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Thematic debate on the follow-up to the twentieth special session of the General Assembly: general overview and progress achieved by Governments in meeting the goals and targets for the years 2003 and 2008 set out in the Political Declaration adopted by the Assembly at its twentieth special session

The world drug problem

Fifth report of the Executive Director

Addendum

Drug demand reduction

Summary

On the basis of the data provided by Member States through the annual reports questionnaire and the biennial reports questionnaire, the present report draws conclusions on progress made in the area of drug demand reduction over the period 1998-2007.

Available information on the drug abuse situation suggests that, at the global level, the consumption of most drugs is pointing towards stabilization and that a decline in consumption generally occurs in countries that have implemented long-term and sustained demand reduction strategies.

Considerable progress was achieved during the period in complying with the demand reduction measures identified by the General Assembly at its twentieth special session. Most States made progress in establishing national demand reduction

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strategies, assessing the drug abuse problem and providing prevention, treatment and rehabilitation services. Nonetheless, if the coverage and availability of all services are considered, the level of compliance with the requirements of the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution 54/132, annex) was rather low in most regions.

Contents

I. Introduction

1. At the twentieth special session of the General Assembly, Member States adopted a Political Declaration (resolution S-20/2, annex) that contained two wide-ranging goals for drug demand reduction: (a) to have new or enhanced drug demand reduction strategies and programmes set up by 2003; and, as a consequence of those renewed efforts, (b) to achieve significant and measurable results in the area of demand reduction by 2008.

2. The two instruments used to measure progress in reaching those goals were the annual reports questionnaire, which collected annual data on the drug abuse situation (analysed in the report of the Executive Director on the world situation with regard to drug abuse (E/CN.7/2008/4)), and the biennial reports questionnaire, which was designed to monitor the action taken by Member States to reduce drug demand. Accordingly, the assessment of the progress made over the past 10 years is based on the information provided by Member States to the Secretariat through those instruments.

3. The Secretariat has informed the Commission on Narcotic Drugs of a number of limitations in relation to the data received through those instruments. One of the main issues was the establishment of a correlation between drug abuse trends and the demand reduction programmes implemented over the past 10 years. Attributing positive trends to specific interventions is difficult for a number of reasons, but mainly because drug abuse behaviours are influenced by multiple factors and because it is difficult to pinpoint a single element as the one causing the observed change. In addition, drug abuse behaviours tend to change slowly, so, although activities begun during the past 10 years may have already produced some results, in most cases their impact will not be clear until further in the future. Nonetheless, one element that has emerged are the positive changes in drug abuse (stabilization or decrease) that are occurring in regions[1] where sustained and adequately resourced drug demand reduction interventions have been carried out.

4. Despite the various limitations, it is possible to use the information provided to draw some general conclusions that could guide Member States in their assessment of the progress made and in determining the way forward in tackling the world drug problem.

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[1] In the present report, countries have been divided into the following regions and subregions:
- (a) The region of Africa and the Middle East, comprising the following subregions:
  - (i) North Africa and the Middle East;
  - (ii) Sub-Saharan Africa;
- (b) The region of the Americas, comprising the following subregions:
  - (i) Latin America and the Caribbean;
  - (ii) North America;
- (c) The region of Asia and Oceania, comprising the following subregions:
  - (i) Central, South and South-West Asia;
  - (ii) East and South-East Asia;
  - (iii) Oceania;
- (d) The region of Europe, comprising the following subregions:
  - (i) Central and Western Europe;
  - (ii) Eastern and South-Eastern Europe.

II. New and enhanced drug demand reduction strategies and programmes

5. Since 1998, the Secretariat has received information from Member States – through the biennial reports questionnaire – on programmes and strategies that addressed the evolving drug abuse situation. States reported mainly on the implementation of different activities in selected areas of drug demand reduction, in line with the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution 54/132, annex). Information provided by international organizations, regional agencies and expert bodies has enabled the Secretariat to supplement the information contained in the biennial reports questionnaire. Regional data sources have also been used to corroborate the analysis of the responses to the questionnaire.

6. Over the past 10 years, the Secretariat has synthesized the information provided by Member States to illustrate changes in the implementation of drug demand reduction strategies and programmes.

7. The present report reviews the information provided since 1998 so that Member States may assess progress made and reflect on future directions. The report is divided into two main sections. The section entitled "Taking action" summarizes information on activities and programmes delivered to specific target groups and settings, while the section entitled "Building institutional capacity" analyses changes in the capacity of States to implement effective demand reduction programmes and strategies.

A. Taking action

8. The following interventions, classified in the biennial reports questionnaire, are the most important ones in terms of taking action in the area of drug demand reduction: (a) prevention; (b) treatment and rehabilitation; and (c) reduction of the negative health and social consequences of drug abuse. Although it is encouraging to see that more States intensified their efforts during the follow-up period to the twentieth special session of the General Assembly, the level of response to the problem remains largely insufficient. Worldwide, more Member States reported the existence of various prevention interventions and treatment modalities in different settings, but progress was limited; and the slight improvement reported over the reporting period 1998-2000 (the baseline period) was owed mostly to the estimated coverage of implemented activities, which was relatively low overall (see figure 1).[2, 3]

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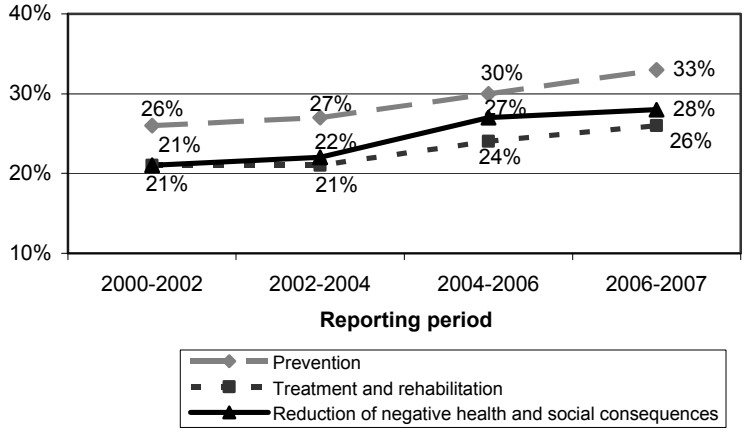
[2] The composite indices that have been developed summarize the responses provided by Member States through the questionnaire with regard to the reported implementation and estimated coverage of activities as requested under the various action plans. An analysis has been conducted using the data provided by all those countries that responded to the questionnaire in each reporting period. The indices are presented as regional averages, ranging from a minimum of 0 per cent to a maximum of 100 per cent. For example, a region reaches 100 per cent when all the reporting countries indicate having all the requested measures in place, while a region where all reporting countries report having none of these measures in place has a rating of 0 per cent.

[3] A composite index helps to address such situations as the reporting by most States that by the

Figure 1
Implementation of demand reduction interventions, by area of intervention, selected reporting periods
(Composite index)



9. A simple tally of the Member States that reported only on the implementation of different types of activities would show greater progress made in many regions, but that would not reflect appropriately the extent of the activities.

1. Interventions focusing on drug abuse prevention

10. Although a number of developments in the area of prevention have taken place since the late 1990s, they are difficult to quantify. The foregoing notwithstanding, the responses received to the biennial reports questionnaire suggest that progress in using prevention as part of the global response to the drug problem has been modest at best, and has remained inadequate in many regions.

11. The implementation of prevention programmes was maintained in areas where they had already been established. Some progress was made in recent years in regions where activities had been largely lagging behind. For example, an increasing number of States conducted drug prevention activities in schools,

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fifth reporting period they had implemented more demand reduction programmes than in the first reporting period, but they estimated coverage to be at a low level and reported little improvement in that regard since the baseline period. The composite index takes into account the estimated coverage of the intervention programme, activity or service. As a result, the scores shown in the composite indices are consistently lower than the proportion of States that actually reported activities in each region. Ideally, coverage could refer, for example, to the percentage of the target population that is effectively participating in a drug abuse prevention programme i.e. that is exposed to such a programme on a regular or periodic basis. As for other concepts and terms used in the current version of the biennial reports questionnaire, a standard definition for "coverage" with regard to different demand reduction interventions was not provided. Therefore, the responses give only a general picture, as the classification of coverage is subjective and pertains to the specific situation in each State. Moreover, the extent and quality of activities remain unclear. Persistent weaknesses in terms of monitoring the quality and the coverage of demand reduction programmes is an important aspect of the analysis of the progress made in implementing demand reduction programmes. It is also a priority area that needs to be considered in the development of future monitoring systems.

although in many cases those activities consisted of sporadic lectures or programmes whose coverage of the target population was weak and generally confined to urban areas.

12. States in North Africa and the Middle East and in Central, South and South-West Asia reported the most notable level of improvement over the baseline situation. In contrast, the responses received from Sub-Saharan Africa, Latin America and the Caribbean and Eastern and South-Eastern Europe suggest relatively limited investment in prevention programmes. In Eastern and South-Eastern Europe, the proportion of States implementing prevention programmes in different settings showed a declining trend over the decade. In Latin America and the Caribbean, while most States had some sort of programme in place, prevention was largely carried out by a small number of specialists and was often limited to activities that lacked cohesion and had limited coverage (see figures 2-10).

Figure 2
North Africa and the Middle East: implementation of prevention interventions, selected reporting periods
(Composite index)

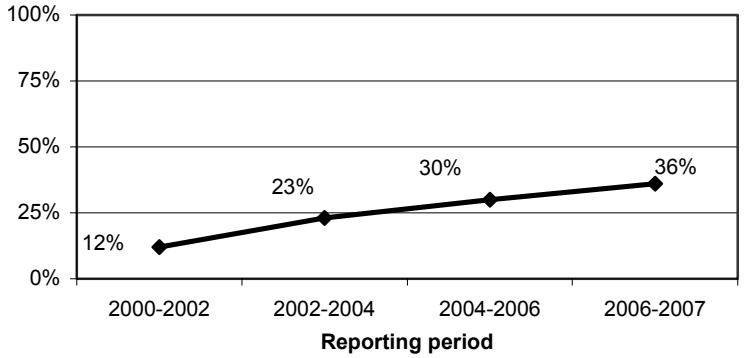


Figure 3
Sub-Saharan Africa: implementation of prevention interventions, selected reporting periods
(Composite index)

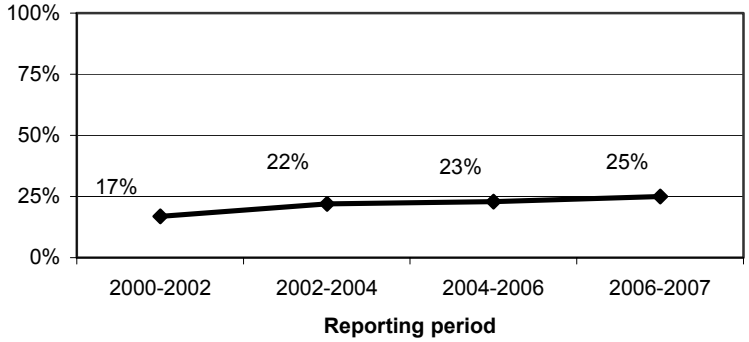


Figure 4
Latin America and the Caribbean: implementation of prevention interventions, selected reporting periods
(Composite index)

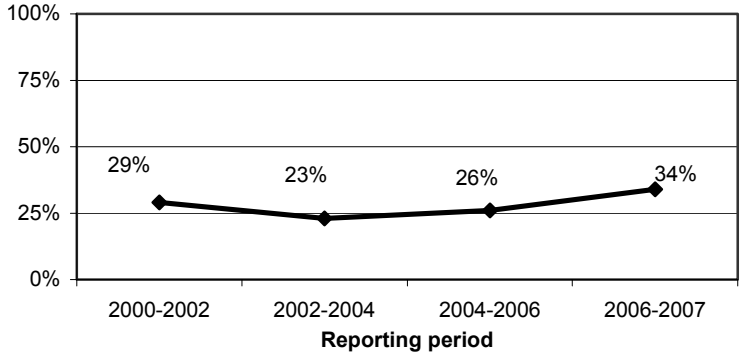


Figure 5
North America: implementation of prevention interventions, selected reporting periods
(Composite index)

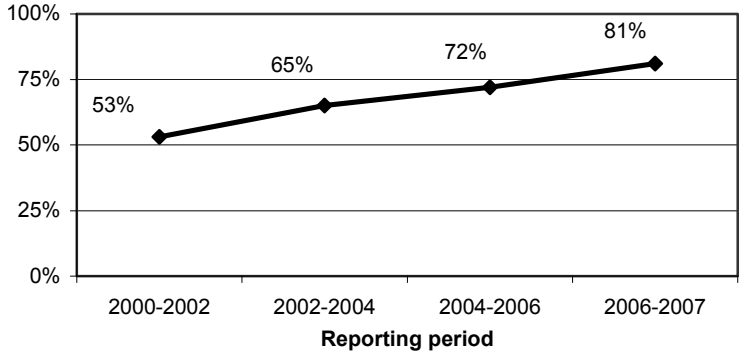


Figure 6
Central, South and South-West Asia: implementation of prevention interventions, selected reporting periods
(Composite index)

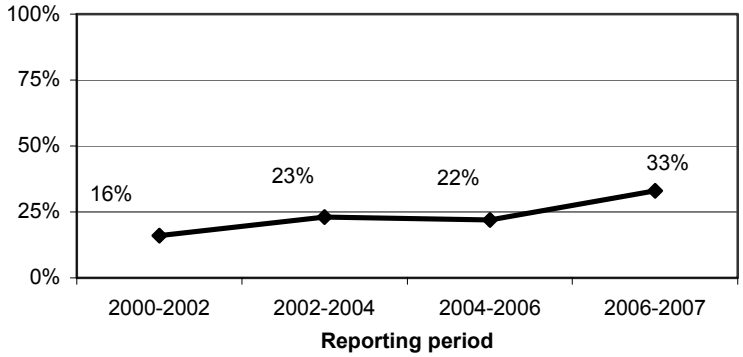


Figure 7
East and South-East Asia: implementation of prevention interventions, selected reporting periods
(Composite index)

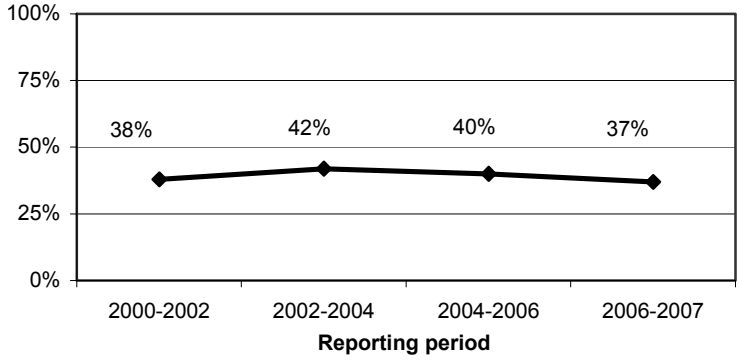


Figure 8
Oceania: implementation of prevention interventions, selected reporting periods
(Composite index)

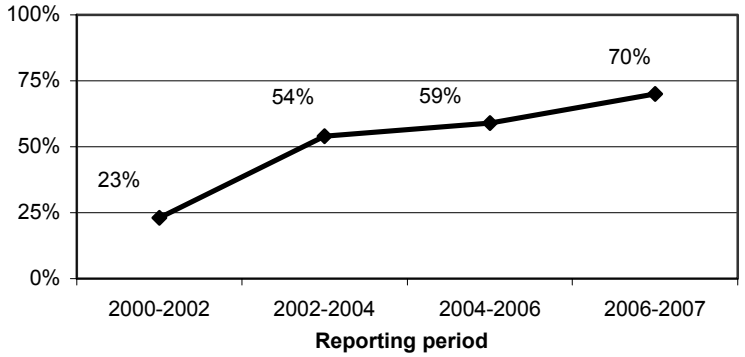


Figure 9
Central and Western Europe: implementation of prevention interventions, selected reporting periods
(Composite index)

