

Drug policies in Africa: What is the ‘health-based’ approach?

Concerned with the health and welfare of mankind,

Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes,

The opening lines of the 1961 United Nations Single Convention on Narcotic Drugs¹

Introduction

Fifty-five years since the Single Convention on Narcotic Drugs was adopted, creating the framework for the global drug control system, there is now mounting evidence that the “war on drugs” approach has led to serious negative consequences.² In response, the international drug policy debate has increasingly embraced the idea of more balanced, health-based approach. In the UN’s ‘Joint Ministerial Statement’ on drugs from 2014, member states agreed by consensus that “the world drug problem... demands an integrated, multidisciplinary, mutually reinforcing, balanced and comprehensive approach”.³ In April this year, the UN General Assembly Special Session (UNGASS) on the world drug problem will include a roundtable devoted to “Drugs and Health”.⁴

At the regional level, the African Union’s Plan of Action on Drug Control 2013-2017 includes

health and social services as one of the four key priority outcomes.⁵ Most recently, the Common African Position for the UNGASS states that “a more balanced approach is needed to focus on the health and human rights of people who use drugs”.⁶ This narrative is also increasingly being used by a number of member states themselves.⁷

While this shift in tone is welcome, it is crucial that the concept of balanced and health-based drug policies does not become an empty, diplomatic phrase. This rhetoric needs to be matched by a real shift in how we respond to drugs on the ground across Africa and the rest of the world. To this end, this advocacy note seeks to elaborate what a health-based approach looks like in practice in Africa, and explores five specific areas that need to be urgently addressed by governments.

Why a ‘health-based’ approach?

At the last UNGASS on drugs, held in 1998, UN member states gathered under the banner of “A drug-free world, we can do it”, with the goal of eradicating all drugs within a decade. In 2009, member states then agreed a new, and similarly unobtainable, target to “eliminate or reduce significantly and measurably” drug cultivation, demand and trafficking by 2019.

Beyond the unavoidable failure to reach these targets⁸ are a series of serious, negative “unintended consequences” – as least some of which have been acknowledged by the United Nations Office on Drugs and Crime (UNODC) itself: the creation of a lucrative criminal drug market, the prioritisation of law enforcement over health, the displacement of drug production to new regions such as West Africa, the displacement of drug use to new and potentially more harmful substances, and the global perception of people who use drugs as criminals.⁹ Therefore, prohibition-led drug policies have resulted in more harms than the drugs they were meant to control.

Globally, there are estimated to be 246 million people who use drugs, and around one in ten of these people report problems linked to their drug use.¹⁰ At the same time, there are estimated to be between 8.5 million and 21.5 million people who inject drugs – 13.5% of whom are living with HIV, and half of whom are living with hepatitis C,¹¹ predominantly due to the lack of access to sterile injecting equipment. At least one in ten people who inject drugs in Africa are living with HIV,¹² including 44% in Mauritius and 34% in Tanzania.¹³ The solution to these issues does not lie in imposing severe criminal sanctions against people who use drugs, but rather in a public health response that will help create safer and healthier communities.

1. Drug prevention

The objective of drug prevention is to prevent, delay or reduce drug use or dependence, as well as its negative consequences. Evidence-based prevention programmes remain under-resourced across Africa and, where prevention programmes are implemented, they often consist of untargeted mass media campaigns that use outdated and ineffective scare tactics.¹⁴ Good quality, holistic drug prevention should seek to address the known ‘risk factors’ for problematic drug use (such as mental health problems, family neglect and abuse, or growing up in marginalised and deprived communities) – but also to strengthen the known ‘protective factors’ (in-

cluding greater psychological and emotional well-being, social competence, and family attachment).¹⁵ Doing this requires more than just warning young people about the dangers of drugs or the harsh penalties they risk by using them – there is currently no evidence to suggest that this approach has any impact.¹⁶

Prevention science has made enormous advances in the last 20 years: we now know that effective prevention programmes can contribute to the positive engagement of children, young people and adults with their families, schools, workplaces and communities; we also know it can build important life skills and capacities that will help individuals respond to multiple influences in their lives – such as social norms, interaction with peers, living conditions and their own personality traits.¹⁷ It is also important that prevention programmes avoid increasing the social stigma and marginalisation faced by people who use drugs.

2. Harm reduction

Harm reduction refers to policies and programmes that focus on reducing the negative consequences of drug use, without necessarily reducing drug consumption itself.¹⁸ Examples include: programmes to distribute sterile needles and syringes to reduce the risk of HIV and hepatitis; providing opioid medicines such as methadone and buprenorphine as substitutes for street drugs to help stabilise and improve lives; distributing naloxone to reverse the effects of an opioid overdose; and providing supervised spaces where people can use drugs without causing public nuisance or risking fatal overdose. The harm reduction approach has a wealth of evidence supporting its global effectiveness and cost-effectiveness, and is widely endorsed – including by the African Union.¹⁹

The World Health Organization, UNODC and UNAIDS have elaborated a ‘comprehensive package’ of services which have the greatest impact for people who inject drugs (Box 1).²⁰ But the harm reduction approach extends beyond this too – including, for example, overdose preven-

tion and naloxone distribution,²¹ and safer drug consumption rooms like those in several European cities, Australia and Canada.²²

Box 1. The UN's 'comprehensive harm reduction package'²³

1. Needle and syringe programmes
2. Opioid substitution therapy and other evidence-based drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy (for HIV)
5. Prevention and treatment of sexually transmitted infections
6. Condom programmes
7. Targeted information, education and communication
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis.

