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Drug demand reduction: World situation with regard to drug abuse

World situation with regard to drug abuse

Report of the Secretariat

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I. Introduction

1. In its resolution 46/7, entitled "Measures to promote the exchange of information on new patterns of drug use and on psychoactive substances consumed", the Commission on Narcotic Drugs requested the Executive Director to report to it at its forty-seventh session on the implementation of that resolution. In its resolution 2003/41 of 22 July 2003, the Economic and Social Council requested the United Nations International Drug Control Programme, in collaboration with the World Health Organization, to report on new trends with regard to cannabis. The present report provides an overview of trends in the abuse of those substances in the period 1998-2002 in each region of the world, based on responses received from Member States through part II of the annual reports questionnaire. In response to Council resolution 2003/41, a section on cannabis use by region is included in the present report on the analysis of the main drug types. The report also contains a discussion of the challenges in assessing the progress made towards achieving the objectives of the Political Declaration adopted by the General Assembly at its twentieth special session (Assembly resolution S-20/2, annex) and the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction (Assembly resolution 54/132, annex). The Commission may wish to provide guidance on possible approaches and options to be pursued.

2. The analysis contained in the present document is based on the replies of 106 countries and territories that had completed and returned part II of the annual reports questionnaire for the year 2002 by 16 December 2003, in compliance with their obligations under the international drug control treaties. Data from the annual reports questionnaire have been supplemented with information from other sources, reflecting the practice adopted in previous years, in line with the agreement of the Commission.[1] The questionnaire, which was used for the second time after its revision, was distributed to 194 countries and territories; the overall response rate for the year 2002 was 55 per cent. The overview on trends in the period 1998-2002 is based on a number of annual responses varying between 40 and 60 per cent.[2]

3. Patterns of drug abuse are often diffused between countries within the same region, underlining the need to understand national trends in drug abuse in their regional context. Member States have been requested each year to report in the annual reports questionnaire increasing, stable or decreasing trends with regard to the abuse of different drug types among their general population (persons aged 15-64) on a five-point scale (large increase, some increase, no great change, some decrease, large decrease). Though that information, which is based on expert opinion, has its limitations, it is the information that most countries have provided in a relatively consistent manner during the various years. Therefore, it is the only information currently available that allows for some kind of medium-term analysis. Other information requested in the annual reports questionnaire is not always available for different years or may be difficult to use for comparative purposes. This problem requires serious consideration by the Commission; it is further discussed in section III of this report.

4. Using the trend information collected from Member States over a number of years, a new analytical tool called *Weighted Analysis on Drug Abuse Trends* was designed to allow more accurate estimation of regional trends in drug abuse, taking into consideration the different population size of the countries within the regions.

This report presents an analysis of the responses between the years 1998 and 2002. The year 1998 is considered the baseline for measuring the progress made towards achieving goals and targets agreed at the twentieth special session of the General Assembly. Therefore, the present analysis was carried out drawing on replies that Member States have annually provided on the basis of information available to national experts on the drug abuse situation in their countries.[3]

5. However, there are some limitations that need to be taken into account when interpreting the results, since the information is provided as expert opinion. Firstly, it cannot be assumed that the difference between various degrees of drug abuse trends (for example, between "some decrease" and "large decrease") means the same in different countries (a large increase in a country with low prevalence may not have the same impact on regional trends as some increase in a country with high prevalence) or even in the same country in different reporting years. Secondly, considering that the calculation used to estimate trends for each country is related to the population of the region, it is not possible to directly compare trends between the regions. Thirdly, reporting trends in the abuse of a drug type, such as amphetamine-type stimulants (ATS), may be biased by differing trends in the abuse of substances in the same drug category (for example, the trend in the use of methylenedioxymethamphetamine (commonly known as Ecstasy) may be increasing while the trend in the use of amphetamine is decreasing). It should also be noted that the present report is limited in that it only provides general directions with regard to the main drug types reported by Member States, inevitably leading to broad generalizations; thus, there is a need for more drug-specific trend analysis to support its conclusions.

II. Overview of the world situation with regard to drug abuse and trends in the period 1998-2002

6. Analysis of the reported trends indicates that since 1998 the global drug abuse trends have been as follows:

(a) Abuse of cannabis has been increasing in most countries (see annex I). In countries with high prevalence and long-term prevention efforts, it seems that prevalence is stabilizing, or even declining (as in Australia, for example), even if it is still at a relatively high level;

(b) Abuse of opioids has been reported as increasing in most regions, Oceania being the most notable exception (see annex II). Within the various regions there are significant differences. In the European region, the major increases are in Eastern Europe, while the situation is stable or declining in Western Europe;

(c) Abuse of ATS has increased in all regions since 1998. The increases are of different intensity and may refer to different substances within the ATS group, but there is overwhelming evidence that ATS have become a major drug of choice in all regions;

(d) Cocaine abuse remains not too widespread, although it has been increasing slightly in the main region of consumption (the Americas) and its rising level of use is causing concern across Europe. In Africa the increasing abuse of cocaine reported during the late 1990s has ceased; in Asia very small increases in

the abuse of that substance have been reported; and in Oceania the situation is stable. Crack cocaine remains a serious problem in some areas.

A. Cannabis

7. In the five-year period 1998-2002, cannabis remained the most abused drug worldwide. Most geographical regions were affected, and the observation that cannabis was the most widely abused illicit substance could apply to an increased number of countries. Prevalence rates for cannabis are often far higher than for other drugs. In addition, the number of people who admit using cannabis regularly is often far higher.

8. Since 1998, the overall trend in cannabis abuse, as reported by the national focal points in charge of replying to the annual reports questionnaire, is clearly increasing in most regions; there may be certain differences between the regions but the trend line is mainly pointing upwards. Cannabis abuse has remained stable with relatively high prevalence in some developed countries, but it has increased—mostly from a lower baseline—in developing countries.

9. The increases are partly attributable to the fact that the perception of the risk associated with cannabis abuse appears to have diminished. A series of campaigns, media messages and public statements, in particular (but not exclusively) in some developed countries, aimed at presenting cannabis as being associated with positive medical effects and relatively minor side effects, may have contributed to that development. Certain segments of society also seem to have a more tolerant attitude towards the abuse of cannabis.

10. The reported overall increasing trend in the abuse of cannabis reflects the more specific epidemiological information reported by countries in the period 1998-2002. The trend line is steeper in Africa and Europe. In Asia the increasing trend seems to have gained momentum in the two-year period 2001-2002. In the Americas the trend line shows a slow increase, tending towards stabilization. In Oceania there has been considerable decrease but it must be noted that the region still has high levels of prevalence. Developing regions seem to be in the process of catching up with the higher levels of prevalence in the developed regions, as indicated by the increasing trends in Africa and Asia.

Africa

11. African countries reported a significant increase in the abuse of cannabis in the period 1998-2002 (see figure I). Cannabis remained the most abused illegal drug in most African countries. Most of the cannabis consumed was cannabis herb and was produced locally. The climate in many parts of Africa, the value of cannabis as a cash crop, the social acceptability of cannabis use and the resource limitations of local law enforcement agencies have made the control of cannabis in that region extremely difficult.

12. Although precise epidemiological information is not available, there is considerable agreement in the replies reported in the annual reports questionnaire that there has been a consistent increase in the abuse of cannabis in most African countries. Consistent increases for the period 1998-2002 were reported in Cameroon,

Côte d'Ivoire, Ghana, Morocco, Namibia, Zambia and Zimbabwe. Overall, prevalence rates remained relatively low compared with those of countries in other regions but the large increases reported in consecutive years suggest that cannabis is becoming more and more popular.[4]

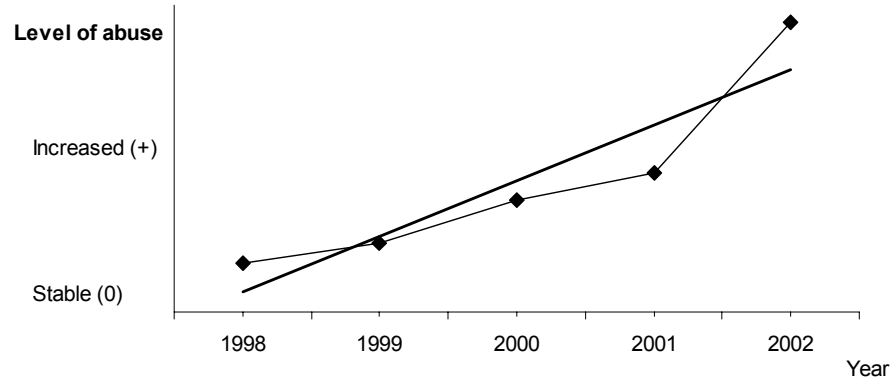
13. This is confirmed by studies on subgroups of the general population, such as school surveys or youth surveys, existing data from treatment services and psychiatric admissions, police data on arrests for possession of drugs and surveys conducted through various research initiatives and rapid assessments of the drug situation.[5]

14. Cannabis is consumed above all by young people. Various school and youth surveys (in the Comoros, Ethiopia, Seychelles, South Africa, Swaziland and the United Republic of Tanzania) indicate that lifetime prevalence varies considerably (up to 30 per cent in Ethiopian private schools) but that recent use is also common (7.5 per cent last month use in male students in Swaziland in 1998). Age of initiation varied from 12 to 15 years among males in Lesotho in 2000.

