

**Commission on Narcotic Drugs****Sixty-fourth session**

Vienna, 12–16 April 2021

Item 6 of the provisional agenda*

**Follow-up to the implementation at the national,
regional and international levels of all
commitments, as reflected in the Ministerial
Declaration of 2019, to address and counter the
world drug problem****World situation with regard to drug abuse****Report of the Secretariat***Summary*

The present report contains a summary of the information available to the United Nations Office on Drugs and Crime (UNODC) on the extent of drug use and its health consequences. In 2018, an estimated 269 million people had used an illicit substance in the preceding year; of those, approximately one in eight were estimated to have suffered from drug use disorders. UNODC, jointly with the World Health Organization, the Joint United Nations Programme on HIV/AIDS and the World Bank, estimates that 11.3 million people inject drugs and that approximately one in eight people who inject drugs is living with HIV. Globally, drug use remains multifaceted, characterized by the concurrent and sequential use of several substances, including conventional plant-based drugs, synthetic stimulants, opioids, pharmaceutical drugs and new psychoactive substances (including those with opioid effects). Opioids, including heroin and pharmaceutical opioids, continue to have a detrimental impact on the health of people who misuse them. Of particular concern is the number of deaths attributed to the use of fentanyl and its analogues, in particular in North America, and the rapid expansion of the non-medical use of tramadol in parts of Asia and Africa. Globally, there were nearly half a million deaths attributable to drug use. The lack of reliable information on most epidemiological indicators of drug use hinders both the monitoring of emerging trends and the implementation and evaluation of evidence-based responses to drug use and its health consequences.

* E/CN.7/2021/1.



I. Introduction

A. Emerging global trends

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

(a) Opioid use, including heroin use and the non-medical use of pharmaceutical opioids and new psychoactive substances with opioid effects (such as U-47700, AH-7921 and MT-45), is a major concern in many countries because of the serious health consequences of such use;

(b) There are indications of an increase in the use of cocaine in Western and Central Europe, while its use has stabilized at high levels in North America;

(c) Cannabis use is stable at high levels in Europe and is considered to be increasing in the Americas, Africa and Asia;

(d) The use of amphetamines, especially methamphetamine, is considered to be increasing in many parts of Asia and in North America, whereas their use in Western and Central Europe, especially in high-prevalence countries, is either declining or remains stable;

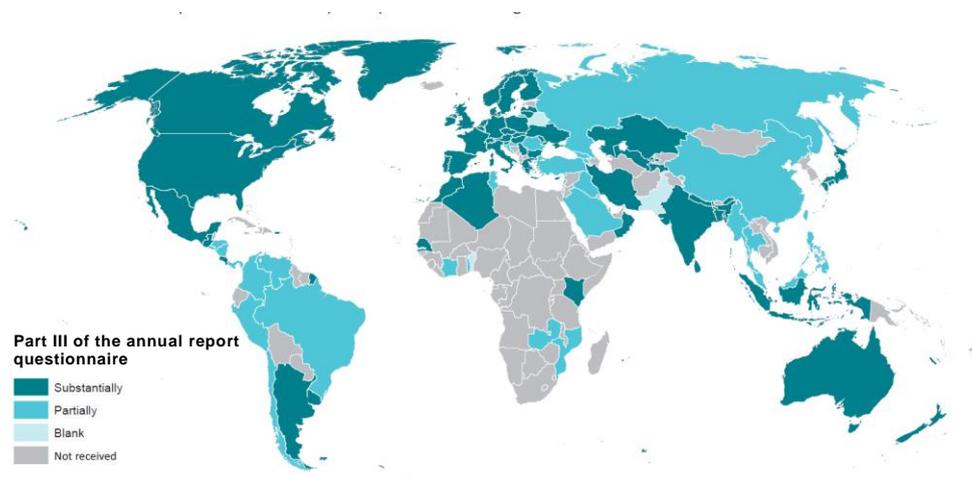
(e) With regard to the measures to prevent or slow down the spread of the coronavirus disease (COVID-19) in different parts of the world, experts responding to a survey have suggested that there has been an increase in the use of cannabis, benzodiazepines and pharmaceutical opioids, while they considered that the use of opiates, amphetamine and cocaine in their countries appeared to have declined. They also indicated that there had been an increase in or a shift towards injecting drugs, as well as an increase in drug-related morbidity and mortality among regular drug users.

B. Challenges in understanding the extent and patterns of and trends in drug use

2. Member States' responses to the annual report questionnaire form the basis on which the global extent of and trends in drug use are reported each year. As at 1 December 2020, 91 out of 200 States and territories had returned part III of the questionnaire, on the extent and patterns of and trends in drug use related to 2019.

3. Of the questionnaires submitted by Member States, 62 per cent were substantially filled in, meaning that the State had provided information on more than half of the indicators of drug use and its health consequences. In terms of coverage, the 91 Member States that had returned the questionnaire represented almost 62 per cent of the world's population (see figure I).

Figure I
Responses to part III of the annual report questionnaire
Member States that provided drug demand data in the annual report questionnaire for 2019*



Note: The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Dashed lines represent undetermined boundaries. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

The final boundary between the Sudan and South Sudan has not yet been determined.

* Reflects status of submission as at 1 December 2020.

II. Global overview

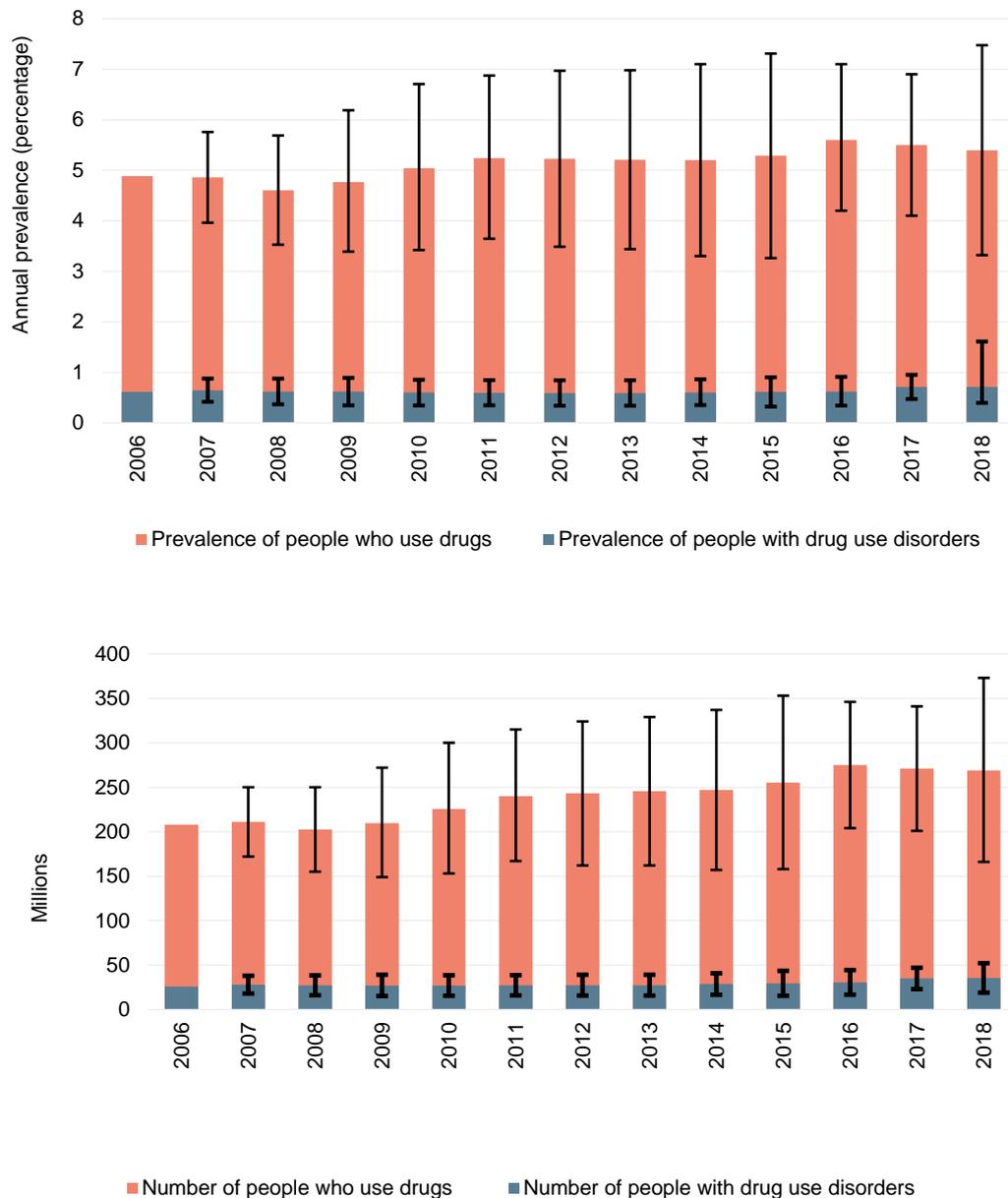
A. Extent of drug use¹

4. In 2018, an estimated 269 million people worldwide had used drugs at least once in the previous year. This corresponds to 5.4 per cent of the global population aged 15 to 64.

5. Over the period 2009–2018, the estimated number of past-year users of any drug globally increased from 210 million (range: 149 million to 272 million) to 269 million (range: 166 million to 373 million) – by more than a quarter (28 per cent) – partly as a result of growth in the global population. Consequently, the prevalence of drug use increased by more than 12 per cent, from 4.8 per cent (range: 3.4 to 6.2 per cent) of the adult population in 2009 to 5.4 per cent (range: 3.3 to 7.5 per cent) in 2018. However, considering the wide uncertainty intervals of these estimates and that in any given year the global estimates represent the best available data, any comparison of estimates over time should be undertaken with caution.

¹ Unless specified otherwise, the information on the extent of and trends in drug use is based either on the responses of Member States to the annual report questionnaire or on the *World Drug Report 2020*.

