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Rewriting history

A response to the 2008 World Drug Report

The world today is not any closer to achieving the ten-year targets set by the 1998 UN General Assembly Special Session (UNGASS) on drugs. These goals were "eliminating or significantly reducing the illicit cultivation of coca bush, the cannabis plant and the opium poppy by the year 2008." Instead global production of opiates and cocaine has significantly increased over the last ten years. According to the United Nations Office on Drugs and Crime (UNODC) global illicit opium production doubled from 4,346 tons in 1998 to 8,800 tons in 2007. This is mainly due to the massive increase in opium production in Afghanistan. The estimated global cocaine production increased from 825 tons in 1998 to 994 tons in 2007, an increase of 20%.[1]

Ten years of failure

In the past decade international drug control emphasised eradication of illicit crops, before having alternative livelihoods in place. Hundreds of thousands of peasants have been condemned to poverty and robbed of a life in dignity. In several key producing countries, crop eradication has aggravated violent conflict rather than contributing to conflict resolution.

By 2007 Afghanistan was producing some 8,200 tons of opium, or 93% of global production. These record production levels have led to more aggressive forced eradication of opium crops. Apart from causing immense suffering to local communities, these campaigns have significantly contributed to the growing insecurity in the country.

In Colombia, ten years of indiscriminate aerial spraying of coca crops have failed to reduce coca cultivation, while creating a vicious circle of

1. *Afghanistan: Opium Survey 2007*, UNODC, October 2007, p. 12; *Coca cultivation in the Andean Region: A survey of Bolivia, Colombia and Peru*, UNODC, June 2008, p. 17

KEY POINTS

- The 1998 UNGASS targets of reducing opium and coca cultivation have not been met. In the last ten years global opium production doubled and cocaine production increased with 20%.
- The WDR uses twisted logic to fabricate comparisons with higher opium production a century ago, and the figures used in the report are controversial.
- China did not have 'tens of millions of opium addicts'. Opium use in China was mostly moderate and relatively non-problematic, often for medical use.
- Early international drug control agreements helped to reduce legal production and trade; the current UN conventions have not curbed the illicit market.
- It is a mystery how a comparison between 1000 tonnes of cocaine produced now for an illicit market and the 15 tonnes licitly produced before cocaine was under international control can be presented as a success.
- The zero-tolerance punitive framework that replaced the early regulatory model resulted in the unintended consequences mentioned in the WDR.
- The prohibition regime has led to limited availability of essential medicines.
- The current approach to drug control has failed. Instead of unrealistic targets, there is a need for a more rational, pragmatic and humane approach.
- The WDR proposals to make the system 'fit for purpose' by a focus on crime prevention, harm reduction and human rights are welcome, but require the undoing of the punitive nature of the treaties.

Ten years of failure

(according to the WDR)

Cocaine

1998	2007	INCREASE
825 mts	994 mts	20 %

Opium

1998	2007	INCREASE
4,346 mts	8,800 mts	102 %

The last 10 years have seen:

- Too many people in prison, and too few in health services
- Too much resources for repressing drugs, too little for prevention, treatment, rehabilitation and harm reduction
- Too much emphasis on destruction of the illicit crops, too little resources for development of peasant farmers
- Too much emphasis on punishing drug users and producers, too little emphasis on human rights

human, social and environmental damage, displacement, human right violations and fuelled the decades-old civil conflict in the country.

Opium production in the Golden Triangle (Burma, Thailand and Laos) – once the world's largest producer - has indeed declined from 1.435 metric tons in 1998 to 472 metric tons in 2007, or 5% of global production. Those who are paying the price for this trend are the opium farmers, who need the income from opium to buy food and medicines.

Rewriting history

These changes in production levels are not particular brilliant indicators for progress in drug control over the last ten years. Instead, there is overwhelming evidence that the current approach to drug control has failed. In an attempt to at least claim some success, UNODC decided in the 2008 World Drug Report (WDR) to go back 100 years into history.

