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DOMESTIC DRUG CONSUMPTION IN GHANA

*AN UNDER-REPORTED
PHENOMENON*

LUCIA BIRD



JULY 2019





DOMESTIC DRUG CONSUMPTION IN GHANA

An under-reported phenomenon

Lucia Bird

July 2019



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Acronyms and abbreviations

NACOB	Ghanaian Narcotics Control Board
NDC	National Democratic Congress
NGI	non-governmental rehabilitation institution
NPP	New Patriotic Party
PWID	people who inject drugs
PWUD	people who use drugs
UNODC	United Nations Office on Drugs and Crime
WACD	West Africa Commission on Drugs
WHO	World Health Organization



Executive summary

West Africa's emergence in the mid-2000s as a transit hub in the international illicit drugs trade and the consequent surge in the quantity of drugs transiting through the region have been well documented. However, the dramatic growth in domestic drug consumption in the countries of this region and the challenges faced by the expanding population of people who use drugs (PWUD) are far less reported. For a long time, commentators suggested that the impact on domestic consumption was minimal, masking a growing phenomenon to the extent that it has been almost invisible in international discourse. There is now growing recognition that the drugs trade has had a far more significant domestic socio-political impact on the region than was first believed, with the increase in drug trafficking undermining governance structures through corruption and illicit financial flows.

The lack of available data, however, prevents us from accurately assessing the prevalence of drug use, and our understanding of the characteristics of the domestic market is therefore limited. This absence of clarity is an obstacle to effectively addressing the growing phenomenon of domestic drug use and has, thus far, meant that the problem has been largely ignored by policy actors.

This report responds to the current apathy of the Ghanaian state and society in general towards the increasing prevalence of drug use in the country. It draws on field and secondary research, tracking drug-consumption patterns and exploring the characteristics of the population of PWUD, as well their treatment by society, to propose a set of recommendations for reducing the harms and risks that PWUD currently face.

“There is now growing recognition that the drugs trade has had a far more significant domestic socio-political impact on the region than was first believed.”

Since 2010, drug-consumption patterns in Ghana have trended towards polysubstance abuse – most PWUD who seek treatment are reported to have been using a combination of marijuana, cocaine and heroin. A surge in the global production of heroin and cocaine, two of the most commonly used illicit drugs in Ghana, will most likely lead to an increase in domestic consumption of these drugs. Similarly, reports of methamphetamine production beginning in Ghana could mean that yet another challenge is on the horizon for law enforcement and the health system – although PWUD and health professionals interviewed in 2017 had not used or encountered (respectively) the use of methamphetamines, suggesting that this class of drugs has not yet entered the market in any significant manner. In addition to these developments, the spike in misuse of tramadol, an opioid medically prescribed for pain relief, particularly among the Ghanaian youth, is causing further strain to be placed on already limited healthcare resources.

Although drug use is believed to be endemic across Ghana's social demographic range, it is most visible among the country's lower socio-economic groups. Drug use is also believed to be significantly more common among men than women, but this could be attributed to significant under-reporting by female PWUD, who face greater social stigma for drug use. Although female users experience the brunt of public criticism, condemnation of drug use is widespread; it is often spoken about using the language of religion and perceived to be unholy or the result of moral failure. Adding to this is the widespread belief that drug use is intrinsically linked to mental illness, and that it is therefore incurable, even when it is represented as a public-health issue. Although societal attitudes towards drug use appear to be static, with PWUD invariably shunned, this could be due to the lack of education on the issue of substance abuse.

In addition to their facing public disapproval, there is very little support available to PWUD. State-run health facilities rarely include specialized substance-disorder units, and privately funded rehabilitation clinics are unable to meet



the demand for treatment. The practice of sending PWUD to prayer camps, which is the case for many, and where they are sometimes subjected to severe human-rights abuses in the name of religion, is also of extreme concern.

Even non-governmental rehabilitation institutions (NGIs), which are largely funded by religious organizations, have a zero-tolerance approach to drug use. There are also restrictions on whom these inpatient centres treat: they cater exclusively to men and typically charge a fee for their services, which most PWUD are unable to pay. Meanwhile, state-run institutions are scarce, and although psychiatric units often offer detoxification programmes, they do not provide ongoing addiction support, so relapses are therefore common.

Also absent in Ghana are such harm-reduction strategies as needle and syringe programmes, a preventative response in which sterile needles and syringes are supplied to PWID in order to curb the transmission of HIV and other blood-borne viruses. Despite forming a major part of international harm-reduction programmes, needle and syringe programmes are disapproved of by Ghana's health-professional community. Local health professionals and PWUD interviewed believe levels of injecting drug use to be low in Ghana, despite the country's high rate of heroin use, which is predominantly smoked instead. The majority of people who inject drugs are instead believed to use pethidine, a prescription drug, and come predominantly from the medical community and therefore have easy access to needles.

The challenge of domestic drug consumption in Ghana is set within the wider problem of drug trafficking across the region and the ineffectiveness of local law enforcement in combating it. Two main factors are behind the inadequacy of the response. First, the investigatory capability of local law enforcement is no match for the sophistication of the criminal networks that transport drugs across West Africa. Secondly, the significant amount of drugs money filtering into Ghana's political sphere prevents effective action to be taken against these criminal networks. The reported links between the New Patriotic Party (NPP), currently in power in Ghana, and members of the drugs trade suggest that the complicity of political elites in this trade is a problem.

The treatment of PWUD in Ghana is generally unsympathetic, and the current legislative framework governing the use of illicit drugs takes a hard-line approach. The country's 'war on drugs' mentality means that significant sentences are handed down for drug-related offences. Significantly, a draft Narcotics Commission Bill, which has been going through the government and cabinet process for over three years, seeks to decriminalize drug use while retaining heavy sentences for trafficking offences. This shift towards treating substance use as a public-health issue is laudable, but it would need to be accompanied by the allocation of resources towards improving rehabilitation services if it is to have any real impact.

Key recommendations

- Step up research on domestic drug use in Ghana, particularly to determine its prevalence with greater accuracy. Ensure that the data gathered is gender-disaggregated to shed further light on the plight of female PWUD, whose treatment needs are currently almost entirely unmet.
- Work to recast addiction as a public-health issue, using the significant influence that the church wields to shift societal attitudes and destigmatize drug use.
- Increase awareness among health and law-enforcement professionals.
- Implement the proposed regulatory reform by passing the Narcotics Commission Bill 2017, and accompany this legislative change with increased allocation of resources to rehabilitation services.
- Increase the number of rehabilitation services available and improve their quality.
- Embed harm-reduction principles into national and foreign donor strategies, giving rightful emphasis to the harms caused by Ghana's growing domestic illicit drug consumption, rather than purely focusing on Ghana's role in the international drug-trafficking trade.



Introduction

West Africa's emergence in the early years of the 2000s as a key transit hub in the global illicit drugs trade has led to a large number of studies that outline the configurations of networks moving drugs across the region and their routes. It is only more recently that the deeply destabilizing and corrupting effects of the international drugs trade on the region's governance mechanisms have been recognized. Nevertheless, the focus of research is still largely confined to law-enforcement approaches for combating trafficking. Only recently has the impact of the increase in drugs flowing through the region on domestic consumption drawn the attention of the international press and, to a lesser extent, policy actors.



Jamestown, Accra, an area reported to have a number of drug hubs

Photo: Peter Watson

This report sheds light on the growing market for illicit drugs in Ghana, which has so far remained in the shadows in the rhetoric of state and international institutions alike, and is only now starting to garner media attention. By approaching drug use in Ghana as a public-health issue and describing domestic consumption trends, this report highlights the challenges faced by PWUD in Ghana rather than focusing on the criminal networks supplying them.

“Increases in the global production of heroin and cocaine suggest that the challenges posed by increasing consumption of illicit drugs in West Africa will escalate.”

Drawing on interviews with health and law-enforcement professionals, individuals working in the drug-policy space and PWUD, together with extensive desk research, the report examines the kinds of drugs being used, who is using them and what kind of rehabilitation support is available for PWUD. It aims to start a conversation about drug use in Ghana that emphasizes the human rights of PWUD and suggest ways of mitigating the harms they suffer. Although this report touches on the wider implications of the illicit drugs trade on Ghana's institutions and communities, the risks faced by PWUD remain at its centre.



