ESACD
Eastern & Southern Africa Commission on Drugs

The Eastern & Southern Africa Commission on Drugs

Prevention and treatment of drug dependence in Eastern and Southern Africa

Andrew Scheibe

MAY 2022

ABOUT THE AUTHOR

Dr Andrew Scheibe is a medical doctor by training who works in harm reduction research, programmes and policy in South Africa and the southern African region. His work focuses on the intersections between infectious diseases, determinants of health and rights. He is a technical advisor for TB HIV Care, a researcher at the University of Pretoria's Department of Family Medicine and a visiting professor at the Durban University of Technology.

Contents

Acronyms and abbreviations

ATS	Amphetamine-type stimulant
AU	African Union
ESA	Eastern and Southern Africa
HIV	Human Immunodeficiency Virus
NSP	Needle and syringe programme
OST	Opioid substitution therapy
SDGs	Sustainable Development Goals
STIs	Sexually transmitted infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

SUMMARY

Social, economic and health challenges, the desire for pleasure and the need to cope with contemporary realities – combined with increased drug availability – contribute to the use of drugs in the Eastern and Southern Africa region (ESA).[1] Heroin (an opiate/opioid), cocaine and amphetamine-type stimulants (ATS) are unregulated drugs that contribute to most drug-related harm.[2] About one in ten people who start using a drug will develop dependence.[3] The likelihood of developing dependence is associated with early onset of use, socio-economic challenges and co-occurring mental and physical health conditions.[4] Given the growing population in the region, the consequences of drug dependence for development are likely to be extreme – without appropriate interventions in place.

Decades of scientific research have contributed to a strong evidence base that shows effective interventions mitigate the effects of drug dependence. Effective prevention includes ensuring safe and healthy pregnancies and early childhood development. It entails supporting parenting skills and the educational, emotional and social skills development of adolescents and young adults.[5] Drug use screening and brief interventions are effective in helping prevent progression to drug dependence.[6]

Drug dependence is usually a chronic condition.[7] But it can be treated through a combination of medical and psychosocial interventions. Medical treatment of opioid dependence using opioid substitution therapy (OST) is the recommended intervention.[8] Overdose prevention and management, needle and syringe services, and testing and treatment of HIV, viral hepatitis, sexually transmitted infections (STIs) and tuberculosis (TB) are also integral to comprehensive, effective responses.[9]

The return on investment in evidence-based drug prevention, treatment and harm reduction equates to between US$4 and US$12 for each dollar spent.[10] Access to treatment for drug dependence is a universal right for all people.[11] However, globally, only one in six people with drug dependence benefits from such services.[12]

Findings

The African Union (AU) Plan of Action on Drug Control and Crime Prevention (2019–2023) outlines an intention to engage on prevention and treatment of drug use through training (i.e. parental skills training, and life skills training for children and young people), harm reduction and implementing alternatives to punishment for drug use.[13] The plan of action provides a clear evidence-based policy framework.

Assessing the baseline of country responses in 2019 (or more recently) is very challenging due to a lack of data on prevention interventions, drug treatment and harm reduction coverage. Since the AU Plan of Action, there has been a mixed policy response in countries in ESA. The criminalization of drug use and possession for personal use was identified in all countries in the region (with the exception of cannabis in South Africa).[14] Not all ESA member states have drug policies, and even some of the more recent policies do not explicitly note the need for evidence-based interventions. In contrast, some countries include public health interventions in their policy while at the same time handing down high penalties for drug possession. Since 2019, several countries have started, or at least plan to develop policies aligned with the AU Plan of Action. Support for evidence-based harm reduction interventions, including OST, is more common in HIV-related policy than for OST as part of evidence-based treatment for opioid dependence.

In the region, there has tended to be emphasis on state media campaigns and multi-component initiatives for drug prevention (with little to no reference to the underlying evidence base or theoretical framework informing such interventions, or evaluation of their effectiveness), and inclusion of skills-based structured programmes for learners. Little mention has been made of how screening and brief interventions can form a significant component of drug dependence prevention and treatment.

Encouragingly, more emphasis is today being placed on evidence-based prevention, treatment and harm reduction. However, the persistence of punitive approaches in policy continues to contribute to a hostile environment for people who use drugs, and is most likely a barrier to service access and persistence in care.

Most countries in the region rely on provision of services within specialized mental health facilities, while many provide community-based services run by civil society organizations. Detoxification services are available in 10 countries in the region; however, only seven have established OST services (ranging from one to 42 OST sites per country). OST is provided in at least one prison in four countries. Coverage of OST services for opioid-dependent people who inject drugs is far below the targets needed for HIV and viral hepatitis epidemic control.

Across the region, there appears to be a huge drug dependence treatment gap. Although there is likely to be significant under-reporting of people accessing drug treatment centres, in most countries drug use is common, but treatment coverage low. Furthermore, the data suggests a disjuncture between drugs responsible for most potential harm and the primary substance of use among those accessing treatment, as cannabis accounts for the majority of treatment admissions in most countries.

Recommendations

- Overarching AU member state policies should align with the AU Plan of Action on Drug Control and Crime Prevention (2019–2023), with appropriate review and revision of health and non-health sector policy to foster a supportive environment for public health and rights-based responses to be implemented.
- Centralized coordination of responses across sectors is important.
- Policymakers and service providers should be capacitated in evidence-based policy and practice.
- Services should be designed and delivered in line with international standards, and should follow evidence-based guidelines.
- A mix of prevention interventions is needed, focusing on universal prevention efforts to support childhood development, and including screening and brief interventions for adults.
- The bulk of drug treatment interventions should take place in community settings, and these should incorporate a mix of psychosocial and medical treatments.
- OST as maintenance should be scaled up for people with opioid dependence.
- Harm reduction should be integrated into services for people who use and inject drugs.
- Sustainable, domestic financing solutions should be developed so as to ensure drug dependence treatment and harm reduction forms part of universal health coverage.
- Infrastructure needs to support the provision of quality services.
- Strategic information collection, reporting and evidence-based decision making should inform all responses to drug dependence.

BACKGROUND

Drug use is common in Africa and is increasing.[15] In 2019, there were 3.6 million opiate users (predominantly of heroin); 2.0 million cocaine users and 2.7 million ATS users in Africa.[16] In that year, there were an estimated 260 000 people who inject drugs in East Africa and 150 000 people who inject drugs in Southern Africa. By 2050, it is estimated that an additional 14 million people will use drugs in sub-Saharan Africa.[17]

This brief provides an overview of policy issues relating to prevention and treatment of drug dependence in ESA. It focuses on heroin, cocaine and ATS, as these substances have the potential to cause relatively more harm to individuals and society than other unregulated drugs.

DEFINING DRUG DEPENDENCE

Drug dependence is a disorder of the regulation of drug use. Dependence arises from repeated or continuous use of a drug or drugs. It is characterized by a strong internal drive to use the drug(s), as shown by impaired ability to control use, with increasing priority given to use over other activities. Drug use continues despite the harms or negative consequences incurred. A subjective sensation of urge (craving) to use the drug is common. Physiological features of dependence include tolerance to the effects of the drug(s), withdrawal symptoms following cessation or reduction in use of the drug(s), or repeated use of the drug or similar substances to prevent or manage withdrawal symptoms. The features of dependence usually persist for at least 12 months or for at least three months if use is daily or almost daily.

