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Report

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The Report of the International Narcotics Control Board for 2017 (E/INCB/2017/1) is supplemented by the following reports:

Narcotic Drugs: Estimated World Requirements for 2018—Statistics for 2016 (E/INCB/2017/2)

Psychotropic Substances: Statistics for 2016—Assessments of Annual Medical and Scientific Requirements for Substances in Schedules II, III and IV of the Convention on Psychotropic Substances of 1971 (E/INCB/2017/3)

Precursors and Chemicals Frequently Used in the Illicit Manufacture of Narcotic Drugs and Psychotropic Substances: Report of the International Narcotics Control Board for 2017 on the Implementation of Article 12 of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 (E/INCB/2017/4)

The updated lists of substances under international control, comprising narcotic drugs, psychotropic substances and substances frequently used in the illicit manufacture of narcotic drugs and psychotropic substances, are contained in the latest editions of the annexes to the statistical forms ("Yellow List", "Green List" and "Red List"), which are also issued by the Board.

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Report
of the International Narcotics Control Board for 2017

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Foreword

Each year, the complexity of the world drug situation increases. The International Narcotics Control Board (INCB) is tasked with monitoring States' implementation of the international drug control treaties and supporting Governments in ensuring the availability of narcotic drugs and psychotropic substances for medical and scientific purposes while preventing their diversion and abuse. Through evidence-based research and documentation, INCB strongly urges Governments to adopt humane and balanced drug policies that reflect a human rights-based approach, implementing the international drug control conventions and applying the principles of proportionality and adherence to the rule of law embedded in the treaties. Without due consideration of human rights, there are devastating consequences.

In commemorating the seventieth anniversary of the Universal Declaration of Human Rights, INCB recalls that human rights are the foundation of the mission and work of the United Nations. The anniversary provides an opportunity to explore the links between human rights and drug policy and discuss the implications for national responses to the drug problem. The outcome document of the thirtieth special session of the General Assembly, entitled "Our joint commitment to effectively addressing and countering the world drug problem",[1] places the treatment of drug use disorders, rehabilitation and social reintegration among the key operational objectives of its recommendations. In the light of the milestone anniversaries of several human rights instruments, INCB has put specific focus on human rights, which is included as a special topic in this year's annual report.

Article 25 of the Universal Declaration of Human Rights sets out the right to health as part of the right to an adequate standard of living. The thematic chapter of the present report focuses on treatment, rehabilitation and social reintegration for drug use disorders as essential components of drug demand reduction. Here, we draw attention to the protection of the rights of people impacted by drug use disorders and emphasize the importance of non-discriminatory access to treatment, rehabilitation and social reintegration services. We make a number of recommendations, which, if widely implemented, would contribute to the realization of the Sustainable Development Goals, particularly Goal 3, relating to good health and well-being. These recommendations include investing in and providing multi-tier structures for the delivery of treatment services and ensuring multisectoral coordination in efforts to reduce supply and demand. INCB believes that if leaders, policymakers and the wider society follow the principles set out in that chapter and pay particular attention to treatment needs, it will have a significant impact on the public health of often-neglected groups.

In chapter II of the annual report, INCB reviews treaty compliance by States and highlights a number of substantive policy matters. In section F ("Special topics") of that chapter, we draw attention to matters that should be the focus of policymakers.

Under the special topic on the therapeutic use of cannabinoids, the Board carefully re-examines terminology and, drawing on the Single Convention on Narcotic Drugs of 1961, concludes that precision is required. Thus, we discuss the therapeutic use of cannabinoids and eschew the notion of "medical cannabis". This is done to ensure that when reference is made to medicinal products, it is understood to refer to products that have been appropriately tested, have passed a full scientific evaluation and clinical trials and are licensed as medicines. INCB notes that there have been anecdotal reports of some cannabinoids having therapeutic effects and that some jurisdictions have licensed such products even though there is still insufficient evidence of their therapeutic value and clinical trials are still ongoing. Therefore, the Board points out that when considering the possibility of using cannabis derivatives for the treatment of certain health conditions, it is most appropriate to speak about the therapeutic use of cannabinoids. We emphasize that in deciding to license

[1] General Assembly resolution S-30/1, annex.

medicines, Governments should examine the results of scientific studies and clinical trials to ensure that prescription for medical use is performed with competent medical knowledge and supervision.

As expressed in our 2016 annual report[2] and the special report entitled *Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes — Indispensable, Adequately Available and Not Unduly Restricted*,[3] billions of people around the world have limited or no access to medicines containing narcotic drugs. The imbalance in the availability of opioid analgesics disproportionately impacts low- and middle-income countries. As done in the past, I call upon States to close what I have termed the "global pain divide".

As well as addressing the underuse of opioids, we also explore the opioid overdose epidemic in North America. Our report highlights the risks associated with long-term opioid use and advises Governments to be aware of the risks linked to the abuse of prescription drugs. Although the situation is particularly acute in one part of the world, the Board is directing its attention to this matter and recommends that other Governments learn from this crisis.

As recalled above, we are witnessing a binary opposition, the underuse and overuse of opioids. Both epidemics are the cause of much suffering worldwide. However, opioids are not to be feared; if administered and monitored properly, opioids are a vital tool for pain management and palliative care. In this year's annual report, we call for the provision of training for health-care professionals and responsible authorities, for ensuring rational prescribing practices and for the implementation of the operational recommendations in this regard adopted at the thirtieth special session of the General Assembly. We believe that efforts by States are essential to confront these dual challenges.

Continued violence and extrajudicial acts against persons suspected of drug-related activities, be it simple use or criminal acts, undermine the rule of law and internationally recognized due process standards. INCB reminds States that extrajudicial actions of any kind are contrary to the international drug control treaties, a matter on which we elaborate in the report.

According to the World Tourism Organization, there were over 1.2 billion international tourist visits in 2016, a number that increases greatly when including those travelling on business or attending conferences. When travellers go abroad, many of them are undergoing medical treatment, which requires them in some cases to carry medicines containing substances under international control. INCB draws attention to this matter and calls upon Governments to make their requirements in this regard well known to potential visitors and relevant officials to ensure that visitors to their countries are not unduly delayed or importuned. Here, we ask Governments to help make it possible for travellers carrying medical preparations to continue their medical treatment while abroad.

The *Afghanistan Opium Survey 2017*, published by the Afghan Ministry of Counter-Narcotics and the United Nations Office on Drugs and Crime, revealed that the area under opium poppy cultivation has increased by 63 per cent since 2016, reaching a new record high. That matter is also discussed in the present report. The illicit drug economy in the country further exacerbates an environment of instability and increases funding to terrorist groups in Afghanistan and beyond. Aware of the challenges and difficulties faced by the Government and the people of Afghanistan effectively to address the extraordinary situation in the country, the Board once again calls upon the Government, in cooperation with local, regional, and international partners, to develop and implement a balanced, effective and comprehensive effort to address the issue. INCB stands ready and calls upon the international community and Afghanistan to work together to give high priority to redressing the situation.

[2] E/INCB/2016/1.

[3] E/INCB/2015/1/Supp.1.

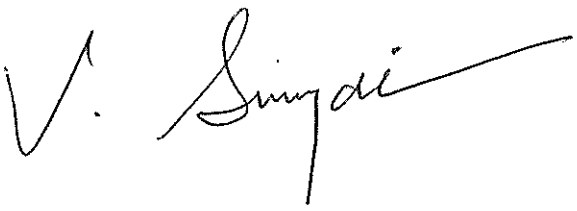
The annual report draws attention to other important developments that have an impact well beyond national boundaries. Thus, we note the record level of illicit coca bush cultivation in Colombia in 2016 and the signing of the peace accord between the Government of Colombia and the Revolutionary Armed Forces of Colombia-People's Army (FARC-EP) in November 2016. The peace accord contains commitments on drug control and is expected to have a positive impact on the eradication of illicit drug crop cultivation and trafficking in cocaine. The Board will continue closely to monitor developments in the Andean region.

INCB also highlights a number of tools and initiatives available to support Governments in the implementation of the treaties and the outcome document of the thirtieth special session of the General Assembly. Among those tools is INCB Learning, an initiative to build the capacity of national authorities to monitor the trade in controlled substances and promote their availability for medical use. Similarly, a new system to facilitate licit international trade in controlled substances, the International Import Export Authorization System (I2ES), has been put in place. It joins an array of tools developed by the Board, such as the Pre-Export Notification (PEN) Online system, the Precursors Incident Communication System (PICS) and more recent initiatives to counteract new psychoactive substances. In addition, the INCB International Drug Control System (IDS), a database platform used by the Board, acts as the backbone connecting the data supplied by Governments on meeting their regulatory obligations. IDS provides the basis for analysing the functioning of the system of licit international trade in controlled substances, providing the Board with the information needed to assist Governments. Today, IDS is in urgent need of modernization.

We aim to continue expanding our analysis and support capacities to assist Governments around the world. INCB aims actively to contribute to the realization of the Sustainable Development Goals and the objectives adopted at the thirtieth special session of the General Assembly, within the areas of its mandate. For this, we will continue to rely on active dialogue with, and support from, all States.

Drug policies must follow an approach that seeks to promote the health and welfare of humankind. The three international drug control conventions provide ample scope for the international community to achieve this objective.

I hope that this year's annual report will further inspire cooperation, multilayered strategies, multisectoral efforts and action by States and the international community. Together, we can move closer to improving the well-being of individuals around the world and contribute to attaining the Sustainable Development Goals by 2030.



Viroj Sumyai
President
International Narcotics Control Board

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Explanatory notes

Data reported later than 1 November 2017 could not be taken into consideration in preparing this report.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Countries and areas are referred to by the names that were in official use at the time the relevant data were collected.

References to dollars ($) are to United States dollars, unless otherwise stated.

The following abbreviations have been used in this report:

AIRCOP	Airport Communication Project
APAAN	*alpha*-phenylacetoacetonitrile
CARICC	Central Asian Regional Information and Coordination Centre
CICAD	Inter-American Drug Abuse Control Commission
ECOWAS	Economic Community of West African States
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
Europol	European Police Office
GBL	*gamma*-butyrolactone
GHB	*gamma*-hydroxybutyric acid
ha	hectare
I2ES	International Import and Export Authorization System
INCB	International Narcotics Control Board
INTERPOL	International Criminal Police Organization
IONICS	Project Ion Incident Communication System
LSD	lysergic acid diethylamide
MDMA	3,4-methylenedioxymethamphetamine
OAS	Organization of American States
OSCE	Organization for Security and Cooperation in Europe
PEN Online	Pre-Export Notification Online
PICS	Precursors Incident Communication System
SCO	Shanghai Cooperation Organization
SMART	global Synthetics Monitoring: Analysis, Reporting and Trends programme
THC	tetrahydrocannabinol
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAMA	United Nations Assistance Mission in Afghanistan
UNODC	United Nations Office on Drugs and Crime
WCO	World Customs Organization
WHO	World Health Organization

Chapter I.

Treatment, rehabilitation and social reintegration for drug use disorders: essential components of drug demand reduction

A. Background

1. Concern for the health and welfare of humankind is the cornerstone of the international drug control framework. The Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol,[4] the Convention on Psychotropic Substances of 1971[5] and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988,[6] known collectively as the international drug control conventions, all refer to this concern. To ensure the health and welfare of humankind, the conventions mandate States parties to take measures for the treatment, rehabilitation and social reintegration of people affected by drug problems (article 38 of the 1961 Convention and article 20 of the 1971 Convention). The International Narcotics Control Board (INCB) emphasized this point in its annual report for 2015.[7]

2. Treatment of drug use disorders, rehabilitation and social reintegration are among the key operational objectives given in the recommendations on drug demand reduction contained in the outcome document of the thirtieth special session of the General Assembly, entitled "Our joint commitment to effectively addressing and countering the world drug problem"[8] In the outcome document, the General Assembly recognized drug dependence as a complex health disorder characterized by a chronic and relapsing nature that can be treated through evidence-based and voluntary treatment programmes, and called for enhanced international cooperation in developing and implementing treatment initiatives.

3. The use of mood-altering psychoactive substances has been part of human civilizations for millennia. For certain substances or in certain contexts it can assume a pathological pattern that needs to be addressed. Throughout the history of human civilization, societies have displayed varying levels of tolerance and permissiveness towards, and control over, the use of psychoactive substances. Some of those substances, such as tobacco and alcohol, have been regulated more or less strictly in most societies. Other substances have been judged harmful and hence have been placed under strict control. This is the case for narcotic drugs and psychotropic substances controlled under the international drug control conventions.

4. Irrespective of the level of control, regulation and societal approval or disapproval, one factor common to all psychoactive substances, referred to in this chapter as "drugs" for the sake of brevity, is their propensity to lead to drug use disorders following use, whether frequent or occasional. Drug use disorders are associated with significant levels of disease (morbidity) and disability, constitute a burden on national resources, and cause immeasurable human suffering. The World Health Organization (WHO) estimates that the global burden of disease[9] attributable to alcohol and illicit drug use amounts to 5.4 per cent of the total burden of disease.

[4] United Nations, *Treaty Series*, vol. 976, No. 14152.

[5] Ibid., vol. 1019, No. 14956.

[6] Ibid., vol. 1582, No. 27627.

[7] E/INCB/2015/1, para. 1.

[8] General Assembly resolution S-30/1, annex.

[9] WHO, Global Health Observatory (GHO) data, Resources for the prevention and treatment of substance use disorders. Available at www.who.int/gho/substance_abuse/en/.

Specifically, drug dependence accounts for 0.9 per cent of the global burden of disease from all causes, as expressed in disability-adjusted life years, with opioid dependence contributing the largest share of that burden.[10] Association of drug use with public health risks such as the spread of HIV and other blood-borne infections has added yet another dimension to the health impact. Thus, all countries and jurisdictions must have in place mechanisms and systems to provide help and succour to people suffering from drug use disorders.

B. Treatment, rehabilitation, and social reintegration as essential components of demand reduction

5. Drug demand reduction involves two overlapping but distinct approaches: preventing the onset of drug use (or primary prevention), and treatment, rehabilitation and social reintegration.

6. Demand reduction interventions often focus more on primary prevention activities. Primary prevention frequently receives more support and hence is more prominent in national drug demand reduction frameworks and programmes. Nonetheless, many primary prevention activities are thought to be based on limited evidence, have limited coverage and be of unknown quality.[11] The value of treating, rehabilitating and socially reintegrating people affected by drug use disorders (to be discussed later in this chapter) needs greater recognition. There are compelling reasons why Governments should invest in treatment and rehabilitation services:

(a) People affected by drug use disorders suffer from significant damage to their physical and mental health and well-being, in addition to the reduction in their quality of life and productivity;

(b) Some people affected by drug use disorders may resort to illegal and/or criminal acts to support their drug use, perpetuating a vicious cycle of addiction and suffering, and contributing to the increased burden of crime on society;

(c) Research indicates that peer pressure is a significant factor in the onset of drug use. Thus, providing treatment to people with drug dependence reduces the risk of other people starting to use drugs under their influence. In other words, treatment and rehabilitation services for affected individuals may serve to prevent drug use among other individuals in their network;

(d) As parties to the international drug control treaties, Governments are required to provide treatment services to people affected by addiction. Both article 38 of the 1961 Convention and article 20 of the 1971 Convention require Governments to give special attention to and take all practicable measures for the prevention, treatment, rehabilitation and social reintegration of persons affected by drug dependence, to coordinate their efforts to that end, and to promote the training of personnel in those fields;

(e) Respecting the right of people affected by drug use disorders to health and treatment services will contribute to reducing the stigma and discrimination associated with those disorders;

(f) Research consistently shows that investing in treatment saves Governments money. The financial cost of providing treatment is much lower than that occasioned by drug-related disorders and related problems, including unemployment, absenteeism, crime (including the cost of criminal justice and law enforcement), morbidity, early mortality and disability;

(g) Critical to achieving Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) is action on target 3.5 (Strengthen the prevention and treatment of substance abuse).

7. Worldwide, there is a significant gap in the availability of resources for treatment and rehabilitation services. WHO has estimated that, globally, only 1.7 beds per 100,000 people are available for the treatment of drug and alcohol dependence, the number of beds available in higher-middle-income countries being 10 times higher than that in lower-middle-income countries (7.1 beds per 100,000 people compared to 0.7 beds).[12] The United Nations Office on Drugs and Crime (UNODC) reports that, at the global level, only 1 out of 6 people in need of drug dependence treatment has access to treatment programmes. For

[10] Louisa Degenhardt and others, "Global burden of disease attributable to illicit drug use and dependence: findings from the *Global Burden of Disease Study 2010*", *The Lancet*, vol. 382, No. 9904 (9 November 2013), pp. 1564–1574.

[11] *World Drug Report 2015* (United Nations publication, Sales No. E.15.XI.6), chap. I, sect. D ("What works in drug use prevention?").

[12] WHO, *Atlas on Substance Use (2010): Resources for the Prevention and Treatment of Substance Use Disorders* (Geneva, 2010).

Latin America, the corresponding figure is 1 out of 11 and, for Africa, it is 1 out of 18, showing that the resource gap is more pronounced in lower- and middle-income countries. While higher-income countries spend around $50 on mental health per person annually, lower- and middle-income countries spend only about $2. In addition, access to treatment and rehabilitation services tends to be unequal within countries. For example, health systems are often equipped to provide services for alcohol use disorders, but not for drug use disorders. Treatment services for drug dependence tend to be available only in the larger cities. Similarly, while drug dependence is more prevalent among men than among women, women with drug problems have disproportionately less access to treatment and rehabilitation services owing to stigma and a lack of gender-sensitive treatment services.[13] Another important facet of the treatment gap is the difference in the type of treatment available and accessible. Globally, more than a third of countries report the availability of psychosocial interventions, whereas less than a quarter report the availability of pharmacological interventions, although there is a strong evidence base showing that pharmacological interventions are effective in the treatment of many types of drug use disorders. In addition, whenever treatment services are available and accessible, their quality can be poor, and interventions may not be based on evidence or supported by international standards or guidelines.

C. Basic concepts related to drug use disorders

8. It is important to distinguish between terms such as drug use, drug abuse, harmful use of drugs, drug dependence and drug addiction, since inappropriate use of terminology can contribute to stigmatization and discrimination. From a criminal justice perspective, in some countries, even the one-time use of a psychoactive substance scheduled as a narcotic drug or psychotropic substance may incur a sanction.[14] From the perspective of addiction and behavioural sciences, however, a single instance of drug consumption may not necessarily be pathological. It is the pattern of drug use and the resulting consequences that distinguish pathological from non-pathological, though often dangerous, behaviour.

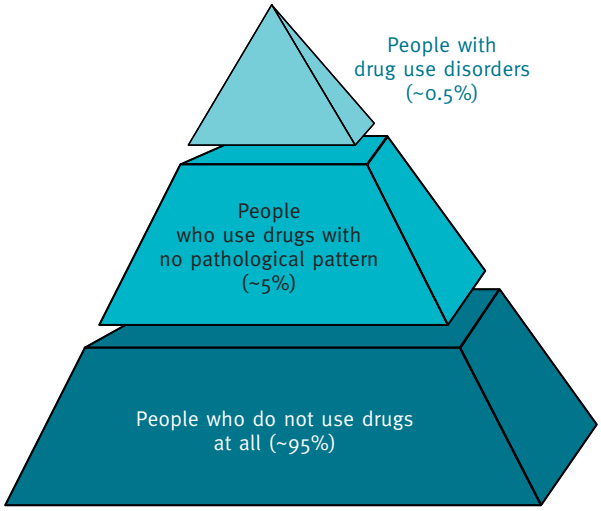
9. The tenth revision of the International Classification of Diseases (ICD-10) describes two major diagnostic entities due to drug use that are relevant to this discussion: harmful use and dependence syndrome. Harmful drug use is understood as a pattern of drug use that causes damage to the physical or mental health of the individual. Drug dependence is a condition in which drug use becomes one of the highest priorities in the user's life, and carries with it a range of associated behaviours. The older term "addiction", whose meaning is largely similar to that of "dependence", is ingrained in the scientific literature and popular parlance and continues to be used for that reason. "Drug abuse" was used as a diagnostic entity in the past, but has largely been replaced by the terms "harmful drug use" and "drug use disorders". Given that context, the terms mainly used in this chapter are "drug use" and "drug use disorder".

10. People who begin to use drugs may, as their drug use and its adverse consequences escalate, attain the stages of harmful use and, ultimately, dependence. Drug use, harmful drug use and drug dependence form a continuum of increasing severity and pattern of use. In any given society, the pattern of drug use can be represented as a pyramid. As seen in the figure below, the base of that pyramid is made up of people who do not use drugs at all. The middle layer of the pyramid represents a smaller group of people who do use drugs, but whose drug use pattern is not pathological. Lastly, the smallest section, the top of the pyramid, represents people who suffer from drug use disorders. Although they form the smallest piece of the pyramid, it is important to note that people who suffer from drug use disorders account for the largest share of harm and adverse consequences for themselves and for the largest related burden of disease on society as a whole. In the *World Drug Report 2017*, UNODC observed that, globally, 28 million years of healthy life were lost in 2015 as a result of drug use. Of that number, 17 million years of healthy life were lost owing to drug use disorders, even though only around 10 per cent of the people who used drugs suffered from drug use disorders. Unfortunately, only one out of six people with drug use disorders globally have access to treatment services. Thus, top priority should be given to making treatment and rehabilitation services available to people suffering from drug use disorders. However, people who use drugs but do not suffer from a drug use disorder may also need help to prevent further escalation of their drug use problems.

[13] United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), "A gender perspective on the impact of drug use, the drug trade, and drug control regimes", Policy brief (July 2014).

[14] The Board has clarified on many occasions that, under the United Nations drug control treaties, parties are not obliged to apply criminal justice sanctions to people who use drugs.

Pyramid of drug use patterns (representational)



D. Factors associated with drug use disorders

11. Drug use disorders are best viewed as being bio-psycho-social in origin. There is no single factor that causes an individual to use drugs. A variety of risk factors and protective factors interact with each other and may result in drug use and subsequent dependence. Those include pre-existing personality, as well as genetic and biological factors that have their origins in the neurobiological dysfunctions in the brains of people using drugs. In addition there are environmental factors. Among those, there are a number of social, cultural, and legal factors that enhance the risk that a person will use a drug and subsequently develop drug dependence. Social and cultural permissiveness relating to the use of a drug may enhance its availability, influencing the risk of people using it. Similarly, socioeconomic deprivation has been found to be associated with the risk of drug use, and drugs may be used as a form of self-medication to cope with personal problems that sometimes stem from adverse childhood experiences such as abuse, neglect and other forms of household dysfunction. Finally, there are drug-related factors that may also determine the risk, as some drugs are more likely than others to lead to drug use disorders. Some drugs, such as opioids, are considered more addictive than others, such as cannabis. A number of factors responsible for drug dependence are beyond the control of people who use drugs. People do not determine their own genetic or biological vulnerability, they do not have the agency to influence the cultural practices in their neighbourhoods, and they have no control over their national laws and policies determining the availability of drugs. To what extent people have control over or a choice in the risk of developing drug dependence is a matter of debate.[15] Thus, people affected by drug use disorders need to be seen not as victims and sufferers, but as patients, and they should not be treated as wilfully engaging in undesirable or illegal behaviours. The ideal settings in which to help them are those of treatment and rehabilitation.

E. Course and trajectory of drug use disorders and recovery

12. Once developed, drug use disorders run their course like other chronic, non-communicable diseases such as diabetes or hypertension. The treatments for all such chronic, non-communicable diseases, share certain characteristics:

(a) Treatment reduces the symptoms, without necessarily removing the root cause of disease;

(b) Adopting changes in behaviour and lifestyle is an important part of the treatment;

(c) Relapses are common, in spite of treatment.

13. Recovery from drug use disorders is possible, but it often involves multiple attempts and long-term engagement with the treatment programmes. For most individuals, recovery from drug use disorders is a process rather than an event. The majority of people with drug use disorders typically go back to taking drugs after a treatment episode. Lapse (a single instance of drug use after achieving abstinence) and relapse (using drugs following a pattern of dependence after achieving abstinence) are seen as integral and expected stages in the process of recovery. It is not realistic to expect someone to achieve long-lasting abstinence following an episode of short-term treatment, just as it is not realistic to expect a patient with hypertension to have normal blood pressure at the end of a one-year period if the anti-hypertensive medications have been provided for only a few days and then tapered off. Thus, treatment and rehabilitation programmes should be designed as long-term interventions that include strategies for relapse prevention. Importantly, national laws and policies should not sanction users for

[15] Allison Kurti and Jesse Dallery, "Review of Heyman's addiction: a disorder of choice", *Journal of Applied Behaviour Analysis*, vol. 45, No. 1 (2012), pp. 229–240.

relapsing following treatment. It is important to note that, for drug use disorders, treatment works. In other words, modern health-care science offers effective treatment strategies for drug use disorders. The single most important predictor of a good treatment outcome is retention in the treatment for as long as required.

14. It is a widespread myth that people suffering from drug dependence do not want to quit taking drugs. Unsuccessful attempts to stop taking drugs are a hallmark and diagnostic feature of drug dependence. It is the poor availability and accessibility of appropriate and acceptable treatment services that deprives affected people of the opportunity to reduce or cease their drug-taking behaviour. In a recent survey in Punjab, India, it was reported that out of more than 232,000 estimated opioid-dependent people, more than 80 per cent had made attempts to stop taking drugs. However, only about 15 per cent had ever received any help from the organized treatment sector, indicating widespread demand for but poor availability of treatment services.[16]

15. Even after achieving abstinence, many individuals with drug use disorders find it challenging to regain their place and status in their families and societies. The stigma associated with drug use poses a serious hindrance on the path to recovery. In a study conducted on behalf of WHO in 14 countries all over the world, out of 18 health conditions, drug addiction was found to possess the highest degree of stigma or social disapproval.[17] National demand reduction programmes must address stigma and discrimination and provide assistance towards rehabilitation and social reintegration to afford people affected by drug use disorders an opportunity to reclaim their places in society as responsible and productive citizens.

16. The outcome of treatment for drug dependence should not be defined only in the binary terms of continued drug use versus complete abstinence. It has been demonstrated that even without achieving complete abstinence, some people may be able to reduce the harmful consequences of their drug use and may go on to lead relatively stable and productive lives. Improvements in personal health and social functioning (employment, family and social relationships), as well as reductions in risky behaviour or crimes are all valid and desirable outcomes of treatment for drug use disorders in addition to reduced drug use. Thus, treatment and rehabilitation services should not remain exclusively focused on the final objective of ceasing drug use, but should also consider the intervening goals of reducing drug use and its harmful consequences as part and parcel of the process towards complete rehabilitation and social reintegration.

F. Principles of treatment interventions

17. Drug use disorders are treatable health conditions for which effective treatment and rehabilitation interventions are available. They are considered complex bio-psychosocial conditions and their treatment is equally complex and multi-faceted. In order to be effective, treatment typically involves multiple components directed at various aspects of drug dependence and its consequences. WHO and UNODC have outlined nine principles for the treatment of drug dependence:[18]

Principle 1. Availability, accessibility, affordability, attractiveness and appropriateness of drug dependence treatment. People affected by drug addiction should have access to a wide range of treatment services that address a variety of needs. Factors such as affordability, geographical accessibility, timeliness and flexibility of opening hours, user-friendliness, and responsiveness to the needs of individuals contribute to the accessibility of drug dependence treatment.

Principle 2. Screening, assessment, diagnosis and treatment planning. A comprehensive diagnostic assessment process is the basis for an effective and individualized treatment approach. Components include screening (e.g., for drug use and associated risk behaviours), assessment and diagnosis (e.g., drug dependence and other comorbid psychiatric illnesses), comprehensive assessment (e.g., stage and severity of illness, temperament, personality and employment status) and an individualized treatment plan.

Principle 3. Evidence-informed drug dependence treatment. The stringent standards applied for approving treatment for other health conditions must be applied to treatment of drug dependence as well. Thus, all the treatments of drug dependence approved in a given country should be rooted in the latest evidence-informed good practices and

[16] India, Ministry of Social Justice and Empowerment, and Government of Punjab, Department of Health and Family Welfare, "Punjab opioid dependence survey: brief report". Available at http://pbhealth.gov.in/.

[17] Robin Room and others, "Cross-cultural views on stigma, valuation, parity and societal attitudes towards disability", in *Disability and Culture: Universalism and Diversity*, T. Bedirhan Üstün and others, eds. (Seattle, Hogrefe and Huber Publishers, 2001).

[18] UNODC and WHO, "Principles of drug dependence treatment", discussion paper (March 2008).

accumulated scientific knowledge, taking into account the constantly evolving nature of health science.

Principle 4. Drug dependence treatment, human rights and patient dignity. People with drug dependence should not be discriminated against because of their drug use history. The standards of ethical treatment applied to other health conditions must also be applied to the treatment of drug dependence. That includes the right to autonomy and self-determination for patients and the principles of beneficence, non-maleficence and confidentiality on the part of care providers. In that context, the Board welcomes the recent joint United Nations statement on ending discrimination in health-care settings.[19]

Principle 5. Targeting special subgroups and conditions. Population subgroups such as adolescents, women, pregnant women, people with medical and psychiatric comorbidities, sex workers, ethnic minorities and socially marginalized individuals, including migrants and refugees, may have their special needs. Their treatment for drug dependence must account for those needs.

Principle 6. Addiction treatment and the criminal justice system. Drug use is treated as a crime in itself in some jurisdictions. However, since drug use disorders are health conditions, the ideal setting for treatment is the health-care system rather than the criminal justice system. The health-care system should be the preferred environment in which to manage these problems, and treatment capacity should be developed where it is lacking. Treatment as an alternative to incarceration has the dual benefit of reducing suffering and disability as well as reducing crime. The resulting significant cost reduction contributes to the cost-effectiveness of this approach.

Principle 7. Community involvement, participation and patient orientation. A paradigm shift in the delivery of treatment is needed from a directive to a more cooperative, community-based service delivery with the involvement of people who use drugs, their families, communities and local stakeholders in the process of planning, implementing and monitoring the treatment services.

Principle 8. Clinical governance of drug dependence treatment services. Accountable and efficient systems of clinical governance could be achieved through written policies and protocols, and through mechanisms for monitoring and supervision by qualified staff. In addition, systems for accreditation, certification and quality assurance for treatment services should be in place.

Principle 9. Treatment systems: policy development, strategic planning and coordination of services. A logical, step-by-step approach is recommended that includes formulating treatment policies, assessment of the situation, building the capacity of care providers, and systems for quality assurance.

G. Treatment approaches and modalities

18. Not every activity that results in the reduction of drug use can justifiably be labelled as treatment. Treatment for drug use disorders and associated physical and mental health issues has been defined as "an activity (or activities) that directly targets people who have problems with their drug use and aims at achieving defined outcomes with regard to the alleviation and/or elimination of these problems, provided by experienced or accredited professionals, in the framework of recognized medical, psychological or social assistance practice".[20]

19. While the general principles of treatment for drug dependence may appear to be similar across drug types and populations, ideally, every patient should receive individualized and personalized treatment, the nature of which may vary depending on factors such as the type of drug used, the severity of the dependence, the level of motivation and the availability (or lack) of social support. Drug dependence being a chronic, remitting-relapsing illness, short-term, one-time treatment is usually not sufficient for most individuals and ongoing engagement of the patient with family and community support can be beneficial.

20. UNODC and WHO have jointly developed international standards for the treatment of drug use disorders to support Member States in developing effective and ethical treatment services.[21] A variety of treatment modalities and approaches have been evaluated in terms of the extent to which their effectiveness is based on evidence. Those modalities and approaches include:

[19] United Nations and WHO, "Joint United Nations statement on ending discrimination in health-care settings", 2017. Available at www.who.int/.

[20] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *EMCDDA Treatment Strategy*, Work programmes and strategies series (Lisbon, April 2010).

[21] UNODC and WHO, "International Standards for the Treatment of Drug Use Disorders: Draft for Field Testing" (March 2017).

(a) Community-based outreach. These activities primarily target people who use drugs but are not currently receiving treatment. The core services provided by outreach programmes include basic support, drug-related education, screening and brief interventions, referral for drug dependence treatment and needle exchange services;

(b) Screening, brief interventions, and referral to treatment. These interventions are largely aimed at people with drug use problems in non-specialized settings, such as primary care, emergency care, social services and prisons. Standard and valid screening tools as well as culturally adaptable manuals are available for brief psychosocial interventions. Such programmes are effective in reducing drug use, particularly among those who are at the early stages of their drug use trajectories;

(c) Short-term inpatient or residential treatment. This type of treatment, also known as detoxification, is largely aimed at providing relief from drug withdrawal symptoms and facilitating the stabilization of the patient's physical and emotional state in a safe, protected setting. For benzodiazepines, opioids and many other drug categories the mainstay of detoxification is the pharmacological treatment of withdrawal symptoms. In the case of opioids, there is strong evidence to suggest that withdrawal symptoms are best treated using agonist medications such as buprenorphine and methadone.[22] For sedative hypnotics such as benzodiazepines it has been recommended to use long-acting benzodiazepines in sufficient doses that taper off over the course of a few days. Very often detoxification is erroneously regarded as complete treatment in itself. However, withdrawal management is only the first step in the long-term treatment of drug dependence. The risk of relapse and overdose is high following any form of detoxification. To prevent relapse, preparations need to begin in this phase of the treatment for activities aimed at ensuring the patient's long-term and sustained engagement in the treatment process;

(d) Outpatient treatment. Outpatient treatment is largely aimed at those individuals who have sufficient social support and resources at home, but who do require long-term pharmacological and/or psychosocial interventions. The majority of people with drug use disorders do not require inpatient care and can be managed as outpatients. A strong evidence base exists for the effectiveness of a variety of pharmacological interventions offered as part of long-term treatment for drug dependence. As opioid agonist maintenance treatment WHO recommends using buprenorphine or methadone in adequate doses.[23] Another form of pharmacological outpatient treatment for opioid dependence is the opioid antagonist naltrexone, which is recommended for highly motivated patients. However, there is only modest evidence for its effectiveness.[24] For the treatment of cannabis and psychostimulant dependence (i.e. dependence on amphetamines or cocaine) there is no evidence at present that any pharmacotherapy is consistently effective. Thus, psychosocial treatment remains the primary approach for those drug categories. In addition to pharmacotherapy, a host of psychosocial interventions are effective in preventing relapse and rehabilitating patients, including contingency management,[25] motivational interviewing,[26] cognitive behavioural therapy[27] and relapse prevention therapy. Most of those produce the best outcomes when combined with pharmacotherapy;

(e) Long-term residential treatment. The most common form of long-term residential treatment is the therapeutic community, where patients are expected to stay for an extended duration of between 6 and 24 months. Traditionally, long-term residential treatment consisted of psychosocial treatment only, but modern approaches may involve the use of medication. Large-scale reviews have shown that there is little evidence that therapeutic communities offer significant benefits, except if they are operated in prison settings;[28]

(f) Recovery management. Recovery management, also known as aftercare or social support, is a long-term, recovery-oriented care model for those who have achieved abstinence through other forms of treatment. The focus is on preventing relapse by supporting change in individuals' social functioning and personal well-being, and by helping them to regain their place in their community. Relapse is an almost inevitable part of recovery. Therefore, instead of letting patients go through multiple episodes of short-term treatment, the recovery management approach offers

[22] L. Gowing, R. Ali, and J. White, "Opioid antagonists with minimal sedation for opioid withdrawal", *The Cochrane Library*, No. 2 (2002).

[23] WHO, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* (Geneva, 2009).

[24] S. Minozzi and others, "Oral naltrexone maintenance treatment for opioid dependence", *Cochrane Database of Systematic Reviews*, No. 4 (2011).

[25] M. Prendergast and others, "Contingency management for treatment of substance use disorders: a meta-analysis", *Addiction*, vol. 101, No. 11 (November 2006), pp. 1546–1560.

[26] G. Smedslund and others, "Motivational interviewing for substance abuse", *The Cochrane Library* (11 May 2011).

[27] M. Magilland, L. A. Ray, "Cognitive-behavioral treatment with adult alcohol and illicit drug users: a meta-analysis of randomized controlled trials", *Journal of Studies on Alcohol and Drugs*, vol. 70, No. 4 (2009), pp. 516–527.

[28] L. A. Smith, S. Gates and D. Foxcroft, "Therapeutic communities for substance-related disorder", *Cochrane Database of Systematic Reviews*, No. 1 (2006).

support services for a longer duration but at a much lower intensity and cost, focusing on patients' autonomy and ensuring the participation of their communities;

(g) Interventions aimed at reducing the adverse consequences of drug use. Certain approaches are used for reducing the adverse consequences of drug use rather than directly reducing drug use per se. They are widely employed, in particular in the context of reducing the risk of HIV and other blood-borne viral infections spreading among people who inject drugs. WHO, UNODC and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have endorsed a comprehensive package of nine interventions for the prevention, treatment and care of HIV among people who inject drugs.[29] The Board recognizes that this comprehensive package has been endorsed widely, including by the General Assembly,[30] the Economic and Social Council,[31] and the Commission on Narcotic Drugs.[32] The nine interventions in question have undergone scientific evaluation. They are most effective when delivered in combination with each other, as a package. They are: *(a)* needle and syringe programmes; *(b)* opioid substitution therapy and other drug dependence treatment; *(c)* HIV testing and counselling; *(d)* antiretroviral therapy; *(e)* the prevention, diagnosis and treatment of sexually transmitted infection; *(f)* condom distribution; *(g)* targeted information, education and communication; *(h)* prevention, vaccination, diagnosis and treatment for viral hepatitis; and *(i)* prevention, diagnosis and treatment of tuberculosis;[33]

(h) Other approaches. There has been an ongoing discussion for many years about other activities beyond the comprehensive package that are considered by some as interventions aimed at reducing the adverse consequences of drug use. Some Governments have been conducting trials with prescription heroin maintenance programmes for patients not receiving other forms of treatment, although that is not a form of first-line treatment.[34] Research indicates that prescription heroin maintenance treatment may help heroin-dependent individuals to remain in treatment, limit their use of street drugs and reduce illegal activities.[35] However, owing to the risk of adverse effects and a number of operational factors, this treatment has not been recommended by WHO or other United Nations agencies. Yet another type of intervention that often generates debate and discussion is supervised injection facilities, or drug consumption rooms. Their purpose is to provide drug users with safe injecting equipment and safe surroundings in which to inject drugs. Supervised injection facilities do not usually provide the drugs themselves. A review of their effectiveness examined 75 published studies and concluded that safe injection facilities succeeded in attracting hard-to-reach populations, promoting safer injections, reducing the risk of overdose and reducing public drug injections and dropped syringes in the community.[36] Thus, the scientific evidence for their effectiveness is rapidly evolving. In its annual report for 2016, the Board stated that the ultimate objective of such facilities must be the reduction of the adverse consequences of drug use without condoning or encouraging drug trafficking, and that referral to treatment and rehabilitation programmes must be an integral aspect of such interventions.[37]

H. Cost effectiveness of treatment of drug use disorders

21. When investing in drug dependence treatment, costs are an important consideration. Unfortunately, fewer than half of all countries globally have a budget line dedicated specifically to the treatment of drug dependence, and lower- and middle-income countries are not among them. The three most important methods for financing treatment services are tax-based funding, out-of-pocket payments and non-governmental organizations, in that order. Lower- and middle-income countries appear to rely mostly on out-of-pocket payments.[38]

22. In general, studies in different settings and countries have uniformly shown that treatment for drug dependence is highly cost-effective. Every dollar spent on drug treatment yields a return of 4 to 7 dollars because of

[29] WHO, UNODC and UNAIDS, *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users: 2012 Revision* (Geneva, WHO, 2012).

[30] Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS (General Assembly resolution 65/277, annex).

[31] Economic and Social Council resolution 2009/6.

[32] Commission on Narcotic Drugs resolution 53/9.

[33] WHO, Evidence for action series, technical papers and policy briefs on HIV/AIDS and injecting drug users. Available at www.who.int/hiv/pub/idu/idupolicybriefs/en/index.html.

[34] Ambros A. Uchtenhagen, "Heroin maintenance treatment: from idea to research to practice", *Drug Alcohol Review*, vol. 30, No. 2 (2011), pp. 130–137.

[35] M. Ferri, M. Davoli and C. A. Perucci, "Heroin maintenance for chronic heroin-dependent individuals", *Cochrane Database of Systematic Reviews*, No. 12 (2011).

[36] Chloé Potier and others, "Supervised injection services: what has been demonstrated? A systematic literature review", D*rug and Alcohol Dependence,* vol. 145, No. 1 (2014), pp. 48–68.

[37] E/INCB/2016/1, para. 720.

[38] WHO, *Atlas on Substance Use (2010): Resources for the Prevention and Treatment of Substance Use Disorders* (Geneva, 2010), chap. 2, pp. 26 and 27.

reduced crime rates and reduced costs for the criminal justice system. If savings for the health-care system are also included, total savings exceed a ratio of 12:1. A review of 11 economic evaluation studies on a variety of treatments explored economic benefits in various outcome domains (criminal activity, health service utilization, employment earnings and expenditures on illicit drugs), and concluded that the reduction in criminal activity and the utilization of health-care services were the greatest economic benefits of the treatment of drug use disorders.[39] In addition, drug dependence treatment is much less expensive than criminal justice interventions. For instance, the cost of methadone maintenance in the United States of America has been estimated at approximately $4,700 per patient per year, while incarceration is estimated at $24,000 per prisoner per year.[40] It has been estimated that by providing treatment to just 10 per cent of eligible offenders, the criminal justice system could save around $4.8 billion.[41] An extensive review of the scientific literature has concluded that in terms of cost-effectiveness, agonist maintenance treatments, such as methadone and buprenorphine, should be considered first-line treatment options for opioid dependence.[42]

I. Organization and management of treatment service delivery

23. Despite the widespread recognition that drug dependence is a health condition, in many countries drug dependence treatment remains separate from health-care delivery. This separation adversely affects the quality of care available to affected individuals and increases avoidable and unnecessary expenditure. Integration of drug dependence treatment with general health-care services is important because:

(a) Drug use is interconnected with mental illness and other medical conditions;

(b) Integration of services leads to better care coordination, ultimately improving health outcomes;

(c) Delivery of drug treatment in the general health-care system is cost-effective;

(d) Integration may reduce health disparities and waiting times at drug use treatment facilities.

24. Integration of services for drug use disorders with health-care services enables the health-care system to provide services to people with mild to moderate drug use problems, the largest proportion of people who use drugs. This lessens the need for more intensive and expensive drug treatment and prevents drug problems from escalating further. Various models along a continuum of care have been described: drug treatment and health-care services can be coordinated, which means that they remain separate but have some degree of collaboration and communication; they can be co-located, meaning that they are in close, physical proximity but continue to exist separately; and they can be integrated, which means that they collaborate closely based on the full integration or merger of services. Each of these models has its own advantages and disadvantages, but where feasible, maximum integration appears to be the most efficient manner to deliver services, particularly in settings with limited resources. Thus, whether substances are controlled or not, it is helpful to provide services for substance use disorders in the same setting, regardless of the substance type. Such services should be integrated with the general health-care system. However, the focus on drug treatment must not be lost.

J. Treatment for special populations

1. Children and adolescents

25. Adolescents have unique drug use patterns and treatment needs. Among adolescents, any use of drugs is a cause for concern, even if they are merely experimenting, as drug use exposes them to more risk behaviour and increases the risk and severity of later drug use disorders. Research has identified serious adverse consequences of drug use on the developing brains of children and adolescents.[43] Hence, treatment is beneficial for adolescents

[39] Kathryn McCollister and Michael French, "The relative contribution of outcome domains in the total economic benefit of addiction interventions: a review of first findings", *Addiction*, vol. 98, No. 12 (2003), pp. 1647–1659.

[40] United States, Department of Health and Human Services, National Institute on Drug Abuse, *Principles of Drug Addiction Treatment: A Research-based Guide*, 3rd ed., NIH Publication No. 12-4180 (2012).

[41] Gary Zarkin and others, "Lifetime benefits and costs of diverting substance-abusing offenders from State prison", *Crime & Delinquency*, vol. 61, No. 6 (2012), pp. 829–850.

[42] Chris Doran, "Economic evaluation of interventions for illicit opioid dependence: a review of evidence", background document prepared for the third meeting of the technical development group for the WHO guidelines for psychosocially assisted pharmacotherapy of opioid dependence, held in Geneva from 17 to 21 September 2007.

[43] Lindsay M. Squeglia and Kevin M. Gray, "Alcohol and drug use and the developing brain", *Current Psychiatry Reports*, vol. 18, No. 5 (May 2016).

who use drugs, even when they are not suffering from diagnosable drug use disorders. The challenges of providing effective treatment to children and adolescents include: *(a)* inadequate research on drug use issues in this population; *(b)* uncertainty about the effects of medication meant for adults on children and adolescents; and *(c)* age-appropriate psychosocial intervention for adolescents taking into account their levels of cognitive development and life experience. Family and community play an important role in adolescent drug treatment. Many adolescents who use drugs have a history of physical, emotional or sexual abuse, and those should be identified and, where applicable, addressed concurrently.[44]

2. Women

26. Worldwide, men are almost three times more likely to use illicit drugs than women, whereas women are more likely than men to use prescription opioids and tranquilizers. While drug use disorders have been more commonly observed among men, the prevalence of drug use has been increasing among women over the past two decades, especially in some high-income countries. Moreover, once the drug use begins, it escalates to dependence much faster among women than among men. Importantly, very few drug-dependent women are able to access treatment services. One in three people who use drugs are women, while only one in five people who receive treatment are women. Stigma is the most important barrier to seeking treatment. Though fewer women use drugs, the public health consequences of drug use disorders among women are substantial and need to be addressed by gender-sensitive treatment services. Specifically, issues that need to be addressed include childcare assistance, sexual, pregnancy and reproductive health, psychiatric comorbidity, violence, sexual abuse, female sex work and housing.[45] WHO has developed guidelines for the management of drug use during pregnancy.[46] INCB devoted special attention to the topic of women and drugs in chapter I of its annual report for 2016.[47]

3. People in prisons and other custodial settings

27. In spite of repeated clarification in United Nations documents that the international drug control treaties do not require States parties to apply criminal justice sanctions for the use of drugs or compel such sanctions for the possession of drugs for personal use, some national governments continue to have laws that mandate penal measures, including incarceration for people who use drugs. It needs to be reiterated that under the international drug control treaties, treatment and rehabilitation services can be provided as a full-fledged alternative to criminal justice sanctions, as stated by the Board in 2007 and in 2016.[48, 49, 50] People facing charges for drug use or possession of small quantities of drugs for personal use need to be provided the option of care outside the criminal justice system. Prison-based treatment is important for inmates who have drug use disorders. The standards and quality of treatment offered in prisons should match those of services available in the wider community, and all options for the psychological and pharmacological treatment of drug dependence available in the community must also be available in prison. Linkages with services outside prison are also essential to ensure continuity of care after an inmate is released. Among psychosocial interventions, long-term residential treatment in therapeutic communities has been found to be particularly suitable for prison settings.

4. People with co-occurring drug use and other mental health disorders (dual diagnosis)

28. It is a well-known fact that drug use and other mental health conditions frequently co-occur. This co-occurrence can manifest itself in many forms. People who use drugs may simultaneously suffer from mental health symptoms or mental health disorders. Conversely, people with mental health disorders may either use drugs in a non-pathological manner or develop drug use disorders. In terms of aetiology or temporal association, either of these conditions may predate or follow the other. Pre-existing mental health conditions may contribute to drug use problems (as in the case of self-medication, for example) or the mental health conditions may be a consequence of drug use. Drug dependence treatment services

[44] United States, National Institute of Drug Abuse, *Principles of Adolescent Substance Use Disorder Treatment: A Research-based Guide*, NIH Publication No. 14-7953 (Washington, D.C., 2014).

[45] R. Orwin, L. Francisco and T. Bernichon, "Effectiveness of women's substance abuse treatment programs: a meta-analysis", NEDS Analytic Summary No. 21 (Fairfax, Virginia, Center for Substance Abuse Treatment, 2001).

[46] WHO, *Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy* (Geneva, 2014).

[47] E/INCB/2016/1.

[48] E/INCB/2007/1.

[49] UNODC, "From coercion to cohesion: treating drug dependence through health care, not punishment", discussion paper, 2010.

[50] E/INCB/2016/1.

should be equipped to assess patients for co-occurring mental health symptoms and to provide treatment or referral.

5. Other special population groups

29. Among other groups, migrants and ethnic minorities may face special challenges in terms of accessing treatment services. Although migration (whether forced or not) is occurring on a large scale globally, the research on drug use among migrants is limited. Migrants may be at particularly high risk of drug use disorders on account of their traumatic experiences, associated mental health problems, challenges of acculturation and socioeconomic inequality.[51] Treatment services for this group must take into account cultural factors which affect demand for and utilization of health and welfare services.[52] People engaged in sex work represent another especially vulnerable and often neglected group. The stigma associated with both drug use and sex work hinders access to treatment, and criminalization of both activities compounds the problem. Collaboration with civil society partners that work with both, people who use drugs and people who engage in sex work is recommended as an especially useful approach to reach out to those groups.[53] In addition, the development of specific targeted interventions for those groups should be a priority, since there is no firm evidence that existing interventions are effective.[54]

K. Drug dependence treatment as a human right

30. The International Covenant on Economic, Social and Cultural Rights sets out the right to health, which is described as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Since the treatment of drug dependence does improve the physical and mental health of affected individuals, such treatment is justifiably considered an element of the right to health.

31. In general comment 14 (2000) of the Committee on Economic, Social and Cultural Rights on the right to the highest attainable standard of health,[55] the Committee interpreted the right to health as defined in article 12.1 of the Covenant by stating that the right to health in all its forms and at all levels contains a number of interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party. For treatment and rehabilitation services, those conditions include:

(a) Availability: treatment services should be available in sufficient quantity taking into consideration the expected requirements, including the adequate amounts of medicines required for the treatment of drug dependence (such as methadone and buprenorphine for the treatment of opioid use disorders and naloxone for the treatment of overdose);

(b) Accessibility: important aspects of accessibility include non-discrimination (with particular attention paid to vulnerable and marginalized populations), physical accessibility, economic accessibility (i.e., affordability) and confidentiality;

(c) Acceptability: all treatment services should be culturally appropriate for beneficiaries and must be respectful of medical ethics;

(d) Quality: adequate quality implies the provision of medically and scientifically appropriate treatment services delivered by skilled treatment providers using evidence-based methods such as the prescription of medication with scientifically proven effectiveness.

32. Thus, in the light both of the international drug control conventions and of the International Covenant on Economic, Social and Cultural Rights, States should endeavour to ensure that the provision of drug dependence treatment services meets the above standards.

33. The discussion about mandatory drug dependence treatment is particularly significant in connection with the human rights of people with drug use disorders. Many countries have provisions in their national drug control frameworks stipulating that the criminal justice system can motivate, order, and/or supervise certain forms of drug dependence treatment. In some cases, patients are made to undergo treatment without their consent. Such treatments often involve detention in prison or other custodial facilities. In some other cases, the individual may be offered a choice between incarceration and treatment

[51] Danielle Horyniak and others, "Epidemiology of substance use among forced migrants: A global systematic review", PLOS One (2016).

[52] International Centre for Migration Health and Development, *Migrants, displaced people and drug abuse: A public health challenge*, 1998.

[53] Harm Reduction International, "When sex work and drug use overlap: considerations for advocacy and practice", London, 2013.

[54] Nikki Jeal and others, "Systematic review of interventions to reduce illicit drug use in female drug-dependent street sex workers", *BMJ Open*, No. 5(11):e009238, DOI: 10.1136/bmjopen-2015-009238.

[55] HRI/GEN/1/Rev.9 (Vol. I), chap. I.

with informed consent. Only in certain rare and limited cases may short-term treatment without consent be warranted, such as the legally sanctioned, involuntary hospitalization of individuals with severe mental health problems.

34. Compulsory treatment, i.e. treatment administered without the expressed consent of the affected individual, should be discouraged for the following reasons:

(a) The evidence for their effectiveness is poor;

(b) They threaten the health of people undergoing the treatment, including through increased vulnerability to HIV and other infections;

(c) They are in direct conflict with the human rights principles as stated in the International Covenant on Economic, Social and Cultural Rights.

35. Many United Nations agencies have strongly advocated for the closure of compulsory drug detention and rehabilitation centres and for the implementation of voluntary, evidence-informed and rights-based treatment services, a position which has been reiterated by the Board.[56, 57]

36. An essential component of quality and availability of treatment services is access to the medications required to treat drug dependence. Certain medications that are demonstrated to be unequivocally effective in the treatment of drug dependence, such as methadone and buprenorphine, are internationally controlled substances. Many national drug control policy frameworks make it difficult for treatment facilities to provide treatment using such controlled medications. Many controlled substances play a critical role not only in the treatment of drug dependence but also in, for example, pain relief, anaesthesia, surgery and the treatment of mental disorders. The obligation to prevent their diversion, trafficking and abuse has received much more attention than ensuring that they are available in adequate quantities for medical and scientific purposes. Some countries explicitly prohibit the use of such medications. Elsewhere, even if the medications are available, service providers are reluctant to use them owing to cumbersome regulatory requirements. While the inappropriate prescription of controlled medications by health-care professionals must be discouraged, the Board has clearly recommended removal of legal sanctions for unintentional mistakes in handling opioids.[58] Still, in some countries, the practice of interpreting and applying the laws too stringently in relation to treatment providers continues. As an example, in India, in 2014, two psychiatrists were arrested and jailed over charges of providing buprenorphine to their patients. This led to a substantial number of doctors withholding buprenorphine treatment, leaving a large population of patients bereft of an effective treatment and forced to continue their illicit use of heroin.[59] Unfortunately, India is not alone in this respect. It has been pointed out that medications are diverted despite very low levels of consumption for medical purposes. This demonstrates that restricting access to medications for medical purposes is not enough to prevent misuse.[60]

37. It is in the spirit of the international drug control conventions to ensure access to controlled narcotic drugs and psychotropic substances for medical and scientific purposes. States should therefore take measures to remove the legal and policy barriers that prevent access to them. It is essential that national laws governing the availability of pharmaceutical products in general are in line with the drug control treaties in that they curb illicit use and facilitate access to medicines for use in treatment. It is sometimes noted that national policies and regulations make a distinction between different medical purposes, facilitating access to controlled medications for the treatment of certain health conditions, such as pain associated with terminal cancer, and yet hindering the access for the treatment of drug dependence. Controlled medications must be equally accessible for all the health conditions for which they are needed, as required by the international drug conventions and consistent with scientific evidence. Undue restrictions on providing treatment using controlled medications is a violation of the right to health.

L. Monitoring and quality assurance of treatment programmes

38. Appropriate monitoring and evaluation systems are essential to monitoring the coverage and quality of

[56] UNODC and others, "Compulsory drug detention and rehabilitation centres", joint statement, 9 March 2012. Available at www.unodc.org/.

[57] E/INCB/2016/1.

[58] *Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes — Indispensable, Adequately Available and not Unduly Restricted* (E/INCB/2015/1/Supp.1).

[59] Atul Ambekar and others, "Challenges in the scale-up of opioid substitution treatment in India", *Indian Journal of Psychiatry*, vol. 59, No. 1 (April 2017).

[60] Briony Larance and others, "The availability, diversion and injection of pharmaceutical opioids in South Asia", *Drug Alcohol Review*, vol. 30, No. 3 (2011), pp. 246–254.

treatment, rehabilitation and social reintegration services in the public and private sectors. This is a prerequisite for establishing priorities effectively and tailoring responses to assessed needs, including the need to improve the quality of care, the need to help policymakers to determine the return on investment of treatment, the need to identify gaps in treatment provision and the need to plan required treatment programmes.

39. With that purpose in mind, it is important to establish health-focused indicators, for instance the proportion of people recovering from drug use disorders, and in doing so go beyond measuring only the frequency or the type of drug used. The encouragement of operational research and sharing of good practices are important mechanisms to help to ensure that the results of treatment programmes are put to better use as part of a continuous quality improvement process.

M. Recommendations

40. The obligation of States parties, enshrined in the three drug control conventions, to provide treatment for people with drug use disorders as part of a broad spectrum of demand reduction measures is central to improving public health worldwide. In addition, strengthening the treatment of drug use disorders is a critical target in attaining Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages). One of the main objectives pursued in this chapter is to promote the treatment of drug use disorders based on the requirements of the drug control treaties, and to prevent non-evidence-based practices from being implemented in the name of the conventions. Countries should be aware of and utilize the resources and tools for drug dependency treatment and care that have been developed thanks to the collaboration between UNODC and WHO.[61] The cooperation is an effort by the United Nations system to promote an integrated and balanced approach to drug treatment by effective interaction between the public health, drug control and law enforcement sectors.

41. The Board recommends that States should:

(a) Gather data on prevalence of drug-use disorders and the accessibility and utilization of treatment. There is a need to allocate resources to improving mechanisms for effective information collection, including through comprehensive national drug use surveys applying recognized methodologies, to assess the extent and patterns of drug use and treatments;

(b) Invest in making evidence-based treatment and rehabilitation services available and accessible. Considering that drug use disorders place a significant burden on national resources and cause suffering to humankind, it is essential for States to invest in making evidence-based treatment and rehabilitation services available and accessible to people affected by drug dependence as part of the health-care system. It is difficult to prescribe the exact amount or proportion of resources that need to be allocated to cover the entire gamut of drug control activities. Drug control consists of supply reduction (e.g., regulatory control, law enforcement, interdiction and criminal justice) and demand reduction (e.g., prevention, treatment and rehabilitation, and prevention of adverse consequences). However, resource allocation should be balanced, taking into account the extent and pattern of drug problems, national priorities and the scientific evidence base;

(c) Ensure coordination among government agencies and ministries in their efforts to reduce supply and demand. The skills and expertise required for supply reduction and demand reduction are very different. Even within the demand reduction sector, the expertise required for primary prevention is markedly different from that needed for treatment and rehabilitation. Thus, while law enforcement agencies are better suited for managing various control measures, the treatment of drug dependence is best handled by the departments and ministries responsible for the health sector. At the same time, coordination among all agencies engaged in drug control must be ensured;

(d) Give due attention to drug dependence treatment among other health and welfare needs. National resources must be allocated to the treatment and rehabilitation of drug use disorders, based on local needs. Even if resources are made available as a package for a large basket of health and welfare services, a certain proportion needs to be earmarked for treatment and rehabilitation. Resources need to be prioritized for treatment approaches whose effectiveness is supported by a strong evidence base;

(e) Develop a cadre of skilled and trained human resources. To ensure the quality of drug dependence treatment programmes, States must develop mechanisms to build the capacity of a variety of treatment professionals, including university-trained specialists in addiction medicine or addiction psychiatry, general medical professionals equipped to deal with common drug-related problems and other professionals, including nurses, counsellors,

[61] UNODC and WHO, *UNODC-WHO Joint Programme on Drug Dependence Treatment and Care* (2009).

psychologists, social workers and occupational therapists. For outreach activities in the field, peer counsellors from among the community of people who use drugs have been found to be very effective in reaching out to hard-to-reach populations of drug users and motivating them to access services. In addition, it is important that other professionals who may encounter people with drug problems, including those working in general health care, education, social services or criminal justice, should receive training for early recognition, referral or intervention. All training programmes must incorporate elements of human rights and ethical treatment practices;

(f) Collaborate with civil society partners. NGOs could be very effective partners for national governments in a variety of ways, including by enhancing the reach of services by forging links between affected individuals and service providers, ensuring that the rights of people who use drugs are protected and serving as advocacy platforms to provide a voice for affected communities. National governments should foster cooperation with civil society groups that could assist in ensuring compliance with the international drug control conventions in terms of enhanced reach and coverage of treatment interventions;

(g) Follow principles of justice and equity. Treatment services should be made easily accessible to all those who need them, with particular attention paid to special population groups or marginalized, disadvantaged and vulnerable sections of society, in particular women, children and adolescents, sexual minorities, economically weaker groups and racial and ethnic minorities. It should be ensured that people affected by drug dependence are not discriminated against, including on the basis of the kind of drug they have been using (controlled versus non-controlled substances) and whether they have been in contact with the criminal justice system or not. Treatment services in prison or other custodial settings must have the same level of quality and intensity as those available in the community; it needs to be ensured that all people with drug use disorders are able to exercise the right to treatment;

(h) Provide health insurance and other benefits for the treatment of drug use disorders. People with drug dependence must have access to the same benefits and welfare services as those with other health conditions. Drug use disorders need to be listed among the conditions for which health insurance benefits are available. Similarly, disability benefits, if available, also need to be extended to people suffering from drug dependence;

(i) Improve access to controlled medications. Policies and procedures governing controlled medications (such as methadone, buprenorphine and other medications needed for treatment of drug dependence) should be streamlined to facilitate access. While procedural oversight and monitoring are essential to prevent the diversion and misuse of pharmaceutical products, rules and procedures that are too restrictive deter professionals from using them. It is necessary to create an environment that lets professionals provide standard treatment services that involve prescribing and dispensing controlled medications where needed. National laws and policies should not discriminate between various health conditions for which such medications are required. The health sector and health professionals should be entrusted with the clinical decisions regarding the choice of medications in line with the prevailing knowledge base of medical science;

(j) Institute a multi-tier structure for the delivery of treatment services. Treatment rehabilitation and social reintegration services need to be made available in a variety of settings. Overreliance on specialized settings, such as specialist rehabilitation centres, may be counterproductive in that they may stigmatize users and make services difficult to access and afford. Instead, as capacity is developed, a multi-tier structure should be instituted for the delivery of treatment services under which common and less-severe problems are addressed by general and primary health-care services, while more severe problems are addressed by specialist-level care. Such a structure would facilitate early identification and treatment for those with relatively less severe problems and prevent an escalation of their drug dependence and its consequences. Governments are encouraged to use the resource materials developed by WHO for promoting prevention and treatment of drug use disorders in general health-care systems within the framework of universal health coverage;[62]

(k) Move from a criminal justice response to a health and welfare system response. National drug policy frameworks need to be favourable to providing treatment and rehabilitation services and avoid an inadvertent tilt towards a criminal justice response to the drug problem. Some countries have instituted significant legal and policy reforms to that effect. The overall drug policy environment at the national level needs to be conducive to the provision of evidence-based treatment and rehabilitation services; it must be ensured that the human rights of persons with drug use disorders are respected at all stages and that such persons are not subjected to discrimination in any form;

[62] WHO, *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-specialized Health Settings: Mental Health Gap Action Programme (mhGAP)* (Geneva, 2010).

