

4. Towards the creation of an Illicit Drug Index

4.1 Introduction

International drug control is about a century old. The notion of a ‘drug problem’, as well as the will to tackle it, have thus gained a strong foothold in public opinion, government policy and multilateral cooperation. Yet, traditionally presented as a supply-demand issue, split between the three sectors of production, trafficking and consumption, and further broken down into various drug categories, the “drug problem” has so far not found a representation that goes beyond the existing mosaic of perceptions and statistics, and encompasses them into a single standard measure.

The resulting heterogeneity has made it difficult to establish benchmarks and to make straightforward comparisons of the drug problem across regions/countries and over time. One of several consequences has been, for instance, a difficulty in bridging the divide, established in public discourse, between producing and consuming countries. Another effect has been to limit possibilities of exploring correlations with other socio-economic indicators and indices. Of even more direct relevance to drug control, this absence of a suitable yardstick has perpetuated the difficulties of assessing the impact and effectiveness of drug control policies. For how should one decide if the drug problem is getting better or worse when, say, the number of abusers changes and abuse shifts from one substance to another? Or when production declines but consumption increases in a given region?

Indicators and indices are necessarily reductionist and cannot represent the whole truth. The loss in complexity they entail is commensurate with the degree of aggregation they require. The risk of distorting reality through oversimplification is further compounded by

weaknesses in the underlying data on illicit drugs. Provided their drawbacks are clearly kept in mind, indicators and indices can nevertheless be useful, as reflected in their increasing presence in social sciences and policy. They contribute, in particular, to introducing more objective approaches in policy debate, in programme monitoring and in impact evaluation. They also help countries to assess their relative positions on a global scale and to better gauge the significance of the problem they face, or the overall progress they have made in any particular area.

Entrusted by Member States with the responsibility to promote and support a coordinated and multilateral response to the world’s drug problem, UNODC has been striving to improve the analytical tools at the disposal of governments and the international community to develop increasingly effective control measures. In this context, it has been working with governments and a variety of organizations to establish norms and standard indicators; to improve data collection and reporting systems; and to facilitate the dissemination of data and information on the nature, extent and evolution of the drug problem and its various dimensions. As part of the ongoing effort to expand the knowledge base that informs policy making, UNODC is now working towards developing a global Illicit Drug Index (IDI) with a view to fill the gap identified above. To initiate the multifaceted discussions and efforts that such an undertaking will necessarily require, preliminary work was undertaken by a working group established in the Policy Analysis and Research Branch of UNODC.¹ The initial results of this work are presented in the following pages. They should be seen as work in progress and it

¹ Members of the working group included the following individuals : Anna Alvazzi Del Fratte, Sandeep Chawla, Thibault le Pichon, Thomas Pietschmann, Barbara Remberg, Wolfgang Rhomberg, Howard Stead, Javier Teran and Melissa Tullis.

is hoped that they will generate the interest and the contributions that the further development of such a tool requires. The Index is intended primarily to establish values and enable comparisons at country level. At this early stage, however, results are only presented at the regional level and for the year 2002, as a way to illustrate the basic concept and methodology.

The purpose of an Illicit Drug Index

The objective is to create a single standard measure of the drug problem that would enable direct comparisons across regions/countries and over time.

The Illicit Drug Index would provide a single, standard and comparable measure of a country's overall drug problem, weighted by the size of its population.

4.1.2 Assumptions, choices and limitations

In the preparatory work undertaken thus far, a number of assumptions and choices were made and several limitations were identified. They apply to the preliminary version of the index presented here (referred to as 'the index' hereafter).

- The index is based solely on component drug indicators, and unlike many indices in other domains, does not rely on other socio-economic correlates. At this stage, this is seen rather as an advantage, since it enables a more direct measure of the drug problem. Moreover, too little research has been done so far to explore possible correlations between the drug problem and other socio-economic dimensions. In the longer-term however, the inclusion of component indicators drawn from other domains could enrich the index and help to compensate for some of the many weaknesses of the illicit drug data set.
- The Index is a function of illicit drug production, trafficking and abuse and is therefore based on the combined extent of those three traditional sectors of the drug problem. It does not include other variables such as money laundering, corruption or drug related acquisitive crime. Apart from the issue of data availability, it was assumed that such problems tend to be closely related to the extent of drug production, trafficking and abuse in a given country. While this may be true in most cases, there are likely to be some exceptions, such as the laundering of drug money in an offshore centre, which may otherwise not be particularly affected by drug production, trafficking or abuse.

