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Drug demand reduction: World situation with regard to drug abuse

World situation with regard to drug abuse

Report of the Secretariat

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I. Introduction

1. This report provides an overview of trends in drug abuse for the period 1998-2003, based on responses received from Member States through part II of the annual reports questionnaire (E/NR/2003/2). The report also contains an overview of the world situation with regard to treatment demand to assess the progress made towards achieving the objectives of the Political Declaration adopted by the General Assembly at its twentieth special session (Assembly resolution S-20/2, annex) and the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction (Assembly resolution 54/132, annex).

2. Since 1998, the reported drug abuse trends have been as follows:

(a) Abuse of cannabis has increased in most of Asia, Africa and Europe, while remaining stable or decreasing in the rest of the world;

(b) Abuse of opioids has decreased in Europe and Oceania, while increasing in most of Asia. In North America, the trend is stable;

(c) Recent trends suggest that cocaine abuse is stable in the Americas, although it is still widespread. Increasing cocaine abuse in Europe is becoming problematic;

(d) Abuse of amphetamine-type stimulants (ATS) has increased in Asia and Europe since 1998. In North America and Oceania the trend is stable.

3. Regarding the demand for treatment, the major issues are:

(a) Globally, the abuse of opioids and cocaine still account for the majority of cases involving treatment for drug abuse, but the abuse of ATS and cannabis is being regarded more and more often as the primary reason for seeking treatment;

(b) The mean age of people requiring treatment varies between 27 and 29 years. However, demand for treatment by young cannabis users under 20 years of age is increasing in many regions;

(c) Men account for the majority of the drug abusing population and of those persons seeking treatment for drug abuse in all regions. Women experience difficulties in utilizing specialized treatment services in many regions;

(d) Gender differences are smaller with regard to the use of ATS but larger with regard to the abuse of cannabis and opioids;

(e) Overall, there is a lack of standardized treatment data—data based on harmonized methods and concepts.

II. Drug abuse trends in 1998-2003

4. Member States have been requested each year to report in the annual reports questionnaire increasing, stable or decreasing trends with regard to the abuse of different drug types among their general population (persons aged 15-64) on a five-point scale (large increase, some increase, no great change, some decrease, large decrease). Though the reported information, which is based on expert opinion,

has its limitations, it is that information which most countries have provided in a relatively consistent manner over the years.

5. Other information requested in the annual reports questionnaire (prevalence among the general population, school population, demand for treatment etc.) is not always available for different years or may be difficult to use for comparative purposes. That problem requires serious consideration by the Commission and it needs to be taken into account in the process of monitoring progress since 1998.

6. In the absence of a comprehensive data set on drug abuse prevalence, the present report quantifies expert opinion to show regional trends. The Weighted Analysis on Drug Abuse Trends (WADAT), presented to the Commission for the first time in 2004, has been used for weighted estimations of regional trends in consideration of different population sizes in reporting countries.[1] However, there are limitations that need to be taken into account when interpreting the results:

(a) The information is provided as expert opinion and it may not adequately reflect actual trends;

(b) The difference between various degrees of drug abuse trends (for example, between "some decrease" and "large decrease") may not be interpreted in the same way in different countries or even in the same country in different reporting years;

(c) Reporting trends in the abuse of a drug type, such as ATS, may be affected by differing trends in the abuse of different substances (Ecstasy abuse may be increasing while amphetamine abuse is decreasing).

7. The present report provides only the general directions with regard to the main drug types reported by Member States, inevitably leading to broad generalizations. Sometimes the experience of one or two countries in each region may differ from the overall regional trend. Thus, there is a need for more drug-specific trend analysis to support its conclusions. However, irrespective of such caveats, the overall results—wherever comparison with other indicators could be made—were found to be basically in line with the indicators.

8. The analysis of opinions of informed national experts allows a broader basis for trend analysis in the situation, since most countries still do not have the capacity to provide data on illicit drug abuse based on population surveys or prevalence estimation studies.

9. The overview on drug abuse trends in the period 1998-2003 is based on a number of annual responses, the global response rate varying between 40 and 60 per cent.[2] The response rates with regard to 2003 are presented, by region, in table 1.

Table 1
Responses to the 2003 annual reports questionnaire (part II), by region

Region	*Questionnaires distributed*	*Questionnaires returned*	*Countries and territories responding (percentage)*
Central, South and South-West Asia	14	9	64
East and South-East Asia	16	13	81
Europe	48	39	81
Latin America and the Caribbean	32	16	50
North Africa and the Middle East	18	9	50
North America	3	2	67
Oceania	14	3	21
Sub-Saharan Africa	47	18	38
Global	**192**	**109**	**57**