Source: WHO, Drug use disorders: International classification of diseases, 11th edition, https://icd.who.int/ct11/icd11_mms/en/release

Data for this brief was drawn from a desk review with inputs from in-country experts. The document is organized into three parts: this background section; followed by sections on prevention of drug use and harm reduction, and implications and actionable policy recommendations.

Drugs, their effects and potential harms

The type of drug(s) used, patterns of use, individual characteristics of people who use drugs and the context in which drug use occurs contribute to potential harms, including the development of dependence.[18] Criminalization of drug use, drug-related stigma and discrimination, combined with limited access to evidence-based interventions, are important contextual contributors to the negative effects of drug use.[19]

Globally, people with opioid dependence have a 25-fold higher risk of death than people in the general population,[20] largely due to overdose.[21] Despite the relatively small absolute number of people who injects drugs, in 2013 the burden of disease due to injecting drug use (mostly of heroin) in sub-Saharan Africa was 1% for HIV, 1% for hepatitis B virus and 26% for hepatitis C virus infections.[22] Drug injecting may also result in soft-tissue injuries, and severe local and generalized infections.[23] Drug use can indirectly increase the risk of HIV and other STIs through unprotected sex.[24] Incarceration, common among people who use drugs in jurisdictions where drug use is criminalized, is associated with an increased risk of TB while in prison and overdose upon release.[25] People who use drugs have been particularly affected by the COVID-19 pandemic through having to undergo involuntary withdrawal and interruptions in services.[26]

Drug dependence often has negative effects on personal well-being and mental health, as well as on the family, and social and occupational functioning.[27] The potential consequences of drug dependence are greater among women who use drugs because of issues related to patriarchy, stigma and limited access to gender-responsive services.[28]

Evidence-based interventions for drug dependence prevention, treatment and harm reduction

Investing in evidence-based drug use prevention, treatment and harm reduction provides a return on investment of between US$4 and US$12 for every dollar spent.[29] Benefits include saved lives, reduced disease and disability, healthier populations, improved occupational performance and reduced costs linked to criminal justice.[30] More than two decades of scientific research provides clear evidence of what works.

Prevention

Prevention aims to avoid or delay the onset of drug use and, in cases of drug use, to prevent the development of drug dependence. Early onset of frequent drug use is associated with drug dependence in later life. Therefore, the healthy and safe development of children are critical for prevention. Effective interventions foster protective norms and behaviours, mitigate vulnerabilities and address structural issues that contribute to potential drug use, drug dependence and their consequences (see Figure 1).[31]

Protective factors	Individual vulnerabilities	Structural issues
■ Psychological and emotional well-being ■ Personal and social competence ■ Language and literacy skills ■ Strong attachment to parents/care givers	■ Limited awareness of drug use and potential consequences ■ Mental and behavioural disorders ■ Trauma and childhood adversity ■ Poor attachment to schools and communities	■ Housing, education, safety and employment ■ Social integration and social support ■ Socio-economic development ■ Social normative beliefs around substance use ■ Laws and policies around drug use and possession ■ Stigma and discrimination

FIGURE 1: Components of effective approaches to drug use prevention.

Source: UNODC, International standards on drug use prevention, second updated edition, UNODC and WHO, 2018; WHO, Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016

Impactful prevention responses necessitate a comprehensive mix of interventions focusing on different human developmental stages and delivered in a range of settings (see Figure 2). Interventions to improve parenting skills or increase school retention rates are important during childhood; programmes targeting schools, workplaces, entertainment venues and the media can influence risk in older age groups.[32] Early identification of potentially harmful substance use followed by a brief intervention is effective in preventing progression to substance dependence (this is covered later in this brief).[33] The social, safety, criminal justice and other sectors need to collaborate to address the structural issues that contribute to drug use and harm[34] – areas that are beyond the scope of this brief.

<table>
<tr><th colspan="6">Life stage</th></tr>
<tr><th>Setting</th><th>Pregnancy and infancy</th><th>Childhood</th><th>Adolescence</th><th>Adulthood</th></tr>
<tr><td rowspan="2">Family</td><td>Prenatal and infancy visitation</td><td colspan="2" rowspan="2">Parenting skills</td><td rowspan="2"></td></tr>
<tr><td>Interventions for pregnant women</td></tr>
<tr><td rowspan="4">School</td><td rowspan="4"></td><td>Early childhood education</td><td>Prevention education based on social competence and influence</td><td rowspan="3"></td></tr>
<tr><td>Personal and social skills education</td><td>Addressing individual vulnerabilities</td></tr>
<tr><td>Classroom mamagment</td><td>Programmes to enhance school attendance</td></tr>
<tr><td>Policies to keep children in school</td><td colspan="2">School policies on substance abuse</td></tr>
<tr><td rowspan="4">Community</td><td colspan="2"></td><td colspan="2">Alcohol and tobacco policies</td></tr>
<tr><td colspan="4">Community-based multi-component initiatives</td></tr>
<tr><td colspan="2" rowspan="3"></td><td colspan="2">Media campaigns</td></tr>
<tr><td>Mentoring</td><td></td></tr>
<tr><td colspan="2">Prevention programmes in entertainment venues</td></tr>
<tr><td>Workplace</td><td colspan="2"></td><td colspan="2">Workplace prevention programmes</td></tr>
<tr><td>Health sector</td><td>Interventions for pregnant women</td><td>Addressing mental health disorders</td><td colspan="2">Brief interventions</td></tr>
</table>

FIGURE 2: Evidence-based interventions in relation to life stage and implementation setting.

Source: UNODC, International standards on drug use prevention – second updated edition, UNODC and WHO, 2018

Treatment

Access to evidence-based treatment of drug dependence is a universal right.[35] The objectives of drug treatment for people with drug dependence are improved health and quality of life; improved social functioning; reduced harms; and changes in drug use aligned with an individual's goals. Effective treatment requires diversified psychosocial and medical (pharmacological) interventions that should align with international standards (see the box below).

WHO AND UNODC KEY PRINCIPLES AND STANDARDS FOR THE TREATMENT OF DRUG USE DISORDERS

1. Treatment should be available, accessible, affordable, attractive and appropriate.
2. Ethical standards of care should be ensured in treatment services.
3. Treatment through effective coordination between the criminal justice system and health and social services should be promoted.
4. Treatment should be based on scientific evidence and respond to the specific needs of individuals.
5. Interventions should respond to the special treatment and care needs of population groups.
6. Good clinical governance of treatment services and programmes should be ensured.
7. Treatment services, policies and procedures should support an integrated treatment approach, and linkages to complementary services require constant monitoring and evaluation.

Source: UNODC and WHO, International standards for the treatment of drug use disorders, 2020

The three broad components of drug treatment are discussed below, with a summary of indications of treatment by drug type provided in Figure 3.