Figure II
Global trends in the annual prevalence of drug use and drug use disorders,
2006–2018



Note: Estimates of people who use drugs are for adults (aged 15–64) who used drugs in the past year. The global estimates of the extent of drug use and drug use disorders reflect the best available information for the year 2018. Changes compared with previous years largely reflect the information updated by countries, for which new data on the extent of drug use were made available in 2018. Therefore, the global and regional estimates presented in a given year are based on both the new estimates that were available for a particular country in the reference year and the most recent estimates available for the other countries.

6. Over the past decade, the types of substances available on the drug markets have diversified. In addition to traditional plant-based substances such as cannabis, cocaine and heroin, a dynamic market for synthetic drugs has emerged and the non-medical use of pharmaceutical drugs has increased. The availability of more potent drugs, the increasing number of substances and their consecutive or sequential use among occasional or regular users pose an even greater challenge to the prevention of drug use and the treatment of drug use disorders than in the past.

7. In recent years, hundreds of new psychoactive substances have been synthesized. The majority of those substances are stimulants, followed by synthetic

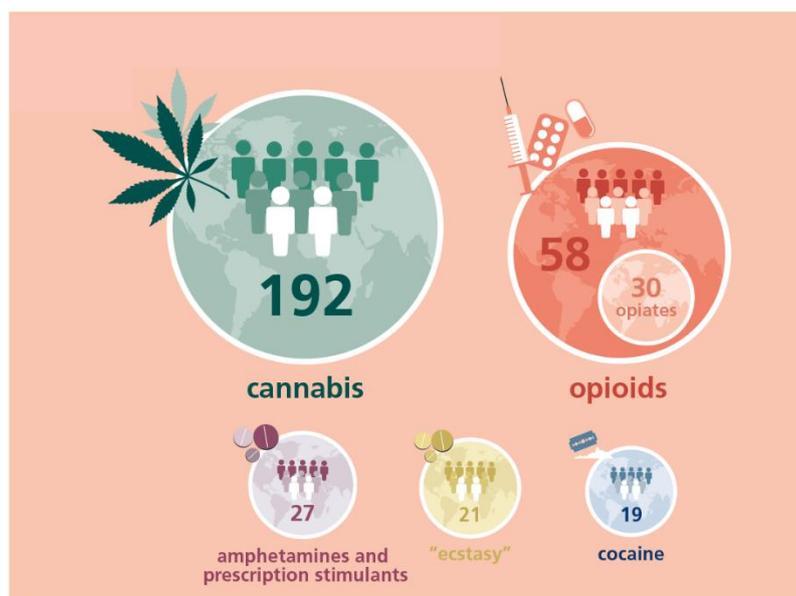
cannabinoid receptor agonists, and an increasing number of them are opioids (fentanyl analogues or research opioids). New psychoactive substances within the same effect group (e.g., stimulants) comprise a wide range of chemical substances; thus, their effects remain unpredictable, and they sometimes have severe adverse health consequences. Most new psychoactive substances tend to be transient and have not carved out a niche of their own in the drug markets. However, patterns of use of those substances have been observed, in particular the use of synthetic cannabinoid receptor agonists among marginalized, vulnerable and socially disadvantaged groups, including homeless people and those in prisons or on probation.

8. The global picture of drug use is further complicated by the fact that many people who use drugs, whether occasionally or regularly, are polydrug users (using more than one substance concurrently or sequentially, with the intention of enhancing, potentiating or counteracting the effects of other drugs). This blurs the distinction between users of a particular substance and presents a picture of interlinked epidemics of drug use and related health consequences.

9. Approximately one in eight people who use drugs are estimated to suffer from drug use disorders. Among the estimated 269 million people who used drugs in the past year, some 35.6 million people (range: 19.0 million to 52.2 million) are estimated to suffer from drug use disorders, that is, their pattern of drug use is harmful, or they may experience drug dependence and/or require treatment. This corresponds to a global prevalence of drug use disorders of 0.7 per cent (range: 0.3 to 0.9 per cent) among the population aged 15 to 64.

10. In 2018, drug use disorders accounted for 17.8 million disability-adjusted life years (the number of years of healthy life lost as a result of disability or premature death).² More than 70 per cent of the total, or 12.7 million disability-adjusted life years, were attributable to opioid use disorders. Of particular concern are the 8 million disability-adjusted life years attributed to hepatitis C, including liver cancer, cirrhosis and other chronic liver diseases resulting from hepatitis C, among people who use or inject drugs.

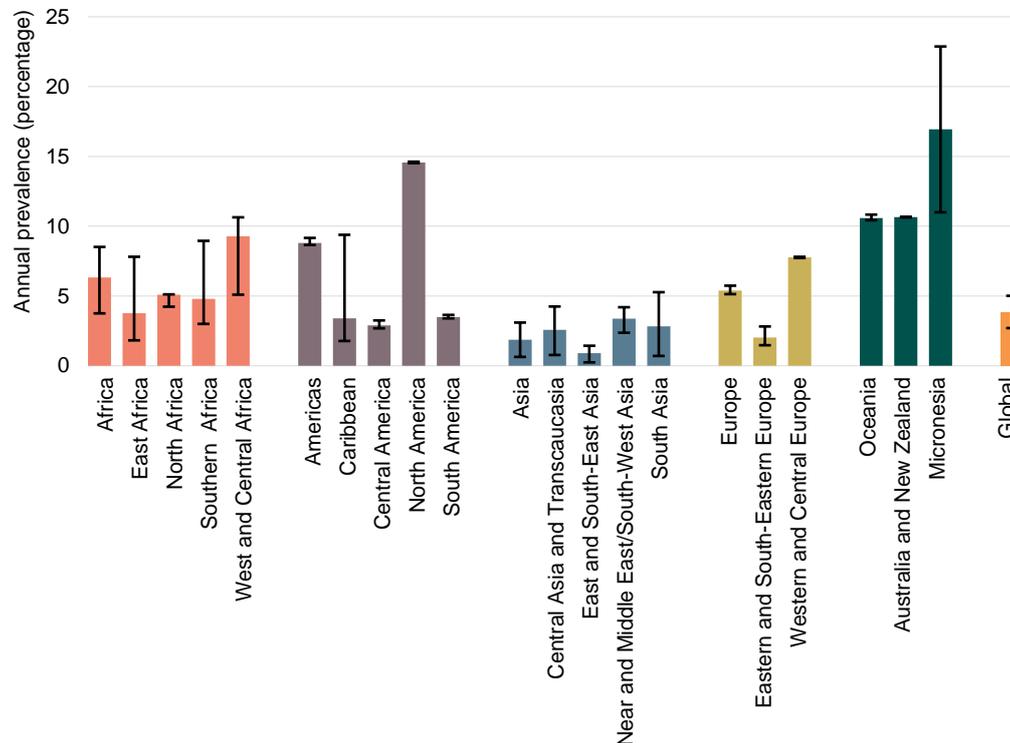
Figure III
Number of past-year users in millions, 2018



² Institute for Health Metrics and Evaluation, Global Health Data Exchange, Global Burden of Disease Study Results Tool. Available at <http://ghdx.healthdata.org/gbd-results-tool>.

11. Worldwide, there were an estimated 192 million past-year users of cannabis in 2018, corresponding to 3.9 per cent of the global population aged 15 to 64. The past-year use of cannabis is substantially higher than the global average in North America (14.6 per cent), Australia and New Zealand (10.6 per cent) and West and Central Africa (9.3 per cent).

Figure IV
Use of cannabis, by region, 2018



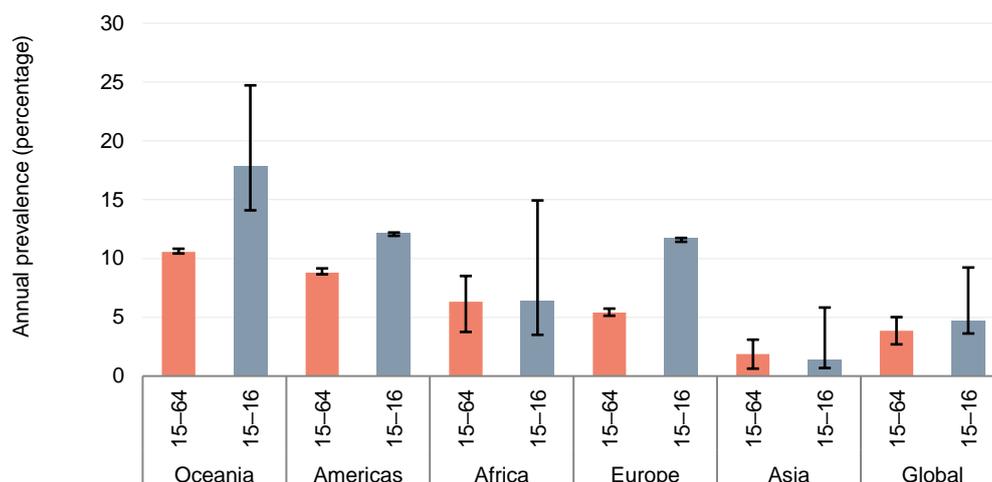
12. Cannabis is the drug most widely used among young people. Globally, it is estimated that there were 13 million past-year users of any drug among students aged 15 and 16 in 2018, with an estimated 11.6 million past-year users of cannabis. This corresponds to an annual prevalence of cannabis use of 4.7 per cent among that age group, a rate that is higher than the rate among the general population (3.9 per cent). Past-year use of cannabis among young people aged 15 and 16 is high in Oceania (17.8 per cent), the Americas (12.1 per cent) and Europe (11.7 per cent).

13. The risk of developing dependence on cannabis among those who have ever used it has been estimated at 9 per cent by studies in the United States of America.³ Other studies have shown that the risk of developing dependence was 17 per cent among those who reported lifetime use and had started using cannabis in adolescence.⁴

³ Catalina Lopez-Quintero and others, "Probability and predictors of transition from first use to dependence on nicotine, alcohol, cannabis, and cocaine: results of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)", *Drug and Alcohol Dependence*, vol. 115, Nos. 1–2 (May 2011), pp. 120–130.

⁴ James C. Anthony, "The epidemiology of cannabis dependence", in *Cannabis Dependence: Its Nature, Consequences and Treatment*, Roger A. Roffman and Robert S. Stephens, eds. (Cambridge, Cambridge University Press, 2006), pp. 58–105.