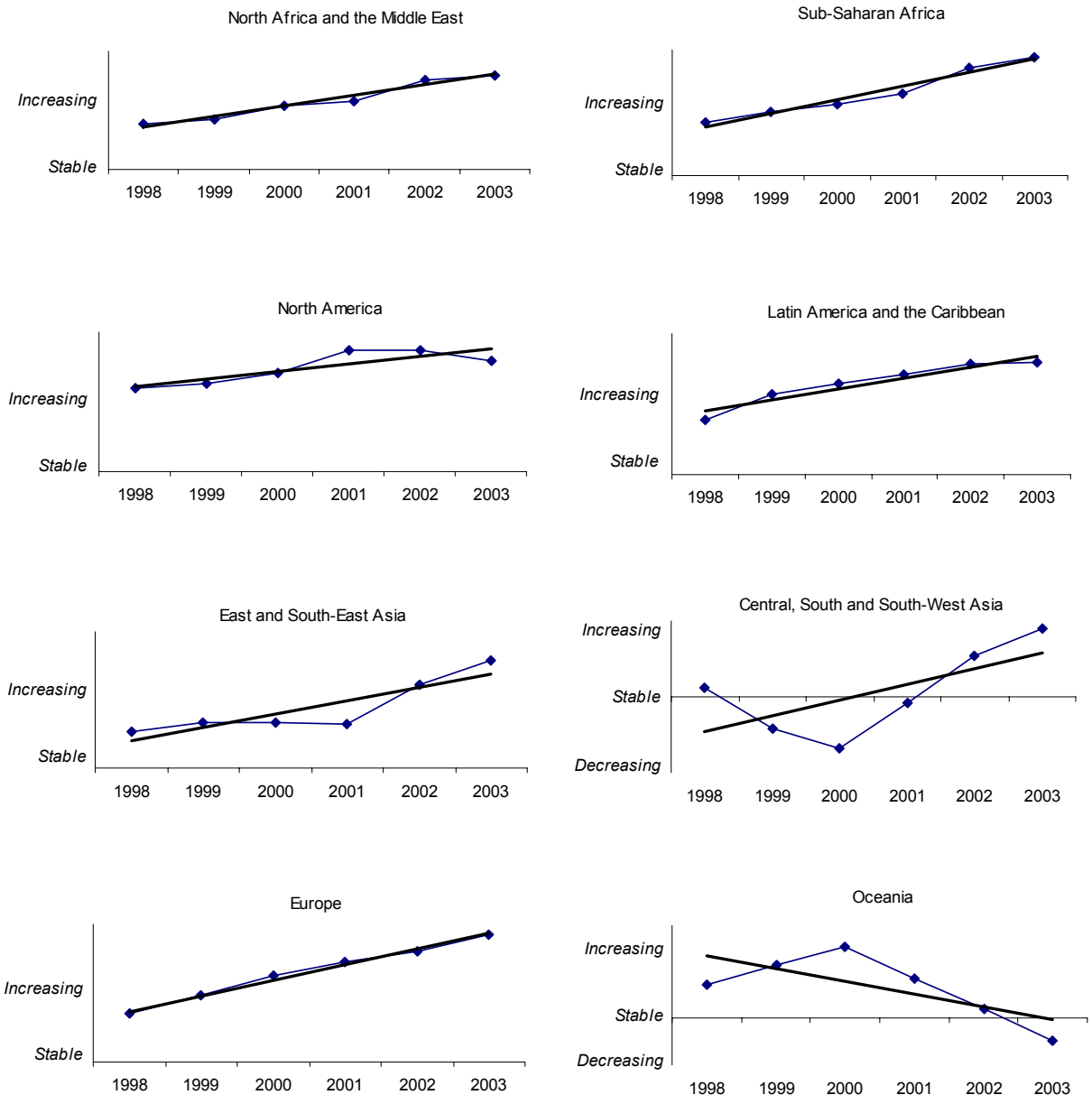
A. Cannabis

10. Cannabis remains the most abused illicit drug worldwide. In terms of overall trends, the level of cannabis abuse appears to have increased in most regions since 1998. However, in some regions where prevalence among the general population is high (for example, in North America), the trend is decreasing or stabilizing. In Asia, North Africa and the Middle East, Sub-Saharan Africa and Europe, the trend in the abuse of cannabis is on the increase (see figure I).

B. Opioids

11. Reports from Europe and Oceania indicate decreasing levels of abuse of opioids, while in North America the trend appears to be stable. Even if heroin is still the primary drug of concern in most Eastern European countries, fewer countries in the region reported an increasing trend than a stable or decreased trend in the abuse of opioids in 2003. Some increases were reported in countries where opioids have traditionally not accounted for the majority of drug problems, such as countries in Sub-Saharan Africa (see figure II). Of particular concern are the countries of Asia, in particular Central Asia, where injecting of opioids has been rapidly spreading in the past few years. It should be noted, however, that the trends in Asia can partly be explained by increases seen in China and India (because the system used to calculate trends is in relation to the size of the population of each country). That is confirmed also when looking at the global situation: if China and India are excluded from the analysis, the global trend in the abuse of opioids seems to be decreasing.

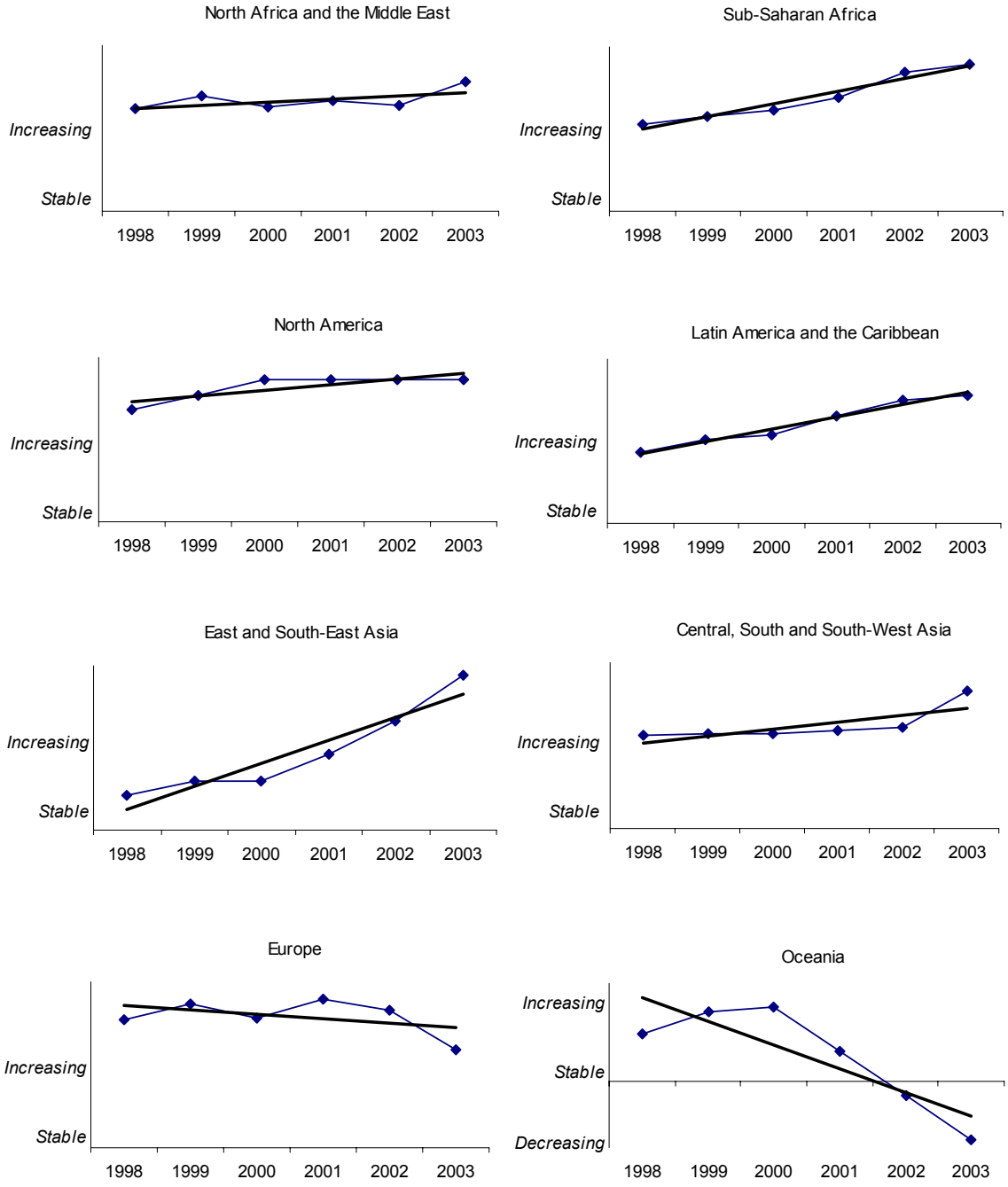
Figure I
Trends in cannabis abuse, by region, 1998-2003



Source: Annual reports questionnaire.

Note: National trend estimates weighted by population size.

