This information package presents the results of an international study on cocaine executed by the World Health Organization (WHO) and funded by the United Nations lnterregional Crime and Justice Research Institute (UNICRI).

The material included does not represent the official views of WHO or UNICRI. Conclusions of the study require careful interpretation, particularly when making comparisons between different substances of their harmful health consequences. In no way should it be read that WHO or UNICRI endorse the use of any psychoactive substance. It is recognized that there are risks associated with the use of all such substances.

ACKNOWLEDGEMENTS

We would like to express our thanks to the United Nations Interregional Crime and Justice Research Institute (UNICRI) and to the generous contribution of the Italian Ministry of Interior.

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Introduction and Contents

Between 1992 and 1994 the World Health Organization Programme on Substance Abuse (WHO/PSA), in association with the United Nations Interregional Crime and Justice Research Institute (UNICRI), undertook the largest global study on cocaine ever. Through the WHO/UNICRI Cocaine Project, information was collected from 22 cities in 19 countries about how cocaine and other coca products are used, who uses them, what effects they have on the users and the community, and how governments have responded to the cocaine problem.

The information collected represents the largest body of current knowledge on cocaine use at a global level. This briefing kit contains information sheets which summarize the findings of the project. The complete findings of the study wilt be made available in a set of project documents and publications which will be released by WHO/PSA later in 1995.

The views expressed in these information sheets are those of the researchers who participated in the WHO/UNICRI Cocaine Project. They do not represent the official views or recommendations of the World Health Organization.

This Briefing Kit contains the following information sheets:

Summary Papers

Highlights

Summary Paper 1: Introduction & Background

Summary Paper 2: Project Methodologies

Summary Paper 3: Patterns of Use

Summary Paper 4: Consequences of Use

Summary Paper 5: Responses to Health Problems

Summary Paper 6: Conclusions

Summary Paper 7: Recommendations

Country Facts

Australia
Bolivia
Brazil
Rio de Janeiro (Brazil)
Sao Paulo (Brazil)
Canada
The Netherlands
Nigeria
Peru
Russian Federation
Spain
Sweden

Colombia
Ecuador
Egypt
Maldives
Mexico
Republic of Korea

United States of America
Flagstaff (USA)
New York (USA)
Providence (USA)
San Francisco (USA)
Zimbabwe

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3 March 1995

Highlights

• The WHO/UNICRI Cocaine Project is the largest study on cocaine ever undertaken. The study was made possible through the generous contribution of the Italian Ministry of Interior. The project produced:

- Country Profiles on Cocaine from 19 developed and developing countries;
- Key Informant Study reports from drug users and others with an extensive knowledge of cocaine use from 19 cities on almost every continent;
- A Natural History Study report on four sites in South America and Africa.

• The research methods developed for the project can now be used to collect information on cocaine in other countries and information on other drugs, and to monitor trends in the future.

• It is not possible to describe an "average cocaine user". An enormous variety was found in the types of people who use cocaine, the amount of drug used, the frequency of use, the duration and intensity of use, the reasons for using and any associated problems they experience.

• However, three general patterns of use were found across the participating countries:

1. The snorting of cocaine hydrochloride (by far the most popular use of coca products worldwide).
2. The smoking of coca paste and crack, and the injection of cocaine ' hydrochloride, are minority behaviours, and tend to be found among the socially marginalised.
3. The traditional use of coca leaves among some indigenous populations in Bolivia, Ecuador, Peru, northern Chile and Argentina as well as some groups in Brazil and Colombia.

• Generally cocaine users consume a range of other drugs as well. There appears to be very little "pure" cocaine use. Overall, fewer people in participating countries have used cocaine than have used alcohol, tobacco or cannabis. Also, in most countries, cocaine is not the drug associated with the greatest problems.

• Health problem; from the use of legal substances, particularly alcohol and tobacco, are greater than health problems from cocaine use.

• Few experts describe cocaine as invariably harmful to health. Cocaine-related problems are widely perceived to be more common and more severe for intensive, high-dosage users and very rare and much less severe for occa^s^ional, low-dosage users.

• A majority of health consequences may not be directly attributed to cocaine use. Cocaine often contributes to or exacerbates the conditions reported, rather than causing them.

• There are widespread myths bet few scientific studies of the relationship between cocaine and sexual behaviour. One finding was that sexual problems seem to occur among high-dosage regular cocaine users.

• A range of mental health problems are associated with cocaine use, though they are mainly limited to high-dosage users.

• There is a complex relationship between cocaine use and crime, particularly theft and violence.

• Use of coca leaves appears to have no negative health effects and has positive therapeutic, sacred and social functions for indigenous Andean populations.

• Responses to cocaine-related health problems are poorly coordinated, inconsistent, often culturally inappropriate and generally ineffective.

• Education, treatment and rehabilitation programmes should be increased to counterbalance the current over-reliance on law enforcement measures. They should not necessarily concentrate exclusively on cocaine, bet should be integrated into a mix of strategies to deal effectively with a range of drugs.

• In many settings, educational and prevention programmes generally do not dispel myths bet sensationalize, perpetuate stereotyping and misinformation.

• Most treatment services are poorly coordinated, often being culturally inappropriate and ineffective in achieving rehabilitation. Those most likely to be denied access when seeking treatment are the poor and heavily dependent.

• In most settings, people who have enough money to pay for cocaine - and who are familiar with a supplier - are able to obtain the drug despite its illegality.

• In many settings, cocaine users complained about the level of corruption among law enforcement officials and alleged abuses of human rights. Users made it clear that such abuses and exploitation would generally not be effective in changing their drug use behaviour.

• Coca paste use may be increasing in Andean countries and crack, use appears to be increasing in Nigeria and Brazil.

• Cocaine injection rates appear to be relatively stable and at low levels relative to the injection of other drugs.

• Most countries believe there needs to be more assessment of the adverse effects of current drug policies and strategies.

• Some countries have shifted the focus of their drug policy to a broad range of goals in which abstinence is appropriate for non-users and some users of coca products, while other users are encouraged to use the drug as safely as possible.

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Background

The WHO/UNICRI Cocaine Project is the largest study on cocaine ever undertaken. Between 1992 and 1994, information was collected from 22 sites in 19 countries about how cocaine is used, who uses the drug, what effects cocaine has on users, and how governments have responded to cocaine use. From the coca leaf chewers of the Andes to the crack smokers of New York and Lagos, from cocaine injectors in Sao Paulo and San Francisco to cocaine sniffers in Sydney and Cairo, the project has examined cocaine use and users across a broad spectrum of cultures.

1.1 Beginnings

The WHO Initiative on Cocaine was announced by Dr Hiroshi Nakajima, Director-General of the World Health Organization in a speech to the World Ministerial Summit to Reduce Demand for Drugs and to Combat the Cocaine Threat, in London in April 1990. Dr Nakajima stated clearly that this initiative, along with much of WHO's work in the area of psychoactive substance use, was focused specifically on demand reduction rather than on law enforcement measures which attempt to reduce illicit drug supplies.

The initiative was developed by the WHO Programme on Substance Abuse (PSA) during a series of meetings in 1991 in collaboration with the United Nations Interregional Crime and Justice Research Institute (UNICRI). The WHO/UNICRI Cocaine Project was designed to collect up-to-date information on patterns and trends in cocaine use and related problems from a selection of countries around the world, and to investigate the effectiveness of policies and strategies which address cocaine-related problems.

1.2 Participating countries

Countries taking part in the project (see Table 1.1) were placed in the following categories:

Type I: Countries which grow coca or process coca products and which now have cocaine-related problems;
Type II: Non-producing countries which have substantial numbers of cocaine users and cocaine-related problems;
Type III: Countries in which cocaine use and problems are not so widespread, but are causing increasing concern;
Type IV: Countries in which cocaine use has not appeared as a major problem

Table 1.1

Type I	Type II	Type III	Type IV[1]
Bolivia	Canada	Australia	Egypt
Brazil	Mexico	Italy	Maldives
Colombia	USA	Netherlands	Nigeria
Ecuador		Spain	Republic of Korea
Peru		Sweden	The Russian Federation
			Zimbabwe

Such a broad mixture of countries has never before been studied together in a drugs-related research project. Participating countries included both developed and developing, and included countries on all continents except Antarctica. The project's reports allow nations with major cocaine-related problems to learn from countries with fewer problems and vice versa.

1.3 Types of coca products

Throughout these summary papers, several coca products are mentioned.

Cocaine is often used to refer to all coca products, especially when used in the phrase "cocaine-related problems". When used with the other terms below, *cocaine* refers to cocaine hydrochloride, the while powder form of cocaine prepared from coca leaves. It is water soluble and burns at a very high temperature: this allows it to be snorted, swallowed or injected, but not smoked.

Coca leaf refers to leaves of the coca bush, of the genus *Erythroxylum,* which are chewed/sucked, used as an infusion or smoked by some groups in Andean countries.

Coca paste is a paste prepared from coca leaves as part of the process of manufacturing cocaine hydrochloride. It is not soluble in water, though it is soluble with kerosene or petrol, and is usually smoked with tobacco or cannabis. It is almost exclusively found in South America.

Crack or cocaine freebase is a brown or beige crystal produced by heating cocaine hydrochloride with other chemicals. It is smoked and has become very popular in North America.

1.4 Summary Papers

There are seven Summary Papers in this series to provide some insights into this important and innovative research project and its major results:

1. Introduction and Background

2. Project Methodologies

3. Patterns of Use

4. Consequences of Use

5. Responses to Health Problems

6. Conclusions

7. Recommendations

In addition, a range of site and country summary reports is included.

Project Methodologies

The WHO/UNICRI Cocaine Project has broken new ground in the way it has collected information across national borders, across cultures and across subcultures. More. than 40 leading researchers from around the world were involved in designing and implementing the project. Due to the difficulty in obtaining reliable information on a sensitive topic such as cocaine use, the project has used a range of methods for collecting information, including in-depth interviews with hundreds of cocaine users and others; a review of the scientific literature; and an analysis of existing data from participating countries. Results of this research can also be used as baseline information so that any future repetition of the projects can provide information on trends over time.

The project involved three related research approaches, carried out from 1992 to 1994. These projects produced:

- Country Profiles on Cocaine from 19 countries;
- Key Informant Study reports from drug users and others with an extensive knowledge of cocaine use from 19 sites/cities;
- The Natural History Study report.

These reports attempt to synthesize a vast amount of information to provide the findings outlined briefly in these Summary Papers. The research methods developed for the project can now be used to collect information on cocaine in other countries and information on other drugs.

2.1 Country Profiles

The Country Profiles bring together a set of information that was often inaccessible in the past, allowing researchers, policy makers and others within each participating country to gain a clearer picture of the cocaine situation across their country. The profiles also provide a set of 19 national reports which al low governments to compare the cocaine situation in their country with the situation in other nations.

Researchers assembling the Country Profiles on Cocaine were asked to:

1. Describe the social and cultural context of cocaine use.
2. Present national data on rates and trends of cocaine use and related problems, and characteristics of cocaine users
3. Assess cocaine and its trends in relation to other substance use.
4. Describe health-related problems associated with each coca preparation (e.g.' coca leaf, coca paste, cocaine hydrochloride, crack) and the extent to which people with cocaine-related problems are using health care services.
5. Describe cocaine treatment procedures and services.
6. Describe activities designed to prevent cocaine use or related problems.
7. Describe cocaine control measures.

8. Identify issues for the future.

For many of the countries participating in the project, this was the first time that detailed answers were attempted to such complex research questions. One result of the project in several developing countries is the assembly of country profiles which may assist in the establishment of appropriate drugs data collection systems.

2.2 Key Informant Studies

The Key Informant Studies attempt to address the enormous variation which exists, for example, between coca leaf chewing in Bolivia and crack use in New York. These studies involved in-depth interviews with hundreds of cocaine users: people who can provide information from their own experience of using cocaine. In addition, the researchers interviewed a group they call "non-cocaine using intermediaries": people who have close contact with cocaine users. The third group interviewed were "professionals": people who work with cocaine users or work to prevent or resolve cocaine-related problems, in prevention and treatment settings, in government or in law enforcement.

Question areas for these interviews included:

- Demographic details such as age, sex, location, residence;
- Patterns of cocaine use;
- Availability of cocaine;
- Consequences of cocaine use;
- Responses to cocaine use.

These three groups of interviews were carried out in 19 sites (mostly cities) across the participating countries (see Table 2.1). Because a range of different interviews was carried out at each site, researchers are able to compare the answers of, for example, users and police to the same questions. This allows researchers to gain a more comprehensive picture of what it is like to use cocaine in these sites. It also allows researchers to learn about the myths and stereotypes which arise about cocaine use.

Many researchers involved with these studies note that the Key Informant Study provided them with the first opportunity to systematically collect information on patterns and consequences of cocaine use. Also, for some researchers, this was the first time they had asked questions of cocaine users, and this was felt to be a significant advance over previous methodologies. They plan to use similar studies to track drugs and drug use trends and new products, and to examine other drugs, regions and subcultures.

Table 2.1 The 19 sites of Key Informant Studies were:

North America	South America	Pacific
Flagstaff,Arizona (USA)	Cochabamba (Bolivia)	Sydney (Australia)
Mexico City (Mexico)	Lima (Peru)	
New York, NY, (USA)	Medellin (Colombia)	**Africa**
Providence, Rhode Island (USA)	Quito (Ecuador)	Harare (Zimbabwe)
San Francisco, California (USA)	Rio de Janeiro (Brazil)	Ibadan and Lagos (Nigeria)
Vancouver, British Columbia (Canada)	Sao Paulo (Brazil)	
Middle East	**Asia**	**Europe**
Cairo (Egypt)	Seoul (Republic of Korea)	Barcelona (Spain)
		St Petersburg (The Russian Federation)

2.3 Natural History Study

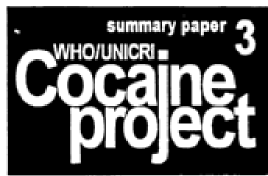
In this project, new qualitative techniques have been applied during both sampling and analysis to provide an in-depth study of the various coca products and methods of use. The project interviewed 311 cocaine users:

- 182 coca leaf and coca paste users and cocaine snorters in Cochabamba;
- 50 crack users and cocaine snorters in Ibadan;
- 43 crack users and cocaine injectors in Sao Paulo;
- 36 crack users and cocaine injectors in Rio de Janeiro.

Snowball and targeted sampling was used to recruit users of coca products to the study. Users were interviewed about their experiences, using a semi-structured questionnaire designed to collect information on sociodemographic and biographical aspects; history of the use of other drugs; the culture of use; the nature of use; contexts of use and supply; functions, effects and consequences of use.

In each of these centres, the project examined the natural history of cocaine use patterns, focusing on four groups:

- those who are in drug treatment and who mainly use cocaine;
- those who are not in drug treatment, who use cocaine or have a history of cocaine use, but where cocaine is used in the context of polydrug use;
- those who are not in drug treatment and who use cocaine
- a control group of those who are in drug treatment and who do not currently use, or have previously used, cocaine.



Patterns of Use

People across the Andes Mountains in South America discovered the stimulating properties of the coca bush 7000 years ago. The bush was cultivated and adapted to nearby environments, and the use of coca leaves was made sacred in the Aymara and Quechua cultures hundreds of years before the Inca conquest in the fifteenth century. During the Inca period, production and distribution of coca leaves were controlled by the state. Coca was used in rituals, as a state gift to faithful subjects and as a physical stimulant for work in the mines.

The main alkaloid of the coca leaf, cocaine, was isolated about 1860 and was synthesized to be used in manufacturing popular patent medicines, beverages and 'tonics", particularly in Europe, North America and Australia until the early years of this century. Concern about cocaine use began in many countries in the 1910s and 1920s, centred on dependence on the drug and subsequent "moral ruin", particularly among the young.

Laws restricting the availability of cocaine saw a drop in consumption in most of the countries surveyed from the 1920s until the 1960s. From that time, cocaine use, along with the use of many other now illicit drugs such as cannabis, became popular among young people in many developed nations and in the coca-producing countries of South America. Cocaine use has now also become popular in some developing nations in Africa.

The increasing attractiveness of cocaine in the past two decades may be related to:

- the "glamour" of illicit drug use in general;
- increased international travel;
- "zeitgeist": cocaine use fits the spirit of the fast-changing 1980s and 1990s;
- increased wealth allowing more people access to what they believe is the most glamorous of all illicit drugs;
- widespread poverty or social disadvantage in countries such as the USA at a time when cheap coca preparations like crack have become widely available.

3.1 Wide variation among users

One of the clearest findings of the WHO/UNICRI Cocaine project is that it is not possible to describe an "average cocaine user". Coca product users vary from traditional coca chewers in Bolivia and Peru, for example, to gay nightclub cocaine sniffers in Sydney, to coca paste-using sex workers in Colombia, to homeless young cocaine injectors in Mexico, to wealthy Nigerian crack users who are said to be in the 'last lane" of success.

Cocaine users are found in both sexes, in all ages from children to the very old, married and unmarried, across wide geographic areas, among all ethnic groups and across all socioeconomic classes. Some centres believe cocaine users are largely heterosexual, while reports from Sydney, Providence and St Petersburg note that cocaine use is common within homosexual and/or bisexual populations. Also, while most users are reportedly unmarried, sites such as Quito and Vancouver

suggest marital status has little or no bearing on cocaine use. More people use cocaine in urban areas than in rural areas.

Participating countries outside North America and Spain report that many cocaine users tend to be young (20-35) and male. In most countries between 1 % and 3% of the population have ever tried cocaine: the exceptions to this are the USA, where 11 % have tried cocaine, and Peru where over 26% have chewed coca leaves (a similar rate is likely to be found in Bolivia but this information was not confirmed by researchers). The information from participating countries does not demonstrate an "explosion" of cocaine use throughout the world, but a "diffusion" of cocaine use to most countries has occurred.

An enormous range of difference was also found in the amount of drug used, the frequency of use, the duration and intensity of use, and the reasons for using. However, four general patterns of use are found across the participating countries.

3.2 Snorting cocaine

By far the most popular use of coca products worldwide is the snorting of cocaine hydrochloride. This is viewed as a glamorous leisure activity of the social elite in many countries. It is often associated with majority ethnic groups, the well-educated, "intellectuals" such as artists and academics, and wealthy professionals such as business managers.

Snorting cocaine was also most identified with casual, recreational, low-dosage users who take cocaine for leisure or diversion, at social gatherings or during sessions of sexual intercourse. Casual users often start taking cocaine because they believe it enhances their status, makes them more sociable, relaxed and stimulated. Cocaine is also sometimes used to obtain a specific effect in a specific situation, such as to stay alert or to increase energy, for example at nightclubs and dance parties. Most participating countries and sites did not report significant cocaine-relaxed problems among this group of users.