The report concluded "the international drug control system … has succeeded in containing the illicit drug problem across the span of a whole century, as well as over the last decade." The international drug control system, the report says, is "rooted in efforts made a century ago to address the largest substance abuse problem the world has ever faced: the Chinese opium epidemic." It argues that "tens of millions Chinese [were] addicted to opium." The report further argued that "China's attempts to unilaterally address the problem failed, and it was not until the first international agreements were reached that a solution became possible."

Twisted logic is used to fabricate comparisons with higher production a century ago. The report is not only out of touch with reality but is also re-writing history. In the 2006 WDR, UNODC attempted a similar strategy. At the time TNI concluded that the UNODC was trying to find an escape route to compensate for the lack of progress over the ten-year UNGASS period. [2]

In trying to build its case, the UNODC resorts to selectively quoting from a limited amount of sources. It falls back on outdated assumptions based on myths that have been challenged by various sources, repeating them uncritically in order to legitimise the current international drug control system. Views that contradict their findings are conveniently omitted. Much of the information about China was tendentious from the start, as missionary and philanthropic organisations tried to mobilize public opinion against opium and exert political leverage against the trade.[3] The WDR still suffers from that wilful blindness.

A culture of smoking

China has often been portrayed as a passive victim of the economic interests of the colonial powers that forced the country to open itself up for the opium trade, resulting in millions of opium addicts, who were depicted as "lank and shrivelled limbs, tottering gait, swallow visage, feeble voice, and death-boding glance of eye"[4]. The notion of a nation addicted to and poisoned by opium is not supported by evidence. Claims that China was "once a country where perhaps one in four men was a drug addict", as made by

2. *International drug control: 100 years of success? TNI comments on the UNODC World Drug Report 2006*, TNI Drug Policy Briefing nr. 18, June 2006 at http://www.tni.org/policybriefings/brief18.pdf

3. R.K. Newman, 'Opium Smoking in Late Imperial China: A Reconsideration', *Modern Asian Studies*, Vol.29, No.4, October 1995, p. 766.

4. Newman (1995), p. 766.

Options for change

A series of principles have emerged to guide policy changes in the right direction:

Evidence-based. The changes should be based on a thorough evaluation of policies, instead of being based on ideological principles. There are already many studies available indicating policy directions which work and those which do not work, constituting a body of knowledge that should be taken into account.

Differentiation. It is necessary to differentiate between substances and patterns of use. The health risks of cannabis consumption are not the same as those related to injecting heroin or smoking crack cocaine. There is also a significant distinction between natural plants and their concentrated derivatives; coca in its natural form can be beneficial for health, while the consumption of its alkaloid cocaine in concentrated form can lead to problems. And there is a substantial difference between recreational uses and more problematic patterns of drug use.

Harm reduction. A world without drugs will never exist. The ideology of 'zero tolerance' needs to be replaced by the principle of harm reduction, which offers a more pragmatic approach that favours policies capable of reducing drug-related harms as far as possible, for the consumer and for society in general. Conceptually, this principle needs to be expanded to the spheres of reducing drug-related violence and reducing the fuelling impact of the existence of illicit economies on armed conflicts.

Flexibility. Socio-cultural differences need to be taken into account. The current system has been overly influenced by 'Northern' interests and cultural insensitivity. The norms that are established at a global level should leave sufficient room for manoeuvre, enabling countries to adjust them to basic principles of national law, or to protect the rights of indigenous people to continue their traditional practices and customs.

Human rights and proportionality. Drug control should fully respect human rights, which means first and foremost that any sanctions should be in proportion to the crime. Punishing users for the mere fact of consumption, forced eradication against farmers who have no other form of income, heavy prison sentences against small traders, or issuing the death penalty for drug offences are all examples of disproportionality.

Development-oriented. Eradicating poverty and hunger, the number one Millennium Goal, has a clear priority. Drug control efforts should never lead to more poverty and hunger, as now often happens with the opium bans and forced eradication. The creation of alternative livelihoods should come first.

Civil society participation. When formulating policies on drugs, there should be full participation by all the main players: farmers, users, health care practitioners, and local and international NGOs working closely with them. This is the only way to ensure that policies will work, are rooted in practice and can have influence on the often difficult choices people face.

the 2008 *World Drug Report*, belong to the realm of fantasy.

