Guidelines for the Annual Report Questionnaire

Version 1.1

1. General guidelines

Term	Definition
Frequent items/questions	
Ranking	For the topic in question, the various options/modalities/items should be ranked in order of importance/intensity: -1 for the highest value, -2 for the second highest value and so on.
Trends	For the topic in question, please compare the level in the reference year to the previous year and provide an assessment on whether the relevant variable exhibited a “large increase”, “small increase”, etc. The response does not necessarily need to be based on quantitative data, even though the question may make reference to a quantifiable measurement. The question may be answered on the basis of expert assessments, literature reviews, partial quantitative data or other approximate/qualitative methods. See also “Qualitative assessment” below. The guideline below can be used as a reference for the order of magnitude represented by the designations “large increase”, “small increase”, etc. If comprehensive quantitative data are available, they can of course be used to answer the question with precision according to these thresholds For demand topics: For reference, the following magnitudes should be considered in drug use and related topics: *Large increase* – increase greater than 10% *Small increase* – increase between 5 and 10% *Stable* – variation between -5% and 5% *Small decrease* – decrease between 5% and 10% *Large decrease* – decrease greater than 10% For supply topics: For reference, the following magnitudes should be considered in drug trafficking and related topics *Large increase* – increase greater than 25% *Small increase* – increase between 10 and 25% *Stable* – variation between -10% and 10% *Small decrease* – decrease between 10% and 25% *Large decrease* – decrease greater than 25%

	Note the above percentages should be interpreted as a relative (proportional) change in comparison to the baseline, even if the indicator is itself measured in percentage units. For example, in the case of prevalence of use of a certain drug among the general population, an increase from 0.25% to 0.50% the response would be large increase (based on a relative change of 100%, not on the increase of 0.25 percentage points). For disaggregations of trends by drug types/classes, please consider first the underlying indicator for the sub-categories and determine the trend for each. For example, the trend in prevalence of use of cannabis-type substances is determined by the number of people using any such substance (without double counting); the trend in prevalence of use of cannabis resin is determined by the number of people using specifically cannabis resin.
Reference year	Reference year is the year that the quantitative or qualitative information relates to, irrespective of the publication/dissemination date. For *Type I (qualitative)* questions, the 'reference year' for the information provided relates to the year before the moment the ARQ is compiled (e.g. 2020 for the ARQ collected during 2021). For *Type II (quantitative)* questions the most recent reference year is the year immediately preceding the year of data collection (e.g.: year 2020 for ARQ collected in 2021). For type II questions, there will be the possibility to report data for a number of reference years to update previously reported figures and/or to fill data gaps. Calendar years (January-December) are strongly preferred; in the event that data is available for other 12-month periods, these may be used as a proxy for the calendar year which maximizes the overlap. For example, data for April 2020-March 2021 would be a better proxy for the calendar year 2020 (overlap of nine months) than data for April 2019-March 2020 (overlap of 3 months).
Qualitative assessment	Assessment based on methods that are mostly qualitative in nature such as gathering of experts' views (Delphi), review of existing literature and/or use of partial or small-scale studies or quantitative exercises.
Recent years	Up to four years prior to the reference year.
Delphi method	Estimation method based on the assessment provided by multiple experts. The experts answer questionnaires in two or more rounds. After each round, an anonymised summary of the results from the previous round is provided as well as the reasoning of the judgments. Experts are encouraged to revise their earlier answers in light of the replies of other members of the panel. During this process, experts' assessments typically converge towards a common answer.
Primary sources of information	- National data collection system (specify) - Periodic government report (link or attachment)

	- Expert assessment (specify number of experts, name, affiliation and contact information of coordinating expert, method) - Other (specify Even where not explicitly requested, respondents are encouraged to refer to and attach relevant studies, reports or legislative texts.
Substantive terms	
Drug	For the purposes of this data collection instrument, “drug” means any of the substances, natural or synthetic, in Schedules I and II of the Single Convention on Narcotic Drugs, 1961 (as amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs, 1961) or any substance, natural or synthetic, or any natural material in Schedules I, II, III and IV of the Convention on Psychotropic Substances, 1971. See also UNODC 2016. Terminology and Information on Drugs, 3rd edition: https://www.unodc.org/documents/scientific/Terminology_and_Information_on_Drugs-E_3rd_edition.pdf
New Psychoactive Substances (NPS)	Substances of abuse, either in a pure form or a preparation, that are not controlled under the Single Convention on Narcotic Drugs of 1961 or the 1971 Convention, but that may pose a public health threat. In this context, the term “new” does not necessarily refer to new inventions but to substances that have recently become available. Source: *UNODC The challenge of New Psychoactive Substances (2013) :https://www.unodc.org/documents/scientific/NPS_Report.pdf*
Drug class and drug type	The list of drugs included in the ARQ is organized according to drug classes and drug types. For the purpose of the ARQ, a drug class is broadly defined as a set of drugs which have a similar chemical structure and similar psychoactive effects A drug type is a single substance with its own specific chemical structure. A drug class contains a set of drug types. These lists may be simplified and adapted according to the specific questions.
Drug use	Use of controlled psychoactive substances and/or NPS for non-medical and non-scientific purposes
Non-medical use	Use of a pharmaceutical drug or controlled substance, whether obtained by prescription or otherwise, other than in the manner or for the time period prescribed, or by a person for whom the drug was not prescribed. Source: *WHO (World Health Organization): https://www.who.int/substance_abuse/terminology/who_lexicon/en*
People with drug use disorders	People with drug use disorders are drug users who practice harmful use of drugs and/or are affected by drug dependence.

	Harmful use of drug is defined in the ICD-11 as a pattern of use of drugs that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. According to ICD-11, drug dependence arises from repeated or continuous use of drugs. The characteristic feature is a strong internal drive to use drugs, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. Countries are invited to report data according to this definition or other specific operational definitions that may have been adopted.
People who inject drugs (PWID)	Persons who have injected any psychoactive substance(s) for other than medical purposes during a specific reference period.
Polydrug use	The use of two or more drugs by the same person in the given reference period. This includes the use of more than one type of drug by an individual at the same time or sequentially, usually with the intention of enhancing, potentiating, or counteracting the effects of another drug. Please note that, in line with the definition of drugs given above, the use of alcohol and tobacco are not included
Primary drug	Main drug for which a person is seeking treatment, is registered as drug user, or the drug that was the primary cause of drug-related deaths.
Secondary drugs	Drugs that are used in combination with the primary drug.
Specific groups of the population	Specific groups of the population **(List 1)** may be relevant for different indicators. As a general guidance, the following groups will be considered in relation to drug use, treatment, mortality and related indicators: ● Persons with disabilities ● People living in rural areas ● Indigenous people ● Persons with migrant background ● Homeless people ● Sex workers ● People with mental illness ● Other (specify) For certain modules (including A02 Registries on drug users, A03 People who inject drugs and R05 Prevention of infectious diseases), the below specific groups are also added to the above groups **(List 2)**: ● Men who have sex with men (MSM) ● Transgender ● Others (specify) Sources: *60/262. Political Declaration on HIV/AID*, *2006;*

	WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention treatment and care for injecting drug users, 2013; *Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem (UNGASS), 2016;* *WHO UNODC International Standards for the treatment of drug use disorders, UNODC, 2016*; *OHCHR International human rights standards and recommendations relevant to the disaggregation of SDG indicators, 2018;* *OHCHR International human rights standards and recommendations relevant to the disaggregation of SDG indicators, 2018.*
International Classification of Diseases (ICD)	ICD is the international standard for classifying and reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes (https://www.who.int/classifications/icd/icdonlineversions/en/)
Monitoring	Ongoing process by which a phenomenon is measured over time to track changes and overall trends.
Evaluation	Evaluation is a rigorous and independent assessment of either completed or ongoing activities to determine the extent to which they are achieving stated objectives and contributing to decision making. Source: *UNDP Handbook on planning, monitoring and evaluating for development results, 2009*
Coordinating body	An institution or mechanism responsible for the coordination of activities undertaken by different institutions or stakeholders related to drug demand and/or drug supply. The institution/mechanism may operate at national, sub-national or community levels.
Coverage of policies/interventions/services	Describes the extent to which an intervention is delivered to the target population. It defines the percentage of the population reached by the interventions/services/policies among the number of persons who need the intervention. See relevant sections of these guidelines for details. Sources: *WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention treatment and care for injecting drug users 2013;* *UNODC, WHO International Standards on Drug Use Prevention: Second Updated Edition. 2018.*
Sex	Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. List for sex disaggregations: -male -female -unknown/other/third/intersex

	Source: *WHO*

2. Guidelines for modules

A01: Prevalence and extent of drug use	
Drug use	Refer to section "General Guidelines"
Non-medical use	Refer to section "General Guidelines"
Reference population	Unless otherwise specified, the reference population should be taken to be the entire country (for example, in questions A01.01 - A01.03). For type II/III questions on the general population (A01.06), the population may be restricted to the working-age population or adults only (e.g. 15-64, 15+). Please provide the specific age ranges used in the metadata, including age ranges of any subgroups. For type II/III data based on school/university surveys (A01.07), please provide both the educational year(s) in the school system (e.g. 3rd-4th grade in secondary school) as well as the typical ages of that reference population (e.g. 15-16). In addition, for both general population and school/university surveys, please provide any other coverage specificities of the population (e.g. linguistic limitations, urban areas only, working population only, public schools only, males/females only).
Prevalence of drug use in a reference population (period prevalence)	Proportion of the reference population that have consumed the drug (or group of drugs) of concern at least once during the specified reference period prior to the moment of observation. The reference period can be: *Lifetime* – at least once in their lifetime *Annual* (past year prevalence) – at least once in the last 12 months *Monthly / 30-day (past month prevalence)* – at least once in the last 30 days Weekly (past week prevalence) – at least once in the last week Daily (past day) – at least once on the last day prior to the observation (not the same day) For monthly, weekly and daily prevalence: if a different rule is used, please provide information in the metadata section. This can refer for example to cases where reference is made to frequency of use during the specific period (e.g. at least *xx* times during one month or one week). The definition of prevalence may be applied to any *group* of substances. For example, the past-year *prevalence of opiate use* refers to the proportion of individuals in the reference population which used *at least one opiate* (e.g. opium, morphine, heroin) in the given reference period. Note that, once the reference population and the reference period are fixed, the prevalence of use of a group of drugs (e.g. opiates) is always greater than (or equal to) the prevalence of use of each opiate separately (e.g. prevalence of opium use, prevalence of heroin use). However, the prevalence of use of a group of drugs can *not*, in general, be obtained by simply adding the prevalence of each drug in that group.