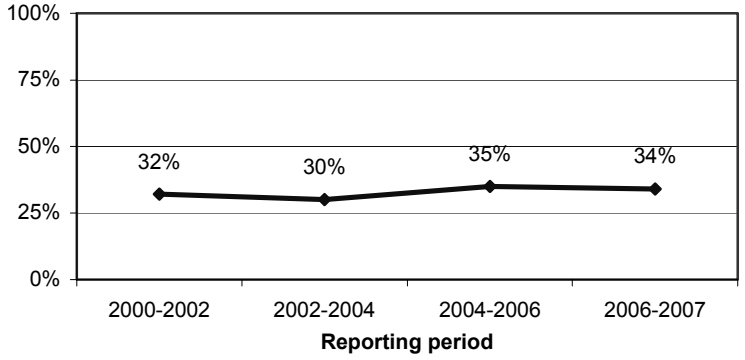
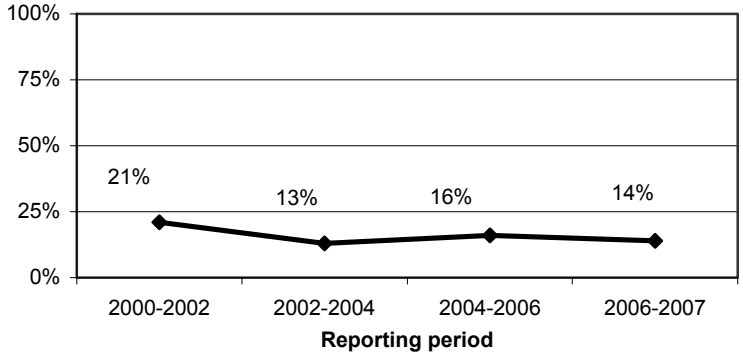


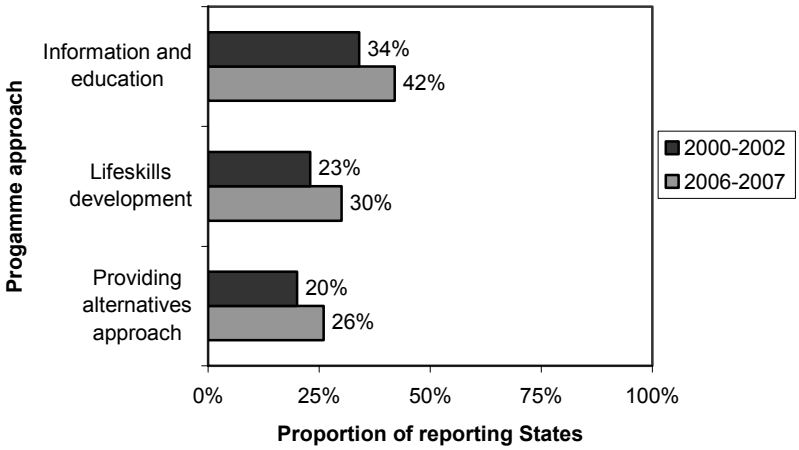
Figure 10
Eastern and South-Eastern Europe: implementation of prevention interventions, selected reporting periods
(Composite index)



13. In Europe, new approaches, such as selective prevention, were introduced by many States, progressively complementing the more classical, universal type of school- and community-based prevention programmes. There was also a qualitative improvement observed with the introduction and extension of quality assurance and evaluation mechanisms in Europe. In many regions, prevention activities are now more diverse and often more evidence-based than they were in 1998.

14. Programmes focused largely on providing information, with life-skills education and the provision of alternatives to drug use remaining less common. At the same time, the global trend suggests that prevention programmes using the life-skills development approach are becoming more popular, while programmes that mainly provide information continue to expand among Member States but at a proportionally slower pace. That is noteworthy in that, of the three drug abuse prevention approaches that Member States are asked to report on in the biennial reports questionnaire, the programmes utilizing a life-skills education approach are those with the most solid evidence of effectiveness (see figure 11).

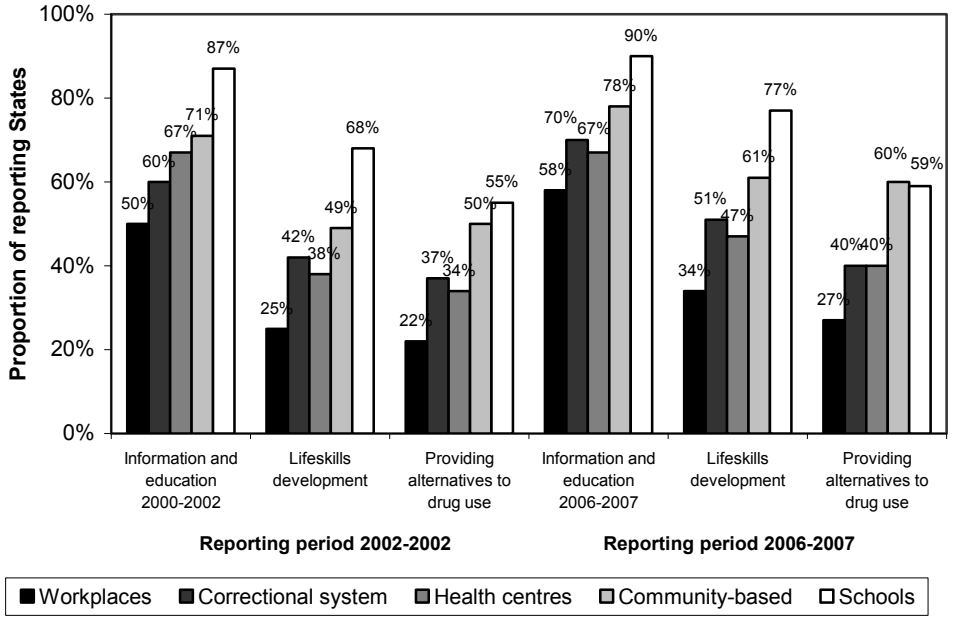
Figure 11
All regions: implementation of prevention interventions by programme approach, 2000-2002 and 2006-2007
(Percentage)



15. Prevention activities take place mainly in schools rather than in workplace settings, in view of the need to target drug abuse prevention activities at children and adolescents who have not yet started to experiment. That being said, comprehensive substance abuse prevention and treatment programmes have shown promising evidence of effectiveness in reducing not only substance abuse but also accidents and absenteeism.

16. Prevention programmes were increasingly implemented in different settings over the review period (see figure 12). That was especially the case in Sub-Saharan Africa, North Africa and the Middle East and Central, South and South-West Asia.

Figure 12
All regions: implementation of prevention interventions, by programme approach and setting, 2000-2002 and 2006-2007
(Percentage)



2. Interventions focusing on the treatment and rehabilitation of drug abusers

17. Most regions have seen an increase in demand for drug treatment since 1998. Both the demand for treatment and the number of States reporting implementation of different treatment modalities have risen. Notable increases have been reported, for example, in North Africa and the Middle East and in Central, South and South-West Asia. States in North America and Oceania reported high levels of implementation of different treatment modalities in all reporting periods (see figures 13-21).

18. In three of the nine subregions (Sub-Saharan Africa, Latin America and the Caribbean, and Eastern and South-Eastern Europe), the number of States reporting the availability of treatment programmes was persistently low, with little improvement reported over the period. The findings of the biennial reports questionnaire that point to an increase in drug-dependence treatment activities in Africa and the Middle East are confirmed by supplementary sources of information (Benin, Egypt, Jordan, Kenya, Lebanon, Mauritius, Morocco and Uganda).

19. It should be noted that substitution treatment, currently available only for opioid dependence, is not relevant for most States in Sub-Saharan Africa and Latin America and the Caribbean, where the demand for drug treatment relates mostly to cannabis and cocaine. That may have skewed the overall composite index for treatment and rehabilitation in those subregions.

Figure 13
North Africa and the Middle East: implementation of treatment and rehabilitation measures, selected reporting periods
(Composite index)

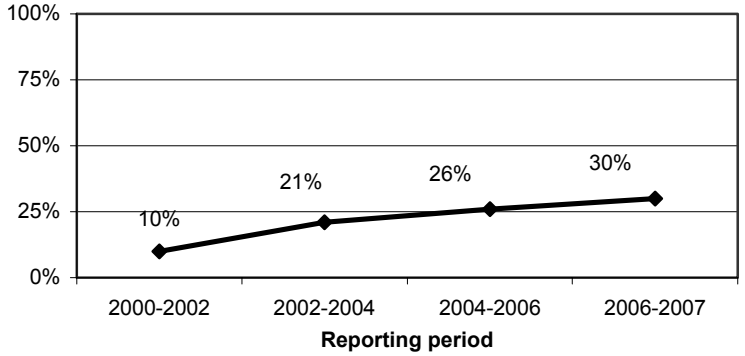


Figure 14
Sub-Saharan Africa: implementation of treatment and rehabilitation measures, selected reporting periods
(Composite index)

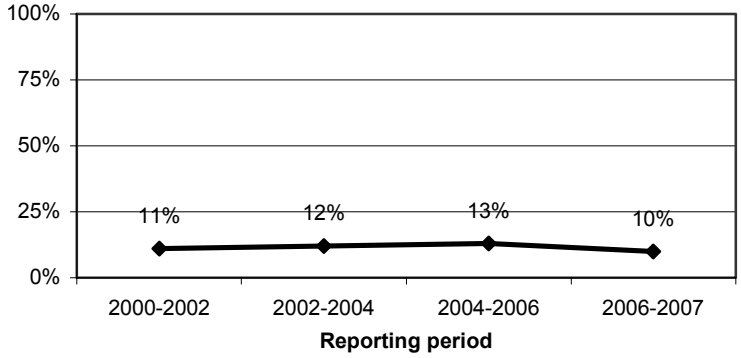


Figure 15
Latin America and the Caribbean: implementation of treatment and rehabilitation measures, selected reporting periods
(Composite index)

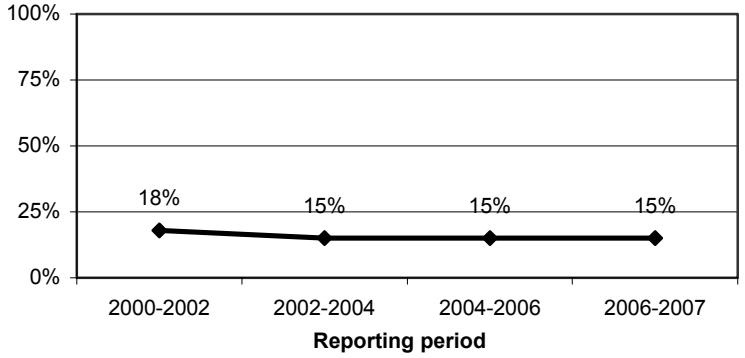


Figure 16
North America: implementation of treatment and rehabilitation measures, selected reporting periods
(Composite index)

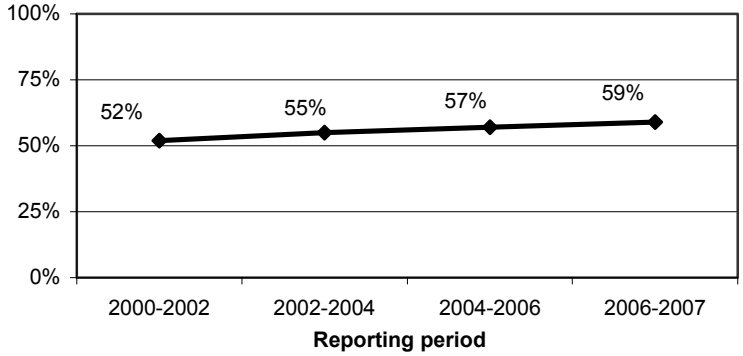


Figure 17
Central, South and South-West Asia: implementation of treatment and rehabilitation measures, selected reporting periods
(Composite index)

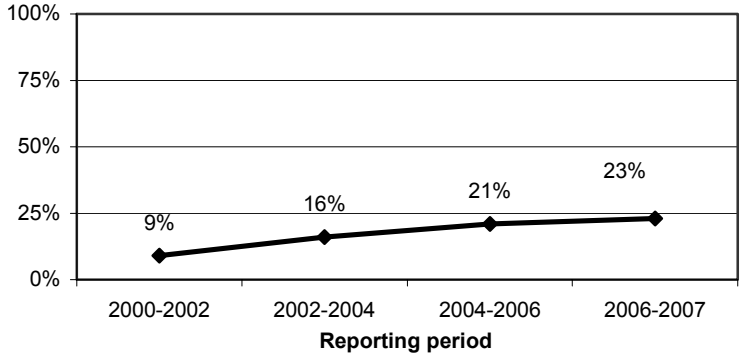


Figure 18
East and South-East Asia: implementation of treatment and rehabilitation measures, selected reporting periods
(Composite index)

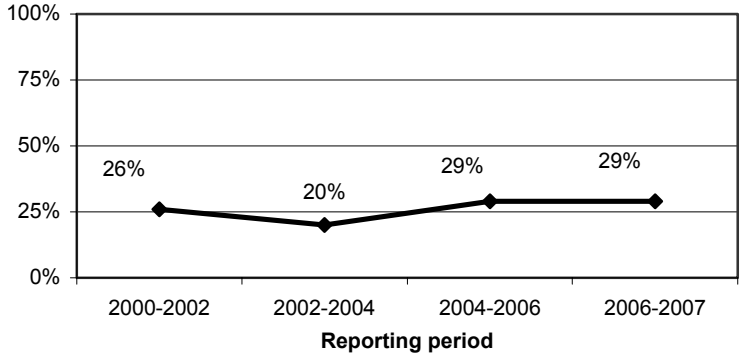


Figure 19
Oceania: implementation of treatment and rehabilitation measures, selected reporting periods
(Composite index)

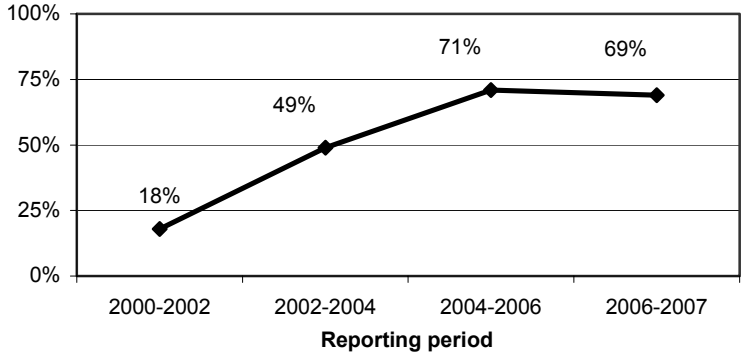


Figure 20
Central and Western Europe: implementation of treatment and rehabilitation measures, selected reporting periods
(Composite index)

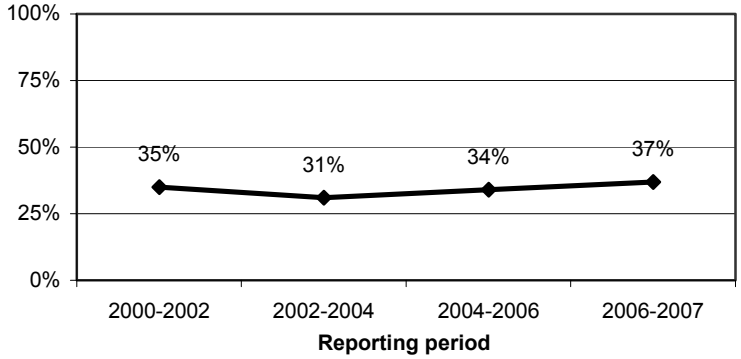
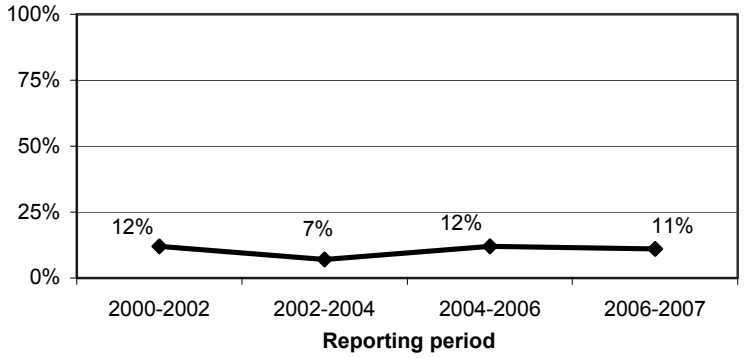


Figure 21
Eastern and South-Eastern Europe: implementation of treatment and rehabilitation measures, selected reporting periods
(Composite index)



20. In Europe, the number of persons receiving treatment is likely to have increased twofold since 1998. That development can be attributed to the increase in outpatient substitution treatments using methadone and buprenorphine and, more recently, to the increase in specialized treatment services for cannabis and cocaine dependence. In addition, many qualitative improvements – achieved through quality assurance, better developed evaluation mechanisms and the dissemination of science-based guidelines – have been reported.

