

THE 2005 UNITED NATIONS COMMISSION ON NARCOTIC DRUGS

The International Drug Policy Consortium (IDPC) is an association of specialist professional networks and Non-Governmental Organisations who share a concern at the current limited progress of drug policies in reducing levels of illicit drug use and related problems. Members of the Consortium, drawn from around the world, share a commitment to developing policies that are evidence-based, use resources effectively to reduce drug related harm, and respect civil rights and judicial principles. The IDPC does not advocate one single preferred solution to the complex range of problems related to drug use around the world, but aims to promote transparent debate, the objective analysis of policy successes and failures, and the rational consideration of future policy options.

BACKGROUND

The Commission on Narcotic Drugs (CND) is the annual forum within which the member states of the United Nations gather to consider issues related to the global system for the control of illegal drugs. This system is enshrined in 3 United Nations Conventions (signed and ratified by most member states), that call for the prohibition of the production, distribution and possession of a wide range of psychoactive substances, such as Cannabis, Cocaine and Heroin. Despite widespread political support for, and financial investment in, this system over the last 40 years, the scale and diversity of drug use has grown significantly in almost all areas of the world. More recently, many countries have implemented policies that, to some extent, accept the reality of continued drug use. Other countries fear that this serves to undermine the global anti-drug consensus, and makes it harder to achieve the stated UN goal of a drug-free world. This has led to some difficult exchanges in recent CND meetings. However, all member states have committed themselves to the current 10-year action plans that were agreed in 1998, and that will be formally reviewed in 2008.

CND meetings are held in March of every year in Vienna, the home of the UN Office on Drug and Crime (UNODC – the UN agency charged with overseeing the implementation of drug policies and programmes agreed by member states).

THE ISSUES

We are in a very difficult period for the UN drug control system: The approach that has been agreed and supported by member states for many years is clearly failing to meet its primary objective of eradicating (or at least significantly reducing) the global trade in illegal drugs; many influential member states have consequently introduced policies that acknowledge a certain level of drug use in their societies, and concentrate on reducing the related harms, such as petty crime or HIV infection; these policies have been implemented widely and with encouraging results, and do not seem to lead to an increase in overall drug use; they remain, however, strongly criticised by other member states, who maintain their belief in an approach that focuses on the disruption of the market, and heavy punishment of users, as the best way to reduce these problems. With a significant, and increasing, division of opinion on these issues, a consensus-led body such as the UN will need to find positions and

structures that can accommodate both viewpoints, and are supported by the growing body of evidence on policy effectiveness.

Our concern is that, in recent years, there are few signs that the CND and its host, the UNODC, are making serious attempts to come to a better understanding of the evidence, and a balanced compromise on the issues raised: Most energy is expended on trying to claim success for existing policies; debates at the CND have consisted of simple re-statements of commitment to existing approaches; and no programme involving the review of evidence and options has been commissioned. This falls short of a responsible approach to policymaking from a body ‘concerned with the health and welfare of mankind’ (1961 Single Convention on Narcotic Drugs), in the light of a clear lack of progress in the last 40 years. This ‘impasse’ in the consideration of drug control policies is leading to significant inconsistencies in the statements emerging from the CND and:

- The positions of other UN agencies (WHO, UNDP, UNAIDS), and;
- The developing practice and policy in a growing number of Member States.

The preparations for the 2005 Commission indicate that these dynamics will once again dominate proceedings. There are two major issues under dispute:

HIV PREVENTION – HIV transmission through injecting drug use represents a serious public health threat in many parts of the world. When first identified in the 1980s, the areas most affected were Western Europe and North America. Experience in these regions, and those more recently affected (such as South East Asia and the former Soviet Union), presents clear lessons to policymakers:

- Where governments respond to an emerging injection-related epidemic with attempts to stifle the drug market, involving strong action against users and dealers, the progression of the epidemic is not reduced, as drug injectors continue to gain access to their drug of choice, and to inject in ever more risky conditions.¹
- However, where governments have responded quickly with programmes that inform drug injectors of the risks of infection, provide them with practical help (for example, free access to clean syringes) to avoid those risks, and provide easy access to drug treatment and general health services that do not require abstinence (a series of activities that have come to be collectively known as Harm Reduction), then significant reductions in rates of infection have been achieved, with the obvious consequential benefits of thousands of lives saved, and billions of dollars of healthcare expenditure avoided.²