Figure II
Trends in the abuse of opioids, by region, 1998-2003



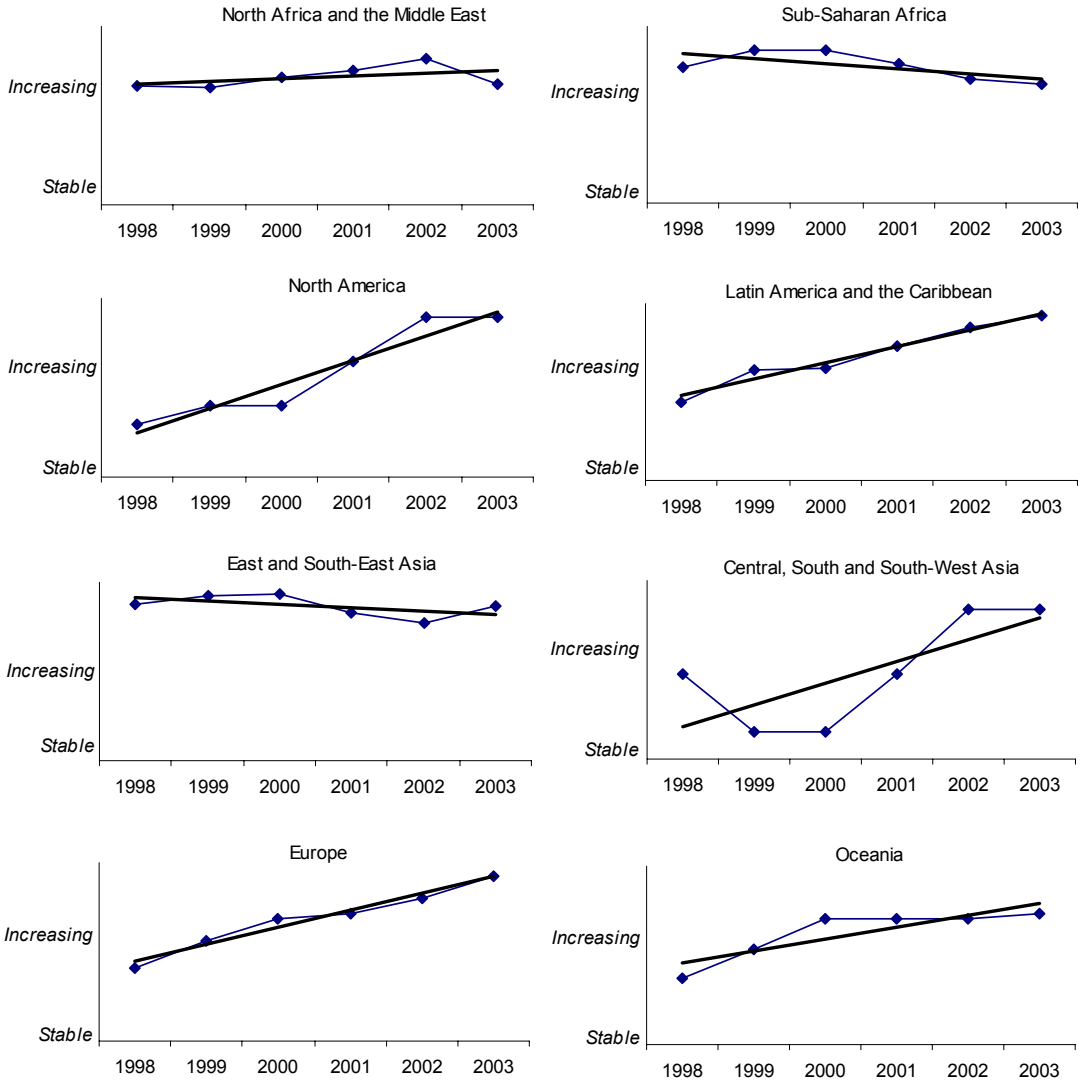
Source: Annual reports questionnaire.

Note: National trend estimates weighted by population size.

C. Cocaine

12. Trends in cocaine abuse show some stabilization in its main regions of consumption, North America and Latin America. In the Caribbean, crack cocaine, in particular, remains a cause of concern. Nearly half of the responding countries in Europe have reported a rising level of cocaine abuse. In Africa, the indicators for cocaine abuse show an overall decrease since 1998; however, the trend appears to have been stable in the past two years. In East and South-East Asia, after a period of decreasing abuse of cocaine, an increase was reported in 2003. In Oceania, the situation with regard to abuse of cocaine remains rather stable (see figure III).

