropic substances and monitors licit activities involving drugs through a statistical returns system, with a view to assisting Governments in achieving, inter alia, a balance between supply and demand”.³⁶ Civil Society Organizations such as Human Rights Watch³⁷, as well as the WHO and the INCB itself, however, have recently drawn attention to the drastic lack of fit between the supply of, and demand for, pain medication. This situation is particularly acute in parts of the developing world—Africa, as ever, bears the most intensive burden of unalleviated pain. As demonstrated by foregoing quotations, the Board has joined efforts to address this unmet need. Its position, however, remains conflicted by the dogmatic attitudes which continue to characterise many of its statements. The situation leads to conflicted and contradictory positions within the text of the *Report*. These conflicting positions stem from a duality that is structured into the Board's role, as its regulatory functions include (1) facilitating the availability of controlled drugs for medical and scientific objectives, and (2) policing the system to prevent their diversion into the illicit market. Its remit involves, therefore,

a balancing of twin objectives, in addition to the technical requirements of matching of supply capacity within the system to the demand it must meet. The Board's core objectives, then, revolve around a question of balance: how successfully, in practice, is this balance achieved?

On examining the 2009 *Report*, it is readily apparent that the resources expended in dealing with ‘abuse’, diversion and the general policing aspect of the Board's role far outweigh the resources directed toward increasing access to, and availability of, controlled medications. If we read the Foreword with this issue of balance in mind, it quickly becomes clear which function gets the lion's share of the *Report's* attention. It is striking that the Foreword contains eight full paragraphs devoted to the Board's repressive functions, and only one paragraph dealing with its more positive, enabling role—this is the one which discusses the availability of opioid-based pain medications. Moreover, this lone paragraph is preceded by two others expressing alarm concerning the misuse of prescription medications, and the effect is to dilute the urgency of the availability issue by associating it with the escalation of risk. “Governments need to be aware that an increased availability of narcotic drugs for legitimate medical purposes may raise the risk of diversion and abuse of those drugs.” (Para 57)

The use of controlled drugs for pleasure in the developed world, and the related phenomenon of internet pharmacies are major topics in this year's *Report*, and there is a tension between the imperatives of (1) expanding access to pain relief and (2) restricting access to unauthorized use. This tension is, as we have said, to some extent an inevitable consequence of the structuring of the Board's role, and can be addressed by achieving the correct balance between its twin functions. Of course, the Board should and must bring important new trends, such as the spread of internet pharmacies supplying controlled medicines, to the attention of governments and the public, in accordance with its remit under the 1961 Single Convention.

The disturbing fact for the IDPC, however, is a general lack of balance and contextualisation in the ways in which it currently does so. In the section dealing with the prevention of diversion of narcotic drugs from licit channels (page 15), the *Report* notes that no cases of diversion from licit international channels into the illicit market came to light in 2009. However, it devotes extensive attention to domestic distribution channels, claiming that such diversion is taking place in an increasing number of countries, with the internet increasingly involved in supplying controlled drugs to end-users (Paras. 54-55.) It is the overall framing of the (in itself laudable) call to governments to improve access within the Board's repeated pointing toward the increased risk associated that blunts its focus on increasing the availability of pain medication. This unbalanced perspective, and the concentration of its resources on the repressive aspects of its remit that tends to undermine, and even to contradict, its more humane and enabling stance with regard to access to pain medication.

The *Report* also adopts a somewhat contradictory position in its use of a concept of 'demand' for medications which derives from its own regulatory structures. Each year, under the provisions of the Single Convention, states must submit to the INCB their licit requirements for the following year. Numerous states, for a complex set of reasons, massively underestimate their needs, submitting estimates which are many times smaller than the amounts used in Europe, for example, or America. It is clear that many countries are basing their estimates of demand on past patterns of usage, rather than an objective assessment of need. Nonetheless, these statistics are used unquestioningly by the Board to calculate global demand, and producing states are only permitted to generate sufficient quantities to answer their stated demand (with a year's stockpiling allowed for unforeseen contingencies). The *Report* states that, "In 2009, according to the information available to the Board, production of opiate raw materials rich in morphine was higher than