Screening, brief interventions and referral for treatment: Screening of alcohol, tobacco and drug use should be done in a range of non-specialist settings (e.g. primary healthcare and social service sites). Screening should be done using a validated tool. People using substances should receive a brief intervention (5–30 minutes), which includes individualized feedback with advice on reducing/ stopping use, and an offer of follow-up. This intervention can prevent progression to more harmful use or dependence. People with ongoing problems should be referred for further care.[36]

Psychosocial interventions: These interventions can support reduction and cessation of drug use, and reduce frequency of return to use among people with drug dependence. They address motivational, behavioural, psychological and psychosocial factors that contribute to drug use. Their effectiveness varies according to the drug(s) of dependence. Several evidence-based interventions exist, including: cognitive behavioural therapy; contingency management; motivational interviewing; the community reinforcement approach; family-oriented treatment approaches, and mutual-help groups.[37] The outcomes of people with opioid dependence who receive only psychosocial interventions (i.e. without medical treatment) are poor.[38]

Pharmacological interventions: OST as maintenance is the recommended treatment for opioid dependence.[39] It involves the prescription of an opioid agonist medication (e.g. methadone or buprenorphine) by a trained medical provider at an appropriate dose for as long as a person requires it. Engagement in psychosocial services increases OST effectiveness. Quality OST results in reduced opioid use, all-cause mortality, HIV and viral hepatitis C transmissions; enhanced social functioning, reduced crime; and improved adherence to HIV treatment.[40]

Withdrawal management (sometimes referred to as detoxification) involves the management of symptoms linked to stopping drug intake in a person with dependence. This is critical for people dependent on a nervous system depressant (e.g. opioids, alcohol and benzodiazepines). Withdrawal management should follow evidence-based protocols. The outcomes of withdrawal management for opioid dependence are poor and associated with increased risk of overdose. Naltrexone, a long-acting opioid antagonist medication, can support efforts to prevent return to opioid use after detoxification among people who are motivated, where OST maintenance is unavailable or if use is based on client preference.[41] Currently, there are no effective pharmacological treatments for dependence on ATS or cocaine.[42]

Drug	Heroin	Cocaine	ATS
Screening and brief intervention			
Psychosocial interventions			
Cognitive behavioural therapy			
Contingency management			
Family therapy			
Pharmacological interventions			
OST maintenance			
Withdrawal management			
Withdrawal management and naltrexone			
KEY:	Recommended treatment	Some effectiveness	Not recommended

FIGURE 3: Recommended drug dependency treatment modalities by drug type.

Source: UNODC and WHO, International standards for the treatment of drug use disorders, 2020; WHO, Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence, 2009

Overdose identification and management: Naloxone is a short-acting opioid antagonist that rapidly reverses opioid overdose. Naloxone should be available in community settings to people who are likely to witness an opioid overdose (e.g. people who use drugs and their family members, peers and police) in order for them to administer it.[43] Stimulant overdose may occur and requires stabilization of cardiovascular function and attention to hydration and management of neurological symptoms.[44]

Tailoring treatment for different populations: An overview of care needs of sub-populations of people with drug dependence is provided in Figure 4. Drug services should be tailored to the specific needs of these groups.

Women
Women who use drugs are at high risk of infectious diseases and violence.[45] Drug use can affect pregnancy and a woman's future child's development.[46] Drug prevention and treatment services should integrate the sexual, reproductive, maternal and child health needs of women who use drugs in a gender-appropriate manner.[47] Barriers to accessing treatment, including safety, fear of losing custody of children and stigma should be removed to maximize service access.[48]
Young people
Interventions for young people who use drugs should address the social norms of drug use among adolescents using evidence-based interventions that build decision making and social skills.[49]
People with co-occurring psychiatric and physical health conditions
Psychiatric and physical health conditions among people with drug dependence should be identified and managed following evidence-based guidelines.[50]
Minority groups
Social exclusion, violence and discrimination (and resultant chronic stress, mental health conditions and trauma) affect gender diverse people, members of sexual minority groups, migrants and other minorities, and can contribute to higher levels of drug use and harm.[51]
People in prison and other closed settings
Screening and brief interventions, psychosocial interventions and pharmacotherapy (including OST for people with opioid dependence) should be provided in prison settings as part of a comprehensive package of health services.[52] Drug-related services should be provided to people in police custody while awaiting trial, and continuation of treatment upon release is important to reduce post-release overdose risk and to support health.[53]

FIGURE 4: Treatment needs of sub-populations of people who use drugs.

Harm reduction

Harm reduction is an evidence-based approach to drug policy and interventions that is rooted in social justice and human rights.[54] Harm reduction empowers people to make decisions on ways to reduce immediate risks (notably death and harms) and supports them to achieve their goals.[55] The WHO's comprehensive package of harm reduction interventions for people who use and inject drugs includes needle and syringe programmes, OST and community distribution of naloxone, as well as testing and treatment of HIV, viral hepatitis B and C, STIs and TB.[56]

Ongoing care and support

Also known as recovery management or aftercare, this process involves long-term psychosocial interventions for people to support improvements in their health and wellbeing. These activities also aim to support social functioning and integration, and the resolution of their drug dependence. This approach aligns with recommended public health management of chronic health conditions, implemented through a network of community-based support structures.[57] Recovery-oriented approaches focus on building strengths, skills and resources. Services are flexible, enable autonomy and foster community participation. Ongoing psychosocial support is usually delivered following an individualized plan in consultation with a case manager, ideally with support from a multidisciplinary team. Individualized plans usually cover issues related to drug use and ongoing treatment, housing, employment, social networks and community reintegration.[58]

DRUG USE PREVENTION, TREATMENT AND HARM REDUCTION IN EASTERN AND SOUTHERN AFRICA

The first pillar of the AU Plan of Action on Drug Control and Crime Prevention (2019–2023) is to implement

> [m]easures to tackle drug demand reduction and health issues associated with drug use, focusing on prevention and treatment of drug use with provisions for training of workers and professionals in these fields, parental skills training, life skills training for children and young people, reducing harm associated with drug use and implementing alternatives to punishment for drug use.[59]

This policy position aligns with the Operational Recommendations from the 2016 United Nations General Assembly Special Session (UNGASS) on the World Drug Problem Outcome Document.[60] The AU's policy commitments also align with the Sustainable Development Goals (SDGs), specifically SDG 3.5.1: to strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.[61] One of the Global AIDS Strategy targets is for 50% of people who inject drugs with opioid dependence to access OST by 2025.[62]

Regional policies on drug dependence prevention and treatment

The use and possession of drugs for personal use remains criminalized in all countries in the ESA region.[63]A matrix of drug prevention and treatment policy by country is presented in Figure 5. Several countries' (Kenya,[64] Mauritius,[65] Seychelles,[66] South Africa[67] and Zimbabwe[68]) drug policies emphasize a public health approach to drug use, referencing evidence-based interventions. Drug policy in Lesotho,[69] Rwanda[70] and Zambia[71] includes drug prevention and treatment but does not emphasize the need for interventions to be evidence-based, nor does it explicitly include harm reduction. Tanzania's Drug Control and Enforcement Act does not stipulate the need for interventions to be evidence-based.[72] However, national HIV guidelines for key populations include harm reduction interventions.[73] eSwatini's Ministry of Health Service's Key Population Implementation Guide provides support for harm reduction.[74] Botswana's Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act only includes the powers of the health minister to establish rehabilitation centres.[75] Namibia and Mozambique are in the process of finalizing drug policies, which are expected to align with the AU Plan of Action.[76] A drug policy is planned for Malawi.[77] Documents and expert inputs were not obtained for insights into drug policy in Comoros or Madagascar.

