

THE EVOLUTION OF ILLICIT DRUG MARKETS AND DRUG POLICY IN AFRICA

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List of acronyms

ACHPR	African Commission on Human and Peoples' Rights
AG	Africa Group of the UN
AU	African Union
BINLEA	US Bureau of International Narcotics and Law Enforcement Affairs
CAP	Common African Position
CEN-SAD	Community of Sahel-Saharan States
CND	Commission on Narcotic Drugs
COMESA	Common Market for Eastern and Southern Africa
CPLP	Community of Portuguese Language Countries
CSO	civil society organisation
EAC	East African Community
ECCAS	Economic Community of Central African States

ECOWAS	Economic Community of West African States
FSI	Fragile State Index
G77	Group of 77 and China
GCDP	Global Commission on Drug Policy
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
ICPAD	International Conference of Parliamentarians Against Drugs
IDU	injecting drug use
IGAD	Intergovernmental Authority on Development
INCB	International Narcotics Control Board
LAS	League of Arab States
NAM	Non-Aligned Movement
NPS	new psychoactive substance
NSP	Needle Syringe Programme
NSVA	non-state violent actor
OHCHR	UN Office of the High Commissioner for Human Rights
OIC	Organisation of Islamic Cooperation
OIF	International Organisation of the Francophonie
OST	opioid substitution therapy
PG	Pompidou Group
PWID	people who inject drugs
PWUD	people who use drugs
RADD	Russian-African Anti-Drug Dialogue
SADC	Southern African Development Community
UMA	Arab Maghreb Union
UN	United Nations
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on Drugs
UNODC	United Nations Office on Drugs and Crime
WACD	West Africa Commission on Drugs
WHO	World Health Organization

Introduction

Globally, support for drug policy reform has grown over the past 10 years. Even as the drug prohibition consensus-keepers in Vienna have voted for yet another 10-year extension to their still unsuccessful 20-year strategy for global drug control at the March 2019 Commission on Narcotic Drugs High Level Review meeting, a reform movement among global member states has been gaining credibility and strength.

The United Nations General Assembly Special Session on Drugs (UNGASS) meeting of member states in New York in 2016 was a soft watershed moment in the history of global drug policy. It was significant in its revelation that the global consensus on drug prohibition that had existed for 55 years now appears to be an openly fractured and vulnerable accord, one that was – and continues to be – in a state of flux.

UNGASS 2016 demonstrated that political space had opened for regional and national reflections on the nature of illicit drugs and countries' domestic responses. By extension, the fragmenting of global drug policy's 'Vienna Consensus' has also provided an opportunity for Africa. The continent could unify and play a leading role in shaping and implementing a new international drug policy approach. Such an approach could be grounded in the human rights, health and social development objectives of its continental Agenda 2030 goal of sustainable development, within the wider context of its Agenda 2063 goal of 'an integrated, prosperous and peaceful Africa'.¹

The purpose of this report is to reflect on the changing drug policy environment in Africa, particularly in the period leading up to and after the seminal UNGASS 2016 meeting of member states. It also examines the politics of continental drug policy prohibition and reform in the context of the growing global movement to embrace drug policy alternatives to the once universal approach of strict prohibition. Observations and recommendations are made regarding incorporating drug policy reform in the context of achieving developmental success with respect to the continental Agenda 2030 and Agenda 2063 goals.

The global order on drugs is collapsing

In March 2016 leaders gathered in New York for the UNGASS meeting on the world drug problem. On the surface, the purpose of this meeting was to discuss interim progress made in the global response to drugs. Specifically, they were to assess whether any progress was being made toward the objectives of the United Nations' (UN) 10-year counternarcotic strategy and plan of action.²

This strategy, grounded in the three international drug conventions and devised by members of the UN's Commission on Narcotic Drugs (CND), was approaching the end of its second decade. Originally launched in 1998, it had been extended an additional 10 years after failing to achieve any of its original objectives. Thus, states were keen to revisit the progress of what was a strongly prohibitionist response ahead of its conclusion, in order to determine what, if anything, needed to be changed in order to achieve the desired results. In this case, these were framed around the aspirational political goal of a 'drug-free world'.

Some African indigenous authorities often were strong advocates of the idea that drug consumption is an international threat

A number of African states are invested in the global 'war on drugs', and recognise – perhaps more than others – the importance of the UNGASS in this regard. After all, drug prohibition has had a long history on the continent. Egypt saw the first modern drug law, a hashish ban, issued in October 1800 by Jacques-François Menou in his capacity as general-in-chief of the French Army of the Orient.³

In addition to the prohibition approaches pursued by colonial regimes, Some African indigenous authorities often were strong and original advocates of the idea that drug consumption is an international threat.

These authorities were proponents of the first global ban against cannabis, which originated at the Second Opium Conference of 1925.⁴ Cannabis and khat were controlled domestically, through either de jure or de facto measures, in several states.

The international drug control regime developed over subsequent decades, driven by the politics of colonial and postcolonial power dynamics, and thematically influenced by orientalist misconceptions and fears around the growing list of internationally controlled substances and their consumers.

African states remained active partners in the process, particularly through the work of the Africa Group of the UN (AG). Consumption of these newly scheduled substances was still limited across much of the continent.

However, as states gained independence and initiated national development strategies there was a natural alignment of African drug and crime responses with the expanding international structures of drug prohibition and control.

This was evident particularly after the UN adopted its third international drug control instrument, the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988), and the 1998 adoption of the CND's original Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem.

The resilience of Africa's illicit drug markets

By this time African states found themselves transit hubs and destination countries for new substances such as cocaine and heroin. Domestic consumption and trade markets were developing along the continent's eastern and western coastal states and infiltrating onwards. At the same time the cultivation and production of cannabis expanded across the continent as consumer demand and infrastructural access drew it to new populations and geographies.

With the traffic in controlled substances always an element of global illicit trade,⁵ African drug markets

soon began to expand alongside the developmental expansion of the continent's newly independent domestic economies.

As international drug control measures squeezed supply chains from South Asian and Latin American source points to their North American and European destination markets, new trafficking routes evolved through African states to circumvent these measures. New supply channels and, consequently, new markets, opened.

African drug markets soon began to expand alongside the continent's new independent domestic economies

The continental consumption, production and distribution of controlled substances such as heroin, cocaine, cannabis and amphetamines grew notably from the 1980s. The impact of this expanding illicit market on state development was significant, and paradoxically symbiotic.

These emerging illicit African drug markets threatened to undermine the development and security of the continent's nascent state institutions and structures. At the same time, they presented new sources of economic livelihood and resilience for the continent's expanding population of poor and vulnerable peoples.⁶

Illicit alternative livelihoods aside, the expansion of drug markets and the correlated securitised, and increasingly militarised, responses developed by (and imposed upon) African states had several unintended consequences.

Already home to 69% of the world's population living with HIV, the rise in African consumption of opiates saw an increase in injection drug use and a correlated increase in HIV, Hepatitis C (HCV) and Hepatitis B (HBV) viral transmission among communities of people who

inject drugs (PWID).⁷ HIV seroprevalence rates among users in these areas went as high as 87%.⁸

Morbidity and mortality among young people who use drugs (PWUD) rose markedly as their adherence rates for anti-retroviral medication (for treatment of HIV) decreased, the stigma associated with (and discrimination by) health officials and law enforcement against PWUD increased,⁹ and fatal and non-fatal overdose rates grew.¹⁰

Access to prescription medicines – particularly opioids – failed to improve across the continent. This failure was caused by misdirected drug control enforcement initiatives targeting opioids, subsequent health institutional reluctance to employ the substances involved, and counterfeiting and diversion by criminal groups of pharmaceutical commodities from licit streams into illicit markets.¹¹ As a result, national pharmacopeia shrank and palliative care options diminished.¹²

The reliance of innumerable rural African households in decaying economic environments on the subsistent cultivation, production and trade in illicit crops such as cannabis and khat made them especially vulnerable to drug prohibition measures.¹³

National prison populations expanded to overcrowded institutional capacity levels of 400% and more, as state security and judicial structures responded by arresting and incarcerating vast numbers of people for drug-related crimes.¹⁴ Generations of young people became disenfranchised owing to criminal convictions for low-level drug crimes, such as drug use or possession of small quantities of drugs for personal use.¹⁵ Disproportionately high unemployment and underemployment rates marginalised people who use (or used) drugs, and those with a criminal conviction for low-level drug offences.¹⁶

The failure of continental drug control efforts

Yet, even as illicit crop fields were destroyed; PWUD arrested, imprisoned and/or forced into treatment; illicit drug labs identified and destroyed; and drug shipments seized; continental drug markets continued to expand.