Instead, studies show that most of opium smokers used only moderate amounts and were able to regulate both the quality and quantity they used. There were (and continue to be) many smokers using only limited amounts and on certain occasions only, who were able to control their use, including reducing or stopping it if needed. There were also different qualities of opium, and different strengths. Sweeping statements about massive opium addiction problems in China are a myth.[5]

Furthermore, traditionally opium smoking in China has been a ritual, performed with social functions, often consumed in teahouses rather than in dark and dirty opium dens, offered at home as welcome gesture to visitors, or at colourful festivals and rich traditional ceremonies. Opium dens were generally speaking also not depressing and secret places, but often clean houses where customers also consumed tea, and various kind of food, reflecting a multifaceted culture of smoking.[6]

5. Frank Dikötter, *'Patient Zero': China and the Myth of the 'Opium Plague'*, Inaugural Lecture, School of Oriental and African Studies, University of London, 24 October 2003.

6. Frank Dikötter, Lars Laamann and Zhou Xun, *Narcotic Culture: A History of Drugs in China*, The University of Chicago Press, Chicago 2004, pp. 65-68.

There is no medical evidence that opium use had any significant negative consequences of health and longevity on the majority of the users.[7] It is undeniably true that opium use did produce addicts, and that some of these were problematic users. It is important to realise though that these also included many patients who started using opium as painkiller for mortal and chronic illnesses. They would nowadays have access to other medication, including opioids.

What is striking, however, is that the majority of the opium consumers in China were non-problematic and moderate users. "The production and consumption of opium were, for most people, normal rather than deviant activities," concludes an article on opium use in late imperial China. "It is not the existence of addiction that requires explanation so much as the fact that, in a society in which opium was cheap and widely available, so many people smoked lightly or not at all." [8]

TNI research in China found that this kind of non-problematic opium use continues until today, for instance among jade traders concluding a deal along the China-Burma border, or at weddings and funerals among the various ethnic minorities in Yunnan province.

Opium: medicines for the people

Probably the most significant flaw in the report is the assumption that all opium production served an addict opium-smoking population. Instead of being a major health hazard in China, opium has been consumed in the region for centuries for medical purposes. In the absence of affordable analgesics for common people opium was often used as a pain killer and also as household remedy for all kinds of familiar ailments such as diarrhoea, dysentery, cough relief, bronchitis, asthma, and against symptoms of cholera, malaria, and tuberculosis. It also helped to overcome tiredness, hunger, and cold. "In a climate marked by frequent and sometimes lethal dysentery, no remedy was more effective than opium."[9]

It is therefore not surprising that several sources indicate many people started using opium as self-medication, especially as a painkiller. Almost all the evidence given to the Royal Commission on Opium in London in 1893 concluded "the relief of pain and sickness was a major reason why people took up smoking."[10]

These findings are supported by contemporary studies from other countries. The Japanese report to the International Opium Commission in Shanghai in 1909 found that no fewer then 93% of the opium smokers in Formosa (now Taiwan – then under Japanese control) first used opium as a medicine.[11] A study on detoxification in Java in 1930 concluded that 80% of the opium smokers had started to use it for medicinal reasons. The study further argued against prohibiting of opium use because the lack of availability of other painkillers.[12]

The current drug control system has restricted cultivation of a crop with great medical value, in a region where many rural communities that have traditionally cultivated the crop still have no or not enough access to medicines.

How reliable are the numbers?

The WDR claims "a clear net improvement with regard to the most dangerous class of drugs: the opiates."[13] The report mentions a record opium production of 41,600 metric tons in 1906/07, almost five times more than the global illicit opium production a century later.[14] China was the main producer with 35,290 metric tons. Looking at licit and illicit opium production combined, the amount went to approximately 12,600 metric tons in 2007. Global licit and illicit opium production declined by 78 per cent, the WDR concludes.

