



MODULE 1

The international drug control system



Aim of Module 1

To situate drug policies globally within a framework of fundamental human rights, and to assess the extent to which current national and international drug policies meet these



Learning objectives

Participants will gain an understanding of:

- The international framework that underpins drug control policies – including the relevant treaties and bodies
- The ideology behind, and history of, the development of international drug control
- The ongoing tensions between drug control and human rights, health and development issues
- The outcomes of the 2016 UN General Assembly Special Session (UNGASS) on drugs
- The possible processes towards the 2019 high-level meeting on drugs.



Introduction

The international drug control regime is more than 100 years old and is underpinned by the belief that a punitive approach will deter people from becoming involved in the illicit drug market. This Module will provide a description and analysis of the global drug control system, as well as describe its global consequences (Slides 1 and 2).

SESSION 1.1:

Activity: Setting the scene – what do we mean by drug policy (20 min)

SESSION 1.2:

Activity: Overview of dominant drug control approaches (20 min)

SESSION 1.3:

Presentation: Background to international drug policy (20 min)

SESSION 1.4:

Presentation: The UN drug control architecture (30 min)

SESSION 1.5:

Activity: 'The tree of bad drug policy' (90 min)

SESSION 1.6:

Presentation: The 2016 UNGASS on drugs (60 min)

SESSION 1.7:

Activity: What comes next: The 2019 High Level Ministerial Meeting (45 min)

MODULE 1

Session 1.1

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

 20 min

Facilitators' note

In case of time constraints, the facilitator may decide to present all definitions used in the training toolkit in this session (i.e. advocacy in [Session 4.1](#), harm reduction in [Session 3.1](#), etc.) This would mean reworking the sequence of sessions later on in the training and merely referring to the already agreed definitions rather than having participants come up with their own definitions.

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

1. Introduce the aim of the session (slide 3).
2. Ask participants to brainstorm the key points for defining policy / drug policy.
3. Present the definitions below using the corresponding slides (slide 4) and ask participants if they agree, or if they can think of other good definitions.
4. Depending on participants’ knowledge, understanding and time available, you could also ensure that participants have a shared understanding of the distinction between drug policies, drug laws and drug strategies.

Examples of definitions

Policy

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

Controlled drugs

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

Drug policy

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

Drug control

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

War on drugs

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

Session 1.2

Activity: Overview of dominant drug control approaches

 20 min

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

1. Introduce the aim of the session (slide 5).
2. Ask participants to brainstorm (without evaluating at this stage) the interventions used by governments to control the supply of, and demand for, controlled drugs. If they mention broader concepts such as the ‘war on drugs’ or harm reduction, ask them to break these down into the specific interventions and practices (see slide 6).
3. Note responses on a flip chart under three columns – demand reduction, harm reduction and supply reduction. (Note: The interventions that come under harm reduction will be discussed further in [Module 3](#) on harm reduction advocacy).
4. Fill in any gaps on the flipchart based on the lists above, and discuss any disagreements about how interventions are categorised. Then ask the participants whether they feel that these interventions have been successful or not, and why.

 **Examples of what participants may come up with**

Demand reduction

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

Etc.

Supply reduction

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

Etc.

Harm reduction

- Needle and Syringe Programmes (NSP)
- Peer outreach
- Opioid Substitution Therapy (OST)
- Heroin assisted treatment (HAT)
- Drug Consumption Rooms
- Overdose prevention/ management

Etc.

5. Put the flipchart up on a wall and explain that we will return to it at different points in the training. As new interventions come up in discussions during the remainder of the training, you may want to keep adding to these lists as well.
6. Summarise (see slide 7) by noting that the dominant strategy of reducing the scale of drug markets and use has been based on the principle of deterrence and focused on implementing tough laws prohibiting the production, distribution and use of drugs – referred to as prohibitionist/punitive approaches. It was believed that this strategy, which seeks to deter any involvement in the illicit drug market with the threat of punishment, would reduce, and eventually eliminate, the global drug market and its associated health and social harms – it would lead to ‘a drug-free world’. These zero-tolerance drug policies are underpinned by the international drug control system, which we will describe in the next session(s).



Session 1.3

Presentation: Background to international drug policy



20 min



Aim – To provide an overview of the international drug control system which informs drug policies at the national level

1. Introduce the aim of the session (slide 8).
2. Before starting the presentation, ask the participants what they know about when and why the international community first came together to discuss setting up a global system for drug control.
3. Present the information below and corresponding slides (slides 9 and 10), and distribute the handout “The UN drug control conventions” for more information.



Facilitators’ note

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



Information to cover in this presentation:

The global drug control system is more than 100 years old, and therefore predates the United Nations system. In the inter-war period, it was administered by the League of Nations, and was inspired by the realisation that no country could regulate drug production, sale and use in isolation, since these commodities were so readily bought and sold across borders and jurisdictions. Effective control would require states to work together.

The beginnings of the international drug control system

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

Countries present in Shanghai met again at The Hague in the Netherlands, where they devised the 1912 International Opium Convention, the first international legally-binding treaty to begin the process of restricting the production, distribution and use of drugs to scientific and medical purposes. However, it was very difficult to persuade the major producing countries to sign up – Turkey and Germany for instance, leading producers of opium and cocaine respectively, were reluctant to enter into this agreement. They were essentially forced to do so when the Opium Convention was incorporated into the Treaty of Versailles that formally ended the First World War in 1919, which all the formerly warring nations had to sign in order to end hostilities. The system developed throughout the 20th century with the adoption of several further drug control conventions and instruments. Between 1912 and 1961, when the

Facilitators' note

'Illicit' drugs?

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

Single Convention was devised, the global approach towards drugs became gradually more restrictive.

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

- **The 1961 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol)** – The Single Convention formally established the current international drug control system that brought together and replaced all previous international agreements on drug control that had been signed since the 1912 Hague Convention. It established a universal system for limiting the cultivation, production, distribution, trade and possession of psychoactive substances strictly to medical and scientific purposes, with special attention on substances derived from plants: opium/heroin, coca/cocaine and cannabis.
- **The 1971 Convention on Psychotropic Substances** – This convention extended international control to cover over 100 synthetic psychoactive substances but, because of international pressure from European and North American pharmaceutical companies, the controls were much weaker than those imposed in the 1961 Single Convention.
- **The 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances** – This latest convention was negotiated in response to massive increases in both demand and supply of cannabis, cocaine and heroin for non-medical use. The rapid growth of illicit trafficking fuelled a criminal black market worth billions. The 1988 Convention provides special enforcement measures to reduce illicit cultivation, production and trafficking of drugs, and the diversion of chemical precursors. The Convention significantly reinforced the obligation of countries to apply criminal sanctions domestically against drug offences. However, there is some flexibility in this Convention which enables governments to implement a less repressive approach towards drug use-related activities – these flexibilities are explored further in Session 2.5 of [Module 2](#).

Overall objectives of the UN drug control treaties

It is important to note that the preambles of all three Conventions state that their fundamental objective is to protect the 'health and welfare of mankind'. Controls in the UN drug control conventions apply to a variety of substances such as cocaine, methadone, oxycodone, diazepam (market name Valium), heroin, morphine and codeine, but these substances are placed in different schedules, each of which entails different levels of control. Each of the treaties encourage – and, in some instances, require – criminal sanctions to be put in place at the national level for certain types of drug offences.¹ The objective is two-fold:

- to prohibit the supply of, and demand for, controlled substances for non-scientific or recreational/non-medical purposes; and
- to ensure adequate access to those substances for scientific and medical purposes.

Traditionally the overwhelming focus has been placed on the former, restrictive aspect² – the various approaches which we will further review later on in this Module.

In addition, in more than the 110 articles that make up the three treaties and cover many areas that impact upon human rights, such as extradition, crop eradication and sanctions, there is scarcely any reference to human rights, except in the preambles of the 1961 and 1971 Conventions. We will also look at this in more detail during the training.

1. For more information, please read: International Centre on Human Rights and Drug Policy, *International drug control law*, <http://www.humanrightsanddrugs.org/international-law/international-drug-control-law/>.
2. For more information, see: Hallam, C. (December 2014), *The International drug control regime and access to controlled medicines*, TNI/IDPC Series on legislative reform of drug policies No 26 (Transnational Institute and International Drug Policy Consortium), <http://idpc.net/publications/2015/01/the-international-drug-control-regime-and-access-to-controlled-medicines>

Session 1.4

Presentation: The UN drug control architecture

30 min

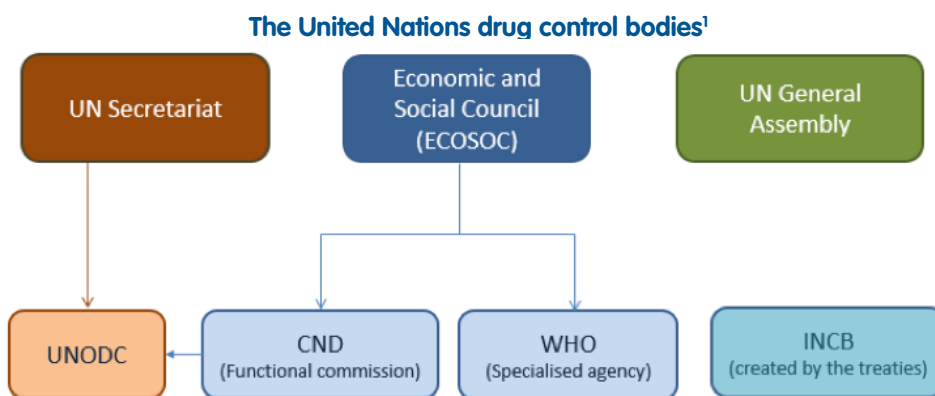
Aim – To provide an overview of the UN bodies that are responsible for overseeing the functioning of the international drug control system

1. Introduce the aim of the session (slide 11).
2. Before starting the presentation, ask the participants which UN bodies they know to be involved in international drug control, what their mandates are, and whether there is scope for civil society engagement.
3. Present the information below and corresponding slides (slides 12 to 25).
4. If you would like the participants to learn more about the UN drug control architecture, you can distribute the handout 'The UN drug control bodies and how to influence them'.

