ESACD

Eastern & Southern Africa
Commission on Drugs

FINAL REPORT AND ACTION PLAN

JUNE 2025

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Please direct inquiries to:
The Global Initiative Against Transnational Organized Crime
Avenue de France 23
Geneva, CH-1202
Switzerland
www.globalinitiative.net

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ACRONYMS

AIDS	Acquired immune deficiency syndrome
AU	African Union
DRC	Democratic Republic of the Congo
EAC	East African Community
ESA	Eastern and Southern Africa
ESACD	Eastern and Southern Africa Commission on Drugs
EU	European Union
FATF	Financial Action Task Force
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
ICEMs	Internationally controlled essential medicines
IDU	Injection drug use
NSP	Needle and syringe programme
OHCHR	Office of the High Commissioner for Human Rights
OST	Opioid substitution treatment
PWID	People who inject drugs
PWUD	People who use drugs
SADC	Southern African Development Community
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
WWUD	Women who use drugs

FOREWORD

Since its launch in 2023, the Eastern and Southern Africa Commission on Drugs (ESACD) has embarked on a journey rooted in a powerful conviction: that the region can confront the challenges posed by the escalating illicit drug trade and use, through informed dialogue, heightened public awareness of the risks and evidence-based policy recommendations. As we present this regional drug report and action plan, almost three years after the inaugural launch, we reflect not only on the ground we have covered but on the potential of shared collaborative action and awareness that now unite stakeholders of the region across sectors and borders.

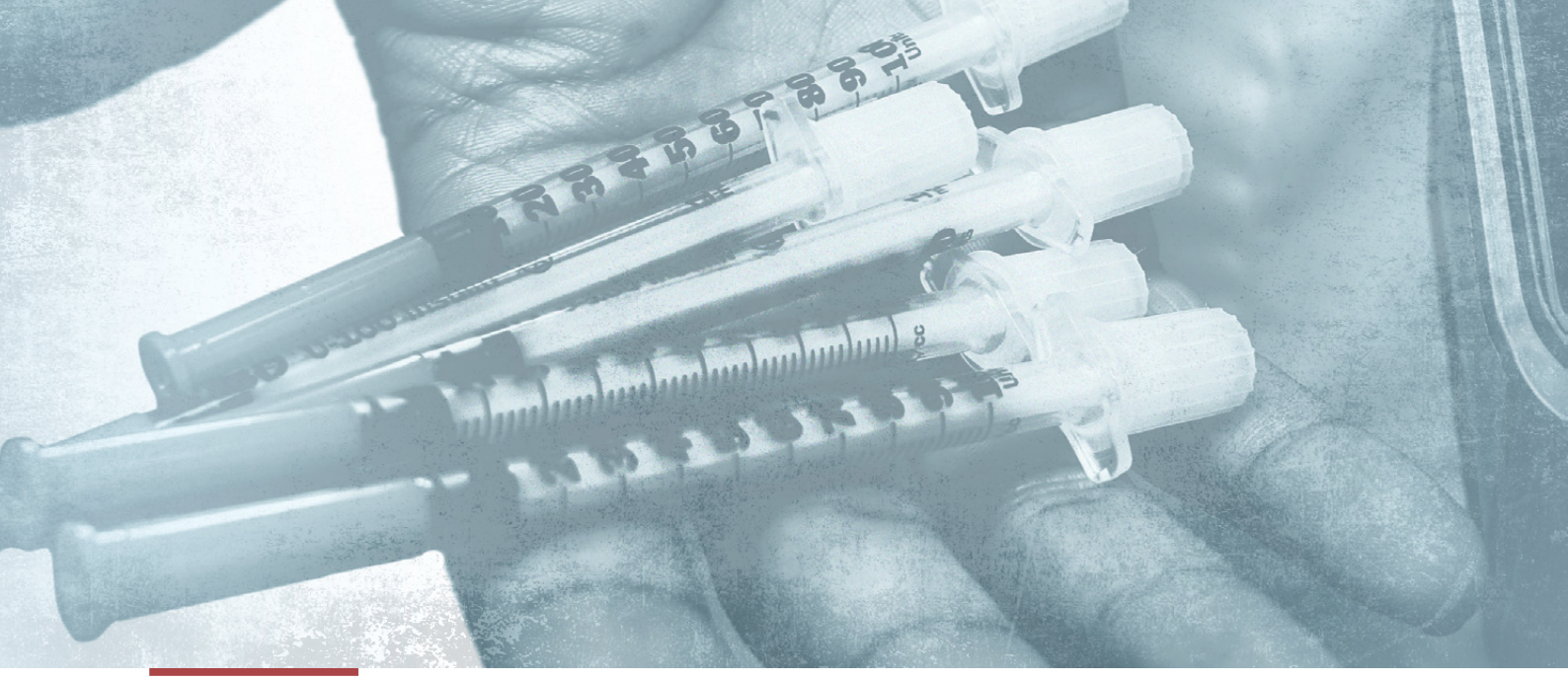
Since it was convened, the Commission has brought together influential agents of change – government leaders, law enforcement, public health officials, civil society, academia and, of course, people who use drugs. Through three high-level meetings, we have raised awareness of drug-related challenges in the region, and reviewed and assessed the impact of current policies. These forums were far more than just dialogue: they have engendered commitment to change by building and catalyzing political will for further action on illicit drugs at the national, regional and international level.

Equally vital has been the regional consultation meetings on cannabis regulation we convened in Maputo, Mozambique, and Gaborone, Botswana. These expert dialogues have supported the development of policy and regulatory frameworks for the legalization of cannabis regulation tailored to each country's particular context and needs. These exchanges have underscored a truth we hold firmly: that reform must be rooted in evidence, guided by public health imperatives, grounded in effective law enforcement and, above all, centred on people – respecting and upholding their rights and dignity.

This flagship drug report, which compiles background analytical work on the regional drug threat and provides an action plan, is more than a record of the activities of the Commission: it is a call to action. To achieve evidence-based and humane policy reform, there must be a continual assessment of the drug market environment and its harms. The action plan offers a roadmap for effective policy recommendations and invites all in the region and beyond to engage with renewed energy and purpose. We believe that meaningful reform is within reach and that together – through collaborative responsibility and bold leadership – we can achieve actionable, sustainable, evidence-based and humane drug policies. The path ahead is challenging, but it is also filled with promise. And we are confident that, united in understanding and determination, the Eastern and Southern region can, and will, rise to meet the challenges.

Kgalema Motlanthe

Former President of South Africa
Chair of the Eastern and Southern Africa Commission on Drugs

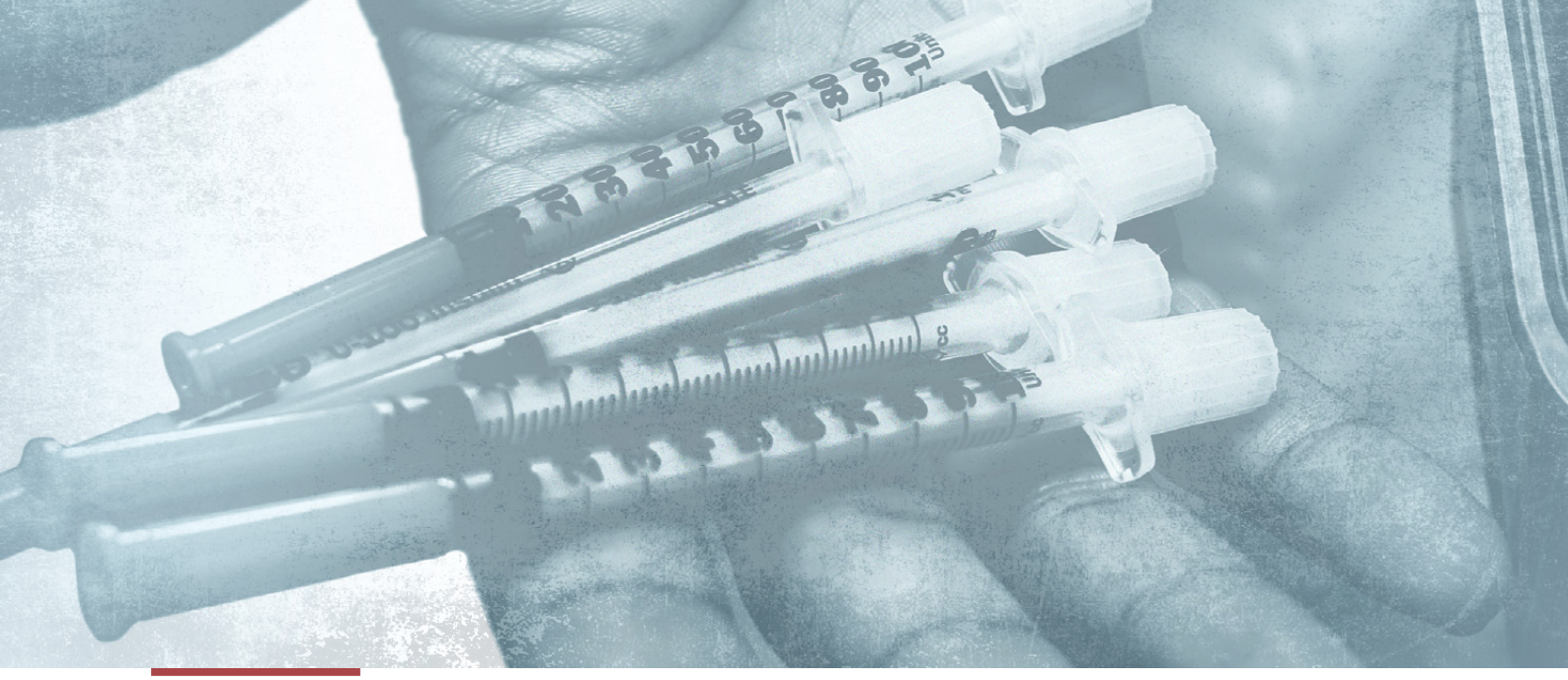


EXECUTIVE SUMMARY

The Eastern and Southern Africa Commission on Drugs (ESACD) was formally launched in 2023 to address the serious and multifaceted problems related to the growing proliferation of illicit drugs and their markets in the region. Countries in Eastern and Southern Africa (ESA) face ever more complex challenges related to the harms associated with illicit drug production, consumption, distribution and transnational trafficking. Regional consultation by the Commission has revealed that many government representatives, civil society actors and expert commentators have acknowledged that the numerous attempted responses to these challenges have met with neither successful disruption of these markets and supply chains, nor the successful reduction of harms related to their operations. Yet instead of the consideration of alternative drug-related policy approaches in the face of such failure, the countries of the ESA region continue to see rote repetition and replication of ineffective policies.

The ESACD's pursuit of regional drug policy change is occurring at a time when the global consensus on illicit drugs is shifting. There is an ever-greater awareness among United Nations member states of the major risks to public health, human rights, and citizen and state security caused by the continued failure of status quo approaches to drug policies grounded in strict criminalization. Discussions about, and the pursuit of, alternative approaches to drugs and drug market harms have emerged among a growing number of states, including those who make up what had been a regional body unified in its support for strict prohibition – the African Group. Reflecting the evolving global drug policy landscape, changing views on the appropriate approach to illicit drugs are also taking root on the African continent, particularly in the ESA region. It is within these emerging spaces of reform that the ESACD seeks to champion alternative approaches to the reduction of drug-related harms and the markets that promote them.

Throughout a series of regional consultation meetings, a diversity of civil society, government and other informants provided a significant volume of information on the drugs situation across the region. This information was provided to and reviewed by Commission members. Drawn from these regional consultation meetings, information was also gathered from bilateral and multilateral briefings provided to commissioners by regional governments, experts, community-based project staff, researchers and activists, and community-based networks of people who use drugs. Based on this information, the Commission developed a regional overview alongside a series of four findings, 12 recommendations and 40 actions in relation to improving the regional response to the illicit drug environment in ESA.



ESACD REGIONAL CONSULTATIONS

First high-level consultation – Cape Town, South Africa, 10–11 February 2023

During the first session of the inaugural ESACD meeting, experts from academia and civil society outlined the landscape of drug markets and drug policy in Eastern and Southern Africa (ESA). This discussion provided an important baseline for the Commission to begin its work. The session began with an acknowledgement that illicit drug markets in Eastern and Southern Africa are growing and diversifying. While it is understood that heroin and methamphetamine are trafficked into and through the region, there is also a need to note the rising prominence of the region's heroin market and the increase in methamphetamine use, especially in Southern Africa and the Indian Ocean island states. At the same time, there is evidence to suggest that cocaine trafficking is on the rise in Southern Africa, and other drug types, such as synthetic cannabinoids, are growing in prevalence. However, it was also recognized that some important elements of these markets remain the same – for example, cannabis is still believed to be the most widely consumed substance in Eastern and Southern Africa and remains illegal and heavily criminalized throughout most of the region.

The availability of drugs in the region has grown alongside an increase in the purity of the substances. However, existing assessments of the scale of regional drug markets are likely to be significant underestimates. Notably, there has been a growth in online drug markets, including with the increased use of social media platforms as marketplaces. Drug markets have also grown and diversified in the face of movement restrictions related to the COVID-19 pandemic. This session highlighted the fact that drug markets are not isolated phenomena. Rather, they are linked to other forms of organized crime, including human trafficking, illicit firearms trade, flora and fauna crimes, and extortion and protection racketeering. These criminal markets drive corruption in law enforcement agencies and other areas of government. There is the additional issue of pathways into drug abuse from legitimate sources (such as medical professionals). This has led to the abuse of certain regulated drugs and medicines, such as opioid analgesics, becoming a developing risk in the region.

The consultation concluded that there is a need to rethink how drug-related issues are addressed. Responses should consider the networked system of the drug trade, its knock-on effects, such as corruption, and the effects on society. Currently, the drug response is dominated by a singular perspective of law enforcement confronting low-level actors, including harsh measures against people who use drugs (PWUD). The consensus was that this strategy does not provide a nuanced approach that effectively uses law enforcement and intelligence capabilities, and does not address societal harms. Instead, it creates many additional social harms. For example, criminalization and stigma about drug use limits the development of health responses that could have positive outcomes for individuals and communities. In many parts of the region, interacting with and assisting PWUD is viewed through a political, criminal lens rather than a health lens.

ESACD Chair Kgalema Motlanthe with commissioners Joaquim Chissano and Quarraisha Abdool Karim, Helen Clark (Global Commission on Drug Policy) and Michel Sidibé (West Africa Commission on Drugs) at the ESACD launch in 2023. *Photo: GI-TOC*

Some conference participants noted that in certain countries law enforcement actors focus their resources on singling out PWUD for drug possession or use, instead of targeting those responsible for the high-level organized crime and violence that sustains the drug market. It was also noted that people in the proximity of PWUD, including health workers and civil society actors providing support, are also sometimes arrested in these crackdowns. Often this approach is driven by incentives for police officers to, for example, maximize the number of arrests they make. More useful measures such as health interventions are scattered thinly in terms of their availability in the region. Reorienting law enforcement activity away from targeting PWUD for drug use and possession offers governments the chance to save resources spent on activities that do little to fundamentally disrupt drug markets and instead impose harms on vulnerable members of society. There have been isolated moves towards reform in the region, however. For example, some countries have enacted laws decriminalizing cannabis possession and use, and in the case of South Africa this has placed possible legalization of the drug on the horizon. The decriminalization approach was indicated as being useful as it can free up policing resources to investigate more serious and violent crimes and reduce the incarceration of people charged with non-violent cannabis-related offences. Alongside decriminalization, some countries have begun instituting harm reduction responses for PWUD, but the issue often remains highly politicized rather than health focused, and countries often struggle to achieve even minimal funding or scale.

Second high-level consultation – Port Louis, Mauritius, 10–11 August 2023

The second consultation was thematically oriented around a discussion addressing the perception that there has been a sharp rise in countries in Eastern and Southern Africa becoming transit hubs and destination points in the illicit drug market, extending as far as the European Union (EU) and the United States (US). Many have also seen a significant escalation in domestic drug use, partly due to the increase in and diversification of drug supply chains, with new markets opening and new geographies and communities being targeted. There is consensus that regional drug policies are not effective enough, and that drug markets are expanding and conversing with other markets despite efforts to disrupt them. What has become an intractable problem has not, however, been met with an adequate and appropriate response, and current policies to combat the illicit drug trade are instead characterized by insufficiency.

These limitations are partly a product of fundamental knowledge gaps about drug markets in the region, including an absence of surveillance and monitoring data, and government underreporting. Indeed, many countries in the region have little or no data with which to understand their drug markets. Some are unable to provide even basic information, such as the number of PWUD present and the types of substances consumed. There is a huge gap in the evidence base, which is an essential starting point from which to tackle the problem meaningfully. More and better data is therefore needed to improve regional understanding of the issue of illegal drug distribution and use and for law enforcement to get a step ahead of these internationally networked and highly adaptable structures.

Furthermore, where a strong evidence base does appear to exist, there has been a reluctance in some cases to give due consideration to the relevance of such data. Local knowledge and first-hand observations by community-based civil society organizations, particularly those that work with PWUD, are often made to yield to international expert assumptions about what is really happening in the region, despite evidence to the contrary. Consequently, the regional

The second high-level consultation, in Mauritius, addressed escalating drug use and supply chain diversification in the region. *Photo: GI-TOC*

attitude to drug markets is characterized by significant oversights and problems that have yet to be acknowledged in the policy approach. These shortcomings are especially apparent in an incomplete grasp of trafficking intricacies, including the complexities of global supply chains and the influence of technological advancements. Moreover, they extend to issues concerning law enforcement's approach to combating the illicit drug trade, which often fixates on low-level offenders, pays insufficient attention to harm reduction, and grapples with problems related to corruption and collusion.

The consultation also discussed the overwhelming perception that the extent and depth of ESA drug markets are underestimated. Part of this is because of heavy reliance by external analysts on drug seizure data, which is an unreliable measure of illicit flows. For example, data shows that drug seizures by the combined maritime forces and naval units tend to be concentrated in the northern region of the Indian Ocean, generating a perspective – incorrectly – that there is little illicit drug flow to be detected in the southern Indian Ocean. The consultation concluded with a discussion about the diversification of illicit drug supply chain shipping routes as regional drug traffickers move further south into the Mozambique Channel.

Consultation on cannabis legalization – Maputo, Mozambique, 5–6 August 2024

Despite being a major producer and consumer of cannabis, the African continent has historically maintained some of the strictest laws regarding its production and use. However, as the global consensus on the effectiveness of prohibition-based measures to combat the illicit drug trade begins to fragment, countries in Eastern and Southern Africa are reassessing their stance, with cannabis widely seen as a good entry point, driven by recognition of the plant's economic potential and supported by ongoing research and cannabis advocacy work.

The consultation aimed to harness this transitional moment by facilitating knowledge sharing and collaborative problem solving to support the development of tailored solutions for regulating the cannabis trade in the region. Participants considered several thematic issues, focusing on the fundamental components of cannabis regulation policy and implementation, as well as the nuts and bolts of regulatory frameworks and compliance strategies. The ensuing discussion reflected the diversity of opinions, understandings and beliefs about the issue of cannabis, and illicit drugs in general, when it comes to establishing policies that seek to disrupt the illicit trade and mitigate the harms that are caused by these controlled substances and the national responses to them.

While South Africa has emerged as a pioneer of regulated recreational cannabis use in the region, it followed in the footsteps of Lesotho, which set a regional precedent in 2017 by becoming the first country to issue licences for the cultivation of medical cannabis. Zimbabwe followed Lesotho's lead in 2018 by regulating the production of cannabis for medical and scientific purposes. Zambia then began to allow the regulated production and export of cannabis for medical and industrial purposes, following a cabinet decision in 2019. Malawi's decision in 2020 to regulate medical cannabis alongside industrial hemp was driven more by economic necessity. As a predominantly agrarian economy faced with declining tobacco revenues, Malawi saw cannabis as an alternative cash crop. This decision reflects a broader trend in the region, where countries have been inspired by booming global markets to explore cannabis regulation as a means of economic diversification and development.

