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FOREWORD

In the past decade, drug control has matured. Policy has become more responsive to the needs of those most seriously affected, along the whole chain of the drug industry – from poor farmers who cultivate it, to desperate addicts who consume it, as well as those caught in the cross-fire of the traffickers. Countries are learning from each others' experiences, and drawing on expertise from the international community.

Drug control is also increasingly taking a more balanced approach, focussed on development, security, justice and health to reduce supply and demand, and disrupting illicit flows. There is an understanding that in regions where illicit crops are grown, it is vital to eradicate poverty, not just drugs. There is a realization that underdevelopment makes countries vulnerable to drug trafficking, and other forms of organized crime: therefore development is part of drug control, and vice versa.

Most importantly, we have returned to the roots of drug control, placing health at the core of drug policy. By recognizing that drug addiction is a treatable health condition, we have developed scientific, yet compassionate, new ways to help those affected. Slowly, people are starting to realize that drug addicts should be sent to treatment, not to jail. And drug treatment is becoming part of mainstream healthcare.

Beware the side effects of complacency

This approach is paying off. The world's supply of the two main problem drugs – opiates and cocaine – has been declining over the last two years. The global area under opium cultivation has dropped by almost a quarter (23%) in the past two years, and opium production looks set to fall steeply this year due to a blight that could wipe out a quarter of Afghanistan's production. Coca cultivation is down by 28% in the past decade. Heroin and cocaine markets are stable in the developed world. Indeed, cocaine consumption has fallen significantly in the United States in the past few years. The retail value of the US cocaine market has declined by about two thirds in the 1990s, and by about one quarter in the past decade. One reason behind the violence in Mexico is that drug traffickers are fighting over a shrinking market.

Shifting the problem to the developing world

Most worrisome are recent developments in the third world. Market forces have already shaped the asymmetric dimensions of the drug economy; the world's biggest consumers of the poison (the rich countries) have imposed upon the poor (the main locations of supply and trafficking) the greatest damage.

But poor countries have other priorities and fewer resources. They are not in a position to absorb the consequences of increased drug use. As a result, there is now the risk of a public health disaster in developing countries that would enslave masses of humanity to the misery of drug dependence – another drama in lands already ravaged by so many tragedies. The warning lights are already flashing. Look at the boom in heroin consumption in Eastern Africa, or the explosion of cocaine use in West Africa or South America, or the surge in the production and abuse of synthetic drugs in the Middle East and South East Asia. We will not solve the world drugs problem by shifting consumption from the developed to the developing world.

Changing to other drugs

Furthermore, stabilization of the cocaine and heroin markets masks a growing problem of the misuse of prescription drugs in many parts of the world. And the global number of people using amphetamine-type stimulants (ATS) is likely to exceed the number of opiate and cocaine users combined. The ATS market is harder to track because of short trafficking routes (manufacturing usually takes place close to main consumer markets), and the fact that many of the raw materials are both legal and readily available. Furthermore, manufacturers are quick to market new products (like ketamine, Mephedrone and Spice) and exploit new markets. We will not solve the world drugs problem if addiction simply shifts from cocaine and heroin to other addictive substances.

What do we propose, at UNODC? We champion placing drug policy at the intersection of health, security, development and justice. Let me explain.

The right to health

a.) Universal access to drug therapy. At the United Nations, we are working with the World Health Organization, and advocate universal access to drug treatment. We work with UNAIDS to prevent an HIV epidemic among injecting addicts. I appreciate the support that is coming from the community level for these initiatives.

(b.) Universal access to therapy by means of drugs. We should not only stop the harm caused by drugs: we should unleash the capacity of drugs to do good. What do I mean? Recall that the Preamble of the Single Convention (from 1961) recognizes that "… *the medical use of narcotic drugs is indispensible for the relief of pain, …. and adequate provision must be made to ensure their availability …"* Although there is an over-supply of opium in the world, many people who suffer major illnesses have no access to palliative care. Why should a Nigerian consumed by AIDS or a Mexican cancer patient, be denied medication offered to their Swedish or American counterparts? Help us overcome cultural, professional, administrative and socio-economic factors that conspire to deny people the opium-based relief (morphine) they need.

The right to development

While the pendulum of drug control is swinging back towards the right to health and human rights, we must not neglect development.

As illustrated in various recent UNODC reports, including this one, drug production and trafficking are both causes and consequences of poverty. Indeed, 22 of the 34 countries least likely to achieve the Millennium Development Goals are in the midst – or emerging from – conflicts, located in regions that are magnets for drug cultivation and trafficking. More development means less crime and less conflict. That is why UNODC is working with governments, regional organizations and development banks to promote drug control policy as ways to foster development, and vice-versa – for example in the Balkans, Central and West Asia, Mesoamerica, West and East Africa.