Country	Drug use or possession for personal use is decriminalized[9]	Law supportive of a public health approach	Policy support for evidence-based prevention	Policy support for evidence-based drug treatment	Policy support for harm reduction	Policy support for OST maintenance
Botswana	No	No	No	No	No	No
Comoros	No	Unable to find	Unable to find	Unable to find	Unable to find	Unable to find
eSwatini	No	No	No	No	Yes	Yes
Kenya	No	Mixed	Yes	Yes	Yes	Yes
Lesotho	No	No	No	No	No	No
Madagascar	No	Unable to find	Unable to find	Unable to find	Unable to find	Unable to find
Malawi	No	No	No policy	No policy	No policy	No policy
Mauritius	No	Yes	yes	yes	yes	Yes

Country	Drug use or possession for personal use is decriminalized[9]	Law supportive of a public health approach	Policy support for evidence-based prevention	Policy support for evidence-based drug treatment	Policy support for harm reduction	Policy support for OST maintenance
Mozambique	No	In draft policy	In draft policy	In draft policy	In draft policy	In draft policy
Namibia	No	No	In draft policy	In draft policy	In draft policy	In draft policy
Rwanda	No	Mixed	Mixed	No	No	No
Seychelles	No	Yes	Yes	Yes	Yes	Yes
South Africa	No	Mixed	Yes	Yes	Yes	Yes
Tanzania	No	No	No	No	Yes	Yes
Uganda	No	Mixed	No	Mixed	Yes	Yes
Zambia	No	Mixed	No	No	No	No
Zimbabwe	No	Yes	Yes	Yes	Yes	Yes

Yes: Policy stipulates evidence-based intervention
No: Policy does not stipulate that interventions should be evidence-based
Mixed: Conflicting policy position – inclusion of some evidence-based interventions and others that are not recommended
No policy: No specific drug policy exists
Unable to find: Unable to find drug policy to review framework around interventions

FIGURE 5: Drug law and current drug policy context, by country, ESA.

Sources: UNAIDS Data 2020, 1-248. https://www.unaids.org/en/resources/documents/2020/unaids-data%0A http://www.unaids.org/sites/default/files /media_asset/20170720_Data_book_2017_en.pdf; eSwatini Health Services – Key Population Program Implementation Guide, 2nd edition, 2020; National Guidelines on Alcohol and Drug Prevention, NACADA, 2021; National Protocol for Treatment of Substance Use Disorders in Kenya, Kenyan Ministry of Health, 2017; Drugs of Abuse Act, Government of Lesotho, 2008; Personal communication, Henry Ndindi, UNODC, Zambia; National Drug Control Master Plan 2019–2023, Republic of Mauritius, 2019; Personal communication, Ana Gabriela Gutierrez Zamudio, medical coordinator, MSF, Mozambique; Ministry of Local Government, National Policy Against Delequency, Government of Rwanda, 2016; Agency for the Prevention of Drug Abuse and Rehabilitation, National Drug Control Master Plan 2019–2023, Government of Seychelles, 2019; Department of Social Development, National Drug Master Plan 4th Edition 2019–2024, South African Government, 2019; Drug Control and Enforcement Act, Chaper 95, Government of Tanzania, 2019; Government of Uganda, Narcotic Drugs and Psychotropic Substances (control) Act 2016; Narcotic Drugs and Psychotropic Act No. 35 of 2021, Government of Zambia, 2021; Illicit Traffic in Narcotic Drugs and Psychotropoic Substances Act 2018, Government of Botswana, 2018

The 2021 Global Drug Policy Index Review assessed drug policy in Kenya, South Africa, Mozambique and Uganda in relation to United Nations principles. For the health and harm reduction dimension, out of a score of 100, the countries scored 46, 37, 21 and 13, respectively (in relation to a median score of 40 across 30 countries from all regions of the world).[78]

Drug dependence prevention, and treatment availability and coverage

Data on the availability and coverage of drug-related services in ESA is limited. Data from AU reports was analyzed, as was publicly available information from the UNODC and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

Prevention: A country summary of prevention interventions included in the AU's Third Ordinary Session of the Specialised Technical Committee on Health, Population and Drug Control (2019) report[79] is given in Figure 6. The report noted prevention interventions in six countries in the region. Drug awareness campaigns were the most widely implemented prevention intervention. Skills-based education in schools as part of drug use prevention was noted in a few countries and parenting skills in one. While a range of activities was reported, few specified alignment with evidence-based practice and/or recommended international standards.[80] No data was identified quantifying the coverage of universal or targeted drug prevention interventions in the region.

Country	Pre-natal and infancy	Early childhood education	Parenting skills	Social and personal skills development in school	Address mental health in school	Multi-component initiatives	Media campaigns	Mentoring	Entertainment / workplace interventions	Screening and brief interventions
Botswana	No	No	No	No	No	Yes	Yes	No	No	No
Comoros	No	No	No	No	No	No	No	No	No	No
eSwatini	No	No	No	No	No	Yes	Yes	No	No	No
Kenya										
Lesotho										
Madagascar										
Malawi										
Mauritius										
Mozambique										
Namibia	No	No	No	Yes	No	Yes	Yes	No	Yes	Yes
Rwanda										
Seychelles										
South Africa	No	No	Yes	Yes	No	Yes	Yes	No	No	No
Uganda										
Tanzania										
Zambia	No	No	No	Yes	No	Yes	Yes	No	Yes	No
Zimbabwe										

Blank spaces: Country progress/interventions not listed in the report
Yes: Intervention reported, with reference to evidence-based practice and/or international standards
No: Intervention either not reported and/or no reference to alignment with evidence-based practice and/or international standards

FIGURE 6: Drug prevention interventions noted in the narrative report on progress in implementing the AU Plan of Action on Drug Control, 2013–2019.

Source: AU, Third ordinary session of the Specialised Technical Committee on Health, Population and Drug Control, Addis Ababa, 29 July–2 August 2019

Availability of treatment and harm reduction services: Most of the available drug treatment services in ESA are provided within mental health facilities, often in hospital settings. Community-based psychosocial treatment services and detoxification services are also provided in most countries. However, only seven ESA member states have harm reduction programmes that include OST maintenance, and only four provide OST in prisons (see Figure 7).

Country	Mental health facility	Specialist treatment centres	Community-based services	Detoxification	Harm reduction with OST*	Treatment service in prison
Botswana	Yes	No	Yes	No	No	No
Comoros	Yes	No	No	Yes	No	No
eSwatini	Yes	No	Yes	Yes	No	No
Kenya	Yes	Yes	Yes	Yes	Yes[7]	Yes
Lesotho	Yes	No	Yes	No	No	No
Madagascar	Yes	Yes	Yes	No	No	No
Malawi	Yes	No	Yes	No	No	No
Mauritius	Yes	Yes	Yes	No	Yes[42]	Yes
Mozambique	Yes	Yes	Yes	No	Yes[1]	No
Namibia	Yes	Yes	Yes	Yes	No	No
Rwanda	Yes	Yes	Yes	Yes	No	No
Seychelles	Yes	Yes	Yes	Yes	Yes[10]	Yes
South Africa	Yes	Yes	Yes	Yes	Yes[22]	Yes**
Tanzania	Yes	Yes	Yes	Yes	Yes[6]	Yes
Uganda	Yes	No	No	Yes	Yes[1]	No
Zambia	Yes	Yes	Yes	Yes	No	No
Zimbabwe	Yes	No	Yes	No	No	No

Yes: Intervention reported
No: No confirmation of delivery of drug treatment services in that setting, or the particular treatment type
* The number of community-based OST sites in the country are provided in superscript.
** South Africa does not provide OST in prison settings

FIGURE 7: Availability of drug dependence treatment services, by treatment setting and country.

