

I. The international drug control conventions: history, achievements and challenges

1. The focus of the present chapter is the origins of international drug control, in particular how it has evolved in the course of the twentieth century. The chapter also includes a discussion of the challenges currently facing the international community in applying the conventions, how Governments are responding to them and what further action they might wish to take.

2. The historical development of international drug control is viewed through the lens of an increasingly globalized world, over a century that has seen the massive growth and transformation of commerce, finance, transport and communications. The falling away of barriers to trade and communications has contributed significantly to human development and brought immense benefits to society, but those benefits have been distributed unevenly. Poverty and economic inequality, the scarcity of vital resources, conflict, environmental degradation and climate change have created new tensions, and the most vulnerable sectors of society have been hit the hardest. Those factors in turn have created new challenges for the implementation of international drug control.

3. Some of the challenges discussed in this chapter fall under the explicit authority of the conventions; other challenges were not envisaged at the time the conventions were being drawn up, yet they affect the capacity of Governments to implement the conventions. Those challenges include:

(a) *Health-related challenges*: how to ensure adequate availability of narcotic drugs and psychotropic substances to meet medical and scientific requirements for pain relief and for the treatment of drug-related health problems;

(b) *Legal challenges*: how to deal with differing interpretations and the implementation of the conventions;

(c) *The challenge of drug abuse prevention*: how to identify and disseminate reliable programmes and best practices that deter young people and other vulnerable segments of society from experimenting with drugs;

(d) *The challenge of globalization*: how to deal with the costs and benefits of globalization within the international drug control system.

A. History

4. Drug control developed during a long process of global change and movement. The congresses of Westphalia (1648), Utrecht (1713) and Vienna (1814-1815) created a series of international norms, such as the juridical equality of all States and the principle that each State was sovereign within its own territory. A consensus also emerged on the need for a balance of power. The growth of a body of international law and diplomacy led to the formation of the League of Nations and ultimately the United Nations. At the same time, international institutions were gradually established for financial and trade cooperation, boosted by the growth of trade in manufactured goods and by the increasing expansion and mobility of private capital.

5. The introduction of controls over the opium trade in the early twentieth century occurred due to an exceptional confluence of interests of three important nations at that time. China, Great Britain and the United States of America all had different reasons for wishing to curb the opium trade: the Government of China, which had long resisted the importation of opium from India by the British, began a renewed campaign against domestic opium smoking and production. The Government of the United States wished to introduce laws against smoking opium on its territory and in homes to put an end to the smuggling of opium from the Philippines (which it had occupied in 1898). In Great Britain, the newly elected Liberal Government, strongly backed by the church-inspired anti-opium movement, began to reverse the pro-opium trade policies of previous Governments. The momentum brought 13 States together to discuss international drug control for the first time at the International Opium Commission, convened in Shanghai, China, in February 1909. The recommendations made in Shanghai were enshrined in the first legally binding, multilateral treaty of its kind

three years later: the International Opium Convention signed at The Hague on 23 January 1912.¹

6. Parties to the 1912 Convention agreed to control the production and distribution of opium and to impose limits on the manufacture and distribution of certain drugs; a mandatory system of record-keeping was imposed. The principle of drug use only for medical and scientific purposes was enshrined in international law for the first time. Germany, with backing from France and Portugal, insisted that all States should ratify the 1912 Convention before it could enter into force; however, the ensuing delay meant that the Convention entered into force only after the First World War, when ratification was incorporated into the 1919 Treaty of Versailles.

7. In 1920, international drug control came under the auspices of the League of Nations, and further international drug control treaties were enacted. The International Opium Convention signed at Geneva on 19 February 1925² introduced many provisions that were later incorporated into the Single Convention on Narcotic Drugs of 1961,³ such as the furnishing of statistics on the production and stocks of opium and coca leaf, the system of import certificates and export authorizations for licit international trade in controlled drugs and controls over “Indian hemp”, as cannabis was known. The Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, signed at Geneva on 13 July 1931,⁴ limited world manufacture of narcotic drugs to the amounts needed for medical and scientific purposes by introducing a mandatory system of estimates. The Convention of 1936 for the Suppression of the Illicit Traffic in Dangerous Drugs,⁵ signed at Geneva, was the first treaty explicitly targeting international drug trafficking, but it was signed by only 13 States and had limited impact because it entered into force in 1939, when the Second World War began. The Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of Opium,⁶ done at New York on

23 June 1953 under the auspices of the United Nations, introduced strict provisions on the consumption, production, export and stockpiling of raw opium, but did not enter into force until after the signing of the 1961 Convention, which superseded it.

8. The function of the 1961 Convention was to merge all existing multilateral treaties in the drugs field, to streamline the mechanisms of drug control and to extend the existing control system to the cultivation of plants grown as the raw material of narcotic drugs. Its aim, as with the previous treaties, was to ensure the provision of adequate supplies of narcotic drugs to be used for medical and scientific purposes, to prohibit all non-medical consumption of such drugs and to prevent the diversion of such drugs into the illicit market. The 1972 Protocol amending the Single Convention on Narcotic Drugs of 1961⁷ called for increased efforts to prevent the illicit production of, traffic in and use of narcotic drugs and to provide treatment and rehabilitation services for drug abusers.