	The prevalence of drug use in a given reference population can also be disaggregated into sub-populations, for example males and females, by considering each sub-population separately. Note that the overall prevalence in a given population of mixed gender will always lie in between the values for the gender-specific sub-populations (more broadly, as long as the disaggregation gives a comprehensive breakdown into mutually exclusive categories, the overall value is a population-weighted average of the separate values of prevalence for each sub-population). Please note that the answers to the question on prevalence of drug use in this module (A01) should attempt to capture also the hidden nature of drug use. Please do not report values representing the simple counts of registered drug users (whether in absolute numbers or expressed as a percentage of the population) – these can be reported in Module A02 – Registries on drug users. The data from registries may be used to inform the responses to questions A01.01-A01.04 to the extent that trends and patterns resulting from these registries are believed to be representative of the general population.
Ranking	Please rank separately the drug classes and, for each drug class, the specific drug types within each drug class (independently of the other drug classes).
Trends in prevalence of drug use	Note the answer to trend questions need not be based on quantitative data. See section on trends in the "General guidelines" in this document. The threshold percentages given in the General Guidelines are indicative only. Moreover, if quantitative data are available, the threshold percentages should be interpreted as a relative (proportional) change in comparison to the baseline, even though prevalence is itself measured in percentage units. For example, in the case an increase from 0.25% to 0.50% in the prevalence of use of a certain drug among the general population, the response would be large increase (based on a relative change of 100%, not on the increase of 0.25 percentage points).
Indirect methods for the estimation of drug use prevalence	Indirect methods make use of one or multiple sources (that partially cover the drug use population and through statistical techniques they estimate the total population of drug users, including the one that is not covered by the available source. The methods include as the Multiplier Benchmark (MB) or Capture-Recapture methods (CRC). Indirect methods such as network scale-up are also used to compensate for under-reporting of drug use behaviours among respondents in a household survey. Indirect methods for the estimation of prevalence of drug use are methods used to estimate the "hidden" nature of regular or high-risk drug use that may not be captured in a conventional household survey or by another direct source. These methods take into account that existing data sources - such as data on the number of people being provided drug treatment - do not cover the entire universe of drug users.

	Please do not report here estimates of prevalence of drug use disorders, or of high-risk drug use . These maybe reported in Module A04 (People with drug use disorders).
Household drug use surveys	Surveys based on a probabilistic sample of the general population that focus on the use of drugs.
School or university surveys	Surveys carried in schools or universities which collect information on drug use among students. They differ from household surveys mainly in the reference population and sampling design.
Polydrug use	The use of two or more drugs by the same person in the given reference period. This includes the use of more than one type of drug by an individual at the same time or sequentially, usually with the intention of enhancing, potentiating, or counteracting the effects of another drug. Please note that, in line with the definition of drugs given above, the use of alcohol and tobacco are not included
A02: Registries of drug users	
Registry of drug users	List/database that contains information on individual drug users. There are often several registries within a country, often managed by different authorities and containing varying information. For example, there could be police registries, treatment registries and mortality registries, among others. Such registries only represent administrative data available to authorities and may not capture all drug users in a country.
Availability of data on registered drug users	Please select the option “Yes, data are available from consolidation of existing registries” if several registries are available but no single one of them includes all the registered drug users
Number of registered drug users, number of drug users newly registered	Number of persons who were registered in a drug use registry during the reference period. This represents the “stock” of registered drug users. Among them there are persons newly registered during the reference period and they represent the “flow” of registered drug users. To the extent possible, please include data from all the relevant registries for this question. Please specify in the metadata which registries were taken into account.
Primary drug class	Class (e.g. opioids, cannabis-type) of main drug e.g. (heroin, marijuana) for which drug user is registered as a user. If the drug user is registered against multiple drug types from multiple classes, please consider the one which constitutes the greater health risk.
Status in registration	- newly registered drug users - drug users being re-entered into the registers - continuously registered drug users
A03: People who inject drugs	
Prevalence of injecting drug use	Proportion of reference population that has injected any drug without medical prescription during a specific reference period. The reference period can be (the last) 12 months (preferred), or any other period according to national data collections. Estimates may draw on

	administrative sources such as registries, treatment data, records of needle-syringe programmes, etc. but should ideally adjust, where possible, for the incomplete coverage of such sources. Please provide relevant details in the metadata.
People who inject drugs (PWID), Injecting Drug Use	These two terms relate to the same concept. The term PWID refers to persons who have injected any psychoactive substance(s) for other than medical purposes during a specific reference period. Injecting Drug Use refers to the action or behaviour of injection practiced by PWID.
Ranking of drugs used via injection (A03.01)	To the extent possible the answer to this question should address injecting drug use among the entire population, although information on specific sub-populations may be used to inform your response. Please include relevant details on the primary sources of information. Also, the answer to this question may take into account multiple drugs used in combination. For example, users injecting mixtures of heroin and cocaine ("speedball") would be counted as cocaine users as well as heroin users. However, injected substances with no or limited psychoactive effects, such as cutting agents, should not be taken into account in this question.
Trends in injecting drug use (A03.02)	To the extent possible the answer to this question should address injecting drug use among the entire population, although information on specific sub-populations may be used to inform your response. Please include relevant details on the primary sources of information.
Prevalence of infectious diseases	Proportion of the reference population affected by an infectious disease. This should refer to people living with the infectious disease during the reference year. Data should preferably be based on testing or diagnoses which reflect users *actively* affected by the disease. Specifically: 1. In the case of Hepatitis C, estimates based on RNA (ribonucleic acid) testing. 2. In the case of Hepatitis B, antigen-based methods (e.g. HBsAg). 3. In the case of tuberculosis, diagnoses of active tuberculosis based on diagnosis of infection with Mycobacterium tuberculosis and characterized by signs or symptoms of active disease. 4. In the case of HIV, positive testing preferably confirmed with high viral load/low CD4 counts. In case the information is based on other testing methods please indicate. Also please indicate if the data is based on administrative records or disease surveillance. The reference populations can be: all people who use drugs, PWID, those who do not injecting drugs.

Infectious diseases	In the context of this questionnaire, they include • HIV: Human Immunodeficiency Virus • HCV: Hepatitis C Virus • HBV: Hepatitis B Virus • TB: Tuberculosis The list of infectious disease may change as new epidemiological patterns emerge among drug users.
Newly diagnosed HIV/HCV cases	Persons who were diagnosed with HIV/HCV during the reference period and had not been diagnosed before. These data should be based on testing or diagnoses which reflect users *actively* affected by the virus. In the case of Hepatitis C, estimates based on RNA (ribonucleic acid) testing are recommended. In the case of HIV, positive testing should preferably be confirmed with high viral load/low CD4 counts.
List of primary sources of information (A03.01-A03.03)	Behavioural survey Treatment registers of drug users Other registers of drug users (please specify) Household survey Other (please specify)
A04: People with drug use disorders	
People with drug use disorders	People with drug use disorders are drug users who practice harmful use of drugs and/or are affected by drug dependence. Harmful use of drug is defined in the ICD-11 as a pattern of use of drugs that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. According to ICD-11, drug dependence arises from repeated or continuous use of drugs. The characteristic feature is a strong internal drive to use drugs, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. Countries are invited to report data according to this definition or other specific operational definitions that may have been adopted. Estimates of prevalence of high-risk drug use (as per EMCDDA guidelines) may be used for the purposes of question A04.05. In such cases please specify in the metadata.
Prevalence of drug use disorders	Proportion of people with drug use disorders among the reference population. Estimates of prevalence of high-risk drug use (as per EMCDDA (European Monitoring Centre for Drugs and Drugs Addiction) guidelines) may be used for the purposes of question A04.05. In such cases please specify in the metadata.

<table>
<tr><th colspan="2">A05: Drug-related mortality</th></tr>
<tr><td>General mortality registry (GMR)</td><td>A national registry system which records deaths. Such registries are mostly maintained by national statistical offices or Health Departments. Usually data from GMRs is to be reported. However, if this is incomplete or more data is collected by the Special Mortality Registries (SMR), both GMR and SMR or SMR data is to be used, accordingly. If both are used, caution is to be taken to avoid duplicate reporting of death cases.

Sources: WHO, EMCDDA</td></tr>
<tr><td>Special mortality registry (SMR)</td><td>A registry ideally developed specifically for drug mortality monitoring by combination of different sources (e.g. forensic, police and others) which allow a high detection rate of cases. Alternatively, in some countries these registries are included in and maintained by existing information systems of police or medico-legal institutions (i.e. forensics institutes, coroners) for all deaths that have required investigation due to their unnatural or unexpected occurrence.

Source: EMCDDA</td></tr>
<tr><td>Direct drug-related deaths</td><td>Deaths where the main underlying cause leading to death was the intake of drugs.

It includes deaths directly caused by drugs, as follows:
1. patterns of drug use causing death - deaths defined under ICD 10 (or an equivalent in other versions of the ICD, e.g. ICD 9 or ICD 11): -Chapter V “Mental and behavioural disorders”: blocks F 11-F16, F18-F19;
2. Accidental drug-related poisoning: (X42, preferably in combination with T-codes T40.0-T40.9, and X41, in combination with T-code 43.6),
3. Intentional drug-related poisoning (Y62, preferably in combination with T-codes T40.0-T40.9, and Y61, in combination with T-code 43.6)
4. Drug-related poisoning with undetermined intent (Y12, preferably in combination with T-codes T40.0-T40.9, and Y11, in combination with T-code 43.6)
5. Exposure to other or unspecified drugs (X44, X64, Y14 in combination with T codes: T40.0-T40.9 or T43.6)

Categories 2-4 correspond to fatal overdoses (drug-related poisoning), which thus constitute a subset of direct drug-related deaths (see separate entry).

Please use the ICD-10 T-codes, and/or any other relevant records, to classify fatal overdoses against the relevant drug type or drug class, and also to ascertain that the substance involved was a drug (as defined in these guidelines), especially in the case of ICD-10 codes X41, Y11 and Y61.</td></tr>
</table>

	For example, a fatal heroin overdose would be recorded against ICD-10 code X42 (accidental poisoning by and exposure to narcotics and psychodysleptics), but the T-code T40.1 would be needed to classify this death against heroin (and hence opioids). If T-codes are not available but other relevant records are available, these should also be used. If ICD-10 coding of deaths is not implemented in your country, ICD-10 causes of death are to be used as a guide, as specified above, using these definitions of drug-related deaths and fatal overdoses, while aiming to provide figures for all the drug classes and types listed in the Drug List for this module. In this case the national definition used for recording drug-related deaths is to be specified in the corresponding metadata part of the module. Note that the above definition is in line with the EMCDDA "Selection B", which gathers information from General Mortality Registries (http://www.emcdda.europa.eu/data/stats2019/methods/drd), with the exception that T-code F13 (cannabinoids) is also included. Data based on EMCDDA "Selection D" (derived from Special Mortality Registries) can also be used for this purpose when they cover the above ICD-10 categories and when data from GMRs are unavailable or incomplete. Note that **indirect deaths** such as those caused by Hepatitis C, HIV/AIDS related to drug use, car accidents, suicide or violent deaths under the influence of drugs should not be considered as direct drug-related deaths. Exceptionally, if it is possible to ascertain that HIV was not the primary underlying cause of death but rather drug use, HIV cases are to be recorded as direct deaths. Due to different reporting capabilities of countries and given that often this is not possible to ascertain this, HIV cases, where it is not possible to differentiate this, are to be recorded separately.
Underlying cause of death	The disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury, in accordance with the rules of the International Classification of Diseases. Source: *WHO*
Drug-related poisoning (fatal overdoses)	Deaths that occur due to poisoning by drugs. For the purposes of the ARQ, these include deaths defined under the following ICD 10 chapters (or an equivalent in other versions of the ICD, e.g. 9 or 11): - XX "External causes of morbidity and mortality: Event of undetermined intent": *- accidental poisoning*: blocks X42, preferably in combination with T-codes T40.0-T40.9, and X41, in combination with T-code 43.6; *-intentional self-poisoning:* blocks X62 preferably in combination with T-codes T40.0-T40.9, and X61, in combination with T-code 43.6;

