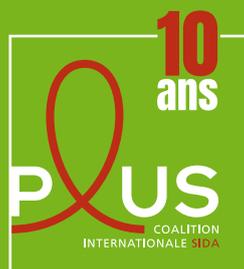


JUST SAY NO TO THE WAR ON DRUGS

**HOW THE WAR ON DRUGS
IS MAKING US SICK**



Coalition PLUS : An Introduction

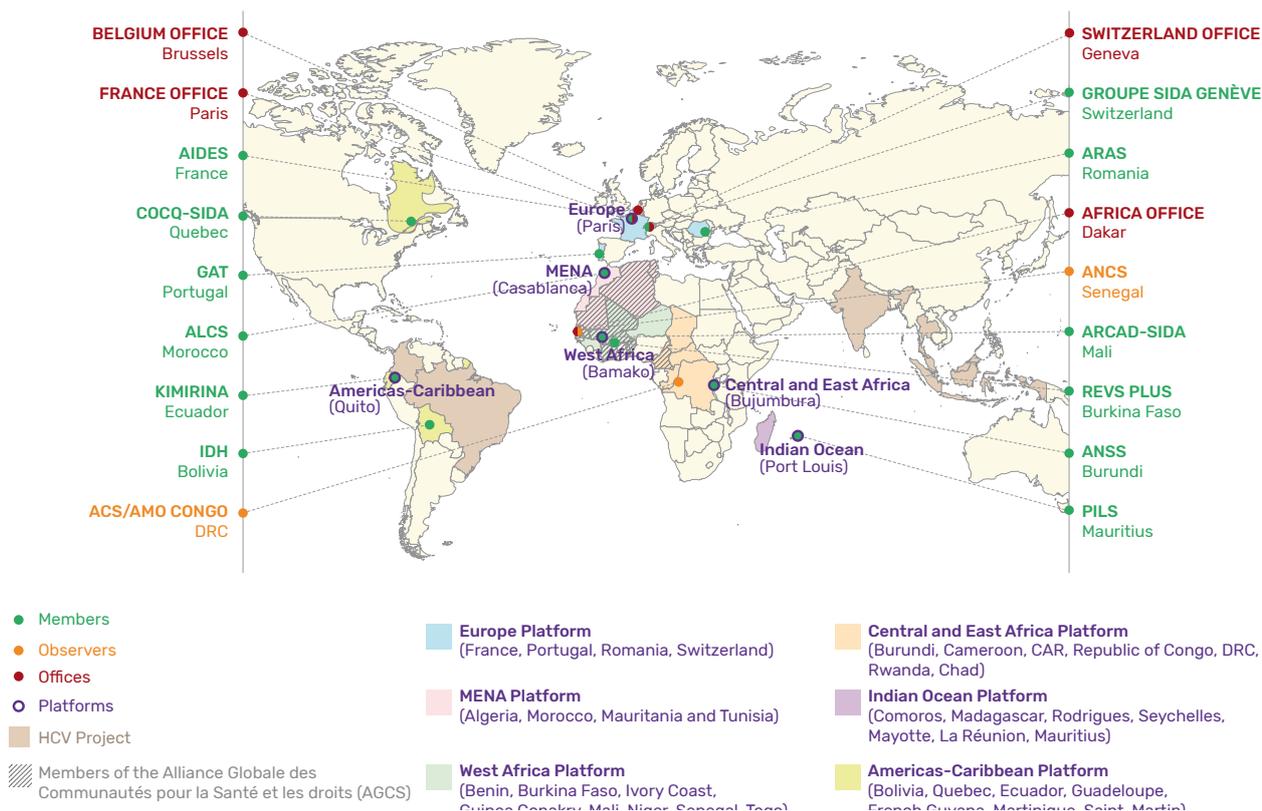
International union of Community-based NGOs working in the Aids and viral hepatitis response, Coalition PLUS was founded in 2008, and is actually active in nearly 40 countries with a hundred of civil society organisations. Through the principle of shared governance, our coalition includes 14 member organisations, North and South, in strategic decision-making.

With a community approach perspective, Coalition PLUS advocates for people who are infected, affected or particularly vulnerable to HIV and HCV to be systematically involved in the decision-making, implementation and evaluation process of their health programs.

Through the various programs of its secretariat and its 6 sub-regional intervention platforms, its objective is to strengthen community organisations' capacities, while promoting spaces for knowledge and expertise sharing.

Committed to excellence in management and the essential principle of democratic governance, Coalition PLUS is labeled « Don en confiance¹ » label by *the Comité de la Charte*.

¹ The "Don en Confiance" is a token of quality for civil society organisations registered in France, based on principles of transparency, search for efficiency, probity and selflessness, among others.



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July 2018 Edition.

STATE OF PLAY AND CURRENT DEBATES ON GLOBAL DRUG POLICY

Content

| | |
|---|-----------|
| Introduction | 5 |
| I. FAILURE AT ALL LEVELS: "JUST SAY NO TO WAR ON DRUGS" | 6 |
| A. A war on drugs that negatively impacts the health of people who use drugs | 6 |
| B. A war on drugs that hampers development, promotes crime and weakens States | 13 |
| II. A RECENT IDEOLOGICAL REPRESSION | 17 |
| A. Drugs and humanity: a long history | 17 |
| B. The American war on drugs | 18 |
| C. Total international control | 20 |
| III. HEALING THE WORLD FROM THE WAR ON DRUGS | 23 |
| A. Community mobilisation | 23 |
| B. The expansion of alternative models meeting public health objectives as opposed to the repressive one | 25 |
| C. What are we missing to end this war? | 27 |
| Conclusion | 30 |



JUST SAY NO
TO THE WAR ON DRUGS

Introduction

Today, the "war on drugs" is the most widespread vision by the vast majority of states in terms of drug policy. This war takes various forms: criminalisation of the people who use drugs (as far as the death penalty in 32 countries), supply reduction by destroying the cultures and productions of controlled drugs, and fighting against the traffic, and making civil society organisations' lives difficult, specifically those working in support of people who use drugs, particularly on the grounds that they encourage drug use by promoting harm reduction tools.

It has had, and still has terrible consequences on our communities globally²: vulnerability, stigmatisation, social exclusion, infections (152,000 people who use drugs infected by HIV in 2015³ alone), deaths (60,000 AIDS-related deaths among people who use drugs in 2015, and 220,000 of hepatitis C⁴ virus), drugs laced with dangerous products, overdoses, homicides. These have taken a heavy toll on our communities, and is unacceptable, as all this suffering is preventable.

Yet attempts at critical and scientific analysis of this war are regularly condemned and portrayed as promoting drugs. The debate is most of the time compromised. As the philosopher Jacques Derrida explains: "We can already conclude that the concept of drugs is a non-scientific concept, instituted on the basis of moral or political evaluations: it carries in itself the idea of norm or prohibition. It does not give any possibility of description or statement, it is a watchword, and is most often prohibitive⁵.

The purpose of this guide is first to broaden the debate, compiling scientific facts, studies, historical analysis in order to place this war on drugs in context.

The reason we created this guide is also because Coalition PLUS member organisations and partners, like all those working in the field, have something to be proud of. By sometimes violating the laws (civil disobedience), they prioritise respect for life and the right to health of people, regardless of their lifestyles, their drug use, their background and their identities.

Our community organisations support people who use psychoactive drugs in accessing care and prevention methods, they distribute clean needles and promote all harm reduction tools, they inform people about their rights and ways not to allow violations of these to go unpunished. Some for a very long time as AIDES in France, GAT in Portugal, ARAS in Romania, PILS in the Republic of Mauritius. Others more recently like REVS PLUS in Burkina-Faso, ALCS in Morocco, ARCAD-SIDA in Mali, etc., and with relentless energy.

Among these people who use drugs, some have become activists in our organisations, and carry the words and expertise of those directly concerned. They take control of their life and they are fighting to enforce their rights, our rights.

Today we are at a tipping point. Pioneer States are finally coming out of repressive policies and decriminalising drug use. Others are even committed to the path of regulated legalisation with a public health perspective. In 2019, we are expecting the assessment of this disastrous war that has been lasting for too long. We want to bring our point of view on this assessment, and on the good policies that could be implemented instead, and that could be implemented right now!

² Our network is made up of community-based organisations, working with minorities, in particular those most affected by HIV/AIDS: Men who have sex with men, People who use drugs, Sex workers, Migrants, Trans people, etc.

³ Source : UNAIDS

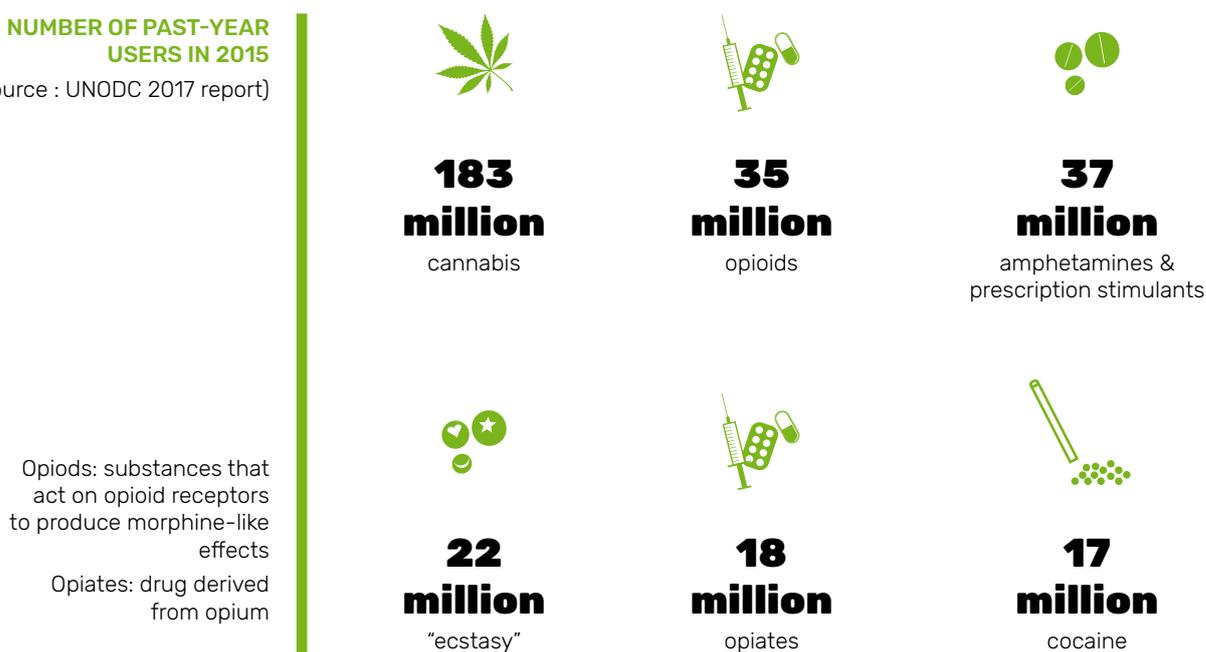
⁴ Source : UNODC

⁵ L'esprit des drogues? (*Drugs spirit ?*) directed by J.-M. Hervieu, in Autrement, série «Mutations», n° 106, Paris, 1989

I. FAILURE AT ALL LEVELS: "JUST SAY NO TO WAR ON DRUGS"

We could just say that the war on drugs is a bitter failure, simply because it does not achieve its objectives: the number of people who use drugs globally has remained stable for the past ten years⁶. Traffic turnover has been steadily increasing and production areas are becoming less and less contained⁷. The permanent appearance of new drug molecules and the development of new delivery methods, especially via the Internet, further undermine the strategies deployed by the partisans of this war.

