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The world drug problem

Fourth biennial report of the Executive Director

Addendum

Drug demand reduction

Contents

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I. Introduction

1. The present report provides an overview of the progress made in drug demand reduction by Member States since 1998. The overview is based on information provided in responses to the biennial reports questionnaire during four reporting periods (1998-2000, 2000-2002, 2002-2004 and 2004-2006).

2. The biennial reports questionnaire was developed as an instrument to monitor progress towards the goals adopted at the twentieth special session of the General Assembly, in 1998.

3. Part VIII of the questionnaire, on drug demand reduction, was designed along the lines of the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution 54/132, annex). It contains seven sections and requests information on initiatives undertaken by Member States in selected areas of drug demand reduction.

4. The information provided in the biennial reports questionnaire is mostly qualitative in nature, based on the opinion of experts filling in the questionnaire on behalf of their country. Although analysing the information presents difficulties, the Secretariat has used the information provided in the various reporting periods to develop a Demand Reduction Index, which it has used to provide graphical representations of the evolution of the demand reduction responses on a regional basis.

A. Summary of the main findings

5. The most important areas of intervention in demand reduction are those classified as prevention, treatment and rehabilitation, and reduction of the negative health and social consequences of drug abuse. In these areas, globally, there has been some progress in the past six years and, although it is encouraging to see that, on average, more States are doing more in the different areas (see figure I), the level of response to the problem remains insufficient, as shown below.

1. Prevention

6. Prevention programmes are being expanded in regions that did not have good coverage and have been maintained at higher levels where they were already well established. The majority of the activities implemented focus on the provision of information. Interventions focusing on life-skills education and alternative activities are less common.

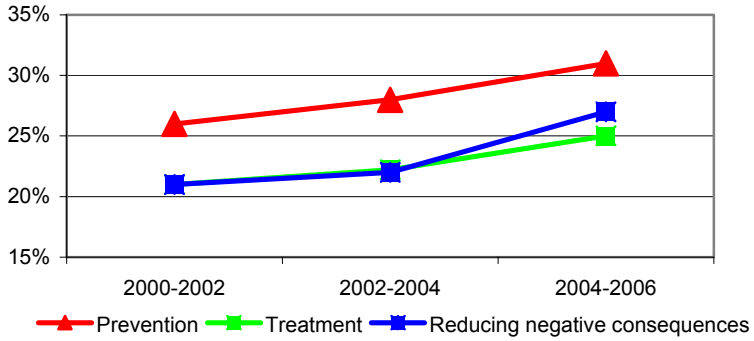
2. Treatment and rehabilitation

7. Although treatment and rehabilitation interventions are also being expanded, they remain below the level reached by prevention programmes and, surprisingly, below the coverage reported for reducing the negative health and social consequences of drug abuse. Detoxification remains the most common intervention, with substitution treatment being the least covered across all regions.

3. Negative health and social consequences of drug abuse

8. Interventions for reducing the negative health and social consequences of drug abuse have registered a strong increase at the global level and have overtaken treatment and rehabilitation interventions in terms of reported coverage of activities. In some regions, this trend appears to be associated with efforts to prevent the spread of HIV and other infections among injecting drug abusers. However, less than one in four States reported that they were providing a comprehensive set of measures for HIV/AIDS prevention and care and, of those, less than one in eight reported high levels of coverage.

Figure I
Extent of responses in prevention, treatment and reducing the negative health and social consequences of drug abuse, global average, 2000-2006



Source: Biennial reports questionnaires 2000-2002, 2002-2004 and 2004-2006.

4. Global trends and main findings in other areas of drug demand reduction

(a) Commitment: policy and strategic responses

9. In the majority of the regions the level of commitment has remained stable at a high level, with some regions reporting marked improvements over time. States of Sub-Saharan Africa and Latin America and the Caribbean reported experiencing difficulties in meeting the target.

(b) Assessing the problem: capacity to collect and analyse information

10. The capacity of States to collect and analyse information is generally increasing. Considerable progress appears to have been made in those regions that invested resources in the establishment of drug information systems or in the improvement of existing ones by utilizing multiple methods and sources of information at the national and regional levels.

(c) Forging partnerships: extent of multisectoral responses and networking mechanisms

11. Many States reported the existence of good networking or decentralizing mechanisms, which have been in place since the first reporting period (1998-2000), and the situation improved further in many regions in the fourth reporting period (2004-2006). In the context of demand reduction activities, such good levels of

action and the expansion of coordinating mechanisms should be maintained in the future.

(d) Focusing on special needs: efforts made to work with vulnerable or special populations

12. In most States, interventions targeting vulnerable and special populations appear to be increasing. In regions with considerable experience in demand reduction and with established and sustained programmes, special programmes are quite common, possibly thanks to the relatively long experience in demand reduction. Other regions have also increased their efforts in this area, but starting from a lower coverage level. The reason for these increases may be related to the increase in interventions with groups at risk of HIV and other blood-borne infections.

(e) Sending the right message: media and public campaign responses

13. The trend regarding coverage of activities implemented to improve media and public campaigns as part of demand reduction efforts showed a slight decrease in the fourth reporting period, although still remaining overall fairly high. The proportion of States that reported having based their campaigns on a needs assessment decreased. Training in conveying demand reduction messages is fairly commonly provided in all regions and evaluating the effectiveness of campaigns has slightly improved since the last reporting period.

(f) Building on experience: evaluation and incorporation of lessons learned

14. As with other kinds of intervention, the regions with sustained demand reduction programmes and consequently dedicated resources appear to be relatively active in all of the three areas of training of practitioners, evaluation of interventions, and sharing and dissemination of best practices in drug demand reduction. Most of the other regions reported covering above 50 per cent, while in Sub-Saharan Africa and Eastern and South-Eastern Europe the importance assigned to these activities remains limited.

B. Analysis of the information

15. The present report reviews the information provided by States and presents an analysis of their responses to provide an idea of the progress made by them in drug demand reduction efforts.

16. The information provided in the biennial reports questionnaire is mostly qualitative in nature, based on expert opinion. Most questions require a simple “yes” or “no” answer; often they ask about the existence of certain structures, programmes, activities and so on, but do not request information about their quality or their impact. Although other sources of information can sometimes provide evidence to support the assessment, it is often difficult to verify the validity of the information provided.[1]

[1] In part VIII, section C, of the biennial reports questionnaire, which is entitled “Tackling the problem” and contains questions on prevention, treatment and rehabilitation, and reducing the

17. The classifications of “low”, “medium” and “high” used in some questions are subjective and relative to the situation in each country. A State with a large number of drug abusers may offer good treatment services and invest considerable resources in those services, but it may nevertheless find it difficult to declare that the coverage of the services is “high” and may therefore choose to classify the coverage as “medium”. A State with a limited number of drug abusers or with limited knowledge of the size of the problem may choose to classify the coverage of its treatment services as “high”, even though this may not properly reflect the actual situation.