9. During the 1950s, concerns began to emerge about amphetamine and barbiturate abuse and the overprescription of sedatives and hallucinogens. Those issues were discussed by the World Health Organization (WHO) and by the Commission on Narcotic Drugs starting in the early 1960s. While there was agreement over the need to bring those substances under greater control, there was disagreement over whether to place them under the control of the 1961 Convention or create a new treaty. There were fears of diluting the impact of the 1961 Convention and of deterring prospective parties from ratifying the Convention by adding a large number of substances to the list of controlled drugs. Moreover, many of the substances that needed to be brought under control were contained in pharmaceutical preparations that were being prescribed on a very large scale. The question of the dependence-producing effects of hallucinogens was also under debate.

10. The Convention on Psychotropic Substances of 1971⁸ dealt with a more heterogeneous range of substances than the 1961 Convention and its scheduling arrangements also differed. In the 1971 Convention, as in the 1961 Convention, substances were classified into four schedules

¹ League of Nations, *Treaty Series*, vol. VIII, No. 222.

² *Ibid.*, vol. LXXXI, No. 1845.

³ United Nations, *Treaty Series*, vol. 520, No. 7515.

⁴ League of Nations, *Treaty Series*, vol. CXXXIX, No. 3219.

⁵ *Ibid.*, vol. CXCVIII, No. 4648.

⁶ United Nations, *Treaty Series*, vol. 456, No. 6555.

⁷ *Ibid.*, vol. 976, No. 14151.

⁸ *Ibid.*, vol. 1019, No. 14956.

according to their potential therapeutic use and their liability to abuse; however, the so-called “similarity concept” appearing in article 3 of the 1961 Convention – that every new substance that is “liable to similar abuse and productive of similar ill effects” as substances already controlled by the Convention is brought under the same degree of control as those substances – did not appear in the 1971 Convention. That has led to more complicated evaluation procedures and delays in scheduling, as the International Narcotics Control Board has noted in the past.⁹ Essentially, under the 1961 Convention narcotic drugs were considered hazardous until it was proved that they were not; psychotropic drugs remained uncontrolled unless WHO advised that there was “substantial evidence” that they were liable to abuse or constituted a public health and social problem that would warrant their placement under international control.¹⁰ The system of estimates was excluded from the 1971 Convention in the interests of the pharmaceutical manufacturing States, although that and many other gaps were corrected subsequently through recommendations made by the Board and sanctioned by the Economic and Social Council in its resolutions. A slower rate of accession meant that after it was opened for signature, the 1971 Convention took almost six years to enter into force, compared with less than four years for the 1961 Convention.

11. The scheduling arrangements for both the 1961 Convention and the 1971 Convention contain inconsistencies from a scientific perspective: cannabis and cannabis resin are narcotic drugs while some of their active ingredients are psychotropic substances and fall under a weaker control system. Coca leaf and cocaine are both narcotic drugs but amphetamines that have similar stimulating effects are psychotropic substances. No plant material is controlled under the 1971 Convention; thus, the raw materials khat and ephedra remain uncontrolled, while their derivatives cathinone and ephedrine are controlled under the 1971 Convention and the United Nations Convention

against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988,¹¹ respectively.

12. The 1988 Convention was perceived as necessary because of the growing transnational organized crime and drug trafficking and the difficulties of pursuing persons involved in drug-related crime and money-laundering at the international level, issues that the 1961 Convention and the 1971 Convention had not addressed in any detail. The aims of the 1988 Convention were to harmonize the definition and scope of drug offences at the global level; to improve and strengthen international cooperation and coordination among the relevant authorities; and to provide them with the legal means to interdict international drug trafficking more effectively. Compared with the other two conventions, the 1988 Convention is a more practical, “hands-on” legal instrument, with specific recommendations on the use of law enforcement techniques. It entered into force less than two years after it was opened for signature.

B. Achievements

13. The international control system for narcotic drugs and psychotropic substances can be considered one of the twentieth century’s most important achievements in international cooperation: over 95 per cent of the Members of the United Nations (representing 99 per cent of the world’s population) are States parties to the three conventions. The number of substances controlled under the 1961 Convention and the 1971 Convention has risen steadily over the years: there are currently 119 narcotic drugs and 116 psychotropic substances under international control. At the same time, demand for narcotic drugs and psychotropic substances has soared: for example, global consumption of morphine rose from less than 5 tons in 1987 to 39.2 tons in 2007.¹² Despite this, no cases involving the diversion of narcotic drugs from international trade were detected in 2007 and no cases involving the diversion of psychotropic substances in Schedules I or II from international trade have been

⁹ *Effectiveness of the International Drug Control Treaties: Supplement to the Report of the International Narcotics Control Board for 1994* (United Nations publication, Sales No. E.95.XI.5), para. 65.

¹⁰ István Bayer, “Genesis and development of the international control of psychotropic substances”, paper prepared for the National Institute on Drug Abuse, United States of America, 1989, pp. 42-43.

¹¹ United Nations, *Treaty Series*, vol. 1582, No. 27627.

¹² *Narcotic Drugs: Estimated World Requirements for 2009; Statistics for 2007* (United Nations publication, Sales No. E/F/S.09.XI.2).

detected since 1990,¹³ although overprescription, theft and diversion continue to occur at domestic level.

