INTERNATIONAL DRUG POLICY CONSORTIUM

THE INTERNATIONAL NARCOTICS CONTROL BOARD: CURRENT TENSIONS AND OPTIONS FOR REFORM

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The International Drug Policy Consortium (IDPC) 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. Based on the findings of our research and written work, the Consortium engages with officials and politicians in national governments and international agencies – through correspondence, face-to-face meetings and involvement in conferences and seminars – to promote effective policies, thereby making the most up-to-date research and practice knowledge available to decision makers.

SUMMARY

Beginning with a discussion of its formal powers and self-proclaimed "unique" position in international relations, this IDPC report explores the tensions surrounding various aspects of the current operation of the International Narcotics Control Board (INCB or Board). These tensions are analysed in light of the INCB's interpretation of the UN drug control conventions and its mandate as laid out within them. It is argued here that in a number of contexts the Board appears prepared to act beyond the limitations which the treaties place upon it and engage in what can be termed mission creep. The report also explores other contexts within which the INCB appears reluctant to meet its mandated obligations and displays what can be described as selective reticence. The report contends that the areas of concern surrounding these mandate issues are further reinforced and complicated by the INCB's culture of secrecy and the lack of transparency which characterizes all its work. It concludes by outlining "A Way Forward" in reviewing the way the INCB operates: a vital and timely endeavour that should be undertaken during the UN-level process to assess the 1998 UNGASS on drugs and the subsequent period of global reflection leading up to a high-level meeting in 2009 where markers for future UN drug control efforts can be adopted.

INTRODUCTION

The International Narcotics Control Board is, according to its own literature, the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control Conventions. These are the 1961 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs), the 1971 Convention on Psychotropic Substances, and the 1988 Convention on Illicit Traffic in Narcotic Drugs and Psychotropic Substances.[1] Established in 1968 in accordance with the 1961 Single Convention on Narcotic Drugs, the Board is based in Vienna.

The Board is technically independent of Governments, as well as of the UN. Its thirteen members, principally pharmacologists, pharmacists, police officers and medical doctors serve in their personal capacities and may call upon the expert advice of the World Health Organization (WHO). According to Article 9 of the Single Convention, they should be persons "who by their competence, impartiality and disinterestedness, will command general confidence." The members are elected in a secret ballot by the UN's Economic and Social Council (ECOSOC), serve for a period of five years and can be re-elected. When electing members ECOSOC must, with due regard to the "principle of equitable geographic representation," be mindful of including on the Board "persons possessing knowledge of the drug situation in the producing, manufacturing and consuming countries." Additionally, three members of the Board with medical, pharmacological or pharmaceutical experience must be taken from a list of persons nominated by the WHO. The Board elects for one-year terms its own President and other officers it considers necessary[2], and meets in closed session twice a year; or more if it is considered necessary.

1 The UN Drug Control Treaties are available at: http://www.unodc.org/unodc/en/treaties/index.html (Date of last access 19th December 2007)

2 For example, First Vice President, Second Vice President, Chairman of the Standing Committee on Estimates and Rapporteur.

CURRENT INCB MEMBERSHIP

Name	Professional Background	Country	Mandate expiring March 1
Joseph Bediako ASARE	Psychiatrist	Ghana	2010
Sevil ATASOY	Forensic Scientist	Turkey	2010
Tatyana Borisovna DMITRIEVA	Psychiatrist	Russian Federation	2010
Philip O. EMAFO	Biochemist	Nigeria*	2010
Hamid GHODSE	Psychiatrist	Iran (Islamic Republic of)*	2012
Carola LANDER	Pharmacist	Germany	2012
Melvyn LEVITSKY	Diplomat	USA	2012
Maria Elena MEDINA-MORA ICAZA	Clinical Psychologist	Mexico	2012
Sri SURYAWATI	Clinical Pharmacologist	Indonesia*	2012
Camilo URIBE GRANJA	Toxicologist	Colombia	2010
Brian WATTERS	Addiction Counsellor	Australia	2010
Raymond YANS	Diplomat	Belgium	2012
Xin YU	Psychiatrist	China	2012

* Elected by ECOSOC from among nominees submitted by the WHO. (For full biographies of INCB Members, where available, see http://www.incb.org/incb/en/membership.html)

The Board has a secretariat that assists in the exercise of its treaty related functions. The secretariat is an "administrative entity" of the UN Office on Drugs and Crime (UNODC) in Vienna, "but reports solely to the INCB on matters of substance."[3]

The INCB has essentially three quite different functions: (a) to administer the system of global estimates to ensure the adequate supply for licit "medical and scientific" uses of substances controlled under the 1961 and 1971 treaties; (b) to monitor the control system for precursor chemicals and recommend changes for the Tables of the 1988 Trafficking Convention; (c) to play a 'quasi-judicial' role in order to ensure that the provisions of the international drug control treaties are adequately carried out by Governments through the maintenance of a 'permanent dialogue'. In recent years a number of significant tensions have arisen in the way the Board performs these functions.

The Board's formal powers

While the INCB is tasked with monitoring national drug policies and assessing their relationship with the treaties, it is important to note that the Board has no police power to enforce the Conventions' provisions. It is generally acknowledged that the INCB usually relies on informal pressure in its attempts to encourage what it perceives to be treaty compliance. The effectiveness of this informal influence is, however, to a certain extent dependent upon the Board's potential to invoke its formal powers. These are drawn from Article 14 of the Single Convention and Article 19 of the 1971 Convention on Psychotropic Substances and constitute a range of actions that increase in severity depending upon the responses of national Governments to INCB requests and proposals.

According to Article 14 of the Single Convention, if, under certain conditions, "the Board has objective reasons to believe 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 this Convention", the INCB has the legal right to propose confidential consultations with and request explanations from the Government concerned. Furthermore, if "without any failure in implementing the provisions of the Convention, a Party or a country or territory has become, or if there exists evidence of a serious risk that it may become, an important centre of illicit cultivation, production or manufacture of, or traffic in or consumption of drugs, the Board has the right to propose to the Government concerned the opening of consultations." Within this context, the Board may call upon the Government concerned to adopt "remedial measures" or propose that the Government undertake a study of the issue in question with

3 Quoted text is from INCB website. http://www.incb.org/incb/en/secretariat.html (Date of last access 11th February 2008)

a view to indicating and carrying out necessary remedial measures. If the Board concludes that the Government concerned has given unsatisfactory explanations, failed to adopt necessary remedial measures or that "there is a serious situation that needs co-operative action at the international level with a view to remedying," it may call the matter to the attention of the Parties to the Convention, ECOSOC and its Commission on Narcotic Drugs (CND); the central policy making body within the UN system for dealing with drug related matters. Under Article 14 failure to resolve a problem in any other way could, after considering the reports of the Board and of the CND if available, lead ECOSOC to draw the attention of the UN General Assembly to the matter. A similar process is outlined in the 1971 Convention on Psychotropic Substances, although this does not include the opportunity to involve the General Assembly.

Such "name and shame" procedures are also bolstered by the possibility of a drugs embargo. The possibility for this most serious intervention exists under both the 1961 Single Convention and the 1971 Convention on Psychotropic Substances,[4] and allows the INCB to recommend to Parties that they "stop the import of drugs, the export of drugs, or both, from or to the country or territory concerned" for a designated period or until it is satisfied with the situation within the country or territory. While such sanctions have never been applied, they are a persuasive mechanism for encouraging what the Board considers to be treaty adherence. As one expert has noted, "Although these powers [regarding sanctions] have never been used, they do represent potentially powerful instruments for enforcing observation of the obligations in the early drug conventions."[5] This is particularly the case since an INCB decision cannot be overturned by a higher body. Indeed, it is these powers that give the INCB both a prosecutorial and quasi-judicial role.

With reference to the 1988 Convention, no provision is made for the Board to take steps against what it regards as a defaulting Party. In fact, apart from its particular function to recommend precursors under article 12, no mandate been given to the INCB to monitor implementation of the 1988 Convention. Indeed, according to the *Commentary* on the Convention, under article 22 the INCB's mandate is "more restricted than those of the parallel articles in the 1961 and 1971 conventions."[6] As one expert notes, "the Board can do nothing to reprimand a state for not cooperating with the terms of the 1988 UN Convention."[7] Explaining this more restricted mandate, the *Commentary* refers to the discretion already required from the Board under the 1961 and 1971 conventions noting that "It is clear such discretion will certainly be called for under the 1988 Convention, where certain articles deal with matters that can be of a highly political character."[8] The difference arose "no doubt because of the very different character of the latter Convention, dealing as it does with matters of criminal law and its enforcement that go beyond the scope of the earlier conventions into areas touching more closely on the sovereignty and jurisdiction of States."[9]

The Board then clearly occupies a central place within the international drug control system. It has has the responsibility to monitor treaty compliance, but also the authority to report perceived infractions to influential bodies within the UN. As such, and although its powers are limited in regard to the 1988 Convention, it can exert considerable pressure upon nation states and influence domestic drug policy debates. Given the seriousness of the issue area and the pivotal role played by the INCB within the field of drug control, it is imperative that the body approaches its tasks in a sophisticated and balanced fashion within the framework laid out in the drug control Conventions.

"Unique" within international relations?

At a press conference held to introduce its 2007 annual report, INCB President Dr. Phillip Emafo and its Secretary Koli Kouame were subjected to questions by journalists concerned about the secrecy in which the Board's activities are cloaked. As will be discussed in more detail below, as well as meeting in closed session, the Board restricts external participation in its sessions and publishes neither minutes of meetings or communications with Parties. Dr.

4 Article 19 of the 1971 Convention follows the precedent set by the Single Convention, but in line with the focus of the treaty refers to "particular psychotropic substances" rather than "drugs."

5 Neil Boister, Penal *Aspects of the UN Drug Conventions*, Kluwer Law International, 2001, p.485

6 The *Commentary* notes that "not only are the Board's powers thereunder limited to matters within its competence as defined by the Convention (rather than extending to the provisions of the 1988 Convention as a whole), but also… the Board does not retain the right under article 22 itself that it has under the other conventions to call the attention of the parties, the Council and the Commission to the matter," unless it related to its regulatory competence in terms of precursors, equipment for manufacture and commercial documents. *Commentary on The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*, United Nations, New York, 1998, p. 380, para. 22.15

7 W. N. Gianaris, "The new world order and the need for an international criminal court" *Fordham International Law Journal,* 1992/3 Vol. 16, No. 88, p. 108 cited in Boister, op. cit., p. 489.

8 *Commentary on The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*, United Nations, New York, 1998, p. 378, para. 22.11.

9 *Commentary on The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*, United Nations, New York, 1998, p. 374, para. 22.2.

Emafo responded to criticisms by claiming that the Board's mandate restricted its discussions to those with governments and governmental agencies such as the UNODC and the WHO. "Our mandate is not with civil society", he insisted. "We have a mandate to discuss with governments. We do not go about seeking information from outside." Mr Kouame then attempted to further defend the Board's position by highlighting its 'unique' status in international relations. He explained that, "Countries sign the conventions…and they are supposed to implement the provisions of the conventions…The international community decided that in addition to the governments they needed an independent body…made of experts, who can…in an objective manner, assess what governments are doing in terms of their obligations vis-à-vis the conventions, so INCB was created. In fact the International Narcotics Control Board is unique in international relations…it is very unique…that's what explains why our deliberations are closed."[10]

This account of the model is clear and familiar enough: a panel of independent experts, whose knowledge and objectivity are widely recognized, is appointed to act in an advisory capacity to signatory governments when requested, and to use its expertise to assist them in compliance with the sometimes complex requirements of international treaties. What is significant, however, is that Mr Kouame's description of the INCB would be equally apposite in describing the creation and mandate of the seven existing independent UN human rights committees. These committees, known as the human rights treaty bodies, are the quasi-judicial committees of experts that monitor implementation of the core human rights conventions ratified by member states of the UN. Compare Mr Kouame's statement above with the following comment from the Office of the High Commissioner for Human Rights (OHCHR) outlining the UN human rights treaty body system:

> *"When the first treaty was adopted, it was recognised that States parties would require encouragement and assistance in meeting their international obligations…Each treaty therefore creates an international committee of independent experts to monitor, by various means, implementation of its provisions."* [11]

The analogy with the equivalent treaty bodies in the sphere of human rights is thus a close one. It is perhaps possible to argue that the INCB deals with an area of such sensitivity that it is, in a sense, unique, and that consequently the opacity of its working practices is justified. However, a contrary and in many ways more powerful argument can be made. Human rights are of equal contentiousness and sensitivity. Furthermore, with the UN Security Council itself currently contemplating enhanced transparency, it is difficult to argue that drug control should remain a privileged topic.

