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ESACD
Eastern & Southern Africa Commission on Drugs

# The Eastern & Southern Africa Commission on Drugs

# Overview of drug-related issues in Eastern and Southern Africa

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# Acronyms and abbreviations

| | |
|---|---|
| AU | African Union |
| CND | Commission on Narcotic Drugs |
| EAC | East African Community |
| ESA | Eastern and Southern Africa |
| ESACD | Eastern and Southern Africa Commission on Drugs |
| GI-TOC | Global Initiative Against Transnational Organized Crime |
| HBV | Hepatitis B virus |
| HCV | Hepatitis C virus |
| HIV | Human immunodeficiency virus |
| INCB | International Narcotics Control Board |
| LGBT | Lesbian, gay, bisexual and/or transgender |
| NGO | Non-governmental organization |
| NSP | Needle and syringe programme |
| OHCHR | Office of the United Nations High Commissioner for Human Rights |
| OST | Opioid substitution therapy |
| PAENDU | Pan-African Epidemiological Network on Drug Use |
| PWID | People who inject drugs |
| PWUD | People who use drugs |
| RECs | Regional economic communities |
| SADC | Southern African Development Community |
| TB | Tuberculosis |
| UN | United Nations |
| UNDP | United Nations Development Programme |
| UNGASS | United Nations General Assembly Special Session |
| UNODC | United Nations Office on Drugs and Crime |
| WHO | World Health Organization |
| WWUD | Women who use drugs |

# SUMMARY

Most countries in Eastern and Southern Africa (ESA) have tried to eliminate drug use largely by criminalizing production, trade and possession, in a reflection of global trends. However, this approach has not achieved its objectives. In recent years, there has been a transformation in the region's drug-related problems and the best available evidence on how to address them. There is an urgent need for a comprehensive reassessment of drug policy. This paper introduces some of the key issues surrounding the region's drug and policy crises.

## Key points

- There is growing global and regional recognition that the prevailing 'war on drugs' policy approach has been ineffective in reducing drug-related harms, and that a new approach is needed that brings drug policy into alignment with health, human rights, and social and human development considerations.
- Whereas drug supply chains once largely passed through ESA to other destinations, a wide and expanding array of drugs are now commonly consumed locally. Drug policies need to be revised to reflect these realities.
- Drugs are a major source of revenue for criminal groups, fuelling corruption and undermining governance.
- Isolated law enforcement disruption activities are unlikely to succeed in reducing the activities of criminal networks, but can have cascading negative effects. Law enforcement interventions should focus on the most dangerous and/or profitable elements of criminal organizations.
- The criminalization of drug use has undermined the availability of appropriate treatment programmes, facilitated the spread of communicable diseases and reduced already inadequate access to essential medicines.
- Punitive policies take a heavy toll on vulnerable populations, including women and young people. New frameworks must recognize their intersecting but distinct experiences and needs in relation to drugs and drug policies.
- Stigmatization of people who use drugs (PWUD) is widespread, making them less likely to receive the support that could help them improve their lives.
- Vast amounts of money are spent on policy approaches that have little or no prospect of achieving their aims.
- Redirecting resources away from criminal justice and towards evidence-based practices in health and harm reduction could reduce drug-related government costs and yield significant benefits for the region.

# INTRODUCTION

There are many ways of understanding the word 'drug'. One is that it is a substance consumed not for purposes of nutrition, hydration or flavour, but because it influences some other biological function. A psychoactive drug is one that affects mental functions: mood, perception, cognition and/or behaviour.[1] Psychoactive drugs (hereafter referred to simply as 'drugs' for brevity) have existed in ESA for centuries. They were once largely regulated through informal and traditional practices.

Over the past three decades, ESA states have shifted from traditional plant-derived local drug economies into major global transit and destination hubs for illegal drugs. The growing volume and range of drugs produced, traded and consumed in the region cause such widespread harms that they pose risks to security and development. There is an urgent need for a comprehensive review of drug policies and for the design and implementation of an evidence-based drug regulatory system.

In the second half of the 20th century, governments were largely in legal agreement that most drugs should exist only for strictly controlled medical and research purposes, and that any recreational, ritual, social, experimental, self-medicating or other use constitutes a crime and should be eliminated.[2] Law enforcement methods and personnel were used to try to suppress drug production, sale and consumption. This approach is characterized by critics as prohibitionist or punitive, and as an extension of the United States' domestic 'war on drugs'. It has been formalized and promoted within international policy and law through various United Nations (UN) treaties and related institutions. Significant financial and political investments over decades have been dedicated to the goal of a 'drug-free world.'