Figure III
Trends in cocaine abuse, by region, 1998-2003

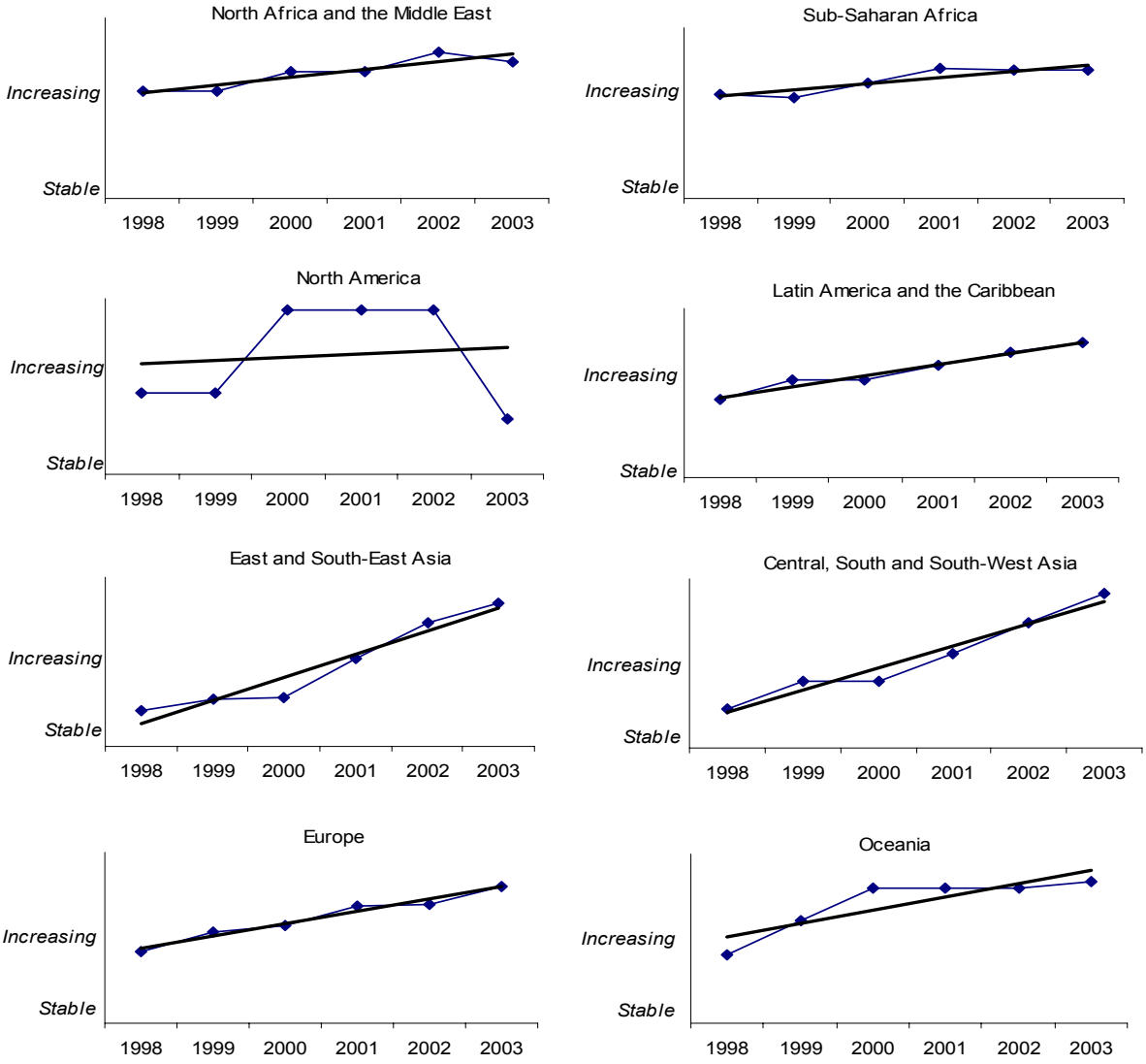


Source: Annual reports questionnaire.
Note: National trend estimates weighted by population size.

D. Amphetamine-type stimulants

13. In East and South-East Asia, although there are still relatively high levels of prevalence and widespread use of ATS among the general population, without the impact of an increasing trend in China, with its vast population, the regional trend in ATS abuse would appear to be somewhat stable. With regard to the other main regions of ATS abuse, the trend indicates an increase in Europe, while showing some stabilization in Oceania (see figure IV). In North America, the trend has been reported to be decreasing. Some responding countries in Africa and the Middle East have also indicated increasing abuse of ATS during the past few years.

Figure IV
Trends in the abuse of amphetamine-type stimulants, by region, 1998-2003



Source: Annual reports questionnaire.
Note: National trend estimates weighted by population size.

III. Drug abuse treatment

14. In order to allow a comprehensive assessment of the progress made towards achieving the objectives of the Political Declaration adopted by the General Assembly at its twentieth special session, the Secretariat will be reporting on the world drug abuse situation with a focus on key epidemiological indicators for the period 1998-2008. In the present report, the focus is on treatment demand data; in the report for 2006 the focus will be on prevalence among youth and in the report for 2007 it will be on the general population.

15. Treatment demand data are important in assessing the extent and nature of the abuse of illicit drugs. They serve both as a direct measure of the demand for treatment services and an indirect measure for assessing drug abuse trends using prevalence estimation techniques. Many countries collect data on the activities and characteristics of drug treatment services and their clients in order to inform planning and develop policy in the area of drug demand reduction, although the concept and the modalities of drug treatment may vary between countries. The utilization of services for drug problems (the number of individuals seeking help for drug problems) has also been identified as a key epidemiological indicator of drug demand for effective drug information systems, used to monitor the situation and trends with regard to drug abuse.

16. In considering the strengths of treatment demand data and their potential uses, it is also important to recognize their inherent limitations. Firstly, because of the time lag between the first use of illicit drugs and the first need for treatment (often amounting to several years), treatment demand data cannot serve as an indicator for the most recent developments in drug abuse.

17. Secondly, the drug abuser population covered by treatment demand data is dependent on the availability and accessibility of treatment services in different countries. Such data exclude those drug abusers who are not reported by treatment facilities, those who are admitted to facilities but do not participate in the reporting system, those not admitted to any treatment facility and those who have not yet experienced drug abuse problems. Because drug abusers often attend different treatment centres in the course of a year, there is a risk of double counting, thus overestimating the total number of people seeking treatment for their drug problems. Such a bias is avoidable by using specific techniques, such as anonymous identifiers, but the solution is not always feasible or acceptable.

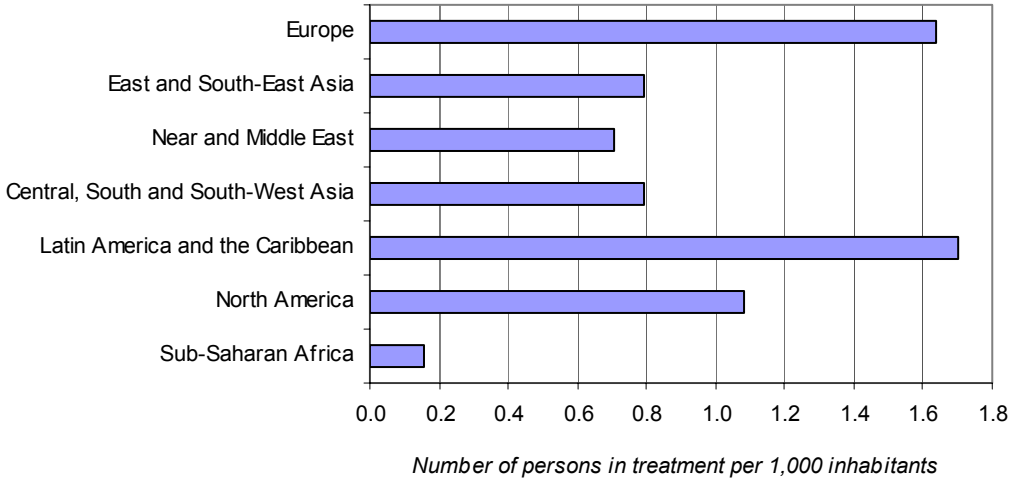
18. Thirdly, there are still many inconsistencies within and between systems in terms of definitions, and clarity is required over which items can be harmonized. With regard to international comparisons, it should be noted that not all countries have individual treatment data and, where standard instruments exist, not all countries collect the full data set. The variety of treatment systems, as well as the differing methods of organizing and financing also influence the availability and quality of treatment demand data and frequency of reporting.

19. Figures V-IX are based on the latest data on treatment demand as reported by States through the annual reports questionnaire during the reporting years 2001-2003. The figures are presented for those regions for which the available data allow a reasonable regional presentation. The comparison between the regions should be interpreted with caution because of the limitations referred to above.

A. Demand for treatment

20. In many regions, data on demand for drug abuse treatment are the main type of data that are routinely available on drug abuse. The number of persons receiving such treatment per 1,000 inhabitants (aged 15-64) (see figure V) is very much influenced by the availability and accessibility of specialized treatment services in different countries and may appear low even if actual demand for drug abuse treatment in a region exists.

Figure V
Number of persons in treatment for drug abuse per 1,000 inhabitants aged 15-64, by region, latest estimates available



Source: Annual reports questionnaire.

21. Demand for drug abuse treatment is on the increase in Latin America and the Caribbean. Cocaine and cannabis have traditionally been the drugs that account for the majority of treatment admissions. However, there are considerable differences in the availability of specialized treatment services for drug abuse among countries. In Peru, the number of people receiving different types of treatment and rehabilitation services has been steadily increasing, and doubled between 2001 and 2002.