Despite its claims, the Board then is not unique within the UN system either in its foundation, structures, mandate or legal status. Indeed, as will be discussed further below, its "uniqueness" stems instead from the working methods that the Board itself has adopted; methods that are arguably out of step with those similarly constituted UN bodies that have chosen to operate via an open and inclusive process.[12] Unfortunately, the issues that do tend to be unique to it are currently linked, rather, to its often confrontational approach to states parties in relation to treaty interpretation and adherence, its secretive culture and its related unwillingness to engage with civil society. It is these issues, and a range of others with which they are connected, that are the focus of this report.

CURRENT ISSUES OF CONCERN.

A growing number of concerns have over recent years been articulated with respect to the ways in which the Board fulfils its role. These concerns relate to a set of interconnected areas and revolve around the particular manner in which the INCB currently interprets its mandate. We will present a short discussion of each of these areas although a common theme is the Board's selective, non-standard, highly restrictive and inflexible reading of the drug control treaties. It is to this question that we initially turn by placing a particular emphasis on the issue of harm reduction.

Treaty Interpretation - developing tension around harm reduction

The Single Convention, the bedrock upon which extant UN drug control system is built, pre-dated the emergence of HIV as a global problem by almost a quarter of a century. Beginning in the 1980s, the AIDS pandemic has led to a number of profound shifts in national and regional drug

10 INCB Press conference, New York, 7th March 2007. Webcast available at http://157.150.195.10/webcast/pc2007.htm (Date of last access 16th December 2007)

11 Fact Sheet No 30 'The United Nations Human Rights Treaty System', Geneva, Office of the High Commissioner for Human Rights available at: http://www.ohchr.org/Documents/Publications/FactSheet30en.pdf (Date of last access 16th December 2007)

12 For a more detailed discussion of this topic see Damon Barrett, *"Unique in International Relations?" A Comparison of the International Narcotics Control Board and the UN Human Rights Bodies*, International Harm Reduction Association, February 2008. http://www.ihra.net/uploads/downloads/NewsItems/Barrett-UniqueinInternationalRelations.pdf

policy; to a greater pragmatism and a widespread realization in many quarters that the theory and practice of drug control must, in order to remain relevant and effective, adapt itself to changing social, cultural and medical circumstances.

According to a 2006 UNAIDS report, an estimated 38.6 million people are living with HIV/AIDS. Injecting drug use is driving HIV epidemics in many countries and accounts for almost a third of new infections outside sub-Saharan Africa. The injection-driven spread of infection is most severe in Russia and the countries of the former Soviet Union, Eastern Europe and South, Southeast and central Asia; in China, nearly half (44%) of the country's 1.1 million infections involve intravenous drug users.[13]

Within this context, UN member states have twice unanimously endorsed their commitment to provide people at risk of HIV with harm reduction services.[14] These include measures such as the provision of sterile syringes. While no single definition exists, harm reduction generally refers to efforts to reduce the adverse consequences of drug use among those who are unable or unwilling to abstain from illicit drugs.[15] In addition to the provision of sterile syringes, harm reduction measures include provision of facilities where drug consumers are offered sterile equipment and medical supervision, prescription of opiate substitutes to reduce illicit drug injection, information or peer counselling on safer injection and prevention of blood-borne illness, overdose prevention and other measures to increase health and safety.

In the past decade, the increase of HIV among injecting drug users and repeated studies showing the efficacy of measures such as syringe exchange and substitution treatment in decreasing HIV risk (and, in the case of substitution treatment, reducing demand for illicit opiates[16]), have led harm reduction to become a part of national strategies in countries ranging from many of those in the European Union to Vietnam, Iran and Brazil.[17] Expanded commitment to harm reduction measures is also among the goals endorsed by all member states in the 2001 Declaration of Commitment following the UN General Assembly Special Session on HIV/AIDS.[18] While this is the case, the INCB has chosen to emphasize repeatedly both what it sees as the negative potential of the approach and the belief that some harm reduction interventions contravene the drug control treaties.[19]

This position is also dissonant with that of important UN agencies involved in drug control and HIV prevention, such as the WHO, UNDP and UNAIDS, that have chosen to engage with many harm reduction interventions. For example, all advocate a comprehensive approach including a variety of harm reduction services for injecting drug users as the only effective way to reverse the HIV epidemic in Asia, Russia and Eastern Europe. Furthermore, UNAIDS, the joint programme that includes ten UN system organizations,[20] has been clear in resolutions by its Programme Coordinating Board and in speeches by its officials that harm reduction and protection of drug users' human rights are a recognized part of the United Nations' response to HIV.[21] Recent months have also seen

13 UNAIDS, *Global Report 2006 Report on the Global AIDS Epidemic,* available at: http://data.unaids.org/pub/GlobalReport/2006/2006_GR-ExecutiveSummary_en.pdf (Date of last access 14th January 2008)

14 UN General Assembly, *Declaration of commitment on HIV/AIDS* (A/RES/S-26/2), August 2, 2001; and UN General Assembly, *Political declaration on HIV/AIDS* (A/RES/60/262), June 15, 2006.

15 See, for example, British Department for International Development, *Harm reduction: Tackling drug use and HIV in the developing world* (Department for International Development, 2005). Available at http://www.dfid.gov.uk/pubs/files/hivharmreduction2005.pdf (Date of last access 11th February 2008)

International Harm Reduction Development Program, *Saving lives by reducing harm: HIV prevention and treatment for injecting drug users* (New York: Open Society Institute, 2006). Available at: http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/saving_20060818. (Date of last access 11th February 2008)

16 WHO/UNODC/UNAIDS position paper. *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention,* 2004. Available at: http://www.who.int/entity/substance_abuse/publications/en/PositionPaper_English.pdf (Date of last access 11th February 2008)

17 See, for example, "Harm reduction seems to be an accepted approach in drug demand reduction policies in all EU Member States," *Prevention and reduction of health-related harm associated with drug dependence: An inventory of policies, evidence and practices in the EU relevant to the implementation of the Council Recommendation of 18 June 2003*, Trimbos Institute, 2006, p. 67; Government of Brazil, Conselho Nacional Antidrogas, Politica nacional sobre drogas. Section on harm reduction (Redução dos danos sociais e à saúde). Available at www.senad.gov.br; Socialist Republic of Vietnam, 11th National Assembly, Session no. 9. Law on prevention and control of HIV/AIDS (article 21, "HIV/AIDS harm reduction interventions"), 2006. English translation of the law obtained by and on file with the Canadian HIV/AIDS Legal Network.

18 UN General Assembly, *Declaration of commitment on HIV/AIDS* (A/RES/S-26/2), August 2, 2001.

19 Since 1993, the Board has issued recurring and unsubstantiated warnings about harm reduction, including that it had "diverted the attention (and in some cases, funds) of Governments from important demand reduction activities such as primary prevention or abstinence-oriented treatment." INCB, *Annual Report for 2000*, para. 446.

20 Office of the United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO).

21 For example, the words of Dr Catherine Hankins, an Associate Director at UNAIDS, in her opening address to the International Harm Reduction Association conference in 2002 are illustrative. "…Let me make it clear from the outset that, to reduce the health and social consequences of drug use, the United Nations fully endorses the fundamental principles of harm reduction: reaching out to injecting drug users, providing sterile injecting equipment and disinfectant materials, and providing substitution treatment. Hankins, Catherine. *UNAIDS Address, Opening Ceremony of the 13th International Conference on Drug Related Harm.* Available at: *http://www.ihra.net/uploads/downloads/Conferences/Ljubljana2002/HankinsLjubljana2002.pdf* (Date of last access 19th December 2007)

the UNODC, itself a UNAIDS co-sponsor, make tentative steps to openly support in its own right syringe exchange and reinforce its position on substitution treatment.[22]

However, in consistently positioning itself as opposed to the harm reduction discourse in general, and in its reticence to speak out in favour of specific harm reduction measures, the INCB is in many ways stifling the development of a system-wide response to the pandemic. Even in its 2003 *Annual Report*, where the Board acknowledged that measures such as needle exchange and opiate substitution treatment did not contravene international conventions, its acknowledgement of the legality of these measures was accompanied by unreferenced warnings about their negative consequences.[23] Like many of the Board's statements on the subject of harm reduction, the assertions included a number of unfortunate omissions and rhetorical devices. For instance, the INCB makes limited reference to the harm caused by HIV; places scare quotes around "harm reduction," even though the term has been endorsed by many UN member states; and cites no scientific evidence or specific examples to justify its assertion that some "so-called 'harm reduction' approaches" cause more harm than good. While the Board points to its 2003 report as evidence of its commitment for harm reduction, subsequent reports by the INCB have been remarkable for their failureto engage the issue. The 2006 report, for example, mentions HIV fifty times, yet fails to make a single mention of needle exchange.

The report of the UNDCP legal experts

The Board has consistently pointed to the conventions as the warrant for its concern about particular harm reduction measures, most particularly facilities known variously as safer injection facilities and drug consumptions rooms, which offer medical supervision and a sterile environment for drug users. These had been described as "shooting galleries" and "opium dens" by INCB members, and repeatedly declared by the Board to be against the terms of the conventions insofar as they are felt to involve the encouragement by governments of illicit drug use and trafficking.[24] These declarations have not been accompanied by legal analysis, and indeed contravene findings of national legal advisers in countries where such facilities had been implemented. Moreover, when in 2002 the INCB asked the Legal Affairs Section (LAS) of the then UN International Drug Control Programme to explore the legality of a number of harm reduction measures vis-à-vis the conventions, the conclusions of the legal experts were unequivocal: most harm reduction measures did not contravene the treaties.[25] The LAS produced an internal document detailing multiple arguments that justified "Needle or Syringe Exchange," "Substitution and Maintenance Treatment," and "Drug-injection rooms" under the terms of the conventions. The document noted that the existence of new threats like the "growing rates of intravenous HIV transmission of serious illness" require that "governments come up with new strategies to cope." "It could even be argued" it continues "that the drug control treaties, as they stand have been rendered out of synch with reality, since at the time they came into force they could not have possibly foreseen these new threats." (See Box 1)

The findings of the LAS were never released or acknowledged by the INCB. This is reflective of a larger pattern whereby the Board, rather than acting as watchdog of the drug control conventions, describing the global situation and bringing attention to emerging challenges and dilemmas, often seems to play the role of guardian of a particular and often opaque interpretation of many of the conventions' provisions. This has resulted in the INCB issuing statements in its public discourse (such as its *Annual Report*) and in its private communications with states parties that are at odds with the evidence base and legal scholarship. This behaviour, and the

22 See *Reducing the adverse health and social consequences of drug abuse: A comprehensive Approach. Discussion Paper*, United Nations Office on Drugs and Crime, January 2008. http://www.unodc.org/documents/prevention/Reducing-adverse-consequences-drug-abuse.pdf (Date of last access 23 January, 2008). Also see WHO/UNODC/UNAIDS Position Paper, *Substitution Maintenance Therapy and the Management of Opioid Dependence and HIV /AIDS Prevention,* 2004 http://www.unodc.org/docs/treatment/Brochure_E.pdf (Date of last access 22 February, 2008)

23 For example, "The Board calls on Governments that intend to include 'harm reduction' measures in their demand reduction strategies to carefully analyze the overall impact of such measures, which may sometimes be positive for an individual or for a local community while having far-reaching negative consequences at the national and international levels." INCB, Annual Report for 2003, para 226. http://www.incb.org/incb/en/annual_report_2003.html (Date of last access 19th December 2007). The Board has also stated that: "[Harm reduction] cannot . . replace demand reduction programmes or be carried out at their expense. Most importantly, 'harm reduction' can never be an end in itself, nor should it be the overall guiding principle behind national drug demand reduction policy. . . . While, in principle, measures to reduce harm in drug-dependent persons should not be seen as being in contradiction with the international drug control treaties, some so-called 'harm reduction' approaches are not what they seem to be in that they cause more harm than they purport to reduce." INCB, Annual Report for 2003, Foreword.