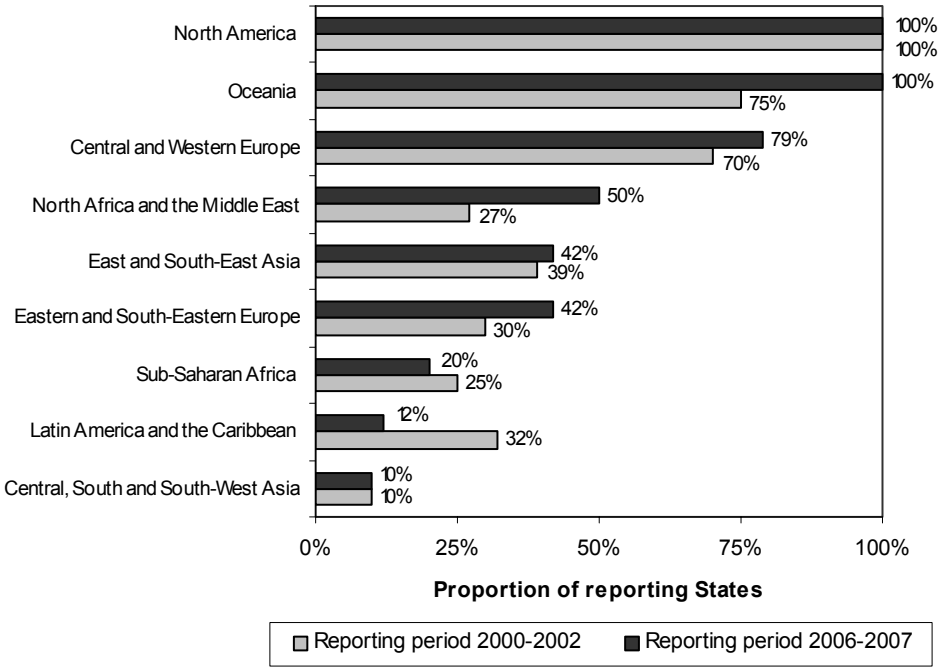
21. With regard to Latin America and the Caribbean, supplementary information from the Multilateral Evaluation Mechanism of the Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States indicates that some progress has been made in the implementation of drug treatment programmes in that subregion. Many States have in place some kind of basic service provided by the public or private sector. Those services offer outpatient and residential treatment options, including day and evening clinics, which provide services such as early detection, outreach and referral of cases, social reintegration and aftercare, and self-help groups. Part of the reason for the limited progress observed is the fact that national drug treatment systems do not pool their various efforts to make them more responsive to patient needs. CICAD is providing assistance in that area by establishing national drug treatment systems, providing communication networks for all treatment services and modalities in each country and creating national case referral systems. That allows care to be centred on the needs of the patient, rather than forcing the patient to adapt to the treatment modality offered by the service provider. Progress was also reported in the development of guidelines or regulations on standards for drug abuse treatment in most countries. The majority of those guidelines are mandatory and cover the delivery of treatment programmes at the national, state, provincial or local level.

22. Globally, detoxification was the most common intervention implemented during the period under review, and most regions reported increased efforts in that regard. Nonetheless, it should be noted that the term “detoxification” refers to a wide range of activities and it is, therefore, difficult to interpret. It would be important to consider detoxification in combination with longer-term treatments and follow-up, as detoxification alone has not been shown to be effective. For example, drug-free inpatient and outpatient treatment is available in all European Union member States; in some of them, it is even the main type of treatment for drug dependency, though the reported number of individuals receiving such treatment is smaller than the number of those who receive substitution treatment.

23. Of the four main types of treatment intervention covered in the biennial reports questionnaire, substitution treatment was the one least commonly implemented. That is of concern particularly where opioid-related problems are present, as it is one of the treatment approaches presenting the strongest evidence of effectiveness. Most notably, for the fifth reporting period States in North America and Oceania reported full implementation of substitution treatment in different settings, followed by States in Central and Western Europe, whose number had increased to the point that such treatment is now available in almost all States in the subregion. However, in many States that availability is only in a pilot stage, so coverage is rather limited. Supplementary sources of information suggest that the findings of the questionnaire with regard to the low proportion of States reporting

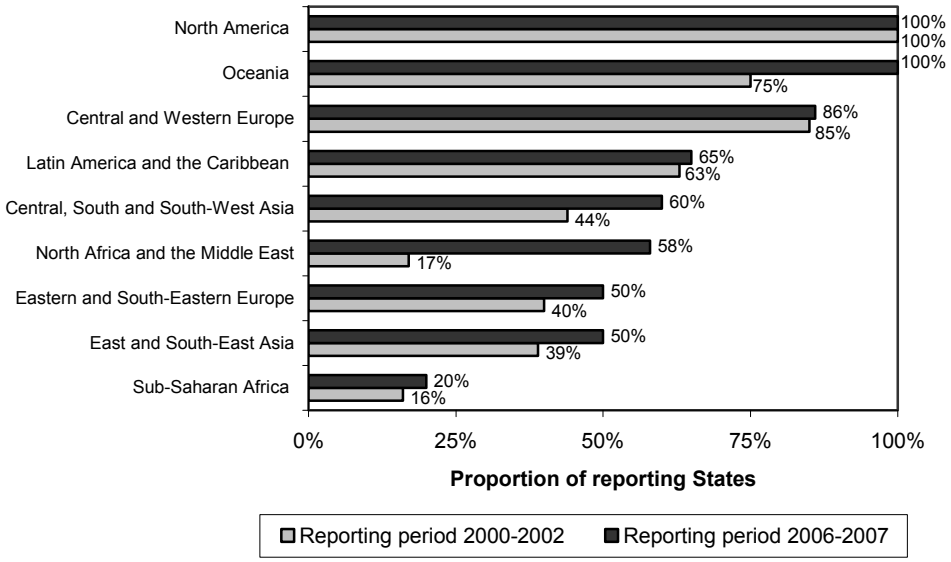
availability of substitution treatment in Latin America and the Caribbean and Sub-Saharan Africa may need to be interpreted with caution (see figure 22).

Figure 22
Availability of substitution treatment in outpatient settings, by subregion, 2000-2002 and 2006-2007
(Percentage)



24. The provision of non-pharmacological treatment increased in most regions during the period under review, particularly in North Africa and the Middle East and in Central, South and South-West Asia (see figure 23). A similar trend was observed in measures focusing on social reintegration. In recent years, the global situation has remained stable. In Europe, social rehabilitation programmes exist in almost all European Union member States, although the level of availability is considered to be limited.

Figure 23
Availability of non-pharmacological treatment in outpatient settings, by subregion, 2000-2002 and 2006-2007
(Percentage)



25. Overall, the progress made in expanding the provision of treatment has been limited and efforts need to be reinforced in order to achieve the goals set. When interpreting the results, it should be borne in mind that national or regional drug situations may require different types of responses. To ensure consistency with the existing evidence base for effective drug dependence treatment, the use of diverse treatment approaches, integrated within a continuum of care, needs to be strengthened. Furthermore, interventions need to be tailored to the changing needs of specific target groups and new drug trends.

3. Interventions to reduce the negative health and social consequences of drug abuse

26. There were noteworthy regional differences in implementation of the measures covered under the subsection of the biennial reports questionnaire dealing with interventions to reduce the negative health and social consequences of drug abuse. For the fifth reporting period (2006-2007), the proportion of States reporting that they had implemented most measures was relatively high (generally 75 per cent or higher) in four of the nine regions (Oceania, North America, Central and Western Europe and Central, South and South-West Asia). In some subregions, such as Sub-Saharan Africa and Latin America and the Caribbean, the proportion was notably lower.

27. It should be noted that, when the responses regarding the target group coverage of available activities are taken into account, the regional level of compliance with implementing the full range of measures monitored in the biennial reports questionnaire is rather low in most regions (see figures 24-32).

Figure 24
North Africa and the Middle East: implementation of measures to reduce negative health and social consequences, selected reporting periods
(Composite index)

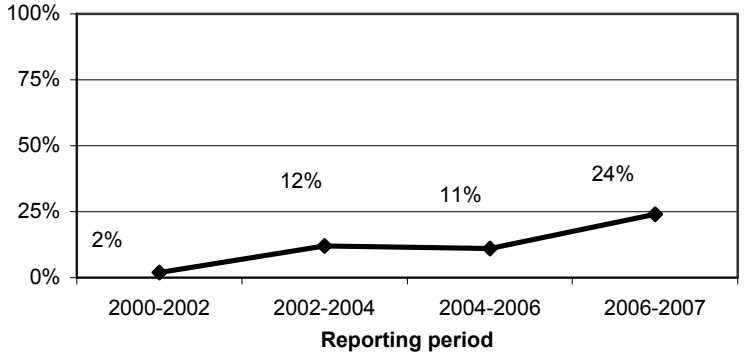


Figure 25
Sub-Saharan Africa: implementation of measures to reduce negative health and social consequences, selected reporting periods
(Composite index)

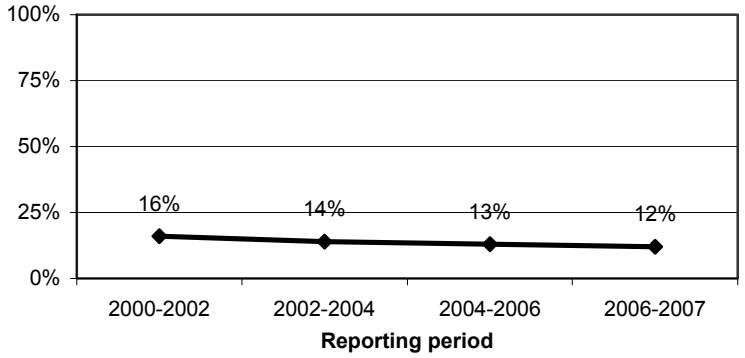


Figure 26
Latin America and the Caribbean: implementation of measures to reduce negative health and social consequences, selected reporting periods
(Composite index)

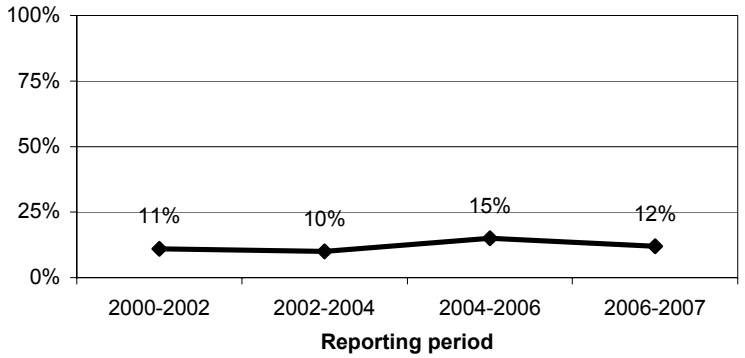


Figure 27
North America: implementation of measures to reduce negative health and social consequences, selected reporting periods
(Composite index)

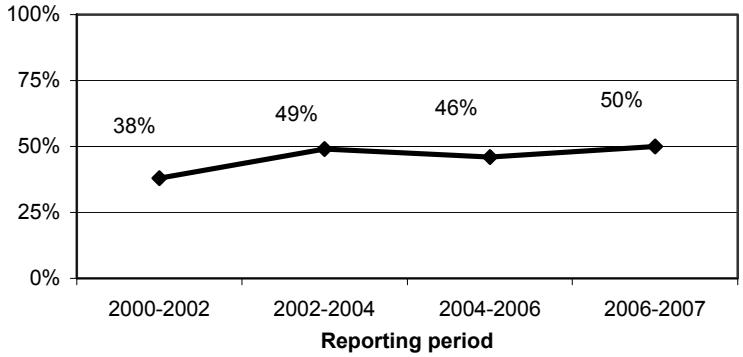


Figure 28
Central, South and South-West Asia: implementation of measures to reduce negative health and social consequences, selected reporting periods
(Composite index)

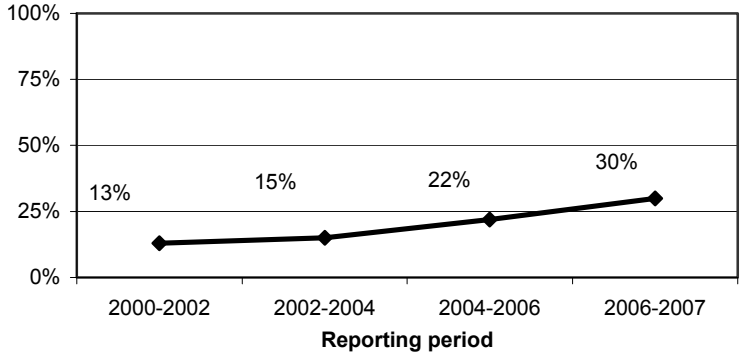


Figure 29
East and South-East Asia: implementation of measures to reduce negative health and social consequences, selected reporting periods
(Composite index)

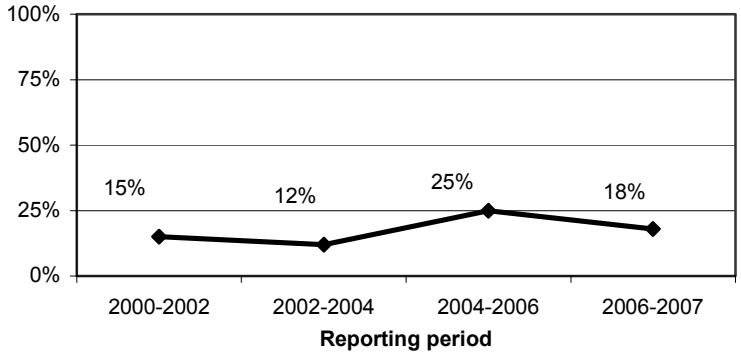


Figure 30
Oceania: implementation of measures to reduce negative health and social consequences, selected reporting periods
(Composite index)

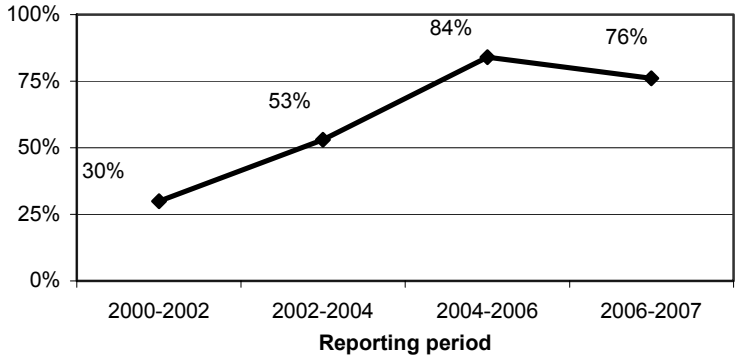


Figure 31
Central and Western Europe: implementation of measures to reduce negative health and social consequences, selected reporting periods
(Composite index)