(l) Extend cooperation, share best practices and build capacity. The importance of international cooperation in the area of drug control is well established and has been emphasized in numerous publications of INCB and the United Nations, as well as in the various resolutions of the Commission on Narcotic Drugs, the Economic and Social Council and the General Assembly. International cooperation is also vital to improving and broadening the coverage of treatment of drug dependence. States are urged to cooperate through the sharing of evidence and best practices and in the training of human resources for the provision of treatment and rehabilitation services;

(m) Provide financial and technical assistance to lower- and middle-income countries. Many countries would require financial and expert assistance to develop and sustain treatment programmes for drug dependence that conform to international standards. Many developed and high-income countries with established illicit markets for controlled drugs seek the cooperation of developing countries that are at the origin of or function as transit points for those controlled drugs. Thus, developed and high-income countries should reciprocate by extending financial and technical assistance to lower- and middle-income countries that are struggling to establish and maintain treatment and rehabilitation services. The low-income and middle-income countries that have been successful in gathering adequate expertise and building their capacities are encouraged to share their expertise with other countries. International donor agencies and United Nations agencies could play a vital role in assisting developing countries in this area;

(n) Ensure research into newer interventions. Scientific advances made in the past few decades have made it possible for the global community to deal with the challenges posed by drug use disorders in an efficient, effective and humane manner. However, despite major advances in the treatment of drug use disorders, a number of challenges remain. While it has been demonstrated that existing pharmacotherapy for opioid use disorders is effective, effective pharmacological treatment for cannabis and stimulant use disorders remains elusive. The advent of new psychoactive substances is yet another area for which the knowledge base regarding effects, consequences and modalities of effective treatment is still evolving. Many countries and jurisdictions have brought about substantial policy and legislative changes related to controlled drugs, in particular cannabis. It remains to be seen what the impact of those policy changes will be on drug use disorders, as well as on the subsequent demand for treatment. Relatively newer forms of intervention, such as heroin maintenance and supervised injection facilities, are being implemented in a number of countries. INCB calls for continued efforts to conduct more research in these areas to inform evidence-based treatments and interventions that are in line with the requirements of the international drug control conventions.

Chapter II.

Functioning of the international drug control system

A. Promoting the consistent application of the international drug control treaties

42. The main corpus of the international legal framework for drug control is composed of the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

43. The elaboration of this framework by the international community was the product of a widespread consensus, reflecting the realization that the adoption of common approaches and concerted action to the regulation, availability and use of controlled substances was imperative for the protection of the health and welfare of humanity.

44. Becoming a State party to the drug control conventions is a solemn undertaking through which Governments commit to adopting legislative, regulatory and policy measures necessary to ensure the full implementation of their legal obligations in their national systems.

45. In particular, the drug control conventions enjoin States to adopt measures for the control of licit trade in narcotic drugs, psychotropic substances and precursor chemicals used in their illicit manufacture, and to facilitate their availability for legitimate medical purposes while preventing their diversion into illicit channels. They require States to elaborate strategies for the prevention of drug use and mechanisms to address addiction through treatment, rehabilitation, aftercare and social reintegration. They provide for State responses to suspected drug-related criminality that are humane and proportionate as well as grounded in the respect for human dignity, the presumption of innocence and the rule of law, and they categorically reject those that are not. Together they are also a vehicle for facilitating mutual legal assistance and extradition between States and for combating money-laundering.

Status of adherence to the international drug control treaties

46. While there were no new accessions to the three international drug control treaties for the period under review, the 1961 Convention as amended, the 1971 Convention and the 1988 Convention are among the most widely ratified international instruments, benefiting from near-universal adherence.

47. As at 1 November 2017, 185 States had ratified or acceded to the 1961 Convention as amended. Among those States having yet to accede, two were located in Africa (Equatorial Guinea and South Sudan), two in Asia (State of Palestine and Timor-Leste) and seven in Oceania (Cook Islands, Kiribati, Nauru, Niue, Samoa, Tuvalu and Vanuatu). Chad remained the sole State having ratified the 1961 Convention in its unamended form.

48. The number of States having ratified or acceded to the 1971 Convention remained at 183, with 14 States yet to become parties to the convention, namely three African

States (Equatorial Guinea, Liberia and South Sudan), one State in the Americas (Haiti), two in Asia (State of Palestine and Timor-Leste) and eight in Oceania (Cook Islands, Kiribati, Nauru, Niue, Samoa, Solomon Islands, Tuvalu and Vanuatu).

49. In the lead-up to the 30th anniversary of its adoption, the 1988 Convention is the most widely ratified of the three drug control conventions, with 189 parties (188 States and the European Union). Most States that are yet to become parties are located in Oceania (Kiribati, Palau, Papua New Guinea, Solomon Islands and Tuvalu). In Africa, only three countries have yet to ratify or accede to the 1988 Convention (Equatorial Guinea, Somalia and South Sudan) and in Asia, only one (State of Palestine).

50. **The Board reiterates its call to all States having not yet become Parties to one or more of the international drug control conventions to do so at the earliest opportunity, and to take all legislative and policy action necessary to ensure their comprehensive implementation at the national level.**

B. Ensuring the implementation of the provisions of the international drug control treaties

51. The fundamental goal of the international drug control system is assuring the health and welfare of humankind. That goal is to be achieved through two, twin actions: ensuring the availability of internationally controlled substances for medical and scientific purposes and, in the case of precursor chemicals, also ensuring their legitimate industrial use; and preventing the diversion of controlled substances into illicit channels.

52. To monitor compliance with the international drug control treaties, the Board examines action taken by Governments to implement the treaty provisions aimed at achieving the overall goals of the conventions. Over the years, the treaty provisions have been supplemented with additional control measures adopted by the Economic and Social Council and the Commission on Narcotic Drugs to enhance their effectiveness. In the present section, the Board highlights action that needs to be taken to implement the international drug control system, describes problems encountered in that regard and provides specific recommendations on how to deal with those challenges.

1. Preventing the diversion of controlled substances

(a) Legislative and administrative basis

53. Governments have to ensure that national legislation complies with the provisions of the international drug control treaties. They also have the obligation to amend lists of the substances controlled at the national level when a substance is included in a schedule or transferred from one schedule to another of an international drug control treaty. Inadequate legislation or implementation mechanisms at the national level or delays in bringing lists of substances controlled at the national level into line with the schedules of the international drug control treaties will result in inadequate national controls of substances under international control and may lead to the diversion of substances into illicit channels. The Board is therefore pleased to note that, as in previous years, most Governments have continued to furnish information to the Board on legislative or administrative measures taken to ensure compliance with the provisions of the international drug control treaties. At the same time, the Board is concerned that some Governments have introduced or are planning to introduce legislative measures in contravention of the requirements of the international drug control treaties. **The Board reminds Governments that in resolution S-30/1, entitled "Our joint commitment to effectively addressing and countering the world drug problem", adopted by the General Assembly on 19 April 2016, Member States reaffirmed their commitment to the goals and objectives of the three international drug control conventions.**

54. On 16 March 2017, the Commission on Narcotic Drugs in its decisions 60/2 and 60/3 included U-47700 and butyrfentanyl in Schedule I of the 1961 Convention as amended. In accordance with article 3, paragraph 7, of the 1961 Convention as amended, that decision was communicated by the Secretary-General to all Governments, WHO and the Board on 21 April 2017, and became effective with respect to each party upon receipt of that notification. **The Board acknowledges the efforts made by Governments that have already put those substances under control and urges all other Governments to amend the lists of substances controlled at the national level accordingly, and apply to those substances the control measures required under the 1961 Convention as amended, and inform the Board in this regard.**

55. The Board also wishes to draw the attention of Governments to the fact that eight substances were placed under international control under the 1971 Convention

by the Commission on Narcotic Drugs on the same date. Pursuant to Commission decisions 60/4, 60/5, 60/6, 60/7, 60/8, 60/9, 60/10 and 60/11, 4-MEC (4-methylethcathinone), ethylone, pentedrone, ethylphenidate, MPA (methiopropamine), MDMB-CHMICA, 5F-APINACA (5F-AKB-48) and XLR-11 were added to Schedule II of the 1971 Convention. In accordance with article 2, paragraph 7, of the 1971 Convention, those decisions of the Commission were communicated by the Secretary-General to all Governments, WHO and the Board on 21 April 2017, and became fully effective with respect to each party on 18 October 2017. **The Board acknowledges the efforts made by some Governments that have already put those substances under control and urges all other Governments to amend their lists of substances controlled at the national level accordingly, to apply to those substances the control measures required under the 1971 Convention, as well as in the relevant resolutions of the Commission and the Council, and inform the Board accordingly.**

56. In accordance with Economic and Social Council resolutions 1985/15, 1987/30 and 1993/38, Governments are required to introduce an import authorization requirement for zolpidem, a substance that was included in Schedule IV of the 1971 Convention in 2001. In response to the Board's request made in its annual reports for 2012 and 2013 and a circular letter sent in 2016, a number of Governments have provided the requisite information. As at 1 November 2017, relevant information was available for 130 countries and territories. Of those, 121 countries and territories have introduced an import authorization requirement, and one country (the United States of America) requires a pre-import declaration. Six countries and territories do not require an import authorization for zolpidem (Cabo Verde, Ireland, New Zealand, Singapore, Vanuatu and Gibraltar). Imports of zolpidem into Azerbaijan are prohibited, and Ethiopia does not import the substance. At the same time, information on the control of zolpidem remains unknown for 84 countries and territories. **The Board therefore again urges the Governments of countries and territories that have not yet done so to supply it with information on the control status of zolpidem as soon as possible.**

57. On 16 March 2017, the Commission on Narcotic Drugs decided to include N-phenethyl-4-piperidone (NPP) and 4-anilino-N-phenethyl-4-piperidine (ANPP), two precursors of fentanyl and of a few "designer" fentanyls, in Table I of the 1988 Convention. The decision became effective on 18 October 2017. **Governments are thus requested to implement these decisions at the national level and inform the Board accordingly.**

(b) Prevention of diversion from international trade

Estimates and assessments of annual requirements for internationally controlled substances

58. The system of estimates and assessments of annual licit requirements for narcotic drugs and psychotropic substances is the cornerstone of the international drug control system. It enables exporting and importing countries alike to ensure that trade in those substances stays within the limits determined by the Governments of importing countries and that diversion of controlled substances from international trade are effectively prevented. For narcotic drugs, such a system is mandatory under the 1961 Convention as amended, and the estimates furnished by Governments need to be confirmed by the Board before becoming the basis for calculating the limits on manufacture and import.

59. The system of assessments of annual requirements for psychotropic substances was adopted by the Economic and Social Council in its resolutions 1981/7, 1991/44, 1993/38 and 1996/30, and the system of estimates of annual legitimate requirements for selected precursors was adopted by the Commission on Narcotic Drugs in its resolution 49/3, to help Governments to prevent attempts by traffickers to divert controlled substances into illicit channels. The assessments of annual legitimate requirements for psychotropic substances and estimates of annual legitimate requirements for selected precursors help Governments to identify unusual transactions. In many cases, the diversion of a drug has been prevented when the exporting country refused to authorize the export of the substance because the quantities of the substance to be exported would have exceeded the quantities required in the importing country.

60. The Board regularly investigates cases involving possible non-compliance by Governments with the system of estimates or assessments; as such, non-compliance could facilitate the diversion of controlled substances from licit international trade into illicit channels. In that connection, the Board provides information, support and guidance to Governments on the working of the system for estimates or assessments, as necessary.

61. Governments are obliged to comply with the limits on imports and exports of narcotic drugs provided for under articles 21 and 31 of the 1961 Convention. Article 21 stipulates, inter alia, that the total of the quantities of each drug manufactured and imported by any

country or territory in a given year shall not exceed the sum of the following: the quantity consumed for medical and scientific purposes; the quantity used, within the limits of the relevant estimates, for the manufacture of other drugs, preparations or substances; the quantity exported; the quantity added to the stock for the purpose of bringing that stock up to the level specified in the relevant estimate; and the quantity acquired within the limit of the relevant estimate for special purposes. Article 31 requires all exporting countries to limit the export of narcotic drugs to any country or territory so that the quantities imported fall within the limits of the total of the estimates of the importing country or territory, with the addition of the amounts intended for re-export.

62. As in previous years, the Board finds that the system of imports and exports of narcotic drugs generally continues to be respected and works well. In July 2017, a total of 9 countries were contacted regarding possible excess imports or excess exports identified with regard to international trade in narcotic drugs that had been effected during the year. As at 1 November 2017, two replies had been received, from Czechia and Saudi Arabia, and reminder letters were sent to the countries that did not reply. The Board will continue to pursue the matter with those countries that have failed to respond.

63. Pursuant to Economic and Social Council resolutions 1981/7 and 1991/44, Governments are requested to provide to the Board assessments of annual domestic medical and scientific requirements for psychotropic substances listed in Schedules II, III and IV of the 1971 Convention. The assessments received are communicated to all States and territories to assist the competent authorities of exporting countries when approving exports of psychotropic substances. As at 1 November 2017, the Governments of all countries and territories, except for South Sudan, for which assessments were established by the Board in 2011, had submitted at least one assessment of their annual medical requirements for psychotropic substances.

64. **The Board recommends that Governments review and update the assessments of their annual medical and scientific requirements for psychotropic substances at least every three years.** However, 26 Governments have not submitted a revision of their legitimate requirements for psychotropic substances for three years or more. The assessments valid for those countries and territories may therefore no longer reflect their actual medical and scientific requirements for psychotropic substances.

65. When assessments are lower than the actual legitimate requirements, the importation of psychotropic substances needed for medical or scientific purposes may be delayed. When assessments are significantly higher than legitimate needs, the risk of psychotropic substances being diverted into illicit channels may be increased. The Board has repeatedly reminded countries that it is important that Governments estimate and assess correctly and realistically the initial needs of their country.

66. As in previous years, the system of assessments of annual requirements for psychotropic substances continues to function well and is respected by most countries and territories. In 2016, the authorities of 29 countries issued import authorizations for substances for which they had not established any such assessments or for quantities that significantly exceeded their assessments. Only two countries were identified as having exported psychotropic substances in quantities exceeding the relevant assessment.

67. In line with the Commission on Narcotics Drugs resolution 49/3, entitled "Strengthening systems for the control of precursor chemicals used in the illicit manufacture of synthetic drugs", Member States are requested, on a voluntary basis, to provide the Board with annual legitimate requirements for imports of four precursors of amphetamine-type stimulants and, to the extent possible, preparations containing those substances. As at 1 November 2017, 166 Governments had provided an estimate for at least one of those substances, thus providing the competent authorities of exporting countries with an indication of the legitimate requirements of importing countries and thereby preventing diversion attempts.

Requirement for import and export authorizations

68. The universal application of the requirement for import and export authorizations laid down in the 1961 and 1971 Conventions is key to preventing the diversion of drugs into the illicit market. Such authorizations are required for transactions involving any of the substances controlled under the 1961 Convention or listed in Schedules I and II of the 1971 Convention. Competent national authorities are required by those conventions to issue import authorizations for transactions involving the importation of such substances into their country. The competent national authorities of exporting countries must verify the authenticity of such import authorizations before issuing the export authorizations required to allow shipments containing the substances to leave their country.

69. The 1971 Convention does not require import and export authorizations for trade in the psychotropic

substances listed in its Schedules III and IV. However, in view of the widespread diversion of those substances from licit international trade during the 1970s and 1980s, the Economic and Social Council, in its resolutions 1985/15, 1987/30 and 1993/38, requested Governments to extend the system of import and export authorizations to cover those psychotropic substances as well.

70. Most countries and territories have already introduced an import and export authorization requirement for psychotropic substances listed in Schedules III and IV of the 1971 Convention, in accordance with the above-mentioned Economic and Social Council resolutions. In response to a circular letter sent in 2016, the Board also received additional and updated information from the Governments of Dominica, the Lao People's Democratic Republic, Lesotho, Morocco, the Philippines and Thailand. In particular, some of these Governments have updated their import and export authorization requirement for phenazepam, which was added to Schedule IV of the 1971 Convention in 2016. By 1 November 2017, specific information had been made available to the Board by 206 countries and territories, showing that all major importing and exporting countries now require import and export authorizations for all psychotropic substances in Schedules III and IV of the 1971 Convention. Twice a year, the Board disseminates to all Governments a table showing the import authorization requirements for substances in Schedules III and IV pursuant to the relevant Economic and Social Council resolutions. That table is also published in the secure area of the Board's website, which is accessible only to specifically authorized government officials, so that the competent national authorities of exporting countries may be informed as soon as possible of changes in import authorization requirements in importing countries. **The Board urges the Governments of the few remaining States in which national legislation and/or regulations do not yet require import and export authorizations for all psychotropic substances, regardless of whether they are States parties to the 1971 Convention, to extend such controls to all substances in Schedules III and IV of the 1971 Convention as soon as possible, and inform the Board in this regard.**

71. The 1988 Convention does not require import and export authorizations for trade in substances listed in Tables I and II of that Convention. However, with a view to preventing the diversion of those substances, the Convention provides for the advance notification of planned shipments to the authorities of the importing Government (see paras. 74 and 75 below regarding pre-export notifications for precursor chemicals).

International electronic import and export authorization system for narcotic drugs and psychotropic substances

72. As part of its endeavours to harness technological progress for the effective and efficient implementation of the import and export authorization regime for licit international trade in narcotic drugs and psychotropic substances, the Board has spearheaded efforts to develop an electronic tool to facilitate and expedite the work of competent national authorities and to reduce the risks of diversion of those drugs and substances. The International Import and Export Authorization System (I2ES) is an innovative, web-based application that was developed by the Board in cooperation with UNODC and with the support of Member States. I2ES allows Governments electronically to generate import and export authorizations for licit imports and exports of narcotic drugs and psychotropic substances, to exchange those authorizations in real time and instantly to verify the legitimacy of individual transactions while ensuring full compliance with the requirements of the international drug control conventions. I2ES significantly reduces the risk of drug consignments being diverted into illicit channels (see section F ("Special topics") below for more details).

73. I2ES was officially launched in 2015 and competent national authorities from 40 countries have registered with the system. In March 2017, a user-group meeting to gather feedback on the system was held on the margins of the sixtieth session of the Commission on Narcotic Drugs. Some 40 experts from 30 countries participated in that user-group meeting. The meeting afforded government officials of participating countries a valuable opportunity to exchange ideas on bringing about the fuller implementation of I2ES and to provide feedback to INCB and the information technology service of UNODC to guide future action and the further development of the system. The user group emphasized the importance of a high level of enrolment in and usage of I2ES by the competent national authorities of Governments around the world, and encouraged all Governments to register and to use the system. **The Board wishes to encourage all competent national authorities that have not yet done so to register with and start using I2ES as soon as possible, as only through its widespread application will Governments be able to avail themselves of all the advantages that the tool provides. The Board stands ready to assist in that regard. The Board reiterates the call to Member States contained in Commission on Narcotic Drugs resolution 58/10 to provide the fullest possible financial support to enable the secretariat of the Board to continue administering and monitoring the system, and the need for support for the system's implementation and further development.**

Pre-export notifications for precursor chemicals

74. Article 12, paragraph 10 *(a)*, of the 1988 Convention allows the Governments of importing countries to make it mandatory for exporting countries to inform them of any planned export of precursors to their territory. As at 1 November 2017, 112 States and territories had invoked the provision and had formally requested pre-export notifications, thus allowing them to carry out the prior verification of the legitimacy of a planned transaction. **To increase the awareness of, and reduce the vulnerability to, precursor chemicals entering their territory, the remaining Governments not having formally requested pre-export notifications are encouraged to invoke article 12, paragraph 10 *(a)*, of the 1988 Convention without further delay.**

75. The Pre-Export Notification Online (PEN Online) system, a secure web-based tool provided by INCB free of charge, allows importing and exporting Governments to communicate with each other as regards the international trade in precursor chemicals and to provide alerts of any suspicious transactions. As at 1 November 2017, a total of 157 Governments had registered to use it. Although this represents an increase compared with the previous year, there is still a noteworthy number of Governments that have not yet registered to use the system. **INCB calls on Governments actively and systematically to use PEN Online and urges the remaining States that have not yet registered to use the system to do so as soon as possible. The Board stands ready to assist Governments in this regard.**

(c) Effectiveness of the control measures aimed at preventing the diversion of controlled substances from international trade

76. The system of control measures laid down in the 1961 Convention provides effective protection to international trade in narcotic drugs against attempts to divert such drugs into illicit channels. Similarly, as a result of the almost universal implementation of the control measures stipulated in the 1971 Convention and the relevant Economic and Social Council resolutions, there have been no identified cases involving the diversion of psychotropic substances from international trade into illicit channels in recent years. In addition, the 1988 Convention requires parties to prevent the diversion of precursor chemicals from international trade to the illicit manufacture of narcotic drugs and psychotropic substances. The Board has also developed various systems to monitor compliance with that aspect of the 1988 Convention and to facilitate cooperation between Governments to that end.

77. Discrepancies in government reports on international trade in narcotic drugs and psychotropic substances are regularly investigated with the competent authorities of the relevant countries to ensure that no diversion of narcotic drugs and psychotropic substances from licit international trade takes place. Those investigations may reveal shortcomings in the implementation of control measures for narcotic drugs and psychotropic substances, including the failure of companies to comply with national drug control provisions.

78. Investigations regarding discrepancies for 2016 related to trade in narcotic drugs have been initiated with 39 countries. As at 1 November 2017, replies had been received from 28 countries. The responses indicated that the discrepancies were caused by clerical and technical errors in preparing the reports, reporting on exports or imports of preparations in Schedule III of the 1961 Convention without indicating it on the form, or inadvertent reporting of transit countries as trading partners. In some cases, countries confirmed the quantities reported by them, resulting in the initiation of follow-up investigations with their respective trading partners. Reminder letters were sent to the countries that did not reply.

79. Similarly, with regard to international trade in psychotropic substances, investigations into 655 discrepancies related to 2015 data were initiated with 52 countries. As at 1 November 2017, 31 countries had provided replies relating to those discrepancies, leading to the resolution of 475 of those discrepancies. In all cases in which the data provided were confirmed by the responding countries, follow-up actions with the counterpart countries were initiated as required. All responses received indicated that the discrepancies were caused by clerical or technical errors: in most cases, either the failure to convert amounts into anhydrous base or "overlapping", i.e., an export in a given year being received by the importing country only at the beginning of the following year. None of the cases investigated indicated a possible diversion of psychotropic substances from international trade.

80. With regard to precursors, the provisions of article 12 of the 1988 Convention have been complemented over the years by a number of resolutions of the General Assembly, the Economic and Social Council and the Commission on Narcotic Drugs. The adoption and implementation by Governments of such voluntary measures has contributed to effective monitoring of the movement of substances listed in Tables I and II of that Convention and to limiting cases of diversion from licit international

trade. To respond to new challenges that Governments and the international community are facing today, the Commission on Narcotic Drugs, in its resolution 60/5 of March 2017, calls for a set of voluntary measures and enhanced cooperation among Governments and with INCB to address the issue of non-scheduled precursor chemicals used in the illicit manufacture of narcotic drugs and psychotropic substances; in that resolution, the Commission also called for action to address criminal activities conducted via the Internet relating to precursors.

81. A critical element in INCB efforts to support Governments in the prevention and investigation of chemical diversion is the real-time nature of the information communicated between Governments. Specifically, the online tools developed by INCB facilitate immediate cooperation and follow-up to identify those responsible for the diversion of and trafficking in precursors. With regard to pre-export notifications, the Board continues to flag suspicious shipments and request explicit clarifications, as necessary. Over the years, these tools have notably developed in terms of the usage as well as the volume and the details of information provided by some Governments.

82. Two initiatives of the Board, Project Prism and Project Cohesion, focusing on precursors used in the illicit manufacture of amphetamine-type stimulants, and cocaine and heroin, have also contributed to closing knowledge gaps and preventing the diversion of controlled substances from international trade as well as from domestic distribution channels.

83. Details related to these projects as well as an in-depth analysis of recent trends and developments observed can be found in the Board's report on the implementation of article 12 of the 1988 Convention for 2017.[63] Chapter IV of that report explores Internet-facilitated trade in precursors.

(d) Prevention of diversion of precursors from domestic distribution channels

84. Diversion from domestic distribution channels remains a major source of substances in Tables I and II used for illicit drug manufacture, as the control measures applied by Governments to domestic trade in and distribution of chemical substances often lag behind those used in international trade and vary from one country to another. One of the loopholes identified in several national precursor control systems relates to registration requirements for new precursor operators and their practical implementation.

2. Ensuring the availability of internationally controlled substances for medical and scientific purposes

85. In line with its mandate to ensure the availability of internationally controlled substances for medical and scientific purposes, the Board carries out various activities related to narcotic drugs and psychotropic substances. The Board monitors action taken by Governments and works with other international organizations and other bodies to support the availability and rational use of controlled substances for medical and scientific purposes and provides, through its secretariat, technical support and guidance to Governments in their implementation of the provisions of the international drug control treaties.

86. To supplement and increase the effectiveness of the action mentioned above, in 2016, the Board launched a project called INCB Learning. The project assists Member States in their efforts to achieve full compliance with the provisions of the international drug control treaties. One of the objectives of the project is to ensure the adequate availability of internationally controlled substances while preventing their abuse and diversion into illicit channels.

87. Under INCB Learning, in 2017 a regional training seminar for competent national authorities of Europe was conducted in Vienna in July 2017 with 57 participants from the national authorities of Albania, Andorra, Austria, Belgium, Bulgaria, Czechia, Denmark, Estonia, Finland, Germany, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Montenegro, the Netherlands, Norway, Poland, Portugal, Romania, the Russian Federation, Serbia, Slovenia, Spain and Sweden. The training also included discussion on the importance of ensuring the availability of opioid analgesics and psychotropic substances for medical and scientific purposes. A training seminar for countries in Oceania was held in Sydney, Australia, in November 2017, and preparations were under way for a training workshop for States members of the Central American Integration System, to be held in Guatemala City in December 2017. As at 1 November 2017, 116 officials from 56 countries, together representing almost half of the world population, had received training under the project (see section F below for more details).

[63] E/INCB/2017/4.

(a) Supply of and demand for opiate raw materials

88. The Board, in fulfilment of the functions assigned to it under the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol and the relevant resolutions of the Economic and Social Council and the Commission on Narcotic Drugs, regularly examines issues affecting the supply of and the demand for opiates for licit requirements, and endeavours to ensure a standing balance between that supply and demand. The present section contains an analysis of the current situation based on the data provided by Governments.[64]

89. In order to establish the status of the supply of and demand for opiate raw materials, the Board analyses the data on opiate raw materials and on opiates manufactured from those raw materials provided by Governments. In addition, the Board analyses information on the utilization of those raw materials, estimated consumption for licit use and stocks at the global level. A detailed analysis of the current situation as it pertains to the supply of and demand for opiate raw materials is contained in the 2017 technical report of the Board on narcotic drugs.[65]

Morphine

90. Over the last four years, the average annual estimated area to be cultivated with opium poppy rich in morphine was 119,370 ha. The area sown and the actual area harvested were always less than the estimate. On average in the period 2013–2016, the actual area sown was 72 per cent of the estimated area (77 per cent in 2016). The actual harvested area was on average 58 per cent of the estimate (48 per cent in 2016). The actual area harvested was on average 80 per cent of the area sown (only 63 per cent in 2016). The advance data for 2017 indicate an estimated decrease of more than 10 per cent in the total area of opium poppy rich in morphine harvested in major producing countries. For 2018, estimates for cultivation of opium poppy rich in morphine will decrease by about 20 per cent relative to 2017.

Thebaine

91. Over the last four years the average estimated area to be cultivated with opium poppy rich in thebaine was 20,089 ha. The area sown and the actual area harvested were always less than the estimated area, but the difference was not as much as in the case of opium poppy rich in morphine. On average, for the years in the period 2013–2016, the actual area sown was 87 per cent of the estimated area (75 per cent in 2016). The actual harvested area was on average 80 per cent of the estimate (70 per cent in 2016). The actual harvested area was on average 92 per cent of the area sown (93 per cent in 2016). In 2017 and 2018, the cultivation of opium poppy rich in thebaine, measured in terms of area harvested, is expected to decrease in some countries while increasing in others.

Codeine

92. The actual area harvested for opium poppy rich in codeine in 2016 decreased by 85 per cent in Australia and 70 per cent in France compared with the previous year. In 2017, Australia is expected to increase its cultivation by 40 per cent, while France stopped its cultivation of this variety of opium poppy. Australia, being the only country among the major producers that is cultivating opium poppy rich in codeine in 2017 and 2018, is projecting an increase in 2018.

Noscapine

93. Recently, an increase in the cultivation of opium poppy rich in noscapine in some producing countries was reported. Noscapine is not under international control. The quantity of opiates under international control that were obtained from the cultivation of this particular variety were included in the analysis of the supply of opiate raw materials and the demand for opiates for medical and scientific purposes where it was appropriate. In 2016, France and Hungary were the only countries that reported the cultivation of opium poppy rich in noscapine. According to the advance data for 2017, Australia expects the production of 1,487 tons of this variety of opium poppy (940 ha area to be harvested). The expected area to be harvested in Hungary in 2017 is reported to be 254 hectares. Australia, France and Hungary are expecting to increase further their cultivation in 2018.

(b) Production of opiate raw materials

Morphine

94. The total production of morphine-rich opiate raw materials in the main producing countries decreased to

[64] The analysis excludes data on China and the Democratic People's Republic of Korea, which produce opiate raw materials solely for domestic use. It also excludes data on the utilization of seized opium that were released for licit use in the Islamic Republic of Iran and on the demand for opiates derived from such opium.

[65] E/INCB/2017/2.

463 tons[66] in morphine equivalent in 2016 from 586 tons in 2015. Global production of opiate raw materials rich in morphine is expected to rise again to about 577 tons in morphine equivalent in 2017. Of that quantity, poppy straw will account for 529 tons (92 per cent) and opium will account for 48 tons (8 per cent). For 2018, it is estimated that global production of opiate raw materials rich in morphine will decrease to 528 tons in morphine equivalent in 2018.

Thebaine

95. In 2016, the global production of opiate raw materials rich in thebaine was 187 tons[67] in thebaine equivalent. Global production of opiate raw materials rich in thebaine is expected to increase to about 292 tons in thebaine equivalent in 2017 as a result of the expected increases in all producing countries. Production of thebaine-rich raw materials in 2018 is expected to increase slightly further to 297 tons.

(c) Global stocks of opiate raw materials and of opiates derived from them

Morphine

96. Stocks of opiate raw materials rich in morphine (poppy straw, concentrate of poppy straw and opium) amounted to about 747 tons in morphine equivalent at the end of 2016 at the same level of 2015. Those stocks were considered to be sufficient to cover 19 months of expected global demand by manufacturers at the 2017 level of demand. Global stocks of opiates based on morphine-rich raw materials, mainly in the form of codeine and morphine, held at the end of 2016 (534 tons in morphine equivalent) were sufficient to cover global demand for those opiates for about 15 months at the expected level of demand for 2017. On the basis of data reported by Governments, total stocks of both opiates and opiate raw materials are fully sufficient to cover demand for morphine-based opiates for medical and scientific purposes for 2018.

Thebaine

97. Stocks of opiate raw materials rich in thebaine (poppy straw, concentrate of poppy straw and opium) decreased to about 224 tons in thebaine equivalent by the end of 2016, from 274 tons in 2015. Those stocks are sufficient to cover the expected global demand by manufacturers in 2017 for about 12 months. Global stocks of opiates based on thebaine-rich raw material (oxycodone, thebaine and a small quantity of oxymorphone) remained stable at 242 tons in thebaine equivalent at the end of 2016 and were sufficient to cover global demand for medical and scientific purposes for thebaine-based opiates for about 18 months.

(d) Demand for opiate raw materials by manufacturers measured as utilization of raw materials

98. The global demand by manufacturers for opiate raw materials rich in morphine (particularly opium and poppy straw) has been decreasing since 2014. In 2016, it declined to 367 tons in morphine equivalent. However, it is expected to increase again in 2017 and 2018 to 460 and 470 tons, respectively.

99. Global demand by manufacturers for opiate raw materials rich in thebaine decreased from 2012 to 2015, but increased from 183 tons of thebaine equivalent in 2015 to 210 tons in 2016. Global demand for raw materials rich in thebaine is expected to increase further, to 220 tons and 230 tons of thebaine equivalents in 2017 and 2018, respectively.

(e) Balance between the supply of and demand for opiate raw materials

Morphine

100. The global production of opiate raw materials rich in morphine has exceeded the global demand for those raw materials since 2009. As a result, stocks have been increasing, with some fluctuations. In 2015, stocks increased to 746 tons and stayed at 747 tons in morphine equivalent in 2016, which were sufficient to cover the expected global demand for about 19 months. In 2017, global production of opiate raw materials rich in morphine is expected to exceed global demand again, with the result that global stocks of those raw materials will further increase in 2018. Stocks are expected to reach

[66] The analysis is based predominantly on raw materials obtained from opium poppy rich in morphine but includes the morphine alkaloid contained in opium poppy rich in thebaine and in opium poppy rich in codeine whenever appropriate.

[67] The analysis is based predominantly on raw materials obtained from opium poppy rich in thebaine but includes the thebaine alkaloid contained in opium poppy rich in morphine whenever appropriate.

864 tons by the end of 2017, which is equivalent to about 22 months of expected global demand at the 2018 level of demand (although not all data are available for a complete forecast). For 2018, producing countries have indicated that they plan to decrease production. Stocks are anticipated to reach about 922 tons at the end of 2018, sufficient to cover more than one year of expected global demand. The global supply of opiate raw materials rich in morphine (stocks and production) will remain fully sufficient to cover global demand.

Thebaine

101. In 2016, global production of opiate raw materials rich in thebaine (187 tons) was less than demand (210 tons) for the first time in five years and led to a decrease in stocks (224 tons) at the end of 2016. Those stocks were equivalent to global demand for 12 months. Production is expected to increase in 2017 and 2018. By the end of 2017, global stocks of opiate raw materials rich in thebaine will likely reach 296 tons, sufficient to cover global demand for about 15 months, and at the end of 2018 may reach 363 tons, sufficient to cover global demand for more than one year. The global supply of opiate raw materials rich in thebaine (stocks and production) will be more than sufficient to cover global demand in 2017 and 2018.

Trends in consumption levels of opioids

102. Over the past 20 years, the global consumption of opioids has more than tripled. The share of consumption of opiates in the total consumption of opioids fluctuated between 59 per cent in 1997 and 51 per cent in 2008. After reaching a peak of a share of 68 per cent of total opioid consumption in 2014, consumption of opiates has been decreasing. In 2016, it decreased to 61 per cent. As a result, the share of synthetic opioids, which are used for the same indications as opiates, increased from 32 per cent in 2014 to 39 per cent in 2016. The overall trend indicates that demand for opiates is expected to increase in the future, but it is not clear if their share in the total consumption of opioids will increase or decline in relation to the consumption of synthetic opioids.

C. Governments' cooperation with the Board

1. Provision of information by Governments to the Board

103. The Board is mandated to publish each year two reports: the annual report and the report of the Board on the implementation of article 12 of the 1988 Convention. It also publishes technical reports that provide Governments with an analysis of statistical information on the manufacture, trade, consumption, utilization and stocks of internationally controlled substances, and with an analysis of estimates and assessments of requirements for those substances.

104. The Board's reports and technical publications are based on information that parties to the international drug control treaties are obligated to submit. In addition, pursuant to resolutions of the Economic and Social Council and the Commission on Narcotic Drugs, Governments voluntarily provide information in order to facilitate an accurate and comprehensive evaluation of the functioning of the international drug and precursor control system.

105. The data and other information received from Governments enable the Board to monitor licit activities involving narcotic drugs, psychotropic substances and precursor chemicals and to evaluate treaty compliance and the overall functioning of the international drug control system. On the basis of its analysis, the Board makes recommendations to improve the workings of the system with a view to ensuring the availability of narcotic drugs and psychotropic substances for medical and scientific needs, while at the same time preventing their diversion from licit into illicit channels and preventing the diversion of precursors to illicit drug manufacture.

2. Submission of statistical information

106. Governments have an obligation to furnish to the Board the statistical reports required by the international drug control conventions on an annual basis and in a timely manner.

(a) Narcotic drugs

107. As at 1 November 2017, the Board had received annual statistics reports from 152 States (both parties and non-parties) and territories on the production,

manufacture, consumption, stocks and seizures of narcotic drugs covering the calendar year 2016 (form C), or about 71 per cent of those requested. That number was higher than in 2016 (148 reports pertaining to 2015) and 2015 (140 reports pertaining to 2014).

108. A total of 89 Governments (42 per cent) had submitted their data on time, i.e., by the deadline of 30 June 2017, which was more than in the two preceding years (84 countries in 2016, and 83 in 2015). As at 1 November 2017, 61 Governments (29 per cent of all Governments) had not submitted their annual statistics for 2016: that is, 56 countries (26 per cent of countries) and 5 territories (24 per cent of territories). Those countries and territories that had failed to submit their reports were in Africa,[68] the Americas,[69] Asia,[70] Europe[71] and Oceania.[72] It is expected that several additional countries and territories will submit the data after 1 November 2017.

109. Almost all countries where major amounts of narcotic drugs were being produced, manufactured, imported, exported or consumed had submitted annual statistics. In its annual report for 2016, INCB highlighted the importance of accurate and timely reporting for the effectiveness and efficiency of the operation of the international drug control system and the significant impact that the availability of reliable data had on the ability of the Board to accurately monitor the world situation. The Board, however, remains very concerned about the quality of some of the data provided, especially those from some of the major producing and manufacturing countries, as they indicate deficiencies in national mechanisms for regulating and monitoring internationally controlled substances. **INCB urges Governments to enhance their national mechanisms to monitor the cultivation, production and manufacture of and trade in controlled substances. This may be achieved, in part, by improving and developing national data systems, training staff of the competent national authorities and ensuring that companies licensed to deal with internationally controlled substances fulfil the legal requirements associated with their licences.**

110. As at 1 November 2017, the complete set of four quarterly statistics of imports and exports of narcotic drugs for 2016 (form A) had been received from 153 Governments (139 countries and 14 territories), i.e., about 72 per cent of the 213 Governments requested. In addition, 19 Governments (about 9 per cent) had submitted at least one quarterly report. A total of 36 countries and 5 territories (about 19 per cent) had failed to submit any quarterly statistics for 2016.

(b) Psychotropic substances

111. As at 1 November 2017, annual statistical reports for 2016 on psychotropic substances (form P) had been submitted to the Board in conformity with article 16 of the 1971 Convention by 151 States and territories, amounting to 71 per cent of those required to do so. The Board notes with appreciation that this rate of submission is higher than for 2015. In addition, 107 Governments voluntarily submitted all four quarterly statistical reports on imports and exports of substances listed in Schedule II of the 1971 Convention for 2016, in conformity with Economic and Social Council resolution 1981/7, and a further 38 Governments submitted several quarterly reports.

112. While the majority of Governments regularly submit their mandatory and voluntary statistical reports, the cooperation of some has not been satisfactory. In 2017, about 63 per cent of the countries that submitted form P for 2016 did so within the deadline of 30 June 2017. Among those that failed to submit form P within the deadline were major manufacturing, importing and exporting countries such as Belgium, Brazil, Canada, China, France, India and the United Kingdom. The Board notes with concern that the Republic of Korea, a significant importer and exporter of psychotropic substances, had failed to furnish its reports for both 2015 and 2016, notwithstanding periodic reminders as sent to all tardy and defaulting Governments.

113. The Board notes with concern that the number of countries and territories that have not furnished form P is highest in Africa, followed by Oceania, and Central America and the Caribbean. A total of 26 countries and territories in Africa[73] (46 per cent of those in that region) failed to furnish form P for 2016. Likewise, 45 per cent

[68] Angola, Burundi, Cameroon, Central African Republic, Chad, Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Guinea, Lesotho, Liberia, Libya, Malawi, Mali, Mauritania, Namibia, Niger, Sao Tome and Principe, Senegal, Somalia, South Sudan, Tristan da Cunha and Zambia.

[69] Antigua and Barbuda, Aruba, Bahamas, Bermuda, Cayman Islands, Cuba, Grenada, Haiti, Mexico, Paraguay, Saint Kitts and Nevis, Suriname and Turks and Caicos Islands.

[70] Bhutan, Cambodia, Iraq, Kyrgyzstan, Singapore, Tajikistan, Viet Nam and Yemen, as well as Hong Kong, China.

[71] Bosnia and Herzegovina, Luxembourg and Romania.

[72] Kiribati, Marshall Islands, Nauru, Niue, Samoa, Solomon Islands, Tuvalu, Vanuatu, and Wallis and Futuna.

[73] Ascension Island, Burundi, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Guinea, Guinea-Bissau, Lesotho, Libya, Malawi, Mali, Mauritania, Niger, Sao Tome and Principe, Senegal, Somalia, South Sudan, Tristan da Cunha and Zambia.

of the countries and territories in Oceania,[74] and 39 per cent of those in Central America and the Caribbean[75] failed to do so. In Europe, form P for 2016 was furnished by 93 per cent of all countries and territories, but three countries did not furnish it for 2016 (Bosnia and Herzegovina, Luxembourg and Romania). In South America, similar to last year, a total of three countries failed to furnish form P for 2016 (Ecuador, Paraguay and Suriname). In Asia, 19 per cent of countries and territories did not furnish form P for 2016.[76]

114. The Economic and Social Council, in its resolutions 1985/15 and 1987/30, requested Governments to provide the Board with details on trade (data broken down by countries of origin and destination) in substances listed in Schedules III and IV of the 1971 Convention in their annual statistical reports on psychotropic substances. As of 1 November 2017, complete details on such trade were submitted by 120 Governments (79 per cent of all submissions of form P for 2016), which is more than for the year before. The remaining 31 Governments submitted blank forms or forms containing incomplete trade data for 2016.

115. The Board notes with appreciation that a number of countries have already submitted consumption data for psychotropic substances on a voluntary basis in accordance with Commission on Narcotic Drugs resolution 54/6. Thus, for 2016, a total of 72 countries and territories submitted data on the consumption of some or all psychotropic substances, more than the 58 countries and territories that did so for 2015 by the corresponding date of the previous year. **The Board appreciates the cooperation of the Governments concerned and calls upon all Governments to report on the consumption of psychotropic substances on an annual basis pursuant to Commission resolution 54/6, as such data are essential for an improved evaluation of the availability of psychotropic substances for medical and scientific purposes.**

116. The Board notes with appreciation that reports on seizures of psychotropic substances were furnished by the Governments of Belgium, India and the Russian Federation, as well as notifications on seizures of internationally controlled licit substances smuggled through the mail, including those ordered via the Internet, furnished by the Governments of Norway, Estonia and Lithuania pursuant to Commission on Narcotic Drugs resolution 50/11. **The Board acknowledges the interdiction efforts of the Governments concerned and calls on all Governments regularly to furnish to the Board information on seizures of psychotropic substances ordered via the Internet and delivered through the mail, pursuant to Commission on Narcotic Drugs resolution 50/11.**

(c) Precursors

117. Under article 12 of the 1988 Convention, parties are obliged to furnish information on substances frequently used in the illicit manufacture of narcotic drugs and psychotropic substances. That information, provided on form D, helps the Board to monitor and identify trends in trafficking in precursors and the illicit manufacture of drugs. It also enables INCB to offer Governments recommendations concerning remedial action and policies, as necessary.

118. As at 1 November 2017, a total of 125 States parties, corresponding to 66 per cent of the States parties to the 1988 Convention, had submitted form D for 2016. However, 52 States parties submitted blank forms or the information contained in them was incomplete. The Board notes with concern that 60 States parties of the 1988 Convention failed to report to the Board.

119. Of the States parties that provided data on form D for 2016, 89 reported the mandatory information on seizures of substances in Table I or Table II of the 1988 Convention, and 60 reported seizures of non-scheduled substances. As in previous years, most Governments did not provide details on the methods of diversion and illicit manufacture.

120. Pursuant to Economic and Social Council resolution 1995/20, Governments are also requested to provide information regarding their licit trade in substances listed in Table I and Table II of the 1988 Convention on a voluntary and confidential basis. As at 1 November 2017, 117 States parties had provided information on licit trade for 2016 to the Board, and 114 had furnished data on licit uses of and/or requirements for one or more of the substances in Tables I and II of the 1988 Convention.

121. Complementing PEN Online, as well as the aggregated seizure data received annually from Governments through form D, the Precursors Incident Communication System (PICS) has since early 2012 provided a secure online platform for sharing information in real time on chemical-related incidents such as seizures, shipments stopped in transit, diversion attempts and the dismantling

[74] Fiji, Kiribati, Marshall Islands, Nauru, Niue, Samoa, Solomon Islands, Tuvalu, Vanuatu and Wallis and Futuna.

[75] Antigua and Barbuda, Aruba, British Virgin Islands, Cayman Islands, Cuba, Curaçao, Grenada, Guatemala, Saint Kitts and Nevis, Trinidad and Tobago, and Turks and Caicos Islands.

[76] Cambodia, Iraq, Kyrgyzstan, Maldives, Republic of Korea, Turkmenistan, Viet Nam and Yemen, as well as Hong Kong, China.

of illicit laboratories. PICS has provided leads for national authorities to initiate backtracking investigations and, on several occasions, the timely communication of details of precursor incidents has led to further seizures or prevented diversion attempts. The usefulness of PICS, however, depends largely on the timeliness of the information provided so that it can facilitate immediate follow-up and cooperation to identify those responsible for the diversion of and trafficking in precursors.

122. As at 1 November 2017, PICS had nearly 480 registered users from more than 240 agencies in 104 countries, who had shared information about almost 2,000 incidents. During the reporting period, more than 300 new incidents were communicated through PICS.

3. Submission of estimates and assessments

(a) Narcotic drugs

123. Under the 1961 Convention, parties are obliged to provide the Board each year with estimates of their requirements for narcotic drugs for the following year. As at 1 November 2017, a total of 158 States and territories, 74 per cent of those required, had submitted estimates of their requirements for narcotic drugs for 2018 for confirmation by the Board. As in previous years, the Board established estimates for those States and territories that had not submitted their estimates on time in accordance with article 12 of the 1961 Convention.

(b) Psychotropic substances

124. As at 1 November 2017, the Governments of all countries except South Sudan and all territories had submitted to the Board at least one assessment of their annual medical and scientific requirements for psychotropic substances. In accordance with Economic and Social Council resolution 1996/30, the Board established the assessments of requirements for South Sudan in 2011 to enable that country to import psychotropic substances for medical purposes without undue delay.

125. In line with Economic and Social Council resolutions 1981/7 and 1991/44, Governments are requested to provide to the Board assessments of their annual medical and scientific requirements for psychotropic substances listed in Schedules II, III and IV of the 1971 Convention. Assessments for psychotropic substances remain in force until Governments modify them to reflect changes in national requirements. To facilitate the submission of such modifications by competent national authorities, the Board created a form, entitled "Supplement to form B/P", which has been made available to all Governments in the six official languages of the United Nations since October 2014 and can be accessed on the website of INCB. As at 1 November 2017, three years after its release, almost all countries were using it. **The Board recommends that Governments review and update the assessments of their annual medical and scientific requirements for psychotropic substances at least once every three years.**

126. Between 1 November 2016 and 1 November 2017, a total of 93 countries and 9 territories submitted fully revised assessments of their requirements for psychotropic substances, and a further 30 Governments submitted modifications to their assessments for one or more substances. As at 1 November 2017, Governments of 36 countries and 4 territories had not submitted any revision of their legitimate requirements for psychotropic substances for over three years.

(c) Precursors

127. In its resolution 49/3, entitled "Strengthening systems for the control of precursor chemicals used in the illicit manufacture of synthetic drugs", the Commission on Narcotics Drugs requested Member States to provide the Board with annual legitimate requirements for imports of four precursors of amphetamine-type stimulants — ephedrine, pseudoephedrine, 3,4-methylenedioxyphenyl-2-propanone (3,4-MDP-2-P), and 1-phenyl-2-propanone (P-2-P) — and, to the extent possible, preparations containing those substances that could be easily used or recovered by readily applicable means. The estimates help Governments to assess the legitimacy of shipments and to identify any excesses in pre-export notifications for these substances.

128. Although provided on a voluntary basis, the number of Governments that have provided an estimate of their annual legitimate requirement for at least one of the above-mentioned substances continued to increase, compared with the previous year, and reached 166 Governments as at 1 November 2017. Similarly, the number of estimates provided (which are published in the annual report of the Board for 2016 on the implementation of article 12 of the 1988 Convention) increased from 851 to 872 in 2017. In 2017, more than 100 Governments have reconfirmed or updated their annual legitimate requirements for at least one substance.

129. Governments provide estimates of annual legitimate requirements on form D and can update them at any time throughout the year. The latest annual legitimate requirements, as submitted by countries and territories, are regularly updated and published on the Board's website. They are also accessible to registered users through PEN Online.

130. In conclusion, the Board wishes to remind all Governments that the total estimates of annual medical and scientific requirements for narcotic drugs and the assessments of requirements for psychotropic substances are published in yearly and quarterly publications and that monthly updates are publicly available on the Board's website. Updated annual estimates of legitimate requirements for precursors of amphetamine-type stimulants are also available on the website.

4. Improving the quality of information provided to the Board

131. It is critical that Governments provide regular, reliable statistical data to the Board for the detection of diversions of controlled substances for illicit purposes, the analysis of trends in the licit international trade in controlled substances and the proper overall functioning of the international drug control system.

132. Problems encountered by Governments in furnishing adequate statistics and/or estimates and assessments to the Board are often an indication of deficiencies in their national control mechanisms and/or health-care systems. Such deficiencies may reflect problems in the implementation of treaty provisions, for instance gaps in national legislation, shortcomings in administrative regulations or a lack of training for staff of competent national authorities.

133. **The Board urges Governments to enhance their national mechanisms to monitor the cultivation, production and manufacture of and trade in controlled substances. This may be achieved, in part, by improving and developing national data systems, training staff of the competent national authorities and ensuring that companies licensed to deal with internationally controlled substances fulfil the legal requirements associated with their licences.**

134. **The Board invites all Governments concerned to find the causes for such deficiencies in reporting statistics and/or estimates and assessments to the Board and to inform the Board accordingly with a view to resolving those problems and ensuring adequate and timely reporting. To assist Governments, the Board has developed tools and kits, as well as several sets of guidelines, for use by competent national authorities. They are available on its website (www.incb.org) free of charge and include training materials and the *Guide on Estimating Requirements for Substances under International Control*. Governments are invited to make full use of these tools in their efforts to comply with the international drug control treaties. The Board also wishes to encourage Governments to avail themselves of the specific training that is provided by INCB upon request.**

D. Evaluation of overall treaty compliance

1. Evaluation of overall treaty compliance in selected countries

135. The scope of the international drug control conventions is vast. It includes the establishment of a regulatory framework to monitor the licit production, manufacture and trade in controlled substances; the adoption of national drug control legislation and policy measures; action to combat drug trafficking and diversion; the provision of prevention, treatment, rehabilitation, aftercare and social reintegration services; and the availability of narcotic drugs and psychotropic substances for rational medical use. The conventions also mandate cooperation with the Board in the form of timely and accurate reporting and responses to Board requests for additional information.

136. In accordance with its treaty mandate as a semi-judicial monitoring body, INCB assists States in the comprehensive implementation of the three drug control conventions. In doing so, the Board is called upon to review the drug control situation in various countries, to engage with Governments in an ongoing dialogue aimed at identifying good practices and areas where implementation of the conventions needs to be strengthened, and to suggest remedial measures, as necessary.

137. In 2017, the Board reviewed the drug control situation in Bolivia (Plurinational State of), Mauritania, Myanmar, the Netherlands and the United Kingdom, and examined the measures taken by the Governments of those countries to implement the international drug control treaties. The Board also reviewed developments in several countries with respect to the adoption of legislative and policy measures regarding medical cannabis programmes, drug consumption rooms and the legalization of cannabis for non-medical purposes.

(a) Plurinational State of Bolivia

138. As part of its ongoing review of compliance by States parties with their treaty-based obligations, INCB has closely followed, over the past years, developments in the Plurinational State of Bolivia with regard to its policies on the cultivation of coca bush and coca leaf production. The Board notes that, following its continuous dialogue with the Government, the Government has raised the level of its cooperation with the Board. The Government is committed to an integrated approach to ensuring that internationally controlled substances are placed under national control and are addressed effectively, and that their diversion from licit distribution channels is countered by effective control measures.

139. The Board notes that the Plurinational State of Bolivia adopted two new laws in March 2017, a significant shift in the country's drug control policy, allowing a significant increase in the area that may be used for licit coca bush cultivation. The general law on coca (Law No. 906) establishes the institutional framework for the regulation, control and monitoring of the production, transportation, sale and revaluation, including by industrial means, of coca in its natural state. The law on combating trafficking in controlled substances (Law No. 913) establishes a mechanism to counter trafficking in controlled substances, including precursor chemicals used in the illicit manufacture of drugs.

140. The Board notes that the Government of the Plurinational State of Bolivia has replaced its previous drug control law with two new drug control laws. The purpose of the change is to enable the use of coca leaf for traditional purposes and for processing into a wide range of industrial products. Some of those products may be intended for export. At the same time, the Plurinational State of Bolivia is committed to continuing to take all necessary measures to control the cultivation of coca bush as well as to prevent its abuse and the illicit production of narcotic drugs that may be extracted from the leaf.

141. However, the Board remains concerned about the recent increase in both the reported total area under coca bush cultivation and the expected coca leaf production. Despite the social control measures currently being pursued by the Government to reduce coca bush cultivation and coca leaf production, the total area under coca bush cultivation in the country in 2016 increased to 23,100 ha, 14 per cent more than in 2015 (20,200 ha). Consequently, the total quantity of coca leaf available for sale on premises authorized by the Government increased by 4 per cent in 2016 to almost 22,000 tons compared with about 21,200 tons in 2015. On the other hand, the total area of so-called surplus coca bush eradicated yearly in the country appears to have declined constantly since the peak reported for 2012. The Board is concerned that those developments have had a negative impact on the Government's ability to control the availability of coca leaves for domestic traditional consumption and have increased the risk of coca leaves being diverted for use in the illicit manufacture of cocaine.

142. The Board expresses serious concern at the fact that, under the new legislation, the total area allowed for the cultivation of coca bush for the purposes referred to in the reservation made by the Plurinational State of Bolivia, in particular traditional coca leaf chewing, has nearly been doubled.[77] The Board wishes to point out that the country has reserved the right to allow in its territory: traditional coca leaf chewing; the consumption and use of the coca leaf in its natural state for cultural and medicinal purposes, such as its use in infusions; and also the cultivation, trade and possession of the coca leaf only to the extent necessary for these purposes.

143. The Board stresses the importance of implementing the treaty obligations under article 26 of the 1961 Convention as amended by the 1972 Protocol, effectively. Those obligations also apply to the Plurinational State of Bolivia and require States allowing the cultivation of coca bush to establish a national coca leaf agency in accordance with the framework provided for in article 23, which outlines the mandate and functions of national opium agencies. Other specific obligations include, but are not limited to: *(a)* the designation of areas and plots of land where cultivation is permitted (article 23, paragraph 2 *(a)*); *(b)* the licensing of cultivators (article 23, paragraph 2 *(b)* and article 23, paragraph 2 *(c)*); *(c)* the taking of physical possession of crops by the national coca leaf agency as soon as possible after the harvest (article 26, paragraph 1); and the uprooting of all coca bushes that grow wild and the destruction of coca bushes cultivated illegally (article 26, paragraph 2).

144. Furthermore, the Board wishes to invite the Plurinational State of Bolivia, in analogy to article 27, paragraph 2, and article 49, paragraph 3 *(b)*, of the 1961 Convention as amended, to furnish to it separate estimates and statistical reports in respect of the reserved activities, in addition to the estimates and statistics mandatory under article 19, article 20 and article 27, paragraph 2, of the 1961 Convention as amended. These estimates and statistical reports should specify the

[77] The Plurinational State of Bolivia made the reservation in question at the time of its re-accession to the 1961 Convention as amended by the 1972 Protocol, effective on 10 February 2013 in accordance with article 41, paragraph 2, of that Convention.

quantities of coca leaf that are estimated to be used and actually used in the country for the reserved purposes. Such information will enable the Board, other States parties and the international community to assess whether the Plurinational State of Bolivia is ensuring that the limits of the reservation are observed, as well as its commitment to the overall fulfilment of the obligations set out in the 1961 Convention as amended, with a view to achieving its purpose.

145. The reservation entered by the Plurinational State of Bolivia is explicitly limited to activities within its territory, thus not conferring and/or broadening any rights to engage in international trade of any kind related to coca leaf other than those explicitly recognized within the legal framework established by the 1961 Convention as amended.

146. **The Board recalls that the Government of the Plurinational State of Bolivia, when introducing its present policies towards coca bush cultivation and coca leaf production, expressed its commitment to continuing to take all measures necessary to control the cultivation of coca bush, applying all the aforementioned provisions of the Convention, in order to prevent the abuse of coca and the illicit production of narcotic drugs that may be extracted from coca leaves. The Plurinational State of Bolivia must ensure full compliance with its obligation under the 1961 Convention as amended, to eliminate all uses of coca leaf other than those provided for in the Convention and those included in its reservation to the Convention. The Board urges the Government to adopt effective policies and to be proactive in the elimination of so-called surplus illicit coca bush cultivation and coca leaf production in the country, as well as to take decisive steps to address the illicit production of and trafficking in cocaine.**

147. The Board will continue to monitor drug control developments in the Plurinational State of Bolivia and maintain an ongoing dialogue with the Government. The Board trusts that the Government will continue to strengthen its efforts in drug control and stands ready to provide further assistance when required.

(b) Mauritania

148. In addition to their activities in local illicit drug production, organized criminal groups have increasingly used West Africa as a transit region in recent years for cocaine originating in South America and destined for Europe. Mauritania has been particularly affected by this type of trafficking, and increased drug abuse has been reported among the local population by countries around the Sahel region. The Board is concerned at the increase in illegal activities in the region, which further strains the already fragile health and economic systems of the affected countries.

149. INCB continues to have concerns regarding the situation in Mauritania. Areas of concern include the lack of adequate national drug control legislation, the absence of a mechanism for government coordination in the area of drug control, and unsatisfactory cooperation with the Board, in particular in the submission of mandatory statistical data on licit trade, consumption and seizures. The Government has not submitted any statistical information to INCB since 2015, although it is required to do so in order to fulfil its reporting obligations under the international drug control treaties.

150. INCB commends the political leadership shown by the Sahel countries (Burkina Faso, Chad, Mali, Mauritania and Niger), the African Union, the Economic Community of West African States (ECOWAS) and UNODC in confronting the immense security issues, the illicit activities (including drug trafficking) and the development challenges facing the region. The Board welcomes the activities undertaken under the project "Support to the ECOWAS regional action plan to address illicit drug trafficking, organized crime and drug abuse in West Africa for the period 2016–2020", as well as its new action plan for the period 2015–2019, which is funded by the European Union and implemented in cooperation with UNODC. The purpose of the project is to strengthen the capacity of ECOWAS and its member States to take sustainable action against drug trafficking, drug abuse and transnational organized crime.

151. The Board notes that UNODC has aligned its new regional programme with the priorities defined in the new ECOWAS "regional action plan to address illicit drug trafficking, organized crime and drug abuse in West Africa for the period 2016–2020". To achieve the objectives of the project, UNODC has committed itself to conducting activities in the areas of drug abuse prevention and drug dependence treatment, legislative development, forensics, and drug law enforcement. Concretely, a project management structure has been in place in Nouakchott since 2016 for building capacity in Mauritania.

152. The Board reiterates the importance of international cooperation in drug control in West Africa and urges the Government of Mauritania to strengthen its cooperation with the Governments of neighbouring countries and with international organizations active in the region. In particular, the Board encourages the Government to seek further support from UNODC and the ECOWAS Commission to implement the ECOWAS action plan, the aims of which are to: *(a)* enhance the availability of reliable and comparable data on drugs for

the development of evidence-based drug policies and programmes; *(b)* strengthen regional capacity to identify and disseminate best practices on drug demand reduction; and *(c)* enhance the capacity of judicial and enforcement authorities and strengthen subregional and regional cooperation and coordination mechanisms.

153. In several of its communications sent to the Government since 2016, the Board invited Mauritania to send a delegation to one of its sessions to brief the Board on the drug control situation in the country and the measures taken to counter the increase in drug trafficking and abuse. At the time of writing, that invitation was yet to be accepted. The Board trusts that the Government of Mauritania will improve its cooperation with the Board and step up its efforts to ensure that significant progress is achieved towards compliance with the international drug control treaties and their reporting requirements. The Board will continue its endeavours to enhance its dialogue with the Government with a view to promoting the country's compliance with the international drug control treaties.

(c) Myanmar

154. Illicit opium poppy cultivation in Myanmar, in particular in Shan State, remains an issue of major concern to the international community. According to UNODC data, illicit opium poppy cultivation in the country, mainly concentrated in Shan State stabilized in 2016 after increasing threefold in the previous decade. Despite this development, Myanmar remains the second largest producer of opium poppy in the world, after Afghanistan. In addition, the diversion of precursor chemicals and the production of and trafficking in methamphetamine in the country has been on the increase.

155. The Government of Myanmar has taken steps to address the drug-related challenges in the country. In 2017, with the support of UNODC, it continued to reform its drug legislation and policy with a view to adopting a drug-control framework consistent with the outcome document of the special session of the General Assembly on the world drug problem held in 2016.

156. Myanmar has continued to play an active part in the Mekong Memorandum of Understanding mechanism, a six-country regional initiative with its neighbours Cambodia, China, the Lao People's Democratic Republic, Thailand and Viet Nam. The mechanism is supported by UNODC and is aimed at strengthening regional cooperation on drug control matters.

157. The prevalence of drug abuse in Myanmar is difficult to gauge in the absence of comprehensive drug use surveys. The Board notes that UNODC is currently supporting the Government in the development of the first national survey on drug use in the country.

158. Myanmar continues to be affected by high rates of HIV/AIDS prevalence among persons who abuse drugs by injection. For 2015, the Government estimated the HIV prevalence among that population to be 28.5 per cent. In May 2017, the Ministry of Health and Sports of Myanmar launched its national strategic plan on HIV and AIDS for 2016–2020, the third of its kind. The plan is aimed at ending HIV as a public health threat by 2030 by bolstering the country's prevention, education, care and treatment infrastructures.