14. The 1971 Convention was less successful in the beginning, for the reasons outlined above and because the majority of psychotropic substances are essential ingredients of widely consumed prescription drugs. However, improvements in control procedures, resulting from Economic and Social Council resolutions, have succeeded in preventing the diversion of substances in Schedule III or IV from international trade. The resolutions have also led to improved prescribing practices, particularly with regard to barbiturates and other hypnotics, while article 13 of the 1971 Convention has provided parties with a legal basis for bilateral and multilateral cooperation and action against diversion. The 1988 Convention has facilitated the implementation of measures such as judicial cooperation, extradition, controlled deliveries and measures against money-laundering. It has also made it mandatory for States to control and monitor certain precursors, chemicals and solvents frequently used in illicit drug manufacture and has facilitated communication between Government authorities to identify suspicious transactions and prevent diversion.

15. As reported by the United Nations Office on Drugs and Crime (UNODC) in 2008, progress has been made towards achieving the goals set in 1998 by the General Assembly at its twentieth special session. In the period 1998-2007, the number of countries affected by illicit drug crop cultivation was reduced; however, where such cultivation continues to occur, the problems have become more acute for the population as a whole. A prime example of this is Afghanistan, where opium is increasingly processed into morphine or heroin and where there has been an upsurge in cannabis cultivation. Afghanistan's problems are not caused by illicit drug crop cultivation but in many respects they are aggravated by it, and they form part of a cycle of conflict and instability that is proving hard to break. Ongoing security problems, together with poor transport infrastructure, corruption and the lack of viable markets for alternative products have limited opportunities for sustained alternative economic development.

16. Progress has also been slow in parts of Oceania. Not all States in that region have acceded to the international drug control conventions. Africa is the region that made the least progress over the 10-year period 1998-2007. In that region, a series of complex developments, including political instability, weak monitoring capabilities, environmental degradation, economic underdevelopment and disadvantages resulting from subsidies given by developed countries to domestic agricultural and commodities markets, have caused a low level of implementation in all areas of drug control.

C. Challenges

1. Health challenges

17. The international drug control conventions, backed by the Declaration on the Guiding Principles of Drug Demand Reduction,¹⁴ obliges parties to take steps to protect the health and welfare of their populations. Governments must ensure the provision of narcotic drugs and of psychotropic substances for medical and scientific purposes; they must take all practicable measures to prevent and reduce or eliminate drug abuse, to provide services for the treatment and rehabilitation of drug abusers and to establish effective measures to reduce the adverse health and social consequences of drug abuse. Meeting those obligations constitutes a major challenge for all Governments, but it is particularly difficult for less developed countries, whose Governments are often struggling to provide primary health care for their populations.

18. When the 1961 Convention and the 1971 Convention were drawn up, neither HIV nor the hepatitis C virus had been identified, and no reference is made in those conventions to the problem of blood-borne infections associated drug abuse by injection. That link was identified by international health authorities only in the mid-1980s. Governments were subsequently encouraged to expand treatment capacity and to take measures to limit the transmission of blood-borne diseases, in order to deal with that

¹³ *Report of the International Narcotics Control Board for 2007* (United Nations publication, Sales No. E.08.XI.1), paras. 77 and 107.

¹⁴ Adopted by the General Assembly at its twentieth special session in 1998 (Assembly resolution S-20/3, annex), the Declaration outlines the priority policies and strategies for reducing the demand for drugs worldwide.

problem.¹⁵ The 1988 Convention, primarily an international criminal law treaty, makes only generic references to health issues, requiring parties to adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering (art. 14, para. 4). In the mid-1980s, some Governments, faced with increasing problems involving drug abuse by injection, viewed “harm reduction” as a pragmatic response, if not a solution, to those problems, and began to introduce measures to deal with that challenge.¹⁶ It was not until 1998, when the Declaration on the Guiding Principles of Drug Demand Reduction was adopted, that specific international policy guidelines were introduced to reduce the demand for drugs and reduce the adverse consequences of drug abuse to individuals and to society.

19. Additional challenges have been created by the rising cost of health care in developed and developing countries. Developing countries have been particularly affected by HIV/AIDS, which in turn has been linked to a resurgence of tuberculosis, and malaria continues to afflict many parts of the globe. In developed countries, the ageing of populations, together with low birth rates, has reduced the share of the working population with respect to the population of retired persons, causing problems for health-care funding. Widespread recourse to so-called “lifestyle drugs”, relating to obesity, sexual performance and stress-related conditions, has also caused health problems in many regions. Individuals in all walks of life are increasingly looking to drugs, whether prescribed or illicitly acquired, as a palliative for the problems of the modern world.

20. The primary objective of the 1961 and 1971 Conventions is to ensure the availability of controlled drugs for medical and scientific purposes and to prevent the non-medical use of those drugs. Access to narcotic drugs such as morphine and codeine, both on the WHO Model List of Essential Medicines, is considered by WHO to be a human right as defined by the International Covenant on Economic, Social and Cultural Rights (General Assembly resolution 2200 A (XXI), annex).¹⁷ Yet, according to WHO, access to controlled medicines is non-existent, or almost non-existent, in over 150 out of the 193 member States of WHO, while almost 90 per cent of controlled medicines are consumed in Europe and North America. It is estimated, with a wide margin of uncertainty, that perhaps as many as 86 million persons suffer from untreated moderate-to-severe pain annually.¹⁸

21. The Board has long been concerned that, despite the existence of plentiful supplies of opiate raw materials to meet global needs, many Governments do not ensure the wider availability of the essential medicines that derive from them.¹⁹ Even in countries that grow the raw materials from which those medicines are derived, it can happen that less than 1 per cent of the population has access to appropriate pain relief.

