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Item 5 (a) of the provisional agenda*
Implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem: follow-up to the high-level review by the Commission on Narcotic Drugs, in view of the special session of the General Assembly on the world drug problem to be held in 2016 — demand reduction and related measures

World situation with regard to drug abuse

Report of the Secretariat

Summary

The present report summarizes the most recent information available to the United Nations Office on Drugs and Crime (UNODC) on the illicit global demand for drugs. The report also addresses the level of strengthening of demand reduction responses and contains an analysis of the responses provided by Member States to part II of the annual report questionnaire. The analysis complements that contained in the report of the Executive Director on action taken by Member States to implement the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (E/CN.7/2016/6). In 2013, between 162 million and 329 million people aged 15-64 were estimated to have illicitly used drugs in the preceding year. The number of problem drug users — those with drug use disorders or dependence — was estimated at between 15.7 million and 39 million people. Drug use, including injecting drug use, remained common in prisons, with use of substances such as heroin estimated to be 14 times higher in prisons than among the general population. UNODC, jointly with the World Health Organization, the Joint United Nations Programme on

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HIV/AIDS and the World Bank, estimates that between 8.48 million and 21.46 million people inject drugs, and between 0.9 million and 4.42 million people who inject drugs are living with HIV.

Globally, a multifaceted picture of drug use is emerging, with an increase in the use of synthetic substances and non-medical use of prescription drugs such as opioids, tranquillizers and prescription stimulants. Recent drug use trends in Europe show a stabilization in the use of cannabis, cocaine, heroin and amphetamine-type stimulants, but an increase in the use of new psychoactive substances. In North America, cannabis use has increased. Cannabis use also appears to be increasing in Africa and in parts of Asia. While heroin use appears to be stabilizing overall, the non-medical use of prescription opioids continues to increase in some regions. The use of amphetamine-type stimulants also continues to increase, in particular in East and South-East Asia. Globally, cannabis remains the most commonly used drug. Treatment is increasingly sought for cannabis use disorders. Opioids continue to be the drugs that cause the most harm globally in terms of treatment demand, injecting drug use and HIV infections and drug-related death. Globally, between 98,300 and 231,400 deaths were estimated as being attributable to drug use; most of the deaths that could have been prevented were fatal overdose cases and occurred among opioid users. The coverage of drug treatment and drug use prevention services and of services for the prevention and treatment of HIV and AIDS among people who inject drugs, and for care for such people, remains low in many regions. There continues to be an overall low rate of response to the annual report questionnaire and a lack of reliable and up-to-date information on most epidemiological indicators of drug use in many countries. This continues to hinder the monitoring of emerging drug trends in most regions, as well as the implementation and evaluation of evidence-based responses to countering the illicit demand for drugs.

I. Introduction

A. Emerging global trends

1. Based on the information available to the United Nations Office on Drugs and Crime (UNODC), the recent trends in drug use observed around the world include:

(a) The use of cocaine is decreasing or stabilizing in Europe and North America, while there are indications of increased use of cocaine in some parts of South America;

(b) Cannabis use is declining or stabilizing at high levels in Europe. In parts of North America, Asia and Africa, cannabis use is considered to have increased;

(c) The use of amphetamine-type stimulants, especially methamphetamine, is perceived to be increasing in East and South-East Asia;

(d) Although the non-medical use of prescription opioids is decreasing in North America, the misuse of prescription opioids and stimulants remains a concern in the region, as well as in Oceania and in parts of Latin America. The non-medical use of pharmaceutical opioids is also being reported from parts of Africa and Asia;

(e) Among first-time entrants in treatment around the world, the proportion of people with amphetamine-type stimulant and cannabis use disorders is higher than that with other substance use disorders, indicating that there is an expanding group of users of amphetamine-type stimulants and cannabis in need of treatment;

(f) Prisons remain a high-risk environment for drug use and communicable diseases. Use in prison of drugs such as heroin remains at much higher levels than in the community;

(g) The introduction of new psychoactive substances, i.e., psychoactive substances that are not under international control, continues to increase and pose public health concerns in all regions.

B. Challenges in understanding levels of and trends in drug use and scope of the response

2. For the most part, Member States' submissions of the annual report questionnaire form the basis on which global trends in drug use are reported each year. The extent and quality of the information reported by the Member States is therefore reflected in the present report. As at 30 November 2015, 96 Member States out of a total of 194 States and 15 territories had returned part II of the questionnaire, on the comprehensive approach to drug demand reduction and supply, and part III, on the extent and patterns of and trends in drug use. This reflects a nearly 50 per cent response rate by Member States. Of the questionnaires returned by Member States, 30 per cent were partially filled in, while the remaining were filled in substantially, i.e., the State had provided information on more than half of the main indicators of drug use (see map 1 and figures I and II below).

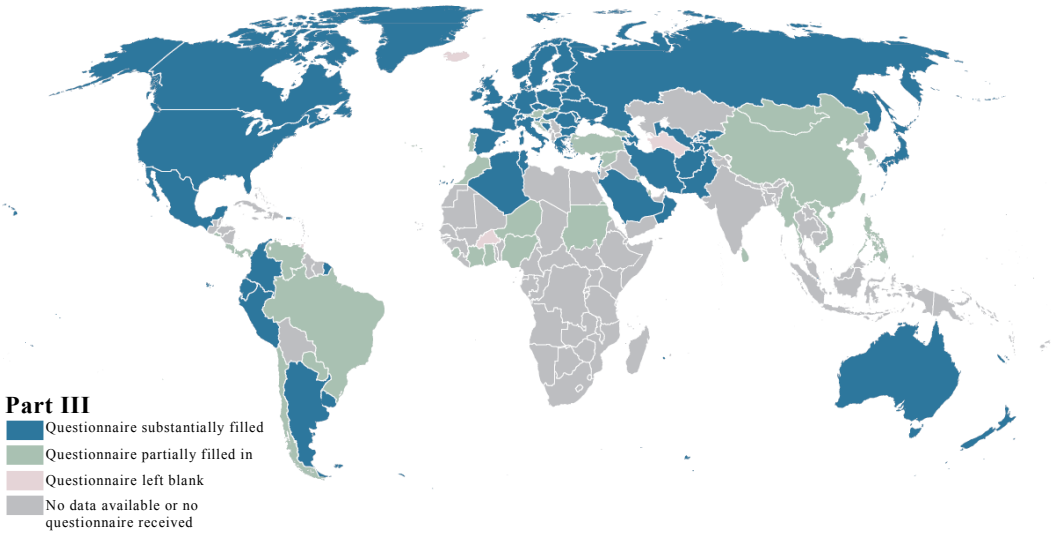
3. In terms of coverage, the 50 per cent of Member States that returned the questionnaire represent over 75 per cent of the world's population. Nevertheless, the

subregions from which responses are missing include most of Africa, from which 11 Member States returned the questionnaire, although mostly with no information. Responses were also not received from many Member States in the Middle East, South, East and South-East Asia and the Caribbean and Central America.

4. As in previous years, the response rate remains low and there is a lack of objective or recent information on drug use. In particular, there is a lack of comprehensive information from some countries with large populations. This lack of information makes it difficult to produce a meaningful analysis of the world situation with regard to drug use and to inform policymaking bodies about required actions. Given that lack of data, efforts have been made to supplement the information, where available, from other government sources and published reports on the drug use situation, especially from countries for which a major part of the relevant information was missing.

Map 1

Responses to part III of the annual report questionnaire (as at 30 November 2015)



Note: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dashed lines represent undetermined boundaries. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between the Republic of Sudan and the Republic of South Sudan has not yet been determined. A dispute exists between the Governments of Argentina and the United Kingdom of Great Britain and Northern Ireland concerning sovereignty over the Falkland Islands (Malvinas).

Figure I

Percentage of Member States, by subregion, that responded to the annual report questionnaire

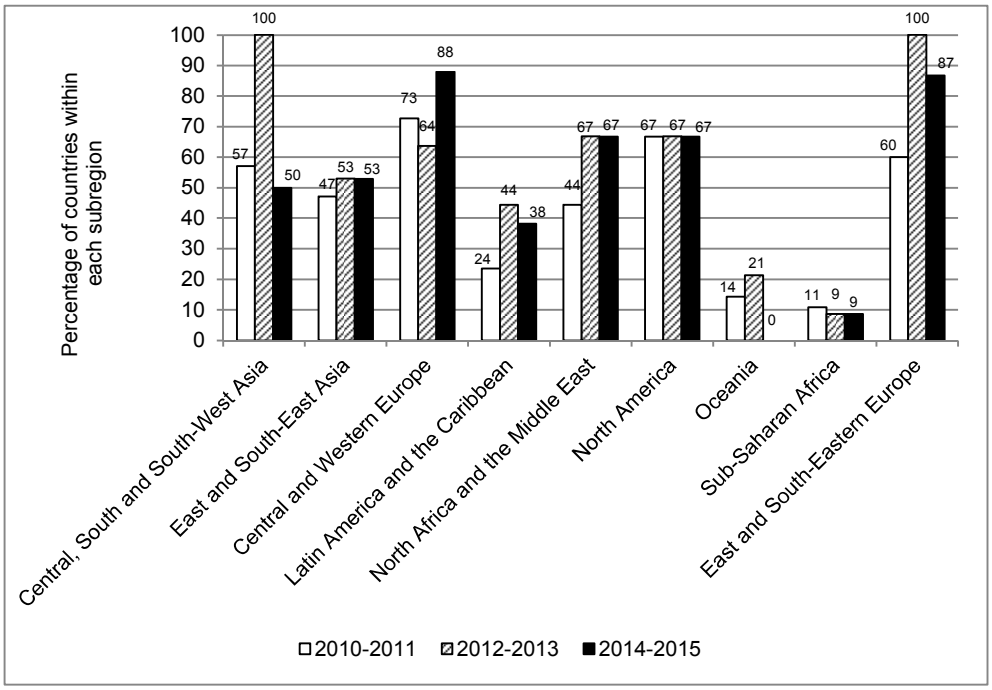
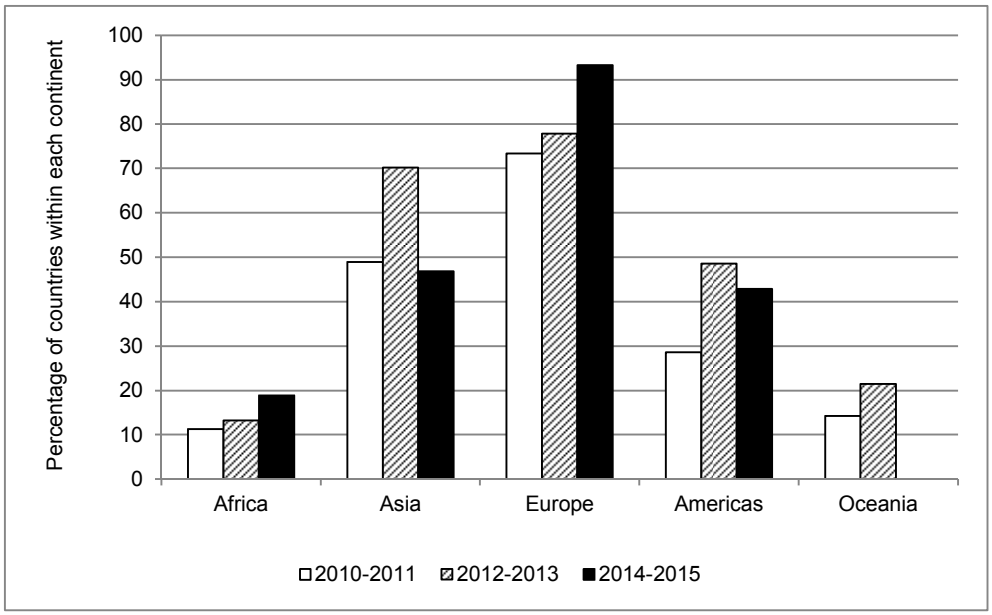