New psychoactive substances, existing outside of international drug convention scheduling, and the misuse of prescription pharmaceuticals, particularly Tramadol, emerged and prospered.¹⁷

The illicit drug trade became entangled with the economic ventures of violent non-state actors, particularly in West Africa and the Sahel.¹⁸ As in other parts of the world, drugs were identified as a core trade commodity and revenue source for continental terrorist organisations.¹⁹ Similarly, drug trade profits have funded democratic electoral campaigns for political office; propped up dictatorial and hereditary government leaders and their regimes; and corrupted state institutions to such an extent that international organisations have begun to view certain countries as potential narco-states.²⁰

The political consensus position of prohibition – the so-called Vienna Consensus – is no longer universal among member states

While prohibitionist interventions have occasionally been able to displace or interrupt illicit continental drug market flows, they have never been able to wholly contain or eliminate them. This result has not been unique to Africa.

Despite this reality, and the fact that 100 years of global drug control has neither resolved nor contained the harms of the illicit drug industry, the most common response by member states has been to double down on existing global prohibition strategies and cooperative interdiction measures.

The International Narcotics Control Board (INCB) even stated that what was needed for success in the global (and, by extension, continental) war on drugs was not new approaches to drug policy but rather for member states to 'try harder' to succeed with the current approaches as outlined in the existing strategy.²¹

Yet the political consensus position of prohibition – the so-called Vienna Consensus – is no longer universal among member states. Many have quietly been questioning the efficacy of prohibition measures to control and curtail the world's illicit drug industry, and some have pursued alternative soft policy approaches to domestic prohibition. Several have even gone so far as to decriminalise and/or legalise the drugs that they once so strongly prohibited.

This epistemological reconciliation is happening across the globe, from Ottawa to Cape Town, from Accra to Auckland. In this sense, the emergent questioning of illicit drug policy evident across the continent is a reflection of a wider global trend rather than a non-conformist act voiced by a marginalised few within the continental whole.

A brief history of the drug trade in Africa

Africa has a long history with drug cultivation, production, consumption and trade. Khat (*Catha edulis*), an indigenous crop of the Horn and coastal East, has been used as a recreational stimulant in Ethiopia and Yemen since the 12th century.²² Cannabis, originally imported from Asia, has a history of at least several hundred years of production and use. Alcohol, tobacco and caffeine have been produced, consumed and traded throughout the sociocultural history of drug use on the continent.²³

Initially, the informal policies surrounding the governance of these drugs were developed and driven by traditional social networks and cultural beliefs and practices.²⁴ Although not completely unknown substances to African consumers in the past, it is the large-scale trade in and widespread use of opiates, stimulants and other synthetic substances that is a relatively recent phenomenon on the continent.

While the presence of small amounts of opium and heroin was not uncommon, the African drug trade began to expand its boundaries in 1952.²⁵ At the time Lebanese traders were using West Africa as a staging point for the shipment of large heroin consignments to US markets. Around the same time, organised Nigerian criminal groups began smuggling African cannabis to consumers in expanding European markets.²⁶

Intra-continental trade in cannabis exploited traditional precolonial networks and routes that had supported the trade in commodities such as gold and ivory, and connected coastal markets with those in the continental interior.²⁷ Shortly thereafter the continental relationship with drugs began to transform rapidly.

The post-colonial era

From 1960 to 1977 a total of 44 African states gained their independence from European colonisers. Economic and institutional development in these new nations was slow, often inequitably distributed, and vastly underfunded, as many invested heavily in mining and other extractive industries in order to raise development capital. Young Africans were the most directly affected.

Amid growing economic stress, high rates of youth unemployment, and rapid, dramatic and deeply unsettling socioeconomic transformations, cannabis, in particular, became a symbol of political resistance for the disenfranchised as they confronted the myriad growing centres of domestic African state power.²⁸ Demand for and use of cannabis within Africa expanded accordingly, as did its means of production and its illicit economic marketplaces.

The global expansion of containerisation and intermodal shipping through the 1970s, and the launch of new long-haul mass transport vehicles such as the Boeing 747 passenger aircraft, reshaped the global economic landscape in general and the African marketplace in particular.

Alongside the development of the continent's air- and seaports, new African transport hubs were included in and integrated into global transport and communication networks. New *entrepôt* trade and commerce marketplaces emerged across the continent. Additionally, the expanding trafficking flows saw technological innovations designed to increase the volume of drug commodity movement and decrease the risk of seizure.²⁹

At the same time, the crumbling of the South African state as it struggled under international sanctions,

and the eventual collapse of its apartheid system, saw increased local production, use of and trade in manufactured drugs.³⁰ These were soon propagated in other continental marketplaces.

Emerging and re-emerging conflicts, and the concomitant economic malaise across the rest of the continent in the 1980s, particularly in those economically undiversified countries hardest hit by the global recession of the 1970s, saw significant rapid growth in the drugs trade. North American and European law enforcement authorities began to arrest increasing numbers of West African drug couriers.

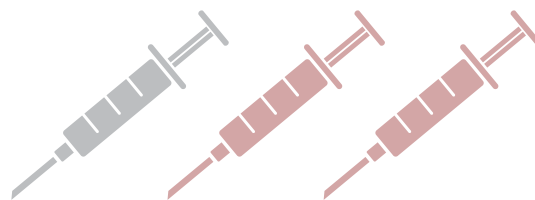
The many nascent networks of African drug traders – in particular, those dominated by the Nigerian and Ghanaian diaspora – further consolidated their entrenched positions in the market economies of East Asia, the Middle East, Europe and North America, traveling along with their cannabis, cocaine and other drugs to these new destinations.³¹

In the mid-1980s the United States (US) Drug Enforcement Administration (DEA) opened its first African office in Lagos,³² as Africa began to be viewed by European and US political interests as a significant international drug trade concern.

The boom of the 90s

The 1990s were to herald the economic transformation of African states through the implementation of the UN's New Agenda for the Development of Africa (NADAF), which it had imposed on the continent at the beginning of the decade. It was a spectacular failure, with 80 million more Africans living in poverty at the end of the NADAF decade than at its beginning.³³

The decade was conducive to significant and rapid drug trade expansion across the continent, again in West Africa in particular. Trade in cocaine from Latin America to Europe became a core commodity of the regional drug economy. Transport nodes in countries such as Guinea-Bissau and Ghana were used to repackage and ship the product onward to the European market and its consumers. International organisations began to take notice. West Africa, in particular, was increasingly viewed as a collection of corrupt, failed or failing states.³⁴



Nearly two-thirds of the heroin seized in 1991 at JFK airport in New York City came from Nigerians or other Africans recruited by Nigerian drug organisations

Nearly two-thirds of the heroin seized in 1991 at the JFK airport in New York City came from Nigerians or other Africans recruited by Nigerian drug organisations.³⁵ The market reach of Nigerian (and Ghanaian) trafficking networks, further empowered by diasporic connections in destination countries, was vast.

US intervention expanded as it openly waged its growing global war on drugs by targeting what it deemed to be extraterritorial US drug trade threats. It opened more DEA offices on the continent (Accra, Nairobi, Pretoria) and did not hesitate to use the threat of decertification, and other political pressures, against African countries that it perceived as being 'weak on drugs'.³⁶

Still, the drug trade economies of Africa grew as its entrepreneurs expanded their linkages with organised criminal groups in Latin American and Asian origin points, while consolidating their interests continentally.

The cocaine connection between West African transit hubs and Latin American suppliers expanded enormously through the 2000s. Tonnes of cocaine were transiting the western states of the continent en route to markets in Europe and the Middle East.³⁷ International organisations began to panic.

The UN Office on Drugs and Crime (UNODC) issued a statement warning that 'narco-trafficking, through a vulnerable region that has never previously faced a drugs problem, is perverting weak economies'.³⁸ Its executive director warned that 'this is more than a drugs problem – it is a threat to public health and security in West Africa'.³⁹

Continental diffusion of illicit drug markets

In addition, Afghan heroin was beginning to emerge in volume in East Africa, as its former Taliban-led government fled the US military intervention and Afghan-based armed groups rapidly expanded their cultivation of opium poppy and production of heroin to fund their conflict needs.

Brought in by dhow to Kenyan and Tanzanian ports from Pakistani and Iranian departure points, repackaged and trans-shipped to European and US markets, it was inevitable that product leakage would occur and local use would grow.

The injection of heroin spread with the product along the east coast of Africa, emerging in Kenya, Tanzania, Mozambique and South Africa. Use patterns continued to disperse further inland as those who injected tended to be among the poorest and most vulnerable members of society. They migrated to other places for work or other reasons, taking their substance use with them.

Heroin injection appeared in Zimbabwe, Zambia, Malawi, Uganda, Rwanda, Burundi, eSwatini, Namibia, Angola and the Democratic Republic of Congo (DRC). Before long it would be difficult to identify an African nation that did not have some number of people who injected heroin or other drugs.

With the diffusion of heroin and injection as its means of consumption came increased transmission of HIV and HCV, and subsequent high levels of seroprevalence – and related morbidity and mortality – among drug-injecting populations of the region.⁴⁰

In the span of less than 60 years from the 1961 inauguration of the Single Convention on Drugs, Africa's drug use, production and trade environment transformed from one grounded in the traditional crops of khat and cannabis to the large-scale, widespread industrial production, use of and trade in opiates, like heroin;⁴¹ stimulants, like cocaine and amphetamine-type substances (ATS) like crystal meth;⁴² diverted pharmaceuticals, like Tramadol, codeine and fenethylline;⁴³ and new psychoactive substances (NPS), like synthetic cannabinoids.⁴⁴

It has become a marketplace as much organised and driven by Africans and African groups as it is influenced and supported by foreign investment, institutions and organisations.⁴⁵ This rapid evolution has engendered and validated a unified response across the continent: the securitisation and militarisation of national and regional approaches to drugs and their control.

