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The Historical Foundations of the Narcotic Drug Control Regime

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Abstract

This paper outlines the institutional history of the international narcotic drug control regime. It details the evolution of the control system, from its foundations at the beginning of the twentieth century – a period of mass, unregulated narcotic drug use – to the current period. The paper argues that the contemporary control model is ill-positioned to address the dynamic and rapidly changing nature of the global narcotics trade. The persistence of anachronistic guiding first principles, specifically the utopian idea of prohibition, is identified as the key impediment to the adoption of a more humane and effective policy approach. But while there is growing pressure for a revision of founding ideas, this is not supported by a host of powerful actors that includes the United States.

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The Historical Foundations of the Narcotic Drug Control Regime

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Introduction

The international system of narcotic drug control is based on a complex series of accords and conventions that are administered by a dedicated drug bureaucracy within the United Nations and national level partner agencies. These lock individual nation states into the universal goal of eradicating the cultivation, production, distribution and consumption of narcotic drugs. The global drug conventions set out a comprehensive strategy for the achievement of a 'drug free world' - an end to which all nation states are obliged to work cooperatively. Underscoring the universal nature of the system, by 2005, 180 states were party to the 1961 Single Convention on Narcotic Drugs, 175 were party to the 1971 Convention on Psychotropic Substances, and 170 states had ratified the 1988 Convention against Illicit Traffic.

The drug control regime is a remarkable model of international collaboration and consensus. The core principle underpinning drug control, that states should step in and act coercively to prevent the use of dangerous substances, is accepted by all national governments regardless of regime type, religion, ideological orientation or level of national development. This cohesion of action and principle owes much to the longevity of the campaign to prohibit narcotic drugs. The drug control system has evolved over a 100-year period and during this time the prohibition model has become institutionalized, consolidated and global.

The foundations of the international quest to eliminate the market for intoxicating substances were laid at a meeting of global powers that was held in Shanghai in 1909 and which was convened by the US. This was the first significant foray by the US on the stage of global diplomacy. Through the anti-drug initiative, the US came to define and shape the drug 'problem' and responses. The position maintained by the U.S. was that the trade in dangerous drugs had to be prohibited. A century later, this remains the end goal of the control regime.

The Shanghai conference was held against the backdrop of global, free and mass markets for substances such as opium, cannabis and cocaine, and derivative opiates such as morphine and heroin. U.S. steps to control and regulate the trade in intoxicating substances was revolutionary given the pervasiveness of 'drug' use and the powerful vested interests in maintaining an unfettered trade. The U.S. initiative also went against a 2,000 year long history of drug cultivation, production, trading and use.

Intoxicating Substances in Historical Context

Drug Use

People have cultivated and ingested naturally occurring intoxicating and hallucinatory substances since the beginning of civilization. The most widely used naturally occurring drugs were opium from the opium poppy (*papaver somniferum*); the flowers, leaves and resin of the cannabis plant (*cannabis sativa*); and the leaves of the coca plant (*erythroxylum*).

There were six main reasons for drug consumption in ancient and modern societies (Inglis 1975). The most significant was pain relief. Ancient Indian and Chinese manuscripts recommended the inhalation or eating of cannabis for a range of diseases such as gout, cholera, tetanus, neuralgia and for pain relief in childbirth. Underscoring the medicinal value of cannabis, the U.S. pharmacopoeia recommended it for the primary treatment of more than 100 illnesses in its publications from 1850 to 1937. Owing to the presence of 46 alkaloids including the analgesics codeine and morphine, opium was also highly valued for medical treatment, beginning with the Persians and Greeks. After Greek traders introduced opium to South Asia, the drug was used in medical practice in India and China, according to records dating from 400 A.D. (Booth 1999; Scott 1969).

The seventeenth century brought the commercialization of medical ‘drug’ use, underscored by the launch of *Sydenham’s Laudanum*, an opium based medication in the UK in the 1680s. Competition among apothecaries and rising demand for self-medication among the new urban working classes in the nineteenth century spurred the opium based patent medicine market, with products such as *Gowan's Pneumonia Cure*, *Godfrey’s Cordial* and *Dr. Moffett's Teethina* sold without prescription or regulation in grocery stores (Berridge 1981; Hodgson 2001).

After the isolation in 1803 of morphine, the analgesic compound in opium, the German pharmaceutical firm E. Merck and Company began commercial manufacture and morphine-based products such as *Winslow’s Soothing Sirup, Children's Comfort, Dr. Seth Arnold's Cough Killer* and *One Day Cough Cure* were launched as a superior form of pain relief. The popularity of morphine was in turn surpassed by diacetylmorphine, which was sold under the brand name Heroin by the German company Bayer. First synthesized from boiling morphine in 1874, it was ten times stronger than morphine and marketed worldwide as a cure for bronchial problems. Indian cultivated cannabis was also commercialized by the burgeoning

pharmaceutical sector with Parke Davis, Squibb, Lilly and Burroughs Welcome engaged in its manufacture and marketing.

After the active constituent of the coca leaf was identified in 1859 and named cocaine, this drug emerged as a popular remedy for a range of physiological and psychological illnesses such as allergies, nasal congestion, nymphomania and morphine dependence and it was recommended by the *British Medical Journal* for anesthesia in eye surgery. Produced and marketed by Merck and the American firm Parke, Davis, cocaine based products such as *Ryno's Hay Fever and Catarrh Remedy* and *Agnew's Powder*, which contained 99 percent and 35 percent pure pharmaceutical cocaine respectively, gained mass markets in the US and Western Europe.

A second driver of drug use was the need for physical stimulation. Coca, cannabis and other natural plant based stimulants such as betel, khat and tobacco were traditionally ingested by indigenous and indentured laborers. In the Andean region of South America, Spanish colonists encouraged the chewing of coca by indigenous workers in the silver mines, as it boosted physical endurance and depressed the appetite. In the second half of the nineteenth century, the commercialization of coca leaves allowed for the development of a new mass market for stimulant tonics such as Vin Mariani, which was first marketed in Europe in 1863 (Streatfeild 2001). Coca based stimulants also found a receptive market in the U.S., where French Wine Coca, a mixture of wine and cocaine manufactured in Atlanta, was marketed as a 'brain-tonic'. It was re-launched in 1886 as Coca-Cola after the alcohol prohibition movement objected to the wine content of the product.

A third factor accounting for the preponderance of 'drugs' was their cultural and spiritual significance in religious, pagan, shamanic and cultural ceremonies across the world. From the Dagga cults of West Africa, indigenous Indian communities in North and South America to Hindu festivals in India, coca leaves, opium, cannabis and hallucinogenic plants such as peyote and psilocybin, were used as religious sacraments and venerated as gifts from nature or the gods (Schultes and Hoffman 1992).