- Although illicit drugs can create a variety of related harms (violence, corruption, etc.), the potential harm to individual health was selected as central to drug control policies as a whole and thus established as a common denominator for the components of the IDI. This choice is necessarily limiting but finds clear support in the underlying philosophy of the drug control system: protecting public health by limiting potentially harmful psychoactive substances to medical and scientific use. The most fundamental reproach that a drug control agency will make to an illicit opium farmer is that he produces dangerous drugs that will endanger the health of other people. The fact that, in doing so, he also contributes to perpetuating an illicit market is considered, under the drug control system for which this index is established, as an important but secondary harm. The same reasoning applies to a drug trafficker with respect to, say, violence or corruption.
- Due to the many gaps and weaknesses in the data set used to calculate the index, additional caveats, over and above the ones usually associated with indicators and indices, must be made. While the results obtained thus far were considered encouraging and meaningful enough to be presented for further discussion, they should still be seen as very tentative and subject to revision.

Technical challenges

Any attempt to develop a global illicit drug index will necessarily face formidable technical challenges. If not, such an index would have been established a long time ago. Two main obstacles, in particular, need to be cleared at the outset.

- The substance boundary, created by the existence of various drug categories and related effects. How does one compare cocaine, cannabis or heroin?
- The sectorial boundary, resulting in the differing mix of production, trafficking and consumption found in any given region or country. How does one compare the production of a kilogram of opium by a farmer with its subsequent consumption (in the form of opium and/or heroin) by hundreds of consumers?

Technical solutions

- To remove the first stumbling block, the various drug categories were converted into a single hypothetical reference drug. As explained further

below, this was achieved by establishing the potential harm to health of each drug category² and by merging their measurement into a common scale.

The Illicit Drug Index combines all the main categories of illicit drugs by converting them into a hypothetical reference drug.

- The second obstacle, created by the difficulty of comparing production, trafficking and consumption, was removed by identifying the common element in the three main sectors and using it to establish a single measure for all three of them. One can indeed view production, trafficking and abuse as sequential steps in a market continuum along which illicit drugs are processed and moved. Using the reference drug and the harm factor mentioned above, activities in all three sectors can then be defined as the act of processing/moving a certain amount of potential harm associated with a given quantity of the reference drug along the market chain. In other words, what the opium farmer, the drug trafficker and the drug addict have in common is that they are all handling a certain amount of potential harm to the health of individuals and contributing to actualising that potential. That harm is associated with the quantity of drugs (converted into the reference drug) they are moving along the supply-demand chain. As noted above, while there are several other forms of harm associated with illicit drugs (violence, corruption, etc.), at this stage, potential harm to health was chosen as the central unifying factor.

The Illicit Drug Index combines the extent of illicit drug production, trafficking and abuse into a single measure of potential harm that moves along the market chain.

The Illicit Drug Index thus attempts to capture all the main dimensions of the drug problem into a single measure. This measure, in turn, can be disaggregated into its various component indicators, thus allowing for a more specific representation of, say, a country's drug problem in terms of production, trafficking or abuse for all substances combined, or in terms of a particular substance for all three sectors combined.

The size of a country's population is taken into account in the calculation of the IDI, which is therefore based on a value per capita. The preliminary version of this index is based on more than 4800 data records for the year 2002, provided by Member States to UNODC and

covering 177 countries and territories. An average of 27 data records per country have thus been used to generate this version of the index. As noted earlier, results presented below are aggregated at the regional level.

The Illicit Drug Index reflects the extent of the drug problem affecting a particular country in comparison with others, weighted by the size of its population.

4.2 Methodology

The IDI is a composite of three sub-indices which reflect the situation of a country in terms of drug production, drug trafficking and drug abuse.

4.2.1 Main components of the index

Illicit drug production sub-index

Production is calculated in terms of the quantity of illicit drugs produced in a country. For the main plant based drugs, the estimates are generally based on surveys of the area under cultivation, yields and the typical transformation rates for the conversion of the psychoactive plant products (opium, coca leaf) into the respective end products (heroin or cocaine).

In the case of cannabis, Member States' estimates of areas under cannabis cultivation and yields were used. Given the lack of scientific surveys for most countries, the overall reliability of these estimates is much lower than in the case of heroin or cocaine.