Figure V
Global and regional estimates of cannabis use among people aged 15–16 and among the general population aged 15–64, 2018



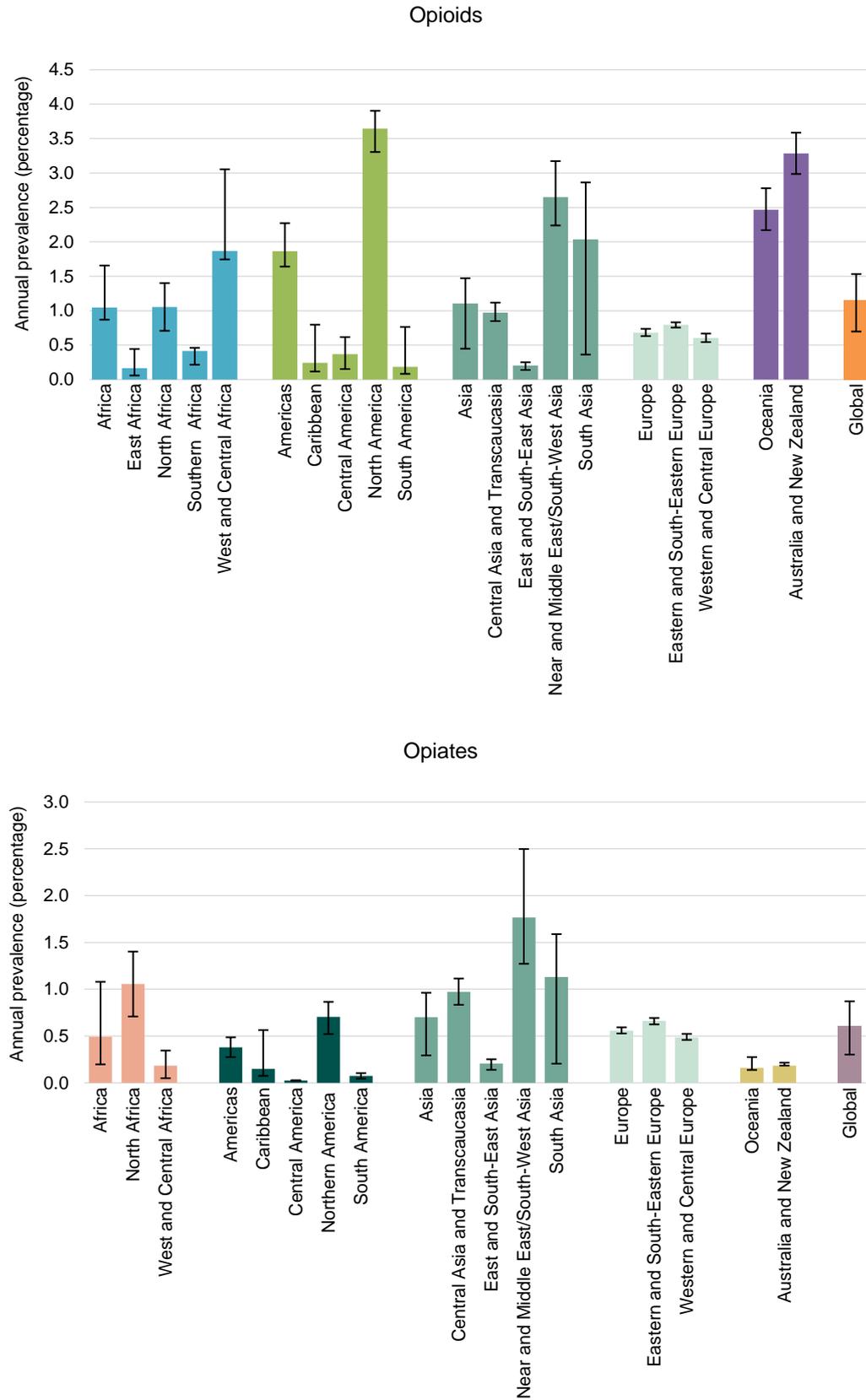
14. Beginning in 2010, cannabis use, particularly among young people, was reported as stabilizing or declining in countries with established cannabis markets, such as those in Western and Central Europe, North America and Australia and New Zealand, but that trend was offset by increasing consumption in many countries in South America, Africa and Asia. While cannabis use in Western and Central Europe is still reported as stabilizing at high levels, it has increased considerably over the past decade in the Americas, Africa and Asia.

15. In 2018, an estimated 57.8 million people worldwide had used opioids in the past year, including those who had used opiates (30.4 million) and those who had misused pharmaceutical opioids.⁵ This corresponds to a past-year prevalence of opioid use of 1.2 per cent of the global population aged 15 to 64.

16. The use of opioids is higher than the global average in North America (3.6 per cent), Australia and New Zealand (3.3 per cent), the Near and Middle East and South-West Asia (2.6 per cent) and South Asia (2.0 per cent). While the population of South Asia accounts for only about 20 per cent of the global population aged 15 to 64, more than one third of the estimated number of opioid users worldwide live in that subregion. The past-year prevalence of opiate use is higher than the global average (0.6 per cent) in the Near and Middle East and South-West Asia (1.8 per cent) and South Asia (1.1 per cent), two subregions that together account for almost 60 per cent of the estimated number of opiate users worldwide.

⁵ The term “misuse” denotes the non-medical use of pharmaceutical drugs.

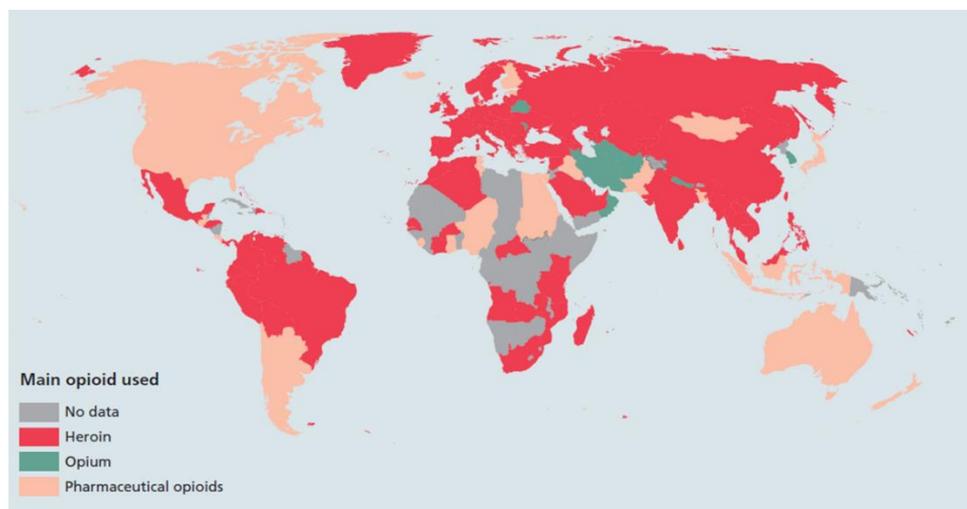
Figure VI
Use of opioids and opiates, by region, 2018



17. The opioid crisis continues in North America, with the increase in opioid overdose deaths attributed to the use of fentanyl in particular. The other opioid crisis concerns the non-medical use of tramadol, which has emerged in recent years as an opioid of public health concern in many subregions, in particular West, Central and North Africa. This is reflected in the number of people in treatment for tramadol-related problems and the number of tramadol overdose deaths reported in some countries in those subregions. There are also increasing signs of non-medical use of pharmaceutical opioids in Western and Central Europe, as reflected in the increasing proportion of people accessing treatment services for such use in the subregion.

Figure VII

Most commonly used opioid, 2018 or latest available data



Source: UNODC, responses to the annual report questionnaire.

Note: Information is based primarily on the reported prevalence of opioid use and, when that was not available, on the ranking or data on treatment of opioid use reported in the annual report questionnaire.

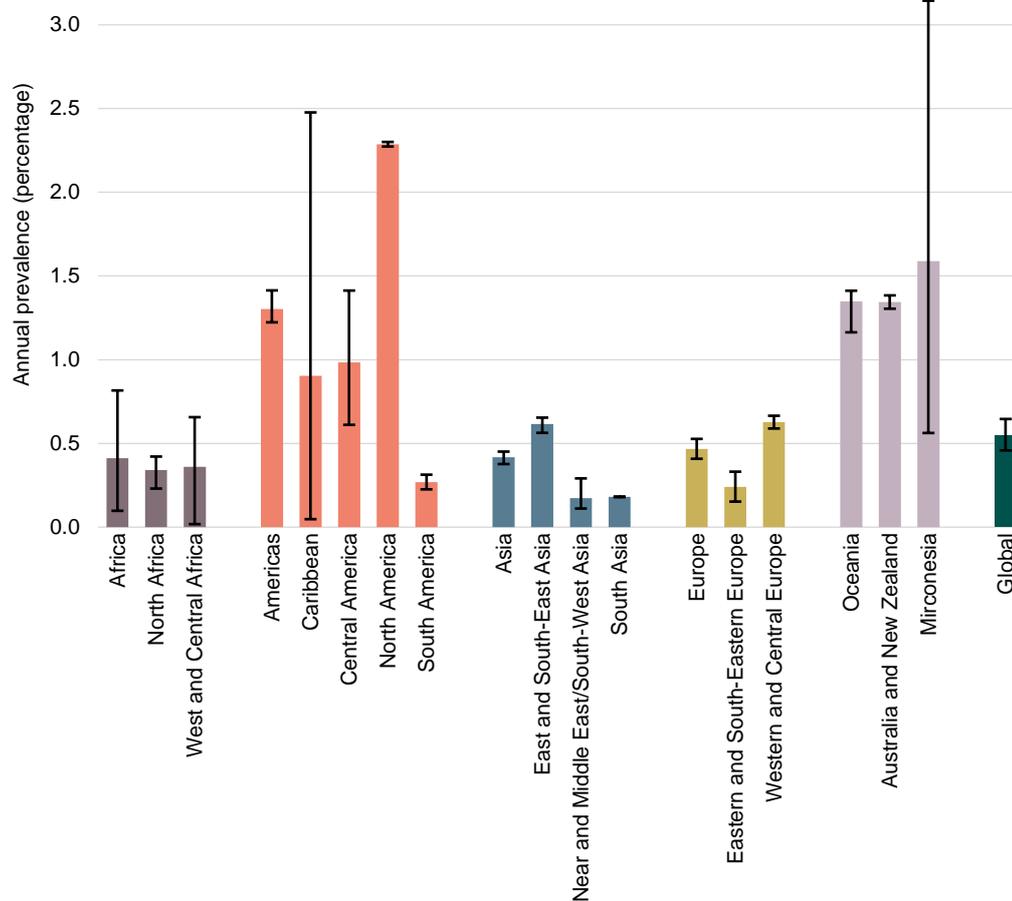
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dashed lines represent undetermined boundaries. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between the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

18. The use of amphetamines also remains widespread. An estimated 27 million people worldwide, corresponding to 0.5 per cent of the adult population, are estimated to have used amphetamines, including amphetamine, methamphetamine and pharmaceutical stimulants, in the past year. The past-year prevalence of the use of amphetamines is particularly high in North America (2.3 per cent of the population aged 15–64) and Australia and New Zealand (1.3 per cent). The corresponding figure in Asia is at a similar level (0.4 per cent) to the global average. Nearly half of the estimated global number of past-year users of amphetamines (12.7 million people) reside in Asia.