Facilitators' note

When presenting information on each drug control body, it is useful to ask the participants to share their experience of how they may have engaged with these bodies in their advocacy work. If you are doing advocacy work with these bodies, feel free to add more information about your own experience as well. These lived experiences are often a way to make this session more dynamic and less removed from the participants' work.

Information to cover in this presentation:



UN General Assembly (slides 12 to 14)

The General Assembly is the main deliberative, policy making organ of the UN. It is also the most democratic and representative UN body – with each UN member states having one vote. Although the General Assembly is not generally involved in drug control, it can be requested to organise special session on urgent and critical topics (including drugs), either by a majority of member states or by the UN Security Council. So far, three UN General Assembly Special Sessions (UNGASS) on drugs have been held: in 1990, 1998 and 2016. We will come back to these in Session 1.6.

Economic and Social Council (ECOSOC) (slides 15 and 16)

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

Commission on Narcotic Drugs (CND)

The CND is the central policy-making body for the UN drug control system. It meets every year for a week in March in Vienna, Austria, to discuss drug policy issues and adopt resolutions on the direction of international drug control for the coming year. It comprises 53 UN member states elected by ECOSOC, with a geographical distribution of seats – but all other UN member states can participate in CND sessions, as can civil society organisations and UN agencies. The Commission is mandated by the UN drug control conventions (see Session 1.3) to consider all issues relating to the objectives of the conventions. Under ECOSOC resolution 1991/38, the Commission is requested to give policy guidance and monitor the activities of the United Nations Office on Drugs and Crime (UNODC)³. The secretariat of the CND resides within the Division of Treaty Affairs of UNODC. The CND is the final decision maker on proposals by the World Health Organisation (WHO) to schedule, de-schedule or re-schedule a psychoactive substance.

International Narcotics Control Board (INCB) (slides 19 and 20)

The INCB is the only drug control body directly created by the 1961 Convention (Article 9). It is made up of 13 individual members elected by ECOSOC, who each serve five-year terms, and is based in Vienna, Austria. At least five members are nominated from a list put forward by the WHO, and ten by UN member states. In its election of INCB members, ECOSOC must consider the principle of 'equitable geographical representation' with members coming from different regions of the world. The INCB has a secretariat that assists it in its functions and aims to oversee the implementation of the drug control conventions. In its role as 'guardian of the treaties', it monitors member states' compliance with the treaties, and can raise the matter with individual governments if it judges them to be in contravention with the conventions. It is, however, supposed to approach such countries in a spirit of cooperation. It can also raise matters with the CND and ECOSOC, and produces annual reports.⁴ In the past, the INCB has been one of the most conservative UN drug control bodies and has regularly criticised countries that sought to develop more progressive drug policies based on human rights and public health – although the INCB has more recently adopted a less ideological and more progressive approach.⁵

The second function of the INCB is to ensure access to controlled drugs for medical and scientific purposes. This includes monitoring countries' provision of controlled drugs for healthcare and scientific purposes. In addition to monitoring compliance, it must also support governments to fulfil their obligations. According to the conventions, governments must provide the INCB with estimates of controlled drugs to meet their medical and scientific needs. The INCB then subjects these estimates to analysis to ensure they meet countries' requirements, but do not exceed them. The Board deals with 'competent national authorities' which represent national governments in the process. The process is one of considerable technical complexity, and has been subject to critical interrogation in recent years.⁶

United Nations Office on Drug Control (UNODC) (slides 20 and 22)

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

1. Research and analytical work to increase knowledge and understanding of global drugs and crime issues. This includes the production of documents such as the World Drug Report.
2. Normative work to assist States in the ratification and implementation of the international treaties. This work is of a more general nature than the technical interventions of the INCB. It may involve, for example the 'goodwill ambassadors' or the International Day against Drug Abuse and Illicit Trafficking. In other words, the UNODC publicises norms surrounding drugs and their use.

3. Field-based technical cooperation projects to enhance the capacity of member states to counteract illicit drugs, crime and terrorism.

World Health Organisation (WHO) (slides 23 and 24)

WHO is the UN specialised agency for health, established in 1948. Its objective is the attainment by all peoples of the highest possible standard of health. Health is defined as a state of complete physical, mental and social wellbeing — not merely the absence of disease or infirmity. The WHO is the only UN body that is mandated by the drug control conventions to conduct medical and scientific assessments of psychoactive substances and advise on their scheduling. The WHO Expert Committee on Drug Dependence (ECDD) can recommend to upgrade or downgrade the classification of a substance between the four schedules of the 1961 and 1971 Conventions, or recommend to add or remove a substance from the lists altogether. The CND can adopt or reject the WHO recommendation by vote (simple majority for substances under the 1961 Convention, two-third majority for substances under the 1971 Convention). However, a lack of funding has largely prevented the ECDD from meeting on a regular basis, resulting in some assessments being long overdue. For instance, cocaine, morphine and opium have never been reviewed by the ECDD or League of Nations entity since 1912, while cannabis and the coca leaf have not been reviewed since 1935 and 1965 respectively – although in late 2016 the ECDD announced that it would conduct a pre-review of cannabis by March 2018.⁷ The influx of so-called ‘new psychoactive substances’ on the market is also placing increasing pressure on the ECDD’s workload.

Other relevant UN agencies (slide 25)

There are a number of other organisations which mandate is not directly related to drugs but that do have a role to play in drug control. The most relevant are highlighted below:

- **UNAIDS:** UNAIDS has a key relationship with the global drugs issue. UNODC and WHO are among the co-sponsors of UNAIDS, with UNODC taking the lead role in UNAIDS’ response to HIV amongst people who use drugs and in prisons. To achieve the system-wide coherence needed by the UN as a whole, and to effectively and realistically address the HIV epidemic, it is vital that drug policies are in line with the objectives and work of UNAIDS.
- **UN Development Programme (UNDP):** In the lead up to the 2016 UNGASS, UNDP has analysed the impacts of drug control on development.⁸ The Sustainable Development Goals⁹ also present an important avenue to promote a development-oriented approach to tackling illicit production, sale and use.
- **Office of the High Commissioner on Human Rights (OHCHR):** In 2015, OHCHR produced a study on the impact of drug policy on human rights.¹⁰ Since then, the Office has played a critical role in promoting drug control strategies that are better equipped to avoid and respond to potential human rights abuses.
- **UN Women:** Women continue to be particularly affected by overly negative drug policies – including in access to healthcare, as victims of violence, harassment and overincarceration. UN Women plays an important role in highlighting these harms and redressing them.

1. A full organisation chart of the UN bodies is available here: <http://www.un.org/en/aboutun/structure/pdfs/un-system-chart-color-sm.pdf>
2. Charter of the United Nations, <http://www.un.org/en/documents/charter/index.shtml>
3. For more information, please read: <http://www.unodc.org/unodc/en/commissions/CND/cnd-governing-body.html>
4. Available here: <https://www.incb.org/incb/en/publications/annual-reports/annual-report.html>
5. For more information and analysis on the INCB, visit the INCB Watch: <http://idpc.net/incb-watch>
6. Ibid
7. Nutt, D. (22 December 2016), ‘Better late than never? After 82 years the WHO reviews cannabis!’, *Drug Science*, <http://www.drugscience.org.uk/blog/2016/12/22/better-late-than-never-after-82-years-the-who-reviews-cannabis>
8. http://www.unodc.org/documents/ungass2016//Contributions/UN/UNDP/UNDP_paper_for_CND_March_2015.pdf
9. <http://www.un.org/sustainabledevelopment/sustainable-development-goals/>
10. http://www.unodc.org/documents/ungass2016//Contributions/UN/OHCHR/A_HRC_30_65_E.pdf

MODULE 1

Session 1.5

Activity: 'The tree of bad drug policy'



90 min

Facilitators' note

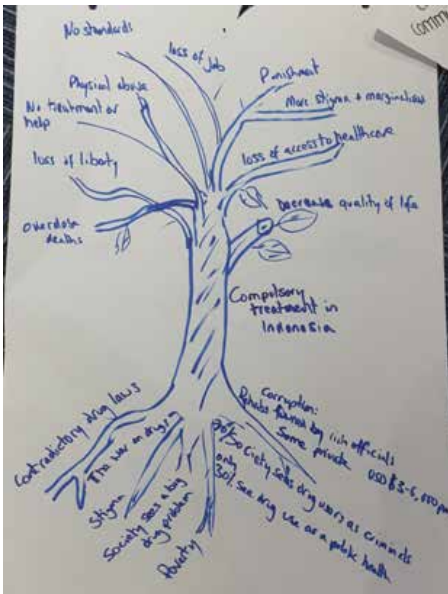
In case of time constraints, it is possible to conduct this activity at the same time as Session 2.2 (the 'Tree of good drug policy') in Module 2, by splitting the participants into groups. Some groups can work on the tree of bad drug policy, while others can work on the tree of good drug policy. The discussions can then focus on comparing the findings of all groups on what they consider good and bad policies. If there is time, you can also encourage groups to think about how to reverse their 'tree' to become good or bad.