159. As in many countries in the region, the availability of narcotic drugs and psychotropic substances for licit purposes in Myanmar is very low and likely insufficient to meet medical needs. The Board has therefore continued to encourage the Government to review its methodology for evaluating its needs regarding narcotic drugs and psychotropic substances, identifying obstacles to availability and taking corrective action to ensure that actual medical needs are met.

160. The Board is concerned by reports of the forced displacement of persons belonging to minority ethnic groups in Rakhine State and by the humanitarian crisis it has caused in Myanmar and in neighbouring countries, in particular Bangladesh. The Board calls upon the international community to provide aid to affected persons, including, as required, through the provision of emergency medical supplies.

161. In the pursuit of its mandate, the Board stands ready to assist the Government of Myanmar in whatever way possible in the implementation of the international drug control conventions.

(d) Netherlands

162. During the reporting period, the Board has continued its dialogue with the Government of the Netherlands on several drug-related developments, including its "coffee shop" policy and legislative initiatives related to the cultivation of cannabis. In order to discuss matters pertaining to drug control in the country, the President of the Board met with a delegation of the Netherlands on the margins of the sixtieth session of the Commission on Narcotic Drugs, in March 2017. The Board received

communications from the Government of the Netherlands providing further explanations on the issues discussed.

163. In February 2017, the lower house of parliament of the Netherlands narrowly voted to approve a bill regulating the cultivation of cannabis for non-medical purposes. Once the bill becomes law, it will exempt licensed cannabis growers from prosecution, provided they meet certain conditions. According to the information available to the Board, the public prosecution office of the Netherlands has raised concerns that legalizing cultivation of cannabis for non-medical purposes would put the Netherlands in contravention of the international drug control treaties. The Ministry of Health, Welfare and Sport has also been critical of the legislative initiative. According to the communication received from the Government in August 2017, the bill still needed to be approved by the upper house of parliament to become law. The Board reiterates that, should the bill become law, the provisions permitting cultivation, production and distribution of cannabis for non-medical purposes would be inconsistent with the 1961 Convention as amended, in particular article 4, paragraph *(c)*, which requires States parties to limit those activities to medical and scientific purposes.

164. The Board continued to monitor the developments regarding enforcement in municipalities of the Netherlands of the criterion according to which only residents of the Netherlands can be admitted to "coffee shops". The residence criterion was introduced in January 2013. According to the information provided by the Government in August 2017, enforcing the residence criterion is the responsibility of local authorities. Out of the 102 municipalities that have one or more coffee shops, 83 municipalities have included the residence criterion in their local drug policies, while 16 municipalities have declared their intention to do so in the future. The Government stressed that the aim of its policy is to make the "coffee shops" smaller and more manageable and reduce "drug tourism". The Government had observed only a minor increase in "drug tourism" in 2015 compared with 2014. **While noting the efforts of the Government to contain the number of its "coffee shops" and their effects, the Board reiterates its call upon the Government to take steps to close its "coffee shops", because that policy contravenes the provisions of the international drug control treaties.**

165. The Board notes that cocaine seizures in the port of Rotterdam in 2016 reached a record high of 13 tons, surpassing the previous peak of 9.8 tons for 2013. While the number of cocaine seizures remained stable, there was an increase in the amounts of cocaine per seizure. The intercepted cocaine shipments ranged from 1.5 kg to nearly 4 tons. The port of Rotterdam (together with the port of Antwerp, Belgium) appears to remain a major hub for the smuggling of heroin and cocaine into the European Union. The Board acknowledges the cooperation it has continued to receive from the Government in the provision of up-to-date information on the drug control policies of the country, and looks forward to continuing its dialogue with the Government to promote the implementation of the international drug control treaties.

(e) United Kingdom

166. The Board has continued to monitor the implementation of the three international drug control treaties by the Government of the United Kingdom, including on matters related to licit trade, timely mandatory reporting and estimates of annual medical and scientific requirements for narcotic drugs and psychotropic substances. The Board appreciates the effective cooperation received from the Government on these matters and continues to monitor the drug control efforts of the country.

167. The Board notes the adoption, in July 2017, by the Government of the United Kingdom of *Drug Strategy 2017*, which builds upon the 2010 drug strategy it replaces. The new strategy set out in the document confronts several threats, including: drug abuse, in particular among young people; emerging markets for new psychoactive substances; abuse of so-called "image- and performance-enhancing drugs" (substances that promote weight loss, change skin colour, build muscle and allow longer, harder training); "chem-sex" drugs (used before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience), prescription medicines and drug-related criminality.

168. As noted in *Drug Strategy 2017*, the economic cost related to drug abuse in the United Kingdom is estimated to be 10.7 billion pounds a year, with drug-related theft (e.g., burglary, robbery, shoplifting) alone costing 6 billion pounds. In 2016, almost 8 per cent of 16- to 59-year-olds in England and Wales, or 2.7 million persons, had used illicit drugs in the past year. The proportion of young people taking drugs is higher: 18 per cent of 16- to 24-year-olds. The document discusses the rapid appearance of new psychoactive substances on the market and notes problem use among homeless persons and prison inmates. Emerging problems such as use of "image- and performance-enhancing drugs" and polydrug use are highlighted, as is the dramatic increase in drug misuse deaths in the country since 2013.

169. The Board notes that the new strategy encourages cooperative action between police, health agencies and local communities, and focuses on four areas: demand reduction, supply reduction, recovery and global action.

The strategy includes targeted interventions to give drug users tailored support, including treatment, rehabilitation, employment and housing. Finally, it provides for stronger border control and intelligence-sharing, and calls for increased international cooperation.

170. The Board notes that, as stated in *Drug Strategy 2017*, the Government of the United Kingdom is committed to cooperating with European partners, including the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), while the United Kingdom is still a member of the European Union. The United Kingdom has also committed itself to working with European and other international partners once the country will have left the European Union.

171. The Board calls upon the Government of the United Kingdom and the relevant institutions of the European Union to continue effective cooperation under existing mechanisms where possible and/or to agree on cooperation arrangements facilitating effective drug control in Europe in the future.

172. The Board will continue to monitor developments in the United Kingdom with respect to drug control, including the progress with implementing the new strategy. The Board looks forward to continuing its close cooperation with the Government of the United Kingdom on matters relating to drug control.

(f) Medical use of cannabis and its derivatives

173. The 1961 Convention as amended, restricts the use of narcotic drugs under international control to medical and scientific purposes, subject to certain conditions. Those conditions, or control measures, vary from substance to substance according to their placement under the Convention's various schedules.

174. The Board notes that, since the publication of its annual report for 2016, additional States have taken legislative or regulatory measures to provide for the medical use of cannabis or its derivatives for medical purposes.[78]

175. While the 1961 Convention as amended, provides for the use by States of cannabis for medical purposes, the drug is controlled under Schedules I and IV and is therefore subject to the most stringent control measures under the Convention. This is due to the recognition by States of the particularly dangerous properties of these drugs.

176. As is the case for other substances controlled under the 1961 Convention as amended, the use of cannabis for medical purposes is subject to the general licensing and reporting obligations. However, States setting up medical cannabis programmes must comply with the additional obligations laid down in articles 23 and 28 of the 1961 Convention as amended. Those articles require States providing for the use of cannabis for medical purposes to establish a national cannabis agency to control, supervise and license its cultivation. Such agencies must designate the areas in which the cultivation of cannabis is permitted; ensure the licensing of producers; purchase and take physical possession of stocks; and maintain a monopoly on wholesale trading and maintaining stocks.

177. States must take measures to prohibit the unauthorized cultivation of cannabis plants, to seize and destroy illicit crops, and to prevent the misuse of and trafficking in cannabis. **Similarly, the Board wishes to draw the attention of all Governments to its previously stated position that personal cultivation of cannabis for medical purposes is inconsistent with the 1961 Convention as amended because, inter alia, it heightens the risk of diversion. All medical cannabis programmes must be developed and implemented under the full authority of the State concerned, in accordance with the requirements laid down in articles 23 and 28 of the Convention.**

178. **The Board urges all States having established medical cannabis programmes or considering doing so, to ensure that effective legislative and regulatory frameworks are put in place to ensure rational, medically supervised use and to prevent diversion, in accordance with the 1961 Convention as amended. The Board calls upon Governments allowing the medical use of cannabis to ensure that cannabis is prescribed by competent medical practitioners according to sound medical practice and based on sound scientific evidence.**

(g) Legalization of cannabis for non-medical purposes

179. Over the period under review, some States parties to the international drug control conventions have taken steps to establish or further develop legal and regulatory frameworks for the non-medical use of cannabis.

180. **The Board wishes to reiterate that any measures that permit or would permit the use of cannabis for**

[78] The following States have reported to the Board consumption of cannabis of over 10 kg in 2016 and are known by the Board to allow the use of cannabis and/or its derivatives for medical purposes: Australia, Austria, Belgium, Canada, Czechia, Denmark, Finland, Germany, Israel, Italy, The Netherlands, Norway, Poland, Spain, Sweden and Switzerland.

non-medical purposes are in clear violation of article 4, paragraph *(c)*, and article 36 of the 1961 Convention as amended, and article 3, paragraph 1 *(a)*, of the 1988 Convention. INCB also reiterates that the limitation of the use of controlled substances to medical and scientific purposes is a fundamental principle to which no derogation is permitted by the 1961 Convention as amended.

181. The Board has continued its dialogue with the States parties concerned to foster compliance with international drug control conventions, which set out legal obligations to which all States parties have agreed to be bound.

182. In March 2017, Uruguay submitted a report to the Board on the status of implementation of Law No. 19.172 adopted in December 2013, which had created a regulated market for the non-medical use of cannabis. Uruguay continued to develop its institutional and regulatory framework for the implementation of the law, covering such areas as the sale of cannabis for non-medical purposes in pharmacies; the establishment of the procedures to be followed in the event of consumption of cannabis and other drugs in the workplace; and the registration, sale and dispensation of cannabis for non-medical use.

183. As of January 2017, the national regulatory authorities had registered 6,057 individual domestic growers of cannabis for non-medical purposes and 33 "members' clubs", which are groupings of 15–45 persons created for the purpose of planting, cultivating and distributing cannabis for non-medical purposes.

184. In July 2017, pharmacies in Uruguay started selling cannabis to registered users for non-medical use. The Board takes note of the Government's plans to assess the public health consequences of the law in the near future and inform the Board about the outcome of the assessment. At the same time, the Board reiterates that the legalization and regulation of cannabis for non-medical purposes is contrary to the relevant international legal framework, which categorically restricts the use of controlled substances such as cannabis to medical and scientific purposes (article 4, paragraph *(c)*, of the 1961 Convention as amended).

185. The Board notes with concern that in Canada, draft legislation intended to authorize and regulate the non-medical consumption of cannabis was introduced in the House of Commons in April 2017. The draft legislation, which the Government aims to have adopted by July 2018, provides for a framework for controlling the production, distribution, sale and possession of cannabis for non-medical purposes. As the Board has stated repeatedly, if passed into law, provisions of Bill C-45, which permit non-medical and non-scientific use of cannabis would be incompatible with the obligations assumed by Canada under the 1961 Convention as amended.

186. As discussed in paragraph 163 above, in February 2017, the lower house of parliament of the Netherlands approved a bill authorizing and regulating the cultivation of cannabis for non-medical purposes. Once enacted, the legislation would allow the cultivation of cannabis by licensed growers, subject to certain conditions. To become law, the bill still needs to be approved by the upper house of parliament. The Board takes note of steps taken by municipalities in the Netherlands to contain "drug tourism" from outside the country by restricting admission to "coffee shops" to residents of the Netherlands. Nonetheless, the Board reiterates that the operation of "coffee shops" is inconsistent with the 1961 Convention as amended.

187. The Board continued to monitor the developments in the United States regarding the control of cannabis, including the initiatives taken at the level of the country's constituent states to legalize cannabis for non-medical purposes through ballot initiatives.

188. Jamaica continued to apply its legislation, amended in 2015, that decriminalizes certain conduct relating to the cultivation, sale and transporting of cannabis and allows the cultivation of cannabis plants for religious reasons. The Board reminds the Government of Jamaica and all other parties that under article 4, paragraph *(c)*, of the 1961 Convention as amended only the medical and scientific use of cannabis is authorized and that use for any other purposes, including religious, is not permitted.

(h) "Drug consumption rooms"

189. As it has done in the past, including in its annual report for 2016, the Board reiterates that the ultimate objective of "drug consumption rooms" is to reduce the adverse consequences of drug abuse without condoning or encouraging drug use and trafficking. Accordingly, any such facility must provide, or refer patients to, treatment, rehabilitation and social reintegration services. Governments must also take note that the establishment of drug consumption facilities does not replace other initiatives aimed at preventing drug abuse, which remain of fundamental importance.

190. During the period under review, there were developments in several States with respect to the establishment or continued operation of supervised drug consumption facilities or "drug consumption rooms". For several years, the Board has expressed reservations

concerning the operation of "drug consumption rooms" because of concerns that their operation may increase the risk of drug abuse and trafficking. The Board has also expressed unease at the provenance of the substances used in "drug consumption rooms", as they are or may have been illicitly obtained.

191. In France, the Government continued to implement Law No. 2016-41, adopted in January 2016, which provided the legal basis for the opening of "lower-risk drug consumption rooms". In November 2016, the second such facility was opened in Strasbourg, the first having been established earlier that year in Paris. The facilities in question provide medical, social and psychological services to the individuals frequenting them.

192. In Canada, in May 2017, bill C-37 amending the Controlled Drugs and Substances Act and related legislation received royal assent. The amendments contained in the bill simplify the process of applying for permission to open a supervised consumption site by reducing the number of application criteria from 26 to 8. They also allow the review of applications to begin before all supporting documentation is formally received by Health Canada, increase transparency in the decision-making process by making both the decisions and any grounds for refusal public, as applicable, and simplifying the renewal process. The approval process will continue to require broad-based consultations with stakeholders and community representatives, as well as the provision of satisfactory information about the security of the site and the safety of those who use the facilities, those employed there and members of the surrounding communities. To date, 16 facilities, located in the provinces of British Columbia, Ontario and Québec, have been approved, with other applications under review.

193. In May 2017, the President of Ireland signed into law the Misuse of Drugs (Supervised Injecting Facilities) Act 2017. The Act provides for the licensing and establishment of supervised injecting facilities by the Minister for Health. The Act also grants authorized users dispensation from the criminal provisions on possession while they are at the facility with the permission of the licence holder. In July 2017, the Government of Ireland released a new national drug strategy entitled "Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017-2025". The strategy provides for supervised injecting facilities and commits the Government to enabling the operation of such facilities in order to stem the problem of street drug injection.

2. Country missions

194. In order to gain a comprehensive overview of the drug control situation in States parties to the international drug control treaties, the Board periodically undertakes country missions.

195. While in a country, the INCB delegation holds meetings with major stakeholders in the drug control field, including executive government officials and officers responsible for regulatory authorities, providers of treatment and rehabilitation services, and representatives of civil society groups.

196. Based on the findings, the Board then adopts confidential recommendations to improve compliance with the international drug control framework, which are communicated to the Government in question.

197. Recommendations issued by the Board may cover several areas, including: national drug policy; interagency cooperation; the regulation of the licit production of and trade in substances subject to international control under the drug control conventions; the prevention of drug abuse and the treatment and rehabilitation of drug users; access to narcotic drugs and psychotropic substances for rational medical use; law enforcement; measures to address illicit drug production and manufacture, and drug trafficking; and the control of precursor chemicals and new psychoactive substances.

198. During the period under review, the Board undertook a mission to Egypt. As at 1 November 2017, additional missions to Australia, Guyana, the Russian Federation and Switzerland were scheduled to take place before the end of 2017.

199. Additional missions have been accepted, in principle, by the Governments of Colombia, Jamaica, Kuwait and Uzbekistan. However, those have not yet been carried out as the Governments in question have failed to communicate dates or ensure appropriate arrangements for the missions' conduct. In addition, the Board has contacted the Governments of the Democratic Republic of the Congo, Papua New Guinea and Qatar, but has not yet received confirmation that they would accept a mission. In the case of Papua New Guinea, the Board has invited the authorities to attend one of its sessions for consultations, but so far without success. The Board is currently in discussion with other States for the holding of future INCB missions in 2018 and 2019. **INCB reminds all States parties of the importance of cooperating with the Board in the exercise of its mandate, including by facilitating the holding of country missions, so that the Board may be**

fully appraised of national developments in the field of drug control and be able to provide feedback and advice to Governments on fulfilling their treaty obligations.

Egypt

200. In June 2017, an INCB mission visited Egypt. The objective was to review the drug control situation and the Government's compliance with the three international drug control conventions.

201. The Board notes that, since its last mission in 2001, the Government has made progress in various areas of drug control. The Board also notes the commitment of the Government to complying with the international drug control treaties, in particular through the work of the Anti-Narcotics General Administration. The Government has taken tangible steps to address the problems generated by increasing levels of drug trafficking and abuse and the need to provide adequate treatment to the affected population. The Board commends Egypt for the progress made in areas of law enforcement and encourages the Government to continue implementing vigorous supply reduction measures to further reduce the availability of illicit drugs trafficked through Egypt.

202. Egypt continues to be used as a transit country for illicit shipments of drugs and precursor chemicals on their way to markets in West Asia and North Africa. Further measures need to be taken to step up specialized training to law enforcement authorities. The Board encourages the Government to continue strengthening border control, regional cooperation and information-sharing mechanisms to prevent drug trafficking within and through Egypt.

203. Significant challenges remain, in particular in the areas of prevention, treatment and rehabilitation. The Board discussed with the authorities the need to carry out regular national drug use surveys, in particular among young people, and use the findings to further adjust drug control policies and the services provided as necessary to cover the entire affected population.

204. In Egypt, the availability of narcotic drugs and psychotropic substances for pain management and the treatment of disease remains relatively limited. The Board therefore discussed with the Government the need to better assess the requirements for narcotic drugs for purposes of pain management, to identify possible impediments to their availability and to ensure that narcotic drugs and psychotropic substances are available in adequate quantities to those in need.

3. Evaluation of the implementation by Governments of recommendations made by the Board following its country missions

205. To follow up on the implementation by Governments of the Board's post-mission recommendations, the Board undertakes an annual review of drug control developments. Three to four years after a country has received a mission, the Board solicits detailed information from the Government on the legislative and policy measures adopted in furtherance of the Board's recommendations.

206. In 2017, the Board invited the Governments of Bahrain, Iceland, the United Republic of Tanzania and Venezuela (Bolivarian Republic of), which had received INCB missions in 2014, to report how their drug control situations had developed in the intervening time.

207. The Board wishes to express its appreciation to the Governments of Bahrain, the United Republic of Tanzania and Venezuela (Bolivarian Republic of) for the information received. Their cooperation has assisted the Board in its review of their treaty implementation and has contributed to the important dialogue that the Board maintains with States parties to the international drug control conventions through the active exchange of information.

208. The Board renews its call to the Government of Iceland to provide the information requested. Once it is received, the Board will review the information with a view to including it in its annual report for 2018.

(a) United Republic of Tanzania

209. The Board notes that the Government of the United Republic of Tanzania has made some progress in the implementation of its recommendations since the INCB mission to that country in 2014.

210. In 2015, the United Republic of Tanzania adopted the Drug Control and Enforcement Act, 2015, pursuant to which the Drug Control and Enforcement Authority was established. The Authority has been empowered with a broad mandate in the control of drug trafficking and abuse, including executive powers to seize illicit drugs and arrest, investigate and prosecute persons suspected of involvement in drug-related crimes. The Board trusts that the establishment and continued activities of the Authority will contribute to strengthening the Government's efforts to effectively address challenges posed by drug trafficking and abuse in the United Republic of Tanzania.

211. The Board further welcomes the establishment of a multisectoral defence and security task force made up of representatives from the Police Force, the Immigration Department, the Revenue Authority, the National Intelligence Department and other government offices working at the country's border control points. The task force monitors the movement of products crossing the country's borders, including drugs and precursor chemicals, verifies the legitimacy of cargo, intercepts suspicious cargo and reports to the Drug Control and Enforcement Authority.

212. While acknowledging these positive developments, the Board notes that the United Republic of Tanzania still lacks a comprehensive national drug control strategy. Additional progress is needed in the implementation of the Board's recommendation with regard to effective interministerial coordination and cooperation in drug control activities. The Board encourages the Government to continue its drug control efforts and, in particular, to take the steps necessary to ensure, as soon as possible, the adoption of a national drug control strategy and the elaboration of an action plan aimed at ensuring that strategy's effective implementation.

213. While the availability of illicit drugs in the United Republic of Tanzania is increasing, the extent of drug abuse in the country is not yet fully known to the authorities. The Board wishes to remind the Government of the importance of carrying out a comprehensive national assessment that includes the collection and analysis of data on the incidence and prevalence of drug use in order to determine the extent and nature of drug abuse in the country, and of tailoring its drug control policies on the findings. An objective assessment is indispensable for the effective design of programmes for the prevention of drug use and the treatment and rehabilitation of those affected. The Board recommends that the Government of the United Republic of Tanzania increase its drug abuse prevention activities and ensure that they are broad enough to include all segments of the population. The Board notes that further action is needed in the areas of treatment, rehabilitation and social reintegration of drug-dependent persons.

214. The Board further notes that progress is still lacking in many areas in which it has identified room for improvement. In particular, the Board continues to encourage the Government of the United Republic of Tanzania to take additional measures to promote the adequate availability and rational use of narcotic drugs and psychotropic substances for medical purposes, including through the adequate provision of training for medical students and health-care professionals on the rational use of medicines containing controlled substances. INCB also encourages the Government to review current laws and regulations that may unnecessarily restrict the licit manufacture, import, distribution, prescription or dispensing of narcotic drugs and psychotropic substances for medical purposes.

215. The Board encourages the Government to take the steps necessary to ensure that further progress is made in the areas identified above so as to ensure full compliance with the international drug control treaties, including with assistance from the international community.

(b) Bolivarian Republic of Venezuela

216. The Board notes that, since its mission to the Bolivarian Republic of Venezuela in 2014, the Government has taken a number of measures to implement the Board's recommendations and that progress has been made in certain areas of drug control. Shortly after the Board's mission, the Government adopted the national anti-drug plan 2015–2019, which is aimed at reducing drug abuse and stepping up activities in drug abuse prevention. The national anti-drug office has expanded its anti-drug education training and its programmes to raise awareness of drug reduction and prevention activities throughout the country.

217. The Bolivarian Republic of Venezuela has further strengthened its regional and cross-border cooperation in tackling drug trafficking by engaging with international organizations and the relevant agencies of other Governments. The Board notes the active participation of the Government in the second phase of the Cooperation Programme on Drug Policies between Latin America and the European Union, in which countries from both regions carried out joint activities to address the world drug problem. Another example is the fourth joint committee on drugs of the Bolivarian Republic of Venezuela and the Netherlands, which met in The Hague in May 2016 and offered an opportunity to exchange experiences on policies to prevent illicit drug use. During the sixtieth session of the Commission on Narcotic Drugs, in March 2017, the Government of the Bolivarian Republic of Venezuela held a side event entitled "The promotion of citizenship participation in the prevention of illicit traffic in and abuse of drugs: the experience of Venezuela's national anti-drugs fund". The Board welcomes such exchanges and encourages the Government to continue its involvement in international cooperation in drug control matters.

218. The Board notes that the Government has continued to implement its air control and interception

programme based on its law regulating comprehensive airspace defence. According to the Government, that law is consistent with relevant international standards and protocols, in particular the Convention on International Civil Aviation of 1944.

219. The Board, while acknowledging those positive developments, notes that significant challenges remain for the Government of the Bolivarian Republic of Venezuela. Despite the concrete steps it has taken, opium poppy and cannabis continue to be cultivated on a substantial scale and drug trafficking continues to pose serious problems. In addition, though the Government continues to make considerable efforts, the rate of drug abuse remains high, in particular among schoolchildren and young people. The Board encourages the Government to conduct an assessment survey of the drug abuse situation in the country in order to develop an evidence-based drug control policy, tailored to the specific needs of the country's population.

220. The Board notes that there appears to be limited progress in several other areas, including efforts to ensure the adequate availability of narcotic drugs for medical needs, in particular pain management. The Board is encouraged by the fact that the Government, in line with the recommendations of the Board resulting from its 2014 mission, guarantees its citizens access to opioid analgesics for the treatment of acute and chronic pain.

221. The Board also notes that the competent national authorities have revised their estimates of the requirements for narcotic drugs and have made adjustments to increase the domestic supply of narcotic drugs and psychotropic substances for medical purposes. Nevertheless, the availability of opiates for the treatment of pain in medical institutions continues to be inadequate according to the data the Government has reported to the Board.

222. According to the national anti-drug office, an evaluation of the estimates compared to the actual quantities of drugs consumed is conducted at the end of each year with a view to adjusting the amounts required to meet the real needs of the population. The Board requests the Government to examine the current situation and take the steps necessary to ensure that narcotic drugs and psychotropic substances, including opiates, are made available in adequate amounts to meet medical needs. In order to do so, the Board recommends that the competent authorities of the Bolivarian Republic of Venezuela consider the recommendations contained in the Board's report *Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes — Indispensable, Adequately Available and Not Unduly Restricted*,[79] as well as the *Guide on Estimating Requirements for Substances under International Control*, developed by the Board and WHO.

223. The Board notes that there appear to be weaknesses in the inspection of retail outlets dispensing pharmaceutical preparations containing controlled substances. There also continues to be a need to provide training for pharmacists in ensuring that the dispensing of controlled substances is appropriately monitored and that such substances are used only for medical purposes.

224. The Board urges the Government to make additional efforts so that progress is made in the above-mentioned areas. The Board acknowledges the commitment of the Government of the Bolivarian Republic of Venezuela to drug control and trusts that measures will continue to be taken against illicit crop cultivation, illicit drug manufacture and drug trafficking, the diversion of controlled substances and drug abuse. The Board encourages the Government of the Bolivarian Republic of Venezuela to continue its efforts to implement and fully comply with the international drug control treaties and stands ready to assist the Government, in accordance with its mandate.

E. Action taken by the Board to ensure the implementation of the international drug control treaties

1. Action taken by the Board pursuant to article 14 of the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol and article 19 of the Convention on Psychotropic Substances of 1971

225. Where the Board has reason to believe that the aims of the Conventions are being seriously endangered by the failure of a State party to implement their provisions, it may invoke the provisions of the conventions related to compliance by States parties.

226. The provisions in question are article 14 of the 1961 Single Convention as amended by the 1972 Protocol, article 19 of the 1971 Convention and article 22 of the 1988 Convention. These articles set out a process through which the Board engages in a dialogue with the States in

[79] E/INCB/2015/1/Supp.1.

question in order to foster compliance with the Conventions when all other means have been unsuccessful.

227. In the past, INCB has invoked article 14 of the 1961 Single Convention and/or article 19 of the 1971 Convention with respect to a limited number of States. Following a confidential process of engagement and dialogue, most of the States concerned have taken remedial measures to address the Board's concerns, resulting in a decision by the Board to terminate the action taken under those articles with regard to those States.

228. The Board first invoked article 14, paragraph 1 *(a)*, of the 1961 Single Convention to encourage dialogue with the authorities of Afghanistan to promote compliance with the Convention in 2000. In 2001, the Board invoked article 14, paragraph 1 *(d)*, of that Convention, in order to bring about cooperative action at the international level to assist the Government of Afghanistan in ensuring compliance with the Convention. Afghanistan remains the only State for which article 14 of the 1961 Single Convention is currently invoked.

2. Consultation with the Government of Afghanistan pursuant to article 14 of the 1961 Single Convention on Narcotic Drugs as amended by the 1972 Protocol

229. During the current reporting period, the Board's consultations with the Government of Afghanistan have continued. Following the high-level INCB mission to Afghanistan in May 2016, the Board adopted a set of recommendations for addressing the drug control situation in the country and improving compliance with the international drug control treaties through legislative, policy, institutional and practical measures. These recommendations were communicated to the Government in December 2016, and since then, the Board has been engaged in an ongoing dialogue with the Government of Afghanistan to facilitate the implementation of these recommendations.

230. **The Board remains concerned about the overall drug control situation in Afghanistan. INCB once again draws the attention of the international community to the challenges faced by Afghanistan and stresses that efforts to stabilize the country will not be sustainable without also effectively controlling the country's illicit drug economy. The Board reiterates to the international community that drug control is a cross-cutting issue. Unless local, national, regional and international efforts to address this challenge are effectively pursued, poverty, insurgency, terrorism and obstacles to development will remain unaddressed.**

Cooperation with the Board

231. Consultations between the Board and the Government of Afghanistan pursuant to article 14 of the 1961 Convention continued over the reporting period. In January 2017, the Secretary of the Board met with the Chargé d'affaires of the Permanent Mission of Afghanistan to the United Nations in Vienna to discuss the Government's implementation of the international drug control treaties, including matters relating to follow-up action taken by the authorities towards the implementation of the Board's recommendations following the high-level mission of May 2016.

232. In March 2017, the President of the Board met with the delegation of Afghanistan led by the Deputy Minister of the Interior for Counter-Narcotics on the margins of the sixtieth session of the Commission on Narcotic Drugs, held in Vienna. The meeting focused on the challenges and opportunities existing in the country to improve the drug control situation and to strengthen Afghanistan's implementation of the international legal framework relating to drugs. The President of the Board mentioned that he brought to the attention of the sixtieth session of the Commission the concerns of the Board regarding developments in Afghanistan and the need for further international technical and financial assistance to the country. He also informed the delegation that INCB continued to call the attention of the international community to the drug challenges in the country by issuing a statement in advance of the Brussels Conference on Afghanistan held in October 2016, stressing that sustainable development was not possible without effective drug control in the country. The President of the Board encouraged the Government of Afghanistan to continue to share with the international donor community tangible results achieved in the field of drug control, such as the inauguration of a major new drug abuse treatment facility in Kabul in May 2016.

233. In July 2017, the President of the Board held consultations with the Permanent Representative of Afghanistan to the United Nations in New York on drug-related developments and challenges in the country and the need to effectively implement the Board's recommendations following its high-level mission to Afghanistan of May 2016.

234. At the coordination and management meeting of the Economic and Social Council held in July 2017, the President of the Board also reiterated to the Council the Board's grave concern about the deteriorating drug control and security situation in Afghanistan and the need for sustained international assistance to the country in the spirit of common and shared responsibility. During the same mission to New York, the President of the Board

also held consultations on Afghanistan with the President of the Economic and Social Council and the President of the General Assembly.

United Nations action

235. In March 2017, the Security Council unanimously adopted resolution 2344 (2017), in which it extended the mandate of the United Nations Assistance Mission in Afghanistan (UNAMA) until 17 March 2018. In the resolution, the Security Council decided that UNAMA and the Special Representative of the Secretary-General for Afghanistan would continue to lead and coordinate international civilian efforts to assist Afghanistan, guided by the principle of reinforcing the country's sovereignty, leadership and ownership, and that UNAMA and the Special Representative would promote more coherent support by the international community to the Government's development and governance priorities. In the resolution, the Security Council also called upon States to strengthen international and regional cooperation to counter the threat to the international community posed by the production of, trafficking in and consumption of illicit drugs originating in Afghanistan in accordance with the principle of common and shared responsibility.

Situation in Afghanistan

236. The security situation continued to deteriorate during 2016 and 2017. The United Nations recorded 23,712 security incidents in 2016, which represented an increase of almost 5 per cent compared to 2015 and was the highest number of security incidents ever recorded by UNAMA in a single year. The security forces of Afghanistan continued to face significant challenges, in particular regarding operational capacity. According to UNAMA, the challenges included shortcomings in the areas of command and control, leadership and logistics, and high attrition rates.

237. The Board remains extremely concerned about the substantial increase in the illicit cultivation of opium poppy and production of opium in the country over the past two years. According to the *Afghanistan Opium Survey 2017*, released by UNODC and the Ministry of Counter-Narcotics on 15 November 2017, opium production in Afghanistan increased by an astounding 87 per cent compared with 2016, reaching a record level of 9,000 tons in 2017. The survey also found that the total area under cultivation in 2017 had soared to 63 per cent more than in 2016, reaching 328,000 ha. These are the highest levels ever recorded for opium poppy cultivation and opium production, surpassing the previous record levels of 2014. The increase in production is mainly attributed to an increase in the area under opium poppy cultivation, as well as to an increase in opium yield per hectare. Opium poppy cultivation expanded into new areas, resulting in an increase from 21 provinces to 24 provinces affected by such cultivation. The survey also indicated large increases in cultivation in almost all major poppy-cultivating provinces, including in Helmand (an increase of 63,700 ha, or 79 per cent), Balkh (an increase of 10,000 ha, or 37 per cent), Kandahar (an increase of 7,500 ha, or 37 per cent), Nimroz (an increase of 6,200 ha, or 116 per cent) and Uruzgan (an increase of 6,000 ha, or 39 per cent). Most of the cultivation took place in the southern region of the country (almost 60 per cent of total cultivation), followed by the western region (17 per cent), northern region (13 per cent) and eastern region (7 per cent).

238. Afghanistan began its annual opium poppy eradication effort in March 2017. In 2017, the Afghan Ministry of Counter-Narcotics and UNODC experts verified that a total of 750 ha of poppy fields had been eradicated in a Governor-led effort. While that represents an 111 per cent increase in the area eradicated compared with 2016, when 355 ha were eradicated, it is negligible in the context of the overall cultivation reported for that year, as the area eradicated amounted to less than one quarter of 1 per cent of the total cultivated area. The eradication mainly took place in 14 provinces of Afghanistan, compared with 7 provinces in 2016. The main reason for the extremely low overall level of eradication was the poor security situation in most of the provinces that had the highest levels of opium poppy cultivation. In addition, there has been resistance by some farmers to opium poppy eradication campaigns, including in the form of violence, resulting in human casualties.

239. There are also growing concerns about trafficking in and the production and abuse of synthetic drugs in Afghanistan. There have been reports of growing numbers of methamphetamine seizures, an increase in the manufacture of methamphetamine and a rise in the number of admissions into treatment of people with drug use disorders in certain parts of the country.

240. Afghanistan is developing a new drug control law. An initial draft was approved by the Council of Ministers in 2016. As of 1 November 2017, the draft was being considered by the National Assembly. Once enacted, the new law is expected to restructure the drug control infrastructure in the country and bolster the coordination of drug control initiatives through increased oversight by the President's office.

Cooperation with the international community

241. Afghanistan continued to intensify its bilateral cooperation with neighbouring countries. During the reporting period, high-level delegations from Afghanistan visited Iran (Islamic Republic of), the Russian Federation, the United Arab Emirates and Uzbekistan to discuss bilateral relations on a range of cooperation issues, including economic, security and political issues.

242. At the same time, bilateral relations between Afghanistan and Pakistan were strained. On 16 February 2017, Pakistan closed its border with Afghanistan to all traffic for approximately one month and conducted cross-border shelling, targeting suspected militants inside Afghanistan. The border was reopened on 20 March by order of the Prime Minister of Pakistan. The United Kingdom hosted high-level bilateral talks in March 2017 with the aim of building confidence. The talks, which were attended by the national security adviser to the President of Afghanistan and the adviser to the Prime Minister of Pakistan on foreign affairs, resulted in the establishment of a cross-border cooperation mechanism between the two countries.

243. Afghanistan also continued to strengthen its participation in multilateral diplomacy. Under the Heart of Asia initiative, a ministerial conference was held in Amritsar, India, in December 2016. In February 2017, Afghanistan, China, India, Iran (Islamic Republic of), Pakistan and the Russian Federation came together to discuss the deteriorating security situation in Afghanistan and explore ways to accelerate their joint efforts to support the peace process in Afghanistan. At a meeting of senior officials involved in the Heart of Asia initiative held in Baku in March 2017, participants reaffirmed their commitment to enhancing economic and security cooperation through the Heart of Asia-Istanbul process.

244. In April 2017, a ministerial meeting of the Shanghai Cooperation Organization (SCO) was held in Astana. Participants reiterated the Organization's commitment to initiating a political dialogue between parties to the conflict in Afghanistan.

245. In August 2017, the President of the United States made a statement in which he expressed the view that a precipitous withdrawal of foreign troops from Afghanistan would create a vacuum for terrorist groups, including Al-Qaida and Islamic State in Iraq and the Levant. According to his revised strategy, the United States would continue its support for the Government and the military of Afghanistan, although the involvement of the United States would depend on a set of specific conditions rather than on any time limit.

Conclusions

246. After years of conflict and struggle, Afghanistan faces significant and complex challenges that are related to security, the peace process and political transformation, and that stand in the way of establishing a unified Government capable of territorial control and providing leadership, vision and reconciliation. The year 2016 marked a new record in the number of security incidents in the country identified by the United Nations. While negotiations on the designation of responsibilities among senior government officials continued, several key positions in the Government remained vacant. There was no tangible progress in establishing peace between the Government and the Taliban, despite statements by the Government affirming its intention to engage the Taliban in a constructive dialogue. In addition, the reporting period saw a straining of bilateral relations with Pakistan, although they seem to have improved again thanks to efforts to create mechanisms for better cross-border cooperation. Cooperation with the rest of the neighbouring countries seems to have strengthened.

247. In 2017, there was a substantial increase in the cultivation of opium poppy and the production of opium, continuing the alarming trend observed over the previous two years, following the decline in 2015. Although eradication efforts in the country have increased somewhat, they are still not adequate to make a meaningful impact on the level of cultivation, owing to resource limitations and the poor security situation in many provinces. In addition, there are growing concerns about the manufacture of synthetic drugs and their abuse in Afghanistan.

248. **The Board is aware of the challenges and difficulties that the Government and people of Afghanistan continue to face. Nevertheless, because Afghanistan's extraordinary drug-related challenges must be effectively addressed in order to stabilize the country, the Board again calls upon the Government, in cooperation with local, regional and international partners, to develop and implement a balanced, effective and comprehensive strategy to address those challenges. Such a strategy must involve local as well as national political leaders and include eradication, interdiction and the effective use of Afghan and international law enforcement capacity to deter involvement in the illicit drug-based economy. The prevention of drug use and the treatment of people with substance use disorders should be an integral component of such a strategy.**

F. Special topics

1. Drug control and human rights: marking the anniversaries of the Universal Declaration of Human Rights and the Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights

249. The year 2018 will be a milestone marking several anniversaries: the seventieth anniversary of the adoption of the Universal Declaration of Human Rights in 1948, the twenty-fifth anniversary of the Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights in 1993 and the thirtieth anniversary of the adoption of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. These anniversaries provide a unique opportunity to reflect on the relationship between drug control and human rights and on the implications of that relationship for national responses to the world drug problem.

250. In the outcome document of the special session of the General Assembly on the world drug problem held in 2016, the international community reiterated its commitment to respecting, protecting and promoting all human rights, fundamental freedoms and the inherent dignity of all individuals and the rule of law in the development and implementation of drug policies. One of the operational recommendations contained in the outcome document is to enhance the knowledge of policymakers and the capacity, as appropriate, of relevant national authorities on various aspects of the world drug problem in order to ensure that national drug policies, as part of a comprehensive, integrated and balanced approach, fully respect all human rights and fundamental freedoms and protect the health, safety and well-being of individuals, families, vulnerable members of society, communities and society as a whole, and to that end encourage cooperation with and among UNODC, INCB, WHO and other relevant United Nations entities, within their respective mandates. The importance of protecting and advancing human rights principles and standards has also been fully recognized and reflected in all 17 Sustainable Development Goals of 2030 Agenda for Sustainable Development, adopted by world leaders in September 2015.

251. The Board has repeatedly stressed the importance of respecting and protecting human rights and fundamental freedoms as part of the effective implementation of the international drug control treaties. **The Board continues to emphasize that for drug control action to be successful and sustainable, it must be consistent with international human rights standards.**

252. The right to health is set out in article 25 of the Universal Declaration of Human Rights in the context of the right to an adequate standard of living. The right to the highest attainable standard of health is recognized in article 12 of the International Covenant on Economic, Social and Cultural Rights. For the full enjoyment of the right to health it is important to have access to essential medicines.[80] WHO has compiled a list of medicines considered essential to satisfying the priority health-care needs of the population. The list contains several narcotic drugs and psychotropic substances under international control. The international drug control treaties require States parties to ensure the availability and rational use of internationally controlled narcotic drugs and psychotropic substances for medical purposes.[81] Since its establishment, the Board has promoted national and international measures to strive towards an adequate availability of internationally controlled drugs for medical purposes that is not unduly restricted.

253. For the full enjoyment of the right to health it is also important that States provide equal opportunities for everyone to enjoy the highest attainable level of health and the right to the prevention and treatment of diseases. The international drug control treaties require parties to take measures to prevent drug abuse and to ensure the early identification, treatment, education, aftercare, rehabilitation and social reintegration of those who abuse drugs.[82] The need for non-discriminatory access to health care, rehabilitation and social reintegration services, in particular for women, including in prison and post-prison settings, was underscored in the 2016 report of the Board. The Board highlighted the importance of giving priority to providing easily accessible health care, including targeted and evidence-based interventions, to drug-dependent women. Drug-dependent women often face stigma preventing them from seeking and/or accessing the services they need. The Board also discussed the need for effective preventive measures in its annual reports for

[80] See also general comment No. 14 (2000) on the right to the highest attainable standard of health, adopted by the Committee on Economic, Social and Cultural Rights (E/C.12/2004/4), and OHCHR, *Fact Sheet No. 31*, Human Rights Fact Sheet Series (Geneva, June 2008).

[81] In the preambles of the 1961 Convention as amended by the 1972 Protocol and the 1971 Convention, the States parties recognized that adequate provision must be made to ensure the availability of narcotic drugs and psychotropic substances, respectively, for medical purposes. See also art. 9, para. 4 of the 1961 Convention as amended by the 1972 Protocol, which requires INCB, in cooperation with Governments, to ensure the availability of narcotic drugs for medical and scientific purposes.

[82] See art. 38 of the 1961 Convention as amended by the 1972 Protocol and art. 20 of the 1971 Convention.

1997 and 2009, whose thematic chapters were devoted to preventing drug abuse in an environment of illicit drug promotion and to primary prevention of drug abuse. The annual report for 2013 discussed how drug abuse could disproportionately affect specific populations such as women, low-income populations and children. **The Board stresses the importance of protecting the rights of persons with mental illness and improving mental health care in line with General Assembly resolution 46/119 of 1991 and the Convention on the Rights of Persons with Disabilities. The Board also highlights the need to protect children from drug abuse and prevent the use of children in the illicit production of and trafficking in illicit substances, in accordance with the Convention on the Rights of the Child, in particular its article 33.**

254. **The Board stresses the need to protect the rights of alleged drug offenders and drug users at all stages of the criminal justice process.** The prohibition of arbitrary arrest and detention, torture and other forms of ill treatment, the right to life, the prohibition of discrimination, the presumption of innocence and the right to a fair trial are among the important elements of an effective criminal justice system, as provided for in the international human rights instruments. Violations of these principles undermine the rule of law and are contrary to the aims of the international drug control treaties. The international drug control treaties, the Political Declaration adopted by the General Assembly at its twentieth special session and the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem all call for a balanced approach, respect for the principle of proportionality and respect for human rights.

255. **Under the international drug control treaties, States are required to be proportionate in their responses to drug-related offences and their treatment of suspected offenders.** The obligation under the international drug control conventions to establish certain types of conduct as punishable offences and to ensure that serious offences are liable to adequate punishment is subject to the constitutional principles of States and to the principle of proportionality. While serious offences may be punishable by incarceration, other forms of deprivation of liberty, pecuniary sanctions or confiscation, offences of lesser gravity are not necessarily subject to such punitive sanctions. In appropriate cases of a minor nature, States are encouraged to provide alternatives measures such as education, rehabilitation or social reintegration, in particular for persons affected by drug abuse.

256. **Extrajudicial responses to drug-related criminality are in clear violation of the international drug control conventions, which require that drug-related crime be addressed through formal criminal justice responses, as well as of the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights, which require adherence to internationally recognized due process standards.**

257. **Although the determination of sanctions is a prerogative of States, the Board continues to encourage all States that retain the death penalty for drug-related offences to commute death sentences that have already been handed down and to consider the abolition of the death penalty for drug-related offences in view of the relevant international conventions and protocols, and resolutions of the General Assembly, the Economic and Social Council and other United Nations bodies on the application of the death penalty.**

258. States parties have achieved varying levels of progress in the adoption of drug control policies that are consistent with international human rights law. **The Board will continue to highlight the importance of respect for human rights and fundamental freedoms in the implementation of international drug control conventions and invites all States to seize the opportunity provided by the anniversaries noted above to reflect and to act on this important issue.**

2. The risk of long-term opioid use and the consumption of opioid analgesics

259. Based on its mandate, the Board has been drawing the attention of States parties to the importance of ensuring the availability of internationally controlled drugs for medical purposes, and has highlighted the great disparity in that availability around the world. The Board has encouraged countries to ensure adequate access to opioid analgesics in countries with low levels of consumption. The Board has continued to emphasize the importance of ensuring the rational medical use of opioid analgesics. However, despite the emphasis on the need for the adequate availability of controlled drugs for medical and scientific purposes, it remains of great importance for States parties to ensure rational prescribing and implement measures to prevent the diversion and the risk of abuse of these drugs.

260. Global consumption of opioid analgesics has been increasing in recent decades. In particular, the consumption of fentanyl increased considerably from 2000 to 2010. Since then it has fluctuated at relatively high levels. The largest consumer, the United States, has seen a decrease in consumption since 2013 due to the introduction of stricter

prescription requirements. Similar patterns were recorded for other opioid analgesics such as hydrocodone, hydromorphone morphine and oxycodone. Canada, Australia and Belgium have experienced a similar development in the consumption of fentanyl, albeit at lower levels. Some other countries, such as Germany, Spain and Italy, have not experienced the same level of consumption and some of its consequences (such as overdose deaths), and their consumption of fentanyl has been increasing steadily.

261. The strong increases in the consumption of opioid analgesics since 2000, particularly in high-income countries, does not seem to be related to a proportionate increase in the morbidity rate of cancer but rather to the increase in the prescription of strong opioid analgesics for the treatment of chronic non-cancer pain. There are a number of factors that have influenced this development, including social and economic issues that made certain demographic groups more vulnerable than others. Among the suggested causes of the extensive prescription and subsequent abuse of opioid analgesics are overprescribing by medical professionals, and aggressive marketing by pharmaceutical companies combined with the targeted training of practitioners by the same companies offering various incentives to prescribers. These are considered to be two of the most significant drivers in the increase in prescribing opioid analgesics.

262. Another factor contributing to the increasing prescription of opioid analgesics is the use of the limited findings of some studies on hospitalized cancer patients showing evidence that strong opioids had low risk of causing dependence. These findings were frequently quoted in peer-reviewed journals and were used to justify the widespread prescription of strong opioids for non-cancer chronic pain.

263. However, a more recent study by the Centers for Disease Control and Prevention of the United States on the characteristics of initial prescription episodes and the likelihood of long-term opioid use in the country between 2006 and 2015 highlighted the opposite, namely that people who received a prescription for opioid pain relievers for non-cancer pain were highly likely to develop opioid dependence.

264. Once the authorities in the United States intervened by introducing stricter regulations, many of those dependent on prescription opioids had difficulties in obtaining them switched to illicitly procured prescription opioids or heroin that in many cases was mixed with fentanyl and fentanyl analogues to reproduce the strength of the synthetic opioids previously used. The mixing of heroin with stronger synthetic opioids has exponentially increased the number of overdose deaths because users are not aware of the adulteration of heroin or do not understand the risk associated with even very small quantities of strong opioids.

265. The opioid overdose crisis has been most visible and received most publicity in the United States, but it has also affected Canada, Australia and, to a limited extent, the United Kingdom and some other European countries. In the United States, the number of deaths caused by overdoses of opiates has reached historical levels. Drug overdose deaths nearly tripled from 1999 to 2014. In 2014, among 47,055 drug overdose deaths, 61 per cent involved opioids. Drug overdoses killed about 64,000 people in the United States in 2016, according to the National Center for Health Statistics at the Centers for Disease Control and Prevention. From 2013 to 2014, deaths associated with the most commonly prescribed opioids (natural and semi-synthetic opioids) continued to increase slightly. However, the rapid increase in overdose deaths appears to have been driven by heroin and synthetic opioids other than methadone. From 2014 to 2015, the death rate from fentanyl and other synthetic opioids other than methadone increased by 72.2 per cent. The death rate for heroin increased by 20.6 per cent.

266. In Canada, the dispensing rate for high-dose opioid formulations such as morphine, oxycodone and fentanyl, increased by 23 per cent between 2006 and 2011. The 2013 tobacco, alcohol and drugs survey conducted by Health Canada found that nearly one in six Canadians older than 14 had used opioids in the preceding 12 months. Between 2009 and 2014 there were at least 655 deaths in Canada where fentanyl was determined to be a cause or a contributing cause, and at least 1,019 deaths where post-mortem toxicological screening indicated the presence of fentanyl.

267. A report published in Australia by the National Illicit Drug Indicators Project reported 597 accidental opioid overdose deaths for 2013 among those aged 15 to 54, compared to 564 reported for 2012, and 668 deaths across all ages for 2013 compared to 639 for 2012. In 2013, 32 per cent of accidental opioid deaths among Australians aged 15 to 54 were due to heroin, while the rest were due to prescription opioids.

268. EMCDDA reported the detection of 25 new synthetic opioids between 2009 and 2016 and 18 new fentanyls between 2012 and 2016. According to the 2017 European Drug Report, a total of 8,441 overdose deaths, mainly related to heroin and other opioids, were estimated to have occurred in Europe in 2015, a 6 per cent increase on the estimated 7,950 deaths in 2014. Increases were reported for almost all age groups. The United Kingdom accounts for 2,655 of those deaths, or 31 per cent. Germany is a distant second with 15 per cent.

269. The increase in the abuse of prescription opioids and the consequent increase in overdose deaths has so far been limited to certain countries. However, all Governments should be aware of the risks associated with the abuse of prescription drugs as they work to ensure that controlled substances are available for medical and scientific purposes. Some Governments have introduced measures and the Board would like to draw the attention of all Governments to this issue.

270. Several countries are requiring the prescription of controlled substances by medical and health professionals to be guided by a rational approach to prescribing as described in the WHO *Guide to Good Prescribing: A Practical Manual*,[83] which recommends that patients receive medications appropriate to their clinical needs and for a specific therapeutic objective, in doses that meet their own individual requirements, with information, instruction and warnings, for an adequate period of time during which the treatment is monitored and eventually stopped, at the lowest cost to them and their community. In addition, when prescribing controlled substances that may entail risks of generating dependence, medical practitioners should conduct clinical interviews to assess the risk of dependence and the concomitant presence of health conditions that may make the individual more vulnerable to the development of drug use disorders.

271. For patients suffering chronic non-cancer pain, national health authorities in some countries have developed guidelines recommending alternatives to opioid analgesics.

272. Some government agencies responsible for the safe use of controlled substances have introduced control measures to reduce and eliminate the misuse of prescription drugs. Those measures include programmes to monitor electronic or digital prescriptions to ensure that only the prescribed amount is dispensed to the patient.

273. Various countries have taken regular initiatives to take back prescription drugs to ensure that expired and/or unused medications are returned, properly disposed of and not used improperly.

274. In some countries, health-care professionals are required to receive adequate independent and unbiased training on the use of medications, including ways to avoid the associated risk of dependence and measures to mitigate those risks. In addition, national health authorities have put in place campaigns to raise public awareness of the risk of dependence and of the proper use of medications.

275. Some countries have expanded treatment services for opioid use disorders, while ensuring that opioid substitution therapies (such as medication-assisted treatments with methadone and buprenorphine) are available and accessible to patients and that first responders in areas affected by the abuse of opioids have access to overdose reversing medication (such as naloxone).

276. Abuse deterrent formulations are promoted by some companies as the solution to the problem of prescription drug abuse, despite the fact that to date there is virtually no evidence of their effectiveness in reducing the risk of abuse. Further research is required to find effective technological solutions to address the abuse of pharmaceutical formulations containing opioids, as such solutions appear to be still some distance away from being found.

277. **The Board encourages Governments to adopt, wherever appropriate to their national situation, some of the measures described in this section and work together with public health officials, pharmacists, manufacturers and distributors of pharmaceutical products, physicians, consumer protection associations and law enforcement agencies to promote public education about the risks associated with prescription drugs, their abuse and their potential to cause dependence, in particular those prescription drugs containing narcotic drugs and psychotropic substances under international control.**

3. National requirements for travellers carrying medical preparations containing internationally controlled substances

278. The international drug control system allows travellers to carry small quantities of preparations containing narcotic drugs and psychotropic substances for personal medical use only. The drug control treaties do not regulate this matter directly, but article 4 of the 1971 Convention permits Governments to introduce special provisions for international travellers to carry small quantities of preparations with psychotropic substances other than those listed in Schedule I of that Convention. The 1961 Convention as amended by the 1972 Protocol, does not contain any provision to that effect. In its report for 2000, INCB recommended the development of guidelines for national regulations concerning international travellers under treatment with internationally controlled drugs.

[83] WHO/DAP/94.11.

279. Pursuant to Commission on Narcotic Drugs resolution 44/15, UNODC convened a meeting of experts to develop such guidelines in cooperation with INCB and WHO. The resulting international guidelines for national regulations concerning travellers under treatment with internationally controlled drugs were published in 2003 in the six official languages of the United Nations.[84]

280. The guidelines are intended to support competent national authorities in establishing a regulatory framework for travellers under treatment carrying small quantities of preparations containing internationally controlled substances. Although it is not compulsory for States to implement the unified procedures suggested in the guidelines, their wide application would facilitate both the mutual disclosure of relevant information through INCB and the work of government authorities.

281. In 2003, mindful of the need for travellers to be kept informed of relevant national requirements, the Commission adopted resolution 46/6. In it, the Commission strongly encouraged parties to the 1961 Convention, that Convention as amended by the 1972 Protocol and the 1971 Convention to notify INCB of restrictions currently applicable to travellers under medical treatment with internationally controlled substances and requested INCB to publish the above-mentioned information in a unified form, in order to ensure its wide dissemination.

282. Consequently, in 2004, INCB sent all Governments a circular letter in which it asked them to provide the information required by the Commission. Since then, INCB has continued to seek regular information updates from Governments and has compiled and published standardized summaries for each country that has provided the requested information. The summaries are published on the INCB website. They provide the following information to competent national authorities and prospective travellers: documentation required for carrying medical preparations containing internationally controlled substances (e.g., medical prescriptions), qualitative and/or quantitative restrictions (e.g., doses sufficient for a specific maximum amount of time) and contact details of the competent national authority in the intended country of destination or transit of the prospective travellers.

283. Over the years, many prospective travellers have asked INCB about the regulations applicable to medical preparations in the countries they were planning to visit and transit through. Most travellers, when approaching the Board, expressed their concern over the possibility of not having access to the medical preparations necessary to continue their treatment while in a foreign country. Some expressed genuine fears of being accused of, or imprisoned for, attempted drug trafficking. Others, planning to stay abroad for several months, wished to know whether they could carry with them doses sufficient for the entire duration of their visit.

284. As of 1 November 2017, information regarding national requirements for travellers under medical treatment who carry small quantities of substances under international control has been obtained from 107 countries. In the light of the growing mobility of travellers under treatment and the concerns expressed by many of them, INCB strives to provide the necessary assistance and disseminates the latest information at its disposal. The relevant information INCB possesses is directly received from the Governments and their competent national authorities, and the Board solely depends on them to provide it.

285. Many countries have not submitted the relevant information to date, while others have not updated the information they had initially provided. **Given the importance of ensuring that patients are not forced to discontinue their medical treatments while travelling abroad and that their safety, security and even their freedom should not be put at risk because of their need for medication while travelling, the Board urges all States parties to the 1961 and 1971 Conventions to notify INCB, through their competent authorities, of restrictions currently applicable in their national jurisdictions to travellers under medical treatment with internationally controlled drugs, using the forms available on the Board's website (www.incb.org). The Board also wishes to invite countries that have already submitted information to inform INCB about the validity of the summary published on the INCB website concerning their domestic regulations and to submit updated information as necessary as early as practicable.**

286. **Furthermore, the Board encourages all Governments to deepen the cooperation among their competent national authorities, law enforcement agencies, customs, immigration and border control authorities, and tour operators so that all are aware of their national regulations permitting travellers under medical treatment who are carrying prescription medications containing substances under international control to enter their territory and not be unduly delayed or otherwise importuned when crossing international borders.**

[84] Available at www.incb.org.

4. The therapeutic use of cannabinoids

287. A growing number of Governments around the world are authorizing the use of cannabinoids for medicinal purposes. Such use is permissible under the 1961 Convention as amended by the 1972 Protocol provided that a number of conditions are met. In several cases, the issue of legitimate access to cannabinoids for medical purposes has been brought to the attention of national and local legislatures and sometimes the courts. In some situations, legislative bodies have passed legislation in an attempt to regulate access and use, or the courts have handed down judgments confirming the right of people to access the medication they need.

288. The 1961 Convention addresses cannabis, cannabis resin and extracts and tinctures of cannabis, and places them in Schedule I (substances whose use should be limited to medical and scientific purposes), and cannabis and cannabis resin are also controlled under schedule IV (substances liable to abuse and to produce ill effects and such liability is not offset by substantial therapeutic advantages). The 1971 Convention lists in Schedule II *delta*-9-tetrahydrocannabinol (THC) obtained through chemical synthesis.

289. There is a large variety of preparations containing cannabinoids in various regions of the world, with different dosage forms and concentrations of active and psychoactive ingredients, and using different routes of administration. They are used for the alleviation of a wide range of symptoms. While there are indications that some cannabinoids could be used for the treatment of certain health conditions and while some countries have authorized their medical use, evidence for their therapeutic value is not conclusive and — more importantly — there is no clarity about the composition of medications containing cannabinoids (active principles and dosage), the best route of administration (the medical community generally agrees that smoking is not recommended), or the side effects.

290. Even though there is still insufficient evidence for the therapeutic value of cannabinoids, the 1961 Convention as amended assigns national authorities the responsibility for permitting its use for medical purposes, as the Board stated in its annual report for 2003. That implies that the requirements of the 1961 Convention as amended are to be fulfilled.

291. The Board is mandated to monitor the implementation of the international drug control conventions. The conventions require parties to ensure the adequate availability of narcotic drugs and psychotropic substances for medical and scientific purposes, while ensuring that they are not diverted for illicit purposes. In its annual report for 2014, the Board devoted a special topic to the control measures applicable to programmes for the use of cannabinoids for medical purposes pursuant to the 1961 Convention as amended.

292. After detailing the requirements and provisions contained in the Convention, the Board urged "all Governments in jurisdictions that have established programmes for the use of cannabis for medical purposes to ensure that the prescription of cannabis for medical use is performed with competent medical knowledge and supervision and that prescription practice is based on available scientific evidence and consideration of potential side effects".

293. Article 4 of the 1961 Convention as amended requires parties to take legislative and administrative measures to limit exclusively to medical and scientific purposes the production, manufacture, export, import and distribution of, trade in, use and possession of drugs.

294. According to the Commentary on the Single Convention on Narcotic Drugs, 1961, the term "medical purposes" has not been uniformly interpreted by Governments when applying the provisions of the Convention. The Commentary states: "Its interpretation must depend on the stage of medical science at the particular time in question; and not only modern medicine, sometimes also referred to as 'western medicine', but also legitimate systems of indigenous medicine such as those which exist in China, India and Pakistan, may be taken into account in this connexion."

295. In its annual report for 2003, the Board stated that, because of the differences in the experience of therapeutic usefulness, safety and efficacy of a drug between countries, "it seems that the drafters of the international drug control conventions did not purposely leave the term 'medical use' ambiguous but it is that they could not reach agreement on a universal definition." In the same report, the Board, while reminding parties that the 1961 Convention as amended leaves the definition of the term up to them, stressed that the 1971 Convention requires from WHO an assessment of the "usefulness" of a substance when it is considered for international control. The 1961 Convention as amended also assigns WHO the responsibility of establishing the substance's liability to abuse and potential therapeutic advantages as part of the scheduling process.

296. In its annual report for 2003, the Board stated that "the usefulness of the drug must take into account the balance between risk and benefit. … Therapeutic efficacy

and safety are basic conditions that have to be established before the drug can be marketed. Many Governments have accepted the responsibility of ensuring that the drugs made available comply with established standards of efficacy and safety."

297. In addition to the specific references in the international drug control conventions, the WHO Constitution states that the mandate of WHO is to "develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products" (article 2). Over the years, Member States have relied on WHO for expertise and guidance regarding the regulation, safety and quality assurance of medicines through the development and promotion of international norms, standards, guidelines and nomenclature.

298. In 1999, the World Health Assembly, in its resolution on the revised drug strategy (WHA52.19), urged member States "to establish and enforce regulations that ensure good uniform standards of quality assurance for all pharmaceutical materials and products manufactured in, imported to, exported from, or in transit through their countries" and "to enact and enforce legislation or regulations in accordance with the principles of the WHO Ethical Criteria for Medicinal Drug Promotion, to encourage the pharmaceutical industry and the health community to establish an ethical code, and to monitor drug promotion in collaboration with interested parties".

299. In the past, the Board has invited WHO to evaluate the potential medical utility of cannabinoids and the extent to which cannabis poses a danger to human health, in line with its mandate under the 1961 Convention as amended. The Board takes note of the recommendation of the thirty-eighth meeting of the WHO Expert Committee on Drug Dependence, held from 14 to 18 November 2016, to conduct pre-reviews of the cannabis plant, cannabis resin, extracts of cannabis and tinctures of cannabis to establish their abuse and dependence potential as well as their therapeutic efficacy and safety for a number of specific medical conditions. The Board also takes note of the 2016 WHO report entitled "The health and social effects of nonmedical cannabis use".

300. WHO has provided guidance on good manufacturing practice with guidelines on the development of quality management, which ensures that products are consistently produced and controlled according to the quality standards appropriate to their intended use and as required by the marketing authorization, clinical trial authorization or product specification. WHO has also developed guidelines on good clinical practice for trials on pharmaceutical products.

301. The medical use of narcotic drugs is considered "indispensable" in the preamble of the 1961 Convention as amended. Therefore, if the symptoms of certain clinical conditions may be relieved by treatment with cannabinoids, it is important for countries to carefully establish the therapeutic value of such treatment through the collection of concrete evidence, and to clearly establish the active principles and the dosages to be used. Several countries have conducted or are conducting studies and trials to establish the best therapeutic applications of cannabinoids for the treatment of certain health conditions.