the utilization of those materials."³⁸ It adds that, "according to the plans of the producing countries, global production will exceed global demand in 2010 as well."³⁹ These claims, however, sit somewhat paradoxically alongside the Board's own statements as to lack of availability. "Although there is sufficient supply of opiates raw materials worldwide, access to opioid analgesics is non-existent or almost non-existent in many countries and entire regions." (Para 80.) It is obvious that the supply of these materials is concentrated overwhelmingly in the rich countries; but it remains unclear in what sense there may be said to be "sufficient quantities" to satisfy global demand, unless 'demand' is restricted to the bureaucratic figures whose construction is alluded to above; this notion of demand, is, however, obviously different to actual *need*, which, while difficult to quantify, would undoubtedly compose a much greater sum. It is this unmet need, palpable in the sufferings of millions, that international control system is duty-bound to address. Should that figure, once it is estimated, be found to outstrip present productive resources, it would be a simple enough matter to increase production. Indeed, this could, if necessary, be done on an incremental basis over a number of years.

A number of other aspects of the *Report's* treatment of this topic give cause for some concern. As mentioned, the Board observes that many nations enact legislative restrictions whose stringencies go beyond what is required of them under the 1961 Single Convention, but there is no mention of any action by the Board to address these restrictions, that constitute a barrier to one of its treaty obligations. This is an example of what the IDPC has previously referred to as selective reticence.⁴⁰ As we shall see, the Board continues to be much more willing to engage in outspoken interventions toward governments in relation to its repressive functions than it does in relation to its enabling prerogatives. Related to the question of pain medication is that of the provision of Opiate Substitution Therapy (OST), for which INCB has long provided only tentative and equivocal

support. These problems seriously detract from the Board's more positive contributions, though there are signs of gradual movement away from some of the dogmatic postures that cause tensions in relations with both governments and civil society, and limit its effectiveness.

Consistency in Inconsistency – Harm Reduction, Coca and Human Rights

It has been noted elsewhere that, the operation of the Board within the international drug control system is greatly dependent upon the overall quality of the annual reports; “For the system to function as intended...assessment of treaty compliance needs to be supported by a uniformly accurate description of the contemporary global situation.”⁴¹ Indeed, the Board describes its annual report as a “comprehensive survey of the drug control situation in various parts of the world.”⁴² While in many respects wide-ranging and balanced, recent annual reports have at times displayed a certain asymmetry. And continuing this trend, the *Report for 2009* is in many ways also inconsistent in its approach to its subject matter. At a basic level, this is a concern in terms of evenness of coverage. Moreover, however, the areas that the Board chooses to mention and sometimes comment upon and those that it simply ignores provide an insight into the mindset of its current membership. While not exhaustive, the following examples of “selective focus of subject matter” reveal those areas where the Board wishes to exert its influence and those where it wishes to remain aloof and selectively reticent.

- **Harm Reduction.** The Board sidestepped some of the more overtly problematic aspects of previous reports this year, particularly the highly emblematic use of scare quotes around harm reduction,⁴³ by avoiding mention of the term and direct discussion of the approach altogether. Nonetheless, as in preceding years, its lukewarm, or at times openly hostile,

