ESACD
Eastern & Southern Africa Commission on Drugs

The Eastern & Southern Africa Commission on Drugs

Drug policy reform in Eastern and Southern Africa

Discussion paper

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Contents

Acronyms and abbreviations

CND	Commission on Narcotic Drugs
ESA	Eastern and Southern Africa
ESACD	Eastern and Southern Africa Commission on Drugs
EAC	East African Community
GI-TOC	Global Initiative Against Transnational Organized Crime
GCDP	Global Commission on Drug Policy
INCB	International Narcotics Control Board
SADC	Southern African Development Community
UNGASS	United Nations General Assembly Special Session on Drugs
UNODC	United Nations Office on Drugs and Crime
WACD	West Africa Commission on Drugs

INTRODUCTION

The seductive but one-dimensional war on drugs policy deployed against Africa's illicit drug markets has failed, as it has globally. In the six decades since UN member states agreed the Single Convention on Narcotic Drugs, the use, production and trade in controlled substances across Eastern and Southern Africa (ESA) and the continent as a whole has expanded exponentially, all in a long-term context of prohibition. Many African drug markets have transformed from the geographically restricted traditional plant-based drug economies of khat and cannabis, to become an industrial hub for the manufacture, production and trans-shipment of a variety of controlled drugs, whose related economies have significantly skewed the ability of some states to effectively manage the health and social impacts of these developments. The imposition of internationally defined and domestically attractive prohibition measures have been unsuccessful in arresting the growth of these trades, or the violence and institutional erosion that they engender.

Like much of the continent, drug control in ESA has been defined through the securitization lens, extending to the militarization of security structures by external forces. Where international actors feel that African efforts are inadequate, foreign military powers have deployed assets to support continental drug prohibition efforts and to execute drug interdiction measures on African territory directly.1 Yet, these efforts have been unsuccessful in significantly curtailing the regional drug trade. Further, some would argue that in fact it is the prohibition measures themselves that give rise to some of the violence and market expansion seen in recent years.[2]

This failure is not a product of ESA; rather, it is a product of global (and, by extension, continental) drug policy myopia. However, key policy actors have lately begun to acknowledge this damaging bias. The clear proliferation of drug cultivation, trafficking and consumption within the context of prohibition is generating impetus for drug policy reform thinking and action. More than 50 countries around the world have now eschewed strict prohibitionist drug policy approaches and begun to liberalize, in varying degrees, their approach to the drug trade and the health and rights of consumers, reflecting a significant recognition of the need for a sophisticated and holistic approach. That eleven African countries have also begun to embark on this path of reflection and reconsideration is equally remarkable, particularly as this has only taken place since the 2016 UN General Assembly Special Session (UNGASS) on the World Drug Problem.

This trend towards more liberal drug policies globally - incipient within ESA – has evolved primarily through nations' policy positioning on cannabis. There is an evolving global consensus that cannabis, although scheduled, is less harmful (the 'soft drug' thesis), and potentially more beneficial to society and its members from a socio-medical and livelihoods development perspective, when it is either decriminalized or legalized rather than prohibited. In some countries, cannabis has become a mainstream consumer commodity, alongside tobacco and alcohol. This drug's consumer base has evolved in these countries to consist largely of recreational, middle-class users. It has rebranded from a drug of the marginalized to become a commodity of the mainstream, and the potential financial benefits afforded to the state from the taxation of its trade has been key to its legal transition.

The addition of health and human rights focused criteria to the drug policy reform debate has stoked the further acceptance of policy reform, particularly in the health institutions of the region. Unfortunately, however, the securitization of drugs remains the predominate lens through which African security forces view cannabis and other drugs. It remains the channel for assistance by external forces - often to domestic security institutions directly - that seek to peddle traditional prohibition-oriented programming.

HOW DID WE GET HERE? THE FOUNDATION FOR ESA DRUG POLICY

The international historical consensus on illicit drug control is changing. However, this transitional situation means that institutional structures are riven today by member state tensions, soft political defections and outright policy contraventions. What was once an iron pact among UN member states, grounded in the bureaucratic terms and conditions of the Vienna-based international drug conventions,[3] and overseen by the UN triumvirate of the Commission on Narcotic Drugs (CND), the United Nations Office on Drugs and Crime (UNODC), and the International Narcotics Control Board (INCB), has become an increasingly fragmented alliance. It is ideologically polarized on the way forward, with a waning majority of states still clinging to a securitized political investment in the global war on drugs.

This evolution in drug policy interpretation and practice at the global level has impacted Africa as well. Traditionally viewed as a bastion of conservative, prohibitionist-oriented drug policies '…designed to strengthen authoritarian institutions and repressive state capacity'[4], Africa has become the focus of drug policy pressure from states and institutions on both sides of the rapidly polarizing global drug policy debate. Diplomatic tensions between so-called drug policy prohibitionist and reformist countries at the global level is replicated at the continental and regional levels, as prohibitionist African states seek to convince their more progressive neighbours to remain party to a historical prohibition consensus perceived as still being the 'African position'.

Significant forces remain vested in the promotion and maintenance of a restrictive, prohibition-based continental drug policy framework. The governments of several ESA states are rigidly opposed to any consideration of drug decriminalization or legalization. In some countries, this opposition goes further to embrace political positions that oppose even the implementation of health-related programming or services for people who use drugs. Such positions are inconsistent now with the emerging global drug policy paradigm. In fact, they are inconsistent also with the evolving African position.

Current ESA drug policy frameworks traditionally have been developed in conjunction with the objectives, terms and approaches drawn from the legal frameworks of the three international conventions and their related global strategy.