**NUMBER OF PAST-YEAR
USERS IN 2015**
(source : UNODC 2017 report)



Opioids: substances that act on opioid receptors to produce morphine-like effects

Opiates: drug derived from opium

But it is first and foremost the disastrous consequences of this war on our health and the health of our communities that we wish to condemn, and put back in the center of this debate. Can a policy really be considered as beneficial if it stigmatises, put in a vulnerable situation and negatively impact the health of those whom it intends to "save"?

A. A war on drugs that negatively impacts the health of people who use drugs

Repressive policies are the ally of HIV, viral hepatitis and tuberculosis epidemics, as they put people who use drugs in a vulnerable situation and hinder accessibility to harm reduction tools and treatments. They are also largely responsible for the overdose epidemic observed in North America in recent months, which has been fueled by drugs being laced with dangerous substances. Moreover, they also hinder prevention efforts led by community organisations that are too often condemned as "showing drugs with a favorable angle".

6 UNODC, The World Drug Report, 2017.

7 UNODC, op. cit., 2017.

8% of people who use drugs among new HIV infections in 2015: 2nd population most exposed to the risk of HIV after men who have sex with men (MSM)] in the world (UNAIDS, 2017)

80% of scientific studies agree on this: the criminalisation of drug use has worsened the HIV and viral hepatitis⁹ epidemics, and is still a health threat. People who use drugs account for 8% of new HIV infections in 2015 globally, and 20% outside sub-Saharan Africa⁷. A share that is increasing, especially in Eastern Europe and Central Asia, and that is becoming significant in North Africa, as well as West and Central Africa.

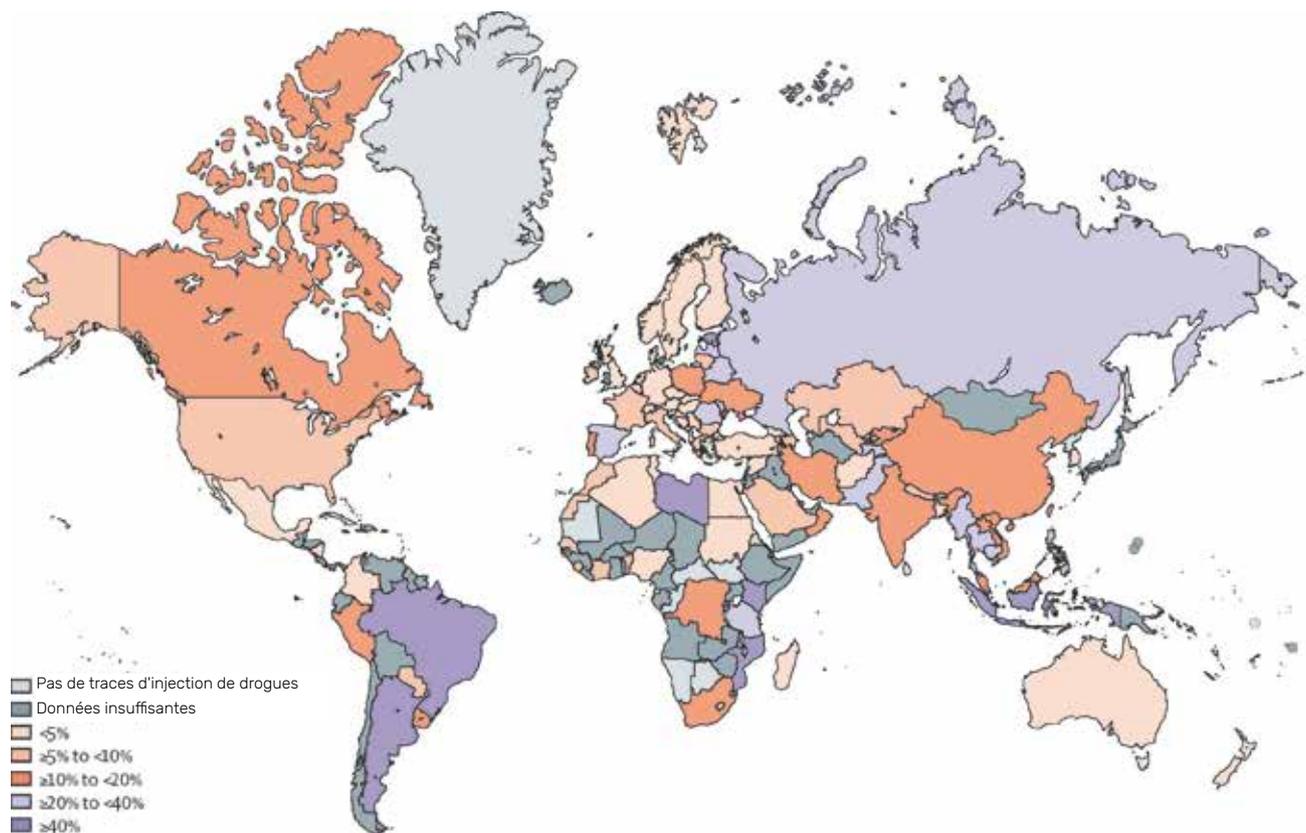
1. Over 150,000 infections yearly that are dually preventable globally

a. 30 years after harm reduction onset, we still have to share our syringes: "Just Say Yes to Harm reduction"

Infections on the rise ...

It is estimated that 15.6 million people worldwide - 3.6% of whom are women - inject psychoactive substances. Of these, 17.8% (2.8 million people) live with HIV, 52.3% with Hepatitis C Virus [HCV], 9% with Hepatitis B Virus [HBV]¹⁰ and 8% with Tuberculosis [TB].

Prévalence estimée du VIH parmi les personnes qui s'injectent des drogues



Source : Degenhardt L, Peacock A, Colledge S, et al. Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review. *The Lancet Global Health*. 2017;5(12).

8 HIV and the criminalisation of drug use among people who inject drugs: a systematic review, DeBeck, Kora et al., *The Lancet HIV*, Volume 4, Issue 8, e357 - e374

9 UNAIDS, 2017.

10 Degenhardt, L. et al. (2017), Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review, *The Lancet*, Volume 5, (No. 12, e1192-e1207).

every 4 minutes a person who injects drugs is infected with HIV in the world for lack of access to prevention and harm reduction tools

Globally, the number of HIV infections among people who inject drugs has also increased significantly between 2011 and 2015 from 114,000 to 152,000 additional cases per year (+ 33% in 4 years).

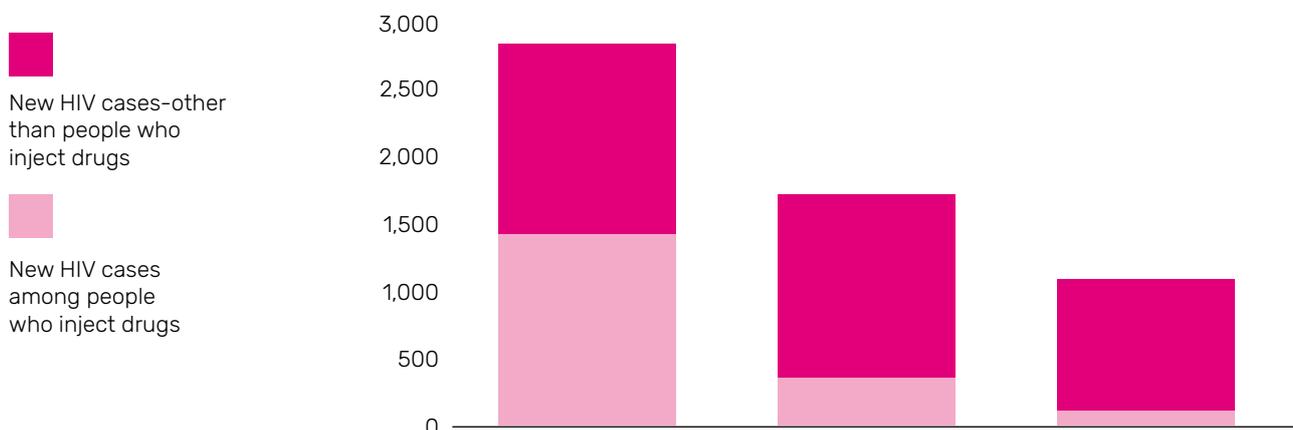
... while they could easily be avoided : "Just Say Yes to Harm Reduction"

This dramatic health crisis, however, has not yet produced coordinated responses in line with the degree of challenges it raises at global level. In 2016, only 90 countries had, for example, at least one accessible needle and syringe program. Moreover, access to harm reduction has not progressed in the last few years¹¹.

only 90 countries have a needle and syringe program

Yet, harm and risk reduction tools have proved their worth: provision of sterile equipment (syringes and needles, filters, straws, pipes, etc.), safe injection techniques, supervised drug injection centres, etc. This is particularly the case in Portugal, where massive investments in harm reduction strategies since the early 2000s have drastically reduced the number of infections among people who inject drugs.

Numbers of people newly diagnosed with HIV in Portugal since the increase of harm reduction efforts and the decriminalization of drug use 2000-2013



Sources: Domoslawski A. Drug policy in Portugal: the benefits of decriminalizing drug use. Warsaw: Open Society Foundations; 2011.

Relatório anual 2013: a situação do país em matéria de drogas e toxicodependências (Annual report 2013: state of the country in drugs and drug addiction). Lisbon: Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências.

Only 8% of people who inject drugs globally have enough access to harm reduction tools.

At global level, only 8% of people who use drugs and need harm reduction tools actually have full access to them! People who inject drugs, for example receive an average of 33 clean syringes per year, well below the threshold of 200 syringes recommended by the World Health Organisation (WHO)¹².

However, several studies have shown that harm reduction is cost-effective¹³. A New Zealand study¹⁴ for example, has shown that it is 20 times less costly than life-time antiretroviral therapy. And considering the prohibitive costs of anti-HCV treatments available since 2014, this observation is yet more obvious.

11 Harm Reduction International, The Global State of Harm Reduction, 2016

12 Larney S, et al. (2017). Global, regional and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs : a systematic review, The Lancet, Volume 5.

13 Onusida, The Gap Report, 2014

14 The Centre for Harm Reduction 2002

b. Access to health care hindered: "Just Say Yes to Health Care Services"

Deaths that should no longer happen: "Just Say Yes to Test & Treat"

in 2015, 220,000 people who inject drugs died of HCV, and 60,000 of HIV

In 2015, there were 220,000 hepatitis C related deaths among people who use drugs, and 60,000 AIDS-related deaths¹⁵. These deaths could have easily been avoided and should have been. Hepatitis C is indeed curable in 12 or even 8 weeks with the most recent treatments. HIV infection can effectively and sustainably be controlled by regularly taking antiretrovirals, making the viral load of the person living with HIV undetectable, thus breaking the chain of new infections. We have known this since 2008, and these treatments are getting gradually cheaper (US \$ 100 per person per year for first-line generic antiretroviral treatment, \$ 286 for second line treatment, \$ 1859 for third line treatment¹⁶).

In a global context already marked by the scarcity of global funding¹⁷, people who use drugs are confronted in some countries, with constraints and specific barriers, such as abstinence from psychoactive substances for access to certain HIV and HCV treatments (especially due to the fact that they are very expensive). In many States, people who use drugs have less access to antiretrovirals treatments than others¹⁸. In Russia, they account for only 25% of people on treatment while they make up 67% of people living with HIV. In Asia, only 18% of people who use drugs were on treatment in 2013. Many governments require total abstinence from psychoactive drugs to access treatment¹⁹.