19. The type and form of amphetamines used vary considerably across different regions and subregions. In North America, the non-medical use of pharmaceutical stimulants and methamphetamine is most prevalent; in East and South-East Asia and Australia and New Zealand, it is methamphetamine; and in Western and Central Europe and the Near and Middle East, it is amphetamine. In the latter subregion, amphetamine is commonly known as “captagon”. In many countries in South and Central America, especially those that have reported recent survey data, the non-medical use of pharmaceutical stimulants is more common than the use of other amphetamines. The non-medical use of weight loss pills is reportedly more prevalent among women than among men, with substances such as sibutramine hydrochloride monohydrate and phentermine, along with methylphenidate and amphetamine,

reported to be the most commonly misused pharmaceutical stimulants in those subregions.^{6,7}

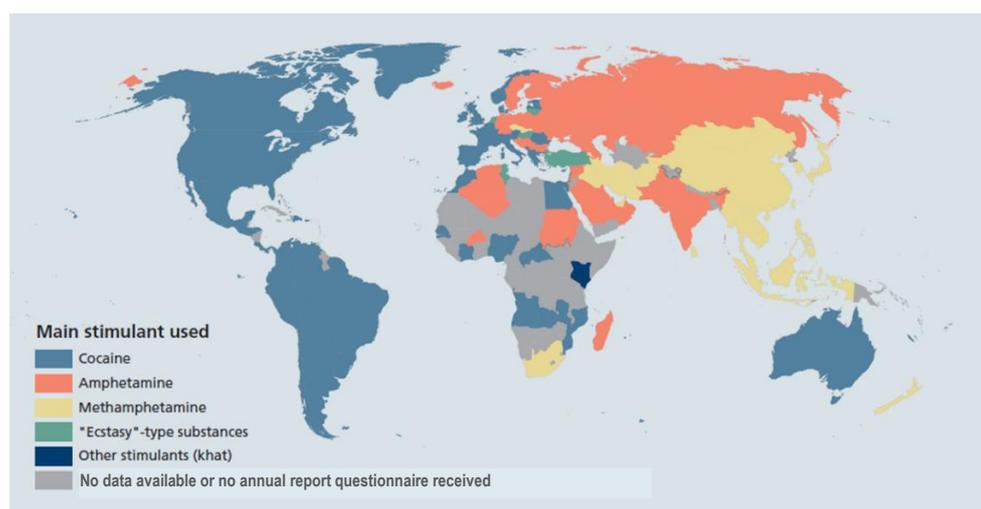
Figure VIII
Use of amphetamines, by region, 2018



⁶ Argentina, Secretaría de Políticas Integrales sobre Drogas de la Nación Argentina (SEDRONAR), *Estudio Nacional en Población de 12 a 65 años, sobre Consumo de Sustancias Psicoactivas: Argentina 2017 – Informe de Resultados No.1: Magnitud del Consumo de Sustancias a Nivel Nacional* (Buenos Aires, 2017).

⁷ Mario E. López López and Alma C. Escobar de Mena, *Estudio Nacional Sobre Consumo de Drogas en Población General de El Salvador 2014* (San Salvador, Dirección Ejecutiva de la Comisión Nacional Antidrogas, 2014).

Figure IX
Main stimulant drug used, 2018 or latest year



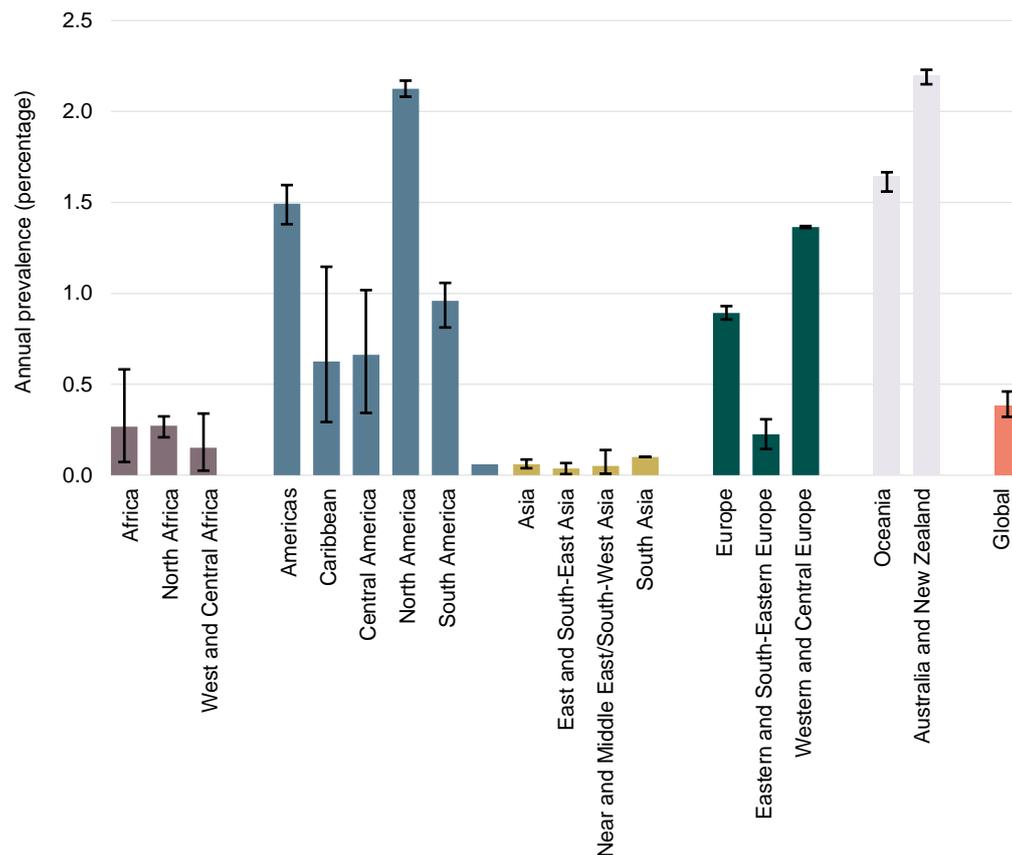
Source: UNODC, responses to the annual report questionnaire.

Note: Information is based primarily on the reported prevalence of stimulant drugs (cocaine, amphetamine, methamphetamine and “ecstasy”) and, when that was not available, on the ranking or data on treatment of stimulant drug use reported in the annual report questionnaire.

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

20. Globally, an estimated 19 million people were past-year users of cocaine in 2018, corresponding to 0.4 per cent of the global population aged 15 to 64. The main cocaine markets continue to be North America and Western and Central Europe, with a prevalence of use of 2.1 per cent and 1.4 per cent, respectively, while the highest prevalence of past-year cocaine use is in Australia and New Zealand, at 2.2 per cent of the population aged 15 to 64. The use of cocaine is also higher than the global average in Central America (0.7 per cent) and South America (1.0 per cent). Cocaine use in the other subregions remains much lower than the global average.

Figure X
Use of cocaine, by region, 2018

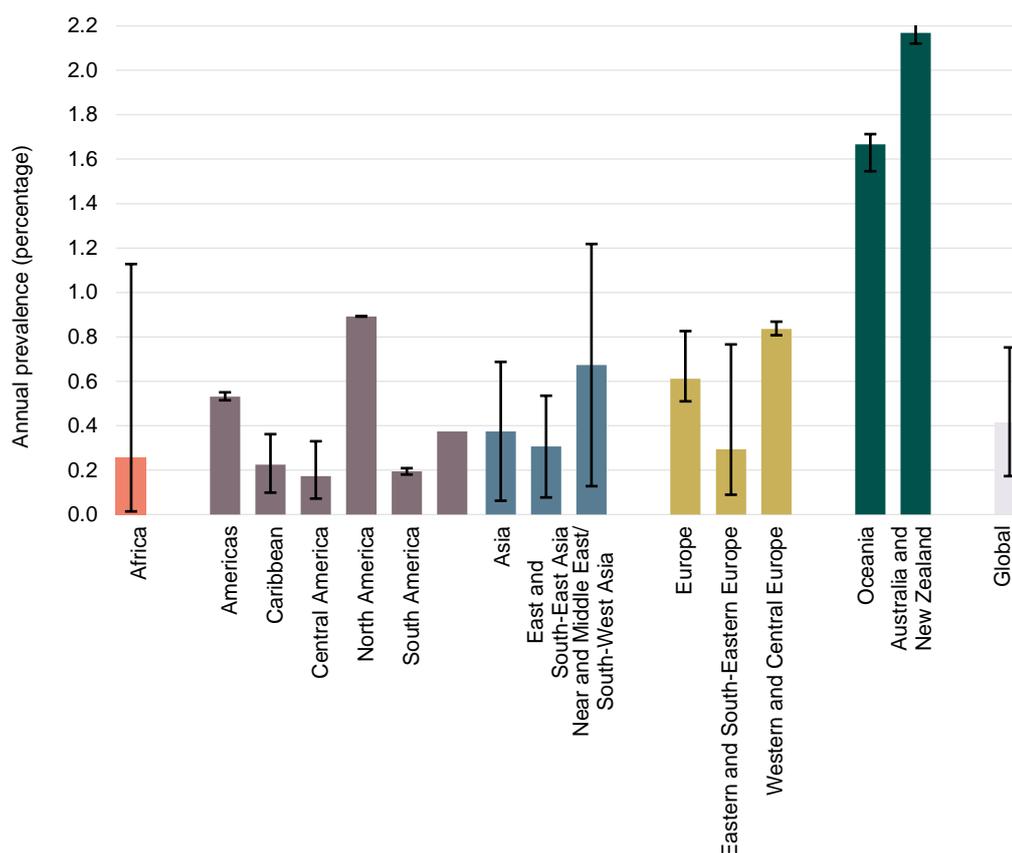


21. The use of cocaine continues to take place both among socially integrated recreational users, for example, in nightlife settings, and among socially marginalized drug users who also use “crack” cocaine. In South America, the use of cocaine base paste, previously confined to cocaine-manufacturing countries, has also spread to countries further south. In parts of Asia and West Africa, increasing amounts of cocaine have reportedly been seized, which indicates that cocaine use could potentially increase, especially among affluent, urban segments of the population.