Cannabis, coca and the opium poppy were also cultivated as a food source. Hemp, a member of the *cannabis sativa* family, produces highly nutritious hemp seed and seed oil. It was a staple of rural diets in China, South and Central Asia and the Balkan region for centuries. Hemp was also used for rope, rigging, paper making and textiles. The utility of hemp was first recognized by the Chinese and its cultivation

spread to Central Asia and Europe in the thirteenth century and, following transplantation by the Spanish conquistadors and Pilgrims, into North and South America in the seventeenth century (Herer 1998). This points to a fifth driver of drug cultivation – the use of these plants in early bartering and financial systems, the Spanish for example transformed coca leaves into one of the most highly commercialized products in the Andes by using coca as means of payment.

Relaxation, recreation and experimentation were the final factor accounting for the popularity of drug use. However, in both ancient and modern societies this was the preserve of the elite. The synthetic drug revolution in the second half of the nineteenth century did see an increase in recreational drug experimentation, but this remained confined to bohemian groups, literary and artistic figures and secret societies, who transformed non-medical drug use into a 'social signifier' of rejection of mainstream society values (Keire 1998). The invention of the injecting syringe in 1843 did create new recreational as well as medical markets for cocaine and opiates, the 1890s Sears Roebuck catalogue for example offering a syringe and vial of cocaine for $1.50.

A significant exception to the model of elite recreational use was the Chinese – and broader South East Asian market for opium. Opium consumption in China was common among all social classes and owing to the intensity of demand – and addiction - domestic cultivation had to be reinforced by opium imports from India, Persia and Turkey. Recreational opium smoking was also common among Chinese immigrants scattered across port cities such as London and San Francisco.

The Trade in Drugs

Drug cultivation and use has persisted across time, but there was a dramatic change in patterns of cultivation, production and use during the eighteenth century when opium, and to a lesser extent coca, became commercialized. This was catalyzed by Western efforts to expand their commercial and colonial presence in Asia. A brief assessment of the early opium trade puts into perspective the significance of the U.S. effort to regulate and ultimately eliminate what was one of the most important globally traded commodities in the international market.

Early Portuguese traders were responsible for initiating the 'mass' market for opium. They first discovered opium poppy cultivation and opium production in India after their arrival in the country in 1501. As part of early efforts to enter the Chinese

market, the Portuguese introduced the practice of smoking opium with tobacco shipped from Brazil. The Dutch deepened the Asian opium market through the commercial vehicle the Vereenigde Oost-Indische Compagnie (V.O.C.), which by the 1640s had pushed Portugal out of Indonesia and gained control of the profitable trade in spices and opium. Indicative of the rapid growth of the Dutch controlled opium market after this date, imports of Bengal opium from India into Indonesia increased from 0.6 metric tons (m.t.) in the 1660s to 87 m.t. by 1699. The V.O.C. realized profits in excess of 400 percent through the re-export of Bengal opium to China and as a result of the lucrative nature of the opium enterprise, the spice trade declined in value and commercial significance (McCoy 1972; La Motte 2003).

The most dramatic change came with the arrival in India in 1608 of the British East India Company (E.I.C.), which was originally created to boost Britain's commercial interest in the spice trade. Through military confrontation with the Indian opium merchants, the E.I.C. gradually acquired control of the lucrative opium sector and absorbed peasant cultivators into a loose syndicate system. Opium for export was sold through E.I.C. auction houses in Calcutta, while domestic demand was met through the sale of heavily taxed opium through an E.I.C. monopoly of 10,000 retail outlets in India.

Opium as a commodity was of enormous fiscal and commercial significance for Britain, which expanded cultivation in the Bengal area from 90,000 acres in 1830 to 176,000 in 1840, reaching a high of 500,000 acres by 1900 (McCoy 1972; Richards 2003). Revenues from opium exports, which climbed from 127 m.t. in 1800 to 6,372 m.t. by 1857 (Ul Haq 2000: 27) and domestic sales taxes contributed 11 percent of total revenues accruing to the British administration in India. Aside from financing the colonial enterprise in India and other British territorial possessions in South East Asia, opium was intensely valuable to Britain because it reversed a significant balance of trade deficit with China. While there was strong demand in the U.K. for Chinese goods, such as tea, silk and ceramics, the Chinese market for British manufactured exports was limited and no foreign traders were allowed to operate outside of Canton. The export of Indian opium to China reversed this negative trade flow. The opium trade also enabled Britain to gain a strong commercial foothold in China. As in India, this was achieved by Britain's use of military force. Successive Chinese emperors had sought to restrict the use of opium, which was seen as offensive to Confucian morality. However, prohibition decrees issued by Emperor Yung Cheng in 1729 and

Kia King in 1799 met with resistance from British merchant smugglers and when these were repelled by the Chinese, the British government launched naval attacks in their defense. Under the resulting peace agreements of the two 'opium wars' fought between Britain and China in 1839 and 1857, China was forced to open the treaty ports of Amoy, Tinghai, Chunhai and Ningpo to the British, Britain gained Hong Kong and the Chinese were forced to legalize the opium trade.

Summary

When the U.S. convened the first opium conference at the turn of the century, opium cultivation and consumption was at an all time high. Production levels were in the region of 41,624 m.t. per year, the bulk of which was produced in China in Yunnan and Szechwan provinces. The Persian and Ottoman Empires had emerged as significant cultivator countries having stepped up opium poppy cultivation and opium production in the second half of the nineteenth century in order to meet rising global demand. National governments, commercial trading houses and the pharmaceutical sector all had significant interests in the opium trade. The colonial powers, U.K., Spain and the Netherlands had operated opium retail monopolies across South East Asia for over one hundred and fifty years and these contributed to the administrative costs of the colonial enterprise. In Java, Indonesia the Dutch administered 1,065 opium retail outlets, which covered 15 percent of administration costs, while in the British colony of Malaya (Malaysia), opium sales contributed 53 percent (McCoy 1972).

Further developing the picture of a large global market and commercial interest in 'narcotic' drugs, coca cultivation had expanded out of native cultivation areas in South America such as the Yungas in Bolivia and Huanuco, Libertad and Cuzco in Peru. British and Dutch pharmaceutical companies and commercial interests transplanted coca leaf cultivation to Jamaica, Sri Lanka, Malaysia, India, Indonesia and British Guyana in order to reduce shipping times and to meet rising demand for cocaine. The Dutch had set up cocaine manufacturing facilities in Indonesia following the introduction of the coca leaf to Java in 1900 and by the turn of the century, the Dutch were the world's leading cocaine producer (Gootenberg 1999). As with opium production, national governments in coca cultivation areas also invested heavily in their new comparative advantage, the Peruvian government for example devised a

strategy for national development based on the promotion of the coca paste export sector (Walker 1996).