More recently, Uganda has also taken steps to regulate cannabis, with a law signed in February 2024 allowing for licensed industrial cannabis cultivation and medical use. However, this law has yet to be enacted. Mauritius has taken a more cautious approach, so far introducing only a highly restricted market for medical cannabis with strict requirements for patients and prescribers. In contrast to these varying degrees of legalization, countries such as Tanzania and Mozambique maintain policies of criminalization for the production, trade and use of cannabis, with no consensus yet reached on regulation, either medical or recreational.

The consultation in Maputo was aimed at supporting countries in the region in developing tailored solutions for regulating cannabis. *© Waldo Swiegers/Bloomberg via Getty Images*

The discussion revealed several common challenges that countries in the region face as they navigate cannabis regulation. Many are struggling to balance the potential economic benefits of a regulated industry with public health and safety concerns. Implementing and enforcing new regulations has been difficult, often due to limited resources and complex compliance processes. A widespread concern across the region is the protection of traditional growers and local economies. There is a recognized need to ensure that new regulatory frameworks do not harm traditional growers or disrupt micro-level local economies that may have historically relied on informal cannabis cultivation, reflecting the complex socio-economic dimensions of cannabis regulation in the African context. The affordability of compliance processes emerged as a significant issue, with speakers noting that small-scale farmers often struggle to meet the financial requirements of new regulations. This raises concerns about inadvertently creating barriers to entry for small-scale cultivators and potentially concentrating the benefits of legalization in the hands of larger, better-resourced actors at the risk of corporate capture. Regulation should work to ensure the even distribution of the benefits of legalization.

Despite these challenges, the depth and nuance of the contributions from regional representatives demonstrated that African countries are actively engaging with the complexities of cannabis regulation. The discussion also showed that the global repositioning on cannabis is not just a Western phenomenon. Countries in Eastern and Southern Africa are carefully considering the potential benefits and risks, and working to develop context-specific regulatory approaches that reflect their economic, social and cultural circumstances.

Third high-level consultation – Zanzibar, Tanzania, 3–4 September 2024

For this consultation the ESACD had identified synthetic drugs as the most significant emerging challenge to drug control in the region, particularly in terms of the consequences for public health and public security. The dynamic nature and growth of synthetic drug markets, and the challenges states face in developing effective countermeasures, have made synthetics a priority issue for the Commission. As one civil society representative explained, 'the growing synthetic drug trend is worsening, doing so widely and rapidly, and Africa is following this trend'. Within the region, South Africa, Mozambique and Mauritius were identified as particularly affected by the trade in illicit synthetic drugs, in part due to their location on major drug trade routes through the Indian Ocean.

Speakers outlined critical developments in the synthetic drug landscape: the region has shifted from importing finished synthetic cannabinoids to producing them locally by importing precursor chemicals; there is a growing trend of synthetic pharmaceuticals being diverted from state medical facilities to the domestic illicit market; more traditional drugs are being adulterated with or replaced by synthetic alternatives; and the involvement of courier and postal services in micro-trafficking of illicit synthetic substances has increased significantly.

Across the region, synthetic drug production is enabled by ready access to legal, affordable chemicals that are precursors for domestic synthesis. This shift was described as having made production easier and cheaper, leading to an alarming rise in the rate of production and availability of substances. Synthetic drugs are also readily available on dark web platforms, which impedes detection efforts by allowing traffickers to bypass intermediaries and reach consumers directly. To complicate matters, these drugs are often disguised as legitimate items, making them more difficult to identify and easier to transport undetected.

The discussion in Zanzibar drew attention to the emerging challenge of synthetic drugs in the region. *Photo: GI-TOC*

Unlike legal chemical and pharmaceutical synthetic substances, which are synthesized in a controlled, regulated production environment, the multitude of new synthetic drugs emerging across regional drug markets are manufactured in clandestine labs that can be located anywhere and which adhere to no standards of production control. This makes these drugs particularly dangerous for people to consume, with new generations of synthetic cannabinoids, for example, becoming more potent than previous generations.

At the same time, countries in Eastern and Southern Africa lack the capacity within essential state drug control and public health bodies to disrupt the rise of the market, a situation exacerbated by the existence of inadequate national policy frameworks and institutional structures of resilience to the harms of these markets. Participants emphasized that developments in the synthetic drug trade 'underscore the need for innovative, multifaceted responses, both in the public security and in the public health domains', but especially in the development of effective treatment services. Inadequate harm reduction capacity was identified as a particular vulnerability, with treatment services in the region barely able to cope with more traditional drug addiction concerns, such as opioid dependence. Meanwhile, synthetic drugs – a significant proportion of which are not opioids – require a different treatment regime.

While synthetic drugs pose a substantial challenge to the region, participants also noted that 'it is not too late to begin to respond'. However, they cautioned that the window of opportunity to respond was rapidly closing. In outlining the nature of the threats the region faces from the expansion of the synthetic drug trade, the first panel session foregrounded the discussion on services, surveillance and strategies that would provide participants with an opportunity to address the challenges the region faces from synthetic drugs and the illicit drug trade more broadly.

The dedicated panel on synthetics discussed trends in drug production, distribution and consumption, while the conversation about services focused on effective harm reduction, prevention, treatment, rehabilitation and social reintegration services for PWUD, acknowledging that the rise of synthetic substances raises new questions about how to effectively integrate essential services.

Participants stressed the new challenges that synthetic drugs pose for harm reduction efforts, noting that traditional treatments such as methadone would be ineffective against synthetic substances such as methamphetamine. However, speakers also recognized that service provision issues in the region go beyond synthetics, highlighting the overall deficiency in the availability, accessibility and standard of harm reduction services in general. There was therefore a strong call for readily available and integrated services that address not only the medical needs but also the social, economic and psychological needs of PWUD.

Through the discussion on harm reduction, speakers also brought into focus the social justice dimension of the drug trade and response strategies, noting that marginalized communities are disproportionately affected by substance use disorders and therefore bear the brunt of the impact of badly designed drug policies. Considering the development of services, participants observed that supply-focused, strict prohibitionist policies have been shown to be among the least successful in addressing the illicit drug trade, especially when compared to public health-oriented policies, which have proven highly effective. Participants therefore urged the integration of law enforcement and public health approaches, not just as a matter of policy but also as a moral issue.

In expanding on what one participant described as the need to tackle 'more than the presence of the drug itself', the consultation considered the other essential services that should support harm reduction, including vocational training, condom programming and the provision of naloxone for overdose prevention. In providing other kinds of services, drug treatment can become an 'entry point' for accessing vital forms of treatment, particularly for comorbidity problems such as tuberculosis (TB), HIV and mental health disorders. Speakers noted that harm reduction should also be integrated with social reintegration and psychosocial support programmes, designed to improve the quality of life of PWUD rather than necessarily aiming for abstinence. However, current harm reduction services, where they exist, are often concentrated in major urban areas, leaving many rural areas underserved.

Discussing effective strategies, participants noted the need to leverage new technologies, including artificial intelligence, to combat the illicit drug trade. Among the measures proposed were developing a coordinated maritime enforcement strategy, implementing decriminalization for personal use and redirecting efforts towards high-level traffickers. The conversation also touched on the need to include measures targeting connected illicit markets such as money laundering and terrorist financing, with proposed strategies including the seizure of assets purchased with criminal proceeds from the illicit drug trade.

Additionally, referring PWUD to treatment centres as an alternative to arrest and incarceration, establishing safe consumption sites and working to reduce discrimination were all mentioned as critical components of good drug policy. Pragmatism was emphasized as being beneficial in the establishment of service delivery structures, prioritizing low-cost and low-threshold services to ensure accessibility to PWUD while also appealing to potential donors. At the same time, participants also highlighted the need to use resources more effectively, building on what is already in place and avoiding duplication of effort.

The importance of drug-checking services was also identified as a critical intervention, especially given the unpredictable nature of synthetic drugs. These are locally based initiatives, often run by civil society groups, which enable PWUD to have their drugs tested to identify whether the substance is what it is supposed to be; and to identify whether it has been adulterated. As one speaker noted, 'There's nothing new about synthetic drugs. But when we buy them on the street or on online services through couriers, we really don't know what we are buying, and therein lies the danger.' This pre-empted the discussion on data gathering, with participants agreeing that the danger of the unknown does not apply only to synthetics – 'Even the drugs we think we know have unknown elements in them.'

Finally, criminalization and stigmatization of drug use were cited as significant barriers to accessing essential services. Representatives from PWUD communities noted that public awareness and education could help reduce discrimination and improve uptake of services, and advocated for PWUD to be treated not as patients but as 'equal partners in harm reduction intervention'.

Expert meeting on cannabis legalization for medical and scientific purposes – Gaborone, Botswana, 2–3 April 2025

The meeting was aimed at countries in Eastern and Southern Africa that have decided to reform policy and regulate cannabis use and production, particularly for medicinal and scientific purposes, and for countries that are considering it. Thematically, the meeting focused on three core elements: sharing experiences and lessons from countries that have already embarked on reforming policy and regulating cannabis for medicinal and scientific purposes; discussing how countries should conceptualize and design the initial framework, bearing in mind varying national contexts; and the importance of implementing robust frameworks focused on compliance and oversight to mitigate challenges these reforms may bring about.

President Duma Gideon Boko of Botswana (left) and Kgalema Motlanthe, former President of South Africa and chair of the ESACD, at the expert meeting in Botswana. *Photo: GI-TOC*

> **Our task is to educate the leaders themselves – don't assume they know. They need to be assisted, guided, educated and given proper tools of analysis.**

DUMA GIDEON BOKO, PRESIDENT OF BOTSWANA

The ESA region is witnessing a transformative shift in drug policy, with cannabis increasingly viewed as a pivotal entry point for broader reforms. Building upon discussions initiated in Maputo on 5–6 August 2024, participants in Botswana explored deeper dimensions of cannabis regulation, highlighting regional efforts toward progressive and tailored policy frameworks. The Maputo meeting had previously underscored the historical ineffectiveness of prohibitionist approaches, emphasizing the need for regulatory reforms grounded in economic pragmatism, public health considerations and cultural sensitivity.

The gathering in Botswana reinforced the notion that countries in the region are moving toward cannabis regulation at varying paces and with distinct national objectives. Participants shared experiences and lessons from the implementation of cannabis regulations. Discussions highlighted the essential components of effective cannabis policy, including comprehensive regulatory frameworks, robust compliance strategies, community engagement and the protection of legacy cannabis growers.

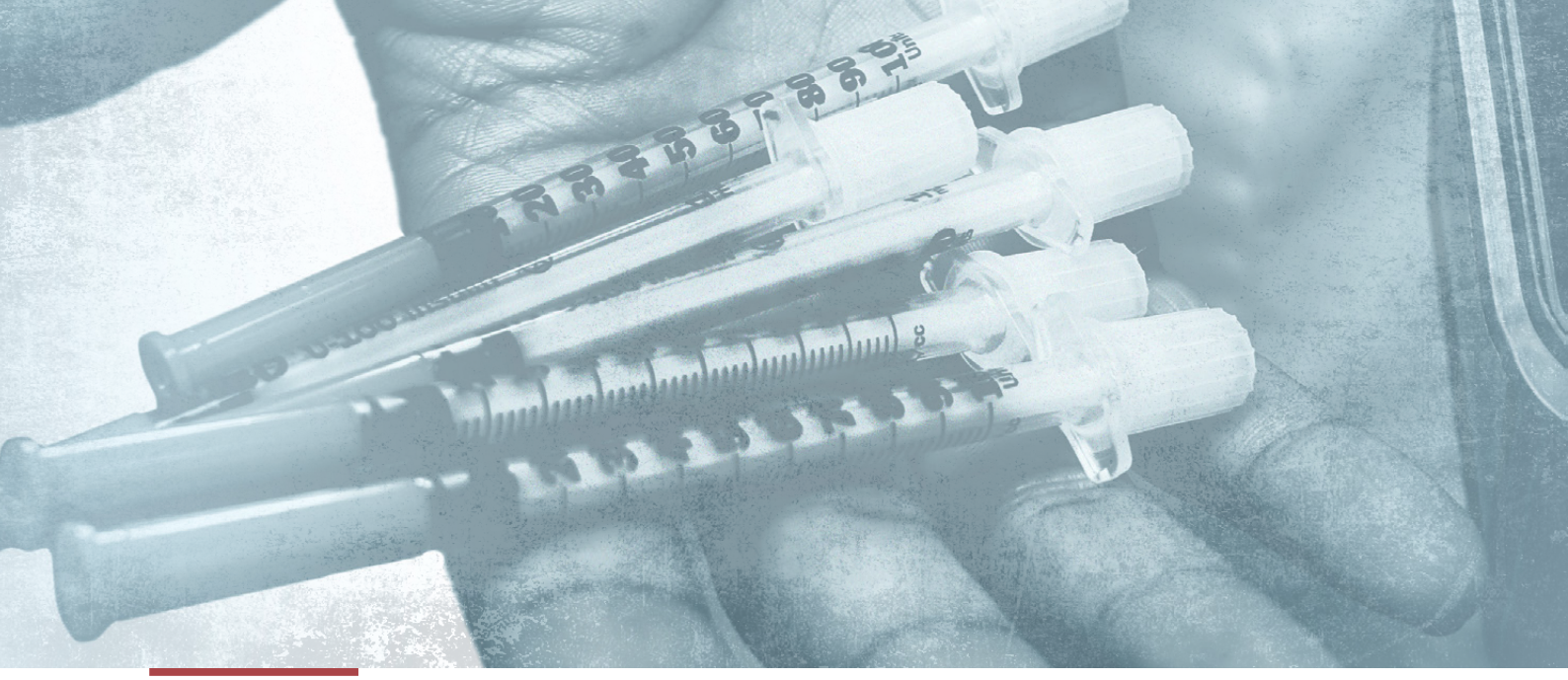
Regional delegates from Lesotho, Malawi, Mauritius, Mozambique, South Africa, Tanzania, Uganda, Zambia and Zimbabwe, representing government, law enforcement and civil society, were joined by academics from universities in the United Kingdom and participants from countries that are further along in the regulatory process, including Canada and Ghana, who shared their experiences. The meeting was solution-oriented and focused on collaborative problem-solving, with the hope that ESA delegations would be encouraged to advance their existing cannabis regulatory policies into practice.

In his capacity as host, President Duma Gideon Boko of Botswana underlined his government's unwavering commitment to evidence-based cannabis regulation rooted in human rights principles. President Boko emphasized the importance of developing informed policy frameworks, particularly highlighting the therapeutic potential of cannabis and supporting inclusive regulatory practices. Reflecting on societal perceptions, he urged policymakers to resist populist demands for increased criminalization, asserting instead the necessity of education and courage in leadership. 'Our task is to educate the leaders themselves – don't assume they know. They need to be assisted, guided, educated and given proper tools of analysis,' he said, reinforcing the call for evidence-driven policy.

Participants in the meeting engaged in comprehensive discussions focused on practical experiences and evidence-based approaches to cannabis regulation for medical and scientific purposes, emphasizing lessons learned globally and across the African continent. The panels explored effective regulatory frameworks, highlighting the necessity of tailoring policies to regional contexts and specific national circumstances. Discussions consistently emphasized the importance of grounding regulatory efforts in scientific evidence, balancing public health priorities with commercial interests, and continuously refining policies to adapt to emerging challenges and opportunities.

The Gaborone meeting was notable not only for the depth of its discussions but for the strength of political engagement it showcased. Botswana's openness to expert guidance and collaboration was demonstrated in President Boko's keynote address and through the strong institutional representation of his government, with the participation of three ministers and a deputy minister. Their presence signalled a clear and deliberate interest in drawing on the knowledge and experience of the ESACD to inform and support the country's emerging cannabis regulatory framework.

Importantly, this willingness to collaborate with the Commission is not limited to Botswana. It reflects a broader opportunity for all countries in the region to use the ESACD as a platform for dialogue and debate, capable of leading to the development of effective and context-sensitive drug policy. With its emphasis on evidence-based analysis and its growing repository of regional knowledge and insights, the ESACD can be a valuable resource for countries looking to transition from prohibitionist approaches toward systems that are legally robust, economically viable and socially inclusive.



ILLICIT DRUGS IN EASTERN AND SOUTHERN AFRICA: A MARKET-BASED OVERVIEW

Countries in Eastern and Southern Africa have a long history of illicit drug cultivation, production, consumption and trade. Khat, a crop indigenous to the Horn and coastal East Africa, has been used as a stimulant since the 12th century.[1] Cannabis, originally imported from Asia, has a history of several hundred years of production and use in the region. Initially, informal policies surrounding the control of these drugs were driven by traditional social networks, and cultural beliefs and practices.[2] Today, however, it is the more recent large-scale trade in and widespread use of opiates, stimulants and other synthetic substances that are recognized as a harmful phenomenon and a risk to the region.

As container and intermodal shipping grew rapidly through the 1970s, alongside long-haul mass transport and passenger aircraft, the global economic landscape in general, and illicit drug marketplaces in particular, were reshaped. The development of the region's air and sea ports, and their integration into global transport and communication networks, saw the emergence of new entrepôt trade, and hubs of commerce became networked across the continent. Meanwhile, technological innovations designed to increase the volume of drug commodity movement and decrease the risk of seizure began to emerge.[3] With these developments, many nascent networks of African drug traders began to consolidate their positions in the drug economies of ESA.[4]

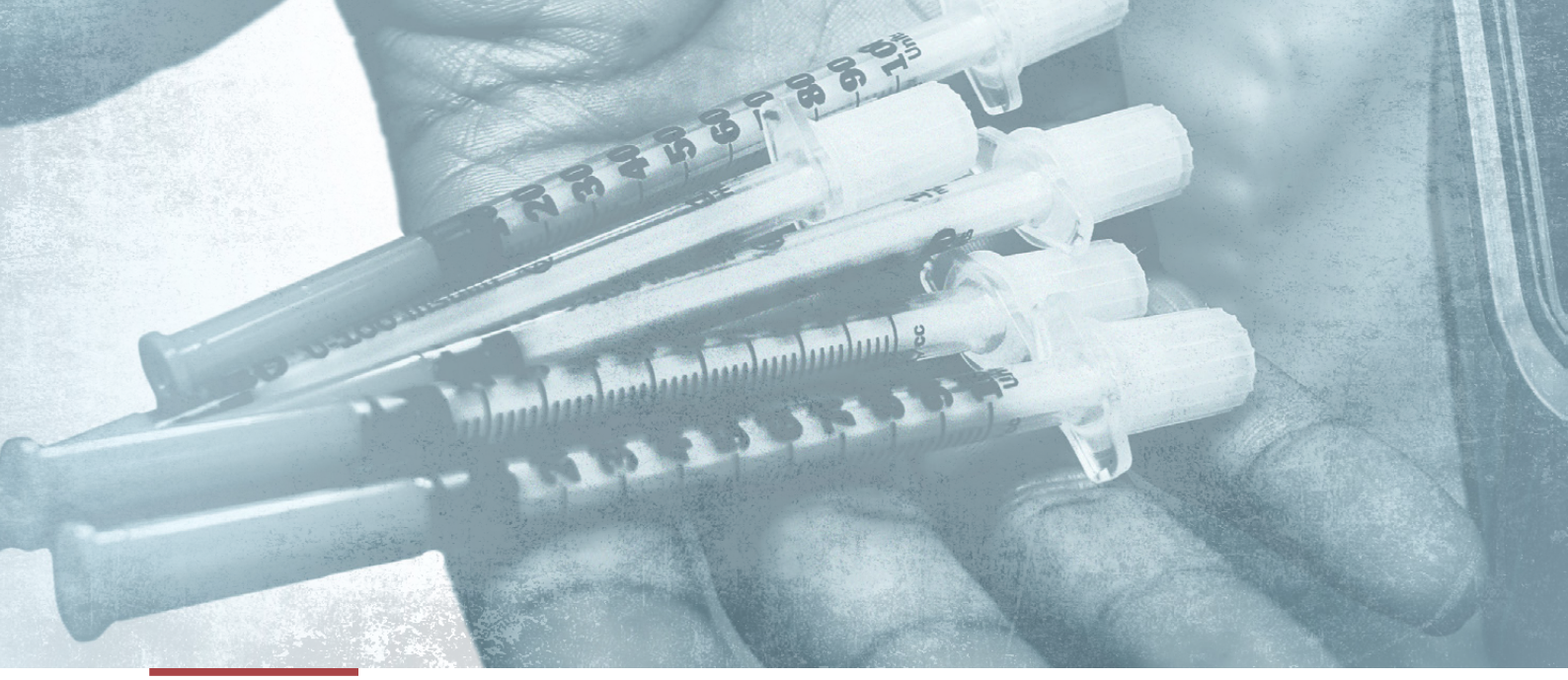
As international drug control measures began to restrict supply chains from South Asian and Latin American source points, trafficking routes evolved in ESA states to circumvent these measures, opening new supply channels and markets. From the 1980s, the continental consumption, production and distribution of substances such as heroin, cocaine, cannabis and synthetic drugs grew notably. The impact of this expanding illicit market on development was significant and paradoxically symbiotic. The emerging illicit drug markets were simultaneously a threat to development and security in the region and a new source of economic livelihood for populations of poor and vulnerable communities.[5]

The 1990s saw significant, rapid drug trade expansion across the continent as Afghan heroin began to emerge in volume in East Africa. Shipped by dhow to Kenyan and Tanzanian ports from Pakistan and Iran, initially to be repackaged and trans-shipped to European and US markets, local heroin use began to grow. Heroin use spread along the east coast and to South Africa and island states such as Mauritius and the Seychelles. Across the region

heroin users tended to be among the poorest and most vulnerable members of society. Injection drug use (IDU) soon emerged in Zimbabwe, Zambia, Malawi, Uganda, Rwanda, Burundi, Eswatini, Namibia, Angola and the Democratic Republic of the Congo (DRC). Cocaine, methamphetamine and other synthetic drugs soon followed.

