movement continued. The US, the British and the Chinese authorities, apparently independent from each other, came up with a similar idea for broadening the accession base of the Opium Convention: to build it into the peace treaties. Article 295 of the peace *Treaty of Versailles* (28 June, 1919) stipulated:

"Those of the High Contracting Parties who have not yet signed, or who have signed but not yet ratified, the Opium Convention signed at The Hague on January 23, 1912, agree to bring the said Convention into force, and for this purpose to enact the necessary legislation without delay and in any case within a period of twelve months from the coming into force of the present Treaty.

Furthermore, they agree that ratification of the present Treaty should in the case of Powers which have not yet ratified the Opium Convention be deemed in all respects equivalent to the ratification of that Convention and to the signature of the Special Protocol which was opened at The Hague in accordance with the resolutions adopted by the Third Opium Conference in 1914 for bringing the said Convention into force.

For this purpose the Government of the French Republic will communicate to the Government of the Netherlands a certified copy of the protocol of the deposit of ratifications of the present Treaty, and will invite the Government of the Netherlands to accept and deposit the said certified copy as if it were a deposit of ratifications of the Opium Convention and a signature of the Additional Protocol of 1914.[99]

An almost identical text is found in Article 247 of the *Treaty of Peace between the Allied and Associated Powers and Austria* (St. Germain-en-Laye, 10 September 1919) which entered into force in 1920.[100] Similar text is also found in Article 230 of the *Trianon Treaty* with Hungary, in Article 174 of the *Neuilly Treaty* with Bulgaria, in Article 280 of the *Sévres Treaty* with Turkey, and in Article 100 of the *Lausanne Treaty* (1923), which superseded the *Sévres Treaty*. Thus, virtually at the stroke of a pen, the first International Opium Convention gained a near-universal adherence after 1919. More than 60 countries and territories ratified the Hague treaty and by 1949 the number had risen to 67.[101] All key opium/morphine and coca/cocaine producing, exporting and importing countries were signatories and most countries ratified the peace treaties, and thus the International Opium Convention, between 1919 and 1921.[102]

2.3 Drug control under the League of Nations, 1920-1945

The peace treaties of 1919 also laid the foundation of the League of Nations, the predecessor of the United Nations. With the creation of the League of Nations in 1920, it became obvious that an international convention, such as the Opium Convention, should not be overseen by an individual country (in this case, the Netherlands), but by the newly founded international organisation, which had 42 founding members.

Thus, by a resolution of the League of Nations of 15 December 1920, the newly founded "*Advisory Committee on the Traffic in Opium and Other Dangerous Drugs*", usually referred to as the "*Opium Advisory Committee*" (OAC) was authorized to take over the functions laid down in the Hague Opium Convention of 1912.[103] Composed of governmental representatives the OAC initially met quarterly during its early years, and later annually and can be thus seen as the forerunner of today's *Commission on Narcotic Drugs* (CND). In addition, the League created an "*Opium and Social Questions Section*" (often referred to as the '*Opium Section*') within its secretariat for administrative and executive support. The League Health Committee (forerunner of the World Health Organization) took responsibility for advising on medical matters.

The new international drug control organs focused considerable initial efforts on gauging the extent of the problem. The OAC requested information about imports, exports, re-exports, consumption, reserve stocks, etc. The staggering size of the world drug problem soon became apparent. Conservative estimates suggested that world production of opium and coca exceeded 'legitimate' need (for medical and scientific purposes) by at least a factor of ten, clearly indicating the world had a long way to go to achieve a reasonable equilibrium. In addition, a substantial percentage of manufactured drugs were still sold for non-medicinal purposes in many countries. Against this background, the OAC urged states to adopt an import/export certification scheme modelled after the British system introduced during World War I.[104]

One specific problem in the initial years of international drug control was the fact that several key players –in particular the United States – did not join the League of Nations. Thus, a number of rather complex institutional solutions had to be found (some of which are still in existence) to mitigate the consequences and enable at least some collaboration in the international drug control area.

Not being in the League, the USA could not lead international drug control efforts, as it did for the Shanghai Conference or the conference leading to The Hague Convention. This role was now increasingly taken over by the United Kingdom, which emerged in the inter-war period as the lead nation promoting international drug control efforts.