Figure II

Percentage of Member States, by continent, that responded to the annual report questionnaire

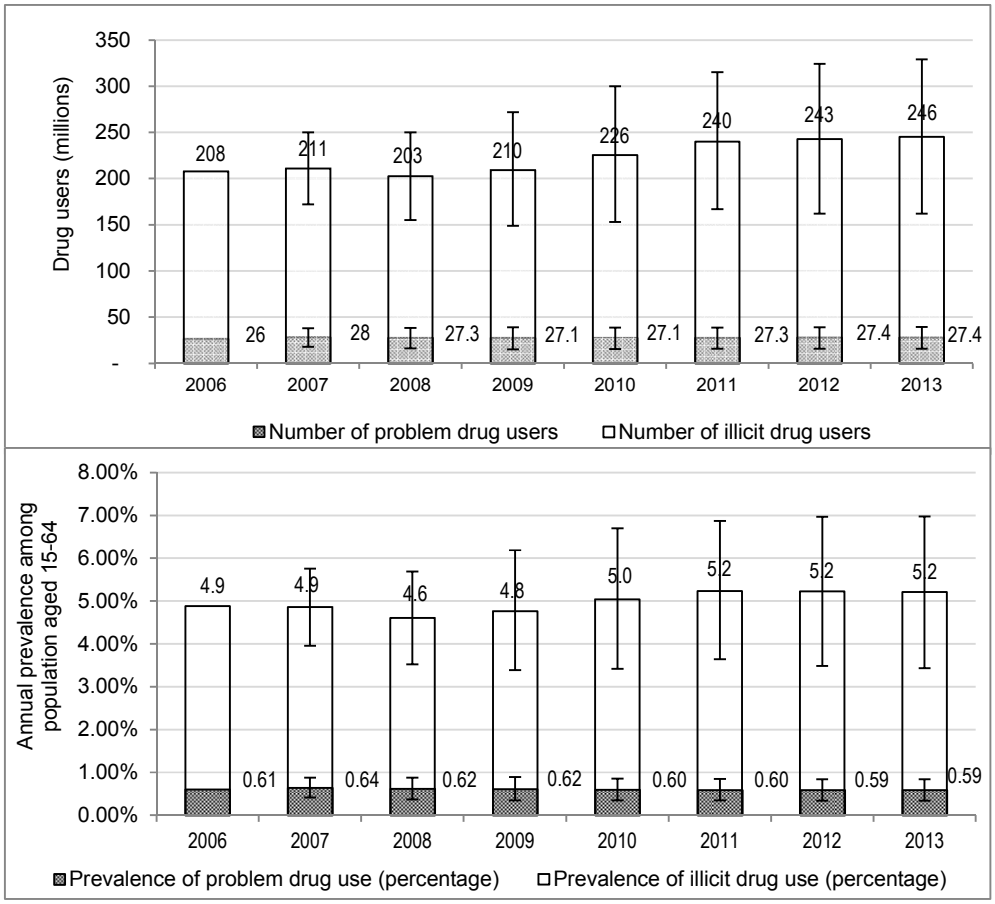


II. Global overview

A. Extent of drug use

5. In 2013, UNODC estimated that between 162 million and 329 million people aged 15-64, corresponding to between 3.4 and 7 per cent of that population, had used an illicit substance in the preceding year (see figure III). While the extent of drug use had remained stable over the previous three years, varying trends in drug use could be observed at the regional and country levels. Similarly, the numbers of problem drug users — those with drug use disorders or dependence — remained stable and were estimated at between 15.7 million and 39 million people.[1]

Figure III
Annual prevalence of illicit drug use among the global population aged 15-64, 2006-2013



Source: *World Drug Report 2015* (United Nations publication, Sales No. E.15.XI.6).

[1] The number of problem drug users is driven mainly by the estimated number of cocaine and opiate users and therefore reflects the overall stable trends in the use of those drugs.

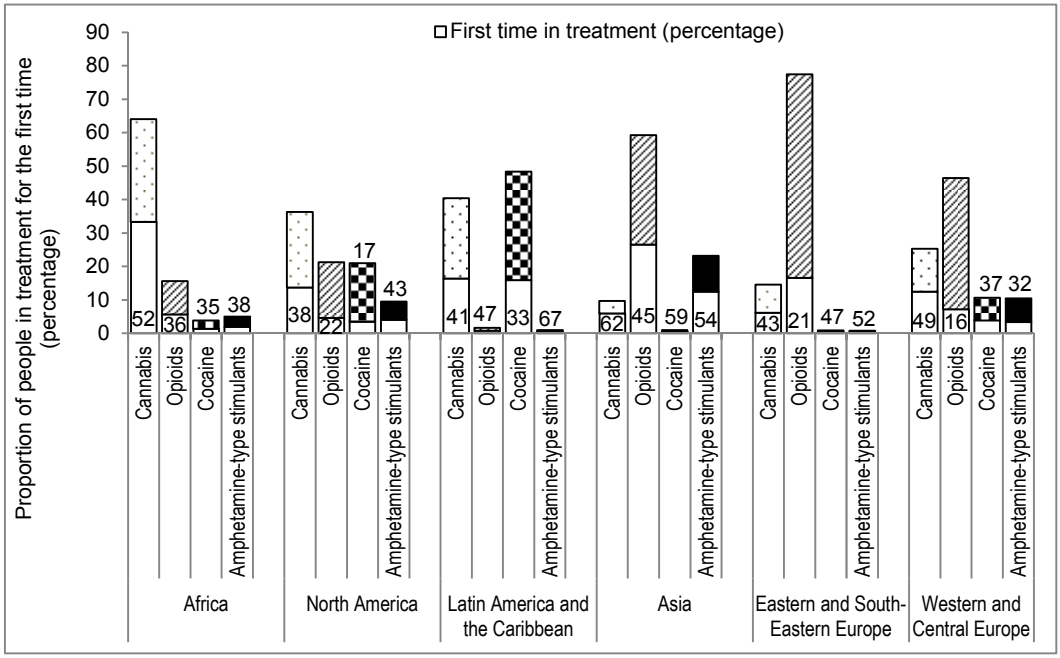
Gender and drug use

6. Compared with drug use among men, overall drug use remains low among women. Men are three times more likely than women to use cannabis, cocaine or amphetamine, whereas women are more likely than men to misuse prescription drugs, particularly prescription opioids and tranquillizers.[2] It is believed that the differences in drug use by men and women may mainly reflect differences in opportunities to use drugs, which are the result of social influences or the cultural environment, rather than an intrinsic gender vulnerability.[3]

Problem drug use as reflected in the demand for drug treatment

7. Treatment demand reflects the extent to which problem drug use varies by region. Globally, almost half of the people who access treatment for drug use are first-time entrants. The proportion of first-time entrants in treatment for amphetamine-type stimulant and cannabis use disorders was higher than for other substances, indicating that, compared with other substances, there is an increasing number of amphetamine-type stimulant and cannabis users who need treatment. In Asia, the number of people accessing treatment for cannabis use disorders is small, but the proportion of first-time entrants (62 per cent) is the largest. The high proportion of people in treatment for opioid use in Asia and Eastern Europe reflects the extent of problem opioid use in these regions. Amphetamine-type stimulant users are another group with a high proportion of first-time entrants in treatment in Asia (see figure IV).

Figure IV
Proportion of people in treatment for the first time, by primary drug, by region (2013 or latest available data)



[2] This is based on prevalence of use of any drug among males and females reported to UNODC by Member States through the annual report questionnaire.

[3] See *World Drug Report 2015* (United Nations publication, Sales No. E.15.XI.6).

Drug use in prisons

8. Prisons remain a high-risk environment for drug use and communicable diseases. Although there are limited data on drug use in prisons, the available data indicate that drug use remains a common phenomenon in prisons. Cannabis is the most commonly used drug, but lifetime and current use of heroin is also common and is much higher than in the general population. It was estimated that between 0.8 per cent and 11.5 per cent of people in prison had used heroin in the past year, compared with between 0.3 per cent and 0.5 per cent of the adult population in the community.