Inaction and Detachment: The US and the Early Opium Question

The US was relatively marginal to the trade in opium, coca and cannabis throughout the centuries of the drug market's operations. It was only at the beginning of the twentieth century, when the use of narcotic substances was at a high point, that the US became engaged in the nascent drug 'debate'. When it did so, the country assumed a radical posture, pressuring for the complete elimination of the trade, a position that 'required little sacrifice from Americans while demanding fundamental social and institutional change from others' (McAllister 2000: 66).

This was a belated entry, particularly given that Christian based anti-opium campaigns in countries such as the U.K. and India had been mobilizing around the 'trade in misery' for over 30 years. Three factors account for U.S. detachment from the opium question during the emerging debates of the mid-nineteenth century. Firstly, alcohol, rather than drugs were seen as the most pressing social problem in the U.S. The explosion of saloon bars associated with vice, gambling and drunkenness catalyzed the emergence of a powerful Christian based prohibition lobby that focused political attention on the need for a ban on alcohol rather than regulation of the drug trade.

Even if the federal government were minded to intervene to regulate intoxicating substances it was powerless to act. The constitutional separation of powers limited the responsibility of federal government to foreign policy, inter-state commerce and revenue raising measures such as taxation. As a result, it could not impose legislation on states, which retained jurisdiction over policing, criminal and civil law and the regulation of trade and transport (Whitebread 1995). This was despite evidence of a rising problem of morphine addiction among women and civil war veterans in the second half of the nineteenth century. An estimated 40,000 former combatants of the Northern army suffered from 'soldier's sickness' or the 'army disease', a morphine dependence that followed from its routine administration on the battlefield (Ul Haq 2000: 40; Whitebread 1995). Middle class women were the largest constituency of American opiate addicts, which totaled an estimated 300,000 people out of a population of 76 million. Intra-muscular morphine injection was commonly

prescribed for female 'problems of mood' that included gynecological infection, depression and nymphomania (Courtwright 1982; Keire 1998; Walker 1996: 39).

The absence of federal government regulation contrasted with the situation in the U.K. where the national government introduced the 1868 Pharmacy Act in response to a rise in overdose-related deaths. The U.K. legislation did not restrict the sale or use of drugs; it simply required that opiates and cocaine be clearly labeled as poisons. It was highly effective in reducing drug-related morbidity, particularly in small children. When anti-opium legislation was finally introduced in the U.S. in the 1870s and 1880s, this was on the initiative of individual states and it was specifically targeted at Chinese nationals. It was part of a wider anti-Chinese campaign that was led by organizations such as the American Federation of Labor and the Workingmen's Party and it came as part of a package of measures that included restrictions on the rights of Chinese immigrants to marry, own property and practice certain professions. As such, the first U.S. drug laws were premised on racial prejudice, not a preoccupation with national health.

A final important factor accounting for the tardiness of US engagement with the drug issue was the country's lack of overseas territorial possessions. Unlike Britain, Spain and the Netherlands, the U.S. had no colonial enterprise and the country maintained only a marginal trading presence in South East Asia. As a result, it was divorced from the broader debate on the morality of the opium trade and the operations of the market more generally. It was alcohol rather than drugs that pre-occupied the moral conscience of white, Christian U.S. society.

It was not until the end of the nineteenth century that a national debate on foreign policy and the need for 'empire building' began to take hold in the U.S. Preoccupation with the consolidation of national territory, unification of North and South and prevention of foreign incursion into the Southern hemisphere inhibited aspirations of overseas expansion. It was not until 1898 that the U.S. acquired its first overseas possession, Hawaii, a move that followed intense pressure for expansion on then Republican President McKinley from agricultural, media and financial interests.

US Narco-Diplomacy

The drastic change in the position of the U.S. federal government, from one of detachment from the opium question to leadership on the issue was triggered by the acquisition of the Philippines from Spain. This followed the Spanish defeat in the

Spanish American war of 1898 and the subsequent ceding of the Philippines, Guam, Cuba and Puerto Rico to the U.S. under the Treaty of Paris. Under ongoing pressure for U.S. territorial aggrandizement, the McKinley government assumed direct responsibility for the Philippines. On the basis that the Philippines had been entrusted to the U.S. 'by the providence of God', the U.S. set about 'civilizing' its people, while granting independence to Cuba and Puerto Rico.

Having acquired direct responsibility over the Philippines, the US federal government was forced to address the opium question. A decision had to be made on the retention of the opium retail outlets that had been established by the Spanish, 190 of which operated in Manila alone. The immediate response of the Governor General William Howard Taft was to allow opium sales to continue, with the finances raised ring-fenced for education spending. This provoked a vigorous and immediate response from Christian missionaries in the Philippines that included the Protestant Episcopal Bishop of Manila, Charles H. Brent and Reverend Wilbur Crafts, the president of the International Reform Bureau (I.R.B.), the main American missionary organization. Brent and Crafts intensively – and successfully - lobbied the federal government for a commission of enquiry on opium use in the Philippines.

The resulting Philippines Opium Commission of 1903 was the first federal government enquiry into the use and effects of intoxicating substances. It was headed by Bishop Brent and its findings contradicted those of the earlier British Royal Opium Commission, which had been convened in 1895. While the British Commission had found opium-related problems in India 'comparatively rare and novel', thereby legitimizing continued British participation in the trade, the Philippines Commission found that the unregulated sale of opium had grave effects on the health and moral capacity of users. It recommended that the import, sale and use of opium should be based on medical need only, thereby ending a centuries long tradition of unregulated and promiscuous use in South East Asia (McAllister 2000). The recommendations of the Philippines Opium Commission were accepted by the U.S. Federal government, which put in place a three-year transition timetable phasing out the use of opium among the 12,000 registered consumers in the Philippines.

The influence of the Christian Missionaries did not end with this measure. Brent and Crafts lobbied the Roosevelt administration to convene an international opium conference. This was a significant step and it marked the beginnings of US 'narco-diplomacy'. Brent and Crafts argued that without an international agreement to

curb the supply of opium, the domestic regulations put in place in the Philippines would fail. Two important principles had therefore been set out by the influential missionary groups. Firstly, that the use of intoxicating substances was morally wrong and injurious and that national governments had the responsibility to step in to prevent people from doing harm to themselves. Secondly, that this could only be achieved by reducing the supply of narcotic substances from cultivator and producer countries. This prohibitionist, supply-side focused thrust shaped the structure and orientation of the international control regime that was to emerge.

The Shanghai Opium Conference

All of the great powers, with the exception of the Ottoman Empire, accepted the US invitation to participate in an international opium conference, on the understanding that participants did not have plenipotentiary powers and consequently national governments would not be bound by a final resolution.