22. In 2018, around 20.5 million people globally were estimated to have used “ecstasy” in the past year, corresponding to 0.4 per cent of the adult population. The prevalence of past-year use of “ecstasy” is relatively high in Australia and New Zealand (2.2 per cent), North America (0.9 per cent) and Western and Central Europe (0.8 per cent). The use of “ecstasy” is mainly associated with recreational nightlife settings, with higher levels of use observed among younger people.⁸

⁸ See, for example, *World Drug Report 2018*, booklet 4, *Drugs and Age: Drugs and Associated Issues among Young People and Older People* (United Nations publication, 2018) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *European Drug Report 2019: Trends and Developments* (Luxembourg, Publications Office of the European Union, 2019).

Figure XI
Use of “ecstasy”, by region and in selected subregions, 2018



23. Between 2007 and 2012, most countries in Western and Central Europe reported stable or declining trends in the use of “ecstasy”; however, in subsequent years, with an increasing availability of high-purity “ecstasy” in Western and Central Europe, as well as other subregions, there were indications of an overall resurgence in its use. The forms of “ecstasy” have also diversified, with high-purity powder and crystalline forms becoming available and commonly used.

24. While global estimates of the non-medical use of pharmaceutical drugs are not available, such misuse remains quite widespread, in particular among polydrug users. Between 2010 and 2018, the non-medical use of pharmaceutical opioids, benzodiazepines and pharmaceutical stimulants began to be reported as a growing health problem in a number of countries. The non-medical use of benzodiazepines remains the most common: between 2015 and 2018, approximately 60 countries ranked sedatives and tranquilizers – mostly benzodiazepines – among the three most commonly misused substances, while some countries reported a higher prevalence of their non-medical use than that of other drugs, including cannabis. Benzodiazepines are also frequently reported in fatal overdose cases involving opioids.

25. The use of *gamma*-hydroxybutyric acid (GHB), *gamma*-butyrolactone (GBL) and benzodiazepines such as flunitrazepam has also been associated with drug-facilitated sexual assault, which occurs when alcohol or other drugs are used to compromise an individual’s ability to consent to sexual activity. The use of GHB and GBL has also been reported over the past two decades among subgroups of drug users,

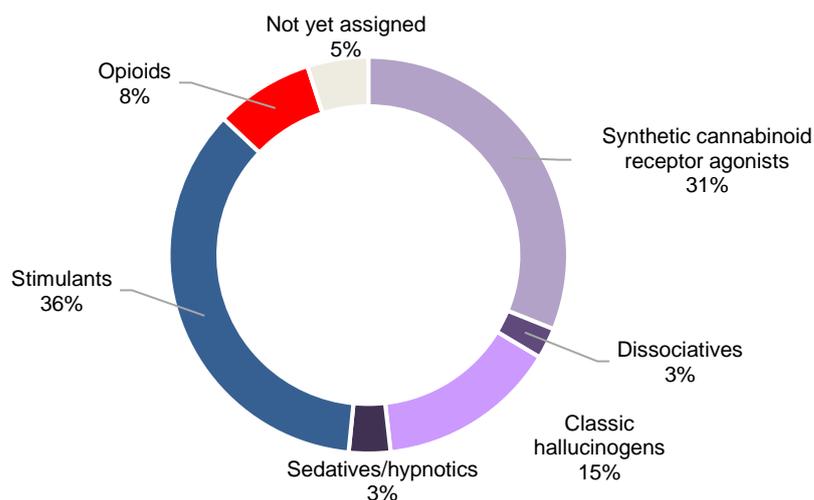
such as those attending dance events,^{9,10} and in gay and lesbian communities in Australia, Europe and North America.¹¹ The use of GHB, along with methamphetamine and mephedrone, is also frequently reported among people who engage in “chemsex”.^{12,13,14}

26. The global market for new psychoactive substances continues to be characterized by the emergence of new substances belonging to diverse chemical groups. By December 2019, a total of 950 new psychoactive substances had been reported to UNODC. While the global market for such substances remains widely diversified, with the exception of a few, they do not seem to have established themselves on drug markets or replaced traditional drugs on a larger scale. Moreover, the injecting of stimulant new psychoactive substances remains a concern, particularly in view of the reported high-risk injecting practices associated with such use. The use of new psychoactive substances in prisons also remains a concern in some countries in Europe, North America and Australia and New Zealand.

27. Grouped according to their main pharmacological effect, most of the new psychoactive substances identified in the period 2009–2019 were stimulants (mostly cathinones and phenethylamines), followed by synthetic cannabinoids and hallucinogens (mostly tryptamines). The main concern for the authorities in a number of countries, however, has been the emergence in recent years of synthetic opioid receptor agonists, including fentanyl analogues. Although fewer in number than other categories of new psychoactive substances, they have proved to be particularly potent and harmful, leading to increasing numbers of overdose deaths in North America and, to a lesser extent, in Europe and other regions. From 2009 to 2019, approximately 8 per cent of all new psychoactive substances identified were opioid receptor agonists.

Figure XII

Proportion of new psychoactive substances reported for the first time, by psychoactive effect, 2019



⁹ Judith C. Barker, Shana L. Harris and Jo E. Dyer, “Experiences of gamma hydroxybutyrate (GHB) ingestion: a focus group study”, *Journal of Psychoactive Drugs*, vol. 39, No. 2 (June 2007), pp. 115–129.

¹⁰ Mark A. Bells and others, “The role of an international nightlife resort in the proliferation of recreational drugs”, *Addiction*, vol. 98, No. 12 (December 2003), pp. 1713–1721.

¹¹ Raffaele Giorgetti and others, “When ‘Chems’ meet sex: a rising phenomenon called ‘ChemSex’”, *Current Neuropharmacology*, vol. 15, No. 5 (July 2017), pp. 762–770.

¹² The term “chemsex” indicates the voluntary consumption of psychoactive and other drugs in the context of sex parties and sexual intercourse with the intention of facilitating or enhancing sexual encounters, mostly among men who have sex with other men.

¹³ Hannah McCall, Naomi Adams and Jamie Willis, “What is chemsex and why does it matter?”, *British Medical Journal*, vol. 351 (2015).

¹⁴ Claire Edmundson and others, “Sexualized drug use in the United Kingdom: a review of literature”, *International Journal of Drug Policy*, vol. 55 (2018), pp. 131–148.

B. Consequences of drug use

28. The health consequences of drug use can include a range of outcomes, such as drug use disorders, mental health disorders, HIV infection, liver cancer and cirrhosis associated with hepatitis, overdose and premature death. The greatest harms to health are those associated with the use of opioids and injecting drugs, because of the risk of acquiring HIV or hepatitis C through unsafe injecting practices.

29. In recent decades, the recognition of psychiatric comorbidities among people with substance use disorders has been growing. Although substance use disorders commonly occur together with other mental health disorders, it is often unclear whether one is a cause of the other or whether common underlying risk factors contribute to both disorders. The relevance of the comorbidity of substance use and mental health disorders is related mainly to the difficulty of managing them, particularly given the lack of integration of drug treatment, mental health and overall health-care delivery services in most countries. People with substance use disorders and psychiatric comorbidities also report lower rates of treatment success, a higher rate of psychiatric hospitalizations and a higher prevalence of suicide than those without comorbid mental health disorders.¹⁵

1. People with drug use disorders as reflected in treatment

30. There is overwhelming evidence that the cost of providing evidence-based treatment for drug use disorders is much lower than the cost of untreated drug dependence. Scientific evidence-based treatment of drug use disorders not only helps to reduce drug-related harm but also improves the health, well-being and recovery of people with drug use disorders while reducing drug-related crime and increasing public safety and positive community outcomes, for example, by reducing homelessness, requirements for social welfare and unemployment.¹⁶ Nevertheless, in many countries there remains a major shortfall in national capacities and in the provision of evidence-based drug treatment services as part of the public health-care system. For people with drug use disorders, the availability of and access to treatment services, in particular science-based services, remains limited at the global level, as only one in eight people with drug use disorders receives drug treatment each year. Moreover, although women account for one in three drug users, they continue to account for only one in five people in treatment.

31. The coverage of drug treatment services is influenced by a number of factors related to the availability and accessibility of the services, including national policy for the provision and cost of drug treatment (health insurance, government-provided treatment, out-of-pocket expenses); the extent of integration of drug treatment services within the health-care delivery system, including a system of referrals at various levels within the health-care system and across the criminal justice system; the number, setting and geographical coverage of available drug treatment facilities; the capacity or the number of drug treatment slots available in a treatment facility in a given period; the nature and range of interventions provided, for instance, long-term opioid agonist treatment for opioid use disorders as opposed to the management of withdrawals and other psychosocial interventions; and the existence of a national treatment reporting system and of reliable estimates of both the number of people with drug use disorders (or of those in need of drug treatment) and the number of those receiving drug treatment. An understanding of those contextual factors is therefore key when interpreting data on the coverage of drug treatment services.