24 See for example, "The Board believes that any national, state or local authority that permits the establishment and operation of drug injection rooms or any outlet to facilitate the abuse of drugs (by injection or any other route of administration) also facilitates illicit drug trafficking...By permitting drug injection rooms, a Government could be considered to be in contravention of the international drug control treaties by facilitating, aiding and/or abetting the commission of crimes involving illegal drug possession and use, as well as other criminal offences, including drug trafficking." INCB, , Annual Report for 1999, para, 176. Also see Annual Report for 2003, para 223. With reference to the Board's use of the term 'Opium Dens' see P. Emafo (President, INCB). Letter to Kofi Annan, 18 May 2006. For the context of this letter see Joanne Csete & Daniel Wolfe, *Closed to Reason: The International Narcotics Control Board and HIV/AIDS* OSI, 2007. Available at: http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=672 (Date of last access 14th January 2008.) In reference to 'Shooting galleries' see statement of former INCB President Laureno Martins to CND, 2000; also quoted in Csete & Wolfe, ibid.

25 UNDCP Legal Affairs Section, *Flexibility of treaty provisions as regards harm reduction approaches*, E/INCB/2002/W.13/SS.5 (UNDCP Legal Affairs Section, September 2002) Available at: http://idpc.info/php-bin/documents/UN_HarmReduction_EN.pdf (Date of last access, 17 February, 2008)

Box 1 - THE REPORT OF THE UNDCP'S LEGAL AFFAIRS SECTION

The fundamental legal principle underlying the UNDCP's Legal Affairs Section report to the INCB —*Flexibility of Treaty Provisions as regards Harm Reduction Approaches*— is drawn from all three drug control conventions. It stems from the obligation within the conventions

> *'To take all practicable measures for the prevention of drug abuse and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of drug addicts.'*

The LAS recognizes that while many treaty provisions are straightforward, this one—

> *'…is not so clear-cut, since given its very nature, compliance with this obligation will necessarily depend on the interpretation by the Parties of concepts like prevention, treatment, rehabilitation and social reintegration, which are not defined by the treaties. State practice has shown that such interpretation may vary greatly from country to country and with it their understanding of how best to handle their respective drug-abuse related problems, while complying with their treaty-based obligations.'*

The LAS Report goes on to say—

> *'On the latter, it is worth noting that the treaties, also in their preambles, express their concern for the health and welfare of mankind, and for the health and social problems resulting from abuse. This might easily be construed as clear intent on the part of the treaties to combat drug abuse out of concern for its health and welfare consequences. Proponents of harm reduction might view this, in combination with the provisions of article 14, paragraph 4 of the 1988 Convention, as an express consent to alleviate the human suffering associated with drug abuse through harm reduction policies.*
>
> ***11.** The provisions in article 14 go even further, authorising Parties to base their demand reduction measurers on recommendations of, inter alia, the United Nations. General Assembly resolution A/RES/S-20/4 (Declaration on the Guiding Principles of Drug Demand Reduction) would no doubt qualify as a United Nation's recommendation. In this respect, it should be noted that this resolution clearly states that:*
>
> *(b) Demand reduction policies shall:*
>
> *(i) Aim at preventing the use of drugs and at **reducing the adverse consequences** of drug abuse;*
>
> *(ii) …*
>
> *(iii) Be sensitive to both culture and gender;*
>
> *(iv) Contribute to developing and sustaining supportive environments.*
>
> ***12.** From this, it could easily be argued that the Guiding Principles of Drug Demand Reduction provide a clear mandate for the institution of harm reduction policies that, respecting cultural and gender differences, provide for a more supportive environment for drug users. The implementation of such a mandate would of course be open to the Public interpretation.'*

The paper notes, in addition, that this position is in line with the UN system paper *Preventing the Transmision of HIV among Drug Users*, endorsed by the High Level Committee on Programmes in 2001 and published in 2002. The document containing the advice from the LAS has never been released, nor had its existence publicly acknowledged, by the INCB.

UNDCP Legal Affairs Section, *Flexibility of treaty provisions as regards harm reduction approaches,* E/INCB/2002/W.13/SS.5 (UNDCP Legal Affairs Section, September 2002) is available at http://idpc.info/php-bin/documents/UN_HarmReduction_EN.pdf

lack of mechanisms for countries to respond to or engage in dialogue with the Board, generate unnecessary tension between the INCB and Parties to the conventions since the INCB's interpretation of the treaties is not universally held – indeed the treaties themselves allow for a certain amount of room for manoeuvre. They are forged by political consensus, and are not self-executing (i.e. enforcement powers lie with the Parties). Furthermore, they do not define such basic categories as 'medical and scientific purposes'. As such, it may be argued that differing interpretations are an inevitable, even an in-built, part of the treaty-system. Additionally, as the *Commentary* on the 1972 Protocol Amending the Single Convention explains, the Board "has to maintain friendly relations with Governments, guided in carrying out the Conventions by *a spirit of cooperation rather than by a narrow view of the letter of the law.*" (emphasis added.) Even 'a narrow view of the letter of the law' might be a generous rendering of many Parties' experience of the INCB, since the Board's concerns are rarely accompanied by legal analysis. Indeed, no one currently on the INCB is a legal expert, a fact that has raised concern on the Board itself. Then INCB President Laureno Martins observed to ECOSOC in 1999

that "experience in applying and interpreting the law…is essential when analyzing government performance under the treaties." Despite this, no Board member since 2001 has possessed training in international law.[26]

Beyond the strictly legal issue of treaty interpretation, the Board's attitude on harm reduction can also be seen to undermine UN system-wide coherence, its ability to 'Deliver As One',[27] and the global effort to halt and reverse the spread of HIV/AIDS; one of the UN Millennium Development Goals.

Problems around the INCB's Mandate

The Board's interpretation of its mandate is clearly central to these questions. In a number of contexts it appears prepared to act beyond the limitations which the treaties place upon it and engage in what can be termed mission creep. In other contexts the Board appears reluctant to meet its mandated obligations and displays what can be described as selective reticence. The question of the Board's fulfilment, or otherwise, of its mandate is thus a double-sided one.

1: Mandates: The Board's Mission Creep.

Despite the LAS advice that a good legal case could be made that drug consumption rooms are not in contravention of treaty provisions, the Board has always been quick to roundly condemn those states that adopt them. Beyond selective and non-universal treaty interpretation, in so doing this is an example of the INCB exceeding its mandate in a number of significant ways.

For instance, the UN drug control conventions describe the authority of the Board explicitly in terms of co-operation and dialogue. For example, Article 9, paragraph 5 of the 1961 Single Convention (as amended by the 1972 Protocol) states: "All measures taken by the Board under this Convention shall be those most consistent with the intent to further the co-operation of Governments with the Board and to provide the mechanism for a continuing dialogue between Governments and the Board which will lend assistance to and facilitate effective national action to attain the aims of this Convention."

As mentioned above, the only exception to the spirit of cooperation and dialogue relates to conditions laid out in Article 14 of the Single Convention and the associated article 19 of the 1971 Convention. Article 14 of the Single Convention is particularly noteworthy because it refers to action relating 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 this Convention" (emphasis added).[28]

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".[29] However, 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. 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.[30] Such conduct is outside their remit, unless and until the Board has objective reasons – which they need to substantiate - to argue that certain countries are undermining the aims of the convention in such a serious way that it may affect other parties of the treaty. Even then, the INCB can only call the attention of others to such 'violations' (for example, in their *Annual Report*) "if the aims of this Convention are

26 Quoted in Csete & Wolfe, op. cit.

27 *Delivering As One (DAO)* is the title of the report of the High-level Panel on U.N. System-wide Coherence in the areas of Development, Humanitarian Assistance and the Environment. It was published in early November 2006 as part of broader moves towards UN reform and the achievement of the Millennium Developments Goals. See http://www.un.org/events/panel/resources/pdfs/HLP-SWC-FinalReport.pdf (Date of last access 22 February 2008)

28 Key here is the wording of 'objective reasons' and 'seriously endangered'. The 1972 Protocol substituted the words 'objective reasons' for the word 'reason' in the language of the original 1961 treaty text. The *Commentary* to the 1972 Protocol explains that the "new phrase including the word 'objective' was introduced in order to reassure some delegates to the 1972 Conference that the Board would have to base its actions on objective facts and not on purely subjective considerations" (*Commentary on the Protocol Amending the Single Convention on Narcotic Drugs, 1961,* United Nations, New York, 1976, p. 25, para. 12). The original 1961 text already stressed the serious nature of the violation before article 14 could be invoked. The *Commentary* stated that the "conclusion that a serious situation of this kind exists will be justified if lack of control or defective control in one country or territory appears to endanger the effectiveness of control in another country or territory" (*Commentary on the Single Convention on Narcotic Drugs, 1961,* United Nations, New York, 1973, p.178, para. 1). As such, article 14 of the Single Convention and article 19 of the 1971 Convention constitute (which contains the term "reason rather than objective reasons") the only existing 'enforcement' procedures of the international drug control regime which might ultimately lead to a recommendation of an international embargo on the import or export of drugs for medicinal purposes. This "serious and delicate matter," according to the *Commentary* on the Single Convention, "requires the Board to apply the provisions of that article with particular prudence" (p.178). At present, only article 14 of the Single Convention has been invoked by the Board. This is in relation to Afghanistan (since 2000).

29 *Commentary on the Protocol Amending the Single Convention on Narcotic Drugs, 1961,* United Nations, New York, 1976, p. 13, para 10

30 For example, the 1972 Protocol amending the 1961 Single Convention specified several of the Board's functions and the "*restrictions imposed upon its authority*". The *Commentary* on the Protocol spells out: "The Board may lend assistance or give advice only to a Government requesting it expressly or by clear implication. [..] the Board may in particular not recommend remedial measures to an individual government without its agreement, except in accordance with article 14, paragraph 1, subparagraph (b)." *Commentary on the Protocol Amending the Single Convention on Narcotic Drugs, 1961,* United Nations, New York, 1976, p.13, para. 11.

seriously endangered and it has not been possible to resolve the matter satisfactorily in any other way."[31] The *Report* needs to include "an account of the explanations, if any, given by or required of Governments together with any observations and recommendations which the Board desires to make."[32]

It seems clear, therefore, that the INCB is currently exceeding its authority as laid out in the conventions and has, over the years, illegitimately extended its role within the international drug control system. When comparing the Board's recent actions and general attitude with a close reading of specific articles within the conventions and their accompanying commentaries, it is hard to argue that the INCB has not been engaged in a form of mission creep. Among other areas, evidence of this can be found in:

- The current attitude of the Board towards member states, which it often apparently sees itself as at least an equal, and other parts of the UN system (for example, the WHO) towards which it apparently regards itself as superior. (See Box 2)
- The general tone of the Board's annual report; specifically its criticisms of some member states.[33]
- The absence of balanced representations in INCB public statements, including its Annual Report, of states' explanations and responses to questions from the Board.
- The lack of due process and transparency in the discharge of its 'quasi-judicial' function (See below.)
- The growing number of issues the Board considers within its competence to make judgements about without being requested to do so and without engaging in a process of consultations first. (See Box 3)
- Individuals exploiting Board membership to advise and criticize nation states on policy questions (See Box 4)

Thus, rather than maintaining a mandated position as a facilitator of dialogue within specific spheres of competence, the INCB has expanded its mandate and power to become 'judge, jury and executioner' on any drug policy issue. The Board is privileging selective interpretations of the conventions, and overstepping its mandate when it tries to influence or control the internal policies of governments as regards the use of controlled drugs, particularly when a government takes a different view from the Board, or individual Board members, in matters of public health policy, crime prevention, clinical practice or reduction of demand for illicit drugs. The Board frequently condemns the policies of sovereign states in these areas, even when it is unqualified to comment.