22. The reasons are varied and complex and may relate to longstanding cultural traditions. In many countries, medical schools provide little or no training in palliative medicine; tight restrictions and excessive paperwork deter doctors from prescribing opioids, and fears persist among patients and clinical staff alike with regard to the addictive potential of opioids – largely without foundation when administered under

¹⁵ *Report of the International Conference on Drug Abuse and Illicit Trafficking, Vienna, 17-26 June 1987* (United Nations publication, Sales No. E.87.I.18), chap. I, sect. A, “Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control”, target 33, para. 389.

¹⁶ There is no universally agreed definition of harm reduction; however, it is generally taken to mean a range of practical measures and policies that are aimed at reducing the negative consequences of drug abuse and that do not necessarily include abstinence. The Board believes that the goal of any programme to prevent drug abuse should be abstinence.

¹⁷ “General Comment No. 14 (2000): the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)” (E/C.12/2000/4, 11 August 2000), para. 17.

¹⁸ World Health Organization, *Access to Controlled Medications Programme: Biennial Report 2006-2007* (Geneva, 2008), pp. 1-2.

¹⁹ *Report of the International Narcotics Control Board for 1999* (United Nations publication, Sales No. E.00.XI.1), paras. 30 and 40.

medical supervision in the treatment of moderate-to-severe pain.²⁰

23. In order to deal more effectively with this challenge, in 2005 the World Health Assembly, in its resolution WHA 58.22, and the Economic and Social Council, in its resolution 2005/25, called on WHO to improve access to opioid analgesics. That led to the creation of the Access to Controlled Medications Programme, an initiative in which the Board is an active participant. The Board has been drawing attention to those problems for many years, and it will continue to promote that Programme. The Board calls on Governments to increase their support for the Programme.

24. In addition to improving access to pain-relieving opioids, Governments are faced with the challenge of ensuring adequate supplies of controlled substances to meet the increasing demand for opioid substitution therapy, while at the same time preventing the diversion of those substances for illicit purposes. The Economic and Social Council, in its resolution 2004/40, emphasized that psychosocially assisted pharmacological treatment was one of the treatment options available for improving the health, well-being and social functioning of persons dependent on opioids and for preventing the transmission of HIV and other blood-borne diseases. Such treatment is also associated with reducing the illicit use of opioids, criminal activity and deaths attributable to overdoses.²¹

25. The Board acknowledges the challenge of preventing HIV transmission among persons who abuse drugs by injection and recognizes a spectrum of treatment modalities, including the use of substitution therapy in the treatment of drug abuse. However, substitute drugs should only be provided under a medically supervised treatment programme aimed at eventual abstinence and should be accompanied by adequate measures to prevent the abuse and diversion of drugs.

2. Legal challenges

26. The three international drug control conventions, like other international treaties, are not self-executing, and their provisions must be incorporated into domestic law by legislative acts. However, it is a principle of international law that the definition of offences lies solely within the powers of a State. Some of the provisions of the conventions state categorically that parties “shall provide...” or “shall furnish...”. Others are predicated with what is called a safeguard clause: “Having due regard to their constitutional, legal and administrative systems, ...”; or “Subject to its constitutional principles and the basic concepts of its legal system...”.

27. The process of translating legal obligations from the international to the national sphere may introduce discrepancies between national legal provisions and international norms and may also be coloured by political considerations. The Board acknowledges the respect accorded to national legal systems under the conventions but is concerned that differing interpretations of international obligations are weakening the overall efficacy of the control system.

28. According to article 26 of the 1969 Vienna Convention on the Law of Treaties,²² “every treaty in force is binding upon the parties to it and must be performed by them in good faith.” A State that has contracted international obligations cannot excuse non-observation of them by recourse to a deficiency or contradiction in domestic law.²³ The fact that certain terms used in the conventions, such as “drug abuse”, “medical and scientific purposes” or measures adopted “with a view to reducing human suffering”, are not defined allows Governments to interpret them in diverse ways. In the Board’s view, some Governments interpret their international obligations in ways that call into question their commitment to pursuing the aims of the conventions.

29. The Board considers that certain “harm reduction” measures are not in conformity with the

²⁰ World Health Organization, “Briefing note: Access to Controlled Medications Programme”, March 2007.

²¹ World Health Organization, Joint United Nations Programme on HIV/AIDS and United Nations Office on Drugs and Crime, “Policy brief: reduction of HIV transmission through drug-dependence treatment”, Evidence for action on HIV/AIDS and injecting drug use series (WHO/HIV/2004.04).

²² United Nations, *Treaty Series*, vol. 1155, No. 18232.

²³ J. Obitre-Gama, “The application of international law into national law: policy and practice”, paper commissioned by the World Health Organization for the International Conference on Global Tobacco Control Law: towards a WHO Framework Convention on Tobacco Control, New Delhi, 7-9 January 2000.

conventions and serve primarily as a form of social control. Those measures include the establishment of so-called “coffee shops” where the sale, possession and consumption of small quantities of cannabis is tolerated, and so-called “drug consumption rooms”, where the illicit possession and consumption of controlled drugs are permitted. The Board accepts that any narcotic drug or psychotropic substance may be prescribed and administered under controlled medical and scientific conditions; however, the 1961 and 1971 Conventions do not permit the illicit possession and use of controlled drugs that have not been medically prescribed.