Even before starting treatment, people who use drugs are among the ones that access testing at a latest stage. Moreover, they take the longest time to get into care after being positively tested for HIV. This is the case, for example, in France, where the median time between infection and testing is 3.7 years (compared with 3.2 years of median time in the general population and 2.8 years for MSM)²⁰. And it takes another 4 months on average to initiate treatment, which is very far from international recommendations. The reason is simple: vulnerability reinforced by criminalisation, and stigmatisation in access to health.

less frequent testing and often more complex access to ARVs.

Inadequate access to OSTs and drug dependency treatments: "Just Say Yes to OST"

only 80 countries offer access to opiate substitution treatment.

In 2016, only 80 countries had at least one access to opiate substitution therapy (OST)²¹ like methadone or buprenorphine. However, OST stabilises drug use and thus improves the overall health of people. In addition, a study published in 2012 showed that active injection of heroin, cocaine or both at the time of initiation of antiretroviral therapy was associated with lower suppression rates of viral load. However, access to OST seems to promote adherence to antiretroviral therapy²².

More broadly, access to modern drug dependence treatments is very often limited. Many countries either do not invest in this health field, or limit themselves to the management of closed rehabilitation centres that often combine serious human rights violations: arbitrary arrests and detentions, violence, barriers to access to health, etc.

However, in order to achieve a sustainably suppressed viral load, it is necessary to create favorable conditions for good treatment compliance over time. Vulnerability, therapeutic injunction, obstruction in accessing OSTs or drug dependence counseling, criminalisation of people who use drugs pushing them underground are all major obstacles to this central 90-90-90 objective.

15 UNODC, op.cit. 2017.

16 MSF Access Campaign, *Untangling the Web of Antiretroviral Price Reduction*, 18th Edition, 2016.

17 According to UNAIDS, \$ 7 billion a year is needed to reach 90-90-90 by 2020, ending AIDS as a global public health threat by 2030.

18 Mathers BM, Degenhardt L, Ali H, et al., *HIV prevention, treatment and care services for people who inject drugs: a systematic review of global, regional and national coverage*. *Lancet*, 2010 ; 375(9719) : 1014-1028.

19 Lert F. and Kazatchkine MD (2007, August), 'Antiretroviral HIV treatment and care for injecting drug users: an evidence-based overview', *International Journal of Drug Policy* 18(4). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2020510/>

20 Virginie Supervie. Délai entre infection et diagnostic, (*Time lapse between infection and diagnosis*) Inserm, 2018.

21 Harm Reduction International, *The Global State of Harm Reduction*, 2016

c. A lack of political will and financial means: "Just Say Yes to harm reduction funding"

HIV response: only 3.3% of funds specifically for people who use drugs.

People who use drugs are not the only one concerned by the lack of financial resources specifically targeting key populations²³ of the HIV epidemic. In 2015, while 44% of new HIV infections occurs among key populations (and their relatives and clients)²⁴, only 9.2% of the \$ 18 billion invested annually is specifically dedicated to them. For people who use drugs, this represents 3.3% of available funds²⁵ (including funding for ARV treatment), three-quarters of which are funded through international organisations, including the Global Fund to Fight AIDS, Tuberculosis and Malaria.

While HIV domestic funding in developing countries tend to increase to offset the decline in international funding, the share targeting harm reduction programmes remains extremely low, often for political and ideological reasons. The threat of being confronted in the coming years with deteriorating access to harm reduction in many countries is very real.

The trend in international funding is unfortunately not increasing, since the contributions of donors have decreased since 2014. Due to a lack of sufficient financial resources, the Global Fund, the first harm reduction funder, plans to withdraw from 24 middle income countries, even though these countries are experiencing a sharp rise in infections among people who use drugs.

Only 7% of the financial needs covered. Harm reduction is the poor relation in the AIDS response.

Regarding harm reduction alone, Harm Reduction International (HRI) estimated the financial need for basic access in 2014 to be about \$ 2.3 billion. However, only \$ 160 million was available, or 7% of estimated needs. The idea that the objective of an AIDS-free world will be achieved without specific resources for people who use drugs and without guaranteeing the respect of their fundamental rights is totally unreal.

Recent research by HRI and the Burnet Institute has shown that by redirecting only 2.5% of the resources earmarked to fight illicit drugs (\$ 2.5 billion internationally), we could provide adequate access to harm reduction, to OSTs and ARVs for people who use drugs, which would reduce by 65% the number of deaths, and by 78% the number of new HIV infections by 2030. And with 7.5% (\$ 7.5 billion), we would have the means to ensure optimal access to Harm Reduction anywhere in the world, which would put an end to the epidemic in this specific population by 2030.

23 "Key populations" refers to people at high risk of HIV, TB and malaria who have limited access to services and face criminalisation, marginalisation or human rights abuses. For UNAIDS, the top five key population groups that are particularly vulnerable to HIV and often lack access to adequate services are gay men and other men who have sex with men (12% of infections in 2015).), people who inject drugs (8%), sex workers (5%), transgender people, and prison inmates

24 UNAIDS, 2017.

25 Global AIDS Response Progress Reporting, 2010-2014.

2. Repression: An ally of the epidemic

a. Criminalisation, clandestinity and increased vulnerability

Increase in repression = increase in HIV.]

Many studies have shown that repressive policies aimed at eradicating drug trafficking drive people who use drugs away from health services and push them into marginalised environments²⁶.

Reported cases of police violence and torture of people who use drugs are numerous²⁷, as well as cases of police harassment, with confiscations of clean syringes or arbitrary arrests. These repressive practices promote clandestinity, distance people who use drugs from health systems and community actors, and *de facto* lead to sharing of used syringes^{28 29}.

The paroxysm of these repressive policies is reached in Philippines and Bangladesh, with the proliferation of extrajudicial killings of people who use drugs. In Philippines, President Duterte's bloodshed became a reality: in one and a half years, 4,251 people were reportedly killed by police according to the government; more likely between 12,000³⁰ and 20,000 according to various reports from civil society organisations. Such an open war clearly puts access to health and prevention in the background ...

b. Prison, a virus incubator: "Just Say Yes to Harm Reduction in Prison"

16% of prison inmates globally use drugs regularly, including 3.2% of heroin.

According to the UN, a third of the ten millions of prison inmates globally use drugs, 16% of which are regular users³¹, compared to 5.3% in the general population. A figure that seems obviously underestimated. Most of these detainees are not drug traffickers: 83% of drug-related offences around the world are in fact linked to personal use³². And nearly 60% of people who use drugs around the world have an incarceration history.

Cannabis is the most popular psychoactive drug in prison, followed by heroin³³. 9.6% of prison inmates report heroin use during their incarceration, including more than 3.2% of regular use.

Yet, still today, prison is a very favorable environment for the development of infectious diseases, with high levels of HIV, viral hepatitis and tuberculosis prevalence rates namely. The average HIV prevalence rate is estimated at 3.8% in prison globally, but more than 40% in some specific prisons. The overrepresentation of people living with HIV in prison, and the barriers to access treatment and harm reduction services undoubtedly feed the epidemic in this context. Indeed, only 43 countries allow access to opiate substitution therapy in prison and only 8 countries in the world allow access to sterile needles and syringes . The common lack of basic prevention tools, such as condoms, obviously also promotes sexual transmission of HIV.

The prison is also a place that promotes initiation to injection. It is moreover a place of de-socialisation and vulnerability. When exiting prison settings, people's health are worse, and they are more vulnerable, which reinforces their social stigmatisation and multiplies the obstacles met with regard to access to health.

3.8% of average HIV prevalence in prison globally!

26 Kerr T., Wood E. The public health and social impacts of drug market enforcement: a review of the evidence, *Int J Drug Pol.*, 2005; 16(4):210-220.

27 Jurgens R, Csete J, Amon JJ, Baral S, Beyrer C, People who use drugs, HIV and human rights, *Lancet*, 2010 ; 376(9739) : 475-485.

28 Rhodes T, Mikhailova L, Sarang A, et al., Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation : a qualitative study of micro risk environment, *Soc Sci Med*, 2003 ; 57(1) : 39-54

29 Sarang A, Rhodes T, Sheon N, Page K, Policing drug users in Russia : risk, fear, and structural violence. *Subst Use Misuse*, 2010: 45(6):813-864

30 Human Rights Watch, janvier 2018

31 UNODC, op.cit., 2017

32 UN Commission on Crime Prevention and Criminal Justice, World crime trends and emerging issues and responses in the field of crime prevention and criminal justice, 2013, E/CN.15/2013/9, www.unodc.org/documents/data-and-analysis/statistics/crime/World_Crime_Trends_2013.pdf.

33 UNODC, op.cit., 2017

34 Harm Reduction International, op. cit., 2016.

Incarceration promotes therapeutic failure and thus viral load increase, as well as the emergence of resistance to certain molecules

We also know that the more people are incarcerated, the less likely they are to achieve antiretroviral treatment adherence³⁵. A study conducted in Baltimore (USA) has shown that periods of incarceration increased the risk of needle sharing by twice as much, and that of treatment failure³⁶ seven times as much.

c. Stigmatisation, exclusion and racism

Global stigmatisation of problematic drug users

Drug dependency commonly leads to strong social disapproval, and stigmatisation³⁷. People with problematic drug use are less assisted, supported and cared for than people living with a mental illness or physical disability³⁸. The main idea is that people who use drugs would not be able to take care of themselves, that treating them would be a waste of time, that it is *"naive to think that addicts are receptive to the rules of hygiene that one would like them to follow"*³⁹.

This social rejection also affects the medical community: the majority of healthcare professionals have a negative and stereotypical view of people who use drugs⁴⁰. This stigmatisation is a major barrier to accessing health, treatment⁴¹, and harm reduction materials. A vicious circle then sets in: stigmatisation keeps people who use drugs away from care and makes them even more vulnerable, further increasing stigmatisation and social exclusion.

A reinforcement of social and ethnic stigmatisation

The criminalisation of drug use is not applied to all social categories in the same way, it follows a gradient of class and ethnicity⁴². Racialised⁴³ or disadvantaged people are thus more often controlled by the police, more often prosecuted and more often condemned, all other things being equal⁴⁴.

In rich countries, the media reinforce this image, portraying the dealer as a young person, coming from the popular social classes and of African origin. The user is necessarily marginal and de-socialised.

This fantasy contradicts scientific studies, obscures the great plurality people who use drugs' profiles, and at the same time reinforces the idea of a dangerous class that would be out of control and out of step with common values and norms.

Strong stigmatisation by health professionals

Racialised people are in average more controlled, more prosecuted and more condemned.

35 Milloy ML, Kerr T, Buxton J, et al., Dose-response effect of incarceration events on nonadherence to HIV antiretroviral therapy among injection drug users, *J Infect Dis*, 2011 ; 203(9) : 1215-1221.

36 Westergaard RP, Kirk GD, Richesson DR, Galai N, Mehta SH, Incarceration predicts virologic failure for HIV-infected injection drug users receiving antiretroviral therapy, *Clin Infect Dis*, 2011 ; 53(7) :725-731.

37 Goffman, E. (1963). *Stigma: Notes on the management of a spoiled identity*. Englewood Cliffs: Prentice-Hal

38 Corrigan, PW, Kuwabara, SA, & O' Shaughnessy, J. (2009) The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work*, 9(2), 139-147

39 Charles Pasqua, then French Interior Minister, March 1987

40 McLaughlin, D. & Long, A. (1996) An extended literature review of health professionals perceptions of illicit drugs and their clients who use them. *Journal of Psychiatric and Mental Health Nursing*, 3(5), 283-288

41 Luoma, JB, Twhig, MP, et al (2007) An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors*, 32(7), 1331-1346.

42 Wacquant, L. (2010). « La fabrique de l'État néolibéral. « Workfare », « Prisonfare » et insécurité sociale », (*The neoliberal state factory. "Workfare", "Prisonfare" and social insecurity*), *Civilisations*, vol. 59-1, n°1, pp. 151-174.