302. **The Board recommends Governments that are considering such medical use of cannabinoids to examine the results of those studies and trials and to ensure that the prescription of cannabinoids for medical use is performed with competent medical knowledge and supervision and that prescription practice is based on available scientific evidence and the consideration of potential side effects. Also, Governments should ensure that pharmaceutical material containing cannabinoids is made available to patients in line with the WHO guidelines mentioned above and with the international drug control conventions.**

5. New psychoactive substances

303. Since the publication of its annual report for 2010, the Board has been warning the international community about the problem of trafficking in and abuse of new psychoactive substances. New psychoactive substances are substances that are abused either in their pure form or in a preparation and that may pose a threat to public health, although they are not controlled under the 1961 Convention as amended by the 1972 Protocol, or under the 1971 Convention.[85] They can be made of natural materials or synthetic substances and are often deliberately chemically engineered to circumvent existing international and domestic drug control measures.

304. New psychoactive substances are a very heterogeneous category. Their number continues to grow in every region of the world. As at September 2017, the UNODC early warning advisory on new psychoactive substances, a system that monitors the emergence of new psychoactive substances as reported by Member States, listed 796 unique substances, a steady increase from the 739 substances reported by 2016. The most reported substances continued to be synthetic cannabinoids, synthetic

[85] Other definitions of new psychoactive substances may also be used occasionally. For example, the definition used for the UNODC early warning advisory encompasses both synthetic and plant-based substances, as well as substances with established medical use.

cathinones and phenethylamines, which together accounted for over two thirds of all the substances reported. While many of the detected substances do not stay on the market for a long time, at least 76 different types of substances have been involved in incidents taking place in 2017 as at 1 November, according to the INCB Project Ion Incident Communication System (IONICS).[86]

305. To assist Member States in coping with the ever-growing number of new psychoactive substances and the challenges associated with their transient nature, the Board, through Project Ion, provides national authorities with infrastructure to share information in real time on incidents involving new psychoactive substances (such as suspicious shipments, trafficking and manufacture or production) and to follow up on those incidents. The aim of Project Ion is to prevent new psychoactive substances from reaching consumer markets by assisting Governments to conduct their investigations and devising practical solutions. The Project Ion global network of focal points for new psychoactive substances has expanded to 125 countries and territories in every region of the world. The INCB task force on new psychoactive substances, which steers Project Ion activities, held two meetings in 2017.

306. IONICS was launched in December 2014. IONICS is a secured web-based platform for the real-time communication of incidents involving suspicious shipments, or involving trafficking in, the manufacture of or the production of new psychoactive substances. As at 1 November 2017, after almost three years of operation, the system had over 210 users from 75 countries, and almost 1,100 incidents had been communicated through the system. The majority of those incidents involved synthetic cathinones (e.g., methylone (*beta*-keto-MDMA), mephedrone, 4-chloromethcathinone (4-CMC), *alpha*-pyrrolidinopentiophenone (*alpha*-PVP), 3-methyl-*N*-methylcathinone (3-MMC) and *N*-ethylbuphedrone (NEB)) and synthetic cannabinoids (e.g., 5-fluoro-AMB and 5F-APINACA). Since 2016, IONICS has received reports of at least 25 incidents involving five types of fentanyl analogues: acryl fentanyl, carfentanil, furanyl fentanyl, (iso)butyryl fentanyl and *para*-fluorofentanyl. The incidents were communicated by three countries in Europe. Information communicated through IONICS has triggered several follow-up investigations in the countries of destination and origin.

307. In March 2016, in response to growing concerns over risks of synthetic opioid abuse and overdoses in North America spreading worldwide, the INCB task force on new psychoactive substances decided to pursue operational activities to examine global patterns in the sources of, the flows of, the illicit manufacture of and trafficking in fentanyl, designer fentanyls, other opioid-type new psychoactive substances and their precursors. Following the task force's decision, the Board, in early 2017, conducted a survey on fentanyls. The survey was focused on target substances encountered in 2015 and 2016.

308. Forty-nine countries and territories, as well as the European Commission, returned the questionnaire, providing information about the situation in 58 countries and territories. Twenty countries from Europe returned the questionnaire and the European Commission supplemented information on nine countries that did not return the questionnaire directly. The results therefore describe the situation in Europe in greater detail than they do for other regions, and they should not be understood to give a comprehensive picture of opioid prevalence in the world.

309. Forty types of opioids (fentanyl, fentanyl analogues and other opioids) were encountered in 37 countries and territories; 26 of those were in Western and Central Europe, 2 in South-Eastern Europe, 2 in East and South-East Asia, 3 in West Asia, 3 in North America and 1 in Oceania. The substances had originated from 18 countries and territories; 13 of those were in Western and Central Europe, 2 in East and South-East Asia, 2 in North America and 1 in Eastern Europe. The risks of synthetic opioid abuse and overdoses spreading worldwide appear to be serious, as synthetic opioids are being seized in various parts of the world.

310. New psychoactive substances are traded in part through online platforms. Unlike narcotic drugs and psychotropic substances under international control, which are often traded through the so-called darknet, new psychoactive substances, in most cases, are openly sold on the ordinary Internet, such as in online new psychoactive substances shops and business-to-business trading platforms. Dedicated online shops selling new psychoactive substances are sometimes closed down by the law enforcement authorities of the countries where they are located. By contrast, sale offers and purchase requests regarding new psychoactive substances exchanged through legitimate business-to-business trading platforms are often not investigated because the platforms themselves are legitimate and are often located in third-party jurisdictions where neither the sellers nor the buyers are located.

311. As national control is expanded to cover more new psychoactive substances, there is an increased risk of

[86] As IONICS is a communication platform through which registered users from participating national authorities voluntarily exchange information related to a limited number of incidents, data from IONICS, including the number of substances reported during a certain period of time, do not represent a comprehensive view of NPS situations in the world.

legitimate business-to-business trading platforms being used for the sale and purchase of substances under national control. While misuse of legitimate platforms for illicit purposes needs to be prevented, hindering the development of legitimate economic activities through the Internet needs to be avoided. **The Board encourages Governments to consider appropriate measures, in accordance with national law, to monitor and act on attempts to trade in new psychoactive substances through online trading platforms, including, possibly, voluntary monitoring and information-sharing, and to consider involving the operators of trading platforms.**

6. Illegal Internet pharmacies and the sale of internationally controlled drugs on the Internet

312. The Internet has permeated every aspect of people's lives in recent years and that includes matters of health. This has made it possible to buy medicines online, including those containing internationally controlled drugs. Unfortunately the online sale of medicines is sometimes conducted illegally, since some Internet pharmacies operate without licenses or registration and dispense pharmaceutical preparations containing narcotic drugs and psychotropic substances without requiring a prescription.

313. Illegal Internet pharmacies usually have dedicated websites. Those may be portal sites that advertise drugs and act as conduits to other websites where customers place their actual orders and pay. The drugs most frequently sold online include narcotic drugs, mostly oxycodone, hydrocodone, dextropropoxyphene and other opioids, and psychotropic substances, in particular benzodiazepines, stimulants and barbiturates. Precursors, i.e. chemicals that are frequently used in the illicit manufacture of narcotic drugs and psychotropic substances, are also traded online. In recent years the Internet-facilitated trade in precursors has expanded, an issue that is further examined in a special section of the report of the Board for 2017 on the implementation of article 12 of the 1988 Convention.[87]

314. The scope of the phenomenon and the number of customers frequenting illegal Internet pharmacies is hard to gauge, as there have been no global data surveys or extensive clinical case studies on the matter. The Alliance for Safe Online Pharmacies, a non-governmental organization based in the United States, estimates that some 36 million Americans have purchased medications without a prescription at some point in their lives. A scientific systematic review has found that the number of people reporting that they have purchased medicines online, mostly from studies in the United States, ranges between 1 and 6 per cent of the population, a figure that is slightly higher in studies where the intention to buy online was also considered.

315. Illegal Internet pharmacies are often international operations with servers, pharmacy shipping operations and other parts of the business located in different countries. Most illegally operating Internet pharmacies do not require prescriptions from their customers at all, while some issue "prescriptions" after a brief online consultation or the completion of a short questionnaire. Illegally operating Internet pharmacies are the main sources of prescription-only medicines sold without prescriptions and of falsified prescription-only medicines.

316. Actions taken against illegal Internet pharmacies include helping the general public to identify websites that sell medicines legally. In the European Union, a common logo has been established indicating in which member State an online pharmacy or other type of online medicine retailer is based. The logo appears on the websites of all online medicine retailers registered with one of the national regulatory authorities in the European Union. A similar scheme exists in the United States, where the dot-pharmacy programme of verified websites is operated by the National Association of Boards of Pharmacy with the aim of ensuring that participating pharmacies are operating safely and legitimately.

317. To assist Governments in their endeavours to address the challenge of illegal Internet pharmacies, the Board has published the *Guidelines for Governments on Preventing the Illegal Sale of Internationally Controlled Substances through the Internet*,[88] available on the Board's website (www.incb.org). The *Guidelines* were developed with the help of national experts and relevant international organizations such as the International Criminal Police Organization (INTERPOL), the Universal Postal Union, Internet service providers, financial service providers and pharmaceutical associations. The publication contains 25 individual guidelines that cover legislative and regulatory provisions, general measures and national and international cooperation. Their aim is to provide authorities assistance in formulating national legislation and policies to prevent the illegal sale of internationally controlled drugs through the Internet. Illegal Internet pharmacies are a growing phenomenon that has the potential to cause serious public health problems.

[87] E/INCB/2017/4, chap. IV.

[88] United Nations publication, Sales No. E.09.XI.6.

318. Governments in all regions have used the *Guidelines* in drafting and subsequently adopting legislation that empowers authorities to investigate and take legal action against illegal Internet pharmacies. This includes legislation allowing for the inspection of shipments by mail suspected of containing internationally controlled substances and legislation providing a framework for the operation of Internet pharmacies.

319. The continued growth of Internet access around the world, the widespread availability of online communication channels and the vastness of the deep web, the part of the Internet that is not accessible to search engines, all contribute to making drug trafficking over the Internet, whether through illegal Internet pharmacies or by other means, a significant crime threat. **In that connection the Board calls on Governments to continue to use the *Guidelines* pursuant to the recommendation expressed in the outcome document of the special session of the General Assembly on the world drug problem held in 2016.**[89]

7. The International Import and Export Authorization System (I2ES): modernizing import and export authorization to ensure the availability of and access to controlled substances

320. Making indispensable narcotic drugs and psychotropic substances available for medical and scientific purposes while ensuring that there is no diversion or abuse: these two fundamental principles were set forth in the 1961 Convention as amended by the 1972 Protocol and the 1971 Convention. The commitment of the international community towards these goals was further reiterated in the outcome document of the special session of the General Assembly on the world drug problem held in 2016.

321. Pursuant to the 1961 and 1971 Conventions and to relevant resolutions of the Economic and Social Council, import and export authorizations are required for the international trade in narcotic drugs and psychotropic substances. An efficient and effective import and export authorization system that enables competent national authorities to expedite the process is crucial to ensuring the adequate availability of and access to controlled substances and to reducing the risk of diversion.

322. The volume of licit trade in narcotic drugs and psychotropic substances under international control has increased continuously over the last decade. That rise is expected to persist, as the availability of and access to internationally controlled substances for medical and scientific purposes increases in more and more countries.

323. I2ES, a web-based electronic system developed by the Board together with UNODC and with the generous financial and technical support of Member States, was designed to modernize the import and export authorization system and assist competent national authorities in managing their increasing workload. By achieving these goals, I2ES contributes to the implementation of the import and export authorization system as stipulated in the Conventions, and operational recommendation 2 *(c)*, contained in the outcome document of the thirtieth special session of the General Assembly, on ensuring the availability of and access to controlled substances for medical and scientific purposes.

324. I2ES is provided to all Governments free of charge and serves as a secure and safe platform for uploading and exchanging import and export authorizations between trading countries. Competent national authorities can save much time and resources on verifying the authenticity of import and export authorizations via the secure portal. Real-time communication and exchange of information between authorities of trading countries is also possible whenever transactions require clarification or further processing.

325. The new tool modernizes the import and export authorization system while taking into consideration the needs and national systems of various Governments. I2ES enables countries with no existing national electronic systems to generate and transmit import and export authorizations electronically and to download and print them as necessary. It also provides them with a repository and databank of all their international trade in controlled substances, making it easier for them to monitor the trends in the use of controlled substances. Governments with existing national electronic systems can link up their systems with I2ES so that relevant data can be utilized for the further processing and exchange of import and export authorizations.

326. Throughout the development of I2ES, the Board has ensured that all business rules underlying the system fully comply with the relevant provisions of the 1961 and 1971 Conventions regarding import and export authorizations, and that the format and content of the authorizations fulfil all the requirements provided for in the Conventions and relevant decisions of the Commission.

327. With a number of built-in functions and automatic alerts, I2ES enables Governments to monitor the licit trade of internationally controlled substances and prevent their diversion. When, for a particular substance, the

[89] General Assembly resolution S-30/1.

envisaged trading volume exceeds the latest estimate or assessment of the importing country, a warning message is displayed automatically and further processing is blocked until the relevant estimates and/or assessments are updated. Furthermore, by enabling authorities of an importing country to verify in real time the amounts actually received, authorities of the exporting country can be notified immediately should those quantities be smaller or larger than those authorized for export.

328. The Commission on Narcotic Drugs, in its resolution 58/10 of March 2015, welcomed the launch of I2ES and urged Member States to promote and facilitate the fullest possible use of the system. It also invited the secretariat of INCB to administer the system and encouraged Member States to provide the fullest possible financial support for its administration and maintenance and the provision of trainings.

329. User-group meetings were held on the margins of the fifty-ninth and sixtieth sessions of the Commission in March 2016 and March 2017. Authorities from around 40 countries, together with the INCB secretariat and UNODC, shared their views on and experience with using I2ES. In particular, participants assessed the progress made, gave feedback and suggestions regarding the further development of I2ES and identified specific actions to promote its use.

330. One user-group meeting focused on the latest version of the UNODC National Drug Control System and the technical aspects of its data exchange with I2ES. The meeting was organized jointly by the competent national authorities of Switzerland and UNODC, and was held at the beginning of October 2017. The secretariat of INCB participated and gave an overview of I2ES. Authorities from about 15 major countries trading in narcotic drugs and psychotropic substances shared their experiences with and vision for using these applications.

331. The Board wishes to express its appreciation to all Governments that have provided financial, political and technical support during the development and testing of I2ES. **While its development was completed entirely with extrabudgetary resources, further funding is required to enable the secretariat of INCB to administer I2ES in line with its mandate and in accordance with all relevant resolutions of the Commission.**

332. As at 1 November 2017, 40 countries (Afghanistan, Algeria, Australia, Austria, Bangladesh, Belgium, Brazil, Canada, Chile, China, Colombia, Comoros, Estonia, Finland, Germany, Hungary, India, Indonesia, Italy, Jordan, Lao People's Democratic Republic, Lithuania, Luxembourg, Malaysia, Maldives, Mexico, Papua New Guinea, Peru, Poland, Portugal, Romania, Rwanda, Saint Lucia, Saudi Arabia, Singapore, Spain, Switzerland, Thailand, Turkey and Zambia) had registered with I2ES.

333. **The Board would like to encourage all competent national authorities to register with I2ES as soon as possible and start utilizing it.** As more and more Governments join hands in issuing and exchanging import and export authorizations via the system, its power and effectiveness in expediting the process increase rapidly. In particular, the active participation of major trading countries for narcotic drugs and psychotropic substances is of paramount importance. More widespread utilization of I2ES will not only improve the efficiency and workflow of competent national authorities, but also serve as a basis for further strengthening the international drug control system.

334. Applying the principle of common and shared responsibility, States parties have successfully reduced the diversion of controlled substances thanks to their concerted efforts to implement the import and export authorization system and regulate the licit trade of narcotic drugs and psychotropic substances under international control. It is time to apply the same spirit to realizing the full potential of I2ES so as to modernize the import and export authorization system and ensure adequate availability of and access to controlled substances for medical and scientific purposes.

335. **The Board would like to invite Member States to consider what further measures would be needed to ensure the fullest utilization of I2ES, its maintenance and further development.**

8. Training for competent national authorities, and INCB Learning

336. The provision of estimates, assessments and statistics to the Board, together with the control over international trade lie at the core of the international drug control system. The Board has observed, however, that many countries have difficulties in meeting the requirements set out in the international drug control conventions and related resolutions of the Economic and Social Council and the Commission on Narcotic Drugs.

337. The insufficient capacity of some Governments to comply with the provisions of the international drug control conventions increases the risks of diversion, trafficking and abuse and can lead to inadequate availability of controlled substances for medical, scientific and, in the case of precursor chemicals, legitimate industrial

purposes. This can result in medical centres, pharmacies and doctors not having access to essential medicines, in diseases going untreated, in unnecessary suffering and in the diversion and non-medical use of controlled substances, with considerable impact on the health and welfare of society. With regard to precursors, the difficulties some Governments face in establishing a balanced monitoring system may hamper legitimate international trade and fuel the illicit manufacture of drugs and drug abuse in their own countries and abroad.

338. Over the years and through its secretariat, the Board has been providing training to Governments on an ad hoc basis on the margins of the annual sessions of the Commission on Narcotic Drugs and through the Board's participation in meetings of the Commission's subsidiary bodies, at conferences and meetings of regional organizations, in specific events and through the visits of staff of competent national authorities to the offices of the secretariat of the Board.

339. In early 2016 and in response to requests from Member States, the Board launched INCB Learning as a global project in order to strengthen the capacity of Governments in the regulatory control and monitoring of the licit trade in narcotic drugs, psychotropic substances and precursor chemicals. The ultimate goal of the project is to support Governments in ensuring the adequate availability of controlled substances while preventing their diversion, trafficking and abuse. With the INCB Learning initiative, the Board contributes to efforts to achieve Sustainable Development Goal 3, to ensure healthy lives and promote well-being for all at all ages.

340. To provide training in a cost-effective manner, regional seminars are held under INCB Learning for staff from competent national authorities. The first training seminars were conducted in Nairobi in April 2016 for countries in East Africa, and in Bangkok in July 2016, for countries in South and East Asia and the Pacific. A seminar for European countries followed in Vienna in July 2017. A training seminar for countries in Oceania was held in Sydney, Australia, in November 2017 and a training workshop for States members of the Central American Integration System, to be held in Guatemala City, was under preparation. As of 1 November 2017, 116 officials from 56 countries, together representing almost half of the world population, had received training under the project.

341. Also through INCB Learning, the Board is updating its training materials for competent national authorities and is developing e-learning courses to enable the staff of those authorities to receive INCB training on demand. It is expected that this approach will help to ensure that competent national authorities retain the relevant knowledge even at times of staff turnover. Under the project, pilot e-learning courses have been developed focusing on the estimates system for narcotic drugs, on the assessment system for psychotropic substances and on the estimates of annual legitimate requirements for imports of certain precursors of amphetamine-type stimulants. In addition to those training activities, national workshops have been conducted under INCB Learning in an effort to raise awareness of the importance of ensuring the availability of and access to narcotic drugs and psychotropic substances for medical and scientific purposes. Workshops for Kenya and Thailand brought together participants from national authorities, the international community and civil society to discuss national challenges and opportunities to improve medical access to controlled substances.

342. INCB Learning responds to the operational recommendations contained in the outcome document adopted at the special session of the General Assembly on the world drug problem held in 2016 entitled "Our joint commitment to effectively addressing and countering the world drug problem". In it, Governments agreed to a set of recommended measures designed to ensure the availability of and access to controlled substances exclusively for medical and scientific purposes, while preventing their diversion. Paragraph 2 of the outcome document specifically recommends the strengthening of the proper functioning of the national drug control systems and domestic assessment mechanisms and programmes. It also recommends the training of competent national authorities and the conducting of awareness-raising campaigns to ensure access to controlled substances for medical and scientific purposes. INCB Learning collaborates with WHO and UNODC, which have contributed to and participated in INCB Learning training seminars and awareness-raising workshops, providing inputs in the area of essential medicines and palliative care. The operational recommendations of the outcome document of the special session also make reference to the Board's online tools, such as I2ES and PEN Online, for which training is provided during the seminars.

343. In the spirit of article 9, paragraph 5 of the 1961 Convention as amended by the 1972 Protocol, the Board assists Governments in complying with the international drug control conventions. As the repository of technical expertise, the secretariat of the Board is in a unique position to provide training to competent national authorities. Training conducted under INCB Learning has proved to be an effective tool for increasing Member States' compliance with the conventions and related resolutions of

the Economic and Social Council and the Commission on Narcotic Drugs. Very positive feedback has been received in which participants stress the high relevance of the training for their work and the need to sustain, repeat and further develop INCB Learning.

344. Notwithstanding the assistance provided by INCB, it is the responsibility of Governments under the international drug control treaties to enable their competent national authorities to receive training. The importance of ensuring that national drug administrators have adequate qualifications for the effective and faithful execution of treaty provisions is highlighted in article 34 *(a)* of the 1961 Convention. Article 38, paragraphs 2 and 3, of the 1961 Convention and article 20, paragraphs 2 and 3, of the 1971 Convention require States parties to provide training to prevent the abuse of narcotic drugs and psychotropic substances. Such training should target, among other things, the capacity of competent national authorities to determine legitimate requirements of narcotic drugs and psychotropic substances, to monitor and control their use, and to furnish accurate reports to INCB. The need for appropriate training of law enforcement and other personnel on the control of narcotic drugs, psychotropic substances and precursor chemicals is also covered by article 9, paragraphs 2 and 3, of the 1988 Convention.

345. The international drug control conventions and the outcome document of the special session, in its paragraph 6, call on the international community to enhance cooperation and lend technical and financial assistance to countries requesting support. INCB Learning stands ready to assist, in collaboration with other United Nations entities such as WHO and UNODC, countries in fulfilling their treaty obligations in order to strengthen the international drug control system and ensure the adequate availability of narcotic drugs, psychotropic substances and precursor chemicals for licit purposes. To achieve that goal and to support Governments, the Board relies on voluntary contributions from Governments to its capacity-building activities. **The Board is grateful for the contributions to INCB Learning made by the Governments of Australia, France and the United States, and for the in-kind support provided by the Government of Thailand. The Board calls on Governments to provide further and regular contributions to sustain and expand activities under the INCB Learning initiative. Such commitment by Governments is required to ensure broad geographical coverage, the sustainability of the project and the provision of support and advice to all Governments.**

9. Upgrading the International Drug Control System platform

346. The international drug control system is based on three international conventions: the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. The 1961 Convention as amended and the 1971 Convention established control measures for narcotic drugs and psychotropic substances, whereas the 1988 Convention established control measures for precursor chemicals used in the illicit manufacture of narcotic drugs and psychotropic substances. By becoming parties to these conventions, States accept the obligation to implement in their national legislation the provisions of the conventions.

347. The international drug control conventions were elaborated in recognition of the fact that certain substances, while of great benefit to humankind, also had the potential to cause harm. Therefore, the conventions established a control system that would ensure the availability of controlled substances for medical and scientific purposes while preventing their illicit production, trafficking and abuse. If applied correctly, this system should not hinder but rather promote access to controlled substances and prevent their diversion.

348. INCB is the body responsible for monitoring the compliance of Governments with the international drug control treaties and for providing support to Governments in this respect. The capacity of INCB to monitor the functioning of the international drug control mechanisms established by the conventions relies, in part, on the ability of Governments to provide it with estimated quantities of controlled substances required for legitimate purposes in their countries. These quantities are known as estimates when referring to narcotic drugs, as assessments when referring to psychotropic substances, and as annual legitimate requirements for precursor chemicals and substances frequently used in the illicit manufacture of amphetamine-type stimulants.

349. The accurate estimation of requirements for controlled substances is an essential step in ensuring their adequate supply for medical and scientific purposes. While underestimation of requirements can contribute to problems, notably shortages, overestimation can lead to surpluses, waste and increased risk of diversion of controlled substances. To supplement its annual report, the Board publishes three technical reports on narcotic drugs, psychotropic substances and precursor chemicals. These reports are based on information furnished by Governments

to the Board in accordance with the relevant provisions of the international drug control conventions.

350. The data provided by countries are stored in the INCB International Drug Control System (IDS), an information management system that provides automated analysis tools and reporting facilities to INCB while implementing its mandate of monitoring compliance with the international drug control treaties. IDS became operational in 2004 and was formally launched at the margins of the forty-eighth session of the Commission on Narcotics Drugs in March 2005.

351. The system provides tools for INCB to monitor the implementation of the drug control treaties and facilitate the management of data received from reporting countries and territories to INCB under these treaties. It also provides tools to monitor and control the global import and export of narcotic drugs and psychotropic substances as well as precursors. The system is a tool for INCB to monitor the information on licit production, cultivation, utilization and stocks of the controlled substances by the countries and territories. The system is capable of providing several automated control mechanisms, analysis and reporting tools to the Board.

352. IDS has been used by INCB for 13 years, and it was enhanced and extended according to the requirements over the years. It is a vital tool for the Board to monitor compliance with the international drug control treaties. IDS is used for the processing of the data furnished by the countries and territories submitted in different forms to INCB throughout the year.

353. The data contained in IDS are analysed for the preparation of the publications of the Board. The publication of statistical data provides information for analytical purposes, inter alia, on the availability and use of narcotic drugs, psychotropic substances and precursor chemicals in various countries and territories. The preparation of estimates and statistics for submission to the Board requires the participation of several national administrative departments (health, police, customs, justice, etc.). IDS is used to analyse the global situation with respect to ensuring the availability of internationally controlled substances for medical and scientific purposes. The analysis tools for the quarterly statistics are used for identifying and reporting on trade discrepancies and import/export excesses.

354. One of the core activities of INCB is to monitor the licit trade of precursor chemicals listed in Tables I and II of the 1988 Convention and to assist Governments in preventing the diversion of such chemicals into illicit traffic. The exchange of pre-export notifications among exporting and importing Governments remains the most effective means of verifying the legitimacy of individual trade transactions. The information on the licit trade of precursor chemicals is instantly recorded in the IDS database with the PEN Online system acting as the main data entry mechanism for precursors in IDS since its launch in March 2006.

355. Since the systematic collection of pre-export notifications began in 1997, about 269,000 notifications have been recorded and processed in the IDS database, of which 87 per cent have been received, in real time, via the PEN Online system. IDS enables INCB to conduct timely assessments and analyses of trade information (substances, amounts, countries, companies) to identify licit trends and possible diversion and illicit traffic, based on which potential weaknesses in national control systems can be identified and proposals for remedial action be made, thus contributing to effectively carrying out the Board's function as mandated under the 1988 Convention. Furthermore, IDS contains seizure and licit trade information received on the yearly form D submissions, which is essential for the preparation of the report of the Board on the implementation of article 12 of the 1988 Convention, as well as for the coordination and support of regional and international precursor control initiatives.

356. However, IDS needs to be upgraded. IDS was implemented with the technologies that were available more than 13 years ago. As information system technologies rapidly evolve and advance, the system is becoming obsolete. It is now becoming increasingly difficult to support and maintain the current system as the software tool underpinning it is rapidly disappearing from the market, making it increasingly difficult to find computer specialists able to provide support for the now outdated technologies used by IDS.

357. A system upgrade can take advantage of improvements in hardware and networking. Modern software systems offer better user interfaces and incorporate common user experiences. An upgraded system will make IDS more compatible with the new hardware and software tools. For example, as increasing numbers of new psychoactive substances are brought under international control following the recent scheduling of a significant number of substances by the Commission, there is a need to develop new business functionalities into IDS. The current system is not flexible enough to cover all these changing needs. An upgraded IDS will be able to interact better with the national systems of Governments, which would increase the treaty compliance monitoring capacity of the Board, while providing a more secure platform for Governments to integrate their national systems.

358. The data available to INCB would be much easier to publish on the web or in response to queries from mobile devices. The technical tables and statistical information, which are made publicly available through the INCB annual report and the supplementary technical publications, could be shared and made accessible through various media.

359. IDS currently accepts XML-based submissions of the various forms for the statistical information furnished by Governments. With an upgrade, IDS would gain the capacity to receive this information online through a secure web interface. This would enable Governments to upload their statistical information in an effective and efficient manner. Competent national authorities and the Board could save much time and resources when entering and verifying statistical information.

360. IDS is the main information management system supporting the work of INCB in implementing its mandate of monitoring compliance with the international drug control treaties. The technological advances of today were unforeseeable 13 years ago when the system was developed, and INCB should adapt its operations to these advancements and upgrade its system.

361. The effectiveness of the international drug control system relies on Member States' collective efforts to implement and monitor the implementation of the conventions. **The modernization of IDS (development and maintenance) has financial implications, and INCB would like to urge Governments to consider providing the financial support needed for upgrading the system to ensure that the Board continues to operate efficiently and effectively while also simplifying the work of competent national authorities in the submission of treaty-mandated information.**

Chapter III.

Analysis of the world situation

Highlights

- While Africa remains a key transit region for drug trafficking, the use of various types of drugs, including cocaine, opioids, amphetamine-type stimulants, tramadol and emerging new psychoactive substances, is growing.
- Several countries in Africa have improved their drug dependence treatment services, although most health systems lack the required resources and capacity.
- The trafficking of cocaine continues to be a major challenge for Central America and the Caribbean, although countries in the region are strengthening cooperation among themselves and enhancing their interdiction efforts to counter the illicit trade of cocaine.
- The data available for countries in Central America and the Caribbean show that cannabis has the highest rate of prevalence among internationally controlled substances used by the population, with some countries reporting rising prevalence rates for that drug.
- The countries of North America, in particular the United States and Canada, continue to face a deadly opioid epidemic driven by the increasing availability of street drugs adulterated with fentanyls.
- In the United States, where the number of deaths from drug overdose exceeded 64,000 in 2016, the Government declared a national public health emergency in 2017.
- Governments and jurisdictions in North America have continued to pursue policies with respect to the legalization of the use of cannabis for non-medical purposes, in violation of the 1961 Convention as amended.
- The availability of cocaine appears to be growing in North America, as is cocaine abuse. In the United States, the number of overdose deaths where cocaine was reported as the underlying cause of death, with or without opioids present, increased by more than 50 per cent from 2015 to 2016.
- In South America, the Government of the Plurinational State of Bolivia adopted legislation in 2017 allowing for the cultivation of up to 22,000 ha of coca bush for traditional purposes, pursuant to its reservation to the 1961 Convention, even though that would amount to nearly double the area required according to the study conducted by the Government in 2013.
- In Colombia, the area under illicit coca bush cultivation increased by more than half, from 96,000 ha in 2015 to 146,000 ha in 2016. Following the signing of the Final Agreement for Ending the Conflict and Building a Stable and Lasting Peace in November 2016, the Government of Colombia and UNODC signed an agreement valued at approximately $315 million to monitor implementation of the country's policy to reduce illicit crop cultivation and strengthen alternative development programmes as a crucial part of the country's ongoing peacebuilding efforts.
- In Uruguay, contrary to the country's obligations under the 1961 Convention as amended, the Government began the sale of cannabis for non-medical use in pharmacies in July 2017.

- Illicit manufacture of methamphetamine and illicit markets for methamphetamine continue to expand in East and South-East Asia and pose serious challenges to supply and demand reduction in the region.
- Given the continuous emergence and rising use of new psychoactive substances in East and South-East Asia, greater attention and more resources should be devoted to collecting relevant data and providing treatment services.
- In South Asia, increases in the illicit manufacturing, trafficking and abuse of methamphetamine and the continued emergence of new psychoactive substances pose serious challenges to the Governments in the region.
- Trafficking in and the abuse of cannabis in South Asia remain a significant drug-related challenge, as do reported increases in heroin trafficking in much of the region.
- Drug trafficking from Afghanistan poses major challenges to drug control efforts of the countries in the West Asia region.
- Instability and continued conflict in the Near and Middle East have led to a significant increase in drug trafficking and abuse affecting many countries in the region.
- The number of new psychoactive substances detected in European countries continued to grow in 2016, although at a slower pace; not all detected new psychoactive substances remain on or are present on the market at all times.
- A number of European countries introduced controls on several new psychoactive substances that are not under international control.
- An increase in amphetamine seizures was reported in South-Eastern Europe in 2016, which may be related to the expansion of amphetamine trafficking in and through the Near and Middle East.
- In Oceania, large seizures of cocaine made through cooperation among Australia, New Zealand and Pacific island countries demonstrate the increased targeting of the Pacific island countries and territories by drug traffickers.
- Though the abuse of and trafficking in methamphetamine continues to pose a significant public health and law enforcement challenge in the region, a decrease in both seizures and the prevalence of the substance was observed in Australia in 2016.

A. Africa

1. Major developments

362. The illicit production of, trafficking in and abuse of cannabis, a major drug of concern in Africa, is a persistent challenge. While cannabis herb is illicitly cultivated in all subregions, illicit cannabis resin production remains limited to a few countries in North Africa. Seizures of cannabis resin reported by Morocco increased further in 2016 to nearly 237 tons, while Algeria and Egypt reported a significant decline in seizures.

363. Although cannabis remains the substance most widely abused in Africa, the abuse of cocaine, various opioids (including tramadol), amphetamine-type stimulants and emerging new psychoactive substances is reported to be growing. Drug use, in particular heroin abuse, also appears to have intensified in all subregions of Africa.

364. Trafficking in drugs frequently occurs in parallel with other illicit activities, such as trafficking in persons and arms, thereby worsening insecurity and instability across Africa. In South Africa, drug-related crime rates have increased by 11 per cent since the previous reporting period. Eight out of nine provinces in South Africa have experienced an upsurge in drug-related crime.

365. Transnational organized crime networks in Africa, including those involved in drug trafficking, are increasingly exploiting the Internet for their illicit activities. In Nigeria, the National Drug Law Enforcement Agency reported that various web pages and blogs had become the most common sources of drugs, and that drugs were increasingly advertised and traded online.

2. Regional cooperation

366. In November 2016, INTERPOL carried out an eight-day operation code-named "Adwenpa II" to reinforce border security in the West Africa subregion. The operation built on the success of the first operation "Adwenpa", which had been part of a capacity-building programme to strengthen border management in West Africa. "Adwenpa II" involved 28 key border crossing points between 14 countries: Benin, Burkina Faso, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo. It resulted, inter alia, in multiple seizures of cocaine, cannabis, heroin, methamphetamine and other drugs.

367. In 2016, UNODC, ECOWAS and the European Union launched a call for proposals for the funding of innovative drug prevention initiatives and pilot programmes. The initiatives and programmes that were selected were in Burkina Faso, Cabo Verde, Liberia, Mauritania, Sierra Leone and Togo. The main target group consists of young people. The grants were to enable civil society organizations to implement interventions and policies that the available scientific evidence has shown to be effective in preventing substance abuse, as outlined in the UNODC International Standards on Drug Prevention. Support was also provided to national authorities and institutions to promote intra-sectoral cooperation.

368. The second meeting of the African Union Specialized Technical Committee on Health, Population and Drug Control was held in Addis Ababa from 20 to 24 March 2017. Participants from 34 African Union member States, African Union organs, ECOWAS, United Nations agencies, intergovernmental and non-governmental organizations and cooperation partners attended. The African Union member States represented at the meeting were Algeria, Angola, Burkina Faso, Cameroon, Chad, the Comoros, the Congo, the Democratic Republic of the Congo, Egypt, Eritrea, Ethiopia, the Gambia, Guinea, Kenya, Lesotho, Mali, Mauritania, Morocco, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, South Sudan, Sudan, Swaziland, Togo, Tunisia, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. The ministers' meeting, which was part of the event, endorsed a number of recommendations, including: to consider and treat drug use disorders as health conditions; to fully develop and adopt national drug policies; to ensure that people who use drugs are provided with access to treatment and psychological services; to recognize the special risks that young women and girls face regarding drug use; and to include drug use prevention in core curricula of law enforcement and medical institutions in order to broaden the prevention workforce in Africa.

369. In January 2017, the African Union Mechanism for Police Cooperation (AFRIPOL) was officially created in Addis Ababa. AFRIPOL held its first general assembly in Algiers in May 2017. Participants from 45 African Union member States agreed on the adoption of a three-year workplan (2017–2019) that sets out strategic outcomes for various crime areas, including drug trafficking.

370. In March 2017, in Zanzibar, the representatives of the Triangular Initiative countries gathered for the first time with representatives of States of the African and Indian Ocean regions. The participating countries included six African States: Kenya, Madagascar, Nigeria, Seychelles, South Africa and the United Republic of

Tanzania. The meeting facilitated interregional sharing of experiences and best practices in detecting, investigating and disrupting the methods used by transnational organized crime groups to finance their activities.

371. The Twenty-seventh Meeting of Heads of National Drug Law Enforcement Agencies, Africa, was held in Hurghada, Egypt from 18 to 22 September 2017. Discussions focused on regional and subregional cooperation in countering drug trafficking. During the working groups, participants considered the following topics: effective measures to counter money-laundering and illicit financial flows; enhancing coordination of the regional communication platforms that support drug law enforcement across Africa; trafficking in new psychoactive substances, including khat (*Catha edulis*), benzodiazepines and tramadol, and law enforcement responses; and addressing the specific needs of women and girls in the context of the world drug problem.

3. National legislation, policy and action

372. In March 2017, Seychelles amended its Misuse of Drugs Act by inserting into Schedule I synthetic cannabinoids in any form.

373. In Somalia, the new national development plan 2017–2019, launched by the federal Government in November 2016, states that drug trafficking presents a major threat to the country's maritime security. The strategic geographic location of Somalia offers vast opportunities for illegal activities, including drug trafficking. The plan stresses that drugs are a serious problem affecting young people in Somalia today. The national development plan focuses on increasing economic opportunities for young people as a way of stopping those negative trends.

374. In May 2017, the parliament of Tunisia adopted Law No. 2017-39 amending Law No. 92-52 on narcotic drugs. The amendment provides for the repeal and replacement of article 12 of Law No. 92-52. Under the new article, judges, at their own discretion (as authorized by article 53 of the penal code), may choose not to impose the minimum jail sentence and fine provided for by Law No. 92-52. This applies only to consumption or possession of narcotics for personal use.

375. In February 2017, the Drug Control and Enforcement Authority of the United Republic of Tanzania formally replaced the Drug Control Commission as the leading organization for drug control in the country. The Authority was established under the Drug Control and Enforcement Act, 2015, which had replaced the Drugs and Prevention of Illicit Traffic in Drugs Act, 1995. The Authority has been entrusted with coordinating a national drug response and given the power to conduct investigations, seize drugs and arrest offenders.

4. Cultivation, production, manufacture and trafficking

(a) Narcotic drugs

376. Africa remains a key transit region for drug trafficking. Cannabis continues to present challenges on the continent. While cannabis herb is illicitly cultivated in all subregions, illicit cannabis resin production remains limited to a few countries, in North Africa in particular, with Morocco being reported most often the source country. Reportedly, most cannabis resin in North Africa is trafficked to Europe. On the other hand, the available information suggests that cannabis herb is trafficked mostly within Africa. Africa's relevance as a transit region for cocaine is also growing. While in previous years, West African countries were the main transit area for cocaine trafficking, North African countries are increasingly also being used as a transit route for cocaine originating in South America and on its way to Europe. According to UNODC, cocaine reaches Africa by various routes, but it mainly arrives directly from South America or indirectly via the Sahel region and West Africa or, to a lesser extent, via Europe. Opiates originating in Afghanistan are transiting through Africa, and then being trafficked onward to Europe, North America and other consumer markets.

377. In 2016, several African countries reported seizures of cannabis herb. Seizures reported by Egypt dropped by about 45 per cent in relation to the previous year, from 360 to 200 tons. Similarly, in Madagascar, reported seizures dropped by 62 per cent, from 8 to 3 tons, while in Zambia, the reported figures increased from 17 to 20 tons. Notable seizures of cannabis herb were also reported by Ghana (more than 2 tons), Kenya (almost 9 tons), Mozambique (more than 1 ton), Nigeria (more than 4 tons), and Sudan (45 tons).

378. In 2016, Morocco reported one of the largest seizures of cannabis resin worldwide, nearly 237 tons, compared to 235 tons in 2015. Most of the cannabis resin seized in Morocco was bound for European markets, in particular Spain and France, while some was meant for local consumption. Also, trafficking in cannabis by sea continues to be a major challenge for the Moroccan authorities.

379. Algeria and Egypt also once again reported large seizures of cannabis resin. However, the quantities reported by both Governments had significantly declined over the previous few years, in particular since 2013. In Algeria, seizures of cannabis resin declined to 109 tons in 2016, 14 per cent less than in 2015 (127 tons) and 48 per cent less than in 2013 (211 tons). It was estimated that 75 to 80 per cent of the cannabis resin was being trafficked through provinces located in the north-west of the country, including through maritime ports. The remainder, 20 to 25 per cent, was destined for local consumption. Egypt reported some 29 tons of cannabis resin seized in 2016, 12 per cent less than in 2015 (33 tons) and 65 per cent less than in 2013 (84 tons).

380. Various reports from European Union countries point to an emerging trafficking route for cannabis resin using Libya as a major transit hub. Cannabis resin originating from Morocco is increasingly being trafficked across the Mediterranean, mainly to Italy, and from there onwards to various other destinations. However, most cannabis resin leaving Morocco is still going to Spain, with only smaller amounts going to Italy, either directly or via Libya.

381. The data reported by African countries on the eradication of cannabis remain limited, therefore it is a challenge to assess their efforts in that regard. However, according to the information available, worldwide, Morocco ranked second and Nigeria third in terms of the areas of cannabis cultivation they had eradicated over the period 2010–2015. Although the area under cannabis cultivation in Morocco may have decreased in recent years as reported by the national authorities, yields seem to have stabilized owing to the introduction of high-yield varieties. New production techniques and high-potency plants have reportedly been introduced in Morocco recently. In addition, Kenyan authorities eradicated 12 ha of cannabis and seized 6,095 marijuana plants in 2016, while authorities of Zambia seized almost 40 tons of cannabis plants.

382. Africa's growing relevance as a transit region for cocaine was confirmed by a series of large cocaine seizures reported by various countries on the continent. UNODC considers that this development may be attributed to the expansion of the cocaine market worldwide.

383. Cocaine was mostly transported to Morocco from South America along commercial air and sea routes. For 2016, authorities in Morocco reported the largest quantity of cocaine ever seized in the country, totalling 1,621 kg, compared to 120 kg seized in 2015. In October 2017, Moroccan authorities reportedly seized 2.5 tons of cocaine in a single operation, taking place in two locations. The cocaine came from Brazil and was bound for countries in Africa and Europe. In addition, in January 2017, the country's Judiciary Police reported about 116 kg of cocaine seized in Tangier.

384. Tunisia also reported unprecedented seizures of cocaine from South America. Tunisia seems to be a transit as well as a destination country for South American cocaine. In September 2016, authorities in Brazil seized 602 kg of cocaine concealed in 18 bags of organic sugar placed in a container bound for the port of Tunis via Italy. In March 2017, more than 31.5 kg of cocaine were seized in the Mediterranean by the Tunisian Maritime Guard. In 2016, seizures of cocaine were also reported by Algeria (59 kg), Egypt (26 kg), Kenya (113 kg), South Africa (191 kg), the Sudan (10 kg) and Zambia (26 kg).

385. Other countries in Africa, including Djibouti, Ghana, Madagascar, Mali, Mozambique, and Nigeria also reported seizures of cocaine. In January 2017, police in Djibouti seized 500 kg of cocaine at the main port in a shipment originating from Brazil. According to the authorities, it was the biggest seizure of cocaine in Djibouti and in East Africa as a whole since 2004. In addition, Ghana seems to be an important transit country for cocaine destined for Europe, although seizures made in Ghana have declined and are now rather modest. In 2016, Ghana reported seizing 6 kg of cocaine (which had originated in Brazil), down from 465 kg seized in 2014 and 901 kg seized in 2013. In 2016, Madagascar and Mozambique reported modest amounts of cocaine being seized, with both countries reporting less than 1 kg each.

386. In Mali, in December 2016 and January 2017, the joint airport interdiction task forces established under the UNODC-INTERPOL-World Customs Organization (WCO) Airport Communication Project (AIRCOP) seized 2 kg of cocaine in Bamako that had originated in Latin America and was being trafficked to Europe. In 2016, Nigeria reported cocaine seizures totalling 82 kg.

387. Trafficking in opiates originating in Afghanistan via the southern route has continued, and the abuse of opiates in Africa has continued to increase. In South Africa, there were several cases in which heroin had been smuggled from Pakistan to be sent onward to the United States. However, most of the heroin trafficked into South Africa was intended for local consumption. In 2016, very few African countries reported seizures of heroin; they were Algeria, Egypt, Ghana, Kenya, Madagascar, Morocco, Mozambique, Nigeria, South Africa, the United Republic of Tanzania and Zambia. The quantities seized were between 30 grams and 816 kg. Between January and June 2017, authorities in the

United Republic of Tanzania seized more than 27 kg of heroin. Seizures of heroin trafficked from Africa were also reported by authorities in Europe. The Combined Maritime Forces, operating in the Indian Ocean off the coast of Eastern Africa, regularly make seizures of several hundred kilograms each. In May 2017, for example, the Royal Navy of the United Kingdom detected and destroyed 266 kg of heroin found in a freezer on a fishing boat.

388. In South Africa, abuse of the street-drug mixture "nyaope" although illegal since March 2014, is on the rise. Its main active ingredient is heroin, and it is highly addictive. "Nyaope" is usually wrapped in a cannabis leaf and smoked. The withdrawal symptoms are very severe. "Nyaope" is consumed mostly by young people from poor backgrounds, as it is more affordable than other drugs and easily available in townships and informal settlement areas.

(b) Psychotropic substances

389. In Morocco, officials reported the seizure of more than 1 million tablets of psychotropic substances in 2016.

390. Concern about methamphetamine manufactured in West Africa is growing. In the past few years, methamphetamine was smuggled to Asia and Oceania from various African subregions, primarily North, West and Central Africa. Organized criminal networks in Nigeria manufacturing and trafficking methamphetamine primarily target markets in South-East Asian countries. Between 1 November 2016 and 1 November 2017, the National Drug Law Enforcement Agency of Nigeria reported seizures of several drugs, including methamphetamine. The total amount of methamphetamine seized was 40 kg. In 2016, authorities of Kenya and South Africa reported methamphetamine seizures of 9 kg and 440 kg, respectively.

391. Operation "Lionfish", one of the operations led by INTERPOL, revealed a network of West African organized crime groups involved in methamphetamine trafficking. In total, more than 120 kg of methamphetamine were seized during the operation. A number of arrests were made as a result of specific intelligence-sharing. The arrests helped to identify a cocaine trafficking route via Ethiopia to the Middle East, Asia and the Pacific.

392. In 2016, the South African Police Service reported an increase in the number of clandestine laboratories manufacturing synthetic drugs, including methamphetamine, that are largely destined for the domestic market. East Asia and, to a lesser extent, South Africa are the main markets for methamphetamine manufactured in East Africa.

(c) Precursors

393. Because of the poor response rate for form D, reliable data for the region on seizures of substances listed in Tables I and II of the 1988 Convention and of substances not under international control remain limited or are non-existent. As at 1 November 2017, only 21 African countries returned form D for 2016, and in most cases data were either missing or insufficient. However, incidents communicated through PICS confirm that Africa continues to be affected by trafficking in precursor chemicals.

394. According to data communicated through PICS, between 1 November 2016 and 1 November 2017, the African countries involved in precursor-related incidents as countries of origin, transit or destination were Mozambique, Nigeria, South Africa and the United Republic of Tanzania. The main precursor communicated through PICS was ephedrine, which is used in the illicit manufacture of methamphetamine. Other precursors communicated were acetic anhydride (a key chemical in the manufacture of heroin), acetone and methyl ethyl ketone.

395. The available data suggest that South Africa remains a key destination for smuggled ephedrine and pseudoephedrine. In November 2016, the National Drug Law Enforcement Agency of Nigeria shared information through PICS about a single seizure it had made at Lagos airport of almost 84 kg of ephedrine destined for South Africa. The Narcotics Control Bureau of India seized 15 kg of pseudoephedrine, also destined for South Africa.

396. According to authorities in the United Republic of Tanzania, the diversion of precursor chemicals continued in 2017. One seizure of various chemicals included 25 litres of acetic anhydride that had originated in France. Other cases involving large quantities of precursor chemicals were still under investigation.

397. A comprehensive review of the situation with respect to the control of precursors and chemicals frequently used in the illicit manufacture of narcotic drugs and psychotropic substances in Africa can be found in the report of the Board for 2017 on the implementation of article 12 of the 1988 Convention.

(d) Substances not under international control

398. Trafficking in and abuse of substances not under international control remains a serious concern in a number of African countries. The available data suggest that the non-medical use of tramadol, a synthetic opioid

analgesic, is growing, as evidenced by seizures in Central, North and West Africa.

399. Increased abuse of tramadol was observed in the Sahel region. In 2016, more than 8 million tablets were seized in the Niger, which is particularly affected by tramadol misuse. Authorities in Nigeria reported seizing 3.1 tons of tramadol in 2016. Misuse has also increased in Libya, which is considered a major source of tramadol trafficked to Egypt. Drug seizures made in 2016 by Governments in West Africa as part of the UNODC Container Control Programme included more than 10 tons of tramadol. In Sudan, almost 700,000 tablets were seized in 2016.

400. In November 2017, Indian authorities reportedly seized a record 23.5 tons of methaqualone tablets. The raw materials for methaqualone were imported from Indonesia, and the final product was intended for delivery in Mozambique or South Africa. South African authorities reported seizing almost 4 tons of methaqualone in 2016.

401. Khat (*Catha edulis*) is a plant-based substance not under international control. Between 1 November 2016 and 1 November 2017, several incidents involving khat originating from African countries were reported. In 2017, authorities in Spain reported the seizure of two shipments of khat, one of 75 kg originating in Kenya and another of 100 kg originating in Ethiopia. In addition, authorities in Malaysia reported 10 incidents involving a total of 231 kg of khat originating from Ethiopia. Seizures were in the range of 8 kg to 78 kg per incident. Seizures of almost 11 tons of khat were reported by Sudan for 2016.

5. Abuse and treatment

402. Cannabis still remains the primary drug for which drug users seek treatment in Africa. Available data suggest that the annual prevalence rate of use of cannabis among Africans aged 15 to 64 continues to be high and is estimated to be 7.5 per cent, nearly double the global average. West and Central Africa are the subregions with the highest prevalence rates, estimated at 12.4 per cent. However, the true extent of drug abuse in Africa is unclear, as prevalence data are mostly outdated or unrepresentative, or are nonexistent. This applies to drug types other than cannabis as well.

403. Based on the limited data available, Africa seems to be experiencing a greater increase in heroin use than other regions. According to UNODC, Côte d'Ivoire, Kenya, Mozambique, Nigeria, South Africa, the United Republic of Tanzania and Zambia reported an increase in the abuse of heroin. Of those countries, Mozambique, Nigeria, South Africa and the United Republic of Tanzania also reported an increasing number of people seeking treatment for opioid use disorders. It is estimated that the annual prevalence of the use of opiates in Africa among people aged 15 to 64 is 0.30 per cent, or more than 2 million people, a rate comparable to the global average estimate of 0.37 per cent.

404. In Nigeria, drug abuse is on the rise, especially among women and young people. Moreover, treatment options are limited and drug users face stigma in their communities. Nonetheless, drug dependence treatment in Nigeria improved in the past years with the introduction of national minimum standards for drug dependence treatment and of a standard policy and practice guidelines for counsellors working with the National Drug Law Enforcement Agency. The strategies recommended by that agency for dealing with the rising rate of drug abuse included the orientation and education of young people, demand reduction, rehabilitation and the reintegration of drug-dependent individuals into society.

405. In June 2017, the Ministry of Health of Kenya launched a national substance disorders treatment protocol. Kenya is experiencing an increase in substance abuse. The upsurge in the abuse of drugs by injection can be attributed to increasing international drug trafficking coupled with the location of Kenya at a crossroads for international trade in the region. Statistics indicate that more than 50 per cent of drug users are aged 10 to 19, something that could have devastating effects on the socioeconomic development of the country and the health of its population. Evidence suggests that the strengthening of treatment services for substance abuse disorders and the constant improvement of those services play a crucial role in reducing the demand for drugs, HIV transmission among drug users and drug-related crime.

406. Health systems in most African countries do not have the resources or the capacity to ascertain the extent and patterns of drug use or to offer adequate drug abuse prevention and treatment services. However, in Burundi, Cabo Verde, Eritrea, Ethiopia, Kenya, Liberia, Madagascar, Mauritius, Mozambique, Nigeria, Senegal, Seychelles and the United Republic of Tanzania, drug dependence treatment has improved noticeably.

407. Opioid substitution therapy is now available in several African countries including Algeria, Kenya, Mauritius, Morocco, Senegal, South Africa and the United Republic of Tanzania. In addition, Egypt is contemplating a pilot project, and Seychelles is assessing a pilot project. According to the African Union, needle and syringe programmes for people who abuse drugs by injection are available in Kenya, Mauritius and the United Republic of Tanzania. Moreover, Morocco opened two new addiction centres in 2017, while

Egypt opened a drug treatment facility in Cairo. Since 2016, buprenorphine has been approved for use in Morocco, in addition to methadone. Similarly, Mauritius introduced the use of buprenorphine and naltrexone for relapse prevention, while Zanzibar, United Republic of Tanzania, initiated the use of methadone.

408. As of 31 December 2016, the Centre for the Integrated Management of Addiction, at the University Hospital of Dakar, had had 651 drug users apply to be enrolled in its opioid substitution treatment programme but admitted only 178 due to capacity restraints. The substitution drug used was methadone.

409. In February 2017, the only drug abuse treatment and prevention centre in Tunisia, "El Amal", reopened with the support of the Health Ministry. It had been closed several years ago. Its reopening strengthens the treatment of drug users in the country.

410. In 2016, a study was published on patterns of substance abuse among university students in South Africa. It found that current cannabis use stood at 17.3 per cent. Another study, also published in 2016, found that polydrug use among students in Botswana aged 10 to 19 combined illicit drugs and tobacco (26.6 per cent), alcohol, tobacco and illicit drugs (18.7 per cent), and illicit drugs and alcohol (12.3 per cent). In each case, males were more likely to have engaged in multiple substance use than females. Another finding was that the lifetime use of habit-forming substances was common in Botswana. The finding pointed to a need for immediate programme interventions.

411. Countries in Africa were still lagging behind in offering treatment for substance abuse. According to UNODC, only one third of countries in Africa are likely to have a budget allocated for treating substance abuse. Treatment and rehabilitation facilities, as well as basic drug-related treatment and health services were still scarce in many African countries. The bulk of the treatment provided was detoxification, sometimes with psychosocial support. Available facilities were generally poorly funded and had few qualified personnel. Care was usually provided in overcrowded psychiatric hospitals without specialized drug dependence services, or offered by non-monitored traditional healers and faith-based facilities.

B. Americas

Central America and the Caribbean

1. Major developments

412. The region of Central America and the Caribbean remains a major trans-shipment area for illicit drugs trafficked from producing countries in South America, notably for cocaine from Colombia and Peru being trafficked to destination markets in North America and Europe. According to the UNODC *World Drug Report 2017*, the Drug Enforcement Administration of the United States estimated that in 2015, 76 per cent of the cocaine departing South America transited the eastern Pacific, often by ship or semi-submersible vessel, entering Central America or Mexico before being transported overland to the United States. The Dominican Republic is the primary transit area for cocaine in the Caribbean subregion.

413. A study published in May 2017 estimates that 15 to 30 per cent (1,500 to 3,000 ha) of the forest loss in Guatemala, Honduras and Nicaragua in the past decade was caused by cocaine trafficking. Of that forest loss, 30 to 60 per cent occurred within nationally or internationally protected areas. Such deforestation due to cocaine trafficking has been observed throughout the subregion but is less severe in the other countries of Central America. The study links drug trafficking to land purchases for illegal logging and cattle farming in order to launder money. Additionally, the construction of secret roads and clandestine airstrips to facilitate the movement of illicit drugs is cited as a factor contributing to forest loss.

2. Regional cooperation

414. At the twenty-seventh Meeting of Heads of National Drug Law Enforcement Agencies, Latin America and the Caribbean, participants assessed the regional drug trafficking situation and conducted follow-up to the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, as well as a review of the implementation of Commission on Narcotic Drugs resolution 60/1. Additionally, participants considered several topics including regional communication platforms to support drug law enforcement; links between illicit drug trafficking and other forms of organized crime; alternatives to imprisonment for certain offences, such as demand reduction strategies; and measures to respond to the specific needs of children and youth in order to prevent and treat abuse and address their involvement in drug-related crime.

415. At its sixtieth regular session, held in the Bahamas in November 2016, the Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States (OAS) adopted the Hemispheric Plan of Action on Drugs, 2016–2020. The Plan of Action builds upon previous strategies and identifies five strategic areas for action: institutional strengthening, demand reduction, supply reduction, control measures and international cooperation.

416. El Salvador, Guatemala and Honduras signed a tripartite security agreement in November 2016 creating the Tri-national Task Force. Under the agreement, the three "Northern Triangle" Governments committed to cooperating and coordinating, until 15 November 2017, in seven areas including organized crime, border security, drug trafficking and customs issues.

417. In July 2017, at the third technical meeting on combating drug trafficking between drug enforcement authorities of Cuba and the United States, officials signed a bilateral agreement to strengthen cooperation between the two Governments to combat trafficking in narcotic drugs and psychotropic substances.

418. Panama, pursuant to its Law No. 21 of 1 July 2016, is now working to harmonize its policy and actions with Peru in an effort to prevent and control the illicit production and trafficking of narcotic drugs and psychotropic substances. Additionally, the law provides support for prevention efforts and the rehabilitation of those affected by drug abuse. Similarly, in November 2016, Panama promulgated Law No. 62, which coordinates policy with Paraguay to combat illicit drug trafficking and drug abuse.

419. According to UNODC, Governments in the region have increased their participation in the UNODC/WCO Container Control Programme. The Governments of Cuba, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica and Panama all participate in the programme, which has been further expanded to include not only marine cargo but also air cargo. In 2017, the Container Control Programme contributed to the seizure of over 35 tons of cocaine and 200 kg of cannabis across Latin America and the Caribbean.

3. National legislation, policy and action

420. In April 2017, the Government of Saint Kitts and Nevis established the National Commission on Cannabis, consisting of stakeholders from the education, health, law enforcement, banking and religious sectors. The mandate of the Commission is to research the various implications of the potential decriminalization of cannabis in the country.

421. The Cannabis Licensing Authority of Jamaica, established by the Dangerous Drugs (Amendment) Act of 2015, began issuing conditional approvals for licences to operate for several growers and processors of cannabis in the country. The Cannabis Licensing Authority anticipates that legal commercial production of cannabis can begin by the end of 2017.

422. In March 2017, the Government of the Bahamas released its National Anti-Drug Strategy for 2017–2021. The Strategy establishes a common framework for all drug control efforts and activities in the Bahamas and incorporates elements from the CICAD Hemispheric Plan of Action on Drugs, 2016–2020, the recommendations set out in the outcome document of the thirtieth special session of the General Assembly on the world drug problem, held in 2016, and the 2030 Agenda for Sustainable Development. A key change from the previous five-year anti-drug strategy is the shift towards a public health approach, instead of a criminal justice approach, in dealing with the national drug problem.

423. Lawmakers in Costa Rica have enacted a series of new laws and reforms to their national legislation and control procedures. Law No. 9449 of May 2017 reforms several articles of the country's Law No. 7786. The reforms tighten procedures for monetary transactions carried out by financial institutions and professionals in order to combat the laundering of money from illicit activities.

424. The Senate of the Dominican Republic approved new legislation to counter money-laundering and the financing of terrorism. The legislation repealed the earlier Law No. 72-02 on the laundering of proceeds of crime from drug trafficking and established a new regulatory framework for financial institutions. The new legislation also updated the categories of money-laundering offences and the financing of terrorism, together with the applicable sanctions.

425. El Salvador has established a new five-year national anti-drug strategy incorporating human rights, gender equality, and science-based evidence. The strategy was developed in consultation with 17 institutions of El Salvador in the areas of demand and supply reduction, control of substances, money-laundering and international cooperation. Additionally, the Government is reforming its legislation on money-laundering and the laundering of assets, with the assistance of UNODC, in line with the new strategy.

426. In January 2017, the Government of Honduras enacted the Law on the Financing, Transparency and Auditing of Political Parties and Campaigns, which was developed with the assistance of the Mission to Support

the Fight against Corruption and Impunity in Honduras. The legislation allows for reduced sentencing for minor offences for persons cooperating with authorities in cases against criminal gang leaders and those involved in corruption.

427. Panama deployed Joint Task Force Eagle, an anti-narcotics and anti-crime force, in March of 2017. The task force consists of some 300 law enforcement officials across the country, including national police, the border service, the National Air and Naval Service, and agents of the Ministry of Public Security. The Government cites the need for the force due to the increased manufacture of cocaine in Colombia. Units of the task force are deployed to trouble spots in cities and neighbourhoods throughout the country to combat gangs and criminal networks involved in drug trafficking and other criminal activity.

428. **The Board wishes to draw the attention of all Governments in the region to the fact that measures permitting the use of cannabis for purposes other than medical or scientific use are contrary to the provisions of the 1961 Convention.**

429. **The Board welcomes the efforts by Governments in the region that are working to strengthen cooperation among themselves in combating drug trafficking.**

4. Cultivation, production, manufacture and trafficking

(a) Narcotic drugs

430. The principal problem in Central America and the Caribbean is drug trafficking — primarily cocaine trafficking — and not drug production and manufacture, except for the production of cannabis in some countries. Governments in the region are responding by strengthening cooperation among themselves and the capacity of law enforcement officials to combat the criminal networks driving drug trafficking.

431. According to seizure data from official reporting, trafficking of cocaine in Central America remained stable in 2015 in comparison with previous years, with 86 tons of cocaine seized. Available data for 2016 indicate a marginal decrease in total cocaine seizures in the region, and the flow patterns may have varied, as Panama reported a major increase in cocaine seizures and Honduras reported a significant drop in seizures, in comparison with 2015. Cocaine trafficking rates in the Caribbean in 2016 were comparable to those of 2015, and the rate of interdiction by Governments and international partners also remains high. The Dominican Republic continues to be one of the main Caribbean transit hubs for illicit substances destined for markets in Europe.