32. With regard to treatment delivery, opioids remain of major concern in South-West and Central Asia and in Eastern and South-Eastern Europe. In South-Eastern Europe, nearly three out of every five people receiving treatment for drug use

¹⁵ EMCDDA, *Comorbidity of Substance Use and Mental Disorders in Europe*, EMCDDA Insights Series, No. 19 (Luxembourg, Publications Office of the European Union, 2015).

¹⁶ Nicole Kravitz-Wirtz and others, "Association of Medicaid expansion with opioid overdose mortality in the United States", *JAMA Network Open*, vol. 3, No. 1 (January 2020).

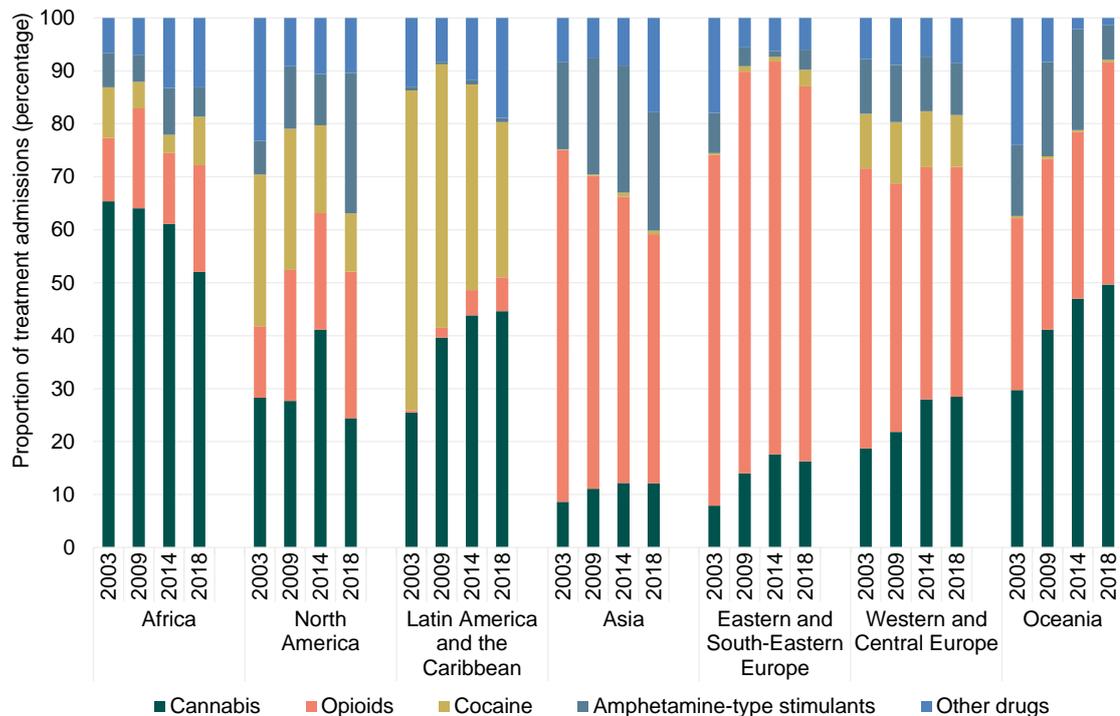
disorders are in treatment for opioid use disorders. Compared with users of other drugs, those entering treatment for opioid use disorders tend to be older, in their mid-thirties, and one quarter to one third of them are first-time entrants. This corresponds to findings published in scientific literature, for instance studies from Europe, which suggest that there is an ageing cohort of opioid users in that region.¹⁷

33. Treatment for cocaine use remains prominent in North America, Latin America and the Caribbean and, to a lesser extent, in Western and Central Europe, while amphetamines remain a problem in East and South-East Asia and, to some extent, in North America. In Latin America, as in other subregions, people entering treatment for cocaine use disorders tend to be in their mid-thirties, and 30–40 per cent are first-time entrants. In Asia, where half of the people in treatment for drug use disorders are receiving treatment for opioid use disorders, the number of people in treatment for disorders resulting from the use of methamphetamine has been increasing.

34. Cannabis is the main drug for which treatment is sought in Africa, but many countries in the region have reported an increasing number of people entering treatment for opioid use disorders. Over the past decade and a half, all regions other than Africa have seen an increasing proportion of drug treatment being provided for cases of cannabis use disorders. In most of the regions, nearly half of the people entering treatment for cannabis use disorders were first-time entrants, with a mean age of 26 years. As is the case with cannabis users, people with amphetamine use disorders who are in treatment tend to be younger – in their mid-twenties – than users of opioids in treatment, and the majority of them are likely to be first-time entrants.

Figure XIII

Trends in the primary drug of concern in drug treatment admissions, by region, 2003, 2009, 2014 and 2018



¹⁷ Anne Marie Carew and Catherine Comiskey, “Treatment for opioid use and outcomes in older adults: a systematic literature review”, *Drug and Alcohol Dependence*, vol. 182 (2018), pp. 48–57.

2. People who inject drugs

35. People who inject drugs are often subject to marginalization and stigmatization, which create social and economic barriers to accessing public health services and services for the prevention of the adverse health consequences of injecting drug use.¹⁸ Injecting drug use is a significant public health concern and causes morbidity and mortality owing to the risk of overdose and blood-borne infections (mainly HIV and hepatitis B and C)¹⁹ transmitted through the sharing of contaminated needles and syringes and other drug paraphernalia or risky sexual behaviour in some groups^{20,21,22,23,24,25} and subsequent severe immunosuppression, cirrhosis, neoplastic disease and inflammation sequelae. Social and physical effects can further aggravate potential underlying mental health conditions.

36. The joint UNODC/World Health Organization (WHO)/Joint United Nations Programme on HIV/AIDS (UNAIDS)/World Bank estimate of the number of people who injected drugs worldwide in 2018 was 11.3 million (range: 8.9 million to 15.3 million), corresponding to 0.23 per cent (range: 0.18 to 0.31 per cent) of the population aged 15 to 64. This estimate is based on the most recent information available.

37. The prevalence in 2018 of people aged 15 to 64 who inject drugs continued to be the highest in Eastern Europe (1.26 per cent) and Central Asia and Transcaucasia (0.63 per cent). Those percentages are, respectively, 5.5 and 2.8 times higher than the global average. More than a quarter of all people who inject drugs reside in East and South-East Asia, although the prevalence in that subregion is relatively low (0.19 per cent). The three subregions with the largest numbers of people who inject drugs (East and South-East Asia, North America and Eastern Europe) together account for more than half (58 per cent) of the total global number of people who inject drugs. It is noteworthy that, as in previous years, while three countries – China, the Russian Federation and the United States – account for just 27 per cent of the global population aged 15 to 64, they are home to almost half (43 per cent) of all people who inject drugs.

¹⁸ D. Richardson and C. Bell, “Public health interventions for reducing HIV, hepatitis B and hepatitis C infections in people who inject drugs”, *Public Health Action*, vol. 8, No. 4 (December 2018).

¹⁹ WHO, *Guidance on Prevention of Viral Hepatitis B and C among People Who Inject Drugs* (Geneva, 2012).

²⁰ United Nations Office on Drugs and Crime (UNODC), *HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs: Technical Guide* (Vienna, 2019).

²¹ Vic Arendt and others, “Injection of cocaine is associated with a recent HIV outbreak in people who inject drugs in Luxembourg”, *PLOS One*, vol.14, No. 5 (May 2019).

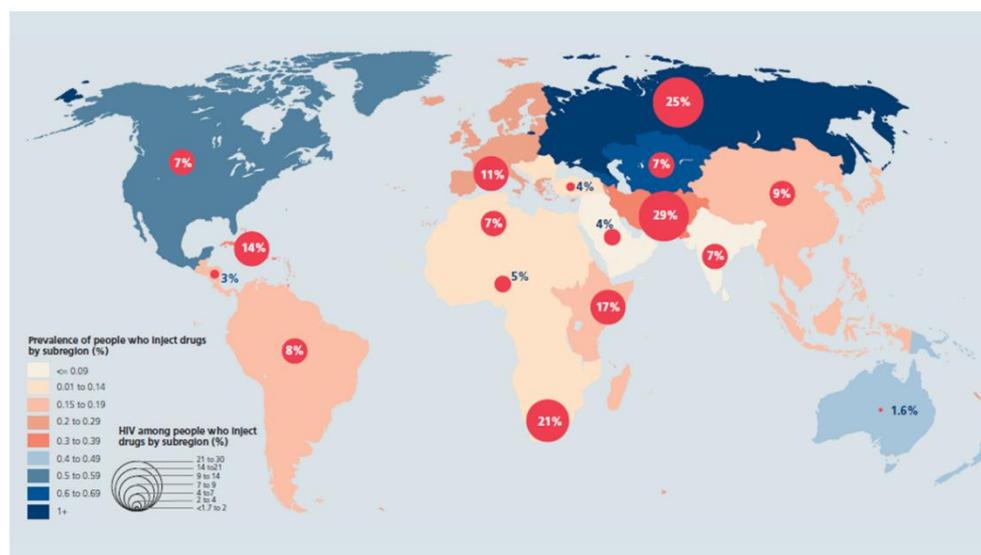
²² Naomi Braine and others, “HIV risk behavior among amphetamine injectors at U.S. syringe exchange programs”, *AIDS Education and Prevention*, vol. 17, No. 6 (December 2005).

²³ Catherine Mwangi and others, “Depression, injecting drug use, and risky sexual behavior syndemic among women who inject drugs in Kenya: a cross-sectional survey”, *Harm Reduction Journal*, vol. 16, No. 35 (May 2019).

²⁴ Bach Xuan Tran and others, “Factors associated with substance use and sexual behavior among drug users in three mountainous provinces of Vietnam”, *International Journal of Environmental Research and Public Health*, vol. 15, No. 9 (August 2018).

²⁵ Erica L. Pufall and others, “Sexualized drug use (‘chemsex’) and high-risk sexual behaviours in HIV-positive men who have sex with men”, *HIV Medicine*, vol. 19, No. 4 (April 2018).

Figure XIV
Estimated subregional prevalence of people who inject drugs and HIV among them, 2018



Source: UNODC, responses to the annual report questionnaire, supplemented by other data sources.

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. A dispute exists between the Governments of Argentina and the United Kingdom of Great Britain and Northern Ireland concerning sovereignty over the Falkland Islands (Malvinas).