30. In a few countries a legal impasse has developed between international and national law with regard to the implementation of provisions concerning coca leaf. At the time the 1961 Convention was drawn up, the phasing out of coca bush cultivation was seen as beneficial for the people living in the Andean subregion, as well as a means to eliminate or reduce the illicit manufacture of and trafficking in cocaine at the international level. Today, there is a movement to elevate the status of the coca leaf to that of a symbol of national and ethnic identity used by indigenous peoples to reaffirm their cultural roots and historic rights. A few Governments have continued to permit the cultivation of coca bush and the use of coca leaves, and even to encourage those practices.

31. The Board believes that drug control must be, and is, fully reconcilable with respect for human rights. However, the international drug control conventions do not accept the existence of a “right” to possess narcotic drugs or psychotropic substances unless they are to be used for medical or scientific purposes. The position of coca leaf in Schedule I of the 1961 Convention is clear: non-medical consumption of the coca leaf without prior extraction of its principal active alkaloids, including cocaine, is prohibited. In 1992, following a request from the Government of Bolivia to examine the issue, the WHO Expert Committee on Drug Dependence decided against recommending any change of control measures on the grounds of extractability: “coca leaf is appropriately scheduled ..., since cocaine is readily extractable from the leaf”.²⁴

²⁴ WHO Expert Committee on Drug Dependence: *Twenty-eighth Report*, WHO Technical Report Series, No. 836 (Geneva, World Health Organization, 1993).

32. Despite the fact that Bolivia, on signing the 1988 Convention, made a reservation with regard to article 3, paragraph 2, on the grounds that the provisions of that paragraph were “contrary to principles of its Constitution and basic concepts of its legal system”, Bolivia is still bound, according to article 25 of the 1988 Convention, by its prior obligations under the 1961 Convention. The Board reminds the Government of Bolivia of those obligations and invites it to remain committed to fulfilling its international treaty obligations.

33. The inconsistent implementation of provisions on cannabis control is a legal challenge of a different nature, since no Government has legalized the cultivation of cannabis for non-medical use. The original objective of the 1961 Convention was to prohibit the use of cannabis in a few countries where its non-medical use was traditional. Today, its non-medical use has virtually disappeared, and cannabis has become the most widely used illicit drug worldwide. In the past two decades, new, more potent forms of cannabis have been developed, mostly in industrialized countries. Sophisticated growing technologies produce cannabis with tetrahydrocannabinol (THC) levels that are considerably higher than that of the cannabis produced during the 1980s. That development may be associated with the increased demand for cannabis-related treatment services in several countries. Apart from the known risks of smoking tobacco, with which cannabis is frequently mixed, there are indications that cannabis consumption may be associated with an increased risk of psychotic disorders and schizophrenia.

34. The Board believes that cannabis represents a challenge on several counts:

(a) The tolerance of “recreational” use of cannabis in many countries is at odds with the position of cannabis in Schedules I and IV of the 1961 Convention;

(b) The relationship between the cannabis policies implemented in different countries and impact of those policies on patterns of illicit use is unclear;

(c) Public perceptions of the alleged “medical” uses of cannabis and its “recreational” use are overlapping and confusing;

(d) Developing countries that struggle to eliminate illicit cannabis cultivation are discouraged by

the tolerant policies of their wealthier neighbouring countries and, perhaps as a consequence, receive little alternative development assistance.

3. The challenges of prevention

35. The issue of cannabis is closely related to the challenge of primary prevention for young people and other groups vulnerable to illicit drug use, given that cannabis tends to be the first and most widely used illicit drug. The welfare and protection of the young are priorities within the United Nations treaty system: the Convention on the Rights of the Child²⁵ (art. 33) requires parties to the Convention to “take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances ... and to prevent the use of children in the illicit production and trafficking of such substances” (art. 33).

36. During the past century, considerable resources have been devoted to understanding the “preventive” and “risk” factors that influence first drug use. A study of youth in ethnic and indigenous groups revealed that social exclusion and isolation, perceived social and economic inequalities and an absence of community networks were among the significant risk factors.²⁶ A global review of prevention programmes indicated that retention and engagement within education were critical protective elements of the structural environment shaping young people’s development. Truancy and exclusion from school may contribute to the development and consolidation of social networks and values that favour regular drug use and may exacerbate problems among the most marginalized and vulnerable youth.²⁷

37. The problem of drug abuse does not necessarily derive from age. The stresses of modern life and the constant pressure to achieve are frequently presented in terms that encourage reliance on pharmacological assistance. There is a sense, often reinforced by

targeted advertising, that artificial and chemical remedies can provide an answer to life’s problems. Youth are particularly vulnerable to marketing pressure and to the importance of “image”. The challenge for Governments, in the Board’s view, is to identify and disseminate policies appropriate to the national setting that are consistent with a more holistic or “ecological” approach to health and well-being and that encourage individuals to value and manage their own health.