The emphasis on prohibition that informed the views of the U.S. delegation to the meeting was a minority position. The British, Dutch and other significant stakeholder countries were prepared to concede the need for regulation of the opium trade, but they emphasized regulation over prohibition. The British had already moved toward a ten year supply-reduction agreement with China, were an estimated one in four males where addicted to the drug. This 1907 Anglo-Chinese accord proved highly successful in reducing opium cultivation and availability. There was also a strong view that banning opium would be futile – particularly given the scale of the sector - and counterproductive. In previous experiences, the prohibition of substances ranging from coffee to wine and tobacco, black-markets had flourished while illicit supply and demand had persisted. Moreover, the U.S. delegation's emphasis on enforcement of prohibition through punishment of 'offenders', as proposed by the U.S. Opium Commissioner and head of the U.S. delegation Dr Hamilton Wright, was viewed as punitive and extreme. These divisions between the U.S. and other participant countries: 'remained central points of contention for decades' (McAllister 2000: 29).

Although no concrete agreement came out of Shanghai, the meeting was of enormous significance. It laid the foundations for international dialogue on opium and other drugs. This was fully capitalized on by the U.S. missionary groups that had placed themselves at the helm of the anti-opium campaign. They successfully lobbied

for a follow-up international conference which was held in The Hague in 1911. U.S. narco-diplomacy also forced the introduction of domestic anti-drug legislation in the U.S. It was recognized that the U.S. would have no credibility on the international stage if domestic restrictions were not in place but a circuitous route had to be devised in order that that the federal administration could bypass constitutional obstacles to national regulation. In 1906, the Pure Food and Drug Act was introduced as an exercise in the right of federal government to regulate interstate commerce. As with the earlier British Pharmacy Act, this did not prohibit drug use, it simply required that alcohol, morphine, opium, cocaine, heroin, chloroform and cannabis contents were labeled on medicines and tonics.

Although the new law was successful in reducing the use of patent medicines (Courtwright 1982), it did not meet the Christian lobby position that all non-medicinal drug use should be banned as consumption was immoral, degrading and dangerous. This principle was not realized in legislative form until 1909, when the Federal government introduced the Smoking Opium Exclusion Act in line with its constitutional right to regulate overseas trade. This prohibited the import of opium for non-medicinal purposes, making the 1909 law the first federal measure banning the non-medical, 'recreational' use of a substance.

The Exclusion Act was a triumph for the Christian Missionary lobby, but the strategy for achieving support for the Act's introduction was divisive. There was a strong reliance on the use of racist language and imagery to galvanize popular and political support for strict anti-drug measures and this was to become a core feature of anti-drug measures in the U.S. In his role as the first U.S. drug 'tsar' Hamilton Wright worked with William Randolph Hearst's newspaper empire to generate concern around substance use among minority groups. In an interview with the *New York Times* in March 1911, Wright focused public and media attention on the dangers posed to white American society by cocaine use among African Americans. This was further developed in the *Literary Digest* and *Good Housekeeping*, were Wright elaborated on the danger posed to white women by 'negro cocaine peddlers' and 'cocainized nigger rapists'. These 'Negro fiends' with cocaine induced superhuman strengths easily substituted for the opium wielding Chinese 'devils' of the earlier anti-opium propaganda. Public pressure for action was in turn channeled toward domestic legislation in the U.S., while strengthening the hawkish, prohibition oriented position of the U.S. delegation to The Hague conference of 1911.

Building the Early Control Regime

The 1912 International Opium Convention

Between The Hague meeting of 1911 and the outbreak of the Second World War, substantial progress was made in creating the founding structures of the international control regime. In contrast to the Shanghai meeting, delegates to The Hague did have plenipotentiary powers and as a result, participating countries were bound by the resulting *International Opium Convention*. This 'raised the obligation to co-operate in the international campaign against the drug evil from a purely moral one to the level of a duty under international law' (May 1950).

The Convention institutionalized the principle that medical need was the sole criterion for the manufacture, trade and use of opiates and cocaine. National governments were thereby required to enact 'effective laws or regulations' to control production and distribution and to restrict the ports through which cocaine and opiates were exported. While the Convention was a groundbreaking document, it did not create mechanisms to oversee implementation of the agreement, nor did it set targets for reducing the volume of drugs manufactured. It was also loosely worded and, most problematic of all, could only come into effect if unanimously approved. Amid mounting suspicion and enmity between governments in the drift to war in 1914, consensus was difficult to achieve and only China, The Netherlands, the U.S., Honduras and Norway ratified the Convention (Bewley Taylor 2001; McAllister 2000).

The First World War removed the obstacles to ratification and administration of the Opium Convention. Firstly, Austria Hungary and the Ottoman Empire - reluctant supporters of the measure - were defeated in the conflict and this made it possible to craft a new consensus and for the U.S. and West European powers to impose the Convention. This was done by conjoining ratification of the Convention to the Versailles Peace Agreement of 1919 (McAllister 2000). Secondly, the League of Nations was created in the aftermath of the First 'Great War' and this provided the international community with a centralized body for the administration of the Convention.

On assuming responsibility for overseeing the Opium Convention, the League created specialized support bodies that included the Opium Section, which provided administrative and executive support to the League Council, and the Health

Committee of the League, forerunner of the World Health Organization, which advised the League's Secretariat on drug related matters. The most important and specialized of these bodies within the new control regime was the Advisory Committee on the Traffic in Opium and Other Dangerous Drugs, known as the Opium Advisory Committee (O.A.C.), which in turn created the Opium Control Board to assist it in its duties.

From this institutional foundation, the League went on to incrementally develop a comprehensive control regime. Knowledge and operational gaps in the system were identified and addressed through follow up conferences and the introduction of new conventions. This process of building up the control system proceeded with two conferences in Geneva in 1924 that sought to address the problems encountered by the O.A.C. in developing a comprehensive picture of the 'legitimate' medical drug market.

The Geneva Convention

The Geneva Convention of 1928 expanded the manufacturing control system by establishing compulsory drug import certificates and export authorizations that were to be administered by national authorities and which were required for all drug transactions between countries. This sought to prevent countries importing or exporting drugs beyond medical and scientific requirement. In order to determine the level of legitimate medical drug requirements, parties to the Convention were to provide annual statistics estimating production, manufacture and consumption requirements for opiates, coca, cocaine and, for the first time in drug control, cannabis. This information was to be supplemented by quarterly statistics detailing the volume of plant based and manufactured drugs imported and exported and estimated figures for opium smoking. A new drug control organ, the eight-person Permanent Central Opium Board (P.C.O.B.), which replaced the Opium Control Board, assumed responsibility for processing the statistical information. The P.C.O.B. had the authority to request explanations from national governments if they failed to submit statistical information or if stated drug import or export requirements were overshot. The Board could also recommend an embargo of drug exports or imports on any country that exported or imported in excess of stated production levels or medical need. This extended to countries that were not party to the Convention, universalizing the control system. Aside from refining the institutional structure and remit of drug

control, the 1928 Convention increased the number of drugs subject to the control regime and created an open-ended schedule that classified drugs according to their danger to health and relevance to science.