However, the majority of people in each participating country reject cocaine use, believing it to be harmful and morally weak, indulgent behaviour. The snorting of cocaine has increased in most of the participating countries in the past five years, but now appears to be stabilising or declining in the USA, Australia, Canada, the Netherlands, Spain and Mexico, but increasing in Brazil and Peru.

3.3 Smoking crack/paste

The second pattern involves the smoking of coca paste and crack. These are very much minority behaviours in the countries surveyed, and are mainly seen among the unemployed, the homeless, the poor and other minority and socially isolated groups such as sex workers and street youth. Users of these coca products are mostly seen as morally degenerate and delinquent, are often actively discriminated against, and are sometimes threatened with violence including death in some countries and sites.

Coca paste, referred to as *pasta, pasta basuca* or *basuco*, is almost exclusively used in South American countries, though it was reported in the Korean Key Informant Study. (While *basuco* is smoked in Quito, it is unclear whether it is exactly the same as the coca paste smoked elsewhere or a different product.) It is used by, for example, 3% of university students in Bolivia; 5.6% of the population in Peru, and around 1 % of the population in Ecuador and Colombia. Paste use appears most common among the young and unemployed who cannot afford to buy cocaine hydrochloride. It is said to involve daily use and often continuous and uncontrolled smoking. Therefore, it is often considered to be more harmful than cocaine snorting. Coca paste use may be increasing in Andean countries, in particular in Ecuador.

Crack is used extensively in some cities in North America. It is also reportedly used at low levels in many other countries: around two-thirds of the 19 sites reported crack use. While crack is usually manufactured from cocaine hydrochloride, reports from Sao Paulo refer to two different types of crack:

pedra, made from coca paste, and *casca*, made from cocaine hydrochloride. Generally crack is smoked in pipes but, in Barcelona, users refer to *en plata* or *chino,* which means "chasing the dragon" by burning the drug on a slip of aluminium foil and inhaling the vapours.

While sites such as Cairo, Cochabamba, Harare, Lima, Quito and Sydney report little or no evidence of crack use, it has recently become as popular as, or perhaps more popular than, cocaine snorting in centres such as Flagstaff, Ibadan, Providence, some sections of San Francisco and Sao Paulo. Other cities such as Mexico City, St Petersburg, Seoul, and Vancouver describe crack as a minor problem but a potential concern for the future.

The image of crack smokers in the USA and Canada is similar to that of coca paste smokers in South American countries. In both cases, the drug is believed to be highly addictive and associated with violent behaviour and criminal delinquency. Crack users are also often compared to cocaine injectors. Crack use is almost universally regarded as more harmful than snorting cocaine. In same centres, it is seen as more harmful than cocaine injection. Crack use appears to be increasing in Brazil and Nigeria, and among groups such as sex workers and opiate users in the Netherlands.

3.4 Cocaine injection

While intravenous injection of cocaine is reported by a majority of centres, injecting remains a minority practice in most sites outside the United States. Cocaine hydrochloride is infected either as a solution, or in a mixture or "cocktail" (e.g. combined with heroin as a "speedball" or with methadone). Cocaine injection is identified with the unemployed or other lower socioeconomic status groups and socially isolated populations such as street youth, sex workers and heroin injectors. A majority of respondents, including cocaine users themselves, see injecting as more likely to be problematic than cocaine sniffing, though Sydney reports that problems are less common for homosexual nightclub users than they are for other groups such as sex workers and heroin injectors.

Injection is of particular concern due to the spread of blood-borne viruses such as HIV (the virus which causes AIDS) and Hepatitis B and C. These infections can spread via needle sharing and unsafe sex among injecting drug users, and from injectors to non-injectors. Drug injectors are extremely marginalised in most countries, and are regarded with contempt as "junkies". Injection rates appear to be relatively stable in the countries surveyed, and falling in some countries due to fears of being infected with HIV. There are isolated pockets such as Rio de Janeiro (Brazil) and Sao Paulo where cocaine injecting has become very common, though a move to crack use now appears to be gaining popularity in these centres.

3.5 Coca leaves

The final pattern is the traditional chewing of coca leaves among various indigenous populations in Argentina, Bolivia, northern Chile, Ecuador and Peru as well as some groups in Brazil and Colombia. Coca cultivation is the basis of the subsistence economy of many peasant communities in Bolivia and Peru.

Consumption of coca leaf is fully integrated into the Andean cultural tradition and worldview. For most users, coca leaf retains its sacred character. Its main uses are:

- increased energy for work and to fight fatigue and cold: while it reduces the sensation of hunger, coca leaf is not considered a food;
- medicinal:, in infusions, syrups and poultices to diagnose and treat culturally delimited diseases, considered to have supernatural causes, which express interpersonal conflicts or conflicts within social structures;
- sacred: to communicate with the supernatural world and to obtain its protection, especially in offerings to Pachamama, a personification and spiritualization of the Earth;

- social: to maintain social cohesion and cooperation between community members, used in all community ceremonies, reciprocal exchanges of work and sociability relations.

The traditional method of using coca leaf, called *acullico*, consists of keeping a saliva-soaked ball of coca leaves in the mouth together with an alkaline substance that assists in extracting cocaine from the leaves. Preparing the bal] takes 10 to 20 minutes, after which the ball is sucked for two to three hours. During work, *acullico* structures periods of work and rest. In a normal day, three balls would be used (equivalent to 25 grams of coca leaf). If the work takes longer or is more arduous than usual, more leaves will be used.

Both men and women perform *acullico*. Use is very stable, beginning in adolescence when starting work and may not be interrupted throughout life. In towns, consumption is less and the traditional culture of the coca leaf is adapted to modern society. As a result of these processes, some traditional uses have become irrelevant or have been lost.

3.6 Less common cocaine patterns

One report from Harare suggested that cocaine could be drunk in solution. Reports of oral use like this are vague and are often based on speculation rather than observation. Cochabamba reports the use of cocaine in the form of eye drops and nasal drops. Reports from Cochabamba, Mexico City, New York and Sydney refer to applications of cocaine to genital mucous membranes during sex to delay or prolong orgasm.

3.7 Cocaine and other drugs

Generally cocaine users consume a range of other psychoactive drugs as well. There appears to be very little "pure" cocaine use, and few people initially experiment with cocaine: most cocaine users have a prior history of drug use, and often an extensive history of polydrug use. Globally, cocaine users tend to smoke tobacco and drink alcohol, frequently smoke cannabis, and, to a lesser extent, take benzodiazepines and other illicit drugs. Countries such as Australia, Brazil, Canada, Mexico, The Netherlands, Spain, Sweden and Zimbabwe note the use of alcohol with cocaine either to moderate the effects of cocaine or to reduce negative after-effects. These and other countries report the use of cannabis to reduce negative cocaine reactions. Australia, Nigeria, and The Russian Federation report that alcohol and tobacco are used with cocaine to enhance the pleasurable effects of the drug.

Australia and The Republic of Korea note the use of amphetamine and cocaine together to enhance the effects of each drug, and The Netherlands reports the use of "speedballs", a combination of heroin and cocaine injected together. In South American countries, coca paste is often smoked with tobacco or cannabis, with alcohol, and sometimes with hallucinogens. The majority of coca leaf chewers in Peru do not use it with any other substances, while about a third regularly mix it with alcohol and tobacco use.

Overall, fewer people in participating countries have used cocaine than have used alcohol, tobacco or cannabis. Also, in most countries, cocaine is not the drug associated with the greatest level of harm. Other illicit drugs viewed as more problematic than cocaine are amphetamines (Australia, Brazil, Republic of Korea, Sweden), inhalants (Bolivia, Brazil), benzodiazepines (Brazil), heroin (Egypt, the Maldives), "cheaper and more available drugs (The Russian Federation). The general public in most of the countries surveyed are reportedly poorly informed about cocaine-related harm or drug-related harm in general: specifically, there is little knowledge about the role played by drugs such as alcohol in causing problems usually associated with cocaine use.

3.8 Continuum of use

A continuum can be identified for cocaine use, ranging from experimenting with low doses of cocaine once or twice with often no negative consequences, to compulsive or dysfunctional use which usually results in serious relationship, work, legal and health problems. Although the consequences of cocaine

use are provided in more detail in Summary Paper 4, a brief description of this continuum of use appears below. It should be noted that this continuum does not apply to the chewing of coca leaves.

3.8.1 Experimental use

Low doses of cocaine are tried one to several times on an intermittent basis, often among younger people such as adolescents and young adults. Other drugs, such as alcohol and cannabis, are often tried prior to cocaine being used.

3.8.2 Occasional use

This is the most typical pattern of cocaine use, in which the drug is used as an aid in social intercourse. Acute sensations such as euphoria, enhanced self-confidence and greater energy are experienced. Negative effects may include anxiety, irritation, panic attacks, as well as accidents and injuries which may occur due to the user's excitement and poor judgement. A mild withdrawal syndrome follows even small acute doses, usually comprising fatigue, depression and agitation. However, there are generally few problems associated with this pattern of use.

3.8.3 Situation-specific use

Cocaine is used to obtain a particular effect in a specific situation e.g. to focus attention or increase energy in some occupations, or to augment sexual performance. While this use is occasional, few problems are likely. But tolerance develops to the drug's effects if it is used often, requiring larger doses to maintain the desired effect and potentially leading to more frequent use.
Snorting cocaine is most identified with these first three categories though cocaine injecting and using paste and crack are also found in these types of use.

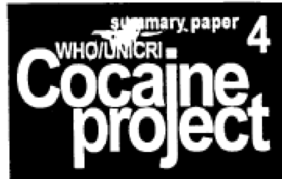
3.8.4 Intensive use

This is where cocaine use becomes an integral part of the user's lifestyle. It is similar to the next category, but the user is able to maintain a level of control, and social functioning is maintained. Intensive cocaine users and, to a lesser extent, occasional and situation-specific users, use rituals or rules to help them control their drug use. Intensive users are often reported to start taking cocaine because of peer pressure or as an escape from unfavourable circumstances. A majority of intensive users are reported to have a poor self-image and negative view of cocaine use. Injection, crack and coca paste use are also more identified with intensive cocaine users, though some snort cocaine.

3.8.5 Compulsive/dysfunctional use

An uncommon type of use is where some intensive users' lives become totally focused on obtaining and using the drug. High doses and routes of administration such as smoking or injecting (which can deliver a large amount of drug to the brain very quickly) combine to produce rapid and maximal effect. The drug is administered repeatedly in an attempt to maintain the initial effects of exhilaration and enhanced self-confidence.

This sequence, known as a "run", cannot be sustained and is followed by a period of physical and emotional exhaustion (the "crash"), a prolonged period of sleep, then fatigue and depression. The user often repeats the cycle to relieve the negative feelings from the crash. These compulsive or dysfunctional users often have serious relationship, work, legal and health problems.



Consequences of Use

Cocaine-related problems should be kept in perspective. In all participating countries, health problems from the use of legal substances, particularly alcohol and tobacco, are greater than health problems from cocaine use. Also, in many countries, chronic problems related to poverty, hunger, infectious diseases, war and social disorder overshadow any health problems related to cocaine use. Most participating countries agree that occasional cocaine use does not typically lead to severe or even minor physical or social problems, though there is evidence of increasing cocaine-related health problems in some parts of North America.

Because of the great differences between the ways that coca leaves and all other coca products are used and viewed, coca leaf chewing will be dealt with separately at the end of this paper.

4.1 Consequences and patterns

The intended consequences of using cocaine are euphoria, stimulation, confidence and, for some, enhanced enjoyment of sex. About 50-75% of cocaine users in each site surveyed for these reports said that using cocaine is harmless and beneficial to them. Cocaine-related problems are widely perceived to be more common for intensive, high-dosage users and either unknown or very rare for occasional, low-dosage users.

Occasional, high-dose users or binge cocaine users may be at risk of acute physical and mental health problems. Increases in problems also may be related to particular ways of using (such as smoking or injecting) and to general impoverished lifestyles.

4.2 Physical consequences

Few informants describe cocaine as invariably harmful to health. Use of cocaine leads to feelings of enhanced energy and may lead to greater stamina, confidence and creativity, though users have mixed feelings about the effect of cocaine use on work. The most common acute problem related to cocaine use is overdose, though these overdoses are often a combination of cocaine with other substances such as alcohol and minor tranquillisers. Death due to cardiac arrest is cited but it is very rare.

Negative physical consequences most commonly reported from cocaine use include: appetite and weight loss, sinus problems, perforated nasal septum, scarring and collapsed veins with injection, and cardiovascular, pulmonary or nervous system damage. Cocaine use in pregnancy has been associated with birth defects, including anecdotal accounts of deformed children.
Cocaine use is associated with impulsive acts which can lead to accidents. However, cocaine users are not thought to be generally at higher risk of accidents, with the possible exception of road accidents among high-dosage regular users who drive trucks.

The USA country profile notes there are widespread myths but few scientific studies of the relationship between cocaine and sexual behaviour. Respondents in two-thirds of the sites agreed that low doses of cocaine intensify sexual pleasure and performance and prolong orgasm, particularly in males. Most sites also report that males regularly offer cocaine to seduce females or (less often) other males, as it is thought to reduce inhibitions.

Some Barcelona and New York informants believe claims that cocaine use enhances sex are a myth. Reports from around half the sites stress that prolonged and high doses of cocaine can produce

diminished libido and impotence, though alcohol use may also play a role in this. Regular, high-dose male users reportedly encounter difficulty achieving erection and orgasm. A small number of centres such as Ibadan and Sao Paulo claim that cocaine regularly suppresses sexual behaviour. The sexual behaviour of users warrants fresh study to eliminate sexual and gender stereotypes.

Cocaine use is associated with increased rates of sexually transmitted diseases, and increased HIV transmission, both sexually and via needle sharing. Even occasional cocaine use can lead to impaired judgement, increased risk of unsafe sex, and chaotic sexual behaviour. Although rare, this behaviour can lead to the transmission of HIV or other sexually transmitted diseases. Also, the spread of HIV, Hepatitis B and C and other blood-borne infections is a particular concern among injecting cocaine users. Access to injecting equipment varies enormously across the participating countries, with the result that injectors in some areas consistently use new or cleaned needles and syringes while others face great difficulties in acquiring sterile equipment.

A majority of the health consequences above may not be directly attributed to cocaine use. For example, cocaine does not, in itself, induce weight loss. Rather, users may experience appetite loss or may lack sufficient resources to ensure a healthy diet. These factors would, in turn, foster undernutrition and weight loss. Cocaine often contributes to or exacerbates the conditions reported, rather than causing them.

Also, particular coca products may be linked with conditions not necessarily caused by cocaine use. Bolivian users of coca paste, for example, often have bronchitis, poor nutrition and tooth caries, but this may be due to the multiple products which make up the paste, or to its combination with alcohol and tobacco in *pitillos* and *tocos* (cigarettes and pipes of coca paste) or the precarious lifestyle led by many paste users. These findings raise important considerations for drug policy.

As well as negative physical consequences, the Key Informant Studies provide reports of positive effects. A few respondents in Cochabamba, Mexico City and Sao Paulo suggest that cocaine is sometimes used as an analgesic, usually for toothache. Anecdotal reports from Rio de Janeiro indicate that some women inject cocaine to relieve pre-menstrual tension or pain. Some respondents believe (wrongly) that cocaine is a useful contraceptive or prophylactic against sexually transmitted diseases. Some Sao Paulo and Sydney respondents claim cocaine use reduces alcohol intoxication and Harare and Sao Paulo informants report that taxi drivers, garbage collectors and other labourers use cocaine to increase work capacity and ward off sleep. Two respondents in Medellin indicate that coca products are used to treat "evil eye", a culture-specific disorder which is attributed to witchcraft.

4.3 Mental health consequences

A range of mental health problems are associated with cocaine use, though they are mainly limited to high-dosage users. Respondents in Flagstaff and Sao Paulo conclude that crack use is most likely to produce mental health problems. The Key Informant Studies found that cocaine users and intermediaries with a knowledge of the cocaine scene were less likely and professionals were more likely to report that cocaine influences mental health.

The most commonly mentioned mental health consequences of cocaine use include: paranoia (especially among crack users), memory loss, depression, anxiety, loss of cognitive skills or intellectual capacity, apathy, mood swings, aggression, social withdrawal and low self-esteem. A small number of respondents reported hallucinations, psychosis, sociopathy and obsessive-compulsive behaviour. While these conditions may be very problematic while they last, they are usually transient. Also, it is difficult to discover what role cocaine has in bringing on these mental health problems, and what roles are played by pre-existing psychological conditions and the use of other drugs.

Many respondents believe cocaine use has a negative effect on school studies and concentration, though opinion is; divided on cocaine's effects on creative or artistic ability. Overall, a slight majority of consultants and centres believe that short-term and low-dosage cocaine use enhances creative potential, but many others either disagree or have too little information to make a decision. Few

mentioned the types of artistic or creative endeavour with which cocaine might be linked, but Providence and Seoul reported the use of cocaine to enhance musical performance.

Long-term intensive use is also associated with psychotic symptoms such as delusions and aggression. The Canadian country profile notes that most cocaine users who experience serious or chronic problems are frequent users and that

only a minority of cocaine users exhibit patterns of use that could develop into more substantial difficulties. Cocaine users are reported to be involved in a disproportionate number of attempted suicides and, possibly, suicides. Domestic violence is reported among some cocaine users but, again, it is difficult to identify the specific role of cocaine use.

Cocaine dependence is another concern to health authorities. However, most respondents state that cocaine dependence is rare and that most cases involve drugs other than cocaine. Vulnerability to dependence is related to a range of factors, including intensity of use and form of coca product - with crack and coca paste being perceived as highly addictive - as well as personality characteristics such as self-esteem and self-control. Using other drugs together with cocaine increases the risk of dependence on one or more of the drugs being used.

4.4 Social consequences

The most frequently mentioned problem associated with cocaine use is a perceived increase in crime, particularly theft and violence. Cocaine use is said to disrupt families, contribute to unemployment or decreased productivity, promote juvenile delinquency, increase prostitution, and promote corruption (particularly within law enforcement agencies).

Crack and coca paste use are associated with violence, unemployment and social marginalization. What is not clear is whether the drug use causes unemployment and violence, or whether all of these social problems are caused by the often systemic or societal problems related to poverty and social marginalization.