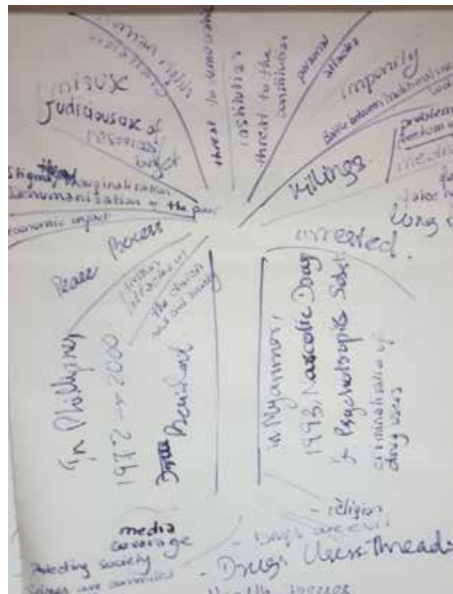
Aim – To explore the efficacy and consequences of prohibition-led policy and practice

1. Introduce the aim of the session (slide 26).
2. Ask the participants to work in small groups of four or five people and select one of the prohibition-led interventions or policies identified in [Session 1.2](#) that is relevant in their context – e.g. incarceration/criminalisation of people who use drugs, abstinence-based approach to drug use, compulsory detention, death penalty, disproportionate sentencing, inappropriate and badly sequenced alternative livelihoods, crop eradication, etc.
3. Ask each group to produce a large drawing of a tree with a trunk, roots and branches, and write their chosen intervention on the trunk (see examples below, and use slide 27).
4. Encourage participants to identify the **rationale behind the intervention** – i.e. how is the intervention rationalised/justified by governments or in their government's drug strategy. Draw these along the roots of the tree.
5. Next, encourage participants to identify the **main effects and consequences of the intervention** (both desired and undesired). Ask them to write each effect as a branch of the tree. Ask participants to pay particular attention to the consequences of the chosen intervention on the lives of people who use/grow drugs (i.e. in terms of stigma, discrimination, social marginalisation, service uptake and self-esteem).
6. When completed, ask each group to present and discuss what their tree shows. For example, how do the reasons for and the effects of the intervention relate to each other? Does the intervention have the desired effect as stipulated by the drug strategy rationale? Are there harmful consequences? Can these be grouped – e.g. harms to public health, human rights, development? Make sure that other participants have time to comment on the trees of other groups.
7. As a wrap-up, present the information below and accompanying slides (slides 28 to 30). This will pave the way for subsequent sessions.

Examples of 'trees of bad drug policy'



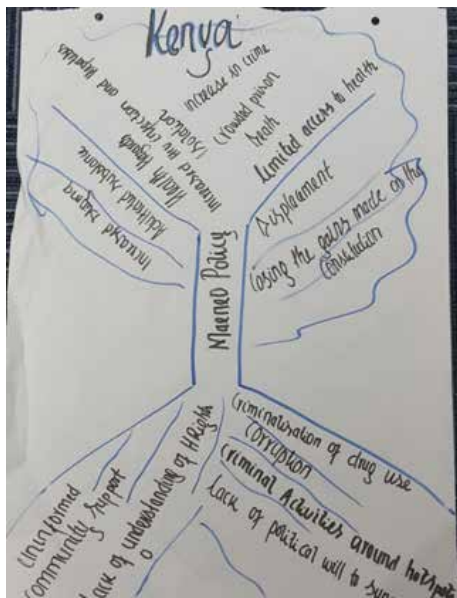
Workshop in Mombassa, Kenya, 2017



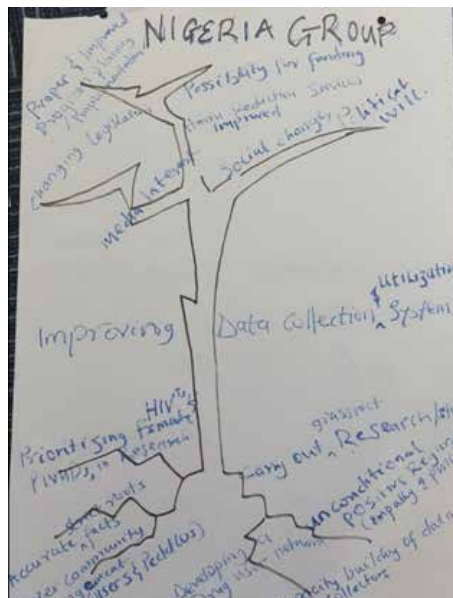
Asia fellowship, London, UK, 2017

Facilitators' note

If you are using this exercise, we would love to receive photos of the trees produced during your workshop. Please send them to us at contact@idpc.net.



Workshop in Mombassa, Kenya, 2017



Workshop in Mombassa, Kenya, 2017

✔ **Information to cover in summary presentation:**

This exercise and the previous sessions have highlighted fundamental problems with prohibition-led drug policies. The 1961 Convention was forged on the belief that punitive drug laws and their enforcement against all those involved in drug cultivation, production, distribution and use would lead to the achievement of a 'drug free world'. In practice, the global scale of illicit drug markets – largely controlled by organised crime – remains as large as ever, with over 255 million people using drugs worldwide, 12 million of which via injection. Similarly, in 2015 the global production, seizures and use reportedly increased worldwide for cocaine, cannabis and methamphetamine.

In addition, the current regime has led to serious negative consequences. There is mounting recognition that the 'war of drugs' approach has failed. This is a position now supported by various policy makers, including UN leaders and

former heads of state. UNODC itself recognised the following harms related to drug control in 2008:

- The creation of a huge criminal black market
- Policy displacement – with a diversion of resources away from public health
- Geographical displacement – also called the ‘balloon effect’, where tight controls over one area may stop cultivation or trafficking in that region, but will lead to increased production or trafficking in another
- Substance displacement – where reducing either supply or demand for a specific drug may result in users turning to other, sometimes more harmful substances
- Marginalisation and stigmatisation of people who use drugs.

Additional harms include an increase in violence and corruption, prison overcrowding, severe human rights violations (including extrajudicial killings, impunity, torture and ill-treatment) and health harms (overdose deaths, HIV and hepatitis C infections, etc.).

It is clear today that the global drug control regime is alarmingly outdated. It was created more than 50 years ago, pre-dating the HIV epidemic and globalisation. And over the years, the system has not been able to adapt to new health and social realities.

The increasingly strong call for global drug policy reform led the Presidents of Colombia, Mexico and Guatemala to request that a UN General Assembly Special Session (UNGASS) be held to urgently discuss global drug control and consider all available options. As a result, an UNGASS was convened in April 2016. As part of this process, IDPC called for:

- an open and inclusive debate
- reviewing the objectives of drug policy and prioritising health, human rights and development
- supporting policy experimentation and innovation, including legal regulation
- ending the criminalisation of the most affected populations
- promoting harm reduction

Highlights from the UNGASS will be presented in Session 1.6.

1. See: United Nations Office on Drugs and Crime (2017), *UNODC World Drug Report 2017*, <https://www.unodc.org/wdr2017/index.html>
2. www.globalcommissionondrugs.org
3. Costa, A.M. (7 March 2008), *“Making drug control ‘fit for purpose’: Building on the UNGASS decade” – Report by the Executive Director of the United Nations Office on Drugs and Crime as a contribution to the review of the twentieth special session of the General Assembly*, E/CN.7/2008/CRP.17, https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_51/1_CRPs/E-CN7-2008-CRP17_E.pdf

Session 1.6

Presentation: The 2016 UNGASS on drugs



60 min



Aim – To provide an overview of the 2016 UN General Assembly Special Session (UNGASS) on drugs, and highlight some of the key wins and failures of the Special Session

1. Introduce the aim of the session (slide 31).
2. Ask the participants what they know about the UNGASS, and whether any of them participated.
3. Present the information below with the corresponding slides (slides 32 to 39) and leave time for comments. Distribute the handout 'Timeline of international drug control' when discussing slide 32.



Information to cover in this presentation:

At the High Level Segment of the CND in 2009, UN member states adopted a Political Declaration and Plan of Action on global drug control.¹ The objective was to achieve a measurable reduction of the scale of the illicit drug market by 2019. The next big moment in global drug control was therefore supposedly planned for that date, when governments would meet to review progress made since 2009. However, things did not go as planned. Latin America, which bore the brunt of the consequences of the war on drugs – including the rise in powerful and violent organised crime groups, prison overcrowding and health harms – called for an urgent debate on the global drug control strategy.

In October 2012, the governments of Colombia, Guatemala and Mexico issued a joint declaration calling for an UNGASS to be held urgently on the drugs issue. The proposal, supported by 95 countries, led to the organisation of a Special Session in New York from 19 to 21 April 2016. The Outcome Document² of the UNGASS was adopted at the opening session, having previously been negotiated and approved by consensus after long and fraught negotiations in Vienna.

This was the 30th UNGASS in total, and the third focused on drugs (with the first one held in 1990, and the second in 1998 under the slogan 'A drug-free world, we can do it').³ Unlike before, however, the 2016 UNGASS took place in a context of unprecedented local and national reforms, as well as widespread and growing calls for a less repressive approach towards drugs. The Special Session was therefore considered a key opportunity to conduct a long overdue review of global drug control, with high hopes for governments to consider (and embrace) alternative options to prohibition.

Ahead of April 2016, IDPC came together to agree on five headline policy asks for the UNGASS.⁴ These will be reviewed one by one to highlight what was, and what was not, achieved.



Facilitators' note

If the participants have little knowledge of the UNGASS, it may be useful to conduct, before this session, one or two background exercises on the UNGASS included in [Module 5](#) (in particular Sessions 5.1 and 5.2).

The presentation below should take no longer than 20 to 30 minutes. If some of the participants have attended the UNGASS, leave sufficient space for them to share their experience. If you have attended the Special Session, you may also want to add some personal insights.

Facilitators' note

For more information about IDPC's UNGASS asks, refer back to [Session 5.4](#), or [click here](#).

Ask 1. Ensure an open and inclusive debate

What IDPC called for: An honest assessment of what has, and has not, worked in global drug control and a consideration of all available options for reform. We also requested that all stakeholders be included in the process – including all relevant UN agencies (and not only those working on drug control), academia and civil society – in particular the Civil Society Task Force which was especially set up to feed into the UNGASS process.

What we achieved: The UNGASS was characterised by a high number of calls for new strategies and drug policy reform from progressive governments.⁵ The contributions from UN agencies at the UNGASS were unprecedented, with strong written contributions⁶ and oral statements by UNAIDS, WHO, the UN Development Programme, the Office of the High Commissioner on Human Rights, UN Women and others.⁷ As such, the UNGASS was a critical step towards more UN system-wide coherence on drug control issues. In addition, despite the many logistical obstacles that hampered civil society participation at the UNGASS and their involvement in the drafting of the UNGASS Outcome Document (which was mainly negotiated behind closed doors), NGO presence was stronger and more diverse than ever before. Indeed, a large number of reform-oriented NGOs fed into the UNGASS process, including non-drugs NGOs focusing on human rights, criminal justice, palliative care or gender. The Civil Society Task Force – set up as the official mechanism for civil society engagement in the process – also played a key role for NGOs to be adequately included in discussions and panels throughout the UNGASS process.