African nations played a strong role in the criminalisation of cannabis and the origin treaties of modern drug control

The evolution of continental drug policy

However, the traditional pan-African 'prohibitionist agenda' cannot be understood to be as unanimous a position today as it was prior to the UNGASS 2016 debates. This is despite the near unanimity among states in their ratification of the three international drug control treaties.

Africa was the birthplace of modern drug control, following Menou's colonial *ordre du jour* in 1800.⁴⁶ African nations played a strong role in the criminalisation of cannabis and the origin treaties of modern drug control. As a post-colonial bloc, the African Group at the UN and its 54 constituent states continue to be formidable prohibitionists, endorsing and re-endorsing innumerable measures and statements advocating prohibition, control and punishment.

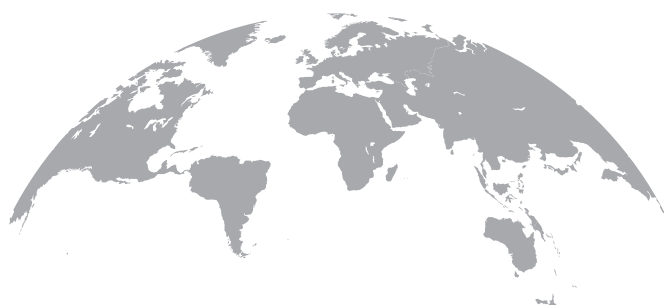
For decades of international drug control, and with few exceptions, they were strident stalwarts of the Global Order on Drugs and its Vienna Consensus. What this means is that they believed in the complete illegality of all substances scheduled by the three international drug conventions, and committed to a criminalised national response to drugs in which the possession, use, production, trade and transit of these substances were punishable criminal offences.

International bodies (like the UN) and developed states – mostly those with populations that consume the drugs transiting Africa – have attempted to influence, through firm and soft measures alike, the drug policy direction and implementation measures of some African states. Yet, as historian Charles Ambler has noted, these externally-driven and/or imposed ‘global initiatives related to drugs in Africa have focused largely on the international trade rather than on “protecting” African communities from drugs’.⁴⁷

This is as true for bilateral support initiatives (aimed at promoting the domestic security response to drug interdiction) provided to one state as it is for global or regionally focused anti-trafficking or prevention initiatives. Naturally, such assistance endeavours often were not an exercise in benevolence but instead a shrewd political investment in moral suasion.

Various attempts at political influence and interference continue today, especially since the global drug policy consensus has begun to lose its foundation of support, and particularly because in Africa expressions of doubt have begun to grow, and national decisions on drug reform has begun to be made.

It is important to recognise that while the international consensus on illicit drug control continues to evolve, its institutional structures are now rife with member state tension, soft political defections, and outright policy contraventions.



Globally, 45 countries now have liberalised their domestic drug policies with the intention of decriminalising or legalising the use, production and/or trade of a scheduled drug or drugs

What was once a universal ‘iron pact’ among UN member states, particularly among and between African states, grounded in the terms and conditions of the Vienna-based international drug conventions⁴⁸ and overseen by the UN triumvirate of the CND, the UNODC and the INCB, has become a fragmented alliance. This alliance is ideologically divided on the way forward, increasingly polarised, and sees a decreasing majority of states still clinging to a traditional, securitised political investment in a global ‘war on drugs’.

Since UNGASS 2016, a global meeting intended as a watershed moment for global drug policy, 19 countries have legalised cannabis for medical use in some form.⁴⁹ A further five countries have decriminalised its use,⁵⁰ and an additional two countries have legalised its use within their borders.⁵¹ Further, five more US states⁵² have legalised the recreational use of cannabis, bringing to 10 the total number of US jurisdictions with a legal cannabis trade.

Globally, 45 countries now have liberalised their domestic drug policies with the intention of decriminalising or legalising the use, production and/or trade of a scheduled drug or drugs. This total represents nearly one-quarter of the 193 member states of the UN. Clearly, the Vienna Consensus is broken.

The depth of this ‘crisis of consensus’ was illustrated in November 2018 in the final session of the UN General Assembly’s Third Committee when, for the first time, a consensus could not be reached on the endorsement of the UN’s annual ‘drugs omnibus resolution’,⁵³ as China did not join the consensus and instead lodged a reservation to the document before its formal adoption.⁵⁴

This evolution in drug policy at the global level is reflected in changes within the African drug policy environment.

Traditionally, Africa was a bastion of conservative, prohibitionist drug policies, perhaps condescendingly described as a drug policy environment ‘designed to strengthen authoritarian institutions and repressive state capacity’.⁵⁵ Now the continent is the focus of drug policy pressure from states and institutions on both sides of the rapidly polarising global drug policy debate.

Political and diplomatic conflict between so-called drug policy prohibitionist and reformist countries at the global level is replicated at the continental level. Prohibitionist African states strive to reinforce (or force) among their less enthusiastically driven neighbours a historical prohibitionist consensus perceived as still being the 'African position'.

While most drugs still remain de jure illegal across the continent, there is a wide discrepancy in how they are being policed and controlled

African drug policy has become a dynamic political space, with regional and global vested interests placing often-competing political positioning requirements on member states. The membership and political positioning of regional African groups, as well as that of global and regional alliances in which African nations have a stake and/or a formal membership, infuse a political variance into the domestic practicalities of drug policy debates.

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

The crisis of confidence enveloping the continent's drug policy consensus is exacerbated by the fact that Lesotho (2016), South Africa (2018), Zambia (2017)⁵⁶ and Zimbabwe (2018) have legalised domestic cannabis use and/or production in some form. In addition, four more African states⁵⁷ are considering either the

decriminalisation or legalisation of cannabis or all drugs within their borders.

Furthermore, while most drugs still remain de jure illegal across the continent (with the aforementioned exceptions), there is a wide discrepancy in how they are actually being policed and controlled within each state's borders.

Cannabis, for example, is routinely policed in many states of the continent as if it were de facto legal. The same can be said for the lenient position several African states have begun to take regarding the possession of small amounts of other illegal substances – defined variably as 'for personal consumption'. In this regard, a further three African states could be classified as treating cannabis as de facto legal through their non-enforcement (or very lax enforcement) of domestic prohibition laws.⁵⁸

Thus, 11 African states – or 20% – have liberalised (or are considering the liberalisation of) their drug control policies and approaches either in law or its practical application. All of this has occurred in the 18 months since the 2016 UNGASS meeting.

This defection by a minority from what had been regarded as the traditional continental consensus platform of prohibition to an agenda aligned with the global drug policy reform movement has divided the continent and injected further ambiguity into the wider continental debate around its now fractious drug policy platform.



11 African states have liberalised (or are considering the liberalisation of) their drug control policies and approaches either in law or its practical application

While this may seem surprising, ambiguity is not uncommon to the African drug policy debate. This becomes apparent if one looks at the fluid political contexts that have surrounded the continent's two traditional 'drug crops' of khat and cannabis.

The ambiguity of khat

Khat has been called the 'archetypal quasi-legal substance'.⁵⁹ A plant indigenous to Eastern and Southern Africa, it contains the psychoactive alkaloids cathine and cathinone and has been used as a recreational stimulant in Ethiopia and Yemen since the 12th century.⁶⁰ Khat cultivation extends from Ethiopia and Yemen through Kenya, Uganda, Rwanda and Burundi to the eastern provinces of South Africa, and northern Madagascar.⁶¹

A culturally important commercial crop, its value lies not only in its price stability as a tradeable commodity but also in the fact that it can be planted year-round on marginal land, requires minimal inputs to cultivate, and does not compete for land with traditional food crops.⁶²

Until the late 1970s khat use was confined largely to its region of production.⁶³ This geographic inertia was caused by the perishability of the plant. A plant that is most commonly chewed, its leaves and stems need to be consumed fresh as the alkaloids normally deteriorate within three days of harvesting.

However, as transport and communication structures and systems expanded in the 1970s, and African air and sea ports became more developed and better integrated into the expanding global marketplace and its commodity distribution networks, khat too began to expand in its reach, alongside the wider expansion of the continental drug trade.

While its active alkaloids have been listed under international control, unlike cannabis, the coca leaf and the opium poppy, its plant matter is not likewise listed.⁶⁴ The incongruent nature of its scheduling has contributed to khat's classification status straddling the boundaries of both the legal and illegal, the licit and illicit, depending largely on the contexts of its particular consideration.⁶⁵

This ambiguity extends even further, to the confounding of research and health debates on the subject of whether khat use is harmful or benign throughout medical research from the 1950s to today.⁶⁶

In point of fact, 'some substances or activities are socially viewed as licit even though by law they are illegal, and vice versa'.⁶⁷ When it comes to drug control, khat is a perfect example of this ambiguity. No matter how the drug is classified in domestic or international law, what matters most is how it is treated 'by those tasked with upholding the law and by wider society',⁶⁸ since it is the socio-cultural, political and historical context in which khat is consumed that contributes to this determination.⁶⁹

In this regard, khat is an interesting case.