43 «The notion of "racialised group" seems more appropriate to us than "racial group", "race "or "visible minority". The process of racialisation here means "the extension of a racial meaning to unclassified or racially categorised relations in an earlier phase." Thus, the racialised group refers to groups carrying a precise citizenship and national identity, but targets of racism» (Micheline Labelle, *Un lexique du racisme Etude sur les définitions opérationnelles relatives au racisme et aux phénomènes connexes*, UNESCO et CRIEC, 2006)

44 Alexander, M. (2010). *The New Jim Crow, Mass Incarceration in the Age of Colorblindness*. The New Press, USA.

Nixon establishes the same sentences for 5g of crack as for 500g of cocaine!

This differentiated treatment can even be part of the law. In the United States, driven by President Nixon, prison sentences have been considerably higher for years for crack users as compared to those who use cocaine, which is more expensive to buy. Thus, a person controlled in possession of 5 grams of crack could get the same penalty as a person intercepted with 500 grams of cocaine. But in the United States, cocaine is mostly consumed by white people, and crack by Afro-Americans, without it being scientifically proven that crack is significantly more dangerous than cocaine.

B. A war on drugs that hampers development, promotes crime and weakens States

1. For producers: the A scorched-earth policy

a. Aggressive actions with no effect on long-term supply

The coca leaf, the poppy opium and marijuana grow in the wild and have been cultivated for hundreds of years. The cultivation of opium has been well documented since the 17th century, and was even used as a social neutralisation weapon by English settlers in the Victorian era. Classified as controlled substances by the 1961 *United Nations Single Convention on Narcotic Drugs*, they are still being cultivated, while demand from northern users stimulates their production.

Several international actions have since targeted supply to reduce the availability of a psychoactive drug, in such a way as to cause an increase in price and a decrease in purity, thus causing a decrease in demand.

Being part of a policy called "crop substitution", these actions oppose peasants practising subsistence farming to police patrols or heavily armed military contingents. Mostly unsuccessful, they have a negative impact on ecological (burning and fumigations) and social (job loss, displacement) levels. Since 2013 for example, the violence of 'Plan Colombia' and its aerial fumigations have led to the redeployment of production in Peru, causing a third boom of coca in this country where pulp-base was created, and which is again considered the leading producer of coca and cocaine. Note that this "balloon effect" also characterises the production dynamics within one same country, especially when farmers whose crops have just been fumigated re-settle a little further to replant coca.

b. Problematic "alternative development" policies

In some producing countries, forced crop eradication has been the first strategy to tackle illegal production. In this respect, it is an important element of the prohibitionist system. It has proved, quite immediately however, that it is not a viable method. By depriving peasants, very often, of their only source of income, it does nothing but reinforce the misery in which these communities live.

For this reason, Andean countries cultivating coca leaves, as well those producing opium poppy, have been quick to put in place policies to promote development in coca growing areas. The notion of "alternative development" refers to a more multisectoral approach and aims at addressing the structural causes of farmers' dependency on illegal crops.

If these initiatives were partially unsuccessful, it is, according to Vanda Felbabd Brown⁴⁵, because its actors did not sufficiently take into consideration all the incentives of the illegal economy. While the question of economic stability is important, it is not enough to explain the fact that farmers become coca producers. In fact, supplying local drug traffickers with raw material (coca) often comes back to benefitting from their protection. But, as Felbabd Brown puts it, "minimising risks in a high-risk environment is often more important than maximising profit".

Supply reduction has an impact on the quality of the psychoactive drug, and thus on health.

⁴⁵ Vanda FelbabdBrown, «*Improving Supply-Side Policies: Smarter Eradication, Interdiction and Alternative Livelihoods – and the Possibility of Licensing*» in LSE Expert Group on the Economics of Economics

2. From the producer to the consumer: a path full of obstacles, to the detriment of health and safety

a. A repression that favors lacing and overdoses

Each intermediary can lace the product to maximise its profit.

The first impact of repression on production and trade is manifested through the quality of the product itself. Indeed, each intermediary, at each step of the drug flow, is tempted to dilute the product by lacing it with different substances, in order to maintain a price that is acceptable to his client, while maximising his profits⁴⁶.

Fentanyl crisis: 90 fatal overdoses per day in the United States.]

However, the criminalisation of consumption often prevents any "quality control" of the drugs. The consumption of these substances used for lacing, most of the time, without the user being aware of it, can have a serious health impact: intoxication, increased risk of overdose, mixture of incompatible molecules, etc. The overdose epidemic seen today in North America is also largely related to the use of substances of which people do not know the real nature. Thus heroin is often laced with fentanyl, a very cheap substance that is 50 times more powerful than the former. Of the 90 daily fatal overdoses in the United States, a significant part is attributable to fentanyl.

b. A war that fuels local insecurity and crime

More repression = more violence and homicides

Without even falling into the ignominy of Philippines' model, it is observed that the intensification of repressive measures is always associated with an increase in violence on the drug market⁴⁷. Increased repression increases homicides and armed violence.

The war on drugs causes an average of 20,000 deaths per year in Mexico.

The stranglehold of gangs and drug trafficking criminal organisations on certain neighborhoods reinforces social exclusion, and deprives populations of access to health through the scarcity of public health services, the departure of health professionals and difficulties of access faced by community actors.

Tens of thousands of homicides are also directly linked to drug trafficking worldwide each year. For example, Mexico has seen 25,339 homicides in 2017 (official figure), making this year the deadliest since the establishment in 2006 of the government crackdown on drug cartels. Less than 20,000 homicides on average were recorded each year before.

c. A war that finances crime and terrorism at the international level

35% of criminal groups worldwide are involved in drug trafficking.

In 2014, it was estimated that 35% of international criminal groups were involved in the drug trade which generated between a fifth and a third of their income through the sale of narcotics. Mobile communications offer new opportunities for traffickers, while Darknet allows users to purchase narcotics anonymously online by using cryptocurrencies, such as bitcoin.

Although drug trafficking on Darknet remains low for the time being, there has been an increase in drug transactions of around 50 % per year between September 2013 and January 2016. Typical buyers are recreational users of cannabis, ecstasy, cocaine, hallucinogens and new synthetic products (NPS).

Terrorism: drug trafficking accounts for nearly half of the Taliban's incomes in Afghanistan.

Although not all terrorist groups depend on the benefits of drug trafficking, this is the case for some of them. Without the profits generated from drug production and trafficking, which account for nearly half of the Taliban's annual income, the reach and impact of the Taliban would probably not be what they are today. As much as 85% of Afghanistan's opium crop is in Taliban-controlled territory, with sales of at least \$ 150 million in 2016 alone.

46 Preble, E. and Casey, J.J. (1969) 'Taking Care of Business - The Heroin User's Life on the Street', in, *International Journal of the Addictions*, 4, pp. 1-24.

47 Werb D, Rowell G, Guyatt G, Kerr T, Montaner J, Wood E, Effect of drug law enforcement on drug market violence : as systematic review. *Int J Drug Policy*. 2011 ; 22(2) : 87-94.

3. A North / South dynamic that has to be questioned

a. The heavy human toll of the war on drugs in the South

Faced with the failure of demand reduction, supply reduction policies have finally contributed in worsening security crisis, particularly in Central America and Central Asia, leaving behind an unbearable human toll on the population.

In 2012, families and relatives of victims crossed Mexico to the symbolic city of El Paso, in the United States, to protest the conflict. The "Caravan for Peace and Dignity", led by the poet Javier Sicilia, stopped in about twenty towns during his journey, organizing gatherings and meetings, where victims' relatives could exchange, meet, and express their exasperation at the situation. This initiative was echoed around the world, reminding Western countries consuming drugs of the human cost of their war on drugs in Latin America.

But this human toll does not limit itself to security crisis and the violence engendered by the militarisation of conflicts. Indeed, many human rights abuses were committed in the name of the war on drugs by the States themselves; violations of the right to life, the right to health, the prohibition of torture, etc.

Not only has the war on drugs caused an extremely heavy human toll, but it has also created obstacles to development in some developing countries.

b. A war on health: the example of access to controlled medicines

Access to controlled essential medicines

The international drug treaties are major barriers to access to painkillers in many countries, particularly in Africa.

It is estimated that 5.5 billion people have no access, or limited access, to controlled opioid analgesics - in particular morphine - and are thus exposed to preventable suffering⁴⁸. Some of these medicines, like methadone or buprenorphine, are used to treat opioid addiction.

The goal of strict control is to prevent misuse. This prompted China to seek the inclusion of ketamine on the list of United Nations controlled substances. However, putting under control this analgesic, widely used in Africa in particular, would have seriously hindered access to essential and urgent surgeries in countries where no other means of affordable anesthesia is available.

Medical cannabis: Just Say Yes to Medical Marijuana

The International Association for Cannabis as Medicine (IACM) lists the many therapeutic applications of cannabis, which are largely hampered by repressive policies. These applications include: nausea and vomiting, anorexia, spasms, movement disorders, pain, glaucoma, epilepsy, asthma, cravings, depression, autoimmune diseases and inflammation, etc.

For people living with HIV, medical cannabis can soothe nausea and vomiting associated with some antiretrovirals and also has added value to peripheral neuropathies. However, combating the undesirable effects of treatment helps to reinforce the therapeutic adherence, thus the sustainable maintenance of an undetectable viral load; which breaks the chain of new infections. People living with HIV and under treatment are also regularly eligible for therapeutic cannabis programs in the countries that allow for it.

The legalisation of the therapeutic use of cannabis in the world remains very marginal, even if it is increasing, especially in America and Europe. Zimbabwe became on April 28, 2018 the first African country to allow for it.

Violations of rights, torture, extrajudicial executions: a heavy human toll.

5.5 billion people in the world do not have sufficient medical access to painkillers.

Obstacles in access to therapeutic cannabis: a missed opportunity for people living with HIV.

C. The huge cost of the war on drugs

100 billion dollars a year wasted in an all-out crackdown: 5 times more than the total financial resources available for the AIDS response in the world every year!

A \$ 330 billion market that generates no tax revenue.

Globally, the repression of the production, trade and use of illicit drugs costs at least \$ 100 billion a year⁴⁹ to the States. According to the Drug Policy Alliance (DPA), US \$ 50 billion is spent annually in the United States alone, including through the Drug Enforcement Administration (DEA), US federal narcotic police service created in 1973 and also present in 70 countries.

This repression did not even allow to bring down consumption around the world. This is indeed constantly rising, with more than 300 million people using illicit drugs.

Finally, this \$ 100 billion does not help to limit a booming market: drug trafficking accounts for at least \$ 330 billion in annual revenue. This market is a parallel economy, escaping the tax administrations, and could release huge sums to invest in prevention, access to health and medical research specifically.

In Colorado (USA), where cannabis was legalised in 2012, tax revenues are huge. The tax rate of 30% thus raised \$ 76 million as of 2014. In 2016, \$ 200 million was generated through this channel. This would fully cover the financial needs for harm reduction, prevention, and access to health, without having to mobilise police force and the justice system.

Partial conclusion:

The war on drugs, which is still a priority for many governments today, is a failure: drug use is still on the rise. Everyone agrees at least on this point. But above all, this war has negatively impacted our health: people who use drugs impacted through overdoses and infectious diseases, peasants made vulnerable by the destruction of their cultures, direct or indirect victims of criminal networks and gang violence.