Extent of use by substances

9. Notwithstanding regional trends in the use of different drugs, cannabis use has continued to rise since 2009, while the use of opiates and the misuse of pharmaceutical opioids has stabilized overall. The use of cocaine is stabilizing or decreasing in North America and in Western and Central Europe, while the use of amphetamines[4] is perceived to be increasing, notably in South and South-East Asia.

10. Global and regional trends in drug use are estimated using nationally representative surveys as well as studies that use indirect methods to estimate the number of high-risk users. Many Member States, mainly in Asia and Africa, do not conduct such surveys, while others conduct them at intervals of three to five years. As a result, estimates from a limited number of countries available in a given year are used to compute regional and global estimates. Rather than real-time global or regional trends, year-on-year changes thus reflect the best available estimates of drug use at that time. Therefore, from a global policy perspective, it is more prudent to look at long-term trends in drug use.

11. Cannabis remains the most widely used illicit substance: between 128 million and 232 million users aged 15-64 years were estimated to have used cannabis in the previous year. The regions with a prevalence of cannabis use higher than the global average continued to be West and Central Africa (12.4 per cent), North America (11.6 per cent), Oceania (essentially Australia and New Zealand, 10.7 per cent), South America (5.9 per cent) and Western and Central Europe (5.7 per cent) (see table 1).

Table 1
Subregions with high prevalence of cannabis use, 2013

	Annual prevalence (percentage)	*Estimated number of people*
Global	3.9	181 790 000
West and Central Africa	12.4	29 310 000
North America	11.6	36 660 000
Oceania	10.7	2 650 000
South America	5.9	16 030 000
Western and Central Europe	5.7	18 400 000

Source: *World Drug Report 2015*.

[4] In this report, the term “amphetamines” has been used to refer to amphetamine and methamphetamine.

12. The use of amphetamine-type stimulants, excluding 3,4-methylenedioxymethamphetamine (MDMA, commonly known as “ecstasy”), remains widespread globally, and their use appears to be increasing. Although recent prevalence estimates are not available from Asia and Africa, experts from those regions continue to report a perceived increase in the use of such substances. High levels of use of amphetamine-type stimulants were reported in Oceania (2.1 per cent in Australia and New Zealand), North America (1.4 per cent) and Africa (0.9 per cent). Although the estimated annual prevalence of such use in Asia (0.7 per cent) was comparable with the global average, the region had the highest number of users globally (see table 2).

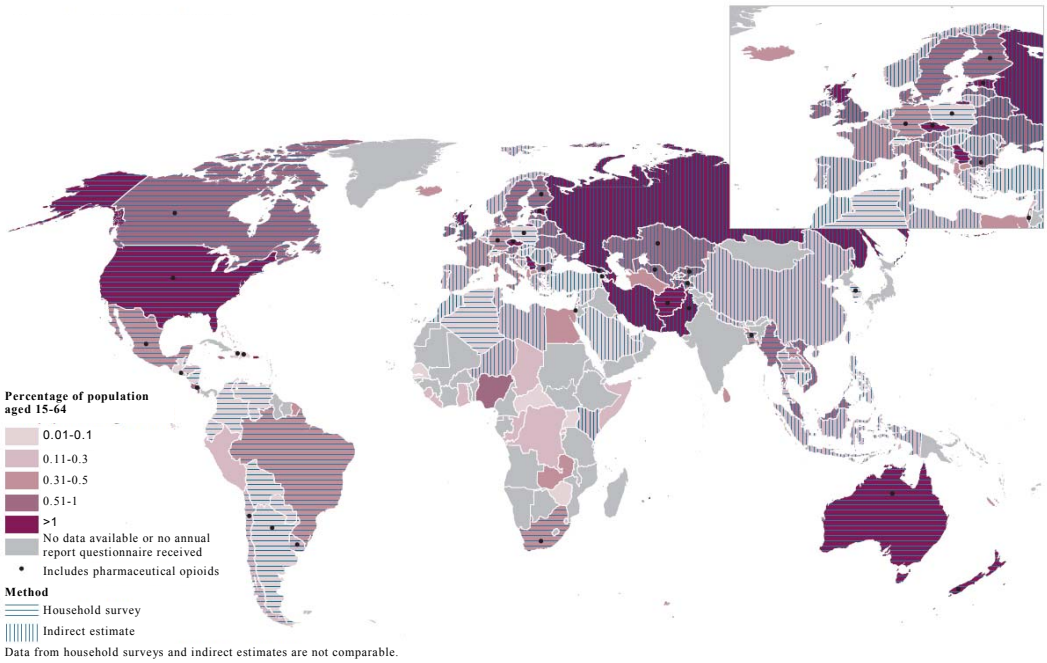
Table 2
Subregions with high prevalence of use of amphetamine-type stimulants, 2013

	Annual prevalence (percentage)	*Estimated number of people*
Global	0.7	33 900 000
Oceania	2.1	510 000
North America	1.4	4 430 000
East and South-East Asia	0.6	9 060 000

Source: *World Drug Report 2015*.

13. The overall prevalence of the use of opioids (heroin, opium and prescription opioids) was estimated at between 0.6 and 0.8 per cent of the population aged 15-64, while that of opiates (heroin and opium) was estimated at between 0.3 and 0.4 per cent of the adult population. North America and Oceania are characterized by high levels of misuse of prescription opioids, while opiate use continues to remain high in South-West Asia (1.2 per cent) and Eastern and South-Eastern Europe and Central Asia (0.8 per cent each) (see map 2).

Map 2
Prevalence of opiate use and misuse of prescription opioids, 2013



Source: *World Drug Report 2015.*

Notes: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dashed lines represent undetermined boundaries. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between the Republic of Sudan and the Republic of South Sudan has not yet been determined. A dispute exists between the Governments of Argentina and the United Kingdom of Great Britain and Northern Ireland concerning sovereignty over the Falkland Islands (Malvinas).

According to the Government of Canada, data on heroin use based on the household survey is not reportable and the Government of Canada does not report an estimate based on indirect methods.

14. Globally, between 13.8 and 20.7 million people had used cocaine in the previous 12 months. Cocaine use remained high in North and South America (with an annual prevalence of 1.7 per cent and 1.2 per cent, respectively), Oceania (1.6 per cent) and Western and Central Europe (1 per cent). Cocaine use appeared to be stabilizing at high levels in the main and established markets.

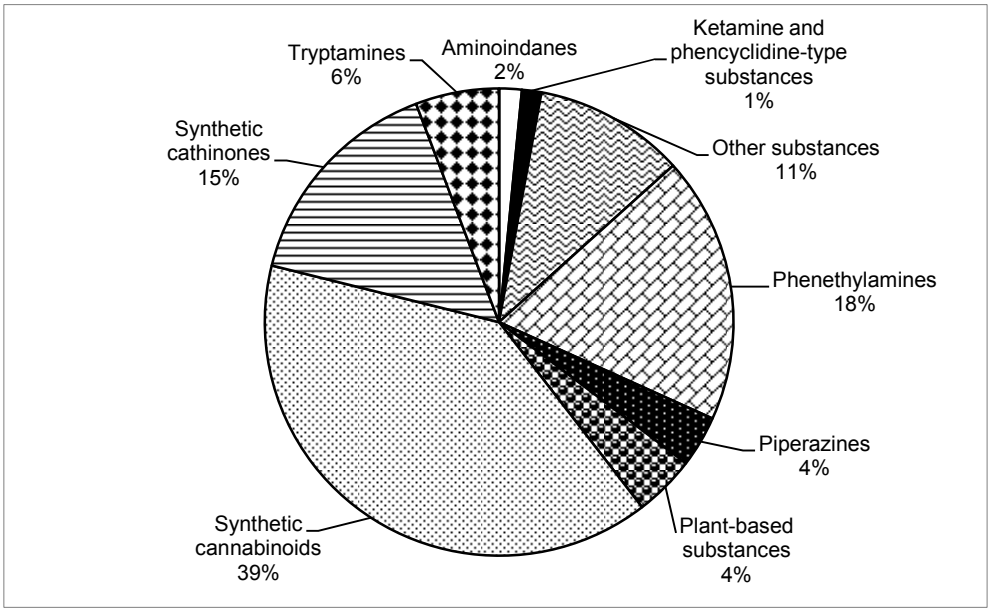
15. Between 9.3 million and 28.4 million people were estimated to have used “ecstasy”, in the preceding year. The three regions with a high prevalence of “ecstasy” use continued to be Oceania (2.5 per cent), North America (0.9 per cent) and Europe (0.5 per cent). The use of “ecstasy” continued to be associated with young people and recreational and nightlife settings in urban centres.

16. While global estimates of non-medical use of prescription drugs are not available, such use remains a major public health concern. The non-medical use of tranquillizers such as benzodiazepines remains widespread and some countries

report higher prevalence rates for their use than for many illicit substances. In many countries, benzodiazepines are frequently reported in fatal overdose cases involving opiates. Misuse of prescription opioids, including tramadol, also remains a concern, with high levels of misuse reported from many countries. The misuse of prescription stimulants or medications for attention deficit hyperactivity disorder (ADHD) is only reported in a few countries, among both the general and youth populations. With the exception of Indonesia, most countries reporting misuse of prescription stimulants are in South and North America.

17. As at December 2014, a total of 541 new psychoactive substances had been reported to UNODC. Synthetic cannabinoids continued to account for the majority of such substances reported, followed by phenethylamines and synthetic cathinones (see figure V). It is noteworthy that some new psychoactive substances have an established presence and have been reported by countries over several years. They include ketamine (58 countries), khat (51 countries), mephedrone (46 countries) and JHW-018 (44 countries). More than a quarter of countries reporting the emergence of new psychoactive substances reported only one substance, most of which were plant-based substances such as khat, kratom and ketamine.