15. Another feature of abuse of cannabis in Africa is that it concerns mainly the male population. Survey data from selected countries in the region also show that cannabis abuse is predominantly a problem among young males.[6, 7] A general population survey on drug use conducted as part of a rapid situation assessment in Botswana during 2001 found that 25 per cent of males (but only 5 per cent of females) reported ever using cannabis and 5 per cent of the males surveyed used the drug daily. A 1998 survey of substance abuse among students in Swaziland found that 7.5 per cent of male students had taken cannabis in the past month, compared with only 1.4 per cent of female students. A notable exception to this is the fact that survey reports on the United Republic of Tanzania indicate the involvement of women in drug abuse, which is surprising considering the long history of drug abuse being mainly a male problem.

16. Cannabis abuse accounts for a substantive proportion of psychiatric admissions in several countries.[8] In South Africa, cannabis was the primary drug of abuse of between 40 per cent (Cape Town) and 61 per cent (Gauteng) of patients under 20 years of age receiving treatment for drug problems. Data from 2000 show that in Lesotho most of the patients treated were treated for alcohol-related problems and the remaining patients (24 per cent) were treated for cannabis-related conditions.

Figure I
Trends in cannabis abuse in Africa, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

Americas

17. In the Americas, the most common drug of abuse is cannabis, as is the case in most other regions of the world. The overall trend shows a slowly increasing trend, which seems to lean towards stabilization (see figure II). Recent prevalence estimates for abuse of cannabis are not available for all countries but those that are available vary considerably between countries in the region.

18. In the United States of America, cannabis was the most commonly used illicit drug (used in the past month), the rate being 6.2 per cent (or 14.6 million persons) among the general population in 2002. Of those, about one third (or 4.8 million persons), had used cannabis on 20 or more days in the past month.[9]

19. However, notwithstanding the fact that the abuse of cannabis is common, several studies indicate that its consumption has stabilized, if not declined, in the United States. In recent years, there has been some evidence that cannabis use is stabilizing in certain areas of the United States, following the previous upsurge in use between 1990 and 1998. Use of cannabis among secondary school students has stabilized since 1999 and declined among all grade levels in recent years.[10] Despite that stabilization of use, demand for treatment for cannabis remained high, mainly because of its widespread use.

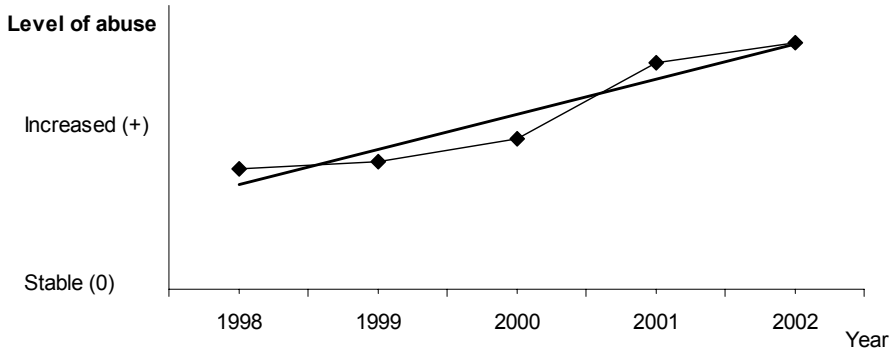
20. Canada also reported a stabilizing trend in cannabis abuse. Canadian student survey data from Ontario indicate a stable trend, but at an elevated rate, after significant increases in the 1990s.

21. Countries in Central and South America reported increasing cannabis abuse in the period 1998-2002. The Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States reported an increase in cannabis abuse in the subregion.

22. Cannabis use is also common in the Caribbean. School survey data from the subregion indicate that lifetime use of cannabis among students ranged from

8 per cent to 26.9 per cent. Problems associated with cannabis use were also evident in the overseas countries and territories in the Caribbean.

Figure II
Trends in cannabis abuse in the Americas, 1998-2002



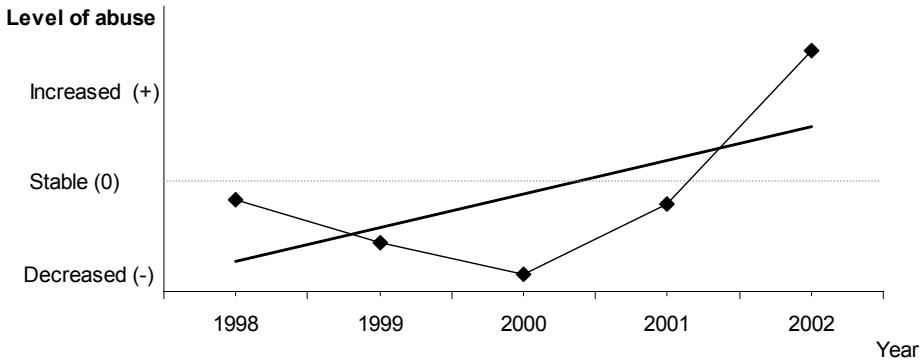
Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

Asia

23. In Asia, the overall trend is towards a slow increase in the abuse of cannabis. The decreases reported in 1998 and 1999 have been largely compensated by increases in the following three years (see figure III). Certain countries in the region are influencing the overall trend. After some years of reporting a stable situation, China has reported large increases. In India, after some decreases in the late 1990s, increases in cannabis abuse were reported. The first national household survey in India, which was carried out in 2001 on a sample of the male population aged 12-60, found prevalence of 4.1 per cent for lifetime use of cannabis and 3.0 per cent for current use (use in the past month), thus suggesting a high probability of continuing use following exposure to the drug.[11] Japan, Saudi Arabia and Sri Lanka reported increases throughout the period 1998-2002. Significant increases were also registered in Myanmar, Pakistan and the Republic of Korea. In Central Asia and in the Caucasus the picture is mixed.

Figure III
Trends in cannabis abuse in Asia, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

Europe

24. In Europe, cannabis abuse has shown a consistent increasing trend, following the increase in cannabis prevalence during the 1990s in the countries of the European Union (see figure IV). As in other regions the overall trend is the result of a mixed process: while in some countries cannabis abuse has stabilized, in others, especially where prevalence was relatively low, it has increased. There seems to be a convergence in the patterns of abuse whereby the abuse level of countries with low prevalence is gradually approaching the abuse level of countries with higher prevalence.

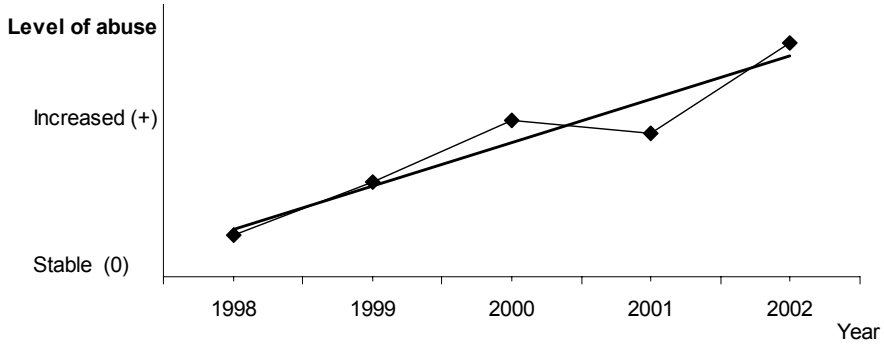
25. There are differences among the various countries in terms of cannabis abuse in the general population, but differences are far less marked when the youth population is compared. Most member States of the European Union report lifetime experience of cannabis among the general population in the range 20-25 per cent, with only few exceptions (ranging from 7-10 per cent in Portugal and Finland to around 30 per cent in Denmark and the United Kingdom of Great Britain and Northern Ireland). It has been suggested that in Western Europe cannabis use is mainly occasional, and more frequent use of the substance would remain rather unusual, in particular among persons over 40 years of age.