Establishing estimates for synthetic drugs, such as amphetamines (methamphetamine and amphetamine) or ecstasy, is a far more challenging task. For such drugs, UNODC has developed a triangulation approach, which involves the following elements:

- a) estimates based on the number of consumers and the typical amounts consumed per user;
- b) estimates based on seizures of end products; and
- c) estimates based on seizures of precursors.

The average of the three estimates was used as UNODC's global production estimate for amphetamines and ecstasy. In the next step, the global production estimate was allocated to countries, based on Member States' information on source countries identified, laboratory seizures, and drug seizures. The resulting estimates are necessarily only indicative of likely levels of production.

² Namely: opiates, cocaine, cannabis (herb and resin), amphetamines and ecstasy. These drugs account for the bulk of the drug problem worldwide. Production, trafficking and abuse of other drugs were disregarded as they would hardly change the overall index.

The results in weight equivalents were then transformed into typical consumption units ('doses'), reflecting the fact that a typical 'dose' of cannabis herb (around 0.5 grams), for instance, is larger than a typical dose of cocaine (around 0.1 grams), ecstasy (0.1 grams), heroin (around 0.03 grams) or amphetamines (0.03 grams)³.

Even transformed into typical drug doses, the results could still be misleading, as some drugs are known to have a higher abuse risk and associated harm than others. Compared with other illicit drugs, opiates, for instance, have a consistently worse record in terms of treatment demand, spread of blood-borne diseases such as HIV-AIDS and drug related deaths. Thus, the total number of doses produced in a country were weighted by a 'harm/risk factor' (see below for details on the harm/risk factor), which gives, for instance, a higher weight to opiates than to cannabis.

Illicit drug trafficking sub-index

Measuring illicit drug trafficking is notoriously difficult and can only be done through indirect indicators. For the purposes of this model, the establishment of the illicit drug trafficking sub-index relied on the combination of two indicators:

- a) Reported illicit drug seizures ('seizure indicator')
- b) Reported illicit drug seizures routes ('route indicator')
 - a) Seizure indicator

The first component of the illicit drug trafficking sub-index is the quantities of drugs seized by law enforcement services in a country, transformed into typical doses and then weighted by the harm factor (see below).

Seizure records offer one of the most developed global datasets on illicit drugs and therefore present considerable value for monitoring the evolution of the trafficking problem over time. If law enforcement capabilities were identical across the world, seizures could be a good proxy for assessing the extent of drug trafficking activities. This, however, is clearly not the case. The level of resources allocated and the priority given to controlling drug trafficking varies significantly from country to country. Seizures may therefore reflect as much the importance of the problem as the extent of the effort to tackle it, with no straightforward way of assessing the potential bias thus introduced in the measure of the actual volume of trafficking. The seizure indicator therefore needs to be complemented with another source of information.

b) Route indicator

The second component of the trafficking sub-index is itself composed of three elements, or sub-indicators:

- (i) countries identified by reporting countries as main origins of drug shipments,
- (ii) countries identified as main transit countries and
- (iii) countries identified as main destination countries.

As part of UNODC's Annual Reports Questionnaire, Member States report the place of origin, transit and destination of drugs seized on their territory. 'Origin' in this context does not necessarily mean the source country of the drugs, but the country from which drug traffickers arrested in the reporting country typically obtained the drugs. The three sub-elements – origin, transit and destination countries – were then aggregated into a 'route indicator'.

If several countries identified a specific country as a country of origin, transit, or destination, it is likely that such a country is afflicted with significant levels of drug trafficking activities (even if itself made, or reported, no drug seizures, or only few of them).

Such reports do not, however, provide any information on the actual volume of trafficking from, through, or to, a given country. This creates a technical difficulty. Should the information provided by a country with a small drug abuse population and located far away from major drug trafficking routes be given the same weight as the information provided by a country with a large drug market? Probably not, as overall trafficking to a country with a small market is most likely significantly less than trafficking to a country with a big market. The size of the population is not necessarily an appropriate weighting factor in this case. For instance, information on the origin or the transit of cocaine reported by countries such as India or China – which have very limited cocaine consumption, but very large populations – would have more weight than reports from the USA, the world's largest cocaine market.