Figure V
New psychoactive substances reported to the UNODC early warning advisory, 2009-2014



Source: *World Drug Report 2015.*

B. Consequences of drug use

1. People who inject drugs

18. The joint UNODC/World Health Organization (WHO)/Joint United Nations Programme on HIV/AIDS (UNAIDS)/World Bank estimate for the number of people who inject drugs ranges between 8.48 million and 21.46 million (best

estimate 12.19 million). This corresponds to between 0.18 per cent and 0.46 per cent (best estimate 0.26 per cent) of the population aged 15-64. By far the highest prevalence of people who inject drugs continues to be in Eastern and South-Eastern Europe, where 1.27 per cent of the adult population is estimated to be injecting drugs. However, in terms of the actual numbers of people who inject drugs, with an estimated 3.15 million, approximately one in four people who inject drugs worldwide reside in East and South-East Asia. Large numbers of people who inject drugs also reside in Eastern and South-Eastern Europe (24 per cent of the global total) and North America (17 per cent of the global total) (see table 3). Together, China, the Russian Federation and the United States of America combined account for nearly half (48 per cent) of the global estimated total number of people who inject drugs.

Table 3
Estimated number and prevalence of people who inject drugs, 2013

		People who inject drugs					
		Estimated number			*Prevalence (percentage)*		
Region	*Subregion*	*Low*	*Best*	*High*	*Low*	*Best*	*High*
Africa		**330 000**	**1 000 000**	**5 590 000**	**0.05**	**0.16**	**0.91**
America		**2 150 000**	**2 820 000**	**3 970 000**	**0.34**	**0.44**	**0.62**
	North America	1 780 000	2 070 000	2 380 000	0.56	0.65	0.75
	Latin America and the Caribbean	370 000	750 000	1 590 000	0.11	0.23	0.49
Asia		**3 380 000**	**4 560 000**	**6 110 000**	**0.12**	**0.16**	**0.21**
	Central Asia and Transcaucasia	360 000	410 000	470 000	0.66	0.75	0.87
	East and South-East Asia	2 330 000	3 150 000	4 300 000	0.15	0.20	0.27
	South-West Asia	400 000	670 000	940 000	0.22	0.37	0.51
	Near and Middle East	30 000	70 000	130 000	0.03	0.08	0.13
	South Asia	250 000	260 000	260 000	0.03	0.03	0.03
Europe		**2 500 000**	**3 680 000**	**5 630 000**	**0.45**	**0.67**	**1.02**
	Eastern and South-Eastern Europe	1 790 000	2 910 000	4 780 000	0.78	1.27	2.09
	Western and Central Europe	710 000	770 000	850 000	0.22	0.24	0.26
Oceania		**120 000**	**130 000**	**160 000**	**0.49**	**0.53**	**0.66**
Global		**8 480 000**	**12 190 000**	**21 460 000**	**0.18**	**0.26**	**0.46**

Source: *World Drug Report 2015.*

2. HIV among people who inject drugs

19. The burden of HIV among people who inject drugs remains high. People who inject drugs account for an estimated 30 per cent of new HIV infections outside sub-Saharan Africa. It was estimated that between 0.92 million and 4.42 million (best estimate 1.65 million) people who inject drugs were living with HIV worldwide in 2013. That represents a global HIV prevalence of 13.5 per cent among people who inject drugs (see table 4).

Table 4
Estimates of people who inject drugs who are living with HIV, 2013

		HIV among people who inject drugs			
		Estimated number			*Prevalence (percentage)*
Region	*Subregion*	*Low*	*Best*	*High*	*Best estimate*
Africa		**30 000**	**112 000**	**1 582 000**	**11.2**
America		**167 000**	**237 000**	**416 000**	**8.4**
	North America	141 000	182 000	248 000	8.8
	Latin America and the Caribbean	26 000	55 000	168 000	7.3
Asia		**344 000**	**576 000**	**993 000**	**12.6**
	Central Asia and Transcaucasia	26 000	31 000	40 000	7.5
	East and South-East Asia	211 000	329 000	612 000	10.5
	South-West Asia	90 000	196 000	314 000	29.3
	Near and Middle East	1 000	3 000	9 000	3.8
	South Asia	17 000	17 000	18 000	6.8
Europe		**373 000**	**724 000**	**1 428 000**	**19.7**
	Eastern and South-Eastern Europe	322 000	665 000	1 359 000	22.8
	Western and Central Europe	51 000	59 000	69 000	7.6
Oceania		**1 000**	**1 000**	**2 000**	**1.0**
Global		**915 000**	**1 651 000**	**4 421 000**	**13.5**

Source: *World Drug Report 2015*.

20. The available gender-disaggregated data on HIV prevalence among people who inject drugs point to the existence of gender disparities that are quite large in some countries. Data reported to UNAIDS show a higher prevalence of HIV (over 120,000) among females who inject drugs in many countries with large populations of people who inject drugs and in countries that have a high prevalence of HIV among people who inject drugs. In many countries, the prevalence of HIV among females in prison is higher than among male prisoners.

3. Hepatitis among people who inject drugs

21. Hepatitis C has the potential to pose serious health problems for those infected, and it causes liver failure and liver cancer. An estimated 2.2 per cent of the global population are infected with hepatitis C; this proportion is 25 times higher among people who inject drugs, and is estimated at 52 per cent, or 6.3 million people worldwide. In some countries, the prevalence of hepatitis C among people who inject drugs is considerably higher, including in countries with large populations of people who inject drugs. The prevalence of hepatitis C among people who inject drugs is 60 per cent or higher in 29 countries, and 80 per cent or higher in 10 countries.

4. Drug-related deaths

22. It is estimated that in 2013 there were between 98,300 and 231,400 drug-related deaths worldwide, corresponding to a mortality rate of between 21.5 and 50.5 deaths per million people aged 15-64 (see table 5). Overdose is the primary cause of drug-related deaths worldwide and opioids are the main drug type implicated in those deaths. However, substantial proportions of drug-related deaths occur in the context of polydrug use.

Table 5
Estimated number of drug-related deaths and mortality rate per million inhabitants aged 15-64, 2013

Region	*Number of drug-related deaths*			*Mortality rate per million aged 15-64*			*Availability of mortality data (percentage of total population in region)*
	Best estimate	*Lower estimate*	*Upper estimate*	*Best estimate*	*Lower estimate*	*Upper estimate*	
Africa	37 800	18 000	57 700	61.9	29.4	94.3	
North America	43 300	43 300	43 300	136.8	136.8	136.8	100.0
Latin America and the Caribbean	6 000	4 900	10 900	18.4	14.9	33.4	80.0
Asia	81 100	13 600	100 700	28.2	4.7	35.0	9.0
Western and Central Europe	7 300	7 300	7 300	22.5	22.5	22.5	100.0
Eastern and South-Eastern Europe	9 500	9 500	9 500	41.5	41.5	41.5	92.0
Oceania	2 000	1 700	2 100	82.3	69.9	83.3	75.0
Global	**187 100**	**98 300**	**231 400**	**40.8**	**21.5**	**50.5**	

Source: *World Drug Report 2015.*

Note: Because of very limited reporting of data from countries in Africa, the source of information used is Louisa Degenhardt and others, “Illicit drug use”, in *Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors*, vol. 1, Majid Ezzati and others, eds. (Geneva, World Health Organization, 2004).

III. Regional summaries

23. The information on drug use presented below highlights major trends and new information where it was available from the countries. The regional and subregional estimates of the prevalence presented in each section are UNODC estimates published in the *World Drug Report 2015*.

A. Africa

24. Although there is limited information available on the drug use situation in Africa, the use of cannabis in the region was considered to be high in comparison with the global average (ranging between 3.3 per cent and 9.7 per cent of the population aged 15-64). Similar or lower levels of consumption than the global average were estimated for opiates (ranging between 0.2 per cent and 0.4 per cent),

cocaine (between 0.1 and 0.8 per cent) and amphetamine-type stimulants (between 0.2 and 1.5 per cent).

25. Along with the use of illicit substances, many countries in the region reported an increasing trend in the non-medical use of prescription opioids and tranquillizers.

26. Information on new trends was available from only a few countries in the region. In Algeria for instance, tranquillizers were ranked as the second most commonly used substance after cannabis. In 2014, experts perceived a large increase in the use of benzodiazepines and an increasing trend of injecting buprenorphine among affluent youth.[5] Experts in Côte d'Ivoire reported an increase in the use of benzodiazepines and of buprenorphine. The misuse of the synthetic opioid analgesic tramadol is also a major concern in the region: experts in Côte d'Ivoire and Nigeria reported an increasing trend in the non-medical use of the substance. Egypt, Libya, Mauritius and Togo have also reported its misuse in previous years.[6]

27. The South African Community Epidemiology Network on Drug Use regularly reports trend data based on treatment admissions across the country. According to its recent report, heroin use remained a growing problem, with a steady increase in the number of patients reporting injecting heroin. There were also reports of injecting other drugs, such as cocaine and methcathinone. Cannabis remained the most commonly used substance, especially among young people attending specialist treatment centres, while methamphetamine was the second most common substance for young people (aged under 20) seeking treatment. Treatment demand related to cocaine use remained low and stable in South Africa.[7]

B. Americas

28. Cannabis continued to be the most common illicit substance used in the Americas, with an annual prevalence of 8.4 per cent among the population aged 15-64. That rate was driven mainly by high levels of use in North America. Opioids were the second most used illicit substances, with an annual prevalence of 2.0 per cent, some three times the global average. The annual prevalence of cocaine use in the region also remained high, at 1.4 per cent. The use of amphetamines and "ecstasy" were also above their respective global averages.