3. HIV and hepatitis C among people who inject drugs

38. Injecting drug use is estimated to account for approximately 10 per cent of HIV infections worldwide and 30 per cent of all HIV cases outside Africa,²⁶ while in the eastern countries of the WHO European Region,²⁷ more than 80 per cent of all HIV infections occur among people who inject drugs.²⁸ People who inject drugs are estimated to be 22 times more likely than people in the general population to be living with HIV.²⁹

39. The joint UNODC/WHO/UNAIDS/World Bank estimate of the global prevalence of HIV among people who injected drugs in 2018 was 12.5 per cent, amounting to 1.4 million people who inject drugs living with HIV. That estimate is based on reports of the prevalence of HIV among people who inject drugs by 121 countries, covering 96 per cent of the estimated global number of people who inject drugs. In 2018, new or updated estimates of HIV prevalence among people who inject drugs were available for a total of 40 countries.

40. The subregional prevalence of HIV among people who inject drugs continues to be the highest in South-West Asia (29.5 per cent) and Eastern Europe (25.2 per cent), followed by Southern Africa (21.4 per cent). In Africa, HIV prevalence among people aged 15 to 64 who inject drugs was estimated at 11.3 per cent, compared with 3.9 per cent among the general population aged 15 to 49 for the same year. In Europe, the HIV prevalence among people who inject drugs was 20.1 per cent, compared with 0.4 per cent among the general population.³⁰ HIV prevalence in people who inject

²⁶ World Health Organization (WHO), Global HIV, Hepatitis and STIs Programmes, “People who use drugs”. Available at www.who.int/hiv/topics/idu/en/.

²⁷ Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

²⁸ WHO, Regional Office for Europe, “People who inject drugs (PWID)”. Available at www.euro.who.int/en/.

²⁹ Joint United Nations Programme on HIV/AIDS (UNAIDS), “Update: worldwide, more than half of new HIV infections now among key populations and their sexual partners”, 5 November 2019.

³⁰ WHO, Global Health Observatory (GHO) data, “Prevalence of HIV among adults aged 15–49 (%)”.

drugs in East Africa and the Caribbean was also higher than the global average, at 17.4 and 14.0 per cent, respectively.

41. The largest number of people who inject drugs living with HIV reside in Eastern Europe, East and South-East Asia and South-West Asia, which together account for 67 per cent of the global total. Although the prevalence of HIV among people who inject drugs in East and South-East Asia (9.3 per cent) is below the global average, a fifth of the global number of people who inject drugs living with HIV reside in that subregion. A small number of countries continue to account for a large proportion of the total global number of people who inject drugs living with HIV. In 2018, for example, people who injected drugs living with HIV in China, Pakistan and the Russian Federation accounted for almost half of the global total (49 per cent), while people who injected drugs in those three countries made up only a third of all people who injected drugs worldwide.

42. A systematic review undertaken in 2017 of the coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs showed that needle and syringe programmes were available in only 52 per cent of countries where injecting drug use was reported, while opioid substitution therapy was confirmed to be available in 48 per cent of countries worldwide. In addition, only 34 countries were identified as providing HIV testing programmes for people who inject drugs.³¹ Besides providing an opportunity to deliver prevention messages and connect patients to health-care and support services, HIV testing services are also a critical entry point to antiretroviral therapy and are therefore a crucial component of HIV prevention programmes. Global data on antiretroviral therapy coverage are scarce. Access to antiretroviral therapy varies considerably, but coverage is reported to be consistently low, with only 8 per cent of people in need receiving effective antiretroviral therapy in the WHO European Region and people who inject drugs only accounting for 20 per cent of those who receive that therapy.³²

43. People who inject drugs are a key population affected by hepatitis C. Global estimates suggest that 71 million people worldwide were chronically infected with hepatitis C in 2017 and that 23 per cent of new hepatitis C infections and one in three hepatitis C-related deaths are attributable to injecting drug use.³³ Hepatitis C-related morbidity and mortality continue to rise, mainly as a result of cirrhosis, hepatocellular carcinoma and death in cases of untreated hepatitis C.³⁴

44. UNODC, WHO, UNAIDS and the World Bank jointly estimated the prevalence of hepatitis C among people aged 15 to 64 who injected drugs worldwide in 2018 to be 48.5 per cent, or 5.5 million (range: 4 million to 7.8 million). This estimate is based on estimates from 108 countries, covering 94 per cent of the estimated global number of people who inject drugs.

45. Although data coverage was low in the Caribbean, the highest prevalence of hepatitis C among people who inject drugs was found in that subregion, at 76 per cent, followed by East and South-East Asia, Western and Central Europe, North America, and Central Asia and Transcaucasia, where prevalence ranged between 61 and 54 per cent.

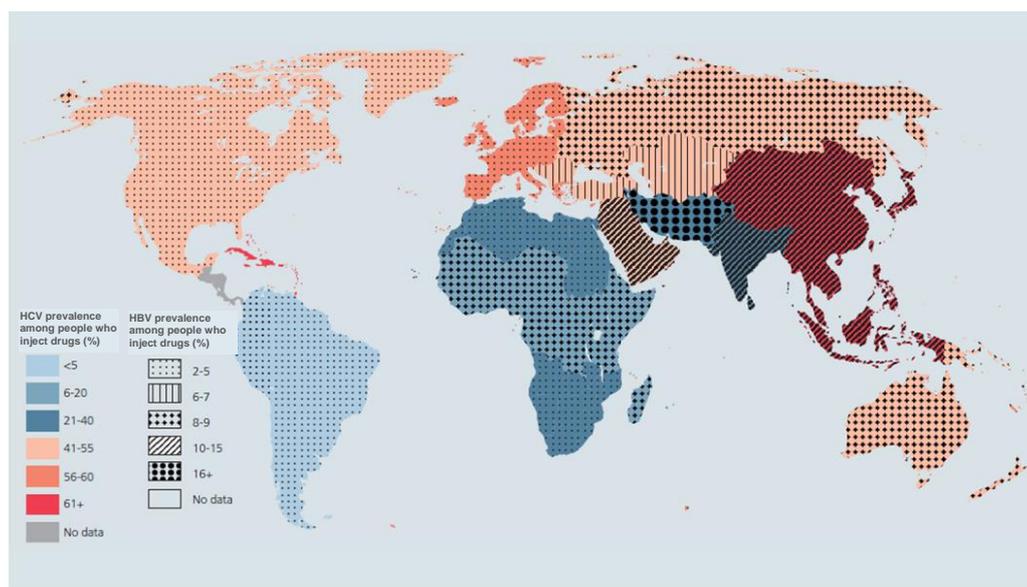
³¹ Sarah Larney and others, “Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review”, *Lancet Global Health*, vol. 5, No. 12 (December 2017), pp. 1208–1220.

³² WHO, Regional Office for Europe, “People who inject drugs (PWID)”.

³³ WHO, “Access to hepatitis C testing and treatment for people who inject drugs and people in prisons: a global perspective”, Policy brief (WHO/CDS/HIV/19.6).

³⁴ Jeffrey D. Stanaway and others, “The global burden of viral hepatitis from 1990 to 2013: findings from the Global Burden of Disease Study 2013”, *Lancet*, vol. 388, No. 10049 (September 2016), pp. 1081–1088.

Figure XV
Estimated subregional prevalence of hepatitis C (HCV) and hepatitis B (HBV) among people who inject drugs, 2018



Source: UNODC, annual report questionnaire supplemented by other data sources.

Note: Subregional estimates are not presented if hepatitis B/hepatitis C data coverage is less than 20 per cent or if the represented total population of the countries providing data for hepatitis B/hepatitis C is less than 10 per cent of the total subregional population.

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46. The joint UNODC/WHO/UNAIDS/World Bank 2018 global estimate of the prevalence of hepatitis B among people who injected drugs was 8.3 per cent; in other words, an estimated 0.94 million people who injected drugs were living with an active hepatitis B infection.³⁵ This estimate is based on data for 93 countries, covering 71 per cent of all people aged 15 to 64 who injected drugs worldwide.

4. Drug-related deaths

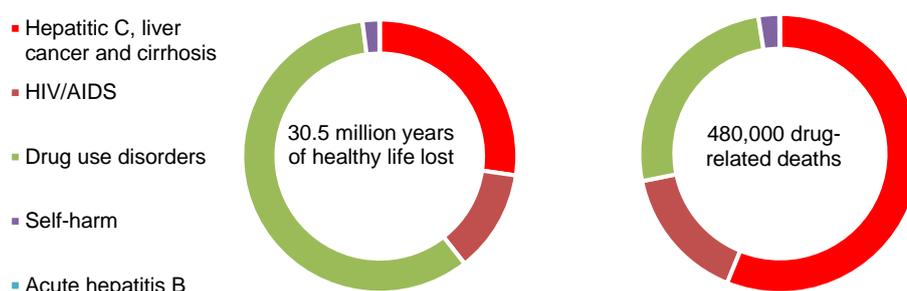
47. Drug-related deaths are defined as deaths that are directly attributable to drug use disorders, primarily overdose, and deaths that result from other risk factors, such as HIV and AIDS, tuberculosis, hepatitis C and liver cancer or cirrhosis among people who use drugs.

48. In the Global Burden of Disease Study, it was estimated that 30.5 million disability-adjusted life years and some 480,000 deaths in 2018 were attributed to drug use. Overall, more than half of those deaths were attributable to liver cancer, cirrhosis or other chronic liver diseases among people who use or inject drugs, while one quarter were directly attributable to drug use disorders (mostly opioid use disorders).

³⁵ The HBV prevalence estimate is intended to refer to active infection (HBsAg), rather than anti-HBc, which indicates previous exposure. However, it is not always possible to differentiate that in the data reported to UNODC.

Figure XVI
Leading causes of death attributable to drug use and drug use disorders, 2018

Hepatitis C and opioid use disorders are responsible for most of the deaths and disability attributed to the use of drugs



Source: UNODC, based on data from the Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2019 results (2020).

III. Impact of COVID-19 on drug use

49. The restrictions on movement and gatherings and the social distancing required in most places where measures were imposed to counter the COVID-19 pandemic led to a decrease in the use of certain drugs but also resulted in an increase in the use of others. The former was true in the case of drugs that are consumed mostly in recreational settings.