26. In many Western European countries cannabis ranks second after heroin in terms of the number of users seeking treatment for drug abuse problems; that figure is increasing, most notably among persons treated for such problems for the first time (24.7 per cent of the total number of new admissions are cannabis users).[12]

27. In Eastern European countries school survey data suggest that on average the lifetime prevalence of cannabis use by 16-year-olds is 16 per cent, ranging from 1 per cent in Romania to 34 per cent in the Czech Republic. In addition to increasing trends in use of cannabis there is also evidence of increasing social

acceptance of cannabis experimentation among young people in the Central and Eastern European countries.[13]

Figure IV
Trends in cannabis abuse in Europe, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

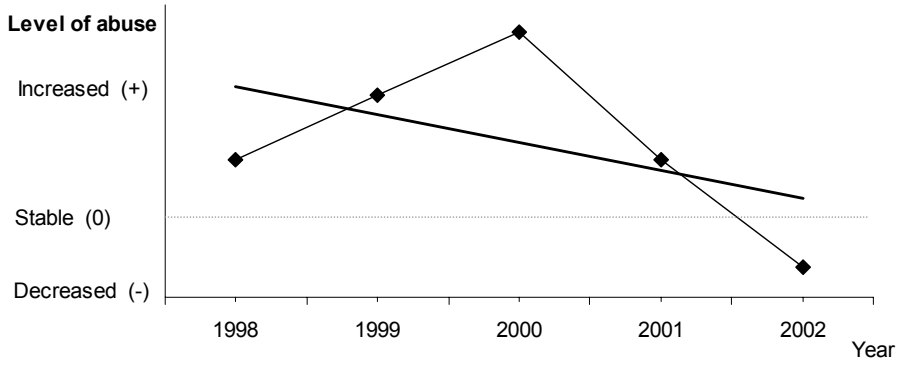
Note: National trend estimates weighted by population size.

Oceania

28. The only exception to the increasing trend in cannabis abuse in the various regions of the world is in Oceania. After an initial increase in cannabis abuse from 1998 to 2000, Oceania reported a considerable decrease in such abuse between 2001 and 2002 (see figure V). The trend is clearly influenced by developments in Australia, as that country's population accounts for a large portion of the population in the entire region.

29. Latest nationwide data available in Australia, for the year 2001, showed that exposure to illicit drug use is common both among males and females aged 14 years and over, around 37 per cent of males and 29 per cent of females having used cannabis at least once in their lifetime.[14] The Illicit Drug Reporting System indicators suggested a relatively stable situation with regard to the use of cannabis-type drugs in 2002, but the use of such drugs still remained widespread and the availability of the substance remained high in all jurisdictions.[15] In 2002, the trend in cannabis use was reported to continue declining among the general population.

Figure V
Trends in cannabis abuse in Oceania, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

B. Opioids

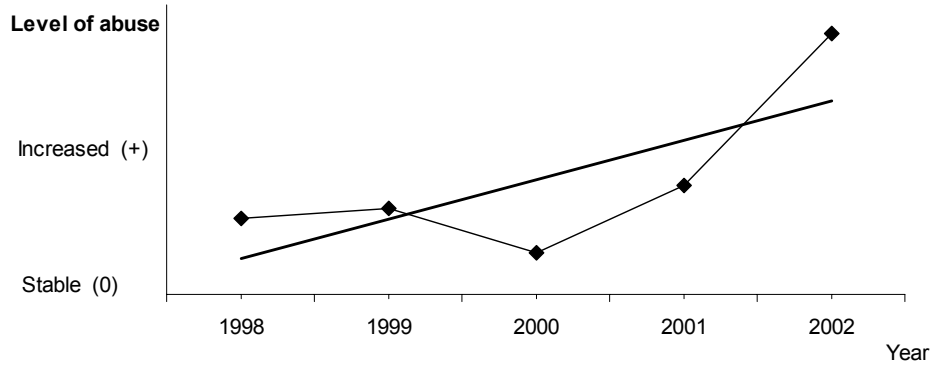
30. The abuse of opioids, in particular heroin, is responsible for considerable damage both to individuals and communities in many parts of the world. The problem of heroin abuse mostly involves drug injection, and the sharing of injecting equipment carries a high risk of viral infection. In the late 1990s, trends were increasing in most regions but declining abuse of opioids was reported in all regions in 2000. In the years that followed, the decreasing trend continued in Oceania and the trend stabilized in the Americas. In Europe the trends in the abuse of opioids in 2001 and 2002 were mixed. In Africa significant increases in the abuse of such drugs were reported in 2001 and 2002.

Africa

31. The majority of African countries that sent replies reported an increase in the abuse of opioids; those replies came from countries in all parts of the continent (see figure VI). Increases were reported in parts of Africa with no real history of heroin abuse, such as several East African countries; however, those increases were from very low levels. During the past five years, increases in the abuse of such drugs have been reported in Côte d'Ivoire, Mauritius, Morocco, Mozambique, Namibia, South Africa and the United Republic of Tanzania. In particular in South Africa, over the past 5-7 years, demand for treatment for drug abuse, with heroin being the primary drug of abuse, has increased substantially in Cape Town and in Gauteng province, from below 1 per cent to over 6 per cent of all patients in treatment; however, more recently, that trend has levelled off. Treatment demand indicators from neighbouring countries also indicate an increase in demand for treatment for heroin.[16] Even if most heroin is smoked, injecting is common among those patients in treatment for heroin as the primary drug of abuse.[17] Injecting heroin has been reported in a number of other countries in Africa, most notably Kenya and the United Republic of Tanzania, and to a lesser extent in Burundi, Namibia and

Uganda. The perception among both health and law enforcement professionals is that local heroin abuse is related to the spillover of transit trafficking involving heroin consignments from Asia passing through Africa on their way to Western Europe.

Figure VI
Trends in the abuse of opioids in Africa, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

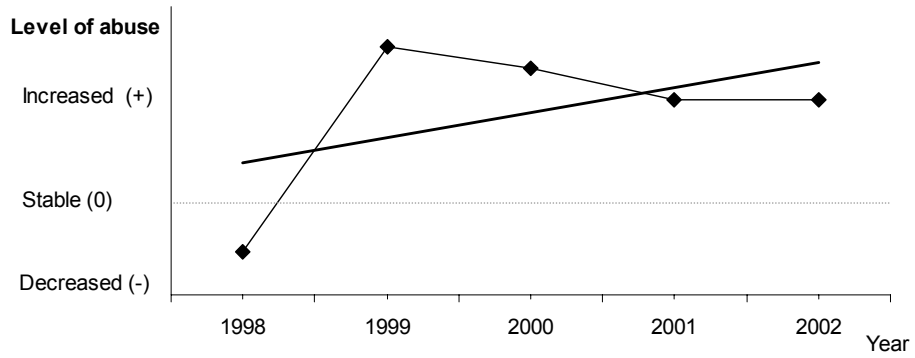
Americas

32. The situation in the Americas with regard to the abuse of opioids has shown signs of stabilization in recent years (see figure VII). The United States has reported stable or decreasing trends. Canada reported stable trends for 2001 and 2002. Some increases from relatively low levels were reported in Argentina, Colombia, Ecuador and Venezuela.

33. In the United States, long-term trends in emergency department visits for heroin increased from 1998 to 2000 but stabilized in the last two years.[18] According to the Community Epidemiology Work Group of the National Institutes of Health of the United States, most recent indicators for heroin suggest that polysubstance abuse involving heroin abuse is common. Prevalence among the general population was stable to decreasing between 1999 and 2001, while there was a constantly decreasing trend among students beginning in 1999.

34. In Mexico, the situation was stable until 2001; however recent data from 53 cities, collected by the Sistema de Vigilancia Epidemiológica de las Adicciones (system of epidemiological surveillance of addictions) of Mexico, indicate that there was a significant increase from 2001 to 2002 among patients in non-governmental treatment centres reporting heroin as their primary drug of abuse.[19]

Figure VII
Trends in the abuse of opioids in the Americas, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

Asia

35. In Asia, there has been an increasing trend in the abuse of opioids over the past few years (see figure VIII), while more recently some signs of decreasing abuse of such drugs have also been reported.