Box 2 — THE INCB AND WHO — TENSIONS OVER THE SCHEDULING OF SUBSTANCES

The 2007 CND session brought to the fore tensions over the dividing lines between the respective mandates of INCB and the World Health Organization (WHO). In a critical presentation from the WHO, the secretary to the Organization's Expert Committee on Drug Dependence pronounced himself "astonished" that the INCB had called on governments to schedule ketamine. He noted that the WHO experts had to date found insufficient evidence of adverse effects from abuse to justify scheduling, and urged the commission to ignore the INCB recommendations in their report. [1]

In addition, Bolivia reacted strongly to the Board's expressed opposition to the emerging proposal for the rescheduling of coca leaf. The Board, in its 2006 Annual Report and at the 2007 CND plenary, also spoke out against the WHO recommendation to reschedule Dronabinol (delta-9-tetrahydrocannabinol, THC, the active ingredient of cannabis) from Schedule II to III under the 1971 treaty.[2]

Something similar happened in a section of the INCB report on khat, a non-scheduled substance that, in principle, should not concern the INCB at all. The mandate to advise Member States on the scheduling of narcotic and psychotropic substances under the 1961 and 1971 conventions has been given explicitly to the WHO. The role for the INCB with regard to the lists of controlled substances is restricted to advice on the listing of precursor chemicals under the 1988 Convention on Trafficking. This appears to represent a clear example of the Board overstepping its mandate to provide unsolicited scheduling advice for the 1961 and 1971 Conventions, highly problematic because in all these cases the Board's recommendations contradict those coming from the WHO.

31 1961 Convention, Article 14, para. 1, d.

32 1961 Single Convention, Article 15, para. 1.

33 See *The International Narcotics Control Board: Watchdog or Guardian of the UN Drug Control Conventions?*, Beckley Foundation Drug Policy Programme, Report 7, February 2006. http://internationaldrugpolicy.net/Reports/BeckleyFoundation_Report_07.pdf (Date of last access 19th December, 2007.)

1 International Drug Policy Consortium, Briefing No.5 *The 2007 Commission on Narcotic Drugs* http://www.idpc.info/php-bin/documents/IDPC_BP_05_2007UNCND_EN.pdf (Date of last access 19th December 2007)

2 Ibid, and see also E/CN.7/2007/10, *Changes in the scope of control of substances*. Note by the Secretariat, 22 January 2007.

2: Mandates: The Board's selective reticence

As mentioned above, there is a curious dual aspect to the problems around the Board's mandate. Alongside the recent colonization by the INCB of areas outside its remit as defined by the conventions and their commentaries, there is, on the other side of the coin, a coyness and timidity about certain elements of its role. The Board sometimes refrains from interdiction where circumstances, and its duties under its mandate, would warrant a robust response. Below we discuss the INCB's selective reticence in relation to four key areas; opiate substitution therapies and essential medicines; human rights; the resolution of ambiguities regarding coca; and engagement with civil society.

Opiate substitution therapies and essential medicines

The UN drug control conventions require governments to put in place treatment for drug dependence,[34] and the WHO includes methadone and buprenorphine in its Model List of Essential Medicines.[35] The INCB's annual reports and associated public statements, however, have demonstrated at best a lukewarm support for opiate substitution therapies (OST) such as those employing methadone and buprenorphine. Indeed, the Board rarely mentions substitution therapies, although they are amongst the best researched interventions for drug dependence, or that OST has also been shown to assist in HIV prevention. Additionally, the Board has neglected to call to account those countries which fail to make available these treatments to their citizens.

The INCB Annual Report for 2003 clearly stated that OST did not breach the UN drug conventions and also noted that the Board, over the years, had "discussed and confirmed quantities (of opiates) Governments have needed for such purpose."[36] Nonetheless, the INCB has failed to remark on the fact that estimates of need for methadone by countries such as Russia, Kazakhstan, Ukraine, and Vietnam have remained unchanged despite injection-driven HIV epidemics and fast rising rates of illicit opiate use.[37] While the use of opiates to relieve pain from cancer and other chronic conditions is mentioned frequently in INCB speeches and reports,[38] OST is mentioned most often in INCB reports in the context of concern about diversion of methadone and buprenorphine to illicit markets.[39]

INCB documents and speeches by Board members routinely fail to note the ways that HIV epidemics heighten the importance of substitution treatment. In a speech to the World Health Assembly in May 2006, Dr. Emafo did acknowledge the connection between OST and HIV prevention, though the comment was notable mainly for its tentativeness.[40] The INCB's annual report for 2005 noted that China had responded to HIV prevalence by implementing methadone programmes. The observation, itself unusual in INCB reports, was made without expression of appreciation or praise.[41]

The Board has demonstrated some leadership and commitment in urging countries to expand medical opiate use for pain relief. It has worked with WHO and academic centers such as the University of Wisconsin's Pain and Policy Studies Group to highlight shortages in, and facilitate greater access to, opiates for pain relief. "The Board believes that the medical need for opiates is far from being fully satisfied in both less developed and developed countries," noted a 1996 INCB special report on medical uses of opiates.[42] Yet the report noted use for OST only in two instances. The first was the inclusion of addiction treatment in a list of medical applications for opiates that included treatment of diarrhoea and cough, and use for veterinary purposes. The second was a table noting (without comment) that 45 percent of countries that provided information to the INCB allowed

34 For example, the 1961 Single Convention on Narcotic Drugs, article 38, states that: "The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends."

35 Available at http://www.who.int/medicines/publications/essentialmedicines/en/ (Date of last access 11th February 2008)

36 INCB, *Annual Report for 2003*, para 222

37 International Narcotics Control Board, *Estimated world requirements of narcotic drugs for 2005* (Vienna, 2006); International Narcotics Control Board, *Estimated world requirements of narcotic drugs for 2001* (Vienna, 2002). Both available at www.incb.org.

38 See, for example, INCB, *Availability of opiates for medical needs* (special report prepared pursuant to Economic and Social Council resolutions 1990/31 and 1991/43) (Vienna, 1996), iii, 5-6 ff.; INCB Annual Report for 2005, para 88; INCB, Annual Report for 2004, para 137; INCB, Annual Report for 2003, 173-174; statements by INCB presidents to the 42nd session of CND in 1999, the 43rd session in 2000, the 1999, 2000, 2001 and 2004 substantive sessions of ECOSOC, the 59th session of the World Health Assembly in 2006, the 46th Directing Council of the Pan American Health Organization in 2005, and the WHO Regional Committee for Africa in 2006. All speeches available at www.incb.org

39 See, for example INCB, *Annual report for 2004*, para 93; INCB *Annual Report for 2005*, paras 116, 138, 495, 562, 652.

40 Emafo said the INCB looked forward to working with WHO on the development of guidelines for the use of medications to manage opiate dependence, "which *might be* a component of community-based approaches for the prevention of HIV infection among injecting drug abusers" (emphasis added) P.O. Emafo (president, INCB). Statement to the 59th session of the World Health Assembly, May 2006, Geneva. Available at www.incb.org/incb/speeches/

41 INCB, *Annual Report for 2005*, para 467

42 INCB, *Availability of opiates for medical needs*, op. cit.

Box 3 - THE INCB AND CANNABIS

In 2003 the INCB was highly critical of UK government's decision to re-classify cannabis from a Class B to a Class C drug. This means that possession of the drug remains illegal but, unless there are aggravating factors, is not automatically an arrestable offence. In a letter to Board, Secretary Herbert Schaepe, UK Under Secretary of State for Anti-Drugs Co-ordination and Organized Crime, Bob Ainsworth, noted that the Board had used alarmist language, omitted any reference to scientific evidence on which the decision to reclassify was based and presented the decision in a misleading way to the media.[1] During questioning on the issue by a House of Commons Select Committee, Ainsworth commented that the Home Office was "…astonished at what was said in that regard. I do not know what legal basis there was for the comments that were made or what research was put into the announcement that was made... I do not know what legal advice they have taken with regard to our changes of classification on cannabis…I think UN bodies ought to base their pronouncements on evidence, fact and legal basis, and not on reaction and knee-jerk comment. It certainly seemed to me that that was exactly what they were doing. If they have some evidence that anything we have done is in any way in contravention of international Conventions, they had better let us know. I do not believe they have, and I do not believe there is any justification for the comments that they made."[2]

The Board, in its 2001 report, dedicated a special section to 'Control of Cannabis' warning of an increased tension between expanding tolerance practices and strict treaty adherence. The INCB noted "some shifting towards a more liberal cannabis policy in several developed countries," specifying that in Italy, Luxembourg, Portugal and Spain, "possession of cannabis for personal consumption is not considered a criminal offence, and acts preparatory to personal consumption, such as acquisition, transportation and possession of cannabis are not penalized. Only administrative sanctions apply to those acts."[3] The report also worried about legislative changes then under consideration in Belgium, the United Kingdom and Switzerland.

INCB criticism of domestic cannabis policies deemed by national authorities to be in line with the UN Conventions has been something that the Dutch have long lived with. Indeed, despite the flexibility and interpretative variation within the treaties the Board regularly criticizes the Dutch coffee shop system. In its *Annual Report* for 1997 it went so far as to say that it constituted "an activity that might be described as indirect incitement."[4] Under the present arrangement in the Netherlands the possession of cannabis remains a statutory offence, but the government employs the "expediency principle" and has issued guidelines on the use of discretionary powers that assign the "lowest judicial priority" to the investigation and prosecution of cannabis for personal use (up to 5 grams). The guidelines further specify the terms and conditions for the sale of cannabis in authorized coffee shops, whereby the sale of up to 5 grams of cannabis per transaction is tolerated and a coffee shop is permitted to hold up to 500 grams of the drug. The result is de facto decriminalization of personal use.

Dutch authorities contend that the policy operates within the letter of the conventions. For example, a good legal case can be made that the law and implementation strategy are permitted under Article 36 of the Single Convention concerning penal provisions. As one expert notes "The Single Convention… [does] demand criminalization of possession, trafficking, dealing, cultivating, and producing soft drugs as well as hard drugs. This obligation is met in Dutch legislation in the Opium Act." "But" he continues, "there are no clauses in the relevant UN conventions that concern the actual *enforcement* of the legislation" (Original emphasis.)[5] Furthermore, the Dutch assert that they are in compliance with the 1988 Convention's requirement that parties make the possession of drugs for personal consumption a criminal offence under domestic law because it says nothing about the scope of the required enforcement.[6] Article 3 of the 1988 Convention also contains an escape clause allowing states to apply constitutional principles and basic concepts of their legal system; a position that was highlighted in a reservation made by the Netherlands at the time of signing.[7]

Despite the continuing legal dispute regarding the latitude within the conventions and the Board's own lack of mandate to monitor the implementation of the 1988 Convention, the INCB has for many years pursued a narrow legal interpretation of the conventions and repeatedly expressed its strong objection to any move towards decriminalization of possession for personal use, lowering law enforcement priorities for cannabis or reclassification (placing cannabis under a lighter control regime than heroin under domestic legislation).

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1 Travis, Alan (2003), High Stakes, *The Guardian*, April 16, Retrieved from http://society.guardian.co.uk/societyguardian/story/0,7843,937205,00.html April 17, 2003 and Ainsworth, Bob, (2003) Letter to Herbert Schaepe, 22 March. Retrieved from http://www.drugscope.org.uk/news_item.asp?a=1&intID=981 20 July 2004.

2 For the full account of the Select Committee discussion see http://www.publications.parliament.uk/pa/cm200203/cmselect/cmhaff/uc559/uc55902.htm

3 E/INCB/2001/1, *Report 2001*, INCB *Annual Report for 2001*, para 214.

4 Report of the INCB *Annual Report for 1997*, United Nations,, para 28. In other reports the INCB limited itself to buying, stocking and selling cannabis products for non-medical use does not conform with the provisions of the 1961 Convention." (1996 and 2001 annual reports).

5 Jos Silvas, "Enforcing Drug Laws in the Netherlands," in Ed Leuw and Ineke Haen Marshall (Eds) *Between Prohibition and Legalization: The Dutch Experiment in Drug Policy,* Kluger Publishers, 1994, p. 49.