50. In the first half of 2020, many countries reported drug shortages at the retail level, including heroin shortages in Europe, South-West Asia and North America in particular.³⁶

51. Experts (mainly addiction medicine specialists) from 77 countries³⁷ who participated in a global survey conducted within the International Society of Addiction Medicine network³⁸ on changes in the use of alcohol and drugs in April and May 2020 suggested that the use of cannabis had risen, as increases were reported by 42 per cent of the countries, while only 25 per cent saw a decline. They also reported increases in the use of alcohol, sedatives (benzodiazepines) and pharmaceutical opioids during the COVID-19 pandemic (reported by 63 per cent, 64 per cent and 41 per cent, respectively, of the countries that participated in the survey).

52. On the other hand, the use of opiates, amphetamine and cocaine appears to have declined in some countries, with decreases reported by health professionals in 31 per cent, 29 per cent and 29 per cent, respectively, of the countries participating in the global survey. As mentioned above, this decline in use was mainly linked to social distancing, lockdown regulations and increased prices of those drugs.

53. The Global Drug Survey,³⁹ an online survey of nearly 60,000 people, mostly from Western Europe, the Americas and Australia and New Zealand, reported results similar to those of the International Society of Addiction Medicine survey. The Global Drug Survey revealed increases in the frequency of use of alcohol, cannabis, benzodiazepines and pharmaceutical opioids in May and June 2020 compared to the period prior to the COVID-19 pandemic, while the frequency of the use of drugs used

³⁶ UNODC, “COVID-19 and the drug supply chain: from production and trafficking to use”, Research brief (May 2020).

³⁷ The number of addiction medicine professionals participating in the survey ranged from 1 to 13 per country.

³⁸ Ali Farhoudian and others, “A global survey on changes in the supply, price and use of illicit drugs and alcohol, and related complications during the 2020 COVID-19 pandemic”, pre-print (July 2020).

³⁹ Global Drug Survey, “GDS COVID-19 special edition: key findings report”, September 2020.

in recreational settings, notably “ecstasy”, but also amphetamine, GHB/GBL, ketamine and LSD, declined. The same also applied to cocaine.

54. In areas that reported shortages in supply and an increase in the prices of drugs, such as opioids, it is speculated that the situation could have prompted regular or dependent users of opioids to substitute other, more readily available substances, such as alcohol, benzodiazepines or polydrug use involving synthetic drugs. Some countries in Europe warned that heroin users might switch to substances such as fentanyl and its derivatives.⁴⁰

55. A decline in the availability of drugs can also lead to more harmful patterns of use, such as switching to injecting or more frequent injecting, as in the case of amphetamines. The respondents to the International Society of Addiction Medicine survey suggested that there had been some increase in or switch to injecting drugs (in 16 per cent of the participating countries), while experts in one third of the countries considered that there had been no change in injecting patterns among people using drugs. Similarly, around one quarter of the experts reported that the sharing of injecting paraphernalia had increased, while another quarter indicated that there had been no change in sharing. It is worth noting that approximately half of the experts responding to the questions on injecting behaviours chose the “Other” option, implying that there was either a lack of information or a reluctance to respond to the questions on injecting patterns.

56. The shortage in the supply of opioids is also considered to have led to a surge in the number of people seeking treatment for drug use disorders,⁴¹ an increase in overdose cases and an increase in other harms, such as HIV and hepatitis C, associated with injecting or polydrug use. Among the experts participating in the International Society of Addiction Medicine survey, more than one third considered that mortality rates among people with drug use disorders had increased, while one third considered that there had been no changes in fatal and non-fatal overdose rates among people using drugs.

IV. Demand reduction and related measures

57. In an effort to continue to support Member States in responding to the challenges of the world drug situation through a health-centred and balanced approach based on human rights and gender mainstreaming, UNODC has published various resources on drug prevention, treatment, care and rehabilitation.

58. The first two resources were presented on the margins of the sixty-third session of the Commission on Narcotic Drugs, namely the UNODC/WHO *International Standards for the Treatment of Drug Use Disorders: Revised Edition Incorporating Results of Field-Testing* (UNODC/WHO treatment standards) and the UNODC “Handbook on youth participation in drug prevention work”.

59. The UNODC/WHO treatment standards are intended for all those involved in the policy development, planning, funding, delivery, monitoring and evaluation of treatment services and interventions for drug use disorders. The document is based on currently available scientific evidence on the treatment of drug use disorders and sets out a framework for the development and expansion of effective, evidence-based and ethical treatment of drug use disorders, in line with principles of public health care. The treatment standards identify major components and features of effective systems for the treatment of drug use disorders. They describe treatment modalities and interventions to match the needs of people at different stages and severities of drug use disorders, in a manner consistent with the treatment of any chronic disease or health condition.

⁴⁰ UNODC, “COVID-19 and the drug supply chain”.

⁴¹ Farhoudian and others, “A global survey on changes in the supply, price and use of illicit drugs and alcohol”.

60. The UNODC “Handbook on youth participation in drug prevention work” is targeted at leaders who are in charge of substance use prevention and health promotion for their constituencies at the local, regional, national or international level. The handbook offers rationales for such participation, as well as examples and concrete advice on how to increase youth participation in substance use prevention by harnessing their insights on the most important target group for prevention: their peers. It is designed to support all decision makers in capitalizing on the power of youth participation and exploring their full potential as a force for change. It includes an overview of different models of participation and best practices on how to make youth participation accessible, safe and relevant, mobilizing youth on preventing drug use and other risky behaviours in a variety of settings, namely, schools and other educational institutions; families; media and online environments; political processes, governmental structures and public discussions; communities; and prevention systems as a whole.

61. In response to the COVID-19 pandemic, UNODC developed and published a new series of tools to support Member States in ensuring continuity in their responses to drug use and drug use disorders under these challenging circumstances.

62. The booklet entitled “Suggestions about treatment, care and rehabilitation of people with drug use disorder in the context of the COVID-19 pandemic: a contribution to the health security of countries and communities”, which is available in 15 languages, addresses continued access to services and the safety of staff and patients at those services, as well as making sure the premises of the services are clean and hygienic and providing people with information and means to protect themselves on every possible occasion. The services covered include low-threshold, pharmacological and psychosocial therapies, with a particular focus on supporting homeless people, including those with drug use disorders.

63. A second group of tools was aimed at supporting parents and caregivers in coping with the stresses of the pandemic in such a way as to enhance the resilience of children, youth and families and to protect children and youth from the vulnerabilities generated by this challenging situation. A leaflet entitled “Information on parenting during COVID-19”, which is available in more than 40 languages, and a booklet entitled “Caring for your child during COVID-19” provide simple and concrete tips for parents and caregivers on what they and their children might be experiencing and what they can do to help themselves and their children, for example by ensuring safety, providing warmth and support, giving praise, spending time together and talking, encouraging good behaviour and discouraging fighting and aggression. Those themes were echoed in the second phase of the “Listen First” campaign, in which 10 sets of videos and related parenting resources were disseminated under the theme “The science of care”. To date, five sets, covering the themes of affection, family activities, active listening, play and patience, have been released in three languages and have reached more than 2 million people. Lastly, a specific tool entitled “Information for parents or other caregivers in crowded communities or refugee settings during the COVID-19 pandemic” was developed, as was a guide entitled “Practical guidance for risk communication and community engagement (RCCE) for refugees, internally displaced persons (IDPs), migrants, and host communities particularly vulnerable to COVID-19 pandemic”, published together with the United Nations Children’s Fund, the International Organization for Migration, the John Hopkins Center for Communication Programs, WHO and the International Federation of Red Cross and Red Crescent Societies.

V. Conclusions and recommendations

64. As the COVID-19 pandemic continues, the social, psychological and economic burdens it has imposed may render people who use drugs further marginalized, and the need for services for the prevention of drug use, the treatment of drug use disorders and the prevention of adverse health consequences of drug use may further increase. Member States may consider investing resources to ensure the continuity of the range

of services available for the prevention and treatment of drug use and drug use disorders and to mitigate the risks arising from the syndemic of COVID-19 and drug use disorders.

65. Given the spread and non-medical use of pharmaceutical opioids in different regions, it is important to develop early warning systems that analyse the emergence and consequences of their non-medical use. In order to facilitate access to pain medication for those who need it, while at the same time preventing the diversion and misuse of such medication, countries may consider developing guidelines on pain management, including the management of chronic non-cancer pain, prescription monitoring programmes and the development of targeted prevention messages educating people on the potential harms and consequences of misusing pharmaceutical opioids.

66. It is also important to increase the accessibility, availability, coverage and quality of interventions for the prevention and treatment of drug use disorders in line with the UNODC/WHO *International Standards on Drug Use Prevention* and *International Standards for the Treatment of Drug Use Disorders*. Such interventions are needed more than ever, especially during and in the aftermath of the COVID-19 pandemic.

67. Furthermore, it is recommended to strengthen prevention responses that take the form of selective interventions for at-risk groups over and beyond the general population, as well as to strengthen treatment responses at the community level and in closed settings to ensure equity of responses.

68. The evidence base for policies and programmes at the national, regional and international levels requires reliable and valid data on the drug situation and responses. That makes it necessary to improve the evidence base through support in the implementation of drug monitoring systems on the basis of epidemiological indicators of drug use, including by building the capacity of experts in high-priority countries and regions, and developing innovative methods and the use of new technology, such as the use of social media and big data (large data sets) in order to understand the patterns and trends of drug use and associations relating to people's behaviour and to predict health outcomes.

69. The strengthening and expansion of the global base of scientific evidence also requires investing in the monitoring and evaluation of the process, outcome and impact of drug prevention and treatment strategies to ensure their effectiveness and minimize the risk of negative outcomes.

70. Some indicators for monitoring the drug situation that require particular attention are the development and implementation of innovative and cost-effective methods for estimating the extent of drug use in both the general population and high-risk drug users, including those who inject drugs, in resource-constrained countries; drug related mortality; the number and extent of people with drug use disorders; and coverage of treatment interventions for drug use disorders. The latter two are the key components of the monitoring and reporting of Sustainable Development Goal indicator 3.5.1.