Ghana is not the only West African country to have experienced an increase in drug use: in 2014 the West Africa Commission on Drugs (WACD) concluded that increases in drug trafficking and consumption over the last decade had ‘taken on a dimension that threatens the security, governance and development trajectory of many countries in the region’.¹

A surge in the global production of heroin and cocaine suggests that the challenges posed by growing consumption of illicit drugs in West Africa will escalate. Heroin use, in particular, has seen a vast increase across the continent, with Africa experiencing the biggest upsurge in heroin consumption globally in 2017.² This spike was predominantly caused by ‘spillover’ effects from South Asia across the southern route, which links heroin shipped from Afghanistan to the coast of East Africa and then across a network of routes along eastern and southern Africa towards countries in Asia, Africa and Europe.³ The little-documented western route, by which heroin is moved overland from eastern and southern Africa through Uganda and onto West Africa,⁴ may also be behind increases in regional consumption. This upsurge has, however, reportedly tailed off: the 2018 UNODC World Drug Report concludes that heroin use is stabilizing or even declining across Africa.⁵

Global cocaine production also reached a new high in 2017, rising by 56% between 2013 and 2016, and 25% between 2015 and 2016.⁶ This is likely to further depress prices across West Africa, and ensure that the domestic cocaine market remains well stocked as the drug flows through the region towards the US and Europe, where demand is also growing.

Methodology

This report draws on the findings of about 30 long, semi-structured interviews with four key groups:

- Health professionals, including those working in state-run institutions, either in units specifically targeting drug addiction or in more generalist psychiatric hospitals in Accra and Cape Coast, and the management and staff of privately funded rehabilitation clinics and outreach centres in the Greater Accra region.
- Law-enforcement professionals, including senior members of the Ghanaian police force from the investigation of serious crimes unit, members of Ghana’s Narcotics Control Board (NACOB) and barristers working on drug-related topics.
- Non-governmental and international organizations working on matters relating to drug trafficking and drug use, including UNODC and the International Drug Policy Consortium.
- PWUD, including those currently habitually using drugs, those undergoing treatment at inpatient or outpatient centres, and those who have completed treatment.

These interviews were supplemented by an extensive review of the body of literature on illicit drugs use in West Africa, and more specifically in Ghana.

The sample size of this study is too small to provide any usable quantitative data or accurate estimations of the prevalence of drug use in Ghana. Instead, this report outlines the broad characteristics of a growing phenomenon and showcases the findings of field research and interviews that place Ghana’s PWUD population at the centre of the discussion. Although attempts were made to collect more data from rehabilitation centres, most of the data gathered was incomplete and could therefore not be fully utilized.

The primary data collected for this report is limited to Ghana. A greater understanding of the regional context could be gained by undertaking further investigation among Ghana’s francophone neighbours and other countries in the region.



An under-reported phenomenon: Where is the data?

In the early 2000s, Ghana's political elites repeatedly denied that there had been any increase in the domestic consumption of drugs.⁷ But, in recent years, this trend has become more difficult to ignore. Health professionals, lawyers and law-enforcement officers in Ghana now report a dramatic increase in the domestic consumption of illicit drugs over the past decade. However, the scale of the increase remains unclear, as figures to accurately quantify the prevalence of drug use in Ghana do not exist.

Although both state and international actors have repeatedly acknowledged this lack of data, progress in filling the gap remains extremely slow. NACOB, for its part, is now working to collect data on the prevalence of drug use in Ghana. Recognizing that their information remains patchy, preliminary findings have nevertheless led NACOB officials to conclude that drug use is 'widespread, more than we realize. [Drug use] is everywhere.'⁸

Health professionals working at state-funded psychiatric hospitals estimate that about 10% of inpatient, and between 20% and 30% of outpatient cases are now linked to substance abuse.⁹ Spikes in drug consumption have placed an enormous burden on state healthcare facilities, few of which include specialized drug-use treatment centres.

The absence of verifiable data on the prevalence of drug use in West Africa has meant the scale of the phenomenon has largely gone unreported and almost entirely unaddressed at a policy level. Consequently, health and law-enforcement resources for dealing with this worsening societal situation are notable by their absence.

Background: Emergence of the West African drug-transit route

The transit trade for illicit drugs through West Africa is said to have originated in the 1950s as, first, Lebanese and, later, Nigerian networks began operating in the region.¹⁰ But it was not until the early years of this millennium that the region gained prominence as a key transit hub in the international drugs trade.

This shift was triggered by an upsurge in the volume of cocaine, and the profits it generates, transiting through the region. This was, in turn, due to increased law-enforcement efforts against drug trafficking in Latin America and the Caribbean, which diverted trafficking routes into West Africa. The cocaine moving through West Africa is primarily en route to markets in Europe; analysts estimate that about 10% of the cocaine circulating in Europe transits through this region.¹¹

Within the region, Ghana's deep-water ports make the country an attractive logistics hub for drugs being moved overseas, while its anglophone status strengthens its links with Nigeria, from where there is a significant overland transit route into Ghana. Opera, the name of an area of central Accra near the shoreline, is known to be home to many Nigerians who immigrated before independence but who retain links to Lagos. This is reportedly a key spot for heroin to be brought into Ghana. According to one interviewee, the drugs are typically smuggled into the country concealed in bags of Thai white rice – lending heroin its local street name, 'Thai'.¹²

West Africa's weak law enforcement and limited political will to tackle the drugs trade have made the region a relatively safe haven for drug trafficking – the region simply does not have the capacity or resources needed to address organized crime of this scale.

The groups that traffic drugs through West Africa are believed to operate as fluid networks, rather than highly organized hierarchical structures, and include actors from the political and business spheres, as well as on-the-ground fixers. In Ghana, the drug-trafficking groups are believed to be typically less organized and professional



than their counterparts in Nigeria and East Africa.¹³ There is some evidence to suggest that, in line with the criminal diversification patterns observed in other jurisdictions, certain networks combine the movement of people with the transiting of drugs along their routes.

Meanwhile, profits from drug trafficking have scarcely benefited the regional economy, as the bulk of the proceeds are transferred offshore.¹⁴

As the prices paid for illicit drugs, and the profits to be made from them, are far higher in Europe and the US than in West Africa, large-scale traffickers generally seek to ship illicit drugs through the region to the international markets. However, in some cases low-level drug traffickers are paid in kind and lack the resources or networks to move the drugs across borders. Consequently, they flood the local market with illicit drugs, contributing to the growth in domestic consumption rates, which this report examines in detail.

As noted above, a spike in heroin and cocaine production since 2016 is the likely explanation for the increase in the volumes of each drug type transiting through West Africa.¹⁵ Following rudimentary economics of supply and demand, the increased supply of cocaine and heroin to the domestic markets in the region will lead to falling prices. PWUD who participated in interviews for this report said that the 2017 price for one 'hit' of heroin or crack cocaine, the unit the drugs are typically purchased in, was just over US\$2.¹⁶

The growing sophistication of drug-trafficking groups generally continues to outstrip the investigatory capacity of law-enforcement authorities. This has led a number of players in the international community involved in tackling the regional drug trade, together with members of the local Ghanaian police force, to predict that the situation will get worse before it gets better.¹⁷

The notable absence of investigatory capacity in most of the Ghanaian police force is a major obstacle in tackling drug trafficking at the local level. Although a successful operation may result in a seizure, the capacity to track down the larger networks responsible is generally lacking.

“Low-level drug traffickers are paid in kind and flood the local market with illicit drugs.”

Meanwhile, another challenge has emerged in Ghana: as the market for synthetic drugs expands, precursors are becoming an increasingly important element of the trade. These are harder to detect and present an enormous challenge to the local police and NACOB. Even if an investigation is successful, the weak adherence by law enforcement to necessary processes poses further barriers to conviction: contamination or loss of evidence, and poor adherence to investigatory procedures result in many cases being thrown out of court by judges.

A number of interventions have sought to bolster the capacity of Ghanaian law enforcement to tackle organized crime.¹⁸ However, their effectiveness is hampered by high-level corruption among politicians and within the judiciary,¹⁹ which prevents convictions even where investigations have been successful.²⁰ In line with global trends, those incarcerated tend to be low-level users rather than senior players.