But this has not been achieved. In fact, the volumes of drugs produced globally have never been greater; the range available has never been wider (with new threats and markets evolving rapidly); drug-related deaths are on the rise; and even those who once advocated punitive drug policies now acknowledge that they are 'ineffective in reducing drug trafficking or in addressing non-medical drug use and supply, and continue to undermine the human rights and well-being of persons who use drugs, as well as of their families and communities'.[3]

African nations have historically upheld the traditional model of drug control, although there have always been wide discrepancies in enforcement.[4] In broad terms, all countries in ESA continue to place law enforcement at the forefront of their drug response.

Yet the consensus for prohibition is fracturing. The growing recognition that the 'war on drugs' approach has not had the desired impact and has instead had devastating consequences has led to various initiatives to reassess current policies and recommend alternatives. This was pioneered on a high-level regional scale by the Latin American Commission on Drugs and Democracy and the West Africa Commission on Drugs. A similar Eastern and Southern Africa Commission on Drugs (ESACD) was proposed to review and assess drug policy across this region – namely, in Botswana, Comoros, Eswatini, Kenya, Lesotho, Malawi, Madagascar, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, Uganda, Tanzania, Zambia and Zimbabwe.

A series of background papers comprising data and analysis on topics relating to the nature and impact of drugs and drug policy in the region have been produced to inform the Commission's work programme. The background documents provide the ESACD with the best available information and evidence to inform its final report and policy recommendations. This paper provides context and an overview of these other documents. It is a brief introduction to certain key issues in the areas of public expenditure, health, governance and justice that illustrate the importance of considering drug policy reform in ESA. More extensive discussion, data, case studies, references and recommendations can be found in the relevant briefing papers.

# POLICY CONTEXT

Traditionally, African nations have been staunch supporters of drug prohibition, often influenced by international entities and developed states, which showed little concern for the autonomy or well-being of African communities.

The international policy framework that underpins most UN member states' drug laws is primarily shaped by three conventions: the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The custodians of the conventions are the Vienna-based Commission on Narcotic Drugs (CND), the International Narcotics Control Board (INCB) and the UN Office on Drugs and Crime (UNODC).

As demonstrated during and after the 2016 UN General Assembly Special Session (UNGASS) on the World Drug Problem,[5] there is increasing divergence from the prohibitionist stance among other UN bodies, notably the World Health Organization (WHO), UNAIDS, the UN Development Programme (UNDP) and the Office of the High Commissioner for Human Rights (OHCHR). In September 2023, the UN High Commissioner for Human Rights released a key report on drug policy and human rights.[6] The report integrates existing human rights standards, introduces new guidelines, and promotes a transition from punitive measures to a health- and rights-focused approach, making it the most ambitious and progressive UN guide to aligning drug policies with human rights.[7]

The explicit inclusion of health and human rights considerations in the debate has expanded the 'Overton window', or the range of politically viable policy options for addressing the problem of illicit drugs. More than 50 countries worldwide, including several in Africa, have already to some extent liberalized their drug policies, particularly with regard to cannabis. Other governments remain staunchly against reform, positioning themselves in opposition to the evolving global and African perspectives.

The African Union (AU) has become increasingly progressive in its approach, as is evident from the content of the Common African Position on Drugs it presented at the UNGASS in 2016, the AU Plan of Action on Drug Control and Crime Prevention (2019–2023), and its development of the Pan-African Epidemiological Network on Drug Use (PAENDU) to collect the data required for evidence-based policies. However, continental or regional consensus remains elusive, and diplomatic relations are fraught.

Meanwhile, traditional law enforcement strategies largely persist in ESA countries, despite their clear failure to curb the expansion of drug markets and associated harms. By progressively aligning drug policies with those on health, human rights, and social and human development, the ESA region has the potential to establish itself as a pioneer in effective drug strategies.

- *This topic is further explored in the ESACD discussion paper 'Drug policy reform in Eastern and Southern Africa'.*[8]

# CONSUMPTION, PRODUCTION AND TRADE

Tracking the trade and use of drugs in Africa is difficult because reliable data is scarce. But evidence suggests that large-scale drug markets began to emerge in the 1970s, when growth in commerce and communications technology and the development and integration of infrastructure into global networks provided the platform for the expansion of legal and illegal trade. In the 1980s, international drug control measures put pressure on supply chains from source points in South Asia and Latin America to destination markets in North America and Europe. This led to the establishment of new trafficking routes through Africa, as well as small but growing domestic markets. The 1990s saw Afghan heroin bound for European and US markets shipped from Pakistan and Iranian departure points to Kenyan and Tanzanian ports using dhows (traditional wooden fishing vessels). Local heroin use began to grow, and the use of cocaine, methamphetamine and other synthetic drugs soon followed.