Sources: AU, Third ordinary session of the Specialised Technical Committee on Health, Population and Drug Control, Addis Ababa, 29 July–2 August 2019; The Global State of Harm Reduction 2020, Harm Reduction International 2020; Agency for the Prevention of Drug Abuse and Rehabilitation, National Drug Control Master Plan 2019–2023, Government of Seychelles, 2019

Treatment and harm reduction service coverage: No data was accessible on the SDG 3.5.1 (Coverage of treatment intervention for substance use disorders) for any ESA member states.[81] Data submitted by ESA member states to the UNODC on people admitted to drug treatment centres (out- and in-patients, with varying inclusion of OST treatment data) points to very low treatment coverage. A total of 27 538 people were reported to have received drug treatment in 2020 (the latest year for which data was available). Most treatment was for cannabis as the primary substance of use. Treatment admissions related to opioids (mostly heroin) range from 0% in Botswana to 100% in Tanzania (see Figure 8). In 2020, OST coverage among people who inject drugs was 73%, 54%, 26%, 24% and 1% in Seychelles, Mauritius, Kenya, Tanzania and South Africa, respectively.[82] Besides a few pilot projects, no countries provide peer-delivered naloxone services for opioid overdose management.[83]

FIGURE 8: Number of drug treatment admissions by country and type of primary drug of use (latest data).

Source: UNODC, https://dataunodc.un.org

Drug dependence treatment gap: In Africa, one in eighteen (6%) people in need of drug use treatment access it.[84] Quantification of the drug dependence treatment gap in ESA is difficult, partly due to limited estimates of the number of people with drug dependence, and limited centralized reporting. An indication of the drug dependence treatment gap can be made based on reported drug treatment data (minus cannabis),[85] regional annual drug use prevalence estimates,[86] population estimates[87] and the assumption that 10% of people who use drugs have dependence.[88] Despite the many limitations of this method, the large treatment gap is evident in Figure 9.

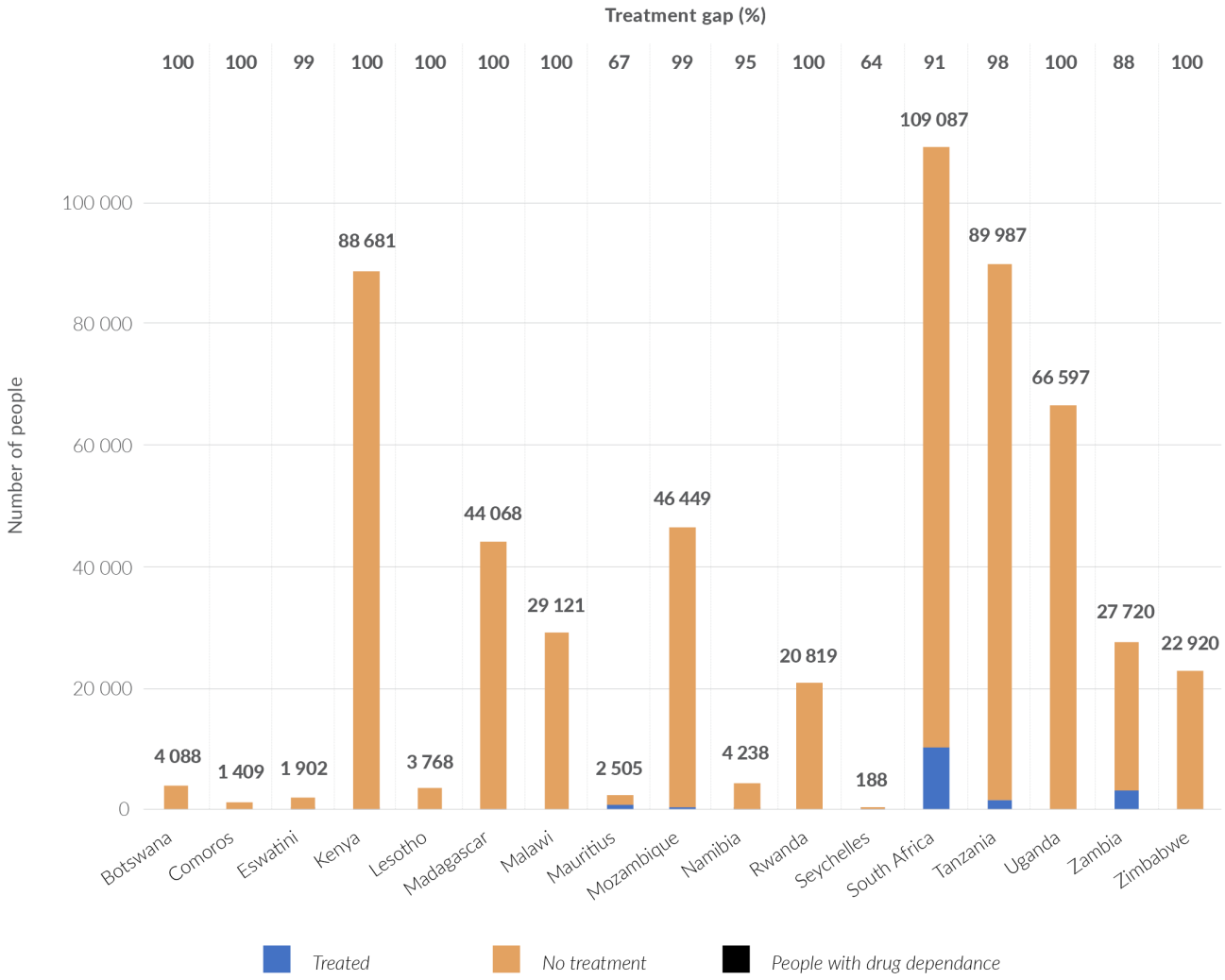

FIGURE 9: Drug dependence treatment gap by country based on reported UNODC data (excluding cannabis).

Sources: World Bank Data, ages 15–64, https://data.worldbank.org/indicator/SP.POP.1564.TO?contextual=region&end=2020&locations=ZW&start=2020; UNODC, https://dataunodc.un.org/.

IMPLICATIONS

The historical emphasis of drug control policy through a criminal justice approach, rather than a rights- and public health-based approach, reflects the enormous unmet need for evidence-based drug prevention, treatment and harm reduction policy and services in ESA. Criminalization of people who use drugs perpetuates stigmatization. Furthermore, the health and social harms as well as costs associated with the incarceration of people who use drugs will continue unless significant policy reform takes place. Effective drug dependence prevention, treatment and harm reduction can only occur in supportive policy environments.