Despite this clear evidence of public health benefit (acknowledged by the World Health Organisation, UNAIDS and UNODC in a joint position paper produced in 2004, *Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission*), there remains strong resistance in the UNODC, and at the CND, to the introduction of these measures in countries and regions that are now facing injecting-related HIV epidemics. Attempts to introduce resolutions in previous years that acknowledge the importance of public health responses, and promote their implementation in stricken areas, have been vetoed or reworded so as to be of little impact. Conversely, resolutions that call on member states to continue and strengthen the ‘zero-tolerance’ approach (that has clearly failed to impact on HIV epidemics) are routinely passed unopposed. Furthermore, there are signs that this position may be hardening, with the USA in particular

exerting pressure on the UNODC Executive Director, Antonio Costa, to maintain a clear position against Harm Reduction measures. If this is what happens in 2005, it will leave the UNODC clearly out of step on this issue with the rest of the UN system, and will discourage those governments (in Eastern Europe, Asia and South America) who are currently considering their responses to existing or potential epidemics, from introducing the very measures that are most likely to protect their citizens. This is not therefore only political posturing -the effects of this official discouragement can be seen in places like Russia, the Ukraine and Thailand, where the governments have consistently failed to introduce widespread public health measures for drug injectors, referring to the statements coming from Vienna as one of their justifications. These countries are, unsurprisingly, therefore experiencing the most widespread injecting-related epidemics. We consider it unacceptable, and perhaps unique, that a UN body is actively discouraging the implementation of policies and programmes that are proven to protect the health and lives of thousands of people.³ On the contrary, the CND and UNODC should be encouraging, by their statements and through practical support, the implementation of effective infection control measures in the member states most at risk of future epidemics.

AFGHANISTAN – In the last 15 years, Afghanistan has developed into the world's major source of Opium, from which Heroin is derived. By the year 2000, it was estimated that Heroin sourced from Afghanistan accounted for up to 90% of the entire European market, and the Opium economy within this war-ravaged country accounted for an estimated 60% of its entire Gross Domestic Product. Since then, the pattern of cultivation has undergone a series of upheavals:

- The amount cultivated plummeted in late 2000/early 2001 in response to a fatwa issued by the Taliban authorities, that banned Opium cultivation under the then strictly (and brutally) enforced sharia laws.
- These reductions in cultivation were quickly reversed in 2002 and 2003 after the country was invaded by Western forces, and the interim government of Hamid Karzai took power. Cultivation returned to pre-fatwa levels, despite the commitment and resources of the Karzai government, supported by a UK-led international coalition of partners dedicated to the eradication of opium cultivation within 5 years.
- These high levels of production have been maintained through 2004, leaving some partners to call for a much stronger forced eradication effort (along the lines pursued by the USA against Coca cultivation in Colombia) to replace the negotiation-based approach that has been favoured in Afghanistan so far.

We suggest that, learning from the experience of Afghanistan over the last few years, and the evidence from other attempts to suppress supply at the point of cultivation, there are the following lessons for policymakers:

- That significant reductions in cultivation have only been achieved where the economic and social well-being, and civil and judicial rights, of some of the poorest people in the world are infringed.
- That, even where reductions in cultivation are achieved, they are normally short-lived and, despite the best efforts of the international community, are not possible to maintain.
- That, even where cultivation of a particular substance is temporarily suppressed in one area, there is no resulting shortage further down the supply chain, as cultivation in other areas, or warehoused stocks, are used as replacements. (Throughout the upheavals in cultivation and price of Opium in Afghanistan, availability and price in Europe remained relatively stable).
- That the primary objective of stifling supply and raising prices in consumer markets, with a consequent reduction in use, has never been achieved. Cannabis, Heroin and Cocaine have been supplied at levels and prices that have remained essentially unchanged by supply reduction efforts throughout the 40 years of the current global control system.