What we failed to achieve: Despite efforts by NGOs, many UN agencies and reform-minded governments to discuss the harms of current strategies and the need for new policy options, the UNGASS Outcome Document does not acknowledge the failures of the current drug control regime. Many of the most progressive inputs and language did not make it into the final version.⁸ Moreover, the negotiation of the Outcome Document was marked by an unacceptable lack of transparency and accountability, with civil society participation being overtly rejected from the process – although many NGO representatives ended up feeding indirectly into the positions of their governments.

Ask 2. Reset the objectives of drug policy

What IDPC called for: Member states to shift away from the goal of achieving a drug-free world and the use of indicators focused on arrests, seizures or hectares eradicated; and move towards the UN objectives of protecting health and human rights, and promoting security and development, with new indicators to measure how effectively drug policies are contributing to these UN priorities.

What we achieved: Traditionally, previous debates and declarations on drugs have been organised under three headings: demand reduction, supply reduction and international cooperation – omitting a focus on health and social harms, access to controlled medicines, or human rights. It was therefore a major win that the UNGASS debates were structured under five thematic areas (health, crime, human rights, development, and new threats and challenges). Even better, the Outcome Document was structured with seven thematic chapters, with dedicated sections on access to controlled medicines, human rights and development for the first time. The Outcome Document also gives prominence to the Sustainable Development Goals (SDGs), in an attempt to better link drug control and development imperatives.

What we failed to achieve: Nevertheless, the Outcome Document continues to reaffirm the wholly unrealistic objective of achieving a 'society free of drug abuse', and the final text includes very few measurable targets, making it (deliberately)

difficult to evaluate its implementation and impacts. The proposal to develop new indicators to assess drug policies was removed during the consensus-based negotiations process.

Ask 3. Support policy experimentation and innovation

What IDPC called for: An open discussion on, and support for, alternatives to overly-punitive drug policies using the wiggle room in the drug control treaties to promote harm reduction, decriminalisation, alternatives to incarceration, etc. (for more information on this point, see [Session 2.5](#) in Module 2). Beyond these measures, we also called for the consideration of policy options going beyond what is permitted in the conventions, including the legal regulation of certain substances. We asked that an expert working group be established to consider all these options to respond to the existing tensions between treaty obligations and the reforms currently being implemented on the ground (i.e. regulatory frameworks for cannabis, coca and new psychoactive substances).

What we achieved: The UNGASS was marked by unprecedented calls by governments for new approaches to drug control. 18 governments called for a shift in paradigm away from the war on drugs, while 36 promoted more proportionate penalties, 22 supported decriminalisation and 9 favoured legal regulation.⁹ These progressive positions were facilitated by the creation of new strategic alliances between progressive governments (e.g. the Cartagena Group¹⁰), with support from civil society, ahead of the UNGASS.

What we failed to achieve: Unfortunately, these calls for reform were not reflected in the Outcome Document, which fails to mention legal regulation or the need to set up a mechanism to review the tensions between cannabis regulatory frameworks and the treaties. Moreover, although many governments have become more vocal about reform, there remain a significant number of countries that actively continue to promote a war on drugs approach (24 countries in favour)¹¹ and a drug-free world (28 countries in favour).¹²

Ask 4. Ending the criminalisation of the most affected populations

What IDPC called for: The decriminalisation of people who use drugs and subsistence farmers involved in illicit crop cultivation. We also promoted more proportionate sentences for all drug offenders, including the use of alternatives to incarceration for low-level offenders, and the abolition of the death penalty.

What we achieved: A number of governments called for less punitive measures, with 22 supporting decriminalisation, 36 promoting proportionate sentencing, and 61 making statements against the death penalty.¹³ Ahead of the UNGASS, 15 UN agencies published progressive contributions in which they all challenged the continued criminalisation of drug use.¹⁴ And for the first time, the Outcome Document called for ‘alternative... measures with regard to conviction or punishment’ and included the concept of proportionate sentencing. Finally, a strong gender component was included in both the Outcome Document and the UNGASS debates.¹⁵

What we failed to achieve: Despite these important gains, the Outcome Document fails to explicitly mention the death penalty and, unsurprisingly, legal regulation – which truly was the elephant in the room for the best part of the UNGASS. In addition, most progressive paragraphs within the Outcome Document are strongly caveated with wording like ‘as appropriate’ and ‘according to national legislation’.

Ask 5. Commit to the harm reduction approach

What IDPC called for: Member states explicitly support harm reduction, and reallocate funding away from drug law enforcement and into harm reduction services.¹⁶

What we achieved: During the UNGASS, 45 countries explicitly supported harm reduction.¹⁷ This was the widest support ever achieved for this approach at a UN drug policy forum. Only two countries spoke out explicitly against harm reduction – Singapore and China (despite the latter having widely scaled up harm reduction interventions throughout its territory). Harm reduction also got unanimous support in UN agencies' contributions.¹⁸ The Outcome Document itself failed to include the term 'harm reduction', but it does include some of the strongest language yet in a UN drug policy document – with specific mentions of naloxone and overdose prevention, the distribution of injecting equipment and medically-assisted therapy (namely, opioid substitution therapy). These were hard-fought wins and some of the last paragraphs of the document to be agreed upon during the negotiations process.

What we failed to do: Once again, the term 'harm reduction' was not included in the final text – despite it being agreed language at the UN General Assembly in the context of HIV/AIDS declarations. The Outcome Document is also silent on the need to redirect funding, fails to acknowledge the missed 2015 HIV targets (which had set out to reduce by 50% new HIV infections among people who use drugs by 2015), and continues to promote a 'society free of drug abuse'.

To conclude...

There were therefore mixed feelings after the UNGASS in terms what was achieved, and what didn't happen:¹⁹

- Firstly, the Outcome Document was disappointing in many respects, but it does represent a significant improvement over previous high-level political declarations on drugs and can be a useful advocacy tool for national and international efforts on drug policy reform.²⁰
- Secondly, the country statements at the UNGASS – and the difficulty of the consensus-based negotiations – clearly showed that the consensus on global drug control is now irrevocably broken.
- Thirdly, the UNGASS created a momentum for UN agencies to get involved in drug control policies, with efforts made to achieve better coherence across the UN system on drug policy, human rights, health, development and security imperatives.
- Finally, civil society was more vocal than ever before, and the movement is growing. The UNGASS constituted a key moment to build upon the momentum of the past years and strengthen the NGO voice and presence in global drug policy debates. In several countries, NGOs are now considered as important partners and experts, who are regularly invited to feed into discussions and negotiations. At the UNGASS itself, eight governments included NGO representatives in their official delegation – Bolivia, Costa Rica, Japan, Mexico, New Zealand, Norway, Sweden and Switzerland.²¹

4. End the session (slide 40) by showing the video 'A broad consensus: It's time for change #supportdontpunish' (3:55 mins long). This video, produced under the banner of the Support Don't Punish campaign,²² is intended as a light-hearted demonstration of the lack of consensus on key drug policy issues at the UNGASS, including on harm reduction, the abolition of the death penalty, decriminalisation and legal regulation. Subtitles for the video are available in Arabic, Czech, English, Finnish, French, Greek, Japanese and Spanish.



1. Available here: <https://www.unodc.org/documents/ungass2016/V0984963-English.pdf>
2. Available here: <http://www.un.org/Docs/journal/asp/ws.asp?m=A/S-30/L.1>
3. <http://www.un.org/en/ga/sessions/special.shtml>
4. See: International Drug Policy Consortium (April 2015), *The road to UNGASS 2016: Process and policy asks from the IDPC*, <http://idpc.net/publications/2014/10/the-road-to-ungass-2016-process-and-policy-asks-from-idpc>
5. See the CND Blog interactive maps on country positions on key drug policy issues: www.cndblog.org/maps/
6. All UN written contributions for the UNGASS are available here: http://www.unodc.org/ungass2016/en/contribution_UN_Entities.html
7. For an analysis of key drug policy reform aspects included in UN contributions for the UNGASS, see: Hallam, C. (March 2016), *IDPC Briefing Paper – Striving for system-wide coherence: An analysis of the official contributions of United Nations entities for the UNGASS on drugs* (London: International Drug Policy Consortium), <http://idpc.net/publications/2016/03/striving-for-system-wide-coherence-an-analysis-of-the-official-contributions-of-united-nations-entities-for-the-ungass-on-drugs>
8. <http://idpc.net/media/press-releases/2016/04/diplomacy-or-denialism-the-language-that-the-ungass-outcome-document-overlooked>
9. For more information about country positions for and against key drug policy issues, visit: <http://cndblog.org/maps/>
10. To read more about the Cartagena Group and their recommendations for the UNGASS, see: *International dialogue on drug policies: Supporting the process towards UNGASS 2016*, Cartagena, Colombia, 22-24 November 2015, <http://idpc.net/publications/2016/01/international-dialogue-on-drug-policies-supporting-the-process-towards-ungass-2016>
11. See: <http://cndblog.org/maps/war-on-drugs-vs-new-paradigm/>
12. See: <http://cndblog.org/maps/drug-free-world/>
13. For more information, visit: <http://cndblog.org/maps/>
14. Hallam, C. (March 2016), *Striving for system-wide coherence: An analysis of the official contributions of United Nations entities for the UNGASS on drugs* (London: International Drug Policy Consortium), <http://idpc.net/publications/2016/03/striving-for-system-wide-coherence-an-analysis-of-the-official-contributions-of-united-nations-entities-for-the-ungass-on-drugs>
15. For more information, see: Fernandez Ochoa, J. & Nougier, M. (March 2017), *How to capitalise on progress made in the UNGASS Outcome Document: A guide for advocacy* (London: International Drug Policy Consortium), <http://idpc.net/publications/2017/03/how-to-capitalise-on-progress-made-in-the-ungass-outcome-document>
16. For more information on this point, refer to the 10by20 campaign led by Harm Reduction International: <https://www.hri.global/10by20>
17. See: <http://cndblog.org/maps/harm-reduction/>
18. Hallam, C. (March 2016), *Striving for system-wide coherence: An analysis of the official contributions of United Nations entities for the UNGASS on drugs* (London: International Drug Policy Consortium), <http://idpc.net/publications/2016/03/striving-for-system-wide-coherence-an-analysis-of-the-official-contributions-of-united-nations-entities-for-the-ungass-on-drugs>
19. For more details, see: International Drug Policy Consortium (September 2016), *The United Nations General Assembly Special Session (UNGASS) on the world drug problem: Report of proceedings*, <http://idpc.net/publications/2016/09/the-ungass-on-the-world-drug-problem-report-of-proceedings>
20. For more details on how to use the UNGASS Outcome Document for advocacy purposes, see: Fernandez Ochoa, J. & Nougier, M. (March 2017), *How to capitalise on progress made in the UNGASS Outcome Document: A guide for advocacy* (London: International Drug Policy Consortium), <http://idpc.net/publications/2017/03/how-to-capitalise-on-progress-made-in-the-ungass-outcome-document>
21. For more details, see: International Drug Policy Consortium (February 2017), *IDPC Advocacy Note – Lessons learned from NGO participation in government delegations at the UNGASS*, <http://idpc.net/publications/2017/01/lessons-learned-from-ngo-participation-in-government-delegations-at-the-ungass>
22. www.supportdontpunish.org