When a policy is bad in every respect, one needs enough courage to question it. But for the war on drugs, rationality and scientific evidence seem ineluctably discarded or ignored in favour of purely dogmatic and moral considerations.

⁴⁹ The Alternative World Drug Report: Counting the Costs of the War on Drugs, Transform Drug Policy Foundation, 2012.

II. A RECENT IDEOLOGICAL REPRESSION

This "war on drugs" is not as old as mankind, but rather the opposite⁵⁰. This war is a recent political choice, which might be hard to understand when put into context, the reasoning behind being based on moral considerations rather than scientific facts. The most emblematic case is the considerable difference in treatment between alcohol and products like cannabis, while the former is significantly more dangerous individually and socially⁵¹.

Above all, the very principle of hindering the personal consumption of a psychoactive substance is opposed to the right to dispose of one's body and in that, to our fundamental freedoms. It stems from a desire for social control over our bodies and minds, and goes against the right to pleasure.

A. Drugs and humanity: a long history

1. Psychoactive substances used since the origins of humanity

Anthropologists agree on the existence of psychoactive substances use from the first steps of the human being in the knowledge of his vegetal environment. Traces of hallucinogenic plant use are attested as early as Prehistory.

Opium poppy cultivation is documented as early as 4000 BC in Mesopotamia⁵², that of the coca leaf is attested in Ecuador and Peru to more than 2000 BC and the oldest known reference to the psychoactive uses of cannabis dates back to 2700 BC in China⁵³. These plants have even been traded very early: the regions least equipped with psychoactive plants have in fact experienced a wide range of different drugs supply.

The desire to control drugs in an "integral" way, from production to use, is therefore quite a recent phenomenon.

2. The first Globalisation of drugs

At the time of the "great discoveries", psychoactive products are among the first to circulate in Europe, as early as 1520 for tobacco imported from South America.

In 1595, in Amsterdam, the VOC, *Verenigde Oost indische Compagnie* is created, and is the first company of the East Indies. This organisation, financed by shares listed on the stock exchange, has considerable powers: it can sign treaties, raise armies, build fortresses, declare wars, exercise justice, issue coins, raise taxes. Its objective is simple: to generate a maximum of profit through trade. The VOC is the first major capitalist multinational.

The VOC grows as Europe "discovers" and, above all, colonises the world. It carries and sells tobacco, rice, sugar but also drugs: it gets the monopoly on the opium harvested in India, which it sells massively in China. This is the first drugs globalisation.

Traces of hallucinogenic plant use are attested as early as Prehistory

1520 : tobacco imported from South America to Europe, first Globalisation of drugs

50 Pierre-Arnaud Chouvy et Laurent Laniel, « De la géopolitique des drogues illicites » (*Illicit drugs geopolitics*), Hérodote no112, p. 7-26, 1^{er} trimestre 2004, La Découverte

51 Global Commission on Drug Policy, *The World Drug Perception Problem*, 2017.

52 Dugarin Jean, Nominé Patrice. *Toxicomanie : historique et classifications. Histoire, économie et société (Drug dependency: history and classifications. History, economy and society)* n°4. Toxicomanies : alcool, tabac, drogue, 1988

53 Chouvy, *Des plantes magiques au développement économique (Magical plants for economic development)*, p. 18-24

Imported opium (tons)



With 300 to 400 tons of opium imported into China each year, and the consequences in terms of health dependency, the prohibition of opium is decreed by the Manchu emperor on its territory in 1729. England, which supplants the VOC with the EIC (East Indian Company) and holds the Indian monopoly as from 1758, then organises contraband, followed by war. Two opium wars (1839-1842 then 1856-1860) led by England (but also France, the United States and Russia for the second) put China on its knees. In 1858, the Tientsin Treaty legalises the import of opium into China. In 1884, 6,500 tons are imported. Opium represents more than 41% of the colonial profits of England. In response, China develops its own cultivation, which reaches a production of 12,000 tons in 1896 and annihilates English commercial profits. Ironically, Queen Victoria then declares in the House of Commons that the opium trade is immoral.

3. Industrialisation: new supply and new demand

The 19th century sees the rise of the industrial revolution. Mines, factories and mills gradually develop, with extremely harsh working conditions. Great Britain sees a massive rise in the consumption of psychoactive substances, especially opium and its derivatives, in coronas and working class suburbs, and this trend gradually spreads throughout Europe and the United States.

At the same time, chemistry allows for the discovery of new products: morphine in 1803, cocaine in 1860, heroin in 1874. Opiates are sold over the counter, in various forms: morphine tablets, codeine candies, potions, elixirs, balms, etc. Hashish is sold over-the-counter and cannabis cigarettes are even strongly promoted.

Gradually, medical discourse evolves in the field of psychoactive drugs and moves away from the notion of pleasure by confining it strictly to a therapeutic use⁵⁴, especially with regard to the social and health consequences of drug abuse in the industrialised societies during the 19th century. In addition, morphine, which is widely used, poses a problem for Catholic doctors, since the patient runs the risk of losing consciousness of his "last duties".

1803: discovery of morphin

1860: discovery of cocaine

1874: discovery of heroin

B. The American war on drugs

1. The religious origin of the war on drugs

The first attempts at regulating the consumption of psychoactive substances are old: Islamic law (sharia law) forbids, for example, any consumption of toxic substances. And, as early as the 13th century, the Emir of Egypt tries to ban the use of cannabis. Pope Innocent VIII also bans it in a papal bull of 1484, without much success.

In the 17th century, the economist Jean-Baptiste de Montyon brings out the notion of "vicious substance", notion which comes with the proposition of taxing immoral behavior⁵⁵.

During the opium wars in China, the American temperance leagues are outraged at this forced trade of an alienating substance for the sole purpose of profit. This constitutes the first steps of modern prohibition, based on the supposed virtue of abstinence (a principle derived from Protestant morality). These leagues then take an important place in American politics, influencing debates and international politics.

Religions (islam, catholicism, postantism) try to regulate drugs uses.

54 JJ Yvorel, « L'évolution du discours médical sur la drogue de 1800 à 1916 » (*The evolution of the medical discourse on drugs from 1800 to 1916*), dans Collectif, *Le Corps et la santé*, actes du 110^e Congrès national des sociétés savantes, Montpellier, 1985, section d'histoire moderne et contemporaine, CTHS, 1985, Tome I, pp 173-190.

55 René Stourm, *Systèmes généraux d'impôts (General tax systems)*, Lib. Felix Alcan, Paris, 3^e éd., 1912, p. 38-39

At the beginning of the century, the active advocacy of Charles Henry Brent, bishop of the Episcopal Church, convinces the American President Theodore Roosevelt (1901-1909) to prohibit the non-therapeutic use of drugs. The justification for repression and prohibition is rooted in the assumption that the use of psychoactive substances is morally reprehensible because of its link to the quest of pleasure. The public health arguments put forward are actually conditional to a dominant culture of Protestant ethics⁵⁶, of which Charles Henry Brent is one of the leading figures.

The Pure Food and Drug Act, the first federal drug regulation law, is voted in 1906 to protect society from the deleterious effects of drug abuse, mainly opium and its derivatives. A second law, the Harrison Narcotics Tax Act, is voted in 1914, and specifically targets opium and its derivatives. It regulates and taxes the production, importation, distribution and consumption of opiates. Any non-medical use of cocaine, opium, morphine and heroin is prohibited. In 1919, the Volstead Act and the 18th Amendment prohibits any alcoholic beverage of more than 0.5 °.

This offensive against psychoactive substances grows very fast internationally. In 1908, at Brent's instigation, who opposes their use "for moral reasons", legal sales of opium are prohibited in Philippines, an American colony from 1898. He is then part of a commission of three men responsible for investigating the use and trafficking of opium in Asia. He considers opium as "the greatest evil of Filipino society".

2. The internationalisation of the war on drugs

Brent's offensive takes on a global scale in February 1909 during the International Opium Commission in Shanghai. He is then "chief commissioner of the American delegation". The first non-binding international agreement is limited to opium, but nevertheless provides the basis for controlling the drug trade.

In 1912, Brent becomes president of the American delegation when the first international drug control treaty is signed in The Hague: opium, morphine and cocaine are included. The Coca-Cola company is even forced to 'decochain' the coca leaf that it uses⁵⁷. This first convention also has an impact in many countries. Thus France bans all narcotic substances (heroin, morphine, cocaine) in 1916.

This text marks the shift from a free and legal drug market system to a regulation of the latter. Officially, this regulation is a response to a "real humanitarian tragedy: the Chinese epidemic of opium"⁵⁸, in the words of the United Nations Office on Drugs and Crime. In fact, Western states are defending the interests of "their" then-expanding pharmaceutical industry, as they have clearly understood the financial stakes of marketing psychoactive substances such as opiates, with strong analgesic and anesthetic potential. The international drug control system continues to be built up throughout the twentieth century in this ambiguity, between morality and the satisfaction of economic and geostrategic interests.

In 1925, the League of Nations concludes in Geneva the International Convention on Narcotic Drugs, which also deals with cannabis and ecgonine (close to cocaine). Six international conventions are signed in 1931 and 1953: they all aim at reinforcing the prohibition of use and sanctioning the sale.

Nevertheless, the European powers have challenged the prohibitionist position of the United States until the 1950s⁵⁹. Decolonisation leads them to join the US position, stigmatising developing countries as drug producers.

1906: Pure Food and Drug Act, first American federal drug regulation law.

1909 : International Opium Commission in Shanghai, first international agreement on opium.

1912: first international control treaty signed in The Hague (Netherlands).

57 Nourrisson, D. (2008). La saga Coca-Cola (*Coca-cola saga*). Paris, France : Larousse.

58 UNODC, Cent ans de Contrôle des drogues, Catastrophe sanitaire mondiale, évitée. Les plus vulnérables, toujours exclus, (*100 years of drug control, global health disaster, averted. The most vulnerable, always excluded*), 2010

59 Guillermo Aureano, « L'État et la prohibition de (certaines) drogues » (*The state and the prohibition of (some) drugs*), in Cemoti, no32 - Drogue et politique, juillet-décembre 2001

C. Total international control

1. The three international conventions in force: 1961, 1971, 1988

1961: Single Convention on Narcotic Drugs (and creation of INCB)

1971: Convention on Psychotropic Substance

1988: Convention against the Illicit Trafficking of Narcotic Drugs and Psychotropic Substances]

The war on drugs takes a compulsory and binding character after the Second World War, under the aegis of the United Nations. The Single Convention on Narcotic Drugs of 1961, ratified on March 20, 1961⁶⁰ and amended on 25 March 1972, is the first of the three conventions which constitute the contemporary international legal framework applicable to States. It unifies the existing international texts, extends the control of the sale and distribution to the production, and especially, classifies the substances considered henceforth as narcotics and whose use will be controlled.

The 1971 Convention on Psychotropic Substances⁶¹ completes the 1961 Convention by taking into account, inter alia, the phenomenon of synthetic drugs.

The 1988 Convention against the Illicit Trafficking of Narcotic Drugs and Psychotropic Substances⁶² accentuates the repressive nature of the 1961 Convention, in particular by removing certain ambiguities about the criminal provisions laid down according to the offences. States parties are therefore obliged to translate these conventions into their national legislation.

At the same time, the United Nations system develops its organs dedicated to drug policy monitoring. The International Narcotics Control Board (INCB), created by the 1961 Convention, is responsible for the compliance of the States with the conventions. Every year, the INCB produces a report reviewing States Parties and their compliance or non-compliance with the Conventions.