Drugs and democracy

Widespread collusion among politicians is said to have facilitated the illicit drugs trade in Ghana, with profits from drug trafficking reportedly infiltrating and financing the country's political system.²¹ One of the main reasons for



the collusion is said to be the high cost of running election campaigns within democratic systems of governance. In Ghana, Africa's oldest postcolonial democracy, the cost of presidential election campaigns is believed to have increased significantly; however, no official figures are available.²² The legal framework lacks provisions to create a level playing field in campaign financing. In particular, it provides no campaign spending limits, or caps on the size of political donations that can be accepted by political parties or candidates. Transparency in political party financing is low, with political parties regularly failing to comply with legislative requirements to submit their annual audited accounts to the Electoral Commission.²³ The 2016 election year was no exception. Similarly, parties contesting elections are required by law to submit their financial statements to the Ghana Electoral Commission 21 days prior to election day – neither the NDC nor the NPP (the two main political parties contesting the 2016 elections) complied, and the Electoral Commission was criticized for failing to take action.²⁴ The cost of campaigning to become a member of parliament has also increased year on year, and is estimated to have risen by 59% between the 2012 and 2016 national elections alone.²⁵ Most Ghanaian MPs reported self-funding their campaigns, with a significant proportion taking loans from friends.²⁶ Ghana's soaring election costs have often surpassed those of many of its neighbours, causing national think-tanks to lobby for regulatory changes in order to lower spending, warning that the rising cost of elections is putting 'undue strain on [...] democracy'.²⁷

With legislation limiting party dues, the low salaries paid to MP, and a lack of transparency in campaign financing, sources of political funding are widely recognized to include profits from the illicit drugs trade. For example, in June 2017, Kofi Bentum Quantson, a retired NACOB official, said publicly that 'nobody does politics with his own clean money', referring to the impossibility of conducting campaign financing based solely on permitted political party dues.²⁸



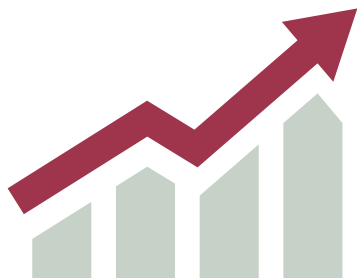
Fishing harbour, Jamestown, Accra

Photo: Peter Watson

The NPP, the party currently in government, has a history of links to key players in the drugs trade. In 2008 Raymond Kwame Amankwah, allegedly one of Ghana's most wanted drug barons, who had evaded arrest warrants issued by the UK and INTERPOL for drug trafficking, was arrested in Brazil after a complex international investigation and sentenced to seven years in prison. However, Nana Akufo-Addo, at the time attorney general of Ghana, is reported to have quietly returned the state-seized assets of Amankwah to his family a few months after his arrest.²⁹ Amankwah, who happens to be Akufo-Addo's brother-in-law, is believed to have become a major donor to the NPP.³⁰ Akufo-Addo, now leader of the NPP, became president of Ghana in December 2016.



The cost of campaigning to become a member of parliament has increased year on year.



It is estimated to have risen by 59% between the 2012 and 2016 national elections alone.

While PWUD on the streets are publicly stigmatized, the collusion of politicians enmeshed in the drug trade attracts less criticism – rather the opposite, as illustrated by the case of MP Eric Amoateng, who returned to Ghana in 2014 after being imprisoned in the US for his involvement in heroin smuggling. Amoateng was given a hero's welcome on his return, celebrated by the ruling NPP and constituency members alike, and greeted at the airport by supporters bearing placards that read 'Cocaine or no cocaine, we love U Amoateng'.³¹

The way that drugs money has come to infiltrate politics and finance political figures has had the effect of creating a cordon of impunity around them: none of the many mid- and high-level public figures found to be complicit in the drugs trade have ever faced serious punishment. Meanwhile, senior law-enforcement officials believe that the influence of drugs money in the Ghanaian political system continues to grow.³²

Opposition parties, which usually have more limited sources of funding, are often more dependent on illicit financing. Incumbents are believed to abuse state resources to finance election campaigns – a pattern noted by the EU Electoral Commission in relation to the NDC's financing of the 2016 presidential election campaign – leaving parties in opposition heavily reliant on donations by 'friends' to compete.³³ This creates a vicious cycle of increasing political patronage: funds gained are typically repaid through political favours or, at the very least, political apathy towards cracking down on the drugs trade, which creates an enabling environment for criminal networks. This cycle of corruption is believed to have increased with the rise to power of the NPP in the 2016 elections, as the party is widely believed to be more heavily dependent on drugs money than the previously incumbent National Democratic Congress (NDC).³⁴

Drug use in Ghana: Demographics and consumption patterns

Tracking consumption patterns: The rise of polysubstance use disorders

The scale and patterns of drug use in Ghana have changed in response to the development of drug-trafficking routes through the region. Health professionals track a clear shift from the 1990s, when they predominantly treated patients for alcohol consumption or, less commonly, marijuana use,³⁵ to the early 2000s, which saw a spike in the number of cocaine users treated, in parallel with West Africa's emergence as a key cocaine-transit region.

Health professionals charted a shift from mono-drug use to polysubstance use in 2010, and by 2017 the vast majority of people seeking treatment had reportedly been using more than one substance, typically a mixture of alcohol, marijuana, cocaine and heroin.³⁶



Drug hubs in Ghana

Four middle-aged Ghanaian men sit on plastic chairs on the pavement of the main street in Tema, a large port town in the south of Ghana about an hour's drive from the capital, Accra. One is the chieftain of an adjacent neighbourhood, a shanty town that is known to be an area where drug dealers and users congregate. The neighbourhood is commonly referred to as a 'drugs ghetto' by rehabilitation workers and health professionals in Ghana but termed a 'drugs hub' in this report.



A small, unpaved alley marks the entrance to the shanty town – a series of narrow mud streets flanked by low-rise temporary constructions. One corpulent man, wearing the traditional white dress of a province of northern Ghana, is a dealer in the area. He objects to the presence of the manager of the rehabilitation centre who accompanied the author, because he resents the loss of clients to treatment programmes. None of the dealers use drugs themselves; instead, they regularly try out new batches on users to determine the purity and strength, often targeting those in the early stages of addiction in order to fuel further consumption.

It is early on a Saturday morning and the breakfast *waakye*³⁷ stall serves huge portions of rice and beans to a queue of people, 90% of whom are male, and the majority are smoking or preparing to smoke. The ubiquitous white spliffs are made not only with tobacco or marijuana; many contain crack cocaine or heroin.

The combination of cocaine and heroin is often referred to by PWUD as 'heat and cool', because of the drugs' respective uses as a stimulant and depressant. Combining the two drugs is also a way of making cocaine consumption more cost-effective. When using only cocaine, PWUD estimated their daily expenditure on drugs to be between GH¢200 and GH¢300 (US\$40–US\$60),³⁸ roughly the equivalent of a month's wages at Ghana's minimum



wage between 2017 and 2019.³⁹ Although the prices of a hit of cocaine and a hit of heroin are roughly the same, the effects of cocaine, particularly after extensive usage, last for mere seconds while those of heroin usually last a few hours. PWUD therefore perceive the introduction of heroin into their drug-consumption patterns to significantly lessen the financial cost of drug use. When habitual cocaine use becomes too expensive, PWUD frequently turn to heroin as a money-saving measure.

The gateway theory: From marijuana to heroin

Early on a Saturday morning in Tema, most of the people in sight will be preparing or smoking roll-ups; the overwhelming majority of them are men. Roll-ups are frequently the method of choice for the administration of the most common illegal drugs – marijuana, cocaine and heroin.

Although marijuana can also be mixed into food or beverages (usually tea), in Ghana it is most commonly smoked. Cocaine is also primarily smoked, usually in the form of crack cocaine, which is by far its most common manifestation in Ghana. The small amount of pure cocaine available circulates exclusively among the middle and upper classes, and among foreigners. Likewise, heroin, or so-called 'brown sugar', is rolled up and smoked either on its own or together with marijuana.

This common method of consumption makes marijuana, cocaine and heroin usage largely indistinguishable by sight. Although the 'gateway' theory, which poses that the use of marijuana leads to experimentation with harder drugs, has been rejected by most academic studies, it remains a belief widely held among professionals working in Ghana's health services and law enforcement. They emphasized in interviews that this shared mode of administration helps to collapse the distinction between the drugs for PWUD who also lack adequate knowledge of the substances. Thus, marijuana users are more likely to graduate to other harder drugs.

Demographics of drug use

The demographic of PWUD in Ghana has changed significantly since the mid-1990s, when cocaine and heroin use was largely confined to more affluent individuals. In the current landscape, drug use is believed to be most prevalent across middle- and lower-income demographics, and most visible in the latter.⁴⁰



In Ghana, PWUD are predominantly male and young – generally between the ages of 18 and 40.