2.3.1 The 1925 Convention

Renewed efforts to strengthen international cooperation and international drug control were made in 1924/25. Back-to-back conferences were held and two separate

treaties were concluded. The first concluded with an *Agreement Concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium,* which was signed on 11 February 1925 and entered into force on 28 July 1926.[105] It focused on opium-producing nations and stated that the signatory nations were, "*fully determined to bring about the gradual and effective suppression of the manufacture of, internal trade in and use of prepared opium*".

Article I required that, with the exception of retail sale, the importation, sale and distribution of opium be a government monopoly, which would have the exclusive right to import, sell, or distribute opium. Leasing, according, or delegating this right was specifically prohibited. Article II prohibited sale of opium to minors, and Article III prohibited minors from entering smoking divans. Article IV required governments to limit the number of opium retail shops and smoking divans as much as possible. Articles V and VI regulated the export and transport of opium and dross. Article VII required governments to discourage the use of opium through instruction in schools, literature, and other methods.[106]

This treaty was signed and ratified by seven major powers: Britain, India, France, Japan, The Netherlands (including the Netherlands Indies, Surinam and Curaçao), Portugal and Thailand.[107]

A Second Opium Conference in 1924/25 adopted a new *International Opium Convention* (Geneva, 19 February 1925), mainly detailing the 1912 The Hague Convention.[108] Three years later, it entered into force (1928) and was eventually signed and ratified by 56 countries.[109] This included many of the key players in the drugs trade, both League of Nations members and non-members, including the British Empire, India, the Netherlands, France, Japan, the Soviet Union, Germany, Switzerland, Turkey, Portugal, Egypt, and Bolivia. However, the Convention was not signed and ratified among other key players such as the United States of America, China, Persia (signed but not ratified) and Peru.[110] The main achievements of this Convention were to detail the content of the Hague Convention, to institutionalize the international control system and to extend the scope of control to cannabis.

The British import/export authorisation model was formally adopted as the way forward to control the international trade (Chapter V). This system is still in place today. The system of import certificates and export authorizations is to assure that every international transaction in narcotic substances is controlled from both ends by the competent authorities of the importing country as well as those of the exporting country.[111] The 1925 Convention also provided details on the statistical reporting requirements under the Hague Convention, spelling out the exact figures signatories were obliged to supply.

Chapter II of the Convention dealt with internal control of raw opium and coca leaf. While states agreed to 'control' production, the Convention still fell short of requiring them to 'limit' production to medical and scientific needs. Thus the president of the conference, Sir Malcolm Delevingne (UK) concluded: "*The American principle for a limitation of production to medical and scientific purposes, though accepted as a principle both by the Advisory Committee on the Traffic in Opium and the Assembly, has not been included in the Convention as a contractual obligation."*[112]

Due to the inability of the delegates to come to an agreement on reductions in opium production, the US delegation, followed by the Chinese delegation, withdrew from the conference and did not sign and ratify the 1925 Convention.

In contrast, in Chapter III, dealing with the internal control of manufactured drugs, as opposed to cultivation of plant based drugs, the drafters were able to go a step further. Article 5 declares: "*The Contracting Parties shall enact effective law or regulation to limit exclusively to medical and scientific purposes the manufacture, import, sale, distribution, export and use of the substances to which this Chapter applies….".*

The 1925 Convention also established the Permanent Central Board (Chapter VI, Art. 19-27), the forerunner of the International Narcotics Control Board (INCB). The Permanent Central Board was set up as an impartial body whose members should not be Government representatives but should serve in a personal capacity, not holding any offices which would put them in a position of direct dependence on their Governments.[113] The main task of the Permanent Central Board, sometimes also referred to as Permanent Central Opium Board (PCOB), was to administer the statistical information sent by States Members to Geneva and, according to Article 24, to "watch the course of the international trade. If the information at its disposal leads the Board to conclude that excessive quantities of any substance covered by the present Convention are accumulating in any country, or that there is a danger of that country becoming a centre for the illicit traffic, the Board shall have the right to ask, through the Secretary-General of the League, for explanations from the country in question." The Board also established the system of import certificates and export authorizations for the licit international trade in narcotic drugs.[114]

The drafters of the convention may have chosen to create a new regulatory body – the Board – rather than

use the existing Opium Section of the League of Nations in order to include non-members, such as the United States and Germany, in the process.[115] Another difficult issue was the degree to which the Board could or should control the production, manufacture of and trade in drugs. The original proposal of mid-1924 envisioned a Board with wide ranging powers, including the authority, after receiving estimates from governments, to authorise the amount of drugs to be manufactured each year. Imports and exports would then have been limited to the quantities specified in the estimates. The Board would have had the power to fix estimates for countries that failed to submit their own estimates, and question estimates that seemed excessive.[116]