The 1924 Geneva conference also resulted in a second convention, *The Agreement Concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium*, which came into force in 1926. This established a 15-year timetable for the elimination of recreational opium use in Southeast Asia.

Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs

The Geneva Convention failed to prevent legitimately manufactured drugs seeping into the illegitimate market. The O.A.C. determined that between 1925 and 1929, legitimate demand for opium and cocaine based drugs was in the region of 39 tons per year, while one hundred tons of opiates had been exported to unknown destinations from licensed factories (Anslinger and Tompkins 1953). A follow up conference, addressing this weakness resulted in the 1931 Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs. The Convention set out that the quantity of manufactured drugs required globally was to be fixed in advance. This was to be determined by a compulsory estimates system, under which all countries were required to detail the quantities of drugs required for medical and scientific purposes for the coming year. The system of indirect limitations was administered by a new body, the four-person Drug Supervisory Board (D.S.B.), which was authorized to draw up its own estimates of individual country needs as a means of checking the information submitted and it devised estimates for those countries that did not submit their drug requirements. No greater quantity of any of the drugs set out in the D.S.B. final report was to be manufactured.

In a further tightening of the control regime, the P.C.O.B. was empowered under the 1931 Convention to directly embargo any country that exported or imported beyond its stated manufacturing volumes or consumption needs. Signatory states were also required to establish a dedicated national drug enforcement agency to ensure compliance with domestic drug laws that had been introduced at the local level in line with international obligations.

Convention for the Suppression of the Illicit Traffic in Dangerous Drugs,

The final element of the inter-war control regime was the 1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs, an initiative of the International Police Commission, the forerunner of Interpol. Unlike previous conventions, which sought to demarcate a legitimate trade in medical drugs, the 1936 Convention addressed the illegal market. It imposed punitive and uniform criminal penalties for trafficking illicit substances, with Article 2 of the Convention recommending that national anti-trafficking laws should be based on 'imprisonment, or other penalties of deprivation of liberty'. National governments were obliged to set up a dedicated agency responsible for monitoring drug traffickers and trafficking trends, in co-ordination with corresponding agencies in other countries.

Table 1: Pre-World War Two Drug Conventions

Date, Place Signed	**Title of Convention**	**Into Force**
January 1912, The Hague	International Opium Convention	Feb. 1915 and June 1919
Feb. 1925, Geneva	Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium	July 1926
Feb. 1925, Geneva	International Opium Convention	Sept. 1928
July 1931, Geneva	Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs	July 1933
Nov. 1931 Bangkok	Agreement for the Control of Opium Smoking in the Far East	April 1937
June 1936, Geneva	Convention for the Suppression of the Illicit Traffic in Dangerous Drugs	Oct. 1939

Evaluating the Inter-War Control Regime

The international community made remarkable progress in working collectively (an unprecedented development in itself) to control the supply of harmful substances. In 1933, the O.A.C. reported that: 'the sources of supply [of drugs] in Western Europe, as a result of the close control now exercised, appear to be rapidly drying up' (Renborg 1964). World opium production declined 82 percent between 1907 and 1934, from 41,624 tons to an estimated 16,653 tons. Legitimate Heroin production fell from 20,000 pounds in 1926 to 2,200 pounds by 1931. South East Asia, the biggest 'problem' market saw a 65 percent fall in opium sales and in the Netherlands Indies (Indonesia), there was an 88 percent fall in opium consumption (McCoy 1972). This was a major achievement given the difficulties inherent in negotiating a universal

agreement that had to reconcile diverse and competing interests, ensure an adequate global supply of medical drugs while altering patterns of individual behavior. The control model was all the more remarkable as it was a first step in the direction of states surrendering overview of their sovereign affairs to an international body. Drug control was also groundbreaking as it led to the introduction of uniform penal sanctions across countries and established principles of criminal law on an international basis.

The instauration of a comprehensive substance control regime was a major success for the U.S. Christian lobby groups that had first initiated the drug control discourse at the turn of the twentieth century. The U.S. was able to pull dissenting national voices into the system and override competing regulatory proposals as a result of two key factors: evolving attitudes toward the drug trade in Europe and astute U.S. diplomacy.

As understanding of addiction and dependence evolved, West European states acknowledged the need for a stronger control framework, a paternalist orientation that was reinforced by the creation of rudimentary welfare state systems that afforded government responsibility for the heath of citizens. The roll out of European welfare state additionally eliminated the need for self-medication, further legitimizing medical and political arguments in favor of controlled drug use (Berridge 2001).

This is not to suggest that European and other governments were in full accord with the prohibition orientation of the U.S., which was the driving force behind the introduction of increasingly punitive sanctions in the Conventions. The Dutch, British, French and Spanish all remained skeptical of the U.S. view that recreational drug use could be terminated through ‘shock’ strategies and they remained convinced of the importance of medical support for drug users over the penal approach advocated by the U.S. Moreover they did not accept that cultivation of opium or coca could be rapidly eradicated and on this issue they did achieve a significant victory over the U.S. by introducing a protracted 15 year timeframe for cultivation controls. As a result, by 1939, state opium monopolies continued to operate in Burma, British Malaya, Netherlands Indies, Siam, French Indo-China, Hong Kong, Macao, Formosa and Kwantung Leased Territory. Overall however, the U.S. delegation was effective in defining the shape and orientation of the control system – largely because of political posturing and by acting on the outside of the League of Nations.

European countries were determined to bring the U.S. into the League, which it finally did in 1924. It was primarily through concern that the U.S. would withdraw from the body that European powers acceded influence to the U.S. on drug related matters. U.S. representatives at the drug conferences and within the control bodies, such as Harry J. Anslinger, director of the Federal Bureau of Narcotics and Herbert May of the P.C.O.B. were forceful individuals and: 'their beliefs, morals, ambitions and single-minded determination enabled them to exert exceptional influence over the shape of the international drug control regime' (Sinha 2001). When the American position was rejected, the U.S. withdrew from proceedings. Ironically the U.S. was not party to the most important founding conventions including the 1928 Geneva Convention and the 1936 trafficking convention, on the grounds that they were not rigorous enough (Bewley Taylor 2001; McAllister 2000; Sinha 2001). The U.S. also signed bilateral policing agreements with 22 countries during the inter-war period. While this went against the spirit of cooperation that the League was seeking to create, it allowed the U.S. to extradite and prosecute drug traffickers independent of the international control system (Anslinger and Tompkins 1953).