6 Neil Boister, op. cit., p. 130, note 241.

7 See: United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988: Treaty adherence as of 13 July 2007 (http://www.unodc.org/pdf/treaty_adherence _convention_1988.pdf)

use of opiates for addiction treatment.[43] The report did not analyze either the lack of availability of methadone or buprenorphine to injection drug users, or the potential role of these medications in increasing social integration or reducing HIV risk. HIV/AIDS was mentioned only in the context of opiate use as palliative care for people living with AIDS. The annex listing non-governmental organizations consulted in the preparation of the report included no mention of HIV or harm reduction organizations.[44]

The INCB has failed to remark on lack of methadone or buprenorphine in numerous countries where HIV prevention and care are severely hampered by lack of OST. The INCB annual report for 2005 noted the link between heroin injection and HIV in Kazakhstan, but said nothing about that country's failure to honour its pledge to provide OST using its grant from the Global Fund to fight AIDS, Tuberculosis, and Malaria.[45] In Ukraine, which has the highest national HIV prevalence in Europe and an HIV epidemic concentrated among injection drug users, the Board noted that methadone remained prohibited in 2005, and then unhelpfully observed that countries were entitled to impose stricter restrictions on methadone than those required by the UN drug conventions.[46] This stands in stark contrast to recent recommendations to Ukraine on OST from the Committee on Economic Social and Cultural Rights. In November 2007 it recommended "that the State Party… make drug substitution therapy and other HIV prevention services more accessible for drug users."[47]

Use of heroin is growing in sub-Saharan Africa,[48] but OST is largely unavailable across the continent.[49] The Board made visits in 2005 to Lesotho and Swaziland, where more than 20 percent of adults are HIV-positive, and noted that it "is concerned that the current situation could be further exacerbated by insufficient drug abuse prevention programmes."[50] The INCB made no mention of insufficient addiction treatment programmes or to harm reduction of any kind. Philip Emafo also spoke in August 2006 to the WHO Regional Committee for Africa — an exceptional chance to reach African ministers of health — yet did not mention HIV or OST.[51]

Russia, where the HIV epidemic is one of the fastest growing in the world and where UNODC estimates that 1.9 million people inject drugs, has chosen to impose a legal ban on substitution treatment. Despite the INCB's mandate to ensure the availability of medical opiates and of drug treatment for those in need, INCB representatives visited Russia in 2005 and made no public comment on the ban. Instead, their report "noted the commitment of the government of the Russian Federation to addressing the problems of drug abuse and trafficking." [52]

The INCB has urged governments to increase controls on OST in ways likely to undermine national commitment to expansion of the treatment. Observing that worldwide consumption of methadone has increased by almost three and a half times in the last decade, the INCB's annual report for 2005 raises concern about potential diversion of methadone and urges governments to consider restricting access through supervised methadone consumption, short dispensing intervals, and central registration of all opioids prescribed for medical use.[53] This recommendation ignores the multiple research articles and government guidelines that have noted the potential positive impact of allowing take-home doses of methadone as a means of retaining some patients in treatment.[54]

The Board also considers buprenorphine almost exclusively in terms of its potential for diversion, repeatedly referencing its use for illicit purposes. The INCB annual report for 2005

43 Ibid., iii and 6. When the medical uses of opiates were noted in a 2000 speech to ECOSOC by then-INCB president A. Lourenço Martins, he mentioned anaesthetic, analgesic, veterinary and dental purposes with no mention of treatment of narcotics addiction. See A. Lourenço Martins (president, INCB). Statement to the 43rd session of the Commission on Narcotic Drugs. Vienna, March 2000.

44 INCB, *Availability of opiates for medical needs*, Annex II, 23.

45 INCB, *Annual Report for 2005*, paras 517, 559, 560; see also IRIN News, Kazakhstan: fight against HIV/AIDS continues (Nairobi: UN Office for the Coordination of Humanitarian Affairs) August 23, 2005. Available at www.irinnews.org/print.asp?ReportID=48722.

46 INCB, *Annual Report* for 2005, para 584.

47 Committee on Economic, Social and Cultural Rights, Thirty-Ninth session. Session, 5-23, November 2007, Consideration of reports submitted by states parties under articles 16 and 17 of the Covenant, Concluding observations of the Committee on Economic, Social and Cultural Rights: Ukraine. E/C.12/UKR/CO/5 para 51, http://www2.ohchr.org/english/bodies/cescr/docs/cescr39/E.C.12.UKR.CO.5.pdf

48 UNODC, *World drug report 2006* (Vienna, 2006), esp. 67, 75.

49 According to INCB data, of the 51countries in North Africa and sub-Saharan Africa that provided estimates of need for narcotic drugs, 13 estimated some need for methadone. Of these, all but three said their estimated need was less than 40 grams. See International Narcotics Control Board, *Estimated world requirements of narcotic drugs for 2005*.

50 INCB, *Annual Report for 2005*, para 300.

51 P.O. Emafo (president, INCB). Statement to the WHO Regional Committee for Africa, Addis Ababa, August 28, 2006. Available at http://www.incb.org/incb/speeches/speech_who_2006-08-28.html

52 INCB, *Annual Report for 2005*, para 587.

53 INCB, *Annual Report for 2005*, para 75.

54 See, e.g., Health Canada, *Best practices: methadone maintenance treatment* (Ottawa: Health Canada, 2002), 44 and 58: "Programs should balance the advantages of ensuring compliance and having regular contact with clients/patients with the need for flexible, client/patient-centred treatment that takes into account the realities of clients'/patients' lives." Research has shown that flexible take-home doses are an important factor in patient retention. Also, regulations should specify how these requirements are to be judged. Examples of tools for assessment are listed in New Zealand Ministry of Health, *Opioid substitution treatment: New Zealand practice guidelines*, February 2003, 28. See also "Carry Policy" guidelines in The College of Physicians of Ontario [Canada], *Methadone maintenance guidelines* (Toronto, 2001), 18–21.

Box 4 - INDIVIDUALS EXPLOITING BOARD MEMBERSHIP

In 2005 an INCB member and former Russian health minister, Tatyana Dmitrieva, was one of five public figures in Russia to sign a memorandum entitled *"No to methadone programs in Russia",* which was published in the *Meditsinskaya Gazeta*, a widely read newspaper for medical professionals. Dmitrieva was identified in the memorandum as an INCB member.[1]

The text contained numerous inaccuracies and half-truths about methadone. Amongst other things, the memorandum insinuates incorrectly that WHO has opposed methadone therapy for most of its history and that the CND has rejected methadone as a tool for treating heroin addiction. The authors included many assertions of the ineffectiveness or dangers of methadone, without citing evidence to support their claims. Scientists from the United States, the United Kingdom, Iran, the Czech Republic, Italy, Australia, Albania, Switzerland, Croatia, Germany, Canada and France issued a heavily referenced, point-by-point reply to this statement, correcting the article's many errors.[2] The INCB, despite the use of its name in the memorandum, has issued no public comment or correction.

It is important to recall that the conduct of Board's membership is itself governed by the Conventions. Article 9, paragraph 2 of the Single Convention states that, *"Members of the Board…during their term of office…shall not hold any position or engage in any activity which would be liable to impair their impartiality in the exercise of their functions."* Given the activities of Tatyana Dmitrieva, and the lack of comment they drew from the Board, it would be difficult to argue that the INCB can presently be viewed as an independent arbiter of the debates around, for example, harm reduction. Indeed, there appears to be little reflection on the Board of the diversity of views on drug policy that exists within the broader fabric of contemporary society.

Dmitrieva, however, is not the only INCB member whose statements in a personal capacity call into question the impartiality of the Board and the clarity of its positions on harm reduction. In late 2002, after receipt of the legal advice from UNDCP that found harm reduction to be acceptable under the conventions, then INCB president Dr. Phillip Emafo was quoted in a UN publication as saying that needle exchange amounted to *"inciting people to abuse drugs, which would be contrary to the provisions of the conventions."*[3] Melvyn Levitsky, an American member to the INCB, serves on the editorial board of the *Journal of Global Drug Policy and Practice*, which is funded by the U.S. government and which features regular attacks on what it refers to as "so-called" harm reduction. The most recent issue includes an article by A. Hamid Ghodse, who is identified as an INCB member and past Board president, and who reiterates that availability of sterile syringes and needles may make the transition to injecting easier and more acceptable and might encourage more young drug abusers to start injecting and to do so sooner, and that the existence of such programs may reduce incentives for others to give up injecting. Harm reduction, he notes, *"is motivated more in unthinking self-interest than in a genuine concern for the well-being of drug abusers."*[4]

This confusion between the 'independence' of the Board and an absence of accountability when its members issue statements in their 'personal capacities' that contradict official statements of the Board and the United Nations represents a further area in need of clarification.

1 V Krasnov et al. *"Nyet metadonovym programmam v Rossii"* (No to methadone programs in Russia). *Meditsinskaya Gazeta* no. 29, 30 March 2005, 7. Slightly altered version available in Russian at http://www.healthinstitute.ru/catalog/memorandum.htm

2 C Aceijas et al. "Say no to methadone" memorandum: Correcting the record (memo and open letter). Available at http://www.opiateaddictionrx.info/pdfs/SayNo2Methadone.pdf (Date of last access 22 February 2008.)

3 Interview with Dr. Philip O. Emafo, President of the International Narcotics Control Board (INCB), *UNODC Update*, December 2002, p. 7.

4 Professor Dr A. Hamid Ghodse, Member and Past President, INCB, "Harm Reduction: The Idea and the Ideology" *Journal of Global Drug Policy and Practice,* Volume 1, Issue 4, http://www.globaldrugpolicy.org/1/4/1.php. Dr Ghodse's statement on initiation via needle syringe programmes ignores the evidence refuting this position to be found in *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users,* WHO, 2004. http://www.who.int/hiv/pub/prev_care/en/effectivenessterileneedle.pdf (Date of last access 22 February 2008)

urges the WHO to consider tightening the control status of buprenorphine to reduce diversion, but makes no reference to the substantial impact rescheduling would have on access to substance abuse treatment or HIV prevention. The Board notes concerns about buprenorphine diversion in France,[55] while failing to mention that measures such as widespread buprenorphine prescription and needle exchange programmes have reduced to nearly zero new HIV infections linked to drug injection.[56]

55 INCB, *Annual Report for 2005*, para 138.

56 EuroHIV, *HIV/AIDS surveillance in Europe — end-year report 2005* (Saint-Maurice: Institut de veille sanitaire, 2006), esp. 58.

As we noted above, the Board has demonstrated some leadership in its commitment to expanding the provision of opiate medications for pain relief. Nonetheless problems do remain about its performance in this area, and these are closely related to its conceptualization of need or demand for these medicines. For example, in November 2007, an INCB press release appeared under the banner, "Current Supply of Legal Opium Adequate to Meet World Demand, says INCB President". The text went on to state that "global demand for opiates for medical purposes is fully satisfied…For 2007, supply of opiate raw materials is estimated to exceed demand by about 550 metric tons in morphine equivalent." [57]

This statement suggests satisfaction with the status quo, but it is actually misleading for at least two reasons. First, the apparent surplus production represents in reality an effect of market forces on both producing and consuming states, which stockpile in order to manage prices and supplies. Second, and more fundamentally, the conception of 'demand' as used here relates to a category constructed by markets and regulatory structures, foremost amongst which is the INCB itself. Article 21 of the 1961 Single Convention stipulates that countries must submit estimates of their requirements of controlled medications for the following year. Once validated by the Board, these totals become binding for the state concerned. Concomitantly, producing states are permitted to produce only such raw materials the Board considers necessary to meet the estimates. It is important to understand, however, that 'demand' as constructed by the regulatory system does not equate to actual *need* for these substances as determined by clinical criteria. In the words of the WHO's *Access to Controlled Medications Programme*:

> *"Severe pain is commonly experienced by individuals suffering from diseases such as cancer. The majority… an estimated 80%, do not receive adequate medical treatment for this pain…the opioid medicines that could provide relief have been categorized as 'controlled substances'…They are therefore subject to strong control and often rendered inaccessible…Unrelieved severe and prolonged pain causes immense suffering and has devastating effects on individuals, their families and the communities to which they belong."*[58]

This unmet need, while 'latent' in terms of markets and regulatory systems, is of course fully real and material in terms of suffering and symptomatology, and is concentrated overwhelmingly in developing countries. The WHO lists the reasons for its existence, which it estimates will impact negatively upon the healthcare of at least 600 million people now living, as (1) Regulatory impediment; (2) Impediments related to attitudes and knowledge, and (3) Economic and procurement impediments.