432. Of the 70 tons of illicit substances seized by Panama authorities in 2016, 65 tons were cocaine. That was a significant increase of 25 per cent, as Panama had reported just over 52 tons of cocaine seized in 2015. Authorities in Panama reported that despite their improved capacity to combat drug trafficking, the overall drug problem in the country continued to worsen, with drug-related violence and crime, as well as money-laundering of drug trafficking profits in the banking sector, on the rise.

433. The seizure of cocaine in Honduras saw a sharp drop, with 735 kg seized in 2016, down from 2,032 kg seized the previous year. Seizures of "crack" cocaine nearly doubled, from 3,665 pieces in 2015 to 6,401 pieces in 2016. The Honduran Government believes that the rise in "crack" cocaine seizures is due to an increased number of illicit domestic drug laboratories, in addition to an increase in trafficked chemical precursors.

434. The national authorities of Guatemala reported a significant increase in the amount of cocaine seized in 2016, which totalled 12.8 tons, more than double the 6.1 tons seized in 2015. Seizures of "crack" cocaine saw a decrease in the country, from 6.12 kg in 2015 to 5.24 kg in 2016. Authorities also reported a significant increase in the amount of heroin seized, which rose from 83 kg in 2015 to 143 kg in 2016. The country's authorities noted that the modality of trafficking has changed significantly, as traffickers have shifted from using commercial cargo containers to using speed boats.

435. Costa Rica reports that it is no longer only a transit country for illicit drug shipments but that, based on seizure information, it has now become also a temporary holding point for illicit drugs before their final shipment to destination markets. Additionally, authorities report that they continue to find cannabis plantations in rural and urban areas and believe that most local cannabis production is for domestic consumption. Furthermore, authorities underscored that the country's geography is an enabling factor for drug traffickers and that the terrain of the country's border regions makes drug trafficking interdiction particularly challenging.

436. The Dominican Republic registered an increase in cocaine seizures from the end of 2015 through the first half of 2016, probably due to an increased trafficking flow, but also as a consequence of higher rates of

interdiction. Authorities report that captains of Dominican vessels, posing as licensed fishermen, travel beyond the country's territorial waters in order to facilitate the movement in the high seas of illicit drugs originating in South America, by transferring cocaine shipments to vessels bound for destination markets in North America and Europe.

437. According to the El Salvador national drug report for 2016, over the period 2011–2015, there was a considerable increase in cocaine seizures, from 649.7 kg in 2011 to 3,057.6 kg in 2015. The report suggests that this indicates an increase in the trafficking of drugs through the country, in particular via speedboats on the Pacific coast.

438. In February 2017, the Coast Guard of Trinidad and Tobago, in a joint operation with the United States Coast Guard, seized 4.2 tons of cocaine off the coast of Suriname with an estimated value of $125 million. Local authorities considered the seizure to be one of the largest in the Atlantic basin since 1999.

439. Law enforcement authorities in the Bahamas seized a total of 7,252.9 kg of cannabis and 700 kg of cocaine in 2015. Seizures of cannabis were down by 22 per cent compared with 2014, but cocaine seizures increased by 66 per cent. Local authorities reported no heroin seizures in the Bahamas in 2015.

440. The Royal Netherlands Navy and the United States Navy, in several joint interdictions in the first half of 2017, seized over 1.1 tons of cocaine from speedboats. Seizures occurred in the southern Caribbean Sea in the waters between Curaçao and Colombia.

441. Grenada reported that the trafficking of cocaine in the country continues to decline, with 12 kg seized in 2016, from a previous high of 71 kg in 2014. In 2016, the country's law enforcement authorities also seized 1,421 kg of cannabis, over 6,000 cannabis plants and 640 grams of "crack" cocaine, and reported no seizures of opioids.

442. Honduras reported a major decline in the amount of cannabis seized, with 155 kg seized in 2016 in comparison with 2,363 kg seized in 2015. However, seizures of cannabis plants rose to 24,253 units in 2016 from 10,072 in 2015.

443. Guatemala reported a major increase in cannabis seizures in 2016, with 1.5 tons seized. That was more than a fourfold increase from 2015, when 347 kg were seized. Guatemalan authorities noted a similar increase in the number of cannabis plants seized, with 3.1 million plants seized in 2016, compared with 692,000 plants seized in 2015.

444. In El Salvador, there has been an increase in the number of young people prosecuted and tried for possession of drugs, rising from 396 cases in 2011 to 1,013 cases in 2015. Of those, 98 per cent of individuals detained for drug possession were young men between 15 and 24 years of age who were found in possession of cannabis. Authorities of El Salvador note that the country does not have large-scale cannabis production; however, there is evidence that cannabis is being trafficked from neighbouring countries for distribution on the local market.

445. Jamaica reported being a major trans-shipment area for drugs from South America destined for the United States and Europe. It also reported that corruption of law enforcement officers and staff at ports and airports facilitated trafficking and complicated interdiction. National authorities continue to make efforts to combat corruption through arrests and prosecutions.

446. Three primary trans-shipment routes have been identified in Honduras that enable the trafficking of drugs from South America to markets in North America. Honduran authorities indicate that the most frequently used route is by air through the country. Coastal routes along the Atlantic are also used to move illicit substances through the country. In border regions, both land and sea routes are typically used. Authorities also note difficulty in tracking illicit drug movements as traffickers have begun using microtrafficking techniques in the Caribbean region of Honduras, masking trafficking activity by using local fishing boats as cover.

447. The national authorities of Guatemala declared a state of emergency in the municipalities of Ixchiguán and Tajumulco, in the Department of San Marcos, initially for 30 days in May 2017. The declaration was issued to restore control after talks over land control between local communities in the area broke down, followed by violent clashes. National authorities believe that the cultivation of opium poppy and cannabis was one of the causes of the conflict. The state of emergency was finally lifted on 8 August 2017 after law enforcement officials eradicated more than 300,000 cannabis plants and nearly 360 million opium poppy plants. A police presence is being maintained in the province while the national authorities mediate disputes between local community leaders.

(b) Psychotropic substances

448. On the basis of available information, the production of and trafficking in psychotropic substances does not appear to pose a significant challenge in the region, as few countries report significant seizures.

449. In the Bahamas, seizures of 3,4-methylenedioxymethamphetamine (MDMA, commonly known as "ecstasy") tablets more than doubled in 2015, to 195 tablets, from the annual average of 54 tablets over the period 2010–2013. In 2014, the Government made an exceptional seizure of 18,000 tablets of MDMA.

450. In Guatemala, authorities discovered that an abandoned laboratory had been used for the clandestine manufacture of amphetamine-type stimulants, although the amounts or specific substances manufactured could not be determined. Equipment at the site had trace amounts of precursors, indicating that the substances were in the early stage of production.

451. Local authorities in Honduras reported the discovery of two clandestine laboratories for the manufacture of amphetamine-type stimulants, along with other illicit substances. It was the first official report of amphetamine-type stimulants being illicitly manufactured in the country.

(c) Precursors

452. The Government of Costa Rica reported that precursor substances were not manufactured in the country, with the exception of some substances extracted from calcium carbonate, but that authorities were closely tracking the movement of precursors in the country. Authorities noted that the lack of strong international cooperation and coordination hindered efforts to track the cross-border movement of precursor chemicals, making it more difficult to prevent diversion.

453. In recent years, several countries in the region have been subject to trafficking in precursors for the illicit manufacture of drugs. In some cases, the trafficked precursors were for the supply of domestic clandestine laboratories manufacturing cocaine or amphetamine-type stimulants. In other cases, the precursors were trafficked from Guatemala and Belize to Mexico. A comprehensive review of the situation with respect to the control of precursors in the region can be found in the report of the Board for 2017 on the implementation of article 12 of the 1988 Convention.

(d) Substances not under international control

454. In 2017, the Board of Narcotic Drug Surveillance of the Ministry of Health of Costa Rica reported having placed ketamine on its schedule of controlled psychotropic substances as of December 2015, and specific measures regarding the trade and movement of ketamine were implemented in July 2016.

455. **The Board wishes to thank Governments in the region for their continued interdiction and control efforts to combat the illicit production of and trafficking in substances under international control.**

5. Abuse and treatment

456. Cannabis is the most widely abused drug in the region, although other narcotics are abused at lower levels of prevalence. Prevalence rates for abuse of psychotropics and other stimulants are very low, and they account for only a small fraction of persons treated for drug abuse. In the region, governmental efforts for drug abuse prevention focus on public information campaigns and similar initiatives. The ability of Governments to provide comprehensive treatment options for persons abusing drugs is limited by structural issues in many medical systems, technical capacity and inadequate financing. In addition, many countries in the region have no country-wide prevalence studies on illicit drug abuse and treatment among the general population.

457. According to the *World Drug Report 2017*, the annual prevalence of the use of cannabis in the Caribbean is estimated at 2.1 per cent of persons aged 15–64 years, opioid use is estimated at 0.24 per cent, and opiate usage at 0.15 per cent. The prevalence of cocaine use is estimated at 0.61 per cent in Central America and at 0.62 per cent in the Caribbean. For amphetamines and prescription stimulants, the prevalence rate is estimated at 0.71 per cent in Central America and at 0.86 per cent in the Caribbean. Annual prevalence of use of "ecstasy" is the lowest among controlled substances, estimated at 0.06 per cent in Central America and 0.16 per cent in the Caribbean.

458. In Costa Rica, according to the fourth national survey on drug use among the secondary education population in 2015, published in 2017, the age of onset of use of tranquilizers and stimulants without a prescription was 13 years of age. The main source of tranquilizers and stimulants obtained without medical prescription was found to be the student's home. Prevalence of cannabis use was found to be the same for males and females, in contrast with previous surveys that found greater prevalence among males. Prevalence of cocaine consumption was low throughout the country.

459. Costa Rican authorities report that in 2016 approximately 3.3 per cent of the population between 12 and

70 years of age needed treatment for drug abuse. That was a threefold rise from 2011, when official reporting identified 1.1 per cent of the population as requiring treatment. Of treatment services provided, approximately 86 per cent were inpatients, with the remaining 14 per cent being outpatients. Among persons receiving treatment, 87 per cent were receiving treatment for the first time. Cannabis (59 per cent) and cocaine (38 per cent) accounted for the vast majority of drug abuse cases of those being treated. Local authorities noted the lack of methadone clinics to treat people dependant on opium-derived substances. Additionally, lack of funding, training and institutional weakness were cited as challenges to delivering drug abuse treatment.

460. While Grenada has no prevalence data to track usage rates among the general population, authorities reported that the vast majority of people admitted to hospitals and treatment centres for drug abuse were males abusing cannabis.

461. The Institute on Alcoholism and Drug Dependency of Costa Rica launched a prevention campaign targeting primary age schoolchildren called "Learn to fend for myself". The Institute initiated several other programmes in Costa Rica to promote drug abuse prevention in the workplace, as well as several media-based prevention campaigns across the country, including the television miniseries "La Urba".

462. Based on reporting by the Government of Honduras, a host of drug prevention and intervention activities for both the general population and at-risk groups have been enacted. Preventative campaigns were conducted, in particular for the International Day against Drug Abuse and Illicit Trafficking. Additionally, vocational programmes were promoted as an alternative to drug abuse through various community networks in the country.

463. Honduras reported that it provides some drug treatment services with limited coverage to the local population, but no such services to prison populations. A lack of funding was cited as the primary reason for the limited expansion of drug treatment programmes, with the lack of qualified personnel and infrastructure being an additional contributing factor.

464. The Narcotics Division, the principal anti-narcotics unit of the Jamaica Constabulary Force, implemented a demand reduction programme aimed at reducing demand for "hard drugs" and deterring individuals from participating in the illicit drug trade. Staff of the Narcotics Division implemented the programme nationwide, in various venues including universities, schools, churches and community centres.

465. Panama's health system is still undergoing structural changes to address the needs of drug abusers and their rehabilitation. The National Commission for the Study and Prevention of Drug-related Crime (CONAPRED) is the lead entity coordinating the changes, while hospitals, clinics and other providers in the national health system are responsible for implementation.

466. In May 2017 a national workshop in Panama, organized by the Ministry of Health along with the Pan American Health Organization, was held to address the problematic use of psychoactive substances in the country. The workshop established new guidelines to update public health policy with respect to psychoactive substances and identified competencies necessary to strengthen the public health sector's response.

467. **The Board recommends that countries in the region that have not yet done so should produce or update prevalence studies according to internationally recognized parameters and use the results to inform the development and adoption of targeted drug demand reduction policies and programmes.**

468. **Additionally, the Board encourages countries in the region to enhance their capacity to treat persons using drugs and encourages the international community to provide assistance to help develop cost-effective drug rehabilitation programmes and services tailored to the individual needs of countries in the region.**

North America

1. Major developments

469. The proliferation of illicit fentanyls and the growing volume of fentanyls and opioids being shipped to North America by mail were major causes for concern in 2016, especially because the overall volume of international packages in general and of international packages containing fentanyls in particular continued to grow, as did global illicit supply. The prevalence of counterfeit prescription pills and of heroin and other illegal drugs containing deadly levels of fentanyl have led to substantial increases in the numbers of overdoses and deaths. Faced with this region-wide opioid crisis and overdose epidemic, the countries of North America are urgently adopting new plans, measures and legislation to combat it. In the United States, the reported number of drug overdose deaths in 2016 exceeded 64,000, with the sharpest increase being the

number of deaths related to fentanyl and fentanyl analogues (synthetic opioids), at over 20,000 overdose deaths.

470. Legislation and policy pertaining to cannabis continue to shift throughout North America. Changes to national and local laws are expected to continue throughout 2017 and into 2018, with noticeable effects on availability and demand. Public health campaigns to prevent drug abuse among young people are also expected to continue. Meanwhile, the scope for acceptance of supervised drug consumption sites is widening, especially in Canada.

2. Regional cooperation

471. Effective cooperation in law enforcement matters and in combating illicit drug manufacture and trafficking continue to be promoted through regional mechanisms for North America. Canada, Mexico and the United States have been participating in the "North American dialogue on drug policy" initiative since its inaugural meeting in October 2016. At the North American Leaders' Summit in June 2016, the Presidents of Mexico and the United States and the Prime Minister of Canada agreed that the "North American dialogue on drug policy" should be held on an annual basis and that its purpose was to exchange information on drug trends, increase trilateral coordination on drug policy and develop initiatives to protect the citizens of Canada, Mexico and the United States from harmful drugs and drug trafficking.

472. Under the "Five eyes law enforcement group" initiative, United States federal law enforcement authorities, in cooperation with Canada, have initiated "Operation Hyperion" to develop a unified response to the growing use of the darknet by individuals trying to buy and sell illegal drugs. The aim is to identify new smuggling networks and trends, including for synthetic drugs.

3. National legislation, policy and action

473. On 19 June 2017, the President of Mexico signed a decree to amend the general health law and the federal penal code, giving authority to the Ministry of Health to regulate research into and the production of pharmacological derivatives of cannabis and their medical use. The decree institutes a legal framework for the cultivation, production, distribution and delivery of cannabis for medical and scientific purposes.

474. In December 2016, the President of the United States signed into law the Twenty-first Century Cures Act, which provides for grants to help states and territories to combat opioid addiction. Funding is awarded on the basis of the number of overdose deaths and unmet addiction treatment needs.

475. In the United States, executive order No. 13767 on border security and immigration enforcement improvements was issued in January 2017. The executive order focuses on stopping the activities of transnational criminal organizations operating on both sides of the southern border and prioritizes the immediate construction of a physical wall with the aim of preventing drug trafficking, among other things.

476. On 29 March 2017, the President of the United States established the Commission on Combating Drug Addiction and the Opioid Crisis. The Commission focused on assessing the availability of and access to addiction treatment and overdose reversal services, and on identifying areas of the country that were underserved. The Commission also considered the effectiveness of state prescription drug monitoring and evaluated state prescription practices. Action to address the opioid epidemic has also been taken at the level of the federal states. In March 2017, the Governor of Ohio announced new opioid prescription limits aimed at reducing prescription drug abuse. On 26 October 2017, the President of the United States declared a national public health emergency to tackle the opioid overdose crisis in the country. Under the Public Health Services Act, no additional federal funding will automatically be made available to tackle the crisis, but federal agencies will be directed to allocate more of their existing budgetary resources for that purpose and to take action to overcome bureaucratic delays and inefficiencies. It was reported that the Federal Government would work with Congress to provide funding for the Public Health Emergency Fund and increase federal funding in year-end budget negotiations taking place in Congress at the time of the announcement. On 1 November 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis presented its final report, which lists 56 recommendations, including measures to expedite federal funding for state governments; the implementation and assessment of evidence-based programmes; and the immediate and complete elimination by the Department of Health and Human Services of patient pain evaluation questions from assessments conducted by health-care providers. The report also encourages the Federal Government to establish drug courts in every federal judicial district, adjust reimbursement rates for addiction treatment and streamline federal funding used by state and local governments to implement drug treatment and prevention programmes. In addition, it recommends making changes to reimbursement rates set by federal addiction treatment

providers, allowing more emergency responders to administer naloxone and tightening requirements for prescribers. It further recommends that the Administration support the Prescription Drug Monitoring Act of 2017, which mandates states that receive grant funds to comply with the requirements of the Act, including data sharing, and directs the Department of Justice to fund the establishment and maintenance of a data-sharing hub. The Act also mandates the establishment and implementation of prescription drug monitoring programmes by states that receive federal funding to deal with the opioid crisis, imposes strict prescription drug monitoring requirements, such as a 24-hour reporting requirement following dispensation of a controlled substance, and helps to facilitate data-sharing across states. The Commission also recommended that the Administration develop a model training programme to be disseminated at all levels of medical education (including among all prescribers) on screening for substance use and mental health status to identify at-risk patients; that the Controlled Substance Act be amended to require all Drug Enforcement Administration registrants to undertake training in the proper treatment of pain; and that the Department of Health and Human Services be required to ensure additional training opportunities, including continuing education courses for staff.

477. Also in the United States, the Food and Drug Administration approved several abuse-deterrent opioid formulations, but their effectiveness in preventing the abuse of prescription opioids has been questioned. In June 2017, the Food and Drug Administration announced that it would evaluate the impact of abuse-deterrent opioid formulations on the opioid epidemic. It also requested the withdrawal of some opioid formulations from the market after determining that their public health benefits no longer outweighed the risk of abuse.

478. In July 2017, the Department of Justice and the Medicare Fraud Strike Force in the United States announced the largest enforcement action against health-care fraud. A total of 412 defendants across 41 federal districts were indicted for participation in fraud schemes, and more than 120 defendants, including doctors, were indicted for their roles in illegally prescribing and distributing opioids and other narcotics.

479. In December 2016, the Minister of Health of Canada announced the "New Canadian drugs and substances strategy", replacing the former national anti-drug strategy. One of the main aims of the strategy is to reduce the harm associated with drug abuse, as part of the Government's efforts to confront the current opioid crisis. Support for supervised consumption sites and increased access to naloxone are part of the strategy.

480. Also in Canada, in May 2017, Bill C-37 received royal assent. The Bill amended the Controlled Drugs and Substances Act, the Customs Act and the Proceeds of Crime (Money Laundering) and Terrorist Financing Act. The purpose of the amendment was to better equip both health-care and law enforcement officials to reduce the harms associated with drug and substance use in Canada. The Bill will simplify the process of applying for permission to open a supervised consumption site, prohibit the unregistered importation of certain devices that may be used to illicitly manufacture controlled substances, amend the Customs Act to allow border officers to open mail weighing 30 grams or less to prevent fentanyl from entering the country illicitly through the mail system, and allow accelerated temporary scheduling of new and dangerous substances. Applications for new supervised consumption sites are being received by Health Canada from many provinces, including Alberta, Ontario (Toronto and Ottawa), and a third site is set to open in Quebec (Montreal) in the autumn of 2017.

481. **The Board wishes to remind Governments that the operation of supervised injection sites should be consistent with the international drug control conventions and that certain conditions must be respected. The objective of such sites should be to reduce the adverse consequences of drug abuse through the provision of, or active referral to, treatment and rehabilitation services, and social reintegration measures. Supervised injection sites should not replace demand reduction programmes, particularly prevention and treatment activities.** While recognizing that the sites may reduce the adverse consequences of drug abuse through treatment, rehabilitation and reintegration, due consideration must be given to preventing any encouragement of drug abuse and to preventing drug trafficking in and around the sites.

482. At the end of November 2016, Canada's task force on cannabis legalization and regulation published its final report. The report contained advice on the design of a framework for the legalization, regulation and restriction of access to cannabis. Along with research by other ministries, such as that reflected in *Measuring Illicit Cannabis Seizures in Canada: Methods, Practices and Recommendations,* the final report of the task force was part of the Government's data collection effort in advance of measures to legalize access to cannabis in July 2018. Bill C-45, introduced by the Minister of Justice and Attorney General of Canada on 13 April 2017, would permit the non-medical use of cannabis. If the bill is enacted, adults aged 18 years or older will legally be allowed to possess up to 30 grams of dried cannabis or an equivalent amount in non-dried form. It will also become legal to grow a maximum of four cannabis plants

simultaneously for personal use, buy cannabis from licensed retailers, and produce edible cannabis products. **The Board wishes to reiterate that article 4 *(c)* of the 1961 Convention restricts the use of controlled narcotic drugs to medical and scientific purposes and that legislative measures providing for non-medical use are in contravention of that Convention.**

483. Also in Canada, the Precursor Control Regulations were amended on 18 November 2016 through the addition of six fentanyl precursors to Schedule IV of the Controlled Drugs and Substances Act. The goal of the amendment was to help to protect the health and safety of Canadians by instructing law enforcement agencies to take action against any person who imports, exports or possesses precursor chemicals without proper authorization.

484. On 4 May 2017, the Good Samaritan Drug Overdose Act became law in Canada. Together with the "New Canadian drugs and substances strategy", the Act provides some legal protection for people who experience or witness an overdose and call the emergency services. The aim of the Act is to reduce the country's growing number of overdoses and deaths caused by opioids by protecting people who call the emergency services from criminal punishment, such as for simple possession.

4. Cultivation, production, manufacture and trafficking

(a) Narcotic drugs

485. North America continues to face an opioid and fentanyl crisis of unprecedented proportions. Large quantities of counterfeit prescription medicines contain various sorts of fentanyls, including carfentanil and other analogues that present a serious threat of overdose and loss of life. Since 2014 there also appears to be a growing trend of clandestine pill press operations working with fentanyls across North America. There have been multiple seizures of fentanyl. Although the quantities were small in terms of their weight, they represented millions of potentially lethal doses being sold on the streets in counterfeit pill form or mixed into other drugs of abuse.

486. The most significant and expanding drug threats to the region continue to be the increasing and widespread availability of heroin, the contamination of heroin with fentanyl and its analogues and the abuse of controlled prescription drugs. Most of the heroin available in the United States comes from Mexico and Colombia as the cultivation of opium poppy and the production of heroin in Mexico continue to rise. Between July 2014 and June 2015, about 9 per cent of opium poppy worldwide was cultivated in Mexico. In contrast to the United States, Canada is typically the end point of the opiate and heroin trafficking routes from Pakistan and India, with seizures indicating South-West Asian origins. There are indications that Mexico is sometimes a trans-shipment point for fentanyls from China. The quantity of fentanyl seized by United States Customs and Border Protection increased from just under 1 kg in 2013 to approximately 200 kg in 2016.

487. In 2016, seizures of cocaine along the south-western border of the United States increased compared with 2015. Cocaine availability was likely to continue to increase in 2017, and Colombia remained the primary source country. Most cocaine was being smuggled into the United States over the south-western border. In 2016, the Canadian Armed Forces assisted in the seizure of or the disruption of the trafficking in approximately 5,750 kg of cocaine. Nonetheless, in 2016, drug offences involving cocaine continued to decline in Canada for the fourth consecutive year and were 8 per cent lower than in 2015.

488. The situation pertaining to cannabis cultivation and trafficking in North America continues to be in flux owing to the widening scope of personal non-medical use schemes in force in certain constituent states of the United States. The decriminalization of cannabis has apparently led organized criminal groups to focus on manufacturing and trafficking other illegal drugs, such as heroin. This could explain why, for example, Canada saw a 32 per cent increase from 2015 to 2016 in criminal incidents involving heroin possession. The United States saw increased domestic cultivation of cannabis leading to an overall increase in its availability. Canada's rates of cannabis-related drug offences declined for the fifth consecutive year in 2016; the overall offence rate for possession of cannabis declined 12 per cent from 2015.

(b) Psychotropic substances

489. The *World Drug Report 2017* refers to a growing concern about methamphetamine production, trafficking and abuse in North America. The availability of methamphetamine produced in Mexico appears to be increasing: 26,044 kg were seized in 2016 along the south-western border of the United States, in comparison with 19,202 kg the year before. This increase follows the continued decrease in domestic methamphetamine production in the United States, along with some increases in liquid methamphetamine seizures near the south-western border.

490. In Canada, the rates of criminal possession of methamphetamine increased by 22 per cent in 2016. However, criminal possession of "ecstasy" declined by 40 per cent in 2016. Trafficking, production and distribution crimes declined by 18 per cent from the previous year. According to the *World Drug Report 2017*, Canada continued to be a source and transit country for "ecstasy" destined for the United States and other international markets, while Asian organized criminal groups were active in the cross-border smuggling of large quantities of "ecstasy" between Canada and the United States.

(c) Precursors

491. In 2016, a total of 5,549 operational clandestine laboratories were seized in the United States, of which 5,078 were methamphetamine laboratories. In the first half of 2016, forensic profiling showed that 94 per cent of the methamphetamine tested in the United States had been produced according to the so-called P-2-P method. That number increased to 98 per cent in the second half of 2016. A large proportion (51 per cent in the first half of 2016, and 66 per cent in the second half of that year) had been obtained through the new P-2-P production process in Mexico, also known as the nitrostyrene method, using nitroethane and benzaldehyde as the main precursors.

492. A detailed analysis of the situation with respect to the control of precursors and chemicals frequently used in the illicit manufacture of narcotic drugs and psychotropic substances in the region can be found in the report of the Board for 2017 on the implementation of article 12 of the 1988 Convention.

(d) Substances not under international control

493. The continued rapid emergence of new psychoactive substances in North America posed a significant challenge to the Governments in the region. The new psychoactive substances market in the United States continued to grow, with a strong and growing threat of synthetic opioids, synthetic cannabinoids and synthetic cathinones originating from parts of Asia.

494. The United States has recognized that new psychoactive substances pose a national and regional threat, given that they are inexpensive, widely available and sometimes disguised as other drugs, such as "ecstasy". In the United States, the special testing and research laboratory of the Drug Enforcement Agency noted that, in 2016, there were 21 substances reported as seized and analysed for the first time, and that FUB-AMB and 5F-UR-144 were the most commonly reported synthetic cannabinoids. In the first half of 2017, there were 477 synthetic cannabinoid identifications, an increase of nearly 250 per cent from the 193 identifications made in the same period in 2016. In 55 per cent of these synthetic cannabinoid identifications, the substance found was FUB-AMB.

5. Abuse and treatment

495. Fuelled by over-prescription, widespread availability, weak controls and a lack of public information, prescription drug abuse has, in recent years, emerged as one of the biggest drug control challenges in North America. The situation has been further exacerbated by the aggressive marketing of medicines containing opioids by the pharmaceutical industry to the general public and medical practitioners, as well as the industry's lobbying efforts to influence drug policy. In an attempt to address the problem, Governments in the region have adopted a series of measures to stem prescription drug abuse, including the establishment of prescription drug monitoring systems, awareness-raising measures, the creation of safe disposal initiatives and increased oversight of the drug production and supply chain.

496. As control of the prescription and sale of prescription drugs has been strengthened, patterns of abuse have shifted towards illicit drugs. This has manifested itself in sharp increases in heroin abuse, which had previously been in decline. The consumption of heroin and other drugs adulterated with fentanyl and fentanyl analogues have led to significant increases in the number of deaths from overdose, as many people abusing those drugs are unaware that they contain fentanyl, which is much more potent than heroin itself.

497. In Canada, there were 2,458 apparent opioid-related deaths in 2016, representing a rate of 8.8 such deaths per 100,000 people. In addition, recently issued reports indicate that First Nations populations in British Columbia, Canada, are five times more likely than non-First Nations people to experience an overdose event. Members of First Nations accounted for 10 per cent of all overdose deaths in the province. They were also three times more likely to die from an overdose. According to figures released by the Coroners Service of British Columbia, the proportion of opioid-related deaths linked to fentanyl or fentanyl in combination with other drugs has risen sharply, exceeding 80 per cent of cases of death caused by overdose in 2017, compared with 4 per cent of such cases in 2012.

498. According to the Centers for Disease Control and Prevention of the United States, drug overdose deaths in the United States increased by an average of 5.5 per cent per year between 1999 and 2015, with rates increasing for all age groups. On that basis, it was estimated that every day during that period, 91 Americans died from opioid overdose. That figure increased significantly to 142 deaths per day in 2016, the estimated total number of such deaths exceeding 64,000. According to estimates by the Centers for Disease Control and Prevention, as reported by the President's Commission on Combating Drug Addiction and the Opioid Crisis, drug overdoses killed more people than gun homicides and car crashes combined. Thus, in 2016, the average number of deaths caused by drug overdose per day in the United States was 175.

499. In the United States, opioid overdoses have quadrupled since 1999, and opioids (both prescribed and obtained by illicit means) are the main substances responsible for overdose deaths. Opioids were involved in 33,091 deaths across the United States in 2015. The five states with the highest rates of overdose deaths in 2015 were West Virginia (41.5 per 100,000), New Hampshire (34.3 per 100,000), Kentucky (29.9 per 100,000), Ohio (29.9 per 100,000) and Rhode Island (28.2 per 100,000). Some local areas in the United States have been funding public service campaigns to publicize the effects of the opioid epidemic on local communities. New York City, for example, launched an online campaign entitled "Fentanyl kills" to publicize the increases in overdoses between 2015 and 2016 and the record 1,374 people who died in 2016 from drug overdoses in the city.

500. Heroin use and demand in the United States continued to increase significantly in 2016, with many younger adults turning to heroin to feed addictions they had developed to opioids initially prescribed to them for pain management. Limited access to health insurance in the United States continues to impede the management of addiction and the provision of adequate care and treatment. The percentage of persons under 65 years of age who were uninsured in 2016 remained around 28.5 per cent.

501. Cocaine use has been increasing in North America and cocaine-related overdose deaths have increased since 2010. There were 10,619 deaths in the United States in 2016 where cocaine was reported as the underlying cause of death — of which 2,278 were reported to involve cocaine without opioids and 4,506 were reported to involve cocaine combined with opioids — compared to a total of 6,784 in 2015. This recent increase has been attributed to the growing supply and simultaneous abuse of heroin and of cocaine laced with fentanyls. In British Columbia, Canada, for example, there was an increase of 194 per cent in the number of drug overdose deaths involving fentanyl from 2015 to 2016. In New York, there were warnings that in 2016, 37 per cent of overdose deaths involved cocaine and fentanyl, without heroin, up from 16 per cent in 2015.

502. In the United States, the National Institute on Drug Abuse highlighted in April 2017 that research based on national survey data indicated that laws legalizing medical cannabis were associated with increases in illicit cannabis use and cannabis use disorders. The authors estimated that easier access to the drug following the passage of medical cannabis laws could result in an additional 1.1 million adult illicit cannabis users and an additional 500,000 adults with a cannabis disorder.

503. In 2016, the National Institutes of Health released their annual survey on substance abuse among teenagers ranging in age from 13 to 18, as part of its ongoing study "Monitoring the future". The survey showed that there was a long-term decline in the use of many substances and that past-year use of any illicit drug was the lowest in the survey's history for pupils in their eighth school year. The survey also showed that, among twelfth-year pupils in states where the medical use of cannabis was legal, cannabis use was 5 per cent higher than in states where medical use was illegal. Teenagers in states where medical use was legal also reported a higher use of cannabis edibles.

504. In states of the United States where the non-medical use of cannabis is now allowed, that substance is available for purchase in various forms, which include products that can be inhaled through smoking or vaporization or eaten, such as baked goods and candy. Since the legalization of non-medical cannabis, the states of Colorado and Washington have experienced an increase in cases of unintentional exposure of children to cannabis.

505. According to a 2016 study entitled "Unintentional Pediatric Exposures to Marijuana in Colorado, 2009-2015", "15 of the 32 exposures seen in the children's hospital in 2014 and 2015 were from recreational marijuana, suggesting that the legalization of recreational marijuana did affect the incidence of pediatric exposures."[90] Similarly, in the State of Washington, the Washington Poison Center experienced another year of increased calls relating to marijuana exposures and poisonings, reporting that in 2016 the Center received 280 cannabis-related calls, 49 of which concerned children 0-5 years of age.

[90] Georg S. Wang and others, "Unintentional pediatric exposures to marijuana in Colorado, 2009-2015", *JAMA Pediatrics*, vol. 54, No. 9 (2016), pp. 840–846.

506. A national study entitled "Characterization of edible marijuana product exposures reported to United States poison centers"[91] reported that over a 36-month study period from January 2013 to December 2015, 430 calls relating to exposure to edible cannabis were made to the National Poison Data System, the age group most commonly affected by such exposure being that of children under 6 years of age. Furthermore, 381 (91 per cent) of those calls came from states that had implemented medical cannabis programmes or permitted the non-medical use of cannabis.

507. In order to address public health and safety concerns, various measures have been developed. On 1 October 2017, Colorado adopted new rules regarding medical and non-medical cannabis products, including the requirement that the packaging of such products should bear standardized symbols and the warning "Contains marijuana. Keep out of the reach of children". The packaging of every standardized edible cannabis retail product must be individually marked; if the packaging cannot be marked in this way owing to the nature of the product (as in the case of bulk goods, for example), the product must be in a childproof container; the words "candy" or "candies" must not be shown on the packaging (unless part of the name of the establishment); the product must not resemble animal shapes, cartoon characters, fruits or humans; and each container must be labelled with necessary and relevant information for consumers, including a potency statement and a statement that the product has been tested for contaminants.

508. In February 2017, the Washington State Liquor and Cannabis Board introduced a new warning label (showing a hand gesturing "Stop", the words "Not for kids", and the 24-hour emergency telephone hotline for poison control) to identify cannabis-infused edibles. In Alaska, edible cannabis products must identify the retail store's logo, the establishment license number and the estimated amount of THC in the product. They must also bear warnings such as "For use only by adults 21 and older. Keep out of the reach of children." In California, it is prohibited to market edible cannabis products that are appealing to children or which can be easily confused with commercially sold candy or other foods that do not contain cannabis, and prohibited to make cannabis-containing products in the shape of a person, animal, insect or fruit.

509. The Canadian Research Initiative in Substance Misuse issued "Lower-risk cannabis use guidelines" in 2017. The document is a health education and prevention tool that acknowledges that cannabis use carries both immediate and long-term health risks. The guidelines contain ten recommendations on topics including the choice of cannabis products, the age of initial use, the frequency and intensity of use, and cannabis use and driving.

510. In March 2017, the Canadian Community Epidemiology Network on Drug Use issued an information bulletin entitled "Calling 911 in drug poisoning situations". The bulletin provides estimates of how many people call the emergency services in drug overdose situations. According to data collected from 2013 to 2016, members of the public who had used a naloxone kit to treat an overdose did not call the emergency services in up to 65 per cent of overdose situations. The bulletin advises laypeople to call emergency medical services in all overdose situations, even if they already have naloxone kits, so as to reduce the number of fatalities or brain injuries. A fentanyl overdose can sometimes take more than one naloxone kit or other type of medical intervention to increase the chances of survival. After naloxone has been administered, it is advisable that the patient remain in a medical or health-care facility; naloxone wears off faster than many opioids, and the patient could return to a state of overdose. Naloxone can also cause severe withdrawal symptoms or other unpredictable complications.

511. In June 2017, the National Commission against Addictions in Mexico presented the results of the national survey on the use of drugs, alcohol and tobacco 2016–2017. One of the main findings in relation to drug use trends was that the lifetime prevalence of use of any drug had increased from 7.8 per cent in 2011 to 10.3 per cent in 2016. Also from 2011 to 2016, the prevalence of past-year use had gone from 1.8 per cent to 2.9 per cent, and past-month prevalence from 1 per cent to 1.5 per cent. Over the same period, the lifetime prevalence of the use of any illegal drug had increased from 7.2 per cent to 9.9 per cent, past-year prevalence from 1.5 per cent to 2.7 per cent and past-month prevalence from 0.8 per cent to 1.4 per cent. Again from 2011 to 2016, in the adolescent age group (12–17 years of age), the lifetime prevalence for cannabis had increased from 6 per cent to 8.6 per cent (from 10.6 per cent to 14 per cent for boys and from 1.6 per cent to 3.7 per cent for girls) and past-year prevalence from 1.2 per cent to 2.1 per cent (from 2.2 per cent to 3.5 per cent for boys and from 0.3 per cent to 0.9 per cent for girls). In the case of cocaine, lifetime prevalence rates remained stable (3.3 per cent against 3.5 per cent), while annual prevalence increased from 0.5 per cent to 0.8 per cent. In the adolescent population group (12–17 years of age), the lifetime prevalence of illegal drug use increased significantly from 2.9 per cent to 6.2 per cent, and past-year prevalence from 1.5 per cent to 2.9 per cent. Past-month

[91] Dazhe Cao and others, "Characterization of edible marijuana product exposures reported to United States poison centers", *Clinical Toxicology*, vol. 54, No. 9 (2016), pp. 840–846.

prevalence remained stable (0.9 per cent in 2011; 1.2 per cent in 2016). Prevalence for cannabis had also increased significantly for both lifetime use (2.4 per cent to 5.3 per cent) and past-year use (1.3 per cent to 2.6 per cent). The abuse of cocaine and inhalants did not show any significant growth compared to 2011: 0.7 per cent for lifetime abuse of cocaine and inhalants in 2011, compared to 1.1 per cent in 2016. The corresponding figures for past-year use were 0.4 per cent compared to 0.6 per cent for cocaine, and 0.3 per cent compared to 0.6 per cent for inhalants.

512. Also in Mexico, in August 2017, the National Commission against Addictions relaunched its national programme for the prevention of psychoactive substance abuse and for citizen participation. The programme involves the participation of the federal, state and municipal levels of government and includes collaboration with the private sector and social organizations. It provides for the treatment of drug use disorders, the prevention of tobacco and alcohol consumption and restrictions on the sale of inhalants to minors, among other measures. The programme will establish 340 outpatient facilities in high-risk communities to provide early detection and intervention services for drug users. In addition, in cooperation with CICAD, Mexico will establish a pilot programme to train and certify addiction counsellors. Also, to implement the recommendations of the outcome document of the thirtieth special session of the General Assembly on the world drug problem the Government of Mexico will initiate a series of dialogues with civil society organizations and researchers to share experiences, best practices and information regarding trends with the aim of drawing up ten principles (a "Decalogue") to address drug issues in that country.

South America

1. Major developments

513. In South America, Argentina, Colombia, Paraguay and Peru launched initiatives to regulate the sale of cannabis for medical purposes. The availability of cannabis in the region continued to increase, driven by policies and legislative initiatives aimed at permitting and regulating the medical and non-medical use of cannabis in several States, thereby lowering the perception of risks associated with its use. Cannabis continued to be the illicit drug most widely available and commonly abused in the region.

514. In the report of 2016 on the monitoring of coca bush cultivation, the Government of the Plurinational State of Bolivia and UNODC indicated that the area dedicated to that crop had increased by 14 per cent, from 20,200 ha in 2015 to 23,100 ha in 2016, but remained smaller than that of 2006 (27,500 ha) and 2010 (31,000 ha).

515. The area under coca bush cultivation in Colombia increased by more than 50 per cent, from 96,000 ha in 2015 to 146,000 ha in 2016. Following the signing, in November 2016, of the peace accord with the Revolutionary Armed Forces of Colombia-People's Army (FARC-EP), which contains a chapter on the solution to the illicit drug problem, the Government of Colombia agreed in October 2017 to sign with UNODC a historic multi-year project, valued at around $315 million, focusing on the development, implementation, monitoring and evaluation of Colombia's national policy on illicit drug crop reduction and the national strategy on territorial and rural development, as a crucial part of the country's ongoing peacebuilding efforts. The project includes UNODC technical assistance to the Government in the implementation of the national policy and strategy on territorial and rural development, integrated monitoring of illicit crops and support for voluntary substitution of illicit crops, including interventions for sustainable alternative development and the formalization of rural property.

516. In Uruguay, in the context of the implementation of Law No. 19172, measures were put in place to establish a national regulatory framework with a view to permitting the sale of cannabis in pharmacies to registered users from July 2017.

2. Regional cooperation

517. South America strengthened cooperation at the bilateral and multilateral levels. Countries in the region improved the exchange of information to provide an adequate response to illicit drug-related activities through coordination at the policy and operational levels.

518. According to the global survey of the implementation by Member States of Security Council resolution 1373 (2001) (see S/2016/49), in spite of the efforts made by a number of Member States (e.g., subregional and international cooperation), corruption, weak public institutions, weak legislation, porous borders and a lack of human resources posed serious challenges to cooperation in the field of counter-terrorism. Owing to the linkages between counter-terrorism and counter-trafficking, these challenges may have an impact on efforts to counter drug trafficking.

519. International cooperation efforts to improve drug control in Colombia remained a priority, as the country began to implement the post-conflict transition process following the signing of the Final Agreement for Ending the Conflict and Building a Stable and Lasting Peace with the Revolutionary Armed Forces of Colombia-People's Army in November 2016. The process will require significant investments in social and economic development programmes. In that context, the European Union renewed its commitment to supporting the implementation of the Final Agreement, with special emphasis on rural reform.

520. In February 2017, the first regional meeting on new psychoactive substances in the western hemisphere was held in Colombia with the aim of exchanging information on the identification of public health risks and the use of early warning systems as effective ways of addressing the problem of new psychoactive substances.[92]

521. The Twenty-seventh Meeting of Heads of National Drug Law Enforcement Agencies, Latin America and the Caribbean, was held in Guatemala City from 2 to 6 October 2017. The meeting gathered government law enforcement experts from all countries of the Americas and focused on: *(a)* the coordination of the regional communication platforms supporting drug law enforcement across Latin America and the Caribbean; *(b)* links between drug trafficking and other forms of organized crime, including money-laundering; *(c)* alternatives to imprisonment for certain offences as demand reduction strategies that promote public health and safety; and *(d)* practical measures tailored to the specific needs of children and young people to prevent and treat drug abuse among them and to address their involvement in drug-related crime. The meeting resulted in specific recommendations on those topics to Governments in the region, which would also be considered by the Commission on Narcotic Drugs at its sixty-first session, in 2018.

3. National legislation, policy and action

522. Argentina, Colombia, Paraguay and Peru reported on initiatives to permit and regulate the medical and scientific use of cannabis.

523. Following the enactment of relevant legislation in 2016, Colombia approved the medical and scientific use of cannabis through decree 613 of 10 January 2017. The decree regulates the sale of cannabis derivatives, the use of seeds for grain production, the cultivation of psychoactive and non-psychoactive cannabis plants for medical and scientific use and the use of non-psychoactive cannabis plants for industrial purposes.

524. On 22 February 2017, the President of Peru transmitted to Congress draft legislation that would permit the use of cannabis for medical purposes with a medical prescription where other therapeutic options had failed. The draft legislation provides that, two years after the promulgation of the law, the Ministry of Health is to evaluate its implementation and that, on the basis of its findings, the executive branch is to assess the appropriateness of submitting further draft legislation to authorize the production of cannabis products for medicinal purposes. Also in February, the Government established, by ministerial resolution, a committee of experts to evaluate the use of cannabis as an alternative medicine in Peru.[93] The Committee of Experts submitted its report to the Ministry of Health in April 2017, and the congressional commission examining the draft legislation adopted it in September 2017, and the Congress approved it on 19 October, followed by promulgation by the Executive Branch in November.

525. In Argentina, in April 2017, Law No. 27350 entered into force, permitting the use of cannabis oil and its derivatives for medical purposes and setting up a regulatory framework under which to prescribe and distribute such products to patients. The Law established a regulatory framework for medical and scientific research on the medicinal and therapeutic uses of the cannabis plant and its derivatives and their use in the palliative treatment of pain with a view to guaranteeing and promoting comprehensive health care. The Law also established a national programme for the study of and research on the medicinal use of the cannabis plant and its derivatives, as well as of non-conventional treatments, under the Ministry of Health.

526. In June 2017, the House of Representatives of Paraguay considered two draft laws to allow and regulate the medical and scientific use of cannabis.

[92] The event was organized by UNODC and based on the outcome document of the special session of the General Assembly on the world drug problem held in 2016 (General Assembly resolution S-30/1, annex). Participating countries included Argentina, Brazil, Canada, Chile, Colombia, Costa Rica and the United States.

[93] Ministerial resolution No. 096-2017, Ministry of Health, 14 February 2017. The resolution provided a deadline of one month to these experts to submit a report with concluding observations. See *Actualización de la Revisión y Síntesis de la Evidencia sobre Regulación del Uso Médico de Cannabis*, National Health Institute. Series No. 01-2017 (Lima, April 2017). The proposed legislation would authorize the import, sale and use of cannabis products for medicinal purposes as determined in regulations to be elaborated by the executive branch within a maximum of 30 days after the adoption of the bill.

527. In Uruguay, in 2016, a review and compilation of data on the indicators for monitoring the implementation of Law No. 19172 were carried out with respect to non-medical uses of cannabis. In December of the same year, the Ministry of Public Health completed the first annual report, for 2016, to the parliament of Uruguay on the status of implementation of the Law.[94] In March 2017, the National Drugs Council of Uruguay announced a series of measures aimed at widening access to cannabis for non-medical use under Law No. 19172. Foremost among those measures was the establishment of a user registry. At the same time, the Council announced the launch of a large-scale media campaign on the risks of drug abuse. The sale of cannabis in pharmacies began in July 2017, after being delayed on several occasions owing to an insufficient State-grown supply. Once the system is fully implemented, registered buyers will be able to purchase up to 40 grams of cannabis per month (capped at 10 grams per week) from registered pharmacies. Those pharmacies will have fingerprint recognition units, and each purchase will have to be recorded in a government database to ensure that individuals do not exceed their allowance.

528. **The Board reiterates that any measures that permit the use of cannabis for non-medical purposes are in clear violation of article 4, paragraph *(c)*, and article 36 of the 1961 Convention as amended, and of article 3, paragraph 1 *(a)*, of the 1988 Convention. INCB also reiterates that the limitation of the use of controlled substances to medicinal and scientific purposes is a fundamental principle to which no derogation is permitted under the 1961 Convention as amended.**

529. Other legislative developments in the region included the promulgation of Law No. 27283 in Argentina in October 2016, by which Congress established the Federal Council on Chemical Precursors. The Council has the mandate, inter alia, to analyse matters related to controlled substances and chemicals; make recommendations on substances to be brought under control; prepare reports and conduct research on the evolution and emergence of new chemical precursors, and produce and maintain a related map; and propose the implementation of public policies to improve the control of their production. In November 2016, Argentina enacted Law No. 27302, which amended Law No. 23737, criminalizing the international diversion of precursor chemicals and establishing additional sanctions for the production, sale and cultivation of drugs, as well as new border control measures to counter drug trafficking. Moreover, Law No. 27319 on the prosecution of complex cases, adopted in November 2016, contained provisions on special investigative techniques.

530. In January 2016, in Uruguay, Law No. 19355 came into effect establishing the National Secretariat for Combating Money-Laundering and the Financing of Terrorism, the role of which is defined under the procedures established in the regulations of the fund of confiscated assets of the National Drug Board.

531. In March 2017, the Plurinational State of Bolivia took further steps to reform its legal framework for narcotic drugs and precursors extending government control over the production and sale of coca leaf. On 8 March, the Government adopted Law No. 906, the General Law on Coca, repealing articles 1 to 31 of Law No. 1008 of 1988 and establishing that an area of up to 22,000 ha may be devoted to the cultivation of coca bush under the reservation that the country entered in 2013 in respect of the 1961 Convention as amended, thereby nearly doubling the area permitted for supplying the demand for coca leaf for the traditional practice of chewing that had been set at 12,000 ha under Law No. 1008.

532. Law No. 906 also allows for the use of coca leaf for ritual, medicinal, nutritional, research and industrial purposes and provides for the establishment of the National Council for the Re-evaluation, Production, Sale, Industrialization and Investigation of Coca,[95] and for the implementation of a register of coca producers by the Ministry of Rural Development and Land.

533. The Board expresses its concern regarding the decision of the Government of the Plurinational State of Bolivia, through the adoption of the new General Coca Law of 2017 and pursuant to its reservation with respect to the 1961 Convention as amended to permit the almost doubling to 22,000 ha of the area designated for the cultivation of coca bush. According to a study conducted by the Government with the support of the European Union and published in 2013, the amount of coca leaf deemed sufficient in 2012 to meet the demand for the purposes described in the country's reservation was 23,219 tons per year, which could be produced from the cultivation of around 14,700 ha.[96]

[94] The assessment is being implemented under the technical cooperation agreement among the National Drug Board, the Pan American Health Organization and WHO. See www.ircca.gub.uy.

[95] At the bilateral meeting held between the President of INCB and a delegation of the Plurinational State of Bolivia, the Bolivian authorities stated that the 22,000 ha of permissible cultivation established by the law was an upper limit and that the Government was able to limit the actual area to a size that reflected the quantity of coca production required to meet licit needs. The Government hopes to boost the export of coca leaf products, according to the Razón newspaper.

[96] See UNODC, *Estado Plurinacional de Bolivia: Monitoreo de Cultivos de Coca 2016*. Available from www.unodc.org/documents/crop-monitoring/Bolivia/2016_Bolivia_Informe_Monitoreo_Coca.pdf.

534. In March 2017, the Plurinational State of Bolivia also enacted Law No. 913 on Combating Trafficking in Controlled Substances, by which it established mechanisms for countering traffic in controlled substances by means of prevention and law-enforcement measures, the control of precursors and a strengthening of the regime for the seizure and confiscation of assets.

535. The Board notes the open dialogue that it has maintained with the Government of the Plurinational State of Bolivia over time and its ongoing requests to the Government to provide information on the measures that the Government has taken or plans to take to ensure full compliance with the provisions of the international conventions on drug control, including the reservation entered when adhering, in 2013, to the 1961 Convention as amended, and in relation to other matters, including the estimates that the Government must provide to the Board as part of its obligations under said convention. The Board trusts that the Government of the Plurinational State of Bolivia will comply fully and without delay with the Board's various requests for information.

536. Several policy initiatives were reported in the region. In December 2016, the Government of Guyana launched a new national drug strategy master plan for 2016–2020. The plan strikes a balance between public health and public security. It addresses demand and supply reduction, control measures, institutional strengthening, policy coordination and international cooperation.

537. In Colombia, in December 2016, the National Narcotics Council approved the manual eradication of illicit crops and the use of glyphosate for that purpose. The Government of Colombia aims to eradicate 50,000 ha of illicit cultivation of coca bush in 2017 and to substitute 50,000 ha of such cultivation with licit crops in 2017, as the country prepares for the implementation of its post-conflict counter-narcotics strategy. In addition, the national police have implemented a strategy against microtrafficking with the support of the Office of the Attorney General and other State authorities. In January 2017, the Government launched the comprehensive national strategy for the substitution of illicit crops with the aim of promoting the voluntary substitution of illicit crops and helping poor and marginalized rural families affected by illicit crop cultivation.

538. Peru adopted a new national drug control strategy for the period 2017–2021, which was aimed at reducing the country's coca-growing area by 50 per cent by strengthening cooperation among relevant institutions, sharing intelligence, enhancing prevention and seizing chemical precursors used for the manufacture of illicit drugs. Peru will focus its efforts on the eradication of the cultivation of coca bush, seizure activities, alternative development strategies, weakening the population's links with armed groups and drug trafficking and restoring security and respect for the rule of law.

539. In Ecuador, situational studies on drug supply and demand are being conducted in priority areas of the country within the framework of the Emerging Intervention Strategy 2016.

540. Countries in South America have responded to the emergence of new psychoactive substances, including by establishing early warning systems, issuing alerts and introducing new legislation. By decree No. 69/2017, issued in January 2017, the Government of Argentina updated its list of controlled substances by adding 61 new such substances in January 2017. In Uruguay, decree No. 320/016 was issued to include *para*-methoxymethylamphetamine (PMMA) in the list of substances under national control. On 29 December 2016, Uruguay amended its Law on Psychotropic Substances to reflect the transfer of *gamma*-hydroxybutyric acid (GHB) from Schedule IV to Schedule II of the Convention on Psychotropic Substances of 1971.

4. Cultivation, production, manufacture and trafficking

(a) Narcotic drugs

541. The impact on protected areas of the illicit cultivation of coca bush remains a threat to biological diversity in the region.[97] The area under such cultivation in Colombia increased significantly, from 96,000 ha in 2015 to 146,000 ha in 2016. Following the suspension of aerial spraying in October 2015,[98] the Government sought new strategies, such as the implementation of round tables with the communities affected by illicit crop cultivation and an increase in interdiction efforts. The impact that the suspension of spraying might have had on the yield will be assessed in new yield studies planned for 2017.[99]

[97] UNODC, Colombia, Monitoreo de territorios afectados por cultivos ilícitos 2016. Available from www.unodc.org/documents/colombia/2017/julio/CENSO_2017_WEB_baja.pdf.

[98] After the suspension of fumigation of crops with the herbicide glyphosate in Colombia in 2015, the use of that substance was reintroduced in 2017 for use in manual fumigation. Since it stopped using one of its main coca eradication methods, namely, the aerial fumigation of crops with glyphosate, the Government has uprooted a far smaller amount of coca bush, according to government statistics published by the Drug Observatory of the Ministry of Justice.

[99] Colombia, Monitoreo de territorios afectados por cultivos ilícitos 2016.

542. In the Plurinational State of Bolivia, monitoring results showed an increase in the area under cultivation between 2015 and 2016. In 2016, the total area of coca bush under illicit cultivation was estimated at 23,100 ha, that is, 14 per cent more than in 2015. In 2016, the potential production of sun-dried coca leaf was estimated at 38,000 tons. Similarly, the total volume of coca leaf sold on markets for traditional use reached 21,952 tons, that is, 751 tons more than 2015. The reduction of coca crop surplus in permitted areas, a process known as rationalization, and the eradication of coca bush cultivation in forbidden areas amounted to 6,577 ha nationwide, representing a decrease of 40 per cent compared with the area eradicated in 2015 (11,020 ha).[100]

543. According to the coca cultivation survey in Peru for 2015, published by UNODC and the Government of Peru in July 2016, the area under illicit cultivation of coca bush was estimated at 40,300 ha. Peru also reported some illicit cultivation of opium poppy that could yield up to two harvests per year. At the time of finalization of the annual report of the Board for 2017 (1 November 2017), the findings of the coca cultivation survey for 2016, conducted by UNODC and the Government of Peru, had not yet been published.

544. During 2016, a majority of countries in the region cited land transport as the major means of drug trafficking. Nevertheless, the damage done to landing strips in Peru suggests that trafficking by air might have affected drug prices in the country.

545. Among the drug trafficking routes identified, it is important to mention the "Amazonian trapezoid", also known as the tri-border area, between Brazil, Colombia and Peru. The area is on one of the main drug trafficking routes to the United States and Europe.

546. In its 2016 annual report, the Drug Trafficking Observatory in Chile reported that drug trafficking in the country was on the rise. Chile serves as a trans-shipment country between coca-producing countries and consumer markets in Europe, North America and Oceania.

547. One of the challenges faced by countries with sparsely populated areas that border drug-producing countries is that they serve as transit countries for drugs bound for North America and Europe. South American criminal organizations tend to be relatively small, local and family-based to ensure the confidentiality needed to perform their operations. Those organizations are the basis for groups formed at the national level that seek international links, often joining larger groups that have a fragmented and decentralized structure, which makes tracking those groups difficult. Those organizations are diverse and adaptable, which allows them to modify their trafficking routes and modi operandi whenever necessary. In addition, South American countries lack a system to follow the price fluctuations of illicit drugs.

548. The Government of the Plurinational State of Bolivia reported the seizure, in 2016, of more than 102 tons of cannabis plants and of 29 tons of cocaine salts most of which had been trafficked by road. During the reporting period, 4,065 clandestine cocaine base laboratories were seized in the country.

549. According to information provided by the national authorities of Paraguay, the eradication of cannabis crops increased from 2006 to 2008, with 1,786 ha eradicated, then sharply declined from 2009 to 2012, to 780 ha. From 2013 to 2015, there was a marked increase in eradication efforts, with the area of cannabis crops destroyed rising from 1,803 ha in 2013 to 1,966 ha in 2014 and a reported 2,116 ha in 2015. Such crops, however, are difficult to identify in areas where they are mixed with licit crops. The authorities reported the seizure of 413,970 kg of cannabis in 2016.

550. A total of 30,150 ha of illicitly cultivated coca bush were eradicated in Peru in 2016, which is slightly above the target of 30,000 ha for that year. The quantities of cocaine base paste seized in Peru amounted to 11.1 tons in 2014, 11.6 tons in 2015 and 14.0 tons in 2016, while the corresponding figures for cocaine hydrochloride were 18.7 tons, 8.4 tons and 13.9 tons, respectively.

551. The Government of the Bolivarian Republic of Venezuela reported the seizure of more than 34 tons of cocaine salts and more than 1 ton of coca leaves, highlighting the proximity of laboratories on Venezuelan territory to border crossing points with Colombia. The Government also reported dismantling six cocaine-processing facilities in 2016. The seizures suggest that the country was also affected by the increased cultivation of coca bush in Colombia in 2015 and 2016.[101]

[100] UNODC, *Estado Plurinacional de Bolivia: Monitoreo de Cultivos de Coca 2016*. Available from https://www.unodc.org/documents/crop-monitoring/Bolivia/2016_Bolivia_Informe_Monitoreo_Coca.pdf.

[101] The authorities of the Bolivarian Republic of Venezuela recently announced cocaine seizures of almost 3 tons, illustrating the persistent flow of drugs across the country's border with Colombia.

(b) Psychotropic substances

552. The problem of the manufacture, trafficking and abuse of psychotropic substances in South America differs from country to country. According to the Organized Crime Observatory in the Bolivarian Republic of Venezuela, the use of psychotropic substances is on the rise. During the reporting period, the Governments of Argentina and Uruguay reported seizures of more than 220,000 tablets of "ecstasy"-type substances, while the Government of Peru reported seizures of 0.25 kg of the same substance.

(c) Precursors

553. Most of the potassium permanganate seized in South American countries was reported to have been manufactured in the country of seizure. Seven countries of South America reported seizures totalling 585 tons of potassium permanganate to INCB for 2016, of which 582.5 tons were seized in Colombia. The Plurinational State of Bolivia reported 2 tons, Peru less than 250 kg, and the Bolivarian Republic of Venezuela 200 kg. Reported seizure totals in other countries of the region were of less than 10 kg. Seizures of significant amounts of chemicals not under international control were reported to INCB for 2016, especially by the three coca-producing countries. These chemicals are common acids and bases, oxidizing agents and solvents used for the manufacture of cocaine and are controlled at the national level.

554. A detailed overview of the situation in South America with respect to the control of precursor chemicals can be found in the report of the Board for 2017 on the implementation of article 12 of the 1988 Convention.

(d) Substances not under international control

555. Several countries in the region reported seizures of a variety of non-scheduled chemicals used in the processing, reprocessing, refinement or cutting of cocaine. Those chemicals included various hydrocarbon solvent mixtures, such as common thinners, kerosene, diesel and various types of gasoline.

556. Non-scheduled substances constituted a large share of the seizures of chemical products in the region, especially non-scheduled solvents, which were seized in volumes exceeding those of scheduled solvents. The growing number of seizures of sodium metabisulfite and calcium chloride, two chemicals used to increase the efficiency of cocaine processing, indicates increasing levels of organization of the related illicit activities and continued high levels of recycling of solvents.

557. In its *World Drug Report 2017*, UNODC noted that countries in South America had taken action regarding the emergence of hallucinogenic new psychoactive substances, including by setting up early warning systems, issuing alerts and introducing new legislation. As examples, it noted that Colombia had set up an early warning system in 2013, and issued alerts on new psychoactive substances sold as lysergic acid diethylamide that were made available online to the general population.[102] In Chile, a total of 100 new psychoactive substances, including several NBOMe compounds, were placed under national control as psychoactive substances in 2014 and 2015. In Brazil, the Brazilian Health Regulatory Agency placed 11 NBOMe compounds in the national list of controlled substances in May 2016.

558. In Argentina, the Secretariat for Planning the Prevention of Drug Abuse and the Fight against Drug Trafficking launched, in December 2016, an early warning system for the identification of new psychoactive and emerging substances and new patterns of drug use and commercialization. The early warning system, under the Argentinian Drug Observatory of the Secretariat, will assess the health risks of the substances identified and develop responses. The system will work collaboratively with the Ministry of Justice and Human Rights, the Ministry of Health, the Ministry of Security and the Ministry of Science, Technology and Productive Innovation, the national administration for medicines, food and medical technology, the national service for health and quality in agricultural food products and customs service, which all provide information to the Secretariat's Observatory. The Observatory acts as the central repository of information, systematizing it and producing analyses in order to formulate public policies on problematic consumption of psychoactive substances, based on updated scientific data. Similar systems are already in place in Chile, Colombia, Mexico and Uruguay, with which Argentina will work in the exchange of information.

5. Abuse and treatment

559. In the South American region, the lifetime prevalence of cannabis varied from 26.1 per cent in Uruguay to 19.7 per cent in Argentina and 3.6 per cent in Bolivia (Plurinational State of) and Peru. The lifetime prevalence of opioids was reported to be under 1 per cent by all

[102] UNODC, "Global SMART programme Latin America", Information Bulletin No. 2 (September 2016).

those countries. Variations among countries were seen in lifetime prevalence rates of cocaine base paste use, ranging from 0.1 per cent in the Plurinational State of Bolivia to 0.5 per cent in Argentina and 1.47 per cent in Peru.