ESA countries are now substantial drug transit and destination markets for various drugs, with supply growing significantly over the past decade. Drugs flow largely undetected through the region's air, land and sea ports, alongside legitimate trade. Recently, there have been concerns about the spread of new psychoactive substances (namely, synthetic cannabinoids, stimulants and other chemical compounds, primarily produced in India and China), which are designed to mimic the effects of known illegal substances but differ from them chemically, and thus fall outside the 'normal' regulatory system.

Local production of most drug types is fairly limited but growing. Most of the heroin, cocaine and methamphetamine consumed in ESA is produced in Afghanistan, Mexico and Nigeria, although some countries are manufacturing increasing quantities of crystal meth. Clandestine laboratories for several other substances have been identified or suspected in some countries, apparently to meet regionally specific substance demands rather than as a substitute for importation. However, cannabis is widely cultivated, largely for domestic or regional consumption.

Cannabis is the most commonly consumed drug in the region, typically smoked as dried buds or in resin form (known as 'hashish') or ingested as an edible product. There is substantial use of heroin and cocaine, and increasing use of methamphetamine and other synthetic drugs. Heroin in the region was once predominantly consumed through inhalation, but injection has become a common method of use. Cocaine is available in all countries, either in the more expensive powder form or in the cheaper and more common 'crack' form, which is produced by mixing powder cocaine with sodium bicarbonate (baking soda) and drying it into small pieces ('rocks'). Both are heavily adulterated with other substances. Methamphetamine use is growing rapidly, replacing crack cocaine as the stimulant of choice in many communities. It is usually smoked, although there are some reports of injecting use. Methamphetamine production and

consumption are expected to continue rising. Other synthetic drugs, such as methaqualone (Mandrax) and methcathinone, are also available in several countries.

It used to be the case that drug supply chains largely passed through ESA's coastal periphery to points further downstream, that local production was negligible, and that drug use was dominated by cannabis smokers and a few 'hard' substance users in urban centres. None of this holds true today. A wide and expanding array of drugs are now available and consumed in all secondary towns and settlements, supplied by markets that are becoming more socially embedded and resilient. These developments present a host of new governance challenges. Drug policies need to be revised to reflect these realities.

- *This topic is further explored in the ESACD background paper 'Illicit drug markets of Eastern and Southern Africa: An overview of production, supply and use'.*[9]

## Maritime trafficking

Despite intensified interdiction efforts, transnational maritime drug trafficking in the ESA region is escalating. It is affected by four primary maritime routes: three for import and one for export.

- The southern route transports heroin and, increasingly, methamphetamine from Afghanistan through Iran and Pakistan, south around the Horn of Africa to East Africa. To avoid interdiction by the Combined Task Force 150 (CTF-150) of the Combined Maritime Forces (CMF), some traffickers take a longer route further out into the western Indian Ocean. The primary carriers are dhows, supplemented by larger vessels. Madagascar is emerging as a major regional hub.
- The lusophone route sees larger ocean-going vessels transporting cocaine and, increasingly, methamphetamine from Latin America, predominantly Brazil, across the southern Atlantic to ports ranging from Angola in the south-west to as far up the east coast as Kenya.
- The Asian route brings synthetic drugs and precursor chemicals (used in the production of drugs such as methamphetamine, methaqualone and synthetic cannabinoids) from laboratories in China, South East Asia and India.
- The Indo-Pacific route starts in ESA, and targets the Australian and New Zealand drug markets with cocaine transferred from the lusophone route and methamphetamine transferred from the southern route or produced in the region.

The most common maritime trafficking methods are direct point-to-point cargo delivery using vessel holds; ship-to-ship transfer between vessels, normally in international waters; ship-to-shore transfer from a larger 'mothership' to smaller vessels for immediate shoreline delivery; parasitic attachments of small watertight containers to a ship's external hull; drop-off bundling, in which watertight packages are dropped at pre-arranged locations at sea, sometimes with GPS trackers, for smaller boats to retrieve; and container concealment using standard, steel-based international shipping boxes.