22. With regard to North America, the total number of treatment admissions in the United States of America has been fairly stable over the past decade. In Mexico, the prevalence of cocaine abuse is on the increase: cocaine accounts for the majority of treatment admissions, and the number of people attending treatment facilities for cocaine abuse is rising. The actual number of people in need of such treatment has been estimated to be as much as seven times higher than that shown in treatment data.[3]

23. Most of the countries in South-West and Central Asia have reported an increase in demand for treatment for the abuse of drugs, especially opioids, over the past few years. For example, in Kazakhstan, the total number of drug abusers who received treatment in 2003 reflects an increasing demand over the previous years. In

Tajikistan, however, there has been over the past two years a decline in the number of persons receiving treatment for drug abuse.

24. In Sub-Saharan Africa, the treatment data collection and reporting systems are mostly lacking, and the availability of treatment and rehabilitation services in general is lower than in the other regions. That needs to be taken into consideration when the low number of people in treatment in the region is compared with the situation in other regions. The most representative treatment data are reported through the Southern African Development Community (SADC) Epidemiology Network on Drug Use (SENDU). In the countries covered by SENDU, there was an overall increase in the demand for treatment for illicit drug abuse in 2003. In particular, in Mauritius, Mozambique, Namibia, South Africa, Swaziland, the United Republic of Tanzania and Zambia, there seems to be demand for treatment for the abuse of a greater range of substances than in the other countries covered by SENDU.

25. In the Near and Middle East, only a few countries have collected and reported treatment data in a standard, systematic manner. Some national experts hold the opinion that treatment demand is increasing in the region. In Lebanon, the number of people seeking treatment for drug dependence nearly doubled between 2001 and 2003. On the other hand, the United Arab Emirates reported a reduction in the number of cases treated since 2001.

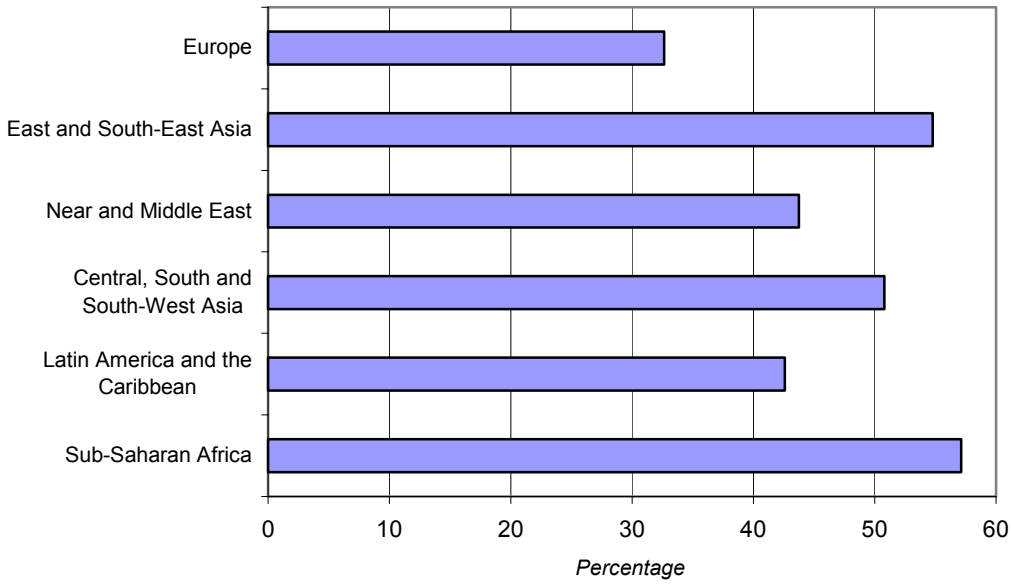
26. In Australia, the trend in the number of people receiving treatment for drug problems has been on the increase over the past few years. In New Zealand, there has been some increase in treatment for the abuse of cannabis, methamphetamine and opioids other than heroin. Treatment for drug problems primarily related to heroin, cocaine, amphetamine and Ecstasy use was stable in 2003.

27. Comparing the number of people receiving treatment for drug abuse (see figure V) with the number receiving treatment for the first time (see figure VI) provides an indication of more recent or emerging trends in drug problems. For example, the proportion of people being treated for the first time appears markedly high, over 50 per cent, in Sub-Saharan Africa and East and South-East Asia, while the number of people in treatment (per 1,000 inhabitants aged 15-64) has remained relatively low. This seems to be indicative of a growing drug problem, as well as possible improvement in the coverage of services.

28. In East and South-East Asia, most countries have reported an increasing number of new abusers of ATS (predominantly methamphetamine in tablet form), and more abusers of other substances have been reported to have added ATS to their polydrug patterns of abuse. National trends may, however, appear different from the regional situation because of differences in patterns of abuse. For example, in China, where opioids and cannabis still account for the majority of drug problems, the incidence of new drug abusers reported by the treatment institutions nationwide has been reported to be decreasing substantially both among males and females since 2001.

29. Central, South and South-West Asia, as a region, has one of the highest proportion of new clients receiving treatment for drug abuse. In Pakistan, for example, of all those who received treatment for their drug problems in 2003, more than two thirds received treatment for the first time. In Kyrgyzstan, nearly half of the inpatient treatment admissions in 2003 were new cases.

Figure VI
People treated for the first time for drug abuse as a percentage of all those receiving treatment for drug abuse, by region, latest estimates available



Source: Annual reports questionnaire.

30. In Europe, an increasing trend in the total number of people entering treatment services has continued. That increase could be partly attributable to improvement in the reporting system and in the availability of treatment services throughout the region. However, the proportion of people entering treatment for the first time appears to be stable and, in general, lower than in the other regions.[4]

B. Primary reason for receiving treatment

31. For many countries, some of the data are based on treatment admissions; some countries have national registries of people undergoing treatment for drug abuse. While the treatment demand data may be disaggregated by drug type, there are differences in using the concept of primary drug for seeking treatment for drug problems. The concept, which defines the illicit drug that causes the patient the most problems, is of great importance for implementing more effective treatment intervention. Standardized use of the concept would result in increased comparability with regard to the importance of different drug types for treatment in different regional settings.

32. In Sub-Saharan Africa, as in many other regions, the lack of standardized, routinely collected treatment data impedes efforts to monitor trends in illicit drug use. Of the 18 countries of Sub-Saharan Africa that responded to the questionnaire, 5 countries reported an increase in the number of people receiving treatment primarily for cannabis use (Ethiopia, Mauritius, Namibia, Seychelles and Zambia), and 4 countries reported an increase in demand for treatment primarily for heroin

use (Mauritius, Seychelles, South Africa and Zambia). The proportion of patients for which cannabis was their primary drug of abuse varied greatly in 2003, ranging from 4 per cent in Namibia to 85 per cent in Malawi.