attitude towards various harm reduction interventions permeate the *Report for 2009*. Indeed, since the patterns displayed generally repeat those in earlier reports, and have consequently been discussed at length in IDPC responses to the Board's reports and activities, there is no need to reprise them fully here. Suffice it to say, the Board unavoidably notes widespread engagement among Parties to the conventions with harm reduction approaches like opioid substitution therapy (OST) and to a far lesser extent, needle exchange programmes (NSPs). As we observed in 2009 “in fulfilling its mandate to describe the global situation relative to the conventions within the Report, the Board has little choice but to once again implicitly acknowledge the existence of harm reduction interventions.”⁴⁴ In this respect it is interesting and somewhat unexpected to see the Board noting, without criticism, the introduction of “diamorphine-supported treatment” and its availability in “a few other countries in Western Europe” (Para 698.) However, the Board's coverage of harm reduction interventions elsewhere is telling. For example, reference to NSPs is restricted to just two mentions (Paras 775 & 779), both in New Zealand; this is particularly surprising bearing in mind not only repeated reference to “drug injectors” and to the problem of HIV epidemics driven by injection drug use within the *Report*, but also the fact that in 2008 seventy-seven countries engaged with the intervention.⁴⁵ Moreover, the Board remains reluctant to comment upon the scientifically proven efficacy of both interventions. The closest it comes to this is the oblique statement concerning a cohort of “drug abusers” in paragraph 775. Here the *Report* notes “Eighty-nine per cent of frequent drug abusers obtained needles through a needle exchange programme in 2007; 91 per cent had not shared a needle with another person in the past six months.” Such a combination of reticence and

caution is also apparent in case of OST. The report does contain a welcome call to ensure that methadone and buprenorphine are available for use in substitution treatment. Nonetheless, as with the issue of essential medicines discussed above, there remains an overarching concern regarding diversion in to illicit channels (E.g. para. 60.) In this regard Luxembourg is singled out by the Board for having apparently made a “lack of progress in the implementation of [the Board’s] recommendations on the prevention of diversion of methadone prescribed as part of substitution for heroin addiction” in that country (Para. 212.) The Grand Duchy is also the focus of criticism for engagement with policies that it considers to be counter to the conventions. Following missions to both Luxembourg and Australia, including what must have been an interesting site visit in the former, the Board revealed a continuation of its narrow interpretative position with condemnation of the operation of “so-called” drug consumption rooms (Paras 185, 210 & 211.) The INCB’s ongoing hostility towards the intervention ensures that the issue is included as one of the Report’s recommendations, with the Board calling upon governments to close “‘drug consumption rooms’ ” and ‘drug injection rooms’, where persons can abuse with impunity drugs acquired on the illicit market” and to “promote the access of drug abusers to health and social services, including services for the treatment of drug abuse, in conformity with the provisions of the international drug control treaties.” (Recommendation 32.)⁴⁶ This phrasing of this recommendation is ironic, as one of the primary purposes of these facilities is the promotion of access to health and social services.

- **Bolivia and coca leaf.** Mindful of the profile given to the issue by President Evo Morales at the High Level Segment of the CND in 2009,⁴⁷ it is little surprise

that the Board chose to devote attention to Bolivia’s position on the coca leaf. Still clearly a cause for anxiety, this year’s report notes the INCB’s concern for the diversion of coca leaf for illicit purposes (Para 156-159.) Concern regarding the increased production of cocaine is of course reasonable. However, as is evident within the Report, such a stance is closely related to continuing discomfort at the country’s proposed amendment to article 49 of the Single Convention. (Para 160-166.) This amendment seeks to remove the reference made in the 1961 Convention to the intended abolition of traditional practise of coca chewing. As discussed elsewhere, such a move would not imply an end to the ambiguities within the treaty system with regard to coca, which would be more appropriately addressed by a de-scheduling or re-scheduling request; instead, it would simply recognize the fact that this use is not going to disappear. Resolution of these longstanding tensions would clarify the legal status of the widespread and culturally ingrained practice of coca chewing in Bolivia, and other Andean states, many years after the end of a 25-year transition period laid down in the Single Convention. Perhaps reflecting the realization of an untenable legal position, article 47 of the Single Convention after all allows for states to move to amend the treaty, the Report adopts a more conciliatory position than last year.⁴⁸ Indeed, the Board points out that it has provided the Bolivian Government with relevant information on the proper mechanism for changing the scope of the Convention.” The Board, however, takes the opportunity “to remind the Government that until such amendments are effected, all the uses of coca leaf considered by the Government as traditional, including coca-leaf chewing and the manufacture and consumption of coca tea, as well as all other products derived from the coca leaf of which alkaloids have not been removed, continue to be illicit activities under the

terms of the Convention.” (Para 162.) This again is a fair point. Yet it is significant that the Board concludes its main discussion of the issue by reiterating its “concerns over the Government’s policies with regard to coca bush cultivation and coca leaf production.” (Para 165.)