38. At the end of the 10-year reporting period 1998-2007, the Executive Director of UNODC noted that, despite some improvements, progress in using prevention as part of the global response to the drug problem had been “modest at best”.²⁸ For all Governments, understanding what prevention policies work and why is one of the greatest challenges. Most Member States (94 per cent) reported having carried out public information campaigns in 2007, but only half of those States reported that the results had been evaluated.²⁹ The early onset of drug abuse has been identified as a predictor of the development and severity of subsequent health and social problems for the individual and for society as a whole. For that reason, the Board believes that intensified, sustained efforts by Governments to give priority to drug abuse prevention programmes targeting youth and other vulnerable groups would be cost-effective.

39. The Board notes that there are evidence-based programmes for drug abuse prevention in a variety of geographical and socio-economic settings. Wider dissemination of the experiences gained in those programmes might help Governments to meet the challenge of reducing the demand for illicit drugs. There is evidence indicating that drug abuse prevention programmes can be most effective when:

(a) They are linked to the prevention of other problem behaviours such as alcohol and tobacco abuse;²⁹

(b) They are based on reliable information on the nature and extent of the drug abuse situation and on

²⁵ United Nations, *Treaty Series*, vol. 1577, No. 27531.

²⁶ *Drug Abuse Prevention among Youth from Ethnic and Indigenous Minorities* (United Nations publication, Sales No. E.04.XI.17), p. 10.

²⁷ David Hawks, Katie Scott and Nyanda McBride, *Prevention of Psychoactive Substance Use: a Selected Review of What Works in the Area of Prevention* (Geneva, World Health Organization, 2002).

²⁸ “Fifth report of the Executive Director on the world drug problem: drug demand reduction” (E/CN.7/2008/2/Add.1, 21 February 2008), paras. 10 and 42.

²⁹ *Preventing Amphetamine-Type Stimulant Use among Young People: a Policy and Programming Guide* (United Nations publication, Sales No. E.07.XI.7), p. 9.

the risk and protective factors that prevail in the community;³⁰

(c) Programmes are tailored to age, gender and ethnicity, pay attention to the norms, values, aspirations and language of youth culture and involve the target group in planning, testing and evaluation;³¹

(d) The approach extends beyond the focus on drugs: life-skills education approaches are those with the most solid evidence of effectiveness,³² while parent- and family-based interventions can be useful in reinforcing family bonding and relationships;³³

(e) More vulnerable youth and families can be identified by health, education and social services and should be offered appropriate psychosocial support;

(f) Media prevention campaigns are coordinated with corresponding activities at the grass-roots level. It has been shown that media campaigns alone are unlikely to change attitudes or behaviour, despite effectively changing levels of information and awareness.³⁴

4. The challenges of globalization

40. Globalization has been facilitated by successive technological revolutions that have cut the costs of transportation, information and communications, bringing benefits to many. There are now more opportunities for developing countries to become integrated into the world economy, but the process is imperfect and incomplete and the benefits have been unevenly distributed. The educational and knowledge requirements imposed by global technologies and markets may marginalize or exclude those who lack the appropriate background, and that potentially limits the

availability of the new technologies to a few countries, social groups and enterprises.³⁵

41. Increased trade and foreign direct investment have been accompanied by the growing influence of transnational corporations, with the result that Governments have less influence over the labour environment than in the past, particularly with regard to their more vulnerable populations. In many countries, there has been a weakening of social safety nets once provided by the state, the employer and the family, and a consequent reduction of social capital.

42. Other problems such as poverty, climate change, environmental degradation, flooding, drought and the search for new sources of energy have resulted in shortages of staple foodstuffs and inflated prices of raw materials. Those consequences, together with the unknown consequences of the current global financial crisis, may contribute to social and political instability, conflicts over scarce resources and waves of economic migration. According to the Centre for Research on the Epidemiology of Disasters in Brussels, displacements resulting from environmental disasters such as floods and cyclones affected 197 million people in 2007, Asia being the continent most badly hit.³⁶ Refugee flows linked to conflict have the greatest impact on developing countries: the poorest of those countries receive 80 per cent of all refugees. According to United Nations data, at the end of 2007 there were about 11.4 million refugees: Iran (Islamic Republic of) and Pakistan together were hosting about 3 million refugees, almost all of them from Afghanistan, and the Syrian Arab Republic was hosting 1.5 million Iraqi refugees.³⁷

43. In the Board's view, those developments pose serious challenges to the capacity of Governments to fulfil their international drug control obligations. It has been shown, for example, that the involvement of

³⁰ Ibid., p. 10.

³¹ Ibid., p. 13.

³² "Fifth report of the Executive Director on the world drug problem: drug demand reduction" (E/CN.7/2008/2/Add.1, 21 February 2008), para. 14.

³³ United States of America, Department of Health and Human Services, National Institutes of Health, *Preventing Drug Use among Children and Adolescents: a Research-Based Guide for Parents, Educators, and Community Leaders*, 2nd ed., NIH publication No. 04-4212(A) (Bethesda, Maryland, National Institute on Drug Abuse, 2003), p. 2.

³⁴ "Fifth report of the Executive Director on the world drug problem: drug demand reduction" (E/CN.7/2008/2/Add.1, 21 February 2008), para. 41.

³⁵ United Nations, Economic Commission for Latin America and the Caribbean, *Globalization and Development* (LC/G.2157(SES.29/3)), report prepared for the twenty-ninth session of the Commission (2002).