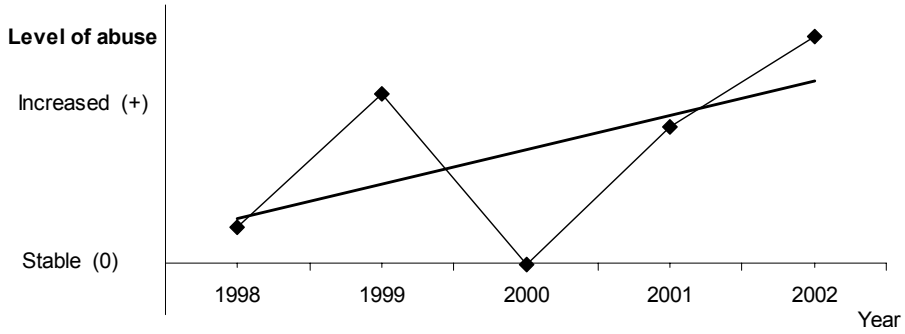
36. Countries in Central Asia have been experiencing a rapidly increasing drug problem; that has mainly been the result of an increase in the abuse of opioids, primarily heroin. Heroin abusers represent 70-90 per cent of all registered drug users in the subregion. Drug abuser profiles and patterns of abuse indicate that it is young persons (aged 25-30), mostly males, who are injecting opioids. In Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan, rates of ever injecting remain high among registered drug abusers, ranging from 50 per cent to over 90 per cent, and sharing of injecting equipment is common. More recently, since 2001, the number of newly registered drug abusers in most Central Asian States has levelled off or even declined, as in Kazakhstan and Tajikistan, but severe heroin abuse problems and a high level of drug injection underline the importance of addressing those areas in the treatment and rehabilitation of drug abusers.

37. In China, heroin is currently the main substance of abuse, used by 83 per cent of the registered addict population. National drug abuse surveys and statistics in China indicate that the rate of registered drug abusers was 12.9 times higher in 2001 than in 1990, involving mostly young people 17-35 years of age, while the drug abuse problem has spread, affecting over two thirds of the country.[20]

38. Increased abuse of opioids was reported in Bangladesh, India and Nepal. In India, the national household survey conducted in 2001 among the male population estimated that there were 2.04 million current (within past month) abusers of opiates (opium and heroin), or 0.7 per cent of the general population.[21]

39. Decreased abuse of opioids was reported in Myanmar, Pakistan, Qatar and Saudi Arabia, as well as in the Caucasus, but those decreases did not have a major influence on the overall trend in the region.

Figure VIII
Trends in the abuse of opioids in Asia, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

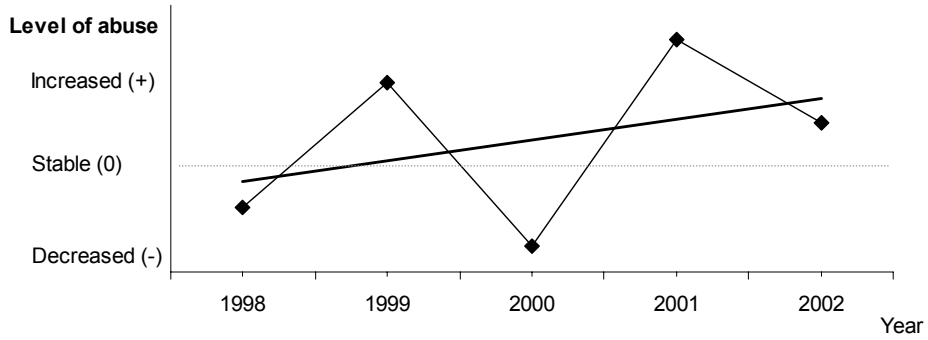
Europe

40. In Europe, the abuse of opioids increased slightly over the period 1998-2002 (see figure IX). The overall picture seemed to vary, appears variable, possibly reflecting considerable subregional differences in the situation with regard to drug abuse.

41. The injecting of drugs (not only but mostly heroin) has been stable or decreasing since 1998 in most countries in Europe. Estimates available for "problem drug use" suggest that the abuse of opioids increased in Western Europe after the mid-1990s, but the trend has stabilized since the period 1998-2000. Prevalence estimates of "problem drug use", primarily the abuse of opioids, in most Western European countries ranged between 2 and 10 cases per 1,000 among members of the general population aged 15-64.[22]

42. In the Central and Eastern European countries, most of the increases in "problem drug use" in the 1990s, and especially after the mid-1990s, were attributable to the abuse of heroin, which is currently the main drug of concern in every country. Many of those increases were accompanied by increases in injecting drug abuse, although smoking heroin is common in Poland and is also reported among young abusers in some other countries. It is more difficult to analyse current trends, as more recent data are often not available. In the Czech Republic, Hungary, Slovakia and Slovenia, and perhaps in Bulgaria, it appears that the overall level of "problem drug use" may be stabilizing, while in Estonia, Latvia, Lithuania, Poland and Romania, it seems to be increasing (in particular in relation to heroin abuse).[23]

Figure IX
Trends in the abuse of opioids in Europe, 1998-2002



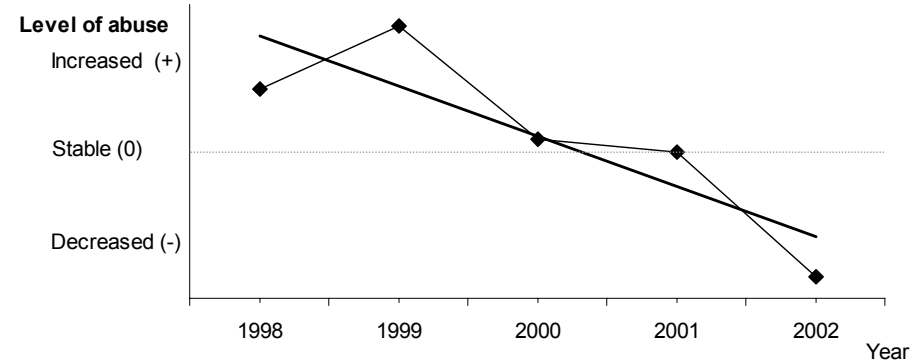
Source: United Nations Office on Drugs and Crime, annual reports questionnaire

Note: National trend estimates weighted by populations size.

Oceania

43. In Oceania, there has been a steady decrease in the abuse of opioids since the late 1990s, coinciding with reduced availability of heroin in the region (see figure X). In Australia, even if availability of heroin increased again in 2002, the prevalence and frequency of abuse did not return to the levels seen in 2000. The observed decreasing trend in the abuse of heroin coincided with changes in drug abuse behaviour: the abuse of heroin was supplemented with the illicit consumption of pharmaceutical opiates or barbiturates. In addition, there were a total of 306 deaths attributed to opioids in 2001 among persons aged 15-44, the lowest number in 10 years and a significant reduction compared with the figure for previous years (958 deaths caused by opioid overdose in 1999 and 725 in 2000).[24, 25]

Figure X
Trends in the abuse of opioids in Oceania, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

C. Cocaine

44. Since 1998, the overall trend in the abuse of cocaine has been mixed. In some regions, expert opinion indicates an increase in cocaine abuse in the past five years, while in others the overall trend is stable or sharply declining. Such information needs to be compared with the extent of cocaine abuse in the various regions to understand the significance of the reported trends.

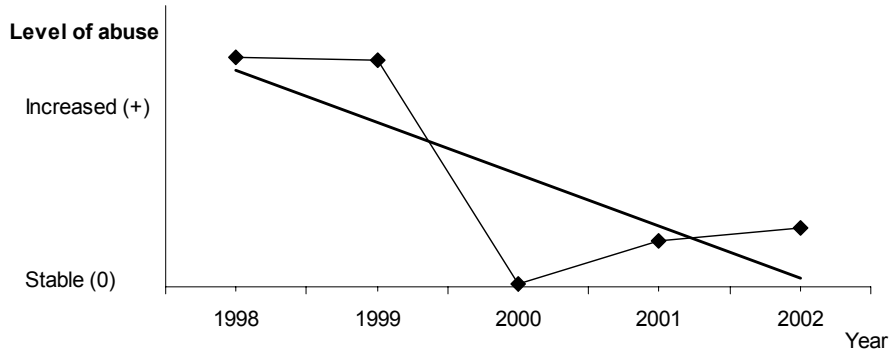
45. Since 1998, there has been an increase in the abuse of cocaine in Latin America and the Caribbean. Some declines have been noted in the United States, a major market for cocaine, while an increase has been registered in Australia and European countries and even in some African countries (though the increases in African countries were from very low levels). Most reports referred to the abuse of cocaine powder rather than crack cocaine (cocaine base), the abuse of which appears to be far more restricted.

46. In addition, since prevalence rates vary greatly between countries, the relative significance of increasing or decreasing trends in terms of the number of persons affected also varies. For example, in some countries the population of cocaine abusers is very small or virtually non-existent. Overall, the abuse of cocaine is still concentrated in the Americas.