The Commission on Narcotic Drugs (CND), founded by the United Nations Economic and Social Council (ECOSOC), has a legislative role and can clarify the conventions if needed, but has an operational role as well in their implementation.

2. Nixon and his total war on drugs

Reagan revives the war on drugs with the “Just Say No” campaign.

The election of Richard Nixon, the “law and order” candidate at the United States’ presidency in 1968 has an important role in strengthening the war on drugs. On September 21, 1969, Nixon launches Operation Interception, which aims at searching vehicles on the Mexican border to fight against cannabis trafficking.

His televised speech on June 17, 1971 is generally considered the United States’ official declaration of war on drugs. The United States will actively participate in the strengthening of the international drug control system, including through the 1971 and 1988 conventions.

The American presidency of Ronald Reagan (1981-1989) constitutes a new revival, with the famous “Just Say No” campaign”, popularised by Nancy Reagan, which aims at dissuading young people from experimenting with the use of psychoactive substances.

The choice to classify a product as illicit is not correlated to their physical, psychological or social danger.

3. The non-scientific nature of the classification of narcotic drugs

Four tables, annexed to the 1961 Convention, classifies narcotics according to their dangerousness and their addictive potential.

This classification, which has been strongly criticised for being random and not scientifically sound, includes opiates, opioid, coca and cannabis derivatives. These substances, which circulated freely at the beginning of the century, are now subject to strict controls. The latter are so strict that they effectively prohibit the production, transportation, distribution, sale and use of drugs outside the medical, pharmaceutical or scientific framework.

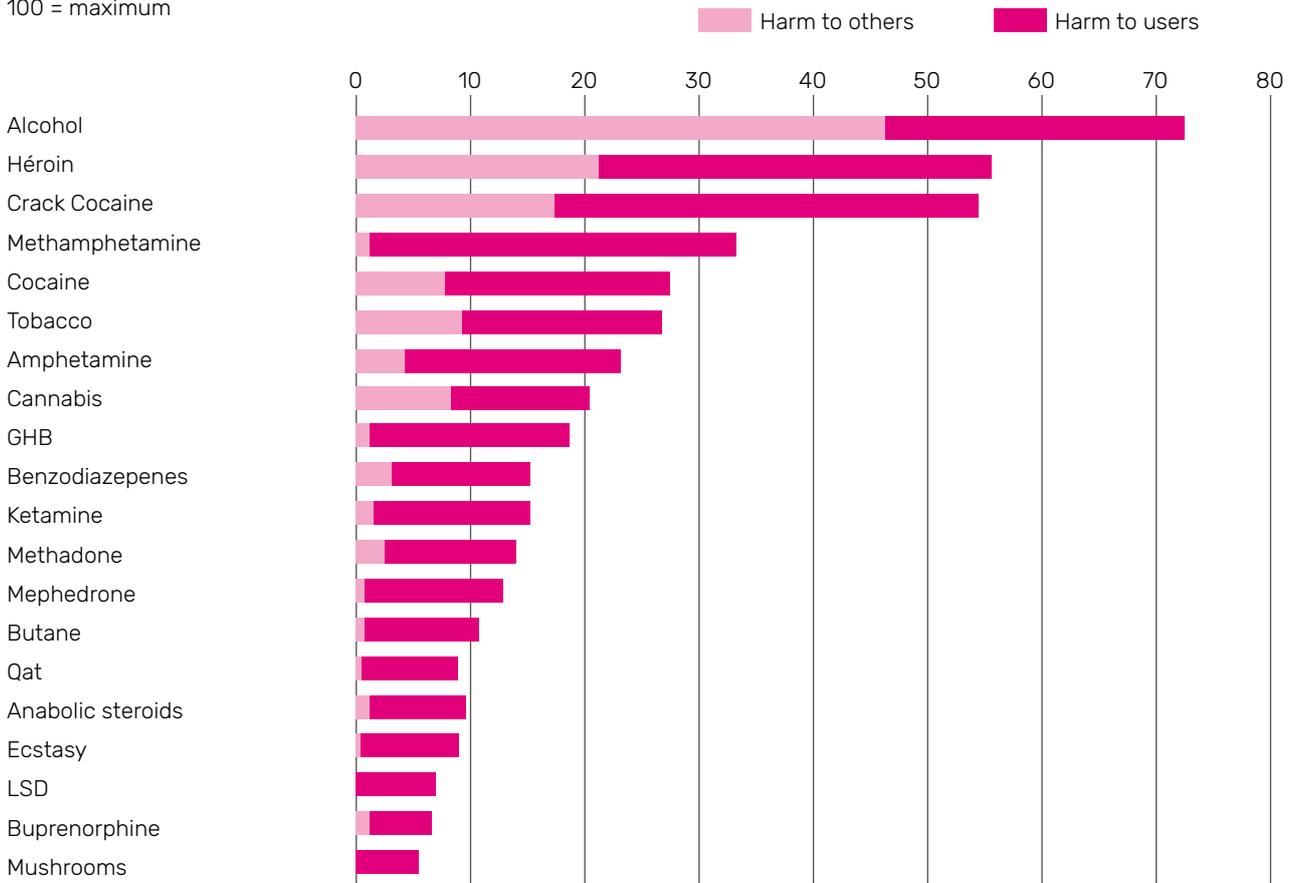
60 Single Convention on Narcotic Drugs, 1961, As amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961 https://www.unodc.org/pdf/convention_1961_en.pdf

61 Convention On Psychotropic Substances, 1971 https://www.unodc.org/pdf/convention_1971_en.pdf

62 United Nations Convention Against Illicit Traffic In Narcotic Drugs And Psychotropic Substances, 1988, https://www.unodc.org/pdf/convention_1988_en.pdf

Harm caused by drugs⁶³

100 = maximum



Classification of drugs – levels of harm vs levels of control

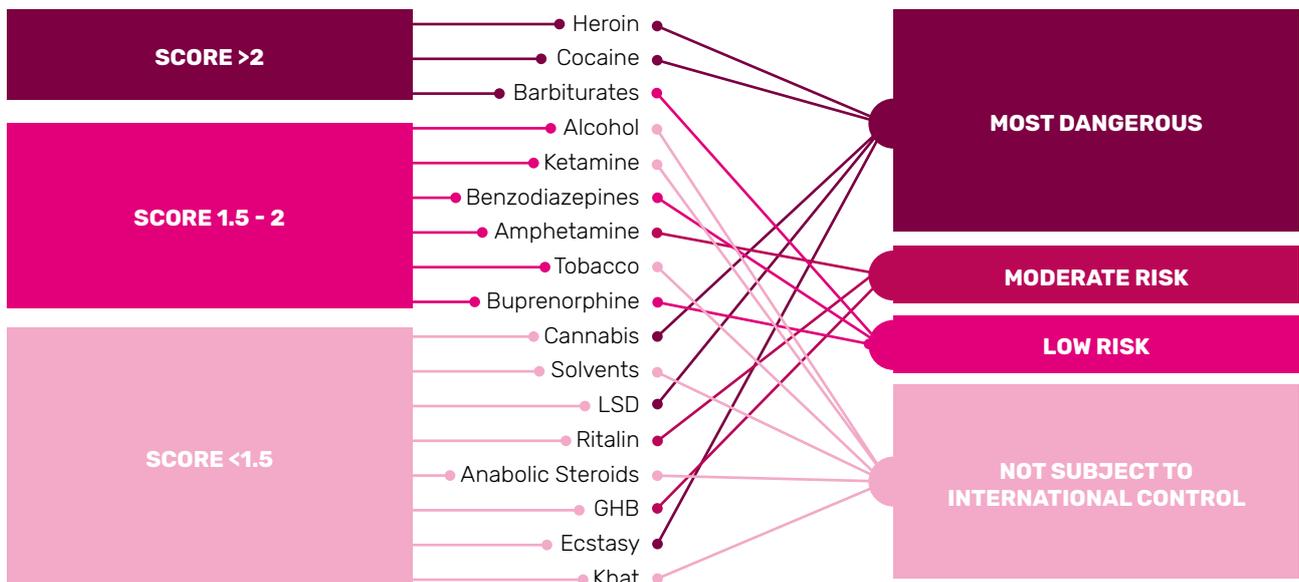
(Global Commission on Drug Policy, 2017)

LEVELS OF HARM

independent expert assessments of risk

LEVELS OF CONTROL

un classification of drugs



63 Nutt, David J et al., Drug harms in the UK: a multicriteria decision analysis, The Lancet , Volume 376 , Issue 9752 , 1558 - 1565

Cannabis is more controlled than alcohol, while it is less harmful to oneself and others.

However, the choice of products is not correlated to their physical, psychological or social danger. Thus, cannabis is extremely controlled and its consumption strongly repressed, while it is significantly less dangerous in every respect than alcohol or tobacco⁶⁴.

Partial conclusion:

Gradually, throughout the 20th century, the US has imposed on the world its total war on drug: a war against people who use drugs, against producers and against intermediaries. This offensive is a failure as massive as the means mobilised: psychoactive drug use is increasing, in deplorable health conditions, the criminal groups are proliferating, and violence is reinforced. As this war cannot be justified by scientific facts or even public health goals, many voices are rising to demand that an end be put to it.

64 Nutt, David J et al., Ibid.

III. HEALING THE WORLD FROM THE WAR ON DRUGS

The disastrous state of the war on drugs and the difficulties in challenging it could lead to many militant motivations being worn out. There are, however, objective reasons to keep the faith.

On the one hand, community mobilisation, of which we are partners, has never been stronger and more structured. Legitimate community expertise has emerged, and sustainable alliances have been forged nationally and internationally. Above all, this mobilisation, that has fought for and implemented harm reduction services, has shown its effectiveness. It is slowly but surely helping to change the way our societies look at people who use drugs.

This mobilisation is starting to bear fruit: some States are finally coming out of repressive policies and decriminalising the use of drugs, while others are embarking on the path of regulated legalisation, with a public health perspective. Several international bodies are now calling for a change in policy, and "public opinion" is increasingly agreeing on the failure of repressive policies. If the road seems long before this devastating and therefore counterproductive war ends, this mobilisation is our greatest strength.

A. Community mobilisation

1. The first tipping point: the HIV epidemic and the emergence of harm reduction

The HIV epidemic could never have been a topic among people who inject drugs. How many infections and deaths could have been avoided if clean needles had been freely available throughout the 1980s?

The first informal needle and syringe programs date as far back as the 1970s, in response to the hepatitis B epidemic (discovered in 1963). However, they remained very marginal until the arrival of the HIV epidemic, which motivated a relatively rapid adoption of this health measure around the world⁶⁵.

The first official programs are set up in 1984 in the Netherlands, in 1986 in Australia, in 1987 in the United Kingdom. In France, AIDES - Coalition PLUS French member - chose civil disobedience and syringe exchange as early as 1987, long before the first experimental programs were authorised in 1989. Until the authorities wake up, thousands of people injecting drugs are contaminated with HIV.

This major health crisis urges people directly concerned to get organised, in survival mode. This gives rise to "harm reduction" strategy, carried by community actors opposed to the therapeutic injunctions and the abstinence condition imposed for accessing care.

This strategy is still not clearly understood in half of the countries globally. And it is regularly pointed out by prohibition advocates: "some organisations and local governments actively advocate the legalisation of drugs and promote policies such as "harm reduction" that accept drug use and do not help drug users to become free from drug abuse. This undermines the international efforts to limit the supply of and demand for drugs. "Harm reduction" is too often another word for drug legalisation or other inappropriate relaxation efforts, a policy approach that violates the UN Conventions".⁶⁶

1984: the first needle and syringe program in the Netherlands.