The AU Plan of Action on Drug Control and Crime Prevention (2019–2023) provides policy direction for member states. International standards on drug prevention and treatment, and evidence-based guidance for harm reduction and clinical interventions exist to maximize quality. The multifactorial causes of drug dependence necessitate responses that adopt an all-of-society approach. Unless evidence-based reforms are translated into policy – and implemented – drug dependence responses will fail.

Implementation of evidence-based drug dependence prevention, treatment and harm reduction interventions is key to mitigate the effects of the probable increase in drug use in ESA. The apparent emphasis on media campaigns and education for learners highlights the gaps in support for pregnancy, parenting skills, early childhood development and skills-based development of young people to delay onset of drug use. Limited mention of screening and brief interventions highlights a critical gap. Meanwhile, limited utilization of community-based services points to an area where efficiencies can be achieved if this mode of treatment intervention was rolled out. Weak information systems limit the ability to assess gaps and make informed decisions.

There is a need to shift the emphasis from specialized drug treatment services in mental health facilities towards early intervention in community settings. Significant scale-up of interventions is needed to meet the drug dependence challenge.

Effective collaboration across sectors and across the prevention–harm reduction continuum will be important, as these interventions will be a significant departure from previous policy and operation paradigms in many countries.

Human resource capacity was not assessed here, but is a fundamental service delivery building block. Service providers would need to be capacitated to implement evidence-based interventions, and to ensure quality.

Recommendations

National drug prevention, treatment and harm reduction systems should be embedded and integrated into a larger health-centred and balanced system that includes appropriate law enforcement and supply reduction efforts.

Overarching drug policy: Public health- and rights-based approaches should inform policy relating to drug dependence. Public health and rights principles should also be integrated into policies of other sectors that have a bearing on drug control (e.g. education, criminal justice, social development and housing).[89]

Leadership, governance and coordination: Centralized coordination of a harmonized approach to address drug use and dependence and related issues through a designated entity should be a priority.

Training of policymakers and service providers: Policymakers and service providers (in the health, social services, education, law enforcement and criminal justice sectors) need to be trained on the rationale of public health- and rights-

based approaches to manage drug use and dependence, and on evidence-based interventions. Training should cover implementation of operational policies and guidelines. Integration of training into in-service and pre-service training is important for sustainability.

Service delivery: The public health system should lead efforts aimed at treating drug dependence in collaboration with social and other services. Prevention programmes should include a mix of universal interventions that support optimal early childhood development, retaining children in school and supporting skills development among learners that can support social functioning and integration. Parenting skills training is important and should focus on marginalized and vulnerable communities. The education and health systems should identify and support people with mental health conditions and early onset, or harmful substance use to prevent progression.

Emphasis should be placed on community-based screening and brief intervention and community-based drug dependence treatment modalities. Most drug dependence treatment services should be outpatient-based and located in communities where they are accessible. Services should include evidence-based psychosocial services for people with drug dependence, with access to OST maintenance for those with opioid dependence. Sufficient coverage is required for a public health impact, with universal access to people who require treatment.

Services should be tailored for specific sub-populations, including women, people in prison settings, young people and other minority groups, following evidence-based guidance.

Financing and infrastructure: Countries should commit to developing sustainable financing solutions for universal and targeted prevention interventions, as well as access to a package of evidence-based drug treatment and harm reduction services in community and prison settings. States should work towards domestic financing of drug treatment and harm reduction services as part of universal health coverage.[90] The bulk of resource and infrastructure development should target community-based services (integration into health and social service delivery platforms), rather than resource-heavy specialized drug treatment centres that reach few people.

Strategic information: Countries should adapt and/or develop their national monitoring and evaluation frameworks to collect data that align with the regional and global indicators. Regular data review, evaluation and programmatic adjustments need to be undertaken in light of the changing nature of the drug market, drug use practices and developments in evidence-based practice.

ANNEX 1:
SELECTED DRUGS AND THEIR EFFECTS

Description	Behavioural effects	Tolerance and withdrawal	Effects of prolonged use
Heroin			
An opiate derived from the opium poppy	Euphoria, analgesia, sedation and respiratory depression	Changes to receptors leads to tolerance. Watering eyes, runny nose, yawning, sweating, restlessness, chills, cramps, muscle aches	Long-term changes in opioid receptors. Adaptations in reward, learning and stress responses.
Cocaine			
A (psycho)stimulant derived from the coca plant. Available as free base (crack) or hydrochloride (powder).	Increased alertness, energy, motor activity, feelings of competence; euphoria, anxiety, restlessness, paranoia	Potentially short-term acute tolerance. Withdrawal limited to 'post-high down'.	Cognitive deficits, impaired motor function, cardio-vascular complications, strokes and cerebral bleeding
Amphetamine-type stimulants (ATS)			
Synthetically manufactured (psycho)stimulants derived from alpha-methylphenethylamine (amphetamine); includes amphetamine and methamphetamine	Increased alertness, arousal, energy, motor activity, speech, self-confidence, concentration, feelings of well-being; decreased hunger, increased heart rate, increased respiration, euphoria	Tolerance develops rapidly to behavioural and physiological effects. Withdrawal causes fatigue, increased appetite, irritability, emotional depression and anxiety.	Sleep disturbances, anxiety, decreased appetite, increased blood pressure, decreased brain dopamine

Source: WHO, Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence, 2009

ANNEX 2:
ADDITIONAL DETAILS ON EFFECTIVE PREVENTION INTERVENTIONS

Pregnancy and infancy
■ Pre-natal and infancy visits by trained nurses/social workers that provide parenting skills and support for a range of health and social issues to women in difficult circumstances. ■ Screening, brief interventions and referral for treatment. ■ Early childhood education programmes to support social and cognitive development of children (2–5 years).
Childhood
■ Parenting skills programmes that enhance bonding, role modelling and discipline. ■ Interactive personal and social skills education (multiple sessions) by trained teachers/facilitators that develop social and personal skills for mental and emotional well-being. ■ Classroom environment programmes that build teacher capacity to support children to socialize and address early aggressive and disruptive behaviours. ■ Policies to retain children in school, including building new schools, nutrition programmes and conditional cash transfers. ■ Identifying and addressing mental health disorders through behavioural and psychological interventions for children and caregiver skills for carers. Pharmacological interventions, in specialized settings, may be needed.
Adolescence
■ Multi-session, skills-based, interactive prevention education based on social competence and influence provided by trained teachers/facilitators that include practice of personal and social skills (coping, decision making, resistance) and change perceptions of risk. ■ School policies on substance use that support normal school functioning, developed with all stakeholders, and are supportive of learners, with referral for health/psychosocial care. ■ Enhance school attachment through participation, commitment and bonding to the school. ■ Trained professionals to identify and address individual psychological vulnerabilities to provide people with skills to cope with emotions arising from their personality. ■ Structured mentoring programmes that match young people with adults to spend time together. ■ Evidence-based alcohol and tobacco policies.
Adulthood
■ Screening, brief interventions and referral for treatment. ■ Workplace prevention programmes that are multicomponent and non-punitive. ■ Community-based multi-component initiatives that mobilize stakeholders to support enforcement of substance-related policies and delivery of interventions in a range of settings. ■ Targeted media campaigns based on a solid theoretical basis and informed by formative research that connect with existing programmes aimed at shifting cultural norms around drug use.