Today, ESA countries have become significant illicit drug transit hubs and destination markets for a diversity of illicit drugs. Growing consumer demand and improved infrastructure have shaped and facilitated the availability and accessibility of illicit drugs across the region. Consequently, domestic and regional drug trade flows and user markets have become embedded features of the region's illicit economies.

Growth in container shipping has shaped drug marketplaces, producing networked hubs of licit and illicit commerce across the region. *© Geof Kirby/Alamy Stock Photo*



ILLICIT DRUG SUPPLY, PRODUCTION AND USE IN EASTERN AND SOUTHERN AFRICA

Eastern and Southern Africa has become a major transit region in the global flow of illicit drugs. Significant quantities of heroin, cocaine and methamphetamine are shipped to and through the region's air, land and sea ports each year. These flows arrive and transit through supply hubs alongside licit trade, and an overwhelming volume of the drug flows remain undetected. It is difficult to fully comprehend the scale of the maritime trade environment, particularly as it relates to the region's coastlines: the area is vast, the traffic patterns varied, and the formal and informal trade flows involve many vessel types and sizes.

Intelligence and research confirm that maritime flows of heroin enter the region via coastal points in Tanzania and central Mozambique. South Africa and Kenya are key entry points for cocaine. Mozambique is also the primary regional entry point for methamphetamine from Afghanistan. Madagascar is increasingly emerging as a significant trans-shipment hub for heroin and cocaine, as well as for the intraregional distribution of these drugs and cannabis. The island is also a significant repackaging and redistribution hub, operating as a break-bulk point (where large shipments of illicit drugs are divided into smaller loads for onward transit). Tanzania and the central coastal region of Mozambique serve this break-bulk purpose for heroin and methamphetamine from Afghanistan, as do South Africa and Kenya for cocaine from Latin America, and South Africa for methamphetamine from Mexico and Nigeria.

Methamphetamine interdicted north of Mayotte in 2024. The growing synthetic drug trade highlights the need for a regional drug observatory to enhance threat monitoring. *Photo: Mayotte Prefecture Facebook page*

These transit hubs and their break-bulk functions are important elements in the regional flow of these illicit substances. They are close to transit points, such as container ports and airfields, have weak governance and surveillance measures in place, and monitoring or enforcement institutions that are easily corrupted or compromised.[6] It is the embedded complicity of such 'brokers' that enables these illicit supply chains to endure.

There is significant transregional trade in these illicit drugs, particularly in flows extending from coastal arrival points to markets inland, networked supply chains connecting the primary and secondary air hubs and sea ports of the region to one another, and strong inter-island and intercoastal trade between Mauritius, the Seychelles, Madagascar, Comoros, Mayotte and Réunion. While much attention in respect of illicit drug trafficking is often fixed on the role of the east and southern African coastline, one should not discount the volume and breadth of traffic within and between the region's Indian Ocean island countries, and how this is influenced by and connected with the region as an evolving illicit market ecosystem.

Drug supply

The supply chains for cannabis are largely intraregional in nature. Unlike other substances, in general cannabis produced in the region is also consumed there. While there is evidence of some additional supply from countries of neighbouring regions, Kenya, Eswatini, Malawi, Tanzania and Uganda have been identified as important origin countries for the supply of cannabis in the region.[7] Lesotho and Madagascar are also source countries for the illicit intraregional cannabis trade.

Heroin in the region originates in Afghanistan, where it is produced from the gum of the opium poppy plant. For many years, Afghanistan has been the world's largest producer of opium and the largest source for its semi-synthetic derivative, heroin. In recent years this has changed, however, after the Taliban government's ban on opium poppy cultivation in April 2022. Since then, the estimated area of opium poppy under cultivation and opium produced have decreased significantly, with annual production estimated to have declined from 6 400 tonnes before the ban to 330 tonnes.[8] Heroin continues to make its way to ESA, however, as Afghan-based production continues with the use of opium stores.[9]

The so-called 'southern route', which connects heroin production points in Afghanistan to East African markets, began in earnest in the 1990s when heroin began to be transported in bulk across the Indian Ocean on dhows. These traditional vessels would dock in international waters and offload their cargo onto smaller craft, such as local fishing boats, which would then ferry the heroin to beaches and other informal harbour sites along the region's unmonitored shorelines. As these criminal networks accrued wealth from the heroin trade, they bought access to major ports through bribery and protection from many officials within the criminal justice systems across the region. This opened heroin smuggling routes using container shipping and airports. In short, one of the most important evolutions in the regional heroin market over time has been geographic, an evolution that implies political and social shifts. Trafficking has shifted from primarily marine-based transport to a variety of transit modes and a proliferation of interior routes. Control of the heroin trade has since moved from coastal ports to the greater logistical and economic benefits afforded by globally connected capital cities, and regional heroin distribution networks have developed in towns and cities across the region.

Despite being a major producer and consumer of cannabis, the African continent has maintained some of the strictest laws regarding its production and use. *© Riana Raymonde Randrianarisoa*

Increasing volumes of cocaine from South American source points are arriving in ESA, particularly the coastal states of Kenya, Mozambique, Namibia and South Africa. Shipments arrive either aboard container ships and other transoceanic vessels, or in smaller volumes by air via West Africa. Most of the cocaine that reaches the region is intended for onward trans-shipment to markets in Europe and Asia, but an increasing amount remains in the region to supply growing domestic consumer markets. Regional flows of cocaine move overland along major cargo transport routes and border points, as well as through airports in Angola, the DRC, Kenya, Malawi, Mozambique, South Africa, Uganda and Zimbabwe. International departure points by air to European, Middle East and Asian markets for cocaine include multi-segment passenger and cargo flights originating in Uganda, Malawi, South Africa, Zambia and, further north, Ethiopia. These shipments are facilitated by corrupt officials at all stages of transit.

The supply of methamphetamine in the region began in South Africa in the early 1990s. This market was rooted in the illicit trade of poached marine resources (particularly abalone) in exchange for precursor chemicals.[10] South African gangs traded abalone to Chinese criminal syndicates in return for chemicals, which they used to produce methamphetamine locally. Nigerian organized criminal groups, which had operated in a brokerage capacity between the domestic methamphetamine manufacturers and local wholesale buyers, shifted to the distribution of their own supply in the region after the emergence and expansion of industrial production labs in and around Nigeria in 2016. Nigerian-based supply chains appear to dominate the flow of methamphetamine into the region, but there is competition.

A significant recent development has been the identification of two new and previously unknown methamphetamine supply chains which are supplying domestic ESA marketplaces. The first emerged in Afghanistan. Shipped along the so-called Afghan heroin 'southern route' to Tanzania and Mozambique, a significant volume of Afghan methamphetamine for the growing base of southern African users has been flowing alongside heroin shipments – often in the same vessels – since 2019. The second production point is in Latin America, under Mexican cartel control. Mexican methamphetamine is shipped to South Africa via Brazil, alongside cocaine shipments on the same route. The emergence of southern Africa as a significant node in the global methamphetamine supply chain involving the cartels of Mexico in the west and the Taliban provinces of Afghanistan to the east has, in many ways, been inevitable.

The growing supply of novel cannabinoid, stimulant and psychoactive chemical compounds from Indian and Chinese production points appears to be a significant new development in the region. Often ordered from online providers and supplied by post, as well as through more traditional air and sea supply methods, these substances began arriving in the region in 2011. Since 2015, they have been identified as a concern in the Indian Ocean island countries of the region in particular, as well as in South Africa's larger cities.

Domestic chemical production of methcathinone, methaqualone and MDMA has been confirmed in Mozambique and South Africa, and is suspected to be taking place in several other countries in the region. These production points are the sources for intraregional flows of these synthetic drugs to neighbouring marketplaces. MDMA is also supplied in volume from European production points, and methaqualone from India, in addition to both being produced locally. Other synthetic substances, such as lysergic acid diethylamide (LSD), ketamine and gamma hydroxybutyrate (GHB), are supplied almost exclusively from European, Chinese and South Asian production and distribution points.

The rise of synthetic opioids has been a significant new characteristic of the regional market. Nitazene compounds from China have been identified through forensic analysis in Mauritius, fentanyl was detected in South Africa in 2024, and both are said to be expanding in the region. While demand characteristics for opioids remain significantly different in the ESA region than in North America prior to the fentanyl crisis that subsequently overwhelmed drug markets in Canada and the US, the potential deterioration of heroin supply chains from Afghanistan may lead to the adulteration of local supplies in anticipation of supply disruption and potency decline.

Finally, the street-based supply of controlled yet diverted pharmaceutical medications, particularly opioids (e.g. tramadol), many of which are diverted from medical facilities, is another emerging concern in the region. This is relevant not only for the impact these substances may have locally, but also because the diversion of such drugs affects domestic pharmaceutical stocks. Palliative care measures rely heavily on pharmaceutical-grade opioids, and stricter enforcement measures to tackle potential stock leakages to the illicit market may have a negative effect on the ability of medical bodies to acquire and maintain sufficient stocks of these medicines.

FIGURE 1 Indo-Pacific route.

FIGURE 2 Lusophone route.

FIGURE 3 Southern route.

FIGURE 4 Asian route.

Drug production

Cannabis production is ubiquitous in ESA. The drug has been cultivated in the region for several hundred years. Although it is produced in every country in the region, the UN has previously identified the DRC, Eswatini, Lesotho, Malawi, South Africa and Zambia as countries with 'probable sizeable' domestic cannabis cultivation and/or production.[11] Madagascar, Tanzania and Uganda also have widespread cultivation of cannabis. Much of the drug is grown for local and regional consumption, though there is growing evidence that some is exported to markets in the EU. This level of domestic illicit production capacity and geography no doubt has expanded in several countries as policies have eased regarding legalizing cannabis for medical and scientific purposes, and with full legalization in South Africa.

Although governments have traditionally taken a prohibitive stance on cannabis cultivation and production, effective interdiction remains a challenge to many. The ubiquity and ease of cultivation across vast stretches of outdoor, often inaccessible, rural environments, the scale of production and the ease with which cannabis is moved to markets all constrain enforcement efforts to disrupt production and supply chains. Eradication campaigns often result in the destruction of only small areas under plantation, and these are often replanted. The role that the limited but growing legalization of cannabis cultivation for medical purposes will have on illicit production dynamics in the region remains an area for additional inquiry. The most challenging element affecting the further growth of illicit cannabis cultivation and production in the region is not the risk posed by law-enforcement interdiction or other government control measures: it is far more fundamental. Access to water for crop irrigation, in sufficient quantities and from reliable sources, is the greatest limiting factor to illicit cannabis cultivation and yield, and to its future growth potential.

Shards of Afghan-origin crystal meth. The proliferation of synthetic substances is one of the region's greatest drug challenges. *© David Mansfield*

The presence and use of methamphetamine in the region has often been described as a localized issue (usually in relation to use of this drug in the Western Cape province of South Africa) or a minor reporting concern in relation to the potential or actual diversion of related controlled precursor chemicals. However, such perceptions are outdated and, to a point, only compound the incomprehension about what has become a vibrant regional drug industry with continental and global ramifications. 'Crystal meth' is manufactured in the region in rapidly increasing volumes for domestic consumption and sale into international supply chains. Industrial-scale production has been alleged or confirmed in Kenya, Mozambique, South Africa and Zimbabwe. Recently, Nigerian-based industrial production flows have taken a predominant role in the supply of methamphetamine markets in the region. Nigerian methamphetamine, produced in large volumes and with high levels of purity, has been available in the region since 2016. Methamphetamine produced in Afghanistan and Mexico is also a significant and growing contributor to the markets of the region.

Heroin is synthesized in production points in Afghanistan, Pakistan, and to a lesser degree Iran. There is no opium poppy cultivation or heroin production in the ESA region. Heroin marketed in the region originates in Afghanistan, though there is evidence of some originating in South East Asia.[12] The same absence is true for cocaine. While there have been attempts to cultivate coca in highland areas of the continent, currently there is no known coca cultivation or cocaine production in the region. The cocaine found in the region originates from cultivation and production points in the Andean countries of South America.

Several other synthetic drugs are produced in clandestine labs across the region. Domestic synthesis of methamphetamine, methcathinone, MDMA, methaqualone and synthetic cannabinoids has been verified in Kenya, Mauritius, Mozambique and South Africa. Local production is suspected in other ESA countries.

The alarming recent emergence of synthetic opioids in ESA is due to the vigorous illicit trade in precursor chemicals in the region. These include controlled chemicals such as ephedrine, pseudoephedrine, safrole and red phosphorus, which originate from chemical production suppliers in India and China. A smaller volume may be diverted to the regional illicit market supply chain from African and European pharmaceutical and chemical production points. Although some of these scheduled substances have licit chemical uses, such as in the production of medicines or plastics, their diversion from a licit trade flow to an illicit one is a common occurrence that is rarely policed with any efficacy.

Drug use

Cannabis is the most used illicit substance in the region and across the continent. It is available and used in every country of the region, most commonly in its herbal (dried) form but also as a resin (commonly called hashish). Cannabis is smoked in its dried and resin forms or ingested as an edible product on its own or combined with other foodstuffs.

In the early days of heroin use in the region, consumption was predominantly through inhalation. This was because the form of Afghan heroin commonly available was consumed most easily in this manner. Around 2000 there was a significant change in the type and consumption method of heroin in the region. The Afghan supply chain had suddenly contracted and its product had temporarily vanished from the streets. It was replaced by a new, white heroin allegedly from South East Asia.[13] Not easily consumed through inhalation, this new form of heroin was believed to be more effectively used by injection drug use (IDU). In a matter of months, a means of consumption that had hitherto been largely peripheral in the regional heroin market became the dominant means of use. IDU was adopted by a growing number of coastal heroin consumers and continued along the growing transregional heroin flows that began to infiltrate communities of the regional interior. It proved more efficient than smoking in delivering the desired high – particularly for users with a high tolerance or dependency level.[14]

Today heroin is available across ESA in powder and 'stone' form. Both are heavily adulterated products. Where prevalence statistics are available, IDU is estimated to be the mode of consumption for 10%–50% of PWUD in heroin-using communities. Inhalation remains a common form of consumption, and heroin is also smoked in mixtures with cannabis (e.g. nyaope). It is sometimes snorted in the same way as cocaine powder.

Cocaine is available in powder and 'crack' forms in every country in the region. Cocaine powder is snorted and sometimes ingested or inhaled. Crack cocaine, a mixture of cocaine powder and baking soda that forms small pieces ('rocks') when it dries and hardens, is smoked or inhaled. In the region, cocaine powder is five to seven times more expensive than crack cocaine, and generally favoured by consumers with more disposable income. Crack cocaine is estimated to be the most common form of cocaine consumed in the region, due to its lower price and the greater diversity of distribution outlets. There are also reports in several countries of cocaine being injected.

Enforcement strategies need to be refocused around disrupting trafficking and organized crime elites, and away from the arrest and detention of people who use drugs.
Photo: GI-TOC

Methamphetamine is available in all countries of the region. It is becoming the dominant substance used in a growing number of communities where it has displaced crack cocaine as the illicit stimulant of choice. Found only in crystalline form to date, it is usually smoked. However, a growing number of methamphetamine users in the region say they inject it.[15] Recent estimates suggest the consumer base for methamphetamine in South Africa, the country with the largest consumption in the region, appears to be significantly greater than initially imagined, making it potentially one of the largest methamphetamine consumer markets in the world.[16] Meth also has market footholds in Eswatini, Lesotho, Botswana, Mozambique, Malawi, Zambia, Zimbabwe, Uganda and Kenya. It is inevitable that meth will penetrate every other drug market of the region, and its availability, accessibility and use will increase.

While methamphetamine is the most used synthetic drug in the region, it is not the only one. Methaqualone, a sedative that pre-dates the use of methamphetamine in the region and originates in South Africa, is available for use in several regional countries. Sold in tablet form, methaqualone is crushed, mixed with cannabis and smoked. Methcathinone, another stimulant manufactured in the region, is consumed in several countries. Often with a cheaper retail price than methamphetamine, methcathinone is sold in some local drug markets as a methamphetamine substitute. Also called 'cat', it is snorted, smoked and sometimes injected. MDMA is a psychoactive substance that is consumed in tablet and powder form. Its use is particularly associated with nightlife entertainment venues, including bars, nightclubs and similar establishments.

The consumption of other new psychoactive substances, such as the evolving array of synthetic cannabinoids and stimulants, has grown over the past four years. This has been a development of particular concern for several western Indian Ocean states. Mauritius, for example, is experiencing a significant increase in the use of synthetic cannabinoids. A shared feature of these substances is that they are synthesized to mimic the effects of known illicit substances. This means they often fall outside the established regulatory system for illicit substances and exist ambiguously between the legal and illegal domains. It is likely that their availability and use in drug markets of the region will increase, particularly as a more easily concealed substitute for herbal cannabis.

Key takeaways by the Commission

ESA drug markets are diverse, expanding and internationally networked

Illicit drug markets are no longer confined to the coastal periphery or the region's growing urban centres. Nor is the market dominated by cannabis smokers and a few 'hard' substance users. Heroin, cocaine and synthetic drugs are widely available across the region. Drug use occurs in all secondary and tertiary towns and settlements. International drug supply chains connect foreign industrial production points to the domestic markets of the region, no longer simply passing through to points further downstream, but instead supplying domestic markets and their growing number of consumers. With a diversity of substances and modes of use, the region's many domestic drug marketplaces should be viewed as socially embedded, structurally resilient and geographically expansive.

Marginalization, poverty, vulnerability and inequitable development policies and programmes are contributing to the growth in illicit drug markets and their related harms

Urbanization in Eastern and Southern African countries is expected to increase by 74.3% and 43.6%, respectively, by 2050.[17] Five of the top 20 fastest-growing cities in the world are found in the region. Even before the negative developmental consequences of the COVID-19 pandemic, the region was suffering from a period of inadequate investment in housing, transport infrastructure and other social services. This underinvestment has compromised potential socio-economic and infrastructural development gains, and exacerbated existing environments of poverty, sanitation, unemployment and insecurity in many cities and towns across the region. The situation has been aggravated by the corresponding absence of widespread industrialization, something that developed alongside urbanization in other parts of the world. Historically, industrial work has provided mass employment for uneducated or low-skilled populations, as well as providing tax revenue which governments can reinvest in infrastructural development.[18] These developmental challenges have influenced drug market evolution in the region.