The right to security

Yet, the stakes are high and getting higher. Drug-trafficking has become the main source of revenue for organized crime, as well as to terrorists and insurgents: in other words, drug-related illegality has become a threat to nations in so many theatres around the world. Recent developments in West Africa, the Sahel, and parts of Central America show the very real dangers of narco-trafficking to security, even the sovereignty of states.

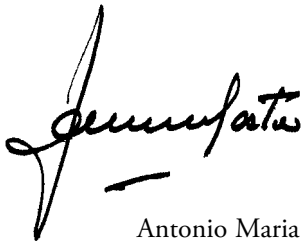
So grave is the danger that the issue is now periodically on the agenda of the Security Council. Unless we deal effectively with the threat posed by organized crime, our societies will be held hostage – and drug control will be jeopardized, by renewed calls to dump the three UN drug conventions that critics say are the cause of crime and instability. This would undo the progress that has been made in drug control over the past decade, and unleash a public health disaster.

Human rights

Above all, we must move human rights into the mainstream of drug control. Around the world, millions of people (including children) caught taking drugs are sent to jail, not to treatment. In some countries, what is supposed to be drug treatment amounts to cruel, inhuman or degrading punishment – the equivalent of torture. In several Member States, people are executed for drug-related offences. In others, drug traffickers are gunned down by extra-judicial hit squads. As human beings, we have a shared responsibility to ensure that this comes to an end. Just because people take drugs, or are behind bars, this doesn't abolish their right to be a person protected by the law – domestic and international.

***The global perspective offered by the* World Drug Report 2010**

In conclusion, this *World Drug Report* shows the various components of the drug market, and explains the dynamics that drive them. It confirms that drug policy must stay the course we have promoted at UNODC over the past years, focussed on the four basic rights of health, development, security and human rights.



Antonio Maria Costa
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INTRODUCTION

Drug control has been on the global agenda for more than a century. As documented in the *World Drug Report 2008*, the Chinese opium epidemic in the early twentieth century spurred concerted international action, chiefly in the form of a series of treaties passed over several decades. These treaties, in particular the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances, continue to define the international drug control system. The United Nations Office on Drugs and Crime (UNODC) is the guardian of these treaties and the United Nations lead agency on drug control.

In March 2009, Member States committed to elimination or significant reduction in the global illicit drug supply and demand by 2019 and emphasized that research, data collection and analysis were essential to support and monitor the efforts required to reach that objective. UNODC has provided comprehensive assessments of the global drug problems and their evolution annually since 1999, and will continue to fulfil its mandate this year with the publication of the *World Drug Report 2010.*

In order to prepare the *World Drug Report*, UNODC relies on Member States to provide data, primarily through the Annual Reports Questionnaire (ARQ). The ARQ was distributed to 192 Member States, and UNODC received 110 replies to the drug abuse section and 114 replies to the illicit supply of drugs section from Member States (and territories). In general, most countries' ability to provide information on illicit drug supply is significantly better than their ability to provide demand-related data. Despite commendable progress, for example in the area of prevalence estimates, far more remains to be done to provide a solid, reliable basis for trend and policy analysis.

The report includes in-depth and cross-sectoral analyses of transnational drug markets (chapter 1) as well as the latest statistical data and trends regarding the world drug situation (chapter 2). This year, the report also discusses the impact of transnational drug trafficking on transit countries (chapter 3).

EXPLANATORY NOTES

Types of drugs:

ATS – Amphetamine-type stimulants (ATS) are a group of substances comprised of synthetic stimulants from the amphetamines-group of substances, including amphetamine, methamphetamine, methcathinone and the ecstasy-group substances (MDMA and its analogues). In cases where countries report to UNODC without indicating the specific ATS they are referring to, the term non-specified amphetamines is used. In cases where ecstasy is referred to in enclosed brackets ('ecstasy'), the drug represents cases where the drug is sold as ecstasy (MDMA) but which may contain a substitute chemical and not MDMA.

Coca paste (or coca base) - An extract of the leaves of the coca bush. Purification of coca paste yields cocaine (base and hydrochloride). The term 'cocaine (base and salts)' is used to refer to all three products in the aggregate.

Crack (cocaine) - Cocaine base obtained from cocaine hydrochloride through conversion processes to make it suitable for smoking.

Heroin HCl (heroin hydrochloride) – Injectable form of heroin, sometimes referred to as 'Heroin no. 4'.

Heroin no. 3 – A less refined form of heroin suitable for smoking.

Poppy straw - All parts (except the seeds) of the opium poppy, after mowing.

Terms: Since there is some scientific and legal ambiguity about the distinctions between drug 'use', 'misuse' and 'abuse', this report uses the neutral terms, drug 'use' or 'consumption'.

Annual prevalence refers to the total number of people of a given age range who have used a given drug a least once in the past year, divided by the number of people of a given age.