Although most Ghanaian law-enforcement and health professionals believe drug use to be equally prevalent across social strata, anecdotal evidence does point to greater prevalence among low-income groups. For one, Robert Fenning, manager of Compassion Rehab Centre, has estimated that over the last five years, about 90% of the centre's patients have come from lower-income backgrounds.⁴¹

By contrast, the findings of a NACOB 2017 survey of about 100 users in treatment in greater Accra found that over 80% of interviewees had completed at least secondary education, a good signifier of a higher income demographic.⁴² Until 2017, secondary school in Ghana was fee-paying, suggesting a substantial number of interviewees came from lower-middle- or



high-income groups. Although this statistic is likely skewed by the fact that most rehabilitation clinics require a fee for inpatient treatment, meaning participants in the NACOB study are probably of a wealthier social demographic than PWUD receiving outpatient or no treatment, it does lend credence to the belief that drug use is endemic across Ghana's social strata.

While the representation of income groups among PWUD is debated, it is clear that in Ghana PWUD are predominantly male (as explored below) and young – generally between the ages of 18 and 40. Health professionals have reported particular growth in drug use among those under 40, charting an ever-decreasing average age of initiation, with widespread and increasing illicit drug use reported in both secondary and tertiary educational institutions, particularly in the form of tramadol misuse.⁴³

Faces of addiction: Kofi

Kofi (not his real name) is a tall man, with broad shoulders and a weathered face. He sits on a low, wooden bench in a small, dark room with no door; PWUD can pay to sit in here while they use. As it is morning, there are only five men in the room. Later in the day, it will be full, and a queue of people will form outside, each of them willing to pay the GH¢2 (US\$0.5) entry fee.

Kofi is a carpenter by profession, and he is married with two children, one eight and one fourteen, both at school. He has been using drugs for over eight years, but was clean for two years until he relapsed in March 2017. He now uses heroin and crack cocaine daily and is here smoking his Saturday-morning hit of heroin before heading to work. He remains employed but fears that he will soon lose his job if he is unable to stop using. 'I can't stop earning,' he says. 'I need to keep my children in school. My family know I use; they don't like it, but what can they do? I want to stop; I know it is bad for me and my family.' But Kofi cannot afford to pay the inpatient fee charged by local rehabilitation centres, and is struggling to stop using alone.⁴⁴

Women who use drugs

In Ghana, the use of illicit drugs is far more visible among men than women, with one health professional interviewed estimating the ratio at 50:1, male to female.⁴⁵ The drugs hubs appear to be almost exclusively populated by men, a startling contrast to street-life elsewhere in Ghana.

Domestic health professionals and ex-PWUD working in rehabilitation centres principally attribute this gender imbalance to two key factors: the deterrent effect of greater social stigmatization of drug use among women and the gendered nature of the household economy. First, women in Ghanaian society primarily occupy the roles of mother and caretaker, and taking drugs would mean breaching these roles. Drug use in women is therefore met with greater disapproval than in men. Secondly, women across all sectors of Ghanaian society, but particularly those within the lower-income demographic, are less likely to have financial autonomy. Household finances, including the wages of female members, are often managed by fathers, brothers or husbands. Therefore, in addition to being less stigmatized, men are more likely to have the financial autonomy to spend money on drugs.

However, greater stigmatization of women may not be responsible for their lower rate of drug consumption, as is widely

50:1 – the ratio of male to female drug users in Ghana.



believed; rather, it may simply mean that fewer women are *reporting* the use of drugs.⁴⁶ Stigmatization drives the isolation of female users; they are shunned from public shared spaces (see the box titled 'Shared public spaces: Kojo's house') and are less likely to seek treatment. This fits the global trend whereby women account for a third of PWUD but make up only a fifth of those in treatment.⁴⁷ In Ghana, the result of this under-reporting is that the number of women who use drugs is likely to be vastly underestimated, which means that their treatment needs go almost entirely unmet.

The treatment needs of women who use drugs are particularly acute, as women often engage in commercial sex work to finance drug use. In doing so, women who use drugs are particularly vulnerable to abuse, as well as health risks in the form of sexually transmitted diseases. Women also tend to seek help at a far later stage of addiction, which leads to a reduced chance of rehabilitation and survival. Women who use drugs are believed to have a more accelerated progression than men from the initiation of substance abuse to the development of substance-abuse disorders, a phenomenon known as 'telescoping'⁴⁸ – the window for treatment before the disorder becomes severe is therefore smaller. Nevertheless, low rehabilitation rates among female PWUD would also appear to be, in part, attributable to the lack of rehabilitation services in Ghana available to them – as of December 2017 there existed no inpatient rehabilitation centres that admitted women.⁴⁹

“Stigmatization drives the isolation of female users; they are shunned from public shared spaces and are less likely to seek treatment.”

Speaking about the establishment of Compassion Rehab Centre, Fenning admitted that the needs of female PWUD go largely unmet: 'When we first set up the centre, we were approached by women and we tried to take them in or at least provide them with some services, but it caused complications and we did not have the resources to provide services to men and women.'⁵⁰ Fenning said that the number of female PWUD that Compassion Rehab Centre has turned away has decreased over time as PWUD have come to know the centre as an exclusively male facility.⁵¹ Similar patterns exist for other NGOs. Enhanced data collection is urgently required, as there may exist a substantial number of unreported female PWUD in Ghana whose treatment needs are unmet.

Shared public spaces: Kojo's house

Kojo (not his real name) is an artist; his lurid paintings adorn the walls of the one-room ground floor of his two-storey house. Inside this dark room, five men are busy cooking heroin. Outside, on the patio, eight men are lying on thin, dirty mattresses; most of them are asleep.

Kojo inherited the house and now provides 'his boys' with a place to sleep and use. All the men go out daily to 'do a one two', meaning to either work or steal to earn money. Of those that find work, most will act as porters carrying loads off the ships in the port of Tema or as shelf-stackers in supermarkets. Those who fail to bring back money lose the right to a spot in the house. All of the men agree that God's help is necessary for sobriety; they recognize that little other help is available.

The author knows of no equivalent of this kind of shared space for women.⁵²



Use of injected drugs

People who inject drugs (PWID) make up one of the four groups most at risk of contracting HIV, the others being prisoners, men who have sex with men, and female sex workers. Although research suggests that injecting drug use is increasing in southern Africa,⁵³ health professionals from Accra's Korle Bu Hospital Addictive Diseases Unit and others interviewed agreed that despite being common in the context of prescription-medicine abuse by the medical community, injecting drug use is rare in Ghana for street drugs such as heroin. If this is indeed the case, it could be one of the reasons behind the finding that injecting drug use contributes far less to the spread of HIV in Ghana than it does globally – 4% versus 10%, according to 2013 figures.⁵⁴

“Health professionals interviewed agreed that injecting drug use is rare in Ghana for street drugs such as heroin.”

A 2014 study by Kwame Nkrumah University of Science and Technology and Boston University conducted a qualitative assessment of the HIV vulnerability of PWID in Kumasi, Ghana's second-largest city. The report was based on findings from interviews and focus-group sessions with 52 participants, who predominantly injected heroin and cocaine.⁵⁵ Local health and law-enforcement professionals interviewed suggested that the image of widespread injection of drugs this report gave was deeply misleading, and strongly believed the injecting of heroin or cocaine to be extremely rare in Ghana.⁵⁶

In the drug hubs of Accra and Tema, no needles are visible and PWUD interviewed reported never having injected heroin and knowing of none (or only one PWUD) who did. Those PWUD known to inject heroin had reportedly always travelled abroad and first injected heroin there, or else had been introduced to the practice by foreign PWUD. Seen as a foreign method of administration, injecting is broadly frowned upon by PWUD themselves, and all heroin users interviewed reported smoking the drug instead. This is in contrast to South Africa and East Africa, where, although smoking heroin remains the most common method of consumption, there are substantial PWID populations in the region, most notably in Kenya (over 55 000), Tanzania (over 32 000) and South Africa (over 75 000).⁵⁷

One person who uses drugs vouched that in over a decade of his using illicit drugs, predominantly while living on the street, he had never seen anyone injecting heroin in Ghana and had only heard of one such person. This person had returned from abroad and had eventually been forced to stop injecting because of the stigma it carried among PWUD in Ghana.⁵⁸ Other PWUD interviewed told similar versions of this story.

A doctor working at the Cape Coast Teaching Hospital, who specializes in drug addiction, summarized the situation as follows: 'We have marijuana, we have cocaine and we have heroin, but we don't have a lot of injection drug use. The few injection PWUD are usually health professionals [who inject pethidine and not heroin].'⁵⁹ Misuse of pethidine, a post-operative sickle cell anaemia drug common in Ghana where the condition is prevalent, is widespread among the country's health professionals. However, needle sharing is believed to be extremely rare among health professionals who are both more aware of the risks and have easier access to fresh needle supplies.