18. Apart from the reliability of the information, there is also a problem with the validity of the sample: following the general trend with regard to responses to the biennial reports questionnaire, only 51 States, or 27 per cent of the world total, have responded to the questionnaire on drug demand reduction for all four reporting periods (see table). In order to ensure that the analysis provides a more representative picture of the regional situation, all States responding in different reporting periods have been included in the analysis. It should be noted that there is a considerable overlap between the States responding in different reporting periods. For example, of the 91 States responding for 2004-2006 on drug demand reduction, 65 (71 per cent) responded to the biennial reports questionnaire for 2002-2004, 75 (82 per cent) for 2000-2002 and 71 (78 per cent) for 1998-2000.

Table
States responding to the section of the biennial reports questionnaire on drug demand reduction for the four reporting periods, 1998-2006

Reporting period	*Number of States*	*Percentage of States*	*Approximate percentage of world population aged 15-64 in responding States*
1998-2000	109	57	90
2000-2002	115	60	92
2002-2004	87	45	61
2004-2006	91	47	87
All reporting periods	51	27	54

19. In spite of the limitations described above in terms of the quality of the information, the response rate and the significance of the sample of States considered, the biennial reports questionnaire still provides important information on how each State perceives itself to be progressing towards achieving the following broad goals set out in the Political Declaration adopted by the General Assembly at its twentieth special session (resolution S-20/2, annex, para. 17):

(a) “Establishing the year 2003 as a target date for new or enhanced drug demand reduction strategies and programmes set up in close collaboration with public health, social welfare and law enforcement authorities”;

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negative health and social consequences of drug abuse, it is possible to provide information on the coverage of the interventions (low, medium or high), on their gender-sensitivity and on the existence of evaluation processes. These items were added to the biennial reports questionnaire in 2000 and therefore data are available for only the second, third and fourth reporting periods.

(b) "Achieving significant and measurable results in the field of demand reduction by the year 2008."

20. In order to facilitate the analysis of the progress made in meeting the goals and targets for 2008, the United Nations Office on Drugs and Crime has developed an analytical tool to quantify the replies to the various sections of the biennial reports questionnaire,[2] which was used for the first time in the third reporting period (2002-2004) to report progress in drug demand reduction (see document E/CN.7/2005/2/Add.1). The present report provides an update, by region, using the method adopted in the previous reporting period, providing a visual representation of changes in the different areas of demand reduction.

21. The information is divided into nine regions or subregions to allow for a more appropriate analysis of the different patterns and trends. However, caution should be exercised when examining information compiled from responses received from a small number of States in certain subregions (in particular, Oceania and North America), since the trend is highly influenced by the responses of a single country.

II. Policy and strategic responses

22. In part VIII, section A, of the biennial reports questionnaire, entitled "The commitment", States are asked whether they have a national strategy for drug demand reduction and whether it was based on an assessment of the drug abuse situation. In addition, States are asked about the coordination of the strategy, the involvement of stakeholders, funding and systems for assessing the results achieved.

23. In the majority of the regions, States responded that they had implemented over 75 per cent of the activities required. Some regions have maintained that level during the reporting periods, with some improvements seen over time. In Central, South and South-West Asia, the trend is unstable, but shows a marked increase from the level of slightly above 50 per cent in the baseline or first reporting period to above 75 per cent in the fourth reporting period. States of Eastern and South-Eastern Europe are approaching the level seen in Central and Western Europe. In East and South-East Asia and North America, the extent of measures taken has remained stable at a high level across all the reporting periods. In Oceania, the extent of policy and strategic responses has been reported to be substantially increasing during the past three reporting periods. States of Sub-Saharan Africa and Latin America and the Caribbean appeared to experience some difficulties in the fourth reporting period, after having been at or above the 75 per cent level in the second reporting period (see figure II).

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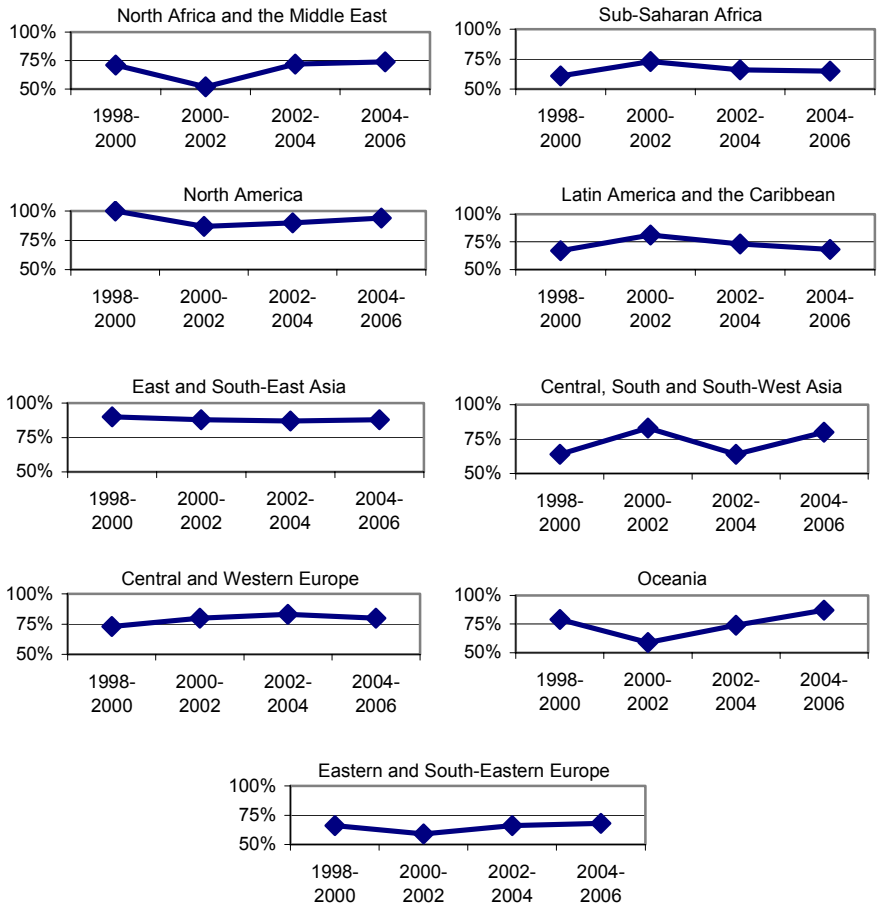
[2] The Demand Reduction Index is based on the responses given by States in the biennial reports questionnaire, focusing on the implementation and coverage of activities in drug demand reduction. An analysis was conducted using the data provided by all those States which have responded to the biennial reports questionnaire in each reporting period. The progress in different areas of demand reduction is presented as regional averages, which are composed of the percentages of the extent of implemented activities in the States within each region.