The CND and INCB

The CND and INCB are the custodians of the three international drug conventions (1961, 1971, 1988) that make up the foundation upon which much current global drug policy is built. The CND is also the authoritative force behind the global drug control strategy that was inaugurated in 2009, and continually renewed in ten-year cycles ever since.[5] These international instruments form the nucleus of the international drug control system and, for many countries, the foundation of their national drug policies and corresponding legal frameworks.

In addition to the CND's influence, there is a collection of drug policy support guidance available from many of the UN organizations.

United Nations instruments

The foremost of these would be the operational recommendations drawn from the 2016 UNGASS on the World Drug Problem. The World Health Organisation (WHO), the UNODC, the United Nations Development Programme (UNDP), the UN Office of the High Commissioner for Human Rights (OHCHR) and the Human Rights Council all have produced guidance around various aspects of drug policy development, with particular emphasis on human rights principles.

Country	1961 Convention	1961 Convention (as amended in 1972)	1971 Convention	1988 Convention
Angola	2005	2005	2005	2005
Botswana	1984	1984	1984	1996
Burundi			1993	1993
Comoros			2000	2000
DR Congo	1973	1976	1977	2005
Eswatini			1995	1995
Kenya	1964	1973	2000	1992
Lesotho	1974	1974	1975	1995
Madagascar	1974	1974	1974	1991
Malawi	1965	1973	1980	1995
Mauritius	1969	1994	1973	2001
Mozambique	1998		1998	1998
Namibia			1998	2009
Rwanda			1981	2002
Seychelles	1992	1992	1992	1992
South Africa	1971	1975	1972	1998
South Sudan				
Uganda	1988	1988	1988	1990
UR Tanzania			2000	1996
Zambia	1965	1998	1993	1993
Zimbabwe	1998		1993	1993

Figure 1: Year of treaty ratification by country for the three UN international drug conventions.

Note: 1961: Single Convention on Narcotic Drugs of 1961; 1961: (as amended in 1972): Single Convention on Narcotic Drugs of 1961 as amended by the 1972 protocol; 1971: Convention on Psychotropic Substances of 1971; 1988: United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.
Source: The tables are compiled using data from the UN Treaty Index.

Country	CAT (1984)	ICCPR (1966)	ICED (2006)	CEDAW (1979)	ICERD (1965)	ICESCR (1966)	ICMW (1990)	CRC (1989)	CRPD (2006)
Botswana	2000	2000		1996	1974			1995	2021
Comoros	2017			1994	2004			1993	2016
DR Congo	1996	1976		1986	1976	1976		1990	2015
Eswatini	2004	2004		2004	1969	2004		1995	2012
Kenya	1997	1972		1984	2001	1972		1990	2008
Lesotho	2001	1992	2013	1995	1971	1992	2005	1992	2008
Madagascar	2005	1971		1989	1969	1971	2015	1991	2015
Malawi	1996	1993	2017	1987	1996	1993	2022	1991	2009
Mauritius	1992	1973		1984	1972	1973		1990	2010
Mozambique	1999	1993		1997	1983		2013	1994	2012
Namibia	1994	1994		1992	1982	1994		1990	2007
Rwanda	2008	1975		1981	1975	1975	2008	1991	2008
Seychelles	1992	1992	2017	1992	1978	1992	1994	1990	2009
South Africa	1998	1998		1995	1998	2015		1995	2007
South Sudan	2015			2015				2015	
Uganda	1986	1995		1985	1980	1987	1995	1990	2008
UR Tanzania		1976		1985	1972	1976		1991	2009
Zambia	1998	1984	2011	1985	1972	1984		1991	2010
Zimbabwe		1991		1991	1991	1991		1990	2013

Figure 2: Year of treaty ratification by country for the nine core UN international human rights instruments.

Note: CAT: Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CRC: Convention on the Rights of the Child
CEDAW: Convention on the Elimination of all Forms of Discrimination Against Women
CRPD: Convention on the Rights of Persons with Disabilities
ICCPR: International Covenant on Civil and Political Rights
ICED: International Convention for the Protection of All Persons from Enforced Disappearances
ICERD: International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR: International Covenant on Economic, Social and Cultural Rights
ICMW: International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families

Importantly, continental and regional institutions and structures have contributed to the development and attainment of consensus on regional and national drug policies. These include:

The African Union (AU)

Among many measures taken, the AU has developed a Common African Position on Drugs (2016), a document reflecting the consensus position of all states. It was presented at the UNGASS in 2016. Grounded in the health approach to drugs and expressive of concerns around traditional policy responses, this represented a newly progressive stance that edged the continent closer to the consideration of alternative policy responses. Cognizant of the fundamental knowledge gaps and deficiencies that exist around drug markets in Africa, the AU sponsored the development of the Pan-African Epidemiological Network on Drug Use (PAENDU). This network parallels the Annual Reports Questionnaire (ARQ) of the UN to some degree, but is entirely African-driven and African-focused. Under this initiative, the AU has provided assistance to a number of member states to enable them to participate in the PAENDU and to collect in-

country information about drugs and drug use. This is key to the development of relevant and evidence-based drug policies.