For example, the growth in the use of synthetic drugs such as methamphetamine can be seen as a consequence of the region's urban development inadequacies. The drug's regional proliferation flows from policies and environments of inequitable, unsustainable development, and it is quickly occupying the deteriorating spaces of the growing number

of marginalized and victimized communities facing limited opportunities for licit socio-economic prosperity. This situation was exacerbated by COVID-19 and the restrictive measures to stop its spread. While lockdowns failed to disrupt the production and distribution flows of local methamphetamine (and other illicit drug) markets, they contributed to decreased personal mobility and a correlated increased economic precarity among societies' poorest people. Consequently, demand for methamphetamine has remained strong in existing regional marketplaces, and is growing in markets where it was once absent.

The arrest of smallholder farmers for illicit crop cultivation and the destruction of their meagre livelihood has impoverished innumerable rural households. National prison populations have expanded in some places to over-capacity levels of 250% and more as state security and judicial structures have responded to the political push against the 'drug threat' by arresting and incarcerating vast numbers of poor people for drug-related crimes. Subsequently, generations of young people have become disenfranchised due to criminal convictions earned for low-level drug crimes, such as drug use or possession of small quantities of drugs for personal use. Disproportionately high unemployment and underemployment rates continue to plague people who use (or used) drugs, especially those who have been marginalized by a criminal conviction for low-level drug offences.

Country	Prison system occupancy level (%)	Rate of incarceration (per 100 000)
Botswana	86	161
Comoros	161	46
Eswatini	120	243
Kenya	177	107
Lesotho	71	104
Madagascar	278	98
Malawi	236	76
Mauritius	177	197
Mozambique	248	67
Namibia	75	318
Seychelles	54	n.d.
South Africa	149	258
Tanzania	109	50
Zambia	265	125
Zimbabwe	130	138

FIGURE 5 National prison occupancy levels and rates of incarceration in Eastern and Southern Africa (2024 or latest year available).

SOURCES: For occupancy levels, see World Prison Brief, Institute for Crime and Justice Policy Research, and Birkbeck, University of London, 2024; for incarceration rate, see Emily Widra, States of incarceration: the global context 2024, Prison Policy Initiative, June 2024.

We overestimate what we think we know about regional drug markets

African drug markets, and particularly ESA markets, continue to be under-researched, and the absence of evidence-based market information is often replaced by political prognostication, misguided analysis and inaccurate proxy metrics. In most countries of the region, there is no reliable determination of some of the basic marketplace denominators needed to assess a drug market, the harms it is creating or the relative effectiveness of measures put in place to address these. Fundamental metrics that lack evidence-based quantification include the numbers of PWUD; which drugs they are consuming, and how; and the frequency of their consumption. In the absence of such basic information, it is not possible to mount an effective national response to illicit drug markets or to measure the effects of such a response. The result is that we tend to underestimate the size and diversity of domestic markets, their relevance and relationships, and the harms they cause; and we tend to overestimate or overdramatize the impact of law enforcement-based interdiction measures on these markets and their flows.

Drug policies that focus on domestic enforcement and interdiction of supply are not working, as drug supply and consumption appear either to be stable or increasing across the region. *© Carl De Souza/ AFP via Getty Images*

Admittedly, there are attempts to quantify fundamental drug market metrics in some regional countries, but many of these are based on imperfect methods that inevitably produce imperfect results. For example, the use of drug seizure data and drug treatment-seeking data are common measures employed by some national government agencies to understand drug markets and develop policy responses. However, if a drug is not seized in a country, it does not mean it is not available, nor does the volume of seizures have any definitive correlation to the characteristics of use or supply in a particular marketplace.

Similarly, the absence of people seeking treatment for a substance does not, on its own, create a realistic picture of the characteristics of local drug demand or drug-use behaviour. Hypothetical thinking that attempts to base conclusive decisions on inconclusive data and results has hampered the ability of policymaking bodies in the region to see that the lack of independent, science-based drug monitoring systems makes it impossible for countries to accurately assess how their drug market environments are evolving and growing.

The diversity of substances available in local drug markets has increased, with new synthetic drugs beginning to challenge more traditional substances, such as cannabis. Markets for some drugs have emerged in places where they were not previously available. Heroin and cocaine have moved from their coastal origins to inland countries. Local methamphetamine production has been supplanted by international industrial-based production and supply chains.

The 'commodity portfolios' of the region's illicit drug distributors are more diverse in their offerings and more secure in their delivery. Many substances are moving through the same routings, vessels, ports, break-bulk points, storage facilities and transport vehicles. Secondary and tertiary towns and settlements now have their own vibrant retail drug markets, particularly for substances such as heroin and crack cocaine. Poly drug use has become the norm in most regional markets, while IDU, with its links to HIV and hepatitis C virus (HCV) transmission, has permeated the entire region.

Strict drug prohibition is not resulting in illicit market disruption

The dominant drug policy approach in the region, founded on the implementation of strict prohibition measures, is failing to disrupt or reduce ESA illicit drug markets. 'Tough on drugs' laws and mandatory minimum sentences are not stopping or reducing illicit drug supply or consumption. The domestic drug markets of the region continue to persevere; the costs of perpetuating these drug policy regimes grounded in strict criminalization, arrest and incarceration of PWUD and low-level actors remain high; and the return on this investment – in terms of less harm, in all its senses – remains poor.

Weak, compromised and corrupt governance structures, institutions and agents broker and sustain regional drug markets

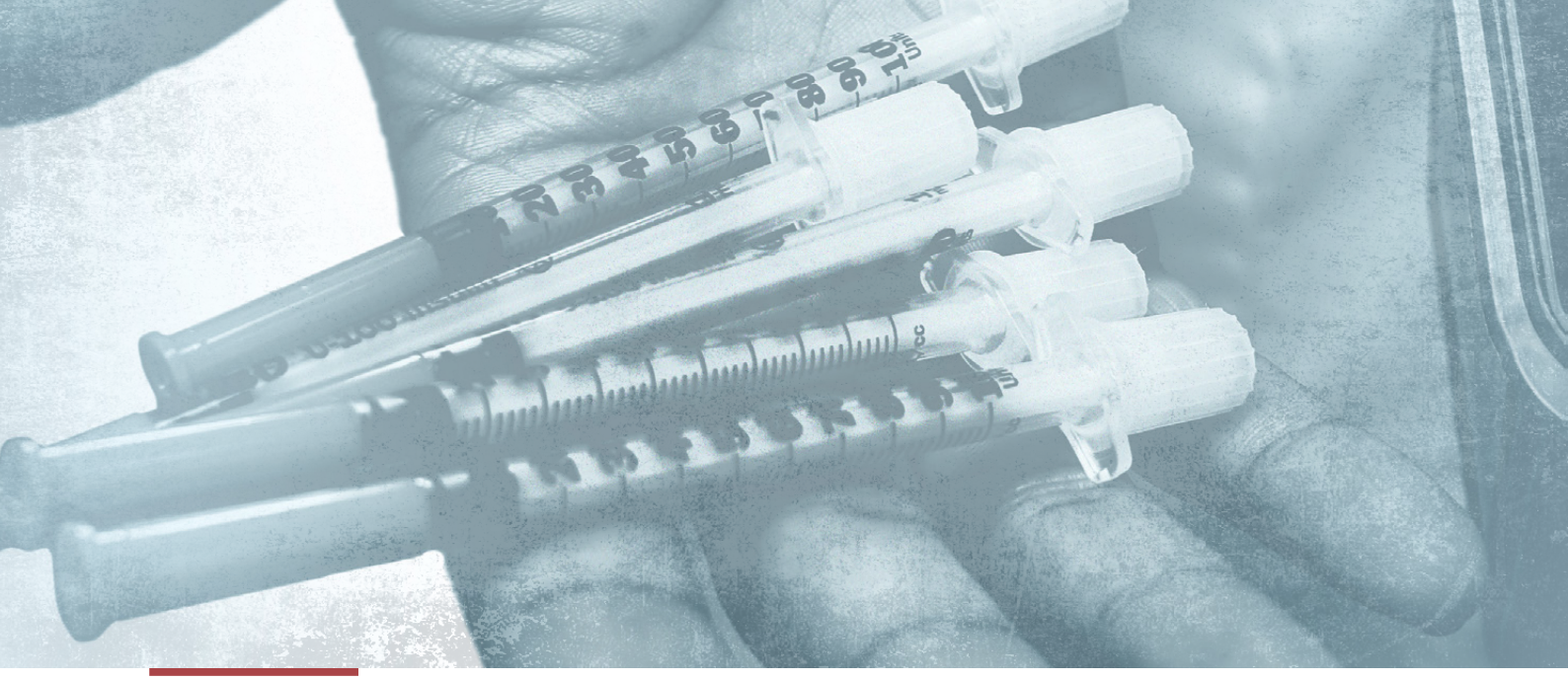
It has frequently been acknowledged throughout the consultation process that some law enforcement and other government officers are corrupt, enabling rather than disabling illicit drug markets. The corruption of domestic enforcement institutions may be the single greatest structural enabler of drug markets across the ESA region.

Incompetence among some officials in the execution of their duties and responsibilities is also a fundamental concern of every enforcement body in the region. There are no serious attempts to disrupt corrupt practices, and no government appears to have demonstrated a willingness to end the structural components of endemic corruption, apart from employing 'anti-corruption' language for politically expedient purposes such as the 'settling of scores', the muzzling of opposition voices or the disruption of democratic principles.

We must acknowledge, therefore, that illicit drug 'shadow economies' are significant components of regional and national gross domestic product. As such, reform of national drug policies and legislation alone is insufficient to foster effective, sustainable development solutions, or to reduce the pernicious influence of these drug-related marketplaces and the corrosive impact of their trade on national development efforts. Policy solutions must mirror the illicit regional market in its structural complexity, and be designed to substantially undermine the power and influence of market structures, and displace their national and regional brokers. They must also be the product of a fundamental effort to undermine these enablers beyond the intuitive yet traditional health, security and social services-oriented approaches to drug policy governance. Long-term multi-dimensional policy approaches integrated into national sustainable development programmes addressing the structural drivers of inequity, vulnerability and human insecurity would mark a positive, fundamental shift in regional drug policy approaches to trafficking and use in the region.

Cannabis policy appears to be an opening for wider reform discussion

Some ESA countries have legalized cannabis in various ways, many for medical and scientific purposes, others for reasons of production and agricultural investment and, in South Africa, for personal use at home. In its meetings and conversations, the Commission has realized that when it comes to cannabis policy, many senior leaders and their constituent governments are more open to discussing policy reform and, in several cases, legalization as a policy solution. Cannabis has always been a curious drug for enforcement. While being de jure illegal in all countries, in many it was treated as de facto legal or, at the very least, as less consequential than what were perceived to be the 'harder' substances – cocaine, heroin, synthetics. In its work to date the Commission has convened regional discussions in Maputo and Gaborone on the nature of cannabis legalization. In both cases, the states present demonstrated curiosity about the potential benefits of such a policy decision in practice, and through discussion about cannabis policy reform they were found to be more receptive to other drug policy and programme response reform possibilities, such as for harm reduction or revised approaches to the policing of drug markets. As such, cannabis policy has been, and may continue to be, a lever with which to open wider discussion about new public health and public security approaches in response to the harms caused by ESA drug markets.



ILLICIT DRUGS IN EASTERN AND SOUTHERN AFRICA: A PUBLIC HEALTH–BASED OVERVIEW

There has been a marked increase in the use of heroin, methamphetamine and cocaine in Africa over the past two decades.[19] Concurrently, IDU is becoming more common across ESA countries,[20] and 14 million additional people are expected to use drugs in sub-Saharan Africa by 2050.[21] Women who use drugs (WWUD) face high levels of violence, stigma and barriers to services.[22] Infectious disease transmission is most acute in relation to people who inject drugs (PWID) and among people in prison.[23] People with opioid dependence are much more likely to die than people in the general population.[24] HIV epidemics among PWID expand in countries without established harm reduction services.[25] The HIV prevalence among PWID is estimated at 16.1% across countries in ESA, compared with 5.7% among the general adult population in the region.[26] Even so, there was a 41% reduction in new infections among PWID in the region between 2010 and 2023, a testament to health policy and programming targeting this sub-population.[27]

Concentrated HCV epidemics exist among PWID in the region.[28] In sub-Saharan Africa, 74% of PWID who are living with HIV have HIV-HCV co-infection, and 14% have HIV-hepatitis B virus (HBV) co-infection.[29] The TB burden among PWUD is high.[30] This is due to high HIV prevalence, poor nutrition and frequent incarceration of PWUD.[31] PWUD were particularly affected by the COVID-19 pandemic.[32] Human rights violations, violence, limitations on movement, involuntary detoxification and interruptions in health and harm reduction services were recorded among PWUD across Africa, including in ESA.[33]

Drug use prevention and treatment

Drug use in Africa is common and increasing.[34] In 2022, there were an estimated 3.6 million opiate users (predominantly of heroin), 2 million cocaine users and 2.7 million amphetamine type stimulant users on the continent,[35] and an estimated 300 000 PWID in ESA.[36] By 2050, it is estimated that an additional 14 million people will use drugs in sub-Saharan Africa.[37] The most commonly used drug across the region is cannabis[38] but an increasing proliferation of synthetic drugs are permeating regional drug market inventories, both as substances for use and as substance adulterants or contaminants.[39]

Drug use prevention

Prevention aims to avoid or delay the onset of drug use, and stop the development of drug dependence. Early onset of frequent drug use is associated with drug dependence in later life. Therefore, the healthy and safe development of

People who use drugs need to be included as essential participants in the development and implementation of drug policy. *Photo: GI-TOC*

children is critical for prevention. Effective interventions foster protective norms and behaviours, mitigate vulnerabilities and address structural issues that contribute to potential drug use, drug dependence and their consequences. Impactful prevention responses necessitate a comprehensive mix of interventions focusing on different human developmental stages and delivered in a range of settings. Interventions to improve parenting skills or increase school retention rates are important during childhood; programmes targeting schools, workplaces, entertainment venues and the media can influence risk in older age groups.[40] Early identification of potentially harmful substance use followed by a brief intervention is effective in preventing progression to substance dependence.[41]

Harm reduction is an evidence-based approach to drug policy and interventions that is rooted in social justice and human rights.[42] Interventions designed to prevent harm empower people to make decisions on ways to reduce immediate risks (notably death and infectious disease) and support them in achieving their goals.[43] The World Health Organization's (WHO) comprehensive package of harm reduction interventions for people who use and inject drugs includes needle and syringe programmes (NSPs), opioid substitution treatment (OST) and community distribution of naloxone, as well as testing and treatment of HIV, viral hepatitis B and C, sexually transmitted infections and TB.[44] All these interventions should be included in a comprehensive drug use prevention strategy.

Speaking at the opening of the African Union's (AU) fifth ordinary session of the specialized technical committee on health, nutrition, population and drug control, the WHO director-general noted that 40 000 Africans die annually from psychoactive drug use and related health conditions. He also noted that 80% of Africans with mental health or substance use disorders receive no treatment for their conditions.[45] These remarks highlight the importance of recognizing that public health services' availability and access for PWUD are vastly insufficient across the continent, and across the ESA region in particular.

Drug dependence treatment

Access to evidence-based treatment of drug dependence is a universal right.[46] The objectives of drug treatment for people with drug dependence are improved health and quality of life, improved social functioning, reduced harms, and changes in drug use aligned with an individual's goals. Effective treatment requires diversified psychosocial and medical (pharmacological) interventions that should align with international standards. There are three broad components of drug treatment:

Screening, brief interventions and referral for treatment: Screening of alcohol, tobacco and drug use should be done in a range of non-specialist settings (e.g. primary healthcare and social service sites) using a validated tool. People using substances should receive a brief intervention (5–30 minutes) which includes individualized feedback with advice on reducing/stopping use, and an offer of follow-up. This intervention can prevent progression to more harmful use or dependence. People with ongoing problems should be referred for further care.[47]

Psychosocial interventions: These interventions can support reduction and cessation of drug use, and reduce frequency of return to use among people with drug dependence. They address motivational, behavioural, psychological and psychosocial factors that contribute to drug use. Their effectiveness varies according to the drug(s) of dependence. Several

evidence-based interventions exist, including cognitive behavioural therapy, contingency management, motivational interviewing, the community reinforcement approach, family-oriented treatment approaches, and mutual-help groups.[48] The outcomes of people with opioid dependence who receive only psychosocial interventions (i.e. without medical treatment) are poor.[49]

Pharmacological interventions: OST as maintenance is the recommended treatment for opioid dependence.[50] It involves the prescription of an opioid agonist medication (e.g. methadone or buprenorphine) by a trained medical provider at an appropriate dose for as long as a person requires it. Engagement in psychosocial services increases OST effectiveness. Quality OST results in reduced opioid use, all-cause mortality, HIV and HCV transmissions, enhanced social functioning, reduced crime and improved adherence to HIV treatment.[51] Withdrawal management (sometimes referred to as detoxification) involves the management of symptoms linked to stopping drug intake in a person with dependence. This is critical for people dependent on a nervous system depressant (e.g. opioids, alcohol and benzodiazepines). Withdrawal management should follow evidence-based protocols. The outcomes of withdrawal management for opioid dependence are poor and associated with increased risk of overdose. Naltrexone, a long-acting opioid antagonist medication, can support efforts to prevent return to opioid use after detoxification among people who are motivated, where OST maintenance is unavailable or if use is based on client preference.[52] There are no effective pharmacological treatments for dependence on amphetamine-type stimulants or cocaine.[53]

Access to harm reduction and evidence-based prevention and treatment services, including opioid substitution therapy, needs to be universal and guaranteed. *Photo: GI-TOC*

Drug dependence treatment gap

In Africa, only one in 18 (6%) people in need of drug use treatment can access it.[54] Quantification of the drug dependence treatment gap in ESA is difficult, partly due to limited estimates of the number of people with drug dependence and limited centralized reporting. An indication of the drug dependence treatment gap can be made based on reported drug treatment data (minus cannabis),[55] regional annual drug use prevalence estimates,[56] population estimates,[57] and the assumption that 10% of PWUD have dependence.[58] Despite the many limitations of this method, the large treatment gap is evident.

Most of the available drug treatment services in ESA are provided in mental health facilities, often in hospital settings. Community-based psychosocial treatment services and detoxification services are also provided in most countries. However, only seven ESA member states have harm reduction programmes that include OST maintenance[59] and only four provide OST in prisons.[60] Psychosocial interventions and pharmacotherapy (including OST for people with opioid dependence) should be provided in prison settings as part of a comprehensive package of health services.[61] Drug-related services should be provided to people in police custody while awaiting trial, and continuation of treatment upon release is important to reduce post-release overdose risk and to support health.[62]

Further, overdose identification and management is an important public health feature that should be included in all drug treatment policy frameworks. Naloxone is a short-acting opioid antagonist that rapidly reverses opioid overdose. Naloxone should be available in all ESA community settings to people who are likely to witness an opioid overdose (e.g. PWUD and their family members, peers and police) in order for them to administer it.[63] Stimulant overdose may occur and requires stabilization of cardiovascular function and attention to hydration and management of neurological symptoms.[64]

The AU Plan of Action on Drug Control and Crime Prevention[65] provides policy direction for member states. International standards on drug prevention and treatment, and evidence-based guidance for harm reduction and clinical interventions, exist to maximize quality. The multifactorial causes of drug dependence necessitate responses that adopt an all-of-society approach. Unless evidence-based reforms are translated into policy – and implemented – drug dependence responses will fail.

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

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

There is a need to shift the emphasis from specialized drug treatment services in mental health facilities towards early intervention in community settings. Significant scale-up of interventions is needed to meet the drug dependence challenge. Effective collaboration across sectors and across the prevention-harm reduction continuum will be important, as these interventions will be a significant departure from previous policy and operation paradigms in many countries.