- **Human Rights.** The IDPC has in the past devoted attention to the Board’s lack of engagement with the often conflictual intersection between human rights and drug policy.⁴⁹ Earlier this year in recalling the centrality of human rights to the ideas and operation of the UN, we reiterated the point that, as the body responsible for monitoring the implementation of the UN drug control conventions, “the INCB should not choose to ignore instances where parties to those conventions seemingly contravene other UN instruments...Put simply, the drug control conventions should not operate in a legal vacuum.”⁵⁰ While this is the case, the Board once again chooses not to comment upon a number of problematic situations in this respect. For example, the Report notes that Vietnam no longer imposed the death penalty for organizing the illicit use of narcotic drugs, yet observes without comment that it “remains in force for offences related to illegally stockpiling, transporting and trading in or appropriating narcotic drugs.” (Para 536) As Rick Lines of the International Harm Reduction Association points out, “Under the International Covenant on Civil and Political Rights (ICCPR), the use of capital punishment, while not prohibited is restricted in several ways.” Indeed, Lines continues, there is “little evidence” to support the argument held by those states maintaining the death penalty that drug offences meet the threshold of “most serious crimes” under Article 6 (2) of the ICCPR; a position that much of the international community shares.⁵¹ In this vein, the report also fails to comment upon the continuing use of the death penalty in other countries,

including notably China and Singapore. Similarly, despite the serious implications in terms of human rights abuses,⁵² the Board notes but fails to comment upon both the extensive use of “compulsory treatment and rehabilitation” within that country (Para. 554) and the use of drug user registries within Vietnam (Para 556.) Incongruously within this context, however, it does choose to commend Mexican counter narcotic policies and “recognizes the vigorous measures taken by the Government of Mexico to combat illicit drug production and trafficking.” (397) As a recent report by the International Centre for Science in Drug Policy points out “Mexico has experienced extreme violence subsequent to the 2006 launch of a massive nationwide counter narcotics campaign.” In 2008, 6,290 drug related deaths were recorded and approximately 17,000 individuals have been killed as a result of the “Mexican drug war since 2006.”⁵³ Further, as the Beckley Foundation Drug Policy Programme and WOLA concluded in 2007, as well as increasing levels of corruption and failing to “make a dent” in the narcotics trade, “more military involvement in the ‘drug war’” has generated human rights violations.⁵⁴ Human rights organizations in Mexico have already documented multiple human rights abuses in military counter drug operations taking place under the Merida Initiative.⁵⁵

Echoing the concluding remarks of the IDPC response to last year’s *Annual Report*, we believe that the INCB has a central role to play within a global drug control system operating at the end of the first decade of the Twenty-First century. Yet, as the issues raised herein highlight, there remain many issues of concern in relation to the Board’s conception of the contemporary global drug policy environment and the actions of nation states within it. It is true that under the Presidency of Professor Atasoy, there was a welcome softening of stance on some of the issues we have previously highlighted as areas of concern. A prime example of this was the dialogue between the President and civil

society in the margins of the 2010 session of the CND.⁵⁶ That experience, echoed by the representatives of several member states, was very positive, but is called into question by the continued focus in the Annual Report on the INCB's unreconstructed role as the guardian of a traditional view of the international drug control system. Indeed, it is telling that despite a less confrontational stance on the thorny perennial of harm reduction, the Board's attitudes as reflected in the *Report* have stayed largely unchanged. Such stasis hints at the powerful institutional inertia that has developed within the body over recent years. The return of Hamid Ghodse as President (for the tenth time) looks set to signal a business as usual approach to dealing with both member states and other parts of the UN drug control system that do not share the Board's outlook. There is now an opportunity for the Board to adopt a much more transparent, co-operative and positive approach to its mandate, putting more emphasis on its facilitating and consultative role, and moving away from the habit of issuing selective and unsubstantiated criticisms. It is the IDPC's hope, therefore, that the more conciliatory aspects of Professor Atasoy's leadership will be embraced and advanced by the new secretary to the Board, Mr Jonathan Lucas.

