COUNT THE COSTS
50 YEARS OF THE WAR ON DRUGS

The War on Drugs: Threatening public health, spreading disease and death

The global "war on drugs" has been fought for 50 years, without preventing the long-term trend of increasing drug supply and use. Beyond this failure, the UN Office on Drugs and Crime (UNODC) has identified many serious negative "*unintended consequences*" of the drug war – including the threat it poses to public health.[1] These health costs are distinct from those relating to drug use, stemming from the choice of a punitive enforcement-led approach that, by its nature, criminalises many users – often the most vulnerable in society – and places organised criminals in control of the trade.

This briefing summarises these health costs. There is naturally overlap with other areas of the Count the Costs project, including: security and development, discrimination and stigma, human rights, crime, the environment, and economics. For briefings and a more extensive collection of resources on these costs see www.countthecosts.org.

Introduction

Over the past half-century, the war on drugs has been promoted primarily as a way of protecting public health. In reality, however, it has achieved the opposite. It has failed to control or eliminate use, and has increased the potential risks and harms associated with drug taking. By fuelling the spread of disease – often with fatal consequences – drug-war policies have had a devastatingly negative impact on the health of a growing population of users.

Contents

> *"The expanding criminal black market obviously demanded a commensurate law enforcement response, and more resources. The consequence was that public health was displaced into the background, more honoured in lip service and rhetoric, but less in actual practice."*
>
> **Antonio Maria Costa**
> Executive Director, UN Office on Drugs and Crime
> 2008

It is worth noting, however, that the treaty which underpins the global drug control framework, the 1961 UN Single Convention on Narcotic Drugs, has two parallel functions. Alongside punitive, criminal justice-led controls on non-medical drug use, it put in place a strict regulatory framework for the production and supply of the same drugs for medical and scientific purposes. This has led to the emergence of two parallel markets: Firstly, the non-medical drug trade, controlled by violent criminal entrepreneurs, paramilitaries and insurgents; and secondly, the medical drug trade, regulated by various government agencies. The contrast between the health and social harms associated with these twin markets could not be more stark, or more instructive (see box, p.6).

The crusading rhetoric of the war on drugs, as outlined in the preamble to the Single Convention, describes drugs as an "*evil*" we must "*combat*". Yet in reality, enforcement is focused on some of the most vulnerable and marginalised populations – those from socially deprived communities, young people, people with mental health problems, people who are dependent on drugs, and people who inject drugs. The war on drugs punishes those most in need – patients and clients. It can more accurately be described as a war on drug users; a war on people. This criminalisation of people who use drugs leads to increased stigmatisation and marginalisation, limiting the potential effectiveness of health interventions, particularly for problematic users.

So although the health harms of problematic drug use and addiction are important, there is an urgent need to examine and find solutions to the public health problems created or exacerbated by the war on drugs itself, namely:

- Maximising the risks associated with use, such as unsafe products, behaviours and using environments[2]
- The health harms created or fuelled directly by drug law enforcement, or indirectly through the wider social impacts of the violent illegal trade it creates, including disastrous impacts on international development and security
- The political and practical obstacles for health professionals in doing their job addressing drug-related health problems and reducing harms, and how they are obliged to work within a legal and policy framework that is often in direct conflict with fundamental medical ethics – not least the commitment to "first, do no harm"

Criminalisation increases the risk of drug-related emergencies, such as overdose (Photo credit: Chris Wong)

Punitive enforcement measures fall most heavily on poor, marginalised and dependent drug users (Photo credit: Nicolas Holzheu)

The health costs of the war on drugs

1. Maximising harms to users

Encouraging risky behaviours and using environments

Criminalising people who use drugs, particularly young people, whilst having, at best, marginal impacts on demand, can exacerbate overall health harms by encouraging high-risk behaviours[3] and push drug use into unhygienic and unsupervised "underground" environments.