Source: WHO, MHGAP Intervention guide for mental, neurological and substance use disorders in non-specialized health settings, Version 2.0, 2016

Notes

[1] Joanne Csete et al, Public health and international drug policy, *Lancet*, 2016, https://pubmed.ncbi.nlm.nih.gov/27021149/.
[2] Alcohol, which *is* regulated, causes more harm to individuals and society than either of these drugs. See David J Nutt, Leslie A King and Lawrence D Phillips, Drug harms in the UK: a multicriteria decision analysis, *Lancet*, 2010, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61462-6/fulltext.
[3] UNODC, World drug report 2017, https://www.un-ilibrary.org/content/books/9789210606233c003.
[4] UNODC, International standards on drug use prevention, Second updated edition, 2018, http://www.unodc.org/documents/prevention/standards_180412.pdf.
[5] Ibid.
[6] WHO and Mental Health Gap Action Programme, mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, Version 2.0, 2016, https://www.who.int/publications/i/item/9789241549790.
[7] WHO and UNODC, International standards for the treatment of drug use disorders, March 2020, https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders.
[8] WHO, Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence, January 2009, https://www.who.int/publications/i/item/9789241547543.
[9] WHO and UNODC, International standards for the treatment of drug use disorders, March 2020, https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders; UNODC et al, Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions, 2017, https://www.unaids.org/sites/default/files/media_asset/2017_HIV-HCV-programmes-people-who-inject-drugs_en.pdf.
[10] UNODC, UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters, What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters, March 2019, https://www.unodc.org/documents/commissions/CND/2019/Contributions/UN_Entities/What_we_have_learned_over_the_last_ten_years_-_14_March_2019_-_w_signature.pdf.
[11] International Centre on Human Rights and Drug Policy, UNAIDS, World Health Organization, UN Development Programme, International guidelines on human rights and drug policy, 2019, https://www.undp.org/publications/international-guidelines-human-rights-and-drug-policy.
[12] UNODC, World drug report 2017, https://www.un-ilibrary.org/content/books/9789210606233c003.
[13] African Union, African Union Plan of Action on Drug Control and Crime Prevention (2019–2023), 2019, https://au.int/sites/default/files/newsevents/reports/36768-rp-aupa_on_drug_control_2019-2023_final_with_foreword_-_english_.pdf.
[14] See Talking Drugs, Drug decriminalisation across the world, https://www.talkingdrugs.org/drug-decriminalisation; UNAIDS data 2020, https://www.unaids.org/en/resources/documents/2020/unaids-data.
[15] UNODC, World drug report 2017, https://www.un-ilibrary.org/content/books/9789210606233c003.
[16] UNODC, World Drug Report 2020, Booklet 1, June 2020, https://wdr.unodc.org/wdr2020/field/WDR20_BOOKLET_1.pdf.
[17] Zachary Donnenfield, Lily Welborn and Julia Bello-Schünemann, Drug demand and use in Africa: Modelling trends to 2050, ENACT, August 2019, https://enact-africa.s3.amazonaws.com/site/uploads/2019-08-28-drug-demand-and-use-in-africa-reaseach-paper-cb.pdf.
[18] Norman Earl Zinberg, *Drug, Set and Setting: The Basis for Controlled Intoxicant Use*. New Haven: Yale University Press, 1984.
[19] Joanne Csete et al, Public health and international drug policy, *Lancet*, 2016, https://pubmed.ncbi.nlm.nih.gov/27021149/.
[20] See WHO, Global health estimates: Life expectancy and leading causes of death and disability, 2019, https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates.
[21]UNODC, World Drug Report 2020, Booklet 1, June 2020, https://wdr.unodc.org/wdr2020/field/WDR20_BOOKLET_1.pdf.
[22] See WHO, Global health estimates: Life expectancy and leading causes of death and disability, 2019, https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates.
[23] Roy Robertson, Barbara Broers and Magdalena Harris, Injecting drug use, the skin and vasculature, *Addiction*, 2020, https://pubmed.ncbi.nlm.nih.gov/33051902/.
[24] UNODC, Were you really raped or did you just not get paid? A needs assessment of women who use drugs in four cities in South Africa, 2019, https://www.unodc.org/documents/southernafrica/Publications/Health/WWUD_In_our_own_words_2019_web.pdf.
[25] Harm Reduction International, The harms of incarceration: The evidence based and human rights framework for decarceration and harm reduction in prisons, June 2021, https://www.hri.global/contents/2134.
[26] International Network on Health and Hepatitis in Substance Users, Harm reduction responses in the age of COVID-19: Documenting the experiences of people who use drugs in South Africa, March 2021, http://fileserver.idpc.net/library/INHSU_FINAL_25_Mar.pdf.
[27] UNODC, World drug report 2017, https://www.un-ilibrary.org/content/books/9789210606233c003.
[28] UNODC, UN WOMEN, WHO, International Network of People who Use Drugs, Women who inject drugs and HIV: Addressing specific needs, 2014, https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf.
[29] UNODC, UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters, What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters, March 2019, https://www.unodc.org/documents/commissions/CND/2019/Contributions/UN_Entities/What_we_have_learned_over_the_last_ten_years_-_14_March_2019_-_w_signature.pdf.
[30] Ibid.
[31] UNODC, International standards on drug use prevention, Second updated edition, 2018, http://www.unodc.org/documents/prevention/standards_180412.pdf; WHO, Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, July 2016, https://www.who.int/publications/i/item/9789241511124.
[32] UNODC, International standards on drug use prevention, Second updated edition, 2018, http://www.unodc.org/documents/prevention/standards_180412.pdf.
[33] WHO and Mental Health Gap Action Programme, mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, Version 2.0, 2016, https://www.who.int/publications/i/item/9789241549790.
[34] UNODC, International standards on drug use prevention, Second updated edition, 2018, http://www.unodc.org/documents/prevention/standards_180412.pdf.
[35] International Centre on Human Rights and Drug Policy, UNAIDS, World Health Organization, UN Development Programme, International guidelines on human rights and drug policy, 2019, https://www.undp.org/publications/international-guidelines-human-rights-and-drug-policy.
[36] WHO and Mental Health Gap Action Programme, mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, Version 2.0, 2016, https://www.who.int/publications/i/item/9789241549790.