The INCB acknowledges the influence of '*some* regulatory, economic and procurement impediments'[59] (emphasis added). Nonetheless, it may be argued that the Board's persistent and inflexible privileging of concerns over diversion, as well as its restrictive ethic more generally, renders virtually unachievable the already difficult balance between its restrictive mandate and its duty to ensure that therapeutic need is met. In addition to its institutional role of overseeing the regulatory regime, the INCB's public discourse (examples of which have been presented throughout this section) can be seen as contributing to the second of the impedimentary factors cited by the WHO; that is to say that relating to attitudes and knowledge.

Human Rights

While technically independent of the UN, the INCB's status as a treaty body that is funded through, reports to and is elected by various parts of the Organization means that it must fulfil its mandate in line with broader UN goals and principles, particularly those contained within the Charter of the United Nations.

This, the constituting document of the Organization, enshrines the binding commitment of signatories to health, human rights and fundamental freedoms. Indeed, human rights are mentioned seven times in the Charter and permeate the entire document.[60] Furthermore, it is stipulated in Article 103 that, "In the event of a conflict between the obligations of the Members of the United Nations under the present Charter and their obligations under any other international agreement, their obligations under the present Charter shall prevail." Within the context of this discussion, this means

57 INCB Press Release 12 November 2007 Available at: http://www.incb.org/incb/en/press_release_2007-11-12_01.html (Date of last access 11th February 2008)

58 WHO Briefing Note: Access to Controlled Medications Programme Available at: http://www.who.int/medicines/areas/quality_safety/access_Contr_Med/en/index.html (Date of last access 11th February 2008)

59 INCB Press release op. cit.

60 According to the Charter of the UN, the Organization's purposes include "To achieve international co-operation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion" (Article 1, para. 3). Among other things Article 55 states "With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote…universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion. Article 56 also states that "All Members pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Article 55." UN Charter available at : http://www.un.org/aboutun/charter

that the drug control conventions must be implemented in such a manner as to be congruent with the human rights commitments inscribed in the UN Charter, which take priority. As a consequence the General Assembly makes annual resolutions stating clearly that drug control must be in line with human rights law.[61]

In 1948 the Universal Declaration on Human Rights was adopted to "give expression" to the human rights obligations of the Charter, with Article 28 guaranteeing an international order within which the rights it contains can be assured. And since then a number of important subsequent documents have further cemented the central place of human rights within the UN system, even as the advent of HIV has endowed them with an added urgency. These include the Universal Declaration on Human Rights, and the Millennium Declaration. With specific reference to human rights and HIV, the UN position paper, "Preventing the Transmission of HIV Among Drug Abusers" notes, "Protection of human rights is critical for the success of prevention of HIV/AIDS. People are more vulnerable to infection when their economic, health, social or cultural rights are not respected. Where civil rights are not respected, it is difficult to respond effectively to the epidemic."[62]

Consequently, as the body responsible for monitoring the implementation of the drug control conventions, the INCB should not choose to ignore instances where parties to those conventions seemingly contravene other UN instruments in the name of drug control, notably the UN Charter. Put simply, the drug conventions should not operate a legal vacuum. Thus while Mr Kouame recently commented that the INCB is not set up to deal with human rights[63] any future member of the Board with legal expertise might explain that this does not equate to an exoneration of engagement with the issue. Currently, however, human rights remains a field in which the INCB's lack of comment is most apparent, as well as its sharp divergence from other UN bodies concerned with drugs and HIV. For example;

- Notwithstanding the UN's opposition to the death penalty, the Board has failed to criticize the regular use (notably by China) of the UN's International Day Against Drug Abuse & Illicit Drug Trafficking in June each year to stage public executions of drug dealers.[64]

- A Board delegation visited Thailand in 2004, several months after police forces commenced a "war on drugs" in which human rights experts documented extrajudicial executions, arrest quotas, use of blacklists, and the internment of tens of thousands of people, including many with no history of drug use.[65] In its report issued after the visit, the Board chose not to condemn the mass arrests. Recent investigations by the Thai government indicate that most of those killed had no involvement with the drug trade.[66]

- In 2004, after Bulgaria mandated imprisonment for possession of any amount of any illicit drug, fear of arrest caused rates of drug injection and syringe sharing to increase sharply.[67] INCB representatives visited Bulgaria in 2005, but the Board's report made no mention of the harsh drug law or its impact, noting instead that national drug control legislation was "well-developed."[68]

There are many other examples that could be listed. The essential point, however, is that the Board consistently privileges enforcement over human rights concerns. Its insistence on the use of a severe and judgemental terminology—drug users of all kinds are almost always referred to as 'drug abusers'—arguably reinforces the very stigmatization and marginalization of individuals that act as an obstacle to the progress of human rights.

61 In 2007 for example, the General Assembly stated that drug control must be carried out in full conformity with the purposes and principles of the Charter of the United Nations and other provisions of international law, and in particular with full respect for…all human rights and fundamental freedoms, and on the basis of the principles of equal rights and mutual respect. UNGA Res 61/183 (13 March 2007) UN Doc A/RES/61/183 para 1; See also, for example, the previous year's resolution UNGA Res 60/178 (22 March 2006) UN Doc A/RES/60/178 para 1. Also see *International Guidelines on HIV/AIDS and Human Rights,* UNAIDS, 2006. http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf (Date of last access February 22 2008)

62 UNAIDS (2000) Preventing the transmission of HIV among drug abusers: A position paper of the United Nations System. UNAIDS Geneva: UNAIDS Available at http://www.unodc.un.or.th/factsheet/hiv.pdf (Date of last access 19th December 2007)

63 INCB Press conference, New York, 7th March 2007. Webcast available at http://157.150.195.10/webcast/pc2007.htm (Date of last access 16th December 2007) Mr Kouame's exact words were: "We are not set up for human right (sic)…and therefore will not talk about human right…we are set up for drug control…and we are talking about drug control."

64 See Rick Lines, *The Death Penalty for Drug Offences: A Violation of International Human Rights Law* IHRA 2007 Available at http://www.ihra.net/uploads/downloads/NewsItems/DeathPenaltyforDrugOffences.pdf (Date of last access 11th February 2008) Article 6.2 of the UN International Covenant on Civil and Political Rights states that: 'In countries which have not abolished the death penalty, sentence of death may be imposed *only for the most serious crimes* in accordance with the law in force at the time of the commission of the crime and not contrary to the provisions of the present Covenant and to the Convention on the Prevention and Punishment of the Crime of Genocide. This penalty can only be carried out pursuant to a final judgement rendered by a competent court.' (emphasis added.)

65 Human Rights Watch, *Not enough graves: The war on drugs, HIV/AIDS and violations of human rights — Thailand* (New York, 2004).

66 The Nation "Most of those killed in drug war not involved in drug" (sic). Available at http://nationmultimedia.com/breakingnews/read.php?newsid=30057578 (Date of last access 19th December 2007)

67 Csete & Wolfe, op. cit. p. 3.

68 INCB, *Annual Report for 2005*, para 614.

In addition, this lack of focus on human rights hinders the Board from taking a balanced view of the interwoven questions of drug treatment, public health, demand and supply reduction and their various impacts and mutual reinforcement, or otherwise. Likewise, it detracts from the coordinated and integrated vision with which the UN as a totality is seeking to confront the new millennium.

The resolution of ambiguities regarding coca

The international legal status of the coca leaf and of its traditional uses in the Andes has long been ambiguous and contested. Consequently, in an attempt to obtain legal recognition for traditional uses, Peru and Bolivia negotiated paragraph 2 of Article 14 into the 1988 Convention, stipulating that measures to eradicate illicit cultivation and to eliminate illicit demand "should take due account of traditional licit use, where there is historic evidence of such use." Bolivia also made a formal reservation to the 1988 Convention stressing that its "legal system recognizes the ancestral nature of the licit use of the coca leaf which, for much of Bolivia's population, dates back over centuries." However, Article 25 of the 1988 Convention guaranteed that its provisions should not derogate from any obligations under the previous drug control treaties. Furthermore, as the Board pointed out in its 1994 supplement on the *Effectiveness of the International Drug Control Treaties*, "the drafters of the 1988 Convention enhanced the non-derogatory clause by including in paragraph 1 of article 14 a provision stipulating that any measures taken pursuant to that Convention should not be less stringent than the provisions applicable to eradication of illicit cultivation of plants containing narcotic drugs and psychotropic substances under the provisions of the previous international drug control conventions."[69]

In its 1994 supplement, the INCB mentioned other ambiguities surrounding the coca issue, such as the fact that drinking of coca tea "which is considered harmless and legal in several countries in South America, is an illegal activity under the provisions of both the 1961 Convention and the 1988 Convention, *though that was not the intention of the plenipotentiary conferences that adopted those conventions*" (emphasis added). At that point there was discussion of coca as an area "where clarifications are needed" with the Board "confident that the Commission on Narcotic Drugs, on the basis of scientific evaluation, will resolve such long-standing ambiguities, which have been undermining the conventions." It consequently called on the WHO to undertake a scientific review. Outcomes of a WHO study on coca/cocaine in 1995, however, proved too controversial to be published. According to the briefing kit summarising the research results the "Use of coca leaves appears to have no negative health effects and has positive therapeutic, sacred and social functions for indigenous Andean populations."[70]

Nothing has happened since to resolve the legal inconsistencies surrounding coca. Indeed, the Board has been reluctant to highlight the situation in its role as a watchdog of the conventions, deal with the nations concerned in a spirit of dialogue and cooperation, and encourage the CND and WHO to move to resolve the matter. Rather the INCB has stepped up its condemnation of traditional use in the Andes and of industrialization of coca products.

As such the Board has been critical of policy positions on coca in a number of Andean states. In its 2005 *Annual Report* the INCB reminded the parties of the fact that "the transitional measures regarding the licit cultivation of coca bush and consumption of coca leaf under the 1961 Convention ended a long time ago".[71] The following *Annual Report* emitted a clear warning to the governments of Bolivia, Peru and Argentina that growing and using coca leaf is in conflict with the 1961 Single Convention. Consequently, countries were asked to adapt their national legislation back in line with the conventions.[72] Bolivia was even the focus of a "Special Topics" section in the 2006 *Annual Report*:

> *"The situation in Bolivia, which for many years has not been in conformity with that State's obligations under the international drug control treaties, continues to be a matter of particular concern to the Board. Bolivia is a major producer of coca leaf, and national legislation allows the cultivation of coca bush and the consumption of coca leaf for non-medical purposes, which are not in line with the provisions of the 1961 Convention."*[73]

69 E/INCB/1994/Suppl.1, *Effectiveness of the International Drug Control Treaties*, Supplement to the Report of the International Narcotic Control Board for 1994.

70 Briefing Kit, WHO/UNICRI Cocaine Project, 3 March 1995. Available at: http://www.tni.org/docs/200703081409275046.pdf (Date of last acess 11th February 2008) For more background see: *Coca, Cocaine and the International Conventions*, TNI Drug Policy Briefing, No. 5, April 2003. Available at http://www.tni.org/detail_page.phtml?page=drugscoca-docs_coca (Date of last access 11th February 2008)

71 INCB *Annual Report 2005*, para 393. The transitional measures allowed countries to phase out coca chewing over 25 years, a period that expired in 1989, 25 years after the convention entered into force in December 1964.