Figure II
Policy and strategic responses, by region, 1998-2006



Source: Biennial reports questionnaires 1998-2000, 2000-2002, 2002-2004 and 2004-2006.

24. In many regions, mechanisms to develop and implement demand reduction strategies were already in place before 1998 and these regions have largely sustained their level of responses throughout all the reporting periods, which indicates a high level of political commitment. While the trend has fluctuated in some regions, the extent of responses with regard to investing in demand reduction programmes has improved in nearly all regions since 1998. Globally, the situation has remained stable in recent years.

25. Nearly all (96 per cent) of the States responding have a national strategy on demand reduction in place and eight out of ten States (81 per cent) reported having based the development of their national strategy on an assessment of the drug problem. Most States (88 per cent) reported that they were implementing their national strategy through a multisectoral approach involving relevant authorities. A markedly smaller number of States reported having a dedicated budget for demand

reduction (65 per cent), with, however, a large variation among the regions regarding this question.

26. The large differences in the magnitude, coverage and scope of national strategies for drug demand reduction make it difficult to analyse the real level of commitment of each country. Analysis of the answers provided in other parts of the biennial reports questionnaire will further illuminate how the high level of policy commitment and awareness translates into concrete actions.

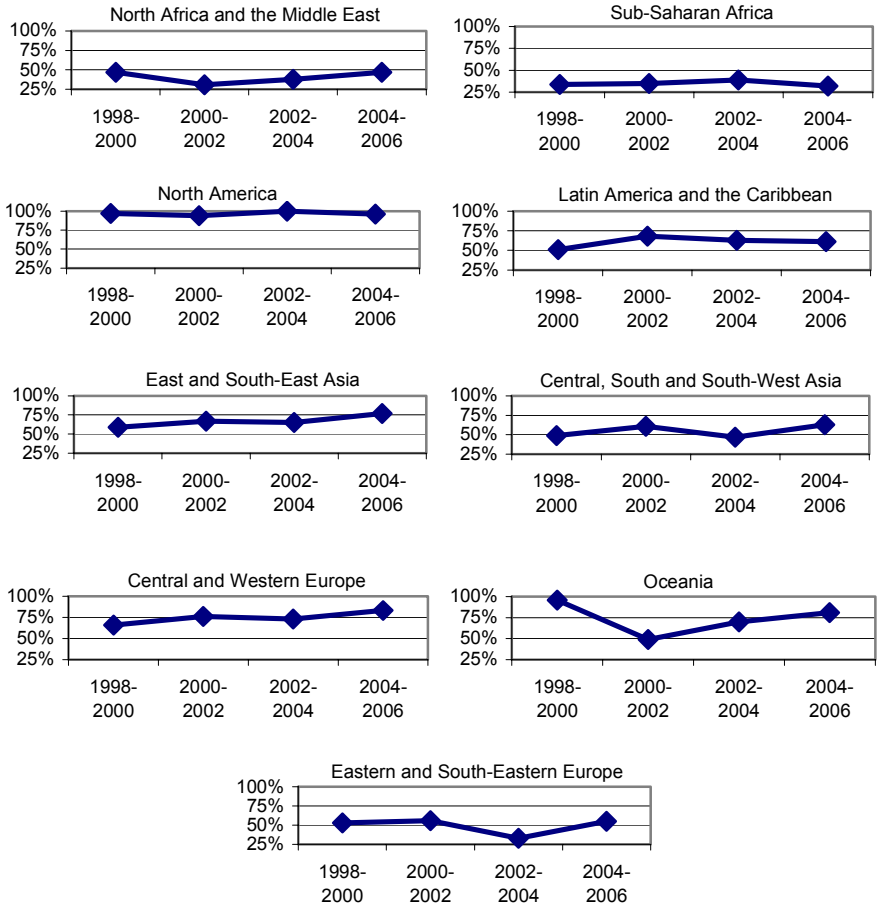
III. Capacity to collect and analyse information

27. With regard to data collection and analysis, the questions cover the availability of a national programme and a mechanism for the assessment of the nature and magnitude of drug abuse and key components involved in the implementation of the national drug information system (prevalence estimates, school surveys, treatment reporting system, and so forth).

28. The regional analysis in this area shows improving trends, particularly in four regions, where levels reported in the baseline period of 1998-2000 were markedly lower than those indicated in 2004-2006. Considerable progress has been made in East and South-East Asia and Central, South and South-West Asia, where the coverage of drug abuse assessment activities has improved since the baseline period by about 30 per cent. The other areas showing large increases in their capacity to conduct regular assessments for the identification of emerging trends in drug abuse were Central and Western Europe and Latin America and the Caribbean, with large increases seen since the baseline period (by 26 and 20 per cent respectively). The drug information systems appear most comprehensive in North America, where the extent of measures taken in this area has been reported to be at or near 100 per cent throughout all the periods (see figure III).

29. Nevertheless, there appears to remain a considerable gap between the regions with long experience and established structures in monitoring drug abuse and related problems, namely North America, Oceania and Central and Western Europe, and those regions with little experience and resources in this area, in particular Sub-Saharan Africa and North Africa and the Middle East. Over the past eight years, the picture in the best-performing regions appears to indicate that important roles are played by national and regional coordination, training and the dissemination of best practices in support of the establishment of drug abuse data collection systems and monitoring mechanisms.

Figure III
Capacity to collect and analyse information, by region, 1998-2006



Source: Biennial reports questionnaires 1998-2000, 2000-2002, 2002-2004 and 2004-2006.

IV. Extent of responses

A. Intervention focusing on drug abuse prevention

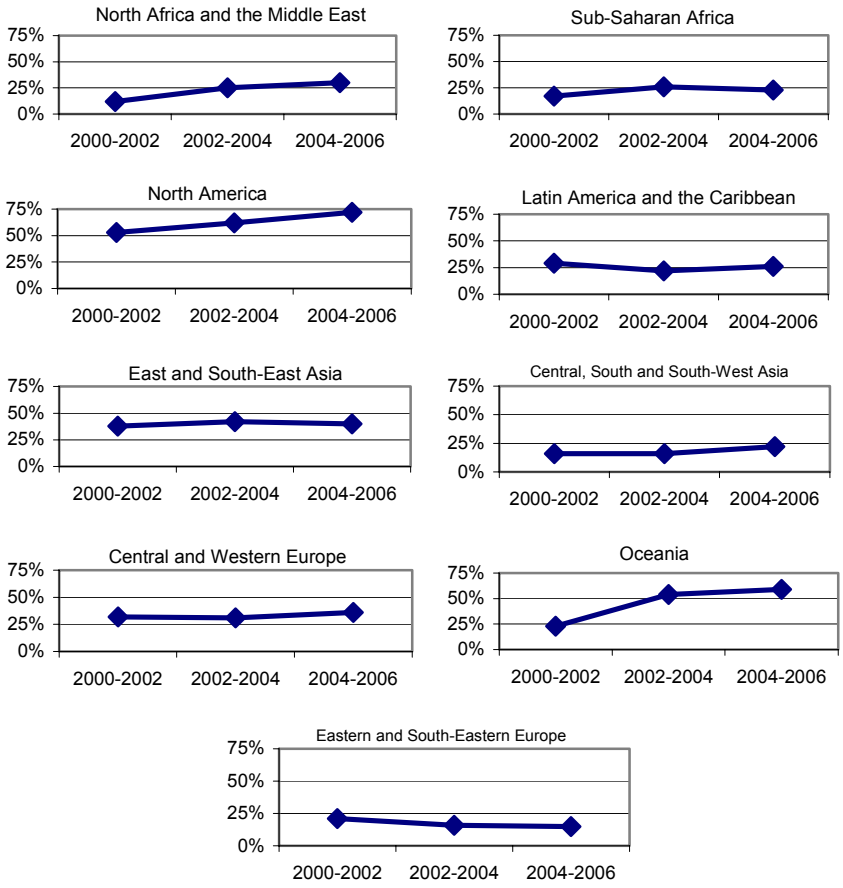
30. The present section analyses the progress made by States towards achieving the goals of new and enhanced forms of intervention focusing on drug abuse prevention in accordance with the principles set out in the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution S-20/3, annex).