It than embarks on some dubious speculative arithmetic to maximize the alleged decline in opium production. Considering that the global population quadrupled – from 1.7 billion to 6.7 billion – "this is even more impressive," the report continues. "While global production of opiates, expressed in opium equivalents, amounted to on average 24.5 grams per capita per year in 1906/07, it declined to 7.5 grams in 1934 and less than 1.9 grams by 2007. Thus data indicate that the harm related to abuse of opiates – which is still substantial – could have been some 13 times larger if the per capita production

7. Dikötter (2003), p. 3.

8. Newman (1995), p. 794.

9. Dikötter, Laamann and Xun (2004), p. 206.

10. Newman (1995), p. 776.

11. 'The International Opium Commission', *The British Medical Journal*, January 8, 1910, p. 93 at http://www.pubmed central.nih.gov/articlerender .fcgi?artid=2330532

12. Dikötter (2003), p. 14.

13. World Drug Report 2008, p. 235

14. World Drug Report 2008, p. 202

levels of the peak year of 1906/07 had been maintained over the subsequent century."

The number crunching might look impressive, but closer scrutiny reveals that it is based on a misrepresentation of the figures and on comparing apples with pears. A lot of opium was used for medicinal purposes, which are treated now by other medications. In order to compare production and consumption figures a century apart one should take into account that a lot of the use in the past is now replaced with other regular medicines and remedies to treat these diseases, such as antibiotics as well as synthetic opioids and other lighter painkillers, the so-called antipyretic analgesics including paracetamol, aspirin and ibuprofen. According to the Aspirin Foundation approximately 35,000 metric tonnes are produced annually.[15]

Another question is how reliable the 1906/07 production figures are. They were based on a report of the Chinese delegation to the International Opium Commission (IOC) in Shanghai in 1909.[16] These estimates were already challenged at the IOC itself. "The statistics in this report are of very little value," according to an article in the British Medical Journal (BMJ), of January 8, 1910, about the report of the Chinese delegation.[17] "They were challenged by the British delegates, with the result that the Chinese delegation has represented to the Government the necessity of obtaining more reliable data. The figures dealing with the growth of the poppy and the consumption of opium are, as a rule, nothing more than rough estimates or mere expressions of opinion."

The production rapidly declined to 22,200 metric tons in 1908, and to 4,000 metric tons in 1911, when the eradication campaigns due to the anti-opium edict issued by the Qing government in 1906 – mandating the cessation of poppy cultivation over a ten-year period and requiring licenses for smokers – began to have an impact. However, other sources quote a production of 16,300 metric tons in 1904,[18] well below the peak in 1906/07 and the 1908 figures. Apparently, production fluctuated and the 1906/07 number seems to be exceptionally high.[23]

On the other hand the figures of 2007 seem to be too low. According to the International Narcotics Control Board (INCB) and the World Health Organisation (WHO) there is now an unmet demand in opiates. Ironically, the current drug control regulations hamper access to controlled opiate medications for therapeutic use. Many patients are unable to access morphine, methadone or an equivalent opioid. Global medical morphine consumption would rise five times if countries would make morphine available at the

Lack of medical access to controlled substances

The prohibitive focus of the UN drug conventions has severely hampered medical access to opioid analgesics around the world. In fact intense under-treatment is reported in over 150 industrialized and developing countries, equaling 80% of the global population.[19] In 2003 the INCB reported that six countries together accounted for 79 per cent of the global consumption of morphine.[20]

The WHO estimates that "annually, up to 10 million people suffer from lack of access to controlled medications. Nearly 1 billion of those living today will encounter this problem sooner or later."[21]

Following the resolutions adopted in 2005 by the World Health Assembly and ECOSOC,[22] the WHO has, in consultation with the INCB, set up the Access to Controlled Medications Programme to improve the access to opioid analgesics.

15. The Aspirin Foundation, at http://www.aspirin-foundation.com/

16. World Drug Report 2008, p. 198

17. International Opium Commission, op. cit.

18. Timothy Brook and Bob T. Wakabayashi (eds), *Opium Regimes: China, Britain, and Japan 1839-1952*, Berkely: University of California Press 2000, p. 215

19. *Access to analgesics and to other controlled medications*, WHO website at http://www.who.int/medicines/areas/quality_safety/access_Contr_Med/en/index.html Accessed 24 June 2008

20. Report of the International Narcotics Control Board for 2004 (E/INCB/2004/1), paragraph 143

21. *Access to analgesics and to other controlled medications*, op. cit.