Consequently the drug control framework that evolved reflected the core values of the U.S. and the internationalization of prohibition oriented ideas and approaches that were culturally unique to the U.S. Owing to the influence of the U.S. the control model that emerged was skewed toward supply, as opposed to demand focused activities, it emphasized punishment and suppression over consideration of why people cultivated, produced and used drugs and it institutionalized the influence of the police, the military, politicians and diplomats while the opinion of stakeholders such as doctors, drug users and peasant cultivators were marginalized (Sinha 2001).

Underscoring a further 'internationalization' of American approaches to drugs, there was a growing reliance on the demonization of drug users in order to justify repressive domestic legislative measures such as the 1919 Dutch Opium Act, the 1929 German Opium Act and the 1920 British Dangerous Drugs Act. The emphasis on embattled nations under attack from subversive forces seeking to enslave, poison and infiltrate the country, of dangerous substances, threatening 'out groups' and criminality, all of which was prevalent in early U.S. anti-drug propaganda, became a stock element of international counter-narcotics propaganda and 'education'. These stereotypes of drug users remain prevalent today (Reinarman and Levine 1997).

In the U.S., themes of race, crime and drugs were even more potent as the federal government labored around the constitutional separation of powers to introduce strict, national prohibition measures. The Harrison Narcotics Tax Act of 1914 and the Marijuana Taxation Act of 1937 were introduced as taxation based measures, in line with the jurisdiction of the federal government. They imposed punitively high taxes on the non-medical exchange of cocaine and opiates, in the case of the former and cannabis transactions, including the sale of industrial hemp, in the case of the 1937 measure. Under the Harrison Act doctors had to register with federal authorities, record all drug transactions and pay a prescription tax. Any individual caught in possession of cocaine or opiates without a prescription was consequently charged with tax evasion rather than a criminal offence (Whitebread 1995). After 1922, doctors were not allowed to prescribe 'narcotic drugs' to addicts to maintain their addiction (Berridge 2001; Courtwright 1982; Whitebread 1995). The Federal Bureau of Narcotics, which was created in 1930 and presided over by Harry J. Anslinger for thirty years, assumed a lead role in disseminating anti-drug propaganda and acculturalizing Americans to the new drug laws. Among the reams of shockingly racist articles from the period was a *New York Times* piece by Edward Huntington Williams. This claimed that cocaine made African-Americans resistant to bullets. (*New York Times*, February 8 1914). In the Congressional hearings into the 1914 Harrison bill, the head of the State Pharmacy Board of Pennsylvania, Christopher Koch testified that: 'Most of the attacks upon the white women of the south are the direct result of the cocaine-crazed Negro brain' (*New York Times*, Feb. 8, 1914). In the build up to the 1937 Marijuana Tax Act, Mexican migrants emerged as the new drug threat. It was claimed that 'marijuana crazed Mexicans' were committing violent acts after smoking the 'loco weed'. By emphasizing the threat faced by American society, the F.B.N. was positioned to substantially increase its share of federal revenues.

After the alcohol prohibition movement was successful in amending the Constitution and achieving national prohibition in 1918, key activists such as Richmond Pearson Hobson of the Anti-Saloon League shifted their attention to the anti-drug campaign. Pearson formed the International Narcotic Education Association in the early 1920s and this organization was responsible for distributing racist, eugenicist, hyperbolic and medically incorrect 'information' about the 'Narcotic Peril'. Support and pressure for drug prohibition persisted even after alcohol

prohibition was lifted in 1933. This was despite the fact that alcohol prohibition had been a failure and that there were important lessons – that were not learned - from the experience. Even though alcohol prohibition had generated a flourishing, difficult to police, gangster dominated illicit industry worth millions of dollars, pressure for domestic and international drug prohibition persisted and was institutionalized in the contemporary drug control framework that evolved after World War Two.

The Contemporary Drug Control Regime

While the First World War provided a strategic opportunity to advance the principle of drug control, World War Two enabled the U.S. to consolidate control of the drug control regime and apparatus. The framework that developed after 1945 addressed the priorities of the U.S. specifically: the prohibition of opium smoking; restrictions on drug plant cultivation; extension of the control system to cannabis and other drugs; enhanced policing and enforcement and the application of punitive criminal sentences for those engaged in illicit plant cultivation, drug production, trafficking, transportation, distribution, possession and use (Bruun, Pan and Rexed 1975). The capacity of the U.S. to consolidate its influence can be attributed to a number of factors that included the geo-strategic changes induced by the conflict and the exercise of U.S. political pressure and leverage.

The work of the Permanent Central Opium Board and the Drug Supervisory Board was transferred from Geneva to Washington in 1941. Reliant on federal funding, both bodies experienced a 'considerable loss of freedom' (McAllister 2000: 146) as they were required to submit technical information to the U.S. government and assist in the development of new anti-drug policies. The War also provided the U.S. with a strategic foothold in South East Asia. At a 1943 meeting with representatives from Britain, France, Portugal and the Netherlands the U.S. won the guarantee that opium monopolies would not be re-established in colonial territories invaded by Japan that were liberated with the help of, or by the U.S. The subsequent offensive U.S. military presence in the region enabled America to impose its model of prohibition. Opium dens and retail outlets were closed down by U.S. troops and on conclusion of the war, strict anti-drug legislation was introduced by the American administration in West Germany and Japan. The diplomatic environment also allowed for negotiations with opium cultivating neutral governments such as Iran, Turkey and

the Yugoslavian governments in exile and this allowed for preliminary agreements on cultivation controls.

In the aftermath of the War, the Lake Success protocol of 1946 transferred administration of the drug conventions from the defunct League of Nations to the newly established United Nations. The U.N. Economic and Social Council (ECOSOC) acquired primary responsibility for overseeing the conventions, and it was supported in this task by the Commission on Narcotic Drugs (C.N.D.), which advised ECOSOC on drug-related matters and prepared draft international agreements. As such, the C.N.D. supplanted the Opium Advisory Committee. In a further innovation to existing control institutions, administrative support that had been provided by the Opium Section was transferred to a new body, the Division of Narcotic Drugs (D.N.D.) The P.C.O.B. and D.S.B. were transferred back to Geneva from Washington, were they continued in their role compiling statistics from national estimates and administering the import / export certification system.

Another new institution, the World Health Organization (W.H.O.) assumed the drug advisory responsibilities formerly exercised by the Health Committee of the League of Nations. The Drug Dependence Expert Committee of the W.H.O. was in turn given the task of determining the addictive potential of drugs and their position on the international schedule of controls (Fazey 2003).