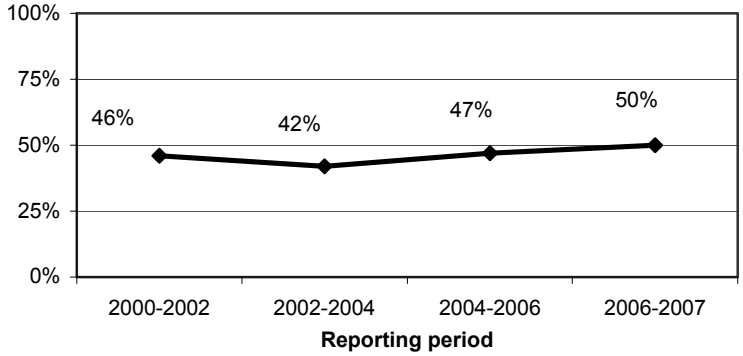
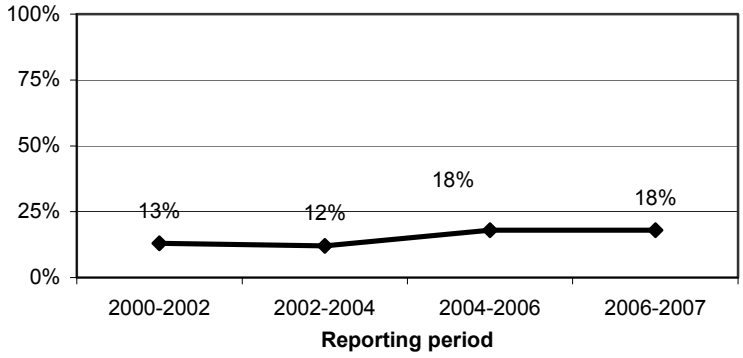


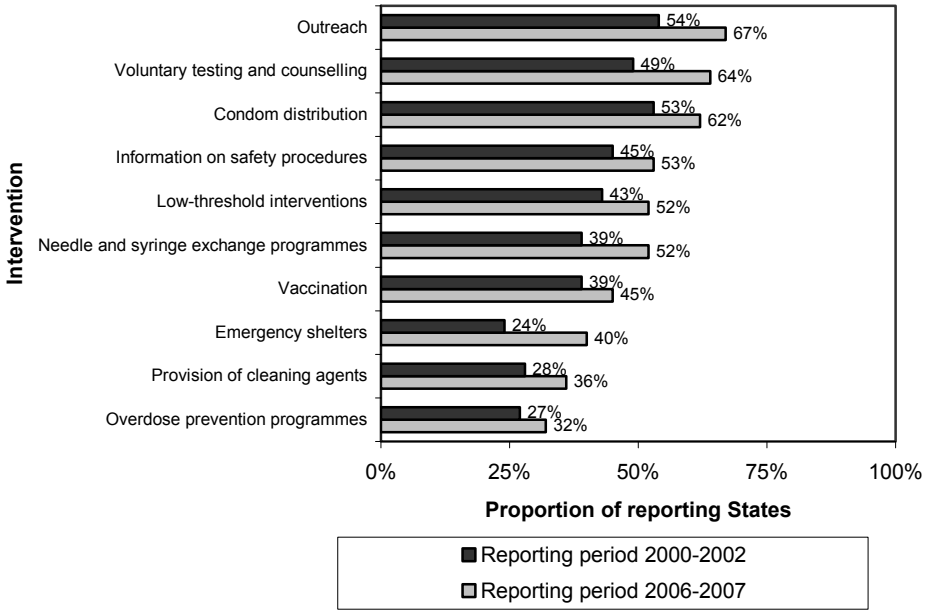
Figure 32
Eastern and South-Eastern Europe: implementation of measures to reduce negative health and social consequences, selected reporting periods
(Composite index)



28. It is estimated that up to 10 per cent of all new cases of HIV infection are attributable to injecting drug use (30 per cent if Africa is excluded) and that approximately 3 million former and current injecting drug users are living with HIV/AIDS. Injecting drug use is a major mode of HIV transmission in several regions and it is emerging as a concern in Africa.

29. In 2005, the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS (UNAIDS) approved and recommended a comprehensive package of HIV/AIDS prevention and care measures, six of which are covered in the biennial reports questionnaire. Focused specifically on HIV transmission through injecting drug use, the package consists of a wide range of treatment options. Globally, the most commonly available measures are peer outreach to injecting drug users (implemented in 67 per cent of States responding in 2007), voluntary testing and counselling programmes (64 per cent), prevention of sexual transmission of HIV among drug users through condom distribution (62 per cent) and dissemination of information and education on safety procedures among drug users (53 per cent). In 2007, substitution treatment was being implemented in less than 50 per cent of the States responding to the biennial reports questionnaire (see figure 33).

Figure 33
Availability of measures to reduce negative health and social consequences of drug abuse, by type of intervention, 2000-2002 and 2006-2007
(Percentage)



30. Large differences exist among the regions with regard to the availability of needle and syringe exchange programmes. In Oceania, North America, and Central and Western Europe, for instance, 90 per cent or more of the States reported having such programmes in place, while in Sub-Saharan Africa and Latin America and the Caribbean, the proportion was 10 per cent or less. The low prevalence of injecting drug use in many countries of Sub-Saharan Africa and Latin America and the

Caribbean may partly explain the limited availability of such measures in those subregions.

31. In Eastern Europe and Central Asia, where the large majority (over 80 per cent) of HIV cases are attributed to injecting drug use, the effective implementation of measures targeting injecting drug users poses a vitally important challenge to many States. The findings of the biennial reports questionnaire suggest some positive developments in that regard. In Eastern and South-Eastern Europe, the proportion of responding States that reported the availability of key interventions increased during the period from 2000 to 2007: outreach programmes rose from 20 to 50 per cent; voluntary testing and counselling for infectious diseases from 40 to 67 per cent; condom distribution from 50 to 67 per cent; dissemination of information and education from 40 to 50 per cent; and needle and syringe exchange programmes from 40 to 58 per cent. Similarly, substitution treatment in outpatient settings has become more common, as the proportion of States reporting its availability increased from 30 per cent in 2000 to 42 per cent in 2007. It was encouraging that 80 per cent of the States in Central, South and South-West Asia reported having available most of the key services, with the notable exception of substitution treatment: only 10 per cent of the States reported availability of that treatment in 2007, meaning there had been no increase since the baseline situation.

32. The foregoing notwithstanding, it is not always clear if reported changes reflect the situation across the whole region or if they are influenced by a reporting bias in some cases. For example, reports of lower levels of voluntary testing and counselling for infectious diseases in Sub-Saharan Africa should be interpreted with caution, considering the rather large efforts made in the subregion in that regard over the past five years.

33. In some regions, increases could be attributed to intensified efforts to counter HIV/AIDS and other blood-borne diseases since 1998. In Central and Western Europe, for example, a large majority of responding States (80 to 90 per cent) reported having implemented various measures to reduce the negative health and social consequences of drug abuse. That information was supported by Council of the European Union recommendation 2003/488/EC of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence.[4] The activities are now part of national drug control strategies and action plans in most States of the European Union. Needle and syringe programmes had already been introduced in almost all European Union member States and Norway before 1998, but the size of those programmes and the number of needle and syringe provision points has increased. Other interventions to reduce drug-related infectious diseases and deaths, such as low-threshold services and dissemination of information material, have also been developed and extended.

34. Supplementary information available through UNAIDS suggests that, globally, the proportion of injecting drug users receiving some type of prevention service has increased in recent years (from 4.3 per cent in 2003 to 8 per cent in 2005, based on estimates from 94 reporting low- and middle-income countries). Specifically, those estimates suggest that in those countries the number of injecting drug users receiving risk reduction information, education and communication increased threefold between 2003 (320,000) and 2005 (1,100,000). The number of persons

[4] *Official Journal of the European Union*, L 165, 3 July 2003.

having access to sterile injecting equipment or to equipment decontamination programmes also increased, from 150,000 in 2003 to 400,000 in 2005, as did the number of those having access to opioid substitution therapy, which rose from 20,000 to 33,000 over the same period. Despite those trends, coverage is still very low relative to the size of the injecting drug user population, which in 2003 was estimated to be approximately 13.2 million worldwide.

35. Although the global trend has shown a significant increase over the years, there is need for improvement. Even when services are available, the extent of their coverage among drug users is often low and, in many countries, their existence is not publicized among the population. In areas such as Eastern and South-Eastern Europe, where injecting drug use accounts for the spread of a large part of blood-borne infections, particularly HIV and the hepatitis B and C viruses, it is of utmost importance to achieve wide-scale coverage of measures among the population groups most at risk, such as street children, sex workers and prisoners.

4. Efforts to work with vulnerable or special populations: "focusing on special needs"

36. The availability of programmes that address the needs of the population groups most at risk has increased since 1998. Particularly large increases were reported in North Africa and the Middle East, where the proportion of States with such programmes rose from 33 per cent in 1998 to 91 per cent in 2007. In Central, South and South-West Asia, activities are generally based more on the identification of risk and protective factors as they were in 1998. In Central America, much has been done and activities have increased, where applicable (see figures 34-42).

Figure 34
North Africa and the Middle East: implementation of efforts to work with vulnerable or special populations, by reporting period
(Composite index)

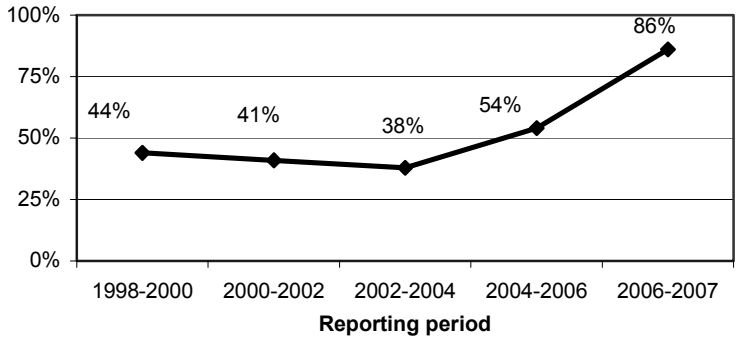


Figure 35
Sub-Saharan Africa: implementation of efforts to work with vulnerable or special populations, by reporting period
(Composite index)

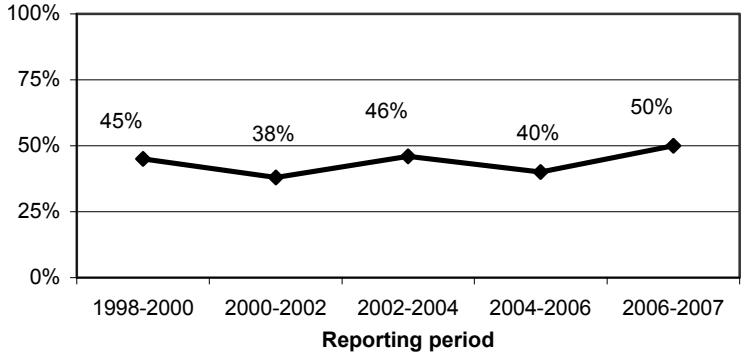


Figure 36
Latin America and the Caribbean: implementation of efforts to work with vulnerable or special populations, by reporting period
(Composite index)

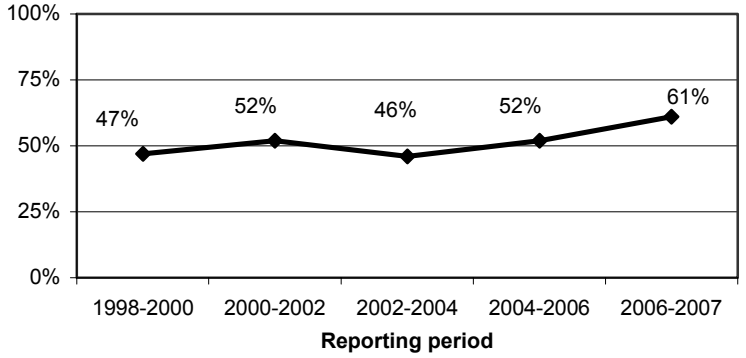


Figure 37
North America: implementation of efforts to work with vulnerable or special populations, by reporting period
(Composite index)

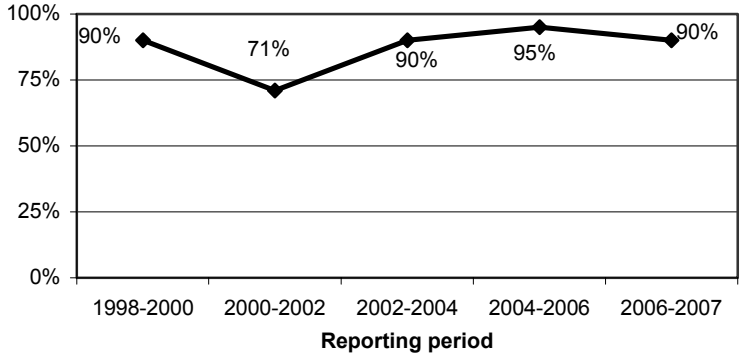


Figure 38
Central, South and South-West Asia: implementation of efforts to work with vulnerable or special populations, by reporting period
(Composite index)

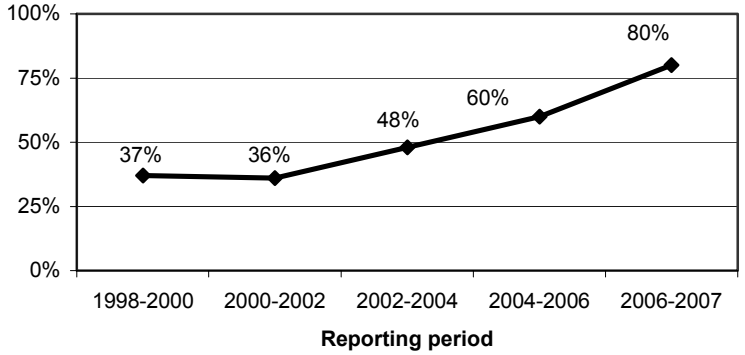


Figure 39
East and South-East Asia: implementation of efforts to work with vulnerable or special populations, by reporting period
(Composite index)

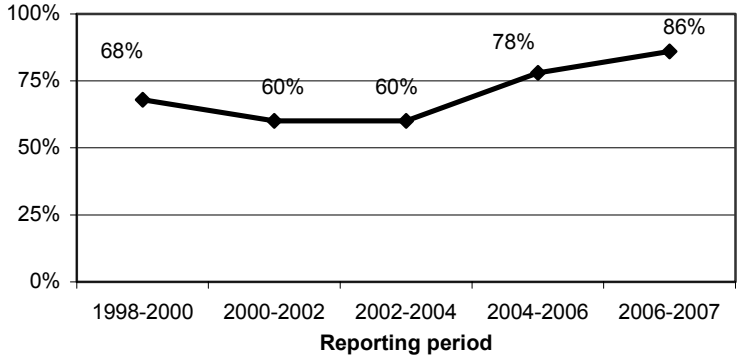


Figure 40
Oceania: implementation of efforts to work with vulnerable or special populations, by reporting period
(Composite index)