Maps: The boundaries and names shown and the designations used on maps do not imply official endorsement or acceptance by the United Nations. A dotted line represents approximately the line of control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. Disputed boundaries (China/India) are represented by cross hatch due to the difficulty of showing sufficient detail.

Population data: The data on population used in this report comes from: United Nations, Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2008 Revision,* 2009.

Regions: In various sections, this report uses a number of regional designations. These are not official designations. They are defined as follows:

- East Africa: Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Mauritius, Rwanda, Seychelles, Somalia, Tanzania (United Republic of) and Uganda.
- North Africa: Algeria, Egypt, Libyan Arab Jamahiriya, Morocco, Sudan and Tunisia.
- Southern Africa: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.
- West and Central Africa: Benin, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Chad, Congo (Democratic Republic of), Congo (Republic of), Côte d'Ivoire, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone and Togo.
- Caribbean: Antigua and Barbuda, Bahamas, Barbados, Cuba, Dominica, Dominican Republic, Grenada, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines and Trinidad and Tobago.
- Central America: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama.
- North America: Canada, Mexico and the United States of America.

- South America: Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay and Venezuela (Bolivarian Republic of).
- Central Asia and Transcaucasia: Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.
- East and South-East Asia: Brunei Darussalam, Cambodia, China (including Hong Kong, Macao, and Taiwan Province of China), Indonesia, Japan, Korea (Democratic People's Republic of), Korea (Republic of), Lao People's Democratic Republic, Malaysia, Mongolia, Myanmar, Philippines, Singapore, Thailand, Timor-Leste and Viet Nam. The Greater Mekong Subregion (GMS) comprises Cambodia, the Lao People's Democratic Republic, Myanmar, Thailand, Viet Nam and Yunnan and Guangxi provinces in China.
- Near and Middle East/South-West Asia: Afghanistan, Bahrain, Iran (Islamic Republic of), Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Pakistan, Qatar, Saudi Arabia, Syrian Arab Republic, United Arab Emirates and Yemen. The Near and Middle East refers to a subregion which includes Bahrain, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, the Syrian Arab Republic, the United Arab Emirates and Yemen.
- South Asia: Bangladesh, Bhutan, India, Maldives, Nepal and Sri Lanka.
- East Europe: Belarus, Moldova (Republic of), Russian Federation and Ukraine.
- South-East Europe: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Romania, Serbia and Turkey.
- West and Central Europe: Andorra, Austria, Belgium, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.
- Oceania: Australia, Fiji, Kiribati, Marshall Islands, Micronesia, Nauru, New Zealand, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu and other small island territories.

EXPLANATORY NOTES

The following abbreviations have been used in this Report:

AIDS	Acquired Immune-Deficiency Syndrome
ARQ	UNODC annual reports questionnaire
ATS	amphetamine-type stimulants
CICAD	Inter-American Drug Abuse Control Commission
CIS	Commonwealth of Independent States
COP	Colombian peso
DAINAP	Drug Abuse Information Network for Asia and the Pacific
DEA	United States, Drug Enforcement Administration
DELTA	UNODC Database on Estimates and Long Term Trend Analysis
DIRAN	Colombian National Police – Antinarcotics Directorate
DUMA	Drug Use Monitoring in Australia
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and other Drugs
EUROPOL	European Police Office
F.O.	UNODC Field Office
GAP	UNODC Global Assessment Programme on Drug Abuse
Govt.	Government
HIV	Human Immunodeficiency Virus
HONLEA	Heads of National Drug Law Enforcement Agencies
IDS	UNODC individual drug seizures database
IDU	injecting drug use
INCB	International Narcotics Control Board
INCSR	International Narcotics Control Strategy Report (United States Department of State)
INTERPOL/ ICPO	International Criminal Police Organization
LSD	lysergic acid diethylamide
MDA	3,4-methylenedioxyamphetamine (tenamfetamine)
MDE	3,4-methylenedioxyethylamphetamine
MDMA	3,4-methylenedioxymethamphetamine
NGO	Non-governmental organization
NIDA	National Institute of Drug Abuse (USA)
OECD	Organization for Economic Co-operation and Development
ONDCP	Office of National Drug Control Policy (USA)
P-2-P	1-phenyl-2-propanone (BMK)
SACENDU	South African Community Epidemiology Network on Drug Use
SAMHSA	Substance Abuse and Mental Health Services Administration (USA)
SRO	safrole-rich oils
THC	tetrahydrocannabinol
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WCO	World Customs Organization
WDR	*World Drug Report*
WHO	World Health Organization
3,4-MDP-2-P	3,4-methylenedioxyphenyl-2-propanone (PMK)

Weights and measurements:

l	litre
g	gram
mg	milligram
kg	kilogram
mt	metric ton