As the production and consumption of khat extended beyond its traditional geographies and cultural grounds, its dissemination tended to follow diasporic routes.⁷⁰ Khat supply and use largely followed Somali populations, the most conspicuous group of consumers. They were scattered to neighbouring African nations – and then to others in Europe and North America – following the violence and rapid deterioration in their country's security and stability in the early 1990s.⁷¹

Owing to advances in transport and shipping systems, khat production and supply could reach further, from its hillside origins to the East African diasporic urban centres of Europe and North America.

Within Africa khat use spread quickly, creating large consumer markets in Eritrea, Sudan, Uganda, Rwanda and South Africa.

Khat demand, in the past largely confined to expatriate Somali and Kenyan populations, but also including consumers from other East African nationalities, expanded to these new migrant communities. Supply soon followed.

While the khat plant was not classified by the Vienna drug conventions as an illegal (controlled) substance, the emergence of this 'new' substance in non-traditional, Western centres still disturbed authorities. Debates ensued as to whether khat was a harmful product and,

if so, whether it should be prohibited.⁷² As Klein et al. noted: '[K]hat has largely been viewed through the prism of drug law enforcement ... legal prohibition so far has followed consumption, which in turn has been a product of Somali migration.'⁷³

That khat, a legal but 'foreign' substance often compared to coffee (i.e. caffeine) in its effect, could be viewed by Western countries with so much suspicion was perhaps a reflection more on their views of the consumers of the product than on the product itself.⁷⁴

Ambler argued that the colonial approach to the prohibition and control of alcohol in Africa was a paternalistic response to a population that was viewed as having a powerless affinity for the harmful consumption of spirits.⁷⁵ One may argue that a similar perception has guided developed nations' policy and drug control responses to the influx of khat supply and the populations that use it.

Regardless, khat's legal ambiguity under the international drug conventions has enabled countries to define it unilaterally as either relatively harmless or relatively harmful; and thus, by extension, to classify its trade as relatively licit or relatively illicit.⁷⁶ As a result, khat, a legal substance, has found itself prohibited in some form in Australia, Canada, Denmark, France, Germany, Italy, Jordan, the Netherlands, Norway, Saudi Arabia, Spain, Sweden, the United Kingdom (UK)⁷⁷ and the US. In Africa it has been prohibited by Rwanda and Tanzania, and it must be licensed in South Africa. The legal had become now the criminalised abroad.

In fact, even in countries where khat was not explicitly controlled through de jure prohibition, it was in many ways still controlled by the state via de facto control measures. These have manifested in the apparent conflation of cannabis and khat, where the latter plant material is often seized by local law enforcement officers on the grounds that it is an illegal crop akin to cannabis. Such seizures likely are more a means of extracting bribes, or increasing local arrest quota statistics, than they are evidence of a defined agenda of khat prohibition. The perception of illegality (and illicitness) among law enforcement as well as segments of the general population nevertheless permeates the trade.

With khat prohibited in Rwanda and Tanzania, neighbouring countries in turn have used this 'other' scheduling of khat to justify their own domestic seizure of plant material, despite khat's being de jure legal in their country.

Khat's legal ambiguity under the international drug conventions has enabled countries to define it as either licit or relatively illicit

Increasingly, the khat trade abroad, and within the continent, faces socially constructed commercial and criminalised prohibition barriers to its market operation and use. Its status has never been more ambiguous.

This trend towards increased criminalisation of khat has raised the not-insignificant possibility that previously non-existent linkages between khat production and trade and transnational organised criminal networks might arise.⁷⁸

After all, the criminalisation of khat in these places will not remove its demand, and historical bans on khat (as was attempted in Somalia in the 1980s) failed owing to a lack of perceived legitimacy, continued increase in consumer demand, and the inability by security forces to control the multiplying smuggling supply routes.⁷⁹

Regardless, the criminalising rhetoric that plagues the status of khat in Africa can be juxtaposed with that which governs cannabis and its trade on the continent.

Africa's de facto legalisation of cannabis

Cannabis, a non-native plant imported from Asia to East Africa via Indian Ocean trade networks, has a long history of production and use in Africa, extending as far back as the 14th century.⁸⁰ It is the most commonly used and traded drug on the continent (excluding alcohol, tobacco and caffeine) with an estimated 38.2 million

consumers,⁸¹ compared to the 5 to 10 million continental consumers of khat.⁸²

The use of cannabis is highest among the peoples of West and Central Africa,⁸³ although it is found throughout the continent.

It has been a product of cultural practices, a medicinal herb used by traditional healers, and a key livelihood crop (like khat) for poor farmers.⁸⁴ Its comparative economic advantage to these farmers is rooted in its structural illegality and illicitness, yet supported by its sociocultural contexts of licitness and de facto legality.

Africa has some of the highest levels of cannabis production in the world, accounting for around 25% of the global total, with much of this production consumed on the continent.⁸⁵

Following its initial importation, cannabis cultivation and herbal production sites migrated southwards and westwards from their arrival points in Eastern Africa, then travelling to northern states, where the production of cannabis resin is more prevalent than on the rest of the continent.

From the 1950s onwards cannabis became increasingly commoditised across the continent, and consequently

became further embedded in the rural economies of Eastern and Southern Africa. Its rise has been seen as a consequence of the economic uncertainties that plagued continental state transitions from colony to neoliberal economic agent. As Africa developed, borders fell, and the continent became increasingly integrated with the global marketplace.⁸⁶

Traditionally viewed as a 'compensation crop' – one that could be grown to make up for a loss of another crop (like cocoa) – today it is an important commercial cash crop in its own right. In Africa, cannabis production and use is ubiquitous.

Initially, most African countries banned cannabis after the enactment of the 1925 International Opium Convention, which also addressed heroin and cocaine. These colonial acts generally were designed in the colonising nation's European capital and imposed on African colonies with little regard for local concerns or conditions.

In fact, until the 1950s many African colonies expressed little concern about domestic cannabis production and use, with some notable exceptions.⁸⁷ It was seen largely as a benign issue, only beginning to gain traction with the widespread commercial expansion of the trade in the 1950s, and the institution of the first international drug control treaty, with the correlated international prohibition perspectives that accompanied its passing.⁸⁸ This was not, however, the stance in South Africa.

Historically, cannabis consumption was seen through a racial lens in South Africa, and the government viewed its use by workers as having significant negative economic ramifications. These racialised ideas around control of the local labour force and production in South African mines and farms were key factors behind the government's determined promotion of cannabis prohibition, and its desire to see cannabis remain under stringent international control.

This strident approach to cannabis specifically, and all controlled drugs more generally, has been a core feature of South Africa's engagement with, and support of, the Vienna Consensus. It appears to continue to influence its actions to this day, even after its transition from its



Cannabis is the most commonly used and traded drug in Africa with an estimated 38.2 million consumers, compared to 5 to 10 million continental consumers of khat

anachronistic apartheid past to a democratic system of majority rule.

In contrast to khat, whose status has been fluid – if largely de jure legal – across the continent, depending on the context in which it is found, the status of cannabis is not in doubt. Traditionally, cannabis has been de jure illegal across the continent. Social perceptions of its nature and use, however, have been very different to that of khat.

Where there is some political flexibility in policy approaches to cannabis and khat, no such aura of flexibility surrounds any other 'drugs'

Legally, cannabis should be much less ambiguous a substance [in Africa] than khat, as it is universally controlled under unified global drug conventions, while its prohibition is decreed by statute in all African countries and has been in some countries for over a century.⁸⁹

Yet, in practice it is not. In khat we have a traditional African substance that is de jure legal yet continues to be viewed through domestic sociopolitical lenses of security and illicitness. In cannabis we have a de jure illegal substance that, in its social and political acceptability, generally is treated less as a criminalised substance and more like a common market vegetable. Thus, the il/legal and il/licit status of both khat and cannabis remains rife with ambiguity.

It is this ambiguity that contributes more broadly to the manner in which African drug policy has begun to change. It also shows how the current reflexive African drug policy reform discussions are representative of those that have been occurring at the global level.

Cannabis and khat aside, the continental approach to the ever-expanding array of globally scheduled

substances has remained unanimous. Cocaine, amphetamine-type stimulants, heroin and other opiates, and the many other scheduled psychoactive substances, are seen continent-wide as both definitively illegal and definitively illicit. Where there remains some political flexibility in policy approaches to cannabis and khat, no such aura of flexibility surrounds any other 'drugs'.