1. North America

29. In North America, all drug types were consumed at levels greater than the global average. Cannabis was the most widely used substance (11.6 per cent of the population had used it in the previous year), and the consumption of opioids (mainly prescription opioids and painkillers) and cocaine was also high. The annual prevalence of opioid use was 3.8 per cent, that of opiate use was 0.4 per cent and that of cocaine was 1.7 per cent (the highest of any region). The use of

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[5] Response of Algeria to the annual report questionnaire for 2014.

[6] UNODC, *2014 Global Synthetic Drugs Assessment: Amphetamine-type Stimulants and New Psychoactive Substances* (United Nations publication, Sales No. E.14.XI.6).

[7] Siphokazi Dada and others, *Monitoring Alcohol and Drug Abuse Trends in South Africa: August 2015, Phase 37, July to December 2014*, SACENDU Report Back Meetings (Cape Town, South Africa, South African Community Epidemiology Network on Drug Use, 2015).

amphetamines and “ecstasy” was also well above the average global levels of consumption, with an annual prevalence of 1.4 per cent and 0.9 per cent, respectively.

30. In the United States, past-year illicit drug use by persons aged 12 or older increased significantly, from 15.9 per cent in 2013 to 16.7 per cent in 2014. The prevalence of cannabis use continued to increase, from 12.6 per cent in 2013 to 13.2 per cent in 2014. Compared with 2013, the use of cocaine also increased (to 1.7 per cent in 2014). In 2014, there was a decrease in the non-medical use of psychotherapeutics[8] (from 5.8 per cent in 2013 to 5.6 per cent in 2014). In particular, a significant decrease in the non-medical use of prescription opioids was reported, from 4.2 per cent in 2013 to 3.9 per cent in 2014.[9]

31. In the United States, the decrease in the use of prescription opioids was partly offset by an increase in the use of heroin, which was evidenced by the high availability and lower prices of heroin.[10] In 2014, 0.3 per cent of people aged 12 or older had used heroin in the past year, which represented about 914,000 people. The increase in heroin use among people aged 12 or older reflected an increase in heroin use by adults aged 26 or older and, to a lesser extent, increases in heroin use among young adults aged 18 to 25.[11]

32. There was also a considerable increase in heroin-related deaths in the United States. Some of the reasons attributed to those deaths were the following: (a) availability of high-purity heroin in parts of the country, causing users to accidentally overdose; (b) an increase in new heroin users, many of whom were young and inexperienced; (c) users of prescription opioids (which have a set dosage amount and no adulterants) starting to use heroin, which contains varying purities, dosage amounts and adulterants; and (d) the presence of adulterants such as fentanyl in heroin in certain areas.[12]

33. In Canada, while the use of most substances was considered stable, the use of opioids was perceived to be decreasing. The reported use of synthetic cannabinoids, (BZP/TFMPP) and mephedrone was monitored for the first time in a 2012-2013 survey of young people. The previous 12-month prevalence among students in grades 7 to 12 was reported as 1.4 per cent for synthetic cannabinoids, 0.5 per cent for BZP and 0.6 per cent for mephedrone. Canada also reported increasing seizures and deaths related to fentanyl. More than 1,000 fentanyl-related deaths were reported between 2009 and 2014.[13]

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[8] The term “use of psychotherapeutics” includes the non-medical use of pain relievers, tranquillizers, stimulants and sedatives.

[9] United States, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *Results from the 2014 National Survey on Drug Use and Health: Detailed Tables* (Rockville, Maryland, 2015).

[10] *World Drug Report 2015*.

[11] United States, Center for Behavioral Health Statistics and Quality, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50 (Rockville, Maryland, 2015).

[12] United States, Drug Enforcement Administration, *2015 National Drug Threat Assessment Summary* (October 2015).

[13] Response of Canada to the annual report questionnaire for 2014.

34. In Mexico, the reported illicit use of drugs remained at low levels, with the past-year consumption of any drug at 1.5 per cent. Past-year use of cannabis was estimated at 1.2 per cent and past-year use of cocaine at 0.5 per cent. Experts perceived an overall stable trend in the use of cannabis, heroin, "crack" cocaine and amphetamine-type stimulants in the country and reported the emerging use of many new psychoactive substances, such as *Salvia divinorum*, "Spice", ketamine, kratom and khat, among young adults.[14]

2. South America and Central America and the Caribbean

35. In South and Central America and the Caribbean, reported levels of cocaine use remained high. In South America, the annual prevalence of cocaine use was estimated at 1.2 per cent, while in Central America and the Caribbean it remained at lower levels (0.6 per cent in both subregions). The illicit use of other substances remained at low to moderate levels in the subregion.

36. As reported in the annual report questionnaire, experts from Argentina, Bolivia (Plurinational State of), Ecuador, Peru and Uruguay perceived a stable or declining use of cocaine in the previous year, while Brazil and Chile reported a perceived increase in such use.

37. According to the 2014 household survey in Chile, there was an increase in the use of cannabis, cocaine and non-medical use of prescription opioids and a decrease in the use of amphetamines and tranquillizers. The annual prevalence of cannabis use was reported at 11.8 per cent in 2014, compared with 7.8 per cent in 2012, whereas cocaine use was estimated at 1.7 per cent in 2014, compared with 1.2 per cent in 2012. Chile also reported some use of ketamine, mephedrone and synthetic cannabinoids.[15]

38. In Uruguay, as reported in its drug use survey for 2014, cannabis use remained high (9.30 per cent of the adult population), while the use of cocaine and amphetamines — mainly misuse of prescription stimulants — remained stable, at 1.8 per cent and 0.4 per cent, respectively.[16]

C. Asia

39. Although reliable estimates of the prevalence rates for the use of different drugs were available for only a few countries in Asia, the levels of consumption of illicit substances such as opiates and amphetamines in the region as a whole were estimated to be at levels comparable to the global ones, ranging between 0.3 and 0.5 per cent for heroin and between 0.1 to 1.2 per cent for amphetamines. However, the use of cannabis (between 1.0 per cent and 3.1 per cent) and cocaine (between 0.02 per cent and 0.08 per cent) remained considerably lower than the global average.

40. Experts in the region perceived an increase in the use of cannabis and stable trends in the use of cocaine in their countries (see table 6). In most of the Member States in East and South Asia, experts perceived an increase in the use of

[14] Response of Mexico to the annual report questionnaire for 2014.
[15] Response of Chile to the annual report questionnaire for 2014.
[16] Response of Uruguay to the annual report questionnaire for 2014.

amphetamines, while opioid use was perceived to be increasing, mainly in South-West and Central Asia.

Table 6
Asia: expert perceptions of trends in drug use, by drug type, 2014

	Member States providing perception data		*Member States reporting an increase in drug use*		*Member States reporting stable drug use*		*Member States reporting a decrease in drug use*	
Drug type	*Number*	*Percentage*	*Number*	*Percentage*	*Number*	*Percentage*	*Number*	*Percentage*
Cannabis	15	33	10	67	3	20	2	13
Amphetamines	11	24	7	64	2	18	2	18
“Ecstasy”	7	16	3	43	2	29	2	29
Opioids	14	31	7	50	3	21	4	29
Cocaine	8	18	3	38	3	38	2	25

Source: Annual report questionnaires for 2014.

1. East and South-East Asia

41. With the exception of amphetamines, the use of other illicit substances in East and South-East Asia remained low; amphetamine users in the subregion (who numbered between 3.5 million and 20.5 million) remained the highest globally.

42. In the absence of reliable data, there are indications that the use of amphetamine-type stimulants has both increased and diversified. The reported use of methamphetamine was perceived to have increased in many countries; experts from Brunei Darussalam, China and Japan, in particular, reported an increase in its use. The market for new psychoactive substances is also rapidly diversifying, with many countries reporting their emergence, in particular China, Japan and Singapore. The number of new psychoactive substances reported in the region increased from 34 substances in 2009 to a total of 137 substances by the end of 2014. While ketamine and kratom have had a long-established presence on the market in several countries, other new psychoactive substances, such as synthetic cannabinoids and cathinones, seem to be on the market for only a short time in the region.[17]

43. By the end of 2014, a total of 2.95 million drug users had been registered in China, including 480,000 newly registered users. Among those registered drug users, more than half (1.66 million) were estimated as being between the ages of 18 and 35 years. Heroin users (1.45 million) accounted for nearly half of drug users registered, while methamphetamine and ketamine users (1.19 million and 222,000, respectively) accounted for the other half. However, among the 480,000 new drug users registered in 2014, 19.7 per cent used heroin and other opiates, while 79 per cent were users of synthetic drugs (methamphetamine and ketamine).[18]

44. The number of people who inject drugs who reside in this subregion (between 2.3 and 4.3 million) represents more than one quarter of the global total. In some

[17] UNODC, global SMART programme, “The challenge of synthetic drugs in East and South-East Asia and Oceania: trends and patterns of amphetamine-type stimulants and new psychoactive substances”, May 2015.

[18] National Narcotics Control Commission of China, *Drug Situation Report 2014* (Beijing, 2015).

countries (such as Cambodia, Indonesia and Thailand), the prevalence of HIV among people who inject drugs is greater than 20 per cent.

2. South Asia

45. There is limited information on the drug situation in South Asia, especially with regard to the consumption of cocaine and amphetamine-type stimulants. The annual prevalence of cannabis use was estimated at 3.5 per cent and the prevalence of opiate use at 0.3 per cent, below the respective global average in both cases. The prevalence of people who inject drugs (0.03 per cent) and HIV prevalence (6.8 per cent) among people who inject drugs remained low as compared with the global average.

46. Sri Lanka was the only country in the subregion that submitted an annual report questionnaire for 2014. With 245,000 registered drug users, of whom 200,000 were cannabis users and the remaining were heroin users, the overall drug use situation in the country was perceived to be stable.[19]

3. South-West and Central Asia

47. The subregion is marked by high prevalence of opiate use. South-West Asia had the highest prevalence (29.3 per cent) of HIV among people who inject drugs.