In the final version of the Convention, the Board did not have the right to question the statistics submitted by governments. The Board could request an explanation only when there was deemed to be sufficient evidence that a country acted as a centre for the illicit traffic of drugs (Article 24, §1), and then it could do so only through the Secretary-General of the League of Nations. The Board had no power to levy sanctions against a state it declared to be a centre of illicit traffic; it could only bring the issue to the attention of the governments of the Contracting Parties and the Council of the League of Nations.[117]

Even with reduced powers, the installation of the Central Permanent Board proved to be useful in reducing the drug trade, especially as the cost of failing to adhere to international rules rose over the years. Most countries did not want to run the risk of being singled out by the Board. By 1925, the Government of British India concluded that the political costs linked to continued opium exportation outweighed the economic advantages and revised its policy. It announced that it would end opium exports to any state or colony acting as a centre for the illicit traffic (such as Macao at the time), even if such a government were to produce any valid import certification. In 1926, the Government of British India declared a gradual reduction of all non-medicinal opium exports. Indian exports dropped significantly in subsequent years.[118]

Another new element of the 1925 Convention was the application of the international drug control system to cannabis. This followed a passionate speech by the head of the delegation from Egypt. As a consequence, the 1925 Convention had a separate chapter on Indian Hemp (Chapter IV). Article 11 §1 stated:

"*In addition to the provisions of Chapter V [Control of International Trade] which shall apply to Indian hemp and the resin prepared from it, the Contracting Parties undertake: (a) To prohibit the export of the resin obtained from Indian hemp and the ordinary preparations of which the resin forms the base… to countries which have prohibited their use, and in cases where export is permitted, to require the production of a special import certificate issued by the Government of the importing country stating that the importation is approved for the purposes specified in the certificate and that the resin or preparations will not be re-exported …* "Article 11 §2 laid down the general rule: "*The Contacting Parties shall exercise an effective control of such a nature as to prevent the illicit international traffic in Indian hemp and especially in the resin.*"

The Convention only dealt with the international dimension of the cannabis trade. It did not prohibit the production of cannabis; it did not request signatories to control domestic traffic in cannabis; it did not prescribe measures to reduce domestic consumption; and it did not ask governments to provide cannabis production estimates to the Board.[119] Therefore, control of cannabis was far less comprehensive than control of opium/morphine/heroin or coca/cocaine.

2.3.2 The 1931 Convention

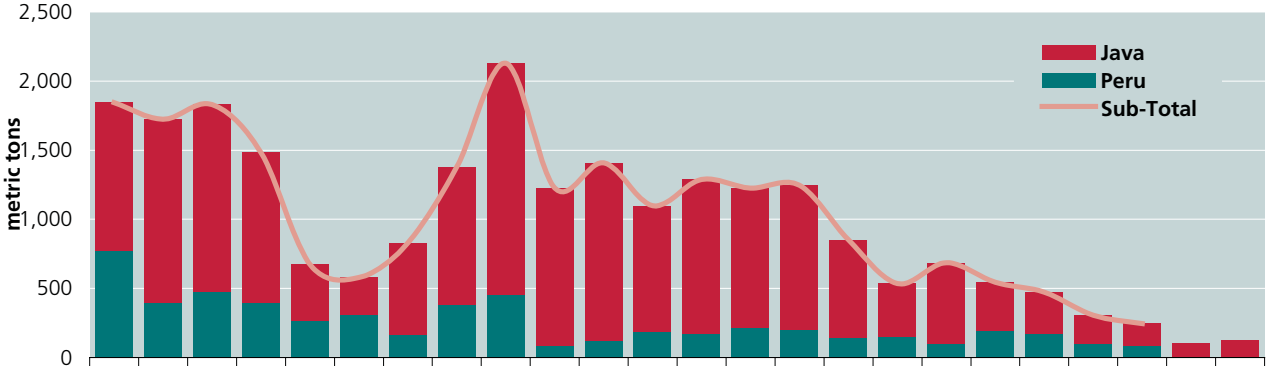
By the end of the 1920s, drug control efforts had achieved several objectives. The 1925 International Opium Convention enjoyed growing acceptance, and even countries which had not signed and ratified it, such as the USA, cooperated to a large degree with the international bodies of the League of Nations, including the Permanent Central Opium Board. Government statistical returns were increasingly received and provided a clearer picture of the supply and demand situation. Many states had strengthened their domestic enforcement efforts. There were signs that the controls in the USA started to show positive results. India, the world's main opium exporter, started to reduce its opium exports.