33. Prevalence of injecting drug abuse remains relatively low throughout Southern Africa. Of the countries in the region, Mauritius has the largest proportion of patients in treatment whose primary drug of abuse is heroin (over 90 per cent), over half of them having injected the drug. In Mozambique and South Africa, the number of patients for whom heroin was their primary substance of abuse has increased over the past few years. In Sub-Saharan Africa, demand for treatment for problems related to the use of cocaine is mainly confined to Namibia and South Africa and, to a lesser extent to Mozambique and Zambia, with some increases being noted in those countries. The number of cases in the region in which ATS abuse was cited as the primary reason for seeking treatment has remained low.

34. In North Africa and the Middle East, heroin and cannabis are the illicit substances most regularly cited as the primary reasons for persons receiving treatment for drug problems (see figure VII). Other frequently reported substances include amphetamines, while treatment for cocaine dependence has been reported in some countries, including Lebanon, Morocco, Tunisia and the United Arab Emirates.

35. In North America, cocaine, especially crack cocaine, continues to be a major problem in most areas, despite some stabilization in recent years. While the number of admissions primarily for treatment of cocaine abuse has declined in the United States since 1992, such admissions continued to account for the highest share of the admissions for the treatment of all drug problems in nearly half of the reporting areas, ranging between 40 and 53 per cent of all admissions. Since 1992, there has been an increase in the number of admissions primarily for the problems involving opioids, cannabis and stimulants. However, in 2003, heroin indicators remained relatively stable, although they remained at a high level in the north-eastern and mid-Atlantic areas, where high-purity heroin powder from South America is available.

36. There has been a substantial long-term increase in admissions for the treatment of cannabis abuse among the adolescent population in the United States. Between 1992 and 2002, treatment admissions of adolescents for whom cannabis was the primary substance of abuse increased from 23 to 64 per cent, while in the same period treatment admissions of adolescents reporting alcohol as the primary substance of abuse decreased from 56 to 20 per cent of all treatment admissions of adolescents for the abuse of substances.

37. Methamphetamine abuse has continued spreading rapidly into new populations in the United States, and it has been reported that abusers of other drugs have switched to methamphetamine. Indicators for Ecstasy have, however, not increased. The primary methamphetamine and amphetamine treatment admission rate has increased from 10 to 52 admissions per 100,000 inhabitants aged 12 years or older between 1992 and 2002, with nearly one fourth (23 per cent) reporting injection as their route of administration in 2002.[5, 6]

Figure VII

Drugs reported as the primary reasons for persons receiving treatment for drug problems, by region, latest estimates available

Source: Annual reports questionnaire.

38. In Latin America and the Caribbean, cocaine was reported as the primary reason for receiving treatment for drug problems in seven countries (Chile, the Dominican Republic, El Salvador, Guyana, Haiti, Trinidad and Tobago and Venezuela) and cannabis in four countries (Argentina, the Bahamas, Ecuador and Grenada). In Brazil, increasing cocaine abuse among adolescents is a growing problem, placing greater demand on the treatment services.

39. In East and South-East Asia, there is an urgent need for specialized treatment and rehabilitation services to address the increased demand for treatment of the rapidly increasing ATS abuser population in the region. ATS is the most abused class of drugs in Cambodia, Japan, the Philippines, the Republic of Korea and Thailand; in China, Indonesia, Malaysia, Mongolia, Myanmar and Viet Nam, it ranks after opioids and/or cannabis. In Japan, methamphetamine is the primary drug of abuse for 51 per cent of the people entering drug abuse treatment facilities in 2003. The Philippines has experienced a slow but steady increase in the number of treatment admissions over the past five years, mostly for methamphetamine use. In Thailand, methamphetamine abuse has increased since the mid-1990s, becoming the

drug of abuse for which most treatment is sought. In some countries, for example, Indonesia, Japan and Myanmar, recent trends in demand for treatment appear to be fairly stable.

40. Despite the increasing prevalence of ATS abuse, demand for treatment for the abuse of opioids is still predominant in many countries of East and South-East Asia. In China, Malaysia and Myanmar, for example, the vast majority of patients seek treatment for abuse of heroin or opium. In China, ATS have only recently become part of the polydrug patterns of abuse, and the abuse of opioids, heroin in particular, accounts for the overwhelming majority (96.8 per cent) of cases involving treatment for drug problems.[7, 8]

41. In Central, South and South-West Asia, most of the treatment is being sought for problems related to the abuse of opioids, heroin in particular. In Central Asian countries, the proportion of primary heroin users among those seeking drug treatment commonly ranges between 60 and 95 per cent. In most cases, they are injecting drug users. In India, the most common drugs abused by people seeking treatment are cannabis, heroin and opium. The proportion of cannabis abusers doubled between 1997 and 2000 in India, but it has been stable in recent years. In contrast, demand for treatment indicates recent increases in treatment for the abuse of heroin and opium, which had been declining at the end of the 1990s. The prevalence of ATS and cocaine abuse has remained low in India, as reflected in demand for treatment for the abuse of those substances.[9]

42. In Europe, opioids, cannabis and cocaine are most frequently recorded as either the primary or secondary reason for being admitted to treatment for drug problems, with notable differences between countries. In most countries, opiates (largely heroin) continue to be the drug for which persons seek treatment most often, accounting for between 40 and 90 per cent of all treatment admissions in Europe. With the notable exception of new European Union member States, there are signs of a decreasing level of injecting among heroin users in some countries, in particular, among new clients attending drug abuse treatment facilities.

43. Cannabis is the second most frequently mentioned drug in Europe, in particular, among entering treatment for the first time: cannabis is reported to be the primary drug problem of nearly one third of such new admissions. Cocaine is the third most common drug of abuse reported by those entering drug abuse treatment facilities, accounting for around 25 per cent of new admissions. In the new member States of the European Union, the demand for treatment of problems involving cocaine use remains low. The use of stimulant drugs other than cocaine appears to be less commonly cited as a reason for attending treatment in most European countries.[4]

44. In the Russian Federation, heroin use accounts for the overwhelming majority (88 per cent) of the cases involving treatment for illicit drug use. The number of cases where the abuse of other substances is cited as the primary reason for seeking treatment remains low. However, there has been an increasing number of people receiving treatment primarily for cannabis use in specialized drug abuse treatment centres and psychiatric institutions.