The AU Plan of Action on Drug Control and Crime Prevention outlines an intention to engage in prevention and treatment of drug use through training (i.e. parental skills training and life skills training for children and young people), harm reduction and implementing alternatives to punishment for drug use.[66] The plan provides a clear evidence-based policy framework. Assessing the baseline of country responses is challenging, however, due to a chronic lack of data on prevention interventions, drug treatment and harm reduction coverage. Since the adoption of the AU plan, there has been a mixed policy response in ESA countries. The criminalization of drug use and possession for personal use was identified as a challenge to programme implementation in all countries in the region (apart from cannabis in South Africa).

In contrast, some countries include public health interventions in their national drug policy while simultaneously imposing high penalties for drug possession. Since 2019, several countries have pledged to develop policies aligned with the AU Plan of Action. Support for evidence-based harm reduction interventions, including OST, is more common in HIV-related policy than for OST as part of evidence-based treatment for opioid dependence. In other words, countries that have adopted OST as an activity have done so generally in the context of a national prevention programme response for HIV transmission among PWUD, not simply as a standalone drug treatment programme solution targeting drug dependence among the national population of PWUD.

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

Encouragingly, more emphasis is being placed on evidence-based prevention, treatment and harm reduction. However, the persistence of punitive approaches in policy continues to contribute to a hostile environment for PWUD, and is probably a barrier to service access and persistence in care. Most countries in the region rely on provision of services within specialized mental health facilities, while many provide community-based services run by civil society organizations. Detoxification services are available in 10 countries in the region[67] but only seven[68] have established OST services (ranging from one to 42 OST sites per country). OST is provided in at least one prison in four countries.[69] Coverage of OST services for opioid-dependent PWID is far below the targets needed for HIV and viral hepatitis epidemic control.[70]

Infectious disease transmission

Drug policy affects health[71] and contributes to the environment in which drug use takes place and the transmission and effects of infectious disease.[72] Ending the epidemics of AIDS, TB and hepatitis by 2030 (included as part of target 3.3 of the UN Sustainable Development Goals) requires that the specific needs of PWUD are accounted for.[73] The dominant drug policy approach in ESA has been based on the criminalization of specified drugs, their possession and use.[74] Criminalization, incarceration, stigma and exclusion resulting from this policy approach have increased the infectious disease burden in Africa.[75] Consequently, the AU has adopted a plan of action on drugs that aligns with the principles of human rights and public health.[76] Most national HIV strategic plans of countries in ESA define PWID as a key population in need of tailored interventions, and several include the need for policy reform.

The WHO has defined a clear set of recommended health interventions and policy recommendations to address HIV and related comorbidities among PWUD in community and prison settings.[77] Core harm reduction interventions include NSPs for PWID, OST for people with opioid dependence, other evidence-based drug treatment interventions, and the prevention and management of overdose. Prevention, testing and treatment of HIV, viral hepatitis, TB and sexually transmitted infections, as well as sexual and reproductive health services for PWUD, should be layered onto harm reduction services. Other important interventions include the decriminalization of drug use, combating stigma and discrimination, ensuring the acceptability of services, empowering community members and addressing violence.[78]

Needle and syringe programmes are an essential part of harm reduction strategies for people who inject drugs. *Photo: GI-TOC*

In Africa, the risks of infection with HIV, HBV, HCV and TB are higher among PWUD than in the general population.[79] Risks of infection are particularly high among PWID.[80] These infections are responsible for much disease and death.[81] Modelling data suggests that between 2018 and 2050 the prevalence of annual drug use will increase by 5% in the ESA region. This increase of about 14 million people[82] will be fuelled by increased drug availability, economic development, population growth and urbanization.[83]

HIV epidemics among PWUD in Africa are expanding. HIV can be transmitted via blood or through unprotected sex, as well as vertically from mother to child.[84] The ESA region saw a 59% decrease in new HIV infections, a 57% decrease in AIDS-related deaths and a 41% decrease in new HIV infections among PWID between 2010 and 2022.[85] However, the prevalence of HIV among PWID in the region remains nearly three times higher than among their counterparts in the general population (16.1% vs. 5.7%).[86] That HIV seroconversion among PWID has almost halved in a decade is a demonstration of the effectiveness of prevention programming, and particularly harm reduction. Seven ESA countries provide OST, seven provide NSPs and one provides for peer distribution of naloxone.[87] Further evidence of efficacy comes from analyses of national harm reduction programmes in Mauritius, Tanzania and Kenya, with findings that these interventions have significantly reduced new HIV infections among PWID.[88]

The COVID-19 pandemic highlighted additional vulnerabilities affecting PWUD.[89] Globally and in the ESA region, access to harm reduction services was negatively affected. For example, in South Africa people experiencing homelessness were placed in emergency shelters without planning to manage opioid withdrawal or continue harm reduction services.[90] In Kenya, NSP and OST services were temporarily interrupted and adherence to OST and antiretroviral therapy was negatively affected.[91] In Tanzania, increased vulnerabilities of WWUD, many of whom engaged in sex work, were

highlighted alongside challenges in accessing harm reduction services.[92] In parallel, the benefits of harm reduction were demonstrated in locations where COVID-19 responses adopted them.[93] The WHO has reaffirmed that NSP and OST are essential health services that should continue uninterrupted in emergency health and pandemic situations.[94]

As such, national drug policies need to provide explicit support for harm reduction interventions. Harm reduction and integrated HIV, TB and viral hepatitis services are required to end these epidemics. The WHO has set a target of 300 injecting packs per person who injects per year[95] and 50% OST coverage[96] to end HCV and HIV as public health threats among PWID by 2030. ESA countries are making weak progress towards meeting these goals, as well as meeting Joint United Nations Programme on HIV and AIDS (UNAIDS) HIV treatment and viral suppression targets for PWID. Still, ESA countries that have committed to harm reduction interventions are demonstrating the positive impact on their HIV epidemics among PWID. Several have demonstrated reductions in HIV prevalence in repeated cross-sectional surveys after sustaining and expanding their harm reduction programmes.[97] The evidence is clear that harm reduction works, and that it works in the ESA region, in particular.

Further, decreasing incarceration rates would have a significant impact on reducing HIV, HCV and TB infections among PWUD in ESA.[98] In communities of PWID with an HIV prevalence over 5%, incarceration is estimated to contribute to 12%–55% of infections – largely due to incarceration and increased drug use practices post-release, as well as disruptions in drug-related treatment.

Finally, decriminalization of drug use alongside access to harm reduction services has been found to significantly reduce drug-related deaths and infectious disease transmission.[99] In Portugal, the decriminalization of drug use (in 2001) and allocation of resources to finance harm reduction and drug treatment services reduced drug-related deaths and drug-related prison offences, as well as halving new HIV infections.[100] Similar public health gains have been noted in the Netherlands, Switzerland and the Czech Republic where decriminalization has been implemented.[101]

Access to essential medicines

Since international drug control bodies began instituting strict control of essential medicines[102] to combat the opioid crisis, the response has led to a different kind of global health crisis that particularly affects lower-income countries: severely limited access to medicines for palliative care. Opioids[103] such as morphine are cornerstone therapeutic agents of the internationally controlled essential medicines (ICEMs),[104] used for the treatment of moderate to severe pain, critical care, terminal breathlessness, neurological conditions, anaesthesia, obstetrics, mental health and palliative care.[105] Between 2010 and 2013, only 0.03% of the opioids distributed globally went to low-income countries.[106] The issue of inadequate access to essential medicines for palliative care around the world persists and presents a particular threat to low-income individuals in ESA.

In April 2021, at the annual meeting of the Commission on Narcotic Drugs, the African Group expressed 'grave concern about the access, availability and affordability of medicines, including pain-relieving drugs, for millions of people who need them most on the African continent'.[107] In 2015, it was estimated that nearly 17 million people in sub-Saharan Africa had serious health-related suffering – the second largest population by subregion, after East Asia – and were in need of essential medicines for palliative care.[108] Yet access to palliative care medicines in Africa is the lowest of all major subregions and has decreased since 1994, while access has vastly increased in other subregions.[109] On average, the African opioid consumption rate is 50 daily doses per million per day, compared with 14 320 in the US, which has the highest global consumption rate.[110] This is despite the fact that an ageing population, the HIV epidemic and noncommunicable diseases have created a marked need for ICEMs in Africa.

As an example, palliative care is required to alleviate pain from serious health-related suffering caused by several life-limiting and life-threatening conditions. The global burden of serious health-related suffering is projected to escalate by 78% by 2060. In other words, an estimated 48 million people will die while enduring significant avoidable health-related suffering.[111] As a result, all WHO member states have pledged to integrate palliative care into primary healthcare.[112] However, these services remain largely underdeveloped in low- to middle-income settings, where over 80% of patients with conditions that require palliative care live. Lack of access to opioids is a significant component of this issue, limiting effective integration of palliative care into other essential health services, such as cancer treatment and control, and impairing health workers' ability to deliver effective palliative care.[113] The laws and policies underlying the limited access to ICEMs in most lower- and middle-income countries, including on the African continent, are rooted in practices dating

back to colonial-era treaties designed to contain the commodification of opium, which was legally marketed and sold throughout the British empire.[114] Although the use of opioids as a therapeutic substance was historically overseen by traditional healers and the medical profession, non-medical use of opioids and other controlled substances has slowly grown into the 'world drug problem'. Notwithstanding the illicit use of these substances, the therapeutic properties of opioids, especially the opium 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 Africa, HIV/AIDS is the largest source of serious health-related suffering requiring palliative care, with 77% of the need stemming from HIV. In general, between 54% and 83% of HIV patients experience pain of moderate to severe intensity.[115] In spite of medical progress, reported pain rates have not diminished in the past 30 years and under-treatment of pain remains an issue. A survey of the availability of ICEMs for managing HIV-related pain and symptoms in East Africa showed a concerning lack of availability of opioid formulations for children and adults.[116] This is particularly troubling. Even though the number of AIDS-related deaths has decreased by 57% in ESA, from 600 000 [490 000–770 000] to 260 000 [210 000–330 000] between 2010 and 2023,[117] the region still has an acute unmet need for ICEMs.

Key takeaways by the Commission

Public health implications of the region's approach to drugs, once showing progress, are now grim

The region is vastly underprepared and under-resourced to address the health, security and welfare requirements of its domestic populations living in environments of emerging and maturing illicit drug marketplaces. With the continent already home to 69% of the world's population living with HIV, the rise in African consumption of opiates and an increase in IDU has led to a correlated increase in HIV and HCV transmission among communities of PWID.[118] HIV seroprevalence rates among PWUD in these areas have been as high as 87%.[119] Morbidity and mortality among PWUD increased markedly as their adherence rates for antiretroviral medication (for treatment of HIV) decreased, stigma and discrimination by health officials and law enforcement against PWUD increased,[120] and fatal and non-fatal overdose rates grew.[121] Access to prescription medicines – opioids, in particular – has failed to improve across the region due to misdirected drug control enforcement initiatives targeting heroin and other drugs; subsequent health institutional reluctance to use the substances involved; and counterfeiting and diversion by criminal groups of pharmaceutical commodities from licit streams into illicit markets.[122]

The recent acute reduction in international donor funding available to support drug-related health programming in the region has exacerbated an already challenging situation. Many of the existing PWUD and PWID targeted programmes that populated the harm reduction service space of ESA lacked national budget support and were, in most cases, heavily reliant on external donor funding. The sudden reduction in external funding available is likely to see many programmes ended, alongside the possible closure of numerous PWUD-focused community groups.[123]

Across the region, there appears to be a huge drug dependence treatment gap

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

Access to essential medicines requires immediate attention

The lack of essential medicines for the relief of severe pain and suffering, including for anaesthesia, trauma, obstetrics, neurological disorders and palliative care, is a persistent challenge in the region. Unlike many other essential medicines, opioids required for these applications are subject to strict international control due to concerns that they contain substances believed to induce dependence under certain circumstances. All WHO member states, including the Africa Group, have pledged to integrate palliative care into primary healthcare; however, ESA's shortages of opioids for palliative care present a clear and ongoing challenge to this integration. This is due to the following factors:

- Restrictive national drug policies and regulations that prioritize narcotics control over public health.
- Lack of workforce capacity to safeguard and prescribe controlled essential medicines.
- General fear of opioids' use in medical settings, based on ideological narratives and lack of appropriate medical training.
- Unaffordability due to diverted pharmaceutical supplies and the contribution of these drugs to the creation of localized unregulated pharmaceutical markets.

Decriminalization should be considered for drug use, low-level possession of drugs for personal use and possession of drug-using equipment

The criminalization of drug use contributes to a large proportion of arrests and incarcerations in ESA. This approach increases exposure to infectious diseases and amplifies transmission in prisons and in the general community. The criminalization of drugs and moral framing of drug use also fuel stigma and discrimination towards PWUD, creating major barriers to healthcare access. This negatively affects retention in care and health outcomes. The criminalization of drug use also contributes to onward transmission of infectious disease among PWUD and their partners, families and the broader community. WWUD in ESA are vulnerable and their health and rights have been negatively affected by current drug policy approaches and the lack of gender-appropriate interventions. The COVID-19 pandemic has amplified inequality and demonstrated that NSPs and OST, as well as infectious disease testing and treatment, are essential services in ESA.

The meaningful involvement of civil society, particularly PWUD, is essential in national drug policy and programmes

The meaningful participation of PWUD in drug policy and drug service processes should include involvement in the monitoring and evaluation of policy implementation and service delivery models, with a goal of striving towards continuous quality improvement. Collaboration and harmonization on public health among the health, social, police and justice sectors are critical to ensure effective responses for drug use treatment as well as infectious disease prevention, treatment and care. Drug policy can and should provide the framework for national consensus building and mutually respected objectives that protect rights and effectively prevent the spread of infectious diseases.

Regional drug policy needs to provide explicit support for harm reduction interventions

There must be clear support for harm reduction interventions in drug and health policy, including the WHO package of health interventions and critical enablers. This includes ensuring access to affordable diagnostics (for HIV, TB, HBV and HCV) and medications that are required for comprehensive harm reduction (including methadone, buprenorphine and naloxone, and medications for the prevention and treatment of HIV, TB, HBV and HCV).

Evidence clearly shows that good coverage of harm reduction services with the integration of screening, vaccination and treatment of infections (e.g. HBV, HIV, HCV, TB) contributes to further reductions in infectious disease transmission among PWUD and their larger communities. Adherence to treatment, notably HIV, HCV and TB treatment, is improved when linked to OST (for people with opioid dependence) and when harm reduction principles are integrated into service delivery. The WHO, the UN Office on Drugs and Crime (UNODC) and the International Network of People Who Use Drugs and other organizations have a wide range of guidance to support planning and implementation of health and harm reduction services.[124] Policymakers should engage with this guidance and ensure these interventions are included, costed and implemented as part of national health, social development and infectious disease strategies.

Risk of HIV infection is disproportionately high among people who inject drugs. HIV prevention, testing and treatment should form part of harm reduction services. *© Nicholas Kajoba/Anadolu Agency via Getty Images*

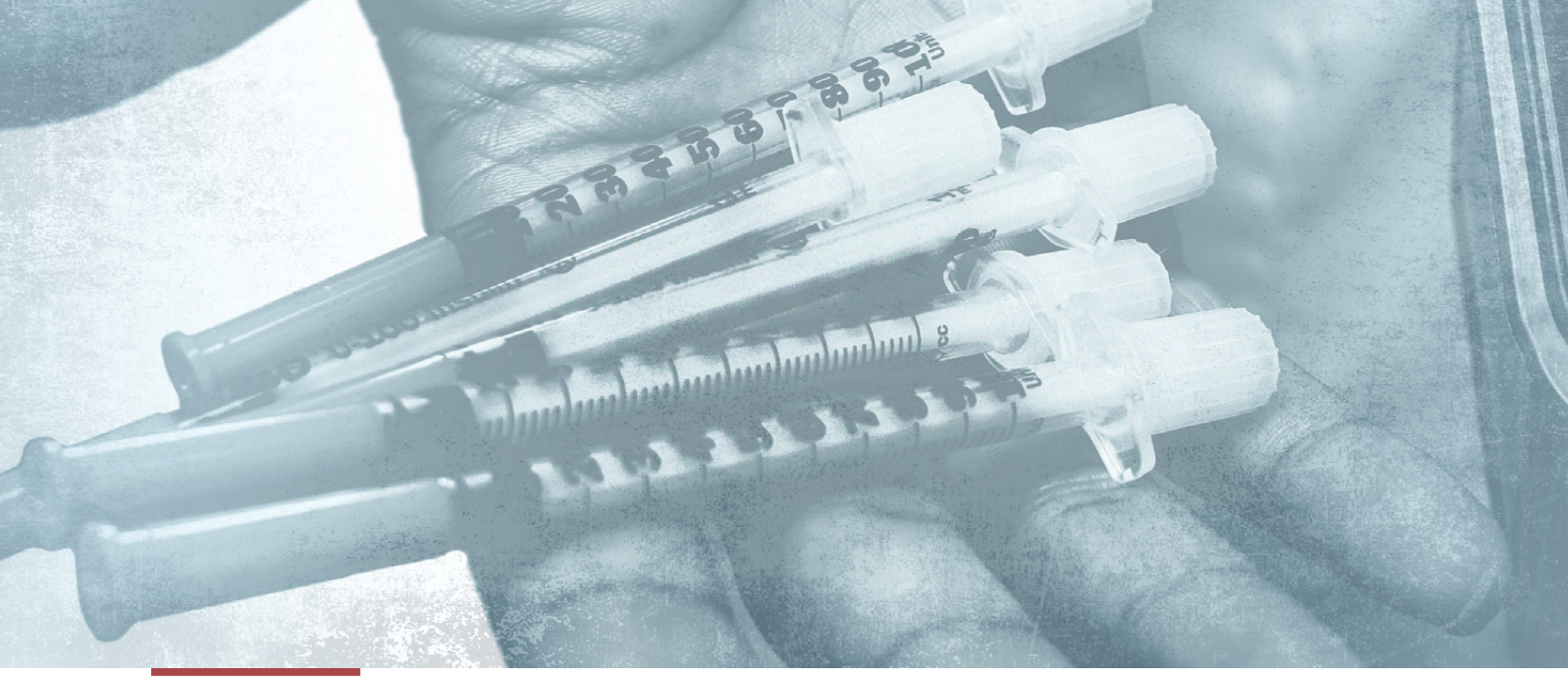
‘Acute reduction in international donor funding available to support drug-related health programming in the region has exacerbated an already challenging situation.’

Sustainable financing solutions are needed for core health and harm reduction interventions

Appropriate prioritization and financing of the implementation of public health-informed drug policy is required for infectious disease epidemic control. Countries should commit to developing sustainable financing solutions for universal access to a package of evidence-based harm reduction and drug treatment interventions in community and prison settings. The WHO provides guidance to develop and implement universal health coverage.[125] Progress should be made towards the inclusion of a package of harm reduction interventions under universal health coverage and as part of national health insurance. Local assessments of resources allocated to punitive approaches to drug policy can be quantified and compared to the health gains that would be achieved through investments in evidence-based interventions. This comparison can be used to advocate for greater allocations towards public-health approaches to drug use.

Decreasing incarceration rates would have a significant impact on reducing HIV, HCV and TB infections among PWUD

The criminalization of drug use contributes to a large proportion of arrests and incarcerations of PWUD across ESA. Many of these people are arrested for simple possession of drugs for personal use, or for having ‘drug paraphernalia’ on their person. This approach to PWUD increases their exposure to infectious diseases and amplifies transmission within prisons and other closed settings, as well as in the general community. The criminalization of drugs also fuels stigma and discrimination towards PWUD, both of which are major barriers to healthcare access. This negatively affects retention in care and health outcomes. The criminalization of drug use also contributes to onward transmission of infectious diseases among PWUD and their partners, families and the broader community. Shifting national policy away from incarcerating PWUD for low level drug-related offences, and releasing from detention those who are already incarcerated, would contribute toward improved health outcomes across communities.