The AU is the custodian also of the AU Plan of Action on Drug Control and Crime Prevention (2019–2023). This document represents the continent's consensus approach to drugs over a five-year period of action, and denotes in its articles the actions member states should take to help achieve the plan's objectives. The principal goal is 'to improve the health, security and socio-economic well-being of the people of Africa by addressing drug trafficking and problematic drug use in all its forms and manifestations and preventing the onset of drug use'.[6]

The African Commission on Human and Peoples' Rights (ACHPR)

Two structures exist within the ACHPR. The first is the African Charter on Human and Peoples' Rights, an instrument that outlines the series of fundamental rights that apply to every African. Article 16 of the Charter, guaranteeing every African's right 'to enjoy the best attainable state of physical and mental health', is key. The second structure is the accumulated body of African human rights-related decisions and declarations through which ESA could ground regional approaches to drug policy reform.[7] After all, the provision of harm reduction and other health services for people who use drugs should not be seen as special or praiseworthy. If the charter is to be respected, then the creation of a drug policy that sees – even as an extraordinary measure – member states sign up to providing health care services for people who use drugs should be a normal duty of care.

Regional economic communities (RECs)

ESA nations belong to either the East African Community (EAC) or the Southern African Development Community (SADC). Created by the Lagos Plan of Action for the Development of Africa (1980) and the Abuja Treaty (1991), the role of these RECs is to facilitate economic integration between members of the respective region and the wider African Economic Community. The relationship between the AU and RECs is mandated by the Abuja Treaty, which came into force under the AU's predecessor, the Organization of African Unity, and by the AU Constitutive Act (2000). It is guided by the Protocol on Relations Between RECs and the AU (2008), the Memorandum of Understanding (MOU) on Cooperation in the Area of Peace and Security Between the AU and RECs, and the Coordinating Mechanisms of the Regional Standby Brigades of Eastern and Northern Africa (2008). The RECs were conceived as cornerstones for promoting and achieving wider African developmental integration, with a view to a future in which the social and economic development of the region and continent is fully integrated. They play an influential role in the development and implementation of national policies, and the generation of consensus on issues deemed important to regional members. Further, both the EAC and SADC have developed a collection of regional strategic plans in relation to drugs. These plans are consensus documents that are intended to guide the REC members in the development of their own relevant national mechanisms.

Country	EAC	SADC
Botswana		X
Comoros		X
DR Congo	X	X
Eswatini		X
Kenya	X	
Lesotho		X
Madagascar		X
Malawi		X
Mauritius		X
Mozambique		X
Namibia		X
Rwanda	X	
Seychelles		X
South Africa		X
South Sudan	X	
Uganda	X	
UR Tanzania	X	X
Zambia		X
Zimbabwe		X

Figure 3: Regional economic community membership status by country.

Note: EAC: East African Community; SADC: Southern African Development Community

HAVE EXISTING ESA DRUG POLICIES BEEN SUCCESSFUL?

Over the course of the past thirty years ESA states have increasingly become transit hubs and destination countries for illicit drugs. Domestic drug consumption and trade markets have developed through the region's island and coastal states, and infiltrated inwards. The cultivation and production of cannabis has expanded across the region. Consumer demand and infrastructural access has drawn it to new populations and geographies. The traffic in controlled substances is a key aspect of global illicit trade, and ESA drug markets expanded alongside the development of the continent's newly independent domestic economies.

International drug supply chains originating from South Asia and Latin America have emerged and consolidated their presence in the region. New supply channels and, consequently, new markets, opened. The regional consumption, production and distribution of controlled substances such as heroin, cocaine, cannabis and amphetamines has grown notably over three decades. The negative impact of these expanding illicit supply chains and retail markets on governance has been significant and symbiotic.

These emerging illicit ESA drug markets are collectively a key and growing impediment to the development and security of state institutions and structures. The reliance of innumerable rural households in decaying economic environments on the subsistent cultivation, production and trade in illicit crops such as cannabis and khat made them especially vulnerable to drug prohibition policy measures.[8] With prohibition comes eradication, arrest and imprisonment, but also increased poverty, increased stigma, and increased socioeconomic marginalization.

The expansion of ESA drug markets and the correlated securitized, and increasingly militarized, responses developed by (and imposed upon) many of the regional states has had several other unintended consequences. Already home to a majority of the world's population living with HIV, the rise in consumption of opiates has seen an increase in injection drug use and a correlated increase in HIV, Hepatitis C (HCV) and Hepatitis B (HBV) viral transmission among ESA communities of people who inject drugs (PWID).[9] HIV seroprevalence rates among users in these areas climbed as high as 87%.[10] Morbidity and mortality among young people who use drugs (PWUD) has risen markedly as adherence rates for anti-retroviral medication (for treatment of HIV) decreased, stigma driven discrimination by health officials and law enforcement against PWUD increased, and fatal and non-fatal overdose rates grew.[11]

Access to prescription pharmaceuticals and other essential medicines – particularly opioids – has failed to improve across the region and remains among the least available globally.[12] This failure has been caused by misdirected drug control enforcement initiatives targeting opioids, subsequent reluctance among health institutions to use, prescribe or stock the substances involved, and counterfeiting and diversion by criminal groups of pharmaceutical commodities from licit streams into illicit markets.[13] As a result, national formularies have declined to stock these medicines and palliative care options have further diminished.[14] The failure of healthcare personnel to alleviate pain as a normal element of therapeutic healthcare, particularly in palliative environments, has become a characteristic by-product of regional drug prohibition. It has also fed into a feeble record on rehabilitation.

National prison populations have exceeded institutional capacities across the region, as state security and judicial organs' contribution to drug control has been to arrest and imprison vast numbers of people for drug-related crimes. Large segments of several new generations were disenfranchised by criminal convictions for low-level crimes, notably the possession of small quantities of drugs for personal use. Disproportionately high unemployment and underemployment rates throughout ESA further marginalized those who use (or used) drugs, and especially those with a criminal conviction for low-level drug offences.