Harm reduction is supported or implemented in at least 90 countries globally,²⁴ but far too few in Africa – despite documented success in Kenya,²⁵ Tanzania,²⁶ Mauritius,²⁷ among others. This approach is emerging in Senegal, South Africa, Nigeria and elsewhere – yet less than 1% of people who inject drugs in Africa has access to needle and syringe programmes or opioid substitution therapy.²⁸ African governments should urgently commit to, and support, the harm reduction approach – to protect the health of people who use drugs, but also for the broader social and economic benefits that this approach is proven to bring.

Harm reduction services are also an excellent way to engage people who use drugs through low-threshold models and outreach – and therefore act as an entry point to other services, including drug dependence treatment and general healthcare. Harm reduction is about meeting people's immediate needs, helping them to reduce risks and address their issues – an investment which will benefit the whole of society.²⁹

As well as funding and implementing evidence-based harm reduction programmes, govern-

ments should also ensure supportive legal environments within which such services can operate successfully. Police practice can directly impede harm reduction efforts – for example, if people are routinely targeted and arrested for possessing needles and syringes. But law enforcement officials can also play an important role in supporting these services – such as by referring people who use drugs and working in partnership with harm reduction organisations.³⁰ Harm reduction programmes should also be made available in prisons as well as in the community.³¹

Crucially, more than 30 years of global experience has clearly shown that the harm reduction approach does not increase or promote drug use – and this evidence needs to be consistently and strongly relayed to the public and the media in order to ensure support. Harm reduction, when properly implemented, will reduce crime and public nuisance (including discarded injecting equipment), reduce the transmission of HIV and hepatitis, reduce overdose deaths, promote drug dependence treatment, and save money.³²

3. Drug dependence treatment

The African Union has developed “Continental Minimum Quality Standards for Treatment of Drug Dependence”.³³ These state that drug dependence is a complex but treatable health condition, and that effective treatment must attend to the needs of the individual. Treatment systems should therefore provide a menu of options to suit individual characteristics, needs and circumstances – including detoxification programmes, opioid substitution therapy (such as methadone programmes) and stimulant substitution treatments, psychosocial treatment and counselling, social support and rehabilitation. These should also be provided in a range of settings – including community-based centres, residential centres, and in other health services that people may access.³⁴ Both UNODC³⁵ and the European Union³⁶ also have extensive guidance and standards for effective treatment programmes – covering key considerations such as accessibility, screening and assessments, staffing, clinical gov-

ernance, informed consent and confidentiality, and the need for aftercare and ongoing support.

It is estimated that just one out of every 18 people reporting drug-related problems in Africa has access to quality drug treatment services – compared to one in six people globally.³⁷ This reflects a general lack of political will and resources (including funding, facilities, personnel and training) across the continent. Even where treatment programmes do exist, they tend to be poorly regulated by government and out of line with the evidence of effectiveness and cost-effectiveness. Too often, scarce treatment resources are also being wasted: it is critical to acknowledge that evidence-based treatment is only an appropriate response for those who are experiencing problems and dependence due to their drug use – and this is only around one in every 10 people who use drugs.³⁸

To protect the basic rights of people who use drugs, and maximise the effectiveness of treatment programmes, drug treatment should always be voluntary.³⁹ Treatment success and ‘recovery’ should also not be understood only as abstinence. Success should be defined by the individual, rather than the state – it may be the cessation of drug use, but could just as legitimately be a reduction in drug use, abstinence from certain drugs but not others, gaining employment, reduction in crime and/or a reduction in harms and risks. If one treatment option does not achieve these goals, then the individual treatment plan should be amended accordingly – this should not be deemed as a person ‘failing’ treatment.

4. Alternatives to arrest and incarceration

A crucial part of a health-based drug policy is considering drug use as a health issue, rather than a criminal one. Therefore, a core element of this approach is the removal of criminal sanctions for drug possession and drug use. This may take many forms, dependent on what is possible in the national context, but the overall commitment is the same: that incarceration is not an adequate response to drug use, and should only

be used as a last resort and only for high-level, violent drug offenders.

Diversion into treatment may be provided at the time of arrest or before prosecuting (and implemented by the police), or at the time of sentencing (and offered through courts as an alternative to prison). Recalling the principle above that not all people who use drugs are in need of treatment, this is nonetheless a practical and more effective response for those who do. It also helps to reduce the burden on the criminal justice system, but does require an effective and well-resourced drug treatment system into which referrals can be made. Such an approach does not require legal reform – it can be implemented through national policy, rather than law. Those who do not require treatment could be referred to harm reduction services and other social support programmes they may need.