	-poisoning: event of undetermined intent: Y12 preferably in combination with T-codes T40.0-T40.9, and X61, in combination with T-code 43.6. *X codes and Y codes are* to be used in combination with T codes in order to explicitly identify the drug causing fatal overdoses: T40.0-40.9 (narcotics): Poisoning by drugs (Opium, Heroin, Methadone, etc.) and T43.6 "Poisoning: Psychostimulants with abuse potential" and also to ascertain that the substance involved was a drug (as defined in these guidelines), especially in the case of ICD-10 codes X41, Y11 and Y61. For example, a fatal heroin overdose would be recorded against ICD-10 code X42 (accidental poisoning by and exposure to narcotics and psychodysleptics), but the T-code T40.1 would be needed to classify this death against heroin (and hence opioids). If T-codes are not available but other relevant records are available, these should also be used. If ICD-10 coding of deaths is not implemented in your country, ICD-10 causes of death are to be used as a guide, as specified above, using these definitions of drug-related deaths and fatal overdoses, while aiming to provide figures for all the drug classes and types listed in the Drug List for this module. In this case the national definition used for recording drug-related deaths is to be specified in the corresponding metadata part of the module.
Indirect deaths	Deaths indirectly related to the use of psychoactive substances. These include those caused by Hepatitis C, HIV/AIDS related to drug use, car accidents, suicide and/or violent deaths under the influence of drugs. In these cases, the use of drugs is not an underlying cause but rather a contributing cause (deaths partially attributable to drug use). If drug use is the main underlying cause leading to death in these cases, it should be recorded as direct deaths.
Polydrug use	The use of two or more drugs by the same person in the given reference period. This includes the use of more than one type of drug by an individual at the same time or sequentially, usually with the intention of enhancing, potentiating, or counteracting the effects of another drug. Please note that, in line with the definition of drugs given above, the use of alcohol and tobacco are not included. When reporting polydrug use cases in the modules A05 (Drug-related mortality), A06 (Drug-related treatment) and R02 (Drug-related acute intoxication and non-fatal overdoses), the primary drug should be used to classify the particular instance. For example, if a client (case) is admitted for the use of heroin and he/she also uses benzodiazepines,

	this client is to be recorded under heroin only since this is the primary drug of admission. This case would also be recorded in, or contribute to, the questions on polydrug use. It would however not be recorded against benzodiazepines since these modules collect data on the primary drug (heroin) and not the secondary drug (benzodiazepines). If the illicit drugs used by a client cannot be specified, this case is to be recorded under the category "Any other drugs/psychoactive substances/medicinal products not listed above"" as 1 case and also in the polydrug question (proportion of polydrug users) as 1 case. In addition, when reporting for the modules on mortality (A05) and R02 (Drug-related acute intoxication and non-fatal overdoses), if death/acute intoxication/non-fatal overdose data is classified by single cause (one drug causing the medical condition) or multiple cause (multiple drugs causing the medical condition), the former is to be recorded against the corresponding drug in the drug list and the latter (multiple drugs) as a case of polydrug use. If the main drug in the multiple cause scenario is identified, the corresponding case is to be recorded against the corresponding primary drug in the drug list. In this scenario, the corresponding data is to be recorded as polydrug use as well.
A06: Drug-related treatment R03: Core treatment services	
Drug treatment	Any structured intervention that is aimed specifically to a) reduce drug use and cravings for drug use; b) improve health, well-being and social functioning of the affected individual, and c) prevent future harms by decreasing the risk of complications and relapse. These include pharmacological treatment, psychosocial interventions and rehabilitation and aftercare (definitions below).
People (patients, clients) in treatment	People who received treatment for the use of drugs during the reference year. This includes first-time entrants, people re-entering treatment and people in continuous treatment. **Note**: For the purpose of this module it is preferable that data on the number of clients/people/patients is reported. Only in cases when this data is not available, episode data is to be reported.
First-time treatment entrants	People who have entered treatment for the first-time during the reference year.
People re-entering treatment	People who returned to be in treatment during the reference year, after not having been in treatment in the previous year. **Note**: If a person re-enters within a year, only the first entry is to be counted in that year. Only first admission is to be reported in that year.

People in continuous treatment	People who are continuing treatment from last year. They might have been in treatment previously as well.
Treatment episodes	The number of times a person commences and ends a treatment service in the reference year, which may correspond to the number of admissions within the reference year. **Note**: For the purpose of this module it is preferable that data on the number of clients/people/patients is reported. Only in cases when this data is not available, episode data is to be reported.
Polydrug use	The use of two or more drugs by the same person in the given reference period. This includes the use of more than one type of drug by an individual at the same time or sequentially, usually with the intention of enhancing, potentiating, or counteracting the effects of another drug. Please note that, in line with the definition of drugs given above, the use of alcohol and tobacco are not included. When reporting polydrug use cases in the modules A05 (Drug-related mortality), A06 (Drug-related treatment) and R02 (Drug-related acute intoxication and non-fatal overdoses), the primary drug should be used to classify the particular instance. For example, if a client (case) is admitted for the use of heroin and he/she also uses benzodiazepines, this client is to be recorded under heroin only since this is the primary drug of admission. This case would also be recorded in, or contribute to, the questions on polydrug use. It would however not be recorded against benzodiazepines since these modules collect data on the primary drug (heroin) and not the secondary drug (benzodiazepines). If the illicit drugs used by a client cannot be specified, this case is to be recorded under the category "Any other drugs/psychoactive substances/medicinal products not listed above"" as 1 case and also in the polydrug question (proportion of polydrug users) as 1 case. In addition, when reporting for the modules on mortality (A05) and R02 (Drug-related acute intoxication and non-fatal overdoses), if death/acute intoxication/non-fatal overdose data is classified by single cause (one drug causing the medical condition) or multiple cause (multiple drugs causing the medical condition), the former is to be recorded against the corresponding drug in the drug list and the latter (multiple drugs) as a case of polydrug use. If the main drug in the multiple cause scenario is identified, the corresponding case is to be recorded against the corresponding primary drug in the drug list. In this scenario, the corresponding data is to be recorded as polydrug use as well.
Primary drug	The primary drug is the drug that causes the client the most problems at the start of treatment. This is usually based on the request made by the clients and/or on the diagnosis made by a therapist, commonly using international standard instruments (e.g. ICD-10; DSM, ASI) or clinical

	assessment. This item is of central importance and it is, in principle, collected for every client. Source: *EMCDDA*
Secondary drugs	Drugs that are used in combination with, or in addition to, the primary drug.
Pathway of referral for treatment	Institution or person/s that have invited the client to access and enter treatment: - Self-referral - Family/friends - General Practitioner (GP); - Other healthcare/treatment facility; - Court/probation/police; - Educational services; - Other (to be specified); - Not known
List of treatment interventions	**1.Pharmacological** - Management of withdrawal - Opioid Agonist Maintenance Therapy (OAMT) - Opioid Antagonist Maintenance treatment - Another agonist treatment (to be specified) **2. Psychosocial and Behavioural interventions** - Cognitive behavioural therapy (CBT) - Contingency management (CM) -Motivational interviewing (MI) and motivational enhancement therapy (MET) - Community reinforcement approach (CRA)-Social support (involvement of family members and concerned significant others) - Peer support groups -Other **Rehabilitation and aftercare (Recovery management and social support)** - Interventions based on scientific evidence and focused on the process of rehabilitation - Recovery and social reintegration – Other Note: If there is one patient in one facility receiving one type of intervention, e.g. pharmacological; and another patient receiving psychosocial in another facility, both are to be summed up for the reporting on the number of people in treatment as two patients receiving treatment for drug use. However, if one patient is receiving pharmacological treatment in one facility and the same one is receiving psychosocial in another, this is counted as one person in treatment for drug use. Source: *WHO, UNODC International standards for the treatment of drug use disorders 2016*
Pharmacological treatment interventions	Refers to interventions that include management of withdrawal, opioid agonist maintenance therapy (OAMT) and antagonist maintenance

	Source: *WHO, UNODC International standards for the treatment of drug use disorders 2016*
Management of withdrawal	Refers to a process carried out in a safe and effective manner aimed at eliminating or minimizing withdrawal symptoms that occur after drugs are no longer taken. Source: *WHO, UNODC International standards for the treatment of drug use disorders 2016*
Opioid agonist maintenance therapy (OAMT)	Refers to the regular administration of a long-acting opioid agonist to stabilize the patient without applying tapering dosage schedules. The primary aim of OAMT is to reduce the use of illicit opioids and manage abstinence by preventing withdrawal symptoms, reducing drug craving, and decreasing effects of additional opioids if they are consumed. Sources: *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users, 2013;* *WHO, UNODC International Standards for the treatment of drug use disorders, 2016*.
Opioid antagonist maintenance treatment	Refers to the regular administration of a long acting opioid antagonist to block opioid receptors and avoid any opioid effect. Source: adapted from *WHO*
Psychosocial and behavioural treatment interventions	Refer to programs that address motivational, behavioural, psychological, social, and environmental factors related to substance use and have been shown to reduce drug use, promote abstinence and prevent relapse. For different drug use disorders, the evidence from clinical trials supports the effectiveness of treatment planning, screening, counselling, peer support groups, cognitive behavioural therapy (CBT), motivational interviewing (MI), community reinforcement approach (CRA), motivational enhancement therapy (MET), family therapy (FT) modalities, contingency management (CM), counselling, insight-oriented treatments, housing and employment support among others. Source: *WHO, UNODC International standards for the treatment of drug use disorders 2016*
Cognitive behavioural therapy (CBT)	Refers to psychosocial interventions aimed at helping patients recognize, avoid and cope with situations in which they are most likely to use drugs. Source: *WHO, UNODC International standards for the treatment of drug use disorders 2016*

Contingency management (CM)	Refers to psychosocial interventions that provide a system of incentives and disincentives designed to make drug use less attractive and abstinence more attractive. Source: *WHO, UNODC International standards for the treatment of drug use disorders 2016*
Motivational interviewing (MI) and Motivational Enhancement Therapy (MET)	Refer to a counselling and assessment technique that follows a non-confrontational approach to questioning people about difficult issues like alcohol and drug use, assisting them to make positive decisions aimed at reducing or stopping such use. Source: *WHO, UNODC International standards for the treatment of drug use disorders 2016*
Community reinforcement approach (CRA)	Is more broadly based on using social, recreational, familial and vocational reinforcers to aid clients in the recovery process. CRA integrates several treatment components, including building motivation to quit, helping cessation of drug use, analysing drug use pattern, increasing positive reinforcement, learning new coping behaviours, and involving significant others in the recovery process. Source: *WHO, UNODC International standards for the treatment of drug use disorders 2016*
Involvement of family members and concerned significant others	Include family-oriented treatment approaches to improve engagement with treatment, reduce drug use, and improve participation in aftercare when compared to care focused on the individual patient. Family-oriented approaches are particularly useful in educating patients and their families about the nature of drug use disorders and the process of recovery. Source: *WHO, UNODC International standards for the treatment of drug use disorders 2016*
Peer support groups	Refers to small groups of peers wishing to assist each other in their struggle with a problem (self-help groups such as Narcotics Anonymous). Source: *WHO*
Rehabilitation and aftercare (Recovery management and social support)	Refers to interventions that are based on scientific evidence and focused on the process of rehabilitation, recovery and social reintegration dedicated to treat drug use disorders. Recovery management combines a variety of activities that promote and strengthen internal and external resources to help patients manage voluntarily and actively drug-related problems and their recurrence. Some of these activities may be already present in the context of a patient's home, neighbourhood and community while others need to be developed. The following factors and activities increase social reintegration and improve chances of stable remission and recovery from substance use disorders:

	• Strengthening individual's resilience, self-efficacy and self-confidence to manage daily challenges and stress while maintaining commitment to recovery and avoiding relapse to substance use • A supportive social network (i.e. partner, family members and friends) that can monitor the stability of recovery, abstinence from drugs and compliance with treatment • Stable accommodation • Meaningful work with appreciation in the work-place that replaces stigma and discrimination • Engagement with individuals and social networks of friends and workmates that have abstinence-oriented norms and are supportive of recovery goals • Political, humanitarian or spiritual involvement that provides a way to attribute meaning to life's stressors and develop a stronger purpose in life • Social participation and integration in educational and vocational pursuits, including volunteering or community involvement • Remediation of legal and financial problems • Active involvement in self-help, religious or other support groups Source: *WHO, UNODC International Standards for the treatment of drug use disorders, 2016*
Living status	Refers to the current situation (30 days prior to the start of treatment) of the person demanding treatment. (Source: *EMCDDA)* It includes the following options: a. Home/Stable accommodation (the client has accommodation and can afford this accommodation, there is no risk of losing the accommodation in the foreseeable future) -living with children -living with spouse/partner b. Unstable accommodation/ homeless (the client is either homeless or lives in an accommodation that can be lost in the foreseeable future) c. Other (to be specified) d. Not known
Educational attainment	-no schooling -some primary education (at least a year) -completed primary education (Europe-ISCED 1) -some secondary education (at least a year) -completed secondary education (for Europe ISCED 3) -some higher education (at least a year) -completed higher education-Bachelor's or equivalent (Europe-ISCED 6) -completed higher education- Master's or equivalent (Europe-ISCED 7) -doctoral or equivalent (Europe-ISCED 8) -informal (community) education (at least a year, years to be specified) Source: adapted from *International Standard Classification of Education (ISCED 11), UNESCO*

Employment status	-unemployed - employed -student -inactive -other
Treatment facility	A separate organisational entity (a medical centre, a department, a programme, etc.) that has its own defined objectives, procedures, rules and scope of services and interventions, its own target group(s), and a team and manager (team leader). Treatment facilities can be stand-alone (e.g. national addiction treatment centres) or integrated with other health care centres, clinics or dispensaries (such as general health care or mental health centres or hospitals). Source: *WHO/UNODC Substance use disorder treatment facility survey, February 2018*
Coverage of treatment (availability)	The number of people receiving treatment as a percentage of the persons with drug use disorders [(number of people in treatment in the given year)/(number of people with drug use disorders)*100] Response options: - fully adequate (>90%), - adequate (75-90%), - some gaps exist (50-75%), - barely adequate(25-50%), - not at all adequate(<25%), - unknown **Note**: Drug use disorders are defined in the Guidelines above (A04)
Accessibility of treatment services	- fully accessible (>90%), - overall accessible (75-90%), - some barriers exist (e.g. in relation costs)-(50-75%), - some barriers exist for certain population groups-(50-75%), - hardly accessible (25-50%), - not accessible (<25%) - unknown
List of treatment facility settings	-Outpatient -Inpatient
Outpatient treatment facilities	Facilities where treatment services are provided without admission for overnight stay.
Inpatient treatment facilities	Facilities that provide treatment services while the patient is admitted and stays overnight.
Beds and /or slots for treating substance use disorders	The number of available beds for clients in inpatient/residential treatment. In centres where sleeping arrangements are less formal (e.g. mats or blankets spread on the floor), the capacity can be counted as the

	maximum number of individuals that could safely spend a night at the facility, as 'bed' is understood to be a measure of sleeping capacity. Slots also specify the potential occupancy of a treatment facility and they refer to the number of patients who can be seen in the treatment system during any given time. Sources: *WHO/UNODC Substance use disorder treatment facility survey, February 2018;* *WHO.*
List of facilities (based on the service provided)	- low-threshold service (outpatient setting) - general (primary) health care service (outpatient setting) - specialised outpatient treatment service (outpatient setting) - mental healthcare service (outpatient setting) - another outpatient unit (specify) (outpatient setting) - hospital-based residential treatment service (inpatient setting) - non-hospital-based residential treatment (inpatient setting) - therapeutic community (inpatient setting) - specialised social reintegration unit/aftercare service (inpatient setting) - other inpatient units (specify) (inpatient setting) Sources: *WHO/UNODC Substance use disorder treatment facility survey;* *EMCDDA facility survey.*
Low-threshold service (treatment service type)	The term 'low-threshold' describes an implementation setting that facilitates drug users' access to health and social services, those that help to prevent and reduce health-related harm associated with drug use. To encourage drug users to enter into contact, the use of these services typically requires little bureaucracy, often no payment, and is not conditional upon being or becoming drug-free. They target current users, 'hard-to-reach' and high-risk groups among drug users and experimental users. This includes outreach services and drop-in centres as well as basic social services. Sources: *WHO/UNODC Substance use disorder treatment facility survey;* *EMCDDA facility survey.*
General (primary) health care service (treatment service type)	Basic or general health care, typically entry point to the health system providing services for a range of disorders. Services are provided to individuals or communities for the purpose of promoting, maintaining, monitoring or restoring health. It is the basis for referrals to more specialized health care as needed. This category includes general practitioners. Among a range of other health services, primary health care providers sometimes also offer elements of drug dependence treatment. Sources: *WHO/UNODC Substance use disorder treatment facility survey;* *EMCDDA facility survey.*

Specialised outpatient treatment service (treatment service type)	Describes a facility or specific hospital department where outpatients are given medical treatment and advice for their substance use disorder. Sources: *WHO/UNODC Substance use disorder treatment facility survey;* *EMCDDA facility survey.*
Mental healthcare service (treatment service type)	The focus is on the provision of a range of mental health care services, which may include treatment of drug use disorders. In general, mental healthcare services include a variety of services provided to people of all ages, including counselling, psychotherapy, psychiatric services, crisis intervention and support groups. However, the focus of these facilities is not solely drug dependence treatment provision. Sources: *WHO/UNODC Substance use disorder treatment facility survey;* *EMCDDA facility survey.*
Hospital-based residential treatment service (treatment service type)	Describes a residential facility that provides 24-hour nursing and/or medical care treatment to sick or injured people, including people with substance use disorders. Sources: *WHO/UNODC Substance use disorder treatment facility survey;* *EMCDDA facility survey.*
Non-hospital-based treatment service (treatment service type)	Residential treatment environments in which drug-dependent individuals live together and follow a program of counselling or therapy in order to achieve social and psychological change. A range of theoretical approaches, including family, psychodynamic, cognitive-behavioural therapy, medical or 12-step approaches may underpin residential treatment programs. Sources: *WHO/UNODC Substance use disorder treatment facility survey;* *EMCDDA facility survey.*
Therapeutic community (treatment service type)	Typically, a drug-free environment in which drug-dependent individuals live together in an organized and structured way in order to promote social and psychological change. The central philosophy is that residents are active participants in their own and each other's treatment and that responsibility for the daily running of the community is shared among residents and staff members. Sources: *WHO/UNODC Substance use disorder treatment facility survey;* *EMCDDA facility survey.*
Specialised social reintegration/aftercare service (treatment service type)	A facility that primarily focuses on social reintegration services (housing, education and employment related services) dedicated to sub-population groups. Sources: *WHO/UNODC Substance use disorder treatment facility survey;*

	EMCDDA facility survey.
Palliative care	Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. For the purposes of the ARQ palliative care managed by treatment facilities is to be recorded. Source: *WHO*
Source of funding of services related to treatment	*Institutions or actors that provide the financial means to implement treatment interventions* *Type of funding:* - *public (government) funding*: activities only financed by government (national, regional, local) -through public resources (taxpayer funding). This includes national health insurance contributions and NGO services only if they are financed with public resources; - *private funding:* includes privately financed centres (for profit and not-for profit only) which rely only on contributions from clients and private donors (also companies or organizations that pay as employer private contribution schemes matched with the company's or organization's contribution). It includes NGO centres run only with private funding. - *mixed funding*: includes resources and centres that rely on a combination of private and governmental (public) funds, including funding by international organisations and Global Fund Financing-institution that fights AIDS, tuberculosis and malaria
Public (government) funding	Interventions financed by government (national, regional, local) funds only (includes NGOs funded only by public funds). It includes national health insurance contributions.
Private funding (for profit and not-for profit)	Services provided only on the basis of private funding contributions (contributions from clients receiving the intervention and/or private sector donors, including companies or organizations that support the service from employer private contribution schemes matched with the company's or organization's contribution). It includes interventions administered by NGO centres, which are run with private funds only.
Mixed funding	Services funded by a combination of private and public funding (including NGO centres funded by both private and governmental funds) and includes funding by international organisations and Global Fund Financing-institution that fights AIDS, tuberculosis and malaria.
A07: Seizures and Trafficking	
Trafficking	Unlawful trafficking, cultivation or production of controlled drugs or precursors not for personal consumption Source: *International Classification of Crime for Statistical Purposes (ICCS)*

<table>
<tr><td>Seizures</td><td>A seizure of a substance/s is a lawful action performed by a law enforcement agency in which legal control of controlled substance/s is taken.
These actions derive from unlawful activities related to controlled substance/s (Drug Law Offences). The outcome of such an action is to put the substance/s under physical custody of national authorities.</td></tr>
<tr><td>Total number of seizures</td><td>A seizure case (instance) is an operation by national authorities where one or more types of drugs are seized. Every and each seizure case should be counted once, even if more than one substance were seized. Drugs seized at the same moment in time and at the same location should be counted as a single instance.</td></tr>
<tr><td>Number of seizures by single drug</td><td>The number of seizure cases per single type of drugs should be counted as following:
A seizure involving one drug type is counted as one seizure for the drug concerned
A seizure involving more than one drug, is counted for each drug involved(and contributes to the total number of seizures of that drug).
The sum of the number of seizure cases of each drug can be higher than the total number of seizure cases</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Countries of departure</td><td>Country that was the point of departure of the drug shipment reaching the country. The drugs may or may not have been produced/manufactured in the departure country. For consignments carried by an individual, please consider the country where the individual acquired the drug or the point of departure in that individual’s itinerary.</td></tr>
<tr><td>Countries of transit</td><td>The last country through which the drugs transited before reaching the country. This could be a neighbouring country, if the drugs were transported by land, or any other country, if the drugs were transported by air.</td></tr>
<tr><td>Countries of destination</td><td>The country to which the drug shipment was destined</td></tr>
<tr><td>Direction of trafficking – Inbound</td><td>Drugs entering the country</td></tr>
<tr><td>Direction of trafficking - Outbound</td><td>Drugs leaving the country</td></tr>
<tr><td colspan="2">A08: Clandestine Laboratories</td></tr>
<tr><td>Clandestine laboratories</td><td>Laboratories where opium, coca leaves, synthetic substances or intermediate products are illicitly processed to obtain the final products (drugs) or other intermediate products to be sold to customers.</td></tr>
<tr><td>Facilities for drug packaging</td><td>Facilities dedicated to refining, tableting, cutting and packaging are where drugs are processed but where no evidence of synthesis exists. These are facilities where for example, MDMA powder is pressed into tablets, where powder or liquid methamphetamine is refined into the crystal form, and where drug powders are diluted (“cut”) to increase bulk and maximize profits and materials temporarily disguised for trafficking purposes (e.g. for cocaine conversion).</td></tr>
</table>