The strong decline of the licit coca sector in the inter-war period is reflected in coca leaf export data from Java and Peru, the two main coca leaf exporting areas. These exports declined by 88% between 1920 (2,130 mt) and 1933 (247 mt).

Despite progress, the opium problem was not solved.[120] Persia and other states started to fill the void created by the Indian withdrawal from the quasi-medicinal market. In addition, there was still the problem of continuing overproduction of opium inside China. Statistical returns also indicated that imports of manufactured drugs into China had started to skyrocket. As European governments pressured pharmaceutical companies to conform to more stringent control standards, a number of operators moved their activities to other states that had not ratified the International Opium Convention.

Rather than attempting to limit agricultural production of narcotic substances, attention shifted to strengthening the control regime at the manufacturing level, i.e. to limit the manufacture of drugs to medical and scientific

Fig. 22: Licit coca leaf exports of the two main coca leaf exporting countries in the early 20th century



	1912	1913	1914	1915	1916	1917	1918	1919	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935
Java	1,075	1,332	1,353	1,089	408	272	662	994	1,677	1,137	1,284	907	1,118	1,008	1,043	709	385	585	354	304	209	161	105	125
Peru	770	393	478	393	266	307	167	386	453	88	124	190	170	217	204	143	150	101	192	170	97	86		
Sub-Total	1,845	1,725	1,831	1,482	674	578	829	1,380	2,130	1,225	1,408	1,097	1,288	1,225	1,247	852	535	686	546	474	306	247		

Source: David F. Musto, "International Traffic in Coca through the Early Twentieth century", in *Drug and Alcohol Dependence*, Vol. 59, 1998, Table 5 and Table 6.

needs. Fifty-seven nations attended the *Conference on the Limitation of the Manufacture of Narcotic Drugs*, which met in Geneva from 27 May to 13 July 1931. Governments managed to agree on indirect limitations, while maintaining a high degree of free trade and competition.

The *Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs*[121], was established and signed on 13 July 1931 and entered into force in July 1933, once the requisite 40 states had ratified it.[122] Eventually 67 countries[123] signed and ratified this convention, including all key drug manufacturers: the United States, Germany, Switzerland, the Netherlands, Great Britain and Northern Ireland, France, Canada, Australia and the Soviet Union.[124] In fact, the 1931 Convention was the only League of Nations drug convention ever signed and ratified by the United States.

The 1931 Convention introduced a compulsory estimates system aimed at limiting the world manufacture of drugs to the amounts needed for medical and scientific purposes and established a *Drug Supervisory Body* to monitor the operations of the system.[125] The Convention was intended to "*..supplement the Hague Convention of 1912 and the Geneva Convention of 1925…*".

Under the new control system, signatories were to submit estimates on the quantities needed for medical and scientific needs. States could revise the estimates in case of medical emergency. In order not to limit free trade, signatories did not have to designate in advance where they would buy their supplies. This allowed them to shop for the lowest price. The treaty also required countries to cease manufacture or imports when they exceeded their annual estimate.

The Convention obliged countries to carefully monitor all manufacturing activities. Responsibility for monitoring the estimate system was given to a newly founded *Drug Supervisory Body*[126] (abbreviated DSB or the Body). The Body was in charge of a comprehensive assessment of global drug requirements, including assessing the needs of countries not party to the treaty. States were obliged to report imports and exports of drugs to the Body after execution of the orders.[127]

The 1931 Convention also introduced what is known today as 'drug scheduling', applying different control measures for different drugs. Under the 1931 Convention, the degree of limitation and regulation varied according to two criteria: the first was the degree of danger presented by a particular drug, and the second was the extent to which a drug was used by the medical profession. From these points of view, the drugs covered by the Convention fell into three groups.[128] Drugs such as codeine and dionine, were subjected to the least stringent measures due to their medical utility and lower abuse potential. Heroin, in contrast, was banned for export, except under special conditions. Under the Convention, any heroin seized should either be destroyed or converted, rather than diverted to medical or scientific use, as was permitted for seizures of some other drugs.