Most notable PWID populations in southern and East Africa

55 000+ Kenya

32 000+ Tanzania

75 000+ South Africa



The World Health Organization (WHO), UNAIDS and UNODC, along with other international organizations, have recommended a package of nine interventions to prevent HIV in PWID; these include the introduction of needle and syringe programmes, and opioid substitution therapy.⁶⁰ Neither of these interventions is currently available in Ghana and all health professionals interviewed were strongly against the introduction of these prevention strategies, suggesting that they are merely standardized Western solutions inappropriate to the local context.⁶¹ The director of the Korle Bu Addictive Diseases Unit argued that the use of needle and syringe programmes risks increasing the popularity of injecting as a form of drug administration: ‘When a heroin user tries injecting for the first time, they will never go back. The hit is much more immediate. You have then created a new problem.’⁶² Health professionals also expressed fears that needle and syringe programmes would prompt an increase in injecting drug use, and thus trigger a spike in fatal overdoses, which are reportedly rare from heroin use in Ghana, although more common from tramadol misuse.

The introduction of either intervention, but particularly of needle and syringe programmes, would likely be met with significant criticism by the Ghanaian medical community. Furthermore, the current legal framework is not conducive to the introduction of these interventions and would therefore require revision in order for them to have any chance of success.

Emerging trends in drug use

Tramadol

The misuse of tramadol has experienced a dramatic escalation globally, prompting the UNODC to refer to a ‘tramadol crisis’ in 2018.⁶³ Tramadol is not internationally regulated by the International Narcotics Control Board, largely due to concerns on the part of the WHO that scheduling tramadol as a drug with high potential for abuse could limit its medical use in the developing world, where pain-relief medicine is hard to come by. This lack of regulation is troubling, as most of the illicit tramadol seized in Ghana is believed to have been manufactured in India and is typically double or even quadruple the strength of FDA-approved forms of the drug.⁶⁴

“Tramadol can induce a sense of euphoria and is widely taken in Ghana to enhance sexual prowess – a common incentive for drug use.”

The popularity of tramadol among PWUD continues to grow across West Africa and internationally, placing further strain on already limited health resources. In a 2018 statement, Ghana’s Mental Health Authority called for tighter control of tramadol imports, demanding a change to current legislation to permit NACOB to regulate imports.⁶⁵

In Ghana, non-medical use of tramadol was first reported in 2016; this prompted the government to deem it a controlled substance, which means that it is illegal to buy tramadol without a medical prescription or to sell it without a licence. After a brief lull, non-medical tramadol use has continued to spread throughout Ghana’s lower-income demographic. Local media have focused on non-medical tramadol usage among children and young adults. PWUD interviewed in Accra referred to tramadol use as a ‘new fad’ among the youth. However, the drug’s widespread use by manual labourers – including porters, drivers and miners, who report taking tramadol to enhance stamina and suppress physical pain – has received less attention. Tramadol can induce a sense of euphoria and is widely taken in Ghana to enhance sexual prowess – a common incentive for drug use (see the box titled ‘Mis-selling Viagra’).



Methamphetamines

West Africa, and in particular Benin, has become a key transit point in the trafficking of methamphetamines towards North America, and East and South East Asia, with Nigeria being a key methamphetamine production country in the region.⁶⁶ Both Benin and Nigeria reported significant seizures of ephedrine, the precursor used to produce methamphetamines, far beyond the countries' reported annual legitimate requirements.⁶⁷ The amount of methamphetamines being seized in Ghana is increasing in line with global figures, which are experiencing year-on-year growth, reaching over 158 tonnes seized globally in 2016.⁶⁸ Law-enforcement officials believe there to be methamphetamine labs in Accra and have therefore identified methamphetamine production and trafficking as a significant new challenge.

“The amount of methamphetamines being seized in Ghana is increasing in line with global figures, which are experiencing year-on-year growth.”

Previously, meth labs had existed predominantly in Nigeria, with the drugs then transported overland across the country's borders primarily into Benin, with some of the drugs then reaching Ghana at a later stage.⁶⁹ Some of those involved in the manufacturing ('cooking') of meth in Nigeria are believed to have travelled to Ghana to teach members of the local population their methods. Law-enforcement officials noted that the presence of these more experienced manufacturers from Nigeria, and the inability of law-enforcement agencies to identify them, helps facilitate the trade.

Significantly, however, none of the PWUD or health professionals interviewed had respectively used or witnessed the use of methamphetamines. This might suggest that although the drug is transiting through Ghana, it has not yet entered the domestic market on a large scale.⁷⁰ Nevertheless, the growth of methamphetamine production in West Africa is troubling and it may well herald an increase in domestic consumption of the drug.

Public perception of drug use and access to treatment

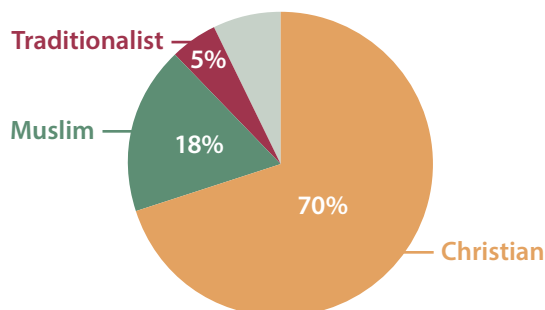
Of the wide range of drugs used for non-medical purposes in Ghana – including marijuana, heroin, cocaine, and prescription drugs like pethidine, diazepam and others – all of which are easily available on the streets of the larger towns and cities, marijuana enjoys the least social stigma. This is due to the drug's long history of cultivation and usage in Ghana, while other newer available drugs, in particular cocaine and heroin, are seen as foreign 'pollutants'. Those who use cocaine and heroin are therefore met with a greater degree of contempt, which is aggravated by the significant influence of the church in Ghanaian society and its shaping of the negative public perception of drug use.

The most recent census shows that 70% of Ghanaian society identifies as Christian, 18% as Muslim and 5% as traditionalist, although a colloquial twist puts traditionalist figures at 100%, accurately summing up how traditionalist orthodoxy envelops both Christian and Muslim beliefs.⁷¹

The influence of religion means that substance-use disorders, already poorly understood, are typically conceived of as issues of morality. In Ghana, the general public typically perceive PWUD as morally defective, under the influence of the devil or otherwise 'unholy'. Unable to escape this religious rhetoric, one rehabilitation worker described the unsympathetic attitude towards PWUD as the result of their 'demonization' by society.⁷² This exemplifies how drug



70% of Ghanaian society identifies as Christian, 18% as Muslim and 5% as traditionalist.



addiction is not typically seen as a disease; however, some rehabilitation clinics and drug professionals are beginning to work towards changing this. For its part, the walls of the small outpatient drug rehabilitation clinic of Korle Bu hospital are plastered with variations on the slogan 'Drug addiction is a disease'.

Even when addiction is contextualized within a public-health framework, it is often seen as intrinsically linked to mental illness. The fact that most of the existing addiction services offered by public institutions are housed within mental-illness facilities has simply reinforced this perceived link between the two conditions. A number of PWUD reported that friends and family believed they had 'gone mad' as their addiction developed.⁷³ Furthermore, according to one former PWUD, 'There is the view that

even if a person stops using they will have a residual mental illness that will be with them for the rest of their lives,' and this has led to the common belief that 'people with addictions can never have a full recovery. The majority of people in Ghana don't think there's any hope at all for addiction.'⁷⁴

One person who uses drugs noted how the scarcity of health facilities in Ghana means that many PWUD are often forced to live on the streets, and that their resulting unkempt appearance further blurs the line between drug addiction and mental illness in the public psyche. This perceived overlap between drug addiction and mental illness is widespread not only among the general populace but also among medical professionals, and is one of the reasons why PWUD are frequently shunned by society.

“In Ghana, the general public typically perceive PWUD as morally defective, under the influence of the devil or otherwise 'unholy'.”

Moreover, there appears to have been no significant change in societal attitudes in Ghana towards drug usage over the past decade, in contrast to its increased prevalence.⁷⁵ A lack of discernible improvement in education about illicit drugs is likely to be one reason why condemnation has remained the prevailing response to PWUD.