The Key Informant Studies also show that the relationship between cocaine use and violence is very complex. Half of all centres profess no knowledge of a link between cocaine use and aggression, or state that informants hold very mixed opinions on this issue. Only Cairo, Flagstaff, Harare, Medellin, Quito and Seoul assert that cocaine use frequently promotes violence. More surprising is the disparity between what users and intermediaries say about violence and what is said by professionals. Users and intermediaries, who are generally stressing the positive aspects of cocaine use, are more likely to think cocaine use promotes violence. Professionals, who invariably stress the negative aspects of cocaine use, are least likely to associate use with violent behaviour. A majority of consultants in Barcelona, Cochabamba, Rio de Janeiro, Sydney and Vancouver conclude that cocaine consumption has no correlation with violent behaviour.

Legal problems are rated as more common and more severe for high-dose, long-term users but are uncommon among casual users. Chief concerns mentioned by informants are drug possession, trafficking or sale, or crimes (such as fraud, assault, robbery or sex work) committed to obtain funds to purchase cocaine. Consultants in Quito, Mexico City and Providence note that a user's ability to manage legal problems often varies with the user's socioeconomic status: arrest is common for poorer or minority users, while wealthier individuals and those with political influence are regarded as virtually immune from police action.

Obtaining cocaine and coca products in those countries where possession, use and supply are illegal poses many hazards including the potential for fraud, extortion or assault. The greatest threat to most users is the threat of police involvement. Coca products purchased on the "black market" are often adulterated or "cut" with a range of additives from sodium bicarbonate, aspirin, laxatives or amphetamines to sugar, flour, powdered milk and powdered brick.

Most respondents and centres report that cocaine use has a negative effect on the users financial status. Many also note that intensive and uncontrolled users face the strong possibility of dismissal

from work and long-term unemployment, leaving such users destitute. However, half of all centres state that financial effects vary depending on the characteristics of users and consumption patterns. For example, respondents in Vancouver report that occasional users suffer little or no financial distress even after many years of use. A few respondents pointed out that cocaine comprises a profitable industry for producers and distributors, and some communities.

Many countries find that cocaine use leads to negative effects on social interaction, with regular cocaine users becoming increasingly isolated, distrustful and focused on finding and using more cocaine. However, people may become intensive users **because of** social isolation and family problems. Informants in Barcelona, Providence, Sydney and Vancouver find that cocaine use has an extremely positive influence on social interaction, leading to occasional users being talkative, engaging and popular.

Similarly, while most centres state that cocaine use leads to breakdowns in relationships with family and friends, many informants believe occasional or controlled cocaine use has no consequences for these relationships. Some respondents note that families may be ashamed of users and reject them, while others suggest that intensive users may act in a more suspicious, aggressive or violent manner so that partners and family members may begin to fear and isolate the user. Flagstaff and Sydney users predict that partnerships are more vulnerable if both partners are cocaine consumers, due to the potential for competition for access to cocaine to provoke conflict.

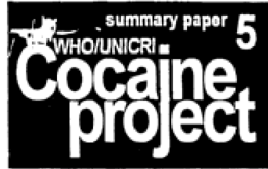
4.5 Consequences of coca leaf use

All users of coca leaf value its beneficial effects of additional energy and therapeutic uses, as well as its ritual and symbolic importance. Those users who form part of the traditional Andean culture stress its sacred culture.

Respondents in Cochabamba emphasize that indigenous peasants chew large quantities of coca leaves for decades yet manifest no ill effects from extended use. The Colombian report notes that the *acullico* habit (see 3.5 in previous summary (paper) has not been reported to lead to any noticeable mental or physical health damage. It is likely that similar results would be found for users of "natural" coca products such as chewing gum and tea bags.

Cochabamba informants note that coca provides a financial benefit to indigenous peasants by assisting them to enhance production in farming, fishing and mining. Medellin informants note that shamanic healers employ coca leaf in religious rituals specifically to intensify their powers.

While it is possible that there are some health problems associated with coca leaf use that are so far unrecognised, this seems unlikely. It may be of more interest to discover whether there are positive health effects from coca leaf chewing, and whether these effects are transferable from traditional settings to other countries and cultures.



Responses to Health Problems

Although many countries have developed comprehensive national drug strategies, the reality is that responses to cocaine-related health problems are poorly coordinated, inconsistent, often culturally inappropriate and generally ineffective.

These responses can be categorised as:

- prevention of cocaine use and cocaine-related problems, including education about the health and other effects of cocaine use;
- treatment of cocaine-related problems, especially those related to acute intoxication, binges and dependence;
- controlling the availability of cocaine through law enforcement, crop substitution and other efforts.

Many professional and intermediary consultants, as well as cocaine users, identify strict limitations to drug control policies which rely almost exclusively on repressive measures. Many key informants believe that current national and local approaches which over-emphasize punitive drug control measures actually contribute to the development of heath-related problems.

5.1 Prevention and Education

Despite a broad range of educational and prevention approaches, most programmes do not prevent myths but perpetuate stereotypes and misinform the general public. Such programmes rely on sensationalized, exaggerated statements about cocaine which misinform about patterns of use, stigmatize users, and destroy the educator's credibility. This has given most education campaigns a naïve image and has reduced confidence in the quality and accuracy of these campaigns. '

Activities to prevent problems related to cocaine use are almost nonexistent. Programmes to prevent the use of cocaine are minimal in most countries. In Brazil, for example, little is formally documented about the nature of prevention activities, which are carried out by nongovernmental organizations such as Rotary and Lions Clubs, churches, trade unions and so on. Fear-based mass media campaigns are carried out in Bolivia, Brazil, Colombia and Ecuador.

5.1.1 Mass media campaigns

The USA and Dutch country profiles differ radically in their overall approach to the use of mass media campaigns. The US researchers believe that newspapers, radio and television play an important role in reducing the demand for drugs. The Dutch report states that publicity campaigns have proved to be ineffective in preventing drug-related problems, particularly when they emphasize dangers, warnings or sensational 'facts". The Dutch have therefore rejected the mass media approach: information and education is provided to "at risk" groups by outreach and youth workers.

Many prevention campaigns are not based on an adequate understanding of the needs of the target groups. They often fail to recognise the need to involve members of the target audience in the planning, production and implementation of information and education materials.

Users of cocaine generally regard health and other relevant professionals as being ill-informed about the real nature and extent of cocaine-related problems. For example, health professionals interviewed

for this study were often unaware of the predominant patterns of cocaine use in combination with other drugs.

5.1.2 Education programmes

Education programmes need to be comprehensive and not just focused on cocaine or on illicit drugs. Comprehensive programmes avoid stigmatizing these drug users and encouraging cocaine users to simply switch to other drugs. Centres in Ibadan, Lima and Sydney identify many governmental and private agencies which sponsor national, regional and local educational campaigns.

Drug education is widespread in schools in some participating countries, but these efforts are not integrated with efforts outside school and their coverage and intensity are usually low. For example, only 20% of educational institutions in Colombia provide drug education, though the USA and several Australian States claim that virtually all schools have instituted drug prevention programmes.

The Dutch drug education system is unusual in that it can provide drug and alcohol education as part of general information to school students about healthy behaviours and social skills to equip them to cope with the risks of life in general. School students are expected to make responsible choices; organizations are expected to spend government funding responsibly by developing, implementing and evaluating health education programmes; and municipalities are expected to develop health promotion activities for the general public. Consequently, schools are free to decide how to carry out their own programmes.

5.1.3 Educational materials

A wide variety of education and information materials is mentioned in the reports from participating countries. These include the expected bulletins, pamphlets, booklets, books, advertisements, videos and magazines as well as the less common computer software, psychodrama on television, radio-programmes and jingles and periodic seminars. Most of these materials appear to be superficial, lurid, excessively negative and ineffective in reaching subgroups such as homosexual users, youths and pregnant women. Cultural irrelevance of education and information materials is a major problem, particularly the supply of materials from the USA in other countries without attempting to assess their cultural relevance or specific effectiveness.

There is a general lack of evaluation of the effectiveness of prevention activities. Even in developed countries where national coordination exists from drug education and prevention activities (such as Canada), little or no funds are allocated to evaluation. A majority of prevention campaigns are rated as poor or, at best, only moderately successful. Only professional consultants engaged in prevention describe prevention campaigns as successful. Some campaigns are regarded as tokenistic or politically motivated, and the use of outdated methods such as information-only approaches is common.

5.1.4 Prevention among special populations

Prevention of the spread of HIV among cocaine injectors is considered by several countries to take a higher priority than preventing any other problems associated with cocaine use. However, most countries provide no drug education to cocaine injectors, though information about not sharing needles is provided to the general public in several countries.

Education programmes for special populations such as prisoners and pregnant women are available in only a few countries. Australia, Mexico, the Netherlands and Peru provide education, usually on drug injecting and HIV/AIDS, to prisoners. Colombia, Mexico and The Russian Federation provide education to pregnant women, and work-based education programmes are reported in Australia, Colombia, Nigeria and the USA though coverage and intensity are not regarded as optimal.

5.2 Treatment

Most treatment services are poorly coordinated, often culturally inappropriate and ineffective in achieving rehabilitation. Unlike heroin - for which methadone is an acknowledged, effective management approach - cocaine dependence has no standard treatment. Virtually no countries offer specialized treatment for cocaine dependence or other related problems. Most participating countries have private treatment facilities available for wealthy cocaine users, and free or low-cost public or non-profit treatment services that are underfunded and overwhelmed by demand.

Cocaine users often cannot name any type or location of cocaine treatment. In general, the few cocaine users who seek treatment are motivated more by poor health, disrupted work and personal relationships, than by concern for legal consequences. Those most likely to be turned away when seeking treatment are poor and heavily dependent. The majority of people who suffer cocaine-related problems eventually recover without receiving any formal treatment.

5.2.1 Abstinence orientation

Formal treatment approaches tend only to try to make users stop using, rather than assisting users to reduce the harm from their cocaine use. These abstinence models are seen as inflexible by some key informants. Harm reduction efforts could include strategies to reduce or control drug use, or to snort cocaine rather than use crack or coca paste or inject cocaine. Most treatment services rely on detoxification, psychotherapy and counselling to promote rehabilitation. A few programmes offer broader treatment services such as pharmacotherapy, group or family therapy, occupational, sports or physical therapy, behaviour modification and spiritual counselling.

Acupuncture is available at more than half the 19 sites surveyed, as are a range of non-medical services such as religious communities, faith healing and indigenous treatment options in centres such as Cochabamba, Ibadan, Medellin, Rio de Janeiro, Sao Paulo and St Petersburg.

Compulsory or involuntary treatment is common: most users being treated for cocaine use are compelled to enter treatment by police or courts, or coerced by family and friends. The effectiveness of these approaches needs to be investigated. Accessibility of services to women and socially disadvantaged groups such as the homeless, street youth and sex workers is poor in many countries.

No single treatment is effective for problems associated with cocaine use. Services need to take an integrated approach, and provide a range of options which individual cocaine users will find helpful. Some countries have outlined a coherent model structure of treatment services, as follows:

1. Hospital accident/emergency units.
2. Detoxification services.
3. Ambulatory care centres.
4. Inpatient treatment centres (psychiatric hospitals, specialist substance abuse treatment centres).
5. Therapeutic (often drug free) communities.
6. Social rehabilitation/self/help groups

For most countries, this is clearly an idealised structure, and drug treatment services are consistently described as poorly coordinated, under-resourced with equipment and materials, and lacking appropriately trained staff.

5.2.2 Training issues

Virtually all sites report that treatment staff lack adequate training and expertise in cocaine and drug treatment. Many professionals engaged in treating users are regarded by key informants as uninformed about the spectrum of cocaine use and the best approaches for treatment, so that those engaged in care have little insight into the true range of patterns and consequences of cocaine use.

Abuse of those in treatment is found in more than 25% of participating countries, with abuses including financial and sexual exploitation, neglect, assault and psychological abuse. Some treatment centres are overzealous in their application of major psychiatric drugs, major tranquillisers such as phenothiazines, and tricyclic antidepressants. While some pharmacological treatments, e.g. benzodiazepines, can assist in cocaine withdrawal and help manage craving, more research is needed into their appropriate use. Research is also needed to develop new pharmacological agents for this purpose.

The role of self-help groups such as Narcotics Anonymous is seen as valuable in some countries but generally ignored in others. However, many informants assert that self-help groups emphasizing a religious orientation alienate or antagonize a number of potential beneficiaries. The role of non-professionals in treatment, especially ex-users, is unclear. Programmes based on religious models or beliefs are widespread, though their effectiveness is often not evaluated or critically examined, and is therefore unknown.

Cocaine treatment for prisoners is often different to treatment offered to the rest of the community. Several countries have no cocaine treatment for prisoners and, where such services do exist, they are minimal. Programmes typically involve work-based activities like police or State-run farms, sometimes combined with a therapeutic community with supportive counselling from professionals or volunteers (often clergy), and self help groups.

5.3 Availability and Supply Control

Most people who have enough money to pay for cocaine and related products - and who are familiar with a supplier - are able to obtain the drug despite its illegality in most of the countries surveyed. Possession, use, sale, supply, trafficking, importing and production of cocaine, coca paste and crack is illegal in all participating countries except Bolivia, Colombia, Peru, The Russian Federation and Spain where possession of small amounts for immediate personal use is not penalized. Possession and use of coca leaves is legal in Bolivia, and in Peru above 1000 metres.

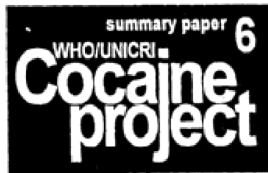
Cocaine is occasionally obtained through gifts or barter for merchandise or sex. Obtaining cocaine and coca products in those countries where possession, use and supply are illegal poses many hazards including the potential for fraud, extortion or assault. The greatest threat to most users is the threat of police involvement. Coca products purchased on the "black market" are often adulterated or "cut" with a range of additives.

5.3.1 Law enforcement

Law enforcement targets users, dealers and traffickers but is thought to focus its efforts on users. Users of minority background or low socioeconomic status are the ones most subject to arrest and prosecution, while wealthier users are virtually immune to prosecution or rarely imprisoned.

Prohibitionist drug policy and enforcement are viewed as repressive and ineffective and police are widely regarded as corrupt. Law enforcement activities are likely to encourage corruption, violence, the adulteration of coca products, and "black market" activities. In many countries, there is a large discrepancy between law enforcement and health authorities about the risks of cocaine use. Education of police should be part of comprehensive drugs training programmes for professionals.

In many sites, cocaine users made complaints about the level of corruption among law enforcement officials and alleged abuses of human rights. Users made it clear that such abuses and exploitation would generally not be effective in changing their drug use behaviour.



Conclusions

6.1 Methodology

The WHO/UNICRI Cocaine Project is the largest study on cocaine ever undertaken. The project used a range of methods for collecting information, including in-depth interviews with hundreds of cocaine users and others; a review of the scientific literature; and an analysis of existing data from participating countries. The research methods developed for the project can now be used to collect information on cocaine in other countries and information on other drugs. These projects produced:

- Country Profiles on Cocaine from 19 countries;
- Key Informant Study reports from drug users and others with an extensive knowledge of cocaine use from 19 cities;
- the Natural History Study report from four sites.

For many of the countries participating in the project, this was the first time that detailed answers were attempted to complex research questions on drug-related topics. In several developing countries, the assembly of country profiles assisted the establishment of appropriate drugs data collection systems. Many researchers involved with these studies note that the Key Informant Studies provided them with the first opportunity to systematically collect information on patterns and consequences of cocaine use. They plan to use similar studies to track drugs and drug use trends and new products, and to examine other drugs, regions and subcultures.

6.2 Patterns

One of the clearest findings of the WHO/UNICRI Cocaine project is that it is not possible to describe an "average cocaine user". An enormous range of difference was found in people who use cocaine, the amount of drug used, the frequency of use, the duration and intensity of use, and the reasons for using. However, three general patterns of use are found across the participating countries":

1. By far the most popular use of coca products worldwide is the snorting of cocaine hydrochloride. Most participating countries and sites did not report significant cocaine-related problems among this group of users.
2. The smoking of coca paste and crack, and the injection of cocaine, are very much minority behaviours in the countries surveyed, and are mainly seen among the unemployed, the homeless, the poor and other minority and socially isolated groups such as sex workers and street youth. Users of these coca products are often seen as morally degenerate and delinquent.
3. The final pattern is the traditional use of coca leaf among various indigenous populations in Argentina, Bolivia, northern Chile, Ecuador and Peru as well as some groups in Brazil and Colombia. Consumption of coca leaf is fully integrated into the Andean cultural tradition and worldview. For most users, coca leaf retains its sacred character. Its main uses are for increased energy, and for medicinal, sacred and social functions.

Generally cocaine users consume a range of other drugs as well. There appears to be very little "pure" cocaine use, and few people begin their drug use careers with cocaine: most cocaine users have a prior history of drug use, and often an extensive history of polydrug use. Overall, fewer people in

participating countries have used cocaine than have used alcohol, tobacco or cannabis. Furthermore, in most countries, cocaine is not the drug associated with the greatest problems.

A continuum can be identified for cocaine use, which includes:

- experimental use
- occasional use
- situation-specific use
- intensive use
- compulsive/dysfunctional use

Experimental and occasional use are by far the most common types of use, and compulsive/dysfunctional is far less common. Compulsive or dysfunctional users often have serious relationship, work, legal and health problems.

6.3 Consequences

In all participating countries, health problems from the use of legal substances, particularly alcohol and tobacco, are greater than health problems from cocaine use. Also, in many countries, chronic problems related to poverty, hunger, infectious diseases, war and social disorder overshadow any health problems related to cocaine use. Most participating countries agree that occasional or experimental cocaine use does not typically lead to severe or even minor physical or social problems.

The intended consequences of using cocaine are euphoria, stimulation, confidence and, for some, enhanced enjoyment of sex. Few informants describe cocaine as invariably harmful to health. Cocaine-related problems are widely perceived to be more common for intensive, high-dosage users and either unknown or very rare for occasional, low-dosage users. However, an apparent paradox lies in the finding that greater levels of cocaine-related problems can arise at the same time that overall levels of use are falling. This increase in problems may be related to changes in the route of administration, or to an increase in cocaine use by marginalized groups while cocaine use is falling among wealthier people.

Negative physical consequences most commonly reported from cocaine use include: appetite and weight loss, sinus problems, perforated nasal septum, scarring and collapsed veins, and cardiovascular, pulmonary or nervous system damage. There are widespread myths but few scientific studies of the relationship between cocaine and sexual behaviour. Cocaine use is associated with increased rates of sexually transmitted diseases, and increased HIV transmission, both sexually and via needle sharing.

A majority of these health consequences may not be directly attributed to cocaine use. Cocaine often contributes to or exacerbates the conditions reported, rather than causing them. This raises important considerations for drug policy and suggests a need to reassess the process for conducting clinical evaluations of cocaine effects.