Endnotes

- 1 INCB Report 2009, Foreword, p.iii
- 2 For example in the Statement by INCB President Phillip Emafo at the 46th Session of the CND, April 2003. <http://www.incb.org/incb/speeches/cnd46.html>
- 3 United nations Office on Drugs and Crime *World Drug Report 2009* <http://www.unodc.org/unodc/en/data-and-analysis/WDR-2009.html>
- 4 INCB Report 2009 p.7 para 24
- 5 Manning, Paul (Ed.) *Drugs and Popular Culture: Drugs, media and identity in contemporary society* Willan Publishing
- 6 Parker, Howard, Aldridge Judith and Measham, Fiona (1998) *Illegal Leisure The Normalization of adolescent recreational drug use* Routledge, London & New York.
- 7 Williams, C. & Stein, A. (2002) *Sexuality and Gender* Wiley-Blackwell, Oxford.
- 8 Ann M. Roche et al (2007) *Drug Testing in Schools: Evidence, Impacts and Alternatives* Australian National Council on Drugs
- 9 Bauman, Z. (2000) *Liquid Modernity* Polity Press, Cambridge.
- 10 Giddens, Anthony (2002) *Runaway World: How Globalisation Is Reshaping Our Lives* Profile Books, London p.46
- 11 See International Drug Policy Consortium (2010) *Drug Policy Guide, Edition 1*. <http://www.idpc.net/publications/idpc-drug-policy-guide-version-1> Accessed 17.05.10
- 12 See for example, IDPC, *The International Narcotics Control Board: Current Tensions and Options for Reform*, Briefing Paper 7, February 2008, p. 9 and IDPC Advocacy Note, A Call to the new Secretary of the International Narcotics Control Board: Ongoing Challenges, March 2010, pp. 3-4.
- 13 The Erratic Crusade of the INCB, TNI Drug Policy Briefing 4, February 2003, p. 3. <http://www.tni.org/archives/policybriefings/brief4.pdf>
- 14 For more details see Expert Seminar on the Classification of Controlled Substances, Transnational Institute, Amsterdam 10 December 2009, pp. 8-10.
- 15 Essential Medicines WHO Model List 16th Edition, March 2009.
- 16 For more details see Expert Seminar on the Classification of Controlled Substances, Transnational Institute, Amsterdam 10 December 2009, p. 13
- 17 In a letter to member states shortly after the earthquake, the Board pointed out that "Under present circumstances, competent authorities may...allow the exports of controlled medicines to Haiti containing narcotic drugs and/or psychotropic substances even in the absence of the corresponding import authorizations and estimates. E/INCB/NAR/C.L 05/2010