REFLECTIONS ON DRUG POLICY IN EASTERN AND SOUTHERN AFRICA

The need to consider gender

Gender equality is recognized as a fundamental human right and is enshrined in international frameworks such as the UN Sustainable Development Goals[126] and international treaties such as the Convention on the Elimination of All Forms of Discrimination against Women (1979). In pursuit of this goal, there have been campaigns in recent decades to incorporate a 'gender lens' – to understand and address gender inequalities – across different policy areas. Drug policy is no exception: provisions to mainstream gender considerations have begun to form part of policy frameworks globally and regionally, including in ESA.

Broadly speaking, women's experiences of drug markets and drug policy may differ from men's for many of the same reasons that gender inequality persists in other spheres of life. These include gender discrimination and patriarchal ideologies that marginalize women, a lack of economic empowerment, victimization through gender-based violence, and the fact that women are more likely to be carers for children and other dependent relatives, which places them under additional economic and social stress.[127] In a context where drug use and possession for personal use are widely criminalized and PWUD are stigmatized and forced to the fringes of society, gender as a social structure plays an integral role in women's pathways to drug use and addiction.[128] Many of the same norms that shape women's experience also shape those of LGBTQ+ (lesbian, gay, bisexual, transgender, queer and other minority) communities.

Globally, most PWUD are men. According to UN data, the differences between men and women's drug use rates are particularly pronounced for opioids such as heroin, cocaine, cannabis and new psychoactive substances. For cocaine, for example, only 27% of users are estimated to be women. However, for other drug types, the gap between male and female use rates appears to be narrowing.[129] For amphetamines and recreationally used sedatives, trends suggest an almost 50–50 split between men and women.[130]

This gender gap is also reflected in ESA, where surveys have found that men report much higher levels of substance use than women.[131] Some ESA studies of PWUD also report higher rates of male use. In a 2021 epidemiological survey of injecting practices among PWUD in Kigali, Rwanda, 81% of respondents were male.[132] Similarly, a study of participants at Mozambique's first drop-in centre for PWUD, established in Maputo in 2018, found that over 90% of screened PWUD were male.[133] Pointedly, these studies may reflect sampling techniques that privilege men's experiences and recruit

from settings that male PWUD are more likely to access; however, they also reflect the global estimates that drug use – particularly of opiates such as heroin – is predominantly male, and that ESA countries appear to reflect global trends.

However, despite making up a smaller proportion of the overall drug-using population, women's experiences of drug use differ from those of men, often in ways that expose them to greater harm. Globally, evidence suggests that WWUD tend to progress more rapidly than men to drug-use disorders,[134] meaning they are over-represented in the proportion of PWUD requiring support and medical treatment.

Women are more likely to experience social stigma because of their drug use. Substance use-related stigma is a significant barrier to healthcare among PWUD in general[135] but gender appears to be an exacerbating factor. A 2021 systematic review of the global literature on substance use-related stigma found that qualitative research showed WWUD experience higher levels of drug use-related stigma than men, and concluded that more quantitative research is needed 'to understand the role of stigma in heightening the disproportionate harms experienced by WWUD'.[136] Patriarchal ideologies about women and their role in society – particularly their role as mothers – mean behaviour judged to be deviant from the norm is criticized more harshly than for men.[137] This has knock-on effects on family relationships, social support networks, and ability to access economic opportunities and health services.

Women may be more likely to engage in some behaviours while using drugs that put them at risk. For example, WWUD, particularly young women, are often introduced to substance use by male partners. In Kenya, one study found that 74% of women who inject drugs in low-income urban areas were introduced to drug use by a sexual partner.[138] Another study, which interviewed women who inject drugs in Nairobi, found that most of them had been introduced to drug use between the ages of 11 and 17 by male partners.[139] These women's relationships with men who use drugs were a key factor in their continued drug use. This can mean that women are dependent on men for the supply of drugs and injecting equipment such as needles and syringes, and therefore have less control over the risk of using contaminated equipment.[140] Research in Rwanda has similarly found that WWUD are more likely than men to share drug injecting equipment, which means increased exposure to viruses such as HCV and HIV.[141]

Studies have found that WWUD are also more likely to experience gender-based violence at much higher rates than women who do not use drugs.[142] This includes physical and sexual violence by intimate partners and non-partners. A 2022 study of the experiences of WWUD in Dar es Salaam, Tanzania, found that more than half of participants (62%) reported experiencing physical violence in the past year, and almost a third experienced sexual violence in the same period.[143] Other studies have reported high levels of coercive behaviour by partners of WWUD.[144] While physical violence is a threat to the lives and safety of WWUD, it also affects their ability to negotiate safe drug-using practices and access healthcare. WWUD are also more likely to have other needs that may affect how or whether they access health services, such as caring for children or other family members; more likely to be socio-economically disadvantaged and to have less control over their own finances; and may have other health needs related to pregnancy or sexual health. Therefore, drug-related health interventions to support WWUD need to be designed to address their needs.

Community-led interventions can provide essential safe spaces for support, education and counselling as participants work towards recovery and reintegration. *Photo: GI-TOC*

While the UNODC and WHO recommend that 'treatment services should be gender-sensitive and oriented towards the needs of the populations they serve',[145] women are reported globally to have less access to harm reduction services and drug use treatment services than men.[146] As a proportion of PWUD,

they are consistently under-represented in enrolment in these services.[147] The UNODC identified this 'treatment gap' as a 'global problem' in its World Drug Report 2022, calling on countries to tailor interventions to women, youth and other at-risk groups in line with the international standards. Interventions, the report stated, should ensure that 'women are safe and not stigmatized, can exercise childcare responsibilities, have access to sexual healthcare and [are] supported with regard to other social, economic or legal needs, have support to address trauma and comorbid mental health disorders, with priorities given to pregnant women'.[148]

This treatment gap is reflected in ESA. The first iteration of the Global Drug Policy Index, a tool designed to provide a data-driven analysis of global drug policies, reviewed four ESA countries (Mozambique, South Africa, Uganda and Kenya) in its 2021 findings. In all four, women were found to have a moderate or severe lack of access to harm reduction services. This reflected the index's global findings: women and LGBTQ+ communities were found to face differential obstacles in accessing harm reduction services in every country surveyed.[149]

A growing body of literature has described this ESA treatment gap and investigated the drivers behind it. Several studies have outlined how discrimination against WWUD is a barrier to their access to health services: women in Kenya and Tanzania have reported being deprioritized by health workers if their drug use is known or if they present with injection-related injuries and health conditions; other research has found that a lack of privacy and confidentiality in harm reduction services prevents women from using these services for fear that their drug use will become public.[150] While these discriminatory attitudes affect all drug-using populations, they have been reported globally to be particularly harmful for women.[151]

Discrimination also shapes women's drug use so that interventions are less likely to reach them. Another study on the low enrolment of women in methadone-assisted treatment in Dar es Salaam found that greater discrimination against WWUD compelled them to use drugs in private or more hidden areas, away from outreach teams and community organizations which focused on outdoor areas where men who inject drugs tended to congregate. It was recommended that expanding outreach, including by women peers, to the places where WWUD use drugs could increase enrolment in the methadone programmes.[152] Similar dominance of male clients in harm reduction programmes has been found globally.[153]

The fact that women's drug use often exposes them to a higher risk of harm and that they are under-served proportionally in access to harm reduction and drug use treatment services is reflected in poorer health outcomes for WWUD globally. Available data suggests that WWUD, including those in ESA, report higher rates of diseases such as HIV and HCV than men.[154] Although progress has been made against the HIV epidemic in the region since 2010, women (and particularly young girls) still account for most new infections.[155] The smaller subset of WWUD in ESA are therefore at the intersection of these risks, where they are at greater risk of contracting HIV for geographical and behavioural reasons.

A further challenge is in relation to measurement. A lack of data on drug economies that includes women or is disaggregated by gender has meant that the experiences of women in the drug economy – and the impact of drug policy on women – have been rendered invisible. This includes data collected by states to measure the impact of drug policy, as well as research by academics and civil society on drug-related health issues, criminal justice and drug law enforcement. This contributes to a gender-blind approach to drug policy, where the role of women in drug economies is not seen and therefore not addressed by the state. The size of the WWUD population is routinely underestimated, in part due to the nature of drug support and outreach.

The discussion of women's rights in relation to drug policy in ESA is inextricably linked to broader questions of how gender identity and sexual expression shape key communities' experiences of drug policy, for several reasons. LGBTQ+ communities include women, such as trans, lesbian and bisexual women. A comprehensive assessment of women's experience of drug policy must therefore include these groups. A report by the Office of the High Commissioner for Human Rights (OHCHR) called on UN member states to adapt their drug policies 'to address the specific needs of women, children and youth, and members of groups in a situation of vulnerability', extending this recommendation for the first time to include the needs of lesbian, gay, bisexual, transgender and intersex people.[156] Research around the world has shown that rates of substance use are consistently higher among LGBTQ+ populations than among their heterosexual counterparts.[157] While the reasons for this difference are undoubtedly complex, it has frequently been attributed, in part, to the higher rates of discrimination, harassment and violence that LGBTQ+ people often experience, leading people to turn to substance use as a coping mechanism.[158]

Impact on young people

Protecting children and young people from harm has often been a key argument in advocacy for prohibitionist, prevention-based drug policy approaches. However, the prevailing trends of drug policy in ESA cause several harms to children and young people – in particular, health and social harms. Key among these are restricted access to harm reduction services; greater exposure to drug-related violence; the negative consequences of imprisonment and criminal convictions; and, more generally, the exacerbated health risks of risky drug use behaviour itself. Often, young people are excluded from data collection and research into drug markets, either as participants or designers of research projects. Their voices are not always heard in drug policy discussions.

The need to reconsider drug policy approaches for young people is perhaps more pressing in the ESA region than elsewhere. Under-18s make up almost half the population of the region[159] and many of its countries have high youth unemployment. For example, data from South Africa shows that its unemployment rate among young people (age 15–34) stood at 45.5%, in contrast to a national average of 32.9%.[160] Botswana, (45.4%), Eswatini (64.9%) and Namibia (38%) also have high youth unemployment rates.[161] This heightens the risk that young people may be drawn into the drug trade and associated criminal activities.

Legal frameworks and international policies on young people and drugs have shifted over time. The three major international drug control treaties that originally cemented the concept of the war on drugs – the Single Convention on Narcotic Drugs of 1961, the Convention on Psychotropic Substances of 1971 and the UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 – are largely silent on concerns relating to children and young people.[162]

The UN Convention on the Rights of the Child (1989) was hailed as a paradigm shift in the law's perception of the child as a subject of rights rather than an object of laws. The convention, which was established to ensure that the laws and policies applied to children are in concordance with their rights, has provided advocacy groups and human rights bodies with a framework to analyze traditional prohibitionist drug policies as an infringement of children's rights – from the harms inflicted on them due to the imprisonment of parents and guardians[163] to their conviction and detention for drug-related crimes.[164]

The UN Committee on the Rights of the Child has subsequently made statements calling for harm reduction services to be made available to children and young people who use drugs, and has called for the decriminalization of drug use among this subgroup in order to prevent their incarceration.[165] The committee has also highlighted how, in many countries, young people who use drugs do not have access to HIV-prevention services.[166]

The outcome document of the 2016 UN General Assembly Special Session (UNGASS) on Drugs – almost 30 years after the adoption of the Convention on the Rights of the Child – included youth as a vulnerable group requiring focused support and provided what has been described as the 'first-ever negotiated agreed language on youth and drugs at the international level'.[167] Policy commentary prior to this noted that little work had been done on an international level to counter child involvement in the drug trade.[168] The document's 'seven pillars' included provisions for health services for adolescents during custody or arrest for drug-related offences, the creation of policies to address the specific needs of youth involved in drug-related crimes, and HIV support services for youth using drugs.

The language contained in the UNGASS outcome document has subsequently been mirrored in regional policy frameworks. The AU Plan of Action on Drug Control and Crime Prevention (2019–2025) replicates the document's pillars. It includes provisions on education for youth (to provide them with opportunities for livelihoods other than the drug trade); engagement with civil society; and alternatives to incarceration for youth, pregnant women and women with young children. It also sets specific targets for its member states on youth education and drug-use prevention strategies.

While the language contained in multilateral frameworks on youth and drug policy has slowly begun to change, advocacy by civil society and testimonies from PWUD, including young people, show that the harms associated with drug use (and exacerbated by drug policies) continue to have a negative effect on children and young people. These gradual shifts in international policies have yet to have a material impact on their lived experience.

Another challenge exists with respect to situations where drug-related data are collected. Young people are sometimes not disaggregated from overall datasets – or not included at all – which makes it difficult to ascertain the impact of drug use and drug policies on youth populations. For example, where data is collected on the prevalence of diseases such as

HCV and HIV among PWID, populations under the age of 18 are often excluded.[169] A complex set of factors which can exclude under-18s from harm reduction services – such as legal barriers, the requirement for parental consent, ethical concerns and the stigma associated with drug use – can exclude young people populations from surveillance. While there is a growing body of literature on youth and drug markets in ESA, routine surveillance of drug markets through a young people lens remains fragmentary.[170]

Civil-society organizations, including those developed and run by PWUD, have argued for years that drug-related research and drug policy development should be undertaken with the meaningful involvement of PWUD.[171] The AIDS and Rights Alliance for Southern Africa, for example, has driven this point home with the publication of 'Don't treat us as outsiders', an analysis of drug policy and the lived experience of PWUD, drawing on input from users across the region.[172] Only by including PWUD in decision-making processes can policies be developed that protect their rights and aspirations, and accurately reflect the realities of how drugs affect society.

The barriers that keep PWUD from participating in research and policymaking – such as stigma, criminalization and marginalization – are even more acute when it comes to the involvement of young people who use drugs. Initiatives to include young people in health research on substance use have documented the practical and social barriers that preclude them from doing so,[173] as have peacebuilding initiatives that have aimed to include young people in conflict resolution on drug-related violence.[174] It must be noted further that with regard to policymaking, civil society-based youth groups may not have the economic or political capital necessary to engage in discussions and make their voices heard.

Notably, drug-use behaviours are often developed in adolescence.[175] Health harms – exacerbated by the criminalization of drug use – are particularly acute for children and young people. Much of the evidence across ESA suggests that drug use is concentrated in young populations – and the increased health harms associated with criminalized drug use are therefore also most severe in these groups. For example, a study in Nairobi, Kenya, in which 306 women who inject drugs were interviewed, found that most of them were introduced to drugs between the ages of 11 and 17.[176] The monitoring of drug use behaviour in Mozambique has also found use to be concentrated in youth populations.[177] In Mauritius, which has seen a dramatic rise in the trafficking and use of synthetic cannabinoids since 2015, the use of these substances tends to be most prevalent among its population of young people.[178] Drug use in adolescence is more likely to lead to longer-term dependence, while young people may also engage in more frequent risky drug-taking behaviour.[179]

The criminalization of drugs and drug use has led law-enforcement and judicial structures in ESA to respond to rising drug use by arresting, convicting and incarcerating large numbers of people – including children and young people – for drug-related crimes. Many of these convictions are for low-level and non-violent crimes, including possession for personal use. Thousands of young people in ESA are marginalized because they have been convicted of drug-related crimes, including use and possession for personal use. Young people across the region already face the challenge of high youth unemployment, and this is exacerbated for those who use drugs or have criminal convictions.[180]

Furthermore, the incarceration of parents and guardians of dependent children has an impact on the children involved. Women are most commonly convicted of low-level drug offences, and because they are most likely to be primary caregivers their incarceration causes their children to suffer as well.[181] Research in Latin America has documented the high toll that parent and guardian imprisonment has on children and adolescents: 'Children suffer from many forms of harm when their parents are imprisoned, including the psychological effects of separation, the risk of severing relationships or the difficulty faced when attempting to preserve them, exposure to neglect, and the financial hardships that place [them] in positions of greater vulnerability in the face of abuse, among others'.[182]

Some of the gravest harms caused by poorly formulated drug policy approaches fall most heavily on children and young people. These harms intersect with social and economic marginalization, as well as gender inequalities, and exacerbate other injustices. The problems caused by current drug policy approaches cut across healthcare, social care, criminal justice and education, and have long-lasting implications for young people well into adulthood.

Drugs, governance and corruption

The ESA region is a growing trans-shipment point in the international drug-trafficking global economy, used by networks transporting drugs from producer nations in Asia and Latin America for lucrative end markets in Europe, and to a lesser extent the US. Increasing profits from the trafficking of ever larger volumes of drugs through the region have

> **In South Africa, the total value of the market for heroin, cocaine and methamphetamine exceeds the combined GDP of the Seychelles and the Comoros.**

fuelled corruption, broadly defined as the 'abuse of entrusted authority for illicit gain',[183] penetrating state systems and fundamentally undermining good governance. The corruption of government officials, and subsequent infiltration of drug profits into state processes, is a powerful structural enabler of drug markets in the ESA region.[184]

The bulk transit of illicit drugs and their precursors through countries in the ESA region has fuelled growing domestic consumption for heroin, cocaine, methamphetamine, and particularly a growing range of synthetic substances. As these regional markets grow, they become increasingly profitable to those who control and coordinate them, and crucially to those who protect their operations. As high-value commodities flow through regions of weak governance, they typically engender the creation of structured protection economies.[185]

The benefit of being part of this protection economy is significant, with vast profits generated by regional consumption and the international transit trade. In South Africa, for example, the largest regional consumer market, the total value of the market for heroin, cocaine and methamphetamine is estimated to be more than US$3.9 billion, a figure that exceeds the combined GDP of the Seychelles and the Comoros.[186] The regional drug trade is lucrative, and it is one of the drivers of corruption across the region.[187]

Corruption and illicit markets have a mutually reinforcing relationship: corruption facilitates the operations and growth of the illicit market, while criminal actors leverage illicit proceeds to entrench existing corruption structures and drive the creation of new ones. While the relationship between illicit flows and corruption is widely recognized, too often commentators 'attribute causality in only one direction – that illicit flows become entrenched because governance is corrupt, not that illicit flows themselves generate or deepen corruption'.[188] The drug market corrupts the pockets of the public administration system that have the greatest friction with the day-to-day operations of the market, including the police, customs and border officials. It also reaches upwards into state hierarchies.[189] Drug markets also offer a tempting source of revenue for political elites, who may then become facilitators and protectors of the market. Consequently, the drug market drives both petty and grand corruption.[190]

State protection has underpinned the growth of drug trafficking throughout the ESA region. High profits make illicit drug markets a tempting source of rents for local officials and political elites. Accessing these rents shifts the way policymakers act, with profound implications for governance. Where policymakers, or the political elite, can access 'unearned' sources of revenue, such as rents from illicit drugs or natural resources, they become less reliant on taxation and economic growth as a main revenue stream.[191] This, however, drives an increasing reliance on rents to balance the books, creating a self-perpetuating cycle which diminishes accountability.[192] This cycle drives the creation of patronage networks, where rents are distributed to a small group of supporters. This contrasts with licit 'earned' state income, which should benefit the population in the form of public services.

Drugs are an important source of rents for certain political elites in countries across the region, driving policymakers to focus on predation, rent creation and capture, with devastating consequences for the provision of public services and the socio-economic development of states. In turn, diminished public trust in state institutions discourages payment of taxes, eroding the revenue base and fuelling greater reliance on alternative revenue sources.[193] A growing drug market is well positioned to provide this alternative funding.

For example, profits from drug markets have fed into electoral financing, creating indebtedness to illicit actors which is repaid through protection and facilitation of the drug market. In fact, the very structure of democracy encourages the penetration of drug profits into state infrastructure. The risk of opposition victories in functioning multi-party democracies requires criminal networks to buy state protection and spread financial support among political players to safeguard business continuity from any electoral upheavals. Reflecting this, in countries across the ESA region the drug market has become intricately intertwined with the state formation process.[194] The growing cost of elections in the region and the ready availability of finances from the profitable drug market pose a constant and considered threat to the maintenance of democratic governance, even in countries that rank highly on international governance indices.