A range of mental health problems are associated with cocaine use, though they are mainly limited to high-dosage users. The most commonly mentioned mental health consequences of cocaine use include: paranoia (especially among crack users), memory toss and delayed response, depression (especially among coca paste users), anxiety, loss of cognitive skills or intellectual capacity, apathy, mood swings, aggression, social withdrawal and low self-esteem. A small number of respondents reported hallucinations, psychosis, sociopathy and obsessive-compulsive behaviour.

While these conditions may be very problematic while they last, they are usually transient. Also, it is difficult to discover what role cocaine has in bringing on these mental health problems, and what roles are played by pre-existing psychologica) conditions and the use of other drugs.

The most frequently mentioned problem associated with cocaine use is a perceived increase in crime, particularly theft and violence. Cocaine use is said to disrupt families, contribute to unemployment or decreased productivity; promote juvenile delinquency, promote corruption (particularly within law enforcement) and increase prostitution.

Crack and coca paste use are associated with violence, unemployment and social marginalization. What is not clear is whether the drug use causes unemployment and violence, or whether all of these social problems are caused by problems related to poverty and social marginalisation.

Use of coca leaves appears to have no negative physical effects and may have a therapeutic value as a tonic.

6.4 Responses

Although many countries have developed comprehensive national drug strategies, responses to cocaine-related health problems are poorly coordinated, inconsistent, often culturally inappropriate and generally ineffective. In view of the current low levels of cocaine problems in most countries key informants believe that the responses to existing cocaine problems should be integrated into the national and local responses to other substance-related problems.

The studies identified strict limitations to drug control policies which rely almost exclusively on repressive measures. Current national and local approaches which over-emphasize punitive drug control measures may actually contribute to the development of heath-related problems. An increase in the adoption of more humane, compassionate responses such as education, treatment and rehabilitation programmes is seen as a desirable counterbalance to the overreliance on law enforcement measures.

Despite a broad range of educational and prevention approaches, this project has determined that most programmes do not prevent myths but perpetuate stereotyping and misinformation in the general public. Most treatment services are poorly coordinated, often culturally inappropriate and ineffective in achieving rehabilitation. Those most likely to be turned away when seeking treatment are poor and heavily dependent.

Most people who have enough money to pay for cocaine and related products - and who are familiar with a supplier - are able to obtain the drug despite its illegality in most of the countries surveyed. Users of minority background or low socioeconomic status are most subject to arrest and prosecution, while wealthier users are virtually immune to prosecution or rarely imprisoned. Respondents were concerned about the level of corruption among law enforcement officials and alleged abuses of human rights. Users made it clear that such abuses and exploitation would generally not be effective in changing their drug use behaviour.

6.5 The future

Most authorities agree that it is unrealistic to expect to eradicate the use of cocaine and other drugs. However, if substance use wilt continue, harm from that drug use need not be inevitable. In most participating countries, a minority of people start using cocaine or related products, use casually for a short or long period, and suffer little or no negative consequences, even after years of use. This suggests it is possible to reduce, if not entirely eliminate, harmful cocaine use.

Predictions about future trends in cocaine use fall into two patterns. The first sees the use of cocaine stabilising or declining slightly, especially among the middle class. The second sees cocaine use spreading downwards from higher to lower social classes. Coca paste use may be increasing in Andean countries, in particular in Ecuador, and crack use has become as popular as or more popular

than cocaine snorting in centres such as Flagstaff, Ibadan, Providence, some sections of San Francisco and Sao Paulo. Yet, Cairo, Cochabamba, Harare, Lima, Quito and Sydney report little or no evidence of crack use.

Other cities such as Mexico City, St Petersburg, Seoul and Vancouver describe crack as a minor problem but a potential concern for the future. Crack use appears to be increasing in Brazil and Nigeria, and among groups such as sex workers and opiate users in the Netherlands.

Injection rates appear to be relatively stable in the countries surveyed, and falling in some countries due to fears of being infected with HIV. There are isolated pockets such as Rio de Janeiro (Brazil) and Sao Paulo where cocaine injecting has become very common, though crack use now appears to be gaining popularity in these centres.

The largest future issue is whether international organisations, such as WHO and the United Nations Drug Control Programme, and national governments will continue to focus on supply reduction approaches such as crop destruction and substitution and law enforcement efforts in the face of mounting criticism and cynicism about the effectiveness of these approaches. Countries such as Australia, Bolivia, Canada and Colombia are now interested in examining a range of options to legalize and decriminalize the personal use and possession of cocaine and other related products. There needs to be more assessment of the adverse effects of current policies and strategies and development of innovative approaches.

Another, related question concerns the implementation of a harm reduction approach to drug policy, prevention, education and treatment. In such an approach, focus shifts away from abstinence as the only goal, to a broad range of goals in which abstinence is appropriate for non-users and some users of coca products while other users not prepared to abstain are encouraged to use the drug as safely as possible. This approach is already government policy in several participating countries, and many other countries are considering ways in which risk reduction approaches can assist in the control of problems related to drug use.

Anticipating and managing negative consequences of substance use are only possible with accurate, relevant information about the motivations which drive drug use and the risk factors which predict harm. Comparisons between negative and positive consequences of cocaine use can assist in improving health by allowing "at risk" groups to make informed decisions about initiating or continuing use. Reducing risks also requires information on whether cocaine causes or merely compounds problems for people who are poor and socially marginalized. Another key factor to be explored is the cultural context in which cocaine use occurs to ensure that education and information materials are culturally relevant.

Finally, some countries call for fresh, sophisticated and objective research on the motivations underlying drug use; short-term and long-term consequences of cocaine use; alternative and more effective treatments for dependence; and use in rural areas.

Recommendations

7.1 General recommendations

1.1 WHO should encourage all Member States to ensure that cocaine issues are incorporated into comprehensive national drug strategies and health plans.

1.2 WHO should develop a programme of activities over a five-year period within a strategic framework aimed at reducing the level of cocaine-related harm throughout the world and for this to be reflected in the Work Plan of the Programme on Substance Abuse.

1.3 Within this proposed programme of activities, WHO should recognize South America as a priority region with particular attention to reducing adverse effects of smokable and injectable methods of coca product administration.

1.4 Within the proposed programme of activities, WHO should recognize a second priority to provide support and assistance to countries such as those in the West Coast region of Africa with demonstrated evidence of emerging problems related to coca product use.

1.5 As increases in domestic cocaine-related problems are related to changes in trafficking routes, WHO should establish, with the United Nations Drug Control Programme and other international organizations, a coordinated exchange of information on change in patterns of cocaine trafficking in order to identify early countries where cocaine-related problems are likely to develop or escalate.

1.6 WHO should encourage Member States to assess the impact of legislation and other drug control measures on health and social wellbeing in their countries.

7.2 Education and prevention recommendations

2.1 The aim of education about cocaine and related products should be to increase understanding about known high-risk patterns of cocaine use, in particular the intensity of use, drug combinations, and the potentially greater levels of harm associated with smokable and injectable methods of coca product administration.

2.2 Public education campaigns should be culturally appropriate and based on the results of sound research rather than myths and stereotypes about the nature and extent of cocaine-related health effects.

2.3 WHO should encourage demonstration projects with innovative approaches to the prevention of cocaine-related harm, particularly those which enhance health promotion activities of primary health care workers and which involve community participation. WHO should promote the development and implementation of strategies such as syringe exchange and safe sex measures to reduce specific health risks such as the transmission of infectious diseases.

2.4 WHO should encourage policymakers to place less reliance on mass-media information campaigns, especially those featuring exaggerated or sensationalist messages or campaigns which are culturally inappropriate.

7.3 Treatment recommendations

3.1 WHO should produce guidelines to promote better management of emergency care for cocaine users with acute adverse reactions and "best practice" approaches for longer term management of cocaine-related dependency.

3.2 In these guidelines, particular attention should be paid to the role of:

- pharmacological agents in the management of cocaine withdrawal and dependence;
- compulsory versus voluntary admission to treatment;
- therapeutic communities because of their widespread utilization;
- traditional or indigenous healing practices.

3.3 WHO should encourage governments at national, regional and local levels to create appropriate regulatory frameworks to ensure that all drug treatment services respect and protect the rights of their clients.

3.4 WHO should encourage Member States to examine cost-effective ways to increase access to existing drug treatment services for groups with special needs, such as prisoners, ethnic minorities, street children, sex workers and other socially marginalized groups.

7.4 Research and data systems recommendations

4.1 WHO/PSA should encourage Member States and other research bodies to adopt and implement the methodology used in the WHO/UNICRI Cocaine Project for undertaking cocaine and other drug research at the local level.

4.2 WHO/PSA should research the impact on health at individual and population levels of different legislation and drug control measures.

4.3 WHO/PSA should investigate the therapeutic benefits of coca leaf.

AUSTRALIA

Introduction

Australia's Country Profile (CP) and the Sydney Key Informant Study (KIS) reveal limited cocaine use and few use-related problems. Most are recreational cocaine hydrochloride users. Very few are intensive injecting users. Use tends to accompany a polydrug experience.

Patterns of Cocaine Use

The CP and KIS identify two patterns of cocaine. The first is recreational use and notably among higher socioeconomic groups. The second is more intensive use by injectors, mostly among lower socioeconomic groups. Sydney's KIS found minimal crack use. The majority are aged 20 to 34 and male. The CP also reports higher rates of experimentation with use among students and recreational drug users but heavier use among prison inmates, street youth and sex workers. The KIS suggests that most initiate use through friends, work colleagues or personal relationships. Data indicate low use prevalence. The CP reports the use frequency of once a month to once or twice a year for the general population at about 1%. Rates are comparable for males and females.
Polydrug use is common. Greater use prevalence was indicated for such substances as tobacco, alcohol, cannabis, and amphetamines. The KIS contends that polydrug use was much more prevalent among injectors while alcohol use is more strongly linked to intranasal users. Access is also a notable factor. Prevalence is higher in urban areas, particularly in state capitals. The geographic distribution for cocaine use is reproduced here from the CP.

Lifetime prevalence of cocaine use among the general population by city Australia, 1985-1991 (percentage data)

	Sydney	Perth	Melbourne	Adelaide	Brisbane	Hobart	Canberra	Darwin	Total
1985	6	3	4	3	4	1	5	10	3
1988	2	4	1	2	1	*	*	*	2
1991	5	2	3	4	4	1	4	5	3

* = not available
Source: Commonwealth Department o! Health, Housing, Local Government and Community Services, 1985 Social Issues Survey, 1988-1993 NCADA National Household Survey

The selection of Sydney as a KIS site was directly related to higher use rates in this location. The CP attributes limited supplies with lack of proximity to cocaine producing countries and trafficking routes. However, increases in drug seizures in 1992 and 1993 may signal efforts to establish a distribution site in Australia. However, both CP and KIS stress that cocaine remains scarce and costly, at AUS $150-400 per gram.

Consequences of Cocaine Use

Very few negative consequences were indicated in either the CP or KIS. Psychological complications are associated with use pattern. Higher income intranasal users exhibit few cases of depression or paranoia and a higher self image with use. Injectors evidence low esteem and more cases of aggression or withdrawal symptoms.

Outcome is similar for health. Reports agree that few problems are attributable solely to cocaine. Most effects are minor, such as dry mouth, enlarged pupils, sweating, increased and irregular pulse and respiration, excitability or irritability. More extreme complications may be noted for intensive polydrug injectors, including greater risk of infectious diseases including HIV. The CP indicates that cocaine injectors are much more likely than are noninjectors to be exposed to HIV through shared needles or unsafe sex. Both CP and KIS stress that users are well-informed on HIV and that needle exchange and condom use levels are high. Still, all cocaine users face risk from polydrug intoxication and unsafe sex. Nevertheless the CP found few serious complications from use in its review of mortality and morbidity indicators.

Responses

No cocaine-specific treatment programmes are available, though the CP notes a broad range of care for alcohol and other drug dependency, including public and private care which employ both psychosocial therapy and pharmacological intervention. Self-help groups such as Alcoholics Anonymous and Narcotics Anonymous were described. However, KIS consultants had little or no knowledge about care.

The CP outlines an extensive range of prevention literature from state and national publications. Many are issued by the Centre for Education and Information on Drugs and Alcohol in New South Wales (NSW) and the National Campaign Against Drug Abuse. Other guides target special user groups. Drug education is required in public schools and similar programmes are offered in private and religious institutions, though none offer a component specific to cocaine.

Legislation focuses on the Federal Crimes Act. It distinguishes between use, trafficking and commercial possession by quantity of cocaine seized. Commercial possession receives life imprisonment while trafficking draws 25 years. Small quantities and first time offences receive variable penalties. The CP indicates that NSW police policy is to direct users to treatment. Still, a few, KIS consultants report some sporadic cases of police harassment, especially of injectors.

Both the CP and KIS report that crack, freebasing and injecting are all minimal in Australia but recommend monitoring of these products and routes. Of primary concern is that Australia could become a trafficking route, increasing supplies and availability. The reports call for cocaine-specific treatment and prevention to compensate for potential growth in trafficking. KIS results spur recommendations to target HIV/AIDS intervention for at-risk populations such as sex workers and injecting cocaine users.

BOLIVIA

Introduction

The Cochabamba centre participated in the Natural History Study, and completed a Country Profile (CP) for Bolivia and Key Informant Study (KIS) for Cochabamba. Bolivia represents a key site for both production of coca and coca products and for traditional coca leaf chewing.

Patterns of Cocaine Use

Bolivia's Quechua and Aymara peasants have used coca since 12 000 BC. Controversy erupted after the Spanish conquest as to whether coca is a "divine plant" or "from the devil" but it did not pose legal problems until 1975. Cultivation and use of coca leaf for chewing and in wine, tea and toothpaste remains legal and widely accepted in the population. However, production and use of cocaine hydrochloride, coca paste and crack are illegal and socially disparaged.

The CP identifies six types of users. The first are Quechua and Aymara who chew leaf and exhibit no dependence or problems. The second are mine workers, of whom 96% chew leaf during work and ritual. Third is the "urban marginal population", rural migrants who enter urban slums and smoke coca paste intensively. A fourth comprises about 500 000 "working children and street children" aged 7 to 18. Fears limit their consumption level but children as young as 7 maybe users. The fifth includes urban professionals and others with stable incomes who are mostly recreational users. Lower economic tiers are more likely to smoke paste while the wealthier "sniff" hydrochloride. Some make ophthalmic, nasal or genital application for medicinal or sexual reasons but crack smoking and leaf chewing are quite rare in this group. The sixth group is based in Cochabamba, where the economic mainstay is the production of coca and "side products". Most residents here chew leaf but reject use of coca paste and cocaine hydrochloride.

Life-long, yearly and monthly prevalence of coca paste and hydrochloride in the population of 13 Bolivian cities: 1992 (Percentage Data)

	Coca Paste	Hydrochloride
At least once during his/her life	1.1	1.3
Yearly prevalence	0.2	0.1
Last month prevalence	0.1	0

Source: DINAPRE, 1992

Note: This table offers information for individuals aged 12-50. The sample includes populations of over 30 000 inhabitants only.

Users range in age from 6-80. Paste users tend to be young while leaf chewers may be older. Male users tend to predominate.

Consequences of Cocaine Use

The CP and KIS conclude that leaf chewers suffer no adverse consequences. The KIS notes that leaf is chewed daily during the working week. The effects of 7-10 gram doses last 2 to 3 hours. Use is curtailed on weekends and there are no signs of withdrawal.

Some urban nightclubs offer trays of leaves to patrons but here the ritual focus is lost. Even here, though, leaf chewers suffer no withdrawal and quantity and frequency of use does not increase over time. Women who chew leaf continue use throughout pregnancy and evidence no problems. Some KIS consultants report that sex workers smoke coca paste and claim that such use may affect pregnancy, offering anecdotal accounts of malformed children.

Problem use and dependence are reported only for coca paste and hydrochloride. The KIS notes that recreational users take about 3 grams of paste per day or 0.75-1 gram of powder per session. For these who develop a dependency, the frequency and dosage increase. The CP and KIS both report use of alcohol with cocaine to balance the effects of each substance. The KIS also reports ties between dependence and criminal behaviour as crime is undertaken to support use. The CP cites the difficulty in assessing cocaine-related health problems because most users engage in polydrug use. Data do not specify total treatment admissions exclusively or primarily for treatment of cocaine-related problems. However, CP and KIS indicate greater dependence on coca paste than for hydrochloride. Paste smoking is more likely to contribute to bronchitis, malnutrition, dental carries and interpersonal problems at home and at work.

Responses

Both the CP and KIS identify substantial problems with treatment. While there are numerous public and private services, these cover only 30% of the population. Bolivia has few psychiatrists and fewer still are trained to treat problems associated with cocaine use. Thus, many centres employ untrained staff. KIS informants knew little about services but felt that most are ineffective.

Various prevention programmes are reported, but the CP concludes that none are very effective. Most fail to coordinate their efforts and none are tailored to unique user populations.

Bolivia predicts that cocaine use will increase in the future. Consequently, effective prevention programmes are needed and should be coordinated for public education. Medical personnel should also be trained in cocaine issues to improve treatment outcomes.

Penalties for cocaine trafficking are 10-25 years imprisonment. Both CP and KIS report widespread police corruption. Many feel that only the "little fish" (small traffickers) are targeted while the "fat fish" (large-scale traffickers) are comparatively immune and can pay bribes to escape prosecution.

BRAZIL

Background

Brazil's Country Profile (CP) uses data from special population surveys of students, street children and patients, and research on sex workers and others. Broader population survey data are not available. Intranasal cocaine hydrochloride use predominates but cases of crack smoking appear among urban poor in areas such as Sao Paulo. Prevalence is attributed to Brazil's role as a trafficking route to the U. S. and Europe. Key Informant Studies (KIS) in Sao Paulo and Rio de Janeiro are summarized separately. Rio de Janeiro and Sao Paulo also participated at the Natural History Study.

Patterns of Cocaine Use

Student surveys indicate that cocaine users total less than 1% of the general student population, typically with intranasal use of 0.5 grams hydrochloride appearing among male students in their middle to late teens. Other forms of use such as crack smoking and injected cocaine hydrochloride were found among street children, especially in Sao Paulo, where lifetime prevalence of cocaine use among street children increased from 25.2% in 1987 to 46.3% in 1993. Past year cocaine use among Brazilian street children was reported at 15.6% for males and 20.1% for females in 1993.
Compared to alcohol, cannabis, inhalants and most other drugs, the use of cocaine is actually quite small. However, alcohol and cannabis are often used in combination with cocaine due to their greater prevalence in the surveyed populations. The CP notes that cocaine hydrochloride was initially used in a recreational manner among the higher socioeconomic classes, though use was considered socially unacceptable to the general population. Recent trends suggest increased use, including injecting, among the lower classes. The CP reports that injecting results from curiosity or from participation in illegal trafficking activities.