Once again, despite the overwhelming evidence suggesting that aggressive action in source countries in general, and forced eradication in particular, are ineffective in reducing the scale of drug markets (and imposes severe hardship on the poorest people in those countries), this approach continues to receive strong political and financial support through the UN system. We have to ask the question why, when such approaches have never worked

before, and divert attention and resources from the need to develop legitimate forms of economic activity in these countries, they continue to be promoted as the solution to the global drug problem? Surely the CND should be an opportunity for member states to discuss the effectiveness of efforts to undermine the illicit drug market, and search for solutions that are consistent with international development objectives. At the very least, a commitment should be made to action in Afghanistan that is realistic in its aims, and prioritises the welfare and civil rights of the citizens of that country.

The CND, as a properly constituted gathering of governments under the auspices of the United Nations, is clearly the appropriate highest-level forum for debates regarding the future of the global drug control system. Decisions made, and positions taken, by governments on these issues have resounding and long-term impacts on the lives of millions of citizens. It is therefore of crucial importance that these discussions are characterised by an objective search for the most effective solutions to drug-related problems, based on a serious review of the available evidence. Too often in the past, decisions in the CND, and on the work programme of the UNODC, have resulted purely from political and financial pressure, not evidence and reasoned argument. We hope that this will start to change with the 2005 meeting, and make the following recommendations for how delegates can promote more evidence-based conclusions.

RECOMMENDATIONS

1. That government delegates to the CND who have had positive experience of implementing harm reduction activities in their countries, or are aware of the evaluation evidence, should ensure that any statements and resolutions on this subject are consistent with this evidence and experience.
2. That the relevant UN agencies (UNODC, WHO, UNAIDS) make a clear and consistent statement of support for proven public health interventions, and step up their support to countries facing drug related HIV epidemics, including the promotion of appropriate harm reduction measures.
3. That the issue of donor dependency of the UNODC should be discussed at the CND. It is not appropriate that the policy positions of a UN agency are determined by pressure from one or two major donors.
4. That any statement on the situation in Afghanistan should make it clear that the CND does not support forced eradication methods, and that development aid to Afghanistan should not be conditional on prior elimination of drug crop cultivation.
5. That these, and other, dilemmas of drug policy should be reviewed under a comprehensive and objective evaluation of the 1998 UNGASS goals and action plans. The methodology and timeline for such a review should be discussed at the 2005 CND.

¹ For example Thailand, China, Russia and Ukraine. *Thailand- Not enough graves: The war on drugs, HIV/AIDS, and violations of human right*, Human Rights Watch, June 2004, Vol. 16, No. 8 (C), Daniel Wolfe, "Condemned to Death: Thanks to the US-Led Drug War, AIDS is Exploding among Injection Drug Users, *The Nation*, April 26 2004, *Locked Doors: The Human Rights of People Living With HIV/AIDS in China*, Human Rights Watch, September 2003, Vol. 15, No. 7 (C), Axel Klein, Marcus Roberts and Mike Trace, "Drug Policy and the HIV Pandemic in Russia and Ukraine," *The Beckley Foundation Drug Policy Programme/Drugscope Briefing Paper Number 2*.

² For example Australia, New Zealand, Canada and many European states. Daniel Wolfe and Kasia Malinowska-Sempruch, *Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches*, International Harm Reduction Development (IHRD) Open Society Institute (OSI), New York, 2004, Neil Hunt et al *A Review of the Evidence Base for harm reduction approaches to drug use*, *Forward Thinking On Drugs*, 2003, Ethan A. Nadelmann, "Commonsense Drug Policy," *Foreign Affairs*, January/February 1998, Vol. 77, No. 1.

³ As research demonstrates, while epidemics among intravenous drug users have been successfully contained through measures such as the provision of sterile injection equipment, early intervention is critical: once prevalence exceeds 5 to 10 percent among intravenous drug users, HIV infection rates frequently climb as high as 50 percent in less than five years. Tim Rhodes, Gerry V. Stimson et al, 1999, "Drug Injecting, rapid HIV spread, and the 'risk environment': Implications for assessment and response." *AIDS 13 Suppl A: S259-69*