The latter is by far the most common method of transporting large quantities of drugs. The scale of the legal worldwide circulation of shipping containers is vast and less than 2% are ever inspected. Traffickers use various smuggling techniques within containers, including:

- Straight-up: Loading a container directly with illegal or grey-market goods, often involving compromised port agents and fraudulent documentation.
- Commingling with legal cargo loads: Drugs camouflaged by legal exports, requiring traffickers to own or set up front companies for disguise.
- Rip-on/rip-off: Tampering with containers of legitimate exports to insert drugs, then using cloned customs seals to hide interference.

- Concealed within the container housing: Hiding drugs in the structure of the container itself, such as walls, ceilings or refrigeration equipment.
- Contamination by drop-off at sea: Inserting contraband after the ship has departed, requiring crew corruption or forcible loading by armed groups.

A number of international maritime security initiatives have been established to disrupt drug flows in the region. However, their effectiveness is hampered by factors such as the embeddedness and adaptability of trafficking networks, the vastness of the region, loopholes in vessel tracking requirements, legal issues of sovereignty, jurisdictional complexities, and gaps in surveillance and enforcement capacity in ports and at sea. Addressing these challenges requires, among other things, enhanced regional cooperation on information sharing, the integration of surveillance tools and harmonization of customs documentation systems.

- *This topic is further explored in the ESACD background paper 'Maritime-based drug trafficking in Eastern and Southern Africa: An overview'.*[10]

# VIOLENCE AND ORGANIZED CRIME

There is a strong relationship between drugs, violence and organized crime. The link between drugs and violence is typically understood through a three-part classification,[11] which suggests that it can take the form of:

- a psycho-pharmacological link, associated with the effects of drugs in stimulating anxiety, aggression or risk-taking in users;
- an economic-compulsive link, which comes from users having to commit crimes to support their habit; or
- a systemic link, which relates to the ways in which illegal markets operate.[12]

Illegal markets repel established, legitimate businesses, and attract those who are socio-economically excluded and have a high tolerance for risk and violence. Participants in illegal markets cannot rely on legal methods to provide security, enforce agreements or settle disputes, so they resort to violence to meet these needs. Typical causes of violence include struggles over power within groups, disputes over reputation or territory between groups, clashes with law enforcement and, more broadly, the normalization of violence as a means of conflict resolution in marginalized communities where organized crime has an established presence.

The type and level of violence depend on the nature of the drug market, which is influenced by how law enforcement responds to it. Levels of violence can sometimes be exacerbated by the police and military.[13] For example, law enforcement actions can create a vacuum for groups with more expansionist and aggressive strategies to fill.[14] Police or military interventions can aggravate community alienation, promote human rights violations and abuses, overwhelm criminal justice systems, contribute to prison overcrowding, reinforce cycles of poverty by triggering violence, and redirect funding away from socio-economic development.[15]

Repressive drug policies can therefore have perverse effects and even strengthen criminal organizations, especially when they focus on low-level offenders and PWUD. Even a focus on producers may not have simple dividends. Impoverished farming communities, for example, may have no alternative sources of income. The focus should be on the most dangerous and/or most profitable elements of the criminal organizations.[16]

Prohibition makes drugs an extremely profitable enterprise and a major source of revenue for criminal groups. The profits fuel corruption to a degree that can seriously undermine governance. Criminal actors make payments in exchange for the security and expansion of their operations. Corruption typically begins with public officials responsible for routine oversight and enforcement, including the police, customs and border officials. This compromises international borders, airports and seaports, damaging the territorial integrity of states and posing a threat to national security. It also normalizes collusion with criminal markets, decreases trust in authorities and feeds a culture of impunity.

Drug-related corruption can extend even further. Private and public institutions may become complicit and even transformed into enablers rather than disablers of the market. Drug profits finance electoral campaigns and provide 'unearned rents' to elements of the political elite, with devastating effects on service provision and socio-economic development. The need to conceal and launder drug profits can also distort the proper functioning of the private sector, create fake bubbles in real estate, and undermine the integrity and stability of financial systems.

- *This topic is further explored in the ESACD background paper 'Drug policy and its impact on governance in Eastern and Southern Africa'.*[17]

# LAW ENFORCEMENT RESPONSES AND CHALLENGES

The prohibitionist approach centres on criminal justice. Existing law enforcement strategies that attempt to disrupt illegal drug markets can be categorized into three broad approaches:

- Product supply-focused disruptions, including drug seizures, and interference with drug production and trafficking (especially import and export), the trade in counterfeit and contraband pharmaceuticals, and cyber-market operations.
- Space-based disruption of local open drug markets, including high-visibility, zero-tolerance and hot-spot policing approaches.
- Person-based disruptions concentrated on drug market participants and their activities, including by means of focused deterrence of drug users, key local market participants, and infiltration and other strategic measures targeting criminal organizations.[18]

Typical criteria for evaluating the effectiveness of such law enforcement measures are drug availability, prices (a proxy that assumes that price increase signals reduced availability), quality (a proxy that assumes that product adulteration signals reduced availability), the length of time for the supply to be replenished and levels of public disorder around open markets.