22. *Cancer prevention and control*, World Health Assembly resolution (WHA 58.22 and ECOSOC 2005/25, 25 May 2005.

23. Newman seems to accept the 1906/07 figures: "whatever their shortcomings, the estimates of the Chinese could not easily be condemned as underestimates." He does not give an explanation for the much lower figures just before and after 1906/07 though. Newman (1995), p. 774

level of the calculated need, according to a recent WHO estimate.

The WDR fails to sound any note of caution about the ambiguity of its estimates. Over-exaggeration of the height and nature of production a hundred years ago, combined with a denial of unmet demand for opiates and substitution with other medicines nowadays, render its calculations invalid and useless.

Still, there can be no doubt that world opium production then was higher than it is now. This '100-year success' story, however, cannot be attributed to the multilateral drug control regime. It was primarily related to specific developments in China, and to new pharmaceutical products replacing the medicinal use of opium.

Reasons for the decline in China

Initial attempts by the Chinese state to control opium were all hampered by the political instability of the country. This instability – which among others resulted in poverty and population displacement – was also a stimulus for opium cultivation and consumption. It is also important to keep in mind that opium cultivation in China took place in different regions for different reasons. The decisive decline of opium consumption and cultivation took place after the World War II.

After the Chinese Communists won the civil war, they started a massive campaign against opium during 1949-1952. The campaign was very much motivated by the communists' state-building efforts, in what they call the period of 'consolidation and reconstruction'. This policy also included land reform, and a campaign against the USA and Korea, and counter-revolutionaries.

The campaign by the new communist government was clearly linked to the construction of a new national identity. "In this process several contrasts were carefully elaborated: the Old China versus the New; the Nationalists versus the Communists; the imperialists versus the Chinese people. By proving that they could do what other regimes could not, the Communists enhanced the legitimacy of their rule." [24]

This policy was not part of any international drug control agreements. In fact it was not until 1971 that the Communist China, now called People's Republic of China (PRC), first occupied China's seat in the United Nations, and became member of the UN Security Council. Until that time China was represented by the Republic of China based in Taiwan, which claimed to be the sole legitimate government of the country. The PRC only acceded to the 1961 and 1971 Conventions in August 1985. These were the first international drug control treaties that the PRC signed.

It is important to realise that the decline in opium use in China was not just a result of the anti-drug crusade by the Chinese Communist Party. There were a number of key changes at the demand side that fundamentally changed opium use in China.

First of all the availability of other medicines, such as penicillin, which was discovered in 1928, and which became available as anti-biotic in China following World War II. Penicillin was able to treat various diseases that previously were treated with opiates.

Furthermore, opium use became less popular in China, and was beginning to be seen as 'old fashioned'. What took place was a major cultural transformation where people changed from smoking opium to smoking cigarettes, which were seen as modern and fashionable. "Opium was decadent. Opium was for grandfathers."[25]

The communist government heavily stimulated both tobacco use and cultivation, and the culture of smoking cigarettes replaced the social and traditional roles of smoking opium. According to a 1998 joint British-Chinese-American research project, daily average cigarette consumption in China increased from one cigarette in 1952 to 10 in 1992. [26]

"Opium should thus be understood as part of a much wider culture of intoxication based on the inhalation of smoke: as Europe took to alcoholic and caffeinated drinks from the sixteenth century onwards, China developed a sophisticated smoking culture, starting with tobacco in the 17th century, followed by madak [opium mixed with other substances including tobacco for smoking] in the eighteenth, opium in the nineteenth and cigarettes in the twentieth."[27]

The fact that so many opium smokers were moderate, light and occasional consumers also explains why many of them could have given it

24. Brook and Wakabayashi (2000), p. 397.

25. Dikötter, Laamann and Xun (2004), p.209.

26. *China's cigarette threat*, BBC News, 19 November 1998, website, http://news.bbc.co.uk/1/hi/health/216998.stm

27. Dikötter (2003), pp. 21-23.

Coca and cocaine: a mysterious success story

The historical development of cocaine control receives very little attention and precision in the section on a century of international drug control in this year's WDR. Its appearance on the world stage as a problem is described without taking into account a number of important facts, just as the report does around opium. Also, the report speaks of coca cultivation and cocaine production as if they represent the same scale, without distinguishing at all between uses of the plant in its natural form and its alkaloid derivative.