Education about illicit drugs and addiction is largely absent from the Ghanaian education system, even more so for children from less affluent backgrounds. Most PWUD reported that they had started using drugs either because of peer pressure or because of family usage patterns, behaviour that might be avoided with better knowledge of the substances' effects. Significantly, a number of PWUD who reported habitually using marijuana revealed having been introduced to heroin by mixing a small amount into marijuana without knowing or understanding its high potential for addiction.

Of the state-funded institutions providing services to PWUD, none are involved in public education activities (with the exception of supporting university degree courses specializing in substance use and addiction). Although one independent rehabilitation worker reported visiting a number of schools and churches to speak about drug addiction, he noted that this was not part of any concerted programme but rather of his own motivation.⁷⁶ This highlights a significant gap in the services provided by the state and NGIs, and could be an important future area of focus.



Mis-selling Viagra

Kweku (not his real name), a shy ex-user six months into the one-year inpatient rehabilitation programme at Compassion Rehab Centre, started using heroin because he believed it to be a form of Viagra, a claim made to him by a local dealer. Drugs to enhance male virility are ubiquitous in Ghana; they are advertised on huge billboards and sold in a perplexing array of forms at small street-side stalls. Notably, tramadol, which is increasingly used for non-medical purposes among Ghana's lower-income demographic, is also known for its ability to enhance sexual performance, with some scientific grounding. The prevalence of these virility drugs and their renown made it easier for Kweku to believe the dealer's claim about his heroin.

Kweku found that the first few times he used the drug it was effective, and so he continued using it. After a while, however, he found that he was unable to have sex when using the drug. But by this point, he had become addicted and, as a result, he lost his job as a construction worker. It was only after what Kweku refers to as two 'lost' years that he was able to seek treatment at Compassion Rehab Centre with the help of his mother, who depleted her savings to pay the clinic's fee.⁷⁷

Religion-based treatments

The perception of PWUD as 'cursed' or 'unholy' has resulted in the proliferation of pseudo treatments that address substance-abuse disorders as religious afflictions.⁷⁸ 'The majority of clients have been treated at churches or prayer camps prior to attending the Korle Bu Addictive Diseases Unit,' noted unit head Dr Logosu Amegashie. Indeed, anecdotal evidence suggests that most PWUD seeking treatment at any type of health facility will have undergone a form of religious treatment first,⁷⁹ ranging from intensive prayer sessions with the local priest to stays at 'prayer camps'. Prayer camps, which are typically based in rural areas (although there are a number within two hours' drive from Accra), claim to treat a range of 'unholy afflictions', which include drug addiction and mental illness.

Prayer-camp 'patients' are typically not allowed to leave at will; their release is conditional upon the approval of the religious figure heading the camp. 'Treatment' typically includes fasting, intensive prayer sessions and physical hardship, with more extreme accounts revealing that patients are whipped or chained to trees in the rain or under the hot sun. PWUD are usually 'checked in' by concerned family members, often without their consent.

Prayer camps: Forced religious treatment regimes

One former user recounted a story he believes to be common among PWUD in Ghana. He had undergone a number of hospital detoxification treatments, which manage physical withdrawal symptoms but do not address the psychological aspects of addiction, and relapsed shortly thereafter. After once again being admitted to hospital for a detoxification programme, he awoke to find himself chained to a bed in a small room. His mother, driven to desperation by her son's repeated relapses and aware that he was sceptical of treatment success of prayer camps, had asked the doctor treating him to assist her in getting her son to one such camp. The doctor had agreed and, unbeknown to the patient, administered a sedative alongside the other medication routinely used in the detoxification process. His mother had then driven him to the prayer camp, where he spent the next six weeks, unable to leave until he was 'cured'. He relapsed just a week after leaving the camp. A year after this relapse, with the support of an NGL, he was able to successfully stop using. He doesn't talk about his prayer camp experience with his mother and does not resent her actions, recognizing they were born from despair and ignorance.⁸⁰



There is extremely scarce data and a wealth of conflicting opinions regarding trends in the number of prayer camps in Ghana. What is clear, however, is that they remain a common form of ‘treatment’ for PWUD. Recognizing that prayer camps are widespread and their use unlikely to decrease in the short term, one rehabilitation worker is educating those managing and funding the camps about drug addiction. His aim is to make camp leaders perceive drug addiction as a disease, and not a curse, to reduce stigmatization of PWUD in the religious community and introduce more effective and humane methods of treatment.⁸¹ Given the immense power wielded by religious institutions in Ghana, greater collaboration with these organizations to improve the treatment of PWUD and educate the greater population could prove effective.

Non-governmental rehabilitation institutions

Most rehabilitation facilities in Ghana are privately owned and funded predominantly by religious bodies. Naturally, the source of funding shapes the treatment of drug addiction at these organizations – all of the NGIs surveyed employ the 12-step rehabilitation programme, an approach premised on the belief that people can support one another to achieve abstinence from substance abuse through surrender to a higher power – in Ghana typically the Christian God. These NGIs supplement the 12-step approach with Bible teachings and prayer sessions, and often offer additional counselling. Additionally, all centres were seen to implement a zero-tolerance approach. Although recommended by UNAIDS and other international organizations, opioid substitution therapy, a method in which PWUD are given a replacement substance in order to lessen withdrawal, is not used in Ghana. Opioid substitution therapy is strongly opposed by the country’s rehabilitation centres and health professionals interviewed, who posit that it sustains rather than treats addiction, a position at odds with the international debate. Ghana’s current legal framework would make the introduction of such therapy extremely difficult, if not unviable.

“Most rehabilitation facilities in Ghana are privately owned and funded predominantly by religious bodies.”

Also common among the NGIs surveyed is a small fee typically charged for their services, which places them out of reach for a significant proportion of PWUD. Compassion Rehab Centre charges GH¢2 000 (about US\$400) per quarter, but it waives all or some of this fee in roughly a third of cases annually.⁸² In almost all other instances, the fee is paid by the family of the PWUD. While the recommended duration of inpatient treatment is 12 months, financial constraints force many patients to leave before completion, which increases the risk of relapse.

The inpatient NGIs interviewed as part of this study catered for between 25 and 200 inpatients at any one time, and all reported that demand consistently exceeded the services they could provide. Critics of the pending Narcotics Commission Bill 2017, which decriminalizes drug use and treats drug addiction as a public-health issue, point to this absence of rehabilitation infrastructure as a key reason why they believe that the Bill, if passed, would fail to have any discernible impact.

Most of the rehabilitation centres also state that they screen clients for hepatitis, tuberculosis, HIV and other conditions prior to admission. However, review of the data collected by two NGIs revealed patchy data-collection methodologies, which prevented corroboration or analysis of this screening.⁸³ NACOB is starting to work more closely with NGIs, particularly in order to collect data on inpatients. One of the findings of this centralized analysis relates to relapse rates, which are reportedly significantly lower for NGI rehabilitation than they are for detoxification at psychiatric hospitals.⁸⁴



The high level of stigma associated with substance abuse, together with Ghana's significant unemployment rates, particularly among the youth, makes finding employment especially difficult for former PWUD. The NGOs therefore seek to reintegrate clients who have completed the 12-step programme into society, trying to find them employment and holding ongoing consultation sessions with family members to ensure that clients have a supportive home to return to and are not driven to use again by stigmatization and lack of work. One reintegration programme run by Compassion Rehab Centre collaborates with a greenhouse farming initiative, training patients in agricultural techniques, so they are more employable upon leaving the centre.⁸⁵

State-run treatment for people who use drugs

The origin of the Korle Bu Addictive Diseases Unit is telling of the long-standing battle to establish effective drug abuse treatment centres in Ghana.⁸⁶ According to Dr Amegashie: 'In February 1991, Dr Isaac Newman, a Ghanaian doctor sponsored to study addiction in Philadelphia, was charged with setting up 110 drug-rehabilitation centres in the then 110 districts of Ghana. He was only able to set up one – Korle Bu.'⁸⁷ Significantly, the resource shortages and cultural challenges Dr Newman faced in his task remain today. Four state-funded facilities are known to provide targeted rehabilitation and treatment to PWUD in Ghana,⁸⁸ but all four are concentrated in the south of the country. Health professionals in the Korle Bu Addictive Diseases Unit and the Cape Coast Teaching Hospital have reported an increase in the number of patients from all regions of the country, whereas, originally, they had treated clients only from the surrounding areas.

Although all teaching hospitals in Ghana have psychiatric units, and many such units offer detoxification programmes and treatment for psychosis, most do not offer focused rehabilitation programmes or ongoing addiction support. As a result, PWUD who underwent treatment in these units reported repeated relapses following detoxification. Adding to the failure of the treatment of substance-use disorders in Ghana is the fact that the stigma associated with attending psychiatric institutions discourages many PWUD from seeking treatment at all.