Generalised typology of national drug policy approaches

Six generalised drug policy approaches are taken in regard to constructing a national response to illicit drugs. Every country's drug policy environment can broadly be interpreted as falling into one of these six categories. For the purposes of this discussion, these drug policy approaches are:

- **Prohibition:** The use, possession, production, transport of and trade in all substances scheduled under the three international drug conventions are criminalised in law and in practice, often classified as a serious offence, and punishable by varying terms of incarceration and, in some states, corporal and/or capital punishment. Prohibition-based drug policy frameworks generally are constructed around the three tenets of the Vienna Consensus. These are: 1) reduction in the use of these substances (demand reduction); 2) reduction in the availability of these substances (supply reduction); and 3) international cooperation efforts undertaken between states in this regard. In such situations, the drug policy and its related legal framework generally are inflexible in terms of their interpretation and application. Law enforcement assets are organised around targeting those who use drugs, as well as those who possess or trade in them. In some cases, a country will even go so far as to prohibit a substance that is not under international control (e.g. khat). In most prohibition frameworks, those who use drugs tend to be the main law enforcement target.
- **Prohibition (hybrid):** The use, possession, production, transport of and trade in substances

scheduled under the three international drug conventions are criminalised in law, and sometimes classified as a serious offence. In practice, however, the application of the law can be flexible. While national policy and the related legal framework remain grounded in the prohibition of scheduled substances, some degree of flexibility in their interpretation is accepted in order to accommodate health and/or human rights principles. Law enforcement focus remains on those who use, possess and/or trade in these substances. For example, policy hybridisations may include the following:

- While all substances may be criminalised, the application of the law within the community may be flexible in terms of some of these substances (e.g. cannabis). In such situations, a substance (like cannabis) may be de jure illegal while interpreted as de facto legal in practice. Canada, the Netherlands, Morocco and Mozambique have undertaken related measures in this regard.
- Possession of drug-related paraphernalia (e.g. needle syringes) may not be criminalised in order to facilitate the implementation of harm reduction health programmes for PWID. If paraphernalia possession is criminalised, then the article may be ignored in practice. Myanmar, Vietnam, South Africa and Tanzania have had some experience with this policy approach.
- **Decriminalisation:** The use, possession, production, transport of and trade in all substances scheduled under the three international drug conventions are not wholly criminalised in law. Generally, there will still be administrative restrictions in terms of possession, production and trade thresholds for these substances. Exceeding these limits will result in criminal prosecution. For example, possession of a small amount of heroin for personal use may be decriminalised, but possession of an amount above a fixed administrative threshold (e.g. 100 g)

may remain a criminalised offence. Portugal is one of the few countries in the world with a decriminalisation approach to all substances. In future, Ghana may become the second.

- **Decriminalisation (hybrid):** The use, possession, production, transport of and trade in one or more substances scheduled under the three international drug conventions are not wholly criminalised in law. It is a more restricted policy approach, and has more in common with *prohibition (hybrid)* than with *decriminalisation*. Often such policy approaches are designed around the decriminalisation of cannabis, either completely for personal use or, more restrictively, for medical use only. In some cases, a *decriminalisation (hybrid)* policy approach is an initial step taken by a state as it considers more general reform of its *prohibition* drug policy environment. While one – or more – substances may be decriminalised in such an approach, administrative thresholds remain in place, and all remaining substances scheduled under the three international drug control treaties remain criminalised. Several states around the world have undertaken this conservative policy approach in their pursuit of drug policy alternatives.
- **Legalisation:** The use, possession, production, transport of and trade in all substances scheduled under the three international drug conventions are legalised under law, and no criminal sanctions apply. All of the substances are regulated by a government authority, and the administrative regulations governing their availability, access, quality and use are similar to those for over-the-counter medicines, tobacco or alcohol. Currently, no country in the world has a fully legalised and regulated drug policy environment in place.
- **Legalisation (hybrid):** The use, possession, production, transport of and trade in one or more substances scheduled under the three international drug conventions are legalised under law, and no criminal sanctions apply. The legal substance

is regulated by a government authority, and the administrative regulations governing its availability, access, quality and use are similar to those for over-the-counter medicines, tobacco or alcohol. Currently, Canada, Uruguay and South Africa⁹⁰ have legalised and regulated the recreational use of cannabis as a national policy measure. Several other countries, including Thailand, Lesotho and Zimbabwe, have legalised cannabis use and/or production for medical purposes. In each of these cases, however, all other scheduled substances not legalised remain criminalised under their national laws. Oddly, owing to its strict retention of prohibition measures, a *legalisation (hybrid)* policy environment has much more in common with a *prohibition (hybrid)* policy environment than with either a *decriminalisation* or *legalisation* policy environment.

Current policy approaches to drugs in Africa

In addition to domestic political influences on the development of AU member states' drug policies, there are other – often competing – structural and political factors that affect domestic policy development processes. In this section, we characterise and discuss state typologies in terms of investment in continental drug policy reform. We also look at the fragmented political disposition of the continent's regional economic communities.

This is followed by a brief consideration of the competing and diverse policy influences of international alliances, actors and institutions on African states, and the often-competing roles of the AU and the AG in the struggle to determine a common continental drug policy. We conclude with a discussion of the fragmented continental consensus on drugs.

Characterisation of drug policy reform across African states

The characterisation of the actions and capacities of African states to address and/or enact drug policy

reform measures is an interesting illustration of the current continental situation on drugs and drug policy. Where once there was a general continental consensus in favour of complete drug prohibition, today such a consensus no longer holds true.

As reform blossoms in various continental places and spaces, so do renewed attempts to reinforce prohibition efforts and entrench prohibitionist positions. Even within states themselves, there are several examples where national structures and systems are neither aligned with nor supportive of the predominant national position on drugs. Intra-state political contestation, where different institutions and structures within the government and state bureaucracy express and/or pursue divergent policy approaches, has become more prevalent.

As reform blossoms in various continental places and spaces, so do renewed attempts to reinforce prohibition

It is apparent that drug policy reform considerations are engaging vastly contested epistemological and ideological foundations in Africa; including those fragile and failed political spaces and places where conflict, political frailty, and human insecurity continue to thrive and prosper. This restricts the ability of states and territories to practice any invested drug policy strategy (no matter their political orientation).

In considering the status of national drug policies across the continent, and in reviewing the nature and context of individual states' abilities to adopt, develop and implement effective drug policy measures in order to respond to the structural vulnerabilities enabling their domestic drug trading environments, we propose a typological characterisation.

The purpose of this disaggregation of states by general typology is to provide a general projection of their

ability to transform, adopt and implement drug policy measures. It will also highlight that the continent itself is not a universal collection of drug prohibitionist entities, with a few state outliers, as would be proposed by the AG.

Rather, the drug policy situation in Africa is a dynamic contemporary mix of progressive legal decisions, reactionary political conflicts and retractions, empty political bluster, and dire developmental futures. In this regard, the five general typologies help to illustrate the current fragmentation of Africa's continental position on drugs and drug policy.

The five typologies are:

- i. Countries with state-led and supported reform processes – the 'reformers'
- ii. Countries with internal state-contested reform processes – the 'contesters'
- iii. Countries with state retraction of implemented reform measures – the 'retractors'
- iv. Countries that are state holdouts on taking a strong position either way on reform – the 'inertials'
- v. Countries that currently are incapable of invoking and/or implementing reform processes – the 'incapables'

State-led reform processes

A growing number of African states have initiated policies that are increasingly aligned with global drug reform objectives instead of the traditional prohibitionist policies of global drug control.

The typology of such state-led reform processes includes countries that have begun to explore, through the adoption of policy reform measures, alternative approaches to traditional demand and supply reduction-focused drug control. These include policy decisions or hard proposals exploring human rights-focused, health-oriented policy foundations and/or decriminalisation and legalisation drug control measures; and, the political benchmark that such reformed drug policy measures and visions are supported by state structures and institutions through either de jure or de facto instruments or means.

Examples are the legalisation by both Lesotho and Zimbabwe⁹¹ of cannabis cultivation and production for medical purposes, and the parliamentary establishment of a national body to investigate cannabis legalisation in eSwatini. The de facto soft enforcement of cannabis cultivation, possession and use in Morocco, one of the largest producers of cannabis resin in the world, and its state consideration of legalising cannabis production, is another.

Perhaps the most appropriate example is that of Ghana and its long-pending law that would see a historically significant drug-trafficking country transform its national drug control approach to one grounded in the principle of decriminalisation of all drugs in the country.

Historically, drug policy in Ghana had been founded on a prohibitionist, 'drug war' stance and governed by its Narcotic Drugs Law (1990), legislation drawn up in an era of rapidly increasing criminal economic development across much of Western Africa. As a result, it was designed to target people who used, possessed, produced or trafficked in illicit drugs, and made them recipients of serious punitive sanction.

Yet today Ghana appears to be on the verge of a significant shift in its drug policy approach as it considers becoming the first African country – and one of the first globally – to decriminalise the personal possession and use of all drugs through the invocation of its pending Narcotic Control Commission Bill (2017).