Finely knit through the report with its historical focus on opium control, coca suddenly appears at the end of the 19th century, when 'recreational and medical use gained popularity'. The regulation of the licit market has proved to be effective in "containing the coca cultivation to just three countries in the world" according to the report, which supposedly confirms the usefulness of the drugs control apparatus. The only other country ever cultivating coca on a large scale was the colonial Dutch empire in Java. The fact that the Netherlands had to stop growing coca for cocaine production was at first contested, but may be a logical consequence of the prominent role the country played in the early treaty process around opium.

Coca had been grown and harmlessly consumed in the Andean region for centuries long before its cocaine content was isolated and discovered as meaningful, causing a major revolution in surgery for its local anaesthetic properties. Its medical use was later replaced by other chemically produced anaesthetics, which explains the demise of its share on the licit market much more than the existence of a 'growing recognition of the problematic usage of cocaine'. Cocaine was further used at some point to counter morphine addiction and prescribed by some psychoanalysts as a treatment for sexual disorders.

The fact that the 'westernised' use of the coca leaf was not primarily meant to produce cocaine is conveniently left out. A large share of coca leaf produced at the turn of the century was, apart from the traditional indigenous chewing in the Andes, destined for a growing market of a great variety of products, with the *Vin Mariani* leading the way. An ever-growing market of products using the coca leaf for drinks and tonics followed the famous wine produced by this Frenchman, which was subsequently demonised and prohibited for the minimal amount of cocaine contained in it, not because of problematic use.

According to the recently published figures of coca cultivation in the Andean region, production levels in 2007 were 16% higher – and cocaine production was 20% higher – than it had been in 1998. The comparison between the 994 tonnes of cocaine estimated by UNODC to have been produced in 2007 for an illicit market, and the 15 tonnes licitly produced in 1903 before the international drug control system started to function and cocaine was prohibited, cannot feasibly be interpreted as an example of drug control success.

up easily when it became unfashionable or illegal.[28]

Unintended consequences

Another impact of the clampdown on opium use and trade was the shift by consumers to using heroin and morphine, either by smoking, snorting or injecting, and in conditions much more harmful than the previous opium use. For instance, when the British colonial authorities in Hong Kong were under American pressure to stop the opium trade and put an end to the state monopolies, most heavy opium smokers were reported to have resorted to using heroin within less then ten years.[29]

Even before the first International Opium Convention in 1912, there were clear warning signals for such unintended consequences. In 1910, the British Medical Journal noted that when the anti-opium edicts were issued in China in 1906, a large number of smokers took to taking anti-opium pills (all containing opium or morphine) or hypodermic injections of morphine. The Journal noted about the anti-opium pills: "it is generally recognized that the pill habit is worse than the smoking habit." Injecting morphine to substitute smoking was on the rise and the Journal said smokers "intimidated and hampered by official restrictions, have only substituted one vice for another."[30]

"If opium was medicine as much as recreation", concludes a study on narcotics culture in China,

28. Newman (1995), p. 790.
29. Dikötter, Laamann and Xun (2004), p.207.
30. International Opium Commission, op. cit.

"this book provides plentiful evidence that the transition from a tolerated opium culture to a system of prohibition produced a cure which was far worse than the diseases. Ordinary people were imprisoned and died from epidemics in crowded cells while those deemed beyond any hope of redemption were simply executed."[31]

The radical approach taken in China still continues to this day, with high incarceration rates and the death penalty, contradicting basic human right principles.