³⁶ Secretariat of the International Strategy for Disaster Reduction, "Disaster figures for 2007", (UN/ISDR 2008/01, 18 January 2008).

³⁷ Office of the United Nations High Commissioner for Refugees, *2007 Global Trends: Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons* (Geneva, June 2008).

small farmers in drug cultivation in the Andes is linked to poverty, insecurity and exclusion from mainstream society. There is no doubt that where unemployment is high and government presence is low or compromised, illicit drug crop cultivation and production can provide income. It is also true that the challenge of offering sustainable alternative livelihoods in rural and urban areas has been inadequately addressed: alternative development projects have reached an estimated 23 per cent of growers of illicit crops in the Andes and only 5 per cent of such growers in Asia.³⁸ Very few alternative development projects have been initiated in Africa, despite the extensive illicit cannabis cultivation in that region and the severity of the problems faced by its populations struggling to survive.

44. As noted by the Board, alternative development must overcome a series of challenges, primarily related to cost and long-term sustainability. Significant resources are needed to improve infrastructure in remote rural areas with fragile ecosystems. Other problems include a lack of technical expertise, market price instability for alternative crops and the absence of public service provision for health, education, law and order and for agricultural credit facilities.³⁹

45. A growing number of organic coffee, fruit and other agricultural cooperatives are now under the umbrella of Fairtrade Labelling Organizations International (FLO), which unites labelling initiatives in North America, Europe and Oceania with networks of producer organizations from Africa, Latin America and the Caribbean and Asia. The aim is to improve the trading position of producer organizations in the southern hemisphere by providing sustainable livelihoods for farmers, workers and their communities. About 600 certified producer organizations in 59 countries now belong to FLO, with benefits reaching 7 million people, while consumers spent about 2 billion United States dollars on such products in 2006, an increase of 40 per cent over 2005.⁴⁰ The Board is aware that alternative

development projects in illicit drug crop cultivation areas are faced with difficult challenges. In the Board's view, however, initiatives such as those mentioned above, which benefit directly from the opening up of markets through globalization, offer encouragement to efforts to extend the scope and sustainability of alternative development projects.

46. The Board has noted that the deregulation and liberalization of commercial practices in the licit drug market has tended to weaken the regulatory power of Governments in terms of public control over trading and access to drugs, their prices and marketing practices.⁴¹ The existence of regional free trade areas such as the North American Free Trade Agreement, the Common Market of the South (MERCOSUR) and the European Union has had, in addition to many benefits, the unintended consequence of making it more difficult for Governments to monitor the movement of chemicals that are used in a wide variety of legitimate industrial uses but also in illicit drug manufacture. Advances in technology that enable tiny changes to be made to the molecular structure of substances, together with the fact that almost all pure substances are now easily recoverable, have blurred the distinction between licit and illicit manufacture and have led to rapid growth in the clandestine synthesis of "designer drugs". Criminals now design and manufacture psychotropic drugs with the explicit aim of bypassing the restrictions imposed by international drug control regulations and then distribute those drugs in parallel markets outside the control system. Those developments pose particular challenges to the implementation of the international drug control conventions.

47. The Board has long been concerned about the role of the Internet in the sale and distribution of controlled and uncontrolled substances and is aware of numerous cases involving illegal Internet pharmacies. While it recognizes that purchasing pharmaceuticals online can be beneficial, especially in areas where hospitals and pharmaceutical services are widely dispersed, it is alarmed that "rogue" pharmacies are encouraging drug abuse among vulnerable groups. In the United States, where the abuse of prescription

³⁸ "Fifth report of the Executive Director on the world drug problem: Action Plan on International Cooperation on the Eradication of Illicit Drug Crops and on Alternative Development" (E/CN.7/2008/2/Add.2, 17 December 2007), paras. 9 and 58.

³⁹ *Report of the International Narcotics Control Board for 2005* (United Nations publication, Sales No. E.06.XI.2), para. 27.

⁴⁰ See the website of the Fairtrade Foundation

(www.fairtrade.org.uk).

⁴¹ *Report of the International Narcotics Control Board for 2000* (United Nations publication, Sales No. E.01.XI.1), para. 33 (d).

drugs by young adults has risen sharply since 2002,⁴² it was reported that 34 illegal Internet pharmacies had dispensed more than 98 million dosage units of hydrocodone products during 2006. Given that in 84 per cent of cases a valid prescription was not required for purchase, the risks for youth or other vulnerable groups is clearly high.⁴³

48. According to the European Monitoring Centre for Drugs and Drug Abuse, more and more online drug retailers have the potential to spread new drug-taking practices or products, and they use targeted marketing strategies that respond rapidly to users' demands and to changing legal and market situations.⁴⁴

49. The Board, convinced that a coordinated global response is needed to address the illegal sale of drugs on Internet pharmacies and websites, has developed the Guidelines for Governments on Preventing Illegal Sales of Internationally Controlled Substances through the Internet.⁴⁵ The Guidelines include recommendations promoting measures to facilitate national and multilateral cooperation, on legal steps such as the registration and licensing of Internet pharmacies and on campaigns to raise public awareness of the risks involved in online purchases.