While this bill has spent months winding its way through parliamentary procedures, it has now been approved by Cabinet. Its likely passing by Parliament will mark a seismic shift in drug policy on the continent, not just in its focus on decriminalisation as a new drug policy approach but also in its recognition that the traditional prohibitionist model is not fit for purpose.⁹²

The prohibitionist model lacks a proportional approach to sentencing for those convicted of offenses under its terms, conflating drug use, possession, trafficking and production under similar sentence structures.

Despite the 11 000 people imprisoned for drug-related offenses in Ghana, its prisons operating at 145% of capacity, and a further 8 600 people waiting on remand

for such offences, drug use has continued to increase.⁹³ Years spent 'trying harder' did not change the result. Prison occupancy rates increase while the drug trade continues to grow.

Some concerns do remain, however. The new bill intends to decriminalise drug use and low-level possession, recommends alternatives to custodial sentences for PWUD, and advocates for the widespread implementation of HIV harm reduction services targeting PWUD.⁹⁴

Thus, if passed in its current form, there will be an increased draw on state health resources, institutions and systems, particularly from PWUD, and those who are compelled to make use of these services by judicial or administrative instruction. It is debateable whether Ghana has the necessary human, technical and institutional resources available and/or in place to accommodate this demand shift.

Legalising a harm reduction programme framework is an important step to align Ghana with its duties of care as outlined in the African Commission on Human and Peoples' Rights (ACHPR) Resolution 141 on Access to Health and Needed Medicines in Africa (2008) and Article 16 of the African Charter on Human and Peoples' Rights (guaranteeing every African the right to enjoy the best attainable state of physical and mental health).

Yet this legislated commitment requires financial and technical resources if it is to be implemented effectively. It is important to note that international donor assistance is funding nearly all of the harm reduction services available in those few countries that provide them, including Ghana. These examples are neither sustainable nor conducive to encouraging strong support among health officials for such service provision.

Donors are increasingly reluctant either to enter into long-term funding commitments for such programmes or to fund them at all.

The only way such programming can be developed and implemented in an effective and sustainable manner is if it were to receive government financing. Yet it is questionable whether there is strong support within the Ghanaian government to make such a regular

commitment, particularly as it would mean re-directing existing funding from other budget lines (for example, law enforcement), which would be unpopular, or implementing some kind of 'user pay' model, which would be unrealistic.

Existing health services in Ghana simply do not have the ability to absorb this new programming alongside that which they already implement.

Finally, incorporating a decriminalised model for use and low-level possession will not necessarily lead to decreases in the traditional policing approach to drug use and possession in Ghana, even if it pursues a reclassification of cannabis (as is proposed under the pending bill). After all, drug use and possession themselves will remain offences. It is only the punishment type that will change, not the fact of punishment itself.⁹⁵

The drug trade environment likely will continue with little impact. Further, while removing imprisonment for simple possession and use is laudable, and in line with attempts to address the health and human rights needs of PWUD, vulnerability to imprisonment remains. Those who are arrested and receive an administrative fine, and are unable to pay, may still face imprisonment – not for drug use, but for failure to pay the adjudicated fine.

Ghana's proposed decriminalisation bill is an important development, but there are several outstanding concerns that require discussion and attention. Will it be enacted and, if so, will it be enforced? While the hope of many is that the passing of this bill and the subsequent policy revolution will inspire other states to follow, political risks remain.

If well-developed, -staffed, -trained and -financed systems, institutions and services are not put in place to support the implementation of this decriminalisation approach, its application could very well fail. Either way, the potential for peer influence is inevitable. In which direction continental peers will move remains unclear.⁹⁶

Morocco is another example of an interesting continental reform outlier. Regionally it is isolated in its approach, even though historically it has been a rather lenient enforcer of cannabis prohibition in particular.

This makes sense in the country's socioeconomic environment.

The illicit cultivation and production of cannabis is a major industry in the country, accounting for up to 10% of its gross domestic product (GDP).⁹⁷ At least 800 000 Moroccans subsist on this production of cannabis herb and resin, and the industry allegedly generates annual sales estimated at US\$10 billion.⁹⁸ Morocco is one of the world's top producers of hashish (cannabis resin).

Even though drugs (including cannabis) have been prohibited since the early 1970s, it is easy to understand why government and law enforcement authorities continue to take a more pragmatic approach to its management and policing, making it de facto decriminalised although de jure illegal.⁹⁹

In 2017 Lesotho became the first African state to legalise cannabis for medical purposes

Currently, there is an internal discussion on whether Morocco should decriminalise (or legalise) cannabis. A legal industry (like that which has been initiated in Lesotho, a much smaller cannabis producer nation) would generate significant export revenues and contribute to the socio-economic development of the nation.



At least 800 000 Moroccans subsist on the production of cannabis herb and resin, and the industry allegedly generates annual sales estimated at US\$10 billion

While all drugs remain criminalised in Morocco, a draft law to legalise cannabis cultivation for medicinal purposes (like Lesotho) has been proposed. It seems likely that Morocco will become a de jure legal cultivator in the near future.

In Lesotho, cannabis has always been a popular livelihood crop. Historically, the mountainous kingdom has produced large amounts of it, with South Africa its principal consumer market. There is also domestic consumption within its own production areas.¹⁰⁰

In 2017 Lesotho became the first African state to legalise cannabis for medical purposes, with Zimbabwe following suit in April 2018.

Since its legalisation Lesotho has signed cannabis production contracts with cannabis supply companies in Canada and Israel. Its ambition to become a market supply leader in the fast-emerging global market for licit supply has influenced other African nations to reconsider their traditional stance on cannabis.

For example, in April 2017 the eSwatini House of Assembly appointed a national committee and tasked it with exploring the possibility of a national drug policy revision to legalise cannabis.¹⁰¹ Cannabis is cultivated widely in the kingdom, and is the most common illicit drug of use.

Cultivated year-round, cannabis has been a long-term subsistence (and cash) crop for rural farmers, with production levels increasing in recent years.¹⁰² Yielding a domestic retail price/mt return of US\$43 300 compared to US\$400 for sugar and US\$175 for maize, it is obvious why the crop is popular among rural farmers.¹⁰³

Like Lesotho, the majority of eSwatini cannabis is exported to neighbouring South Africa for consumption. Although eSwatini remains a prohibitionist country by drug policy design, there has been no political or bureaucratic pushback against the House of Assembly's decision. As such it appears probable that its drug policy will be revised in the near future as it embraces, at the very least, the legalisation of cannabis production for medical use.

The Seychelles has taken a different approach to addressing its national drug control approach. The archipelago has a national drug policy founded on the principle of prohibition and aligned with the three international drug conventions. There are an estimated 4 300 heroin users on the islands, with approximately half of them injecting drug users and spending an average of US\$52 per day on heroin.¹⁰⁴

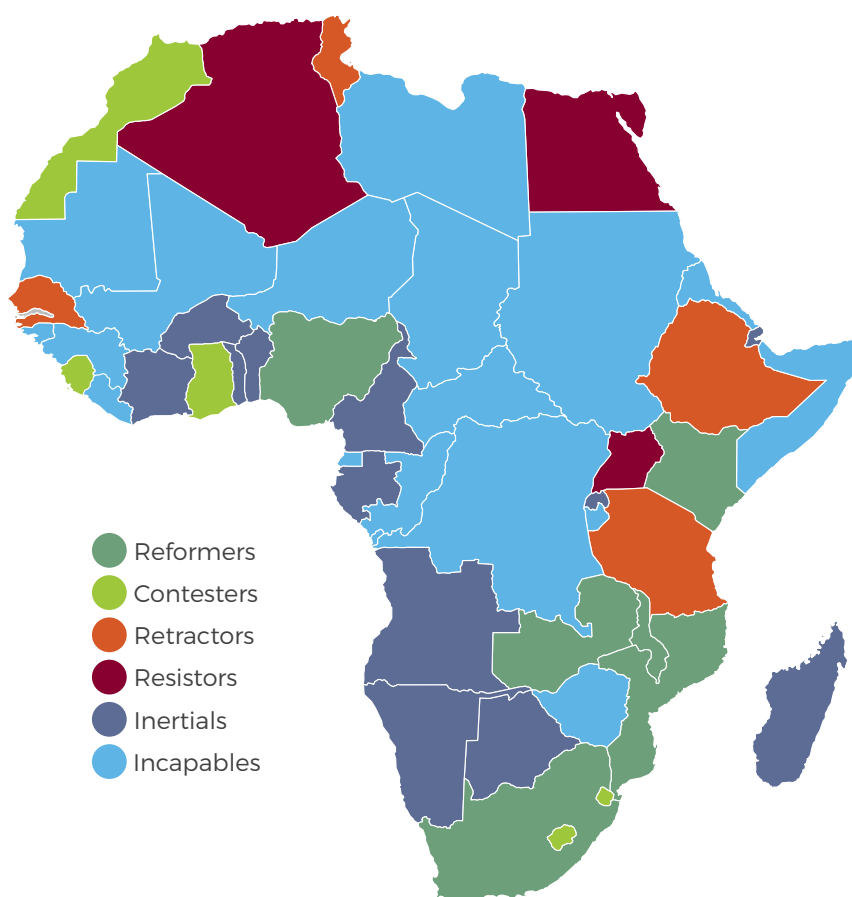
The prevalence of HIV in the Seychellois PWUD population is 8%, and HCV seroprevalence is 36%.¹⁰⁵ Harm reduction and other health services for PWUD populations are limited, but in September 2018 the government decided to trial opioid substitution therapy (OST) in its prison system. This move recognises the health and human rights duties of care a state has toward its people in general, and its PWUD in particular.