In 2018, harm reduction is still not implemented everywhere!

⁶⁵ Ritter, A and Cameron, J (2006) A Systematic Review of Harm Reduction, Drug Policy Modeling Project, Monograph 06, Turning Point Alcohol and Drug Center, University of Melbourne, December

⁶⁶ Declaration of the World Forum Against Drugs, Stockholm, September 10, 2008.

2. The emergence of a speech of the persons concerned

The health crisis of HIV epidemic has reinforced the emergence of self-help groups.

1977: Creation of the first "Junkie union" in Amsterdam.

1992: Creation of Asud (France)

2006: Vancouver Declaration

Creation of IDPC.

The development of access to harm reduction tools and opiate substitution treatment and their success (significant drop in HIV infections, and a lifestyle less focused on the daily search of the substance) have also allowed two major evolutions: a change in perception of people who use drugs – the "irresponsible and suicidal addict" is able to take care of his health, to protect himself/herself and others – and a community dynamic – people who use drugs group together, support each other and share common findings and claims.

On this last point, it is undeniable that the health crisis of the HIV epidemic has reinforced the emergence of self-help groups between people who use psychoactive substances.

In the Netherlands, the "Junkie unions" develop in the late 1970s (1977 in Rotterdam, 15 groups in 1980), and fight against the stigmatisation of people who use drugs. They demand massive deployment of harm reduction tools and reform of the legal framework on drugs.

On the occasion of World AIDS Day 1990, many community activists, including the Rotterdam Junkie Bond, found the European Interest Group of Drug Users (EIGDU) in Berlin, financially supported by Deutsche Aids-Hilfe. EIGDU publishes in 1992 a book to challenge decision makers and public opinion: *Situation for Drug Users in Europe*.

In France, in 1992, Asud (Self-support of people who use drugs – *Auto Support des usagers-ères de drogues*) is created, and organises itself around the publication of a prevention journal, articulating the promotion of harm reduction tools and around political advocacy for decriminalisation: "The Journal of Happy Drug Users".

The structuring of self-help community organisations progresses throughout the 1990s. In the United States, a first union of people who use drugs come into being in 2005: VOCAL (Voices of Community Activists and Leaders). At the international level, several networks are launched, including INPUD (International Network of People who Use Drugs) in 2006 at the Vancouver International Conference. The focus of this conference is the publication of a Vancouver Declaration⁶⁷, which is still relevant today, and begins: "We are people from around the world who use drugs. We are people who have been marginalized and discriminated against; we have been killed, harmed unnecessarily, put in jail, depicted as evil, and stereotyped as dangerous and disposable. Now it is time to raise our voices as citizens, establish our rights and reclaim the right to be our own spokespersons striving for self-representation and self-empowerment"

3. Expertise and echo growing in public opinion

This community dynamic at the international, national and regional levels is strengthening these recent years. Continental networks are emerging, such as the Asian Harm Reduction Network (AHRN), created in 2003, the Asian Network of People who use drugs (ANPUD) created in 2007 or the West Africa drug policy network (WADPN –) established in 2015.

Created in 2006, the International Drug Policy Consortium (IDPC) is a global network of 173 NGOs on issues related to production, trade and use of controlled drugs. The rise of IDPC is one of the signs of the shift operating in community organisations towards the production of expertise, more and more specific and high level, in order to weigh in the public debate and to be seen as legitimate partners in the eyes of national decision makers and the international authorities. This expertise is sometimes based on very thorough studies and community research in the field.

⁶⁷ Vancouver Declaration, 2006 : <http://www.inpud.net/en/vancouver-declaration>



IDPC initiates in 2013 the first edition of "Support Don't Punish". Since then, it has been held every year on June 26th, the International Day against Drug Abuse and Trafficking, as well as the International Day in Support of Victims of Torture. This mobilisation is gaining momentum over the years, all over the world, and brings a unique opportunity of recurrently bringing the subject in the public debate.

B. The expansion of alternative models meeting public health objectives as opposed to the repressive one

Reduce harms, decriminalise or legalise? It is not about choosing between the three models. Nor is it a matter of prioritising these three actions, or putting one above the other. In a public health logic, we need these three approaches in order to promote the most effective access to health: reduce harms with appropriate and accessible tools; decriminalise to get people out of vulnerability and reduce stigmatisation; legalise to control the quality of products and limit their distribution.

1. Limit the harms and risks around drug use (since 30 years)

This is the first alternative model to the all-repressive: "*limiter la casse*"⁶⁸ (limit the damages). It's firstly about dealing with criminalisation and its consequences, with an individual and public health perspective. This model has proved its worth: in countries that have developed harm reduction programs in free environments as well as in prisons settings, initiatives like safer consumption rooms, supervised injection sessions, etc., have caused a consequent decrease in infection rates. People who inject drugs there represent between 0 and 2% of new HIV infections per year. This is the case in France, Portugal, the Netherlands, etc.

Counter-example: in Russia, with severe repression, very limited access to harm reduction tools and care, 93% of new infections occur among people who inject drugs.

2. Decriminalising drug use (over the last 15 years)

Nevertheless, as developed in part I.A. of this guide, harm reduction measures are not enough to create a totally enabling environment for access to health for people who use drugs. Stigmatisation, vulnerability, arbitrary policing are all experiences lived by the people who use drugs every day.

This is what leads Portugal to decriminalise the personal use of all drugs in 2001. The limited amounts considered as personal use are 25g for cannabis, 1g for MDMA, 2g for cocaine, 1g for heroin, 10g for opium, etc. Research conducted by the Cato Institute has shown that, five years after the application of the law, drug use has decreased among adolescents, the rate of HIV infection among people who use drugs has decreased, the number of drug-related deaths has been cut in half and the number of people on drug dependence treatment has doubled⁶⁹.

Other European countries decriminalise personal use for one or all drugs: Spain, Czech Republic, Switzerland, Norway, etc.

The harm reduction model has proved its worth

2001: Portugal decriminalises personal use of all drugs

⁶⁸ Title of an inter-organisation call of 1993 in favor of the deployment of harm reduction in France. The word *casse* in French, literally means the action of breaking something, but can also take different popular meanings, like a breaker's yard, or at the war front, it can mean that there will be many deaths (<http://www.cnrtl.fr/definition/casse>). It can also mean a robbery or a hold-up.

⁶⁹ Glenn Greenwald, « Drug Decriminalization in Portugal : Lessons for Creating Fair and Successful Drug Policies », *Cato Institute*, avril 2009

Several countries decriminalise personal use for one or all drugs in Europe and America.

In Latin America, the subject is also fiercely discussed. In Colombia, possession of drugs for personal use was decriminalised following a ruling of the Constitutional Court in 1994. The latter found that the sentences violated Article 49 of Colombia's Constitution, which guarantees freedom of decision with regards to personal health as long as it does not affect the rights of others. After 2009, the ban on consumption was reintroduced following the adoption of an amendment led by the pro-drug war president Álvaro Uribe, but the sanctions were limited to administrative penalties such as treatment. In August 2011, however, the Colombian Supreme Court ruled that the new law violated individual freedoms and upheld the 1994 ruling. In May 2012, the cultivation of coca, marijuana and opium was decriminalised.

Mexico has also embarked on this path by decriminalising the possession of very small amounts of narcotics in 2009 (up to 5g of cannabis, 0.5g of cocaine, 50mg of heroin and one ecstasy pill).

What are the limits?

Decriminalisation makes it possible to stop sanctioning drug use and eases access to health, even though it is often subject to arbitrary policing in terms of quantity defining a "personal use". It is also limited in terms of product quality, which is the cause of many overdoses in the world today, especially in North America. Decriminalising in northern countries, while pursuing policies to reduce supply in the South, equates to promoting the consumption of substances whose quality is left uncontrolled, and which are therefore often laced with other substances.

3. Legalise (since 1 year)

Several States have taken the path of legalisation, only for cannabis so far though. Several US states have paved the way: Colorado and Washington in 2012, Oregon, Alaska and Washington DC in 2014, Massachusetts, Maine and California in 2016.

In December 2013, Uruguay became the first State to legalise consumption, sale, production and transportation of cannabis throughout its national territory. The legalisation has been effective since July 2017. Canada becomes in 2018 the second State (and the first G7) to legalise cannabis.

Several models that are developing are to be considered, even if there are similarities between most of them: ban on advertising, prohibition of sale to minors and ban on driving after consumption, controlled sale operating via a specific framework (via specialized sales outlets, pharmacies, etc.), product quality control and THC content limitation, and threshold limits (40g per month in Uruguay, 28.4g in Colorado, 50g for Canada).

Dans le cas de l'Uruguay, cette légalisation va de pair avec un renforcement considérable des moyens mis sur la prévention et l'information, notamment à destination des jeunes.

What are the limits?

The first examples of cannabis legalisation do not show a significant increase in consumption, and can limit trafficking and ensure the quality of products used, while limiting their access. In any case, no legalisation model should be implemented in a fully liberal model: as health actors, it is a regulation of the production and the sale which represent a real health and social added value. This would be a means to control the quality of the substance, and the delivery conditions.

2012: Colorado and Washington (United States) legislate cannabis.

2017: legalisation effective in Uruguay, associated with a considerable increase in resources targeting prevention.

Cannabis legalization don't show a significant increase in consumption.

C. What are we missing to end this war?

1. Should we review the international conventions?

Decriminalisation no longer seems to be a real problem at the international level. Indeed, if the international conventions state that consumption of narcotic products must remain prohibited, they leave the choice of the sanctions, or the absence of sanctions, to each country. The INCB now even recognises that Portuguese or Norwegian models have real virtues. The criminalisation of consumption does not appear as such in any international convention.

| Treaty obligations | Derogations from obligations |
|---|--|
| 1961 Convention: "The Parties shall not permit the possession of drugs." (Article 33) | No possible derogation, "except under legal authority" (Article 33) |
| 1961 Convention: "Possession [...] shall be punishable offence" » (Article 36 (1) (a)) | Derogation "Subject to [...] constitutional limitations of Member States (Article 36 paragraph 1. a) "When abusers of drugs have [used an illicit substance as per the terms of Article 36], the Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration" (Article 36 (1) (b)) |
| 1971 Convention : "It is desirable that the Parties do not permit the possession of substances." scheduled as controlled drugs (Article 5 (3)) | "except under legal authority" » (Article 5 (3)) |
| 1971 Convention : "each Party shall treat as a punishable offence, when committed intentionally, any action contrary to a law or regulation adopted in pursuance of its obligations under this Convention" (Article 22 (1) (a)) | "Subject to [...] constitutional limitations" of Member States (Article 22 (1) (a)) "When abusers of psychotropic substances have [used substances according to the terms of Article 22], the Parties may provide, either as an alternative to conviction or punishment or in addition to punishment, that such abusers undergo measures of treatment, education, after-care, rehabilitation and social reintegration" (Article 22 (1) (b)) |
| 1988 Convention : "...each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, (...) the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption » (Article 3 (2)) | "Subject to [their] constitutional principles and the basic concepts of [their] legal system" (Article 3 (2)) "the Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment (...), measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender". (Article 3 (4)(d)) |

The subject of legislation is however more difficult. The international drug control authorities (UNODC, INCB) had already showed their disapproval of cannabis legislation in Uruguay, and again pointed to Canada, saying that these countries were in contradiction with the treaties they had signed. Treaties which seem extremely difficult to reform, in view of the very antagonistic positions between States on the subject.