Yet, even as illicit crop fields were destroyed; PWUD arrested, imprisoned and/or forced into poorly conceived treatment plans; illicit drug labs identified and destroyed; and drug shipments seized, regional drug markets have continued to expand. New psychoactive substances, existing outside international drug convention scheduling, and the misuse of prescription pharmaceuticals, have meanwhile emerged and prospered.

Results have been no better at continental level. Despite its common position, the AU Secretariat struggles to maintain both compliance and consensus. There often appear to be fractures between the common position, and how that position is represented in discussions at the CND by Africa members in debate there. For example, when the Common African Position was developed and transmitted to Vienna for submission, there was conflict with Africa Group members there, who had authored a competing position statement, over which was to be submitted to the UNGASS to represent the one 'true' African statement. The AU common position statement eventually was submitted and accepted, but only after an internal showdown over this schism was averted diplomatically.

This challenge around interpretive consistency stems from wider bureaucratic challenges faced by AU Secretariat members as they interact between ministries and departments of individual states. What a health ministry official agrees at an AU committee meeting might not necessarily be consistent with what a foreign affairs official agrees elsewhere. Such agreements therefore tend to be good for setting broad forward-looking policy guidelines, but substantial bureaucratic inertia, often stemming from contradictory viewpoints, has to be overcome to deliver tangible change.

The challenge of PAENDU implementation is an example of such political inertia. While the concept of a continental monitoring system for drugs is an agreed and necessary feature of AU coordination going forward, many challenges remain in securing member state delivery of the various reporting requirements. AU investment to support states with particularly challenging reporting environments, including those with no national drug-related statistics agencies or drug monitoring foundation, is undermined by the fact that there appears to be little incentive or desire for financial investment by states themselves into driving this mechanism forward. Many ESA countries have little or no surveillance data allowing them to describe and understand their current drug markets. For example, they are unable to provide even the most basic of information, such as the total number of drug users and types of drugs consumed in their country.

	National Overview							
Country	**# of PWUD**	**# of PWID**	**% HIV among PWID**	**% HCV among PWID**	**% HBV among PWUD**	**NSP available?**	**OAT available?**	**Naloxone available?**
Botswana	NA	5.1	NA	NA	NA	no	no	no
Comoros	NA	NA	NA	NA	NA			
DR Congo	NA	NA	NA	NA	NA			
Eswatini	NA	1279	NA	NA	NA	no	no	no
Kenya	NA	36000	11.3	20	3.9	yes	yes	yes
Lesotho	NA	1279	NA	NA	NA	no	no	no
Madagascar	NA	18500	4.5	5.6	5.3			
Malawi	NA	NA	NA	NA	NA	no	no	no
Mauritius	NA	12000	32.3	90	3.5	yes	yes	no
Mozambique	NA	33000	35.5	43.6	24.2	yes	yes	no
Namibia	NA	NA	NA	NA	NA	no	no	no

Rwanda	NA	2000	9.4	NA	NA	no	no	no
Seychelles	NA	2000	12.6	79.1	0.3	yes	yes	no
South Africa	NA	82000	17.9	54.7	5	yes	yes	Yes
South Sudan	NA	NA	NA	NA	NA			
Uganda	NA	9500	17	2	8.4	yes	yes	no
UR Tanzania	NA	30000	35	23.1	6.9	yes	yes	no
Zambia	NA	26840	24	NA	NA	no	no	no
Zimbabwe	NA	NA	NA	NA	NA	no	no	no

Figure 4: The regional public health contexts of drug use environments.

Note:
PWID: People who inject drugs
PWUD: People who use drugs
HBV: Hepatitis B virus
HCV: Hepatitis C virus
HIV: Human immunodeficiency virus
NSP: Needle and syringe programme
OAT: Opioid agonist treatment (e.g. methadone)
Source: HRI, The global state of harm reduction 2022, HRI, 2023

Strategic coordination between the EAC and SADC has remained weak, and despite AU (and some nation state) attempts to foster greater policy coherence between the two RECs, cooperation remains largely limited to infrequent formal contact outside official AU forums. Further, regional cooperation and integration in matters as complex as drug control often prove too challenging, as REC secretariats lack the institutional, financial and human resource capital necessary to monitor and govern the regional partnership. The secretariats operate on tiny budgets. They operate on a consensus model of governance, and do not possess any regulatory, oversight or implementation authority unless it is provided to them by the consensus decision of their regional constituency. State sovereignty remains the regional 'red line' for RECs. Thus, while RECs convene and create consensual positions on a variety of subjects, and develop implementation guides, plans and strategies for their membership, the implementation and enforcement of compliance with such commitments or positions remains subject to sovereign will. The EAC and SADC regional drug (and other) strategies have therefore remained largely ineffective.

Most ESA countries continue to subscribe to traditional law enforcement approaches to counter the drugs trade. Such practices often include the indiscriminate targeting of street-based drug sellers as well as PWUD. Drug-related arrests have been rising year-on-year across the region, driven in part by the use of 'total arrest figures' as a key element of performance measurement by national law enforcement institutions. Thus, PWUD and low-level street dealers are the most likely to be arrested to enable police to meet their monthly arrest quotas. Personal possession or use – rather than trafficking - remains one of the most common reasons given for such arrests. These arrested individuals then stoke growing prison populations, often because they lack the small amount of money necessary for bail, and/or because they are subsequently convicted of a minor drug offence and must serve their sentence due to being unable to pay what may be only a modest fine levied as punishment for the offence.

And still the drug markets of the region have grown in size and durability, a characteristic that has developed alongside an expansion in the inventory of synthetic substances available for consumption or use as contaminants to substances being produced or adulterated in the region. The clear proliferation in drug supply, consumption and processing across ESA therefore requires a fundamental rethink of policy at the regional, continental and global level.