Dump sites	Sites where used chemicals and other materials are unlawfully stored or placed
Kitchen labs	In "kitchen laboratories" only basic equipment and simple procedures are used. Typically, those operating in such laboratories have a limited or non-existent knowledge of chemistry and simply follow the instructions. Usually, there are no significant stores of precursors and the quantity of drugs or other substances manufactured is typically for personal use (a typical manufacturing cycle for amphetamine-type stimulants would yield less than 50 grams of the substance).
Small-scale laboratories	People operating in small-scale laboratories have advanced chemical knowledge. At such laboratories, more complex amphetamine-type stimulants may be manufactured. They may be of similar size to "kitchen laboratories" but frequently employing non-improvised equipment. Small scale laboratories may also include experimental laboratories. The amount manufactured is typically for personal use or for use by a limited number of close associates (a typical manufacturing cycle for amphetamine-type stimulants would yield less than 500 grams of the substance).
Medium-scale labs	Medium-scale laboratories use commercially available standard equipment and glassware (in some cases, custom-made equipment) and may operate for longer periods of time. They are not very mobile, and it is for these types of laboratories for which production estimates are the most viable and reliable. The amount manufactured at such sites is primarily for illicit economic gain (a typical manufacture cycle for amphetamine-type stimulants would yield between 0.5 kg and 50 kg of the substance).
Industrial-scale labs	Industrial-scale laboratories use oversized equipment and glassware that is either custom-made or purchased from industrial processing sources. Such industrial operations can for example produce significant amounts of amphetamine-type stimulants in very short periods of time, the amount being limited only by access to precursors, reagents and consumables in adequate quantities and the logistics and manpower to handle large amounts of drugs or chemicals and process them into the next step (a typical manufacturing cycle for amphetamine-type stimulants would yield 50 kg or more).
A09: Illicit cultivation and eradication of crops	
Illicit cultivation of crops	Cultivation of crops that are under international control, not authorized for scientific or medical use, including any such cultivation in nature reserves. Please include areas of wild growth separately and only if there is evidence that they were being used for illicit harvesting.
Estimates of illicit cultivation and production	Please provide separate estimates for indoor and outdoor cultivation of cannabis. For indoor cultivation, estimates can be in terms of number of plants (cultivation), weight per plant (yield) and weight (production). For cannabis yield and production (indoor or outdoor), please also specify if the product refers to cannabis herb, cannabis resin or other.
Average crop yield	The amount of the product (e.g. opium, coca leaf) usually measured in kilograms) that can be obtained, on average at the national level, per unit

	area of cultivation (usually measured in hectares). The usual unit of measurement is kg/ha. For cannabis, please specify if the product refers to cannabis herb, cannabis resin or other. For indoor cultivation of cannabis, yield can be expressed in terms of weight per plant (yield).
Production	The total amount of the crop product that is produced at the national level. In principle, it should be possible to estimate it by multiplying the total estimated area under cultivation by the estimated average yield (per unit area), or the total number of plants by the average yield (per plant). For cannabis, please specify if the product refers to cannabis herb, cannabis resin or other.
Eradication of crops	Destruction of plants related to internationally control crops which were illicitly cultivated, including any illicit cultivation in nature reserves. Eradication may be carried out manually, with tractors or via aerial spraying. The number of sites refers to individual locations where cultivation (including indoor cultivation) was detected and eradication of the plants took place. There may be many types within the same department/municipality/administrative region. The quantity of eradicated crop may be measured in terms of area or number of eradicated plants. You may use both of these units as most convenient (depending on the form in which data are available) as long as they represent separate eradication activities. Please avoid double-counting the same eradication activity by reporting it in terms of area and number of plants at the same time. For example, if the eradication data includes: - 30 ha in province A; - 20,000 plants in province B; - 10,000 plants corresponding to 50 hectares in province C you may report: - 30 ha AND 30,000 plants OR - 80 hectares AND 20,000 plants Moreover, plants eradicated in the field, as opposed to seized plants, should be reported in this module (A09.07) but not as seizures (A07.05) Please include eradicated areas of wild growth separately and only if there is evidence that they were being used for illicit harvesting.
Source of funds for alternative development activities	*Institutions or actors that provide the financial means to implement alternative development interventions* *Type of funding:* - *public (government) funding*: activities only financed by government (national, regional, local) -through public resources (taxpayer funding). This includes NGO services only if they are financed with public resources;

	- *private funding:* includes privately financed centres (for profit and not-for profit only) which rely only on contributions from clients and private donors (also companies or organizations that pay as employer private contribution schemes matched with the company's or organization's contribution). It includes NGO centres run only with private funding - *mixed funding*: includes resources and centres that rely on a combination of private and governmental (public) funds, including funding by international organisations and Global Fund Financing-institution that fights AIDS, tuberculosis and malaria
Public (government) funding	Interventions financed by government (national, regional, local) funds only (includes NGOs funded only by public funds). It includes national health insurance contributions.
Private funding (for profit and not-for profit)	Services provided only on the basis of private funding contributions (contributions from clients receiving the intervention and/or private sector donors, including companies or organizations that support the service from employer private contribution schemes matched with the company's or organization's contribution). It includes interventions administered by NGO centres, which are run with private funds only.
Mixed funding	Services funded by a combination of private and public funding (including NGO centres funded by both private and governmental funds) and includes funding by international organisations and Global Fund Financing-institution that fights AIDS, tuberculosis and malaria.
A10: Price and purity of drugs	
Wholesale level	Wholesale level is the level of an illicit drug market at which the drug is sold in bulk, to be sold on to consumers at the retail level.
Retail level	The retail level is the level of an illicit drug market at which the drug is provided to consumers (users)
Purity	Purity is a measure of the amount of active substance that is contained in a sample sold or trafficked as the "substance" (for example heroin, cocaine). Purity is expressed in terms of percentage (by mass/weight) of the pure substance as compared to the whole sample containing also related substances, impurities, residual solvents, etc. For cannabis products, please consider the percentage of tetrahydrocannabinol (THC) content (potency). For opium, please consider the percentage of morphine content . For amphetamine-type stimulants in tablet form, please provide the weight (in mg) of the quantity of controlled substance per tablet (for example, 30 mg).
Calculation of typical values	Calculation of "Typical" values for prices and purities could be based on following methodologies: o "Modal" (most common) value o "Median" o "Average"

	o Expert assessment - number of experts, name, affiliation and contact information of coordinating expert, methodology used must be provided o Other methods – methodology used to calculate typical values must be explained **Note**: For datasets with a high degree of precision, modal values can only be used if the data is clustered into bins, e.g. purities of 1.0%-1.99%, 2%-2.99%, 3-3.99%, etc.
A11: Sales of drugs using the Internet and related technologies	
Darknet	This term refers to portions of the internet purposely not open to public view and that can only be accessed via specialized software. In the context of sales of illicit drugs, the Darknet is associated mostly with the TOR network, where most illicit trading takes place.
Ranking and trends	Although the answers to these questions need not be based on quantitative data, as a general guideline they should be based on an indicative approximation of the number of purchases in which the buyer or seller (or both) was located in your country. Please use the reference percentages for supply-side indicators (see “general guidelines” at the beginning of this document).
Web-scraping techniques	Collecting information directly from the internet or the darknet. It can be done using a software that simulates human internet or darknet surfing to collect the information.
Three main countries where sites that sell drugs over the Internet/darknet are located, in order of magnitude of sales	The answer to this question should be based on purchases involving a seller or a buyer (or both) in your country and may be potentially include your own country. Please consider the servers to determine the location of the sites.
Country of departure	Country from where the package containing the seized drugs was sent. This refers to drugs seized entering the reporting country.
Sites	In the context of the darknet, a “site” is a non-physical market where illicit trading of drugs takes place, mostly through technological resources such as internet or darknet pages, groups in social media, applications such as Telegram, or chatting fora for games, among others.
Price of drugs sold over the Internet/darknet	Please specify the typical transaction size. See guidelines for module A10 for more guidelines on prices.
A12: Drug-related criminal justice process	
Drug-related criminal offence	Unlawful acts involving controlled drugs or precursors

	Source: ICCS
Trends	Please use the reference percentages for demand-side indicators (see “general guidelines” at the beginning of this document)
Adult	Person 18 years old and above
Juvenile	Under 18 years of age
Purchase, possession or cultivation for personal use	Unlawful possession, purchase, use, cultivation or production of controlled drugs for personal consumption Source: ICCS
Trafficking	Unlawful trafficking, cultivation or production of controlled drugs or precursors not for personal consumption Source: ICCS
Stages in the investigation that data are collected	o At the time the offence is FIRST reported to the police ('INPUT' statistics) o AFTER the offence is first reported but BEFORE a full investigation ('PROCESS' statistics) o AFTER the offence has been investigated ('OUTPUT' statistics)
Formal contact	“Formal contact” with the police and/or criminal justice system includes persons suspected, arrested or cautioned
Persons prosecuted	“Persons prosecuted” means alleged offenders against whom **prosecution commenced** in the reporting year. Persons may be prosecuted by the public prosecutor or the law enforcement agency responsible for prosecution, irrespective of the case-ending decision.
Persons convicted	“Persons convicted” means **persons found guilty** by any legal body authorized to pronounce a conviction under national criminal law, whether or not the conviction was later upheld.
Final decision	"Final decision" relates to a decision, after an appeal in respect of verdict or sentence has been made and has been decided by the competent authority, or the last decision after the statutory limits for filing such an appeal have expired
Custodial sentence	“Custodial sentence” relates to a sentence passed by a competent authority that entails the deprivation of liberty (i.e., placed in any form of detention or imprisonment in a public or private setting, from which the individual is not permitted, by order of any competent authority, to leave at will.).
Length of sentence	List of categories: - < 1 year - ⩾1 and < 5 years