- Authorities seeking to educate young people about drug risks are simultaneously seeking to arrest and punish them. The resulting alienation and stigma undermines outreach to those most in need. Combined with prevention messages more often driven by politics than science, this leads to distrust in even the best drug education efforts
- Enforcement against possession of drug injecting paraphernalia can encourage needle sharing, increasing blood-borne virus transmission risk.[4] Higher levels of enforcement are also associated with hurried and higher-risk injecting[5]
- The choice of high-risk injecting over safer forms of administration (e.g. snorting or smoking) to maximise "bangs for bucks" can be caused by enforcement-related price inflation[6]
- Displacement from one drug to another can also follow enforcement efforts.[7] The impacts are unpredictable, but as experience with amphetamine-type stimulants demonstrates, can lead to the use of new "designer" drugs about which little is known (a risk factor in itself), creating challenges for police, forensics, harm reduction, treatment and emergency services[8], [9]
- In the Eurasian region economic pressures combined with enforcement against more established drugs have fuelled the emergence of high-risk, domestically manufactured and injectable amphetamine-type stimulants, such as boltushka in Ukraine,[10] and vint[11] and opiates such as krokadil[12] in Russia
- Inadequate access to information can encourage high-risk behaviours such as poly-drug use and bingeing, and increase risks in crisis situations

Promoting more dangerous products

Criminal markets are driven by economic processes that encourage the creation and use of more potent or concentrated drugs that generate greater profits. This is comparable to how, under 1920s US alcohol prohibition, consumption of beer and wine gave way to sales of more concentrated, profitable and dangerous spirits – a process that was reversed when prohibition was repealed.

Under current prohibition, smoked opium has been replaced by injectable heroin, and cocaine markets have evolved towards smoked or injected crack cocaine.[13] More recently, the cannabis market has become increasingly saturated with more potent varieties.

Illegally produced and supplied drug products lack any health and safety information, and are of unknown (and highly variable) strength and purity, creating a range of risks not associated with their counterparts on the licit market.[14]

- Risks of overdose are increased, particularly for injectors, when drugs are unexpectedly potent
- There are poisoning risks associated with the adulterants and bulking agents used by criminal suppliers to maximise profits.[15] Recent examples include Levamisole, a potentially toxic[16] de-worming and cancer treatment pharmaceutical, widely used as a cocaine adulterant (the DEA reported its presence in 69% of seized cocaine in the US in 2009). Even illicit cannabis has been bulked up by other substances, such as lead, which in Germany resulted in 29 hospital admissions for lead poisoning in 2007[17]
- There is a particular infection risk amongst injecting drug users from biological contaminants. The UK for example, has witnessed clusters of infections associated with contaminated heroin, including 35 deaths in 2000 from *Clostridium novyi* bacterium, and over 30 infections with *Bacillus anthracis* (anthrax) leading to ten deaths in 2009-10

> *"Ineffective and punitive drug policies, particularly criminalisation of drug possession, must be reformed to ensure the realisation of human rights, and to support the implementation of evidence-based interventions for people who inject drugs."*
>
> **Official Declaration of the 2011 International Harm Reduction Conference**

2. Creating obstacles to effective harm reduction

A new policy model emerged in the 1980s that pragmatically focused on reducing overall drug related harms, rather than the war on drugs' narrower focus on attempting to eliminate use. This harm reduction approach is summarised by Harm Reduction International (HRI) as:

> *"policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community."*[18]

However, the emergence of harm reduction can be seen, to a significant degree, as a response to harms either created or exacerbated by the war on drugs. There now exists an unsustainable internal policy conflict – with health professionals caught in the middle. Evidence-based harm reduction approaches are evolving and gaining ground across the globe, but operating within the politically driven harm-maximising drug-war framework.

Key interventions such as needle and syringe programmes (NSP) and opioid substitution therapy (OST) expanded

> *"Evidence of the failure of drug prohibition to achieve its stated goals, as well as the severe negative consequences of these policies, is often denied by those with vested interests in maintaining the status quo. This has created confusion among the public and has cost countless lives. Governments and international organisations have ethical and legal obligations to respond to this crisis and must seek to enact alternative evidence-based strategies that can effectively reduce the harms of drugs without creating harms of their own."*
>
> **The Vienna Declaration**
> 2010

primarily in response to HIV transmission risk from injecting, although the approach has grown to encompass a much wider range of drugs, using behaviours and related harms. NSP and OST are now recognised by UN human rights monitors as a requirement of the right to health for people who inject drugs,[19] while methadone and buprenorphine for OST are on the World Health Organization's essential medicines list.[20]

Despite becoming increasingly well established, in 2010 harm reduction "*remains very limited, particularly in low- and middle-income countries*"[21]:

- In Russia, although 37% of the 1.8 million people who inject drugs are infected with HIV, NSP is severely limited and OST is illegal. By comparison, HIV rates amongst people who inject drugs in countries with long-established harm reduction programmes, such as the UK, Australia and Germany, are below 5%
- Of countries/territories where injecting drug use is reported, 76 have no NSP, and 88 have no OST
- In Central Asia, Latin America and Sub-Saharan Africa, OST coverage equates to less than one person for every 100 people who inject drugs

The obstacles to improved provision are more a failure of politics than of resources, as harm reduction is highly cost-effective.[22] Merely using the term "harm reduction" remains a contentious political issue in high-level international fora.[23]

This conflict has led to a widening of harm reduction thinking to include longer term systemic policy and law reform issues, as demonstrated by initiatives such as the Vienna Declaration[24] and the Official Declaraton of the 2011 International Harm Reduction Conference,[25] and their high-profile supporters.

Spreading infectious diseases: HIV/AIDS, hepatitis and tuberculosis

From the outset of the HIV epidemic, transmission amongst people who inject drugs via sharing of needles has been a serious and growing problem:

- Injecting drug use occurs in at least 158 countries/territories. An estimated 15.9 million people inject drugs globally, of whom three million are HIV+ in 120 countries[26]
- In eight countries – Argentina, Brazil, Estonia, Indonesia, Kenya, Myanmar, Nepal and Thailand – HIV prevalence among people who inject drugs is estimated to be over 40%
- Injecting drug use causes one in ten new HIV infections globally, and up to 90% of infections in regions such as Eastern Europe and Central Asia[27]
- Provision of antiretroviral therapy, already limited in many low and middle income countries, is effectively unavailable for the vast majority of HIV+ people who inject drugs

Hepatitis B (HBV) and hepatitis C (HCV) are the most common blood borne virus infections affecting people who share injecting equipment.[28] HCV is much more robust than HIV, and so can be transmitted even more easily. Both HBV and HCV can cause cirrhosis and cancer of the liver, and are significant causes of death.

Whilst the urgency of preventing and treating HIV infection has overshadowed what some call the 'silent' epidemic of viral hepatitis, it is increasingly recognised as a major public health problem, particularly where people living with HIV are co-infected with HBV and/or HCV.

- Brazil, China, Indonesia, Italy, Kenya, the Russian Federation, Thailand, the US, Ukraine and Vietnam account for half of the global population of injecting drug users (8.1 million) and two-thirds of people who inject drugs and are living with HIV (2.1 million).[29] The average HIV prevalence among people who inject drugs in these countries is approximately 25%, HCV prevalence is up to 60%

- China, the Russian Federation and Vietnam have rates of HIV/HCV co-infection in populations of injectors of over 90%

Crucially both HBV and HCV can be effectively prevented, treated and potentially cured. However, it is clear that treatment uptake remains extremely low among people who inject drugs, even where it is available.[30]

Whilst treatment for HCV and HBV remains (or is perceived to be) prohibitively expensive[31] in the short term, in many middle or low income countries prevention measures are relatively inexpensive and of proven cost effectiveness. Yet they remain underdeveloped – despite being strongly supported by the WHO, UNAIDS and UNODC.[32]

Tuberculosis only affects impoverished and marginalised groups, with people already infected with HIV or HCV at particularly great risk. 30% of injecting drug users in Western Europe, 25% in Central Europe and well over 50% in Eastern Europe have tuberculosis.

Parallel example of two heroin users

Perhaps the clearest illustration of the impact of the drug war comes from comparing two injecting heroin users – one in a drug war/criminal supply environment, the other in a legal/prescribed/supervised-use medical environment.[33] Globally, and even within individual countries, these two policy regimes exist in parallel, so a real-world harm comparison is possible.