Africa

47. Cocaine is not a major drug of abuse in Africa, but there have been reports of its abuse in some African countries during the past five years. Overall, experts seem to agree that in the few countries reporting on cocaine abuse, following the increases of 1998 and 1999, the abuse of cocaine has declined and remained relatively stable in the three-year period 2000-2002 (see figure XI). The main decrease in such abuse has been reported in South Africa. According to information from the South African Community Epidemiology Network on Drug Use (SACENDU) Project for 2002, the increase in the demand for treatment for cocaine-related problems in Cape Town, Durban and Gauteng has levelled off. For 11-14 per cent of patients in treatment in Cape Town and Gauteng, cocaine was the primary or secondary drug of abuse. The abuse of cocaine appears to be confined to South Africa, although some isolated cases involving the seizure of cocaine have been reported in other countries in the region. The abuse of cocaine, in particular crack, has been reported in all the major urban centres of South Africa, where such abuse appears to be most prevalent among commercial sex workers.

Figure XI
Trends in cocaine abuse in Africa, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

Americas

48. Cocaine remains the primary drug of concern throughout the Americas and the Caribbean. There are reports of cocaine abuse in other regions but, in terms of the number of individuals affected, the Americas remain the region in which cocaine problems are most pronounced.

49. In the Americas, the trend line indicates a slow increase but that is the result of different trends in the various years: increases in 1999, decreases in 2000 and increases again in 2001 and 2002 (see figure XII).

50. The main market for cocaine in the Americas remains the United States. The latest reports indicate that in the United States, an estimated 2.0 million people (0.9 per cent of the population aged 12 or older) are current cocaine abusers (that is, had used cocaine in the past month), while crack cocaine accounts for over one fourth of current cocaine-type abuse (abused by 0.2 per cent of the population aged 12 or older). The abuse of cocaine (including crack cocaine) among school students declined from 1999 to 2002.[26] However, data from national household surveys show some increase from 2001 to 2002.[27]

51. After an initial decline in 1998 and a stable situation in 2000, cocaine abuse increased in 2001 and 2002. Even though some studies indicate that the population of crack cocaine abusers appears to be ageing, the level of cocaine crack abuse remained high, as did morbidity and mortality associated with the drug, cocaine being responsible for the most drug-related deaths in nine sites studied by the Community Epidemiology Working Group of the National Institutes of Health of the United States. Also, the number of emergency department mentions of cocaine has increased since 1998, though it seems to be levelling off.

52. Survey data from Ontario, Canada, showed a decline in the abuse of cocaine from the mid-1980s to 1998; however, there was a subsequent rise in such abuse, lifetime prevalence rising from 4.6 per cent in 1998 to 6.4 per cent in 2000. Experts

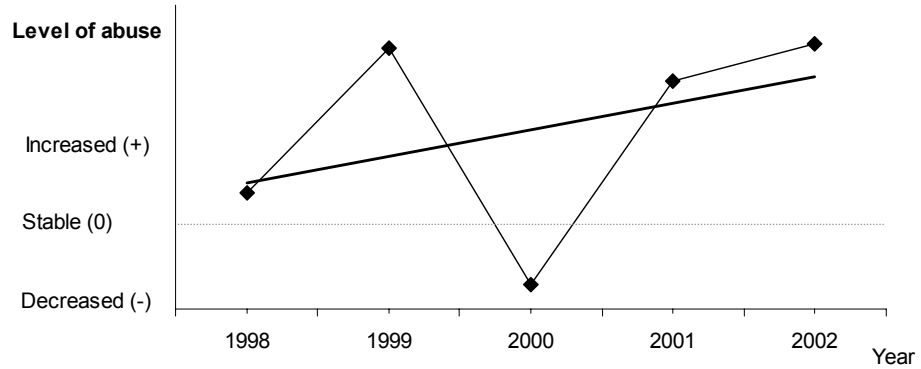
in Canada reported some increase in cocaine abuse in 1998 and 1999, but that trend stabilized in 2001 and 2002.

53. In Mexico, the trend line showed some increase in the late 1990s, but the situation has become stable in recent years. Annual abuse of cocaine-type drugs is most common among persons in the age group 18-34 years (2.36 per cent, compared with 0.35 per cent among the general population). Some Central American countries (such as Costa Rica, El Salvador, Guatemala and Panama), though they do not represent a large portion of the population in the region as a whole, have also reported an increase in such abuse among the population.[28]

54. In the last few years, there seems to have been an increase in cocaine abuse in the countries of the Southern Cone, notably Argentina, Chile and Uruguay. Brazil reported an increase in such abuse in the late 1990s. In Bolivia, the situation was reported to have been stable in 2001, after an increase in such abuse in the late 1990s. Venezuela has reported an increase in cocaine abuse at various points during the past five years. In Chile, data from 2002 revealed that the highest annual prevalence of cocaine (hydrochloride) abuse was found among young adults aged 19-25 (4.39 per cent); such abuse was five times more common among males than females and much more prevalent in metropolitan areas than in rural areas.[29] In Peru, the abuse of cocaine-type drugs was even more common among young males under 20 years of age, where annual prevalence reached a level at least 3-5 times higher (6.78 per cent) among males aged 17-19 than among other age groups.[30]

55. In the Caribbean, the abuse of cocaine, in particular crack cocaine, is widely reported; such abuse is accountable for a substantial proportion of drug-related crime and other community problems in the subregion. Each of the 15 countries participating in the Caribbean Drug Information Network reported cocaine abuse on its territory.[31] Preliminary findings of surveys conducted in the Caribbean in 2002 suggest that the level of cocaine and crack cocaine abuse is still relatively low among secondary-school students, annual prevalence ranging from 0.2 per cent in Guyana and Suriname to 3.6 per cent in Anguilla. The prevalence rate among subpopulations at risk is likely to be considerably higher.

Figure XII
Trends in cocaine abuse in the Americas, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

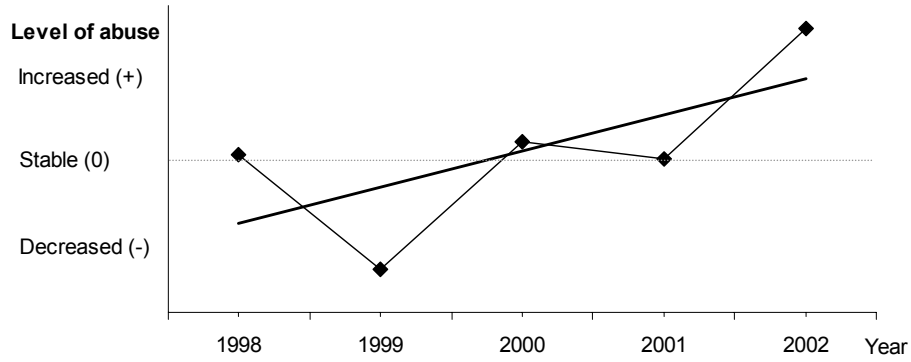
Asia

56. In Asia, where cocaine is traditionally not widely consumed, there were sporadic reports of cocaine abuse during the period 1998-2002. According to experts, there were different trends in the various years, but the overall trend line is gradually but steadily increasing (see figure XIII).

57. The trend line is mainly influenced by increases reported in Bangladesh, India and Saudi Arabia, as well as by decreases reported in Japan, the Philippines and the Republic of Korea.

58. Few estimates of the prevalence of cocaine abuse among the general population exist. Cocaine abuse has been largely limited to certain urban areas; the impact of cocaine abuse on demand for drug treatment is relatively small compared with the impact of the abuse of other substances, such as opioids and ATS.

Figure XIII
Trends in cocaine abuse in Asia, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

Europe

59. In Europe, the trend line for cocaine abuse has shown a consistent increase since 1998, with a tendency towards stabilization (see figure XIV). This seems to be related to increased cocaine consumption mainly in Western Europe, with some increases being reported also in Eastern Europe.

60. In the member States of the European Union, although some indicators suggest a steady increase in the cocaine market, distinct geographical variations can be observed. In several member States (Denmark, France, Germany, Greece, Ireland, the Netherlands, Norway and Spain) increases were reported at various points in time during the period 1998-2002. In Sweden and the United Kingdom after increases in the first few years of the period, the trend seems to have stabilized.

61. Cocaine appears to be most available in larger cities and in those areas with a relatively large number of abusers of other drugs. However, targeted surveys of drug abusers revealed the high level of recreational use of cocaine powder in certain

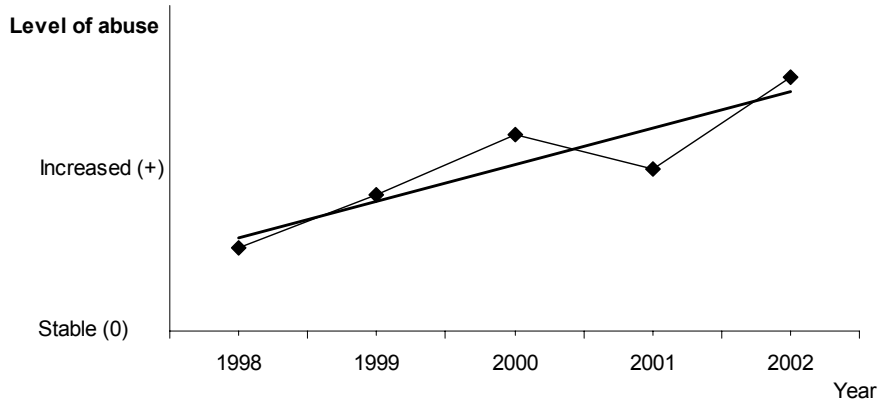
social settings, in particular among groups called “dance-goers” or “clubbers”. In addition, reports from some large metropolitan areas suggested the existence of pockets where cocaine abuse might be increasing.