The Paris Protocol

While there had been a collapse in illicit drug trafficking during the war, the international community had to address complex legacies of the conflict, such as stockpiles of medical opium and semi-synthetic drugs and a burgeoning problem of the dependence on new synthetic drugs such as methadone and pethidine, which had been developed during the war but fell outside of the control schedule established by the 1931 Convention. The first post war drugs conference resulted in the 1948 *Paris Protocol*. This brought any drug liable to cause harm into the schedule of controlled drugs and required states to inform the U.N. secretary-general of any new drug developed that had the potential to produce harmful effects. The progress of the new Convention was not without contention, with the Soviet Union reluctant to acknowledge the authority of the U.N. bodies on the issue, or the existence of a drug problem within its territory. Similarly efforts to restrict opium cultivation proposed by

the U.S. ran into difficulties amid concerns from consumer states that there would be insufficient stocks of medical opium.

The resulting 1953 *Opium Protocol* was a compromise measure. It extended the import and export control system for manufactured drugs to opium poppy cultivation and cultivating countries were required to detail the amount of opium poppy planted and harvested and volumes of opium exported, used domestically and stockpiled. While this marked a significant step forward for the U.S., the reporting requirements were not extended to coca after Andean countries maintained that coca cultivation was integral to indigenous life and culture. However, by the time the Opium Protocol came into force in 1963, it was a redundant instrument as a result of the 1961 Single Convention.

Single Convention on Narcotic Drugs

The 1961 Convention followed from a meeting of 73 countries to explore a single, anti-drug convention that would consolidate the nine drug conventions introduced since The Hague conference of 1911. The resulting Single Convention consolidated past convention provisions; it introduced controls in new areas; it revised the existing control apparatus and it was a major success for the U.S. in terms of advancing the country's drug control agenda.

The Single Convention extended the system of licensing, reporting and certifying drug transactions to all raw 'narcotic' plant materials including cannabis and coca leaves. Cultivator countries were required to establish national monopolies to centralize and then phase out cultivation, production and consumption, over a 25-year period in the case of coca and 15 years in the case of opium poppies, culminating in a full international prohibition of the non-medical cultivation and use of these substances by 1989. The Convention further required immediate domestic legislation to prohibit the non-medicinal use of opium, cocaine and cannabis (which the U.S. maintained was a 'gateway drug'), and in a further tightening of restrictions on medicinal consumption, a new classification schedule was introduced. Drugs considered addictive and 'obsolete' in terms of their scientific and medical value, such as opium poppy, coca and cannabis and their derivatives were classified as schedule I or IV. Drugs that were considered less dangerous and of some medical value were classified as Schedule II or III were (Bewley Taylor 2001; Fazey 2003; Sinha 2001). According to Article One of the Convention, drugs presented: 'a serious

evil for the individual […] fraught with social and economic danger to mankind'. As such, signatory states were required to introduce more punitive domestic criminal laws that punished individuals for engagement in all aspects of the illicit drug trade.

Intended as a 'final' and definitive document, the 1961 Convention also restructured the international drug control apparatus. The P.C.O.B. and the D.S.B. were merged to create a thirteen-person body of independent experts, the International Narcotics Control Board (I.N.C.B.), which evaluated national statistical information, monitored the import-export control system and authorized narcotic plant cultivation for medical and scientific need. These powers were subsequently extended under a 1972 amendment, which gave the I.N.C.B. responsibility for developing and implementing programs to prevent the cultivation, production, manufacture, trafficking and use of illicit drugs and for advising countries that needed assistance in complying with the Conventions. The amendment also addressed extradition and required that any bilateral agreement automatically include drug-related offences. While the thrust of the 1961 Convention was toward a tightening of criminal sanctions, the 1972 amendment did introduce an important shift toward addressing demand-side issues. Parties to the 1961 Convention were now requested to provide 'treatment, education, after-care, rehabilitation and social reintegration' for drug addicts and users.

1971 Convention on Psychotropic Substances

Although the Single Convention was intended as 'a convention to end all conventions' (May 1950) the international community met in 1971 in order to respond to the advances in chemistry and synthetic drug manufacture which had led to new mass markets for psychotropic substances such as amphetamines, barbiturates and hallucinogens that were not incorporated into the existing regulatory framework. The resulting *Psychotropic Convention* introduced a regulatory regime for these drugs modeled on the manufacturing and cultivation control system set out in the 1961 Convention. This included a schedule of four levels of control that were based, like the Single Convention, on a drug's therapeutic value and abuse potential.

The 1961 and 1971 Conventions were followed through at the domestic level by repressive domestic drug policies. There was a significant enhancement of police powers to stop, search, raid, hold without charge and electronically tap suspected traffickers, dealers and drug users, while the death sentence or mandatory life

sentence for offences related to trafficking, production and possession, were routinely introduced. For critics of the approach, the uniformity of strategies owed much to the pressure on regimes stemming from 'youth rebellion', protest movements, revolutionary ideologies, social experimentation and profound East-West tensions. In this interpretation, repressive, penal oriented measures made it possible to suppress political dissent (Gamella and Jiménez Rodrigo 2004).

The domestic response in the U.S. was particularly noteworthy as it marked a deepening of U.S. unilateralism in drug's strategy and a broader incorporation of counter-narcotics policy into foreign policy. The Nixon administration launched a 'war on drugs' in 1969 that was followed by the introduction of the 1970 Controlled Substances Act (C.S.A.). The C.S.A., which is the basis for contemporary U.S. drug policy, brought together all previous federal drug legislation. It established a series of schedules, with cannabis among a number of drugs classified as the most dangerous drugs, or Schedule One narcotics, and it was enforced by a new agency, the Drug Enforcement Administration (D.E.A.), which was created in 1973 following from the closure of the F.B.N.

The 'war on drugs' was re-launched by President Reagan, who in a 1982 speech outlined a new aggressive posture: 'We're taking down the surrender flag … we're running up the battle flag' (*New York Times*, 24 June 1982). The Reagan administration marked the introduction of a plethora of punitive anti-drug measures that included the 1984 Comprehensive Crime Control Act; the 1986 Anti-Drug Abuse Act; the 1988 Anti-Drug Abuse Amendment Act and the 1988 Drug Free Workplace Act. These measures raised federal penalties for all drug-related offences, introduced mandatory minimum sentences, asset seizure without conviction and they established the federal death penalty for drug 'kingpins' (Chase Eldridge 1998). The Reagan period also saw the introduction of the Drug Abuse Resistance Education (DARE) anti-drug program in schools and in 1986 drug testing of federal employees and contractors under Executive Order 12564. This was coordinated by a new agency, the Office of National Drug Control Policy which was created by the 1988 National Narcotics Leadership Act.

This domestic legislative momentum continued into the 1990s and 2000s with the model 1999 Drug Dealer Liability Act that imposed civil liability on drug dealers for the direct or indirect harm caused by the use of the drugs that they distributed. In 2000 the Protecting Our Children from Drugs Act imposed mandatory minimum

sentences on drug dealers who involved children under the age of 18 in the trade or who distributed near schools (Chase Eldridge 1998).