Hospitalizations cited in the profile indicate that cocaine admissions were dominated by males between the ages of 18 and 30. Larger numbers and increases in admissions occurred mainly for urban areas in southeastern and southern Brazil. Surveys point to a continued increase in cocaine use primarily in the major cities of Sao Paulo and Rio de Janeiro. This expansion includes growth in the frequency of injecting and crack smoking in Sao Paulo.

Consequences of Cocaine Use

The CP notes increases of Brazilian hospital admissions due to cocaine use. Nevertheless, such numbers are minor, in relation to admissions for alcohol-related problems. Larger percentages of cocaine complaints are reported in Rio de Janeiro and Sao Paulo. The majority of AIDS cases found in the Southeastern part of Brazil are also related to injecting of cocaine.

The CP directly attributes cocaine use to Brazil's status as a transshipment point for trafficking from Colombia and Bolivia to the United States and Europe. Socially, use remains unacceptable but trafficking has become a profitable industry for the very poorest residents of Brazil's urban centres.

Responses

The CP describes how the dynamics of responses to cocaine use in Brazil are impacted by the legal and political climate of the country. Primary drug laws outlaw trafficking and possession. However, more severe penalties exist for trafficking than for cases of possession. Trafficking draws a 25 year prison sentence while possession often results in mandatory treatment if a convicted offender is determined to be dependent. However, the profile outlines criticism of the law due to its lack of distinction between casual users, intensive users and traffickers.

Treatment programmes are handled in psychiatric hospitals or drug treatment clinics. Services offer broad treatment for drug problems and none are specific to cocaine. Additional treatment is available through therapeutic communities and at religious outpatient clinics. The profile notes that treatment varies from pharmacological to psychological to work-based and traditional or "folk religion" therapies. Most programmes are reimbursed or funded directly by the government.

The profile outlines a complex hierarchy of agencies which administer the National Policy on Drugs. Problems with this highly complex network have prevented the effective development of a national prevention and education programme. This has left prevention efforts in the hands of local religious, labour, or community groups since government approval is necessary to coordinate large-scale state or national programmes. Published materials are limited and CEBRID offers the only continuously published drug information bulletin in the country. Television campaigns were noted as heavily dependent on scare tactics. Most are developed in the United States and are not adapted to local audiences. Consequently, messages have little cultural relevance.

A primary issue for consideration raised in the CP is the heavy political focus on Brazil's position in the cocaine trade routes. Most political action is aimed at halting the trafficking problem throughout the country. External influence on policy (especially from the USA) prevents effective action on drug prevention and education. The CP also argues that highly exaggerated negative stereotypes promoted in media campaigns may actually heighten curiosity about drugs. The CP stresses a need to balance efforts in treatment and prevention with the trafficking focus.

RIO DE JANEIRO (BRAZIL)

Introduction
The Rio de Janeiro participating centre completed a Key Informant Study (KIS) and contributed to the Brazil Country Profile which is summarized separately. A key feature of the Rio KIS was the disparity between the wider population and the poor in Rio's 600 "favelas" or slums. About one-third of Rio's 6 million residents live in slums. Drug use and trafficking reflect social and economic disparities. Dependence and other complications from cocaine injection were common and slums are centres for trafficking.

Patterns of Cocaine Use
The Rio KIS identifies four patterns of cocaine use. The first is "recreational” where use focuses on social activity. "Hedonistic-Transgressor" use is attributed to social rebellion. "Commercial" use refers to involvement in trafficking. Finally "dysfunctional" use reflects intensive and dependent or problem use. Cocaine use predominates among members of middle or upper middle classes and students and among poor residents of the favela slums. Cocaine hydrochloride is the main product employed and intranasal use dominates. Injecting is rarer and associated mainly with slums. Anecdotal reports indicate that some women inject cocaine to relieve pre-menstrual tension or pain. Users often join networks. Most are males with varied education levels. Most use begins in the mid-teens out of curiosity and peer influence. Most use is considered recreational, taking place at dancing parties or discos. Average use was said to total 2 to 3 grams per week. KIS professional consultants felt that dependence fosters continued use while User and Intermediary consultants suggest that pleasurable effects promote more use. Cocaine effects were described as euphoria, excitement and power, and depression as the effects wear off Alcohol is commonly used to enhance or reduce these effects. Pleasant sensations encourage continued use and intensification of use.

While males predominate, other groups were also described. Some felt that women use less cocaine but become masculine, which in turn influences their sex drive. Children use occurs when they work as go-betweens for traffickers. Street children were also said to use cocaine.

Cocaine is widely available and use is limited only by police action or lack of money. Only cannabis and alcohol are more accessible. Most purchases are made through dealers in the slums. Cocaine is sold in small parcels with an average cost of US $10.00. Crack is uncommon. Groups contribute money for purchases, or theft and wages from trafficking are used to fund purchases. The quality of hydrochloride varies substantially and consultants agreed that cocaine is invariably cut with substances such as sugar, salt, starch, marble powder, baking soda, or boric acid.

Consequences of Cocaine Use
Consultants agreed on the broad negative influence of cocaine on the community. The disparity between the general public and the favelas was noted by an acceptance of use and trafficking in slums. The main impact is on work, study and finances. Health effects were noted as weight loss, respiratory problems and fatigue. Some mental health problems were reported, including emotional instability, paranoia and tension. Aggression associated with withdrawal was said to strain family and social ties. Consultants disagreed on the effects of cocaine on sexual drive. Users and intermediaries indicated an increase in sex drive with use while professionals note a decrease. Much of this variation reflects distinctions between recreational and intensive use. However, there was an indication of lowered inhibitions which might promote homosexual or group sex activity. Lowered inhibitions may contribute to an increased risk of HIV/AIDS through unsafe sex. Some also described concerns about

needle sharing among injecting drug users. Professionals noted that the number of injecting drug users with HIV infection in Rio is increasing.

Responses

Several treatment services were noted, including psychological support facilities, self help groups, outpatient and residential services. Consultants indicated that most clients are intensive or heavy users. Facilities are staffed by health professionals, religious members, social workers, or ex-users who performed as counsellors. Some claim staff exploitation of patients is common.

Laws against trafficking and possession were described as largely ineffective and corruption is seen as rampant. Respondents suggested that some police run the drug market. Most recommended more severe Laws and enforcement against traffickers but feit cocaine use should be subjected to less stringent Laws.

Prevention programmes were considered ineffective. Most are media programmes produced in the United States and have no relevance for Brazilian culture. Programmes appear hypocritical as they focus on illicit drugs but ignore alcohol and tobacco. Recommendations suggested school-based programmes with better trained educators and culturally-relevant and realistic campaigns.

SAO PAULO (BRAZII.)

Introduction
Brazil's Country Profile (CP) is summarized separately. The Sao Paulo Key Informant Study (KIS) identified a larger group of crack users than is found in other regions. While other cocaine products are available, crack's low cost and wide availability contribute to its extensive use among Sao Paulo's large population of urban poor. Moreover, crack smoking is viewed as a "clean" alternative to the HIV/AIDS risks of injecting.

Patterns of Cocaine Use
The primary coca products reported by KIS consultants were cocaine hydrochloride ("powder") and crack. "Powder" is generally inhaled and used mainly by young, wealthy or middle class males. Of note, one consultant familiar with the prison system reported that injection is favoured and virtually endemic among prison inmates. Few other consultants describe extensive intravenous use of cocaine. Crack was identified as a highly popular product among the urban poor in "favelas" or slums. Cocaine use was described as extensive for all social classes in Sao Paulo. While the age of users varied from 13 to 45, consultants indicated that most are between the ages of 16 and 25.

The KIS describes cocaine use as group-based. Most networks of 8 to 12 individuals involve members who are 18 to 25 years old, predominantly male, heterosexual and unmarried. KIS consultants contend that networks are formed through commonalities such as friendship or shared social classes. The KIS offers a breakdown of user characteristics including gender, age, class, education level, occupation, prior arrest, residence pattern, recreational activities, marital status, ethnicity and sexual orientation.

The KIS found that clear differences in crack and hydrochloride use appear in association with socioeconomic class. Private, recreational use of inhaled hydrochloride is specific to middle and upper class user groups. By contrast, crack cocaine is smoked intensively by poorer individuals from the slums. Crack is made appealing to the poor because of its availability and low cost.

Both crack and hydrochloride are purchased from "passadores" or dealers in small packets of 0.5 to 1.0 gram which sell for about US $8.00. Again, crack is usually less expensive while "powder" varies more in price and quality. Hydrochloride is imported by traffickers while crack is produced locally in the city by heating mixtures of hydrochloride and sodium bicarbonate. While most transactions are for cash, a few KIS consultants reported instances where women offer sex in exchange for cocaine.

Consequences of Cocaine Use
While KIS consultants agree that cocaine has negative effects for the community, they also indicated that the general public is misinformed about use. Most described social problems associated with cocaine use such as increased crime, social alienation of users and family conflict. Some note the potential for health problems such as AIDS, but most argue that the switch from injecting to crack smoking reduces exposure to HIV. Most stress that society exaggerates the negative characteristics of users. Cocaine was considered "the scapegoat of society."

The effects of cocaine for users differed between hydrochloride "sniffers", injectors and crack smokers. Recreational users who inhale hydrochloride have a better self image and experience few problems from use. Injecting users and crack smokers evidence more harmful effects of intensive use. Crack users and injectors are more likely to have low self esteem and stronger dependence. All cocaine use may cause financial problems, but recreational users are less likely to face hardship

unless frequency of use increases. KIS consultants also suggest that cocaine users may experience interpersonal conflicts but, again, these problems are far more common for crack users.

Responses

KIS consultants characterize treatment services as inadequate. Services include public and private facilities offering a wide range of "therapeutic and psychotherapeutic" treatments. Still, private facilities were assumed to be too expensive for most problem users and public services are insufficient for the number of users with cocaine-related use problems. These limitations reduce confidence in the efficacy of care.

Most consultants are aware of Brazilian laws for trafficking and possession and cite a 25 year prison sentence for such offences. However, most felt that the current system is inefficient and rife with corruption. One offered the opinion that the actual laws in Brazil are "1st - with money you are free; 2nd - without it you are in jail."

Prevention campaigns known to KIS consultants were those offered in schools and churches and media presentations imported from the United States. All were described as poorly designed, misleading and dependent on exaggeration and scare tactics. USA media campaigns were also deemed irrelevant to Brazilian culture.

Consultants of the KIS did offer strategies that they felt would effectively deal with the growing cocaine problem in Sao Paulo. These included the decriminalization of cocaine and promotion of responsible use, expansion and improvement of both treatment and prevention programmes and the reorganization of police agencies to eliminate corruption. Above all, consultants stressed that other drugs such as alcohol pose a far greater problem for the health and well-being of residents than does the use of cocaine.

CANADA

Introduction
Canada compiled a Country Profile (CP) and the participating centre in British Columbia completed a Key Informant Study (KIS).

Patterns of Cocaine Use
The CP reports that cocaine is frequently combined with alcohol or cannabis. Cocaine hydrochloride is the main product used and crack is uncommon. The CP notes that cocaine use peaked around 1980. The lifetime prevalence for hydrochloride and crack use is 3%.

The KIS describes two types of user. The first is recreational use of hydrochloride, used intranasally or smoked with tobacco or cannabis. A second is dependent (steady or binge) users. Dependent steady users tend to inject while binge users smoke crack or freebase. The CP concludes that use focuses among unmarried males aged 25 to 34 and among male and female street youths. Still, the KIS stresses that use transects demographics, except for the very young. Crack users may be younger than users of other routes and products. The CP cites highest risk for use among aboriginal peoples, street youth, referees for drug and alcohol treatment and those convicted of cannabis possession. It also found some regional variations in prevalence. The highest levels of cocaine use are found in British Columbia, Alberta, Ontario and Quebec.

Prevalence of Drug Use: Respondents to a general survey on non-medical use in British Columbia in 1986 (percentage data)

Drug	Overall	18-25 yrs	26-34 yrs	35+yrs
Alcohol	95.21	96.95	99.51	93.63
Amphetamines	6.05	15.27	11.99	2.92
Barbiturates	2.49	6.37	4.67	1.27
Cannabis	33.24	71.46	70.65	16.25
Cocaine	11.21	26.14	29.66	3.39
Designer Drugs	0.69	2.40	1.59	0.18
Hallucinogens	10.43	22.30	25.33	4.14
Heroin	1.02	1.75	2.16	0.54
Inhalants	2.32	+ 6.09	4.64	1.07

The KIS notes that cocaine is easily obtained through a phone call or visit to a private residence. Many dealers deliver supplies. Most are introduced to cocaine by a friend at a party.

Consequences of Cocaine Use

The CP notes popular myths that cocaine use inevitably produces severe problems and that use is growing epidemically. However, use in Canada does not *typically* cause even minor physical or social problems and use remains confined to a small minority of individuals. The few who suffer serious or chronic effects are usually intensive users. Health reports are largely psychiatric in nature - primarily paranoia, anger, anxiety, and irritability. The KIS found that ex-addicts list more negative effects of use. Recreational users report positive results, claiming that cocaine provides energy for work or study and enhances creativity. They consider violence and paranoia to be rare, except for "addicts".

The CP reports that dependence is the most feared outcome of use. Crack is said to be highly addictive and to cause serious mental and physical damage, violence and crime. However, CP and KIS data reveal that dependence is very uncommon. Few recreational users intensify use over time or experience financial distress, though "addicts" are often made insolvent by cocaine expenditures. A key risk is the spread of HIV. The KIS notes negative views of condom use and suggests sex workers earn more if condoms are not used.

Responses

The KIS found contrasting views on care among professionals and users. Professionals and ex-users insist that goals must include abstinence while users prefer that care includes detoxification, reducing drug use and emphasis on improving or maintaining health without requiring abstinence. Professionals also tend to see care as effective while users appear positive to extremely negative or uninterested. The CP found that many resolve problem use by modifying patterns and cease use without formal care.

Canada's Drug Strategy emphasizes prevention and education but policy still focuses on enforcement. The Drug Awareness Programme uses police to address school and community groups. Programmes target youths, street kids, "dropouts", aboriginals, unemployed, women, seniors and families. No federal programmes are specific to cocaine. The KIS reports that warnings on the dangers of drug use are ineffective. The CP questions if education "is preventing drug use or creating a generation of sceptics who increasingly scoff at the sensationalized messages presented to them." Also, needle exchanges face public opposition and government restriction. To some, AIDS represents a means to control drug use more than needle exchanges represent a means to control AIDS.

Trafficking penalties draw seven years to life imprisonment. However, the CP found that cessation of use is motivated by health, family and occupational concerns rather than by legal fears. The KIS asserts that street level users and dealers are more likely to face arrest and prison than do private users and dealers. Cocaine's illegal status elevates price, promoting theft and prostitution. Prison rehabilitation programmes are also viewed as ineffective.

Non-drug using KIS participants recommend legalizing cocaine to reduce harm from contaminated forms and uncontrolled doses. Whereas some cocaine users support stronger legal sanctions against drug use and trafficking.

COLOMBIA

Introduction

A Country Profile (CP) was compiled for Colombia and the Medellin participating centre completed a Key Informant Study (KIS). These provide information on the use and distribution of cocaine in one of the major cocaine producing countries in South America. Colombia has a population of 33 777 550 and the Medellin KIS site is a major industrial and commercial centre with 1 698 000 residents. Columbia is characterized by the use of cocaine hydrochloride through inhalation and the smoking of coca paste with either tobacco or marihuana. The country maintains strong social sanctions against use. Significant cocaine-related violence was reported in the KIS and CP.

Patterns of Cocaine Use

Cocaine use is mentioned for all social classes of Colombia and Medellin. The dominant pattern of use is inhalation of cocaine hydrochloride or "perico" among the wealthy and middle class. Lower socioeconomic classes were reported to smoke coca paste or "basuco." However, both the CP and KIS indicated that basuco has gained in popularity among all levels of cocaine users due to its low cost and widespread availability. Typical cocaine users are between the ages of 15 and 30 with heaviest use in the 20 to 30 age range. Most initiate use in their late teens through friends. The CP cites alcohol as a common precursor to cocaine use. The CP reports that males represent two-thirds of all users and that most users are unmarried. The percentage of users of the two main coca products are indicated in the following tables, taken from the CP. The table indicates higher percentages of Medellin residents engaged in use. This is explained in both the CP and KIS as a result Medellin's status as a major urban centre. Lower income, the unemployed, students and workers are noted in both reports as heavier users.

Last year prevalence. General population in Colombia 1987

Cocaine HCL		Basuco	
Males	0.4%	Males	1.0%
Females	0,1%	Females	0.3%

Last year prevalence- General population in Medellin

	Cocaine HCL			Basuco	
	Men	Women		Men	Women
1984	3.5%	0.2%	1984	4.3%	0.4%
1987	0.6%	0.0%	1987	3.0%	0.6%
1992	3.2%	0.6%	1992	2.2%	0.4%

*Social level General population in Medellin 1992. VESPA *.*

Cocaine HCL		Basuco	
Low	0.9%	Low	2.2%
Middle	3.2%	Middle	1.1%
High	1.7%	High	0.7%

* Epidemiological Surveillance for Psychoactive Substances, Medellin 1993

The Colombia CP and KIS both report that cocaine availability is quite high. Medellin K1S consultants indicated that cocaine and coca paste usually come in 1 gram packs. Paste costs COL$ 800 to COL$ 1200 per gram, while a coca paste cigarette costs COL$ 4200 and cocaine hydrochloride costs COL$ 2000 to COL$ 4000 per gram. Quality is said to be poor and it is "cut" or adulterated with substances such as flour, talcum, detergent, bicarbonate, analgesics and ground brick. Dealers sell cocaine in various public arras.

Consequences of Cocaine Use

Both CP and KIS contend that a major consequence of cocaine is violence taken against paste users. Society commonly regards such users as "degenerates" or "disposables". Violence was described as common. A group called "Milicias Populares" apply terrorist acts against users, pushers and dealers in popular neighbourhoods while rural guerrilla groups punish users often with death, although they are also said to facilitate production and trafficking.

Responses

The CP notes several treatment programmes supported by government, private and religious sources. These include detoxification hospitals, outpatient centres, therapeutic communities, inpatient centres, support groups and guidance and prevention centres. The KIS indicates that user knowledge about service availability is somewhat limited. The CP and KIS both assert that paste users are more highly represented in therapy at these agencies.

Prevention programmes mentioned in the CP consist primarily of public school education developed and supported by national governments. Educational materials discuss drugs in general and offer little direct information on cocaine. The KIS informants expressed little or no knowledge of prevention campaigns.