	- ⩾5 and < 10 years - ⩾10 years.
A13: Legislative, institutional and strategic framework	
Legal instruments	Legal instruments that provide a framework to regulate specific processes. They encompass laws, annexes to laws and decrees, among others.
National drug supply and demand reduction strategy	A policy document that describes the strategy at the national level to tackle or implement a specific issue, such as drugs or alternative development, establishing the actions and their scope, the institutions involved and coordinating mechanisms.
Competent authorities	Competent national authorities empowered to issue certificates and authorizations for the import and export of narcotic drugs and psychotropic substances, and to regulate or enforce national controls over precursors and essential medicines.
A14: Innovative methods for data collection	
Innovative methods	Methods used to collect data related to drug use, trafficking or production, that make use of available infrastructure and/or of new technologies. Examples include wastewater analysis, web-scraping techniques, used syringe analysis, or novel geomatic techniques, among others.
R01: Prisons	
People held in prisons	“Persons held in prisons” are those persons who are in prisons, penal institutions or correctional institutions on a specified day. They exclude non-criminal prisoners held for administrative purposes, for example, persons held pending investigation into their immigration status or foreign citizens without a legal right to stay. In a number of countries, the term ‘Prisoners’ is in use and it is considered equivalent to the term ‘People held in prison’ in the framework of ARQ reporting.
Trends	Please use the reference percentages for demand-side indicators (see “general guidelines” at the beginning of this document), with the exception of the case of offences related to drug trafficking (see list below of types of offence), for which the reference percentages for supply-side indicators should be used.
Unsentenced persons	Persons held in prisons, penal institutions or correctional institutions who are untried, pre-trial or awaiting a first instance decision on their case from a competent authority regarding their conviction or acquittal. Persons held before and during the trial are included. Sentenced persons held awaiting the outcome of an appeal in respect of verdict or sentence or who are within the statutory limits for appealing their sentence are excluded.
Sentenced persons	Persons held in prisons, penal institutions or correctional institutions after a first instance decision or a final decision on their case has been made by a competent authority. This includes sentenced prisoners with a final decision and persons held who are awaiting the outcome of an appeal in respect of verdict or sentence or who are within the statutory limits for appealing and persons held who have been convicted but who have not received a sentence yet. Persons held who have received a custodial sentence for one crime but are still under trial and unsentenced for another crime are to be counted as sentenced persons held.

<table>
<tr><td>Type of offence</td><td>- Offences related to drug use/possession
- Offences related to drug trafficking
- All other drug-related offences
(Please, refer to section A12: Drug-related criminal justice process for definitions)</td></tr>
<tr><td>List of non-custodial measures</td><td>- Suspension of prosecution
- Suspension of court proceedings
- Caution, verbal sanctions, such as admonition, reprimand and warning
- Bail
- Conditional discharge/release (e.g. condition to appear in court on a specified day; to not engage in specific conduct; to not leave a certain area/State; to report on a daily or periodic basis to an authority; to surrender identity documents, etc.)
- Diversion to treatment (including supervised treatment/drug treatment court programmes (drug courts)
- Other (please specify)

Please refer to section on Module R09: Alternatives to conviction or punishment for more definitions.</td></tr>
<tr><td>List of intervention types for prevention of infectious diseases</td><td>- Needle and syringe programmes (NSPs)
- Opioid substitution therapy (OST) and other drug dependence treatment
- HIV testing services (HTS)
- Antiretroviral therapy (ART)
- Prevention and treatment of sexually transmitted infections (STIs)
- Condom programmes for people who inject drugs and their sexual partners
- Targeted information, education and communication
- Prevention, vaccination, diagnosis and treatment for viral hepatitis
- Prevention, diagnosis and treatment of tuberculosis.
-
- Other, including interventions among non-injecting drug users (to be specified by the respondent)
-
Source:
WHO UNODC UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2013</td></tr>
<tr><td colspan="2">R02: Drug-related acute intoxication and non-fatal overdoses</td></tr>
<tr><td>Acute intoxication</td><td><u>A transient </u>condition that follows the administration of a psychoactive substance and results in disturbances in the level of consciousness, cognition, perception, judgement, affect, or behaviour, or other psychophysiological functions and responses. The disturbances are related to the acute pharmacological effects of, and learned responses to, the substance and <u>resolve with time, with complete recovery, except</u></td></tr>
</table>

	where tissue damage or other complications have arisen. Complications may include trauma, inhalation of vomitus, delirium, coma, and convulsions, depending on the substance and method of administration. Source: *WHO lexicon*
Non-fatal overdose	An overdose involves the use of any drug in such an amount that acute adverse physical or mental effects are produced. It may produce transient or lasting effects (termed as non-fatal overdose), or death (fatal overdose); the lethal dose of a particular drug varies with the individual and with circumstances. In case of a non-fatal overdose the patient is not able to visit an emergency service but rather needs to be attended acutely in the place of the occurrence of the non-fatal overdose. Source: *UNODC, adapted from WHO*
Acute intoxication: Emergency visits	These include visits for treatment of acute intoxication, withdrawal symptoms, management of withdrawal treatment and of any related mental and physical health condition/s that a drug user may experience as a result of having used one or more drugs (including overdose, drug-related accidents and trauma). Emergency visits include paramedic help/aid outside hospitals and exclude overnight stay.
Acute intoxication: Hospitalization	Includes treatment on an in-patient basis, i.e. hospital admission that usually involves an overnight stay.
Polydrug use	The use of two or more drugs by the same person in the given reference period. This includes the use of more than one type of drug by an individual at the same time or sequentially, usually with the intention of enhancing, potentiating, or counteracting the effects of another drug. Please note that, in line with the definition of drugs given above, the use of alcohol and tobacco are not included. When reporting polydrug use cases in the modules A05 (Drug-related mortality), A06 (Drug-related treatment) and R02 (Drug-related acute intoxication and non-fatal overdoses) , the primary drug should be used to classify the particular instance. For example, if a client (case) is admitted for the use of heroin and he/she also uses benzodiazepines, this client is to be recorded under heroin only since this is the primary drug of admission. This case would also be recorded in, or contribute to, the questions on polydrug use. It would however not be recorded against benzodiazepines since these modules collect data on the primary drug (heroin) and not the secondary drug (benzodiazepines). If the illicit drugs used by a client cannot be specified, this case is to be recorded under the category “Any other drugs/psychoactive substances/medicinal products not listed above”” as 1 case and also in the polydrug question (proportion of polydrug users) as 1 case. In addition, when reporting for the modules on mortality (A05) and R02 (Drug-related acute intoxication and non-fatal overdoses), if

	death/acute intoxication/non-fatal overdose data is classified by single cause (one drug causing the medical condition) or multiple cause (multiple drugs causing the medical condition), the former is to be recorded against the corresponding drug in the drug list and the latter (multiple drugs) as a case of polydrug use. If the main drug in the multiple cause scenario is identified, the corresponding case is to be recorded against the corresponding primary drug in the drug list. In this scenario, the corresponding data is to be recorded as polydrug use as well.
Antagonist	A substance that counteracts the effects of another agent. Pharmacologically, an antagonist interacts with a receptor to inhibit the action of agents (agonists) that produce specific physiological or behavioural effects mediated by that receptor. Source: *WHO lexicon* Antagonist drugs are used in cases of acute intoxication to reverse the negative effects of the drug that the patient has taken, and which has led to intoxication; to avoid fatality.
Persons with access to antagonists in non-institutional settings	This group of people includes those who, for professional or personal reasons, may be given access to antagonists which can reverse the damaging impact of acute intoxications and overdose. These persons may include drug users, social and/or community workers and members of society involved in assisting people with drug use disorders outside of treatment centres, hospitals and other facilities providing services to people who use drugs. It may include people who administer home visits, organize community groups and training involving people with drug use disorders.
R03 Core treatment services (please see A06 Drug-related treatment)	
R04: Prevention of drug use	
Prevention	The objective of the prevention of the use of psychoactive substances is to help people, particularly but not exclusively of younger age, to avoid or delay the initiation of the use of psychoactive substances, or, if they have already started, to avert the development of substance use disorders. The general aim of substance use prevention, however, is much broader than this: it is the healthy and safe development of children and youth to realize their talents and potential and becoming contributing members of their community and society. In the case of controlled drugs, prevention is one of the main components of a health-centred system to address the non-medical use of these substances, as mandated by the existing three international Conventions (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). Source: *UNODC, WHO, 2018. International Standards on Drug Use Prevention: 2nd updated edition*
Prevention intervention	An intervention refers to a group of activities of a specific kind. This could be a programme that is delivered in a specific setting in addition to the normal activities delivered in that setting (e.g. drug prevention education sessions in schools). However, the same activities could also be delivered as part of the normal functioning of the school (e.g. drug prevention education sessions as part of the normal health promotion curriculum). Normally, the evidence about most interventions is derived from the evaluation of specific 'programmes', of which there can be many per intervention. For example, there are many programmes aiming at preventing drug use through the improvement of parenting skills (e.g. 'Strengthening Families Program', 'Triple-P', 'Incredible Years', etc.). These are different programmes delivering the same intervention (parenting skills/ family skills training). Source: *UNODC, WHO, 2018. International Standards on Drug Use Prevention: 2nd updated edition*
Universal prevention activities	Prevention activities which target the population at large. Source: *UNODC, WHO, 2018. International Standards on Drug Use Prevention: 2nd updated edition*
Selective prevention activities	Prevention activities targeting certain groups of the population (e.g. marginalized groups, groups in marginalized neighbourhoods, etc.) Source: *UNODC, WHO, 2018. International Standards on Drug Use Prevention: 2nd updated edition*
Indicated prevention activities	Prevention activities for individuals that are particularly at risk (also includes individuals that might have started experimenting and are therefore at particular risk of progressing to disorders). Source: *UNODC, WHO, 2018. International Standards on Drug Use Prevention: 2nd updated edition*

List of types of prevention interventions for drug use	List of interventions by target group 1. **Infancy and early childhood** Prenatal and infancy visitation Interventions targeting pregnant women Early childhood education 2. **Middle childhood** Parenting skills programmes Personal and social skills education Classroom environment improvement programmes Policies to retain children in school Addressing mental health disorders 3. **Early adolescence** Prevention education based on social competence and influence School policies on substance use School-wide programmes to enhance school attachment Addressing individual psychological vulnerabilities Mentoring 4. **Adolescence and adulthood** Brief intervention Workplace prevention programmes Community-based multi-component initiatives Media campaigns Entertainment venues **5. Other prevention interventions** After-school activities, sports and other structured leisure time activities Preventing the non-medical use of prescription drugs Interventions and policies targeting children and youth particularly at risk Prevention of the use of new psychoactive substances not controlled under the Conventions Interventions using media Source: *UNODC, WHO, 2018. International Standards on Drug Use Prevention: 2nd updated edition*
Prevention of non-medical use of prescription drugs	Prevention services aimed at reducing the non-medical use of prescription drugs. This may include awareness raising campaigns or regulations for general practitioners.
Levels of provision of prevention interventions	Provision level: - *Full*-existent in nearly all relevant locations - *Extensive*-exists in a majority of relevant locations (but not in nearly all of them) - *Limited*-exists in more than a few relevant locations (but not in the majority of them) - *Rare*-exists in just a few locations - *No provision*: does not exist