50. Linked to the growth of illegal Internet drug sales is another challenge for public health and drug control bodies: the advertising and sale of counterfeit drugs, defined by WHO as medicines that have been "deliberately and fraudulently mislabelled with respect to identity and/or source". WHO, which has launched the International Medical Products Anti-Counterfeiting Taskforce (IMPACT), believes that 7-10 per cent of all pharmaceuticals may be counterfeit. In some African countries, the figure may be as high as 30-40 per cent. According to a study carried out in the United States, worldwide counterfeit drug sales will reach an

estimated US\$ 75 billion in 2010, an increase of more than 90 per cent over the figure for 2005.⁴⁶

51. In addition to violating copyright provisions and constituting an economic crime, counterfeit medicines undermine national health-care systems, result in loss of confidence in drug control and law enforcement systems and pose serious health risks to users. Counterfeiting is inevitably greatest in regions where regulatory oversight is weakest and where vulnerable populations can be more easily exploited. While counterfeiting has become a lucrative international criminal activity, the response of law enforcement has continued to be ineffective, weak and focused on offences such as fake handbags and watches. Technology far outpaces the regulatory environment, and there is a lack of generally accepted norms at the international level.⁴⁷

52. Analysts of organized crime predicted some years ago that cybercrime, which can be defined as crime that is enabled by or directed against electronic communications devices, would increasingly be initiated from jurisdictions that have few if any laws against cybercrime and/or little capacity to enforce such laws. Nowadays, drug traffickers are reportedly among the most widespread users of encryption for Internet messaging and are able to hire high-level computer specialists to help evade law enforcement, coordinate shipments of illicit drugs and launder money. The Convention on Cybercrime,⁴⁸ which entered into force on 1 July 2004, is to date the only multilateral treaty dealing with that problem. It was drafted by member States of the Council of Europe, together with Canada, Japan, South Africa and the United States, and is envisaged not as a European instrument but as a global instrument, to be supported on all continents.

53. The challenges to the international drug control system are at least as daunting today as they were a century ago and perhaps more complex. The conventions continue to be highly relevant in the face of contemporary problems and challenges; in fact, they may be more necessary now than in the past. As global

⁴² United States, Office of National Drug Control Policy, *Current State of Drug Policy: Successes and Challenges* (Washington D.C., March 2008), p. 7.

⁴³ *Report of the International Narcotics Control Board for 2007 ...*, paras. 250-251.

⁴⁴ European Monitoring Centre for Drugs and Drug Abuse, *Annual Report 2007: the State of the Drugs Problem in Europe* (Luxembourg, Office for Official Publications of the European Communities, 2007), p. 74.

⁴⁵ "Guidelines for Governments on Preventing the Illegal Sale of Internationally Controlled Substances through the Internet", to be subsequently issued as a United Nations publication.

⁴⁶ World Health Organization, "Counterfeit medicines", *Fact Sheet*, No. 275 (revised), November 2006.

⁴⁷ United Nations Interregional Crime and Justice Research Institute, *Counterfeiting: a Global Spread, a Global Threat* (Turin, Italy, 2007).

⁴⁸ Council of Europe, *European Treaty Series*, No. 185.

requirements for narcotic drugs and psychotropic substances increase, the conventions provide the framework to ensure that licit medical and scientific demand is matched by adequate global supply. Where globalization has weakened the power of Governments and strengthened corporate influence, there is all the more need for the rigour of independent multilateral oversight. The effectiveness of international drug control depends increasingly on a robust United Nations system to promote universal health and welfare with impartiality and responsibility.

54. The international drug control system has stood the test of time with credit, but it is not perfect. It is undoubtedly capable of improvement; for that reason, there are procedures for its modification. The Board recognizes the difficulties faced by Governments in meeting their international treaty obligations and invites them to adopt constructive approaches to overcoming those obstacles instead of seeking individual solutions that may undermine the coherence and integrity of the international drug control system.

D. Recommendations

55. To ensure more effective implementation of the international drug control conventions, the Board:

(a) Invites Governments to consider how best to ensure the efficient functioning of the 1961, 1971 and 1988 Conventions;

(b) Encourages Governments to make greater investments in prevention, especially with regard to youth and vulnerable groups, and to utilize the experiences and best practices tested in a variety of settings;

(c) Invites Governments to study the discrepancies between international and domestic law with a view to fulfilling their obligations under the international drug control conventions and, in that context, to consider their “good faith” in pursuing the aims of the conventions;

(d) Encourages Governments of countries where the consumption of opioid analgesics is low to stimulate rational use of those drugs through measures promoted by the Access to Controlled Medications Programme and to ensure that such incentives are accompanied by measures to prevent the diversion of

such drugs; and suggests (as it did in its report for 1999)⁴⁹ that Governments might consider working with the pharmaceutical industry with a view to making high-quality opioid analgesics more affordable in the poorest countries and that organizers of international aid programmes might consider donating essential drugs as part of their aid programmes;

(e) Recommends that Governments study the Fairtrade model (www.fairtrade.org.uk) with a view to improving the trading position and market access for products from alternative development projects in areas affected by illicit drug crop cultivation, taking into consideration the appropriateness and feasibility in each case;

(f) Urges Governments to make use of the Guidelines for Governments on Preventing the Illegal Sale of Internationally Controlled Substances through the Internet;

(g) Encourages Governments to support multilateral initiatives against cybercrime.

⁴⁹ *Report of the International Narcotics Control Board for 1999 ...*