Health challenges faced by PWUD

Most rehabilitation centres screen new inpatients for blood-borne diseases and contagious infections. The 2017 NACOB figures of four rehabilitation centres and one psychiatric hospital in the Greater Accra region found that two-thirds of respondents reported having been tested for HIV in the past 12 months, and about 40% for hepatitis B and C.⁸⁹ These screenings are important, as the managers of rehabilitation centres and health professionals working at state-funded institutions suggest that hepatitis and tuberculosis are currently the most prevalent infections among the drug-using population in Ghana. With regard to HIV, the risk of contraction is most acute in cases where PWUD are involved in commercial sex work and become more likely to contract and transmit sexually transmitted diseases through unprotected sex.

Current regulatory framework

In line with other West African countries, Ghana has traditionally ascribed to a 'war on drugs' approach, with punitive sentencing seen as a key tool in eradicating drug use. However, as this approach is increasingly viewed as failing, at least among the international community, Ghana's recent proposed legislation may place it in line with other international policies.



Ghana currently has strict laws, with severe accompanying penalties, to sanction those who commit drug-related offences. The Narcotic Drugs (Control, Enforcement and Sanctions) Law of 1990, currently in force, provides that all drug-related offences, including the personal use of drugs and the purchasing of drugs, are punishable by a mandatory minimum prison sentence of five years, although this can be reduced in (unspecified) mitigating circumstances and if accompanied by a significant fine. This mandatory minimum sentence increases to 10 years for those drug offences deemed to be more serious, including possession and the importing or exporting of drugs.

“In line with other West African countries, Ghana has traditionally ascribed to a ‘war on drugs’ approach, with punitive sentencing seen by the authorities as a key tool in eradicating drug use.”

Although this hard-line attitude towards drug usage reflects the position of most of Ghanaian society, senior law-enforcement officials report a shift in judicial attitudes towards PWUD, with judges increasingly seeking to minimize the penalties meted out to low-level offenders, often changing the charge from ‘possession’ to ‘use’ in order to lower the mandatory sentence. This change in the categorization of the offence is in part enabled by the wording of the law, which separates drug ‘use’, specifically the act of taking the drug, from ‘possession’, which in practice often accompanies use. Similarly, health professionals report a small shift in police-force attitudes towards understanding drug addiction as a disease. One health professional noted that the local police force would occasionally bring PWUD directly to neighbouring outpatient clinics rather than to police stations.⁹⁰ Notably, in doing so, police officers are themselves breaking the law, which mandates a five-year minimum sentence for drug use, and running significant personal risks. However, these stories are the exception to the rule, and the overall level of education among the Ghanaian police force about drug addiction remains extremely low.

For the past few years, legislation has been on the brink of changing as a result of the draft Narcotics Control Commission Bill 2017, which would repeal and replace the previous act and mark a significant shift in the Ghanaian regulatory framework for tackling drug use. This Bill works towards an approach based on harm mitigation rather than one focused on punitive measures, yet may still unfairly target low-income groups. Under the proposed new legislation, a person charged with ‘possession or control of a narcotic drug for use’ will no longer face criminal sanctions. Instead, they will be subject to the civil penalty of a fine and will face imprisonment only if that fine goes unpaid. The fine of between GH¢2 400 and GH¢6 000 (US\$500–US\$1 300)⁹¹ is compulsory and is a substantial penalty when compared to the Ghanaian minimum daily wage of GH¢8 (US\$1.7).⁹² Some commentators, among them Maria-Goretti Ane, African Consultant for the International Drug Policy Consortium and a working barrister in Ghana, have criticized the size of this fine, arguing that it is well beyond what low-level drug offenders can typically afford to pay, and would ultimately result in the poorest continuing to receive prison sentences.⁹³

For certain other drug offences, the proposed new legislation will grant Ghanaian courts greater discretion as to the appropriate punishment, allowing them to impose fines rather than mandatory prison sentences. For example, the punishment for a person convicted of buying narcotics, which currently carries a mandatory prison term of at least five years, would be either a fine or a minimum of four years’ imprisonment. The Bill does, however, retain a lengthy minimum sentence for drug-trafficking offences. Proponents of the new law, including Ane, claim that focusing sanctions on drug trafficking rather than use, which is distinguished in the Bill through the volume of drugs found on the person, will free up resources for combating drug trafficking. A Narcotics Control Commission will be created under the Bill, with the objectives of ‘co-ordinat[ing] the treatment and rehabilitation of drug addicts’ and ‘ensur[ing] that an issue of drug addiction is treated as a public health issue’.⁹⁴



The Bill has been approved by cabinet and was laid before parliament by the Minister for the Interior for the first reading on 21 March 2019.⁹⁵ The Parliamentary Select Committee have reviewed the Bill, with the Bill's working group making both written and oral submissions. Those working on making submissions to parliament believe the Bill is making good progress, and is on track to be passed into law by the NPP before Ghana enters the election period in November 2020.⁹⁶

Extensive delays to date have caused some commentators to doubt whether the Bill will be enacted at all. However, delays can more accurately be ascribed to lags in the parliamentary timetable following the 2016 election, which saw the opposition party rise to power and therefore the revision of a significant volume of draft legislation, together with a new set of legislative priorities. If enacted, the proposed new legislation would represent a significant change in Ghanaian drug policy, at least on paper. However, in order to yield visible results, it would need to be accompanied by an increase in government spending on drug rehabilitation and treatment facilities, a move that the cash-strapped Ghanaian government is unlikely to take when there are so many other more socially acceptable causes requiring attention.

Although the Bill's domestic proponents argue that its evolution came about through grass-roots activism, more cynical voices would suggest there has been significant international pressure to reform legislation away from the 'war on drugs' approach, which, if continued, could reduce financial law-enforcement support from the international community. If accurate, this view would mean that the Bill is superficial, rather than a real attempt at reform. Regardless of which drivers of implementation are accurate, the Bill will act as an important base for advocates in favour of a public-health, rather than purely securitized, approach to substance abuse in Ghana.

Conclusion

Currently, PWUD in Ghana face myriad challenges in the near-absence of support. Promised legislative reform is lagging and, even if successful, may have limited impact if not accompanied by increased government resource allocation towards rehabilitation institutions. Public perceptions of drug use, often framed in the religious rhetoric of morality and associated with mental illness, appear static, and PWUD continue to be ostracized in Ghana.

“Public perceptions of drug use, often framed in the religious rhetoric of morality and associated with mental illness, appear static, and PWUD continue to be ostracized in Ghana.”

Health facilities are already unable to offer adequate support to PWUD – and the number and needs of PWUD are increasing. The growing wave of prescription-drug misuse in Ghana and across West Africa, most notably of tramadol, together with increased methamphetamine production, are emerging trends that add further cause for concern. Global spikes in the production of heroin and cocaine, alongside the continuing high demand in Europe and the US, suggest that supply to Ghana's domestic drug market will remain high.

Recognition of the scale of domestic drug consumption in Ghana is only likely to come with the availability of sufficient data to estimate prevalence. Deeper insights and quantification of Ghana's PWUD population will help shape appropriate responses. Nevertheless, even with the current absence of data, a multi-faceted approach towards domestic drug consumption is urgently required, one that places the needs of PWUD at its core. The following recommendations are a preliminary step in shaping such an approach.



Recommendations

Further research on drug use needed, particularly around prevalence

Accurate and comprehensive data is required on drug use within Ghana to facilitate a quantification of the prevalence and develop a greater understanding of the magnitude and characteristics of this public-health issue. An in-depth appreciation of prevalence may spur, if the figures are as high as anecdotal accounts suggest, greater funding and focus on both drug rehabilitation and law-enforcement approaches to drug trafficking.

Data collected should be disaggregated by sex to better assess the number of female PWUD. Data collection on drug use among women is particularly critical, as female PWUD's needs are currently almost entirely unmet, and the scale of the phenomenon is likely to be significantly larger than currently believed.

Data should shape responses to Ghana's domestic drug-consumption phenomenon, mitigating the risk of applying solutions that are inappropriate to the local context and that could have unexpected and negative consequences. If opiate substitution treatment or needle and syringe programmes are introduced, their initiation must be preceded by in-depth analytical field research to ensure that any roll-out is tailored to the context on the ground. A failure to collect sufficient data risks applying responses that do not fully take into account the specific needs of Ghana's PWUD population, and would ensure that domestic health professionals remain opposed to the programmes, making their success, adoption and promotion unlikely.