An extensive review of the empirical literature shows that all three broad law enforcement strategies have very limited and short-lived effects on drug markets or availability. Despite large-scale national and international efforts, drugs remain plentifully available nearly everywhere. Organized crime groups, networks and markets invariably prove resilient and flexible, adapting quickly to change by reconfiguring or relocating. Isolated law enforcement disruption activities are likely to continue to be unsuccessful in reducing the activities of criminal networks.

This is not to say that law enforcement strategies should not form part of a comprehensive drug control strategy. However, once illicit drug markets are understood as highly adaptable, dynamic ecosystems affected by numerous factors and not just by law enforcement, it becomes important to be realistic about what can be expected to be achieved through law enforcement strategies alone.

Meanwhile, unintended effects often include geographical displacement of activities, increased levels of drug market violence, opportunities created for new market entrants, displacement of PWUD to other drugs, damage to police–community relations, and negative public health effects, including increased rates of drug overdose.

- *This topic is further explored in the ESACD background paper 'Law enforcement strategies to disrupt illicit markets'.*[19]

# IMPACT ON HEALTH

The consumption of drugs is associated with health risks. Long-term use can have a range of effects, such as an increased risk of cancer, heart or lung disease, stomach ulcers, damage to respiratory passages, or dental deterioration. Because they are intended to affect biological and/or mental functions, drugs also have short-term active and/or side effects that affect health. Depending on the drug, these may include rapid or irregular heart rate, increased body temperature, gastric upset, seizures, or injury related to impaired motor function or altered perception. Other major health concerns include dependence and the role of drug use in spreading infectious or communicable diseases.

However, the relationship between drugs and their impact on health is mediated by policy. Until recently, most governments have attempted to reduce drug use largely by using law enforcement methods and personnel to detect and deter the production, trafficking or consumption of drugs. This frames drug policy as a matter of public safety and criminal justice. This is increasingly recognized as neither productive nor cost-effective in addressing the harms associated with drug use.[20] An alternative is to reframe it as a public health issue. Drug policy affects health. Criminalizing drug use pushes it into unsafe channels, makes it difficult for users to verify the content and purity of what they buy, increases associated health risks, undermines the sharing of information and resources for safer use, increases stigmatization, and undermines access to treatment and essential medicines.

## Prevention and treatment programmes

People use drugs for many reasons, including 'youthful experimentation, pursuit of pleasure, socializing, enhancing performance, and self-medication to manage moods and physical pain'. [21] Many may do so only briefly or periodically. However, some proportion (perhaps about 10%)[22] of those who start using drugs develop a pattern of behaviour that may be variously described as 'addiction', 'dependence', 'substance use disorder', 'high-risk use' or 'problematic use'. Definitions of these terms vary and their use is contested. Drug dependence, broadly understood, often has a negative impact on personal, family and social well-being. The likelihood of developing dependence is associated with early onset of use, socio-economic deprivation, and co-occurring mental and physical health conditions.[23]

Scientific research has demonstrated that effective prevention of drug dependence includes programmes targeting safe and healthy pregnancies, parenting skills, early childhood and adolescent development, as well as screening and brief interventions to prevent progression from occasional use to dependence.[24] International guidelines show that existing drug dependence can be treated using a combination of medical (pharmacological) and psychosocial interventions. There can be significant returns on investments in evidence-based prevention, treatment and harm reduction.[25]

However, globally, only one in six people with drug dependence benefits from such services.[26] Available data and local expert opinions show that outdated views and limited resources have resulted in even more inadequate programming in ESA. Most rely on specialized psychiatric (mainly hospital) facilities or some community-based services provided by civil society organizations. Treatment choices are limited and often fail to respect patients' autonomy. Many have a primary focus on detoxification and a goal of total abstinence, which may not be immediately or at all achievable or appropriate for all individuals. Prevention programmes tend to emphasize media campaigns and learner education, neglecting support for pregnancy, parenting skills, and early childhood and adolescent development. There are critical gaps in screening and brief interventions, and in universal, early and sustained psychosocial support in community settings. There is an urgent need to tailor services to the specific needs of subpopulations, including women, young people, people with co-occurring mental and physical health problems, people in prisons and other closed settings, and members of minority groups, including migrants and sexual minorities. The implementation of evidence-based drug dependence prevention, treatment and harm reduction interventions is key to mitigating the effects of increased drug use in ESA.