The information on the origin, transit and destination of drugs was therefore weighted by the quantities of drugs seized in the reporting country. As a consequence, information provided by the USA or Colombia (the two countries reporting the highest cocaine seizures worldwide) on the origin, transit and destination of cocaine is given more weight than cocaine related information

³ These typical doses, derived from scientific literature, INCB and DEA reports, have traditionally been used by UNODC to convert drug units reported into weight equivalents, and vice-versa.

provided by other countries; similarly, information on the origin, transit and destination provided by Iran, Pakistan and China on opiates (which report the largest opiate seizures worldwide), or by Thailand and China on amphetamines (reporting the largest methamphetamine seizures worldwide) is given more weight than information provided by other countries.

The sub-components (origin, transit destination) of the 'route indicator' were established as follows: the breakdown of the countries of origin (or transit, or destination), as reported by Member States, was used to 'allocate' the seizures made by the reporting countries to the countries of origin, transit and destination (e.g. country A 50%, country B 30%, country C 20%). If the reporting country did not provide a breakdown (and no additional information was available), seizures made in that country were distributed equally among the origin, transit or destination countries reported.

The seizures were then transformed into standard drug doses and multiplied with the harm/risk-factor. The scores of countries were then aggregated to establish the second component of the trafficking sub-index.

This method for 're-allocating' seizures of reporting countries to 'countries of origin', 'transit countries or 'destination countries' thus provided an alternative way of assessing trafficking flows. With such an indicator, decreasing seizures in a given country would not necessarily lower that country's position on the international trafficking scale. All things being equal, reduced law enforcement successes against drug trafficking in a given country may lead to increased trafficking flows (and seizures) in neighbouring countries. These countries would, in turn, be as or even more likely than before to identify that particular country as origin or transit area.

One could theoretically consider using the route indicator to replace the seizure indicator altogether. One limitation, however, is related to the consistency of the data. Unfortunately, not all countries provide reports on the origin, transit and destination of drugs, which introduces a potential bias. A second limitation comes from the varying degree to which countries are affected by international drug trafficking as opposed to local drug trafficking. Some countries which are not, or marginally, used as origin or transit countries, but which make significant seizures, will get a low score under the 'route indicator'. The 'route indicator' is thus a powerful tool for detecting trafficking hubs, but the seizure indicator provides an important complement for estimating the level of drug trafficking activities at the national level.

Further steps in the development of the illicit drug index model will include a critical review of the shortcomings of the trafficking index. It is clear that the current version presents a number of weaknesses and can only provide a rough approximation of trafficking volumes. One alternative – which would require substantial research efforts – would be to develop global trafficking flow models for the various drugs, estimating for each country the amounts of drugs entering and leaving the country, taking into account trafficking routes, domestic production, consumption and seizures. Such models would potentially offer a better reflection of the actual quantities of drugs trafficked via various countries. At the same time, however, such models may be less effective in identifying trafficking hot-spots, where drugs change hands among the various criminal groups involved in drug trafficking (and which are thus particularly vulnerable to all of the negative side-effects resulting from drug trafficking).

Abuse sub-index

The method chosen to calculate the abuse index is relatively straightforward. Abuse is measured by the number of people using drugs (based on annual prevalence estimates, established for UNODC's World Drug report), multiplied with an average annual dose per drug and the harm/risk factor.

In order to arrive at such an average annual dose, global production for each drug less seizures (adjusted for purity) was calculated over a 10-year period and divided by the average number of users over this period. This approach was used as a way to mitigate the effects of stocks and time lags along the supply-demand chain, because of which total production and total consumption are not necessarily identical in any specific year. Over longer periods of time, one can assume that stock movements even out and have a neutral effect on the system. This approach – average annual production less average annual purity-adjusted seizures – should thus give a reasonable order of magnitude of average annual drug availability for consumption. This result was then divided by the average number of users over the 10 year period in order to arrive at an average annual amount per user, which was in turn multiplied by the number of drug users to arrive at an estimation of the amount of illicit drugs consumed in a country. The result in kilograms per country was then transformed into typical doses and multiplied with the harm/risk factor in order to make the different drugs comparable.

4.2.2 Aggregating information

Harm/risk factor

One innovative approach in the model proposed for the calculation of an Illicit Drug Index was the establishment of a 'harm/risk factor' for drugs. This allows for aggregating results from different drugs into one single hypothetical reference drug.