62. Although cocaine abuse among the general population remains low, indicators of problems related to cocaine (including crack cocaine) in Europe, such as demand for treatment and deaths due to overdose, point to a steady increase in problems arising from the abuse of cocaine. In particular, treatment attendance for cocaine abuse has been reported to be relatively high in the Netherlands (30 per cent) and Spain (19 per cent). The abuse of cocaine powder still accounts for the majority of cases involving treatment for the abuse of cocaine-type drugs in Western Europe. Prevalence of the abuse of crack cocaine has been reported to be relatively low in most countries in that subregion. However, in some cities, the abuse of crack cocaine reached a level where it is beginning to cause problems.[32]

63. In Eastern Europe, there seem to be indications that cocaine abuse is still at a level below that of Western Europe, even if the picture is not clear because comparable national estimates are lacking. Increased cocaine abuse was reported in Albania, Bulgaria, Croatia, Lithuania and Poland. In Slovakia, the most recent reports indicate that the situation with regard to cocaine abuse is stable. In Hungary the situation is stable and decreasing.

64. School surveys conducted in Bulgaria and the Czech Republic in 2001 reported a stabilizing trend in the lifetime use of cocaine. In Lithuania, results from a survey conducted among students in Vilnius in 2001 showed a substantial increase in the lifetime use of cocaine and crack cocaine, clearly exceeding levels found in a study carried out in 1999 (for cocaine abuse, 1.1 per cent in 1999 compared with 3.0 per cent in 2001; and for the abuse of crack cocaine, 0.3 per cent in 1999 compared with 0.6 per cent in 2001).[33]

Figure XIV
Trends in cocaine abuse in Europe, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

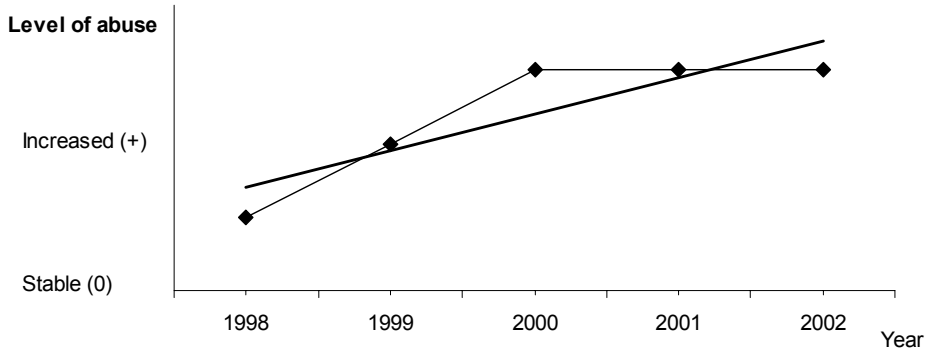
Note: National trend estimates weighted by population size.

Oceania

65. In Oceania, the trend in cocaine abuse is similar to that in Europe: a gradual but consistent increase since 1998 with some indications of stabilization in recent years.

66. Information reported in figure XV refers mainly to Australia. New Zealand reported a stable situation during the entire period 1998-2002. In Australia, the level of cocaine abuse was reported to be stable in 2002, with annual prevalence remaining at relatively low levels, 1.3 per cent among persons aged 14 and over (based on replies to the most recent national household survey, conducted in 2001). Frequency of cocaine abuse decreased among injecting drug users in New South Wales, and cocaine abuse remained relatively uncommon and infrequent in other jurisdictions. Cocaine was reported to be readily available only in Sydney, where its abuse had been apparent for several years. There were reports of a recent increase in cocaine injection in Sydney, possibly in response to the decreased availability of heroin in 2001.

Figure XV
Trends in cocaine abuse in Oceania, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

D. Amphetamine-type stimulants

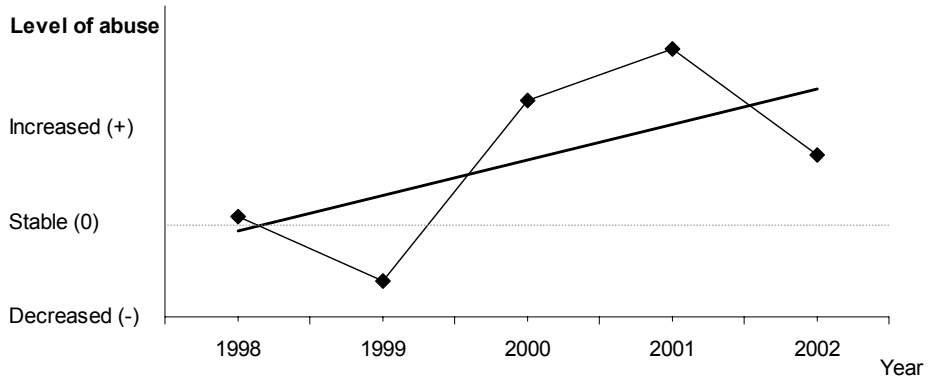
67. The abuse of ATS increased in the period 1998-2002 in all regions of the world. Despite some recent signs of stabilization in the main consumption areas, upward trends dominate the global picture of ATS abuse. The abuse of ATS is increasingly affecting countries with no long history of abuse of synthetic drugs; in countries with a high prevalence of ATS abuse, such abuse has continued to affect broader population groups and consumption scenes.

Africa

68. The overall trend in ATS abuse in Africa appeared to be unstable during the period 1998-2002 (see figure XVI), with sporadic reports of increased abuse of the

drug in urban areas, mainly based on treatment demand data. In general, the level of ATS abuse is low in Africa, as ATS is rarely considered the primary drug of abuse. In Cape Town, South Africa, in 2002 there were isolated reports of the use of crystallized methamphetamine (commonly called "ice") and an increase in the proportion of patients for whom Ecstasy was the primary drug of abuse. In South Africa there is a small but established market for ATS, particularly associated with the rave culture.

Figure XVI
Trends in the abuse of amphetamine-type stimulants in Africa, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

Americas

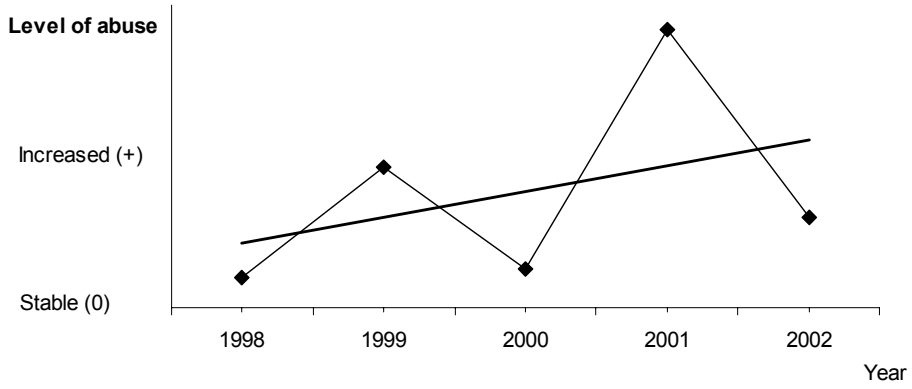
69. The trend in the abuse of ATS in the Americas during the period 1998-2002 reflects mostly changes in the abuse of methamphetamine and Ecstasy: gradually increasing, but changing annually (see figure XVII). This may be partly explained by the various indicator estimates for different drugs within the ATS category; a separate analysis on trends in the abuse of amphetamine, methamphetamine and Ecstasy may be required in order to understand the underlying reasons for such variation over time. In North America, the trend was mixed: the situation was mainly stable, with some increases and decreases depending on the substance considered. Increases from low levels were reported at various points in time between 1998 and 2002 in several countries in Latin America and the Caribbean: Argentina, Chile, Colombia, Dominican Republic, Guatemala, Mexico, Panama, Suriname and Venezuela.

70. The 2002 Monitoring the Future survey of students in grades 8, 10 and 12 in the United States showed, for the first time in years, a decline (from relatively high levels) in the abuse of Ecstasy in all three of the prevalence periods examined (lifetime, annual and past 30-day period) for each of the three grade levels. Those decreases coincided with increased disapproval of Ecstasy abuse among students and a levelling off in the availability of the substance in 2002, following several years of increases.[34] Based on records of a sample of hospitals operating 24-hour

emergency departments, the overall picture with regard to visits induced by or related to ATS abuse in the United States appeared to be more stabilized.