The user of illegal heroin:

- Commits high volumes of property crime and/or street sex work to fund their habit, and has a long – and growing – criminal record

- Uses "street" heroin of unknown strength and purity, with dirty and often shared needles, in unsafe marginal environments

- Purchases supplies from a criminal dealing/trafficking infrastructure that can be traced back to illicit production in Afghanistan

- Often has HIV and hepatitis C

The user of prescribed heroin:

- Uses legally manufactured and prescribed pharmaceutical heroin of known strength and purity

- Uses clean injecting paraphernalia in a supervised quasi-clinical setting where they are in contact with health professionals on a daily basis

- Is not implicated in any criminality, profiteering or violence at any stage of the drug's production or supply, and does not offend to fund use

- Has no risk of contracting a blood-borne infection, and a nearly zero risk of overdose death

"Prisons are extremely high-risk environments for HIV transmission because of overcrowding, poor nutrition, limited access to health care, continued illicit drug use and unsafe injecting practices, unprotected sex and tattooing. Many of the people in prisons come from marginalized populations, such as injecting drug users, which are already at elevated risk of HIV infection. In most cases, high rates of HIV infection in prisons are linked to the sharing of injecting equipment and to unprotected sexual encounters in prison. Syringe sharing rates are invariably higher in prisons than among injecting drug users outside prison."

World Health Organization
2005

The incarceration of drug users is both expensive and counterproductive (Photo credit: California Department of Corrections and Rehabilitation)

Bringing drug use into prisons

The war on drugs has directly fuelled the expansion of the prison population in recent decades (see the Count the Costs Crime and Human Rights briefings at www.countthecosts.org). This growing population therefore has a disproportionate number of current or past drug users. Lifetime prevalence of injecting drug use in EU prisoners ranges from 15-50%.[34]

Some try to portray prison as a useful environment for recovery from drug problems, but the reality is more often the exact opposite. High levels of drug use continue in prisons (unsurprisingly, given the co-imprisonment of dependent users with drug dealers and traffickers), in an environment that creates a range of additional risks, including initiation into high-risk drug using behaviours.

As a general principle of international law,[35], [36] prisoners retain all rights except those that are necessarily limited by virtue of their incarceration. The loss of liberty alone is the punishment, not the deprivation of fundamental human rights including the right to health. As Harm Reduction International note:

> *"Failure to provide access to evidence-based HIV and HCV prevention measures (in particular NSP and OST) to people in prison is a violation of prisoners' rights to the highest attainable standard of physical and mental health under international law, and is inconsistent with numerous international instruments dealing with the health of prisoners and with HIV/AIDS."*[37]

Yet despite clear guidance on such provision from WHO, the UNODC and UNAIDS,[38] prison-based NSPs are currently available in only ten countries, and OST is available (in at least one prison) in fewer than 40 countries.[39]

Increasing overdose risks

Overdose deaths, primarily related to opioids, have become a growing problem in recent decades.

- Overdose is commonly the leading cause of death among people who use drugs[40]
- Around two-thirds of people who inject drugs will

experience an overdose at some point, with around 4% of overdose events resulting in death[41]

- Overdose is a leading cause of death among all youth in some countries, and the leading cause of accidental death among all adults in some regions[42]

The last 15-20 years have established a range of interventions shown to be effective in reducing incidence of overdoses, overdose mortality rates, or both. These include investment in education and awareness building, and increased provision of naloxone (an opiate antagonist) both in a take-home formulation and for use by medical personnel. OST provision has also been shown to reduce overdose. For example, there was a 79% reduction in opioid overdose over the four years following introduction of buprenorphine maintenance in France in 1995.[43] Similarly, supervised injection facilities (SIFs) in eight countries have overseen millions of injections and experienced no overdose deaths.[44] Such services are only available in a very limited number of locations; whilst there are 25 SIFs in Germany there are none in the UK, and only two in the whole of North America.

As with harm reduction more broadly, the issue of overdose shows how the war on drugs both fuels the emergence of a health harm and then creates obstacles to health professionals developing and implementing interventions that reduce it.

3. Wider health impacts of the war on drugs

Undermining development and security

The war on drugs is actively undermining development, human rights and security in many of the world's most fragile regions and states – from Afghanistan and the Andes, to the Caribbean and West Africa, with catastrophic public health impacts in the affected regions (see the Count the Costs Development and Security briefing at www.countthecosts.org)

The criminal entrepreneurs that control drug production and trafficking naturally seek out regions with little economic infrastructure and poor governance, then use corruption and violence to consolidate and expand their interests. Since the Mexican government's 2006 military crackdown on the drug cartels (which has had negligible impacts on production and trafficking), more than 50,000 people have died in drug market-related violence, including over 4,000 women and 1,000 children.