- *This topic is further explored in the ESACD background paper 'Prevention and treatment of drug dependence in Eastern and Southern Africa'.*[27]

## Communicable diseases

Globally and within Africa, the risk of infection with the human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV) and tuberculosis (TB) is often higher among PWUD than in the general population, causing widespread disease and death. The burden of these diseases, which often go untreated, is particularly high among people who inject drugs (PWID). Co-infection is common, accelerating disease progression and increasing the risk of death.

The sharing and (re)use of contaminated injecting equipment (e.g. needles, syringes and cookers) causes disease to spread readily. Exposure can also occur indirectly through unprotected and/or transactional sex in the context of drug use or as a result of sexual violence against PWUD. People in prison are at elevated risk of contracting TB, a burden that is exacerbated by HIV prevalence and poor nutrition. PWUD also face barriers and stigma in accessing health services. Tailored interventions for PWUD are needed to end epidemics of communicable disease in community and prison settings. This has been recognized in the national HIV strategic plans of most countries in ESA.

Various harm reduction interventions can decrease the incidence and mitigate the effects of communicable and other serious diseases among PWUD. These include needle and syringe programmes (NSPs), which provide PWID with safe injecting equipment to reduce their risk of injury and disease transmission; opioid substitution therapy (OST), which improves treatment outcomes and quality of life for people with opioid dependence; the provision of safer drug use education and support; and safe drug consumption sites that allow people to use drugs under non-judgmental medical or trained peer supervision. Some consider harm reduction programmes controversial because they do not necessarily aim to eliminate drug use, which could be interpreted as normalizing it. However, there is growing evidence that these measures can be highly successful and cost-effective in improving health outcomes. Many countries have begun to change their policies to make harm reduction services possible, but the policy provision and practical availability of these interventions in ESA is still extremely limited.

- *This topic is further explored in the ESACD background paper 'Drug policy and infectious disease transmission in Eastern and Southern Africa'.*

## Access to essential medicines

Another key aspect of the relationship between drug policy and public health relates to the availability of essential medicines. International drug control treaties commit to facilitating the availability of drugs that are essential for medical and scientific purposes. However, a public health crisis across Africa is that these controls have contributed to a shortage of analgesics (painkillers), particularly opioids. These are used for the relief of moderate to severe pain and suffering, including for anaesthesia, the treatment of trauma and neurological disorders, and in obstetrics and palliative care (treatment focused on improving quality of life for people with life-threatening illness). The barriers to access are well known, and some African governments are already taking steps in partnership with civil society to overcome them.

In many African countries, the laws governing access to these medicines are rooted in colonial-era treaties designed to limit the commodification of opium, which was legally marketed and sold throughout the British Empire. Although the use of opioids as a therapeutic substance was historically overseen by traditional healers and the medical profession, the non-medical use of opioids has slowly grown into what is now known as the 'opioid crisis'. Yet opioids, in particular the derivative morphine, are officially recognized in the WHO Model List of Essential Medicines, which is a key guide for national-level drug policymaking and health agendas.

In the first decade of the 2000s, a dramatic rise in opioid dependence and overdose deaths in the United States – the world's largest consumer of opioids – led international drug control bodies to institute stricter control measures to limit access to opioids. This has left lower-income countries with even more inadequate access, resulting in millions of poor people dying in avoidable health-related suffering. There is growing concern that the mission to prevent opioid diversion globally has taken precedence over the mission to ensure access to these essential medicines locally, despite the lack of evidence that opioid diversion is, in fact, widespread in ESA.

Related to this problem of an acute shortage of opioid analgesics in African healthcare settings is the unauthorized use of a synthetic opioid analgesic known as tramadol. It is listed on the WHO Pain Relief Ladder as a 'mild opioid', with an estimated tenth of the potency of morphine.[28] It is the only opioid not included in international drug control schedules and is widely used in medical practice – particularly in Africa, where medications like morphine are scarce. However, due to growing evidence of non-medical tramadol use in some countries in Central and West Africa and the Middle East, the INCB and UNODC have begun discussing its inclusion in the list of internationally scheduled substances. Informal importation routes and distribution channels provide certain lower- and middle-income countries with a range of diverted or counterfeit medications and other pharmaceutical products, some of which may be substandard. This includes tramadol. The goal of reducing the unauthorized use of medicines must be balanced against the need to maintain some availability in otherwise underserved communities.