[37] UNODC, International standards on drug use prevention, Second updated edition, 2018, http://www.unodc.org/documents/prevention/standards_180412.pdf.
[38] WHO, Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence, January 2009, https://www.who.int/publications/i/item/9789241547543.
[39] Ibid.
[40] Ibid.
[41] Ibid.
[42] WHO and UNODC, International standards for the treatment of drug use disorders, March 2020, https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders.
[43] WHO, Community management of opioid overdose, 2014, https://apps.who.int/iris/handle/10665/137462.
[44] WHO and Mental Health Gap Action Programme, mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, Version 2.0, 2016, https://www.who.int/publications/i/item/9789241549790.
[45] Janni Leung et al, A global meta-analysis of the prevalence of HIV, hepatitis C virus, and hepatitis B virus among people who inject drugs: Do gender-based differences vary by country-level indicators?, *J of Infectious Diseases*, 2019, https://pubmed.ncbi.nlm.nih.gov/30726973/.
[46] WHO, Guidelines for the identification and management of substance use and substance use disorders in pregnancy, 2014, https://www.who.int/publications/i/item/9789241548731; WHO, Prevention of mother-to-child transmission of hepatitis B virus: Guidelines on antiviral prophylaxis in pregnancy, July 2020, http://www.ncbi.nlm.nih.gov/pubmed/32833415.
[47] Kasia Malinowska-Sempruch and Olga Rychkova, The impact of drug policy on women, Open Society Foundations, 2015, https://www.opensocietyfoundations.org/sites/default/files/impact-drug-policy-women-20160928.pdf.
[48] Ibid.
[49] WHO and UNODC, International standards for the treatment of drug use disorders, March 2020, https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders; UNODC, International standards on drug use prevention, Second updated edition, 2018, http://www.unodc.org/documents/prevention/standards_180412.pdf; WHO, HIV and young people who inject drugs, January 2015, http://www.inpud.net/UNAIDS_YKP_Briefs_PWID_2014.pdf.
[50] WHO and UNODC, International standards for the treatment of drug use disorders, March 2020, https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders.
[51] Global Forum on MSM and HIV, COC, The impact of drug policies on the human rights of lesbian, gay, bisexual, trans and intersex people, Joint civil society submission to Officer of the High Commissioner for Human Rights, 18 May 2018; UNODC, World Drug Report 2020, Booklet 5: Socioeconomic characteristics and drug use disorders, https://wdr.unodc.org/wdr2020/en/socioeconomic.html.
[52] WHO, Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, July 2016, https://www.who.int/publications/i/item/9789241511124.
[53] Adeeba Kamarulzaman et al, Prevention of transmission of HIV, hepatitis B virus, hepatitis C virus, and tuberculosis in prisoners, *Lancet*, 2016, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30769-3/fulltext.
[54] Mary Hawk et al, Harm reduction principles for healthcare settings, *Harm Reduction Journal*, 14, 1 (2017).
[55] Ibid.
[56] UNODC et al, Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions, 2017, https://www.unaids.org/sites/default/files/media_asset/2017_HIV-HCV-programmes-people-who-inject-drugs_en.pdf.
[57] WHO, UNODC. International standards for the treatment of drug use disorders. 2020. doi:10.18356/0489b59b-en; WHO, MHGAP. mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0. 2016.
[58] WHO and UNODC, International standards for the treatment of drug use disorders, March 2020, https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders.
[59] African Union, African Union Plan of Action on Drug Control and Crime Prevention (2019–2023), 2019, https://au.int/sites/default/files/newsevents/reports/36768-rp-aupa_on_drug_control_2019-2023_final_with_foreword_-_english_.pdf.
[60] UNODC, Outcome document of the 2016 United Nations General Assembly Special Session on the world drug problem, 2016, https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf.
[61] See UNODC, Sustainable development goals, https://www.unodc.org/unodc/en/about-unodc/sustainable-development-goals/sdgs-index.html.
[62] UNAIDS, Global AIDS Strategy 2021–2026, March 2021, https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy.
[63] This excludes cannabis, which has been decriminalized in South Africa.
[64] National Authority for the Campaign Against Alcohol and Drug Abuse, National guidelines on alcohol and drug use prevention 2021, https://nacada.go.ke/sites/default/files/2021-07/National%20Guidelines%20on%20Drug%20Use%20Prevention%202021.pdf; Ministry of Health Kenya, The national protocol for treatment of substance use disorders in Kenya, 2017, https://www.afro.who.int/sites/default/files/2017-09/The%20National%20Protocol%20for%20treatments%2014%2007%202017.pdf.
[65] Government of Mauritius, National Drug Control Master Plan 2019–2023, 2019.
[66] Agency for Prevention of Drug Abuse and Rehabilitation, National Drug Control Master Plan 2019–2023, 2019.
[67] Department of Social Development, National Drug Master Plan, 4th edition, 2019–2024, 2019.
[68] Government of Zimbabwe, Dangerous Drugs Act, No. 28 of 1955.
[69] Government of Lesotho, Drugs of abuse Act 2008.
[70] Ministry of local government, National Policy Against Delequency, December 2016.
[71] Government of Zambia, The narcotic drugs and psychotropic Act. No. 35 of 2021, 2021.
[72] The United Republic of Tanzania, The Drug Control and Enforcement Act, Chaper 95, 2019.
[73] National AIDS Control Programme, Comprehensive package of HIV interventions for key population, September 2014.
[74] Health Services Eswatini, Key population program implementation guide, 2nd edition, 2020.
[75] Government of Botswana, Illicit Traffic in Narcotic Drugs and Psychotropoic Substances Act 2018, 2018.
[76] Interview with Johan Strijdom, Division of Social Welfare and Drug Control, African Union; interview with Ana Gabriela Gutierrez Zamudio, Medical coordinator, Médecins Sans Frontières, Mozambique.
[77] Interview with Henry Ndindi, UNODC, Zambia.
[78] The Harm Reduction Consortium, The Global Drug Policy Index 2021, November 2021, http://fileserver.idpc.net/library/2021-10-GDPI-Analytical-Report-Pages-EN.pdf.
[79] African Union, Third ordinary session of the specialised technical committee on health, population and drug control, Addis Ababa, Ethiopia, 29 July–2 August 2019.
[80] Ibid.
[81] See UNODC data: https://dataunodc.un.org/.

[82] See UNAIDS Data 2020: https://www.unaids.org/en/resources/documents/2020/unaids-data%0Ahttp://www.unaids.org/sites/default/files/media_asset/20170720_Data_book_2017_en.pdf; Andrew Scheibe, Insights into the market value of heroin, cocaine and methamphetamine in six countries in southern and eastern Africa, 2021; South African Community Epidemiology Network on Drug Use, Reseach brief Phase 48, 2021.
[83] Harm Reduction International, The Global State of Harm Reduction 2020, https://www.hri.global/global-state-of-harm-reduction-2020.
[84] African Union, Third ordinary session of the specialised technical committee on health, population and drug control, Addis Ababa, Ethiopia, 29 July–2 August 2019.
[85] See UNODC data: https://dataunodc.un.org.
[86] Ibid.
[87] See The World Bank data: Guinea-Bissau, https://data.worldbank.org/country/guinea-bissau.
[88] UNODC, World drug report 2017, https://www.un-ilibrary.org/content/books/9789210606233c003.
[89] See WHO: Promoting health in all policies and intersectoral action capacities, https://www.who.int/activities/promoting-health-in-all-policies-and-intersectoral-action-capacities.
[90] See WHO: Universal health coverage, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

GLOBAL COMMISSION ON DRUG POLICY

GLOBAL INITIATIVE AGAINST TRANSNATIONAL ORGANIZED CRIME

The Eastern & Southern Africa Commission on Drugs

Global Initiative Against Transnational Organized Crime

secretariat@esacd.org

ESACD
Eastern & Southern Africa Commission on Drugs