31. Drug abuse prevention should be comprehensive, that is, it should not only provide information about the dangers of drugs, but it should also equip people, especially young people, with the skills and provide them with the opportunities to make healthy choices. That is why States are requested to provide information about three of the most basic kinds of intervention focusing on drug abuse prevention:

providing information and education about drugs and drug abuse, life-skills development and providing alternatives to drug use. Information about public information campaigns, which should always be connected to a comprehensive prevention response, is given in chapter VII of the present report.

32. Drug abuse prevention should also be comprehensive in terms of the range of settings in which it is implemented, so that drug abuse prevention messages and actions reinforce each other. Therefore, States are requested to provide information about such kinds of intervention in a series of settings: schools, communities, workplaces, correctional systems and health services. Figure IV illustrates the extent to which States have implemented the three kinds of activity (providing information and education about drugs and drug abuse, life-skills development and providing alternatives to drug use) in a series of settings, taking into account whether States have reported that the coverage among the intended target group was estimated to be low, medium or high and whether the activities were gender-sensitive.

Figure IV
Intervention focusing on drug abuse prevention, by region, 2000-2006



Source: Biennial reports questionnaires 2000-2002, 2002-2004 and 2004-2006.

33. States in six out of nine regions reported an increase in the overall level of coverage in prevention interventions when compared to the previous period (Central, South and South-West Asia; Central and Western Europe; Latin America and the Caribbean; North Africa and the Middle East; North America; and Oceania), but the global trend in increasing coverage of implemented prevention interventions appears to be slowing down in 2004-2006. In order for the interventions to have an impact on drug abuse trends, the coverage of all types of drug abuse prevention intervention needs to reach a high level in all settings and be sustained at that level in the medium term.

34. In North America and Oceania, a good level of extent of implementation prevention interventions in different settings and coverage of the target group has been reached, with the composite index over 50 per cent. States of North Africa and the Middle East, East and South-East Asia, Central and Western Europe and Latin America and the Caribbean reported coverage of over 25 per cent, while in Eastern and South-Eastern Europe, Central, South and South-West Asia and Sub-Saharan Africa the proportion of activity areas covered in different settings remained relatively low, below 25 per cent.

35. The provision of information is the kind of prevention intervention with the widest coverage of implemented activities in most regions, with eight out of nine reporting over 25 per cent coverage. The highest figures were reported in North America (81 per cent), followed by Oceania (53 per cent) and East and South-East Asia (52 per cent). With regard to the provision of life-skills education, most regions (five out of nine) reported coverage of over 25 per cent, ranging from 14 per cent in Eastern and South-Eastern Europe to 64 per cent in North America. The lowest levels were generally reported for the provision of alternative activities, with the extent of implemented activities below 25 per cent in five regions. However, the extent of coverage of implementation of this type of intervention has increased in all regions since the previous reporting period.

36. The trend at the global level remains positive: drug abuse prevention interventions are being expanded and have largely been maintained at this improved level. However, this expansion does not appear to be sufficient, with reports from only one region showing a markedly high level of coverage.

37. Although the situation is certainly improving, an increased effort in drug abuse prevention is called for if Member States are to meet the commitments made at the twentieth special session of the General Assembly.

B. Intervention focusing on the treatment and rehabilitation of drug abusers

38. In the fourth reporting period, in the area of treatment and rehabilitation, the composite score indicating the extent of provision of different treatment services in various settings ranged from 11 to 71 per cent, depending on the region. The global situation has remained stable since the third reporting period.

39. The composite scores include 28 individual accumulated measures stretched across four main areas of intervention (detoxification, substitution therapy, non-pharmacological intervention and social reintegration) in seven different settings.

The maximum score for any particular intervention implemented in one setting is obtained by reporting a high level of coverage and gender-sensitivity of services. Obviously, it is not possible to expect that many States will have in place the whole range of interventions in all areas, partly because of lack of resources but also because the real drug situation may not require certain kinds of intervention.

40. As shown in figure V, since the last reporting period in 2002-2004, there has been an increase in the score for implementation of all treatment interventions in Central and Western Europe, Central, South and South-West Asia and North America. East and South-East Asia show the clearest improvement since the previous reporting period (rising from 20 to 30 per cent), while Oceania has reported a steady increase in the coverage of all treatment interventions through all the reporting periods and has now reached 71 per cent of the maximum score.

Figure V
Intervention focusing on treatment and rehabilitation, by region, 2000-2006

Source: Biennial reports questionnaires 2000-2002, 2002-2004 and 2004-2006.

41. The situation has continued to be stable in Eastern and South-Eastern Europe, with the composite score remaining stable at close to the 10 per cent level. The transition from the health care and social systems established by previous political regimes is not yet complete and is having an impact on the current coverage of interventions. The coverage of all treatment interventions in the Latin America and the Caribbean region has remained stable since the last reporting period.

42. The decrease in all treatment interventions in Sub-Saharan Africa is explained by the decrease reported in the coverage of detoxification, substitution and social reintegration interventions. The coverage of non-pharmacological interventions has remained stable in the region. States in the Sub-Saharan region are affected by other major health-care issues that are exhausting the resources available in the region for the coverage of drug abuse treatment services.

43. Detoxification remains the most-used treatment intervention globally. The coverage of detoxification increased in all regions except in Sub-Saharan Africa and Eastern and South-Eastern Europe, where there was a decrease reported in the coverage of detoxification interventions. Oceania and North America reached the highest levels for detoxification, reporting 70 and 61 per cent of the maximum score respectively.