560. In 2017, the Secretariat for Planning the Prevention of Drug Abuse and the Fight against Drug Trafficking of Argentina, in collaboration with the National Directorate of the Argentinian Drug Observatory, conducted the sixth national study on the use of psychoactive substances. The study was based on a survey of 20,658 individuals of 12 to 65 years of age living in urban areas and gathered information on the current patterns of use and abuse of psychoactive substances in different population groups. The study found that cannabis was the most common substance of abuse in terms of prevalence of use among the surveyed population in 2016 (7.8 per cent). With a rate of use of cocaine of 7.7 per cent, individuals of 25 to 34 years of age constituted the population group with the highest rate that same year, while the rates among younger and older people were lower.[103] Furthermore, the study indicated that the lifetime prevalence rate of use of cocaine in the general population had increased to 5.3 per cent in 2017, compared with 2.6 per cent in 2010. The increase in use particularly affected teenagers of 12 to 17 years of age, whose lifetime use reached 1.2 per cent, from a rate of 0.4 per cent in 2010. In addition, 6.2 per cent of the individuals surveyed declared having consumed opioid analgesics without medical prescription at least once, and 54 per cent of those who had consumed opioid analgesics had consumed them before turning 30 years of age.

561. According to the national survey on drug use of 2016 conducted by the Drug Observatory of Colombia, the lifetime prevalence of use in the general population increased from 8.6 per cent in 2008 to 12.17 per cent in 2013. The most widely used drug in Colombia was cannabis, with an annual prevalence of 3.27 per cent in 2013, compared with 2.12 per cent in 2008, which represents an increase of 54 per cent.

562. The increased drug use in Colombia suggests that some criminal structures have been reorganizing their distribution and sale of substances. In addition, Colombia is no longer only a producer country of drugs, but has also become home to an increasing number of consumers. To confront those challenges, the Government continues to follow the national plan to promote public health, prevention and care in connection with the use of psychotropic substances for 2014–2021, which is focused on strengthening institutions, health promotion, prevention and treatment.

563. According to a study on the costs of the drug problem published by the Technical Secretariat on Drugs of Ecuador in March 2017, the estimated cost of the drug phenomenon in Ecuador in 2015 was $13 per capita, representing 0.2 per cent of GDP.

564. Cocaine and cannabis remain the two most prevalent drugs traded and used in Guyana. The majority of cannabis produced in that country is consumed locally. The national survey on household drug prevalence of 2016, carried out with assistance from the Inter-American Drug Abuse Control Commission, revealed that cannabis had the lowest average age of first use of all drugs of abuse (18.9 years) and cocaine the highest (22.6 years). The average age of first use of crack was 19.8 years and that of "ecstasy" 23.8 years. At 0.7 per cent and 0.3 per cent, respectively, the lifetime prevalence rates for cocaine and "crack" cocaine were, however, very low.

565. According to the National Commission for Development and Life without Drugs of Peru, substance use disorders affect approximately 200,000 persons nationwide. Between 32,000 and 60,000 individuals are believed to be addicted to cocaine, while an estimated 100,000 people use cannabis. Abuse of inexpensive, highly addictive coca base paste is increasing, in particular along drug trafficking routes in mid-size cities east of the Andes and in transit cities along the coast. Public treatment facilities in Peru remain insufficient, the public offer of outpatient treatment specialized in addictions consists essentially of health facilities complemented by addiction treatment units established in health-care, judicial and penitentiary institutions.

566. The sixth national survey on household drug use carried out in Uruguay in 2016 included questions about the forms of access to cannabis and the risks associated with the acquisition of cannabis on the illegal market. Twenty-two per cent of all cannabis users in the previous 12 months (i.e., 161,475 users) answered that they had bought the substance on the illegal market, and 43 per cent of those buyers stated that they had been exposed to some type of risk. The proportion of drug offences within the total crime rate increased notably from 2004 to 2012, and the impact of Law No. 19172 remains to be ascertained.

567. With regard to demand reduction initiatives, the third epidemiological study on drug use among university students in the Andean Community was carried out under the Support Project on Reduction of Demand of Illegal Drugs in the Andean Community. In collaboration

[103] Use rates for the other population groups were as follows: 1.2 per cent for people of 12 to 17 years of age; 6.5 per cent for people of 18 to 24 years of age; 6.4 per cent for people of 35 to 49 years of age; and 2.1 per cent for people of 50 to 65 years of age.

with that Project, UNODC continued to support the Andean Youth Initiative in the Plurinational State of Bolivia by expanding young people's access to social networks to prevent drug misuse. An early warning system was developed by the Drug Observatory of Colombia to improve the monitoring of psychoactive substances. Furthermore, during the reporting period, Ecuador and Peru implemented three local selective prevention projects aimed at street children, adolescents and juvenile offenders.

C. Asia

East and South-East Asia

1. Major developments

568. The illicit manufacture of, trafficking in and abuse of methamphetamine continue to be the biggest drug threat for East and South-East Asia. While illicit manufacture continues to take place mainly in China and Myanmar, it has also been detected in other countries in the region. Considerable increases or record high levels of methamphetamine seizures have been reported in recent years, with the result that the region had the greatest percentage of global methamphetamine seizures in 2015. Driven by high street prices, significant quantities of methamphetamine have also been trafficked into the region from other parts of the world, a situation also reflected in the growing levels of abuse reported by most countries in the region.

569. Illicit opium poppy cultivation and opium production continue to be concentrated in the Golden Triangle. In Myanmar, the total area under illicit opium poppy cultivation remained steady yet at 55,000 ha in 2015, considerably more than in the Lao People's Democratic Republic which was reported to have 5,700 ha. Trafficking in and abuse of heroin continue to be of concern for some countries in the region.

570. The greater integration of the region poses new challenges for border control. An increasing number of drug-related criminal activities have been detected at the borders of Brunei Darussalam, Cambodia and Viet Nam. Closer collaboration and the more timely sharing of intelligence among neighbouring countries are crucial for effective joint-border operations.

571. Online drug-related crimes have become more prevalent in some countries. In Singapore, the number of people arrested for buying drugs and drug-related paraphernalia online increased more than sixfold, from 30 individuals arrested in 2015 to 201 in 2016. Authorities in China noted that online drug-related crimes remained widespread and stepped up the corresponding supervision and management of the situation. Legislative change has also been introduced by the Government of the Republic of Korea to prohibit the advertising of illicit drug trade via the Internet.

2. Regional cooperation

572. The Fortieth Meeting of Heads of National Drug Law Enforcement Agencies, Asia and the Pacific, was held in Colombo on 24–27 October 2016. Over 150 participants from the region discussed the status of drug control and treatment and adopted a number of expert recommendations.

573. The 22nd Asia-Pacific Operational Drug Enforcement Conference was held in Tokyo from 20 to 24 February 2017. About 130 participants exchanged views on global cooperation to counter the smuggling of amphetamine-type stimulants and actions to address the threat posed by new psychoactive substances.

574. Ministers and senior officials from countries of the Greater Mekong subregion (Cambodia, China, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam) and UNODC met in May 2017 to endorse a new strategy to address the persistent and evolving drug issues in the region. The new Mekong Action Plan strengthened capacities in four areas: drugs and health; law enforcement cooperation; legal and judicial cooperation; and sustainable development. The new action plan has been adjusted to incorporate the recommendations set out in the outcome document of the thirtieth special session of the General Assembly on the world drug problem held in 2016, as well as the Sustainable Development Goals.

575. The 38th Meeting of the Association of Southeast Asian Nations (ASEAN) Senior Officials on Drug Matters was held in Viet Nam from 25 to 27 July 2017. The annual meeting included meetings of five working groups (preventive education; treatment and rehabilitation; law enforcement; research; and alternative development) and serves as a platform to enhance coordination of joint operations and investigations among drug law enforcement agencies.

576. The Third BRICS Anti-Drug Working Group Meeting was held on August 16, 2017 in Weihai, China. The Working Group adopted "The Working Rule on Drug Control for the Working Group" and decided to strengthen

the bilateral cooperation in drug control under the BRICS framework (Brazil, China, India, Russian Federation and South Africa) and establish consultation mechanisms on information exchange, anti-drug law enforcement cooperation, international drug control policy coordination, personnel training and exchange of experience.

3. National legislation, policy and action

577. The Central Narcotics Bureau of Singapore continues to strengthen controls over a number of controlled substances in order to contain the rapid emergence of new psychoactive substances and their adverse impact on public health. With effect from 1 May 2017, four new psychoactive substances were transferred from the fifth to the first schedule of the Misuse of the Drugs Act. One additional substance, U-47700, was added to the first schedule of the Act, following the decision of the Commission on Narcotic Drugs to include U-47700 in Schedule I of the 1961 Convention as amended by the 1972 Protocol in March 2017. Once listed in the first schedule of the Misuse of the Drugs Act, the trafficking, manufacture, sale, possession and consumption of any of these substances become a criminal offence.

578. In China, four fentanyl-class substances (carfentanil, furanylfentanyl, valeryl fentanyl, and acryl fentanyl) were placed in the List of Non-Medicinal Narcotic Drugs and Psychotropic Substances under Control on 1 March 2017. In addition, four substances (4,4'-DMAR, MT-45, PMMA and U-47700) were added to the list of controlled substances as of 1 July 2017, following the decisions of the Commission in 2016 and 2017.

579. The Republic of Korea placed benzodiazepine diclazepam (chlorodiazepam) and 13 other substances under temporary control in August 2016. A temporary scheduling system was introduced in the country in 2011 in response to the rapid emergence of new psychoactive substances. Substances can be placed under temporary control for a maximum of three years when deemed to require urgent scheduling as if they were narcotics. Once under temporary control, the possession, management, import and export, trade and assistance in the trade of those substances, or the giving or receiving of materials that contain the temporary scheduled substance shall be prohibited.

580. A total of 15 new psychoactive substances, including several hallucinogenic (NBOMe compounds) and cannabimimetic (JWH compounds) compounds, were added to the list of controlled substances in Viet Nam in 2015 to restrict their availability.

581. An amendment was made to the Narcotic Control Act in the Republic of Korea as a response to the increasing use of bitcoin for transactions on illegal online pharmacies. As of June 2017, any dissemination of information related to the illicit cultivation, manufacturing and trade of narcotic drugs through various media shall be prohibited. Any act of advertising drug trades and the posting of a manual for processing narcotic drugs via the Internet will be subject to punishment under the Act.

582. An executive order was signed in March 2017 by the President of the Philippines creating the "Inter-Agency Committee on Anti-Illegal Drugs". The Committee, which consists of 21 State agencies, chaired by the Philippine Drug Enforcement Agency, ensures that the Government's anti-illegal drug campaign is implemented in an integrated and synchronized manner.

583. The Board is aware of the continuing extrajudicial actions, including murder, taking place in relation to purported drug-related activities and/or crimes in the Philippines.

584. **The Board reminds all Governments that extrajudicial action, purportedly taken in pursuit of drug control objectives, is fundamentally contrary to the provisions and objectives of the three international drug control conventions, as well as to human rights instruments to which all countries are bound. All drug control actions should be undertaken in full respect of the rule of law and due process of law.**

4. Cultivation, production, manufacture and trafficking

(a) Narcotic drugs

585. Within East and South-East Asia, the illicit cultivation of opium poppy remains concentrated in two countries of the so-called Golden Triangle. In Myanmar, illicit opium poppy cultivation fell to its lowest level in 2006 but has climbed steadily since then. The total area under illicit opium cultivation was estimated to be 55,000 ha in 2015. Myanmar thus remained the world's second largest opium-producing country after Afghanistan. Close to 90 per cent of the total cultivation comes from the north-eastern part of the country, Shan State of Myanmar. According to the latest socioeconomic survey conducted by UNODC in the villages of Shan State, illicit opium poppy cultivation became more concentrated in 2016. While the proportion of villages producing opium

poppy fell by 30 per cent, the size of the average area under opium poppy cultivation increased. Meanwhile, illicit opium poppy cultivation in the Lao People's Democratic Republic continued to be considerably lower than in Myanmar (5,700 ha in 2015).

586. A significant and growing amount of opium illicitly cultivated and produced in the region continues to be trafficked into neighbouring countries and Oceania. According to UNODC, seizures of heroin and morphine made from opiates produced in the region rose from 7.1 tons in 2010 to 13.3 tons in 2015. The latest seizure data suggest that most heroin seized in China originates in Myanmar. In 2016, China reported heroin and opium seizures of 8.8 tons and 3.1 tons, more than the preceding year. Opium seizures in Myanmar also edged up from 962 kg in 2015 to 1,005 kg in 2016.

587. The illicit cultivation of, trafficking in and abuse of cannabis continues to be of major concern in Indonesia, the Philippines and Viet Nam. Philippine authorities eradicated close to 290 cannabis plantation sites in 2015, most of them located on the island of Luzon. The country also reported considerable seizures of cannabis (dried leaves) in 2016 (1.3 tons). Cannabis herb seizures in Myanmar increased from about 88 kg in 2015 to about 188 kg in 2016. Some cannabis herb has also been trafficked into East Asia, although in much smaller quantities. In China, cannabis herb seizures fell from about 9 tons in 2015 to less than 600 kg in 2016. Close to 160 kg of cannabis herb was seized in Japan in 2016, compared with 105 kg in 2015. In the Republic of Korea, about 21,000 cannabis plants were seized in 2016, compared with about 7,000 plants in the preceding year.

588. The amount of cocaine trafficked into the region has been rather limited, owing to its relatively low prevalence of use. Recent seizure data, however, seem to suggest its growing availability. Between 2010 and 2015, East and South-East Asia accounted for more than half (56 per cent) of the cocaine seized in Asia. Specifically, the amount of cocaine seized in Viet Nam jumped from 2.4 kg in 2013 to 178 kg in 2015. In China, a total of 431 kg of cocaine was seized in 2016, more than four times the amount in 2015 (98 kg). The drug was mainly trafficked in parcels to Guangdong and Hong Kong, China. The Republic of Korea also noted increased seizures of cocaine being trafficked into the country from South America through the United Arab Emirates in 2016. About 430 kg of cocaine was seized in Hong Kong, China, in 2016, considerably more than the year before (227 kg). Meanwhile, Japan and the Philippines reported 113 kg and 70 kg of seizures of cocaine powder.

(b) Psychotropic substances

589. The region continues to witness the further expansion of the methamphetamine market. Annual seizures of methamphetamine in East and South-East Asia increased more than fivefold between 2006 and 2015, according to UNODC. In addition, the total amount of methamphetamine seized in the region in 2015 (64 tons) surpassed the amount seized in North America (55 tons), as well as all other regions, making it the subregion with the greatest amount of methamphetamine seizures worldwide. While such increases may be indicative of the effectiveness of law enforcement, they also signal that trafficking of the substance continues to escalate.

590. China continues to report the largest amount of methamphetamine seizures in the region. Methamphetamine (in tablet and crystalline forms) seized in the country rose from 19.5 tons in 2013 to 36.6 tons in 2015. About 31 tons of methamphetamine seizures was reported in 2016. Almost all methamphetamine tablets were seized in the south-western part of the country neighbouring the Golden Triangle.

591. About 2.2 tons of methamphetamine seizures were reported by the Philippines in 2016, much higher than the average level in the previous five years. A similar trend was found in Japan, where a total of 1.5 tons of methamphetamine were seized in 2016, the second largest amount on record for that country. Around 2.5 tons of methamphetamine were seized in Myanmar in 2016, 200 kg more than in 2015 (2.3 tons). While the amount of methamphetamine seized in the Republic of Korea was comparatively small (28.6 kg in 2016), law enforcement authorities noted a diversification since 2010 of the source of supply (including supply from some African countries and Mexico).

592. Substantial methamphetamine seizures were reported by Indonesia in 2015 (4,420 kg), compared with annual seizures of not more than 2,100 kg in the previous few years. According to the national authorities, the share of crystalline methamphetamine trafficked by sea increased considerably, from around 4 per cent in 2013 to 80 per cent in 2015. This trend poses particular challenges and demands specific attention in the light of the large number of islands and the lengthy coastline of the country.

593. Malaysia has been increasingly used as a transit country for the trafficking of methamphetamine to other countries in the region and Oceania. Between 2004 and 2008, an average annual seizure amount of 135 kg was reported by country officials. However, annual seizures have surged to more than 1 ton per year since 2009. Another 1.1 tons of methamphetamine were seized in 2015.

594. For the first time since 2008, the crystalline methamphetamine seized in the region in 2015 was larger by weight than that of methamphetamine tablets seized. Data for 2016 suggested that that trend was continuing.

595. More than 34 tons of crystalline methamphetamine was seized in the region in 2015, with significant quantities being reported by Cambodia, China, Indonesia, the Lao People's Democratic Republic, Myanmar, the Republic of Korea and Viet Nam. Countries in the Greater Mekong subregion (Cambodia, China, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam) continued to account for the majority (75 per cent) of these seizures. Meanwhile, the retail price and average purity of crystalline methamphetamine remained at high levels.

596. A total of 287 million methamphetamine tablets were seized in the region in 2015. Most of those seizures were reported by the six countries of the Greater Mekong subregion. The average purity of methamphetamine tablets seized in those countries remained steady.

597. Large quantities of methamphetamine tablets (6.33 million tablets) were seized in the Lao People's Democratic Republic in 2015, almost double the level in 2014 (3.83 million tablets). While that spike was mainly due to a single large-scale seizure case, the significant quantities of methamphetamine tablets seized since 2010 suggest that the country remains a major country of transit for tablets originating in the Golden Triangle.

598. In recent years, Cambodia has been frequently used as a source, transit and destination country of amphetamine-type stimulants. A significant increase in methamphetamine seizures was reported in the country, with seizures of crystalline methamphetamine reaching a record level of 73 kg in 2015, more than twice the level in 2013 (32.5 kg). A similar trend was also observed for methamphetamine tablets. More than 260,000 methamphetamine tablets were seized in 2015, compared with around 170,000 tablets in 2013.

599. Both the number and scale of clandestine synthetic drug manufacturing facilities dismantled in the region have increased, indicating a greater capacity for illicit manufacture of methamphetamine. In 2015, close to 600 illicit manufacturing facilities were dismantled in the southern provinces of China, an 8 per cent increase over the preceding year. These facilities were mainly used for the illicit manufacture of methamphetamine. Authorities also noted that organized criminal groups engaging in the illicit manufacture of methamphetamine and ketamine have become equipped with more advanced facilities and have better manufacturing capabilities.

600. Annual total quantities of "ecstasy" seized in the region have often varied greatly due to single seizure cases involving huge drug quantities, and thus no clear pattern or trend is discerned. Large seizure cases reported recently included nearly 2.4 million "ecstasy" tablets containing MDMA seized in Myanmar in 2014, and more than 400,000 "ecstasy" tablets seized in Malaysia in 2015. Malaysia was perceived as being one of the major embarkation points for "ecstasy" found in Brunei Darussalam and Indonesia. In 2016, seven "ecstasy" tableting facilities were dismantled in Malaysia. Indonesia also reported significant seizures between 2010 and 2015, and accounted for more than half of the "ecstasy" seized in the region.

(c) Precursors

601. Despite the large and growing use of methamphetamine in East and South-East Asia, only China had reported significant seizures of ephedrine and pseudoephedrine to the Board in recent years. In 2015, ephedrine seizures reported by the country (23.5 tons) accounted for almost all of the region's total. The limited amounts of precursors seized contrast sharply with the data on the amount of methamphetamine seized in the region.

602. The trafficking of acetic anhydride and other precursor chemicals into China and Myanmar shows no sign of regression. In 2015, more than 11,000 litres of acetic anhydride were seized in China and 60 litres were seized in Myanmar. According to the annual report on the drug situation in China of 2016, close to 1,600 tons of precursors were seized in 2016. Increasing amounts of caffeine, an adulterant used in methamphetamine tablets, had been seized in Myanmar in 2015 and 2016.

603. A comprehensive review of the situation with respect to the control of precursors and chemicals frequently used in the illicit manufacture of narcotic drugs and psychotropic substances in the region can be found in the report of the Board for 2017 on the implementation of article 12 of the 1988 Convention.

(d) Substances not under international control

604. Close to 170 new psychoactive substances, mostly synthetic cathinones and synthetic cannabinoids, were reported by countries in the region between 2008 and 2016.

605. The emergence of several synthetic opioids, benzodiazepine derivatives and a range of other substances suggests a growing diversity of new psychoactive substances.

They are often sold in tablet form, as "ecstasy", or under various street names. Health authorities find the trend disturbing because users are often ignorant of the related health risks.

606. Authorities in China reported that the manufacture and trafficking of new psychoactive substances had been somewhat contained after the scheduling of 116 new psychoactive substances in 2015. However, new legal alternatives and even newly developed analogues have emerged as a way to circumvent legal and regulatory controls.

607. Considerable quantities of ketamine continue to be seized in some East and South-East Asian countries. In 2015, ketamine seizures in the region reached 20.4 tons and made up 97 per cent of the global total. In 2016, China continued to report sizeable seizures (10.4 tons). Around 940 kg of ketamine was seized in Myanmar. A total of 113 illicit ketamine manufacture facilities were dismantled by the Chinese authorities in the same year. While most of the ketamine manufactured was consumed locally, some had been trafficked into Macao and Hong Kong, China, and other countries within the region. Malaysian authorities dismantled an industrial-scale illicit ketamine laboratory in 2016. The misuse of ketamine in China is indicated to have increased over the past six years. Similarly, ketamine use in Brunei Darussalam has increased for three consecutive years since 2013, according to the government expert perception.

608. Some countries continue to report considerable seizures of kratom and khat, two plant-based psychoactive drugs, the former of which is illicitly cultivated in Malaysia, Myanmar and Thailand. Nearly 29 tons of kratom was seized in Malaysia in 2015, the greatest amount reported by that country. Close to 28 tons of kratom was also seized in Thailand. In 2016, authorities in Viet Nam seized considerable amounts of khat entering the country from South Africa and destined for Australia and the United States. In March 2017, a single operation in China resulted in the seizure of 86 kg of khat originating in Africa that was being trafficked by express mail.

5. Abuse and treatment

609. Most countries in the region have struggled with the lack of quantitative data on drug abuse among the general population for some years. Drug abuse surveys usually focus on specific population groups, like registered drug users or those receiving treatment and rehabilitation services. Some positive developments have been observed recently, with the release of results from the 2015 national drug use survey in Indonesia and the Philippines, and the first ever national drug use survey being conducted in Myanmar, with support from UNODC. **The Board takes note of such developments and encourages UNODC and other international organizations to continue providing technical assistance in this regard, taking into consideration the continuous emergence of new psychoactive substances in the region and health threats posed by them.**

610. Qualitative information collected by UNODC on perceived trends in the abuse of drugs indicated by government experts provides an overview of the regional situation. All countries in the Greater Mekong subregion except Thailand perceived increases in the abuse of methamphetamine tablets in 2015. At the same time, almost all countries of East and South-East Asia, except Indonesia and Japan, registered increases in the perceived misuse of crystalline methamphetamine. Several countries, including Cambodia, China, the Philippines, Singapore and Viet Nam, reported perceived consecutive increases in the abuse of crystalline methamphetamine in the past few years. Heroin abuse continued to be a major concern for some countries (Myanmar, Malaysia and Viet Nam), with increasing trends of abuse being perceived in Cambodia, Malaysia, Thailand and Viet Nam in 2015.

611. For most countries, people receiving treatment for the abuse of crystalline methamphetamine constituted the largest share of people admitted for treatment. Over 90 per cent of all persons in drug treatment in Brunei Darussalam in 2015 used crystalline methamphetamine. Three quarters of the drug users admitted for treatment in Cambodia in 2014 used crystalline methamphetamine.

612. Some countries witnessed a spike in the number of drug treatment admissions. For instance, the number of temporary drug treatment admissions in Cambodia jumped from around 1,000 in 2011 to close to 5,000 in 2015. A similar surge was also found in Myanmar, where the total number of persons admitted to drug treatment centres rose from less than 2,000 in 2011 to slightly over 7,500 in 2015, the highest annual total ever reported in the country.

613. Results from the latest national drug use survey in Indonesia revealed that 0.6 per cent of the general population aged 10-59 years was estimated to have used an illicit drug at least once in 2015. Cannabis remained the major drug of concern, with an annual prevalence rate of 0.18 per cent. Second came methamphetamine (0.09 per cent). The abuse of dextromethorphan, a cough suppressant, has increased rapidly, while the abuse of heroin declined.

614. There were about 1.8 million drug users in the Philippines, according to the results of its 2015 national drug use survey. Cannabis remained the most widely used drug in the country, followed by crystalline methamphetamine. The abuse of crystalline methamphetamine continued to account for the majority of drug-related arrests and treatment admissions. The most recent drug treatment admission data (for 2016) revealed that admissions at residential facilities increased from about 5,400 in 2015 to slightly over 6,000 in 2016.

615. China estimated that there were about 2.5 million registered drug users in the country at the end of 2016. The majority of the registered drug users used synthetic drugs (60 per cent), while about 38 per cent of all users used opiates and the remaining portion used cannabis and cocaine. The proportion of synthetic drug users in the country continued to rise in recent years, making it the primary drug group of concern for the country. The trend is particularly dominant among newly identified drug users, among which over 80 per cent used synthetic drugs in 2015.

616. Recent data from Hong Kong, China, suggested a slight decline in the extent of drug use. The total number of reported drug users decreased from about 10,200 in 2013 to less than 9,000 in 2015. While heroin continued to be the most commonly used drug, the number of users of crystalline methamphetamine reached almost 2,200, slightly overtaking the number of ketamine users.

617. The Provincial Committee for Drug Control in the Lao People's Democratic Republic estimated that there were about 65,000 to 70,000 drug users in the country in 2015, equivalent to about 1 per cent of the total population. Methamphetamine tablets remained the primary drug of concern.

618. The number of registered drug users in Viet Nam rose rapidly between 2010 and 2015, from around 143,000 to slightly over 200,000. Although heroin users still accounted for the majority of registered drug users (75 per cent), the number of amphetamine-type stimulant users has grown considerably and constituted the majority of newly registered drug users in recent years. UNODC reported that about 24,000 persons received compulsory drug treatment from drug treatment centres, and another 25,000 drug users received community-based treatment in 2015.

619. Heroin remains the major drug of concern in Malaysia. Yet the number of treatment admission for amphetamine has been rising. Of the drug treatment admissions in 2015 (6,032), around 4,300 were for opiates, followed by amphetamines (1,571). The number of admissions for amphetamine treatment in 2015 was almost twice that of the previous year (839 admissions).

620. The number of persons admitted for drug treatment in Thailand declined considerably in recent years, partly as a result of the Government's promotion of voluntary treatment for drug users. The total number of drug treatment admissions dropped from almost 230,000 in 2014 to about 120,000 in 2015. Methamphetamine continued to be the most common drug of abuse reported by those in treatment, followed by cannabis. The total number of methamphetamine users in the country was estimated to be 2.89 million in 2014; close to 80 per cent of those individuals reported abuse of methamphetamine tablets.

621. National authorities in Singapore reported that almost two thirds of the new drug users in 2016 were less than 30 years old, underscoring the problem of young drug users in the country. Methamphetamine and heroin continued to be the two most commonly used drugs, followed by cannabis.

South Asia

1. Major developments

622. In 2016, the rise in the illicit manufacturing of, trafficking in and abuse of methamphetamine, as well as of the diversion and abuse of pharmaceutical preparations containing narcotic drugs and psychotropic substances remained among the major drug-related challenges in the region. In India, the quantities of amphetamine-type stimulants seized increased tenfold over the previous year's figures. In November 2016, a large quantity of methaqualone (23.5 tons) was seized in India. In 2016, Bangladesh reported one of the largest seizures of methamphetamine tablets ever made in the country. In addition, the region continued to be particularly vulnerable to trafficking in opiates and heroin. The amount of heroin trafficked into Sri Lanka increased almost fivefold in 2016.

2. Regional cooperation

623. The Fortieth Meeting of Heads of National Drug Law Enforcement Agencies, Asia and the Pacific, was held in Colombo from 24 to 27 October 2016. Over 150 participants from the law enforcement, foreign affairs and health sectors discussed the status of drug control and treatment in the region and adopted a number of

expert recommendations focusing on the following topics: national and regional responses to the evolving threat posed by amphetamine-type stimulants and new psychoactive substances; measures to ensure comprehensive and balanced efforts at the national level to reduce drug demand; and best practices in preventing and countering drug-related money-laundering and illicit financial flows.

624. As part of the Indian Ocean Forum on Maritime Crime, Sri Lanka hosted a high-level meeting of security and interior ministers of countries in the Indian Ocean region with a view to countering drug trafficking on the high seas. The meeting, which was held on 28 and 29 October 2016, focused on developing operational priorities and mechanisms for cooperation in the region.

625. In India, the Directorate of Revenue Intelligence under the Central Board of Excise and Customs hosted the fourth regional customs enforcement meeting in New Delhi on 10 December 2016. The meeting was attended by heads of customs enforcement and senior officers from Sri Lanka, Myanmar, Bangladesh, Nepal, Bhutan, Mauritius and Maldives. The participants shared experiences in combating smuggling and evasion of duties and exchanged information about, among other topics, the modi operandi for the smuggling of gold, fake Indian currency notes, narcotic drugs and psychotropic substances, antiques and foreign currency.

3. National legislation, policy and action

626. The Bhutan Narcotics Control Authority held several training and capacity-building activities on drug-related issues. In January 2017, school counsellors from around the country, non-governmental organizations and government organizations completed their final curriculum on the universal treatment certification programme on addiction counselling initiated by the Authority in 2013 with the technical support of the Colombo Plan. In March 2017, a conference on addiction prevention was held for the peer councillors from various drop-in centres in Bhutan. In June 2017, a training and awareness-raising programme on drug testing and on the provisions of drugs and tobacco laws was held for security officials of Paro Airport.

627. On 11 April 2017, the High Court of Delhi, India, in a ruling on the challenge to a conviction for ketamine trafficking, upheld the inclusion of ketamine in the list of psychotropic substances for the purposes of the Narcotic Drugs and Psychotropic Substances Act, 1985. In India, ketamine was included in the list of psychotropic substances with a notification dated 10 February 2011.

4. Cultivation, production, manufacture and trafficking

(a) Narcotic drugs

628. Cannabis is one of the substances most cultivated, trafficked and abused in the region. Law enforcement agencies in India reported seizures of 100 tons of cannabis per year on average between 2013 and 2015. The number of cannabis seizures rose from 8,130 in 2015 to 14,401 in 2016, while the quantities of cannabis seized rose from 94.4 tons to 294 tons over the same period. It was the largest quantity of cannabis seized in India in 15 years. About 45 tons of cannabis were seized in the first half of 2017. Law enforcement authorities eradicated 3,414 ha of illicitly cultivated cannabis in 2016, the largest area since 2010 and a tenfold increase compared with the previous year (331 ha). Trafficking in cannabis from Nepal to India continued to be a major concern.

629. Seizures of cannabis in Bangladesh have been showing an upward trend since 2013. In 2016, the quantities of cannabis seized in the country increased slightly from 41 tons in 2015 to 47 tons. Bangladesh has a history of illicit cannabis production and consumption, and cannabis remained the main substance of abuse in the country. Bangladesh is exposed to drug trafficking of cannabis from its neighbours India and Nepal.

630. Despite eradication efforts and campaigns by the Government of Nepal, the illicit cultivation of cannabis continued during the reporting period. The open border between Nepal and India is vulnerable to cannabis trafficking in the region. Nepal reported seizures of over 4.4 tons of cannabis in 2016, compared with 6.6 tons seized in 2015.

631. Maldives has also emerged as a transit point for narcotic drugs being trafficked to other destinations. The geographical location of Maldives and multiple sea routes around the country make it a vulnerable trans-shipment point for illegal consignments of drugs intended for other countries. Drugs are smuggled into Maldives through seaports and airports. In Maldives, 67.4 kg of cannabis were seized in 2016.

632. Cannabis is the only plant-based drug that is illicitly cultivated in Sri Lanka. Cannabis seizures in Sri Lanka have been declining since 2011, when 203 tons were seized. Since that year, seizures have declined significantly to 81.9 tons in 2013 and 6.56 tons in 2015. In 2016, the decline in cannabis seizures continued and the amount seized was 4.17 tons.

633. In India, while cannabis seizures underwent a large increase, cannabis resin seizures declined from 3.3 tons in

2015 to 2.7 tons in 2016, whereas the number of seizures increased by 10 per cent over 2015 to 2,562 cases in 2016. In addition to having its domestic production of cannabis resin, Nepal is a major source of cannabis resin trafficked in India.

634. In Sri Lanka, about 40 kg of cannabis resin were seized in 2016. The total number of drug-related arrests in the country was 79,398 in 2016, a 4 per cent decrease compared with the previous year.

635. Cannabis resin consignments bound for Tokyo using cargo and couriers were intercepted in Kathmandu. According to the police of Nepal, Japan is becoming a drug trafficking destination for criminal syndicates in the country. In 2016, the quantity of cannabis resin seized in Nepal increased to above 1.9 tons, from 1.5 tons in 2015.

636. In recent years, the South Asia region has been experiencing the impact of the increasing use of the southern route, with larger than usual amounts of heroin from Afghanistan being seized, particularly in Sri Lanka (the southern route is a collection of trafficking routes used by organized criminal groups for the southerly flows of heroin out of Afghanistan). The southern route often originates from ports in Pakistan and the Islamic Republic of Iran. Heroin is the second most common drug of abuse in Sri Lanka. Heroin and other opiates are not manufactured in Sri Lanka. Heroin trafficking into the country has been steadily increasing. In 2016, it increased almost fivefold to 207 kg, from 46.6 kg in 2015.

637. The quantity of heroin seized in India increased to 1.67 tons in 2016, from 1.42 tons reported in 2015. It was the largest quantity of heroin India reported seized in 20 years.

638. Similar increases in heroin trafficking have been observed in Bangladesh, where seizures of heroin more than doubled from 108.7 kg in 2015 to 266.8 kg in 2016. On the other hand, heroin seizures in Nepal decreased from 6.4 kg in 2015 to 3.7 kg in 2016. In Maldives, about 46.9 kg of heroin were seized in 2016.

639. There was a decline in opium seizures in India from 2010 to 2015. However, in 2016, they increased again to 2.3 tons, 30 per cent more than the 1.69 tons seized in 2015. The number of opium seizures also increased during the same period, from 860 to 933, while the quantities of morphine seized declined from 61 kg recorded in 2015 to 28 kg in 2016.

640. Agencies in India use satellite imagery and field surveys coupled with local intelligence-gathering to track and reduce illicit opium poppy and cannabis cultivation. The amount of illicitly cultivated opium poppy destroyed in India rose by almost 90 per cent, from 1,401 ha eradicated in 2015 to 2,635 ha in 2016, the highest in five years.

641. In 2016, authorities in Nepal made 3,696 arrests for drug trafficking offences, compared with 2,656 in 2015. The Narcotics Control Bureau of Nepal reported that the amount of opium seized in the country increased significantly to 64.2 kg in 2016, as compared with 9.8 kg seized in 2015.

642. Trafficking in cocaine in South Asia has historically been limited. The quantity of cocaine seized in India decreased significantly from about 113 kg in 2015 to 28 kg in 2016. Around 5.7 kg of cocaine were seized in Sri Lanka in 2015. In 2016, at the port of Colombo, authorities seized 928 kg of cocaine concealed in a container holding a consignment of timber from Ecuador. The consignment was en route to India and was being transshipped at the port when the seizure was made. It was the largest seizure of cocaine ever made in the history of South Asia by any law enforcement agency. In 2016, the authorities in Sri Lanka made several more cocaine seizures totalling around 500 kg. The cocaine was being trafficked in container cargo originating from Latin America.

643. In Bangladesh, less than 1 kg of cocaine was seized in 2016. That compared with 5.7 kg seized in 2015, the first reported seizure of cocaine in that country since 2009. The trend of increasing seizures of cocaine in Nepal continued in the reporting period. The first case of cocaine trafficking in Nepal was reported in 2012; since then seizures of cocaine in the country have been growing. In 2016, authorities in Nepal seized 13.62 kg of cocaine, the largest quantity of cocaine seized in the country so far and significantly more than the 11 kg seized in 2015. In Maldives, approximately 5 kg of cocaine were seized in 2016.

644. Codeine-based cough syrups were widely abused in Bangladesh and were being smuggled into the country in large quantities. In 2016, 566,525 bottles of codeine-based preparations were seized in Bangladesh. It was the lowest quantity seized in the country since 2010. Synthetic opioids such as buprenorphine (an opioid controlled under the 1971 Convention) and pentazocine in injectable form continued to be trafficked into Bangladesh. Seizures of drugs in injectable form sharply increased to 152,740 ampoules in 2016, from 86,172 ampoules seized in 2015.

(b) Psychotropic substances

645. The manufacture of, trafficking in and abuse of amphetamine-type stimulants in the region remains a challenge. According to reports by the Narcotics Control

Bureau of India, in 2016, the quantities of amphetamine-type stimulants seized increased tenfold over the previous year. In 2016, India seized 1,687 kg of amphetamine-type stimulants in 20 seizures, while in 2015, it seized 166 kg in 21 cases.

646. Seizures of methaqualone in India increased from 89 kg in 2015 to 24.1 tons in 2016. In November 2016, the Directorate of Revenue Intelligence seized 23.5 tons of methaqualone at a clandestine factory in the State of Rajastan in the country's hinterland. It was one of the biggest seizures of methaqualone in India.

647. In January and February 2017, the anti-narcotics cell of the Mumbai police reported having made a number of mephedrone seizures. On 29 January 2017 it reported a particularly large seizure of 104 kg of mephedrone, together with 38 grams of cocaine. In the course of February 2017, Mumbai police reported a number of additional mephedrone seizures consisting of smaller quantities ranging from 1 kg to 25 kg.

648. In April 2017, the Narcotics Control Bureau of India closed down one illegal Internet pharmacy and a large quantity of psychotropic substances including alprazolam, amphetamine, diazepam, clonazepam, lorazepam was seized. Two persons were arrested in relation to this operation under the Narcotic Drugs and Psychotropic Substances Act.

649. The smuggling of "yaba" (methamphetamine) tablets from Myanmar across the country's south-eastern border to Bangladesh has continued; the quantities seized by law enforcement agencies in Bangladesh have been rapidly increasing since 2010. The Department of Narcotics Control of Bangladesh reported seizures of 29.4 million methamphetamine tablets in 2016, the largest amount seized in the country to date. It surpasses the previous high of 20.1 million tablets seized in 2015.

650. Trafficking in and the abuse of psychotropic substances continue to escalate in Nepal. In 2016, 34,977 ampoules of diazepam and 25,191 ampoules of buprenorphine were seized. In the period from January to April 2017, law enforcement authorities seized 11,640 ampoules of diazepam and 11,632 ampoules of buprenorphine.

(c) Precursors

651. Seizures of ephedrine and pseudoephedrine in India increased from 827 kg in 2015 to 21.27 tons in 2016. This sharp rise was the result of one single seizure of more than 20 tons of ephedrine from a facility allegedly involved in the clandestine manufacture of amphetamine-type stimulants. In the same case, 2,661 litres of acetic anhydride were seized. In 2015, only one seizure of acetic anhydride was reported, totalling 4 litres.

652. A comprehensive review of the situation with respect to the control of precursors and chemicals frequently used in the illicit manufacture of narcotic drugs and psychotropic substances in South Asia can be found in the report of the Board for 2017 on the implementation of article 12 of the 1988 Convention.

(d) Substances not under international control

653. Ketamine seizures in India continued in 2016. In April, the Directorate of Revenue Intelligence in Bangalore seized 13.8 kg of ketamine and 170.9 kg of alprazolam in one single case.

654. The emergence of new psychoactive substances poses a unique and difficult challenge for governments and law enforcement agencies in the region. There is an urgent need to strengthen the enforcement and forensic capacities of agencies in the region to meet this challenge. In 2016, UNODC held capacity-building workshops for law enforcement officials and forensic experts from the region on the identification and detection of new psychoactive substances.

5. Abuse and treatment

655. The lack of representative surveys on household drug use and of regular national assessments concerning the nature and extent of drug abuse has made it difficult to keep track of the latest trends in the region. The Ministry of Social Justice and Empowerment of India has constituted a committee to conduct a survey on the use and abuse of drugs in the country. The last such survey was conducted in 2001.

656. According to a study by the Postgraduate Institute of Medical Education and Research, Chandigarh, entitled "Epidemiology of substance use and dependence in the State of Punjab", between 100,000 to 270,000 people, mostly young, poorly educated males, were dependent on opioids in the State of Punjab, India. Their average age was 30 years, and half of them were unmarried. The study was conducted from 2015 to 2017 and the results were released in September 2017. The study revealed that among the 6,600 Punjabis enrolled in the survey from 22 districts, 88 per cent were dependent on opioids. Lifetime

dependency was 99 per cent. The study identified opium and poppy husk as the most common types of opioids abused in the state, while injection opioid abuse was the second most common form. According to the study, there were 78,000 people who injected opioids in Punjab. Among injection opioids, heroin (61.6 per cent) was the most common drug, followed by buprenorphine (used to treat opioid addiction). The study found that the problem of substance abuse and dependence in Punjab was serious, especially in rural areas. There were more than 22 rehabilitation centres, at least one in each district, and more than 30 so-called drug de-addiction centres, in Punjab. The Government has moved forward to tackle the drug problem in the state and has expressed its plans to integrate the drug de-addiction centres with rehabilitation centres.

657. In Sri Lanka, in 2016, cannabis and cannabis resin, heroin and cocaine were the drugs most abused. The estimated number of registered drug users dependent on cannabis was 200,000, whereas for opioids the number was 45,000. According to the drug abuse monitoring system, the number of people who received drug treatment for any controlled substance in Sri Lanka in 2016 was estimated at 2,355. The number of drug users receiving treatment had increased by 59 per cent compared with 2015. Their average age was 34, and only 1.5 per cent were female. Opium and heroin were the main drugs for which they sought treatment. Of the total number of reported drug users, 35 per cent were in government treatment facilities, 29 per cent were in prison drug treatment and rehabilitation programmes and 20 per cent were in treatment facilities operated by non-governmental organizations.

658. According to the survey of the National Dangerous Drugs Control Board of Sri Lanka, among the 45,000 heroin-dependent persons in the country, about 2.5 per cent were people who injected drugs. The majority of them lived in Colombo and the coastal areas. The majority of the people who injected drugs took more than one type of drug. According to the survey findings, 69 per cent of people who injected drugs did so regularly and 31 per cent occasionally.

659. Drug abuse is on the rise in Maldives. Various drugs have become more available in Maldives in recent years. Heroin and hash oil were the most common types of drugs abused by a majority of drug-dependent people in the country.

660. Pharmaceutical preparations of codeine-based cough syrups and controlled substances such as buprenorphine, diazepam and nitrazepam were among the most commonly abused substances in Nepal.

661. In 2016, a total of 12,815 patients with drug-related disorders were treated in private treatment centres in Bangladesh, up from 9,987 patients in 2015. The abuse of "yaba" (methamphetamine) tablets and of codeine-based preparations continued to be widespread in Bangladesh, and was still increasing.

662. Bhutan reported that the majority of drug users in the country were young people and that they were mainly dependent on cannabis and controlled substances such as diazepam, nitrazepam and preparations such as codeine-based cough syrups.

663. Bhutan carried out a national survey on drug use from October to December 2016 that covered 20 districts. Beside being the largest of its kind in Bhutan, the survey was also the first for which prevalence data among young people were collected. The national drug use survey was conducted in schools and university colleges, as well as in community-based settings. The survey found that one in every five students abused cannabis and one out of six students reported abusing solvents. The survey has revealed that the average age at which young people start using tobacco and alcohol was 14 and 15 years, respectively. The average age at which they started abusing cannabis and other illicit drugs was 16 years. The research was coordinated by the Bhutan Narcotics Control Authority.

West Asia

1. Major developments

664. West Asia continues to face major challenges to drug control efforts due to opiate trafficking from Afghanistan. Accounting for two thirds of the estimated global area under illicit opium poppy cultivation, Afghanistan has itself seen increasing social, environmental and economic costs associated with the illicit cultivation, production and consumption of opiates. Moreover, drug trafficking is benefiting the insurgency and terrorism in the country at the hands of the Taliban and other groups, which has potential spillover effects for the entire region and the rest of the world.

665. Although the so-called Balkan route continues to be the main conduit for trafficking in opiates from Afghanistan worldwide, another route, one that transits the Caucasus countries, is being used more frequently. This is because Turkey, one of the countries on the Balkan route, has strengthened its border controls in response to the movement of migrants and refugees.

666. The current instability in the Near and Middle East, due to prolonged conflicts, has led to a significant increase in drug trafficking and abuse affecting many countries in the region. Most notably, recent reports of drug raids and arrests in Iraq indicate that that country's drug problem is growing more severe and, possibly, that there is a shift towards illicit local drug production. Regional instability also seems to have exacerbated the situation in Lebanon, where there are reports that cannabis resin and possibly opium are being produced illicitly. There are indications of increased cocaine trafficking affecting Jordan, Lebanon, Saudi Arabia, the Syrian Arab Republic and the United Arab Emirates. According to the very limited information available with respect to drug-related developments in Yemen, drug trafficking in that country is on the rise owing to the protracted conflict there. Concerned about the ever-stronger links between drugs and violence in the Near and Middle East, INCB urges concerned countries to enhance information-sharing and regional and international cooperation to counter drug trafficking flows into, through and out of the region. In that context, INCB encourages the countries in the region to avail themselves of the technical assistance initiatives implemented by the international community, including UNODC, in the areas of border management, container control, counter-terrorism and the strengthening of criminal justice systems in line with rule of law, and calls upon the international donor community to support such initiatives in the region.

667. In South-West Asia, challenges posed by cannabis trafficking continued to be faced by Afghanistan, Iran (Islamic Republic of) and Pakistan. In addition, there were indications of increasing activity in the synthetic drug market in Afghanistan and the wider South-West and Central Asian subregions.

668. Relatively limited information is collected and reported on trafficking in and the abuse of new psychoactive substances in most countries in West Asia. Nevertheless, the latest available information for 2016 suggests that several of those countries, including Kazakhstan, Lebanon, Tajikistan and Uzbekistan, witnessed an increase in the abuse of new psychoactive substances, in particular synthetic cannabinoids. Several countries in the region continued to see trafficking in and the abuse of tramadol, a synthetic opioid not under international control.

669. Most countries in the region faced a lack of resources for comprehensive and regular drug use surveys. Even though opioids remained a major concern in South-West and Central Asia, some countries reported decreases in the number of persons using heroin in 2016, possibly owing to a shift towards new psychoactive substances such as synthetic cannabinoids. There were concerns about increasing methamphetamine use in South-West Asia, and there was growing evidence of tramadol trafficking and abuse in the countries of the Near and Middle East.

2. Regional cooperation

670. Central Asian countries continued to intensify their cooperation in combating drug trafficking. In 2016, the Central Asian Regional Information and Coordination Centre (CARICC) provided assistance to the competent authorities of Kazakhstan, Kyrgyzstan, the Russian Federation and Tajikistan in coordinating seven international anti-drug operations. As a result, drug deliveries were intercepted on their way from Afghanistan to Tajikistan, from Tajikistan through Kyrgyzstan to the Russian Federation, and from Kyrgyzstan to Kazakhstan, the Russian Federation and Lithuania. Forty-five organizers and active members of transnational drug trafficking organizations in Kazakhstan, Kyrgyzstan, Lithuania, the Russian Federation and Tajikistan were arrested and 192 kg of drugs were seized.

671. On 17 March 2017, the Security Council unanimously adopted resolution 2344 (2017), in which it extended the mandate of UNAMA until 17 March 2018. In that resolution, the Security Council called upon States to strengthen international and regional cooperation to counter the threat to the international community posed by the illicit production of, trafficking in and illicit consumption of drugs originating in Afghanistan, which significantly contributed to the financial resources of the Taliban and its associates, in accordance with the principle of common and shared responsibility in addressing the drug problem in Afghanistan, including through cooperation against the trafficking in drugs and precursor chemicals. The Council also expressed appreciation for the work of the Paris Pact initiative and its "Paris-Moscow" process, and the efforts of SCO. It underlined the importance of border management cooperation and welcomed the intensified cooperation of the relevant United Nations institutions with the Organization for Security and Cooperation in Europe (OSCE), the Collective Security Treaty Organization and CARICC in that regard.

672. The thirteenth Policy Consultative Group meeting under the Paris Pact initiative was held in Vienna on 1 and 2 February 2017. It was attended by more than 100 participants from 30 countries and 11 organizations. Discussions focused on the four pillars of the Vienna Declaration, which was the outcome document of the

Third Ministerial Conference of the Paris Pact Partners in Combating Illicit Traffic in Opiates Originating in Afghanistan, held in Vienna in 2012, namely regional cooperation and initiatives, preventing illicit financial flows, precursor chemicals and drug demand reduction.

673. The twelfth senior officials meeting of the Triangular Initiative, which involves Afghanistan, Iran (Islamic Republic of) and Pakistan, was held in Vienna on 3 February 2017 to take stock of progress made and discuss future cooperation in jointly addressing drug trafficking. The three countries renewed their commitment to strengthening joint operational activities and intensifying border controls, including by developing mechanisms for border meetings among the commanders of border protection forces and the counter-narcotics police to exchange information and intelligence, and by having the heads of the counter-narcotics agencies of the three countries hold regular meetings.

674. In Zanzibar, United Republic of Tanzania, in March 2017, representatives of the Triangular Initiative countries gathered for the first time with representatives of African and Indian Ocean States including Kenya, Madagascar, Nigeria, Seychelles, South Africa, the United Republic of Tanzania and the United Arab Emirates, as well as with Colombia, for the interregional sharing of experiences and best practices in detecting, investigating and disrupting the methods used by transnational organized crime groups to finance their activities. At the conclusion of the meeting, experts recommended that a similar meeting should be held every six months to exchange updates on current money-laundering threats, new methods for disrupting the finances of organized crime networks and priorities for technical assistance.

675. The seventh meeting of senior officials of the counter-narcotics agencies of the SCO member States vested with authority to combat drug trafficking was held in Astana in April 2017. Participants exchanged views on the drug control situation in the SCO member States, the prospects for developing international cooperation in countering drug trafficking and on measures to enhance practical interaction between the counter-narcotics agencies of the SCO member States. In that connection, officials stressed the need to support and preserve the current international drug control system and to adopt adequate measures to improve the regional drug control situation.

3. National legislation, policy and action

676. The Government of Armenia approved a programme of measures for 2017 aimed at tackling drug addiction and countering drug trafficking. The programme consisted of a comprehensive set of measures for addressing prevention, treatment and rehabilitation and combating drug trafficking. Georgia reported that its Government had approved a new regulation on the import and export of precursors.

677. The Anti-Narcotics Force of Pakistan took multiple steps in 2016 to address drug trafficking. It completed the deployment of its personnel at all international airports, seaports and dry ports in Pakistan; continued the destruction of opium poppy crops in coordination with the provincial governments and the administration of the Federally Administered Tribal Areas; established sniffer dog units at each of its regional directorates (Khyber Pakhtunkhwa, North, Punjab, Sindh and Balochistan) and trained its personnel in countering trafficking in precursors and drugs. In 2016, the authorities also carried out intelligence-led operations with their counterparts from Australia, Canada, France, Italy, Qatar, South Africa, the United Arab Emirates and the United States, resulting in seizures of heroin, methamphetamine and other substances.

678. In June 2016, the Cabinet of Ministers of Uzbekistan adopted a decree approving new rules on the carrying of medicines for personal use, including medicines containing narcotic drugs and psychotropic substances.

679. From 9 to 14 July 2017, the Government of Afghanistan, with assistance from UNODC, held a campaign entitled "National mobilization against narcotics" to raise public awareness of the dangers associated with drug production and trafficking. On the first day, a national event was held in which more than 200 people participated, including the Second Vice-President, ministers, religious scholars, members of the National Assembly and representatives of national and international organizations and civil society. Speakers discussed various challenges in addressing the drug problem and called for national, regional and global efforts to overcome them. The national mobilization campaign focused on such issues as responsibilities and actions of the Government, women's affairs, community engagement, religious platforms and engagement with the development sector.

4. Cultivation, production, manufacture and trafficking

(a) Narcotic drugs

680. As discussed in section E of chapter II of the present report, the Board is extremely concerned about the continued substantial increase in cultivation of opium

poppy and production of opium in Afghanistan over the past two years. In 2017, opium production reached a record 9,000 tons, representing an increase of 87 per cent from 2016, according to the *Afghanistan Opium Survey 2017*, released by UNODC and the Ministry of Counter-Narcotics of Afghanistan on 15 November 2017. The area under opium poppy cultivation also increased substantially, by almost 63 per cent, reaching a record 328,000 ha in 2017. These are the highest levels ever recorded for opium poppy cultivation and opium production in Afghanistan. According to the survey, the rise in production is attributable mainly to an increase in the area under opium poppy cultivation and in opium poppy yield per hectare.

681. Opium poppy cultivation expanded into new areas, resulting in an increase from 21 to 24 provinces affected by such cultivation. The survey also indicated large increases in cultivation in almost all major opium poppy-cultivating provinces, including in Helmand (an increase of 63,700 ha, or 79 per cent), Balkh (an increase of 10,000 ha, or 37 per cent), Kandahar (an increase of 7,500 ha, or 37 per cent), Nimroz (an increase of 6,200 ha, or 116 per cent) and Uruzgan (an increase of 6,000 ha, or 39 per cent). Most of the cultivation took place in the southern region of the country (almost 60 per cent of total cultivation), followed by the western region (17 per cent), northern region (13 per cent) and eastern region (7 per cent).

682. In May 2017, UNODC and the Ministry of Counter-Narcotics of Afghanistan published the chapter of the *Afghanistan Opium Survey 2016* devoted to sustainable development in an opium production environment. According to that report, illicit drug crop cultivation and drug production have a multifaceted impact on the economic, environmental and social development of Afghanistan. Illicit drug crop cultivation and drug production have given rise to an illicit economy that affects rural society, making it to a large extent dependent on income from growing opium poppy. Agricultural productivity has also been affected owing to poor land management. In addition, drug users, their families and society in general are burdened with increasing social and economic costs associated with the consumption of opiates.

683. Also according to the chapter of the *Afghanistan Opium Survey 2016* on sustainable development in an opium production environment, the value of opiates produced in Afghanistan was estimated to be about 16 per cent of the country's gross domestic product and worth more than two thirds of the output of its entire agricultural sector. The value of the illicit opiate economy was estimated at $3.02 billion in 2016, almost twice the amount estimated for 2015.

684. On 26 December 2016, the President of Afghanistan, along with a number of ministers and other high-ranking Government officials, held a videoconference with 34 provincial governors and officials on the counter-narcotics and opium poppy eradication operations proposed for 2017. During that videoconference, the President ordered the civilian and national military authorities of the 34 provinces to step up the fight against drugs. He also referred to the Afghan National Drug Action Plan (2015–2019) and the planned annual eradication of 5 per cent of illicit opium poppy cultivation. The President added that the 2017 opium poppy eradication programme had been approved by the National Security Council and targeted a volume of eradication higher than that in 2016. As discussed in section E of chapter II of the present report, Afghanistan began its annual opium poppy eradication campaign in March 2017. As a result, in 2017 a total of 750 ha of poppy fields were destroyed. While this represents an increase of 111 per cent in the number of hectares eradicated compared with 2016, when 355 ha were eradicated, it is a negligible amount, representing less than one quarter of 1 per cent of the total area under illicit opium poppy cultivation.

685. In Afghanistan, the illicit production of and trafficking in drugs occur mostly in areas where State institutions are weak or unable to exercise full control because of the deteriorating security situation, although trafficking is not limited to areas controlled by insurgents. According to the eighth report of the Analytical Support and Sanctions Monitoring Team submitted pursuant to Security Council resolution 2255 (2015) concerning the Taliban and other associated individuals and entities constituting a threat to the peace, stability and security of Afghanistan,[104] up to 90 per cent of drug production in Afghanistan currently falls within Taliban-controlled areas. The value and illicit production of drugs in Afghanistan rose markedly in 2016, as reported in the INCB annual report for 2016, and so did the income the Taliban generated from the drug trade. This compensated for the slight drop in income that the Taliban received from external sources in 2016. In its eighth report, the Analytical Support and Sanctions Monitoring Team also stated that the Taliban now play a direct part in the illicit production of, processing of and trafficking in virtually all heroin produced and trafficked from Afghanistan, rather than simply "taxing" these activities.[105]

686. The Balkan route continues to be the main route in the world for trafficking in opiates from Afghanistan. It runs from Afghanistan to Europe through the Islamic

[104] See S/2017/409.

[105] Ibid.

Republic of Iran and Turkey. Almost 40 per cent of global heroin seizures are made in the countries located along the route. At the same time, according to UNODC, another route has gained importance in recent years. It transits the Caucasus countries Armenia, Azerbaijan and Georgia and then continues across the Black Sea to Ukraine and Romania. Traffickers may have started to use this route more frequently because the movement of migrants and refugees via Turkey to the European Union countries had heightened the attention of law enforcement agencies.

687. Armenia reported an increase in 2016 in seizures of cocaine, opium and cannabis resin trafficked to the country. The drugs originated mainly from South American countries (in the case of cocaine) and the Islamic Republic of Iran (in the case of cannabis resin and opium). In cooperation with the competent authorities of the Russian Federation, the authorities in Armenia dismantled several drug trafficking routes transiting Armenia from the Islamic Republic of Iran.

688. Georgia reported illicit cultivation of wild cannabis for personal consumption on its territory. Heroin is reported to enter the country mainly from Azerbaijan and Turkey. Also in Georgia, there was an increase in trafficking in preparations containing buprenorphine, such as Subutex and Suboxone, mainly from European countries.

689. Opiates continue to be trafficked from Afghanistan along two other major routes: the southern route, which runs through South Asia, the Gulf region, the rest of the Near and Middle East and Africa, and the northern route, which runs through Central Asia to the Russian Federation.

690. The Islamic Republic of Iran reported fewer incidents involving the use of sea routes by drug traffickers because it had strengthened interdiction measures in recent years. Both the Islamic Republic of Iran and Pakistan continued to be confronted with trafficking in opiates and cannabis originating in neighbouring Afghanistan.

691. In Pakistan, in 2016, the area under illicit opium poppy cultivation was 1,599 ha, of which 1,470 ha were destroyed as part of the Government's eradication efforts throughout the year. At the same time, Pakistan reported an increase of 10 per cent in opium seizures (64.6 tons in 2016, compared to 58.9 tons in 2015) and an increase of 42 per cent in heroin seizures (23.1 tons in 2016, compared to 16.3 tons in 2015).

692. There were growing concerns about drug trafficking in Iraq. Reports of drug raids and arrests in 2016 indicated that the country's drug problem was growing more severe, and that, possibly, there was a shift towards increased illicit drug production. There were reports of illicit opium poppy and cannabis cultivation. In October 2016, the security forces reportedly discovered an opium poppy farm of 6.5 ha in Erbil.

693. Uzbekistan reported an increase in opium seizures of nearly 64 per cent to 1.4 tons in 2016, compared to 863 kg in 2015. During the same period, heroin seizures in Uzbekistan decreased by 41 per cent to 108 kg in 2016, compared to 148 kg in 2015. Tajikistan reported a decrease of nearly 56 per cent in its seizures of opiates to 700 kg in 2016, compared to 1.6 tons in 2015.

694. In 2016, Kazakhstan and Uzbekistan carried out their annual campaigns to combat trafficking and eradicate illicitly cultivated crops containing narcotic drugs. As a result, Kazakhstan seized 33.5 tons of drugs, including 52 kg of heroin, 110 kg of cannabis resin and 32.5 tons of cannabis herb. Uzbekistan seized 1.3 tons of drugs, including 3.4 kg of heroin, 49.3 kg of opium, 46 kg of cannabis resin, 462 kg of cannabis herb and 760 kg of opium poppy straw. Uzbekistan reported a substantial increase in so-called anonymous smuggling, whereby traffickers bury the packaged drugs in the ground or leave caches of drugs in the border areas to be picked up by other traffickers for further transportation.

695. Although the cocaine market in West Asia is smaller than those in other regions of the world, cocaine trafficking in West Asia continued to rise. The Near and Middle East (mainly Jordan, Lebanon, the Syrian Arab Republic and the United Arab Emirates) accounted for about 40 per cent of total cocaine seizures in Asia over the period 2010–2015. In 2016, a number of cocaine seizures were reported by Lebanon, Pakistan and Saudi Arabia. Israel and Lebanon were most frequently cited as destination countries for cocaine trafficking in the region. Two large seizures of cocaine made in October 2016, one of 18 kg at the international airport of Sao Paulo, Brazil, and one of 24.5 kg at Charles de Gaulle Airport in Paris, were destined for Lebanon. Reports indicated that King Abdullah port in Saudi Arabia had served as a transit point for cocaine from South America.

696. Nigerian criminal syndicates appeared active in the Middle East and North Africa. The National Drug Law Enforcement Agency of Nigeria reported the arrest during the reporting period of three female couriers at Murtala Muhammed International Airport. They were caught carrying cocaine to Saudi Arabia in amounts ranging from 300 grams to 1.6 kg each.

697. Afghanistan, Iran (Islamic Republic of) and Pakistan observed a substantial increase in seizures of

cannabis resin during the period 2010–2015. Both the Islamic Republic of Iran and Pakistan reported that, in 2016, they continued to be confronted by trafficking in cannabis herb and cannabis resin originating from neighbouring Afghanistan.

698. Lebanon was another country in West Asia where cannabis resin continued to be produced. From Lebanon, cannabis resin was trafficked mainly to Cyprus, Egypt, Israel, Jordan, the Syrian Arab Republic and Turkey. Lebanon also remained one of the five largest cannabis herb producers in the world. In 2016, the Lebanese authorities seized 7.6 tons of cannabis resin. In the first five months of 2017, several significant seizures of cannabis resin were made in Lebanon, including one of 5.5 tons hidden in a shipment of apples bound for Europe and another of almost 500 kg hidden in soap boxes bound for Canada. There were also reports, some based on statements made by Government officials, that the cultivation of cannabis in the Bekaa Valley was expanding because the Government's efforts to eradicate the industry had diminished significantly. In the past, annual eradication programmes had been conducted before each harvest.

(b) Psychotropic substances

699. On 27 January 2017, UNODC released its first assessment of the synthetic drug situation in Afghanistan. According to that report, there were indications of increasing activity in the synthetic drug market in Afghanistan and the wider South-West and Central Asian subregions. Although data and information remained scarce, reports suggested not only that more methamphetamine was being seized in Afghanistan, but also that illicit manufacturing facilities could be operating in the western part of the country. The report stressed that, given the presence of synthetic drugs in Afghanistan, it was important to enhance data collection and monitoring. While reporting mechanisms with regard to opiates had been established in Afghanistan, data on methamphetamine seizures might be incomplete because different law enforcement agencies were using different reporting formats. Afghanistan's current national drug control law provided for considerably lower penalties for trafficking in methamphetamine than it did for trafficking in other drugs such as heroin or cocaine.