45. In Australia, the abuse of heroin, cannabis and amphetamines was reported to be the primary reason for receiving treatment in 2003. There is a large number of people in non-residential treatment in Australia, and the actual number of people

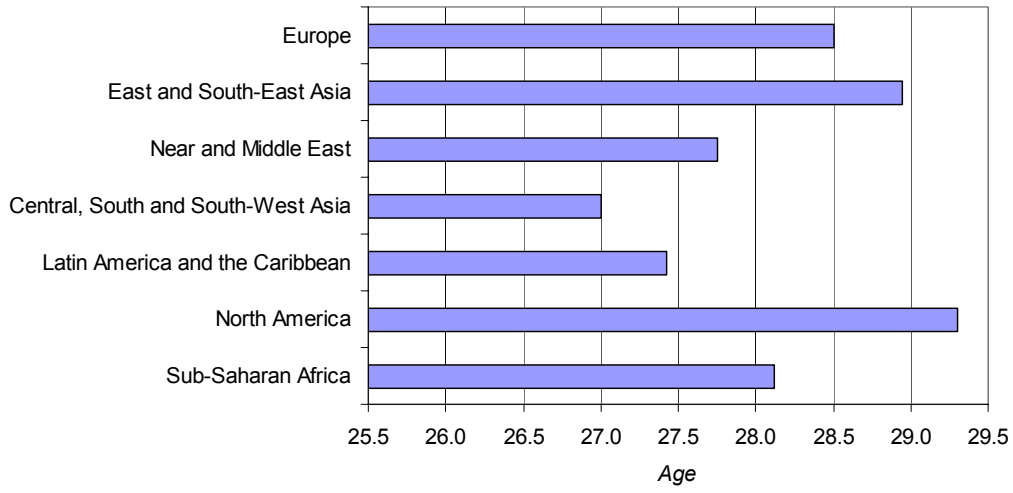
being treated on an outpatient basis could be 5-10 times the number of those receiving treatment in specialized residential settings, depending on the frequency of their visits to a treatment agency.

46. While in Australia cannabis use continues to be the primary and most widespread illicit drug abused, the increasing abuse of synthetic drugs, such as methamphetamine and Ecstasy, may become a significant challenge for drug abuse treatment systems in Australia.[10] In New Zealand, cannabis accounts for most of the demand for drug abuse treatment, while a recent survey focusing on the use of methamphetamine revealed that the number of people seeking treatment for methamphetamine use had increased.[11]

C. Mean age and gender of people in treatment

47. Differences in the mean age of people in treatment for drug problems is relatively small between the regions (see figure VIII). In addition, the mean age for different drug types is fairly similar in all regions. For example, with regard to the use of cannabis the mean age is typically lower than it is for other substances, whereas those being treated for the use of opioids are generally older. In many regions, demand for treatment among cannabis users under 20 years of age is increasing.

Figure VIII
Mean age of persons in treatment for drug abuse, by region, latest estimates available



Source: Annual reports questionnaire.

48. In Sub-Saharan Africa, an increase in the proportion of people under 20 years of age attending treatment for drug abuse has been noted in Botswana, Mozambique and South Africa, although in South Africa the trend has been stable recently. In South Africa, Swaziland and Zambia, more than one in five patients in treatment for drug problems were under 20 years of age in 2003.[12, 13, 14]

49. In North America, the average age of persons in treatment is higher than in other regions, partly reflecting the high proportion of cocaine users. In the United States, the average age at admission was 37 years for those who primarily smoked cocaine and 34 years for non-smokers of cocaine. For heroin admissions, the average age was also high, 36 years, compared with the average age of patients treated primarily for cannabis and methamphetamine (or amphetamine) use (23 years and 31 years, respectively).[5]

50. In Latin America and the Caribbean, the average age of persons in treatment for the abuse of any illicit drugs ranged from 20 to 35 years in 2003. The average age of patients treated primarily for problems involving cannabis is generally lower (17-18 years) than it is for other substances, cocaine in particular. Young cannabis users in some countries of the region are increasingly in need of specialized treatment services.

51. In India, the age distribution among people treated varies considerably by drug type and is somewhat different from what is commonly seen elsewhere. About one third (32.2 per cent) of opium abusers are over 40 years of age; heroin abusers are notably younger, nearly half of them (48.8 per cent) being 21-30 years of age. Demand for the treatment of cannabis use is relatively evenly distributed among different age groups. For all drug types, less than 1 out of 10 persons was under 20 years of age, most notably those abusing opium (3.1 per cent).[9] In Central Asian countries, the average age of drug users in treatment is generally around 30 years.

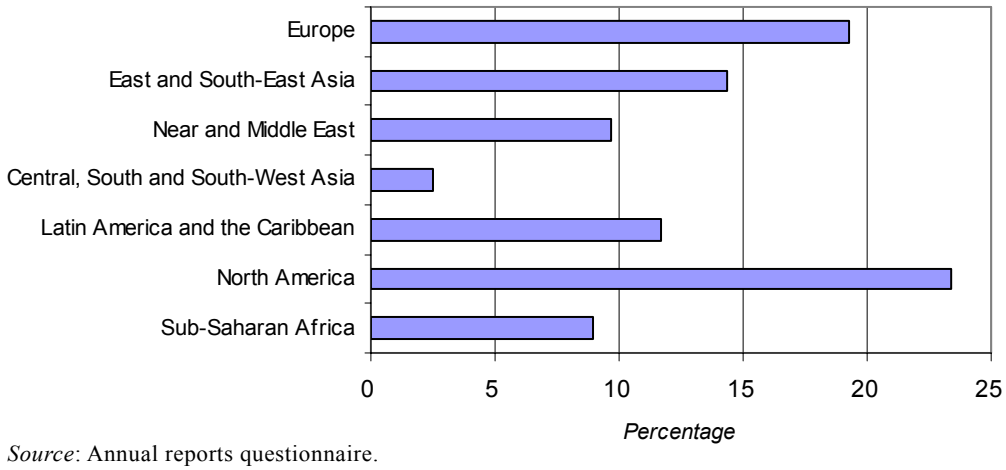
52. In Europe, those receiving treatment for the use of cannabis are typically younger (often under 20 years of age) than those who use other substances, heroin in particular.[4]

53. Men account for the majority of persons in treatment for drug problems in all regions (see figure IX). The lower proportion of women may partly reflect a higher proportion of male drug use and the various difficulties females experience in accessing treatment services, or the fact that they seek help from places other than specialized drug abuse treatment facilities. It should be noted that, globally, only one third of the countries have reported having implemented treatment and rehabilitation services using gender-specific approaches, with only minor regional differences. In many regions, the gender difference in demand for treatment appears smallest for the use of ATS and largest for the use of cannabis and opioids.

54. In Central, South and South-West Asia, the proportion of females receiving treatment for drug abuse is notably lower than in other regions of the world, and males generally account for about 90-95 per cent of those receiving such treatment.

55. In the Near and Middle East, only a few sources provide information about the gender profile of persons receiving treatment for drug problems. In Lebanon and Israel, the proportion of females attending drug abuse treatment services in 2003 was 12 and 15 per cent, respectively. In Kuwait, the proportion of females in such treatment services was only 2 per cent in 2001. In North Africa, data available in Egypt indicate that, in 2001, only a small proportion (2.8 per cent) of the persons receiving treatment were female.[15]

Figure IX
Proportion of females among persons receiving treatment for drug problems, by region, latest estimates available



Source: Annual reports questionnaire.

56. In Latin America and the Caribbean, the proportion of females in treatment for drug problems was, on average, 12 per cent in 2003, although less than half of the countries in the region have treatment data that include the gender of those receiving such treatment.