MODULE 1

Session 1.7

Activity: What comes next: The 2019 High Level Ministerial Meeting

 45 min

Facilitators' note

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

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

Aim – To understand future opportunities for a review of the global drug control system and how to build upon UNGASS wins to move towards 2019

1. Introduce the aim of the session (slide 41).
2. Present the information below with corresponding slides (slides 42 and 43).

Information to cover in this presentation:

The next high-level meeting on global drug control was set to take place in 2019, in order to review progress made ten years after the adoption of the 2009 Political Declaration and Action Plan on drugs.¹ However, because the UNGASS took place in 2016, this has left a procedural vacuum for 2019.

Some of the procedural questions were answered in March 2017, when the CND adopted Resolution 60/1 ‘Preparations for the sixty-second session of the Commission’.² The Resolution establishes that a high level ministerial segment will be held at the margins of the 62nd CND in March 2019 in Vienna, with the participation of member states, UN drug agencies, as well as other relevant UN agencies and civil society (although little clarity has been given on this so far).

However, nothing has so far been decided in terms of the outcome of the meeting: will there be a new political declaration? Or will member states try to operationalise the UNGASS Outcome Document? Or even worse, will the 2009 Political Declaration be extended for the next decade? There seems to be little appetite among UN member states on negotiating a new consensus-based Political Declaration so close to the adoption of the UNGASS Outcome Document – so this remains a major question mark.

Another question relates to the place given to the UNGASS Outcome Document within the 2019 process. Should the 2009 Political Declaration prevail, or should the Outcome Document be the basis for discussions as the latest agreed language on drug control? After much discussion during the negotiations of Resolution 60/1, the final text states that these documents, as well as the 2014 Joint Ministerial Statement (adopted at the mid-term review of the 2009 Declaration) are ‘complementary and mutually reinforcing’ – they will therefore be considered together during the discussions, but nothing has been decided as to the structure of the debates: will the debates follow the new seven-themed pillar of the Outcome Document or revert back to the unhelpful three-pillar structure of 2009?

More discussions will take place in the second half of 2017 and at the 61st Session of the CND in March 2018 on these issues.

3. Beyond procedural issues, explain that civil society will need to keep pushing for key drug policy issues. Ask the participants to split into groups of 5 or 6, and ask them to select a note taker and rapporteur.
4. Distribute the 'Key issues' cards and the handout 'Country positions on key drug policy issues for 2019' to each group and ask them to rank the issues in order of possible levels of consensus in Vienna, filling out the first column of the handout (slide 44).
5. Then, ask the groups to fill the rest of the handout by identifying key countries that will likely push for, or against, each of the issues. Ask them to think of countries that do not yet have an official position on the issues but could be convinced to support it (possible advocacy targets). Also ask the participants to reflect on some of the countries that have significantly changed their position since the UNGASS took place and how this will influence advocacy strategies (e.g. Philippines, Canada – since the arrival of Trudeau, etc).
6. Back in plenary, ask each group in turn to discuss one issue, going from what they believe to be the most controversial ones to the least controversial. For each issue, make sure that the key points below are reflected in the discussion, and leave time for comments and discussion with the rest of the participants.

Facilitators' note

We have created a facilitator's version of the handout to help the facilitator go through this exercise.

Information to cover during this exercise:

Treaty reform – While the drug conventions are flexible enough to allow many measures to be implemented in the spirit of interpretation (see Session 2.5), their focus on tough drug laws and their strict enforcement is outdated and inconsistent with current evidence and local approaches. However, with the exception of Bolivia's request for an amendment on coca leaf chewing (see Sessions 2.5 for more information)³ and Ecuador's recent calls for a reform of the drug conventions, no other country has shown any willingness at this point to explicitly promote treaty amendment. Even Uruguay, which has indeed breached its treaty obligations by creating legally regulated cannabis markets, has not called for treaty reform, instead arguing that they continue to operate within the spirit of the drug conventions and broader international human rights law. Likewise, the US claims that its states' cannabis laws fall within the 'flexibility' of the treaties, and hides behind its federal system to claim that the national government continues to abide by its international drug control obligations.

Legal regulation – Regulated markets for substances scheduled in the international drug control treaties remain prohibited (see Session 2.5). However, as more jurisdictions enact cannabis regulation laws, it becomes more and more apparent that the issue must be resolved at the international level. Although side events have been held in the margins of the CND and a limited number of countries have made statements on the issue, there has as of yet been no official and meaningful debate on legal regulation at UN level, and the issue was by far the largest elephant in the room at the UNGASS.

Death penalty – The struggle to include language against the death penalty for drug offences reached a head at the 2014 High-Level Review – with a failure to include any mention of the topic in the Joint Ministerial Statement, although its adoption by consensus was followed by a statement against the death penalty supported by 58 countries – a statement met with an objection by Iran backed by 16 countries.⁴ The death penalty was once again prominent at the 2015 CND, with Indonesia being strong on its sovereign right to continue using capital punishment as a deterrent to drug traffickers, while an increasing number of countries made statements against executing people for drug offences.⁵ These tensions culminated at the UNGASS, with

inclusion of the death penalty being one of the key points of contention during the negotiations of the Outcome Document. After months of negotiations, it was finally agreed not to include a paragraph on the death penalty. At the UNGASS itself, however, 66 countries pronounced themselves strongly against the practice – with 16 countries making statement in support of capital punishment.⁶

Decriminalisation – Decriminalisation (see [Module 8](#) for more details) has recently become more widely accepted among some countries at the CND. In the lead up to the UNGASS, 15 UN agencies released statements in favour of the policy.⁷ However, there continues to be dissent among countries about the adoption of decriminalisation measures, with several governments strongly disagreeing with this less punitive approach.⁸ In addition, the question remains as to whether this would include subsistence farmers involved in illicit crop cultivation. The INCB has recently changed its position on decriminalisation, repeatedly stating that removing criminal sanctions against people who use drugs is permissible in the conventions.⁹ UNODC has adopted a similar stance.

Harm reduction – Whether the term ‘harm reduction’ is used in official UN documents has been a point of contention since 1998, when it was instead described in the Declaration on the Guiding Principles of Drug Demand Reduction as ‘reducing the negative public health and social consequences of drug use’¹⁰ and in 2009 when the phrase ‘related support services’ was included in the Political Declaration and Plan of Action, supplemented by an interpretive statement signed by 26 member states that this phrase was understood to mean ‘harm reduction’.¹¹ The issue was revisited at the 2014 High Level Review, and again the term ‘harm reduction’ was not included in the Joint Ministerial Statement; instead the document refers to ‘measures aimed at minimizing the negative public health and social impacts of drug abuse that are outlined in the WHO, UNODC, UNAIDS Technical Guide’.¹² As explained earlier, the UNGASS Outcome Document also fails to include the term, although it mentions the Technical Guide and critical interventions – and the debates at UNGASS showed more widespread support for the approach. The term ‘harm reduction’ was included for the first time in the official report of the Commission on Narcotic Drugs (CND) in 2015, as part of the interactive discussions that took place during the UNGASS Special Segment.¹³ More progress was made during the high-level UN meetings on HIV. In 2001, the Declaration of commitment on HIV/AIDS included a target to ‘reduce harm related to drug use’.¹⁴ As for the 2011¹⁵ and 2016¹⁶ Political declarations on HIV/AIDS, they both refer explicitly to ‘harm reduction’.

Alternatives to incarceration – This has become much less controversial in recent years, with countries not willing to call for decriminalisation referring instead of the need to promoting alternatives to imprisonment for people who use drugs, and sometimes also for low-level drug offenders. UNODC and the INCB have also repeatedly called on governments to provide alternatives to imprisonment as an important component of the implementation of the international drug control treaties. What remains unclear is what kind of alternative is acceptable under human rights standards – for example, compulsory detention centres in the name of treatment are clearly not acceptable.

Indicators – The need to identify new metrics and indicators to evaluate the successes and failures of drug control has become more prominent at the UN level in recent years. It seems clear today that numbers of arrests, incarceration rates, seizures and hectares eradicated tell us little about the real impact of drug control. The Sustainable Development Goals (SDGs) offer a key opportunity for member states to develop new indicators that can truly assess the impact of drug policies on health outcomes, poverty alleviation, reductions in violence and corruption, access to employment, etc. Nevertheless, there is still a group of countries that continues to enumerate the numbers of dealers they incarcerated and tons of drugs they seized in their overall objective of achieving a drug-free world.