The policies to reduce opium in China also stimulated corruption, created a black market, and a criminal circuit (underclass). The lessons of the unintended consequences of drug control polices that started a century ago are still very much relevant today. "Prohibition spawned social exclusion and human misery, and encouraged – however inadvertently – the very problems it was designed to contain."[32] As a study on the impact of the illegal drug trade concludes: "A realisation must develop that supply suppression will not solve consumption problems."[33]

Evolution of international control

Another questionable assumption in the WDR is the supposed influence of international drug control agreements on the early national opium suppression efforts in China and on the 'containment' achieved since worldwide. Drug policy has gone through several stages in the past century since in February 1909 in Shanghai the International Opium Commission brought together twelve countries to discuss for the first time options for international controls on the opium trade. The WDR chapter contains a detailed and useful description of the evolution of the international drug control system but fails to specify that most countries were reluctant to embrace the prohibitive philosophy that the US and on certain moments China tried to internationalise.

The first Hague Convention (1912) and the treaties negotiated in the League of Nations era were more of a regulatory than a prohibitive nature, aimed to tame the excesses of an unregulated free trade regime. For example, restrictions were imposed on exports to those countries where national laws had been introduced against non-medical use of opiates, but there were no treaty obligations to declare drug use or cultivation illegal let alone to apply criminal sanctions against it. The series of conventions was rather a set of administrative regulations on import/export of opiates, cocaine and – since 1925 – cannabis, without criminalization of the substances, their users or producers. The United States and China both walked out of the negotiations that led to the 1925 International Opium Convention, because in their view it did not impose sufficiently restrictive measures.

In fact, the early drug control instruments were not dissimilar to the international agreements discussed in the same period on alcohol that emerged in the context of discussions about its prohibition in some countries. "Proposals for government alcohol monopolies were the first expression of a self-conscious 'alcohol control' strategy, where governments took on the task of managing the alcohol market to limit the damages from drinking."[34] Several opium monopolies indeed reduced legal production of opiates under the influence of these agreements.

The 1936 Convention was, as the WDR states, "the first to make certain drug offences international crimes" but was only signed by 13 countries and it only came into effect when WW-II had already started and "drug control was certainly not top priority for most countries". It was only under the United Nations system after WW-II that the necessary political atmosphere was created for the globalisation of the prohibitive anti-drug ideals.

The 1961 UN Single Convention on Narcotic Drugs unified and replaced the different multilateral instruments negotiated throughout the previous half century. It limited exclusively to medical and scientific purposes the use of a variety of psychoactive substances and to gradually eliminate non-medical use of opium over a 15-year period, and coca and cannabis within 25 years. The treaty was heavily biased to suppress plant-based drugs originating at the time largely from the developing countries. "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," according

31 Dikötter, Laamann and Xun (2004), p.207.

32 Dikötter, Laamann and Xun (2004), p.207.

33. LaMond Tullis, *Unintended Consequences; Illegal Drugs & Drug Policies in Nine Countries, Studies on the Impact of the Illegal Drug Trade, Volume Four*, Lynne Rienner, Boulder and London 1995, p. 205.

34. *Alcohol Monopolies and Alcohol Control,* Robin Room, Alcohol Research Group, Medical Research Institute of San Francisco, 1999.

to the former head of the WHO Section on Addiction Producing Drugs.[35]

The 1971 Convention on Psychotropic Substances was developed in response to the diversification of drug use, introducing controls on the use of amphetamines, barbiturates, benzodiazepines and psychedelics. The 1961 and 1971 Conventions together constitute the zero-tolerant backbone of the global legal drug control straitjacket established under the United Nations under heavy US influence.[36] Meanwhile, post-war communist China intensified opium suppression efforts domestically but was no part of the UN drug control treaty system until 1985.

The 1980s marked the start of the real militarised 'war on drugs' and the end of the exemption schemes agreed to in the 1961 Convention to phase out non-medical coca, opium and cannabis uses. The 1988 UN Convention Against Illicit Traffic was negotiated in this context and significantly reinforced the obligation of countries to apply criminal sanctions to control all the aspects of production, possession and trafficking of illicit drugs. The treaty symbolizes the multilateral underpinning of a more aggressive attack against all aspects of the drug trade. Drug laws and sanctions were tightened across the globe and prisons started to fill up rapidly.