A NEW APPROACH TO REGIONAL DRUG POLICY

For decades of international drug control, and with few exceptions, African nations have been strident stalwarts of prohibition, advocating the complete illegality of all substances scheduled by the three international drug conventions. This has also extended to national responses centring on criminalization, making the possession, use, production, trade and transit of drugs punishable. International bodies (like the UN) and developed states - mostly those with populations that consume the drugs transiting Africa – have attempted to influence, through firm and soft measures alike, the drug policy direction and implementation measures of some African states. Yet, as historian Charles Ambler has noted, these externally-driven and imposed 'global initiatives related to drugs in Africa have focused largely on the international trade rather than on "protecting" African communities from drugs'.[15]

This is true both for bilateral support initiatives (aimed at promoting the domestic security response to drug interdiction) and global or regionally focused anti-trafficking or prevention initiatives. Naturally, such assistance was largely driven by the selfish desire to disrupt the supply of narcotics intended for end-users in their own developed donor nations, rather than as a selfless act of benevolence. Various attempts at political influence and interference continue today, especially since the global drug policy consensus has begun to lose its foundation of support, and particularly because in Africa expressions of doubt have begun to grow, and national decisions on drug reform have begun to be made.

While the international consensus on illicit drug control continues to evolve, its institutional structures are now riven by member state tensions, soft political defections and outright policy contraventions. Globally, more than 50 countries have now liberalized their domestic drug policies in some way with the intention of decriminalizing or legalizing the use, production and/or trade of a scheduled drug or drugs. This total represents nearly one-quarter of the UN's 193 member states. This evolution in drug policy at the global level is reflected in changes within the ESA drug policy environment. Traditionally, the region was a bastion of conservative, prohibitionist drug policies, described as a drug policy environment 'designed to strengthen authoritarian institutions and repressive state capacity'.[16] Now ESA is the focus of drug policy pressure from states and institutions on both sides of the rapidly polarizing global drug policy debate. Political and diplomatic conflict between so-called drug policy prohibitionist and reformist countries at the global level is replicated at the continental level. Prohibitionist African states strive to reinforce (or force) among their less enthusiastically driven neighbours a historical prohibitionist consensus perceived as still being the 'African position'. African drug policy has become a dynamic political space, with regional and global vested interests pressing member states to adhere to policy positions that are at times contradictory.

Some alliances adopt a far more human rights- and health-oriented focus on drug control approaches, often contravening existing domestic drug policy and practice, while other alliances' positioning may succeed in reinforcing prohibitionist biases. These global and regional political influences have become more complicated as some African states' soft defections from a prohibitionist control framework evolve to incorporate meaningful steps outside the traditional continental policy consensus.

The crisis of confidence enveloping the continent's drug policy consensus is exacerbated by the fact that Eswatini, Lesotho, Rwanda, South Africa, Zambia and Zimbabwe have legalized domestic cannabis use and/or production in some form already. While the majority have legalized production, cultivation and use for medical purposes only, South Africa continues to pursue efforts to comply with a Constitutional Court decision ordering the legalization of cannabis for recreational use.

Given the emerging quest for alternatives to prohibition, arrest and incarceration, we elaborate below the key principles that should underpin drug policy reform proposals.

WHAT MAKES A GOOD DRUG POLICY?

The Global Commission on Drug Policy (GCDP) defined five pre-requisites for the development of a national drug policy that works.[17] The 2016 UNGASS on the World Drug Problem proposed seven operational recommendation groupings.[18] The UN system has established seven principles and standards necessary for the treatment of drug use,[19] a comprehensive package of 15 services for PWUD in prisons and other closed settings,[20] 13 drug policy obligations arising from human rights standards,[21] and Resolution A/HRC/52/L.22/Rev.1 of the Human Rights Council (HRC). The latter calls upon states to consider alternatives to incarceration, conviction and punishment of PWUD, while emphasizing the 'essential contribution that civil society and affected communities make to the development, implementation, monitoring and evaluation of drug policies'.[22]

Reflecting on these principles and guidelines, and building from the GCDP (2014) principles, it is possible to identify an overlapping series of six core principles that should guide ESA drug policy. These are:

i. Put people's health and safety first. Ensure universal access to harm reduction and evidence-based prevention and treatment services for PWUD in the community, as well as in prisons and other closed settings
ii. Ensure universal access to essential medicines, particularly opioids for pain control
iii. End the criminalization and incarceration of PWUD, and the stigma that accompanies it
iv. Refocus national drug enforcement responses to drug trafficking and organized crime
v. Consider alternative approaches to domestic drug market control, particularly the options of legalization and regulation
vi. Involve civil society and PWUD as essential components in the development, implementation, monitoring and evaluation of national drug policies.

How do current ESA drug policy frameworks measure up?

The table below summarizes a review of current drug policy frameworks across ESA and how they might comply within the context of the six principles outlined above:

Country	Law supports public health approach to drugs?	Policy supports evidence-based prevention?	Policy supports evidence-based drug treatment?	Policy supports harm reduction interventions?	Drug use or drug possession for personal use is decrimalized?	Law supports cannabis legalisation?	Policy ensures improved access to essential medicines?	Country regularly sees essential medicine stockouts?	CSO and PWUD essential drug policy partners?
Botswana	NO	NO	NO	NO	NO	NO	YES	YES	NO
Comoros	n.d.	n.d.	n.d.	n.d.	NO	NO	n.d.	YES	NO
DR Congo	NO	NO	NO	NO	NO	NO	n.d.	YES	NO
Eswatini	NO	NO	YES	YES	NO	Medical purposes	YES	YES	NO
Kenya	Under Review	YES	YES	YES	NO	Under Review	YES	YES	Under Review
Lesotho	NO	NO	NO	NO	NO	Medical purposes	n.d.	YES	NO
Madagascar	n.d.	n.d.	n.d.	n.d.	NO	NO	NO	YES	NO
Malawi	NO	NO	NO	NO	NO	Medical purposes	NO	YES	NO
Mauritius	NO	YES	YES	YES	NO	NO	YES	n.d.	NO
Mozambique	Under Review	Under Review	Under Review	Under Review	NO	NO	n.d.	YES	NO