Gender – There is now widespread evidence that women are disproportionately affected by overly punitive drug policies. They have more restricted access to harm reduction and treatment options, they are victims of stigma, discrimination and harassment, and they are also disproportionately incarcerated for low-level drug offences. This issue has gained more prominence during the UNGASS process, particularly from Latin American countries, without much push back from other member states.

Development and the SDGs – The fact that the SDGs were adopted while governments were negotiating the UNGASS Outcome Document was instrumental in ensuring better links between drugs and development. The issue also yields little controversy – although the challenge now is for member states to clearly lay out what a ‘development-oriented’ approach to drug control should look like.

Access to controlled medicines – A core obligation under the UN drug conventions is the need to ensure adequate access to controlled substances for medical and scientific purposes – this obligation has been largely deprioritised in favour of stringent and restrictive drug control measures. Today, 80% of the world’s population live in countries where there is little or no access to controlled medicines such as morphine to alleviate moderate or severe pain. Access to controlled medicines is part of the right to health, and member states have the responsibility under the treaties to ensure that this right is fulfilled.¹⁷ An increasing number of member states at the CND have raised concerns about this issue – although many member states balance up this obligation with the need to avoid diversion in the illicit drug market. This issue gained much visibility at the UNGASS, with a whole section of the Outcome Document dedicated to it and renewed INCB leadership to work with governments in an effort to remove political, legislative and practical barriers to access.

1. Available here: <https://www.unodc.org/documents/ungass2016/V0984963-English.pdf>
2. Available here: <http://www.un.org/Docs/journal/asp/ws.asp?m=E/2017/28>
3. See <http://www.unodc.org/unodc/en/frontpage/2013/January/bolivia-to-re-accede-to-un-drug-convention-while-making-exception-on-coca-leaf-chewing.html>. See also Jelsma, M. (2011). *Lifting the ban on coca chewing: Bolivia's proposal to amend the 1961 Single Convention*. Retrieved from: <http://www.tni.org/sites/www.tni.org/files/download/dlr11.pdf>.
4. <http://www.cndblog.org/search/label/highlevelsegment>
5. See: www.cndblog.org for more information about countries' positions on the death penalty
6. See: <http://cndblog.org/maps/death-penalty/>
7. Hallam, C. (March 2016), *Striving for system-wide coherence: An analysis of the official contributions of United Nations entities for the UNGASS on drugs* (London: International Drug Policy Consortium), <http://idpc.net/publications/2016/03/striving-for-system-wide-coherence-an-analysis-of-the-official-contributions-of-united-nations-entities-for-the-ungass-on-drugs>
8. See: <http://cndblog.org/maps/decriminalisation/>
9. See, for example: International Drug Policy Consortium (13 November 2016), 'INCB invokes the flexibilities of the UN Drug control treaties to stop punishing drug users', *INCB Watch*, <http://idpc.net/incb-watch/updates/2015/11/incb-calls-on-flexibilities-of-the-treaties-to-stop-punishing-drug-users>
10. Declaration on the Guiding Principles of Drug Demand Reduction, found at <http://www.un.org/ga/20special/demand.htm>
11. Political Declaration and Plan of Action, par. 10, at https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_52/Political-Declaration2009_V0984963_E.pdf
12. Joint Ministerial Statement of the 2014 HLR, par 12, at http://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_57/Draft_Resolutions/E-CN7-2014-L15/V1401384_E.pdf
13. See item E/2015/28-E/CN.7/2015/15, http://www.unodc.org/unodc/en/commissions/CND/session/58_Session_2015/CND-58-Session_Index.html
14. http://www.unaids.org/sites/default/files/sub_landing/files/jc668-keepingpromise_en.pdf
15. See p. 9, http://www.unaids.org/sites/default/files/sub_landing/files/20110610_UN_A-RES-65-277_en.pdf
16. See p. 9, <http://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS>
17. For more information, see: <http://idpc.net/publications/2015/01/the-international-drug-control-regime-and-access-to-controlled-medicines>

Handout: The United Nations drug control treaties

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

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

This convention contained new provisions that established the following:

- A harsher, restrictive system for the control of drugs
- Extended controls to include the cultivation of plants from which narcotic drugs are derived (this impacted directly on countries that traditionally produced plants such as opium poppies, cannabis and coca)
- A ban on traditional practices that included traditional medicinal use of all three plants. Such use was defined as 'quasi-medical' practices that had to be terminated within set time-frames. Opium¹ was to be eliminated over a 15-year period, and coca and cannabis within 25 years
- The classification of more than a hundred substances under varying levels of control in four schedules according to their alleged level of dangerousness. Controversially, cannabis appears under the list of the most dangerous substances.

The 1971 Convention on Psychotropic Substances

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

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

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

This last convention was negotiated in response to massive increases in both demand and supply of cannabis, cocaine and heroin for non-medical (therefore illicit) use. Demand had dramatically increased for these substances in Western countries during the 1970s and 1980s, and large-scale illicit production took place in the traditional producer countries to meet that demand. Prior to the 1961 Convention, this demand for non-medical use had been met partly through leakage from licit production, and partly through illicit cultivation

and production. However, by the 1980s, globalised organised crime groups had established an international industry to handle illicit supply.

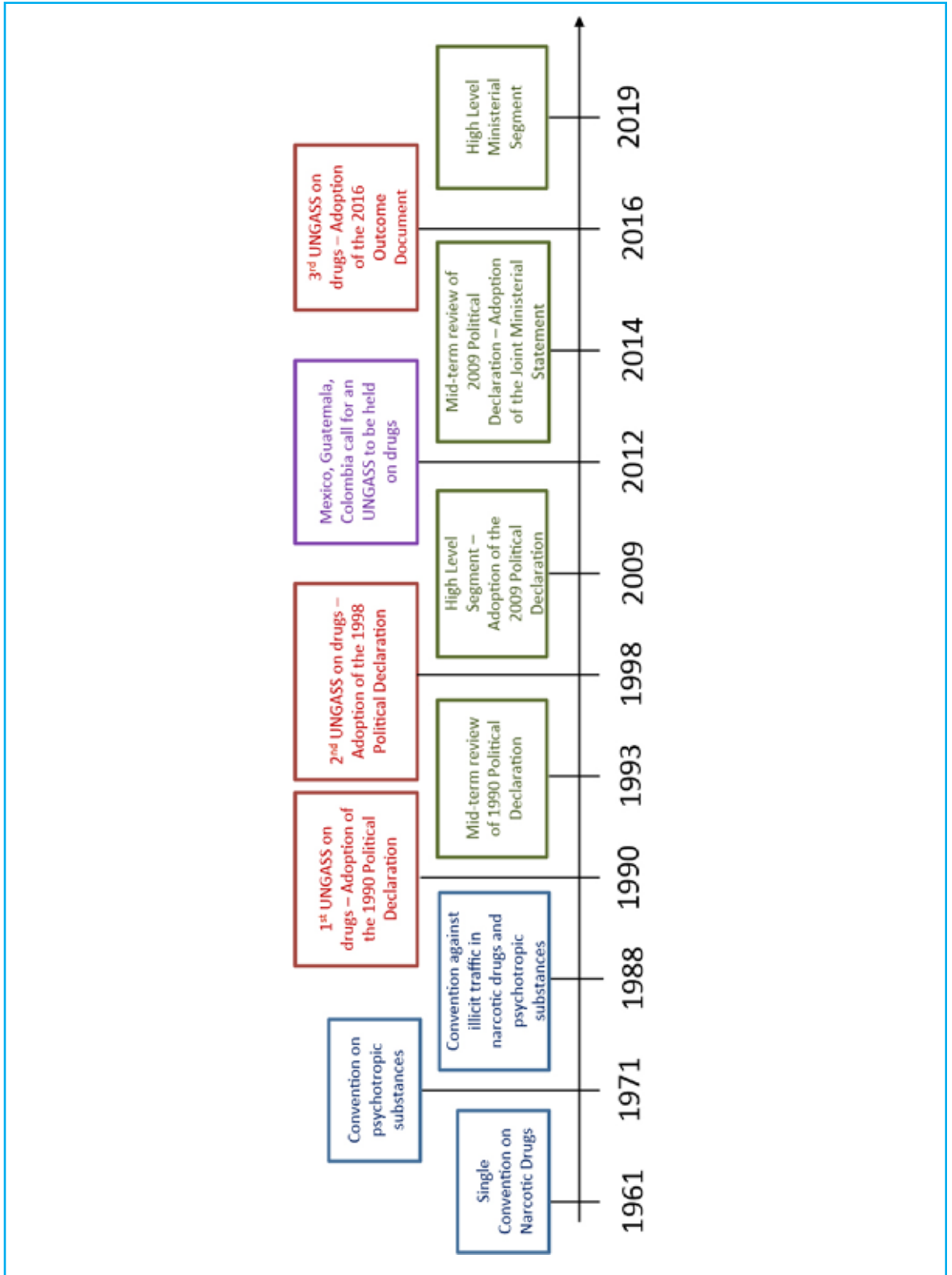
The rapid growth of illicit trafficking of these drugs fuelled a criminal black market worth billions. This development led the international community to negotiate the 1988 convention to provide special enforcement measures focused on reducing illicit cultivation, production and trafficking of drugs,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

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

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

MODULE 1

Handout: Timeline of international drug control



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



Commission on Narcotic Drugs (CND)

The CND is the central policy-making body for the UN drug control system. It meets every year for a week in March in Vienna, Austria, to discuss drug policy issues and adopt resolutions on the direction of international drug control for the coming year. The CND is the final decision maker on proposals by the World Health Organisation (WHO) to schedule, de-schedule or re-schedule a psychoactive substance (although it can only accept or reject the WHO proposal).