The profitability of illegal drugs encourages traffickers to lock producing or transit areas into multi-dimensional underdevelopment, deterring investment and restricting the activities of international health and development NGOs and other bodies. It also diverts large amounts of valuable aid and other resources from health or development efforts into police and military enforcement.

Direct health and human rights impacts of enforcement

Drug law enforcement itself is associated with a range of human rights abuses that involve direct health harms, including: health impacts of chemical eradication, arbitrary detention, torture, corporal punishment, and, in extreme cases, use of the death penalty (see the Count the Costs Human Rights briefing at www.countthecosts.org for more detail).

- In some countries in East and Central Asia, drug users are routinely sent to drug detention facilities, without trial or due process. Whilst sometimes termed "treatment" or "rehabilitation" facilities, they are often indistinguishable from prisons, run by security forces and staff with no medical training, and rarely providing evidence-based treatment. Instead, military drills and forced labour are often mainstays, and detainees are denied access to essential medicines and effective treatment. In China there were approximately 700 mandatory drug detoxification centres and 165 "re-education through labour" centres, housing a total of more than 350,000 people[45]

- At least 12 countries maintain corporal punishment (including flogging and caning) as a sentence for drug and alcohol offences, including for their consumption. Judicial corporal punishment is absolutely prohibited in international law because it constitutes torture or cruel, inhuman and degrading punishment[46]

- In violation of international law, 32 jurisdictions currently retain the death penalty for drug offences, with most executions occurring in China, Iran, Saudi Arabia and Vietnam. Current estimates put the numbers of such executions at over 1,000 a year.[47] Methods of execution include hanging, firing squads, beheading and use of lethal injections

Reducing access to pain control

Global drug control efforts aimed at non-medical use of opiates have had a chilling effect on medical uses for pain control and palliative care. Unduly restrictive regulations and policies – such as those limiting doses and prescribing, or banning particular preparations – have been imposed in the name of controlling illicit diversion of drugs.[48]

Instead, according to the World Health Organization, these measures simply result in 5.5 billion people – including 5.5 million with terminal cancer – having low to nonexistent access to opiate medicines.[49] More powerful opiate preparations, such as morphine, are unattainable in over 150 countries.

Access to essential pain control medicines is impeded by drug war politics (Photo credit: "ckeech")

> *"Drug use may have harmful health consequences, but the Special Rapporteur is concerned that the current drug control approach creates more harm than the harms it seeks to prevent. Criminalization of drug use, designed to deter drug use, possession and trafficking, has failed. Instead, it has perpetuated risky forms of drug use, while disproportionately punishing people who use drugs."*
>
> **Anand Grover**
> UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health
> 2010

Are there benefits?

The theory behind the "war on drugs" is not complex: On the demand side punitive enforcement against users aims to act both as a deterrent to use, and as support for health and prevention initiatives (by "sending a message" about the risks/unacceptability of drug use). At the same time, supply side enforcement aims to reduce or eliminate drug availability, as well as increasing prices so that drugs become less attractive. The dominant measure of benefits of the war on drugs is therefore reduced use, and, for many states, specifically the creation of a "drug-free world".[50]

This theory can now be tested against 50 years of drug-war experience, and it is clear that it is not supported by the evidence. Despite fluctuations between types of drug, regions and populations, drug availability and use globally have risen over the past half-century, albeit stabilising in much of the developed world during the past decade.[51]

> *"One of the priorities is to stop wasting resources on the failed 'War on Drugs' that has turned into a war against people and communities. This war must end. Resources should instead be devoted to providing, to everyone who needs them, evidence-based and human rights-based interventions that prevent problematic drug use, treat drug dependence and ensure harm reduction services for people who use drugs."*
>
> **Michel Kazatchkine**
> Executive Director of The Global Fund to Fight AIDS, Tuberculosis and Malaria
> 2010

Given the centrality of the deterrent effect in drug war thinking there is a striking absence of evidence in its favour, and comparative analysis between countries or jurisdictions with different levels or intensity of punitive user-level enforcement show no clear link.[52] The limited available research points to any deterrent effect being marginal, with other social, cultural and economic variables playing a far more significant role in determining demand.