72 "In Peru, coca bush growers are putting pressure on the new Government to stop manual eradication of coca bush and to remove coca leaf from international control. In Argentina, under current legislation, the possession of coca tea or coca leaf in a natural state for chewing purposes is not considered to be possession or personal use of a narcotic drug." INCB Annual Report for 2006, para. 362. In 2006 the Board also criticized Colombia in a letter for allowing its indigenous peoples to produce and distribute domestically coca tea and a soft drink called 'Coca Sek'. Since 1991 the Colombian Constitution recognizes indigenous territorial and cultural rights, and after several legal battles indigenous groups with a longstanding tradition of coca uses were allowed to also industrialize coca and to sell coca-based tea and soft drinks. In reaction to the INCB letter, Colombia prohibited sales of products made from the coca plant again in February 2007 and police raided several selling points to take coca products off the shelves. Sergio de Leon "Coca-Cola Vs Coca Sek in Colombia," *Washington Post*, The Associated Press, May 10, 2007

73 INCB *Annual Report 2006*, paragraph 171.

The Board has also expressed particular concern over Bolivia's recent desire to withdraw the coca leaf from the 1961 narcotic drugs lists.[74] Bolivian policies and laws on coca leaf have been under review since the 2005 election of President Evo Morales, a coca farmers' leader and himself a habitual coca chewer. The Bolivian government, hoping coca leaf could be 'unscheduled' in order to enable export of coca-based products, has announced its intention but not yet initiated the formal notification procedure.

The strong criticism and the fact that the Board presented this as a 'matter of particular concern' in a 'special topics' section of its *Report*, which sounds very much like a 'waiting room' for the invocation of Article 14, raised the anger of the Bolivian government. When INCB President Emafo presented the *Annual Report* at a press conference in Vienna in early 2007 he made it clear he was opposed to Bolivia's intention to reassess the coca leaf and promote its industrial usage, a move which in his view would be in breach of the international drug control conventions. He also added his 'personal view' that coca chewing "is not good for working people" since taking away their hunger impedes "appropriate nutrition, part of human rights."[75] This was a rare INCB reference to the defence of human rights in drug control, but a selective one as Bolivia defends its new coca policy with reference to its inalienable cultural and indigenous rights, which are equally part of human rights.[76] After the press conference, the Bolivian ambassador in Vienna stated, "Bolivia had invited the Board for a visit in September. The radical position the president has taken toward Bolivia puts into jeopardy the good relations between La Paz and the Board. … I'm not sure under these circumstances a trip to Bolivia will be necessary. I would not be able to understand that this gentleman appears and tells our President: listen, you have to stop chewing."[77] Two INCB representatives did visit Bolivia in September 2007, perhaps showing a more positive stance towards Bolivia's claims.

Nonetheless, ambiguities around coca continue and the INCB, instead of requesting the appropriate WHO and CND guidance to clarify the matter, looks set to continue to make harsh and narrow judgements that condemn countries that permit traditional coca use and the industrialization of coca.

Engagement with civil society

Civil society engagement within UN policy making is specifically mentioned in the Charter of the United Nations as well as a more recent ECOSOC resolution,[78] and increasingly throughout the extended family of UN bodies, civil society organizations and NGOs are seen as a valuable resource, providing additional forms of information and advice and a link to affected communities. Given the UN's heavy reliance on data supplied by governmental actors and agencies, the role of civil society to provide checks and balances against official sources is clearly important. Civil society is, in addition, often best placed to convey information and perspectives from the field, something that the, sometimes remote, UN monitoring and policy bodies are ill-equipped to do. Such a role is of particular significance in the case of a body like the INCB, which is wholly reliant on information supplied by member states. It is at least arguable that, without the different modes of information derived from non-governmental stakeholders, it is impossible for the INCB to gain the insight, understanding and richness of perspective required to fulfil its mandate.

As referred to above, the President of the Board has said that the Organization's mandate is to communicate with governments, not civil society. However, the conventions do specifically mention the Board's ability to use non-governmental sources of information, albeit in rather restricted circumstances.[79] As such, non-engagement is actually the choice of the INCB not the result of mandate or legal barrier. Nothing in the conventions preclude engagement with civil society since it is open to the Board itself to develop its own working methods and rules of procedure in relation to the mechanisms established to fulfil its mandate. In contrast, other similarly constituted UN bodies, notably the human rights treaty bodies, have chosen to engage extensively with civil society.[80]

74 See: *Sending the wrong message, The INCB and the un-scheduling of the coca leaf*, TNI Drug Policy Briefing No. 21, March 2007; and *Coca Yes, Cocaine No? Legal Options for the Coca Leaf*, TNI Drugs & Conflict Debate Paper 13, May 2006. Available at http://www.tni.org/detail_page.phtml?page=drugscoca-docs_coca (Date of last access 11th February 2008)

75 *La coca genera tensión entre la ONU y el Gobierno boliviano,* La Razón, La Paz, 1 March 2007.

76 This also leaves aside the fact that it is a strange idea that an individual's human rights are deemed to be infringed by his or her government's tolerance of the availability of a substance that he or she chooses to ingest.

77 La coca genera tensión entre la ONU y el Gobierno boliviano, La Razón, La Paz, 1 March 2007.

78 See Article 71, Charter of the United Nations, "The Economic and Social Council may make suitable arrangements for consultation with non-governmental organizations which are concerned with matters within its competence. Such arrangements may be made with international organizations and, where appropriate, with national organizations after consultation with the Member of the United Nations concerned." ECOSOC Resolution 1996/31. http://www.un.org/documents/ecosoc/res/1996/eres1996-31.htm (Date of last access 19 January, 2008)

79 The 1961 Single Convention on Narcotics refers to use of NGO resources in article 14.1 (a) "If, on the basis of examination of information submitted by Governments to the Board under the provisions of this Convention, or of information communicated by United Nations organs or by specialized agencies or , provided that they are approved by the Commission on the Board's recommendation, by either intergovernmental organizations or international non-governmental organizations which have direct competence in the subject matter and which are in consultative status with the Economic and Social Council…"

80 See Damon Barrett, op. cit.

As former UN Secretary General Kofi Annan has observed, "Partnership with civil society is not an option; it is a necessity."[81] The Board's position on civil society engagement, which it seeks to justify by reference to the conventions, is once more out of step with the United Nations system as a whole; a system within which these modes of partnership are increasingly viewed as positive and helpful.

The INCB's Culture of Secrecy

The points raised in the course of the foregoing discussion are all reinforced and complicated by the INCB's culture of secrecy and the lack of transparency which surrounds all of its work. For example, it meets in secret, no minutes of its meetings are published and nor are the analyses by which it arrives at its positions on policy issues. Furthermore, all communications and letters with Parties, of which there are thousands each year, are confidential. Although WHO and UNODC staff do attend sessions of INCB meetings, for the most part they do so only as observers with the WHO representative restricted to specific agenda items. The INCB's country visits are also conducted under a cloud of secrecy. It does not publicize them in advance, offer criteria for how the countries are selected for visits or which member of the Board goes where, or hold public forums while on these visits. While the countries visited by the INCB undoubtedly value the chance to discuss their drug policies in confidence, the secrecy surrounding the planning of country visits and the lack of mechanisms for input from health professionals or non-governmental experts surely impedes the effectiveness of the Board's visits. In short, such secrecy insulates the Board from healthy dialogue about its focus and priorities.

The Board justifies this secrecy by reference to its 'independent' nature and the rules of confidentiality legally established under the treaties. However, the only mention of confidentiality relates specifically to actions the Board initiates under article 14 of the Single Convention, article 19 of the 1971 Convention and article 12 of the 1988, and those rules are in actuality meant to protect the countries concerned rather than the Board. The fact that the INCB has applied these rules to the entirety of its conduct is a purely procedural issue and is not related to its mandate as laid out in the conventions. Indeed, the Board's private meetings are in reality relics from the days of the Permanent Central Opium Board, the INCB's predecessor body dating to the League of Nations. As is noted in the Commentary to the 1961 convention, '[s]everal procedural practices of the International Narcotics Control Board, which follow the practices of its predecessor, the Permanent Central Board, may be indicated' including that, with certain exceptions, '[i]ts meetings are held in private.'[82] This does not, however, justify the Board's secrecy today and its decision not to modernise in accordance with current UN standards. Moreover, that Article 11 of the Single Convention permits the Board to develop its own rules of procedure also means that these rules are non-binding and legitimately open to change.

As it is, however, its practice has established the INCB as the least transparent and most secretive of UN bodies, completely lacking any accountability of procedure. This shroud further undermines confidence in the INCB's ability to carry out its mandate in a balanced and sophisticated manner, reflecting both the realities of the twenty-first century global drug situation and the plurality of views that exist on how best to deal with it.

THE WAY FORWARD

Given the multiplicity of problems identified and questions raised in the previous sections, there is a strong argument to review the way in which the INCB operates. The 2008 process at the UN level to assess the outcomes of the 1998 UNGASS on drugs, and the subsequent period of global reflection leading up to a high-level meeting in 2009 where markers for future UN drug control efforts can be adopted, provide a suitable framework to discuss improvements in the functioning of the INCB. In order to reinstate the authority and credibility of the Board, initiatives should be undertaken to:

1. Ensure that their current role does not exceed or contradict the terms of the mandate given to them by Member States in the conventions.
2. Ensure that their functioning reflects best practice that has been developed in other bodies set up to oversee the implementation of other international instruments.

3. Ensure that their deliberations reflect UN system-wide coherence in which legitimate drug control concerns are considered in the context of other priorities of the UN system. This would require them to update their thinking in line with "delivering as one" and the broader UN reform agenda and to incorporate overarching UN goals and principles as embedded in the Charter, human rights treaties and relevant General Assembly resolutions and declarations.

81 Quoted in 'Working with the OHCHR: A handbook for NGOs' Office of the High Commissioner for Human Rights, Geneva, http://www.ohchr.org/english/about/ngohandbook/ngohandbook.pdf (Date of last access 1 November 2007)

82 *Commentary on the Single Convention on Narcotic Drugs, 1961*, United Nations, New York, 1973, p150

On all three levels a number of suggestions can be made about the direction of the reform process the INCB should undergo under the guidance of the CND and the Secretary General.

Mandate

In relation to its mandate to monitor treaty compliance, the INCB has not sufficiently lived up to the ***spirit of cooperation and dialogue*** and seems to have forgotten the prudential guideline established by Member States that the Board is not supposed to "recommend remedial measures to an individual government without its agreement." The mandate establishes its role to be one of assistance to Member States, not to condemn them except in extreme cases of grave violations that undermine the very existence of the treaties, and even then only after a process of consultation. To return to a spirit of dialogue requires in the first place a serious self-reflection of the Board members about the role Member States, via the treaties, have asked them to play and a willingness to engage in a real exchange of views and open debate about differences of opinion. From the side of Member States, this requires more assertiveness and more public challenging of the INCB when they are improperly criticised by it. The dilemmas faced and the choices made are often difficult so the advice of an external independent body of experts can be useful. But that advice is useful only when based on understanding of the complexity of drug policy making today, in respect of other international commitments countries have made and based on "a spirit of cooperation rather than by a narrow view of the letter of the law".

In some areas drug policy making has indeed run into tensions with the letter and spirit of the treaties and the INCB has been struggling with how to deal with them and how to relate to Member States that are faced with those dilemmas. Unhelpfully, in most instances the Board has sided with a narrow interpretation in the debate about the existence of ambiguities or legal conflicts around harm reduction, cultural rights and traditional uses, or liberal cannabis policies. Member States are asked to change their practices and legislation back in line with the Board's views. On some occasions, however, the INCB has called the attention of Member States to these issues and asked them to clarify ambiguities or to examine whether they should be solved by making appropriate adjustments in the treaties.[83] Member States in those cases have largely failed to provide the requested guidance that might have enabled the Board to play a more constructive role and to avoid increasing tensions. The political deadlock hanging over any attempt to question the validity of any treaty article has obstructed the opportunity to modernize and refine the international legal framework in line with policy developments and experience on the ground.