	- *Not known* Source: *EMCDDA*
R05: Prevention of infectious diseases	
Prevention policies, programmes	Policies, programmes and interventions that help prevent infectious diseases related to drug use. A *policy* refers to a regulatory approach either in a specific setting or in the general population. Examples include policies about needle and syringe programmes (NSP), the use of ARVs (antiretroviral therapy), etc.
Prevention intervention	Refers to a group of activities of a specific kind. This could be a programme that is delivered in a specific setting in addition to the normal activities delivered in that setting (e.g., HIV testing toolkit intervention, awareness campaigns about HIV and other infectious diseases). Normally, the evidence about most interventions has been derived from the evaluation of specific 'programmes', of which there can be many per intervention.
Gender identity	It reflects a deeply felt and experienced sense of one's own gender. A person's gender identity is typically consistent with the sex assigned to them at birth. It is widely understood that gender identity, like sexual identity/orientation, is not static and limited to male/female identities, but rather exists on a spectrum. This means that an individual's gender identity is not necessarily confined to an identity that is completely male or completely female. When an individual's gender identity differs from their assigned sex, they are commonly considered to be transgender, gender fluid, and/or gender queer. Source: *WHO*
List for gender identity	-Male (cisgender) -Female (cisgender) -Other (includes transgender, agender, bigender, etc.)
Transgender	Transgender is an umbrella term that describes a diverse group of people whose internal sense of gender is different than that which they were assigned at birth. Transgender refers to gender identity and gender expression and has nothing to do with sexual orientation. The term is increasing in familiarity globally, although other culturally specific terms may be used to describe people who have non-binary gender identities. Source: *WHO*
List of intervention types for prevention of infectious diseases	- Needle and syringe programmes (NSPs) - Opioid substitution therapy (OST) and other drug dependence treatment - HIV testing services (HTS) - Antiretroviral therapy (ART)

	- Prevention and treatment of sexually transmitted infections (STIs) - Condom programmes for people who inject drugs and their sexual partners - Targeted information, education and communication - Prevention, vaccination, diagnosis and treatment for viral hepatitis - Prevention, diagnosis and treatment of tuberculosis. - - Other, including interventions among non-injecting drug users (to be specified by the respondent) - Source: *WHO UNODC UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2013*
Coverage of interventions for the prevention of infectious diseases (percentage ranges)	Definition of coverage: **Percentage of PWID who were reached by an NSP in the specified reporting period during (**last 12, 6 or 3 months) **the reference year** -*Low* <20% of people in need; -*Mid* 20% – 60% of people in need; -*High* >60% of people in need **Percentage of opioid dependent people on OST in the reference year** -*Low* <20% of people in need; -*Mid* 20% – 40% of people in need; -*High* >40% of people in need **Percentage of HIV positive PWID receiving ART in the reference year** -*Low* <25% of people in need; -*Mid* 25% – 75% of people in need; -*High* >75% of people in need **Percentage of PWID tested for HIV** (by NSPs, drug treatment services, or other services targeting PWID, including mobile or outreach services) **during the specified reporting period in the reference year (**12, 6 or 3 months) -*Low* <40% of people in need; -*Mid* 40% – 75% of people in need; -*High* >75% of people in need The above ranges are to be taken as indicative only and the response to the question may be based on expert assessments and other qualitative approaches, as opposed to quantitative data. Quantitative approaches are also acceptable and may be based *either* on independent assessments of individuals reached by the interventions (based on programme data) as well as number of PWID (using indirect estimates), *or else* on survey-based methods. For details on quantitative approaches see Source:

	WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention treatment and care for injecting drug users, 2013.
Monitoring of prevention interventions	Ongoing process by which a phenomenon is measured over time to track changes and overall trends.
Evaluation of prevention interventions	Evaluation is a rigorous and independent assessment of either completed or ongoing activities to determine the extent to which they are achieving stated objectives and contributing to decision making. Source: *UNDP Handbook on planning, monitoring and evaluating for development results, 2009*
Type of funding	- *public (government) funding*: activities only financed by government (national, regional, local) -through public resources (taxpayer funding). This includes national health insurance contributions and NGO services only if they are financed with public resources; - *private funding:* includes privately financed centres (for profit and not-for profit only) which rely only on contributions from clients and private donors (also companies or organizations that pay as employer private contribution schemes matched with the company's or organization's contribution). It includes NGO centres run only with private funding. – - *mixed funding*: includes resources and centres that rely on a combination of private and governmental (public) funds, including funding by international organisations and Global Fund Financing-institution that fights AIDS, tuberculosis and malaria
Public (government) funding	Interventions financed by government (national, regional, local) funds only (includes NGOs funded only by public funds). It includes national health insurance contributions.
Private funding (for profit and not-for profit)	Services provided only on the basis of private funding contributions (contributions from clients receiving the intervention and/or private sector donors, including companies or organizations that support the service from employer private contribution schemes matched with the company's or organization's contribution). It includes interventions administered by NGO centres, which are run with private funds only.
Mixed funding	Services funded by a combination of private and public funding (including NGO centres funded by both private and governmental funds) and includes funding by international organisations and Global Fund Financing-institution that fights AIDS, tuberculosis and malaria.
R06: Links between drug trafficking, corruption and other forms of organized crime	

Drug trafficking groups	A structured group of three or more persons, existing for a period of time and acting in concert with the aim of committing one or more drug trafficking related crimes, in order to obtain, directly or indirectly, a financial or other material benefit
Trafficking in persons	The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs
Trafficking in firearms	Import, export, acquisition, sale, delivery, movement or transfer of firearms, their parts and components and ammunition from or across the territory of one State Party to that of another State Party if any one of the States Parties concerned does not authorize it in accordance with the terms of this Protocol or if the firearms are not marked in accordance with article 8 of the Firearms Protocol
Cybercrime	There is no international definition of cybercrime nor of cyberattacks. National offences typically cluster around the following categories: i) offences against the confidentiality, integrity and availability of computer data and systems; ii) computer-related offences; iii) content-related offences; iv) offences related to infringements of copyright and related rights.
Money-laundering	Method by which criminals disguise the illegal origins of their wealth and protect their asset bases, so as to avoid the suspicion of law enforcement agencies and prevent leaving a trail of incriminating evidence.
Corruption	The promise, offering or giving to a public official, directly or indirectly, of an undue advantage, for the official himself or herself or another person or entity, in order that the official act or refrain from acting in the exercise of his or her official duties; The solicitation or acceptance by a public official, directly or indirectly, of an undue advantage, for the official himself or herself or another person or entity, in order that the official act or refrain from acting in the exercise of his or her official duties;
Terrorism	Acts intended or calculated to provoke a state of terror in the general public, a group of persons or particular persons for political purposes are in any circumstance unjustifiable, whatever the considerations of a political, philosophical, ideological, racial, ethnic, religious or any other nature that may be invoked to justify them. (General Assembly resolution 49/60 para 3)
R07: Supply reduction activities and international cooperation	
Liaison officers	A liaison officer is a person who liaises between two organizations to communicate and coordinate their activities. Generally, liaison officers are used to achieve the best utilization of resources or employment of services of one organization by another.

Extradition	Surrender of any person who is sought by the requesting State for criminal prosecution for an extraditable offence or for the imposition or enforcement of a sentence in respect of such an offence Source: https://www.unodc.org/pdf/model_law_extradition.pdf
Mutual legal assistance	Mutual legal assistance in criminal matters is a process by which States seek for and provide assistance to other States in servicing of judicial document and gathering evidence for use in criminal cases.
R08: Alternative development	
Alternative development	Process to prevent and eliminate the illicit cultivation of plants containing narcotic drugs and psychotropic substances through specifically designed rural development measures in the context of sustained national economic growth and sustainable development efforts in countries taking action against drugs, recognizing the particular sociocultural characteristics of the target communities and groups, within the framework of a comprehensive and permanent solution to the problem of illicit drugs. Source: Measures to Enhance International Cooperation to Counter the World Drug Problem. Action Plan on International Cooperation on the Eradication of Illicit Drug and on Alternative Development ,Resolution A/RES/S-20/4 of September 8, 1998
Preventive alternative development	A state policy that enables a set of measures to enhance the incorporation of the community in productive, socioeconomic and environmental protection projects, to reduce their vulnerability to engage in illicit activities and promote human development. The aim of preventive alternative development interventions is to prevent such situations, in addition to boosting socioeconomic development. Source: *World Drug Report 2015; ECOSOC Resolutions: 2006/33, 2007/12, 2008/26*
Sustainable urban development initiatives	Initiatives aimed at developing urban environments which promote social inclusivity and ensure that all inhabitants are able to live in just, safe, healthy, accessible, affordable, resilient and sustainable cities and human settlements that foster prosperity and quality of life for all. These initiatives target different aspects of urban planning (including schooling, health, transport) that affect citizens of urban communities, including groups of the population at risk of engaging in illicit activities. Sustainable urban development initiatives include the creation or development of urban governance structures that generate urban spaces which offer benefits and opportunities to its inhabitants and that work as a disincentive for illicit a*ctivities.* Sources: *Adapted from: UNODC, 2016;*

	The Urban Agenda, Habitat III; UN System-Wide Strategy on Sustainable Urban Development, 2019.
Alternative development project	Project aiming to: -improve the quality of life of farmers / households, AND -reduce or prevent the illicit cultivation of crops
Direct beneficiary	Farmers / households whom were intended to benefit first-hand by the alternative development projects (primarily targeted farmers / households).
Indirect beneficiary	Farmers / households that benefitted indirectly from alternative development projects (e.g. through increased income available, improved infrastructure, increased security, etc.)
Sequencing measures	Measures or follow up activities in place targeting those households / farmers directly affected by the eradication of illicit crops.
Illicit cultivation	Illicit cultivation of crops, as defined in the "Cultivation and eradication" section.
Indigenous households	Indigenous populations are communities that live within, or are attached to, geographically distinct traditional habitats or ancestral territories, and who identify themselves as being part of a distinct cultural group, descended from groups present in the area before modern states were created and current borders defined. They generally maintain cultural and social identities, and social, economic, cultural and political institutions, separate from the mainstream or dominant society or culture. Source: *WHO*
Types of household	Household that cultivate illicit crops Households that do not cultivate illicit crops
List of crops	- Cannabis - Coca bush - Opium poppy - Plants that are not under international control but are under national control (such as khat etc.)
R09: Alternatives to conviction or punishment	
Caution, verbal sanctions, such as admonition, reprimand and warning	A caution is an alternative to prosecution, could be given by a police officer and may include specific conditions such as drug treatment or attendance at an education session. A warning includes a (written) notice by a police officer, for example given on the street. No action for example includes the police refraining from further action such as a warning.
Diversionary measure	This includes measures aimed to divert people from the criminal justice system, mainly but not only at the (pre-)arrest stage where the police refer the offender into other services such as drug treatment
Suspension of investigation/ prosecution	During the investigation or prosecution stage, the relevant professional (e.g. prosecutor) decides to suspend the case (suspension could depend on specific conditions)