71. In Canada, results based on the Ontario Student Drug Use Survey in 2001 suggested a relatively high level of annual abuse of ATS among students in grades 7-13 (3.8 per cent for methamphetamine; 6.0 per cent for Ecstasy).

Figure XVII
Trends in the abuse of amphetamine-type stimulants in the Americas, 1998-2002



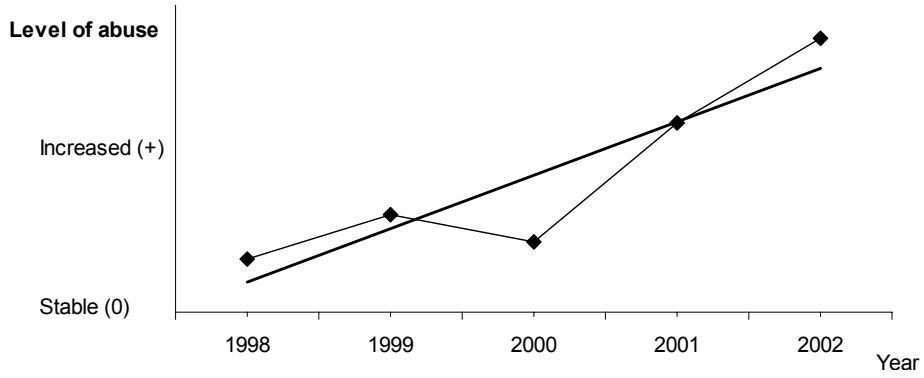
Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

Asia

72. In Asia, the trend in ATS abuse shows a constant increase throughout the region in the period 1998-2002 (see figure XVIII). Several countries (Bangladesh, Brunei Darussalam, Cambodia, India, Indonesia, Myanmar, Nepal, Republic of Korea and Singapore) reported an increasing trend in the abuse of ATS. In South-East Asia, many countries indicated that trends in illicit drug abuse in general are largely led by the abuse of ATS, and some have reported that abusers of other drugs have switched to ATS. For example, in Cambodia abusers of solvents have changed to ATS; and in the Lao People's Democratic Republic, abusers of cannabis and opioids have switched to ATS. While ATS abuse involves smoking in most countries in the region, oral ingestion is also a common route of administration. There have also been reports of increased injecting of methamphetamine in countries in the region. Abusers of ATS are predominantly young persons aged 15-25, representing a range of different population groups, such as street children, university students and employed young adults.

Figure XVIII
Trends in the abuse of amphetamine-type stimulants in Asia, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

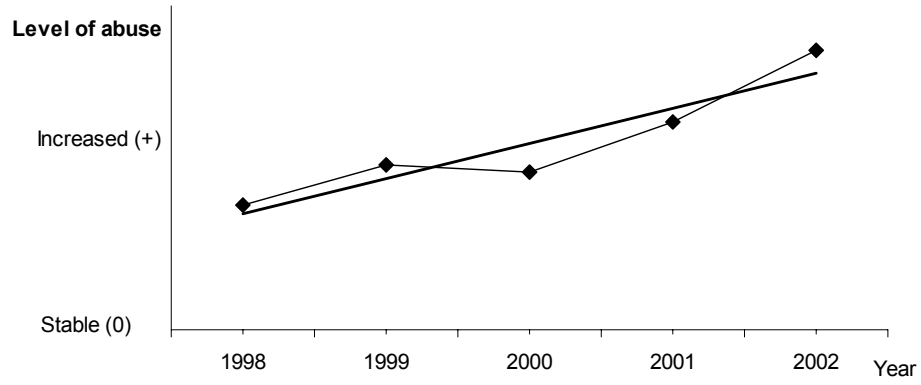
Note: National trend estimates weighted by population size.

Europe

73. In Europe, an overall increasing trend in the abuse of ATS (see figure XIX), as reported by national experts through the annual reports questionnaire, reflects to a great extent increased abuse of Ecstasy in the region over the past few years, in particular among youth in urban areas. There continues to be significant abuse of amphetamines and Ecstasy in Europe: the rates of lifetime use among the adult population range between 0.5 per cent and 5 per cent, the highest rates being among young adults. The overall situation is marked by converging trends. While countries (especially in Western Europe) that experienced strong increases in ATS abuse in the 1990s seem to be stabilizing or decreasing, countries with low prevalence (in both Eastern and Western Europe) are experiencing increases.

74. Recent information suggests that experimental and recreational use of "club drugs", Ecstasy in particular, is increasing in Central and Eastern European countries, and a high lifetime prevalence rate has been found among 16-year-olds for example, 6 per cent in Latvia and 4 per cent in the Czech Republic, Lithuania and Slovenia.[35] In Albania, the abuse of amphetamines, as well as that of other illicit drugs, has increased among youth during the past few years. In Turkey, the abuse of Ecstasy appears to be on the increase, though it is still at a relatively low level. While the percentage of students in secondary school (grade 10) who abused Ecstasy at least once in their lifetime was 2.65 per cent in 1998, the figure reached 3.31 per cent in 2001.[36]

Figure XIX
Trends in the abuse of amphetamine-type stimulants in Europe, 1998-2002



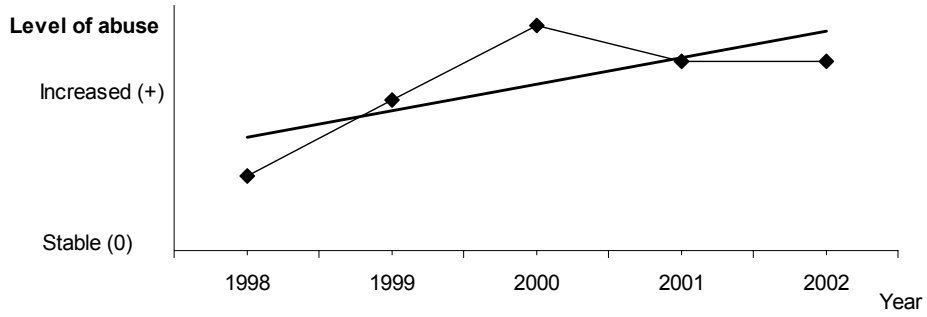
Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

Oceania

75. Despite the recently stabilized situation, the general trend in Oceania since 1998 has shown increases in the abuse of ATS (see figure XX). What is most worrying is that the trend has involved, to a great extent, drug injecting, in particular with regard to the abuse of methamphetamine. In Australia, a substantial proportion of injecting drug users continued abusing all forms of methamphetamine in 2002, while a decrease in the abuse of methamphetamine powder was noted in most jurisdictions. Results of the national household survey conducted in Australia in 2001 showed that, for drug use in the past 12 months among persons aged 14 years and over, the figures were 3.4 per cent for amphetamines and 2.9 per cent for Ecstasy. The highest annual prevalence rates were found among persons aged 20-29: about 10 per cent for each of the substances.[37]

Figure XX
Trends in the abuse of amphetamine-type stimulants in Oceania, 1998-2002



Source: United Nations Office on Drugs and Crime, annual reports questionnaire.

Note: National trend estimates weighted by population size.

III. Measuring progress

76. As mentioned in paragraph 3 above, there are some limitations to the information reported. The present report outlines the major trends on the basis of the opinions of informed experts. Those opinions, often confirmed by epidemiological data, are valuable in terms of pointing out what the trends are for the main substances.

77. The present report, despite its limitations, is an attempt to improve the global database on drug abuse trends by relating estimations to the population of each country in the regional context. That has facilitated the interpretation of the relative importance of the reported increases and decreases. In order to have a better idea of the progress made in reducing illicit drug demand since 1998, more and varied information is needed.

78. Some options on how to proceed in the future are presented below. It should be noted that the discussion that follows refers only to information on drug abuse and drug demand reduction programmes and activities.

A. Biennial reports questionnaire: progress in demand reduction activities and programmes

79. In its resolution 42/11, entitled "Guidelines for reporting on the follow-up to the twentieth special session of the General Assembly", the Commission underlined the need to establish a follow-up mechanism for examining and sustaining progress in meeting the objectives for the years 2003 and 2008 set out in the Political Declaration adopted by the Assembly at its twentieth special session.