- 18 WHO Expert Committee on Drug Dependence: thirty-fourth report, 2006. The Report contained the following information. *Dependence potential*: Various animal models have shown that ketamine can produce a state of dependence, but reports of such dependence in humans are very limited. Tolerance may occur, but there is no evidence of a withdrawal syndrome. *Actual abuse and/or evidence of likelihood of abuse*: Abuse has been reported in a number of countries in the Americas, Asia and Europe, sometimes in a mixture with other substances. *Therapeutic usefulness*: Ketamine is widely used as an anaesthetic and analgesic in human and veterinary medicine. Ketamine was stated as being available for medical use in 70 out of the 74 countries that answered the WHO questionnaire. It is included as a general anaesthetic in the 14th WHO Model List of Essential Medicines . http://whqlibdoc.who.int/trs/WHO_TRS_942_eng.pdf
- 19 E/CN.7/2006/L.11, Listing of ketamine under the Convention on Psychotropic Substances, March 10, 2006. http://www.unodc.org/pdf/resolutions/cnd_2006_49-6.pdf
- 20 WHO Expert Committee on Drug Dependence: thirty-fourth report, 2006. p. 10. http://whqlibdoc.who.int/trs/WHO_TRS_942_eng.pdf
- 21 See http://www.who.int/medicines/areas/quality_safety/35thecddmeet/en/index.html
- 22 See *Report of the International Narcotics Control Board for 2006*, para. 199. Also see *Report of the International Narcotics Control Board for 2004*, para. 390; *Report of the International Narcotics Control Board for 2005*, paras. 199-204 and 457-458 and *Report of the International Narcotics Control Board for 2007*, paras. 222-225.
- 23 The 2006 CND took place from 13 to 17 March 2006, while the WHO Expert Committee on Drug Dependence met in Geneva from 28 to 31 March 2006.
- 24 See Commission on Narcotic Drugs, Report of the 49th Session, E/2006/28/ E/CN.7/2006/10 <http://ods-dds-ny.un.org/doc/UNDOC/GEN/V06/526/23/PDF/V0652623.pdf?OpenElement>
- 25 *Report of the International Narcotics Control Board for 2006*, para. 203
- 26 For more information on the Arriola ruling, see: Drug Law Reform in Argentina; <http://www.tni.org/article/drug-law-reform>
- 27 In its discussion of decriminalization, the Board also takes the opportunity to make what appears to be a thinly veiled attack on the American Commission on Drugs and Democracy. Involving former presidents of Colombia, Mexico and Brazil, the reform oriented Commission is singled out for attention. “Regrettably,” the Board notes, “influential personalities, including former high-level politicians in countries in South America, have publicly expressed their support for that Movement” (Para 453)
- 28 UN’s International Narcotics Control Board’s Annual Report over-steps mandate and interferes with countries’ sovereignty, TNI/WOLA Press release, February 24, 2010; <http://www.idpc.net/alerts/incb-annual-report-oversepts-mandate-interferes-with-countries-sovereignty>
- 29 Cindy S.J. Fazey, “The Commission on Narcotic Drugs and the United Nations International Drug Control Programme: politics, policies and prospects for change,” *International Journal of Drug Policy*, Vol. 14, No. 2, 2003, p. 167
- 30 InterCambiando, Newsletter, No. 26 April 2010. Mexico and to a limited extend the Group of Latin American and Caribbean States (GRULAC) also raised concerns regarding the contents of the Report at the 2010 CND. See IDPC The 2010 Commission on Narcotic Drugs – report of proceedings, April 2010, p. 7 <http://www.idpc.net/sites/default/files/library/CND%20Proceedings%202010%20V6.pdf>
- 31 See IDPC The 2010 Commission on Narcotic Drugs – report of proceedings, April 2010, p. 7 <http://www.idpc.net/sites/default/files/library/CND%20Proceedings%202010%20V6.pdf> Also see Tom Blickman. “Argentina and Mexico clash with the INCB, Italy with Europe,” *Fuoriluogo*, <http://www.tni.org/print/69881>
- 32 UN’s International Narcotics Control Board’s Annual Report over-steps mandate and interferes with countries’ sovereignty, TNI/WOLA Press release, February 24, 2010; <http://www.idpc.net/alerts/incb-annual-report-oversepts-mandate-interferes-with-countries-sovereignty>
- 33 InterCambiando, Newsletter, No. 26 April 2010.
- 34 WHO Briefing note *Access to Controlled Medications Programme* February 2009
- 35 INCB 2009, p.iv.
- 36 <http://www.incb.org/incb/mandate.html>
- 37 Diederik Lohman, Rebecca Schleifer, Joseph J Amon (2010) *Access to pain treatment as a human right* BMC Medicine 2010, 8:8 <http://www.biomedcentral.com/1741-7015/8/8>
- 38 INCB Report for 2009 p.19. para 77.
- 39 INCB Report for 2009 p. 19 para 78
- 40 The INCB- *Current Tensions and Options for Reform* IDPC, February 2008. http://www.idpc.net/sites/default/files/library/IDPC_BP_07_INCB_TensionsAndOptions_EN.pdf
- 41 Dave Bewley-Taylor and Mike Trace, “The International Narcotics Control Board: Watchdog or Guardian of the UN Drug Control Conventions?” The Beckley Foundation Drug Policy Programme, Report Seven, February2006. http://www.internationaldrugpolicy.net/reports/BeckleyFoundation_Report_07.pdf, p. pp. 5-6
- 42 See <http://www.incb.org/incb/mandate.html>
- 43 See IDPC Response to the 2008 Annual Report of the International Narcotics Control Board, June 2009 URL p. 4 <http://www.idpc.net/sites/default/files/library/IDPC%20response%20to%202008%20INCB%20report.pdf>
- 44 See IDPC Response to the 2008 Annual Report of the International Narcotics Control Board, June 2009 URL p. 4 <http://www.idpc.net/sites/default/files/library/IDPC%20response%20to%202008%20INCB%20report.pdf>