Drugs inflict a large number of harms to the individual as well as to society at large. The approach used for the purposes of this model was to concentrate on the health consequences of drug abuse. Thus, the harm-factor used in this model does not include broader societal consequences, such as substance specific differences in the level of drug related violence, corruption, acquisitive crime, organized crime, financing of terrorist groups, etc. Such a broader concept of drug related harm to society in all its manifestations could be envisaged for future development phases of this model. For the time being, most of the data necessary to establish such a broader concept of drug related harm, on a global scale, are not available.

Even focussing on the health consequences of drug abuse does not yield easy answers, given the complex nature of drugs and their interactions with the human body. The consequences of drug abuse differ substantially depending on the drugs used (lung cancer versus brain stroke, cardiac versus renal failure, etc.), making direct comparisons extremely difficult. Thus a common measure for the medical risks and consequences of drug abuse had to be identified.

Following an in-depth review of data currently available in the scientific literature and at UNODC, the following elements were selected to establish the risks and harm related to substance abuse:

- treatment demand (per 1000 drug users), injecting drug use (per drug category) to reflect the risk of diseases such as hepatitis B, hepatitis C or HIV/AIDS,
- toxicity (typical/recreational versus lethal dose); and
- drug related deaths (per 1000 users).

The first key indicator on the consequences of drug abuse is treatment demand. One can assume that the more serious the drug problem for an individual, the more likely drug addicts will seek professional help. In order to be used as a risk measure, treatment demand must be put against the number of people consuming such drugs. Thus one component for the establishment of a composite harm/risk factor is 'treatment demand'

generated by substance abuse, compared to the total number of people using such drugs. Based on treatment demand data provided by 123 countries, and UNODC estimates of the number of people using illicit drugs, it was calculated that an average of 78 people per 1000 users of opiates undergo treatment. This is more than the corresponding rates for cocaine (66 per 1000 users), amphetamines (16) or cannabis (7).

Another indicator for the risks of drug abuse is linked to the route of administration, notably injecting drug use (IDU). It is commonly acknowledged that IDU is a highly problematic route of administration, potentially leading to hepatitis B, hepatitis C or HIV/AIDS infections when injecting equipment is shared among drug users. Information provided by 36 Member States to UNODC shows that opiates have the highest probability of being injected, followed by amphetamines (methamphetamine and then amphetamine), cocaine and ecstasy. Injecting has not been reported for cannabis use. In combination with other risk factors, the IDU indicator thus integrates one key dimension in the harm/risk factor – the risk of the spread of blood borne diseases, which is a serious concern in many countries around the world.

A further risk factor, the toxicity, was used to measure the 'relative safety' of drugs. This provides information on the likelihood of an overdose, as a result of users' mistakes and/or changes in drug purity levels. This factor is based on two sub-indices, the dose index and the toxicology index.

One way of measuring the relative 'safety' of a drug is to consider the ratio (*Dose Index*) between a typical dose and a lethal dose. Such an index (comparing the effective dose (ED50) with the lethal dose (LD50)) is used routinely in clinical pharmacology as a measure of the safety of a drug. The ED50 is defined as the estimated dose required to produce a specified effect in half of a particular population. For this model, the typical 'dose' for each of the drugs (divided by 70 kg for an average adult) is used as the ED50. The LD50 is a measure of the dose which kills half of the experimental animals to whom a particular drug is administered. A comparison of the two suggests, for instance, that ecstasy is more dangerous than cannabis, though less dangerous than other drugs. The comparison of doses for animals with those for human beings, however, has some limitations and results must be interpreted with caution.

Another level of analysis was based on concentration levels of drugs or drug metabolites in the blood of people who died from overdose. Results were then compared with concentration levels in persons who had been given drugs for therapeutic use (*Toxicology Index*).

This index shows, as one would expect, that the greatest risk of dying from an overdose is associated with opiates (already at five times the concentration levels resulting from a therapeutic dose) whereas cannabis has the lowest risk of acute drug related death.

Combining the results of the two sub-indices, a new 'toxicity index' was established. This index suggests that the highest risks of accidental death from a drug overdose is associated with the abuse of opiates, followed by cocaine, amphetamines and ecstasy.

Finally, the actual risk of dying from drugs was established by analysing data supplied by Member States on the number of people reported to have died in connection with the use of specific drugs, as compared to the total number of people using such drugs (drug death index). This analysis – based on information from 20 countries – suggests that, on average, out of 100,000 opiate users, 261 users die in a year (0.3%), far more than the corresponding rates for cocaine (48), amphetamines (18), or ecstasy (3).