700. Although Afghanistan was a growing source of illicitly produced methamphetamine, the Islamic Republic of Iran reported a decrease in methamphetamine trafficking through its territory due, in part, to stronger action being taken at the country's borders, including against precursor trafficking. Armenia reported an increase in seizures of methamphetamine in 2016. The drug was being trafficked mainly from the Islamic Republic of Iran.

701. Instability and continuing conflicts in the Middle East, coupled with a lack of monitoring, led to a significant increase in the manufacture of counterfeit "captagon".[106] It is believed that instability was also a reason behind the major shift in the illicit manufacture of "captagon" from South-Eastern Europe to Lebanon and the Syrian Arab Republic. Furthermore, the chemical precursors needed to manufacture "captagon" seemed to be available within the region. Although data were scarce, there had been media reports of several large seizures: 1 million "captagon" tablets bound for Saudi Arabia seized at the port of Tripoli, Lebanon, at the end of 2016; 1 million tablets bound for Oman seized at Beirut Rafic Hariri International Airport in July 2017; and 250,000 tablets bound for Nigeria seized at the port of Beirut in August 2017. For the first time, "captagon" coming from Lebanon was seized at Charles de Gaulle Airport in France (one seizure of 70 kg in January 2017 and another of 67 kg in February 2017). Investigations showed that, for one of the seized consignments, the end destination was Saudi Arabia via Czechia and Turkey. In October 2016, the authorities in Lebanon intercepted a shipment of "captagon" manufacturing equipment at Beirut Rafic Hariri International Airport that originated in India. The security forces in Lebanon reported the seizure of 12.7 million "captagon" tablets in 2016.

702. Even though most of the synthetic drug seizures in the Middle East were reported by Lebanon and the Syrian Arab Republic, there were concerns that amphetamine-type stimulants (in particular "captagon") were also being manufactured in Iraq. In April 2017, police raided a drug laboratory in Kirkuk in the north of the country, arresting two suspects and seizing 51 cartons of "captagon" tablets.

703. Illicit markets for amphetamines continue to operate in the Gulf countries, in particular in Kuwait, Saudi Arabia and the United Arab Emirates. In May 2017, border guards in Saudi Arabia reported the interception of 2.1 million "captagon" pills hidden in bags of rice in Al Jawf province, near the border with Jordan. United Arab Emirates police intercepted 116 kg of "captagon" in Dubai in February 2017 and, in May 2017, another shipment comprising 1 million tablets, both having the United Arab Emirates as their final destination.

[106] Captagon was originally the registered trade name for a pharmaceutical preparation containing fenethylline, a synthetic stimulant. "Captagon", as encountered in seizures across West Asia today and referred to in the present report, is a counterfeit drug compressed into pills or tablets that are similar in appearance but distinct from the original pharmaceutical preparation Captagon. The active ingredient in counterfeit "captagon" is amphetamine, which is typically combined with other substances such as caffeine.

704. The authorities in Jordan reported a record seizure of more than 13 million "captagon" pills hidden inside tumble dryers in a house near Amman.

(c) Precursor chemicals

705. West Asia continues to be a target destination for precursor chemicals diverted from licit trade, such as acetic anhydride (for the manufacture of heroin), ephedrine, pseudoephedrine, P-2-P, phenylacetic acid (for the manufacture of amphetamine-type stimulants) and others.

706. With regard to seizures of precursors in Afghanistan, the declining trend of recent years was reversed in 2016. Seizures increased again, from 1.7 tons of solid precursor chemicals in 2015 to almost 72 tons in 2016, and from 3,900 litres of liquid precursor chemicals in 2015 to 15,000 litres in 2016, indicating a potential increase in the illicit production of drugs in the country.

707. Even though only one methamphetamine laboratory was officially reported to have been dismantled in Afghanistan in 2015, precursors such as ephedrine and pseudoephedrine, which can be used to manufacture methamphetamine, were widely available in the country. Afghanistan legally imported ephedrine and pseudoephedrine, and additional amounts of those substances may have entered the country across uncontrolled sections of the border. Ephedrine and pseudoephedrine were also available in the form of pharmaceutical preparations in Afghanistan. At the same time, as information was not being collected effectively, there was a lack of official data on seizures of those substances, even though there was a high risk of their being diverted for use in the production of amphetamine-type stimulants in Afghanistan.

708. As reported in the INCB annual report for 2016, a time-bound operation of the Board's Project Prism entitled "Missing Links" was launched in October 2016 with the aim of filling information gaps with regard to the types and sources of scheduled and non-scheduled chemicals used in the illicit manufacture of counterfeit "captagon" tablets, how they were reaching clandestine laboratories, the trafficking organizations involved and any links between them. The operation was concluded in mid-January 2017 and resulted in several findings. The authorities in Lebanon informed the Board of seizures of derivatives of P-2-P methyl glycidic acid (2-methyl-3-phenylglycidic acid, methyl ester), the first time a non-scheduled "designer" amphetamine precursor chemical had been reported to have been seized outside Europe. In addition, forensic analysis of "captagon" tablets seized in the region identified traces of *alpha*-phenylacetoacetonitrile (APAAN), which is an immediate precursor of P-2-P and a pre-precursor of amphetamine and methamphetamine.

709. Further details about the precursor control situation in West Asia can be found in the report of the Board for 2017 on the implementation of article 12 of the 1988 Convention.

(d) Substances not under international control

710. In most countries in West Asia, relatively limited information is collected and reported on trafficking in and abuse of new psychoactive substances. The latest information available for 2016 suggests that the abuse of new psychoactive substances, in particular synthetic cannabinoids, increased in several countries in the region. In Georgia, new psychoactive substances were being trafficked into the country from countries in Europe, and their abuse was spreading among young people. Kazakhstan reported a new trend: young people under 30 were being referred to medical care for their abuse of synthetic cannabinoids, especially in the bigger cities of Almaty, Astana and Pavlodar. Similarly, Uzbekistan reported incidents involving the consumption of synthetic cannabinoids contained in so-called "Spice" products. For the first time, Tajikistan seized packages of smoking mixtures containing the synthetic cannabinoid QCBL-2201 (5F-PB-22). Lebanon saw some new patterns of drug abuse, in particular the abuse of the plant *Salvia divinorum* and of synthetic cannabinoids. In addition, in high schools in Lebanon new cases of abuse of pregabalin were detected, a medicine with relaxing properties used widely to treat epilepsy, neuropathic pain and anxiety, and GHB, a sedative-hypnotic included in Schedule II of the 1971 Convention.

711. Some countries in the region have placed many central nervous system depressants under national control owing to a recent increase in the number of those substances, in particular benzodiazepines, detected in illicit markets. Thus, Turkey placed adinazolam, deschloroetizolam, diclazepam, flubromazepam, flubromazolam, meclonazepam and pyrazolam under national control, and the United Arab Emirates did the same for diclazepam, etizolam, flubromazepam and pyrazolam.

712. Several countries in the region continued to experience trafficking and abuse relating to the prescription drug tramadol, a synthetic opioid not under international control. In the United Arab Emirates, police arrested two men in possession of 110,000 tramadol pills in June 2017, while the customs authorities reported seizing 700,000 tramadol pills at the port of Jebel Ali in 2016. According

to the authorities in Lebanon, one million pills of tramadol were seized in the country in 2016.

5. Abuse and treatment

713. Most countries in the region face problems with the availability of resources for comprehensive and regular drug use surveys. It is therefore difficult to thoroughly analyse rates of and trends in drug abuse in the region as a whole. Nonetheless, individual country reports may shed light on some possible developments and indicate overall trends in the region.

714. Even though opioid abuse remains a major concern in South-West and Central Asia, Kazakhstan, Uzbekistan and several other countries reported a decrease in the number of persons abusing heroin in 2016 as a result of heroin being replaced by other types of psychoactive drugs, such as cannabinoids.

715. In Central Asia, the Caucasus and South-West Asia, the prevalence of drug abuse by injection is above the global average. At the same time, Tajikistan and Uzbekistan reported a decrease in 2016 in the number of persons who abused drugs by injection. Within West Asia, South-West Asia had the highest prevalence of HIV among people who abused drugs by injection, at 28.5 per cent, which was almost twice the global average of 13.1 per cent.

716. Also in South-West Asia, concern was mounting about methamphetamine use. Afghanistan reported an increase in synthetic drug abuse in 2016, as reported by law enforcement agencies, health-care providers and treatment centres in certain parts of the country. The data suggest that the main cause of the rise could be an increase in the use of methamphetamine by opiate users, as smuggling and possibly illicit local manufacture had expanded the market for synthetic drugs in Afghanistan, as discussed in section 4 above.

717. As reported in section 4 above, there is growing evidence that tramadol is being trafficked and abused in the Near and Middle East, especially in Jordan, Lebanon and Saudi Arabia. Many countries in the region, including Bahrain, Iran (Islamic Republic of), Jordan, Qatar and Saudi Arabia, have placed tramadol under national control to address the increased risk of abuse.

718. **INCB urges countries in the region to allocate sufficient human, financial and institutional resources to improve access to drug treatment for all affected segments of the population, including women and youth, and to strengthen mechanisms for the effective collection of information, including through comprehensive national drug abuse surveys based on recognized methodologies, in order to assess the extent and patterns of drug abuse. INCB notes that effective assessments of the extent of drug abuse in the countries of the region could result in information that can be used in formulating evidence-based policies and designing prevention, treatment, rehabilitation and other services. In that regard, the Board urges all relevant stakeholders, including international organizations and partner Governments, to provide to the countries in the region financial and technical advisory support in the design and conduct of such surveys.**

D. Europe

1. Major developments

719. The European illicit drug market is supplied by both domestically cultivated and manufactured drugs and drugs trafficked into Europe from other parts of the world. In the European Union alone, the illicit drug market is estimated to generate about 24 billion euros in profits per year, meaning that drug trafficking is the criminal activity generating the greatest revenue in the European Union. More than a third of the criminal groups operating in the European Union are engaged in the manufacture, trafficking and sale of illicit drugs; two thirds of organized criminal groups engaged in drug-related crime are also involved in other criminal activities. These criminal groups increasingly rely on new technologies, including the use of online marketplaces and cryptocurrencies for sales of illicit drugs, with a view to increasing the efficiency of their illicit activities and circumventing detection.

720. According to EMCDDA, the number of annual drug seizures in Europe exceeds 1 million. In 2015, seizures of cannabis accounted for 71 per cent of all seizures, followed by cocaine (9 per cent), amphetamines (5 per cent), heroin (5 per cent), MDMA (“ecstasy”) (2 per cent), and other drugs (8 per cent). Regarding illicit activities involving precursor chemicals, the Board noted a large increase in diversion attempts involving acetic anhydride identified by several European Union countries during the reporting period.

721. It is estimated that over a quarter of the general population in the European Union (more than 93 million people aged between 15 and 64 years) have tried illicit drugs at least once in their lifetime. The prevalence of cannabis abuse in the European Union is about five times higher than that for other illicit substances. In the current

reporting period, the availability and abuse of high-potency "ecstasy" products and synthetic opioids continued to increase. European Union authorities are concerned about the increasing number of drug overdose deaths, in particular those related to heroin and other opioids, which has risen in the Union for three consecutive years.

722. The so-called Balkan route dominates the Eastern European drug trafficking corridor. On the Balkan route, opioid drugs are trafficked from their original production sites in, in descending order of amount, Afghanistan, Pakistan and the Islamic Republic of Iran, and transit through Turkey and the Balkans onward to Central and Western Europe. The Balkan route has several constantly shifting branches, but the main course runs through Bulgaria, Serbia, Bosnia and Herzegovina, Croatia, Slovenia and Austria, while a smaller branch through the former Yugoslav Republic of Macedonia and Kosovo[107] is used for storage and repackaging. In the opposite direction, synthetic drugs are smuggled from Western Europe. Albanian criminal groups collaborate closely with criminal groups in Greece, Italy, Kosovo, Montenegro, Serbia, the former Yugoslav Republic of Macedonia and Turkey.

723. Trafficking in and abuse of new psychoactive substances, often marketed as "legal" alternatives to controlled substances of abuse, remained a considerable public health challenge in Europe. In 2016, 66 new psychoactive substances were detected for the first time via the European Union early warning system, representing a decrease compared with the 98 substances reported for the first time in 2015. The total number of the new psychoactive substances monitored by EMCDDA by the end of 2016 exceeded 620. According to UNODC, of all new psychoactive substances detected worldwide, since 2009, a group of over 80 of those substances have had an established presence on the global market and continue to be reported annually.

724. With regard to the latest development in drug control, the Board is aware of ongoing discussions among member States of the European Union on issues related to cannabis regulation, including making cannabis available for medical use and permitting cannabis production for non-medical use. In that regard, the Board noted that no legislation in the European Union allows for such non-medical or so-called "recreational" use (see paras. 737 and 738 below).

[107] All references to Kosovo in this report should be understood to be in the context of Security Council resolution 1244 (1999).

2. Regional cooperation

725. In November 2016, a regional round table on law enforcement cooperation in combating new psychoactive substances in Eastern Europe took place in Bucharest, with the participation of OSCE countries and INCB and UNODC. Joint investigation techniques and advantages of a common data collection system figured among the topics discussed.

726. EMCDDA has continued its active cooperation with candidates and potential candidates of the European Union, for example, by assisting Albania, Bosnia and Herzegovina, Serbia and the former Yugoslav Republic of Macedonia, as well as Kosovo, in the development of their internal early warning systems, in line with EMCDDA guidelines.

727. The Cooperation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group) of the Council of Europe continued to contribute to the development of multidisciplinary and evidence-based drug policies in its member States, and to undertake a bridging role, both between European Union and non-European Union countries and between the European Union and neighbouring countries in the Mediterranean region. In 2017, Pompidou Group activities focused, among other things, on securing training for managers from government and public institutions responsible for the development and implementation of drug policies related to reduction of demand for new psychoactive substances.

728. The operation "Channel-Western Barrier" conducted under the auspices of the Collective Security Treaty Organization took place in 2017. More than 30,000 employees of the law enforcement bodies of Armenia, Belarus, Kazakhstan, Kyrgyzstan, the Russian Federation and Tajikistan, as well as of the competent bodies of the observer countries Afghanistan, China, Iran (Islamic Republic of), Lithuania and Poland, and financial intelligence units of INTERPOL member countries, CARICC and OSCE participated in the operation. More than 16.8 tons of narcotic drugs and psychotropic substances were seized, which mostly consisted of 15.5 tons of opium, approximately 647 kg of cannabis resin, 60 kg of cannabis herb, 40 kg of heroin and 220 kg of synthetic narcotic drugs.

729. The Twelfth Meeting of the Heads of National Drug Law Enforcement Agencies, Europe, took place in Vienna on 27–30 June 2017. More than 90 participants from 33 countries discussed the current situation with respect to regional and subregional cooperation in the area of drugs. The meeting covered a wide range of issues and included four working groups on the following topics: *(a)* use of the Internet for drug-related activities;

(b) alternatives to imprisonment for certain offences as demand reduction strategies that promote public health and public safety; *(c)* mainstreaming gender perspectives in drug-related policies and programmes; and *(d)* money-laundering, illicit financial flows and effective countermeasures.

730. The UNODC regional programme for South-Eastern Europe for the period 2016–2019 was launched at the seventh special meeting of the Programme Steering Committee held at UNODC headquarters in Vienna in November 2015. The programme is being implemented in close cooperation and partnership with the Governments of the region, as well as with relevant European Union institutions and regional organizations. The regional programme consists of three pillars: countering organized crime and trafficking, justice and rule of law, and drug demand reduction. One of the UNODC priorities in the region is countering money-laundering and the financing of terrorism, and in the reporting period a regional advisor was posted in Bosnia and Herzegovina to provide support in that area.

731. In February 2017, on the margins of the Munich Security Conference, high-level representatives of the European Union and the Government of Afghanistan signed the Cooperation Agreement on Partnership and Development. The Cooperation Agreement formalizes the European Union's commitment to Afghanistan's development during the "decade of transformation" (2014–2024), and addresses a wide range of economic and political areas such as the rule of law, rural development, health and education, as well as actions to combat corruption, money-laundering and drug-related crime.

3. National legislation, policy and action

732. During the reporting period, EMCDDA published a number of ad hoc publications, technical reports, surveys and overviews that covered a wide range of drug control-related topics, including European Union policies and measures related to drug supply reduction; legislation on cannabis in European countries; penalties for drug trafficking; high-risk drug use and new psychoactive substances; and drugrelated infectious diseases in the region.

733. According to the joint publication of the European Union judicial cooperation unit (Eurojust) and EMCDDA, entitled "New psychoactive substances in Europe: legislation and prosecution — current challenges and solutions", published in November 2016, the established drug control laws struggled in recent years to address the ever-growing market for new psychoactive substances. The legal responses addressing new psychoactive substances in the European Union were based on existing laws that focused on medicinal products or provisions related to consumer or health protection, or were based on new innovative legislation, as introduced by some Governments.

734. In 2016, the Government of Austria adopted the Addiction Prevention Strategy, which aims for a society as free as possible of addiction, treats addiction as a health condition and supports the principle of treatment instead of punishment.

735. In Cyprus, in late 2016, the Parliament adopted three amendments to the Narcotic Drugs and Psychotropic Substances Law of 1977 to revise and consolidate the Law's first schedule and replace the term "cannabis" to exclude industrial hemp from the legal definition, and adopted one amendment to the Narcotic Drugs and Psychotropic Substances Regulations of 1979 to include remifentanil in schedule 2 of the Regulations.

736. In 2016, Switzerland added 35 new psychoactive substances to the list of narcotic substances, and Estonia added 7 new psychoactive substances to schedule I of its list of narcotic drugs and psychotropic substances, namely 4-AcO-DMT, 2C-P, ethylone, 5F-AMB, furanylfentanyl, W-18 and 5F-MDMB-PINACA. In 2016, Estonia added 15 groups of substances to schedule VI of its list of narcotic drugs and psychotropic substances, namely adamantoylindoles, benzoylindoles, phenethylamines, fentanyl derivatives, phenethylacetylindoles, indazolecarboxamides, indolecarboxamides, cathinones, naphthoylindoles, naphthoylpyrroles, naphthylmethyleneindenes, naphthoylmethylindoles, tryptamines, cyclohexylphenoles and cyclopropylcarbonylindoles.

737. In March 2017, EMCDDA published a report entitled "Cannabis legislation in Europe: an overview". According to the report, over the past two decades at least 15 European countries have amended their legislation in a way that affected penalties for cannabis use. It is not, however, clear whether the legal penalties for cannabis use offences, which were increased or reduced in the countries concerned, have had any effect on the prevalence of cannabis use in those countries. The publication points out that despite the tolerated but not condoned existence of cannabis social clubs in a number of European countries and vocal requests to change national or local policies regarding non-medical use of cannabis, European countries have not sought to legalize non-medical use of cannabis, and there is little evidence that proposals for changes in cannabis policy enjoy majority public support.

738. **The Board wishes to reiterate that the 1961 Convention establishes, in its article 4 ("General obligations"), that the parties to the Convention are to take such legislative and administrative measures as may be necessary to give effect to and carry out the provisions of the Convention within their own territories and to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in and use and possession of drugs.**

739. In March 2017, the European Commission proposed the European Union Action Plan on Drugs for the period 2017–2020. The new Action Plan builds on the findings of the evaluation of the European Union Drugs Strategy for 2013–2020 and the Action Plan for 2013–2016, which were published in December 2016. The Action Plan identified new priority areas, including the monitoring of new psychoactive substances, the use of new communications technology for the prevention of drug abuse and the gathering of evidence on the potential connection between drug trafficking and the financing of terrorist groups, organized crime, migrant smuggling or trafficking in persons.

740. In addition, in April 2017, EMCDDA published its Strategy 2025. The EMCDDA strategic objectives for the coming years include improved understanding of the nature and consequences of drug-related crime and an enhanced capacity to identify new drug-related health threats and a rapid response by the European Union and its member States.

741. MDMB-CHMICA was reported to the European Union early warning system in 2014. In February 2017, the Council of the European Union decided to make MDMB-CHMICA subject to control measures throughout the European Union; the member States of the European Union will have to introduce controls on the substance into their national legislation within a one-year period. In March 2017, the Commission on Narcotic Drugs included MDMB-CHMICA in Schedule II of the 1971 Convention. In early 2017, the EMCDDA carried out risk assessments of two fentanyls (acryloylfentanyl and furanylfentanyl). In April 2017, the European Commission proposed to subject acryloylfentanyl, a potent synthetic opioid, to control measures across the European Union.

742. In Germany, prior to the entry into force of the New Psychoactive Substances Act on 26 November 2016, new psychoactive substances were controlled pursuant to the provisions of the Federal Narcotics Act. The New Psychoactive Substances Act placed under control particular new psychoactive substances listed in its annex. The Act defines new psychoactive substances as any substance or preparation belonging to the specified generic definitions for synthetic cannabinoids and compounds derived from 2-phenylethylamine. Substances already listed in the Narcotics Act or Medicines Act were excluded. The Act prohibits manufacture, trade and possession of new psychoactive substances and enables the Ministry of Health to amend the definitions of new psychoactive substances based on expert advice, and empowers police authorities to confiscate these substances using their general powers to protect life and health. The Act makes offences involving new psychoactive substances punishable by up to 3 years in prison, and up to 10 years in aggravating circumstances.

743. During the reporting period, the Government of Spain allocated 8.1 billion euros from the national Fund for Assets Seized from Illegal Drug Trafficking to programmes related to the prevention of drug addiction. The Government also adopted Decree No. 129/2017 of 24 February 2017 concerning the control of precursor chemicals and initiated the evaluation of the National Drug Strategy for 2009–2016 and the preparation of a new national drug strategy for the period 2017–2024.

744. In June 2017, the Parliament of Montenegro adopted a law amending the Criminal Code of Montenegro in accordance with the Financial Action Task Force recommendation for the prevention of money-laundering. Article 8 of the Law proposed the amendment of the definition of "property gain" obtained by the criminal offence. This amendment is harmonized with the measures of the Council of Europe's Committee of Experts on the Evaluation of Anti-Money Laundering and the Financing of Terrorism.

745. The number of deaths in the United Kingdom associated with new psychoactive substances increased by 25 per cent, from 163 deaths in 2014 to 204 deaths reported in 2015. The Psychoactive Substances Act, which came into force in the country on 26 May 2016, criminalized the manufacture, supply or possession with intent to supply of any psychoactive substance knowing that it is to be used for its psychoactive effects. From May to December 2016, the competent authorities of the United Kingdom enforcing the new powers stopped over 300 shops across the country from selling the substances, formerly referred to as "legal highs", and closed down several others.

4. Cultivation, production, manufacture and trafficking

(a) Narcotic drugs

746. Accounting for 38 per cent of the value of the illicit drug retail market in the European Union, cannabis remains both the most widely abused and seized illicit drug in the region.

747. The overall potency (THC content) of both cannabis herb and cannabis resin consumed in the European Union remained historically high and ranged from 7 to 11 per cent and from 11 to 19 per cent, respectively. The black market price of both drugs was almost the same, in the range of 8–11 euros per gram and 7–12 euros per gram, respectively.

748. Cannabis herb used in the European Union is both cultivated domestically, mostly indoors, and trafficked from other regions. Albania remains the main source of cannabis herb trafficked to the European Union. In 2016, indoor cannabis cultivation of varying magnitudes was reported by several countries, including Iceland, Latvia, Lithuania, the Netherlands, Poland, Romania and Slovakia.

749. As indoor cannabis growing equipment and cannabis seeds are now readily available on the Internet and with the expansion of sophisticated growing technologies, the European Police Office (Europol) anticipates further increase of the indoor cultivation of cannabis herb in the European Union in the coming years.

750. Most of the cannabis resin destined for the European Union market was trafficked from Morocco, although there are indications that Libya is becoming a major hub for the trafficking of the drug to Europe and other destinations.

751. In 2015, the amount of cannabis resin seized in the European Union (536 tons) was six times higher than that of herbal cannabis (89 tons), with Spain, Italy and France, in that order, accounting for the largest amounts of cannabis resin seized. In 2016, total seizures of cannabis resin amounting to more than 1 ton were reported by Spain (324.4 tons), Italy (23.9 tons), the United Kingdom (7.2 tons), Denmark (3.8 tons), Norway (3.0 tons) and Germany (1.9 tons).

752. During 2016, in Romania, 75 drug trafficking groups were dismantled, which represents a 17 per cent increase from the previous year, when 64 drug trafficking groups were dismantled. The number of persons involved in those groups also increased slightly in 2016, from 425 persons in 2015 to 528 persons in 2016. Of the 528 persons arrested in 2016 for involvement in a trafficking group, 521 persons were Romanian nationals.

753. In Albania, during 2016 the cannabis situation was characterized by an increase in the number of cultivated cannabis areas, associated with an expansion of maritime trafficking routes and attempts at drug trafficking via air routes. In 2016, due to increased supply, the retail price of cannabis in Albania decreased to a level of 100–400 euros per kg.

754. Seizures of cannabis in Albania increased by 164 per cent from 2015 to 2016, reaching a total of 30 tons in 2016, compared with 11.3 tons seized in 2015. Over the same period, the farm-gate price of cannabis decreased, from 600–1,300 euros per kg in 2015 to 100–400 euros per kg in 2016. The percentage of THC content in street-level cannabis (retail) is estimated to vary considerably, from 0.1 to 18 per cent.

755. In Romania, in 2016 there was a significant increase in the total quantity of drugs seized compared with 2015. This situation was mainly determined by the increase in the quantity of cocaine seized, from 71.2 kg to 2.3 tons, representing 39.3 per cent of the total amount of drugs seized in 2016. Seizures of cannabis plant increased from 293 kg to 2.8 tons, representing 48.2 per cent of the total amount of drugs seized in the country in 2016, and the most seized illicitly cultivated plant in the country.

756. Heroin is the most commonly trafficked and abused opioid in the European Union. Other opioids, including buprenorphine, fentanyl, methadone, morphine, opium and tramadol, that have been seized in smaller amounts in the region in 2015 might have been diverted from legitimate pharmaceutical supplies or illicitly manufactured.

757. Most of the heroin seized in the European Union originated in Afghanistan, although according to the *European Drug Report 2017: Trends and Developments*, some of the heroin that was seized in Europe could have been manufactured in Iran (Islamic Republic of) or Pakistan. Past detections of a small number of laboratories converting morphine into heroin in Czechia and Spain suggest that limited amounts of heroin could also have been manufactured in Europe. According to Europol, depending on several factors, including the possibility of an increase in demand for heroin in Europe and/or any disruptions to trafficking of the substance from Afghanistan, further illicit heroin manufacture may emerge in the European Union in the future. A seizure of heroin, acetic anhydride and other material containing traces of morphine in an illicit laboratory uncovered in

the Netherlands in 2017 might further corroborate the suspected existence of such illicit manufacture in Europe.

758. There are two main routes that traffickers continued to use extensively for smuggling heroin to Europe: the Balkan route and southern route. About 40 per cent of global heroin and morphine captured in 2015 was seized in countries on the so-called Balkan route, one of the world's principal opiate trafficking routes.

759. The so-called southern route of the Balkan route involves the Syrian Arab Republic and Iraq. The route has been increasingly used for the smuggling of heroin from Iran (Islamic Republic of) and Pakistan to Europe, either directly or via the African continent. In addition to these two trafficking routes, traffickers also use the so-called northern route and a route that passes through the southern Caucasus and across the Black Sea.

760. In 2015, the total of 36,000 seizures of heroin in the European Union amounted to 4.5 tons; this amount was considerably lower than the 8.9 tons seized in the European Union in 2014. In 2016, seizures of heroin larger than 100 kg were reported by the United Kingdom (806 kg), Italy (497 kg), Germany (330 kg), Spain (251 kg), the Netherlands (230 kg) and Croatia (120 kg).

761. The number of reports of the emergence of highly potent new synthetic opioids, mostly fentanyl derivatives, communicated through the European Union early warning system has increased since 2012. These substances, which have sometimes been sold as, or mixed with, heroin, other illicit drugs or counterfeit medicines, pose serious health risks not only to their users but also law enforcement officers responsible for combating their manufacture and trafficking and employees of post offices and express courier services who could unknowingly be involved in their transportation and delivery.

762. Trafficking of heroin mainly uses transport by road to bring the heroin to markets in Central and Western Europe, using trucks, buses and private vehicles. Greece and Italy are the main destinations for the trafficked heroin. Increasingly, some of the heroin trafficked has been retained in Albania for local consumers. According to Government statistics, seizures of heroin in 2016 indicate an increase in the quantity of seized heroin to 57.3 kg (an increase of 55 per cent) compared with 36.7 kg in 2015. Wholesale prices and retail prices remained almost identical to the previous year. The price for 1 kg of heroin ranges from 16,000 euros to 18,000 euros. In 2016, at street level, the average price for 1 gram of heroin was 22 euros. The purity of heroin at street level ranged between 1 and 15 per cent.

763. Cocaine available on the illicit markets in Europe originates in Bolivia (Plurinational State of), Colombia and Peru. The traffickers continue to use various means of transportation, including maritime containers, yachts, airfreight, private aircraft, passenger flights and postal services to transport the drug to Europe. The Caribbean countries have often been used as countries of departure for cruise ships smuggling cocaine to the European Union countries. Couriers smuggling cocaine to Europe often travelled directly from Brazil.

764. In 2015, four countries (Belgium, France, Portugal and Spain) accounted for 80 per cent of the total 69.4 tons of cocaine seized in the European Union. In 2016, the countries reporting seizures of cocaine hydrochloride of 1 ton or greater were Belgium (39 tons), Spain (15.9 tons), the Netherlands (12 tons), Italy (4.7 tons), the United Kingdom (4.2 tons), Romania (2.3 tons), Germany (1.9 tons) and Portugal (1 ton).

765. Since 2016, some European countries have reported the destruction of "secondary extraction facilities", used by criminal organizations for the recovery of cocaine from materials in which cocaine had been dissolved or incorporated.

(b) Psychotropic substances

766. The synthetic drugs market has continued to be the most dynamic drug market in the European Union. The revival of the MDMA ("ecstasy") market, combined with the increased average content of MDMA in tablets, has been associated with harms and deaths in the European Union. Criminal syndicates in Belgium and the Netherlands continued to play a major role in the manufacture and distribution of MDMA ("ecstasy") and amphetamine in Europe. The MDMA ("ecstasy") and amphetamine manufactured in those two countries, in addition to satisfying the needs of the European drug users, is also trafficked to other countries worldwide.

767. Illicit manufacture of amphetamine is also occurring in Poland, and to some extent, it may exist in Germany, Hungary and Latvia. In 2016, methamphetamine laboratories were dismantled mainly in Czechia, Slovakia and Poland. However, methamphetamine manufacture has also started appearing in Bulgaria, Lithuania and the Netherlands. According to Europol, illicit manufacture of methamphetamine may in future also emerge in other European Union countries, in particular those where the illicit manufacture of amphetamine is already taking place.

768. In Czechia, methamphetamine is mostly manufactured from pseudoephedrine preparations which are often sourced in Poland, Slovakia and Turkey. Most of the methamphetamine is manufactured in small-scale kitchen laboratories. In 2016, the country reported that methamphetamine was also manufactured in large-scale laboratories with a potential manufacture capacity of 10–12 tons of the drug per year. Most of the methamphetamine manufactured in Czechia was intended for the domestic market, but a portion of the drug was also smuggled abroad.

769. One of the recent trends observed has been an increase in the production of synthetic drugs (especially narcotic drugs of the amphetamine and fentanyl groups) in clandestine laboratories within the Russian Federation. In addition, synthetic drugs are supplied to the Russian Federation mainly from Belgium, Czechia, Lithuania, the Netherlands, Poland, Slovakia and Ukraine. Supply routes pass through Belarus, Estonia, Finland, Kazakhstan and Latvia.

770. In 2015, European Union countries reported seizures of 4.7 tons of amphetamine, 0.5 tons of methamphetamine, 185 kg of MDMA ("ecstasy") and 3.8 million MDMA ("ecstasy") tablets. In 2016, the dismantling of illicit laboratories manufacturing amphetamine was reported by Austria (4 laboratories), Germany (4 laboratories), Poland (18 laboratories) and Spain (2 laboratories). Methamphetamine laboratories were identified in Austria (5 laboratories), Czechia (261 laboratories), Germany (11 laboratories) and Poland (3 laboratories). The Dutch authorities reported dismantling 59 laboratories manufacturing amphetamine or MDMA ("ecstasy") in 2016. In 2016, the Polish authorities also reported dismantling two medium-scale illicit laboratories manufacturing mephedrone.

771. Furthermore, in 2016, European Union countries also reported seizures of synthetic drugs, other than amphetamine-type stimulants. For example, Belgium, Denmark, Finland, Germany, Spain and the United Kingdom reported seizures of lysergic acid diethylamide (LSD); seizures of GHB were reported by Estonia, Finland, Latvia, Poland, Romania and Sweden.

(c) Precursors

772. In 2016 and 2017, traffickers seeking supplies of acetic anhydride targeted a number of European Union countries. The number of identified diversion attempts during that period was the highest in the past two decades. In most cases, delivery of the substance was prevented by the countries concerned in cooperation with INCB.

773. Since October 2014, when APAAN was placed under international control, only four countries in the European Union, namely Belgium, Germany, the Netherlands and the United Kingdom, have reported seizures of small amounts of APAAN.

774. In 2016, Belgium, Bulgaria, Germany and the Netherlands reported seizures of non-scheduled chemicals used in the illicit manufacture of amphetamine-type stimulants, such as 3,4-MDP-2-P methyl glycidic acid derivatives, P-2-P methyl glycidic acid derivatives and *alpha*-phenylacetoacetamide (APAA).

775. A comprehensive review of the situation with respect to the control of precursors and chemicals frequently used in the illicit manufacture of narcotic drugs and psychotropic substances in the region can be found in the report of the Board for 2017 on the implementation of article 12 of the 1988 Convention.

(d) Substances not under international control

776. New psychoactive substances continued to be trafficked to the European region from China, where those substances are manufactured. European users can purchase these new psychoactive substances, often branded as "legal high" products, from specialized conventional stores and on the surface web. In addition, these substances are sold on the darknet and illicit markets, either under their own name, or sometimes sold falsely as being other illicit drugs such as heroin, cocaine, MDMA ("ecstasy") or benzodiazepines.

777. Although new psychoactive substances are mostly manufactured elsewhere and only packaged and sold in the European Union, according to Europol a limited amount of manufacture of new psychoactive substances may also take place within the region. For example, in 2016, the Slovak authorities dismantled an industrial-scale laboratory illicitly manufacturing two psychoactive substances, namely 3-CMC (3-chloromethcathinone (clophedrone)) and *N*-ethylnorpentedrone.

778. In 2015, the total number of seizures of new psychoactive substances reported through the European Union early warning system by the European Union member States, Norway and Turkey reached almost 80,000. This number of seizures was significantly higher than the number reported in 2014 (about 50,000 seizures). In 2015, seizures of cathinones accounted for 33 per cent; cannabinoids, 29 per cent; and benzodiazepines, 11 per cent of all 80,000 seizures. Seizures of phenethylamines, piperazines and other new psychoactive substances

accounted for the remaining 27 per cent of the total number of seizures of new psychoactive substances.

779. The most commonly seized cathinones in the European Union in 2015 were *alpha*-PVP, 3-MMC, ethylone, 4-CMC and pentedrone, and among seized synthetic cannabinoids there were ADB-FUBINACA, AB-CHMINACA, UR-144, 5F-AKB48 and ADB-CHMINACA.[108]

780. Twenty-five new opioids, including 18 fentanyl analogues, have been identified on the European drug market since 2009. Eight of those 18 fentanyl analogues were reported for the first time in 2016. Two of those analogues, namely acryloylfentanyl and furanylfentanyl, have been sold on the illicit drug markets in the form of nasal sprays. Although the number of seizures of fentanyl and its analogues (300–400 seizures) in the European Union in 2015 was relatively low compared with seizures of other new psychoactive substances, the very high potency of the fentanyl analogues makes them a serious threat to individuals and to public health.

781. In Romania, the seizures of khat plants in 2016 increased significantly, from 247.7 tons in 2015 to 454 tons in 2016, accounting for 7.7 per cent of the total amount of drugs seized in 2016. In addition, Denmark reported significant seizures of ketamine, amounting to 3.8 tons.

5. Abuse and treatment

782. With an estimated annual prevalence of 7.0 per cent among persons 15–64 years old, and 13.9 per cent among those aged 15–34 years, cannabis remains the most prevalent drug of abuse in the European Union. Almost 1 per cent of adults in the European Union abuse cannabis on a daily or almost-daily basis (i.e., 20 days or more in the past month). The highest annual prevalence rates for cannabis abuse among persons 15–34 years old in the European Union were reported in France (22.1 per cent), Italy (19.0 per cent) and Czechia (18.8 per cent), while the lowest levels, less than 5 per cent, were reported by Cyprus, Hungary and Romania.

783. Monitoring rates of drug abuse among students provides an important insight into current youth risk behaviours and potential future trends. According to the European School Survey Project on Alcohol and Other Drugs report published in 2016, in the 35 European countries covered by the survey, one in three students (15- and 16-year olds) considered cannabis to be easily available. On average, 3 per cent of the students interviewed had used cannabis for the first time at the age of 13 years or younger; the highest proportion of students initiating cannabis use at 13 years or younger were found in Monaco, followed by France and Liechtenstein.

784. About 17.5 million adults in the European Union countries aged 15–64 years (5.2 per cent of that age group) have used cocaine at some time in their lives, making it the second most prevalent drug of abuse in the Union. The decline in cocaine abuse in the European Union that had been reported in previous years was not observed to have continued in the most recent surveys. Last-year prevalence of cocaine abuse among adults aged 15–34 years old that was greater than 2.5 per cent was reported by Ireland (2.9 per cent), Spain (3.0 per cent), the Netherlands (3.6 per cent) and the United Kingdom (4.0 per cent). Those four countries accounted for about 85 per cent of all reported treatment admissions related to cocaine abuse in the European Union.

785. While heroin remains the most commonly abused opioid, there are indications that licit synthetic opioids, such as methadone, buprenorphine and fentanyl, have been increasingly abused in Europe. Although the latest data confirm that heroin abuse still accounts for the majority (around 80 per cent) of new requests for opioid-related treatment in the European Union, in Estonia, for example, the majority of individuals entering treatment reporting an opioid as their primary drug were using fentanyl. In Czechia, opioids other than heroin accounted for just over half of those entering treatment for opioid abuse in 2015. The average prevalence of high-risk opioid use among adults (aged 15–64 years) is estimated at 0.4 per cent of the European Union population. Of concern is the estimate for drug overdose deaths in the European Union, which has increased for the third consecutive year; opioid overdose accounted for 81 per cent of those deaths.

786. About 1.8 million people in the European Union aged 15–64 years, or 0.5 per cent of this age group have used amphetamines in the past year, and 2.7 million, or 0.8 per cent, of that age group, have used MDMA ("ecstasy") in the past year. While abuse of amphetamine has been commonly reported by most of the countries of the European Union, the abuse of methamphetamine, mostly reported by Czechia and Slovakia, has recently also emerged in other parts of Europe, including countries in northern Europe and Germany.

787. As of January 2016, a total of 633,409 drug users were registered with specialized medical facilities of the Ministry of Health and the Federal Penitentiary Service of the Russian Federation, a decrease of 1.6 per cent in the total number of drug users compared with the previous year. Over the same period, the number of persons

[108] In the meantime, some of these new psychoactive substances have been put under international control.

who abuse drugs by injection that are registered with the health authorities declined to 298,155.

788. According to UNODC, an increase in amphetamine seizures has been reported during the past year in South-Eastern Europe, which may be related to the expansion of amphetamine trafficked in and through the Near and Middle East. The amount of amphetamine seized in South-Eastern Europe accounted for an 8 per cent share, or almost 4 tons, of global amphetamine seized in 2015. The increase in amphetamine seizures in South-Eastern Europe is primarily due to the increase in seizures reported in Turkey, which went up from 0.2 tons in 2014 to 3.8 tons in 2015.

789. The prevalence of MDMA ("ecstasy") abuse peaked in the European Union in the early to mid-2000s. Since then abuse of MDMA ("ecstasy") has shown a declining trend in the Union. The latest data, however, indicate that the use of the substance might have increased again in some countries, as corroborated by an increased presence of MDMA residues in wastewater in about a half of the 32 cities monitored in Europe in 2015 and 2016. In 2016, increased prevalence of MDMA ("ecstasy") abuse was reported in, for example, Finland, Germany, Lithuania and Slovakia.

790. The prevalence of GHB, hallucinogenic mushrooms, ketamine and LSD abuse in Europe remained low and stable.

791. Although there are not enough comparable data on the prevalence of abuse of new psychoactive substances, that prevalence is considered to be rather low among the European Union's general population. According to the 2015 report of the European School Survey Project on Alcohol and Other Drugs, past-year prevalence of the abuse of new psychoactive substances among 15- and 16-year-old school students in the European Union member States covered by the survey and Norway was 3 per cent. An EMCDDA study entitled "High-risk drug use and new psychoactive substances", published in June 2017, confirmed that there was some level of use of new psychoactive substances among high-risk user groups in 22 of the 30 countries monitored by EMCDDA.

792. Around 30,000 newly diagnosed HIV infections have been reported each year over the past decade in the European Union and the European Economic Area countries. However, the number of new HIV infections attributed to injecting drug use have continued declining in the European Union since the early 1990s. In 2015, 4 per cent of all HIV diagnoses in the European Union were among persons who abuse drugs by injection. At the conference on HIV organized by the Maltese Presidency of the Council of the European Union and the European Centre for Disease Prevention and Control in January 2017 European experts deliberated on practical measures such as prioritization of prevention programmes, facilitating the uptake of HIV testing, and easier access to treatment for those diagnosed, which could help the European countries to meet the target of the Joint United Nations Programme on HIV/AIDS to end the AIDS epidemic by 2030.

793. **The Board recommends that all Governments in the region redouble their efforts to sustain the high level of treatment offered, in particular in countries in Central and Western Europe, and continue to provide necessary treatment for drug use-related disorders, including those involving new psychoactive substances and other substances of abuse not under international control. INCB further recommends strengthening the programmes aimed at the detection of such disorders among the entire population, including migrants, and ensuring appropriate referral to facilities providing treatment services.**

E. Oceania

1. Major developments

794. The Oceania region, in particular the Pacific island States, remains vulnerable to trafficking in drugs and precursors, drug-related organized crime and the potential spillover effects of drug abuse within local communities. The combination of the unique geography of the region, in particular the vast coastlines and remote, uninhabited islands, together with poor treaty adherence and the limited resources for monitoring and detecting drug and precursor trafficking, continues to pose a significant challenge.

795. Increasing tourism, enhanced air and maritime connections and improved digital connectivity are linking regions and countries that are major illicit sources of and markets for drugs. This development contributes to the increasing targeting of Pacific island countries by drug trafficking groups for use as transit points and destinations for drugs, in particular methamphetamine. A number of large-scale seizures made at sea in the past year have demonstrated the growing complexity of this challenge. Drugs such as cocaine, heroin and methamphetamine are trafficked through the Pacific island region (for example, through tourist hubs in Fiji, New Caledonia and Vanuatu) on recreational vessels such as yachts and commercial cruise ships.

796. Spillover effects from drugs trafficked through the Pacific region have been observed in some local

communities. Some Pacific island countries have reported recurrent seizures of heroin, cocaine and methamphetamine, for instance in mail packages, as well as recent increases in the availability and abuse of methamphetamine, albeit from a low baseline. However, the illicit drug market in Pacific island countries and territories continues to be dominated by locally cultivated cannabis.

797. **The Board reiterates its concern about the lack of data on the scope of the drug problem in most countries in Oceania, and encourages Governments to prioritize the collection of data on drug abuse and treatment, as well as on the extent of drug trafficking and illicit cultivation and production. In that regard, the Board has noted a number of measures taken in the region to improve data collection, and urges the international community to support such efforts.**

2. Regional cooperation

798. On 28 November 2016, the UNODC global Synthetics Monitoring: Analyses, Reporting and Trends (SMART) programme and the Pacific Islands Forum Secretariat (PIFS) held a regional law enforcement planning development meeting with officials from PIFS member States in Suva to discuss how to address the lack of drug-related data and information in the region. The participants agreed that two national workshops would be organized, one for Solomon Islands and one for Vanuatu. In August 2017, the UNODC SMART programme held national workshops on the development of drug data in Honiara, and Port Vila with the participation of national authorities including police, forensic, customs and health authorities. The workshop participants identified the roles and responsibilities of national authorities in drug-related data collection, and requested support from UNODC to develop data collection tools and provide training in data collection, management and analysis. The development of strategic data and research in the region was one of the key recommendations set out in the UNODC and PIFS publication *Transnational Organized Crime in the Pacific: a Threat Assessment*, which was launched at the Pacific Islands Chiefs of Police annual conference, held in French Polynesia in September 2016. Among other threats posed by organized crime, the publication highlighted the vulnerability of the Pacific islands to trafficking in cocaine, heroin and methamphetamine, and the limited capacity of the authorities to respond.

799. At its nineteenth annual conference, held in Guam from 2 to 5 May 2017, the Oceania Customs Organisation (OCO) endorsed its Strategic Plan for 2017–2022. OCO members endorsed further work towards the establishment of a multilateral mechanism to enable the sharing of information across the region, and acknowledged progress made in the development of a smartphone application for reporting movements of small craft. The members also expressed support for the expansion of the UNODC Global Container Control Programme into the Pacific region.

800. From 28 to 30 November 2017, INCB held a training seminar in Sydney for the competent national authorities of the Oceania region. Representatives of the following countries participated: Australia, Fiji, Kiribati, Micronesia (Federated States of), New Caledonia, Palau, Papua New Guinea, Samoa, Solomon Islands and Vanuatu. Implemented as part of the INCB Learning project, the training seminar was supported by the Government of Australia. It was aimed at enhancing the capacity of the participating Governments to implement the drug control conventions, with a particular focus on the formulation of estimates and assessments of the quantities of narcotic drugs and psychotropic substances required to meet national medical and scientific needs, as well as to fulfil their related obligations to report to INCB. The seminar provided an opportunity to improve cooperation among the competent authorities of the region. It was also an occasion to promote accession to the international drug control treaties among States of the region, which has the lowest rate of treaty adherence worldwide.

3. National legislation, policy and action

801. The level of adherence in Oceania to the drug control conventions remains low, with seven, eight and five countries of the region not yet party to, respectively, the 1961 Convention as amended by the 1972 Protocol, the 1971 Convention and the 1988 Convention. This is of particular concern given the vulnerability of those countries to the emerging threat posed by drug and precursor trafficking and the potential spillover effect of drug abuse among their populations. **The Board reiterates its call upon the Governments of the Cook Islands, Nauru, Niue, Palau, Papua New Guinea, Samoa, Tuvalu and Vanuatu to accede to the international drug control conventions to which they are not yet parties.**[109] The Board stands ready to provide further support to that end and also reiterates its call to the international community, in particular UNODC, to support those countries in their

[109] Kiribati and Tuvalu have not adhered to any of the three international drug control conventions. The Cook Islands, Nauru, Niue, Samoa and Vanuatu are parties to neither the 1961 Convention nor the 1971 Convention. Solomon Islands is a party to neither the 1971 Convention nor the 1988 Convention. Palau and Papua New Guinea are not yet party to the 1988 Convention.

efforts to adhere to and fully implement the three international drug control treaties.

802. Seized proceeds of criminal activities were used to support a range of new initiatives in New Zealand in 2016, including a pilot of a "whole-school approach" framework to reduce alcohol and drug harm. The pilot, carried out by the New Zealand Drug Foundation, the Ministry of Health, the Ministry of Education and the Health Promotion Agency of New Zealand, as well as by service providers and schools, would integrate a range of best-practice and evidence-based strategies to prevent and address substance-related harm at every level of the school environment.

803. In December 2016, the Therapeutic Goods Administration of Australia decided that products containing codeine would no longer be sold over the counter in pharmacies, and would be available only by prescription, effective 1 February 2018. Modelling of the potential economic, social and regulatory impacts of the proposed scheduling change had found that the rescheduling would, inter alia, prevent deaths from accidental or deliberate codeine overdose, improve quality of life as a result of the adoption of more effective treatment options for moderate pain, and reduce dependence and risk of dependency.

804. As reported by the Board in its annual report for 2016, the Narcotic Drugs Amendment Act 2016 entered into force in Australia in October 2016. The Act provides a legislative framework for the cultivation of and access to cannabis for medical purposes. The first meeting of the Australian Advisory Council on the Medicinal Use of Cannabis was held on 7 April 2017. The Council was established to provide advice to the Minister for Health of Australia on issues relating to the medicinal use of cannabis, in particular the implementation of the regulatory scheme allowing for the cultivation and manufacture of medicinal cannabis, the design of prescription guidelines and the use of the Authorised Prescriber Scheme and Special Access Scheme mechanisms, and evidence supporting the use of medicinal cannabis for a variety of medical conditions. The Council comprises 16 members from various professional fields, including medical professionals; Government representatives, including law enforcement officials; patient groups and legal experts. Members also have expertise in the fields of cancer, epilepsy, palliative care, toxicology, law, pharmacology, law enforcement and botany.

805. In New Zealand, changes came into effect in September 2017. The requirement for ministerial approval for the prescription of cannabidiol products was removed, as were related requirements for import licences, the keeping of records on controlled drugs and stock-keeping. Prescriptions from medical doctors would be allowed for a supply of up to three months rather than one, as previously. Another change was that the new Misuse of Drugs Amendment Regulations 2017 allowed for cannabidiol products containing up to two per cent of other cannabinoids, including THC.

4. Cultivation, production, manufacture and trafficking

(a) Narcotic drugs

806. The illicit drug trade among and within Pacific island countries and territories continued to be dominated by the local illicit cultivation of cannabis. A record number of cannabis seizures were made in Australia during the 12-month reporting period 2015/16, with the majority (93.6 per cent) of seizures at the border relating to cannabis seeds. The total weight of cannabis seized at the Australian border increased from 60.2 kg during the period 2014/15 to 101.8 kg during the period 2015/16, while the total weight of cannabis seized within the country remained stable at around 6 tons.

807. The amount of cannabis herb seized in New Zealand decreased from 692.03 kg in 2015 to 524.22 kg in 2016, and the number of cannabis plants seized decreased from 112,073 to 78,358 over the same period. The New Zealand Police reported a greater focus on organized criminal groups involved in illicit cannabis cultivation, which may have had an impact on the illicit supply of cannabis. In 2016, 104,725 outdoor cannabis plants and 18,903 indoor cannabis plants were eradicated across 607 indoor sites.

808. The amount of cocaine seized in Oceania increased from 0.8 tons in 2014 to 1.2 tons in 2015, still significantly less than the peak of 1.9 tons in 2010, with Australia accounting for 99 per cent of the cocaine seized in the region. A record number of cocaine seizures were made at the Australian border and within the country during the period 2015/16, with the total weight seized increasing from 883.4 kg during the period 2014/15 to 1,378.7 kg during the period 2015/16. Owing to a single cocaine seizure of 35 kg in 2016, the total annual amount of cocaine seized in New Zealand reached a record level of 36.38 kg in 2016, compared with 129 g in 2015 and 10.2 kg in 2014.

809. The increased prominence of Colombia as a source country for cocaine seized in Australia continued, with 59.5 per cent of cocaine seized at the border from January to June 2016 originating in Colombia, compared with

49.9 per cent in 2015. Similarly, the proportion of cocaine seized within Australia originating in Colombia increased from 50.5 per cent in 2015 to 83.3 per cent during the period January–July 2016. The proportion of cocaine seized at the border originating in Peru increased slightly, from 8.9 per cent in 2015 to 11.6 per cent in the first half of 2016, still significantly less than in 2013 and 2014 (90.0 per cent and 31.8 per cent, respectively).

810. In February 2017, as a result of an investigation supported by the authorities of Fiji, French Polynesia and New Zealand, a record seizure of more than 1.4 tons of cocaine was made by Australian law enforcement authorities after having intercepted a sailing vessel that was alleged to have met with a "mother ship" in the South Pacific Ocean to collect the substance. In December 2016, an international operation that had been under way for more than two and a half years culminated in the seizure of 500 kg of cocaine trafficked by sea into Australia, in addition to 606 kg of cocaine seized by authorities in Tahiti in March 2016 and 32 kg of heroin seized by authorities in Fiji in December 2014.

811. Oceania accounted for only 1 per cent of the heroin and morphine seized globally in 2015. South-East Asia remained the prominent source region for heroin seized in Australia, and was the only source region identified in seizures at the Australian border in the first half of 2016. The total weight of heroin seized in Australia decreased by more than one half, from 796.6 kg during the period 2014/15 to 370.4 kg during the period 2015/16. A total of 49.27 g of heroin was seized in New Zealand in 2016, representing a level similar to that of 2015 (38.4 g). In 2016, New Zealand customs authorities seized two opioids, acetylfentanyl and U-47700, which were placed under international control in 2016 and 2017, respectively; and fentanyl and benzodiazepines, which are under international control, were found in the form of blotter tabs for the first time.

(b) Psychotropic substances

812. According to UNODC, in Oceania there has been an increase in both the quantities of methamphetamine seized and the prevalence of its use. Trafficking in methamphetamine and its precursor chemicals has increased in the Pacific and adjacent regions in recent years, and Pacific island countries and territories are emerging as transit and destination points for trafficking in methamphetamine within and through the region. Increased trafficking in drugs, including methamphetamine, into North Pacific countries such as Palau has been reported.

813. The total weight of amphetamine-type stimulants (ATS) seized within Australia decreased by 27 per cent, from 12,631.5 kg during the period 2014/15 to 9,218.2 kg during the period 2015/16, the second-highest weight on record in that category. The total weight of ATS (excluding MDMA) seized at the Australian border decreased by 23.4 per cent, from 3,422.8 kg during the period 2014/15 to 2,620.6 kg during the period 2015/16, the second-highest weight on record in that category. Countries in East and South-East Asia remained the main embarkation points for ATS (excluding "ecstasy"). In late March 2017, a concealed shipment of 300 kg of methamphetamine was seized in Melbourne, Australia. It had been discovered in a consignment of large metal gates originating in China. A record seizure amounting to more than 900 kg of methamphetamine, also in Melbourne, was reported in April 2017.

814. The quantity of methamphetamine seized in New Zealand increased from 15 kg in 2013 to 0.4 tons in 2015, then to almost 1 ton in 2016, including a single seizure of 500 kg. The quantity of methamphetamine trafficked into the country increased, whereas in the past methamphetamine had been more commonly manufactured illicitly within the country. At the same time, transnational organized criminal groups, primarily from Asia and South-East Asia, were targeting New Zealand, in particular in connection with methamphetamine.

815. There was extensive trafficking of "ecstasy" from Europe to Oceania, which was becoming an increasingly important market for the substance, either directly or through East and South-East Asia. The total weight of "ecstasy" detected at the Australian border decreased significantly, from 2,002.4 kg during the period 2014/15 to 141.5 kg during the period 2015/16, primarily due to a single detection of 1,917.4 kg in the period 2014/15. The total weight of "ecstasy" seized within Australia decreased by 28.7 per cent, from 6,105.6 kg during the period 2014/15 to 4,352.7 kg during the period 2015/16. In New Zealand, annual seizures of "ecstasy" have fluctuated between 5 kg and 50 kg since 2010, with seizures amounting to 11.38 kg and more than 8,000 tablets in 2016, compared with 8.85 kg and more than 5,000 tablets in 2015.

(c) Precursors

816. Ephedrine and safrole were the predominant precursors detected at the Australian border during the period 2015/16. The weight of ATS (excluding "ecstasy") precursors seized at the Australian border more than doubled, from 500.8 kg during the period 2014/15 to 1,063.7 kg during the period 2015/16. In June 2017, a seizure of 1.4 tons of ephedrine found in a shipping

container represented the largest seizure of a precursor chemical ever made at the Australian border. The weight of "ecstasy" precursors detected at the Australian border decreased from 288.0 kg during the period 2014/15 to 81.1 kg during the period 2015/16. China represented the predominant embarkation point for amphetamine-type stimulant precursors.

817. The number of clandestine laboratories detected in Australia continued to decrease, from 667 during the period 2014/15 to 575 during the period 2015/16, but still represented a 61.5 per cent increase since the period 2006/07. Methamphetamine remained the most predominant drug to be illicitly manufactured in the detected laboratories, along with the continued prevalence of the precursors ephedrine and pseudoephedrine. However, during the period 2015/16, the number of laboratories illicitly manufacturing ATS (including "ecstasy") and "homebake" heroin decreased, while those dedicated to the extraction of cannabis oil and pseudoephedrine increased. Two thirds of the detected laboratories were operated by users themselves, while 51 clandestine laboratories were operating on an industrial scale.

818. With regard to methamphetamine precursors seized in New Zealand, the trend observed in recent years, away from pseudoephedrine (in the form of ContacNT granules) towards bulk amounts of ephedrine powder, continued. Ephedrine made up approximately 95 per cent of all pseudoephedrine and ephedrine seizures during the previous two years, with pseudoephedrine seizures mainly comprising low volumes of medication in which pseudoephedrine was an active ingredient. Large volumes of precursors, mainly ephedrine, were seized regularly at the New Zealand border throughout 2016. The number of clandestine methamphetamine laboratories detected in New Zealand increased from 69 in 2015 to 74 in 2016. However, a decrease was observed when assessments indicating that a suspected clandestine laboratory had not met the criteria for classification as a clandestine laboratory were also taken into account. The first half of 2017 saw a substantial decline in border seizures of ephedrine, and during the first four months of 2017 the number of clandestine laboratories detected was approximately half that of the corresponding period in 2016.

819. In January 2017, the first-ever seizure in New Zealand of the chemical t-boc methamphetamine, chemically masked to prevent detection, was made in the amount of 160 litres. The discovery was made in a consignment imported from Hong Kong, China.

820. A comprehensive review of the situation with respect to the control of precursors and chemicals frequently used in the illicit manufacture of narcotic drugs and psychotropic substances in the region can be found in the report of the Board for 2017 on the implementation of article 12 of the 1988 Convention.

(d) Substances not under international control

821. The amount of new psychoactive substances seized at the Australian border and selected for further analysis almost quadrupled, from 52.7 kg during the period 2014/15 to 204.7 kg during the period 2015/16. However, it was still significantly less than the record amount seized during the period 2013/14 (543 kg). Of those substances, a group of substances termed "amphetamine-type" accounted for 51.8 per cent (by weight), followed by cathinone-type substances (24.6 per cent), tryptamine-type substances (17.4 per cent) and synthetic cannabinoids (5.8 per cent). The number of detections of ketamine at the Australian border more than doubled, from 218 during the period 2014/15 to a new record of 487 during the period 2015/16; most of the ketamine was discovered in the international mail stream. The number of *gamma*-butyrolactone (GBL) detections at the Australian border decreased by 44 per cent, from 157 during the period 2014/15 to 88 during the period 2015/16. Twenty-eight countries were identified as embarkation points for ketamine detections during the period 2015/16, compared with 15 countries during the period 2014/15. Of those countries, the United Kingdom was the embarkation point in 56.9 per cent of cases of ketamine detection during the period 2015/16.

822. New psychoactive substances continued to be encountered in New Zealand. A joint investigation between the customs and police services of New Zealand between June and August 2017 resulted in the seizure of 11 kg of synthetic cannabis and a combined total of 3 kg of AMB-FUBINACA and AB-PINACA, which are used in the illicit manufacture of synthetic cannabis.

5. Abuse and treatment

823. The 2016 National Drug Strategy household survey carried out by the Department of Health of Australia from June to November 2016 found that 15.6 per cent of people aged 14 years or older had abused a drug, including pharmaceutical drugs, in the previous twelve months. That represented a slight increase from 2013 (15.0 per cent), when the previous survey had been conducted, and a gradual increase since 2007 (13.4 per cent). An increase was seen in the abuse of pharmaceutical drugs, with

analgesics and opioids reported as the second-most commonly abused drugs after cannabis.

824. The prevalence among Australian adults of past-year use of methamphetamine and amphetamine decreased significantly, from 2.1 per cent in 2013 to 1.4 per cent in 2016. The prevalence of past-year use of hallucinogens also decreased, from 1.3 per cent in 2013 to 1.0 per cent in 2016. Annual prevalence of cocaine abuse increased from 2.1 per cent in 2013 to 2.5 per cent in 2016, significantly higher than the reported usage in 2004 (1.0 per cent). The level of abuse of cannabis remained stable, with past-year prevalence at 10.4 per cent. The annual prevalence of "ecstasy" use decreased from 3.0 per cent in 2010 to 2.5 per cent in 2013, then to 2.2 per cent in 2016.

825. The household survey found that the average age at which people in Australia first tried any drug of abuse had increased, from 19.3 years in 2013 to 19.7 years in 2016, with increases in the average age of first use reported specifically for cannabis, amphetamines and hallucinogens. People under 30 years of age abused fewer drugs than in 2001, while for people between 40 and 69 years of age, the abuse of some drugs had increased since 2013.

826. The household survey also found that almost two thirds of people in Australia who had used cocaine in the past year had done so only once or twice per year. Similarly for "ecstasy", just over half of those who had used the substance had done so only once or twice per year. Only 2 to 3 per cent of those reporting past-year use of cocaine and "ecstasy" had abused those substances at least once per week. In contrast, of those who reported past-year abuse of cannabis and amphetamines, 36 per cent and 20 per cent, respectively, had used the drugs at least once per week.

827. In 2016, 4.8 per cent of Australian adults surveyed had misused a pharmaceutical drug in the past twelve months, compared with 3.6 per cent in 2013. In terms of past-year use, analgesics and opioids, with an annual prevalence of 3.6 per cent, were the second-most commonly abused drug type after cannabis. Of recent users of analgesics and opioids, about 75 per cent reported having misused over-the-counter codeine products, and 40 per cent reported having misused prescription codeine products, followed by oxycodone (16.7 per cent), morphine (4.3 per cent) and fentanyl (0.9 per cent), which are controlled under the 1961 Convention as amended by the 1972 Protocol, and tramadol (9.5 per cent) and gabapentinoids (1.7 per cent), which are not under international control. The proportion of past-year users of amphetamines specifying prescription amphetamines as the main form abused in the previous twelve months increased significantly, from an estimated 3.0 per cent in 2013 to 11.1 per cent in 2016.