Of crucial significance, the U.S. 'drug war' was also characterized by the stepping up of 'source-focused' policies of cultivation eradication, with a specific focus on South America. In the mid-1980s, the Federal government introduced the drug certification system which terminated bilateral assistance to any country deemed by the State Department not to be co-operating in the drug war. There was also an intense militarization of eradication and interdiction strategies, with the U.S. pressing for and financing the deployment of source country military institutions in enforcement activities. This escalation of unilateral U.S. counter-narcotics activities led to a sharp increase in the federal government's drug budget expenditures, from $1.8bn in 1981 to $12.5 billion by 1993. The D.E.A.'s share of these revenues increased from $200 million to $400 million (Gray 2000), with additional finances available through the 1984 civil forfeiture law, which allowed enforcement agencies to confiscate drug-related assets. By the end of the 1980s, the 1984 law contributed in the region of $500 million to the Drug Enforcement Agency, while the Justice Department received an estimated $1.5 billion in illegal assets between 1985 and 1991 (Blumenson and Nilsen 1998).

1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

The final convention of the current drug control system was negotiated in 1988. As with the pre-war drug control system, this related to the traffic in illicit substances and it addressed mechanism to strengthen compliance with the control regime. The Convention required states to co-operate and co-ordinate anti-trafficking initiatives with international enforcement bodies and partner agencies in other countries and, in response to the new challenges posed by the globalization of trade and services, it called on states to introduce domestic criminal legislation to prevent money laundering and to allow for asset seizure and extradition. The Convention also introduced controls of chemical precursors required for the production of synthetic and semi-synthetic drugs, with states obliged to monitor the manufacture and trade in chemicals that could be used in illicit drug production. It additionally set out procedures for the harmonization of national drug laws, setting out specific offences that individual states were required to legislate against.

Table 2. The Post-War Drug Conventions

Date and Place Signed	Title of Agreement	Date of Entry into Force
Dec. 1946, Lake Success, New York, USA	Protocol amending the Agreements, Conventions and Protocols on Narcotic Drugs concluded at The Hague on 23 January 1912, at Geneva on 11 February 1925 and 19 February 1925 and 13 July 1931, at Bangkok on 27 November 1931, and at Geneva on 26 June 1936.	Dec. 1946
Nov. 1948, Paris, France	Protocol Bringing under International Control Drugs outside the Scope of the Convention of 13 July 1931 for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success, New York, on 11 December 1946.	Dec. 1949
June 1953 New York, USA	Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of, Opium.	March 1963
March 1961 New York, USA	Single Convention on Narcotic Drugs.	Dec. 1964
Feb. 1971 Vienna, Austria	Convention on Psychotropic Substances.	August 1976
March 1972 Geneva, Switzerland	Protocol amending the Single Convention on Narcotic Drugs.	August 1975
Dec. 1988 Vienna, Austria	Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances	Nov. 1990

While no new conventions were introduced after 1988, the institutional apparatus of the drug control regime continued to evolve. In 1991, the separate, geographically dispersed U.N. agencies responsible for administering the conventions were unified under the United Nations Drug Control Program (U.N.D.C.P.). This new body, which derived its authority from the C.N.D., absorbed the D.N.D. and the I.N.C.B. As part of this restructuring process, membership of the C.N.D. was expanded from 40 countries to 53, with seats allocated on the basis of the geographical groupings within the U.N. (Fazey 2003).

In response to the growing inter-linkages between illicit trafficking activities, such as small arms, narcotics and humans, there was a further streamlining of agencies in 1997. The U.N.D.C.P. was merged with the Centre for International Crime Prevention to form the United Nations Office for Drug Control and Crime Prevention (U.N.O.D.C.C.P.) and in 2002 this agency became the U.N. Office on Drugs and Crime (U.N.O.D.C.).

Table 3 The International Drug Control Apparatus

Body	**Economic and Social Council**	**Commission on Narcotic Drugs**
Function	Discusses and analyses drug-related issues; Initiates drug-related studies; Drafts Conventions; Convenes drug conferences.	Analyses drug traffic and trends; Advises ECOSOC; Prepares draft international drug agreements; Provides forum for information exchange.
Body	**International Narcotics Control Board**	**United Nations Office on Drugs and Crime**
Function	Control organ for the implementation of the drug control treaties; Provides advice to the W.H.O.; Determines worldwide medical and scientific drug requirements; Processes technical and statistical information provided by states; Allocates cultivation, production, manufacture, export, import and trade quotas; Advises status on anti-drug measures.	Co-ordinates U.N. anti-drug activities; Provides secretariat services for the C.N.D. and I.N.C.B.; Advises countries on implementation of the drug conventions; Executes anti-drug initiatives in host countries.

Conclusion

Although the drug control regime has reached a high point in terms of its universalism, comprehensiveness and institutional integrity, it is also under unprecedented pressure and there are indications that the consensus underpinning the model is fracturing. The cultivation, production and consumption of illicit substances is at an all time high and drug markets have become more complex, dynamic and diversified. This situation has forced a questioning of first principles. There is a growing acknowledgement that the historically entrenched ideology of prohibition that underpins the control regime is anachronistic, counterproductive and unachievable. European and South American countries have taken the lead in experimenting with regulatory and liberalization oriented strategies, a move that has been informed by the failure of the highly repressive approaches that were pursued in the 1970s and 1980s (Dolin 2001; E.M.C.D.D.A. 2001; Gatto 1999; Fazey 2003). This focus on demand-side issues has run parallel with a revision of strategy in 'supply' countries. The Europeans in particular now place emphasis on 'alternative development' policy in cultivator states, a position that acknowledges the persistence of incentives to produce narcotics for the global market.

There is a wider concern that the emphasis on repression, militarization and enforcement is iatrogenic. The persistence of prohibition thinking and prohibition oriented policies in an age of chemical advances, globalization, HIV-AIDS and enhanced personal freedom may be doing more harm than good. However, the capacity of the current control regime to evolve from a source-focused, criminalization approach toward a more liberal, treatment-oriented and developmentalist strategy is constrained by the persistence of prohibition attitudes among powerful country and regional players, such as China, the U.S., Russia and Saudi Arabia. The mechanisms for debate within the drug control system are rudimentary and the institutional capacity for flexibility, innovation and radical reform is open to question.

The conceptual frameworks that are used to understand and respond to drugs and drug consumption are over a century old. They were framed in a period of colonial enterprise, social tension, racism and a lack of medical and scientific understanding (Sinha 2001). That they continue to inform drug policy today is deeply problematic. Meaningful change can only come from a revision of founding ideas and while some countries have expressed support for such a review, this revolutionary

step is not endorsed by a host of actors owing to narrow vested financial, political and national interests.

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