57. In North America, the gender difference in the United States is particularly large primarily for cannabis, heroin and (non-smoking) cocaine use, males accounting for over two thirds of the admissions for the abuse of those drugs. With regard to the admissions primarily for methamphetamine (or amphetamine) and smoked cocaine use, the gender difference is somewhat smaller.[5]

58. In Europe, the ratio of males to females in treatment for drug problems varies considerably between countries, ranging from 3:1 to 6:1, the highest proportion of female drug users being found in countries in northern Europe and the new member States of the European Union.[4] In the Russian Federation, males account for over 80 per cent of all persons registered for treatment for the abuse of drugs, with some differences by substance. The proportion of females in treatment is lowest for cannabis use (5.6 per cent) and highest for ATS use (20.1 per cent).

IV. Improving the global information base on substance abuse

59. In its resolution 47/1, entitled "Optimizing integrated drug information systems", the Commission on Narcotic Drugs requested the Executive Director to report to it at its forty-eighth session on the implementation of that resolution. Pursuant to that request, this section contains a review of the activities undertaken by the United Nations Office on Drugs and Crime (UNODC) to improve the global information base in collaboration with other international agencies and expert bodies.

60. The data presented above indicate that, although there has been considerable progress in the capacity of countries to collect data on their drug abuse situation, there are still big gaps in the information. Unless Member States and international organizations are able to fill such gaps, it will be difficult to assess the progress made in the reduction of demand for illicit drugs in the next few years.

61. Monitoring progress by Member States towards the goals pertaining to demand reduction is done largely through the annual reports questionnaire, as far as patterns and trends in the abuse of drugs are concerned, and through the biennial reports questionnaire with regard to the implementation of demand reduction strategies and programmes that adhere to the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution S-20/3, annex). In the 2004 report on the world situation with regard to drug abuse (E/CN.7/2004/2), some of the challenges measuring progress towards the goals were discussed.

62. To improve the coverage of global data on substance abuse and improve the use of existing instruments and databases, UNODC has been working together with the World Health Organization (WHO) to ensure that Member States have the possibility to obtain data on the use and abuse both of licit and illicit substances. In particular, there have been discussions and collaboration with regard to the harmonization of the databases on tobacco (UNODC has provided input into the Global Youth Tobacco Survey) and alcohol use managed by WHO and the information on illicit drug abuse managed by UNODC. UNODC is also exchanging information with WHO in the context of the WHO study of mental health resources, the abuse trends linkage alerting system, known as the ATLAS project, which collects information on treatment and prevention resources.

63. In addition, WHO contributed to the project of UNODC and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) for the development of a tool kit for the collection of treatment data. The tool kit, which will assist Member States in compiling comparable treatment data, is being developed as part of the activities of the Global Assessment Programme on Drug Abuse of UNODC, in collaboration with EMCDDA and experts of other international agencies and expert bodies.

64. Since 1999, through the Global Assessment Programme on Drug Abuse, UNODC has provided assistance to 51 countries in the form of training, situation analyses and network establishment. In 49 countries, surveys on population, schools, problem drug users, treatment demand and HIV were carried out. In 23 countries, more in-depth studies were carried out to assist Governments in developing policy and designing programmes, since prevalence data are not sufficient to guide Governments in making decisions. UNODC supported directly the establishment of a regional network in Central Asia, East Africa, Southern Africa and the Caribbean.

65. This has resulted in improved reporting standards, better quality and coverage of the data that have allowed UNODC to produce better global analyses for Member States.

66. Available funding has thus far allowed implementation of regional subprogrammes of the Global Assessment Programme on Drug Abuse in Central and South-West Asia, the Caribbean, Eastern and Southern Africa and North Africa and the Middle East. In 2005, the activities will be expanded to include West and Central Africa.

Notes

[1] Each degree of trend estimation was given a numerical value ranging from –2 to 2 (–2 representing a large decrease; –1, some decrease; 0, no great change; 1, some increase; and 2, a large increase). Estimates for each drug type were weighted by the population size of each country. The national estimates were added to represent the annual regional trend estimate for each drug type, and a cumulative change for each region was calculated. The trend curve represents these cumulative changes since the baseline reporting year. The main advantage of such a weighted analysis is that, at its best, by taking into account the population size affected by the estimated trend, the risk of greatly overestimating or underestimating the magnitude of regional trends is significantly reduced. For example, a large increase in the abuse of cannabis in a country with a small population is considered to have less importance or impact compared with some increase in a country with a large population. WADAT was also used in the *World Drug Report 2004* (United Nations publication, Sales No. E.04.XI.16, vol. 2) where it was referred to as the Drug Abuse Trend Index.

[2] The response rate was 57 per cent (109 replies submitted) for the reporting year 2003, 55 per cent (106 replies submitted) for 2002, 54 per cent (103 replies submitted) for 2001, 41 per cent (80 replies submitted) for 2000, 49 per cent (94 replies submitted) for 1999 and 58 per cent (112 replies submitted) for 1998.

[3] Consejo Nacional contra las Adicciones, *Observatorio Epidemiológico en Drogas: El Fenómeno de las Adicciones en México 2001* (Mexico City, 2001).

[4] European Monitoring Centre for Drugs and Drug Addiction, *Annual Report 2004: the State of the Drugs Problem in the European Union and Norway* (Lisbon, 2004).

[5] United States of America, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Treatment Episode Data Set (TEDS): 1992-2002; National Admissions to Substance Abuse Treatment Services*, DASIS Series S-23, DHHS Publication No. SMA 04-3965 (Rockville, Maryland, 2004).

[6] United States of America, Department of Health and Human Services, National Institutes of Health, *Epidemiologic Trends in Drug Abuse: Advance Report* (December 2003).

[7] United Nations Office on Drugs and Crime, *Regional ATS Update and Training Meeting: Final Report* (Bangkok, 2004).

[8] National Surveillance Center on Drug Abuse, *Report of Drug Abuse Surveillance 2003* (Beijing, 2004).

[9] United Nations Office on Drugs and Crime, Regional Office for South Asia, *National Survey on Extent, Pattern and Trends of Drug Abuse in India: National Report* (2002).

[10] Australian Institute of Health and Welfare, *Alcohol and Other Drug Treatment Services in Australia 2001-02: Report on the National Minimum Data Set*, HSE 28 (Canberra, 2003).

[11] C. Wilkins and others, “Recent changes in the methamphetamine scene in New Zealand: preliminary findings from key informant surveys of drug enforcement officers and drug treatment workers”, paper presented at a Centre for Social and Health Outcomes Research and Evaluation (SHORE) Seminar, Auckland, New Zealand, 16 January 2004.

[12] Parry and others, *South African Community Epidemiology Network on Drug Use (SACENDU): Alcohol and Drug Abuse Trends, May 2004* (Cape Town, 2004).

[13] Charles D. H. Parry and Andreas Plüddemann, "SENDU: the SADC Epidemiology Network on Drug Use", *SENDU Update* (Cape Town), vol. 7, 2004.

[14] United Nations Office on Drugs and Crime, *East Africa Drug Information System (EADIS): Proceedings of the Third Annual Meeting* (October 2003).

[15] United Nations Office on Drugs and Crime, *Assessment of the Current Treatment and Rehabilitation Facilities and Services in Egypt* (2001).