UNGASS

Ten years after the third convention was adopted, the international community gathered in New York for the 1998 UNGASS on drugs. The search for a consensus proved no easy task, owing to the many divisions that existed. On the one hand, there were those who said – in relation to the 1988 treaty – that "*the convention is an instrument with teeth and now we should make it bite*", in other words, those who wanted to dedicate UNGASS to further reinforcing the worldwide system of control. On the other hand, particularly in some Latin American countries, there were those who believed the current regime is biased because it emphasises the producer countries of raw material. This group spoke of the need for a balanced approach under the motto of 'shared responsibility'. More attention should be given to those parts of the market where the responsibility lies with the developed countries. In addition, there was a third group for whom the inability to stop the growing problems, raised the question of the validity of the policies carried out and who advocated for more pragmatic harm reduction strategies which were clearly in dissonance with zero-tolerant ideology.

The 1998 UNGASS also established a new deadline in the Political Declaration – after the failure of the deadlines of the 1961 Convention – to "eliminate or significantly reduce the illicit cultivation of the coca bush, the cannabis plant and the opium poppy by the year 2008". While in the past decade the war on drugs has intensified in the traditional Southern producer countries, the emergence of more pragmatic and less punitive approaches to the drugs issue, under the banners of 'harm reduction', 'decriminalisation' and 'alternative development', also consolidated after the UNGASS. This led to significant cracks in the Vienna consensus marking the beginnings of possible change in the current global drug control regime.

The spread of HIV/AIDS amongst injecting drug users, the overcrowding of prisons, the reluctance in South America to continue being the theatre for military anti-drug operations, and the ineffectiveness of repressive anti-drug efforts to reduce the illicit market, all contributed to eroding global support for the US-style zero-tolerance. The UN Millennium Goals and the two UNGASS meetings on HIV/AIDS in 2001 and 2006 helped to strengthen this drug policy trend in the opposite direction by prioritising poverty alleviation, HIV/AIDS prevention and harm reduction.

Conclusion

Instead of a picture of natural evolution of control and containment over a century as sketched in the WDR, in our view the UN drug control treaty system marked an undesirable shift from a predominantly regulatory model to a zero-tolerance punitive framework, bringing with it all the unintended consequences that the WDR mentions. The regulatory aspects of the early agreements may have helped to bring totally unrestricted legal production and trade under

35. 'Conversation with Hans Halbach', *British Journal of Addiction*, Vol. 87 (6), pp. 851-855, June 1992.
36. David R. Bewley-Taylor, *The United States and International Drug Control, 1909-1997*, Continuum, 2001; J. Sinha, *The History and Development of the Leading International Drug Control Conventions*, Report prepared for the Canadian Senate Special Committee on Illegal Drugs, 2001; William B. McAllister, *Drug Diplomacy in the Twentieth Century: An International History*, Routledge, 2000; Kettil Bruun, Lynn Pan and Ingemar Rexed, *The Gentleman's Club: International Control of Drugs and Alcohol*, University of Chicago Press, 1975.

control and to reduce some of its negative consequences. However, the three currently existing conventions have pushed restrictions and sanctions too far, have lowered access to essential medicines under their control to irresponsible levels, and can definitely not claim to have curbed the illicit market.

There are clear benefits to having an international control system in place, and UNODC has made a most welcome shift towards advocacy for human rights and harm reduction to become key pillars of drug control in the future. However, the way the WDR tries to relate a dubious claim of hundred years of success to the currently prevailing drug control model undermines the urgency for reform. The welcome proposals in the WDR to make the system 'fit for purpose' by focussing on crime prevention, harm reduction and human rights require some fundamental changes in the now universalised criminalizing nature of the system.

As a UK House of Commons report concluded, *"If there is any single lesson from the experience of the last 30 years, it is that policies based wholly or mainly on enforcement are destined to fail."*[37] Instead of setting unrealistic targets, we need to introduce a more rational, pragmatic and humane approach to the global drugs phenomenon. Drug control policies should be based on evidence, fully respect human rights and take a harm reduction approach. Otherwise, we will see another ten years of failure.

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37. House of Commons Home Affairs Committee's Report, *The Government's Drugs Policy: Is it Working?*, London 2002, Paragraph 267.

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