The Botswana Defence Force patrols the Caprivi Strip, a significant crossing point for cocaine. National law enforcement agencies need to be supported to identify substances and disrupt drug supply chains. *© Steve Allen Travel Photography/Alamy Stock Photo*

Corruption of law enforcement bodies largely safeguards middle- and high-level drug market actors from arrest, but the lower levels of the criminal justice system are also targeted by drug market actors. Lower-level organized crime figures typically lack access to informal networks within the judiciary but will be able to target court administration personnel (which can lead to tampering with evidence or disruption of court timetabling, for example)[195] or public prosecutors (who hold significant sway over court outcomes).[196] Such disruption of the prosecutorial process for the benefit of players in drug markets has been reported in countries across the region. A corresponding concern is pressure from political elites which have become facilitators of the drugs trade. This is a common indirect driver for the co-option of the judiciary into trafficking[197] and is particularly common in countries where judicial independence is limited and the executive exerts significant influence over judicial processes.

Over time, criminal influence has also grown to envelop many ESA air and sea ports, with networks using their facilities to trans-ship illicit drug cargo and a range of other illicit commodities.[198] While such commodities are also trafficked in and out of the region using the many informal ports and entry points, official ports are corridors for a significant proportion of the trafficking, particularly in the context of container traffic, which enables greater volumes to be trafficked. The ESA region is littered with corruption-compromised intermodal ports.

Furthermore, while online means of illicit financial transfer are increasing, the ESA drug business remains cash intensive, making cash conversion and concealment crucial to the functioning of the trade. The injection of criminal proceeds into formal business and financial systems undermines economic systems. This can have a serious impact on financial and political stability, distort the proper functioning of the private sector, create fake bubbles in real estate and undermine the integrity of financial systems. The Eastern and Southern Africa Anti-Money Laundering Group has repeatedly identified the drug market as one of the top five sources of illicit funds in countries across the region.[199]

The highly profitable drug markets have had a devastating impact on the governance of countries across the ESA region. Members of political elites have been captured by drug profits, undermining governance and diverting policymaking efforts away from the interests of citizens. Drug markets have destabilized the ESA region's financial systems, driving away investment, entrenching poverty and constraining economic progress.[200] Drug money has also penetrated the criminal justice and security infrastructure. The culture of impunity it has created in these structures has affected the application of justice, not only in the context of drug markets but more broadly, with serious consequences for the rule of law. In some countries, drug markets have contributed to the creation of a shadow state, where those in power draw authority from their ability to control and draw rents from illicit markets, including the drug market.

The combination of governance weaknesses and geography has made the ESA region an attractive trans-shipment point on global drug routes, and these factors do not look set to change. This will contribute to a continued enabling of increased volumes and diversity of drugs being trafficked through the region, including methamphetamine trafficked alongside heroin on the southern route, Latin American cocaine and Asian precursor chemicals. Entrenched corruption structures underpin drug markets across the region and are well positioned to gain greater traction as these trafficking volumes grow.

The economics of drug policy approaches

In the measurement of what is good government policy, matters of principle are important but another key consideration is economic cost. All governments have a responsibility to their citizens to allocate resources as effectively as possible to advance the public good. ESA countries are mainly low- to middle-income economies,[201] which means they must address their numerous pressing social concerns with limited revenues. It is essential that they determine and pursue policy positions that offer value within always tightly constrained budgets. Many of the costs associated with drugs have a bearing on national fortunes but are impossible to quantify. Such factors can be described as reductions in quality of life, community cohesion or human potential, but these can only ever be rough approximations of concepts that, although real, are qualitative and intangible in nature. Other possible drug-related costs to countries' economies are more quantifiable but indirect. Examples include trade losses due to delays in customs inspections, fiscal losses to grey markets, worker productivity losses to premature morbidity and mortality, and domestic and foreign investment losses due to declining confidence in governance.

In broad terms, all ESA countries continue to place law enforcement at the forefront of their drug response. This means criminal justice system expenses are their most prominent and direct drug-related economic costs. These are identifiable and calculable, unlike health system costs. On the other hand, there is major variation in legal frameworks, criminal justice system structures, and data categorization and dissemination practices.

For example, the total combined police budgets for ESA countries in 2019 or the closest year for which data could be sourced was about US$9.1 billion.[202] Prison budgets are much smaller than policing budgets, and total prison spending as a proportion of combined police and prison spending ranged from 1% in Zimbabwe to 31% in Lesotho, with an average across all the countries of 20%.[203] The combined annual prison spending for ESA countries was about US$2.3 billion, and total police and prison expenditures totalled about US$11.4 billion.

As one may expect, there is major variation between the countries. South Africa contributes 73% of the total and Kenya a further 10%. These are, however, also the most populous countries in the region. The average combined police and prison spend on a per capita basis is US$58 but the range spans from US$3 in Malawi to US$285 in Seychelles. For comparison, the 2019 equivalent in the US was about US$625.[204] When the expenditure is expressed as a percentage of gross domestic product, the average is 1.9%, with the Seychelles figure relatively low at 1.7% and that for Eswatini high at 4%.[205]

Country (with available data)	2014 or closest year	2019 or closest year
Botswana	1 115	1 890
Eswatini	2 448	3 355
Kenya	4 965	6 867
Lesotho	211	98
Malawi	517	861
Mauritius	2 091	3 382
Namibia	917	1 333
Seychelles	1 279	1 146
South Africa	25 1944	15 8621
Uganda	2 740	1 714

FIGURE 6 Total recorded arrests for drug-related offences by country in 2014 and 2019, or closest years.
SOURCE: Anine Kriegler, Drug policy and its economic cost: an overview of law enforcement and social costs in Eastern and Southern Africa, ESACD, 2023.

The commissioners greet Filipe Nyusi, then President of Mozambique, ahead of a meeting on cannabis regulation. The ESACD has identified cannabis as a promising entry point for broader discussion on drug policy reform. *Photo: GI-TOC*

While poor data alignment makes precise summation difficult, the combined total number of drug-related arrests over the two years indicated in Figure 6 in ESA countries with available data was about 447 000, suggesting that there were about half a million arrests for drug-related crimes. South Africa accounted for 92% of these arrests.[206] Trends varied, of course. Most of the countries saw an increase in drug arrests between their two time periods. However, South African arrests declined by 37% between 2014 and 2019, explained by the fact that personal possession of cannabis was legalized during this period. A similar decline was seen in Lesotho, where cannabis cultivation has also been partially legalized. Uganda saw a major decline to 2020, which its police ascribed to the COVID-19 lockdown, increased severity in sentencing for drug-related offences, and police successes in disrupting trafficking and cultivation.[207]

The proportion of drug arrests that are for use and/or possession is 89% on average, with a low of 73% in Eswatini and a high of 99% in Namibia.[208] The average proportion of drug-related arrests that are categorized as cases of trafficking (rather than simply use or possession for personal use) was 11%. It may well be that police opt for lesser charges than they suspect because these are easier to substantiate and prosecute. The statistic does suggest, however, that only a tiny fraction of the roughly half a million cases resulted from the kind of organized crime investigation that could plausibly disrupt supply. Instead, the brunt is borne by PWUD and/or low-level, non-violent dealers, typically from poor communities and disadvantaged social and ethnic groups.[209]

Major variation between countries is inevitable, but arrests for drug-related offences represented an average of 7.5% of all arrests. Clearly, a significant proportion of police time is absorbed in these activities. Given that the total combined annual police spending for the 11 countries was about US$9.1 billion, 7.5% of police resources translates to more than US$680 million.

What this ignores is the issue of opportunity costs. An average of 7.5% of police time no longer spent enforcing drug crimes could instead be reallocated to other ends, such as better responses to victims of domestic violence, prevention of human trafficking or improving police-community relations. The figures also suggested roughly what the reduction in arrest numbers would be if police were to stop enforcing these crimes entirely, all else being equal. Whereas Lesotho would see a decline of less than 0.5%, the police in Mauritius would see as much as 21% of their annual arrests fall away. This would be a significant reduction in the number of cases introduced to the criminal justice system and could relieve considerable pressure on judicial and correctional resources as well as policing.[210]

Looking at economic costs related to prisons and other closed settings, total prison costs should not be expected to vary in direct proportion to number of prisoners. For example, prisons retain large fixed costs in infrastructure and relatively inflexible costs in employment. Releasing 10% of prisoners would not result in a 10% reduction in prison costs. It is nevertheless possible to make a generalized estimation of costs per prisoner. The combined annual prison spending for

ESA countries was about US$2.3 billion.[211] This pays, among other things, for the incarceration of a combined number of people, serving a sentence for any offence, of about 347 300. A rough recombination of these figures reveals that an estimate for average annual spending per imprisoned individual was about US$6 500.[212]

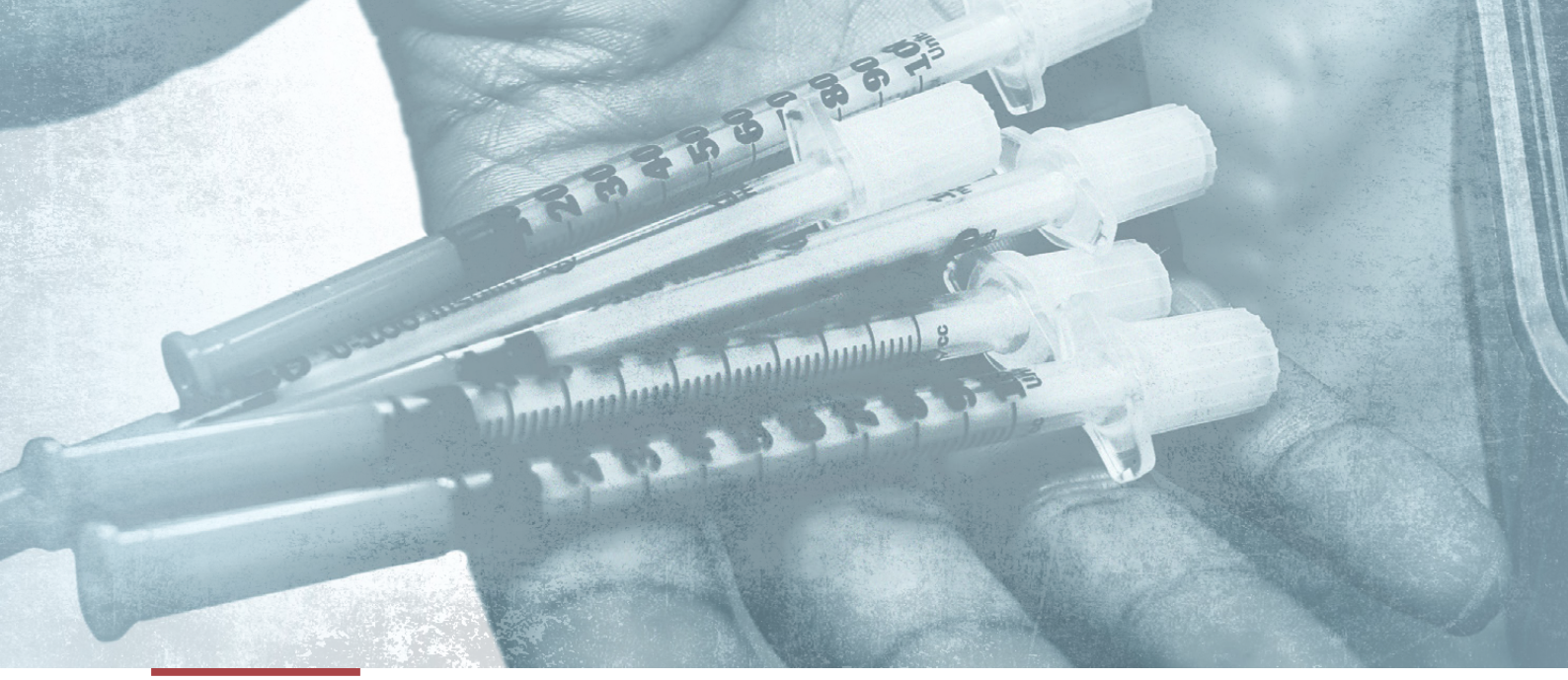
Determining what proportion of this goes towards drug-related offences is difficult. Across the ESA region, the total combined number of individuals incarcerated for drug-related offences ranged between about 17 000 and 38 000. Depending on the source of the figures, the average proportion of total prisoners who were imprisoned for drug-related offences ranged between 5% and 11%. At an average annual estimated spend per imprisoned individual of about US$6 500, this represents total annual spending on imprisonment for drug-related offences of between US$112.8 million and US$248.1 million for ESA.[213]

Even though all ESA countries still understand drug policy primarily as a question of law enforcement, they also bear drug-related health expenditures, including in terms of drug-related deaths, for instance from overdose, and the treatment of secondary illnesses, including HIV/AIDS, HBV and HCV. Drug-related expenditures in the sphere of criminal justice are relatively direct and calculable. Their nature also makes it easier to see that most of those costs are linked to the criminal prohibition of drug use rather than drug use itself. This distinction is less clear in the sphere of health, although it is equally critical.

For example, an overdose may seem directly attributable to drug use, since it occurs after an excessive dose or the simultaneous use of several drugs. Its likelihood, however, is related to variability in drug potency and purity. These are a function of an unregulated market. The outcome of overdose also depends on the extent to which people likely to witness an overdose are trained to identify, prevent or manage one. Overdose is also a common cause of death among people newly released from prison. Policy therefore has a huge bearing on the harms that result from a given level of drug use. Many health costs associated with drug use are in fact health costs of drug use under unsafe conditions, with unsafe equipment, by people who are socially marginalized and unable to access preventive and ongoing help and support from healthcare providers.[214]

What has been made clear throughout the discussions of the Commission is that a significant proportion of criminal justice system resources is devoted to enforcing drug laws, even though most of that activity has little prospect of disrupting drug supply and may even increase harms and costs in the longer term. Drug responses feature far less, and less directly, in health budgets. Yet major long-term costs are associated with drug use under unsafe conditions, with unsafe equipment, by people who are socially marginalized and unable to access preventive and ongoing help and support from healthcare providers. Most countries have no budget for harm reduction measures, even though there is strong evidence for their effectiveness and cost-effectiveness. There is far too little data to conduct a rigorous cost-benefit analysis of drug policy alternatives in ESA. However, based on the best of what data is available, a collection of generalizations may be made.

First, we must recognize that many of the costs incurred are due to the policy approach taken, not to drugs themselves. In this sense, law enforcement expenditures would be more appropriately targeted to upstream activities aimed at transnational trafficking networks and their enabler elites, an approach that would stand a better chance of achieving some form of drug market disruption compared to current street-based PWUD arrest and detention efforts.[215] Furthermore, countries should prioritize health-based considerations and programme expenditure over that for criminal justice initiatives, including significantly increasing harm reduction programme funding. The return on investment of these expenditures in relation to that for criminal justice-biased initiatives is significant.[216] Finally, it would be a prudent step by countries to invest in the development of domestic data surveillance systems to properly monitor and evaluate the costs of these policy decisions and their related outcomes.



THE CHALLENGE AHEAD

The drug and organized crime-related issues of the ESA region will continue to represent a significant, evolving challenge to the integrity, security and health of states. Countries across the region are increasingly becoming pivotal transit hubs and destination points for the global illicit drug trade, due in part to their strategic locations along main Indian Ocean shipping routes. This has led to an increase in the presence of transnational criminal groups, a correlated exacerbation of violence and corruption, and concomitant undermining of national security and stability. These features of social and security erosion highlight the absence of comprehensive and evidence-based drug policies with which to counter these problems effectively, often with punitive measures prioritized over harm reduction and effective models of drug dependence treatment.

Moving forward, the ESACD, as an emergent advisory and support body of the region, will continue to bring together a team of commissioners, including several former heads of state and other respected and influential public figures from a range of disciplines. In so doing, it will contribute to thematic dialogues on various region-specific policy options to respond to illicit drug markets and advocate for reform-based measures and approaches. As a working commission, the ESACD believes there is great value in the pursuit of political buy-in at the highest levels of government. With many of the commissioners former political leaders, the ESACD is uniquely positioned to understand the political dynamics inherent to the drug and drug policy landscape. They are also able to convene bilateral meetings with current leaders to speak about the issues in a private, peer-based manner. The combination of the commissioners' expertise in government, the judiciary and scientific research enables the ESACD to create a unique dialogue space in which participants ranging from local community activists to national leaders can exchange views and contribute to a discussion about challenges and solutions.

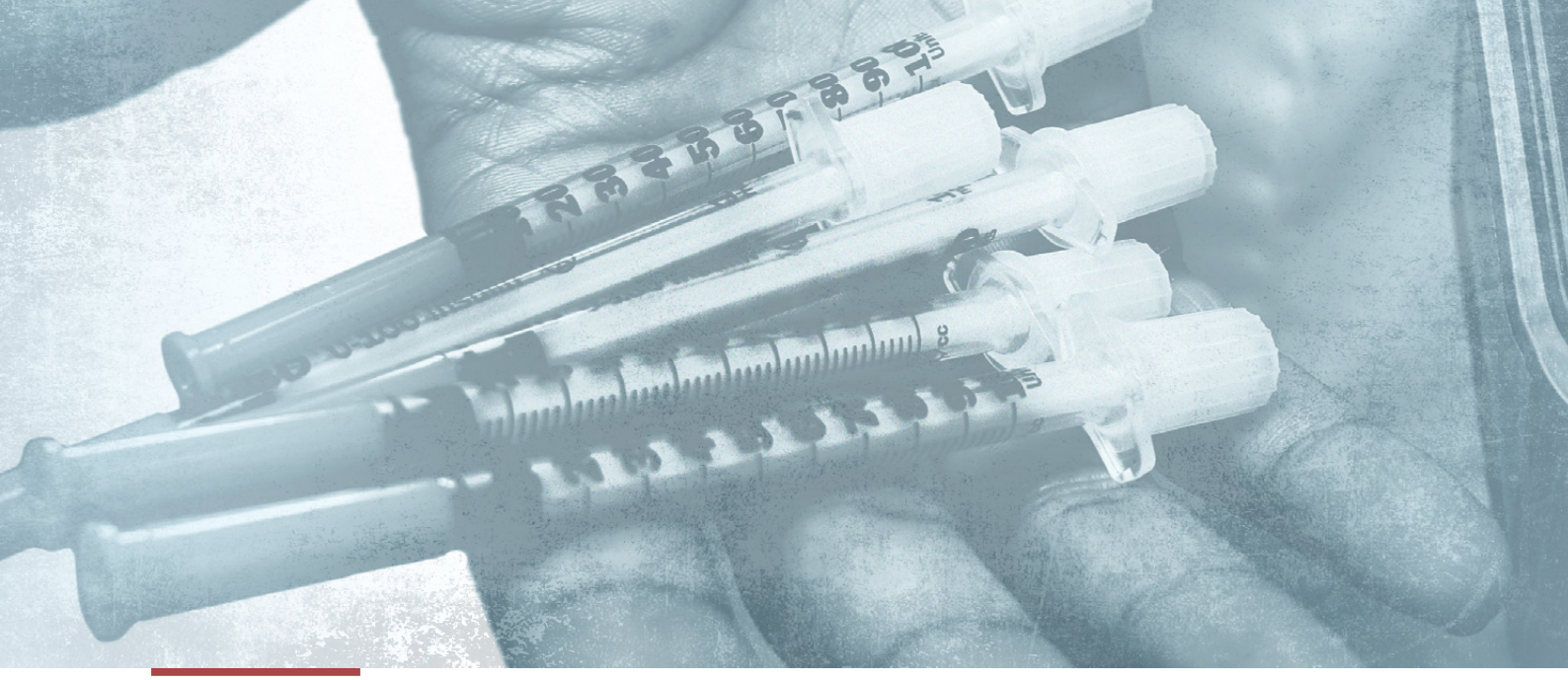
From the diversity of inputs gathered through regional consultations, to the content of bespoke technical briefing papers and the topics of more intimate in-person exchanges with affected community members, the commissioners have considered and discussed a series of drug-related challenges that face the region. These discussions have covered the following:

- The range of law enforcement and other maritime and land-based security initiatives undertaken in various parts of the region and designed to disrupt drug production, distribution and transit.
- Recurring themes about intervention ineffectiveness driven by factors such as the influence of embedded and adaptive drug trafficking networks.
- The geographic vastness of the region and its maritime environment.