The overall 'risk/harm factor', used for the calculations in the Illicit Drug Index model, was established by pooling the results of the four components discussed above. The risks arising from the use of opiates was set at 100 and the average of the four sub-indices was calculated. The four components of the harm/risk factor were given equal weight. The results suggest that the highest risks from a typical dose are associated with opiates, followed by cocaine, amphetamine and ecstasy.

4.2.3 Aggregating the individual components of the Illicit Drug Index and preliminary results

The Illicit Drug Index, as described above, consists of three components: production, trafficking and abuse. In order to arrive at the overall Illicit Drug Index, the various components have to be combined.

The individual scores of production (production in kilograms converted into typical consumption units and multiplied by the harm factor) and consumption (number of drug users multiplied by an average annual dose, converted into typical consumption units and multiplied by the harm factor) can be directly aggre-

gated. The results, in each case, can be interpreted as total production or total consumption of the hypothetical reference drug expressed in typical drug doses.

The aggregation of the trafficking sub-index with the other two components was more complicated and an additional calculation had to be introduced. As drugs are usually moved from the place of production to the place of consumption, the overall amounts of drugs trafficked are basically equivalent to global drug production, less seizures.⁴ Thus, for the purposes of this model, seizures (transformed into doses and multiplied by the harm factor) were subtracted from global drug production (transformed into doses and multiplied by the harm factor) to calculate the global drug trafficking scores. The distribution pattern resulting from the trafficking sub-index was then used to distribute 'total drug trafficking' (production less seizures) among countries. As indicated earlier, this current version of the illicit trafficking sub-index, could be improved in the future by an index derived from detailed trafficking flow models (which remain to be developed).

The preliminary results for the calculations described above suggest that the world's drug problem continues to be primarily associated with production, trafficking and abuse of opiates (56%), followed by cocaine (22%), cannabis (12%) and ATS (10%).

The next two graphs suggest that, on a per capita basis, the Near & Middle East/South-West Asia is the sub-region which is most severely affected by the drug problem. It has the highest drug production problem, the largest trafficking problem and suffers from significant levels of drug abuse. The drug problem of this sub-region is mainly linked to opiates. The second region most affected by the drug problem is South America. The main problems there are again drug production, followed by trafficking and, to a lesser extent, drug abuse, with the problem mainly linked to cocaine. In the case of North America, the third most affected region by drugs, the main problem is drug abuse, followed by trafficking and drug production. The problems in North America are primarily linked to cocaine, though opiates, ATS and cannabis also play a role.

The extent of the drug problem in the Oceania region is above the global average while the drug problem in

⁴ This is, of course, a considerable simplification of reality: (i) The relationship assumes a basically stable drug market. In case of large increases or decreases in production, or the existence of large movements of stocks, the relationship would not hold; (ii) The assumption that the total drug flow is equivalent to production less seizures, does not take into account the actual location of seizures. If seizures took place exclusively in consumer countries, the total trafficking flows would be larger than predicted by the model. In reality, however, significant amounts of drugs are seized in and around the producer countries so the actual potential error should not be too significant; (iii) Subtracting reported seizures may not be entirely appropriate as, along the trafficking route, drugs are usually 'cut' or diluted. Actual seizures in pure drug equivalents should be thus less. However, there are also losses along the trafficking routes. In other words, the two biases may actually offset each other. In short, while this model, assuming that 'production less seizures' equals trafficking flows, can, of course, deviate from reality, it seems to be - as long as there is no dramatic change in the market - an acceptable approximation of reality.

Europe is close to the global average. The drug problem in West & Central Europe as well as in East Europe is mainly linked to abuse, while in South-East Europe (covering Turkey and the Balkan countries) it is primarily linked to trafficking. While a number of substances are present in the drug markets of West and Central Europe, the main problem is related to the abuse of opiates.