The CND is mandated by the UN Charter (article 71) to facilitate NGO participation in its work. There are formal provisions for NGOs which have ECOSOC consultative status to attend the CND as observers; and a small number of NGO representatives have been able to deliver statements at the CND's Plenary session. More importantly, however, the informal sessions at which member states meet to negotiate disputed draft resolutions are closed to civil society, a situation that imposes severe limits on CSO engagement, and even observation. A more efficient channel of influence consists of NGOs liaising directly with their own government's delegation at the CND in the 'corridors' of the meeting. In some cases, NGO representatives can even be included in government delegations, but this will of course depend on the governments' willingness to do so.¹ In any case, as member states are best placed to achieve policy changes at the CND, advocacy directed at national delegates constitutes an effective tool for promoting drug policy reform.

International Narcotics Control Board (INCB)

The INCB is the only drug control body directly created by the 1961 Convention. The INCB aims to oversee the implementation of the drug control conventions. In its role as 'guardian of the treaties', it monitors member states' compliance with the treaties, and can raise the matter with individual governments if it judges them to be in contravention with the conventions. It is, however, supposed to approach such countries in a spirit of cooperation. It can also raise the matter with the CND and ECOSOC. The second function of the INCB is an enabling one, differing from the restrictive mandate outlined in the foregoing. It involves ensuring access to controlled drugs for medical and scientific purposes. The INCB's mandate includes monitoring countries' provision of controlled drugs for healthcare and scientific purposes.

The INCB has traditionally been hostile to any engagement with civil society, citing the 'need for security of information' as the reason for its lack of transparency. However, in the face of extensive criticism from NGOs working in the drugs field and subsequent negotiations between the INCB and the Vienna NGO Committee on Drugs (VNGOC – see below for more information), it has recently made some concessions, in particular the possibility for NGO participation during the INCB country missions. As a result, it is now possible for NGOs to apply² to meet INCB representatives when they undertake visits in member states to examine the drug control situation (a number of these visits are made in various countries each year). At the international level, the INCB chair now meets every year with NGOs at the informal dialogue organised at the CND. To what extent dialogue equates with participation remains to be seen.

United Nations Office on Drug Control (UNODC)

UNODC is the UN agency responsible for coordinating international drug control activities, and is the public face of the drug control system.

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

1. For more information, please visit the INCB Watch page: <http://idpc.net/incb-watch>
2. For more information, please visit the website of VNGOC: <http://www.vngoc.org/>

Handout: Drug control and human rights violations

The tables below, adapted from the [IDPC Drug Policy Guide, 3rd Edition](#), highlights examples of international human rights violations caused by current drug control efforts. If you would like to learn more about drug policy and human rights advocacy, please read:

- Harm Reduction International (2011), *The UN human rights system and harm reduction advocacy: A training package for civil society organisations*, http://www.ihra.net/files/2011/03/29/IHRA_Training_Pack_Final.pdf
- Kaplan, K. (2009), *Human rights documentation and advocacy: A guide for organizations of people who use drugs* (New York: Open Society Institute Public Health Program), http://www.opensocietyfoundations.org/sites/default/files/hrdoc_20090218.pdf

Human right	International human rights convention	Violations in the name of drug control
Right to life	<ul style="list-style-type: none"> • Article 4 of the Universal Declaration of Human Rights, 1948 • Article 6 of the International Covenant on Civil and Political Rights, 1966 	<ul style="list-style-type: none"> • Use of the death penalty for drug offences¹ • Extra-judicial killings by law-enforcement agencies²
Right to the highest attainable standard of physical and mental health	<ul style="list-style-type: none"> • Constitution of the World Health Organisation, 1946 • Article 25 of the Universal Declaration of Human Rights, 1948 • Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966 	<ul style="list-style-type: none"> • Restricted access to essential medicines, including those for pain relief³ • Restricted access to humane and evidence-based drug dependence treatment, including opioid substitution therapy⁴ • Restricted access to harm reduction services that would prevent overdoses and the transmission of blood-borne infections such as HIV and hepatitis C⁵
Right not to be subjected to arbitrary arrest and detention	<ul style="list-style-type: none"> • Article 9 of the Universal Declaration of Human Rights, 1948 • Article 9 of the International Covenant on Civil and Political Rights, 1966 	<ul style="list-style-type: none"> • Targeting of people who use drugs by law enforcement officers to meet arrest quotas⁶ • Arbitrary detention of people who use drugs⁷ • Police harassment and sexual abuse of people who use drugs⁸
Right to a fair trial	<ul style="list-style-type: none"> • Article 10 of the Universal Declaration of Human Rights, 1948 • Article 6 of the European Convention of Human Rights, 1950 	<ul style="list-style-type: none"> • Denial of parole, pardon, amnesty or alternatives to incarceration for people convicted of a drug crime⁹ • Use of pre-trial detention, mandatory sentencing and disproportionate penalties against people involved in minor drug offences¹⁰ • Referral to compulsory centres for drug users without due process or trial¹¹

Human right	International human rights convention	Violations in the name of drug control
Right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment	<ul style="list-style-type: none"> Article 5 of the Universal Declaration of Human Rights, 1948 Article 7 of the International Covenant on Civil and Political Rights, 1966 Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1975 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984 	<ul style="list-style-type: none"> Abuses in compulsory centres for drug users¹² Use of corporal punishment for drug offenders, including caning, flogging, lashing and whipping¹³
Right not to be held in slavery	<ul style="list-style-type: none"> Article 4 of the Universal Declaration of Human Rights, 1948 Article 8 of the International Covenant on Civil and Political Rights, 1966 	<ul style="list-style-type: none"> Use of forced labour in the name of drug treatment¹⁴
Social and economic rights	<ul style="list-style-type: none"> Article 22 (and next) of the Universal Declaration of Human Rights, 1948 Articles 6 and 7 (and next) of the International Covenant on Economic, Social and Cultural Rights, 1966 Convention concerning Indigenous and Tribal Peoples in Independent Countries, 1989 	<ul style="list-style-type: none"> Implementation of forced crop eradication campaigns, leaving many farmers with no means of subsistence¹⁵ Destruction of land, food crops and water supplies due to aerial spraying¹⁶ Denial of the right of indigenous groups to use controlled substances for traditional and religious purposes¹⁷
Right to be free from discrimination	<ul style="list-style-type: none"> Article 7 of the Universal Declaration of Human Rights, 1948 Article 26 of the International Covenant on Civil and Political Rights, 1966 International Convention on the Elimination of All Forms of Racial Discrimination, 1965 Convention on the Elimination of All Forms of Discrimination Against Women, 1979 	<ul style="list-style-type: none"> Discriminatory application of drug control laws, notably towards minority ethnic groups,¹⁸ indigenous people, young people and women¹⁹
Right to privacy²⁰	<ul style="list-style-type: none"> Article 12 of the Universal Declaration on Human Rights, 1948 	<ul style="list-style-type: none"> Practice of stopping and inspecting people, including school children, suspected of carrying drugs²¹ Forced urine testing²² Practice of including people who use drugs in official government registries²³ Sharing of confidential medical information of a person caught for drug use or undergoing drug dependence treatment with the police²⁴
Right to be protected from illicit drug use	<ul style="list-style-type: none"> Article 33 of the UN Convention on the Rights of the Child, 1989 	<ul style="list-style-type: none"> Denial of harm reduction services targeted at young people²⁵ Use of ineffective and stigmatising drug prevention measures²⁶

- At least 33 countries and territories retain the death penalty for drug offences within their legislation. See: Harm Reduction International (October 2015), *The death penalty for drug offences: Global overview 2015*, <http://www.ihra.net/the-death-penalty-doesnt-stop-drug-crimes>; Gallahue, P. (2015), *Drugs and the death penalty* (New York: Open Society Foundations), <https://www.opensocietyfoundations.org/reports/drugs-and-death-penalty>
- See, for example: Centro de Estudios Legales y Sociales (2015), *The impact of drug policy on human rights – The experience in the Americas*, <http://www.cels.org.ar/common/drug%20policy%20impact%20in%20the%20americas.pdf>; Amnesty International (October 2012), *Known abusers, but victims ignored: Torture and ill-treatment in Mexico*, <http://www.amnestyusa.org/research/reports/known-abusers-but-victims-ignored-torture-and-ill-treatment-in-mexico>
- The WHO estimates that approximately 80% of the world's population has either no or insufficient access to treatment for moderate or severe pain. See: World Health Organisation, Access to Controlled Medications Programme (2007), *Improving access to medications controlled under international drug conventions*, http://www.who.int/medicines/areas/quality_safety/access_to_controlled_medications_brnote_english.pdf;

See also: Hallam, C. (January 2015), *The international drug control regime and access to controlled medicines* (International Drug Policy Consortium & Transnational Institute), <http://idpc.net/publications/2015/01/the-international-drug-control-regime-and-access-to-controlled-medicines>; Global Commission on Drug Policy (October 2015), *The negative impact of drug control on public health: The global crisis of avoidable pain*, <http://www.globalcommissionondrugs.org/reports/>