Namibia	NO	Under Review	Under Review	Under Review	NO	NO	YES	YES	NO
Rwanda	NO	NO	NO	NO	NO	Medical purposes	YES	YES	NO
Seychelles	YES	YES	YES	YES	NO	NO	n.d.	YES	n.d.
South Africa	YES	YES	YES	YES	NO	Recreational use, in process	YES	YES	YES
South Sudan	n.d.	NO	NO	NO	NO	NO	n.d.	YES	NO
Tanzania	NO	NO	NO	YES	NO	NO	YES	YES	NO
Uganda	n.d.	NO	NO	YES	NO	Medical purposes	YES	YES	NO
Zambia	NO	NO	NO	NO	NO	Medical purposes	YES	YES	NO
Zimbabwe	YES	YES	YES	YES	NO	Medical purposes	YES	YES	NO

Figure 5: Summary of ESA drug policy frameworks.

Note: 'n.d.' indicates information could not be determined from the documentation available.

Current drug policy frameworks in the ESA region have been inadequate in responding to the challenges of illicit drug economies. Yet, despite their clear misalignment with the core principles of good drug policy, we must accept that forces will continue to be vested in the promotion and maintenance of a restrictive, prohibition-based regional drug policy foundation. Governments of several states remain rigidly opposed to any deviation toward reform measures, let alone consideration of drug decriminalization or legalization scenarios. In some, this opposition goes further to embrace political positions that oppose the implementation of rights- and health-related programming or services for PWUD in their own countries. Such positions are inconsistent with the principles of good drug policy.

However, there is space for discussion. Most ESA states have ratified the nine core international human rights conventions. Some already have drug policy positions that support harm reduction interventions, evidence-based drug treatment, and essential medicine procurement. Some have even decriminalized cannabis. The political foundation for drug policy reform is thus already in place. It is a matter now of exploiting it. Yet, moving forward on a wider regional consensus for drug policy also entails new challenges that must be addressed and, if possible, overcome.

Additional future considerations

Following a review of existing national laws, policies and strategies that make up the drug policy framework in each ESA country, the need to pursue a new regional approach on drug policy is clear. Equally evident is the need to consider various challenges to the current frameworks that must be addressed and overcome. These include:

Diversion and non-medical use of pharmaceuticals

The INCB, CND and WHO have warned that the diversion of pharmaceuticals, and their non-medical use, has become an emerging public health threat in Africa.[23] Tramadol has been identified as a drug of particular concern, alongside other therapeutic pharmaceuticals such as codeine, hydromorphone and fentanyl. Diversion, and efforts to limit it, impact also on the continental availability of opioids for pain management. Africa's use of pain medication - for palliative care and other treatment - is defined as being 'very limited', and among the lowest in the world.[24] We know also that much of this limited availability and supply is the result of physicians and hospital settings being reluctant to procure and prescribe opioids due to the stigma attached to them through drug war propaganda. As such, any new regional drug policy would need to incorporate measures to safeguard the integrity of the pharmaceutical supply chain, as well as ensuring an increased supply and use of opioid based pain medication.

Darknet marketplaces

The darknet is a part of the internet's so-called deep web, where access requires a special browser. It has been the location of various online drug trading sites, the most notorious perhaps being the Silk Road exchange, which was seized and shut down by US Drug Enforcement Agency officials in 2013. Many others have followed, and it seems that as quickly as these online drug trading platforms get taken down by authorities, replacements emerge. As Broséus *et al* (2017) have identified in their analysis of drug trafficking via a highly-frequented darknet marketplace, many Africans have taken to these exchanges, both as clients and vendors.[25] Understanding how best to address the drug commerce facilitated by virtual trading platforms is another challenging feature for drug policy reform in Africa.

Proliferation of new psychoactive synthetic substances

New psychoactive synthetic substances (NPS) continue to emerge. In 2016 UNODC estimated that there were 479 NPS available on the global drug market. Seventy-two of these emerged only in that same year.[26] While largely absent from international scheduling due to the speed with which they are created, and the ever-changing chemistry of their design, the health risks of such unknown chemistry and quality are elements that would require consideration, as would regulation of commoditization. Of further concern is that such substances often are used across the region to adulterate or contaminate more established illicit drugs for the purpose either of reducing input costs, or to increase the perceived purity of a substance.

Overcoming neglect of public health

There has been a marked increase in the use of heroin, methamphetamine and cocaine over the past two decades.[27] Between 0.2 and 1.1% of people aged 15–64 in Africa (1.4 million–7.9 million people) used heroin in 2019.[28] Concurrently, injecting drug use is becoming more common across the ESA region, with an estimated 410 000 people who inject drugs in 2019.[29] Women who use drugs face higher levels of violence, stigma and barriers to services than male counterparts.[30] Infectious disease transmission is most acute for people who inject drugs, and among people in prison.[31] People with opioid dependence are much more likely to die than people in the general population. The HIV prevalence among people who inject drugs ranges from 15% to 21% in East African states and is estimated at 21% across countries in Southern Africa.[32] Women who inject drugs have a notably higher HIV burden than their male counterparts.[33] Concentrated HCV epidemics exist among people who inject drugs in the region.[34] The limited availability in the region of evidence-based drug treatment options, such as opioid agonist therapy (OAT), is vastly outpaced by the illicit distribution and consumption of opioids.[35] These features alone should be evidence enough that a public health emergency is occurring among PWUD populations, and that a national public health response prioritizing the implementation of harm reduction and evidence-based drug treatment services is a necessary core component of any national drug policy.