- 45 Catherine Cook and Natalya Kanaef, *Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics*, International Harm Reduction Association, p. 14
- 46 On the issue of INCB Recommendations, its informative to see the INCB document *Questionnaire: Implementation by Governments of INCB's recommendations published in its annual reports 2005-2007*. http://www.incb.org/pdf/questionnaire/a_r/Questionnaire_E.pdf By seeking information on compliance with recommendations, regardless of whether or not member states are in agreement with the legal basis of particular positions, the Board further demonstrates its reluctance to engage in meaningful dialogue with parties to the conventions.
- 47 See IDPC, *The 2009 Commission on Narcotic Drugs and its High Level Segment – Report of the Proceedings*, April 2009, pp. 4-5.
- 48 See IDPC Response to the 2008 Annual Report of the International Narcotics Control Board, June 2009 <http://www.idpc.net/sites/default/files/library/IDPC%20response%20to%202008%20INCB%20report.pdf> p. 9.
- 49 IDPC, Response to the 2007 Annual Report of the International Narcotics Control Board, March 2008, http://www.idpc.net/sites/default/files/library/IDPC_Response2INCB_AnRpt07_EN.pdf, pp. 5, IDPC, *The International Narcotics Control Board: Current Tensions and Options for Reform*, Briefing Paper 7, February 2008, p.p. 16-7.
- 50 IDPC Advocacy Note, *A Call to the new Secretary of the International Narcotics Control Board: Ongoing Challenges*, March 2010, p.6.
- 51 Rick Lines, “A ‘Most Serious Crime’? – The Death Penalty for Drug Offences and International Human Rights Law,” *Amicus Journal*, Issue 21 2010, p. 21, 26 and passim.
- 52 See Coercive Drug Treatment in China: Human Rights Watch, IHRA and Asia Catalyst submission to the UN Committee against Torture, Human Rights Watch *Where Darkness Knows No Limits*, <http://www.hrw.org/node/87467>
- 53 International Centre for Science in Drug Policy, *Effect of Drug Law Enforcement on Drug Related Violence: Evidence from a Scientific Review*, p. 7 <http://icsdp.org/research/publications.aspx>
- 54 Maureen Meyer with Coletta Youngers and Dave Bewley-Taylor, “At a Crossroads: Drug Trafficking, Violence and the Mexican State, Washington Office on Latin America and The Beckley Foundation Drug Policy Programme, Briefing Paper Thirteen, November 2007, p. 2 and passim <http://www.beckleyfoundation.org/pdf/BriefingPaper13.pdf>.
- 55 See Manuel Pérez Rocha, *The Failed War on Drugs in Mexico*, Transnational Institute <http://www.tni.org/print/68305>
- 56 IDPC The 2010 Commission on Narcotic Drugs – report of proceedings, April 2010, pp. 7-8 <http://www.idpc.net/sites/default/files/library/CND%20Proceedings%202010%20V6.pdf>

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