4. Mendez, J.E. (1 February 2013), *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, A/HRC/22/53 (Human Rights Council), p. 13, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf
5. Mathers, B.M., et al (2010), 'HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage', *The Lancet*, **375**(9719): 1014-1028, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60232-2/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60232-2/abstract)
6. See, for example: Lai, G. (July 2013), 'Towards more proportionate sentencing laws in Thailand', *IDPC Blog*, <http://idpc.net/blog/2013/07/towards-more-proportionate-sentencing-laws-in-thailand>
7. See, for example: Human Rights Watch (October 2011), *Somsanga's secrets – Arbitrary detention, physical abuse and suicide inside a Lao drug detention center*, <https://www.hrw.org/report/2011/10/11/somsangas-secrets/arbitrary-detention-physical-abuse-and-suicide-inside-lao-drug>
8. Eurasian Harm Reduction Network (December 2013), *Human rights of women who use drugs breached by law enforcement officials in Eurasia*, <http://idpc.net/alerts/2013/12/human-rights-of-women-who-use-drugs-breached-by-law-enforcement-officials-in-eurasia>
9. Harm Reduction International & Penal Reform International (May 2015), *Submission: Impact of the world drug problem on the enjoyment of human rights*, http://www.ohchr.org/Documents/HRBodies/HRCouncil/DrugProblem/PenalReformInternational_HarmReductionInternational.pdf
10. See, for example, in Latin America: Colectivo de Estudios Drogas y Derechos (November 2015), *The incarceration of women for drug offenses*, http://www.drogasyderecho.org/publicaciones/pub-priv/luciana_i.pdf
11. Center for Human Rights and Humanitarian Law, Anti-Torture Initiative (2013), *Torture in healthcare settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report*, <https://www.opensocietyfoundations.org/voices/extreme-abuse-name-drug-treatment>; Kamarulzaman, A. & McBrayer, J.L. (2015), 'Compulsory drug detention centers in East and Southeast Asia', *International Journal of Drug Policy*, **26**(1): S33-S37, [http://www.ijdp.org/article/S0955-3959\(14\)00335-1/abstract](http://www.ijdp.org/article/S0955-3959(14)00335-1/abstract); Human Rights Watch (July 2012), *Torture in the name of treatment: Human rights abuses in Vietnam, China, Cambodia and Lao PDR*, <https://www.hrw.org/report/2012/07/24/torture-name-treatment/human-rights-abuses-vietnam-china-cambodia-and-lao-pdr>
12. Ibid
13. Harm Reduction International (2011), *Inflicting harm: Judicial corporal punishment for drug and alcohol offences in selected countries*, <http://www.ihra.net/contents/1211>
14. Human Rights Watch (January 2010), 'Where darkness knows no limits' – incarceration, ill-treatment, and forced labor as drug rehabilitation in China, <https://www.hrw.org/report/2010/01/07/where-darkness-knows-no-limits/incarceration-ill-treatment-and-forced-labor-drug>
15. Mansfield, D. (2011), *Assessing supply-side policy and practice: Eradication and alternative development* (Geneva: Global Commission on Drug Policy), http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_David_Mansfield.pdf
16. See, for example: Isacson, A. (29 April 2015), *Even if glyphosate were safe, fumigation in Colombia would be a bad policy. Here's why*, (Washington Office on Latin America), http://www.wola.org/commentary/even_if_glyphosate_were_safe_fumigation_in_colombia_would_be_a_bad_policy_heres_why; see also: Guyton, K.Z., et al (May 2015), 'Carcinogenicity of tetrachlorvinphos, parathion, malathion, diazinon, and glyphosate', *The Lancet*, **16**(5): 490-491, [http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(15\)70134-8/fulltext](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(15)70134-8/fulltext)
17. The chewing of the coca leaf and traditional use of cannabis and opium are prohibited under the UN drug conventions
18. See, for example: Eastwood, N., Shiner, M. & Bear, M. (2014), *The numbers in black and white: Ethnic disparities in the policing and prosecution of drug offences in England and Wales* (London: Release), <http://www.release.org.uk/node/286>; American Civil Liberties Union (June 2013), *The war on marijuana in black and white: Billions of dollars wasted on racially biased arrests*, <https://www.aclu.org/report/war-marijuana-black-and-white?redirect=criminal-law-reform/war-marijuana-black-and-white-report>, Drug Policy Alliance (February 2014), *The drug war, mass incarceration and race*, <http://www.drugpolicy.org/resource/drug-war-mass-incarceration-and-race>
19. United Nations Office on Drugs and Crime, UN Women, World Health Organisation & International Network of People Who Use Drugs (August 2014), *Women who inject drugs and HIV: Addressing specific needs*, http://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf
20. For more information about the right to privacy, see: International Network of People Who Use Drugs (October 2015), *Consensus statement on drug use under prohibition – Human rights, health and the law*, http://www.inpud.net/consensus_statement_2015.pdf
21. Hallam, C. (April 2010), *IDPC Briefing Paper – Jar wars: The question of schools-based drug testing* (London: International Drug Policy Consortium), http://idpc.net/sites/default/files/library/Schools%20Briefing%20paper%202010%20FINAL_0.pdf
22. See, for example: Drug Reporter (3 October 2015), *Republic of Georgia cuts back its street drug testing program*, <http://drogriporter.hu/en/node/2760>; see also: Lai, G. (August 2015), 'Asia: Advocating for humane and effective drug policies', *International Journal on Human Rights*, **21**, <http://sur.conectas.org/en/issue-21/asia-advocating-humane-effective-drug-policies/>
23. See, for instance, in China: Zhang, S.X. & Chin, K. (2015), *A people's war: China's struggle to contain its illicit drug problem* (Brookings Institute), <http://www.brookings.edu/~media/Research/Files/Papers/2015/04/global-drug-policy/A-Peoples-War-final.pdf?la=en>
24. For example in Central Asia: Eurasian Harm Reduction Network (2010), *Opioid substitution therapy in Central Asia: Towards diverse and effective treatment options for drug dependence*, <http://www.harm-reduction.org/library/opioid-substitution-therapy-central-asia-towards-diverse-and-effective-treatment-options>; and in Greece: Papamalis, F. (2013), *Petition: Greek economic recession from the public health perspective: The social cost*, <http://idpc.net/alerts/2013/02/petition-greek-economic-recession-from-the-public-health-perspective-the-social-cost>
25. International Harm Reduction Association & Youth RISE (2009) *Drugs, harm reduction and the UN Convention on the rights of the child: Common themes and universal rights*, <http://www.ihra.net/child-rights>; Harm Reduction International (December 2013), *Injecting drug use among under-18s*, http://www.ihra.net/files/2014/08/06/injecting_among_under_18s_snapshot_WEB.pdf
26. For example: US Government Accountability Office (January 2003), *Youth illicit drug use prevention: DARE long-term evaluations and federal efforts to identify effective programs*, <http://www.gao.gov/products/GAO-03-172R>. For more information, also see Chapter 2.3 of this Guide



MODULE 1

Handout: Country positions on key drug policy issues for 2019 (for the participants)

UNDECIDED COUNTRIES	
COUNTRIES AGAINST	
COUNTRIES IN FAVOUR	
ISSUE	
	<p>MOST CONTROVERSIAL (UNLIKELY CONSENSUS) ← → LEAST CONTROVERSIAL (LIKELY CONSENSUS)</p>

Handout: Country positions on key drug policy issues for 2019

ISSUE	COUNTRIES IN FAVOUR	COUNTRIES AGAINST	UNDECIDED COUNTRIES
Treaty reform	Ecuador	Most countries	
Legal regulation	Uruguay, Canada, Jamaica	Morocco, Indonesia, China, Japan, Egypt, Russia, Pakistan, Qatar, Algeria	
Abolition of the death penalty	EU, Mexico, Colombia, Costa Rica, Ghana, Australia, Switzerland, Brazil, Canada	Iran, Saudi Arabia, Russia, Pakistan, Indonesia, China, Philippines	
Decriminalisation	Czech Republic, Portugal, Colombia, Ecuador, Switzerland, Jamaica, Israel	Pakistan, Egypt, Morocco, Russia, Iran, China	Various EU member states
Harm reduction	EU, Canada, Colombia, Mexico, Costa Rica, Israel, New Zealand, USA, Vietnam, Tanzania	Russia, Egypt, Pakistan, China, Singapore	Most African countries, Central Asia
Indicators	Netherlands, Norway, Panama, Portugal, Switzerland	Bahrain, China, India, Indonesia, Pakistan, Saudi Arabia, Russia, Singapore	Mexico, Colombia, Thailand
Gender	Costa Rica, Brazil, Ecuador, Colombia, Israel, Uruguay		EU member states, African states, Thailand
Development & SDGs	Costa Rica, Israel, Mexico, Netherlands, Norway, Panama, Portugal, Switzerland, Uruguay, Thailand		Peru, Bolivia, other EU member states
Access to controlled medicines	Australia, Belgium, Colombia, Dominican Republic, Germany, India, Israel, Mexico, New Zealand		
Alternatives to incarceration	Mexico, Colombia, Guatemala, Costa Rica, EU member states, USA		

MOST CONTROVERSIAL (UNLIKELY CONSENSUS)




LEAST CONTROVERSIAL (LIKELY CONSENSUS)



MODULE 1

Drug policy issues cards

Gender	Development & SDGs
Treaty Reform	Death penalty
Harm Reduction	Decriminalisation
Access to controlled medicines	Alternatives to incarceration
Legal regulation	New indicators



Handout: Resources / Further reading

Full texts of the three UN Drug Control Treaties

Single Convention on Narcotic Drugs, 1954, as amended by the 1972 protocol, <http://www.unodc.org/unodc/en/treaties/single-convention.html>

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

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

Analysis of the drug control system

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

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

International Drug Policy Consortium (September 2016), *The United Nations General Assembly Special Session (UNGASS) on the world drug problem: Report of proceedings*, <http://idpc.net/publications/2016/09/the-ungass-on-the-world-drug-problem-report-of-proceedings>

International Drug Policy Consortium (November 2016), *What comes next? Post-UNGASS options for 2019-2020*, <http://idpc.net/publications/2016/11/idpc-what-comes-next-post-ungass-options-for-2019-2020>

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

Sinha, J. (2001), *The history and development of the leading international drug control conventions* (Law and Government Division, Parliament of Canada), <http://www.parl.gc.ca/Content/SEN/Committee/371/ille/library/history-e.htm>

Resources on the UNGASS

Post-UNGASS Webinar Series (available in English, French and Spanish): <http://idpc.net/idpc-post-ungass-webinar-series>

Country positions at the United Nations, www.cndblog.org/maps

International Drug Policy Consortium (September 2016), *The UNGASS on the world drug problem: Report of proceedings*, <http://idpc.net/publications/2016/09/the-ungass-on-the-world-drug-problem-report-of-proceedings>

Fernandez Ochoa, J. & Nougier, M. (March 2017), *How to capitalise on progress made in the UNGASS Outcome Document: A guide for advocacy* (London: International Drug Policy Consortium), <http://idpc.net/publications/2017/03/how-to-capitalise-on-progress-made-in-the-ungass-outcome-document>