48. In Central Asia and Transcaucasia, the annual prevalence of cannabis use was comparable to global levels; however, the use of opiates (0.8 per cent of the adult population) remained considerably higher than the global average. The prevalence of HIV among people who inject drugs also remained high (7.5 per cent). In 2014, experts in Armenia, Azerbaijan and Tajikistan in particular reported an increase in opioid use.

49. Within the Near and Middle East there was little reliable information on the extent of drug use. According to expert perceptions on trends in drug use, cannabis use was perceived to have increased in Israel, Jordan and Lebanon, while opioid use was perceived to have increased in Lebanon, Saudi Arabia and the Syrian Arab Republic, with an increase in the use of amphetamines also perceived in the latter two countries.

D. Europe

50. Cannabis remained the most used illicit substance in Europe (see table 7), with an estimated 23.7 million past-year users (4.3 per cent of the population aged 15-64), followed by cocaine, with 3.7 million past-year users (0.7 per cent of the same age group). The use of opioids (0.8 per cent) and the use of opiates (0.5 per cent) were slightly higher than the global averages of 0.7 per cent and 0.4 per cent, respectively. The prevalence of amphetamine use was lower (0.4 per cent) than the global average (0.7 per cent), but the use of “ecstasy” was slightly higher (0.5 per cent) than the global average (0.4 per cent).

51. The patterns of drug use within Europe differ substantially between the two subregions. The prevalence of cannabis and cocaine use was much higher in

[19] Response of Sri Lanka to the annual report questionnaire for 2014.

Western and Central Europe, and the use of opioids was much higher in Eastern and South-Eastern Europe. With the exception of cannabis, the use of most substances was perceived to be stable in Europe.

Table 7
Europe: expert perceptions of trends in drug use, by drug type, 2014

	Member States providing perception data		*Member States reporting an increase in drug use*		*Member States reporting stable drug use*		*Member States reporting a decrease in drug use*	
Drug type	*Number*	*Percentage*	*Number*	*Percentage*	*Number*	*Percentage*	*Number*	*Percentage*
Cannabis	26	58	12	46	8	31	6	23
Amphetamine-type stimulants	20	44	6	30	11	55	3	15
“Ecstasy”	21	47	7	33	8	38	6	29
Opioids	25	56	5	20	12	48	8	32
Cocaine	21	47	7	33	8	38	6	29

Source: Annual report questionnaires for 2014.

1. Western and Central Europe

52. The annual prevalence of cannabis use remained high in Western and Central Europe (5.7 per cent); however, there was evidence of a stabilizing or decreasing trend, especially in countries with long-established cannabis use. Experts perceived large increases in cannabis use in France and Latvia, with large decreases in use reported for Lithuania, Portugal and Poland. The number of users entering treatment primarily as a result of cannabis use, including those entering treatment for the first time, continued to rise in many Western European countries.[20]

53. The use of cocaine in Western and Central Europe remained high (1.0 per cent of the adult population). However, countries with high levels of use, such as Denmark, Ireland, Spain and the United Kingdom of Great Britain and Northern Ireland, have reported stable or declining trends in recent years.[21] However, as reported in the annual report questionnaires, experts in Germany, Portugal and Romania perceived an increase in cocaine use over the previous year.

54. Past-year use of opioids, mainly heroin, was estimated as 0.5 per cent of the population aged 15-64. However, in Western and Central Europe, other synthetic opioids such as buprenorphine, fentanyl and methadone were available on the illicit market and were increasingly becoming a public health concern: their use being reported by people seeking treatment and being linked to a large proportion of overdose deaths.[22]

55. Although the overall prevalence of opioid use was stable, the number of opioid users in treatment declined. Injecting drug use also declined, as did cases of HIV

[20] European Monitoring Centre for Drugs and Drug Addiction, *European Drug Report: Trends and Developments 2015* (Luxembourg, 2015).
[21] Ibid.
[22] Ibid.

diagnosis among people who inject drugs. However, the number of opioid overdose deaths increased in several countries.[23]

56. The annual prevalence of use of amphetamines (0.5 per cent) was below the average global prevalence rate, while the use of "ecstasy" (0.5 per cent annual prevalence) remained at around the global average. Most countries reported stable trends with regard to amphetamine use, although Spain and the United Kingdom reported a significant decrease.[24]

57. The emergence and use of new psychoactive substances remained a major challenge in Western and Central Europe. As at October 2015, countries in the subregion had reported a total of 483 such substances, of which 30 per cent consisted of synthetic cannabinoids, 20 per cent were phenethylamines and 18 per cent were synthetic cathinones.[25] There is increasing evidence of the adverse health consequences of using new psychoactive substances, with almost 1 in 10 drug-related hospital emergencies involving such substances (particularly cathinones). In Hungary, new psychoactive substances were detected in around 50 per cent of all drug-related deaths in 2013.[26]

2. Eastern and South-Eastern Europe

58. The high level of use of opioids, notably opiates, is a major concern in Eastern and South-Eastern Europe, with an annual prevalence rate of 1.4 per cent and 0.8 per cent, respectively, which were double the global average. The use of other substances, such as cannabis, cocaine and amphetamines, was below global average levels.

59. At 1.27 per cent, the prevalence of people who inject drugs was also the highest in the world (the global average was 0.26 per cent). In addition, the prevalence of HIV among people who inject drugs was 22.8 per cent, which was quite high compared with the global average. Expert perceptions from the Russian Federation pointed to an increase in the use of amphetamines and tranquillizers and an increase in the use of cannabis. There was also a perception of a decrease in the use of cocaine and some decrease in the use of opioids. New synthetic psychoactive substances were the main challenge; such substances have partially replaced "traditional" drugs, especially heroin.[27]

60. In Belarus, while the use of most drugs was considered stable, experts reported an increase in the illicit use of tramadol and methadone.

E. Oceania

61. Information on drug use in the region was limited to Australia and New Zealand and was marked by high levels of use of most substances, including cannabis (10.7 per cent), opioids (2.9 per cent), "ecstasy" (2.5 per cent), amphetamines (2.1 per cent) and cocaine (1.6 per cent).

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[23] Ibid.

[24] Ibid.

[25] UNODC, global Synthetics Monitoring: Analysis, Reporting and Trends (SMART) programme.

[26] *European Drug Report: Trends and Developments 2015*.

[27] Response of the Russian Federation to the annual report questionnaire for 2014.

62. While in Australia the use of most drugs was perceived to be stable, there was an increase in the use of ketamine. In addition, a wide range of drug analogues and new psychoactive substances, primarily cathinone-type substances, other amphetamine-type stimulants and synthetic cannabinoids, became available on the country's illicit drug market.[28]

63. In New Zealand, the use of most substances, including methamphetamine, remained largely unchanged from the previous year. There appeared to be diversification in the market for newer substances, which were mainly 2C drugs (e.g. 2CB, 2CE, 2CI and 2CP), a large number of new synthetic cannabinoids and new analogues of existing controlled drugs and "research chemicals". Similarly to "ecstasy"-type tablets, blotter tabs were increasingly being adulterated with new chemicals such as 25I-NBOMe, rather than the traditional lysergic acid diethylamide (LSD).[29]

IV. Prevention and early intervention

64. A detailed analysis of responses provided by Member States to the annual report questionnaire in its third cycle is described in the report of the Executive Director on action taken by Member States to implement the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (E/CN.7/2016/6). The present section contains an attempt to evaluate the progress made in strengthening drug treatment services. "Strengthening services" is defined as increasing the availability and coverage of services. The analysis has been particularly valuable given the recent approval of the 17 Sustainable Development Goals and the related targets to be achieved by 2030. Under Sustainable Development Goal 3, on ensuring healthy lives and promoting well-being for all at all ages, strengthening drug demand reduction services is explicitly mentioned under target 3.5 ("Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol").

65. To address the question of strengthening drug treatment services, a composite indicator was generated by merging information on availability (yes/no) and coverage (low/medium/high) of each of the 17 treatment interventions listed and defined in question 10 of part II of the annual report questionnaire. Coverage was described as the extent to which a service is provided to the target population (proportion of the target population in need that actually gets it). Those services were merged into three different categories:

(a) Pharmacological (detoxification, opioid maintenance therapy, opioid agonist maintenance);

(b) Social rehabilitation (vocational training, social assistance, educational activities, rehabilitation and aftercare);

[28] Response of Australia to the annual report questionnaire for 2014.

[29] Response of New Zealand to the annual report questionnaire for 2014.

(c) Psychosocial (treatment planning, counselling, peer support groups, screening/brief interventions, contingency management, cognitive behaviour therapy, treatment of comorbidity, motivational interviewing).

66. The composite score for each category was generated by multiplying availability (0 for not available/1 for available) by the coverage (0 for not applicable/1 for low coverage, 2 for medium coverage, 3 for high coverage). The score generated by category was later standardized between 0 and 1 in order to allow for cross comparison.

67. In an effort to track the trend of strengthening services, as required under the Sustainable Development Goal target, information was used from Member States that had provided responses to the questionnaire during the three cycles of reporting (2010-2011, 2012-2013 and 2014-2015). The number of countries providing such information during the three cycles was about 60, or roughly 70 per cent of the Member States reporting in each cycle (45 of which provided data on the questions). Those 60 countries were mostly from Europe, Asia and the Americas (42 per cent, 30 per cent and 21 per cent, respectively).

68. The composite scores generated indicated firstly that the strengthening of treatment responses was about 0.6, on a scale ranging from 0 to 1, with no real progress achieved on strengthening drug treatment service since the first reporting cycle. Secondly, the gap between services at the community level and in prison settings remained wide, despite the slight progress noted on strengthening services in prison settings compared with the first wave. There did not seem to be an indication of any significant closing of that gap since 2010. Thirdly, within the services that were available at both the community level and in prison settings, pharmacological interventions remained the weakest services both in terms of availability and coverage, as compared with other services (see figures VI and VII).