80. The consolidated first biennial report of the Executive Director on the implementation of the outcome of the twentieth special session of the General Assembly (E/CN.7/2001/16) was considered by the Commission at its reconvened forty-fourth session, in 2001. The second biennial report of the Executive Director on that subject (E/CN.7/2003/2 and Add.1-6) was considered by the Commission at its forty-sixth session, in 2003. Both reports were based on replies to the biennial reports questionnaire. The biennial reports questionnaire elicits information on, inter alia, activities and programmes in demand reduction in various settings, their coverage of the target groups and whether the programme execution is gender-sensitive and the results are evaluated. That information makes it possible to monitor how each country is progressing, but it does not allow to make possible a comparison between countries because of the different contexts in which the implementation of programmes takes place. Having an indication of the progress of each country (which can also be expressed in a quantitative manner by interpreting the replies to the biennial reports questionnaire) could be useful in defining regional and global progress in that area.

B. Annual reports questionnaire: progress in the situation with regard to drug abuse

81. Another important aspect of assessing progress in drug demand reduction is monitoring drug abuse patterns and trends. To that end, the annual reports

questionnaire was streamlined to facilitate submission of information by Governments. Governments have been reporting using the revised version of the questionnaire since the reporting year 2001.

82. The present report represents a first attempt to use some of the information provided by Governments to analyse the progress made since 1998.

83. The revised annual reports questionnaire requires information on key indicators that take into account the consensus reached by experts at a meeting on the principles, structures and indicators for drug information systems, held in Lisbon in January 2000. The key indicators are used to develop a good idea of patterns and trends in drug abuse. The basic indicators are:

(a) Drug consumption among the general population (estimates of prevalence and incidence);

(b) Drug consumption among the youth population (estimates of prevalence and incidence);

(c) High-risk drug abuse (estimates of the number of injecting drug users and the proportion engaged in high-risk behaviour, estimates of the number of daily drug users);

(d) Utilization of services for drug problems (number of individuals seeking help for drug problems);

(e) Drug-related morbidity (prevalence of HIV, hepatitis B virus and hepatitis C virus among illicit drug consumers);

(f) Drug-related mortality (deaths directly attributable to drug consumption).

84. However, not all countries are in a position to provide data on all the key indicators. In some cases, comparison of the indicators is difficult because of differences in definitions. Moreover, not all countries may be able to provide information about the situation in 1998, the year used as a baseline for measuring progress.

85. To address these problems, a proactive approach is required. Countries are doing their best to improve the data collection systems. The United Nations Office on Drugs and Crime, within the framework of the Global Assessment Programme on Drug Abuse and other programmes, is providing advice in this regard. However, significant progress in this area requires time.

86. In monitoring progress, it is important to focus attention on key indicators that can be compared. For example, information on drug-related mortality poses serious problems because of differences in forensic requirements and standards.

87. In order to overcome the lack of information (for both the baseline year 1998 and the following years) it may be necessary to produce estimates on the basis of the limited information available. Thus the Secretariat and Governments may need to make estimations using a transparent procedure that may entail the consideration of other sources of information. That will require considerable resources from the Secretariat and the national focal points on drug abuse information.

88. Finally, the key indicators, if available, may be considered separately in order to highlight the different aspects of the drug abuse problem: the size of the problem,

focusing on the general population; indication of potential long-term problems, focusing on youth; and indication of the costs and consequences, focusing on demand for treatment and on HIV prevalence among injecting drug users.

89. It would also be possible to bring those elements together and develop a drug abuse index: an index of the drug abuse situation, along the lines of the Human Development Index, which would include the different dimensions of each indicator and would present them as one value that would serve to compare the drug abuse situation of various countries.

90. Before embarking on such an exercise, the Secretariat would need to receive guidance from the Commission on the matter.

Notes

[1] *Official Records of the Economic and Social Council, 1997, Supplement No. 8* (E/1997/28/Rev.1), part one, para. 80 (a).

[2] The response rate was 54 per cent (103 replies submitted) for the reporting year 2001, 41 per cent (80 replies submitted) for 2000, 49 per cent (94 replies submitted) for 1999 and 58 per cent (112 replies submitted) for 1998.

[3] Each degree of trend estimation was given a numerical value ranging from –2 to 2 (–2 representing a large decrease; –1, some decrease; 0, no great change; 1, some increase; and 2, a large increase). Estimates for each drug type were multiplied by the proportion of the population of the country in relation to the total population of the region. The national estimates were added to represent annual regional trend estimate for each drug type, and a cumulative five-year trend for each region was calculated. The main advantage of such an analysis is that, at its best, by taking into account the population size affected by the estimated trend, the risk of greatly overestimating or underestimating the magnitude of regional trends is significantly reduced. For example, a large increase in the abuse of cannabis in a country with a small population is considered to have less importance or impact compared with some increase in a country with a large population in the region.

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[33] European Monitoring Centre for Drugs and Drug Addiction, *Annual Report 2003: the State of the Drugs Problem in the Acceding and Candidate Countries to the European Union* (Lisbon, 2003).

[34] L. D. Johnston, P. M. O'Malley and J. G. Bachman, *Monitoring the Future National Results on Adolescent Drug Use: Overview of Key Findings, 2002*, NIH Publication No. 03-5374 (Bethesda, Maryland, National Institute on Drug Abuse, 2003).

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Annex I

Abuse of cannabis: trends and reporting, 2002

Trend	*Number of reports*	*Share of reports (percentage)*	*Reporting, by region*
Increase in abuse	16		Africa
			Cameroon, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Malawi, Mauritius, Morocco, Namibia, Seychelles, Somalia, South Africa, Togo, United Republic of Tanzania, Zambia and Zimbabwe
	13		Americas
			Argentina, Bahamas, Barbados, Colombia, Costa Rica, El Salvador, Guatemala, Haiti, Paraguay, Suriname, Trinidad and Tobago, Uruguay and Venezuela
	11		Asia
			Azerbaijan, China, Hong Kong Special Administrative Region of China, India, Israel, Japan, Pakistan, Saudi Arabia, Singapore, Sri Lanka and Uzbekistan
	15		Europe
			Albania, Belarus, Bulgaria, Croatia, Czech Republic, Denmark, Germany, Greece, Ireland, Latvia, Luxembourg, Poland, Slovakia, Spain and Switzerland
Subtotal	**55**	**59**	
Stable level of abuse	1		Africa
			Madagascar
	3		Americas
			Canada, Dominican Republic and United States
	8		Asia
			Bangladesh, Brunei Darussalam, Kyrgyzstan, Lebanon, Nepal, Qatar, Republic of Korea and Tajikistan
	16		Europe
			Austria, Belgium, Finland, France, Hungary, Italy, Liechtenstein, Lithuania, Malta, Netherlands, Norway, Romania, Sweden, Turkey, Ukraine and United Kingdom
Subtotal	**28**	**30**	

Trend	*Number of reports*	*Share of reports (percentage)*	*Reporting, by region*
Decrease in abuse	1		Africa
			Tunisia
	1		Americas
			Chile
	7		Asia
			Armenia, Indonesia, Macao Special Administrative Region of China, Myanmar, Oman, Philippines and Yemen
	1		Oceania
			Australia
Subtotal	**10**	**11**	
Total	**93**	**100**	

Annex II

Abuse of opioids: trends and reporting, 2002

Trend	*Number of reports*	*Share of total reports (percentage)*	*Reporting, by region*
Increase in abuse	12		Africa
			Cameroon, Côte d'Ivoire, Kenya, Malawi, Mauritius, Morocco, Namibia, Somalia, South Africa, Togo, United Republic of Tanzania and Zambia
	5		Americas
			Argentina, Colombia, Dominican Republic, El Salvador and Venezuela
	11		Asia
			Azerbaijan, Bangladesh, China, Hong Kong Special Administrative Region of China, Japan, Kyrgyzstan, Lebanon, Nepal, Oman, Sri Lanka and Uzbekistan
	5		Europe
			Albania, Belarus, Lithuania, Norway and Sweden
Subtotal	**33**	**39**	
Stable level of abuse	2		Africa
			Ghana and Zimbabwe
	9		Americas
			Bahamas, Barbados, Canada, Costa Rica, Guatemala, Paraguay, Suriname, United States and Uruguay
	4		Asia
			Brunei Darussalam, India, Philippines and Republic of Korea
	20		Europe
			Austria, Bulgaria, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Liechtenstein, Luxembourg, Malta, Netherlands, Romania, Turkey, Ukraine and United Kingdom
Subtotal	**35**	**41**	

Trend	*Number of reports*	*Share of total reports (percentage)*	*Reporting, by region*
Decrease in abuse	1		Africa
			Tunisia
	10		Asia
			Armenia, Macao Special Administrative Region of China, Indonesia, Israel, Myanmar, Pakistan, Qatar, Saudi Arabia, Singapore and Tajikistan
	5		Europe
			Croatia, Poland, Slovakia, Spain and Switzerland
	1		Oceania
			Australia
Subtotal	**17**	**20**	
Total	**85**		