Abundant surveillance deficiencies

The region suffers from an abundance of surveillance-related gaps and deficiencies. At its most basic, these include absent systems to generate relevant, regular data on the estimated number of people who use drugs, what drugs are used, how they are used, and the retail price and purity statistics for these substances. Arrest figures, seizure data and treatment statistics are inadequate proxies for such market-based metrics. This is not a surprise to some observers. After all, it is well known that most national governments in the region fail to possess adequate capacity for the generation of relevant statistics necessary to the ongoing surveillance and understanding of their domestic drug markets. This void not only diminishes the ability of nations to design and implement an evidence-based response to the structures and characteristics of their illicit drug markets, it prejudices also the international and regional monitoring systems and tools that rely on such national data for wider collective analysis and threat projection.

The annual World Drug Report (WDR) of the United Nations is one such instrument that is potentially biased by an absence of data disclosure from regional states. For its analytical projections on drugs, the report relies heavily on

information derived from the voluntary annual reports questionnaire (ARQ) tool. This is a questionnaire to which member states are asked to complete and submit national responses. The ARQ collects data on many aspects of national drug responses, but most specifically it addresses elements of drug demand and supply at the national level. Response rates are notoriously low across Africa, however. The response rate for African ARQs that contributed to the WDR published in June 2021 can be taken as one example. Only ten of 55 African countries submitted an ARQ response for this report cycle, and of these ten only three had an ARQ submission that was adjudged by the UN to have been 'substantially' complete.[36] For ESA countries, only one (Kenya) submitted a complete response for that reporting period, while two others (Mozambique and Zambia) submitted incomplete responses. The remaining 16 countries did not submit anything. Designing relevant, evidence-based drug policies for an effective response to the harms and health service deficiencies of local drug markets requires basic drug market data.

Challenging the securitization lens

The current drug policy approach of drug control through a securitized and sometimes militarized response to drug markets is not working. However, the reconsideration of such entrenched approaches, particularly ones that have been used successfully for years to serve political and security-driven domestic narratives, requires action that goes beyond the realm of drugs policy. It requires investment in wider socio- environmental change beyond simplistic language revisions to legislation and policy instruments. It also requires a changing of perception, and active measures to develop and maintain the fundamental human rights duties and responsibilities of African member states. Most importantly, however, is the requirement for leadership. Never more is the role of a body such as the Eastern and Southern Africa Commission on Drugs (ESACD) better placed to exploit an emerging policy schism than now.

While law enforcement bodies have increasingly been steered by national policy frameworks grounded in the theme of 'drug free' absolutism, including a heavy focus on arrest and seizure-type programming, such punitive responses have led to significant health and governance challenges across the region. Policing systems that prioritize performance metrics such as arrest volumes and conviction rates in pursuit of 'drug-free' states have neither disrupted the flow of drugs through the region nor decreased the level of consumption of these substances in any meaningful way. Consideration should therefore be given to a shift in legislative classification of drug use ensuring that laws distinguish between use, possession for use and possession of controlled substances with intent to distribute, to avoid the criminalization and imprisonment of people who use drugs (and who possess only small quantities). Where criminalization of drug use remains in place, law enforcement agencies should be encouraged to focus their efforts away from the suppression of individual drug use and toward the producers, suppliers and large-scale distributors of illicit drugs. Where the arrest and incarceration of individual people who use drugs continues, the judiciary should be encouraged to eschew mandatory sentencing requirements, where they exist, and instead focus on efforts of diversion from incarceration to treatment and other social support services**.** Efforts such as these would contribute to establishing national drug policies that move towards becoming more consistent with human rights-based principles, and particularly the fundamental rights to life and health guaranteed under the ACHPR.

Navigating the corporatization of cannabis reform

Currently seven of the 19 countries included in the ESA region have decriminalized or legalized the use, production and/or trade of cannabis.[37] This represents more than one-third of the region. While the majority of these have done so in reference only to medical cannabis, that not one African country outside the ESA region has done so yet demonstrates that ESA is a continental leader in the drug reform efforts that are gaining ground in the wake of so many decades of failed status quo prohibition efforts. However, the struggle around how this legalization of production should be organized remains a challenge for cannabis reform policy. Cannabis cultivation remains an important livelihood activity in many rural areas of the region. With the advent of a legalized production system to be incorporated into the nation's economic infrastructure, how will this impact the thousands of rural households who have been financially sustained through cultivation and sale from their small-scale plots? How does a state balance the state revenue benefits of large-scale corporate cannabis investment and its monopolistic production models against the potential for increased

impoverishment caused by the potential disenfranchisement of traditional, rural household cultivators? Further, how should the regulatory oversight of such production models be arranged? These issues are challenging government bodies in these seven countries, and they are challenges that need serious consideration in the context of ensuring the durability of this drug policy reform measure.