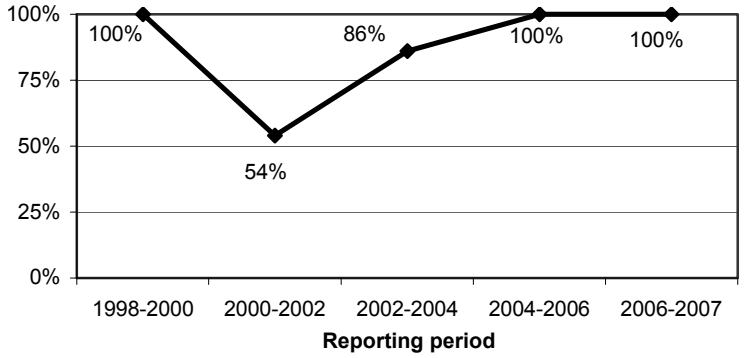


Figure 41
Central and Western Europe: implementation of efforts to work with vulnerable or special populations, by reporting period
(Composite index)

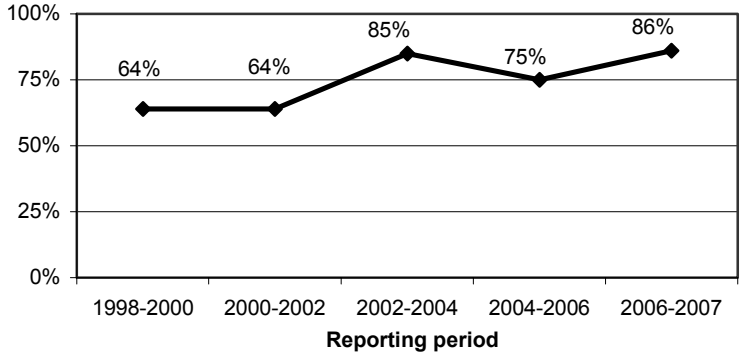
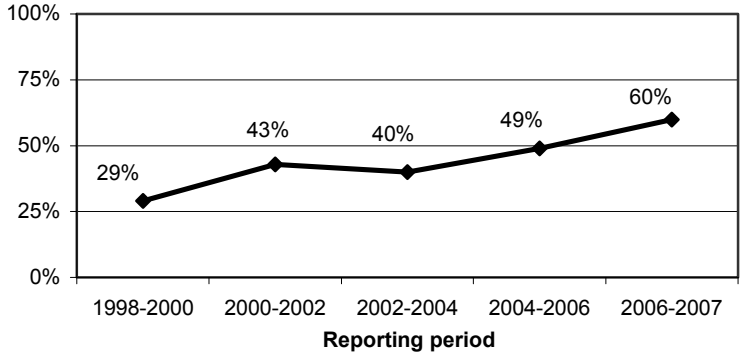


Figure 42
Eastern and South-Eastern Europe: implementation of efforts to work with vulnerable or special populations, by reporting period
(Composite index)



37. Injecting drug users are often exposed to multiple risks, such as those entailed in sex work, and often face imprisonment for possession of drugs, which further increases their risk of contracting and transmitting HIV and other blood-borne infections. In comparison with 1998, programmes in prison settings have become more common. Globally, the proportion of States reporting the availability of in-prison programmes has risen from 53 to 76 per cent, with the largest increases reported in Central, South and South-West Asia (from 29 to 75 per cent) and in Latin America and the Caribbean (from 36 to 83 per cent). In Sub-Saharan Africa, only a few States reported that they had implemented such programmes, with only slightly increasing rates since 1998. However, supplementary regional information suggests that the implementation of special programmes in prisons is much more common in that region than what is suggested by the regional findings from the biennial reports questionnaire.

38. Community programmes for former prison inmates remain less common; the proportion of States reporting their implementation decreased worldwide from

47 per cent in 1998 to 43 per cent in 2007. However, regional sources of information, for example in Sub-Saharan Africa, indicate that, even though after-release programmes remain less common than in-prison programmes, the trend does not necessarily point to a decrease in after-release programmes in most States. Programmes implemented as an alternative to conviction and punishment have become more common; in 2007, 72 per cent of States reported having implemented such programmes, compared with 44 per cent in 1998.

5. Media and public information campaign responses: "sending the right message"

39. With regard to responses to the drug problem that are conveyed through the media, public information campaigns are commonly available in all regions. Still, more attention should be paid to the quality and quantity of such campaigns (see figures 43-51).

Figure 43
North Africa and the Middle East: media and public information campaign responses, by reporting period
(Composite index)

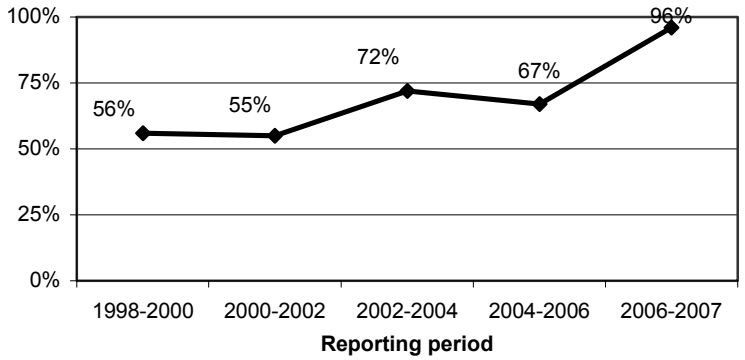


Figure 44
Sub-Saharan Africa: media and public information campaign responses, by reporting period
(Composite index)

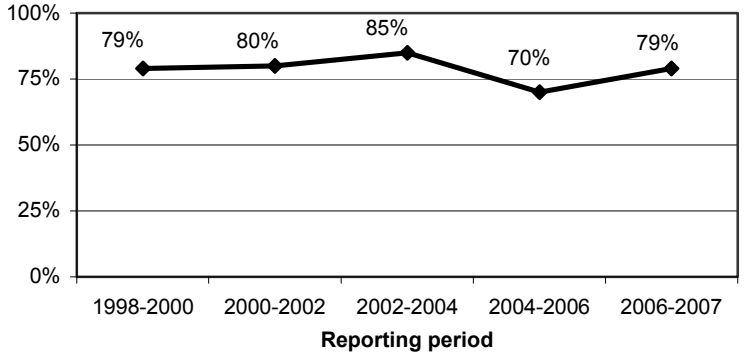


Figure 45
Latin America and the Caribbean: media and public information campaign responses, by reporting period
(Composite index)

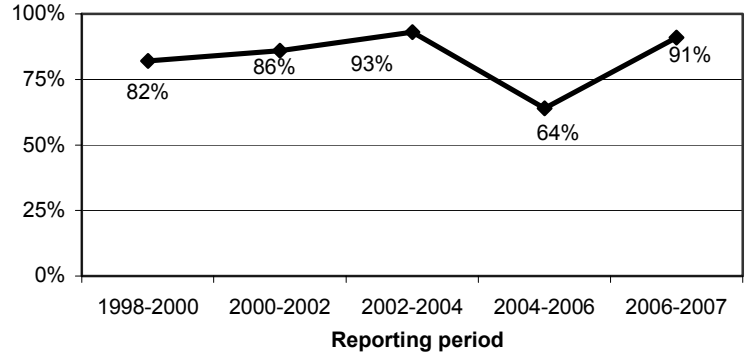


Figure 46
North America: media and public information campaign responses, by reporting period
(Composite index)

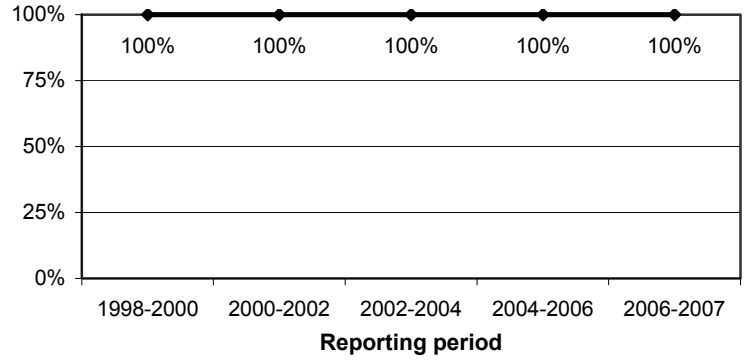


Figure 47
Central, South and South-West Asia: media and public information campaign responses, by reporting period
(Composite index)

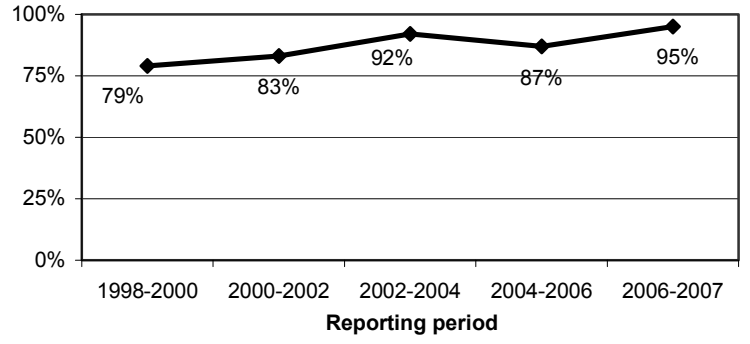


Figure 48
East and South-East Asia: media and public information campaign responses, by reporting period
(Composite index)

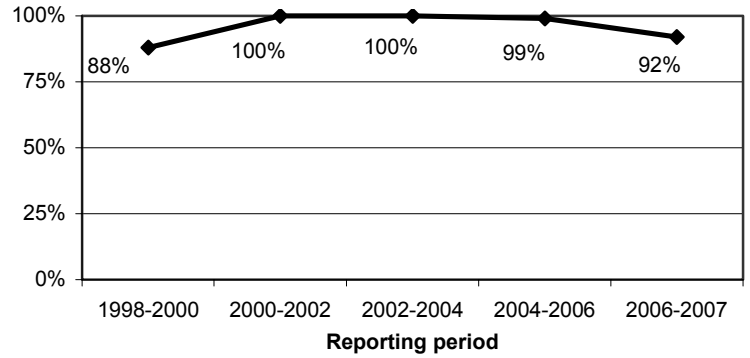


Figure 49
Oceania: media and public information campaign responses, by reporting period
(Composite index)

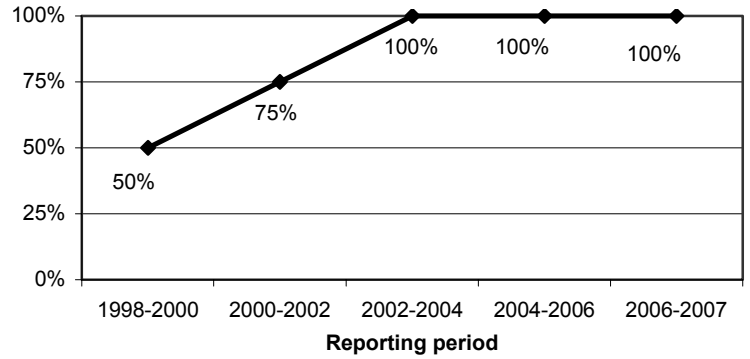


Figure 50
Central and Western Europe: media and public information campaign responses, by reporting period
(Composite index)

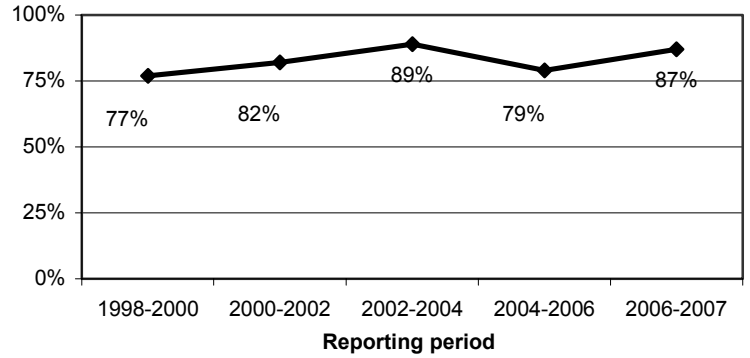
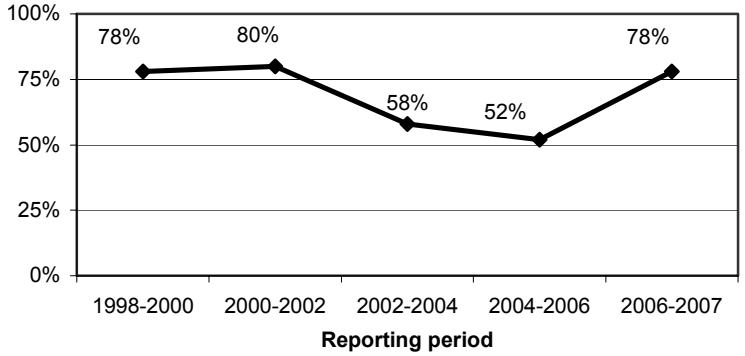


Figure 51
Eastern and South-Eastern Europe: media and public information campaign responses, by reporting period
(Composite index)



40. The implementation of public information campaigns in the context of drug demand reduction was widespread in all reporting periods. In the fifth reporting period, the proportion of States using the mass media to convey demand reduction messages exceeded 80 per cent in all regions. Similarly, training for social mediators was commonly available in all regions (global average of 86 per cent). Efforts have been made to disseminate information related to the drug problem and to communicate information to the public through the Internet, press, radio, television, libraries, research institutes and schools. For example, several States in Latin America had a specific public budget for that purpose.

41. In some regions, the relatively low level of consistency and professionalism in measuring the impact of media and public information campaigns is cause for concern. However, an evaluation of media campaigns in North America showed that even well-funded, well-planned, sustained campaigns had a limited effect on changing the attitudes of the target group, despite effectively changing their level of information and awareness. It may thus be especially important to involve non-governmental partners in conveying appropriate and accurate demand reduction messages.

42. The majority of responding States (94 per cent) reported that they had carried out public information campaigns in 2007, many of them based on a needs assessment that had taken into account the social and cultural characteristics of the target group (77 per cent and 80 per cent, respectively). Only half of those States reported that the results of the campaigns had been evaluated.

43. The subregions with the lowest proportion of States evaluating the results of their public information campaigns were Eastern and South-Eastern Europe (20 per cent) and Latin America and the Caribbean (31 per cent).

B. Building institutional capacity

1. Policy and strategic responses: "the commitment"

44. Globally, the political commitment remained stable at a high level throughout all the reporting periods. The biennial reports indicate that there has been progress in the development and implementation of national demand reduction strategies that reflect international standards (see figures 52-60).