- Loopholes in regulatory frameworks.
- The variety of judicial complications caused by matters of sovereignty and jurisdictional complexities, and the challenge of bringing trafficking cases to a legal conclusion.
- The presence of gaps in surveillance and enforcement capacities at border crossings, air and sea ports, and within sovereign waters.

An additional challenge recognized by the commissioners is the growing view that prohibition-based drug policy and practice has not worked as a prescribed solution to the region's illicit drug market harms. Despite heavily criminalized policy approaches, the use, production and trade in illicit drugs across the ESA region – as well as the negative impact of the markets on host nations – has expanded significantly, particularly over the past decade.

Incorporating the perspectives of civil society groups and people who use drugs is a necessary consultation objective in all aspects of drug policy development and research. *© Yasmeen Sewnarain/Gallo Images*



COMMISSION FINDINGS AND RECOMMENDATIONS

The Commission notes that long-term sustainable solutions to effectively respond to and mitigate 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 the prison cells and compulsory treatment centres of many nations. Rather, they dwell in the eradication of the enablers of domestic inequity, inequality and structural vulnerabilities, and the uplifting development of people.

The foundation for the pursuit of these commitments has already been laid by Africa's leaders. This can be seen in their assent to the Agenda 2030 and Agenda 2063 development goals, and the rights and duties of care bestowed by the African Charter on Human and Peoples' Rights. The alignment of regional drug policy reform in the context of these complementary human development frames could see the ESA region grasp a continental leadership role in defining effective drug responses and undermining the caustic sociopolitical influence of drug market economies, not from a traditional drug war perspective but as a fundamental, long-term social and rights development duty.

In considering consultation testimonies, research reports and other submitted documentation and perspectives, the Commission has agreed on the need for a three-year strategic plan of action driven by the ESACD, in coordination with and support of other regional initiatives, and with the objective of contributing to the initiation of specific drug and drug market change events and processes. The proposed period of the plan of action runs from 2025 to 2028 and would constitute the need for an extension of the Commission's current period of external funding.

In consideration of these issues, the Commission puts forward its findings and recommended actions for the ESA region.

FINDING 1: Regional surveillance on drugs and drug markets is poor, and practical reform is necessary

The mantra that 'we think we know more about drugs and drug markets than we actually do' is one the Commission has encountered repeatedly across the timeframe of its consultations. It is also a position on which the Commission has found much agreement. Contrary to widespread belief, emerging evidence shows that the drug markets of the ESA region are a diverse cornucopia of natural and synthetic substances, competing criminal interests and myriad public health harms. Developing appropriate policy responses to the harms of these markets depends on an intimate understanding of their characteristics, yet most countries in the region are unable to generate data that provides even

the most basic knowledge of their markets: how many people use drugs, what drugs they use and how they use them. Answers to questions such as these are necessary elements of the wider understanding required to produce relevant, effective, timely and appropriate health and safety programmes to mitigate the harms and other challenges specific to each domestic market and the people who make up its population. Such foundational knowledge is also important for improving regional comprehension of drugs and drug markets. Supporting drug market monitoring and understanding markets through measures such as a regional drug observatory is one possible response. The formation of national harm reduction programmes in line with national market characteristics is another important initial point of consideration.

In this regard, the Commission will promote and support the following objectives and actions for the next three-year period:

Objective 1.1: Improve the capability of ESA countries to know more about the drugs and drug markets that exist within their borders.

Recommended actions:

a) Together with existing national drug observatories and agencies of regional states, and based on fundamental market surveillance principles, promote, facilitate and foster the development of a consensus regional dashboard of drug and drug market health and security surveillance metrics.
b) Together with regional states, encourage and support the implementation of national capacity assessments to identify challenges within existing national data surveillance institutions, systems and structures that contribute to limiting the capability of the state to collect the information on the metrics agreed.
c) Through the Commission, provide support for the development and adoption of introductory technical guidance by individual countries to improve their drug and drug market data monitoring systems and strategies.
d) Based on UN-endorsed principles of best practice and tailored to local drug market dynamics, and in partnership with local authorities, encourage the provision of guidance to national institutions in the measurement of the coverage of public and private community harm reduction and drug treatment services (availability and access) across individual countries.

Objective 1.2: Create a regional drug and drug market observatory to serve all regional nations.

This regional observatory would be a regional adaptation modelled on the European Monitoring Centre for Drugs and Drug Addiction. It would have the responsibility of supporting the collection of national drug and drug market datasets necessary to support effective, near-real time knowledge of drugs and drug markets of the region, alongside fulfilling the role of regional drug threat monitoring through a focus on early warning functions alongside existing national observatories of the region.

Recommended actions:

a) Advocate for agreement at senior government level of regional states for the physical establishment and implementation of national illicit drug observatories to collect quantitative data on national drug markets.
b) Advocate for agreement at senior government level of regional states for the physical establishment and implementation of a regional illicit drug observatory, and for the cooperation of regional states in the sharing of quantitative national data sets.
c) Establish a regional drug observatory, connect it to national observatory bodies across the region, and initiate its work.
d) Through the auspices of the observatory, and with the input of regional surveillance partners, encourage and support the publication of annual regional drug and drug market trend reports grounded in the analysis of regional datasets contributed by ESA nations.

“The drug markets of the Eastern and Southern African region are a cornucopia of natural and synthetic substances, competing criminal interests and myriad public health harms.”

Objective 1.3: Advocate for national and external support for the increased availability and use of community-based drug surveillance techniques, as well as the regular collection of baseline data on drug market characteristics.

Recommended actions:

a) Establish and support a community-based drug checking working group to assist regional countries and build knowledge capacity on drug markets of the region. This will be done with civil society and government partners through the development and implementation of community drug checking services using spectrographic field testing of random street-based drug samples, with gas chromatography-mass spectrometry laboratory confirmatory testing where possible.
b) Advocate and provide technical assistance and guidance for regional countries to undertake annual national drug market 'inventory' analyses to identify new or emerging synthetic drug-related substances and the public health harm-related conditions these may cause.
c) Advocate for the establishment of a national drug data clearing house within each national drug observatory and encourage all drug-related programming and research bodies to share their data through the clearing house.

Finding 2: Current national approaches and strategic responses to drugs and drug markets have not worked in the region

Drug-related policies and strategies employed in the region have been ineffective in disrupting drug supply chains and responding appropriately to drug-related harms. Part of this ineffectiveness is rooted in the absence of relevant data necessary to inform the development of targeted, science-grounded and evidence-based strategic frameworks and their related responses in the first place. Improved surveillance – better data, knowledge and foresight of what is coming – is necessary to inform more effective national and regional responses to drug markets and their harms. Even the best strategies can fail if they are too short-sighted, misdirected or cause further harm. Outdated 'drug-free world' nomenclature is no longer employed at UN level and should no longer be referenced in Africa. Developing new strategies that are evidence-driven and fit for purpose requires a multi-sectoral approach. It involves rethinking the way law enforcement bodies prioritize interdiction and enforcement activities, and the way public and private health agencies and institutions develop and prioritize community health programmes such as harm reduction and drug treatment services. It calls for consideration of other social interventions to reduce stigmatization and discrimination of PWUD (particularly those who suffer marginalization and isolation as a result), including the provision of health services to drug-using populations in prisons and other closed settings; consideration of judicial reforms, including the expungement of minor drug use or possession convictions from individual criminal records and the release from prison of those serving sentences for minor use or possession; and consideration of the decriminalization of drug use or possession for personal use. It also calls for strategies to support the reprioritization of law enforcement efforts towards high-level traffickers and away from PWUD.

The Commission will promote and support the following objectives and actions for the next three-year period:

Objective 2.1: Campaign for the region-wide end to the criminalization and incarceration of PWUD, and the stigma that accompanies drug use.

Recommended actions:

a) Advocate for an end to regional and national 'drug-free' goals across the region, 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.
b) Undertake an assessment of existing ESA drug policies, legislation and practices, and use this information to make country-specific recommendations to promote consistency of regional practice in respect of support for public health, gender and human rights principles on PWUD and the unified application of drug policy measures.

Objective 2.2: Refocus national and regional drug enforcement strategies and responses on a primary objective of disrupting drug trafficking and organized crime elites, and away from the practice of 'arrest and detention' of PWUD.

Recommended actions:

a) In partnership with regional economic communities – the East African Community (EAC) and the Southern African Development Community (SADC) – advocate for an assessment of regional law enforcement institutional capacities to identify structural challenges that would require financial, human resource, technical and/or political support to make improvements in line with this objective.

b) Establish and support a regional dialogue for national and regional law enforcement groups to examine ways to scale up asymmetric, intelligence-led policing of drug markets, as well as to encourage and promote joint policing operations with regional and international agencies, where possible and appropriate.
c) Alongside regional economic communities, convene a discussion on the challenges faced by national judiciaries in achieving legal conclusions in prosecutions of high-level drug traffickers and organizations operating across the region's national jurisdictions. Develop a regional strategy to resolve this issue.

Objective 2.3: Consider the adoption of alternative policy approaches to domestic drug market control, particularly the options of decriminalization, legalization and regulation.

Recommended actions:

a) Convene regional discussions to support development of consensus positions on drug policy reform recommendations, such as:
   i. Regional adoption of UN-recommended drug use harm reduction measures, UN drug treatment guidance and best practices, and UN and AU human and rights duties and obligations as they relate to people's health and welfare.
   ii. Decriminalization, legalization and regulation of drugs (with specific initial reference to cannabis and khat).
b) In partnership with the AU and regional economic communities, convene a regional judicial working group on the removal of drug use or minor possession convictions from individuals' criminal records, and legislative or other revisions of government actions needed to effect these changes.
c) Convene a regional analysis to document how 'personal possession' is defined and prosecuted by national drug laws in the region.
d) Establish and support country-specific dialogues to discuss national models, the potential for implementation of cannabis legalization for medical and recreational use, and its related law enforcement and regulatory ramifications and requirements.

Objective 2.4: Civil society and PWUD are included and involved as essential participants in the development, implementation, monitoring and evaluation of national drug control strategies and their related approaches.

Recommended actions:

a) Establish and support a regional civil society forum aimed at engaging key stakeholders and marginalized groups in national high-level drug policy development, implementation, monitoring and evaluation processes.
b) Establish and support a research exchange network with universities in the region, as well as those across the African continent and on other continents, to discuss and share best practice policy and research across the Global South. Include within this network the establishment of a teaching and training programme for regional policymakers to learn from other drug policy experiences.
c) Promote the cross-regional sharing among Global South nations of effective community-based practices and experiences in civil society-inclusive monitoring and evaluation practices for drug policies, strategies and related approaches.

Objective 2.5: Governments of the region should immediately release people imprisoned for drug use or minor drug possession offences, and stay all current criminal cases related to drug use or minor possession.

Recommended actions:

a) Advocate with senior government leadership for regional de-penalization and de-incarceration initiatives in line with international best practices. Provide specific, actionable recommendations and related technical assistance for the adoption and implementation of actions by ESA countries to develop a regional framework.
b) Convene a regional discussion of senior country representatives to identify how to cost-effectively, efficiently and safely implement this recommendation, including defining offence threshold levels for release consideration, release and reintegration needs for government and other public and social service-oriented institutions, communities and released individuals, and how these thresholds can be met.
c) In partnership with regional economic communities – including the EAC, SADC and the Indian Ocean Commission – convene a regional meeting of senior government officials and other important regional stakeholders to discuss the development and adoption of a regional framework to institute this objective region-wide.
d) With ESA regional judicial partners, coordinate the development and agreement of a set of consensus regional definitions for adoption in drug laws across the countries in the region, with the aim of establishing a common regional drug policy orientation and interpretation.

> **Sustainable solutions to effectively respond to and mitigate the region's drug trade … dwell in the eradication of the enablers of inequity, inequality and structural vulnerabilities, and the uplifting development of people.**

Finding 3: The availability of and access to relevant, evidence-based drug-related prevention, treatment and social care services are exceedingly limited for PWUD

With the accumulation of knowledge and the aim of translating it into policy and programming responses comes the need to consider the development of health and welfare services and community interventions. These services represent the actions governments must take to contribute to the reduction of drug-related harms and other community consequences, particularly those related to health, such as the transmission of blood-borne viruses, lack of access to evidence-based drug treatment services and a shortage of equitably distributed general health and welfare services. Incorporating the experiences of civil society groups and the perspectives of PWUD are necessary consultation objectives in establishing these services.

In line with the recommendation of UN General Assembly Resolution S-30/1, Commission on Narcotic Drugs Resolutions 53/4 and 54/6, the UN General Assembly Special Session 2016 Outcome Document, and Resolution 141 of the African Commission on Human and Peoples' Rights, the Commission will promote the need to support the following objectives and actions:

Objective 3.1: Put people's health and safety first by ensuring 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.

Recommended actions:

a) Advocate with governments of the region for the adoption and implementation of accessible, evidence-based harm reduction and drug treatment services in line with UN best practice guidance.
b) Champion voluntary compliance by ESA states with the UN Standard Minimum Rules for the Treatment of Prisoners (the 'Mandela Rules'), with particular reference to adherence with the healthcare standards expressed in Rules 24, 30 and 32.
c) Advocate for gender-based service availability and access, and strive to improve the availability of gender-inclusive prevention and treatment services for populations of PWUD.
d) Establish and manage a regional harm reduction fund to provide grants to innovative harm reduction initiatives, supporting the push to encourage countries to adopt and implement national harm reduction services.

Objective 3.2: Ensure universal access to essential medicines, particularly controlled substances such as opioids for pain control, and stop the diversion of licit medicines from medical settings to the illicit market.

Recommended actions:

a) Advocate for a measurable increase in access to essential medicines for all people across the ESA region, including access to controlled substances included under the UN Drug Conventions.
b) Assist regional economic communities to develop and implement an advisory and support programme to advise countries and national authorities how to achieve and maintain these increases.

Finding 4: The rapid emergence and proliferation of synthetic drugs are an overriding threat to the public health and security of regional states and their populations

The ESACD has concluded that synthetic drugs pose perhaps the greatest emerging challenge to drug control in the ESA region in terms of the ability of states to develop measures to effectively mitigate consequential drug-related harms. This is an issue from public security and public health perspectives, particularly in relation to how an increase in the availability of synthetic substances affects the capacity of national law enforcement and health agencies to respond. The production, distribution and use of synthetic drugs – particularly in settings where they are less recognized or understood – often require vastly different responses, not only from an interdiction perspective but also from the point of view of harm reduction, treatment and support.

The Commission will advocate for and support the following objectives and actions for the next three-year period:

Objective 4.1: Improve the ability of national law enforcement and other security agencies and institutions to identify substances and disrupt precursor supply chains, with particular reference to chemical diversion activities.

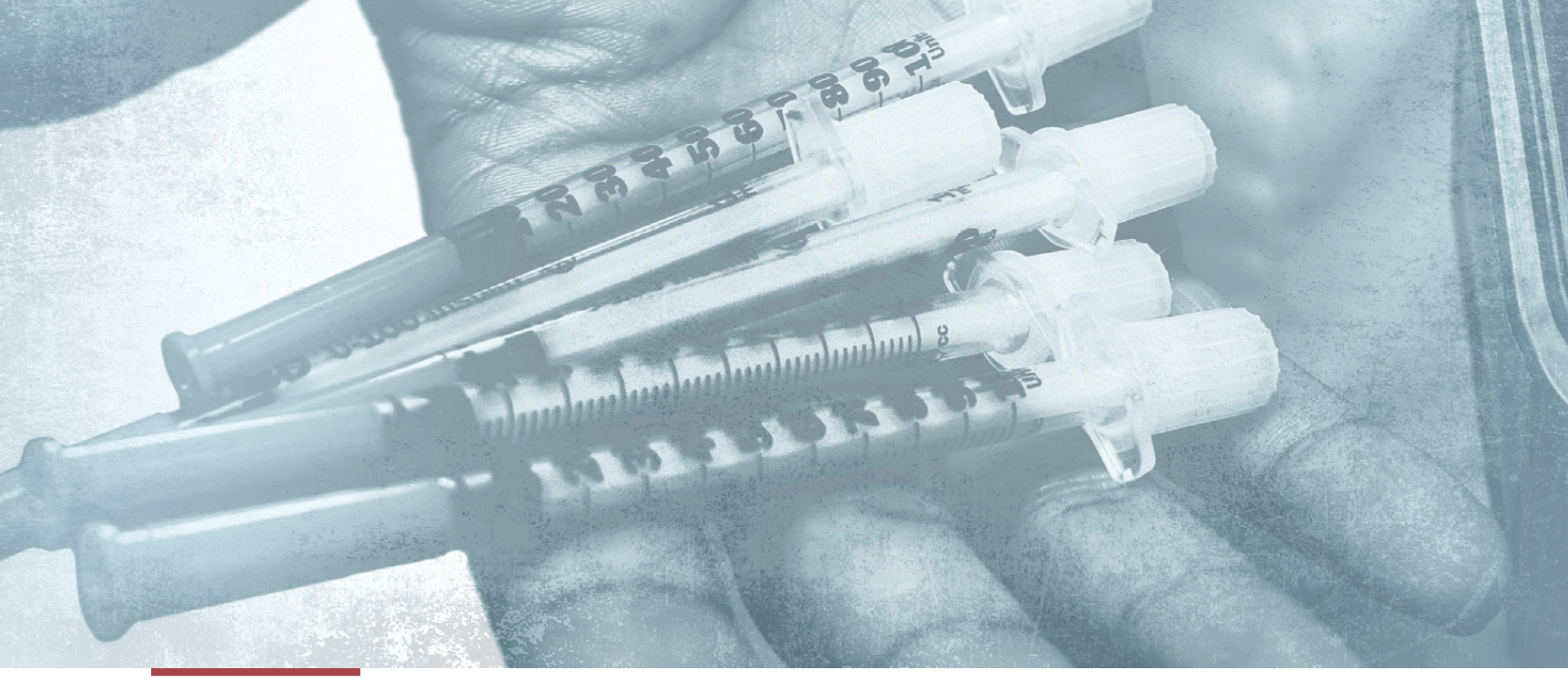
Recommended actions:

a) Advocate for the adoption, funding and implementation of national 'diversion risk assessment strategies' addressing synthetic chemical precursors, essential medicines and other controlled substances in national medical settings, pharmacies, and chemical, agricultural and industrial manufacturing settings.
b) Acknowledge the role that institutional and individual corruption plays in supporting expansions in synthetic illicit drug trafficking across the region, and encourage national institutions to strengthen anti-corruption and anti-money laundering legislation in line with UN, World Bank and Financial Action Task Force (FATF) guidance.
c) Advocate with institutional donors for the contribution to regional states of financial, technical and human resources necessary to support the training of law enforcement, border control and customs institutions, agencies and bodies in the rapid and accurate identification of the diverse catalogue of common illicit drugs and their chemical precursors.
d) Promote regional country support for the creation of a global Chemical Action Task Force, an independent body with form and function similar to that of the FATF but tasked with monitoring individual state compliance with a series of accepted global regulatory standards on safeguarding the global supply chain from chemical precursor diversion and illicit trade.

Objective 4.2: Support improved capacity of regional countries to identify, mitigate and disrupt the contamination of local drug market supplies with synthetic compounds in order to reduce related overdose, harm and death among PWUD.

Recommended actions:

a) Advocate for intraregional assistance and cooperation among ESA countries in the use of forensic lab institutional capacities in undertaking national drug-checking analyses of street-based illicit substance samples on a quarterly basis, and report these findings to the regional observatory.
b) Encourage information sharing among forensic labs of the region, particularly on 'early-warning' identification of emergent synthetic compounds; and notification of regional surveillance bodies, including local civil society organizations working with PWUD populations, of this threat detection.
c) Provide technical guidance on advances necessary for treatment and prevention programming for PWUD in the context of emerging synthetic drugs and related contamination, with particular reference to the region-wide adoption of overdose prevention programming including free distribution of naloxone and other overdose reversal medications.



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The Eastern & Southern Africa Commission on Drugs

secretariat@esacd.org

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