44. With regard to substitution treatment, which concerns only opioid dependence, the same trend has continued from the previous reporting period. Substitution treatment remains the least covered intervention in any setting in all regions. Oceania and North America have reached 68 and 49 per cent respectively of the maximum score across all treatment settings. For other regions, the increases have been relatively small since the last reporting period. In East and South-East Asia, some States, such as China and Indonesia, are scaling up substitution treatment. China has launched an initiative to develop methadone maintenance centres covering the whole country aimed at the prevention of injecting drug abuse-related HIV/AIDS. Latin America and the Caribbean and Sub-Saharan Africa reported decreases in the coverage of substitution therapy,

45. Globally, the coverage of non-pharmacological treatment shows a minor increase since the last reporting period. Central, South and South-West Asia, East and South-East Asia, Central and Western Europe and Latin America and the Caribbean showed modest increases in their scores. Oceania has reached an impressive 88 per cent of the maximum score for non-pharmacological treatment and it continues to be the most-used treatment intervention in the region. The situation has remained stable since the last reporting period in North Africa and the Middle East, Sub-Saharan Africa and Eastern and South-Eastern Europe. In North America, there was a slight decrease in the score for non-pharmacological treatment.

46. With respect to social reintegration, the global situation has remained stable. Central, South and South-West Asia, East and South-East Asia, Latin America and the Caribbean and Eastern and South-Eastern Europe all showed an increase ranging between 4 and 9 percentage points. Oceania has reached 60 per cent of the maximum score and, although the situation in North America has remained stable since the last reporting period, the region has reached 59 per cent of the maximum score. The level of coverage for social reintegration interventions in Central and

Western Europe has remained stable. Sub-Saharan Africa and North Africa and the Middle East reported decreases in the coverage of social reintegration services.

47. Most regions reported relatively good coverage of detoxification interventions. It appears that other types of treatment service need to be developed and strengthened. Different target groups and clients should be considered and services should be made accessible to all drug abusers. The stabilizing trends in Latin America and the Caribbean and Eastern and South-Eastern Europe indicate that renewed efforts are needed. In other regions, with the exception of Oceania, increases in the coverage of services have been modest since the last reporting period. Renewed commitment is necessary to reach the targets by 2008.

C. Intervention to reduce the negative health and social consequences of drug abuse

48. The biennial reports questionnaire provides information on the action taken by States to reduce the negative health and social consequences of drug use. The questions concern the issues of the transmission of infectious diseases such as HIV/AIDS and hepatitis B and C, as well as other issues such as overdose prevention and the provision of emergency shelters.

49. In 2005, following an extensive consultative process with donors, Governments, non-governmental and community-based organizations and other partners, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Programme Coordinating Board approved and recommended a comprehensive package of HIV/AIDS prevention and care measures. Concerning HIV transmission through injecting drug use more specifically, the package consists of the full range of treatment options (including substitution treatment) and the implementation of other measures to reduce the negative health and social consequences of drug abuse (through initiatives such as peer outreach to injecting drug abusers and the provision of prevention commodities), voluntary counselling and confidential HIV-testing, prevention of sexual transmission of HIV among drug users (including the provision of condoms and the prevention and treatment of sexually transmitted infections), access to primary healthcare and access to antiretroviral therapy.

50. In the 2004-2006 reporting period, 75 States provided responses regarding six of the comprehensive package measures. Less than one in four (22.7 per cent) implemented all measures. In those States which implemented all six measures, less than one in eight (11.8 per cent) reported high coverage.

51. In terms of the dissemination of HIV/AIDS safety information and education materials, approximately half the reporting States (50.7 per cent) indicated that these were provided to drug users, but the level of coverage was low in over two thirds (68 per cent) of States. Availability was lowest in North Africa and the Middle East and highest in Oceania.

52. In terms of HIV/AIDS outreach services to drug users, slightly more than half the reporting States (57.3 per cent) indicated that they had implemented such services, but the level of coverage was low in two thirds of States (65.3 per cent). Availability was lowest in Eastern and South-Eastern Europe and highest in North America and Oceania.

53. In terms of condom distribution to drug users, slightly more than half the reporting States (58.7 per cent) indicated that this service was available and, of those, a further half (54.7 per cent) indicated that coverage was high. Availability was lowest in North Africa and the Middle East and highest in North America.

54. In terms of substitution treatment, although approximately half of the reporting States (51.6 per cent) indicated that they provided this service to drug users, almost nine in ten (88.0 per cent) indicated that coverage was low. Availability was lowest in Central, South and South-West Asia and highest in North America and Oceania.

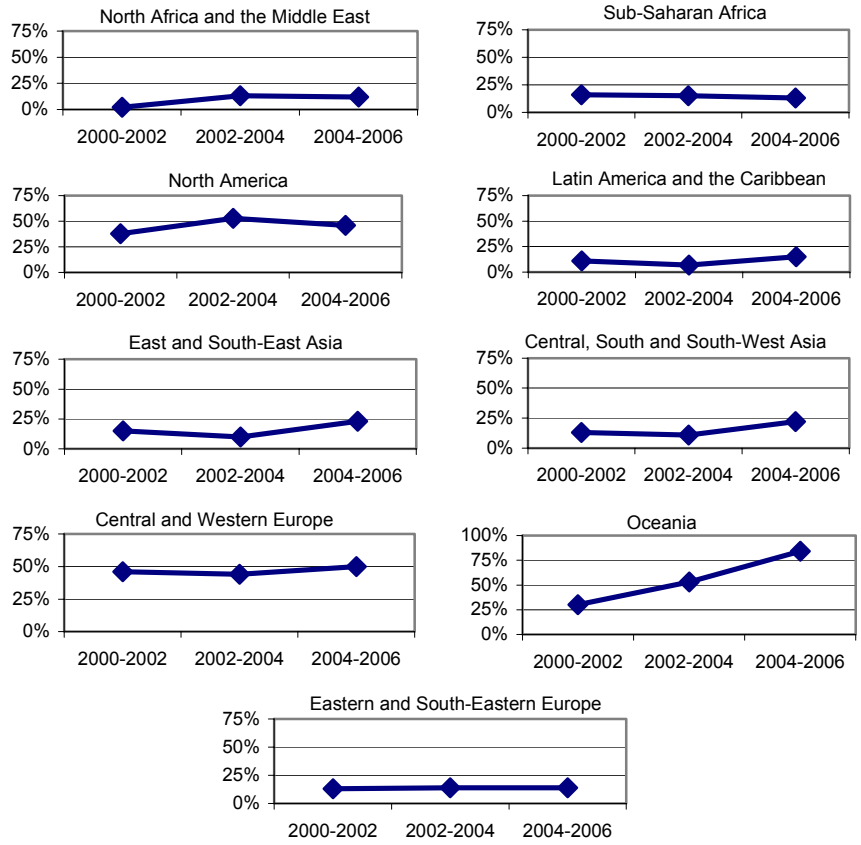
55. In terms of voluntary counselling and confidential HIV-testing for drug users, again, although approximately half the reporting States (54.7 per cent) indicated that this service was available, more than half (60 per cent) of those States indicated that coverage was low. Availability was lowest in North Africa and the Middle East and highest in Oceania.