- *This topic is further explored in the ESACD background paper 'Removing barriers to palliative care medicine: Rational medical use of essential controlled medicines in Africa'.*[29]

# SOCIAL ISSUES

## Impact on youth

Punitive drug policies inflict a heavy toll on the youth, despite aiming to protect them. Criminalizing drug use not only dramatically increases the health risks associated with it, but also exposes users to stigmatization, police abuse and the negative consequences of imprisonment. This is a particular issue for young people, as drug use often starts in adolescence and tends to be concentrated in youth populations.

The junior, front-line roles that young people tend to play in drug markets expose them to abuse and brutality, including at the hands of the police. Law enforcement agencies seek to respond to rising drug use and boost performance indicators by increasing arrests for drug-related offences. The result is a high number of convictions for low-level and non-violent crimes, including drug possession for personal use. Young men from poor socio-economic backgrounds are the most common demographic targeted. Prison conditions are often brutal. Convictions for drug-related offences further marginalize vulnerable young people and exacerbate youth unemployment. The incarceration of parents and guardians also causes suffering for their dependent children.

- *This topic is further explored in the ESACD background paper 'The impact of drug policy on children and young people in Eastern and Southern Africa'.*[30]

## Impact on women

Although most people who use, produce, transport or sell drugs are men, drug policies impose different and sometimes worse harms on women – as consumers, participants in drug markets, family members of men who use drugs, and members of communities affected by drugs. These harms are exacerbated by criminalization.

Data suggests that worldwide, including in ESA, women who use drugs (WWUD) have higher rates of diseases such as HIV and HCV than men who use drugs. WWUD are often introduced to substance use by male partners. This can mean that these women become dependent on men for the supply of drugs and equipment, which can heighten their risk of using contaminated equipment and being exposed to communicable diseases, especially as women are more likely to be the second user of equipment in sharing settings. WWUD may engage in risky sexual behaviour, including as a result of using sex work to support their drug use or themselves.

WWUD are also at higher risk of physical and sexual violence than women who do not use drugs. This violence is often perpetuated by partners, but also by authority figures. WWUD have difficulty accessing health services because they tend to be more stigmatized than men for using drugs, and these services frequently do not cater for women's needs.

Discrimination and exploitation by the police mean that WWUD are often left with no avenue for assistance or filing complaints, as the very people who are supposed to protect them become their greatest threat.

Most of the people convicted of drug-related offences are men, leaving women as the sole caregivers in many families and communities. However, a higher proportion of incarcerated women than men have been imprisoned for drug offences, and more women are incarcerated for drug offences, mostly non-violent offences, than for any other type of crime. This is partly due to the kinds of roles that women usually play in drug trafficking organizations. It is common for women to act as drug mules, carrying drugs across borders on or inside their person. This places them on the front line, at a high risk of detection and arrest, while those in control of the operation are at much lower risk. Women's prisons tend to be fewer and further apart, so women may be incarcerated far from their families. As women are more likely to be primary caregivers, their imprisonment has a greater impact on dependent children.

Policy frameworks must also recognize the intersecting but distinct drug and policy experiences and needs of members of other key vulnerable populations, including sex workers, children and young people, and members of lesbian, gay, bisexual and/or transgender (LGBT) communities.

- *This topic is further explored in the ESACD background paper 'Women and drug policy in Eastern and Southern Africa'.*[31]

# ECONOMIC COSTS

When considering drug policy alternatives, it is essential to take costs into account. This is difficult because most of the necessary data is inaccessible or scattered, and many costs may be indirect or intangible. A more fundamental challenge is to differentiate the costs that are best attributed directly to drug use or trade from those stemming from ineffective drug policies. The prohibitionist stance prevalent in ESA may actually increase drug-related harms and costs, and divert resources away from measures that evidence suggests may in fact have a positive impact.

As ESA countries largely place law enforcement at the core of their drug responses, their most direct and calculable drug-related economic costs are in criminal-justice-system expenditures. Although diverse legal frameworks and data practices make systematic comparison or generalization impossible, certain patterns emerge.