Figure 52
North Africa and the Middle East: implementation of policy and strategic responses, by reporting period
(Composite index)

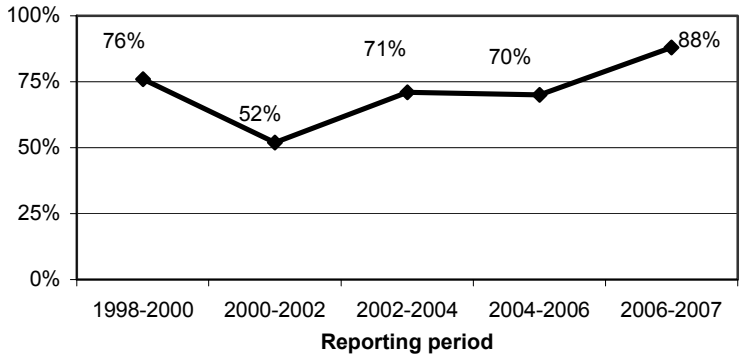


Figure 53
Sub-Saharan Africa: implementation of policy and strategic responses, by reporting period
(Composite index)

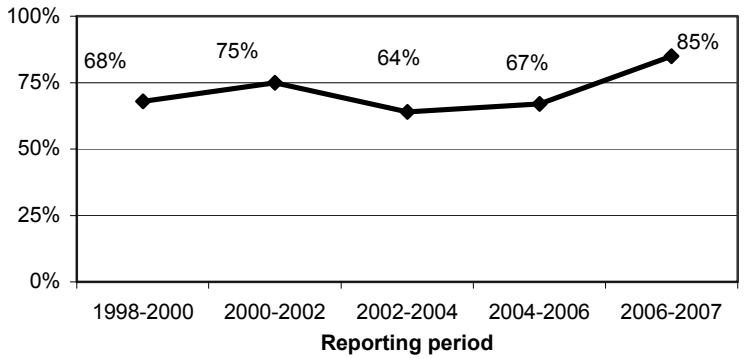


Figure 54
Latin America and the Caribbean: implementation of policy and strategic responses, by reporting period
(Composite index)

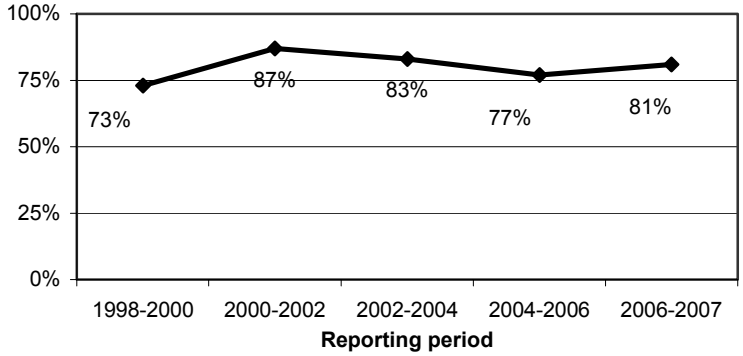


Figure 55
North America: implementation of policy and strategic responses, by reporting period
(Composite index)

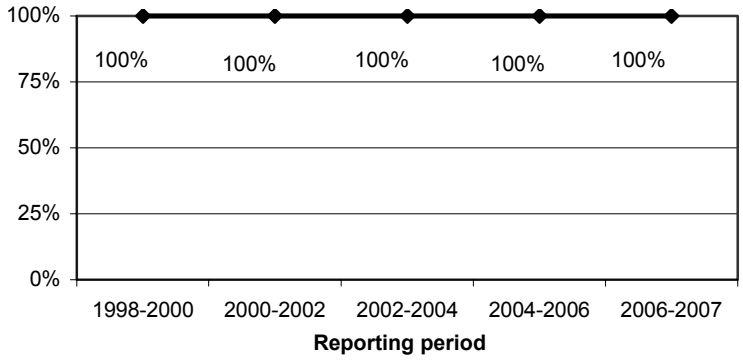


Figure 56
Central, South and South-East Asia: implementation of policy and strategic responses, by reporting period
(Composite index)

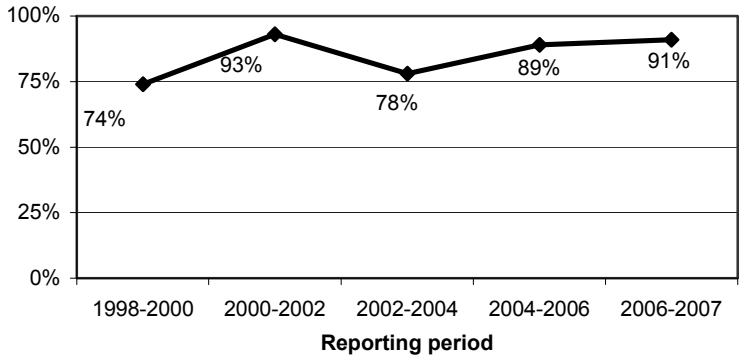


Figure 57
East and South-East Asia: implementation of policy and strategic responses, by reporting period
(Composite index)

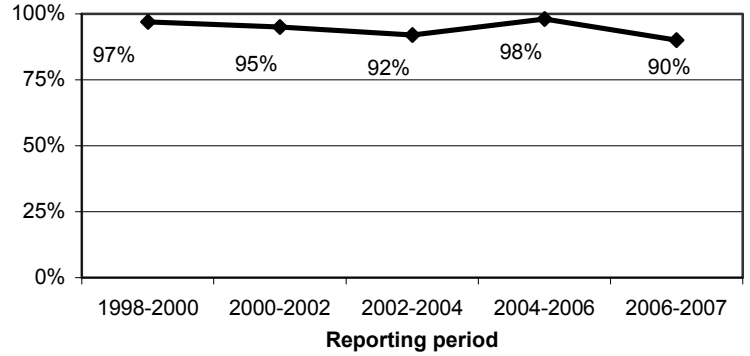


Figure 58
Oceania: implementation of policy and strategic responses, by reporting period
(Composite index)

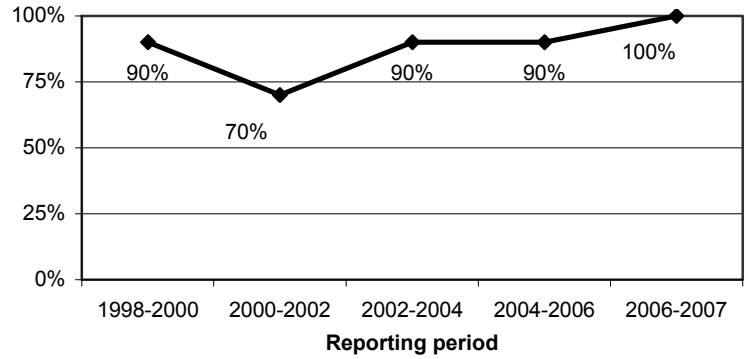


Figure 59
Central and Western Europe: implementation of policy and strategic responses, by reporting period
(Composite index)

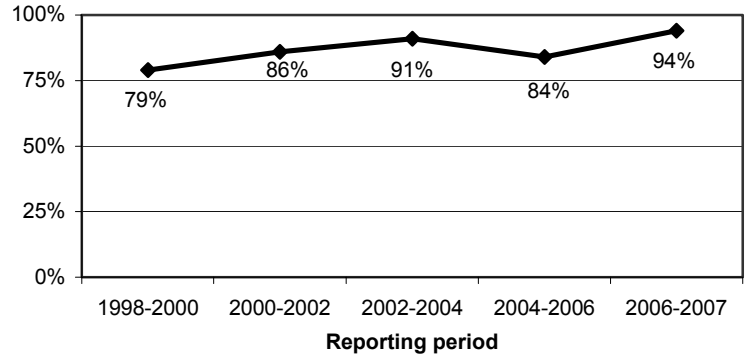
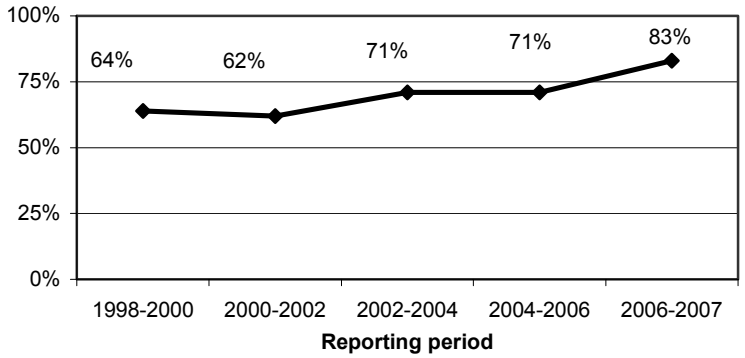


Figure 60
Eastern and South-Eastern Europe: implementation of policy and strategic responses, by reporting period
(Composite index)



45. For the fifth reporting period, the large majority of responding States (90 per cent) indicated that they had a national strategy for drug demand reduction. States that had national strategies in 1998 have maintained them, and those that did not have such strategies in 1998 have taken action to formulate them. Particularly encouraging is the trend in the implementation of national strategies for demand reduction using a multisectoral approach. While the proportion of States was already high (87 per cent) in 1998, it increased over the follow-up period. In 2007, 97 per cent of States involved different sectors of society in the implementation of demand reduction activities. Throughout all reporting periods, the health sector was the one most involved in developing and implementing the national strategies, closely followed by education and law enforcement. Globally, the proportion of States that reported the involvement of those sectors ranged between 70 and 90 per cent. The sector least involved was employment: only half of the States reported having in place programmes that involved the workplace in efforts for drug demand reduction.

46. The proportion of States that reported having established a central coordinating entity for ensuring the coordination and participation of relevant authorities and sectors of society in demand reduction rose from 84 per cent in 1998 to 91 per cent in 2007.

47. Nearly all responding States (91 per cent) reported that they had assessed the extent of the drug problem before developing their strategies for demand reduction. Similarly, a large proportion of responding States (87 per cent) reported having evaluation mechanisms in place for assessing the results achieved by their strategies.

48. In 2007, 66 per cent of the responding States reported that they had a dedicated budget for the implementation of their demand reduction strategies; that represented an increase of 12 per cent over 1998. When compared with other areas of political commitment, the availability of allocated budget is the area that varied the most between the regions. In the subregions with the lowest percentages, namely Sub-Saharan Africa and Latin America and the Caribbean, fewer than half of the States (40 and 47 per cent respectively) had allocated funds to the implementation of national strategies on drug demand reduction. In Latin America and the

Caribbean, that proportion was lower than in 1998. Large differences in the magnitude, coverage and scope of the national strategies and investments for their implementation make it difficult to estimate the real level of commitment towards carrying out the broad range of activities covered by the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction.

2. Extent of multisectoral responses and networking mechanisms: "forging partnerships"

49. As from the first reporting period, States have continuously indicated the availability of networking mechanisms. In 2007, four of every five responding States (79 per cent) had set up multisectoral committees on demand reduction that were active at the national level; that is a decline of 5 per cent since 1998. Networking mechanisms at the local and regional levels remained less common, and the proportion of States reporting their availability has remained at about 50-60 per cent since the first reporting period.

50. In North America, Central and Western Europe and Oceania, networking structures were already in place before 1998, while in Eastern and South-Eastern Europe, Central, South and South-West Asia, North Africa and the Middle East and Sub-Saharan Africa, progress has largely been achieved since 1998 (see figures 61-69).

Figure 61
North Africa and the Middle East: implementation of multisectoral responses and networking mechanisms, by reporting period
(Composite index)

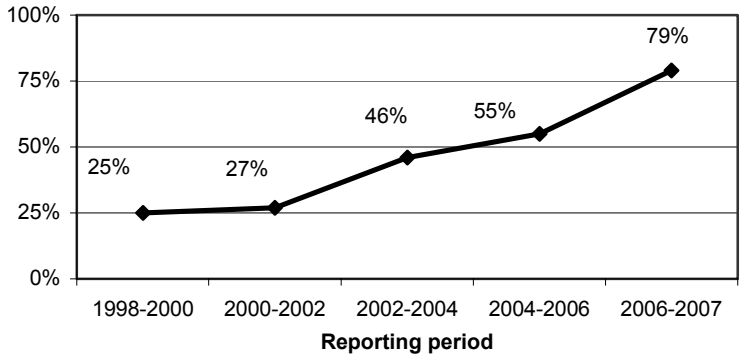


Figure 62
Sub-Saharan Africa: implementation of multisectoral responses and networking mechanisms, by reporting period
(Composite index)

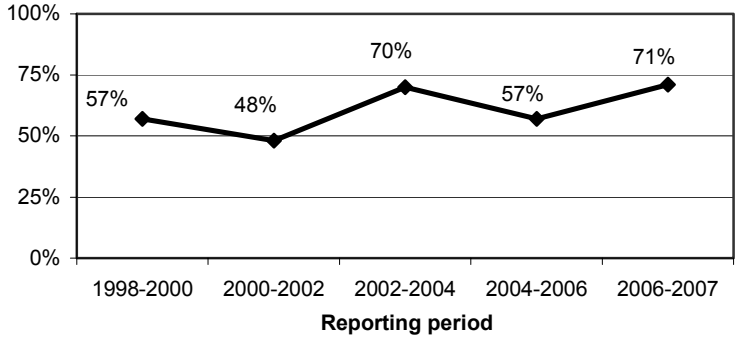


Figure 63
Latin America and the Caribbean: implementation of multisectoral responses and networking mechanisms, by reporting period
(Composite index)

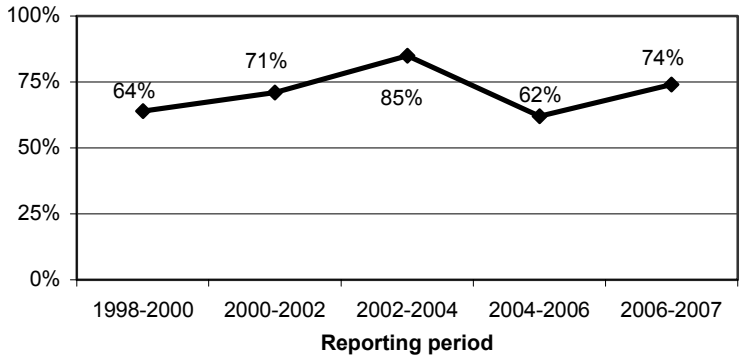


Figure 64
North America: implementation of multisectoral responses and networking mechanisms, by reporting period
(Composite index)

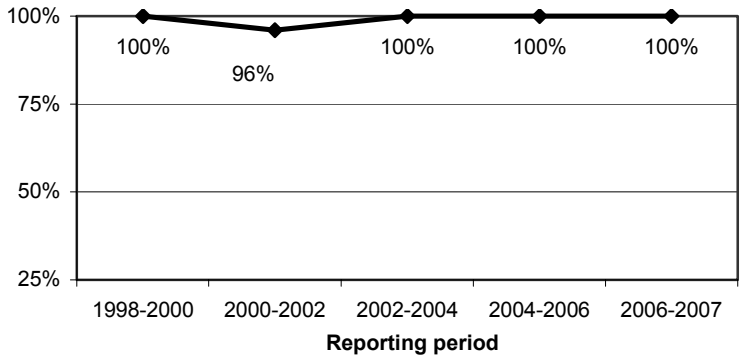


Figure 65
Central, South and South-West Asia: implementation of multisectoral responses and networking mechanisms, by reporting period
(Composite index)

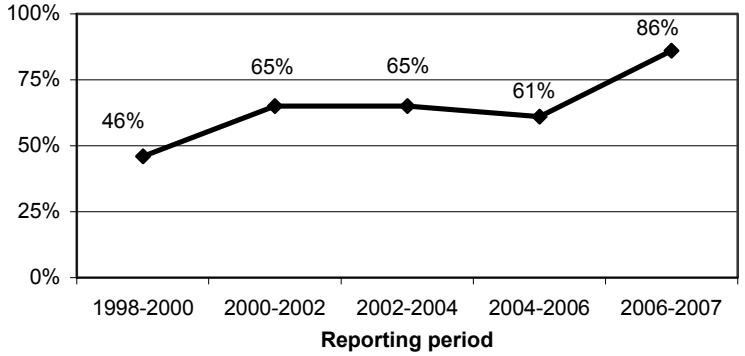


Figure 66
East and South-East Asia: implementation of multisectoral responses and networking mechanisms, by reporting period
(Composite index)

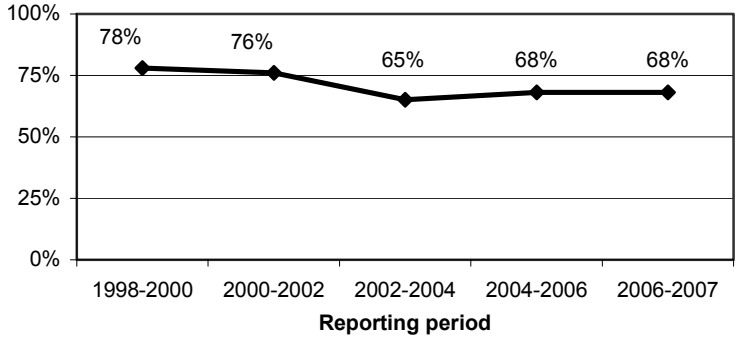


Figure 67
Oceania: implementation of multisectoral responses and networking mechanisms, by reporting period
(Composite index)