56. In terms of sterile needle and syringe programmes, less than half the reporting States (42.7 per cent) indicated that this service was available to drug users and, of those, almost three quarters (72 per cent) reported that coverage was low. Availability was lowest in North Africa and the Middle East and highest in Oceania.

57. Despite some global improvement observed during past years, shown by the responses provided by States through the biennial reports questionnaire, the low composite index achieved in many regions suggests that, even if interventions are being implemented, their estimated coverage among their target groups often remains relatively low (see figure VI). The States where services are being provided at a level indicating medium or, in some cases, high coverage among their target groups are mainly in North America, Western and Central Europe and Oceania. States in North Africa and the Middle East, Sub-Saharan Africa, Eastern and South-Eastern Europe and Latin America and the Caribbean report the lowest availability of the various services; in addition, where services do exist, their target group coverage is often low.

Figure VI

Intervention to reduce the negative health and social consequences of drug abuse, by region, 2000-2006



Source: Biennial reports questionnaires 2000-2002, 2002-2004 and 2004-2006.

V. Extent of multisectoral responses and networking mechanisms

58. The present chapter describes the efforts made by States to develop a multisectoral, community-wide participatory approach to identifying appropriate policies and programmes. Some States have initiated or expanded processes of decentralization of demand reduction responses to the local level.

59. In particular, the questionnaire asks States to report on the existence of collaboration or networking mechanisms at various levels and on whether such collaboration or mechanisms have provisions for identifying and including new partners. Analysis is carried out on the basis of only two questions, so must be treated with care.

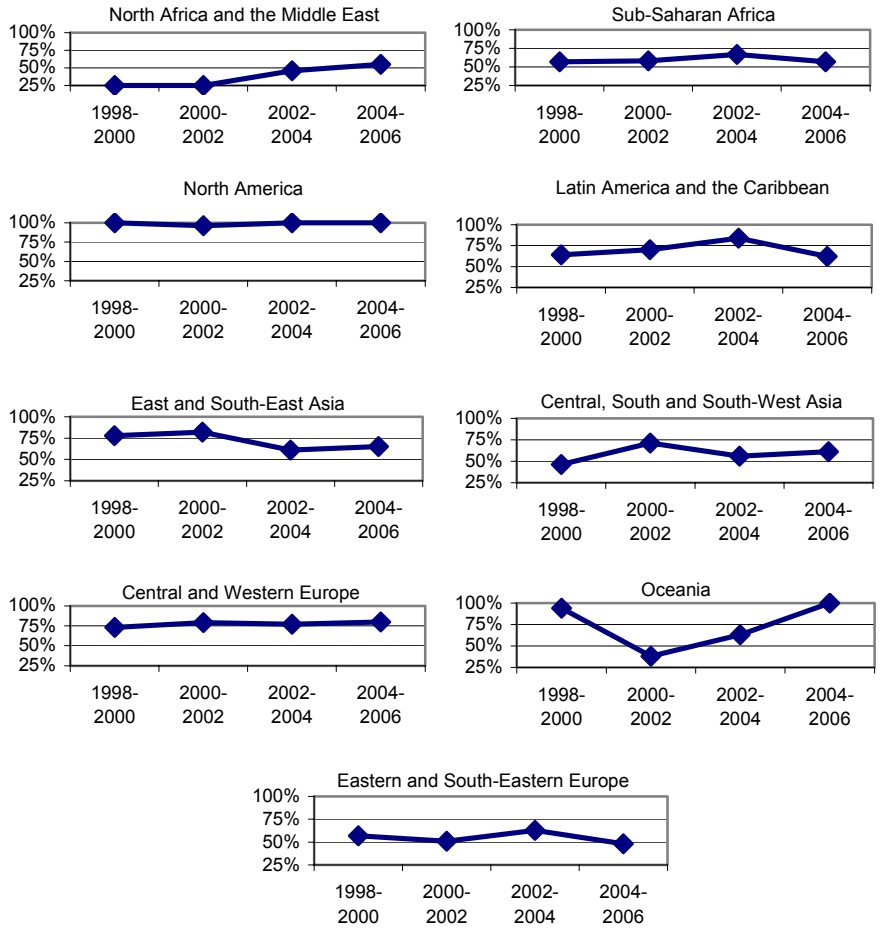
60. This is an area in which most States have reported the existence of good (over 50 per cent), or in some regions excellent (over 75 per cent), networking or decentralizing mechanisms since the first reporting period. It is encouraging to note that the situation in this respect has improved in many regions in 2004-2006, as

shown in figure VII. Even if some decreases were reported in Eastern and South-Eastern Europe, Latin America and the Caribbean and Sub-Saharan Africa, all these regions still remain around or well above the 50 per cent level of extent in their responses. The extent of collaboration or networking mechanisms in place reported by three regions, Central and Western Europe, North America and Oceania, was excellent.

61. It would be desirable that in the future this area of the biennial reports questionnaire continues to produce reports of such good levels of action. In the context of demand reduction activities that require concerted action at different levels and in different sectors, the existence and expansion of coordinating mechanisms is essential to ensure the necessary synergies of intervention.

Figure VII

Extent of multisectoral responses and networking mechanisms, by region, 1998-2006



Source: Biennial reports questionnaires 1998-2000, 2000-2002, 2002-2004 and 2004-2006.