The Commission on Narcotic Drugs, the governing body of UNODC, which meets annually in Vienna in March, is a good illustration of the almost non-reformable nature of treaties: States quarrel for long hours over semantic issues, some seeking to change the international framework towards health objectives and respect for freedoms (Canada, Latin American countries, etc.), while others categorically refuse to do so (Pakistan, Egypt, Russia, United States, China). However, any decision must be taken by consensus, which logically limits in a considerable way the possibilities of evolution.

2016: UNGASS on drugs.

Nevertheless in 2016, at the request of Mexico, Colombia and Guatemala there was a special session of the United Nations General Assembly (UNGASS) on drugs. The declaration from this UNGASS shows significant progress on the implementation of international treaties. To the three traditional and simplistic pillars of the war on drugs (fight against trafficking, production and international cooperation) is now added four new pillars: access to controlled substances for medical and scientific use, human rights, public health and alternative development. This text, adopted by all 193 UN member states, encourages alternatives to incarceration, the use of opioid substitution treatment methods and the provision of harm reduction material (term however not clearly used in the text due to US opposition). It stresses the importance of combating the stigma and discrimination of people who use drugs and encourages a so-called "balanced" approach in the fight against drugs. All signatory countries however have yet to implement these recommendations.

2. Pro and anti, a trench war?

a. Proponents of another vision gradually increasing

As we have seen, some States are gradually deciding to unilaterally end the war on drugs, be it through decriminalisation of use, or legal regulation of production. However, they still represent a very small group of countries globally.

Several UN agencies have taken a stand on rebalancing national drug policies. This is the case of the INCB, which recalls in its 2016 report that "Protecting the health and welfare of humankind remains the ultimate goal of the international drug control system". In the plenary introduction of UNGASS 2016, the INCB Director even stated: "There is no obligation under the treaties to incarcerate people for the possession of small quantities for personal consumption. [...] Punishment and inhuman treatment are not consistent with the treaties".

The debate went up a notch when, on 27 June 2017 the United Nations (UN) and WHO (World Health Organisation) published a joint statement in which they encourage to review and repeal "punitive laws that have been proven to have negative health outcomes and that counter established public health evidence. These include laws that criminalize or otherwise prohibit gender expression, same sex conduct, adultery and other sexual behaviours between consenting adults; adult consensual sex work; drug use or possession of drugs for personal use; sexual and reproductive health care services, including information; and overly broad criminalization of HIV non-disclosure, exposure or transmission"⁷⁰.

On June 26, 2018, the UN Secretary General, António Guterres, former Portuguese Prime Minister, is even clearer: "In accordance with the three international conventions on drug control, I introduced non-criminal responses to the possession of drugs for personal use, while increasing resources for prevention, treatment and social reintegration, and by reinforcing the criminalisation of drug trafficking."

"A notice of the High Commissioner for Human Rights is also expected in 2018.

Finally, in January 2011 the creation of the Global Commission on Drug Policy is also a remarkable initiative. This group brings together personalities from all over the world - former Heads of State or Government (Switzerland, Mexico, Brazil, Malawi, New Zealand, Poland, Colombia, Chile, Nigeria, Greece, East Timor), former Secretary General of the UN, economists, etc.- and advocates for drug policies that are based on scientific evidence, human rights and health. The group thus takes a stand for decriminalisation, supports legalisation and investment in access to people's health. A thematic report is published each year.

2016: INCB director stated "punishment and inhuman treatment are not consistent with the treaties".

27 June 2017: joint statement of the UN and the WHO in which they encourage to review and repeal "punitive law", including laws that criminalize "drug use or possession of drugs for personal use".

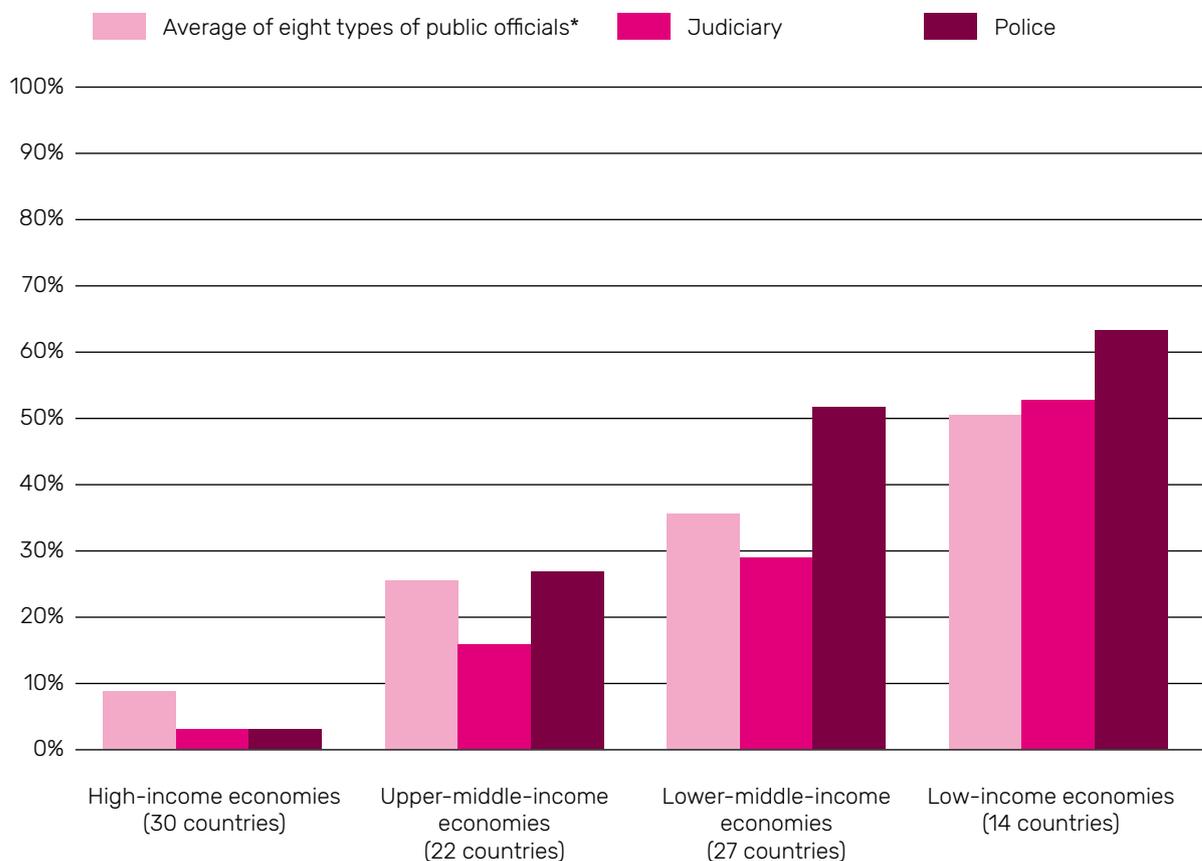
70 "Joint United Nations statement on ending discrimination in health care settings, 27 June 2017. Available at http://www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf

b. Stubborn opponents

At the other end of the spectrum, opponents do not compare unfavourably to drug reform advocates. States of course, but also civil society organisations, mostly cult or faith-based. For example, the Church of Scientology invests considerable resources in promoting the war on drugs, and distributes its pamphlets and calls for complete abstinence, even in international forums.

Another category of opponents, probably more worrying, is traffickers and those they corrupt. With a market of \$ 330 billion a year, drug trafficking represents a colossal financial windfall. A considerable share is reinvested in order to preserve good public relations with some decision-makers or officials not very concerned about the source of the money. Cases are documented in Italy, Mexico and Guinea-Bissau⁷¹. UNODC estimates that corruption affects more than 60% of police officers and more than 50% of magistrates in low-income countries⁷².

Prevalence rates of bribery by type of public official, by level of income, 2013



Source : UNODC calculations based on Transparency International's 2013 Global Corruption Barometer.

* The average of eight types of public officials includes officials from the sectors of education, judiciary, medical and health, police, registry and permits, utilities, tax revenue and customs and land services.

71 UNODC, op.cit., 2017.

72 United Nations, Commission on Crime Prevention and Criminal Justice, World Crime Trends and Emerging Issues and Response to Crime and Criminal Justice, 20 March 2016 E / CN / 15/2016/10.

CONCLUSION:

WHAT IS THE WORLD WITHOUT A WAR ON DRUGS?

The end of the war on drugs is paramount to ending people's vulnerability, various forms of violence and the circulation of substances whose quality is left uncontrolled. However, we also strongly believe that it will not be enough to meet all the conditions of access to health globally.

As community health actors, we are aware that the end of the war on drugs cannot mean the end of the struggle. Indeed, we can imagine a change in the legal framework. Unfortunately, we also foresee the maintenance of a social stigmatisation of people who use drugs and especially a lack of funding and political will for health, be it for prevention, harm reduction or care (opiate substitution treatment, drug dependence treatment, etc.).

Health financing is nowhere near enough to meet needs: only 8% of the financial needs for harm reduction are covered, and the overall shortage of financial resources puts pressure on the Global Fund to withdraw from medium income countries. This may also increase financial needs in the coming years. It is these two battles that we must fight together: the end of a war that has caused countless damage in a century, and the need for massive investment in health to reduce the risks and harms associated with drug use.

RESOURCES

International Organizations:

UNODC – United Nations Office on Drugs and Crime, established to assist the UN in better addressing a coordinated, comprehensive response to the interrelated issues of illicit trafficking in and abuse of drugs, crime prevention and criminal justice, international terrorism, and political corruption. The World Drug Report is a yearly publication that presents a comprehensive assessment of the international drug problem, with detailed information on the illicit drug situation: <http://www.unodc.org/>

INCB – International Narcotics Control Board, is the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions: <https://www.incb.org/>

UNAIDS – Joint United Nations Programme on HIV and AIDS: <http://www.unaids.org/fr> (UNAIDS leads the world's most extensive data collection on HIV epidemiology, programme coverage and finance: <http://aidsinfo.unaids.org/>)

NGOs and think-tanks:

IDPC – International Drug Policy Consortium, is a global network of 177 NGOs that focus on issues related to drug production, trafficking and use. IDPC promotes objective and open debate on the effectiveness, direction and content of drug policies at the national and international level, and supports evidence-based policies that are effective at reducing drug-related harm: <https://idpc.net/>

HRI – Harm Reduction International, a leading non-governmental organisation working to reduce the negative health, social and human rights impacts of drug use and drug policy by promoting evidence-based public health policies and practices, and human rights based approaches to drugs: <https://www.hri.global>

INPUD – International Network of People who use drugs, a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs: <http://www.inpud.net/>

Global Commission on Drug Policy, a group of personalities who advocate for drug policies based on scientific evidence, human rights, public health and safety, for all segments of the population. They publish a report each year: <http://www.globalcommissionondrugs.org/>

Drug Policy Alliance, NGO which envisions a just society in which the use and regulation of drugs are grounded in science, compassion, health and human rights : <http://www.drugpolicy.org/>

TNI Drugs & Democracy Project, which analyses drug policies and trends in the illicit drugs market : www.tni.org/drugs

Site information :

Talking Drugs – managed by Release, the UK's center of expertise on drugs, the law and human rights, is an online platforms dedicated to providing unique news and analysis on drug policy, harm reduction and related issues around the world: <https://www.talkingdrugs.org>

Drug Reporter – drug policy website of the Rights Reporter Foundation: <http://drugreporter.net>

JUST SAY YES

TO DRUG USERS' RIGHTS
TO DECRIMINALIZATION
TO HARM REDUCTION EVERYWHERE
TO NEEDLE EXCHANGE PROGRAMS
TO OPIOID SUBSTITUTION TREATMENT
TO DRUG CONSUMPTION ROOMS



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