This is a political position that is aligned with the Common African Position (CAP) of the AU.

Togo expressed a similar stance in its oral submission to the UNGASS, when Executive Secretary of the National Anti-Drug Commission Kossi Baoumodon publicly opposed the competing statement of the AG by supporting the AU CAP over the latter.¹⁰⁶

Such an enlightened position has not yet been reflected in its national policy instruments, in particular the continued Togolese criminalisation of drug use. However, the significance of its implied opposition to the AG consensus narrative is an important indicator of its altered alignment within the continental drug prohibition frame, even if such measures are still practiced domestically.

Figure 1: Typological classification of African states according to drug policy status and reform capacity



State-contested reform processes

In some states in Africa reform measures have been proposed in, or even thrust upon, the country without the state (or institutions and structures within the state) being supportive of the measures – in some cases it has even been overtly hostile.

This type of ‘contested reform’ exists in several places, but perhaps is most notable in South Africa, a country that has been a vocal global advocate for drug prohibition for more than a century. Prohibition was a theme that transitioned unchanged from the colonial period, through the time of apartheid governance, into post-apartheid South Africa and its ‘Rainbow Nation’ perspective. This all changed when cannabis was legalised in September 2018.

The Constitutional Court of South Africa in a landmark ruling determined that the criminalisation of cannabis possession, use and cultivation for personal use was an infringement of the right to privacy guaranteed to all adults under the South African Constitution.¹⁰⁷ In so deciding, the Constitutional Court upheld a decision made by the Cape Town High Court to this effect. As a consequence, the South African Parliament had 24 months to adopt its binding ruling.

While this decision made South Africa the third country on the continent to legalise cannabis in some form, the implementation of the ruling is more complex than would appear at first glance. While legalising cannabis was the general result, the court was clear that its ruling was intended to address only the private use or possession of cannabis: the cultivation of cannabis by an adult in a private place and only for their private consumption.

It did not legalise the possession of large (non-personal) quantities (e.g. for retail sale or trafficking) or the large-scale (non-personal) cultivation of cannabis. However, in making this distinction the court did not specify what amount constituted the threshold of personal possession/cultivation, instead imposing this responsibility on Parliament. Further, its ruling did not decriminalise the use or possession of cannabis by a child anywhere, or by an adult in public.¹⁰⁸

The irony that South Africa, a prohibitionist drug policy stalwart since the 1920s, had legalisation thrust upon it by its own Constitutional Court was not lost on some observers. A government steeped in drug war histories was now instructed by its judiciary to decide how much cannabis a person may possess or grow without being subject to arrest.

Yet this blurring of foundational principles in its drug policy space is not unusual. South Africa has for many years found itself in a struggle, metaphorically and practically, with its drug policy direction.

In the years prior to this September ruling South Africa pursued a stringent drug prohibitionist policy.¹⁰⁹ In contrast to other African states, it had been a leading global promoter of international drug control measures since the 1920s.¹¹⁰ Its prohibitionist stance only hardened in subsequent years as the continental and, by extension, national drug trade environments expanded in market size, commodity options, and economic volume.

South Africa has for many years found itself in a struggle, metaphorically and practically, with its drug policy direction

Internationally, its approach was one of strident support for the prohibitionist rhetoric of Russia, China and the US. It was a party to the Banjul Declaration, a 13-paragraph multilateral commitment on mutual political support for drug prohibition promotion agreed between Russia and a subset of African states at the first Russian-African Anti-Drug Dialogue in The Gambia in 2015.

Adherence to this commitment led South Africa to fail to support openly the CAP of the AU at the 59th CND Session, even though its own deputy minister of social development was the coordinator of this consensus position statement on behalf of the AU. It also

supported China's push to have ketamine scheduled in the international drug conventions, causing its access to be restricted. A popular anaesthetic in under-resourced health settings, such as those found on much of the African continent, South Africa voted in favour of its scheduling as a 'dangerous drug'.

Yet, at the same time as its foreign policy arm was extended to support a strict 'drug-free' philosophy and policy stance, other segments of the South African bureaucracy were pursuing and/or promoting alternative approaches at the international level.

Deputy Minister of Social Development Hendrietta Bogopane-Zulu has repeatedly advocated, in her role as head of the AU Specialised Technical Committee on Health, Population and Drugs, a more health- and human rights-oriented approach to drug use and those who use drugs. This was at the heart of the CAP that she coordinated on behalf of the AU Commission for submission to the UNGASS 2016 meeting, and one that she delivered at the CND.

Officials from South Africa's prison service and its National AIDS Commission have supported international consensus position statements on the need for health- and rights-oriented programming for PWUD, and the diversion from incarceration to other social and health service options for all those who use drugs.¹¹¹

However, as open as some political arms of the South African government might be to consideration of alternative methods to drug policy implementation, there is still a strong overtone of suppression by senior officials from other ministries as they try to ensure the perception of a unanimous national position on drugs and their prohibition.

This was perhaps most starkly demonstrated at the UNGASS 2016 meeting in New York. Bogopane-Zulu presented the CAP that promoted a continental commitment to improving the health and rights of people who use drugs on the continent, while Police Minister Nkosinathi Nhleko, speaking on behalf of South Africa, struck a decidedly contrary position in declaring his country was totally committed to becoming a 'drug-free' nation. This political struggle also plays out at home.

For example, for years a head of the South African National AIDS Committee (SANAC) refused to admit that South Africa had a heroin problem. Cannabis, sure. It was the most popular drug across the continent, after all; but heroin use, and in particular injection, was not viewed as a South African phenomenon of any significance. People who used 'hard' drugs were few and probably foreign, the narrative went.¹¹²

Talk to any community housing or health activist in the country, however, and a different story emerges. 'If one considers that social conditions in South Africa are dire for many ... this nation does not have a drug problem so much as a drug solution.'¹¹³

Young people in South Africa have had little opportunity to realise their dreams. Youth unemployment is high, whole populations of young people have been disenfranchised, and meaningful change does not seem to be on the horizon.¹¹⁴ South Africa has struggled, and will continue to struggle, with how to address effectively its drug use crisis.

The provision of health services for PWUD is minimal. Harm reduction programmes are limited in technical scope, geographic breadth, operating budget, human resources, and state political support.

Run largely by local non-governmental organisations (NGOs) and community volunteers, these services face regular bureaucratic and administrative impediments, unnecessary police attention, and considerable political and community suspicion. In fact, in some places health workers have been arrested (e.g. Tshwane) for supporting these services, and in others, the services have been suspended indefinitely without cause (e.g. eThekweni).

Opiate substitution treatment is allowed, but the government has entered into an exclusivity agreement with a single pharmaceutical company for the national supply of methadone. As a result, South Africa has some of the highest per capita methadone treatment delivery costs in the world.¹¹⁵ Contrary to scientific evidence and UN recommendations, the programme also restricts dosages, limits dispensary locations, and focuses on using methadone only to support a short-term process of detoxification.

Outside of the limited (and expensive) domestic OST option, the only other option is abstinence-based treatment facilities, most of which are privatised and expensive. It is as if, on the one hand, there is the setting and performance of a more reform-oriented policy approach to drug use, and, on the other, this restricted performance is used to validate the wider political goals of a 'drug-free' and abstinent state.

The development of the fourth Drug Control Master Plan (2018–2022) for South Africa was shaped by international political pressure, in particular to include a formalised and recognised health and human rights approach to drug use and the people who use them.

Unusually, the Central Drug Authority (CDA), the national body responsible for leading the development of this strategy and for advising the government on drugs, has been a vocal advocate of the inclusion of these reforms in the draft policy. The CDA even went so far as to co-convene with civil society a series of consultation meetings with PWUD in a number of cities.

The South African Police Service (SAPS) has been receiving training from civil society advocates on alternative methods of policing drug-use environments, and support among some SAPS senior-level officers for harm reduction and decriminalisation has been growing.¹¹⁶

It is a small but significant development that some elements of the state apparatus responsible for promoting and prosecuting the national war on drugs are engaging, and sometimes agreeing, with drug policy reform advocates and their positions, internationally and domestically.

This shows that cracks are emerging in the ideological foundation of South Africa's prohibitionist posture, cracks that the Constitutional Court's cannabis legalisation decision has forced further apart. How the nation, and its civil society organisations (CSOs) in particular, will build on the Constitutional Court decision and the initial reform opening it has created is still to be seen.