VI. Efforts made to work with vulnerable or special populations

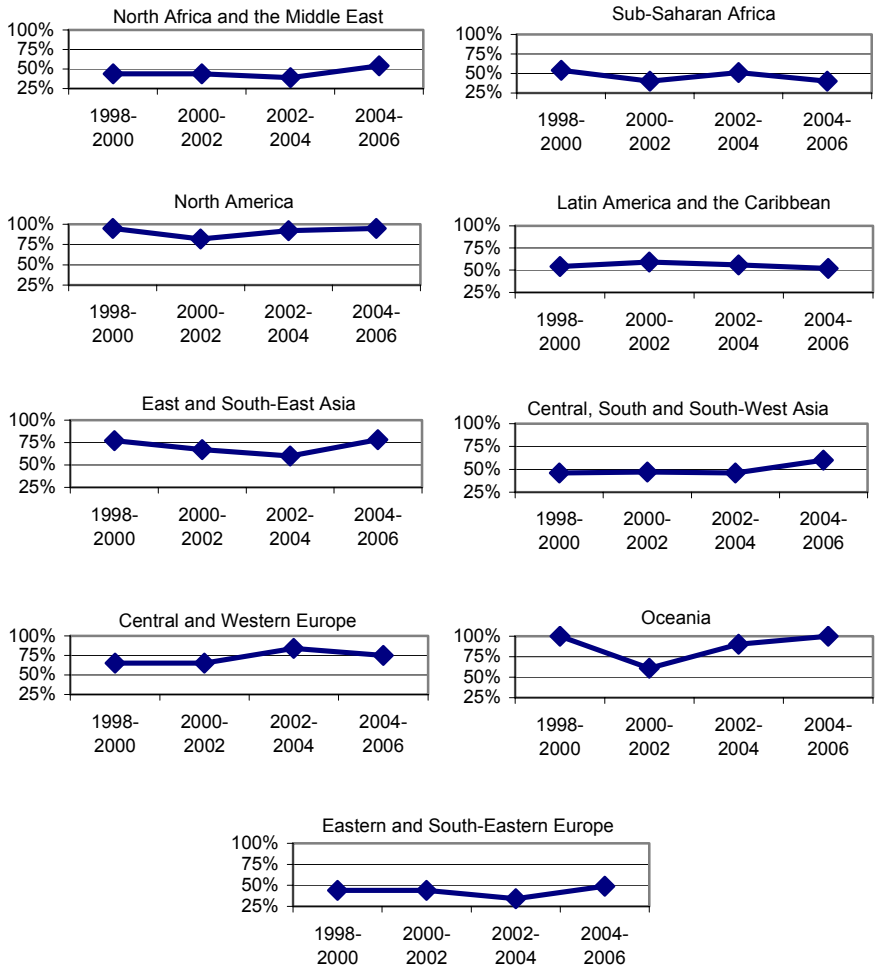
62. One of the problems with demand reduction interventions is the lack of attention paid to special groups, which are often more at risk of drug abuse than mainstream society. Prevention in school is important, but does not reach marginalized youth (such as street children) who do not go to school. Also, treatment services are in most cases designed for "typical" young male drug abusers and do not always recognize the existence of groups with specific needs (such as women and adolescents). Interventions aimed at reducing the negative health and social consequences of drug abuse do, to some extent, target vulnerable groups such as hard-core drug abusers, injecting drug abusers and prison populations, but there are vulnerable groups who are not covered by these interventions. In most States, it appears that the number of interventions targeting vulnerable and special populations is increasing (see figure VIII). In regions with considerable experience in demand reduction and with established and sustained programmes (North America, Central and Western Europe and Oceania), special programmes are quite common, possibly because the relatively long experience in demand reduction in these regions may have made it possible for government agencies and non-governmental organizations to recognize the special needs of groups not covered by the so-called "universal" interventions.

63. It appears that other regions (East and South-East Asia, Central, South and South-West Asia, North Africa and the Middle East and Eastern and South-Eastern Europe) have also increased their efforts in this area, starting from a lower coverage level. The reason for these increases may be related to the increase in interventions with groups at risk of HIV and other blood-borne infections, which has been a main feature of the recent evolution of the drug abuse problem and demand reduction responses in some of these regions. In Latin America and the Caribbean, the reported level of intervention has remained more or less stable, at a medium level. States in Sub-Saharan Africa have reported lower levels of intervention for vulnerable and special groups, with some variations during the various reporting periods, but consistently below 50 per cent.

64. Interventions focusing on special populations are important not only to reduce drug abuse among groups at risk, but also to improve their health and reduce the number of social problems arising from their drug use. These interventions are also a key to the success of broader prevention and treatment interventions.

Figure VIII

Efforts made to work with vulnerable or special populations, by region, 1998-2006



Source: Biennial reports questionnaires 1998-2000, 2000-2002, 2002-2004 and 2004-2006.

VII. Media and public campaign responses

65. Media and public campaigns responses are one of the most common kinds of intervention in the field of drug abuse prevention. Recent findings from the evaluation of media campaigns in North America confirm the view that, even well-funded, well-planned and sustained campaigns have a limited effect in changing the attitudes of the target group, although they have some effect in changing levels of information and awareness. Although changes in information and awareness have not been demonstrated to be linked to changes in behaviour, media and public campaign responses are still part of a comprehensive prevention package, reinforcing messages and values promoted through other activities.

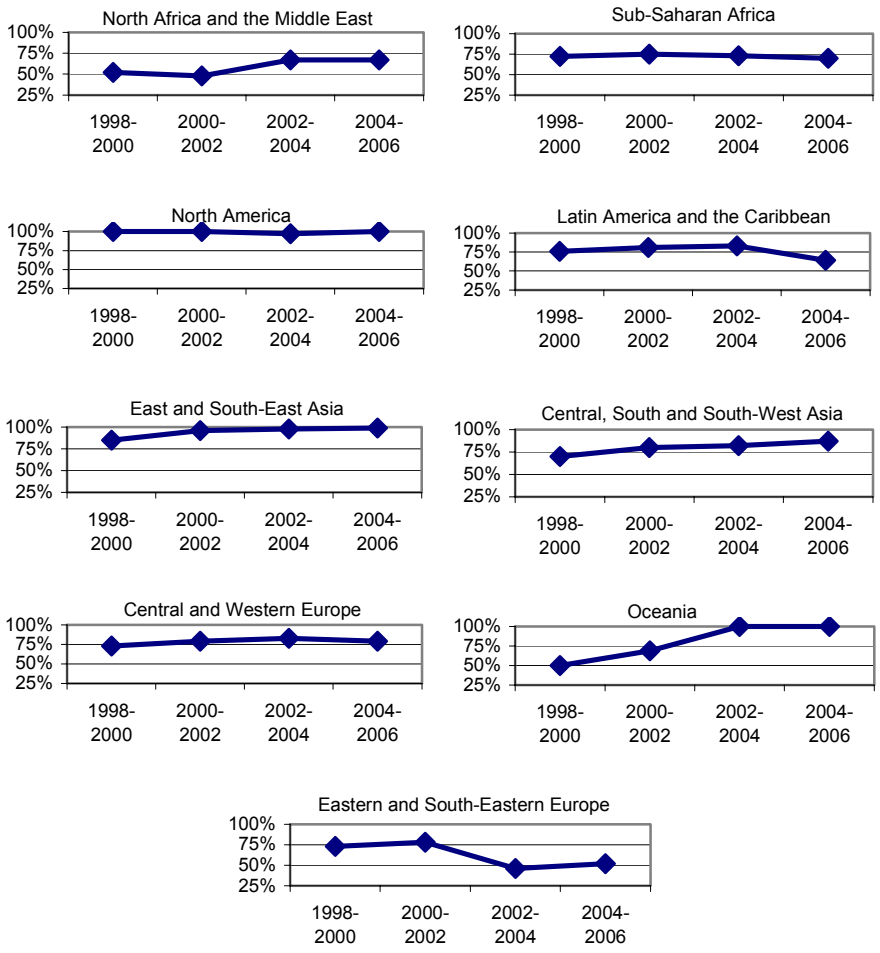
66. The positive global trend seen in the composite index regarding activities implemented to improve media and public campaigns as part of demand reduction efforts showed a slight decrease in the last reporting period, although the proportion is still fairly high, at 76 per cent (see figure IX for regional trends). With regard to individual components of the responses reported under this sub-item, the proportion of States reporting having included public information campaigns as part of their national demand reduction strategy has slightly decreased (from 86 to 80 per cent) since the previous reporting period. It is particularly disappointing to note that the proportion of States reporting having based their campaigns on a needs assessment has decreased (from 75 to 67 per cent), with the most marked decreases reported in Central and Western Europe (from 94 to 67 per cent). This is a serious development as basing campaigns on needs assessments is clearly one prerequisite for their success.