Evidence shows the effectiveness of removing criminal sanctions for drug use.⁴⁰ Through a process of **decriminalisation**, drug use is no longer considered a criminal offence. It may instead be dealt with through non-criminal sanctions – such as fines, drug confiscation or community service – or through suitable referrals to drug treatment and harm reduction services. Removing criminal sanctions means that vulnerable individuals no longer receive criminal records, therefore helping to reduce the stigma and discrimination they experience. It also enables them to access the health and social services they may need without fear of arrest or incarceration. Finally, it enables the police and criminal justice system to focus resources on those most harmful and violent aspects of the illicit drug market.

Such an approach is already adopted in more than 20 countries around the world.⁴¹ Decriminalisation has also now been endorsed by a number of UN agencies⁴² – while UNODC have also promoted the approach⁴³ and confirmed that decriminalisation is permitted within the international drug conventions.⁴⁴

Decriminalisation may be implemented through a change of national drug laws (“*de jure* decriminalisation”), or through a change in practice

whereby criminal penalties are no longer applied by police (“*de facto* decriminalisation”).⁴⁵ The alternative sanctions applied should never be more severe than those under criminalisation, and should encourage access to health and social services. For example, the successes achieved since decriminalisation in Portugal (including reduced HIV infections, overdoses and drug use⁴⁶) can be attributed to the legal reforms but also, crucially, to the increased investments that are being made in drug treatment and health services for people who use drugs.

When decriminalising drug use, governments should be mindful to **ensure more proportionate penalties** for all drug offences. This is much needed across Africa, where sentences for drug offences are often alarmingly disproportionate to the actual severity of the offence: in some cases, ranging from 10 to 15 years for minor offences, and from 15 years to life imprisonment for more serious offences, and with mandatory minimum sentences enforced that remove any discretion on the part of judges and prosecutors.⁴⁷

5. Access to medicines

One of the fundamental aims of the UN drug control system, as defined by the international drug conventions, is to ensure the availability of internationally controlled substances for medical and scientific purposes.⁴⁸ But the system is failing. The World Health Organisation estimates that 5.5 billion people live in countries with low or non-existent access to pain relief and other essential medicines⁴⁹ – including far too many countries in Africa. At the same time, access to opioid substitution therapy remains woefully inadequate in the region.⁵⁰

To remedy this, national drug control regulations should be reviewed using available guidance⁵¹ to ensure that they do not interfere unnecessarily with the availability of medicines. Any existing barriers or legal impediments to such access should be urgently removed, with adequate training being provided for healthcare, law enforcement and drug control personnel. More

scientific research is also needed globally on the therapeutic and medical value of other controlled substances, such as MDMA and cannabis. For the latter, medical marijuana provision can already be found in a number of countries around the world. African governments should therefore consider this additional policy option, as no formal medical marijuana schemes currently exist in the region.

Box 2. The Data Gap

Implementing an effective, evidence-based drug policy requires accurate and up-to-date information about local illicit drug markets. These data include the types and purity of substances being used, trafficking routes and trends, the prevalence of drug use, and drug-related harms such as HIV, hepatitis and overdose.

What sets Africa apart, however, is the lack of such data. Most countries do not possess the expensive and complex mechanisms to capture this information, with estimates from the UN and others relying instead on extrapolation and expert opinion. Improved data capture is clearly an area requiring urgent attention (perhaps through a regional entity similar to the European Monitoring Centre for Drugs and Drug Addiction), as is a more sophisticated understanding of what metrics are the most important to measure the success or failure of drug policies.⁵²

Conclusion

As the drug policy debate evolves, more and more countries – including in Africa – are realising that punishing people who use drugs is not the right approach, and that they need to find new solutions. A more humane, effective and health-based response is clearly needed. Governments must therefore commit to evidence-based drug prevention, harm reduction and drug treatment services, as well as alternatives to incarceration and arrest, and measures to ensure access to essential medicines. If implemented

properly, these five pillars of a health-based approach will reduce HIV, hepatitis and other public health harms, as well as reducing the burden on criminal justice systems.

The public health approach outlined in this paper is in line with the UNGASS recommendations developed by the International Drug Policy Consortium,⁵³ as well as the UNGASS recommendations recently articulated by UNAIDS. The latter include harm reduction in prisons and community settings, the need to decriminalise drug use, the provision of non-coercive and evidence-based drug treatment, human rights protections, the reduction of stigma and discrimination, overdose prevention and civil society engagement.⁵⁴ Crucially, the UNAIDS recommendations also address how this health-based approach can be financed around the world by “rebalancing” the current investments in drug law enforcement, and diverting just a small portion of this funding into health instead.⁵⁵

All African stakeholders – including governments, policy makers, the media, academics, service providers, law enforcement, civil society, and affected populations including people who use drugs – need to come together to understand, evaluate and modernise drug policies, following the progressive guidance and positions of the African Union amongst others. There is no ‘one size fits all’ solution that will work for every African country – but this process starts with an honest assessment of what is, and what is not, working with current national drug laws. This process has to start now.

Endnotes

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About this advocacy note

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About IDPC

The International Drug Policy Consortium is a global network of non-government organizations that specialize in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. It produces briefing papers, disseminates the reports of its member organizations, and offers expert advice to policy makers and officials around the world.

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