Legal responses outlined in the CP indicate that arrest is based on the amount of cocaine in possession. Quantities of a gram or less are attributed to personal use which is punishable by 30 days in jail and a small fine. Larger amounts are attributed to trafficking, which increases the penalty. Possession of less than 100 grams is punished by 1 to 3 years in prison; larger quantities draw a 4 to 12 year sentence. KIS consultants indicated that police are more likely to act against users than producers and traffickers. Corruption was described as a substantial problem.

ECUADOR

Introduction
Ecuador compiled a Country Profile (CP) and the participating centre in Quito completed a Key Informant Study (KIS). Ecuador is notable as a transshipment centre, but is not currently engaged in large-scale coca production.

Patterns of Cocaine Use
Historically, Ecuador supported traditional coca leaf use. This faded after it was declared illegal. The country now operates as a major transport site and laundering base for funds. Cultivation has recently emerged but is limited. Lack of police resources and alternative crops fosters a potential for growth in the industry.

Marijuana remains the most commonly used illicit drug. Ecuador has a large population of young people and the CP indicates that many experience financial and family problems which contribute to high consumption rates in this group. Still, general use remains low, though both CP and KIS note a potential for increased use as cocaine enters local markets. Social sanctions against use are high.

Cocaine hydrochloride and coca paste "base" are available. They are used in a wide range of social classes and users experience less stigma. The CP and KIS suggest such use may be sustained over time. Paste smoking is described as more prevalent since it is cheap and more available. It is used almost exclusively by those with lower economic status and it yields more social rejection.

Most users are males. Users range in age from 18-64 years. Coca paste smokers tend to be males around age 20. Hydrochloride is more common for males in their 30s. The CP reports a total of 400 000 illegal drug users, 30 000 of whom need treatment.

Consequences of Cocaine Use
The CP reports that hydrochloride use is associated with rare cases of suicide or depression but paste is associated with higher rates of hospitalization, suicide, depression and delinquency. KIS respondents report many physical and mental health consequences of use, but most are attributed to intensive use, mainly paste smoking. Several also cite a decline in social and family relations and religious ties.

Responses
Inpatient and outpatient care are offered, as are "alternative" therapies such as acupuncture. Urban centres operate a telephone hotline for dependence questions. Care may range from two months to five years. Prevention uses media and school-based campaigns. Possession, use, cultivation, processing and distribution are all illegal. Penalties are imprisonment and fines. The government is actively involved in suppression of cultivation and trafficking. At this time cocaine is not a mainstay in the national economy.

EGYPT

Introduction
Egypt produced a Country Profile (CP) and the Cairo participating centre completed a Key Informant Study (KIS) for that site.

Patterns of Cocaine Use
Before World War 1 the most common drugs in Egypt were alcohol, hashish and opium. Cocaine briefly appeared at this time but was supplanted by opium. Cocaine reappeared in the 1980s, but remains restricted to the wealthy. It is often combined with other drugs since pure cocaine is extremely costly and supplies are limited.

The CP points out that Egypt is not a cocaine producing country but does represent a consumer base and potential transshipment point. One 1992 study found that cocaine was the least popular drug. This is partly attributed to its high cost. It is currently estimated that only 0.06% of the population has tried cocaine. Still, the CP and KIS indicate that dealers and users easily hide activities and some reports suggest that use is rising. Hashish remains the most traditional and popular drug in Egypt.

The KIS concludes that use is restricted to cocaine hydrochloride. Routes of administration include intranasal, smoking, injecting, or rubbing cocaine on gums, teeth and eyelashes. Males and females both use, but male users are more common. Users range in age from 20-60 years, though use predominates in the 20-35 year age group. The main determinant is wealth, since cocaine is very expensive. Individuals typically use 0.125 to 3 grams daily. Total use increases with dependence and users may shift from intranasal to intravenous use or rub cocaine on mucosal surfaces to intensify the effect.

Consequences of Cocaine Use
Both the CP and KIS cite increased risk for physical and mental health problems, particularly when use is intensive. Dependency is considered common and use is thought to pose increased risk for unsafe sex and needle sharing. However, many emphasize that alcohol and other drugs pose greater risks for health.

Responses
The CP concludes that treatment capabilities are strong but are designed for general drug treatment. Care includes governmental, public and private facilities. Many new centres have opened and now tend to be separated from psychiatric hospitals so that patients suffer less stigma. KIS respondents expressed dissatisfaction with the quality of care. The CP describes a national prevention programme which offers education, early intervention and treatment. Recent legislation poses strict penalties for drug cultivation and trafficking but permits treatment options. The total number of cocaine cases increased between 1988 and 1991 from 18 to 32. KIS respondents proved poorly informed on cocaine laws.

MALDIVES

Background
The Maldives compiled a Country Profile (CP) but did not complete a Key Informant Study (KIS) because very low levels of illicit drug use are found in The Republic of Maldives. It is believed that the few drugs confiscated in the Maldives are not meant for the local market, but that the Maldives serves as a transit point for smugglers. Narcotic drug seizures in general have increased from 112.6 kilograms in 1985 to 11 751.1 kilograms in 1993.

Patterns of Cocaine Use
The CP indicates that no form of cocaine use exists at present. Surveillance data from 1992 indicate that the predominant drugs used are cannabis, benzodiazepines and most recently, heroin ("brown sugar"). However, the total number of users is extremely small. Of the few hundred drug users in the country, most reside in the capital, Male. These tend to be students returning from studies abroad, especially from India and Sri Lanka.

Interviews with drug users found that none had ever seen cocaine except on television. Only 1 % of drug users under age 24 express interest in experimenting with cocaine and only 2% of drug users over 24 years of age demonstrate an interest in trying cocaine. Introduction into drug use occurs exclusively through friends. There is no "pushing" or active marketing of illegal drugs and no organized underground or criminal distribution system exists.

Responses to Cocaine Use
Currently, there is no effort to treat or rehabilitate users. To date authorities have received no requests for rehabilitation or treatment. A drug prevention programme was recently initiated involving the distribution of pamphlets to school children and live call-in programmes broadcast on TV and radio. Also, a major initiative brought together all of the atoll chiefs to educate them to deliver prevention programmes in their respective islands.

Penalties for cocaine use are severe and include a maximum of 22 years imprisonment and a fine. There is no distinction between penalties based on different types or classes of illicit drugs and there is no sentence reduction on the basis of first offender status. Penalties are largely determined by the quantity of the drug seized rather than offender-based attributes. Police report that drug enforcement is complicated by difficulty in accessing and surveillance of the many islands.

Drug suspects are exempt from the current law which provides for no more than 15 days detention without a court appearance. Consequently, it is possible to keep suspects under arrest or protective custody for indefinite periods pending trial.

MEXICO

Background
Mexico's Country Profile (CP) and Key Informant Study (KIS) offer complimentary data on use. CP data employ national surveys and Information Reporting System on Drugs (IRSD) surveillance data on Mexico City. The CP and KIS cite rapidly growing use of cocaine. CP data attributes the spread to urbanization, tourism, industry and trafficking. The KIS reveals expanding use in Mexico City.

Patterns of Cocaine Use
Cocaine hydrochloride predominates and the main route of administration is intranasal, with some injection use. The CP links injection with heavy use. The Mexico City KIS reports some crack smoking. Data indicate that users range from 12 to 60 years. Most are 20 to 24 years old, male, middle to upper class and heterosexual. These features are important given demographics. Of Mexico's 81 249 645 residents, 49.1% are male and 69.6% are below age 29. CP data on Mexico City use prevalence by age is reproduced here.

Life time prevalence and past month prevalence of cocaine use by age groups (1988-1993)

	Life Time	Life time but not last year	Last year but not last month	Last month
	(N=233)	(N=65)	(N=33)	(N=135)
AGE GROUPS	%	%	%	%
10-14	2.3	6.3	3.2	2.3
15-19	19.7	9.4	32.3	24.4
20-24	28.1	17.2	35.5	32.5
25-29	22.8	25.0	9.7	21.9
30-39	22.8	34.4	29.4	18.1
40-49	3.1	6.3	-	1.3
50-59	0.9	1.6	-	0.6
Total	100.0	100.0	100.0	100.0

Source: Ortiz A., 1993.

Sex was often associated with use and the KIS reports homosexual activity as common in use or to obtain drug. Typically, use first occurs in the late teens through friends and a prior history of alcohol and marihuana use is usual. The CP found that students tend to experiment more and have a higher population of occasional users.

Use rates are growing. IRSD data suggest growth in the population which has ever tried cocaine from 1.6% in 1986 to 16% in 1993. Regions with a history of use are those closest to the US border and trafficking routes and tourist or industrial areas such as La Paz, Baja California and Monterrey. The CP suggests that migrants to the USA also gain exposure to use, a point supported by rates of returning migrants admitted for withdrawal symptoms in Mexico.

Cocaine is considered highly accessible in Mexico. Purchases usually total 1 to 2 grams at a cost of 100 to 200 pesos. The purity and quality vary with the users economic class. Wealthier users pay more but obtain higher quality hydrochloride. Cocaine is "cut" with products such as sugar or sodium bicarbonate.

Consequences of Cocaine Use

Both CP and KIS describe negative community attitudes about use, though the CP also reports that some subgroups are more tolerant than are others. Males, the poor and young people aged 15 to 29 appear more accepting, while use remains more discreet for the wealthy and the hidden nature of use may strain social relations.

Health effects noted in the KIS were limited to sinus and nasal problems, headaches and rare cases of heart and blood pressure problems. The CP found that health records associate problems of overdose or interaction with use of alcohol or tranquilizers. Psychological effects like depression, irritability, or paranoia are more common with heavy use. Increased risk of HIV is tied to unsafe sex, encouraged by the disinhibiting effects of cocaine. One major consequence of use is legal problems, particularly as a barrier to drug access. However, such problems appear greater for the poor. The KIS refers to police corruption as pervasive.

Responses

Many treatment options are noted. Public care and psychiatric hospitals offer psychological, social or medical interventions as do private care facilities and self-help groups such as Narcotics Anonymous and Drug Addicts Anonymous. The KIS describes treatment facilities as targeted mainly at "hard core addicts".

Prevention includes school programmes and teacher training. Two nationwide programmes, the Programme for Prevention Education on Addictions and the National Programme Against Drug Abuse, address prevention from value and mental health perspectives. KIS consultants, however, were not familiar with prevention programmes.

Legal codes focus on three areas. Addiction is not prosecuted. Personal use of small amounts is a minor offence drawing a small penalty for first conviction. Larger possession of cocaine, heroin or opium are prosecuted as trafficking and receive 10 to 25 years imprisonment, depending on amount seized. KIS informants view police corruption as a serious and widespread problem.

Major recommendations in both reports concentrate on the need for further research into social and cultural factors in prevention and reduction in cocaine use and harm in Mexican society.

REPUBLIC OF KOREA

Introduction
Korea produced a Country Profile (CP) and the participating centre in Seoul completed a Key Informant Study (KIS). The reports agree that cocaine use remains extremely rare in Korea but consultants report the presence of both cocaine hydrochloride and crack, suggesting a potential for increased use in the future.

Patterns of Cocaine Use
Korea's KIS found that cocaine use is very rare. The CP concludes that methamphetamine poses more concern as it is favoured for its availability, low price, potency and long-term effect. The CP found that drug-using adolescents in detention used solvents, cannabis or methamphetamine. Most adult drug users in Seoul use solvents and cannabis but a few use cocaine and other drugs.

Adult Drug Use in Seoul Survey of 1422 Seoul residents

Substance	Number of Users
Cannabis	18
Organic Solvents	15
Cocaine	8
Methamphetamine	3
Morphine	3
Other Drugs	110

KIS data indicates that hydrochloride is a preferred product but a few report use of crack. Purchases usually total under 2 grams and cocaine is taken once or twice a week. The main route of administration is intranasal. Injection is rare, as is smoking.

Korea's CP found that cocaine is popularly seen as an expensive drug taken in large doses by wealthy North Americans, including Koreans living in the United States. Use in Korea tends to be restricted to upper-middle class businessmen who travel abroad. The KIS describes users as wealthy, college-educated males aged 20 to 30. Many are said to work in the entertainment industry. The KIS reports that initial use begins in this same 20 to 30 year age group. Most are introduced to cocaine by a friend at a private home, party or hotel where they initially use less than one gram of hydrochloride intranasally for reasons of curiosity, to experience a pleasant sensation or merely because it is suggested.

Cocaine supplies are extremely limited. lt is easier to obtain cannabis, benzodiazepines and amphetamines. Cocaine is also very expensive, costing US$ 450 to US$ 500 for 1 to 2 grams. The CP mentions a form of cocaine paste that is less costly than hydrochloride but this product is not clearly described. While cocaine is usually purchased some may offer cocaine in exchange for r sex. Use generally occurs with close friends, during sexual, The Netherlands l intercourse, at parties and

music activities, after drinking or when under stress and combined with alcohol, sedatives or cannabis.

Consequences of Cocaine Use

KIS consultants report that use harms work performance, finances, physical health and mental health. Some may experience insomnia, depression, hopelessness and irritability. However, such effects are largely linked to heavy use. Others assert that use enhances creativity, artistic sensitivity and performance. All of the KIS participants describe cocaine as addictive. Most try to curb use by substituting alcohol or avoiding use environments. Some become dependent and increase the quantity and frequency of use and vary product and route of administration, shifting from hydrochloride to crack or from intranasal to injection use.

Most users believe that there is little risk for HIV transmission since injection use is still quite rare and most report that injecting users do not share needles and that users in general practice safe sex. However, one professional felt that risk increases because sex partners may include prostitutes.

The KIS reports that cocaine use might harm relationships with family and friends. There is little public acceptance of cocaine and users may suffer low self-esteem. A few also associate use with a risk for violence, destructive behaviour or accidents.

Responses

The KIS reports that drug use is treated as a legal problem and punishment-oriented policies are employed to control use. Some stress that such severe drug penalties pose barriers to treatment as users fear exposure and arrest. Both the CP and KIS recommend treating cocaine as a health issue.

The CP reports that in 1988 the Ministry of Health and Social Affairs initiated a drug education programme targeting high school students. Still, public drug prevention is "hardly visible." The Korean public is ignorant about cocaine and drugs in general.
The CP warns that international policing efforts need to be carefully weighted to avoid linkage to the "imperialistic or colonial foreign policies" of some Western nations.

THE NETHERLANDS

Introduction
The Netherlands compiled a Country Profile (CP) but did not conduct a Key Informant Study (KIS). The country is notable for its active approach to treatment, prevention and harm reduction.

Patterns of Cocaine Use
Cocaine has been available in the country since 1870. Dutch colonies in Indonesia developed plantations which produced a particularly potent variety of coca. Use declined in the 1930s but resurged in the 1970s. While cocaine was once viewed as an elite substance it is now illegal and classified as a "hard drug", having lost its positive image as use spread through social classes. Cocaine is now associated with opioid (such as heroin) users.

Public opinion on cocaine varies somewhat on the basis of route of administration. These are more diverse for cocaine than for other drugs, as it is inhaled intranasally, smoked, freebased, injected, smeared on the gums or genital tissues, or ingested. Intranasal use predominates and is favoured by half of all users.

The Netherlands CP lists two user categories. The first are those who usually "sniff' small doses of cocaine at social gatherings. The second category freebases or injects to obtain stronger (yet briefer) effects in a daily or "dependent" manner. Non-opioid users indicate that only "junkies" inject, though freebasing is accepted. The CP notes that crack use is gaining popularity among heroin users. "Sniffers" use less cocaine than do injectors or freebasers. One study in Amsterdam indicates that 88% of first-time cocaine users try the product with friends.

There is little information on the prevalence of cocaine use in the Netherlands. Studies do indicate that in urban areas, such as Amsterdam and Rotterdam, less than 5% of those over the age of 12 have ever used cocaine. Figures are smaller in rural areas. Information is available from LADIS (National Alcohol and Drug Information System) which is a registration system recording data from centres providing treatment for persons with alcohol, drug and/or gambling problems. In 1992, cocaine users represented 22.3% of all drug treatment cases.

LADIS: Total and Percentages of Cocaine Clients

(clients where cocaine is the primary or secondary drug of use)

Year	Total	Percentage of total clients	Percentage of total drug-clients
1988	3290	7.3%	19.6%
1989	3326	7.2%	19.4%
1990	3864	7.9%	20.3%
1991	4416	8.4%	21.5%
1992	4850	8,7%	22,3%

The Netherlands CP contends that most cocaine users do not engage in polydrug use, although most opioid users also use cocaine. Both heroin and cocaine are used openly at home and in public. Elsewhere, cocaine is considered a social drug. Nevertheless, the CP indicates that cocaine and alcohol are often combined because cocaine neutralizes the negative effects of alcohol. No other drugs tend to be taken to enhance cocaine effects. Tobacco, alcohol and cannabis are all used more frequently than is cocaine.

Consequences of Cocaine Use

A Rotterdam study describes diverse user styles and their relationship to consequences. In "Burgundian" use, cocaine plays a minor role and is a luxury used at special social occasions. Use is discreet and cocaine is shared only with close friends. Another type is an "experience" use style, where cocaine is tried out of curiosity. A third type of use is "situational" or in select conditions (e.g. work), or to create a special social occasion like that of "Burgundian" use. A fourth use style is "distinctive". In this group cocaine plays a significant role in lifestyle and such users retain social ties primarily with other cocaine users. A fifth "hedonistic" style involves "unbridled pleasure seeking" with intensive or "binge" use, limited in time and producing no health problems. The sixth style is "routine" and involves stable, long-term use without negative consequences. A seventh pattern is "poly-drug" use where opiates and cocaine are combined and use is associated with a "hard-drug" subculture with higher levels of dependence, physical, psychological and financial problems, and criminal behaviour. The final use style is the "cocainist" who uses only cocaine but in a compulsive or dependent manner and may experience more physical, psychological and financial problems. The CP associates such use with disrupted childhood and suggests these users see themselves as "addicts".

Responses

The Netherlands is considered unique in their approach to drug treatment. A wide range of services are available and include programmes to treat dependence and use-related problems and to reintegrate the patient into society. Therapeutic communities play a major role in this effort. Most facilities treat opioid use problems and many offer methadone. Some larger cities offer treatment for cocaine, including counselling, psychotherapy, group therapy and family therapy. Drug-free prison units are also available for prisoners trying to treat their dependence.

Prevention is integrated into school curricula from the primary levels. The media is not extensively used since it is deemed less effective. Prevention programmes more often focus on "risky" behaviours such as alcohol, smoking and other drug use, and gambling. Goals include keeping occasional cocaine users from becoming dependent or from developing use-related problems. Harm reduction is active and includes needle exchange programmes and condom distribution to prevent spread of HIV. Most programmes focus on heroin and there is a need for more information which addresses cocaine.