Whilst enforcement clearly increases prices and restricts availability to some degree, it is also clear that, even if some hurdles need to be negotiated and expense incurred, drugs are available to most people who want them, most of the time. Supply has generally kept pace with rising demand, and the interaction between the two has kept prices low enough to not be a significant deterrent to use. When supply has fallen below demand (whether due to enforcement or other factors), the result will tend to be falling drug purity or displacement to other drugs (both with unpredictable health consequences), or new entrants to the market until a new equilibrium is established.

Regardless of the actual impacts of the war on drugs, the consensus and shared purpose that the international drug conventions represent – the need to address the problems associated with drug misuse – at least holds the *potential* to develop more effective international responses guided by the principles of the United Nations – improving human rights, human development and human security. This could deliver huge health benefits nationally and internationally.

How to Count the Costs?

Whilst an enormous amount of money is poured into drugs and health research, especially in the US, this has been skewed towards studying drug toxicity and addiction. This work can help establish risks, develop treatments, and support rhetorical justifications for a war against the drugs "threat", but tends to avoid meaningful scrutiny and evaluation of the negative health impacts of the drug war itself.

So whilst it remains important to fully explore and understand drug-related health harms, this needs to be complemented by careful evaluation of all the policies intended to mitigate such harms. Indeed, policy outcomes and policy alternatives should be carefully evaluated and explored.

The responsibility for this has historically fallen largely to NGOs, using a range of established evaluative tools to build up the clear, but admittedly patchwork, understanding that we now have. Government and UN agencies' more systematic participation and support of this area of research – for example by using health impact assessments[53] – would support development of new policies and modification of existing ones. This would ensure the most efficient mitigation of policy related harms at a local, national and international level, both in the short and long term.

Conclusions

A great irony of the war on drugs is that although it was launched with the intention of protecting public health, it has achieved the exact opposite. Not only are impacts of supply- and user-level enforcement measures at best marginal in terms of reducing availability and deterring use, but they have created new harms and hindered proven public health responses. Failed and counterproductive enforcement is hugely expensive (over $100 billion a year globally[54]) and continues to absorb the majority of drug budgets at the direct expense of established public health interventions that remain desperately underfunded.[55]

It is now clear that responding to a serious and growing public health challenge within a punitive criminal justice framework has been a public health catastrophe, the costs of which have barely begun to be acknowledged by policy makers.

For medical and public health professionals the war on drugs approach presents an acute dilemma as they are required to operate within a legal and policy environment that creates and exacerbates health harms, and is associated with wide scale human rights abuses - directly at odds with public health principles and basic medical ethics.

Public health and human rights always suffer in war zones, and the drug war contributes to a culture in which both are marginalised. The drugs issue has become a political football, hijacked by a series of unrelated political agendas including race and immigration, law and order populism, and the war on terror. Science and pragmatic public health thinking has given way to political posturing and moral grandstanding. The resulting public debate has, in the past, pushed meaningful evaluation and rational discussion to the margins.

But it is also clear that the war on drugs is a policy choice. A reorientation towards a public health approach needs to be more than mere rhetoric; other options, including decriminalisation and models of legal regulation, should, at the very least, be debated and explored using the best possible evidence and analysis. Not only are health professionals perfectly positioned to lead this process, but with ever more senior figures all over the globe calling for change, the moment for a genuine debate has come.

We all share the same goals – a safer, healthier and more just world. It is time for all sectors affected by our approach to drugs, and particularly those concerned with public health, to call on governments and the UN to properly *Count the Costs of the War on Drugs and explore the alternatives.*

> *"Individuals who use drugs do not forfeit their human rights. These include the right to the highest attainable standard of physical and mental health (including access to treatment, services and care), the right not to be tortured or arbitrarily detained, and the right not to be arbitrarily deprived of their life. Too often, drug users suffer discrimination, are forced to accept treatment, marginalized and often harmed by approaches which over-emphasize criminalization and punishment while underemphasizing harm reduction and respect for human rights."*
>
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(23) Key countries – including the US and Russia – remain dogmatically opposed to the term. At the UN Commission on Narcotic Drugs, for example, objections led to the term being struck from the final version of the Political Declaration on Drugs in 2009.

(24) For the full text and list of signatories, see:
http://www.viennadeclaration.com/the-declaration

(25) For full text and list of signatories, see:

http://www.ihra.net/declaration

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