2.3.3 The 1936 Convention

The Hague Convention of 1912, the International Opium Convention of 1925, and the 1931 Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs provided a basis for controlling the licit trade in psychoactive substances. The Permanent Central Opium Board concluded that by 1934-35, legal manufacture of opiates and cocaine had dropped to approximately the level of legitimate demand.[129] However, progress made on the licit side

prompted the emergence of rising illegal activities and the increased involvement of international organised crime syndicates.[130]

To specifically address illicit drug activities, the League of Nations convened a conference in 1936 that drafted the *1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs*, signed on 22 July 1936.[131] This was the first treaty to focus explicitly on drug trafficking and the first to make certain drug offenses international crimes.

In Article 2 the Convention stated:

"*Each of the High Contracting Parties agrees to make the necessary legislative provisions for severely punishing, particularly by imprisonment or other penalties of deprivation of liberty, the following acts – namely :*

(a) The manufacture, conversion, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokage, despatch, despatch in transit, transport, importation and exportation of narcotic drugs, contrary to the provisions of the said Conventions;

(b) Intentional participation in the offences specified in this Article;

(c) Conspiracy to commit any of the above-mentioned offences;

(d) Attempts and, subject to the conditions prescribed by national law, preparatory acts.

Also for the first time the Convention dealt explicitly with the issues of drug related crime committed abroad and the related questions of extradition.

Once again, however, the practical importance of this Convention remained limited because a number of key countries did not sign and ratify it. Among these was the USA, for which the convention was not sufficiently far-reaching and still did not render punishable all non-medical cultivation, production and distribution of drugs.[132] In addition, by this time, countries such as Germany and Japan were no longer participating in international conferences of this sort. In total, only 13 countries signed and ratified the 1936 Convention.[h] Moreover, it only became effective in October 1939, after World War II had started, and drug control was certainly not top priority for most countries during this time.[133] It was not until five decades later that these topics were dealt with at the international level, within the framework of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

h Belgium, Brazil, Canada, China, Colombia, Egypt, France, Greece, Guatemala, Haiti, India, Romania and Turkey.

2.3.4 International drug control in the final years of the League of Nations

Increasing political tensions in the late 1930s clearly weakened international cooperation. Germany, which had entered the League of Nations in 1926, left the organisation in 1933, after the National Socialists took power in that country. Japan left the League of Nations in 1933 after the League had voiced opposition to its invasion of the Chinese territory of Manchuria. Italy withdrew in 1937, when the League condemned its invasion of Ethiopia. The Soviet Union, which had only joined the League of Nations in 1934, left in 1939, after discord arising out of its aggression against Finland.[134] But despite the unfavourable political environment, international drug control continued to work rather satisfactorily until the outbreak of World War II. Most countries adhered to the conventions and even supplied statistics until 1939, some even during World War II.[135] Many of the offices of the international drug control system were, as of 1940, gradually transferred to the United States, though the official seat (and some staff) remained in Geneva. The Opium Advisory Committee was moved to Princeton and the Central Permanent Board and the Drug Supervisory Body to Washington.

2.4. Development of the present system under the United Nations

As of 1946, the United Nations assumed the drug control functions and responsibilities formerly carried out by the League of Nations. The functions of the League's *Opium Advisory Committee* were transferred to the United Nations *Commission on Narcotic Drugs* (CND). The functions of the Opium Section were taken over by a new *Division on Narcotic Drugs* (DND), which was headquartered in New York until 1955, when it was moved to Geneva. Similarly, the annual Commission on Narcotic Drugs meetings were held in New York until the mid-1950s and subsequently held in Geneva.[136] The decision to initially centre many of the key activities away from their traditional home in Geneva may have been based upon a desire to reinvigorate the drug control effort.[137]

In this context the technical and research expertise of the new United Nations Division on Narcotic Drugs was strengthened in a number of areas, changing the very character of the new drug control secretariat. One of the most innovative and ambitious programs at the time was the establishment of the United Nations programme for determining the origin of opium by chemical and physical means in 1949. In ECOSOC Resolution 548 (XVIII) D of July 1954, the Economic and Social Council decided (§14) to set up a United Nations narcotics laboratory[138] which was subsequently established in Geneva before being moved together with the other international drug control bodies to the new headquar-