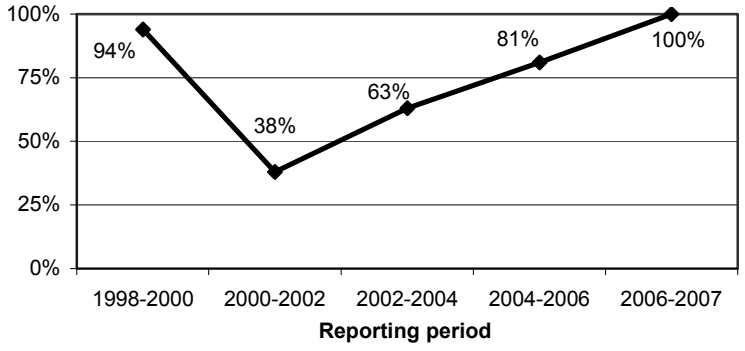


Figure 68
Central and Western Europe: implementation of multisectoral responses and networking mechanisms, by reporting period
(Composite index)

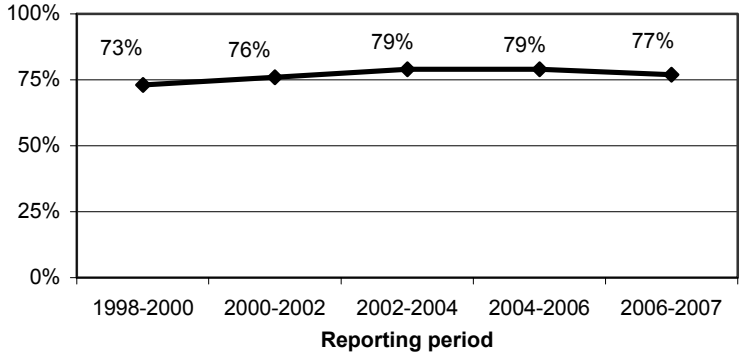
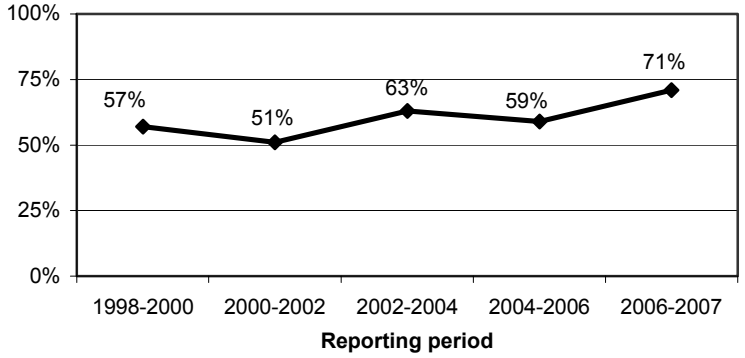


Figure 69
Eastern and South-Eastern Europe: implementation of multisectoral responses and networking mechanisms, by reporting period
(Composite index)



51. At the regional level, the United Nations Office on Drugs and Crime (UNODC) has successfully supported the creation of networks of youth groups and community-based organizations involved in drug abuse prevention among young people in Eastern Europe, South Asia, East Asia, East Africa, Mexico and Central America, and South America as a follow-up and complement to the work of the Global Youth Network against Drug Abuse. The Global Youth Network (www.unodc.org/youthnet) was established as a follow-up to the Drug Abuse Prevention Forum organized by Youth Vision Jeunesse in Banff, Canada, in 1998, on the occasion of the twentieth special session of the General Assembly. Despite the sustained activities and the progress made, renewed efforts are necessary to further advance the development and expansion of coordination mechanisms.

3. Capacity to collect and analyse information: "assessing the problem"

52. Data collection and analysis have expanded worldwide, with more States reporting the availability of mechanisms for the assessment of drug abuse in all regions. The information base on drug abuse and related problems at the national, regional and global levels has improved. The role played by regional and national coordination bodies, expert networks and other existing support structures should be noted in that regard (see figures 70-78).

Figure 70
North Africa and the Middle East: availability of mechanisms for the assessment of drug abuse, by reporting period
(Percentage)

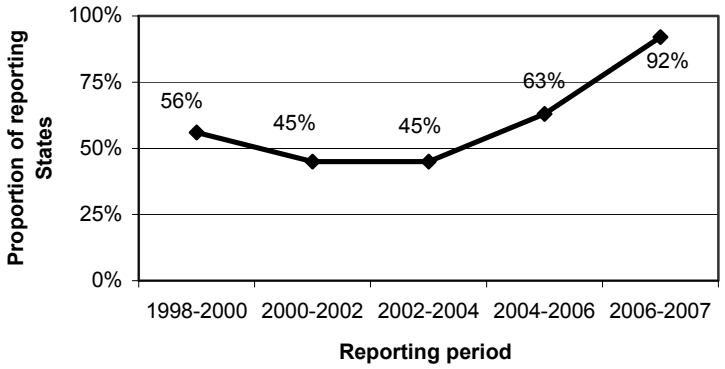


Figure 71
Sub-Saharan Africa: availability of mechanisms for the assessment of drug abuse, by reporting period
(Percentage)

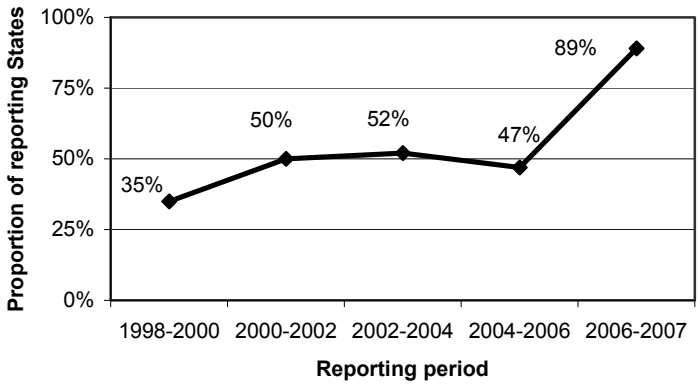


Figure 72
Latin America and the Caribbean: availability of mechanisms for the assessment of drug abuse, by reporting period
(Percentage)

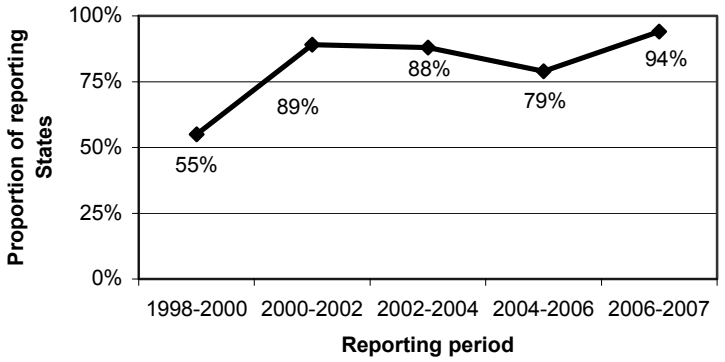


Figure 73
North America: availability of mechanisms for the assessment of drug abuse, by reporting period
(Percentage)

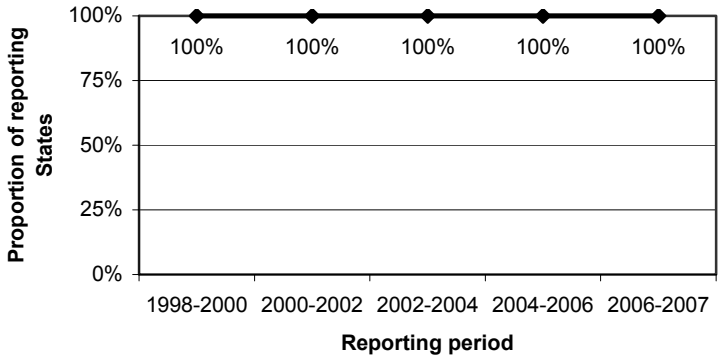


Figure 74
Central, South and South-West Asia: availability of mechanisms for the assessment of drug abuse, by reporting period
(Percentage)

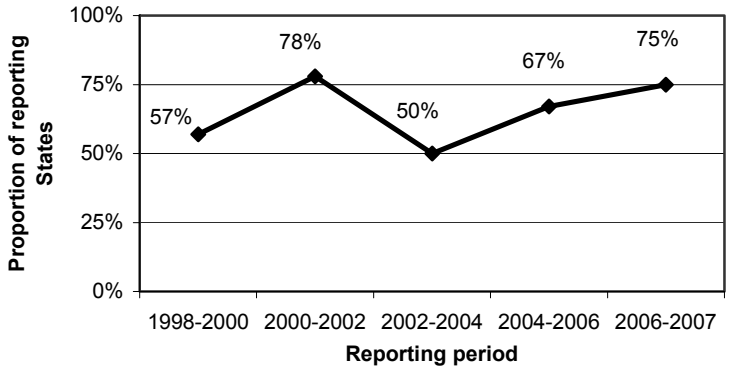


Figure 75
East and South-East Asia: availability of mechanisms for the assessment of drug abuse, by reporting period
(Percentage)

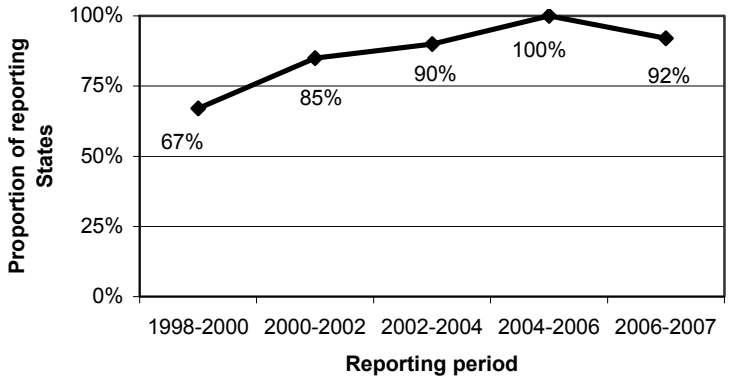


Figure 76
Oceania: availability of mechanisms for the assessment of drug abuse, by reporting period
(Percentage)

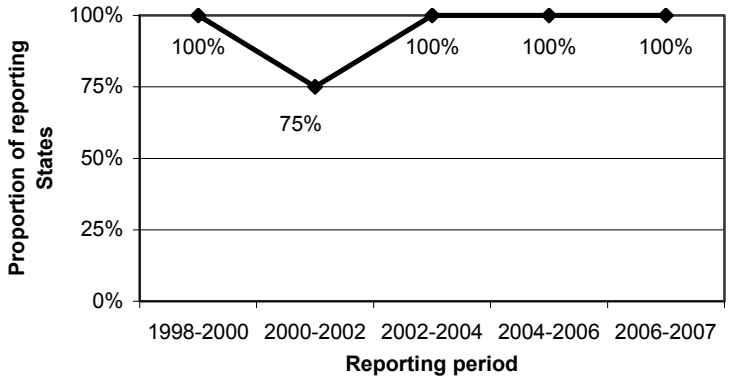


Figure 77
Central and Western Europe: availability of mechanisms for the assessment of drug abuse, by reporting period
(Percentage)

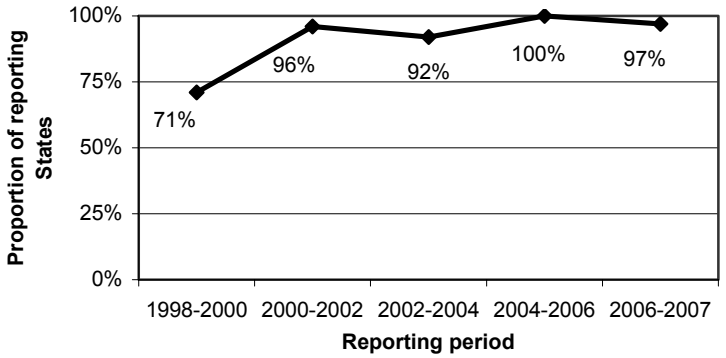
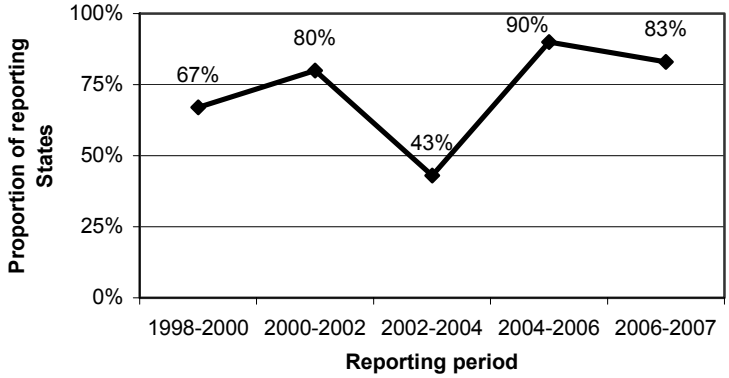


Figure 78
Eastern and South-Eastern Europe: availability of mechanisms for the assessment of drug abuse, by reporting period
(Percentage)



53. The increased availability of assessments of the drug abuse situation, as reported through the biennial reports questionnaire, may present an overly optimistic picture of the existing technical capacity, extent or sustainability of drug abuse data collection and analysis in many countries. However, ongoing capacity-building efforts and the dissemination of evidence-based epidemiological practices, methods and tools to monitor drug use patterns and trends have contributed to the establishment of national surveillance systems in some regions.

54. For example, States in East and South-East Asia and in Central, South and South-West Asia have significantly increased their efforts to monitor drug epidemiological patterns and trends through the establishment of regional expert networks in coordination with UNODC. The establishment of mechanisms such as the Drug Abuse Information Network for Asia and the Pacific to monitor patterns and trends in the abuse of amphetamine-type stimulants and the Central Asian Regional Drug Information Network to monitor demand for treatment has played an important role in building national capacities. States in Latin America and the Caribbean have made significant progress, particularly in the area of school surveys, with assistance provided by CICAD.

55. The regional and national coordination networks (such as the Pompidou Group of the Council of Europe, the European Monitoring Centre for Drugs and Drug Addiction, CICAD, the Community Epidemiology Work Group of the National Institute on Drug Abuse of the United States of America, the Southern African Development Community (SADC) Epidemiology Network on Drug Use and the Association of Southeast Asian Nations (ASEAN) and China Cooperative Operations in Response to Dangerous Drugs (ACCORD)) have assisted Governments in systematically assessing their drug situations in accordance with international core indicators and methodological best practices. Technical assistance has also improved access to statistical information and facilitated the exchange of research results among States. The UNODC Global Assessment Programme on Drug Abuse continued to assist States in the establishment of national drug information systems that promote, support and facilitate the reporting of comparable drug consumption data.

56. CICAD, through the Inter-American Uniform Drug Use Data System (SIDUC), has provided technical and financial assistance to requesting States as they may conduct epidemiological studies among students in Latin America and the Caribbean. Studies among the general population are being conducted in several countries where they could not be conducted previously because of technical and financial difficulties. CICAD is also assisting States in developing national drug observatories and establishing central offices for the collection of information and statistics on drug abuse. In several countries, however, the development and implementation of national information-gathering and management systems continues to face obstacles stemming from limited human, financial and technological resources and from inter-institutional coordination problems.

57. The data collection and analysis capacity of many States was confirmed by the responses received to the annual reports questionnaire, which, since its revision in 2001, has been submitted annually by over 100 countries and today provides a richer and more accurate picture of the extent, patterns and trends of drug abuse than before. The use of a harmonized set of core epidemiological indicators has significantly improved the comparability of the data elicited in the questionnaire. The inclusion of qualitative expert opinions on trends has provided all States with the opportunity to indicate developments even when quantitative data based on surveys, treatment registers or other studies are not available.

58. Despite its limitations, the biennial reports questionnaire represents an important development in monitoring a number of topical areas, especially in the area of demand reduction. The progress made in monitoring in those areas should not be lost, although it has been acknowledged that the reporting tools and mechanisms need to be refined. It has been recognized that any future reporting system should be as efficient as possible and should focus on a core set of methodologically sound indicators. The reporting burden should be minimized by restricting data collection to core areas, using existing capacity and available resources efficiently to avoid any duplication of activities.