'Nothing about us without us'

Currently, much of the information we think we know about drug markets relies predominantly on data from seizures and arrests, mostly provided by national police services. It is important for regional drug policy designers to look at the wider impact of drugs, particularly on health, society and the environment. This could be done by widening the pool of content providers for information on drug use. There have been various calls for the incorporation of a greater role in drug policy processes to be played by civil society.[38] Some countries (Kenya, Mauritius and South Africa) have begun to adopt more inclusive models of consultation and design, but in many countries of the region there is little space provided for the meaningful inclusion of the voices of the population most affected by drug policies: people who use drugs. PWUD often have been the objects of research, the subjects of law enforcement arrest campaigns, and the bearers of a disproportionate burden of the public health consequences of inadequate, prohibition-based drug policy frameworks. Nobody knows more about what is happening now in a country's drug market than the consumers who struggle to live in that market. Countries must break from traditional methods of policy design and consider the meaningful inclusion of PWUD and civil society voices into not only the drug policy design process, but also in the implementation, monitoring and evaluation of national drug policy. The continued exclusion of such voices only serves to perpetuate the empty achievements of past policies and their related national strategies.

STRATEGIC RECOMMENDATIONS

Long-term sustainable solutions to stem the region's drug trade and its corrosive embeddedness within ESA societies are not housed in the text of policy or treaty instruments, nor are they found in nations' prison cells and compulsory treatment centres. Rather, they dwell in the eradication of the enablers of domestic inequality and structural vulnerabilities, and in the uplifting development of people. The foundation for the pursuit of such commitments has already been laid by Africa's leaders. This can be seen in their assent to both Agenda 2030 and Agenda 2063's development goals, and the rights and duties of care bestowed by the ACHPR. The alignment of regional drug policy reform in the context of these complementary human development commitments could see the ESA region grasp a continental leadership role in defining effective drug responses – and undermine the caustic sociopolitical influence of drug market economies – not from a traditional drug war perspective, but instead through fundamental, long-term social and rights development.

Principle 1: Put people's health and safety first. Ensure universal access to harm reduction and evidence-based prevention and treatment services for PWUD in the community, as well as in prisons and other closed settings

1. Advocate for an end to regional and national 'drug-free' goals, and for the development and adoption of universal, meaningful, measurable regional drug policy indicators and targets, aligned with those of the 2030 Agenda for Sustainable Development and the Agenda 2063 goals.

2. Establish a dashboard of metrics, based on UN-endorsed principles of best practice and tailored to local drug market dynamics, to measure community harm reduction and treatment services' coverage across countries.

3. Establish a regional harm reduction fund to provide grants to relevant initiatives supporting the push to encourage countries to adopt and implement national harm reduction strategies and their related implementation.

4. Create an ESA drug markets and policy monitoring agency, modelled on the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), with responsibility for PAENDU-related surveillance in the ESA.

Principle 2: Ensure universal access to essential medicines, particularly opioids for pain control

5. In line with the recommendation of UNGA Resolution S-30, CND Resolutions 53/4 and 54/6, the UNGASS 2016 Outcome Document, and Resolution 141 of the African Commission on Human and Peoples' Rights, advocate for a measurable increase in access to essential medicines for all across the region, including to those medical substances controlled under the Vienna Drug Conventions; and, to convene a working group to assist the region to develop and implement an advisory and support programme to achieve these increases.

Principle 3: End the criminalization and incarceration of PWUD, and the stigma that accompanies it

6. Establish a 'de-penalization and de-incarceration advisory group', which would share best practice across the region and make specific actionable recommendations to ESA countries.

Principle 4: Refocus national drug enforcement responses to drug trafficking and organized crime

7. Establish a regional mechanism for national and regional law enforcement groups to examine ways to scale up asymmetric, intelligence-led policing of drug markets.

8. Establish a 'technologies and drug markets' working group to examine and build knowledge capacity around the intersection between regional drug markets and internet- and technologically based advances in illicit supply and distribution chains.

Principle 5: Consider alternative approaches to domestic drug market control, particularly the options of legalization and regulation

9. Convene regional discussions to establish consensus positions on existing drug policy reform recommendations, such as:

    a. The regional adoption of UN-recommended drug use harm reduction measures;
    b. The decriminalization, legalization and regulation of drugs (with specific, initial reference to cannabis and khat);
    c. The immediate release of people imprisoned for drug use or minor drug possession offences, and the staying of all current criminal cases related to drug use or minor possession; and,
    d. The removal of drug use or minor possession convictions from individuals' criminal records.

10. Establish a drug law modernization working group to examine ESA drug laws and determine means through which these laws can be updated to ensure the enforcement of public health and human rights principles around PWUD and drug policy reform measures.

11. Establish a cross-regional task force to examine models and implementation of medical and recreational cannabis legalization and its related law enforcement reorientation.

Principle 6: Involve civil society and PWUD as essential stakeholders in the development, implementation, monitoring and evaluation of national drug policies

12. Establish a civil society forum aiming to engage key stakeholders and marginalized groups in national-level drug policy development, implementation, monitoring and evaluation processes.

13. Establish a research exchange network with universities in the region, as well as with those on other continents, to discuss and share best practice policy and research. Include with this network the establishment of a teaching and training programme for regional policy makers to learn from other such drug policy experiences.

14. Establish and champion a women's working group on drug policy in the region bringing together experts from government, civil society and the private sector. This working group should focus on engaging more women at the policy level on drug issues.

Notes

[1] See, for example, the work of the Combined Task Force 150 (CTF-150) operating in the Indian Ocean, along the eastern coast of Africa; and the tasking of military assets by US Africa Command for the purposes of active counternarcotic field operations under the banner of Operation Enduring Freedom - Trans Sahara (OEF-TS), now called Operation Juniper Shield, covering the Sahara/Sahel region of Africa; and, Operation Enduring Freedom - Horn of Africa (OEF-HOA), to which CTF-150 is related.
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GLOBAL COMMISSION ON DRUG POLICY

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