The total combined police and prison budgets of ESA countries represent an average of almost 2% of GDP. This expenditure drives about a quarter of a million drug-related arrests per year. Classifications vary, but on average, only about one in 10 of these are for drug trafficking, with the overwhelming majority for low-level charges of drug use or possession. This has little prospect of disrupting drug supply and disproportionately impacts vulnerable PWUD, including women and children, from marginalized communities. Drug-related arrests account for an average of 7.5% of all arrests in the countries surveyed, suggesting that drug-related policing expenditure across the region may be as high as US$680 million per year. In terms of prisons, the total combined number of people incarcerated for drug-related offences ranges from 5% to 11% of the total prison population, which translates into an estimated annual expenditure of between US$112 million and US$248 million on drug-related imprisonment in the region.

Crucially, these direct criminal justice costs to taxpayers represent only a fraction of the broader, long-term impacts. Arrest and incarceration can have profound and cascading negative consequences for families, communities and economies. These costs are not inherent to drug use but arise from specific policy choices, suggesting potential for change.

Despite viewing drug policy primarily through a law enforcement lens, ESA countries also face substantial drug-related health costs. These are difficult to estimate. Many health risks, such as overdoses, are influenced by factors beyond just drug use, including inappropriate policy and unsafe conditions. There are also critical data gaps, with different indirect data sources leading to wildly varying estimates.

Treatment of blood-borne diseases is one of the most prominent drug-related health costs, because rates of HIV/AIDS and viral hepatitis are often much higher among PWID than in the general population. Extrapolating from the limited

data available, the additional annual treatment costs resulting from elevated HIV prevalence among PWID could be as much as US$14.5 million. This cost could be avoided by reducing the incidence of blood-borne diseases among PWID. Yet ESA governments devote negligible resources to the measures that have been proven to be effective and cost-effective in doing so.

Arguably the most evidence-based tools for reducing drug-related harms and costs to governments fall under the umbrella term of 'harm reduction'. This encompasses a range of practices that aim to mitigate the harms of drug use without necessarily eliminating it, including interventions such as needle and syringe programmes (NSPs) and opioid substitution therapy (OST). While these approaches may be seen as normalizing drug use, their efficacy in reducing disease spread and costs among drug users, especially PWID, is established. For instance, NSPs are highly cost-effective and there is compelling evidence of their role in curtailing the spread of HIV among PWID since the early 1990s. OST is more expensive but significantly reduces HIV risk, and combined with NSPs, it can lessen HCV risk by up to 71%. Implementing harm reduction could potentially halve the HIV rates among PWID in the region, saving about US$12.7 million annually on HIV treatment alone. When considering other diseases and complications, such as overdose, the potential savings are even greater. Unfortunately, harm reduction investments in ESA remain minuscule compared to spending on criminal justice.

Rehabilitation, encompassing medical and psychosocial interventions for drug treatment, is another direct drug-related cost to governments. While some prevention programmes show promising results, the effectiveness of most rehabilitation programmes remains inconclusive. Nevertheless, given the significant social costs associated with dependent PWUD, even moderately successful treatments can yield positive returns. Long-term inpatient treatment, combined with ongoing outpatient therapy, often produces better results than short-term detoxification or incarceration. Community-based treatments, emphasizing outpatient care, support and aftercare, have demonstrated some of the best outcomes. Conversely, compulsory drug treatments, such as forced detention, have little supporting evidence and may even be less effective and more expensive than community-based options. There is almost no data available on rehabilitation costs in ESA, but it is estimated that a mere 3% of those who need treatment in the region receive it, with public access limited and private options largely unaffordable.

The bitter irony is that failure to invest in health and harm reduction results in greater costs. Insufficient data makes rigorous analysis impossible, but initial estimates suggest that a shift from a criminal justice-focused policy to a health and harm reduction approach could save ESA governments between US$800 million and US$940 million annually. Shifting priorities and reallocating resources in line with evidence-based practices could bring significant benefits to the region.

- *This topic is further explored in the ESACD background paper 'Drug policy and its economic cost: An overview of law enforcement and social costs in Eastern and Southern Africa'.*[32]

# CONCLUSION

When the 'war on drugs' approach was formalized in international policy, the only feasible foundation for the response to drugs in ESA was criminal prohibition. Globally and continentally, the evidence base and policy landscape have since shifted. So have the scale and nature of the regional drug problem. The costs and harms associated with drugs and with misguided policy are vast and growing.

There is a clear and urgent need to take stock of current policies, assess their impact and consider alternatives. This process cannot be based on preconceptions, inertia or expediency. It must combine the views of the people most affected, the best available data and expertise, intellectual courage and impeccable moral authority. Whatever conclusions it may reach, this is what the ESACD must pursue.

# Notes

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