Figure VI

Standardized composite score, by treatment service category in the community, by reporting cycle

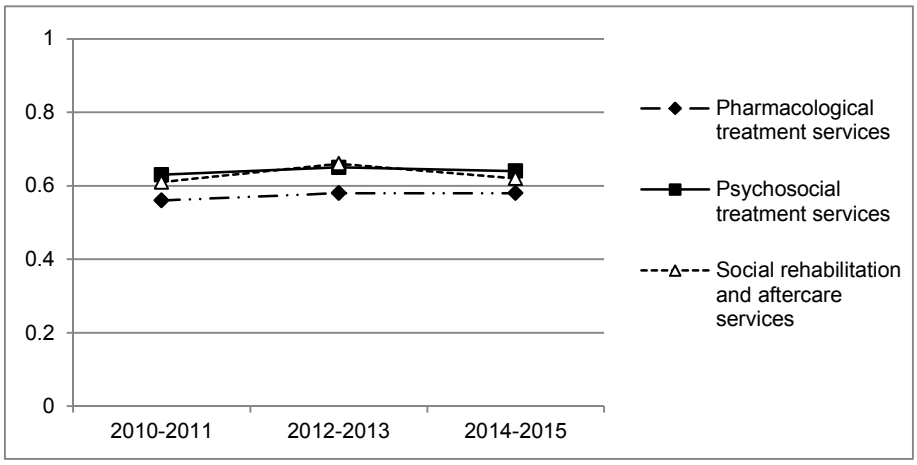
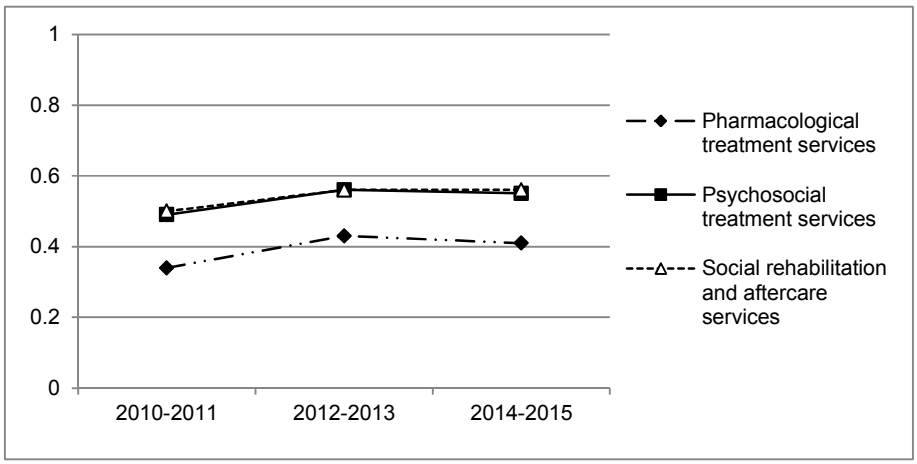


Figure VII
Standardized composite score, by treatment service category in prison settings, by reporting cycle



69. The gap between the availability of services at the community level and in prison settings was evident in the three geographical regions most represented in the responses. Notwithstanding that gap, the composite indicator showed a higher score across categories of treatment services and a better equity between community and prison-based services in Europe compared with Asia and the Americas. Countries in Asia and the Americas reported a lower availability of pharmacological services compared with the other two categories of services. A possible reason for that was the nature of the predominant drug problem in each region (pharmacological support being more present in continents with a predominant opioid problem). Nevertheless, that does not explain the discrepancy and wide gap between the availability of pharmacological services in the community and in prison settings in the same region (see figures VIII-XIII).

Figure VIII
Standardized composite score, by treatment service category in community settings, by reporting cycle: Americas

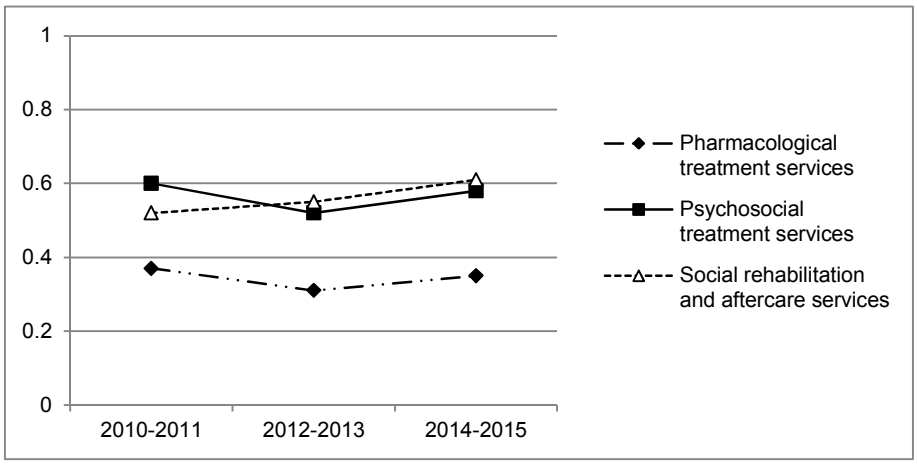


Figure IX
Standardized composite score, by treatment service category in prison settings, by reporting cycle: Americas

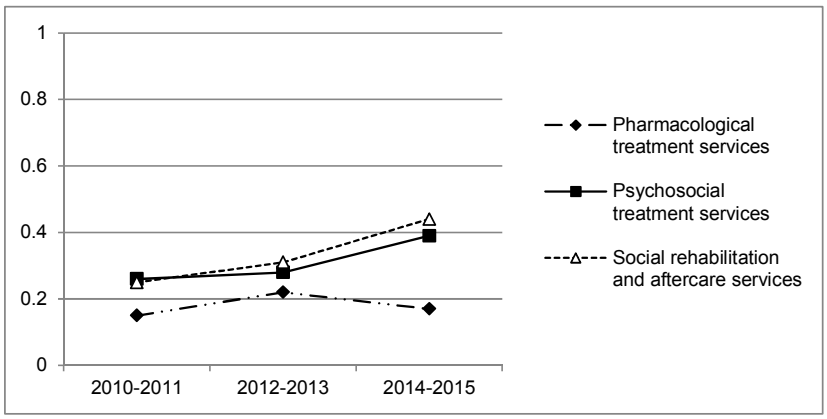


Figure X
Standardized composite score, by treatment service category in community settings, by reporting cycle: Asia

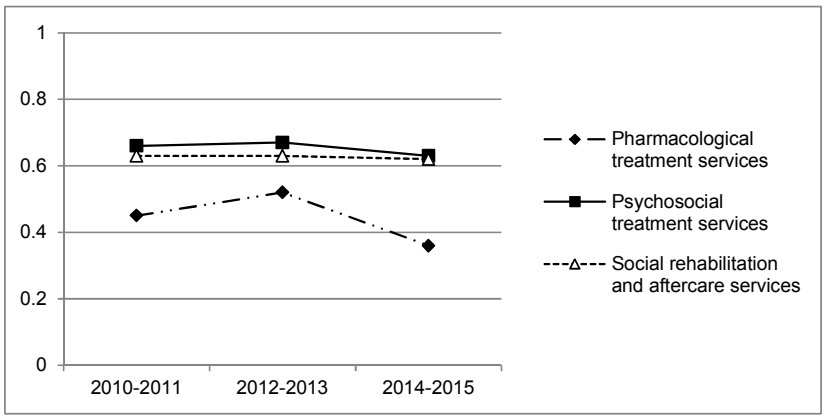


Figure XI
Standardized composite score, by treatment service category in prison settings, by reporting cycle: Asia

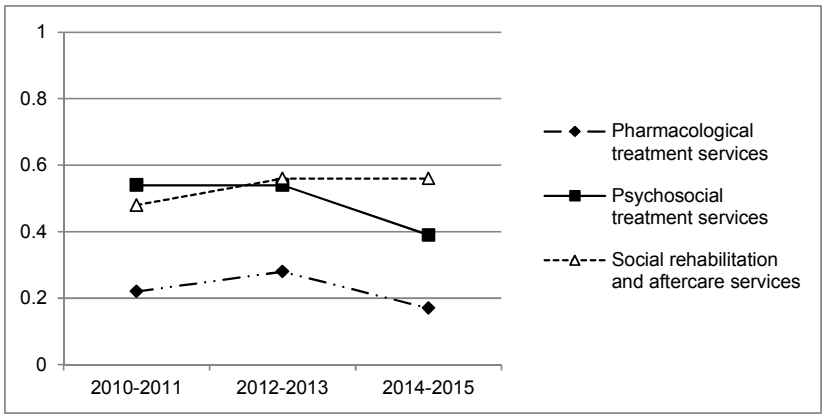


Figure XII
Standardized composite score, by treatment service category in community settings, by reporting cycle: Europe

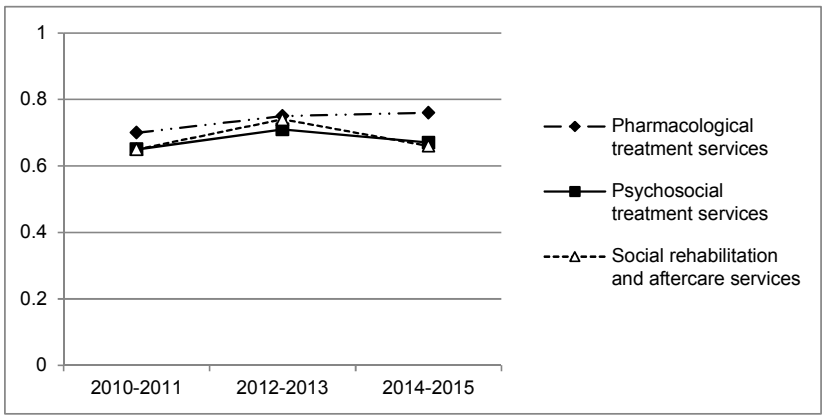
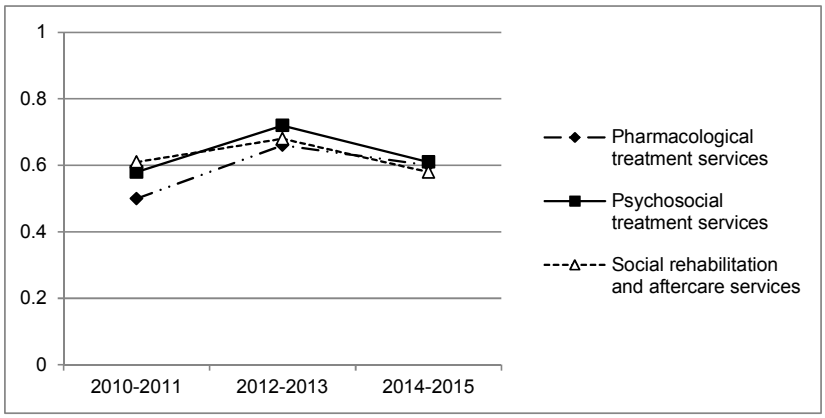