Suspension of court proceedings	During the court stage, the prosecutor or the judge decides to suspend the case/proceedings (suspension could depend on specific conditions)
Suspended or deferred sentence	A sentence of imprisonment that is pronounced but its implementation is suspended for a period on conditions set by the court. There are two types of suspended sentences. A judge may unconditionally discharge the defendant of all obligations and restraints. An unconditionally suspended sentence ends the court system's involvement in the matter and the defendant has no penalty to pay. However, the defendant's criminal conviction will remain part of the public record. A judge may also issue a conditionally suspended sentence. This type of sentence withholds execution of the penalty as long as the defendant exhibits good behaviour or complies with any other obligations imposed. [See Tokyo Rules and UNODC Handbook on prison overcrowding]
Probation and judicial supervision	Supervision of offenders in the community by probation services
Community service order	A sentence served in the community during which offenders undertake unpaid work which is of benefit to the community, under supervision. (See Tokyo Rules and UNODC Handbook on prison overcrowding)
House arrest, electronic monitoring	This entails restricting the offender's movement, such as home arrest and electronic monitoring
Furlough (home leave) and halfway houses	Prisoners who are granted furloughs, that is, short periods of leave from prison in the course of terms of imprisonment, or who live in halfway houses before being released into the community, remain prisoners in terms of the law and subject to the rules of prison discipline. (See Tokyo Rules and UNODC Handbook on alternatives to imprisonment)
Conditional discharge/release	The early release of sentenced prisoners under individualized post-release conditions can be mandatory when it takes place automatically after a minimum period or a fixed proportion of the sentence has been served, or it can be discretionary when a decision has to be made whether to release a prisoner conditionally after a certain period of the sentence has been served. Conditional release or parole is always accompanied by a general condition that the prisoner should refrain from engaging in criminal activities. However, this is not always the only condition imposed. Other conditions may be imposed on the prisoner (such as attendance of a treatment programme). (See Tokyo Rules and UNODC Handbook on prison overcrowding)
Court-supervised treatment / drug	Drug treatment under judicial supervision may be provided in some countries under the name of "drug courts" or "drug treatment courts". This includes post-adjudication/sentencing programmes that require defendants to plead guilty and pre-conviction programmes requiring no

treatment court programmes	guilty plea that only lead to adjudication/sentencing if the defendant fails to complete the programme. (See UNODC Handbook on prison overcrowding and WHO-UNODC publication on treatment as an alternative)
Bail	A legal mechanism used so that a person accused of a crime can be released from detention prior to the conclusion of their case if certain conditions are met. These conditions are designed to ensure that the accused returns to court for trial. They usually involve placing an amount of money as security with the court, which can be forfeited to the state should the accused fail to return to court at the appointed time and place
Economic sanctions and monetary penalties	Fees or other payments imposed by competent authority; freezing of assets and other financial constraints
Confiscation	Permanent removal of assets from the possession of an individual or company
Other	Alternatives to conviction or punishment that could not be included in other classifications
R10: New psychoactive substances identified	
NPS	Substances of abuse, either in a pure form or a preparation, that are not controlled under the Single Convention on Narcotic Drugs of 1961 or the 1971 Convention, but that may pose a public health threat. In this context, the term "new" does not necessarily refer to new inventions but to substances that have recently become available. Source: *UNODC The challenge of New Psychoactive Substances (2013)* *https://www.unodc.org/documents/scientific/NPS_Report.pdf* Please ensure that substances reported as NPS are not under international control (in which case they are considered as "drugs" – see definition in these guidelines). However, please note that, for the purposes of this reporting exercise, substances *not* under international should *not* be reported as drugs (as thus may potentially be considered as NPS) even if they have come under *national* control.
Identification of NPS	Identification of NPS should be based on forensic testing. However, before reporting a substance as a newly identified NPS, please check that it does not already appear in the updated list of NPS (to be provided in the web portal), possibly under an alternative name.
IUPAC Names	IUPAC names are systematic chemical names following recommendations of the International Union of Pure and Applied Chemistry (IUPAC). Please refer to:

UNODC
United Nations Office on Drugs and Crime

	Nomenclature of Organic Chemistry: IUPAC Recommendations and Preferred Names 2013 for guidelines on naming conventions.
R11: Illicit financial flows and money-laundering	
Net income	Income minus expenditures associated with drug trafficking and production activities.
Illicit Financial Flows	This term refers to value illicitly generated, transferred or utilized that is moved from one country to another. In the context of this document, it refers solely to those illicit financial flows associated with drug trafficking and production activities.
Money Laundering	Method by which criminals disguise the illegal origins of their wealth and protect their asset bases, so as to avoid the suspicion of law enforcement agencies and prevent leaving a trail of incriminating evidence.
Cryptocurrency	Digital asset designed to work as a medium of exchange that uses strong cryptography to secure financial transactions, control the creation of additional units, and verify the transfer of assets.
Informal remittance	Transfer of funds across countries through private, unrecorded channels.
Type of assets	- Cash - Financial assets - Real estate - Other assets (specify)
R12: National framework	
Legal provisions	Legal instruments that provide a framework to regulate specific processes. Legal provisions include laws, acts, regulations and provisions.
Substances under international control	Narcotic drugs and psychotropic substances scheduled as such under the 1961 Single Convention on Narcotic Drugs, as amended, and the 1971 Convention on Psychotropic Substances ('the Conventions') They do not include new psychoactive substances –NPS. The "schedules" are lists which specify to which substances the various provisions of the Conventions apply.
Substances under national control	Substances whose production, selling, and transportation are regulated by national legislation as they pose a risk to public health. Substances under international control are typically scheduled also at national level, but substances controlled at national level may contain a larger number of substances. These include for example new psychoactive substances –NPS if they are controlled in the domestic legislation derived from the Conventions.
Legal framework to place under national control those substances that are internationally controlled	In order for national legislation to remain in line with the drug conventions (see above), when the schedules of the conventions are updated, it may be necessary for changes to be made in national laws and regulations. This process is itself usually regulated by specific legal provisions at national

	level. Moreover, there may be specific reference lists which specify the substances to which national control applies.
Criminal / Non-criminal offence	The distinction between criminal and non-criminal offences is defined in national legislations (e.g. penal code vs other legislation) but may not always be . Non-criminal offences may be treated as administrative offences, but this varies across countries and Depends on the different types of responsible authority (court/judge or law enforcement agency) or other criteria. Countries should report on the basis of national practice.
Threshold amounts to define an act as criminal or not	Possession, purchase or cultivation for personal use may not be treated as a (criminal) offence depending on whether a country considers acceptable and justifiable certain amounts for personal use. The ARQ aims at collecting national experiences on the possible existence of thresholds in national legislations that may define quantities that single persons may allow to carry (or cultivate) for personal use.
Challenges in implementing international cooperation in criminal matters	Please distinguish between extradition requests and other forms of cooperation, such as mutual legal assistance requests. Also, please distinguish between requests by your country to other countries, and requests from other countries to your country.
Alternatives to conviction or punishment	Alternative or additional measures with regard to conviction or punishment. These include “caution, verbal sanctions, such as admonition, reprimand and warning; bail; conditional discharge / release (e.g. condition to appear in court on a specified day; to not engage in specific conduct; to not leave a certain area/state; to report on a daily or periodic basis to an authority; to surrender identity documents, etc.); diversion to treatment; suspension of investigation/prosecution; suspension of court proceedings; probation and judicial supervision; community service order; court-supervised treatment / drug treatment (including drug courts); economic sanctions and monetary penalties; house arrest, electronic monitoring; confiscation; suspended or deferred sentence; among others. For more information, refer to the section on “Alternatives to conviction or punishment” in these Guidelines.
Stages of the criminal justice process	When an individual is suspected of committing an offence, s/he will typically go through various stages of the criminal justice process. The first stage often entails formal contact with police or other law enforcement officers. This may be in the form of a formal sanction or an arrest. Prosecution may (or may not) come at a later point in time and itself may or may not result in a conviction.
National strategy	A policy document that describes the strategy at the national level to tackle or implement a specific issue, such as drugs or alternative

	development, establishing the actions and their scope, the institutions involved and coordinating mechanisms.
Extradition	Surrender of any person who is sought by the requesting State for criminal prosecution for an extraditable offence or for the imposition or enforcement of a sentence in respect of such an offence. Source : https://www.unodc.org/pdf/model_law_extradition.pdf
Money laundering	Refer to section on "illicit Financial Flows and Money Laundering" of these Guidelines for a definition.
Financial Intelligence Unit (FIU) (also called Financial Information Unit)	A central, national unit that is responsible for receiving and analysing information from private entities on financial transactions which are considered to be linked to money laundering and terrorist financing. The FIUs disseminate the results of its analyses to the competent authorities where there are grounds to suspect money laundering, associated predicate offences or terrorist financing. Source : https://ec.europa.eu/home-affairs/e-library/glossary/financial-intelligence-unit-fiu-0_en
Joint operations undertaken by the FIU with other national/financial institutions in the last two years	Joint operations with other national/financial institutions refer to investigations or operations which were carried out with the active and concurrent participation of the FIU and at least one other institution in the same country.
Joint operations with other countries on asset recovery and combating money-laundering	Joint operations with other countries refer to investigations or operations which were carried out with the active and concurrent participation of the FIU and at least one other institution from another country, independently of the scale of the operation and the level of cooperation.
Central coordinating entity and other institutions involved in the implementation of policies on the prevention of infectious diseases	Please include information on the institution(s) which cover prevention of infectious diseases in connection with drug use and specify whether these institutions cover prevention of infectious diseases in general.
Egmont Group	The Egmont group is an informal network of FIUs aiming to foster the secure exchange of expertise and financial intelligence to combat money laundering and terrorist financing. See https://egmontgroup.org/en

Opioid substitution therapy (Opioid agonist antagonist maintenance treatment)	Treatment aimed at reducing the use of illicit opioids and manage abstinence by preventing withdrawal symptoms, reducing drug craving, and decreasing effects of additional opioids if they are consumed. Source: *UNODC WHO International Standards for the Treatment of Drug Use Disorders, 2016*
Medical use of controlled substances	A use of a substance under medical supervision which may include the prescription of the substance by a licenced medical staff.
Supply management system	National system for ensuring adequate supply of controlled substances with medical use and for regulating the procurement, distribution, custody and delivery of such substances.
Observatories	A national drugs observatory (NDO) is an organisation that provides its country with factual, objective, reliable and comparable information concerning drugs and drug addiction and their consequences. Source: http://www.emcdda.europa.eu/attachements.cfm/att_118914_EN_EMCDDA-NDO-handbook-en.pdf
Indirect estimation based on administrative data	Refer to section on “Prevalence and extent of drug use” of these Guidelines for a definition (“Indirect methods for the estimation of drug use prevalence”).
PWID	People who inject drugs. See also section on Module A03(People Who Inject Drugs (PWID)), of these Guidelines.
Repository of seizure cases	Database that contains specific information on individual drug seizure cases, such as amounts seized, type of drugs seized, criminals involved, route of the seized shipment, among other items.
R13: Access to internationally controlled medications	
Internationally controlled medications	Substances that are controlled under the 1961 or 1971 drug conventions for medical use and may have medical uses
Ranking	This response can be based on qualitative assessment and , as a general guideline, the ranking should reflect the deficit of the substance (in Standard Defined Daily Doses) experienced by your country during the reference year.
Available stocks for medical use	Please include all available stocks for medical use, without distinction between medications intended for humans or otherwise.

Trends	Please use the reference percentages for demand-side indicators (see "general guidelines" at the beginning of this document)
List of relevant institutions collecting data	Ministry of Health Department of Pharmacy Customs/inland revenue Law enforcement Other/specify
Informal market for internationally controlled medications	An unofficial market in goods or substances, especially in a country with a controlled system for substances
List of settings	• Hospitals • Health centres (primary health care) • Pharmacies (outside hospitals) • Prisons • Other (specify)