What makes the matter worse is the INCB's ***selective reticence*** as referred to in previous sections. The Board is quick to criticise countries when they are perceived to step out of line of a strict zero tolerance approach. On the contrary, the Board rarely challenges countries for poor quality of treatment and rehabilitation services or inadequate access to opiates for medical purposes (including substitution therapy), both key objectives of the UN drug control treaties and thereby of the Board's mandate. This biased imbalance in the Board's concerns undermines its reputation of independence. As a recent article in the *Journal of the American Medical Association* suggests,

> *"the Single Convention is appropriately understood as not only encompassing efforts to control abuse but also promoting efforts to guarantee legitimate access to pain medication for patients. By deviating from the principle of balance underlying the Single Convention, global drug agencies have relegated concerns of medical availability to secondary consideration. This law enforcement approach has been mirrored at the state level. … Notably, the International Narcotics Control Board could use its annual reports to draw attention to access issues at the national level and to encourage countries to undertake needed legal reforms."*[84]

The same applies to opiate substitution treatment, especially in countries where HIV/AIDS is significantly linked to drug injection. Where substitution treatment is illegal or inaccessible, the INCB should emphasize its compatibility with the provisions of the drug conventions and work with authorities to overcome barriers to its effective use.

Overcoming this bias in the Board's concerns and enhancing its impartiality in fulfilling its mandate to monitor treaty compliance also requires more ***accurate substantiation of statements***. The near absence of references to relevant scientific literature or UN documents in INCB annual reports and statements undermines the credibility of the Board. On matters within its mandate, the Board should review and comment on other published analyses and

83 See for example E/INCB/1994/1/Supp.1, *Effectiveness of the international drug control treaties*, Supplement to the Report of the International Narcotics Control Board for 1994, United Nations, New York 1995. The document concludes (para. 21,b,c) that it "does not appear necessary to substantially amend the international drug control treaties at this stage, but some technical adjustments are needed in order to update some of their provisions" and some "shortcomings should be eliminated".

84 Allyn L Taylor, Lawrence O. Gostin, & Katrina A. Pagonis, "Ensuring Effective Pain Treatment: A National and Global Perspective," *The Journal of the American Medical Association, JAMA*, Vol. 299 No. 1, January 2, 2008.

research, especially when it concerns issues of controversy around treaty interpretation or effectiveness of harm reduction interventions. There also needs to be a mechanism to hold to account Board members when they publicly express opinions that do not coincide with an evidence-based position taken by the Board collectively. Ambiguous statements about the supposed illegality of needle exchange or methadone treatment need to be corrected.

With regard to ***scheduling of controlled substances***, the Board's mandate is restricted to precursor chemicals listed in the Tables of the 1988 Trafficking Convention, a task for which the Board convenes an Advisory Expert Group. The INCB should refrain from interfering in scheduling procedures for the 1961 and 1971 treaties, a task delegated by those treaties to the WHO. Representatives of the INCB are invited to attend meetings of the WHO Expert Committee on Drug Dependence to hear its opinion on substances under review. Voicing its own recommendation to the CND about scheduling of narcotic and psychotropic substances, however, is out of the Board's remit and is confusing especially when those opinions contradict the expert advice of the WHO.

Best practices

The INCB needs to bring its transparency, accountability and relations with civil society into line with best practices developed by similar bodies in the UN system. Guidance may be sought from the working methods of the UN human rights treaty bodies in this regard. The self-proclaimed uniqueness with which the Board defends its secretive and isolated modus operandi no longer fits with the reality of the UN today. The discharge of some of its functions may require confidentiality when Member States request it, but there is no justification to shroud their complete operation in secrecy. The view that the independence of the Board would be compromised by interactions with governments, other UN agencies and civil society organisations, is equally unfounded and contradicts the general principle that access to sources of information and conversations with all sectors involved enhance integrity and independence.

More transparency with regard to the minutes of Board meetings and observer mechanisms for those meetings for government delegates, other UN agencies and NGOs with ECOSOC consultative status, would be an important step to take. Country mission reports and correspondence with Member States could also be made publicly available unless the country involved has requested confidentiality. Specific modalities should be developed for receiving information from and consulting with relevant civil society organisations throughout its work, including during country visits. The Board should appoint someone at the secretariat or one of its members as a civil society liaison.

The balance and tone of the *Annual Report* could be greatly improved by ensuring that explanations by governments are duly represented. The INCB has to ensure that the outcome of a dialogue with Member States, not just the Board's side of the argument, is genuinely reflected in the *Annual Report*. Specific comments and views expressed in writing or during the CND debate about the INCB report could be included in the final version of the report as it needs to be approved by ECOSOC and published by the Secretary General. while failing to mention that measures such as widespread buprenorphine prescription and needle exchange programmes have reduced to nearly zero new HIV infections linked to drug injection.

System-wide coherence

In the broader UN reform context, much effort has been devoted recently by UN headquarters to improve system-wide coherence and 'delivery as one'. The drug control part of the UN system has been particularly weak in finding a synergetic relationship with other agencies dealing with related fields such as human rights, health, HIV/AIDS or rural development. Only with the crime section was a closer collaboration established and to some extent with UNAIDS through the UNODC's role as co-sponsor. Earlier attempts to improve UN synergies on the drugs issue have failed. In the 1990s the Subcommittee on Drug Control was established under the Administrative Committee on Coordination (ACC) which, according to an evaluation a decade later, "failed to develop into a mechanism for inter-agency cooperation within the United Nations".[85] Since the ACC structure was abandoned, the UN System Chief Executives Board for Coordination (CEB)[86] has now taken the lead in coordinating system-wide activities and guiding inter-agency collaborative arrangements. Several UN system networks have been set up replacing the former ACC subcommittee structure, including, but only on paper, a United Nations System Network for Demand Reduction, Drug Control and Crime Prevention. In practice, no regular structure or meeting exists where shortcomings in system-wide coherence on the drugs issue can be tabled and discussed. The High-Level Committee on Programmes (HLCP) of the CEB would be the appropriate forum to address this.

85 E/CN.7/1999/5. *Strengthening the United Nations Machinery for Drug Control,* Note by the Secretary-General, 7 December 1998. Availabe at http://www.unsystemceb.org/statements/ (Date of last access 11th February 2008)

86 See UN Chief Executives Board for Coordination (CEB) at http://ia.unsystemceb.org/

The lack of system-wide coherence, therefore, is not only the consequence of poor INCB performance in this regard. Ensuring coherence will require a review of the UN drug control system more broadly, looking at inconsistencies in the drug control conventions themselves, the functioning of the mandated implementing and monitoring bodies (UNODC, INCB, WHO) and the functioning of the CND regarding its mandate to give policy directions for UN drug control. Such a wider review should be undertaken as part of the 'period of global reflection' after the 2008 UNGASS assessment and should result in concrete recommendations to the high-level segment of the 2009 CND where future steps need to be agreed upon.

The different functions of the INCB could be reviewed in this context, including the question whether a structure needs to be maintained that combines the regulatory functions and the quasi-judicial tasks under the INCB umbrella the way it operates now.[87] The Board's regulatory functions are largely implemented by two special committees supported by the secretariat: (a) the Advisory Expert Group (AEG) for matters to be considered under the 'precursor' article 12 of the 1988 Convention, making recommendations for the 1988 Tables similar to the role of the WHO Expert Committee on Drug Dependence (ECDD) for the 1961 and 1971 Schedules; and (b) the INCB Standing Committee on Estimates for reviewing the worldwide supply and demand situation of narcotic drugs and psychotropic substances for medical and scientific purposes. The remaining activities the Board undertakes are monitoring compliance of the treaties and providing an overview of the world drug situation. The latter task overlaps with the mandate given to UNODC to produce its *World Drug Report*.

The quasi-judicial role to monitor treaty compliance should definitely be placed in a system-wide context. What Member States need is an advisory body that is capable of providing guidelines that take into account the drug-policy related aspects of all UN treaties, declarations and action plans, instead of looking narrowly only at the drug control conventions. To move into that direction will also require a more conscious attitude of ECOSOC Member States and the WHO in the nomination and election procedure for the Board's membership.[88] Given the relevance of Board actions to the global HIV epidemic, its membership should include persons with expertise on the intersection of drug policy and HIV/AIDS prevention, something the WHO could ensure when presenting its candidates. ECOSOC election criteria should also take into account a strong preference to include persons with expertise in international law and in the intersection of drug policy and human rights.

Summary recommendations

The UNGASS review process in 2008-2009 provides an appropriate framework to reassess and adjust the functioning of the INCB. Within this context and on the basis of the issues discussed in this report, the IDPC recommends the following:

1. The spirit of dialogue

The INCB should revive the spirit of dialogue that was intended to be the key characteristic of its mandate. Advice to Member States needs to be provided in full understanding of the complexity of drug policy making today, in respect of other international commitments countries have made and based on a spirit of cooperation rather than by a narrow view of the letter of the law.

2. Mandate

The Board should be more cautious not to overstep its mandate especially in light of its having no official mandate with reference to the 1988 Convention and in view of the prudence expressed in the Commentary on the protocol amending the 1961 Convention (i.e. 'the Board may in particular not recommend remedial measures to an individual government without its agreement').

3. Board membership

The Board should include members with expertise on the intersection of drug policy and HIV/AIDS prevention and the intersection of drug policy and human rights, and persons with expertise in international law.

4. Annual Report: balanced & substantiated

Comments and differences of opinion expressed in writing, during country missions or at the CND debate about the Annual Report could be included in the final version of the report, which should also include a more accurate substantiation of statements and references to relevant scientific literature or UN documents.

5. Transparency

More transparency is required with regard to the minutes of Board meetings and observer mechanisms for those meetings. Country mission reports and correspondence with Member States could also be made publicly available unless the country involved has requested confidentiality.

87 The existing INCB structure is the historical outcome of merging in 1968 the pre-UN Permanent Central Opium Board (PCOB) and the Drug Supervisory Body (DSB) under the new mandate given by the 1961 Convention on Narcotic Drugs, and pre-dates the establishment in 1991 of the UN International Drug Control Programme (UNDCP) that later merged into UNODC.

88 Current composition of the INCB is fixed until 2010, so elections for new members will only take place in 2009.

6. Civil society
Specific modalities should be developed for receiving information from and consulting with relevant civil society organisations throughout The Board's work, including during country visits.

7. Scheduling
The INCB should refrain from interfering in scheduling procedures for the 1961 and 1971 treaties, a task delegated by those treaties to the WHO.

8. Legal ambiguities: harm reduction, coca, cannabis
Where legal ambiguities and disagreement persist around some harm reduction practices, coca leaf consumption or cannabis policies, the INCB should stimulate a debate to resolve them and in so doing request and take heed of appropriate legal, WHO and CND guidance, instead of continuing to make its own narrow judgements.

9. System-wide coherence
The drug control part of the UN system needs to find a more synergetic relationship with other agencies dealing with related fields such as human rights, health, HIV/AIDS and development. The Board should evolve towards an advisory body that is capable of providing guidelines that take into account the drug policy related and human rights aspects of all UN treaties, declarations and action plans, instead of looking only at the drug control conventions.

10. Evaluation
The UN Secretary-General could commission an independent evaluation of the performance of the INCB over the past decade, looking at its mandate, at UN best practices and placed in the context of system-wide coherence. This evaluation should include consultations with all relevant UN agencies and with experts and organisations working in the broad field of drug supply, demand and harm reduction.

ACKNOWLEDGEMENTS AND RELATED PUBLICATIONS

Several people contributed to the production of this report which is largely based on previously published research conducted by members of the IDPC. With permission from the authors, some sections in particular draw heavily from Closed To Reason: The International Narcotics Control Board and HIV/AIDS.

Unique in International Relations? A Comparison of the International Narcotics Control Board and the UN Human Rights Treaty Bodies. IHRA, February 2008 http://www.ihra.net/uploads/downloads/NewsItems/Barrett-UniqueinInternationalRelations.pdf

Sending the Wrong Message: The INCB and the Un-scheduling of the Coca Leaf, TNI Drug Policy Briefing no. 21, March 2007 http://www.tni.org/docs/200703091826474065.pdf

Closed to Reason: The International Narcotics Control Board and HIV/AIDS, OSI, Canadian HIV/AIDS Legal Network, February 2007. http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=989

The International Narcotics Control Board: Watchdog or Guardian of the UN Drug Control Conventions?, Beckley Foundation Drug Policy Programme, Report 7, February 2006. http://internationaldrugpolicy.net/Reports/BeckleyFoundation_Report_07.pdf

The Erratic Crusade of the INCB, TNI Drug Policy Briefing 4, February 2003. http://tni.org/policybriefings/brief4.pdf