59. The international community and relevant regional and national reporting entities should work together to develop common and high-quality reporting tools and share information resources and expertise. Continued efforts are needed in order to improve capacity at the national level to conduct the studies required for ascertaining the magnitude and characteristics of the problem in different regions. Analysis at the global level needs to be supported by regional and national experts. It is recognized that approaches need to be tailored to different national and regional contexts according to the level of information available. Furthermore, capacity-building activities are needed for those areas of the world where the reporting capacity is currently insufficient.

4. Evaluation and incorporation of lessons learned: “building on experience”

60. In 2007, 76 per cent of responding States reported that they had national databases on demand reduction, while in 1998 that proportion was only 45 per cent. It is, however, difficult to draw conclusions based on the questionnaire responses without additional information, including on how those databases have been used for policy and programme planning purposes.

61. Training opportunities for planners and practitioners involved in service delivery are commonly available in a number of regions. Globally, 90 per cent of responding States reported that training was available for staff at both specialized and non-specialized agencies, and in about 60 per cent of responding States training was available on an ongoing basis for both groups. Training is an area where considerable improvements have been reported in nearly all regions since the first reporting period. Some of those positive developments are reflected in the composite index constructed from different questions contained in the subsection of the questionnaire entitled "Building on experience" (see figures 79-87).

Figure 79
North Africa and the Middle East: implementation of measures on evaluation and incorporation of lessons learned, by reporting period
(Composite index)

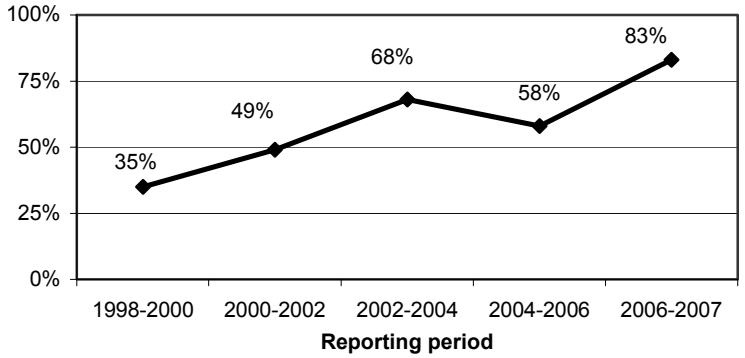


Figure 80
Sub-Saharan Africa: implementation of measures on evaluation and incorporation of lessons learned, by reporting period
(Composite index)

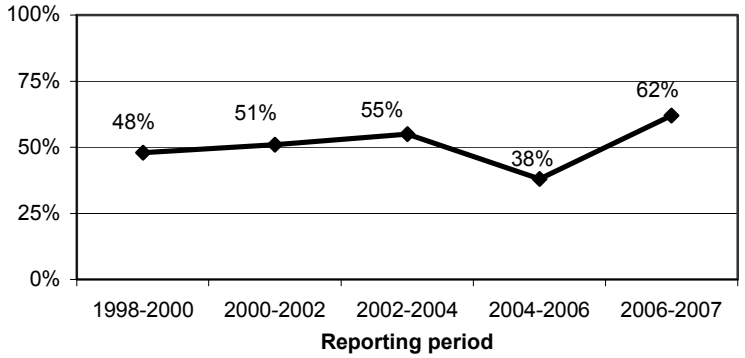


Figure 81
Latin America and the Caribbean: implementation of measures on evaluation and incorporation of lessons learned, by reporting period
(Composite index)

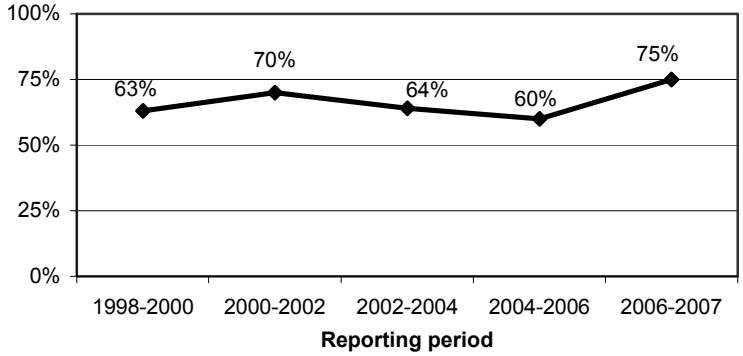


Figure 82
North America: implementation of measures on evaluation and incorporation of lessons learned, by reporting period
(Composite index)

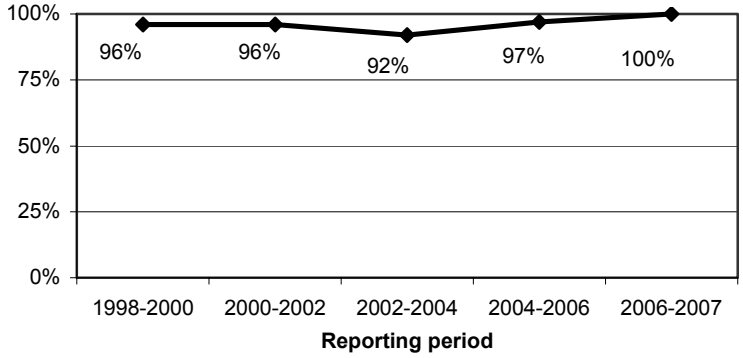


Figure 83
Central, South and South-West Asia: implementation of measures on evaluation and incorporation of lessons learned, by reporting period
(Composite index)

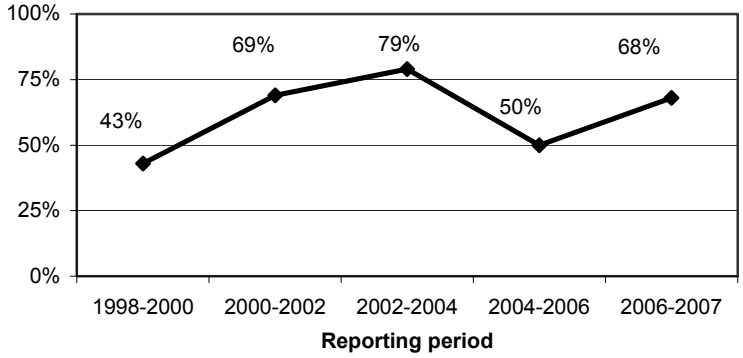


Figure 84
East and South-East Asia: implementation of measures on evaluation and incorporation of lessons learned, by reporting period
(Composite index)

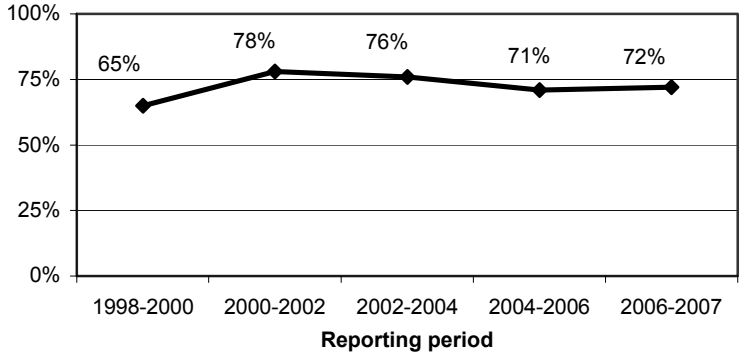


Figure 85
Oceania: implementation of measures on evaluation and incorporation of lessons learned, by reporting period
(Composite index)

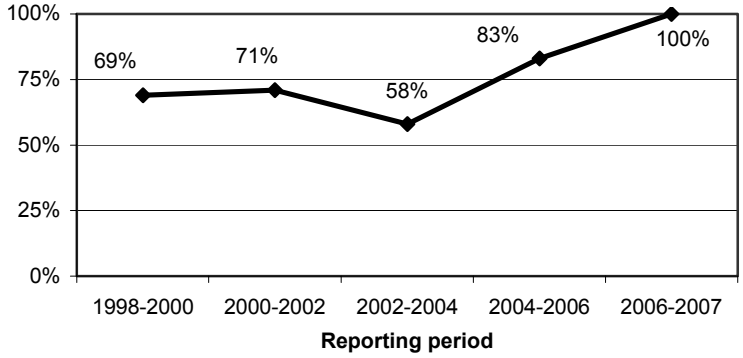


Figure 86
Central and Western Europe: implementation of measures on evaluation and incorporation of lessons learned, by reporting period
(Composite index)

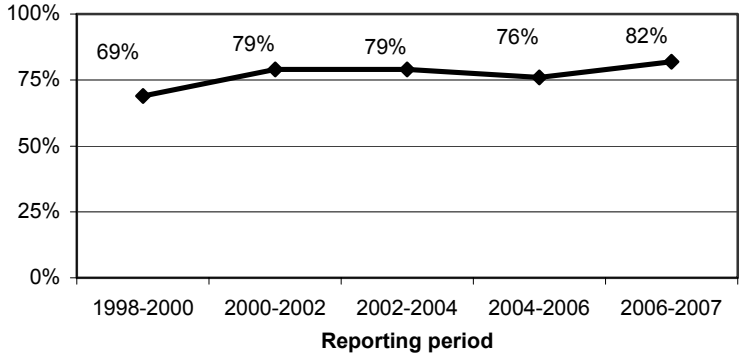
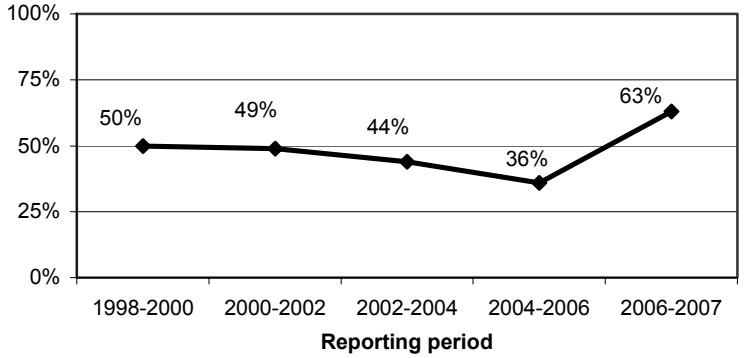


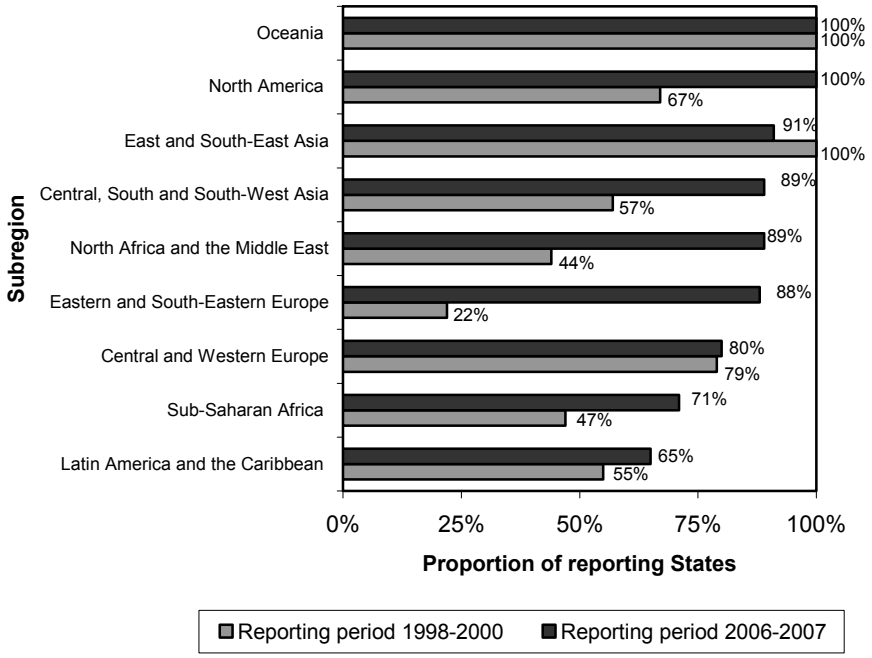
Figure 87
Eastern and South-Eastern Europe: implementation of measures on evaluation and incorporation of lessons learned, by reporting period
(Composite index)



62. In 1998, in North Africa and the Middle East, 44 per cent of States reported having no training available for drug-specialized services staff (that figure was 78 per cent for staff of non-drug-specialized services), while in 2007 only 11 per cent reported that drug-specialized services staff did not receive any training (13 per cent for non-drug-specialized services staff). Moreover, 78 per cent of States responding in that subregion reported that training was provided on an ongoing basis (63 per cent for non-drug-specialized services staff).

63. The biennial reports indicate a positive trend with regard to the evaluation of demand reduction activities and the incorporation of lessons learned (see figure 88). Most responding States have reported a steady increase since the first reporting period, with 81 per cent reporting in 2007 that they monitored and evaluated demand reduction activities, compared with 62 per cent in 1998. It is crucial that that positive trend be maintained and strengthened. It should be noted that 91 of the 108 States responding in the fifth reporting period replied to the question on monitoring and evaluation, and that may have affected the analysis of the trend in some regions.

Figure 88
Monitoring and evaluation of implementation of demand reduction strategies and activities, by subregion, 1998-2000 and 2006-2007
(Percentage)



64. In the Americas, the work by CICAD to develop a practical regional instrument for the evaluation of drug abuse prevention programmes (yet to be finalized) may have contributed to raising awareness among the countries of the region with regard to building on experience.

III. Recommendations

65. The biennial reports questionnaire was the first attempt to comprehensively monitor efforts made by Member States on a global scale. It is important to build on the achievements to date and to continue monitoring activities after 2008, as that is a key component in sustaining and expanding demand reduction activities.

66. In view of the follow-up to the assessment of the twentieth special session of the General Assembly and in order to address a number of areas that require action, the following recommendations are brought to the attention of the Commission and the Member States:

(a) Bearing in mind the high level of political commitment to implementing drug demand reduction measures, those measures should be based on solid evidence and should be maintained or expanded in some regions;

(b) More resources should be devoted to building the foundations for effective national strategies by investing in research and analysis;

(c) Member States need to produce better data and improve their information base and evaluation capacity in order to allow for more informed decision-making;

(d) Existing regional drug information systems should be supported in the long term in order to achieve results in a cost-effective and methodologically sound manner;

(e) There is a general need for States to further expand and improve the coverage of demand reduction programmes and services; while some progress has been made, it cannot be considered sufficient in many countries;

(f) In the area of prevention, effective programmes, such as life-skills education, need to be expanded;

(g) The coverage of treatment and rehabilitation programmes needs to be increased, because, in some regions, the level of provision of services is very low and key elements of the continuum of services (such as substitution treatment) are not widely available;

(h) Member States should consider increasing the coverage and ensuring the availability of the full set of services required in the course of interventions to reduce the negative health and social consequences of drug abuse;

(i) Member States should devote more resources to population groups with special needs and those that are most vulnerable, implementing comprehensive services and programmes for them;

(j) Member States have to broaden partnerships to involve all stakeholders;

(k) Member States need to seek out more opportunities for networking and sharing lessons learned and good practices in drug demand reduction that can be adapted to meet local needs in order to narrow the gap between States with long experience in drug demand reduction and sustained programmes on the one hand, and States that lack the necessary experience and resources on the other hand;

(l) The Commission needs to address the issue of monitoring and reporting in the future and to consider the establishment of a well-resourced and enhanced monitoring mechanism that should:

(i) Allow for the accurate assessment of the quality, extent and coverage of interventions;

(ii) Provide a forum for the standardization and harmonization of methods, concepts and reporting tools;

(iii) Work in close cooperation with international, regional and national bodies to reduce the overall burden of reporting on Member States and to maximize the use of resources;

(iv) Support the building of capacity in data collection and analysis in regions where it is lacking;

(v) Take into account the regional context.