NIGERIA

Introduction
The Country Profile (CP) for Nigeria and the Key Informant Study (KIS) completed with consultants from Ibadan and Lagos points to expanded use of cocaine, particularly crack cocaine smoking. Nigeria also participated in the Natural History Study.

Patterns of Cocaine Use
Cocaine use is a recent trend, mainly involving cocaine hydrochloride and crack. The KIS claims that users employ any product available.

Drug Use: Hospital and Clinic Populations (n=136)

Drug	Percent of sample
Polydrug Use (combination)	47.8
Cannabis	30.14
Alcohol	7.4
Heroin	7.4
Cocaine	5.4
CNS Stimulants	1.5

Main routes of administration are smoking cocaine with tobacco, intranasal "sniffing", or freebasing. Injection use is rare and associated only with Nigerians living in the USA. Use occurs daily, usually at a "joint" where purchased or at parties. The CP notes motivations for use reported in a student survey:

*Reason for Cocaine Use Among Students**

Reason for Use	Percent of sample
Look Older	26.8
Feel Good	26.7
Be Like Friends	16.1
Be Like Parents	2.8
Be Like Stars	13.4
Get Attention	9.3

*survey date and source not noted in Country Profile

Use prevalence is rising in all social classes. Males and females 18 to 55 years old from all ethnic and tribal groups in Southern Nigeria may use although most are single males, 20 to 24 years. Most use

occurs only with trusted friends. Initial use involves either smoking hydrochloride with tobacco or intranasal use. Most initiate use in the late teens or early twenties with friends.

Cocaine is described as highly available. Hydrochloride and crack are sold in pinch (1/2 gram) or chunk (1 gram) quantities for $1 per pinch to $50 per chunk, varying by the exclusiveness of the dealer and drug purity. Hydrochloride may be "cut" with sucrose.

Consequences of Cocaine Use

KIS respondents only indirectly link use with health problems, mainly from poor nutrition due to appetite loss and lost income. Some suggest use may also alter personality or produce paranoia but others note that users may feel more confident, alert and talkative. For some, use negatively affects work, study, social relations, recreational or religious activity. A few link use to road accidents, though the CP points out that Nigeria already has one of the world's highest rates of road accident. Unemployed users may turn to crime to fund purchases and others are financially ruined by use. A few may be more prone to irritability or violence.

Responses

Most treatment is offered through government operated psychiatric hospitals and units in teaching hospitals. Patients and relatives make financial contributions for care. Therefore, KIS respondents suggest that care is restricted to those who can afford it. The KIS professional consultants say that services lack staffing, training and equipment. There are no community based outpatient services specific to cocaine. Care involves detoxification and rehabilitation through counselling and psychotherapy. The KIS also describe traditional curing and faith-healing treatments. The CP explains that Nigerians attribute drug-related problems to spells and seek a "lasting solution" from faith and traditional healers.

Employee assistance programmes and drug-free workplace policies are promoted, as is a "Drug Demand Reduction Unit" for education in schools. The National Drug Law Enforcement Agency also promotes demand reduction, though none specifically target cocaine. Most KIS respondents view such prevention as ineffective.

Cocaine seizures have increased dramatically, from approximately 43 kilograms in 1990 to over 200 kilograms in 1992. Penalties vary, including a maximum of 10 years imprisonment for use and 20 years for "international trafficking." Courts have discretion in sentencing, mainly for first time offenders. The CP reports that law enforcement officials view current policy as an effective deterrent but KIS consultants consider prosecution ineffective.

The KIS advocates employing ex-users in treatment units and using clergy for spiritual rehabilitation. Most KIS respondents also advocate a combination of supply reduction and demand reduction strategies. A few support legalization or decriminalization and the treatment of use as a health issue.

PERU

Introduction
Peru compiled a Country Profile (CP) and the Lima participating centre produced a Key Informant Study (KIS). Peru is notable as a country for cultivation, production and distribution of cocaine and for the traditional practice of coca leaf chewing. Of concern is a rapid growth in coca paste smoking in some social groups.

Patterns of Cocaine Use
Coca leaf has been used in Peru since at least 5000 BC and is still used by indigenous Quechuas and Aymaras and by fishermen and miners. Leaf is used in traditional medicine and chewed during work. Cocaine hydrochloride is largely restricted to higher classes. Most hydrochloride users are described as educated, "while" professionals who experience few use-related problems. Most engage in weekly or special occasion use of 1-5 grams in social groups at bars, nightclubs, parties and private homes. Cocaine hydrochloride is only rarely injected or used in nasal drop solutions. While cocaine is an illegal drug, use is not punished.

Coca paste use has developed only in the last twenty years. It is widely recognized and is smoked in "cigarettes". Coca paste is described as the main drug in Peru, followed by cannabis and alcohol. The KIS suggests that most paste smokers are uneducated members of the middle and lower classes and of mixed ethnicity. Many are described as unemployed or students and most make daily use of paste, totalling as much as 15 grams per day. There is a strong ritual surrounding the preparation of the paste cigarette and sharing in the group. The KIS detected little awareness of crack.

Life prevalence (anytime use) of substances by age group (1988)
(percentage data)

	Coca Paste	Hydrochloride	Coca Leaf
12-14 YRS	0.0	0.6	13.2
15-18 YRS	4.2	0.0	18,8
19-24 YRS	4.6	1.3	23.4
25-29 YRS	6.9	3.9	30.0
30-34 YRS	10.6	2.9	32.3
35-39 YRS	8.6	4.0	31.4
40-50 YRS	3.8	1.2	31.4
TOTAL	5.6	2.0	26.2

SOURCE: CEDRO. Drogas en el Peru Urbano (Estudio Epidemiologico 1992) Monografías de Investigación no.9.1993

The CP reports that hydrochloride and paste users range in age from 15-60 though most paste users are young. Most users are male. The KIS reports a male: female ratio of 4:1 to 10:1. Females are described as more likely to hide their use from the public.

The CP notes that coca produce use is relatively common and that 10.4% of Peruvian men have tried coca paste while 4.1% have tried hydrochloride. Very few women report any use: 1.5% report use of paste and 0.2% report trying hydrochloride. Coca leaf chewing is more common. Leaf has been used by 33.9% of men and 20% of women. Despite its prevalence the KIS was unable to detail leaf use.

Consequences of Cocaine Use

The KIS identifies a trend towards increased use over time for both hydrochloride and paste. Informants consider paste more addictive and associate it more often with crime. Paste users are also described as manipulative and irritable with family and friends. Women who use paste during pregnancy are said to suffer problems including anecdotal accounts of deformed children.

Responses

The CP and KIS describe a variety of inpatient and outpatient treatment facilities. Some traditional healers are also said to treat dependency. The KIS describes problems with treatment, largely associated with a lack of trained medical and counselling staff and the Jack of well-structured and coordinated programmes.

Prevention is taught in schools, through mass media and in some prisons. CEDRO, the Centre of Information and Education for Drug Abuse, was recognized by most KIS informants but most also note a need for more government involvement and better organization.

Legal responses described in the CP and KIS include fines and imprisonment. Penalties vary dramatically (from two years to life) depending upon offences associated with manufacture, sale and trafficking. Personal use is not subjected to prosecution. Some KIS respondents suggest that cocaine markets foster corruption.

RUSSIAN FEDERATION

Introduction
Russia produced a Country Profile (CP) and the St. Petersburg participating centre completed a Key Informant Study (KIS). Data largely reflect use patterns in St. Petersburg and reflect less about the country as a whole. Results show incipient cocaine use, mostly recreational use of cocaine hydrochloride in select subgroups.

Patterns of Cocaine Use
Cocaine entered Russia after World War 1. Most use was by "previously privileged classes" and the homeless and was spurred by alcohol prohibition. Problems emerged in the army and among children and teenagers. The CP reports that in 1925, 48% of those arrested had “sniffed" cocaine as a stimulant or to stem hunger. By the early 1930s homelessness declined and the cocaine "epidemic" faded.

There are no epidemiological data on prevalence in Russia but use appears uncommon, largely because of cost. Most use occurs among the wealthy, students, musicians and artists. Users range from 13 to 40 years old and most are male. A majority make intranasal use of hydrochloride but cocaine is sometimes smoked or injected.

The CP notes rare cases of exclusive cocaine use but both CP and KIS indicate that most cocaine users have a prior drug history. Cocaine is also used most often in combination with alcohol or tobacco to prolong its effect. Cannabis and home-made heroin are more available and cocaine's cost restricts the prevalence of use. Many believe that cocaine does not lead to dependence.

Consequences of Cocaine Use
There is little social awareness of cocaine but elders are less tolerant of drug use. Since use is limited it is "difficult to speak of any associations or importance of various coca products". Most initiate use out of curiosity and with friends and use tends to occur at parties, dances or in casinos. Total use may increase over time, fostering family or social conflict.

Responses
A variety of treatment services are available for users of all types of drugs. These include inpatient and outpatient programmes as well as self-help groups and physician care. In the KIS, some professionals believe that the problem with these programmes "lie in inadequate provision (with medication and the personnel)".

Schools offer prevention programmes and the City Centre for Preventive Medicine trains teachers in health promotion. Women in prenatal care are told about harm associated with use of alcohol, tobacco and drugs. The media also supports prevention programmes.

In Russia it is illegal to sell, warehouse, produce or introduce minors to drugs. Penalties are one to ten years imprisonment. Law enforcement focuses on trafficking and "preventive work".

SPAIN

Introduction
Spain compiled a Country Profile (CP) and the participating centre in Barcelona completed a Key Informant Study (KIS). Spain is notable as a major drug distribution centre for Europe, making products such as cocaine, heroin and cannabis highly accessible.

Patterns of Cocaine Use
Limited use began in the 1920s and broadened somewhat in the 1970s. It is now a significant illegal drug. Personal use is not penalized, but since 1992 public use can be fined. It is still considered an elite drug of the "beautiful people". Concern increased in the mid-1980s as drug seizures and hospitalization for cocaine problems increased.

Heroin continues to pose serious problems in Spain, while cocaine is considered a relatively safe, often recreational drug "with the exception of the heroin sub-culture and of dysfunctional use situations." Cross sectional surveys estimate lifetime prevalence of cocaine use at 3% for the general population and 5% for those aged 15 to 29. A 1989 study on drug mortality found that 17% of blood and 26% of urine tests were positive for cocaine. While these data suggest increasing use, rates still represent a small proportion of the population, particularly in relation to heroin use. Of note, 90% of the 1989 drug mortality cases studied were attributed to heroin. Cannabis has the highest use rate and almost all cocaine users have taken hallucinogens, cannabis and alcohol. Cocaine and alcohol are regularly combined. Only 3% of users have used crack.

Both the CP and KIS report that most use is initiated with friends. KIS respondents in Barcelona claim that initiation usually takes place around the age of 20 and most involves intranasal use. Only heroin users begin use by injecting. Use does not disrupt relationships except in cases of dependency. Users openly use cocaine, usually in nightclubs or at parties. Use tends to be concealed only if employed at work. Typically, one member of a group of users conducts most purchases at private homes.

Most users are males between 25-29 years and represent all social and economic levels, though most belong to the middle class. The KIS attributes cocaine access to Spain's role as a European transshipment point. The cost is US $75-$90 per gram. Cocaine use tends to increase over time, although most appear to regulate use with relative ease. Most use is intranasal, though some inject or smoke cocaine with tobacco. The KIS reports that both injection and needle sharing is rare due to fear of HIV.

The CP notes nine patterns of use which are also outlined in an attachment to the Barcelona KIS. These include "recreational" use, including "experimental", "social" and "circumstantial" subtypes; "instrumental" use, which incorporates situational, elitist and commercial subtypes; and "dysfunctional" use by dependent pure cocaine users and dependent cocaine/ex-heroin and heroin users.

KIS respondents in Barcelona describe three user categories. "Recreational" users predominate, characterized by social use of small amounts of hydrochloride on weekends. They may also employ alcohol or cannabis but reject heroin. An "instrumental" category treats cocaine as a key component of social activity and may make some use of heroin and exhibit greater dependence and physical, mental, economic or legal problems. Finally, cocaine is the focus of "dysfunctional" users who use the substance daily and intensively along with heroin and other drugs. A few Barcelona KIS respondents cite some cases of crack use. Dysfunctional users tend to face greater social isolation.

One key distinction is that recreational users are likely to undertake group purchases of cocaine, while more intensive users generally make personal or individual purchases.

Consequences of Cocaine Use

As noted, the CP and KIS agree that physical, mental, economic, social and legal consequences are directly associated with the pattern of use. Intensive use is most likely to yield harmful outcomes. One KIS respondent linked cocaine and alcohol, as most individuals engage in regular and even long term use without risk, but a small number suffer harm from prolonged and heavy use.

Responses

All citizens "have the right to free medical attention including attention for organic problems and dependence resulting from the use of drugs". Still, a public health-care network for drug dependence was not set up until 1985. Treatment is now widely available in Spain and includes hospital, out-patient and residential units. There are only two centres focused on cocaine dependence and they are experimental. Drug treatment is offered in prisons but is not specific to cocaine. Most centres focus on heroin treatment since heroin use and treatment demand far exceed cocaine use and demand for services. The KIS users were uninformed on treatment and few seek assistance, largely because most are recreational users who never become dependent.

Primary drug prevention takes place in the schools, with parents and professional organizations. None focus on cocaine. The four priority areas are community, schools, workplace and prisons. The media play an important role in campaigns but many are poorly designed. Some programmes target high-risk populations such as prostitutes, the homeless and street children. Harm reduction includes distribution of condoms and instruction on their use.

Trafficking is illegal but use is not. A few may engage in crimes to support a habit. Courts can commute sentences to mandatory treatment. The KIS emphasizes that most users are well integrated into society and hold stable jobs, so few experience the legal problems more common among heroin addicts.

SWEDEN

Introduction
Sweden compiled a Country Profile (CP) but did not complete a Key Informant Study for this project.

Patterns of Cocaine use
Cocaine entered Sweden in three phases. Initial medicinal use began at the turn of the century. During the 1920s cocaine gained popularity and some were hospitalized for use-related problems. Cocaine reentered during the 1970s, slowly emerging as a drug for the "jet set" and did not draw heavy use or trafficking. Efforts were taken to prevent the emergence of the problems experienced in other countries and use was depicted as uniformly negative.

When available cocaine is used mostly for recreational purposes. Use usually takes place in social groups in a private setting. Most users are young males and use is restricted to weekends. It is usually purchased in nightclubs and doses are small so that use is discreet. The drug is said to be appealing because of its newness, costliness and cleanliness. Access is limited and most use appears to be specific to the capital, Stockholm.

Polydrug use appears common with amphetamine being the preferred drug. Amphetamines are far more affordable than other drugs including cannabis. This is partly attributed to the "collapse of communist block Poland". Since then, affordable and high quality amphetamines have flooded the Swedish market.

Consequences of Cocaine Use
Sweden does not have an extensive cocaine problem although it is treated with "restrictive law enforcement". The total number of all drug "addicts" is reported at around 20 000. However, a recent survey of Sweden's population of 8.5 million identified only 500 cocaine users in the entire country. Partly because use remains limited, other consequences of use are not described.

Responses
Sweden developed school-based prevention campaigns to reduce the appearance of problems observed in neighbouring countries. Cocaine was incorporated here as one of many "dangerous substances". Cocaine is considered to be as dangerous as is heroin and, because of this image, legal penalties are described as severe. Nevertheless, cocaine use has not been associated with increased crime or prostitution.

UNITED STATES OF AMERICA

Introduction
The USA has a unique heterogeneous general population that makes summarization of cocaine use patterns difficult. This resulted in a United States Country Profile (CP) that provides an annotated overview of scientific and surveillance literature produced in the country. Participating centres in Flagstaff, New York, Providence and San Francisco also completed separate Key Informant Studies which are described in separate summaries.

Patterns of Cocaine Use
Cocaine use in the United States has an extremely broad range of characteristics. Cocaine hydrochloride was historically used for medicinal purposes. However, in the early 20th century and again in the 1970s through the 1980s it regained broad popularity for recreational use.

The CP notes that current use is largely non-medicinal, mostly in the form of cocaine hydrochloride "powder" and smokable "crack" cocaine. Hydrochloride is generally inhaled intranasally or injected. Smokable cocaine can be smoked as crack, or hydrochloride may be mixed with tobacco or marijuana. An estimated 90% of US users inhale hydrochloride and approximately one-third smoke it.

Surveys reviewed in the CP indicate that use rose drastically in the 1970s and peaked in the middle 1980s. Use has continued to decline. The number of "occasional cocaine users" for the raid to late 1980s totalled 5.9 million and "monthly users" numbered about 2.9 minion. Users in 1992 comprised approximately 3.4 million "occasional" and 1.1 million "monthly" users. However, the total number of "frequent users" remained stable at 650 000 between 1988 and 1992. Use predominates in impoverished inner city neighbourhoods among people between the ages of 15 and 34. Similar patterns appear for all ethnic groups although male users outnumber female users. Use declined by 63% for adolescents.

The profile reports that cocaine availability has increased and prices have substantially decreased over the last two decades. Reports indicate that high quality cocaine is now available at a lower cost than during peak use in 1985.

Consequences of Cocaine Use
The US CP reports several areas of impact on user health. Major negative effects among heavy and chronic users were higher suicide rates, heart and lung problems and difficulty with concentration and memory. Increased sexual stimulation and sexual dysfunction were identified but research in this area is limited. The CP points out that complications caused by cocaine use during pregnancy has been exaggerated by the media. Research generally fails to support cocaine as the source of prenatal problems relative to other social factors such as poverty or poor prenatal care.

One consequence of use cited was a dramatic increase in emergency room and private physician referrals for cocaine-related health problems. This was most notable in major metropolitan areas. Most emergency room admissions were for "detoxification, unexpected drug reactions and chronic negative health effects." Of note, 44 times the number of cocaine-related deaths occurred in 1989 (2332 reported cases) in comparison to 1975 (53 reported cases).

A social consequence reported in the CP is the connection between crime and cocaine use. It notes that two-thirds of all females and one-half of all males arrested test positive for cocaine. Increased criminal

activity was noted for males with heavy use of cocaine. Crack users may also experience more violent or psychotic events.

One of the most significant health consequences posed by cocaine use is its association with increased risk for transmission of HIV/AIDS. Of concern is needle sharing among cocaine and polydrug injectors and an enhanced potential for unsafe sex, fostered by the disinhibiting effects of cocaine and by cases where sex is offered in exchange for cocaine. Harm reduction strategies, particularly needle exchanges, condom distribution and prevention campaigns, are essential to stem HIV spread through all cocaine-using populations.