Figure XIII
Standardized composite score, by treatment service category in prison settings, by reporting cycle: Europe



70. The analysis was repeated for drug prevention services using an analogous composite score that merged information on availability and coverage of interventions. The only distinction was in the categorization of the services, which was made according to the *International Standards on Drug Use Prevention*:

(a) Services with no or limited evidence of efficacy (provision of alternative activities, dissemination of information on the dangers of drugs, media-based campaigns, vocational training and income generation support);

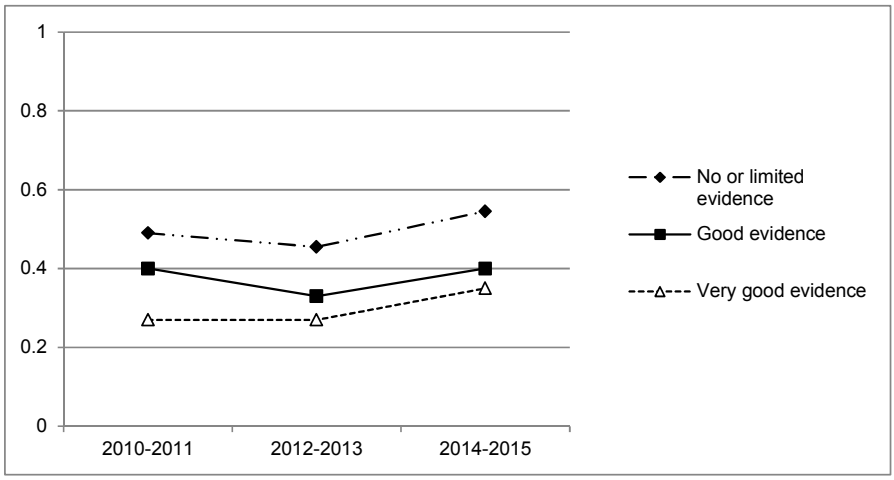
(b) Services with a good level of efficacy (life skills education in schools and workplace drug prevention programmes);

(c) Services with a very good level of efficacy (family and parenting skills training, screening and brief interventions).

71. The prevention standardized composite score indicated a lower availability of prevention services compared with treatment services. Moreover, prevention

services with very good evidence of efficacy scored the lowest, despite the slight progress noted in the third reporting cycle. They were followed by services with a good evidence of efficacy. The services with no or limited level of evidence of efficacy scored highest on the composite score. Those results varied slightly across reporting cycles (see figure XIV).

Figure XIV
Standardized composite score for prevention services, by level of efficacy according to the *International Standards on Drug Use Prevention*, by reporting cycle



72. Furthermore, an attempt was made to generate standardized composite scores for services aimed at preventing infectious diseases among people who inject drugs. Those services were categorized as follows:

(a) Comprehensive package for people who inject drugs according to the *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* (response categories for question 15 of the annual report questionnaire);

(b) Minimum required package of interventions (needle and syringe programmes, HIV testing and counselling, antiretroviral therapy and opioid maintenance therapy);

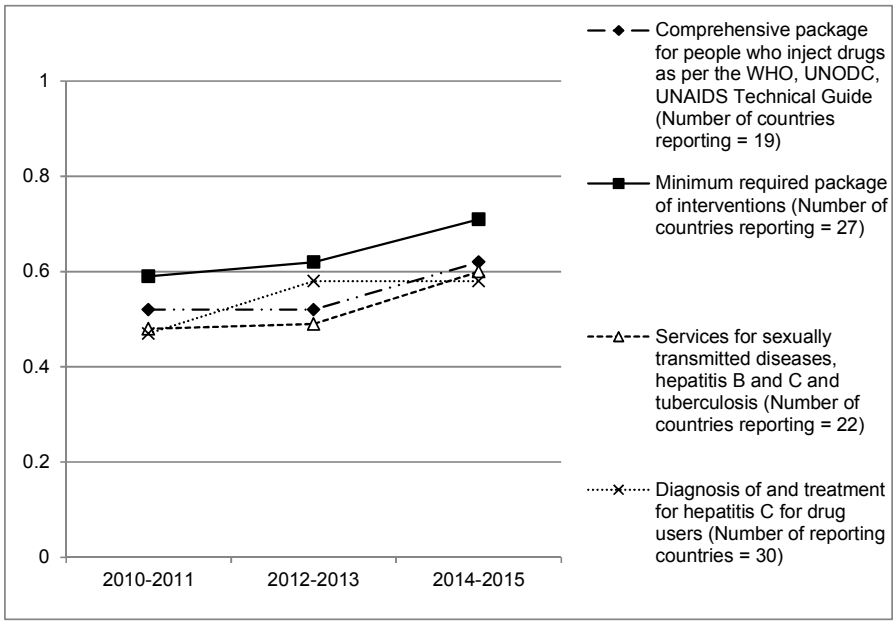
(c) Services for the prevention and treatment of and care for those with sexually transmitted diseases, hepatitis and tuberculosis (screening and treatment of drug users for sexually transmitted diseases; condom distribution programmes; targeted information/education/communication programmes about HIV, hepatitis B and C and other sexually transmitted diseases; diagnosis and treatment of and vaccination for viral hepatitis B; diagnosis and treatment of viral hepatitis C; and prevention of and treatment for tuberculosis);

(d) Diagnosis and treatment of viral hepatitis C for drug users.

73. Owing to the higher number of missing responses on such services, the number of countries for which a composite score could be generated ranged between 19 and 30 countries, depending on the category. Despite that gap, and much

like for drug treatment services, the standardized score was about 0.6, on a scale from 0 to 1, with a slight indication of improvement across reporting cycles. On another positive note, the minimum required services seem to fare slightly better compared with the other categories (see figure XV).

Figure XV
Standardized composite score, by service for the prevention of diseases (including infectious diseases), in community settings, by reporting cycle (Number of countries reporting = 60)



V. Conclusions and recommendations

74. Globally, the nature of drug use is multifaceted and evolving, with the emergence of an ever increasing number of new psychoactive substances and the misuse of prescription drugs. However, there is limited information on the extent of use of those new psychoactive substances. The use of drugs such as heroin and cocaine remains stable or is showing signs of decreasing in many parts of the world. All of these new developments need to be closely monitored in the different regions.

75. Overall, the use of opioids continues to present a major public health concern in terms of overdose cases, drug-related deaths, injecting drug use and the transmission of infectious diseases.

76. There is limited objective information available on the extent and patterns of and trends in drug use, especially in the regions where it is perceived to be increasing or evolving. Data have shown that countries that have set up drug use monitoring systems are in a better position to address their drug use situation in an effective manner.

77. Accordingly, Member States are encouraged to provide the Office with timely and complete responses to the annual report questionnaire in order to enhance the

quality and quantity of reports and thereby enhance the global and regional assessments of the drug use situation and progress made by Member States on their responses to it.

78. The information available from Member States indicates that there is still a large gap to fill in order to make a comprehensive set of drug treatment services (pharmacological, psychosocial and rehabilitation/social reintegration) available in order to appropriately address the needs of people with substance use disorders. This gap in the provision of services is significantly more concerning in low- and middle-income countries.

79. Inequality exists in the availability of services in the community and in prison settings, meaning that people in the criminal justice system are likely to experience an interruption in their treatment, in violation of their right to health care. Significant progress is needed to allow patients to gain access to services, in particular pharmacologically assisted services.

80. For prevention services, significant efforts need to be put in place for services for which evidence of efficacy exists, in line with the *International Standards on Drug Use Prevention*.

81. There is unambiguous evidence that needle and syringe programmes and opioid substitution therapy are effective in reducing the sharing of injecting equipment and in averting HIV infections. There is also compelling evidence of the cost-effectiveness of each of the three core interventions for people who inject drugs, with the average saving per HIV infection averted ranging from $100 to $1,000. However, the coverage of those core interventions is currently too low across almost all the regions to have an impact on the spread of new HIV and other blood-borne infections, such as hepatitis C, among people who inject drugs. It is strongly suggested that the three interventions are urgently scaled up, in combination with expanded HIV testing and counselling services in communities and in prisons and other closed settings.

82. Besides its value for assessing the drug use situation and the progress made on the implementation of the Political Declaration and the Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, the annual report questionnaires have the potential to be used to monitor progress made by Member States on targets under Sustainable Development Goal 3.

83. In that regard it is suggested that Member States take into consideration the existing gaps on the availability and quality of data on drug use indicators, and that they consider strategies to strengthen countries' capacity to collect, analyse and disseminate data related to drug use and its consequences. Those strategies may include advocating and supporting the development of drug monitoring systems through the capacity-building of experts, as well as generating estimates of drug use indicators in countries where large gaps remain, developing cost-effective methods for estimating the extent of drug use by increasing synergies with other existing data-collection systems, and providing resources to set up or strengthen drug monitoring systems and to build capacity in priority regions.