67. Regarding demand reduction practitioners involved in conveying demand reduction messages, a positive note is struck by the fact that most States (82 per cent) provide them with training to carry out this task; the proportion of these States is clearly above 50 per cent in all regions. Such training needs to be sustained, as it is one of the foundations of consistent and effective drug reduction interventions.

68. However, it should be noted that the number of States reporting that they evaluate the effectiveness of their campaigns is still rather low (43 per cent), although it has slightly improved since the last reporting period. This means that currently more than half of reporting States will not be in a position to know whether the campaigns they have implemented have been effective or not. A concerted effort is needed in some regions to improve this situation: in North Africa and the Middle East the proportion has decreased from 63 to 38 per cent since the previous reporting period; decreases were also reported in Eastern and South-Eastern Europe and Sub-Saharan Africa, with only one in five or fewer States having evaluated the results of those campaigns. The number of States reporting that they evaluated their media and public information campaigns increased substantially in Central, South and South-West Asia, East and South-East Asia, Latin America and the Caribbean and North America.

69. It would be desirable for regions such as East and South-East Asia, North America and Oceania, which have been shown through the biennial reports questionnaire to have attained the highest levels of coverage for activities with regard to developing, sending and evaluating appropriate and accurate demand reduction messages, to share their experiences and expertise in this field with a view to assisting improvements in such activities in other regions.

Figure IX
Media and public campaign responses, by region, 1998-2006



Source: Biennial reports questionnaires 1998-2000, 2000-2002, 2002-2004 and 2004-2006.

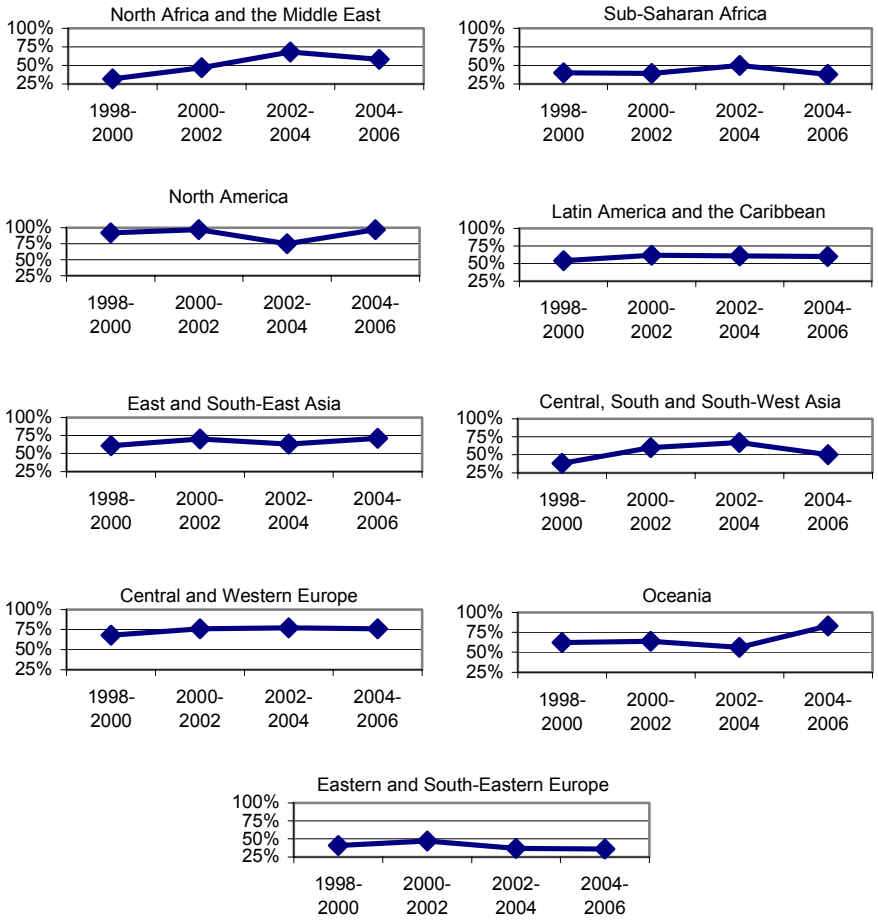
VIII. Evaluation and incorporation of lessons learned

70. In the section of the biennial reports questionnaire on the evaluation and incorporation of lessons learned, questions are asked about three key issues in demand reduction: training of practitioners, evaluation of interventions, and sharing and dissemination of best practices and lessons learned. The importance assigned to these activities by States signals their intention to invest resources in the long term to implement sustained and evidence-based interventions.

71. Again, as is the case for other kinds of intervention, the regions with sustained demand reduction programmes and consequently dedicated resources (such as North America, Europe and Oceania) appear to be relatively active in all three areas (scoring 75 per cent and above). Most of the other regions scored above 50 per cent,

while in Sub-Saharan Africa and Eastern and South-Eastern Europe the importance assigned to these activities is still limited (see figure X).

Figure X
Evaluation and incorporation of lessons learned, by region, 1998-2006



Source: Biennial reports questionnaires 1998-2000, 2000-2002, 2002-2004 and 2004-2006.

IX. Conclusions

72. Despite the efforts made to use the information of the biennial reports questionnaire to provide Member States with some sense of the progress made since 1998, the biennial reports questionnaire remains a tool with considerable limitations and Member States are encouraged to consider, after the conclusion of the 10-year period 1998-2008, the possibility of further improving the biennial reports questionnaire. Information on the real coverage, quality and impact of interventions is crucial to an adequate assessment of real progress.

73. The analysis of the responses provided by States in the sections of the biennial reports questionnaire on drug demand reduction can be used to draw the following basic conclusions for consideration by the Commission:

(a) The political commitment to drug demand reduction remains strong and States have invested resources in building the foundations for effective national demand reduction strategies;

(b) In more and more States the political commitment is reinforced and the related policymaking is informed by research and analysis of drug abuse information;

(c) Progress is being made in implementing the key interventions (prevention, treatment and rehabilitation, and addressing the negative health and social consequences of drug abuse), but the quantum leap required to achieve significant and measurable results in reducing drug demand has yet to be made.