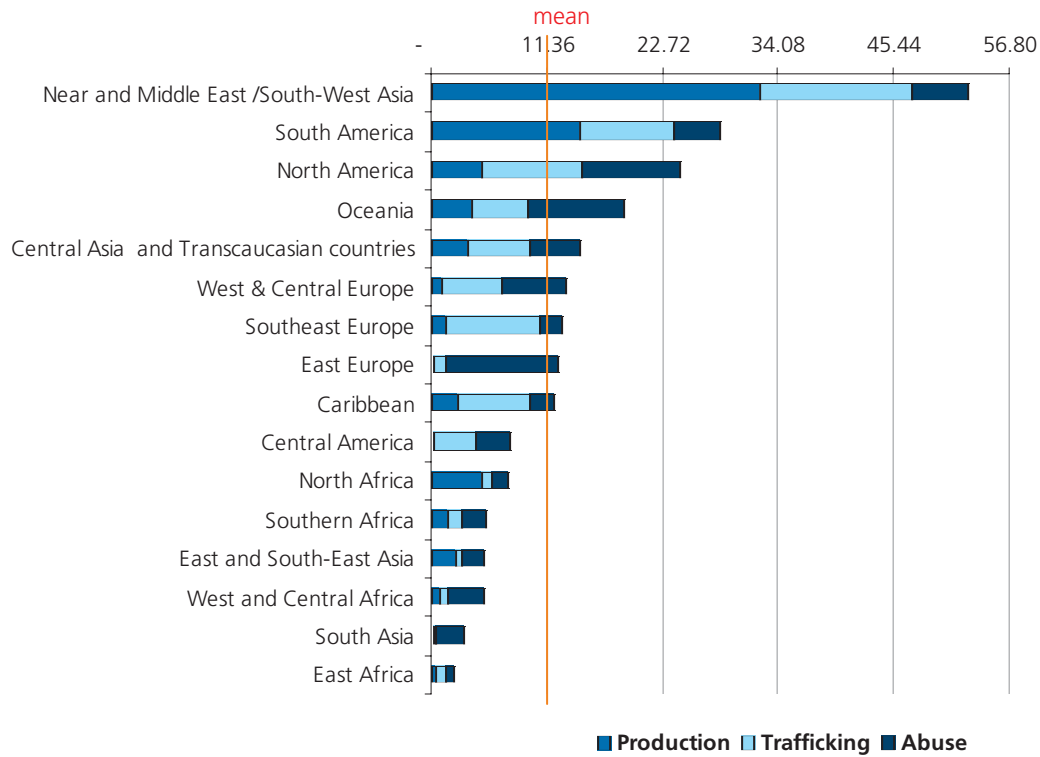
The drug problem in Africa and Asia (except the Near and Middle East/South-West Asia) is relatively low, on a per capita basis. The main problems of production in these two regions are encountered in North Africa, in Central Asia and in East & South-East Asia. In North Africa cannabis constitutes the main problem. The main drug problem for Central Asia and East & South-East

Asia is linked to opiates.

The results presented here are shown at the sub-regional level for illustrative purposes. They could provide a simple way to identify the extent of a country's drug problem as well as its patterns and – once calculated for a number of years – its evolution. The main idea of the IDI is to provide Member States with a comparable measure of the extent and the evolution of the drug problem, which should also improve the targeting of assistance by the international community. This, in turn will increase the efficacy of technical assistance programming and facilitate progress towards the ambitious goals set out in the 1998 Special Session of the General Assembly (UNGASS).

Sub-region	Per capita values			
	Production	Trafficking	Abuse	IDI
Caribbean	2.46	7.21	2.39	12.06
Central America	0.25	4.04	3.32	7.62
Central Asia and Transcaucasian countries	3.53	6.07	4.96	14.56
East Africa	0.30	1.13	0.80	2.23
East and South-East Asia	2.40	0.60	2.09	5.09
East Europe	0.15	1.26	10.96	12.38
Near and Middle East /South-West Asia	32.24	14.95	5.48	52.67
North Africa	4.85	1.12	1.54	7.51
North America	4.98	9.79	9.63	24.40
Oceania	3.87	5.56	9.42	18.86
South America	14.46	9.31	4.49	28.26
South Asia	0.28	0.10	2.68	3.06
Southeast Europe	1.40	9.19	2.15	12.75
Southern Africa	1.52	1.45	2.35	5.32
West & Central Europe	1.07	5.80	6.23	13.10
West and Central Africa	0.82	0.73	3.49	5.03
Mean	4.33	3.26	3.77	11.36

Illicit Drug Index, per capita, by Sub-region and Component, 2002



Illicit Drugs Index, per capita, by Sub-region and Drug-category, 2002