Existing data-collection initiatives, such as that launched by NACOB to gather data from NGIs for centralized analysis should be encouraged, as should the publication of this analysis. Such initiatives not only constitute a first step in collecting more comprehensive data on drug use, but also enable NGIs to spot patterns, assess impact and, where necessary, improve their techniques. Although promising, other data-collection initiatives undertaken by regional bodies, including WACD, risk petering out due to a lack of sustained resources and focus before they are able to produce a meaningful volume of data.

Greater research on injecting drug use should shape the debate along evidential lines, breaking the current stalemate between international best practice and domestic norms heavily shaped by religion. Better understanding of the scale and characteristics of injecting drug use could then inform decisions regarding treatment. The serious health implications of injecting drug use make understanding prevalence particularly crucial – it is key to ensuring that the spike in infectious blood-transmitted diseases associated with injecting drug use, including but not limited to HIV, experienced in other parts of the continent are not replicated, and the already scant health resources further strained.

Recast addiction as a public-health issue

Religious institutions in Ghana occupy a unique position of power from which they are able to influence cultural attitudes towards drug addiction; they could thus help create a shift from viewing addiction as a moral failing to accepting addiction as a disease, and consequently effect a reshaping of treatment methods. Religious facilities could be persuaded to create more effective treatment centres for PWUD, in place of the existing structures, which, in serious cases, allow for human-rights abuses to be committed in the name of religion.

Additionally, reframing drug addiction as a public-health issue would enable the government to allocate more funding towards drug rehabilitation centres, the financial support of which is currently seen as a contentious diversion of funds away from more socially acceptable causes.



Enhance awareness among health and law-enforcement professionals

The stigmatization of PWUD is often worsened rather than mitigated by the attitudes of health professionals who also hold the wide societal belief that drug use is a moral failing. The increasing inclusion of academic courses on addiction in university and vocational training programmes is a positive step in this regard, and should be matched with scaled-up efforts to ensure that the relevant health-system actors are able to access appropriate training on illicit substance use. Capacity-building initiatives focusing on the psychological and physical support PWUDs need in order to break the cycle of addiction should also be offered to NGI staff whose general lack of formal qualifications has serious ramifications for the quality of support the institutions are able to provide.

PWUD are also vulnerable to abuse by law-enforcement officers who share the same societal belief of drug use as unholy. Awareness among local law enforcement of substance-use disorders as a disease remains low. A number of targeted training exercises are starting to emerge to combat this, but these should be significantly scaled up to maximize impact and be accompanied by legislative change to enable police officers to support PWUD in seeking treatment without themselves breaking the law.

Regulatory reform

Passing the Narcotics Commission Bill 2017 into law would constitute a significant step towards treating drug addiction as a public-health issue rather than one of law enforcement. The shift in legislative classification of drug use could start to impact the cultural perceptions of drug use. Furthermore, the judiciary and police would be freed from mandatory sentencing requirements, which merely encourage reoffending in PWUD, and would instead be able to order rehabilitation. The value of the fines for civil penalties outlined in the draft Bill is disturbingly high,⁹⁷ and will likely result in lower-income PWUD continuing to face prison sentences. Efforts to reduce these thresholds prior to the Bill's enactment should be bolstered, aiming to strike a balance between deterrence and not unfairly impacting poorer groups.

Furthermore, if legislative reform is to herald any discernible change, it needs to be accompanied by an increase in government resources allocated to drug-rehabilitation facilities, and investment in capacity-building initiatives for law-enforcement bodies to enhance understanding of the reform and the change in perception it is seeking to effect.

Increase quantity and quality of drug rehabilitation services

The number of state-funded institutions offering specialist drug-addiction support is woefully inadequate. Addiction services should also be optically separated from psychiatric services as far as possible, in order to combat the association of drug use with mental illness. As discussed above, the passing of the Narcotics Commission Bill 2017 could catalyze an increased flow of funds towards state-funded rehabilitation institutions and improve the support available to PWUD, although there is significant uncertainty surrounding this.

Also of potential benefit, the Mental Health Authority, incorporated in 2013, is working to introduce a standardized accreditation system for NGIs. This is a valuable initiative and its roll-out should be accelerated. The results of this accreditation should also be made public, so that PWUD are informed of the quality of the services they are seeking and empowered to seek quality support (to the extent that this is possible given the limited options). This would mitigate the risks inherent in a large, unregulated private 'care market' in a system with no agreed-on standards of treatment.



Embed harm-reduction principles into national and foreign donor strategies

It is crucial that the human rights of PWUD are recognized not only in law, but in practice, and that the current human-rights abuses suffered by the PWUD community at the hands of religious and state institutions, the latter predominantly in the form of neglect, are speedily addressed. The Ghanaian government should draw upon the wealth of international data available that points to the efficacy of harm-reduction strategies in order to develop a plan for implementing these approaches in the institutions that can support PWUD. Harm-reduction approaches can significantly enhance the quality of life of PWUD and constitute cost-effective initiatives with potential positive impacts on communities, ranging from improving the reach of domestic healthcare services and reducing the community burden of disease to triggering a drop in petty criminal offences. As a first step in implementing harm-reduction methods, educational initiatives should be launched to this effect, aimed initially at government officials and religious leaders.

According to Sasha Jespersen, Global Initiative Network Member and director of the Transnational Challenges Practice at Aktis, the 'self-interest of [the] donors or destination countries' that shape international drug strategies means there is the risk of 'local domestic problems arising from drug trafficking' being ignored.⁹⁸ In West Africa, strategies have historically focused on preventing drugs from leaving the region and reaching consumers in Europe and the US, and have largely ignored the rise in domestic drug consumption across the region. The international community can support a shift in this regard by ensuring that aid flows not only towards projects that target the trafficking of drugs out of West Africa, but those that seek to address the growing problem of domestic drug use, and more specifically to improve the lives of PWUD, huge numbers of whom currently face homelessness, destitution and a serious risk of violence. Widespread stigmatization makes PWUD extremely vulnerable to violence from the general public as well as members of the law-enforcement community. In other jurisdictions, the police, in particular, have previously resisted the introduction of harm-reduction strategies and have been heavily involved in approaches that fail to respect the human rights of PWUD. Embedding-harm reduction principles into police training is key to ensuring that such strategies have a real impact on the lives of PWUD, and that they are put into practice, as opposed to existing merely on paper.



Notes

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- 18 One example is UNODC's launch in February 2018 of an investigations best-practice handbook focusing on drug-related crimes as part of the Technical Assistance Project to Ghanaian Authorities to Counter Drug Trafficking and Organized Crime, which was initiated in 2016 in collaboration with UNODC and the government of Ghana with funding from the US Bureau of International Narcotics and Law Enforcement Affairs.
- 19 A 2015 purge of 12 High Court and 22 Lower Court judges claims to have expunged much of the corruption in the judiciary. However, the 2015 investigation found corruption to still be endemic, casting doubt over whether these expulsions addressed the problem entirely.
- 20 Sasha Jespersen, Responding to drug trafficking: A question of motives, in *Militarised Responses to Transnational Organised Crime: The War on Crime*, edited by Tuesday Reitano, Lucia Bird Ruiz-Benitez de Lugo and Sasha Jespersen, London: Palgrave, 2017.
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- 35 Interviews with doctors specializing in substance abuse at Cape Coast Hospital and Korle Bu Addictive Diseases Unit, Accra, November 2017.
- 36 Ibid. 2017 NACOB figures from data collected from four rehabilitation centres and one psychiatric hospital in the Greater Accra region found that from a sample size of 144 users, 23% reported using marijuana as their 'primary substance of use', compared to 14% cocaine and 18% heroin (with 40% reporting alcohol). Unfortunately, the structure of the question used in this survey doesn't allow for information regarding multiple drug use to be provided.
- 37 A traditional Ghanaian dish of rice and beans, often sold by street vendors.
- 38 Interviews with PWUD in Tema and at Compassion Rehab Centre, Dawhenya, November 2017. Currency conversion stated as at November 2017. Note that conversion rates vary significantly over time.



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- 62 Interview with Dr Logosu Amegashie, Accra, November 2017.
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- 79 Interviews with PWUD and health professionals at rehabilitation centres in Greater Accra, September–November 2017; interview with Dr Logosu Amegashie, clinical psychologist and drug counsellor at Korle Bu Addictive Diseases Unit, Accra, November 2017.
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