828. The annual prevalence of use of synthetic cannabinoids among adults in Australia decreased from 1.2 per cent in 2013 to 0.3 per cent in 2016. The use of other new psychoactive substances decreased from 0.4 per cent in 2013 to 0.3 per cent in 2016.

829. The second report of the National Wastewater Drug Monitoring Programme of Australia is based on an analysis, conducted between August 2016 and February 2017, of wastewater from areas covering just over half of the population. The report indicates that, of the substances detected, methamphetamine remained the most-abused drug across all regions in Australia. Nonetheless, there was a slight decrease overall in 2016 compared with the previous year, in line with reported declines in seizures. Still, wastewater data continued to indicate a clear increase in methamphetamine consumption over the period 2013–2016, despite a decline in the prevalence of use of amphetamines over the same period. The programme did not test for cannabis consumption. In contrast to prevalence data, the estimated consumption of "ecstasy" was low across the country, with no consistent trends observed, although average consumption in state and territory capital cities decreased by almost one half. Increased levels of cocaine consumption were evident in a number of geographical areas. Results reported by the programme on four new psychoactive substances indicated that the market for such substances remained small in comparison with established illicit drug markets. For example, neither the synthetic cannabinoid JWH-018, which is controlled under the 1971 Convention, nor the synthetic cannabinoid JWH-073, which is not under international control, were detected at any testing sites across Australia. On the other hand, mephedrone and methylone, which are both controlled under the 1971 Convention, were detected at a number of sites, albeit at negligible levels. According to the study, a gradual reduction in use (both licit and illicit) of pharmaceutical opioids, in particular oxycodone, had been measured over the study period. Average consumption in state and territory capital cities of oxycodone and fentanyl had decreased significantly between August 2016 and February 2017, yet the report indicated that the level of consumption of the two substances continued to be of concern.

830. The aim of the Drug Use Monitoring in Australia programme is to measure drug abuse among people who have recently been apprehended by police. Under the programme, detainees who have been arrested and have been held in custody for less than 48 hours are interviewed and tested on a voluntary and confidential basis. The

findings of the programme indicated that self-reported abuse of methamphetamine had increased to exceed that of cannabis, from 50.4 per cent during the period 2014/15 to 59.7 per cent during the period 2015/16, making it the most frequently reported drug to have been abused by police detainees in the preceding twelve months. The proportion of detainees testing positive for methamphetamine increased from 38.7 per cent during the period 2014/15 to 49 per cent during the period 2015/16, and was, for the first time, higher than the proportion of detainees testing positive for cannabis. The proportion of detainees self-reporting past-year abuse of cannabis has remained relatively stable over the last decade, amounting to 58.3 per cent during the period 2015/16. The proportion of detainees testing positive for cocaine increased slightly, from 0.8 per cent during the period 2014/15 to 0.9 per cent during the period 2015/16, and the proportion of self-reported use of cocaine continued to increase, from 14.2 per cent during the period 2014/15 to 16.0 per cent during the period 2015/16. The proportion of detainees testing positive for "ecstasy" increased from 1.3 per cent during the period 2014/15 to 1.9 per cent during the period 2015/16, while the proportion of detainees self-reporting "ecstasy" abuse increased from 14.7 per cent during the period 2014/15 to 16.2 per cent during the period 2015/16. The proportion of detainees testing positive for heroin has decreased by almost one half since the period 2006/07; it amounted to 5.7 per cent during the period 2015/16, which was the lowest level observed in the past decade. The proportion of detainees self-reporting past-year use of heroin increased from 11.1 per cent during the period 2014/15 to 12.5 per cent during the period 2015/16.

831. In Australia during the period 2015/16, the main drugs causing patients to seek treatment were, after alcohol (32 per cent), amphetamines (23 per cent), cannabis (23 per cent) and heroin (6 per cent). Treatment for the use of amphetamines increased from 11 per cent of treatment episodes during the period 2010/11 to 23 per cent during the period 2015/16. Despite representing 2.7 per cent of the Australian population aged 10 and over, indigenous Australians comprised 14 per cent of clients of treatment services for alcohol and other drugs.

832. A household survey conducted in New Zealand from 2015 to 2016 found that 1.1 per cent of the population aged 16 to 64 years had abused amphetamines in the previous year, representing an increase of 22.2 per cent compared with that of the period 2014–2015 (0.9 per cent), with levels of abuse stable since the period 2011–2012. The survey found that past-year prevalence was greatest (2.4 per cent) among people aged 25 to 34 years. While the prevalence of fentanyl abuse in New Zealand was not known, available information indicated that abuse of the substance was at low levels and had not increased.

833. Wastewater sampling conducted daily in Auckland, New Zealand, from May to July 2014 found that methamphetamine was one of the most commonly detected drugs of abuse in Auckland, having been detected consistently throughout the week. The detection of indicators of cocaine and "ecstasy" consumption was rare and limited to weekends. In December 2016, the New Zealand Police initiated a twelve-month pilot programme to test wastewater for methamphetamine, cocaine, heroin, α-PVP and "ecstasy" in Auckland and Christchurch, in order to establish a baseline of consumption levels. The initial six months of testing detected a small fluctuation in the amounts of methamphetamine, cocaine and "ecstasy" detected at both sites, while α-PVP and heroin were not detected.

834. The New Zealand Arrestee Drug Use Monitoring study monitored levels of alcohol and other drug use, and related harms and problems, among adult police detainees who had been held in custody for less than 48 hours in four central city police watch-houses, through voluntary and confidential interviews and testing. The proportion of detainees who had used cannabis in the previous year decreased from 76 per cent in 2011 to 69 per cent in 2015. Past-year abuse of methamphetamine among detainees increased from 28 per cent in 2012 to 36 per cent in 2015. The proportion of detainees who had abused "ecstasy" in the previous year continued to decline, from 28 per cent in 2011 to 19 per cent in 2015. The reported past-year abuse of cocaine and opioids among detainees remained similar to previous years, at 5 per cent and 6 per cent, respectively. The proportion of detainees who had used synthetic cannabinoids in the previous year declined from 47 per cent in 2014 to 27 per cent in 2015, subsequent to the banning of all synthetic cannabinoid products in May 2014, when all interim psychoactive product licences granted under the Psychoactive Substances Act 2013 were withdrawn.

835. In July 2017, the Chief Coroner and Police of New Zealand issued a warning following at least seven deaths that month in Auckland that appeared to be linked to the use of synthetic cannabis.

836. **In view of the lack of data on drug abuse and treatment in the other countries of Oceania, the Board reiterates its call upon Governments of those countries to collect data on drug abuse and treatment so as to inform national drug policy, and urges the international community to provide support in that regard.**

Chapter IV.

Recommendations to Governments, the United Nations and other relevant international and national organizations

837. The present chapter contains the main recommendations of INCB following the Board's review of the implementation of the international drug control conventions during the reporting period.

Treatment, rehabilitation and social reintegration of drug use disorders: essential components of drug demand reduction

838. The health and welfare of humankind are the cornerstone of the international drug control framework. A substantive review of the basic concepts of, and factors associated with, drug use disorders, treatment interventions, approaches and modalities, has led INCB to come up with a series of specific recommendations in that area. INCB reminds all Governments that parties to the international drug control treaties are required to take all practical measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons affected. Furthermore, treatment of drug use disorders, rehabilitation and social reintegration are among the key operational objectives of the recommendations on drug demand reduction contained in the outcome document of the thirtieth special session of the General Assembly, entitled "Our joint commitment to effectively addressing and countering the world drug problem", adopted by the General Assembly in its resolution S-30/1 of 19 April 2016.

Recommendation 1: **The Board urges all Governments to:**

- ***(a)*** **Gather data on prevalence of drug-use disorders and the accessibility and utilization of treatment;**
- ***(b)*** **Invest in making treatment and rehabilitation evidence-based;**
- ***(c)*** **Allocate sufficient resources to treatment and rehabilitation, the two major components of demand reduction;**
- ***(d)*** **Pay particular attention to special population groups;**
- ***(e)*** **Share, nationally and internationally, best practices and build capacity;**
- ***(f)*** **Stimulate research into new interventions.**

For additional recommendations and more details of proposed action, please refer to the section M ("Recommendations") of chapter I.

Promoting the consistent application of the international drug control treaties

839. Governments have to ensure that national legislation complies with the provisions of the international drug control treaties. Some Governments have introduced or are planning to introduce legislative measures in contravention of the requirements of the international drug control treaties. In particular, there is legislation which allows or would allow the production, trade in and use of cannabis for non-medical purposes.

Recommendation 2: **All Governments are reminded that in the outcome document of the thirtieth special session of the General Assembly, Member States reaffirmed**

their commitment to the goals and objectives of the three international drug control conventions.

Recommendation 3: **Pursuant to those conventions, the use of narcotic drugs and psychotropic substances is limited to medical and scientific purposes. All other uses are incompatible with the international drug control legal framework, and the Board calls upon all States to respect their legal obligations in this regard.**

840. The Board reiterates that in order for the operation of "drug consumption rooms" to be consistent with the international drug control conventions, certain conditions must be fulfilled. First among those conditions is that the ultimate objective of such facilities should be to reduce the adverse consequences of drug abuse without condoning or encouraging drug use and trafficking.

Recommendation 4: **The Board calls upon all States having consented to the establishment of such facilities to ensure that they provide or refer patients to treatment, rehabilitation and social reintegration services, and notes that such services must not be a substitute for demand reduction programmes.**

Human rights

841. The Board has repeatedly stressed the importance of respecting and protecting human rights and fundamental freedoms as part of the effective implementation of the international drug control treaties. INCB continues to emphasize that for drug control action to be successful and sustainable, it must be consistent with international human rights standards.

Recommendation 5: **INCB calls upon all States to adopt drug policies that respect the rule of law and human rights, including the presumption of innocence, the prohibition of arbitrary arrest and detention, the right to a fair trial and protection against all forms of cruel and inhuman punishment.**

Recommendation 6: **States need to protect children from drug abuse and prevent the use of children in the illicit production of and trafficking in illicit substances, in accordance with the Convention on the Rights of the Child, in particular article 33.**

Recommendation 7: **The Board reminds all States of the possibility of providing for education, treatment, rehabilitation and after-care measures in addition to, or as alternatives to, punishment of drug offences of a minor nature and offences committed by persons who use drugs.**

Recommendation 8: **The principle of proportionality must continue to be a guiding principle in drug-related matters. Although the determination of sanctions applicable to drug-related crime remains the prerogative of States parties to the conventions, INCB reiterates its position on the issue of capital punishment for drug-related offences and encourages States that retain capital punishment for drug-related offences to consider the abolition of the death penalty for that category of offence.**

Special session of the General Assembly on the world drug problem held in 2016

842. In the outcome document of the thirtieth special session of the General Assembly on the world drug problem, Member States reaffirmed their commitment to implementing the international drug control treaties and presented a practical plan of action for Member States to deal with the world drug problem.

Recommendation 9: **The Board is ready to continue its cooperation with Governments, relevant international organizations and civil society with a view to improving the drug control situation worldwide in the context of the 2030 Agenda for Sustainable Development. INCB once again encourages all Governments to continue to make progress towards the implementation of the goals and targets set in the 2009 Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem and undertake their review by the target date of 2019.**

Availability

843. The outcome document of the thirtieth special session of the General Assembly contains important elements on improving access to controlled substances for medical and scientific purposes by appropriately addressing existing barriers.

Recommendation 10: **INCB urges all Governments to fully implement the operational recommendations on improving access to controlled substances for medical and scientific purposes, while preventing their diversion and abuse, and the related recommendations contained in previous INCB annual reports. INCB further invites Governments to support and participate in concrete initiatives for the implementation of the operational recommendations and stands ready to continue to support Governments in their efforts to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes, in coordination with other international and national organizations.**

Cannabis

Recommendation 11: **Governments that are considering the medical use of cannabinoids should examine the results of scientific studies and medical trials and ensure that the prescription of such substances for medical use is performed with competent medical knowledge and supervision and that prescription practice is based on available scientific evidence and the consideration of potential side effects.**

Recommendation 12: **Furthermore, Governments should ensure that cannabinoids are made available to patients in line with the relevant WHO guidelines and with the international drug control conventions. The Board reminds all countries having established relevant programmes of the control measures applicable under articles 23 and 28 of the 1961 Convention.**

Opioids

844. INCB stresses the need for the adequate availability of controlled drugs for medical and scientific purposes. Nevertheless, it remains of great importance for States parties to ensure rational prescribing and implement measures to prevent the diversion and of abuse of these drugs. Recent developments related to the opioids crisis, in particular in North America, demonstrate the need for such a balanced approach.

Recommendation 13: **INCB encourages Governments to adopt the measures described in the section on the risk of long-term opioid use and the consumption of opioid analgesics and work together with public health officials, pharmacists, manufacturers and distributors of pharmaceutical products, physicians, consumer protection associations and law enforcement agencies to promote public education about the risks associated with prescription drugs containing narcotic drugs and psychotropic substances, their abuse and their potential to cause dependence.**

Recommendation 14: **INCB urges all Governments to work in a cooperative manner and adopt specific measures against the illicit manufacture of, and trafficking in opioids, including fentanyl, fentanyl analogues and their precursors.**

Psychotropic substances

845. The Board acknowledges the efforts made by Governments that have already put recently scheduled psychotropic substances under national control.

Recommendation 15: **The Board urges all Governments that have not put scheduled psychotropic substances under national control to amend their lists of substances controlled at the national level accordingly to apply to those substances the control measures required under the 1971 Convention and the relevant resolutions of the Commission on Narcotic Drugs and the Economic and Social Council, and inform the Board accordingly.**

Recommendation 16: **The Board welcomes the increasing number of countries which submit data on consumption of psychotropic substances and calls upon more Governments to do so, pursuant to Commission on Narcotic Drugs resolution 54/6, as these data are essential for the evaluation of the availability of psychotropic substances for medical and scientific purposes.**

Precursors

846. The Commission on Narcotic Drugs, in its resolution 60/5 of March 2017, called for a set of voluntary measures and enhanced cooperation among Governments and with INCB to address the issue of non-scheduled precursors; in that resolution, the Commission also calls for action to address criminal activities conducted via the Internet relating to precursors. (An in-depth analysis of recent trends and developments observed can be found in the Board's report on the implementation of article 12 of the 1988 Convention).

Recommendation 17: **INCB urges Governments to give priority to precursor control as an effective means of preventing the manufacture and abuse of dangerous drugs. Specifically, in addition to regulatory controls, INCB emphasizes the importance of maintaining flexible systems for monitoring the movement of precursor chemicals and exchanging information.**

Internet and new psychoactive substances

847. Illegal Internet pharmacies are a growing phenomenon that has the potential to cause serious public health problems. The continued growth of Internet access around the world, the widespread availability of online communication channels and the vastness of the "deep web" all contribute to making drug trafficking over the Internet, whether through illegal Internet pharmacies or by other means, a significant crime threat.

Recommendation 18: **The Board calls on Governments to use its Guidelines for Governments on Preventing the**

Illegal Sale of Internationally Controlled Substances through the Internet, containing 25 individual guidelines that cover legislative and regulatory provisions, general measures and national and international cooperation.

848. As national controls are expanded to cover more new psychoactive substances, there is an increased risk of otherwise legitimate business-to-business trading platforms being used for the sale and purchase of substances under national control. At the same time, hindering the development of legitimate economic activities through the Internet needs to be avoided.

Recommendation 19: **The Board encourages Governments to consider appropriate measures, in accordance with national law, to monitor and act on attempts to trade in new psychoactive substances through online trading platforms, including, possibly, voluntary monitoring and information-sharing, and to consider involving the operators of trading platforms.**

Electronic tools and training

849. The effectiveness of the international drug control system relies on Member States' collective efforts to implement the conventions. A critical element in INCB support efforts is the real-time communication between Governments. Specifically, the online tools developed by INCB facilitate immediate cooperation and follow-up. Over the years, these tools have developed considerably in terms of the usage as well as the volume and the details of information provided by Governments. The maintenance and modernization of INCB electronic tools (IDS, I2ES, PEN Online, PICS and IONICS) are essential in this regard but do have financial implications.

Recommendation 20: **INCB would like to urge Governments to fully utilize all INCB electronic tools and consider providing the financial support needed to ensure that the Board continues to operate efficiently and effectively while also simplifying the work of competent national authorities in the submission of treaty-mandated information.**

Recommendation 21: **The Board calls on Governments to provide further and regular contributions to sustain and expand activities under the INCB Learning initiative. Such commitment by Governments is required to ensure broad geographical coverage, the sustainability of the project and the provision of support and advice to all Governments.**

Specific countries and regions

850. The Board is very concerned about the deteriorating drug control situation in Afghanistan, as evidenced by the most recent UNODC opium poppy survey in that country, as well as by information about production, trafficking and abuse of cannabis and synthetic drugs in Afghanistan.

Recommendation 22: **While INCB understands the challenges and difficulties confronting Afghanistan, after many years in which Afghanistan received considerable international assistance, INCB calls upon the Government to address the illicit cultivation of opium poppy and cannabis by implementing effective crop eradication and alternative livelihood programmes. At the same time, the Board reiterates its call to Afghanistan to counter with renewed strength the production of and trafficking in drugs, to devote due attention to the emerging problem of synthetic drugs and to rapidly and significantly scale up demand reduction services in the country.**

851. In several regions of the world, health-care systems lack the required resources and capacity to deal with drug problems. At the same time, regions such as Africa experience growing abuse of cocaine, opioids, amphetamine-type stimulants, tramadol and new psychoactive substances. There is no detailed and reliable information on the abuse and treatment situation in Africa, West Asia, Central America and the Caribbean and Oceania.

Recommendation 23: **The Board encourages all Governments to provide the necessary political support and appropriate resources to ensure the participation of all relevant actors in the planning, implementation and monitoring of drug control policies in the above-mentioned regions. Treatment facilities for sufferers of drug-related diseases should also be set up, in addition to comprehensive programmes for rehabilitation recovery and social reintegration.**

Recommendation 24: **Countries in those regions should produce or update prevalence studies using internationally recognized parameters and use the results to inform the development and adoption of targeted drug demand reduction policies and programmes. The Board also encourages the international community to provide assistance to help develop drug treatment and rehabilitation services in those regions.**

(*Signed*)
Viroj Sumyai, President

(*Signed*)
Cornelis P. de Joncheere, Rapporteur

(*Signed*)
Andrés Finguerut, Secretary

Vienna, 17 November 2017

Annex I

Regional and subregional groupings used in the report of the International Narcotics Control Board for 2017

The regional and subregional groupings used in the report of the International Narcotics Control Board for 2017, together with the States in each of those groupings, are listed below.

Africa

Algeria
Angola
Benin
Botswana
Burkina Faso
Burundi
Cameroon
Cabo Verde
Central African Republic
Chad
Comoros
Congo
Côte d'Ivoire
Democratic Republic of the Congo
Djibouti
Egypt
Equatorial Guinea
Eritrea
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho
Liberia
Libya
Madagascar
Malawi
Mali
Mauritania
Mauritius
Morocco
Mozambique
Namibia
Niger
Nigeria
Rwanda
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Somalia
South Africa
South Sudan
Sudan
Swaziland
Togo
Tunisia
Uganda
United Republic of Tanzania
Zambia
Zimbabwe

Central America and the Caribbean

Antigua and Barbuda
Bahamas
Barbados
Belize
Costa Rica
Cuba
Dominica
Dominican Republic
El Salvador
Grenada
Guatemala
Haiti
Honduras
Jamaica
Nicaragua
Panama
Saint Kitts and Nevis
Saint Lucia
Saint Vincent and the Grenadines
Trinidad and Tobago

North America

Canada
Mexico
United States of America

South America

Argentina
Bolivia (Plurinational State of)
Brazil
Chile
Colombia
Ecuador
Guyana
Paraguay
Peru
Suriname
Uruguay
Venezuela (Bolivarian Republic of)

East and South-East Asia

Brunei Darussalam
Cambodia
China
Democratic People's Republic of Korea
Indonesia
Japan
Lao People's Democratic Republic
Malaysia
Mongolia
Myanmar
Philippines
Republic of Korea
Singapore
Thailand
Timor-Leste
Viet Nam

South Asia

Bangladesh
Bhutan
India
Maldives
Nepal
Sri Lanka

West Asia

Afghanistan
Armenia
Azerbaijan
Bahrain
Georgia
Iran (Islamic Republic of)
Iraq
Israel
Jordan
Kazakhstan
Kuwait
Kyrgyzstan
Lebanon
Oman
Pakistan
Qatar
Saudi Arabia
State of Palestine
Syrian Arab Republic
Tajikistan
Turkey
Turkmenistan
United Arab Emirates
Uzbekistan
Yemen

Europe

Eastern Europe

Belarus
Republic of Moldova
Russian Federation
Ukraine

South-Eastern Europe

Albania
Bosnia and Herzegovina
Bulgaria
Croatia
Montenegro
Romania
Serbia
The former Yugoslav Republic of Macedonia

Western and Central Europe

Andorra
Austria
Belgium
Cyprus
Czechia
Denmark
Estonia
Finland
France
Germany
Greece
Holy See
Hungary
Iceland
Ireland
Italy
Latvia
Liechtenstein
Lithuania
Luxembourg
Malta
Monaco
Netherlands
Norway
Poland
Portugal
San Marino
Slovakia
Slovenia
Spain
Sweden
Switzerland
United Kingdom of Great Britain and Northern Ireland

Oceania

Australia
Cook Islands
Fiji
Kiribati
Marshall Islands
Micronesia (Federated States of)
Nauru
New Zealand
Niue
Palau
Papua New Guinea
Samoa
Solomon Islands
Tonga
Tuvalu
Vanuatu

Annex II

Current membership of the International Narcotics Control Board

Sevil Atasoy

Born in 1949. National of Turkey. Professor of Biochemistry and Forensic Science, Vice-Rector and Director, Institute of Addiction and Forensic Science; Head, Department of Forensic Science; Director, Center for Violence and Crime Prevention, Uskudar University, Istanbul. Director, Institute of Forensic Science, Istanbul University (1988–2010). Director, Department of Narcotics and Toxicology, Ministry of Justice of Turkey (1980–1993). Expert witness in civil and criminal courts (since 1980).

Bachelor of Science in Chemistry (1972), Master of Science in Biochemistry (1976), Doctor of Philosophy (Ph.D.) in Biochemistry (1979), Istanbul University.

Lecturer in biochemistry, criminalistics and crime scene investigation (since 1982); supervisor of more than 50 master's and doctoral theses in the area of biochemistry and forensic science. Author of over 130 scientific papers, including papers on drug testing, drug chemistry, drug markets, drug-related and drug-induced crime, drug abuse prevention, clinical and forensic toxicology, crime scene investigation and deoxyribonucleic acid (DNA) analysis.

Hubert H. Humphrey Fellow, United States Information Agency (1995–1996); Guest scientist at the School of Public Health, Department of Forensic Science, University of California, Berkeley, and the Drug Abuse Research Center, University of California, Los Angeles; Department of Genetics, Stanford University; Department of Human Genetics, Emory University; California Criminalistics Institute; Federal Bureau of Investigation, Virginia; Crime Laboratories, Los Angeles Sheriff's Department, United States; Federal Criminal Police Office (BKA), Wiesbaden; Ludwig-Maximilian University, Munich Institute for Physical Biochemistry and Institute of Legal Medicine; Center of Human Genetics, Bremen University; Institute of Legal Medicine, Muenster University, Germany; United Nations Drug Laboratory, Vienna; Central Bureau of Investigation, New Delhi.

Member, special commission on preventing drug abuse, Office of the Prime Minister, (2014–present). Founding editor, *Turkish Journal of Legal Medicine* (1982–1993). Member of the scientific board of the *International Criminal Justice Review*. Founding President, Turkish Society of Forensic Sciences; Honorary Member of the Mediterranean Academy of Forensic Sciences. Member of the International Society of Forensic Toxicology; the Indo-Pacific Association of Law, Medicine and Science; the International Association of Forensic Toxicologists; the American Academy of Forensic Sciences; the American Society of Crime Laboratory Directors; and the American Society of Criminology.

Member of the International Narcotics Control Board (2005–2010 and since 2017).[a] Member (2006) and Chair (2017) of the Committee on Finance and Administration. Member of the Standing Committee on Estimates (2007). Second Vice-President and Chair of the Standing Committee on Estimates (2006). Rapporteur (2007). First Vice-President of the Board (2008). President of the Board (2009).

[a] Elected by the Economic and Social Council on 5 April 2016.

Cornelis P. de Joncheere

Born in 1954. National of the Netherlands. Currently Chair of the Netherlands Antibiotics Development Platform, Vice-Chair of the Expert Advisory Group of the Medicines Patent Pool in Geneva and a consultant to WHO on pharmaceutical policies.

Doctor of Pharmacy (Pharm.D) and Master of Science (M.Sc.) in Pharmacy, University of Groningen and University of Amsterdam, the Netherlands (1975–1981); Master's in Business Administration, University of San Diego, United States of America/San José, Costa Rica; Bachelor of Science (B.Sc.). Pharmacy, cum Laude (Honorary student), University of Groningen, the Netherlands (1972–1975).

Previously held positions as Director, Department of Essential Medicines and Health Products at WHO in Geneva (2012–2016), which included work on access to controlled medicines, and the WHO Expert Committee on Drug Dependence; WHO Representative, Kiev, Ukraine (2011–2012); WHO Regional Adviser for Pharmaceuticals and Health Technologies, WHO Regional Office for Europe, Copenhagen (1996–2010); National Essential Drugs Programme Coordinator, Pan American Health Organization (PAHO)/WHO, Brazil (1994–1996); Pharmacist, Essential Drugs Projects Coordinator, PAHO/WHO, Costa Rica (1988–1993); Pharmaceutical expert, PAHO/WHO, Panama (1986–1988); Pharmaceutical supply expert in Yemen, Ministry of Foreign Affairs, Directorate for International Cooperation, the Netherlands (1982–1985); hospital and community pharmacy in Amsterdam, the Netherlands (1981–1982).

President of the WHO Europe Staff Association (2006–2010); Member of the WHO Guidelines Review Committee (2007–2011); Member of the Royal Dutch Pharmaceutical Society and the International Pharmaceutical Federation; author and co-author of numerous publications in the fields of pharmaceutical and health sciences.

Member of the International Narcotics Control Board (since 2017).[b] Rapporteur (2017). Member of the Standing Committee on Estimates (2017). Member of the Committee on Finance and Administration (2017).

Wei Hao

Born in 1957. National of China. Professor of Psychiatry and Deputy Director of the Mental Health Institute, Central South University, Changsha, China. Director of WHO Collaborating Centre for Psychosocial Factors, Substance Abuse and Health. Currently serving as Chair, Education Committee of the Asian-Pacific Society for Alcohol and Addiction Research, and as President, Chinese Association of Drug Abuse Prevention and Treatment and Chinese Association of Addiction Medicine.

Bachelor of Medicine, Anhui Medical University; Master's and Doctorate degrees of Psychiatry, Hunan Medical University.

Previously held positions as Scientist, Substance Abuse Department, WHO, Geneva (1999–2000); Medical Officer, Department of Mental Health and Substance Abuse, WHO, Western Pacific Region, and President, Chinese Psychiatrist Association (2008–2011). Membership in the Scientific Advisory Committee on Tobacco Product Regulation, WHO (2000–2004). Currently holding membership of the Expert Advisory Panel on Drug Dependence and Alcohol Problems, WHO (2006–present); and member of the Working Group on the Classification of Substance Abuse for the eleventh revision of the International Classification of Diseases (ICD-11), WHO (2011–present).

Recipient of research support from various bodies at the national level (Ministry of Health, Ministry of Science and Technology, National Natural Science Foundation) and at the international level (WHO and the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism of the United States of America). Coordinator of a series of WHO/China workshops on addictive behaviour. Member of the Expert Committee of the national project on mental health services in communities in China. Consultant for the development, implementation and evaluation of China's mental health law, and for the development of the anti-drug law and regulations in China.

Published over 400 academic articles and 50 books on alcohol and drug dependence. Selected recent publications in peer-reviewed journals include the following: "Longitudinal surveys of prevalence rates and use patterns of illicit drugs at selected high-prevalence areas in China from 1993 to 2000", *Addiction* (2004); "Drug policy in China: progress and challenges", *Lancet* (2014); "Alcohol and the sustainable development goals", *Lancet* (2016); "Transition of China's drug policy: problems in practice" *Addiction* (2015); "Improving drug addiction treatment in China", *Addiction* (2007); "Stigmatization of people with drug dependence in China: a community-based study in Hunan province", *Drug Alcohol Dependence* (2013); and "Drinking and drinking patterns and health status in the general population of five areas of China", *Alcohol & Alcoholism* (2004).

[b] Elected by the Economic and Social Council on 5 April 2016.

Member of the International Narcotics Control Board (since 2015). Member of the Committee on Finance and Administration (2015–2016). Member of the Standing Committee on Estimates (since 2015). Vice-Chair of the Standing Committee on Estimates (2016). First Vice-President of the Board (2017).

David T. Johnson

Born in 1954. National of the United States. Vice-President, Janus Global Operations; retired diplomat. Bachelor's degree in economics from Emory University; graduate of the National Defence College of Canada.

United States Foreign Service officer (1977–2011). Assistant Secretary for the Bureau of International Narcotics and Law Enforcement Affairs, United States Department of State (2007–2011). Deputy Chief of Mission (2005–2007) and Chargé d'affaires, a.i. (2003–2005), United States Embassy, London. Afghan Coordinator for the United States (2002–2003). United States Ambassador to the Organization for Security and Cooperation in Europe (1998–2001). Deputy Press Secretary at the White House and Spokesman for the National Security Council (1995–1997). Deputy Spokesman at the State Department (1995) and Director of the State Department Press Office (1993–1995). United States Consul General, Vancouver (1990–1993). Assistant National Trust Examiner, Office of the Comptroller of the Currency, United States Treasury (1976–1977).

Member of the International Narcotics Control Board (since 2012). Member of the Committee on Finance and Administration (since 2012). Chair of the Committee on Finance and Administration (2014).

Galina Korchagina

Born in 1953. National of the Russian Federation. Professor, Deputy Director of the National Centre for Research on Drug Addiction (since 2010).

Graduate of the Leningrad Paediatric Medical Institute, Russian Federation (1976); doctor of medicine (2001). Thesis based on clinical and epidemiological research dealing with new ways of looking at management of drug abuse in a time of change.

Previously held positions as paediatrician at the Central District Hospital of Gatchina, Leningrad region, and doctor at a boarding school (1976–1979). Head of the Organizational and Policy Division, Leningrad Regional Drug Clinic (1981–1989); Lecturer, Leningrad Regional Medical Academy (1981–1989); Head Doctor, City Drug Clinic, St. Petersburg (1989–1994); Assistant Lecturer (1991–1996) and Professor (2000–2001), Department of Social Technologies, State Institute for Services and Economics; Assistant Lecturer (1994–2000), Associate Professor (2001–2002) and Professor (2002–2008), Department for Research on Drug Addiction, St. Petersburg Medical Academy of Postgraduate Studies; Chief Professor and Head of the Department for Medical Research and Healthy Lifestyles, Herzen State Pedagogical University of Russia (2000–2008); Professor, Department for Conflict Studies, Faculty of Philosophy, St. Petersburg State University (2004–2008).

Member of many associations and societies, including the Association of Psychiatrists and Drug Addiction Specialists of the Russian Federation and St. Petersburg, the Kettil Bruun Society for Social and Epidemiological Research on Alcohol, the International Council on Alcohol and Addictions and the International Society of Addiction Medicine. Head of the sociology of science aspects of medical and biological research section of the Research Council on the Sociology of Science and the Organization of Scientific Research, St. Petersburg Scientific Centre of the Russian Academy of Sciences (2002–2008).

Author of more than 100 publications, including more than 70 works published in the Russian Federation, chapters in monographs and several practical guides. Award for excellence in health protection from the Ministry of Health of the Union of Soviet Socialist Republics (1987). Consultant, Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (since 2006).

Expert on the epidemiology of drug addiction, Pompidou Group of the Council of Europe (1994–2003); participation in the WHO cocaine project (1993–1994) as leading researcher; WHO Healthy Cities project (1992–1998) as leading coordinator in St. Petersburg; WHO alcohol action plan, realization on the basis of the city treatment centre, St. Petersburg (1992–1998). Co-trainer, WHO programmes "Helping people change" (since 1992) and "Skills for change" (since 1995); and temporary adviser, WHO (1992–2008). Participant in meetings of the Commission on Narcotic Drugs (2002–2008).

Member of the International Narcotics Control Board (2010–2015 and since 2017).[c] Vice-Chair of the Standing Committee on Estimates (2011–2012 and 2017). First Vice-President of the Board (2013).

[c] Elected by the Economic and Social Council on 5 April 2016.

Bernard Leroy

Born in 1948. National of France. Honorary Deputy Prosecutor General and Director of the International Institute of Research against Counterfeit Medicines.

Degrees in Law from the University of Caen, Institute of European Studies of Saarbrucken, Germany, and University Paris X. Graduate of the French National School for the Judiciary (1979).

Previously held positions of Deputy General Prosecutor, Versailles Court of Appeal, 2010–2013. Senior Legal Adviser, United Nations Office on Drugs and Crime (UNODC) (1990–2010). Adviser in charge of international, legislative and legal affairs in the French National Drug Coordination (1988–1990). Investigating judge specializing in drug cases, Evry High Court (1979–1988). Head of the Legal Assistance Programme, UNODC, and Coordinator of the decentralized team of legal experts, Bogota, Tashkent and Bangkok (1990–2010). Leader of the legal assistance team assisting the Government of Afghanistan in the drafting process of the new drug control law, 2004. Co-author of the preparatory study for the law introducing community service sentencing as an alternative to imprisonment in France (1981). Co-founder of "Essonne Accueil", a non-governmental organization providing treatment services for drug addicts (1982). Member of the French delegation for the final negotiations of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. Chair of the study group on cocaine trafficking in Europe, Council of Europe (1989). Author of the report resulting in the first European political coordinating committee to combat drugs (1989). Chair of the World Bank and UNODC joint team (the Stolen Asset Recovery (StAR) Initiative) which organized the freezing and subsequent recovery in Switzerland of the assets stolen by the former dictator Jean-Claude Duvalier in Haiti (2008).

Organizer of the lifelong learning programme on combating drug trafficking and addiction for members of the French judiciary, French National School for the Judiciary (1984–1994). Lecturer for medical graduates in psychiatry in the field of forensic expertise and responsibility, Faculty of Medicine, Paris-Sud University (1983–1990). Lecturer in the field of social work, University of Paris 13 (1984–1988). Lecturer for second year Master's courses in Security and Public International Law, Jean Moulin Lyon 3 University (2005–2013).

Member of the Executive Board of the international section of the National Association of Drug Court Professionals (2006). External member of the Management Board of the French Monitoring Centre for Drugs and Drug Addiction (2013). Member of the committee of the Reynaud report (2013). Honours: Chevalier of the Legion of Honour.

Selected publications include "Le travail au profit de la communauté, substitut aux courtes peines d'emprisonnement", *Revue de science criminelle et de droit comparé*, No. 1 (Sirey, 1983); *Drogues et drogués*, École nationale de la magistrature, studies and research (1983); *Étude comparative des législations et des pratiques judiciaires européennes face à la drogue* (Commission of the European Communities, 1991); *Ecstasy*, Inserm Collective Expertise series (Editions Inserm, 1997); *The International Drug Control System*, in cooperation with Cherif Bassiouni and J.F. Thony, in *International Criminal Law: Sources, Subjects and Contents* (Martinus Nijhoff Publishers, 2007); *Routledge Handbook of Transnational Criminal Law*, Neil Boister and Robert Curie, eds. (Routledge, 2014).

Member of the International Narcotics Control Board (since 2015). Rapporteur (2015). Member of the Standing Committee on Estimates (2016).

Raúl Martín del Campo Sánchez

Born in 1975. National of Mexico. Director General of the National Commission against Addictions (May 2013–December 2016).

Bachelor's Degree in Psychology; Honourable Mention, Autonomous University of Aguascalientes, 1998. Master's Degree in Health Psychology, Faculty of Psychology, National Autonomous University of Mexico, with residency in Addictions, 2002. Specialization in Drug Dependence and Related Crisis Situations, Drug Dependence Treatment Centre, Health Institute of the State of Mexico, 2010.

Director of Coordination of National Programmes against Addictions, Mexican Observatory on Tobacco, Alcohol and Drugs, National Commission against Addictions (2012–2013); Director, Mexican Institute against Addictions (IMCA), State of Mexico (2007–2011); Head of the Indicator Monitoring Department, National Commission against Addictions (2003–2007); Head of Psychology Unit (treatment of drug users), Drug Abuse Treatment Centre, Municipality of Aguascalientes (1999–2000); residential therapist for drug users and psychiatric patients, Addiction Treatment and Rehabilitation Centre (CAPRA) and Neuropsychiatric Centre of Aguascalientes (1999–2000); volunteer providing social services and support to the technical team, youth integration centres, Aguascalientes (1997–2000).

Author and co-author of, and contributor to, numerous publications on drug abuse prevention, treatment, surveys and related subjects, including: *National Survey on Drug Use Among Students, 2014* (INPRFM, National Commission against Addictions, Ministry of Health of Mexico, 2015); "Is the medical use of cannabis supported by science?" (National Commission against Addictions, National Centre for the Prevention and Control of Addictions, 2014); "The treatment model used by the 'Centros Nueva Vida' addiction treatment centres and its relationship to primary health-care services" and "Addiction treatment based on models for the State of Mexico: cases in the study of risk factors and prevention through the Chimalli model", *Actualidades en adicciones 2012*, vol. II (National Commission against Addictions, 2012); "Is alcohol an isolated problem in children and adolescents?", in *Actualidades en adicciones 2012,* vol. IV (National Commission against Addictions, 2012); "*Alcohol in primary care mental health clinics*", in *Alcohol use disorder* (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians, 2010); *State of Mexico Survey on Alcohol, Tobacco and Drug Use among Students* (INPRFM, Mexican Institute against Addictions (IMCA), 2009).

Member of the International Narcotics Control Board (since 2016).[d] Member of the Standing Committee on Estimates (2017).

Richard P. Mattick

Born in 1955. National of Australia. Professor of Drug and Alcohol Studies at the National Drug and Alcohol Research Centre, Faculty of Medicine, University of New South Wales; Professor of Brain Sciences, University of New South Wales; Principal Research Fellow, Australian Government National Health and Medical Research Council (2013–2017), and Registered Clinical Psychologist.

Bachelor of Science (Psychology), Honours, Class 1, University of New South Wales, 1982; Master of Psychology (Clinical), University of New South Wales, 1989; Doctor of Philosophy, University of New South Wales, 1988; and Certificate in Neuroanatomy, Anatomy, University of New South Wales, 1992.

Director of Research, Australian National Drug and Alcohol Research Centre (1995–2001), and Executive Director, Australian National Drug and Alcohol Research Centre, Faculty of Medicine, University of New South Wales (2001–2009). Member, Australian National Expert Advisory Committee on Illicit Drugs (2002–2004), Australian National Expert Advisory Group on Sustained Release Naltrexone (2002–2004), Monitoring Committee of the Medically Supervised Injecting Centre for the New South Wales Government Cabinet Office (2003–2004), Australian Ministerial Council on Drug Strategy Working Party on Performance and Image Enhancing Drugs (2003–2005), Australian Government Department of Health and Ageing Expert Advisory Committee on Cannabis and Health (2005–2006), New South Wales Expert Advisory Group on Drugs and Alcohol for the New South Wales Minister of Health (2004–2013), Australian National Council on Drugs advising the Prime Minister (2004–2010), WHO/UNODC Technical Guidelines Development Group on Pharmacotherapy of Opioid Dependence (2004–2008), Australian Research Alliance for Children and Youth (2005–2015).

Served on the editorial and executive boards of *Drug and Alcohol Review* (1994–2005), and as Deputy Editor (1995–2000) and Executive Editor (2000–2005). Assistant Editor of the international peer-reviewed journal *Addiction* (1995–2005). Editor, Cochrane Review Group on Drugs and Alcohol (1998–2003). Authored over 300 books, chapters in edited volumes on substance abuse, addiction and treatment, and peer-reviewed academic journal articles on those subjects. Recent articles include "Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence", "Young adult sequelae of adolescent cannabis use" and "The Pain and Opioids IN Treatment study: characteristics of a cohort using opioids to manage chronic non-cancer pain".

Recipient of academic and research support from the Australian Government Department of Health; the New South Wales Government Department of Health; the Australian National Drug Law Enforcement Research Fund; the Alcohol Education and Rehabilitation Foundation; UNODC; the National Institute on Drug Abuse of the United States; the Australian Research Council; and the Australian Government National Health and Medical Research Council.

Member of the International Narcotics Control Board (since 2015). Member of the Standing Committee on Estimates (2015–2016).

Luis Alberto Otárola Peñaranda

Born 1967. National of Peru. Lawyer. Postgraduate degree in Public Policy and Public Management from the Pontifical Catholic University of Peru.

[d] Elected by the Economic and Social Council on 8 December 2016.

Executive Director of the National Commission for Development and Life without Drugs (2014–2016). President of the Inter-American Drug Abuse Control Commission of OAS (November 2015–September 2016). Minister of Defence (2012), Deputy Minister of the Interior (2011), Deputy Minister of Defence (2003), Officer of the Peruvian State before the Inter-American Court of Human Rights (2001), Professor of Constitutional Law and Human Rights.

Author or co-author of the following works: *Compendio sobre Tráfico Ilícito de Drogas y Desarrollo Alternativo* (2015); *La Constitución Explicada* (2011); *La Constitución de 1993: Estudio y Reforma a Quince Años de su Vigencia* (2009); *Modernización Democrática de las Fuerzas Armadas* (2002); *Parlamento y Ciudadanía* (2001); *La Constitución de 1993: Análisis Comparado* (1999).

Order of Merit for Distinguished Services at the level of Grand Cross (decoration awarded by the Constitutional President of the Republic). Also received the Order of Ayacucho (highest distinction awarded by the Peruvian Army).

Presenter at the workshop entitled "Responding to the evolving drug challenge", Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), London (2015); presenter on alternative development at the Economic and Social Council, New York (2015); Head of the Peruvian delegation to the seventh meeting of the Peruvian Colombian Joint Committee on Drugs (2014); Head of the Peruvian delegation to the Twenty-fourth Meeting of Heads of National Drug Law Enforcement Agencies, Latin America and the Caribbean (2014); speaker at the second Latin American Seminar on Democracy and Corruption, Montevideo (2014); Head of the Peruvian delegation to the eighth meeting of the Peruvian-Brazilian Joint Committee on Drugs (2014); speaker at the Latin American Seminar on Youth and Democratic Governance, Cartagena de Indias, Colombia (2012); speaker at the Latin American Seminar on Youth, Violence and Culture of Peace, Antigua, Guatemala (2009).

Member of the International Narcotics Control Board (since 2017).[e] Member of the Standing Committee on Estimates (2017).

Jagjit Pavadia

Born in 1954. National of India. Graduate in English Honours (1974), Dhaka University, LL.B from Delhi University (1988), Master's Diploma in Public Administration, Indian Institute of Public Administration (1996). Completed dissertation "Forfeiture of Property under the Narcotics Drugs and Psychotropic Substances Act, 1985" towards completion of Master's Diploma.

Held several senior positions in the Indian Revenue Service for 35 years in the Government of India, including Narcotics Commissioner of India, Central Bureau of Narcotics (2006–2012); Commissioner, Legal Affairs (2001–2005); Chief Vigilance Officer, Power Finance Corporation (1996–2001); Customs Training Adviser Maldives, deputed by the Commonwealth Secretariat (1994–1995); Deputy Director, Narcotics Control Bureau (1990–1994); and retired as Chief Commissioner, Customs, Central Excise and Service Tax, Nagpur, in 2014.

Recipient of Presidential Appreciation Certificate for Specially Distinguished Record of Service on the occasion of Republic Day (2005), published in the *Gazette of India Extraordinary*.

Member of the Indian delegation to the Commission on Narcotics Drugs, Vienna (2007–2012); introduced resolutions 51/15 (2008) and 53/12 (2010), adopted by the Commission on Narcotic Drugs, and organized a side event on the margins of the Commission's 2011 session, presenting issues involved in the illegal movement of poppy seeds to producing, importing and exporting countries. As representative of the competent national authority, attended Project Prism and Project Cohesion task force meetings (2006–2012), and coordinated and organized the Project Prism and Project Cohesion meeting in New Delhi (2008). Participated in the Meeting of Heads of National Drug Law Enforcement Agencies (HONLEA), Asia and the Pacific, held in Bangkok (2006), and organized the Meeting of HONLEA, Asia and the Pacific, held in Agra, India (2011). Member of the INCB advisory expert group on the scheduling of substances (2006), and member of the advisory group finalizing the INCB *Guidelines for a Voluntary Code of Practice for the Chemical Industry* (2008). Rapporteur of the forty-first session of the Subcommission on Illicit Drug Traffic and Related Matters in the Near and Middle East, held in Amman (2006); Chairperson of the forty-second session of the Subcommission, held in Accra, India (2007); organized the meeting of the Paris Pact Initiative Expert Working Group on Precursors, held in New Delhi (2011), and participated in the International Drug Enforcement Conferences hosted by the United States Drug Enforcement Agency, held in Istanbul (2008) and Cancún, Mexico (2011).

[e] Elected by the Economic and Social Council on 5 April 2016.

Member of the International Narcotics Control Board (since 2015). Second Vice-President and Chair of the Standing Committee on Estimates (2015 and 2017). Member of the Committee on Finance and Administration (since 2016). First Vice-President of the Board (2016).

Viroj Sumyai

Born in 1953. National of Thailand. Retired Assistant Secretary-General of the Food and Drug Administration, Ministry of Public Health of Thailand, and clinical pharmacologist specializing in drug epidemiology. Professor, Mahidol University (since 2001).

Bachelor of Science degree in chemistry (1976), Chiang Mai University. Bachelor's degree in pharmacy (1979), Manila Central University. Master's degree in clinical pharmacology (1983), Chulalongkorn University. Apprenticeship in narcotic drugs epidemiology at St. George's University of London (1989). Doctor of Philosophy, Health Policy and Administration (2009), National Institute of Administration. Member of the Pharmaceutical Association of Thailand. Member of the Pharmacological and Therapeutic Society of Thailand. Member of the Thai Society of Toxicology. Author of nine books in the field of drug prevention and control, including *Drugging Drinks: Handbook for Predatory Drugs Prevention* and *Déjà vu: A Complete Handbook for Clandestine Chemistry, Pharmacology and Epidemiology of LSD*. Columnist, *Food and Drug Administration Journal*. Recipient, Prime Minister's Award for Drug Education and Prevention (2005).

Member of the International Narcotics Control Board (since 2010). Member (2010–2016) and Chair (2012, 2014 and 2016) of the Standing Committee on Estimates. Chair of the Committee on Finance and Administration (2011 and 2013). Second Vice-President of the Board (2012, 2014 and 2016). President of the Board (2017).

Francisco E. Thoumi

Born in 1943. National of Colombia and the United States. Bachelor of Arts and Doctor of Philosophy in Economics. Senior member of the Colombian Academy of Economic Sciences and Corresponding Member of the Royal Academy of Moral and Political Sciences (Spain).

Tinker Visiting Professor at the University of Texas, Professor at Rosario University and Universidad de Los Andes (Bogota) and California State University, Chico. Worked for 15 years in the research departments of the World Bank and the Inter-American Development Bank. Founder and Director, Research and Monitoring Center on Drugs and Crime, Rosario University (August 2004–December 2007); Research Coordinator, Global Programme against Money-Laundering, Proceeds of Crime and the Financing of Terrorism; Coordinator for the *World Drug Report*, UNODC (August 1999–September 2000); Researcher, Comparative Study of Illegal Drugs in Six Countries, United Nations Research Institute for Social Development, Geneva (June 1991–December 1992); Fellow, Woodrow Wilson International Center for Scholars (August 1996–July 1997); Research Coordinator, Research Programme on the Economic Impact of Illegal Drugs in the Andean Countries, United Nations Development Programme, Bogota (November 1993–January 1996).

Author of three books and co-author of one book on illegal drugs in Colombia and the Andean region. Editor of three volumes and author of over 70 academic journal articles and book chapters on those subjects. Also authored one book, co-authored two books and published 50 articles and book chapters on economic development, industrialization and international trade issues before focusing on drug issues.

Member of the Friedrich Ebert Foundation Observatory of Organized Crime in Latin America and the Caribbean (since 2008) and the World Economic Forum's Global Agenda Council on Organized Crime (2012–2014).

Member of the International Narcotics Control Board (since 2012). Rapporteur (2012). Member of the Committee on Finance and Administration (2014–2015). Member of the Standing Committee on Estimates (2013, 2016 and 2017).

Jallal Toufiq

Born in 1963. National of Morocco. Head of the National Centre for Drug Abuse Prevention and Research; Director of the Moroccan National Observatory on Drugs and Addictions; Director of the Ar-razi University Psychiatric Hospital and Professor of Psychiatry at the Rabat Faculty of Medicine.

Medical Doctor, Rabat Faculty of Medicine (1989); Diploma of Specialization in Psychiatry (1994); and lecturer at the Rabat Faculty of Medicine (since 1995). Undertook specialized training in Paris at the Sainte-Anne Psychiatric Hospital and Marmottan Centre (1990–1991); and at Johns Hopkins University as a National Institute on Drug Abuse research fellow and Clinical Observer (1994–1995). Conducted research at the University of Pittsburgh (1995); and gained Clinical Drug Research certificates at the Vienna School of Clinical Research (2001 and 2002).

Currently holding positions in Morocco as Head of the Harm Reduction Programme, National Centre for Drug Abuse Prevention and Research; teaching and residency training coordinator, Ar-razi Hospital; Director of the National Diploma Programme on Treatment and Prevention of Drug Abuse, Rabat Faculty of Medicine; Director of the National Diploma Programme on Child Psychiatry, Rabat Faculty of Medicine and Member of the Ministry of Health Commission on Drug Abuse.

At the international level, Representative of the Mediterranean Network (MedNET) for Morocco (MedNET/Pompidou Group/Council of Europe); former permanent correspondent of the Pompidou Group for Morocco (Council of Europe) on drug abuse prevention and research and former member of the Reference Group to the United Nations on HIV and Injecting Drug Use. Founding member and steering committee member, Middle East and North Africa Harm Reduction Association (MENAHRA); Director of Knowledge Hub Ar-razi for North Africa, MENAHRA; Member, Mentor International Scientific Advisory Network (drug abuse prevention in youth); former focal point/expert on prevention, United Nations Office on Drug Control and Crime Prevention (local network for North Africa); founding member, MedNET (advisory group on AIDS and drug abuse policies) of the Council of Europe, and member of the Reference Group to the United Nations on HIV and Injecting Drug Use.

Held consultancy roles with the WHO Regional Office for the Eastern Mediterranean, UNODC and other international institutions, research fellowships and the National Institute on Drug Abuse of the United States. Published widely in the field of psychiatry, alcohol and drug abuse.

Member of the International Narcotics Control Board (since 2015). Member of the Standing Committee on Estimates (2015). Member of the Committee on Finance and Administration (2016).

About the International Narcotics Control Board

The International Narcotics Control Board (INCB) is an independent and quasi-judicial control organ, established by treaty, for monitoring the implementation of the international drug control treaties. It had predecessors under the former drug control treaties as far back as the time of the League of Nations.

Composition

INCB consists of 13 members who are elected by the Economic and Social Council and who serve in their personal capacity, not as government representatives. Three members with medical, pharmacological or pharmaceutical experience are elected from a list of persons nominated by WHO and 10 members are elected from a list of persons nominated by Governments. Members of the Board are persons who, by their competence, impartiality and disinterestedness, command general confidence. The Council, in consultation with INCB, makes all arrangements necessary to ensure the full technical independence of the Board in carrying out its functions. INCB has a secretariat that assists it in the exercise of its treaty-related functions. The INCB secretariat is an administrative entity of the United Nations Office on Drugs and Crime, but it reports solely to the Board on matters of substance. INCB closely collaborates with the Office in the framework of arrangements approved by the Council in its resolution 1991/48. INCB also cooperates with other international bodies concerned with drug control, including not only the Council and its Commission on Narcotic Drugs, but also the relevant specialized agencies of the United Nations, particularly WHO. It also cooperates with bodies outside the United Nations system, especially INTERPOL and WCO.

Functions

The functions of INCB are laid down in the following treaties: Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol; Convention on Psychotropic Substances of 1971; and United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. Broadly speaking, INCB deals with the following:

(a) As regards the licit manufacture of, trade in and use of drugs, INCB endeavours, in cooperation with Governments, to ensure that adequate supplies of drugs are available for medical and scientific uses and that the diversion of drugs from licit sources to illicit channels does not occur. INCB also monitors Governments' control over chemicals used in the illicit manufacture of drugs and assists them in preventing the diversion of those chemicals into the illicit traffic;

(b) As regards the illicit manufacture of, trafficking in and use of drugs, INCB identifies weaknesses in national and international control systems and contributes to correcting such situations. INCB is also responsible for assessing chemicals used in the illicit manufacture of drugs, in order to determine whether they should be placed under international control.

In the discharge of its responsibilities, INCB:

(a) Administers a system of estimates for narcotic drugs and a voluntary assessment system for psychotropic substances and monitors licit activities involving drugs through a statistical returns system, with a view to assisting Governments in achieving, inter alia, a balance between supply and demand;

(b) Monitors and promotes measures taken by Governments to prevent the diversion of substances frequently used in the illicit manufacture of narcotic drugs and psychotropic substances and assesses such substances to determine whether there is a need for changes in the scope of control of Tables I and II of the 1988 Convention;

(c) Analyses information provided by Governments, United Nations bodies, specialized agencies or other competent international organizations, with a view to ensuring that the provisions of the international drug control treaties are adequately carried out by Governments, and recommends remedial measures;

(d) Maintains a permanent dialogue with Governments to assist them in complying with their obligations under the international drug control treaties and, to that end, recommends, where appropriate, technical or financial assistance to be provided.

INCB is called upon to ask for explanations in the event of apparent violations of the treaties, to propose appropriate remedial measures to Governments that are not fully applying the provisions of the treaties or are encountering difficulties in applying them and, where necessary, to assist Governments in overcoming such difficulties. If, however, INCB notes that the measures necessary to remedy a serious situation have not been taken, it may call the matter to the attention of the parties concerned, the Commission on Narcotic Drugs and the Economic and Social Council.

As a last resort, the treaties empower INCB to recommend to parties that they stop importing drugs from a defaulting country, exporting drugs to it or both. In all cases, INCB acts in close cooperation with Governments.

INCB assists national administrations in meeting their obligations under the conventions. To that end, it proposes and participates in regional training seminars and programmes for drug control administrators.

Reports

The international drug control treaties require INCB to prepare an annual report on its work. The annual report contains an analysis of the drug control situation worldwide so that Governments are kept aware of existing and potential situations that may endanger the objectives of the international drug control treaties. INCB draws the attention of Governments to gaps and weaknesses in national control and in treaty compliance; it also makes suggestions and recommendations for improvements at both the national and international levels. The annual report is based on information provided by Governments to INCB, United Nations entities and other organizations. It also uses information provided through other international organizations, such as INTERPOL and WCO, as well as regional organizations.

The annual report of INCB is supplemented by detailed technical reports. They contain data on the licit movement of narcotic drugs and psychotropic substances required for medical and scientific purposes, together with an analysis of those data by INCB. Those data are required for the proper functioning of the system of control over the licit movement of narcotic drugs and psychotropic substances, including preventing their diversion to illicit channels. Moreover, under the provisions of article 12 of the 1988 Convention, INCB reports annually to the Commission on Narcotic Drugs on the implementation of that article. That report, which gives an account of the results of the monitoring of precursors and of the chemicals frequently used in the illicit manufacture of narcotic drugs and psychotropic substances, is also published as a supplement to the annual report.

Since 1992, the first chapter of the annual report has been devoted to a specific drug control issue on which INCB presents its conclusions and recommendations in order to contribute to policy-related discussions and decisions in national, regional and international drug control. The following topics were covered in past annual reports:

1992: Legalization of the non-medical use of drugs

1993: The importance of demand reduction

1994: Evaluation of the effectiveness of the international drug control treaties

1995: Giving more priority to combating money-laundering

1996: Drug abuse and the criminal justice system

1997: Preventing drug abuse in an environment of illicit drug promotion

1998: International control of drugs: past, present and future

1999: Freedom from pain and suffering

2000: Overconsumption of internationally controlled drugs

2001: Globalization and new technologies: challenges to drug law enforcement in the twenty-first century

2002: Illicit drugs and economic development

2003: Drugs, crime and violence: the microlevel impact

2004: Integration of supply and demand reduction strategies: moving beyond a balanced approach

2005: Alternative development and legitimate livelihoods

2006: Internationally controlled drugs and the unregulated market

2007: The principle of proportionality and drug-related offences

2008: The international drug control conventions: history, achievements and challenges

2009: Primary prevention of drug abuse

2010: Drugs and corruption

2011: Social cohesion, social disorganization and illegal drugs

2012: Shared responsibility in international drug control

2013: Economic consequences of drug abuse

2014: Implementation of a comprehensive, integrated and balanced approach to addressing the world drug problem

2015: The health and welfare of mankind: challenges and opportunities for the international control of drugs

2016: Women and drugs

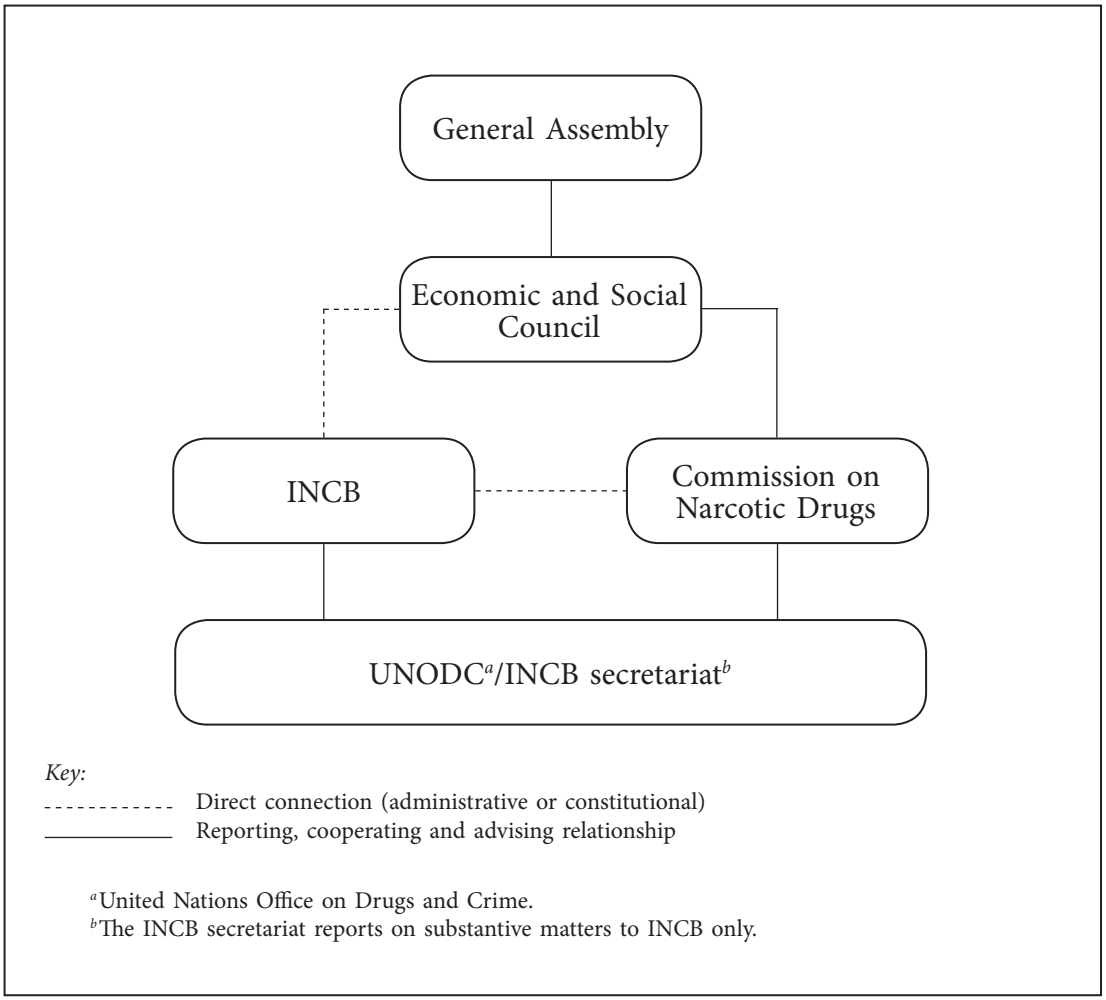
Chapter I of the report of the International Narcotics Control Board for 2017 is entitled "Treatment, rehabilitation and social reintegration for drug use disorders: essential components of drug demand reduction".

Chapter II presents an analysis of the operation of the international drug control system based primarily on information that Governments are required to submit directly to INCB in accordance with the international drug control treaties. Its focus is on the worldwide control of all licit activities related to narcotic drugs and psychotropic substances, as well as chemicals used in the illicit manufacture of such drugs.

Chapter III presents some of the major developments in drug abuse and trafficking and measures by Governments to implement the international drug control treaties by addressing those problems.

Chapter IV presents the main recommendations addressed by INCB to Governments, UNODC, WHO and other relevant international and regional organizations.

United Nations system and drug control organs and their secretariat



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INTERNATIONAL NARCOTICS CONTROL BOARD

The International Narcotics Control Board (INCB) is the independent monitoring body for the implementation of United Nations international drug control conventions. It was established in 1968 in accordance with the Single Convention on Narcotic Drugs, 1961. It had predecessors under the former drug control treaties as far back as the time of the League of Nations.

Based on its activities, INCB publishes an annual report that is submitted to the United Nations Economic and Social Council through the Commission on Narcotic Drugs. The report provides a comprehensive survey of the drug control situation in various parts of the world. As an impartial body, INCB tries to identify and predict dangerous trends and suggests necessary measures to be taken.

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