Responses

The CP identifies more than two million "hard-core" cocaine users in the United States. This was described as problematic since there are no standard treatment programmes for cocaine dependence. It was emphasized that intranasal users had more favourable treatment outcomes than do crack smokers. Also, females were found to demonstrate a better response to treatment than do males. Multiple drug use was common. Alcohol is the major drug used with cocaine.

The primary media responses mentioned in the profile focus on the "war on drugs" that centred on crack. However, the media offers negative, exaggerated and often racialized images of crack users. This is especially apparent for women, who are frequently portrayed as prostitutes and unfit mothers. The CP contends that media prevention campaigns are founded on stereotype and myth.

The primary political response noted in the CP is the Anti-Drug Abuse Act of 1988 which financed several programmes including research on development of medications for treatment of cocaine dependence.

FLAGSTAFF (USA)

Introduction
Flagstaff contributed to the US Country Profile, but served mainly to contrast the rural US cocaine experience with more urban populations in the Key Informant Study (KIS). Flagstaff's population of only 45 000 has an ethnically diverse composition of 66% Anglo American, 15% Hispanic, 9% Native American and 2% African American. User consultants in the KIS were recruited from crack and injection users in an HIV/AIDS prevention study and all exhibited moderate to heavy use patterns. More recreational use among the wealthy is alluded to but is not well-represented.

Patterns of Cocaine Use
The Flagstaff KIS notes two dominant products. The more common is crack cocaine while cocaine hydrochloride or "powder" is less prevalent. Smoking, intranasal "snorting" and injecting are major routes of administration. Smoking is most popular while injecting is less common. Snorting was often described as an Initial method that lead to smoking for a more intense "high."

Cocaine is used in all subpopulations. Initial use takes place in the middle to late teens through friends or family and is often combined with other drugs such as marijuana or alcohol. Many associated crack use with single heterosexual Black and Hispanic males of middle to lower income groups. Crack users were said to hold minor or no jobs, receive welfare or Social Security Income, or support habits with crime and range in age from 8 to 68. Hydrochloride was also noted for high income groups who are more discreet in their use. Its use and distribution were also tied to Mexican immigrants.

A notable characteristic of use here was its affiliation with "drug using networks," described as based on ethnicity, kinship, or routes of administration. Networks are as small as 4 or 5 people or as a large as 15 to 20. Cocaine use within networks occurs mostly in private homes or rarely in local motels or public locations such as wooded areas outside of the town.

Crack was described as highly accessible due to its inexpensive cost and widespread availability. The primary limitation is money. It is purchased in US$20 "rocks." Occasionally, sex or other goods are exchanged. Networks offer access to a dealer who delivers cocaine or has a local place of access. Local dealers travel to nearby urban areas to obtain supplies.

Consequences of Cocaine Use
A major outcome for users is economic disparity. Crack users are characterized as lost labour and candidates for crime, posing a serious problem for the community. Children and adolescents are also harmed by the widespread availability and low cost of crack. Some described economic benefits of sales for cash flow into the impoverished communities where crack is found. However, this was considered minimal in light of continual use and dependency.

Another major outcome of use is its effect on family and personal relationships. Crack users were said to have few social ties, and these become strained as use intensifies. Theft of belongings to pay for the drug and violence associated with a cocaine "crash" as effects wear off, further this deterioration. Arrest was also a potential consequence but was described as an obstacle, rather than a preventive barrier to use.

Very few health effects were addressed in the KIS. The primary areas discussed were decreased sexual desire and loss of inhibitions which promote unsafe sex and risk for HIV/A1DS.

Responses to Cocaine Use
Flagstaff user consultants had limited knowledge about treatment. Self-help groups and agencies mentioned were rated as inefficient due to poor access or high cost. Most felt that users fail to benefit from the treatment. KIS respondents felt that users sec themselves as "different" and unable to succeed in treatment. The KIS also found that professionals have limited confidence in the outcome and indicate that care for cocaine is unavailable.

KIS respondents describe prevention campaigns as failures, noting that media images are negative and provided inaccurate views of use. Public service messages also fail to acknowledge the true complexity of rehabilitation for drug-use problems.

Consultants regard treatment and law enforcement as intimately connected since treatment is forced on most users by the legal system. This fosters resentment and negative views of both law enforcement and treatment professionals.

Law enforcement approaches, as described by the consultants, are believed to vary more for drug offences than for other offences. Penalties range from 2.5 years to life in prison. However, this is all negotiable, especially if an arrestee "snitches" or informs on a dealer or snother user. Legal measures are described in the KIS as an annoyance rather than a discouragement.

NEW YORK (USA)

Introduction
New York produced a Key Informant Study (KIS) site report described here and, with other participating centres, contributed to the United States Country Profile summarized separately.

Patterns of Cocaine Use
New York, with a population of 7 million, is often called the "drug addiction capital of the country". The late 1970s to the early 1980s witnessed increased use, mostly through intranasal and intravenous routes. Crack appeared in the mid-1980s, peaking by the early 1990s. Most users have experienced no use-related problems and the majority discontinue use over time.

The KIS sampled for ethnic, gender and educational diversity. The area is a centre for cocaine research and so professionals proved to be exceptionally well-informed.

Intranasal, smoking, freebasing and injection use of hydrochloride and crack are common. Cocaine is used in all economic and social groups but is particularly common among ethnic minorities and economically disadvantaged. There is speculation that New York's large market may be supported by users with large incomes, although those with low economic status tend to experience more "problem" use. Those treated for cocaine problems, arrested on cocaine related charges or who develop HIV infection through injection "are very likely to be among socially and/or economically disadvantaged groups". Crack smoking and injection are widely viewed as the more dangerous.

The KIS identified vulnerability factors that increase the likelihood of problem use such as low self-esteem, lack of social and family support and inadequate employment or high-wage jobs.

Cocaine is used in streets, "shooting galleries", nightclubs, cars and homes. Individuals use cocaine alone or with friends. Sexual activity is commonly associated with use. The main age group is between 15 and 25. Most begin with intranasal use, try cocaine out of curiosity and then quit. Some who continue use may begin to increase dosage and frequency over time. Such users may develop dependence and shift to injection use or smoking.

Virtually all cocaine users have a prior drug history and most use alcohol, cannabis and/or tobacco. Cocaine is used to offset negative effects of alcohol and cannabis such as drowsiness.

Consequences of Cocaine Use
Violence is associated with cocaine distribution, said to be managed by organized crime. Most violence is associated with street dealing and weapons possession. New York estimates that there are 200 000 injecting drug users, most of whom probably inject cocaine. Approximately half have already contracted HIV.

While women have fewer problems with heroin, almost half of those with problem use are said to be female. Women are also said to exchange sex for cocaine or engage in sex work to obtain money to purchase cocaine. Males often introduce women to cocaine in order to obtain sex. Crack is seen as being particularly attractive and dangerous for women and crack use during pregnancy has increased.

Responses

Numerous treatment services are available in New York, including psychotherapy, therapeutic communities, hospitalization, outpatient care and self-help programmes. Most respondents describe these treatment opportunities as insufficient and ineffective.

Cocaine possession, use and sale is illegal. The law enforcement community is seen as punitive and unjust and KIS consultants assert that the poor are more likely to be arrested and conclude that police should employ greater humanity in their approach to users. Most of the KIS respondents were unfamiliar with drug laws. New York is a centre for debate over the legalization of cocaine and other drugs.

PROVIDENCE (USA)

Introduction
The Providence Participating centre completed a Key Informant Study (KIS) for that site. A US Country Profile is summarized separately.

Patterns of Cocaine Use
Providence respondents report that hydrochloride and crack are the two main products available in Southeastern New England. Use is often combined with tobacco, alcohol, cannabis, heroin and pharmaceuticals.

Form of Cocaine Noted By Informants
(percentage data)

	User	Intermedia	Professional
Hydrochloride	17	5	10
Crack	17	5	8
IV Use	12	5	6
Leaf	3	1	2

Use occurs in all ethnic and linguistic groups but frequency and intensity vary among groups. Heavy use is reported among Hispanics, African-Americans, Cape Verdeans and Portuguese. Some suggest that fishermen represent the heaviest users and that cocaine use is central to sex workers.

Intranasal cocaine hydrochloride users are predominantly recreational and chronic users from the professional, middle and working classes, students, musicians and artists. Smokers more often belong to minority communities who prefer crack and other drugs due to their availability and low cast. "Shooters" or injecting users are often members of marginal underclasses who often use cocaine in a "cocktail" with heroin or methadone.

The KIS reports that cocaine prices have steadily decreased while demand has risen over the past five years. Cocaine is one of the cheapest and most available illicit drugs on the street. Cannabis is reported to be more expensive and more difficult to obtain than either cocaine or heroin.

Cocaine is purchased in 0.5 to 1.5 gram bags for $20 to $50 and must usually be purchased with case. Dealers rarely trade cocaine for sex but may barter for weapons. Quality varies greatly and most buy from relatives, friends or neighbours within ethnic or social networks to ensure quality. Users are reluctant to buy from members of a different ethnic or social group. Dealers have responded to market competition by utilizing beepers, portable phones and a fleet of cars with drivers operating during various times and "shifts".

Most users initiate use out of curiosity, "thrill" seeking or peer pressure. Most are introduced into use by a close friend or family member and start in their early twenties, although users from minority communities start in their early or mid-teens. Most initially inhale and later switch to smoking or injecting.

Consequences of Cocaine Use
Respondents describe positive effects of use such as stimulation and enhanced creativity with recreational use. The influx of black market funds into impoverished communities resulting from cocaine traffic is also reported as a positive consequence of cocaine. Consultants admit, however, that problematic features of use outweigh advantages.

While dependence is a concern to all users, most emphasize that use rarely produces problems. Those at highest risk tend to be chronic tobacco smokers, alcohol dependent or polydrug users.

KIS respondents report an increase in unsafe sexual practices, particularly among users who exchange sex for cocaine. This pattern is more common among crack smokers. While injection users are reported to be more monogamous than crack users, the addition of cocaine to the repertoire of drugs used by heroin and methadone dependents face higher risk for HIV transmission since the frequency of injecting and syringe use increases greatly. Despite local outreach and prevention programmes emphasizing the bleaching of needles, less than half of the informants who inject drugs clean their needles between sessions.

Responses to Cocaine Use
KIS consultants are unaware of treatment programmes specifically for cocaine. They identify programmes for alcohol and heroin, but suggest these inadequately address cocaine-related problems. Differences in education, social class and ethnic background are viewed as a major barrier to communication, empathy and respect between users and treatment professionals. Respondents agree that services are less than optimal but view self-help as more effective for some users than is professional care.

Consultants agree that law enforcement is more inclined to target users and small time dealers rather than major dealers and traffickers. Users view police and law enforcement personnel as corrupt and as enemies. Hispanic and African-American users are thought to be the main targets of police action. Most professionals note that services can only be improved with increased local, state and federal funding. Consultants recommend increased availability of medical treatment services, primarily for adverse health consequences related to poor nutrition and sleep deprivation. Some also raise issues of legalization or of decriminalization of possession and use.

SAN FRANCISCO (USA)

Introduction
The participating centre in San Francisco completed a Key Informant Study (KIS).

Patterns of Cocaine Use
Informants report that cocaine use in San Francisco has declined especially within the last three years. Use is not confined to a particular age-group, gender, socioeconomic class, profession, sexual orientation or ethnicity. All routes of administration can be found in all economic and social status groups. Nevertheless, KIS respondents agree that two clear patterns of use exist.

Consultants describe one user category as middle-class, suburban while heterosexual users who usually snort cocaine hydrochloride. Such use is mostly recreational and typically takes place on weekends. Few such users experience negative effects. Crack smoking is most common among inner-city poor, who often use daily and report the most cocaine-related problems. The key informants suggest that because of financial burden "hardcore" users and especially crack users experience financial losses. Injecting use is the least common route of administration in both urban and suburban users but is more popular in the homosexual community.

Informants report that use begins between ages 18 and 25 for reasons of curiosity and "self-medication". Use sometimes increases in frequency and amount over time. Administration may also shift from "snorting" to smoking or from smoking to injecting use, although injecting is relatively rare.

The San Francisco KIS found that, despite enforcement efforts, cocaine is easy to obtain, especially in urban areas. Suburban users must have a contact to procure cocaine while crack "rocks" can be bought in inner city areas for increments of US$ 1 to US$ 100. Informants report that the price of hydrochloride and crack has dropped dramatically in the last decade. An eighth of an ounce now costs about US$ 140. Informants also indicate that some intensive crack users might offer sex in exchange for cocaine.

Consequences of Cocaine Use
Few informants identify positive consequences associated with cocaine use, although some mentioned were, weight loss, possible increased creativity for artists, constructive communication and conversation, better driving ability, some increased productivity at work (though only for the short-term), increased concentration on menial tasks and increased imagination and vigour during sex. Other positive consequences included employment opportunities provided by the cocaine trade and an infusion of cash into otherwise impoverished and commercially depressed areas.

Many report negative consequences of cocaine for health. These include weight loss, poor diet, decreased immune system capacity, nasal and upper-respiratory ailments, mouth burns (for smokers), eye infections, drug-induced psychosis or mental health problems, impotence and premature aging. Other broader negative effects of use include financial problems, absenteeism or job loss, selling or loss of possession, relationship problems, drug dependence and loss of "quality time" for other activities.
Informants also report that cocaine has negative consequences for the community. This includes gang warfare over drug profits, the "taking over" or conversion of residences into "crack houses", increased

street crime, theft and use of firearms, enhanced law enforcement presence and paternalism, and the spread of sexually transmitted diseases.

Legal problems trouble dealers but have little impact on most users. Informants report some fear of legal problems but suggest that prosecution is rare. Adolescents and children are sometimes employed as "runners" in the cocaine trade because their youth tends to protect them from imprisonment.

Responses to Cocaine Use

San Francisco key informants report that effective treatment programmes exist but are few in number. Long waiting lists are reported for services. Twelve-step models are the most common approach and emphasize abstinence. Several informants claim that women are deterred from treatment as workers "stigmatize" female users. Treatment is less available for women and most fail to offer child care.

San Francisco maintains an active needle exchange programme that distributes needles, syringes, bleach and condoms to injecting heroin and cocaine users. Informants report that, as a result of these efforts, needle sharing is becoming much less common.

Key informants believe that media campaigns such as the Partnership for a Drug Free America have promoted an inaccurate and powerful negative stereotype of cocaine users. Media campaigns create an "us versus them" mentality and cocaine use is inaccurately viewed as spreading like an epidemic. Some informants suggest that the media has actually increased cocaine use by glamorizing it.

Law enforcement is viewed as exacerbating rather than resolving problems. Key informants contend that law enforcement does not deter use or "cure" those it punishes. Some report that police have begun to use more flexible approaches, confiscating supplies without arresting users. .

ZIMBABWE

Introduction
The Zimbabwe Country Profile (CP) and the Harare participating centre's Key Informant Study (KIS) indicate that cocaine use has emerged only in the last five years. While still limited to the small segment of the population who can afford its high pace, the CP concludes that cocaine represents the fastest growing drug problem in the country. The CP supports this by pointing to a notable increase in cocaine seizures between 1989 and 1993.

Patterns of Cocaine Use
The CP and KIS suggest that cocaine supplies remain scarce in Zimbabwe. Users tend to buy it when available, but often buy more available substances such as cannabis, alcohol, and tobacco. The CP and KIS report that cocaine hydrochloride is the most widely used cocaine product but some cite incipient crack use. The Harare KIS reports that hydrochloride is typically sold in quantities of one to two grams for ZIM$ 150 to ZIM$ 500, varying by purity. This price exceeds the monthly income of virtually all residents other than wealthy professionals in business and the entertainment industry.

The KIS reports that cocaine may be used only sporadically or as often as twice a day, depending on supplies and access to money. Most use one to two grams per session but a few become dependent and increase use frequency and dosage. A few may smoke cocaine if they develop nasal problems from "sniffing" but most use tends to be intranasal. A few had heard of injecting but none had seen such use. One KIS consultant claimed that cocaine may be drunk.

KIS consultants describe most cocaine users as single, while male heterosexuals in their late twenties or early thirties. Most are also wealthy and highly educated. The CP reports that cocaine use is more common among whites, Asians and "coloured" groups and uncommon for the majority "blacks", largely because these users enjoy higher socioeconomic status and can afford cocaine. Cocaine is purchased through sophisticated underground networks. A few may engage in crime or prostitution to gain funds for purchases.

Consequences of Cocaine Use
KIS consultants claim that cocaine improves artistic and creative ability and job and study performance by producing energy and excitement. It is employed to enhance sex, to relieve depression, tension, pain and fatigue, for curiosity or for pleasure.

Still, some describe depression and craving sensations following cocaine use and note risks of dependence. The most harmful effect is said to be on mental health, including paranoia. The CP cites some risk of cardiac arrest, weight loss and heightened risk of sexually transmitted disease including HIV.

The CP reports that use initially enhances relationships since it fosters sociability. However, intensive use may lead to irritable and irrational behaviour and interpersonal problems.

However KIS respondents report that violence is uncommon. The KIS and CP agree that prolonged and intensive use may harm family relations, spur arguments or financial problems, theft, fraud and prostitution.

Responses to Cocaine Use
The CP and KIS report that at present there are no treatment services available exclusively for cocaine-related problems. Drug treatment is provided in psychiatric units of general hospitals and in two private clinics in Harare, which offer residential and outpatient care for those who can afford it. KIS consultants describe public hospitals as overcrowded and private facilities as expensive. Consequently, few seek assistance except in life threatening cases.

The CP describes limited drug prevention programmes in Zimbabwe. Existing education covers all health issues including drug problems. Most are designed for health providers and law enforcement.

The CP reports that the maximum penalty for cocaine offences is six to seven years imprisonment. Courts may weigh mitigating factors in sentencing, particularly for young or first-time offenders. The KIS consultants contend that law enforcement approaches to supply control have had very limited success. Penalties noted in the CP are reproduced below.

Penalties For Drug Offences in Zimbabwe
(Possession, Use, Dealing or Trafficking)

Drug	Minimum Penalty	Maximum Penalty
Cannabis	Fine of ZIM $20	10 years prison
Heroin	6 years prison	7 years prison
Mandrax	Fine of ZIM $1500	15 years prison
Cocaine	Fine of ZIM $1000 or 1-12 months in prison	Adjusted (1994) to 6-7 years prison

Of note, most KIS consultants support intensifying enforcement by adding stiffer penalties and using more sophisticated methods for drug detection at points of entry into the country. Still, others recommend enhanced approaches to treatment and rehabilitation.