Zambia is another example of a country that is divided politically on the issue of drug policy reform. It is a

staunch Vienna Consensus-supporting country, having declared at the UNGASS that 'calls for decriminalisation and legalisation of illicit drugs ... are against the spirit of the three international conventions',¹¹⁷ and aligning its drug control approach with that expressed by China.¹¹⁸

Originally a transit country for the movement of heroin, cocaine and synthetic drugs through the continental interior, Zambia has become a net consumer of heroin and cocaine.¹¹⁹ Currently the Zambian Drug Law is under review, and a revised draft law has been submitted to Parliament for its consideration and approval.

Zambia is in the curious situation of having its home affairs minister declare that the cultivation of cannabis for medical purposes has been legalised in the country (making it the third African country to legalise it) while its health minister (from whom a licence to cultivate and produce cannabis is required) has indicated that he would not issue any licences as he personally disagrees with the principle of cannabis legalisation. Thus, Zambia is a country with legalised cannabis in policy but not in practice.

Malawi is in a similar situation. A prohibitionist drug policy state and a small country with porous borders, it has a domestic cannabis cultivation industry. West African organised criminal groups have a strong presence and influence in Malawi. Prison overcrowding in the country has reached capacity levels of 450% and more, with many detained for drug-related offenses.¹²⁰

Malawi expressed strong support at the UNGASS for the current global prohibition framework, and also supported the statement of the AG. It has aligned its drug policy principles with the conservative, prohibitionist position of the G77 and China, but its Parliament endorsed the drafting of a bill in January 2019 that would decriminalise the cultivation, possession and production of cannabis for medical purposes.¹²¹

This move followed the pledge in November 2018 by Malawian Vice President Saulos Chilima to legalise cannabis if he were elected president in 2019.¹²² Although providing the appearance of reform, the opposition of the wider government bureaucracy is a

significant impediment to the implementation of any such policy were it to be adopted.

In Sierra Leone, a post-conflict prohibition stalwart, its Institute for Drug Control and Human Security has declared that the current drug policy of criminalisation and prohibition is ineffective. It has called for a debate on reforming the country's drug control approach.

In a country that employs long, mandatory minimum sentences for drug offences, such a rebuke by a domestic institution is unusual and paradigm threatening. This action has encountered politically-motivated contestation from administration drug policy conservatives.

Taking a broader perspective, there are other means through which drug policy reform could be considered to be state contested in its typology yet not necessarily as clear in its presentation as in the above examples.

In Kenya, for example, political resistance to drug policy change comes from the state apparatus, but endemic institutional corruption also influences the position of the country. Kenya is a staunch, long-term drug prohibitionist state that has embraced the 'war on drugs' mentality completely, and continues to profess its determination 'to be a drug-free nation'.¹²³

A ban on khat was enacted in the 1940s under colonial rule. This was driven by the racial motivations of colonialist authorities and later overturned by local officials.¹²⁴ Kenya is still significantly affected by strong domestic and transnational drug trade economies, including in areas of the country controlled by non-state violent actors (NSVAs).¹²⁵ Its domestic consumer market for heroin is expanding,¹²⁶ and it is a major transit hub for heroin from Asia (to West Africa and Europe) and cocaine from South America (via West Africa).

The transnational organised criminal groups that control these illicit drug economies have penetrated some Kenyan state institutions – through corruption and bribery – to the point that they are subverting and undermining them from the inside.

Kenya is not a 'criminalised or captured state',¹²⁷ but its institutional capacities are deteriorating rapidly.

This is exacerbating its existing structural and systemic socioeconomic and political vulnerabilities, and eroding its regulatory and administrative influence.

More generally, and in apparent contradiction to its avowed 'war on drugs' approach, the issue of cannabis decriminalisation has become a significant local political issue. A bill to decriminalise the cultivation and use of cannabis has been drafted, and the National Assembly of Kenya was petitioned in September 2018 to accept its consideration.

Kenya is still significantly affected by strong domestic and transnational drug trade economies

The draft bill also includes progressive provisions of amnesty for those arrested for cannabis possession, the expungement of prior convictions related to cannabis cultivation or possession, and the development of a regulatory framework.¹²⁸ Under current circumstances, it will be a challenge for Kenyan authorities to operationalise a regulatory model for cannabis decriminalisation without its being vulnerable to the corrupting influences of organised criminal groups.

States retracting reform approaches

Some countries have taken a revised, reformed approach to their national drug control policy, but, for various reasons, have begun retracting these reforms. In some cases, they have even regressed to an earlier policy perspective influenced by the drug war modality.

In 2006 Mauritius became the first African country to implement health service measures targeting PWUD such as clean needle syringe provision (NSP) and OST. It was a pioneer on the continent in this regard. The political evolution of this service provision was rooted in the regional fallout from the publication of the UNODC's 1999 *The drug nexus in Africa* report that noted serious

concerns over the volume of illicit drug consumption in sub-Saharan Africa.

This contradicted the 'drug use is rare in Africa' theory that was common (if untested) wisdom at the time. The report included several anecdotal epidemiological reviews on domestic drug consumption, including in Mauritius, alongside particularly strong advocacy initiatives from civil society groups highlighting the expanding drug use environments and their related harms. It was the latter, by groups such as *Collectif Urgence Toxida* (CUT), that proved especially influential.

In Mauritius, its growing population of PWID raised serious concerns. The increase in PWID was driven in large part by the shifting transport patterns of heroin smuggling across the Indian Ocean, from production nodes in South Asia to the trans-shipment ports of Eastern Africa. This saw a concomitant domestic expansion in the availability and use of heroin.

With needle sharing rates of 50% or more and condom use rates as low as 10% among its 18 000 PWID,¹²⁹ in a region with 63% of the world's people who live with HIV, the possibility of a rapid and devastating HIV epidemic driven by unsafe injecting drug use and related unsafe sexual behaviour was significant.¹³⁰ That HCV seroprevalence was nearly 100% among PWID was an added public health concern.¹³¹

Once established, the Mauritian harm reduction programme was promoted as a potential public health beachhead from which health and human rights-oriented programming for PWUD could be extended across the wider sub-Saharan region.

The introduction, rapid scale-up and decentralisation of its government-regulated OST and NSP services resulted in a dramatic reduction in HIV transmission among its population of PWID.¹³² This was accompanied by a decrease in criminal prosecutions for drugs and petty theft¹³³ and resulted in decreased morbidity and mortality for the nation's PWID.¹³⁴

While becoming a health pioneer as it related to drug consumers, drug use and possession were still criminalised in Mauritius, and the government continued to pursue a strong prohibition-based

drug policy. Thus, interdiction efforts continued in practice, including against PWUD and/or those who had small amounts of these controlled substances on their person.

Yet, despite the occasional high-profile arrest or seizure, the volume of drugs either transiting Mauritius or landing there for domestic consumption seemed to continue to expand.¹³⁵ Concerns abounded around the perceived inefficacy (and complicity) of domestic institutions – in particular the Anti-Drug and Smuggling Unit (ADSU) and the Anti-Narcotic Unit (ANU) of Customs.

In fact, concerns were so serious that at least one neighbouring state began refusing to share trafficking intelligence with Mauritian drug authorities for fear that the information would be leaked to organised crime groups.¹³⁶

In a landmark move, one that recognised the debilitating reality of its prohibition approach, the Mauritian government launched a Constitutional Commission of Inquiry in 2015 to examine all aspects of the drug trade across the archipelago.

After more than two years of investigation and hearings, its report, launched in July 2018, provided damning evidence of the metastasised reality of criminal networks' contribution to the erosion of democratic state structures and systems through their investment in illicit drug market economies.¹³⁷

The commission identified and confirmed the existence of corrupt practices and persons in all institutional bodies that made up the criminal justice and security structures of the nation. It documented claims of significant linkages between senior officials in police, customs, prisons, the legal system and government, and drug trafficking networks.

The report's publication led to the resignation of two senior government officers,¹³⁸ and several recommendations for structural changes to the way in which the government administers its response to drug trafficking. Another recommendation was that the Mauritian ADSU and ANU be disbanded and replaced by a new National Drugs Investigation Commission.

This dissolution of the two primary units of drug enforcement, with an explicit discussion of the reasons why they could not be reformed, was seen as a particularly scathing assessment of their dysfunction and corrupted structure.¹³⁹

In a further commentary on the failure of the reformed drug interdiction architecture to challenge the illicit flows and systemic evolutions of the nation's illicit drug economies, the one place where they did find success was in their continued enforcement measures securing the criminalisation of drug use, and in their constant conflict with health authorities.

The renewed criminalisation of drug use in Mauritius worsened discrimination against people who use drugs

Despite the widespread health-oriented approach taken to PWID over the previous 10 years, the renewed criminalisation of drug use in Mauritius worsened the stigmatisation of and discrimination against PWUD, particularly by law enforcement and health service employees. This led to increased violence against PWUD.

While NSP services existed, in the absence of legislation changes still they contravened the Dangerous Drugs Act (DDA) that criminalised the possession of instruments such as needle syringes for the purpose of the illegal consumption of drugs. That the HIV and AIDS Act, which contained provisions for the implementation of these programmes, conflicted with the DDA was another point of conflict between law enforcement authorities and public health authorities.

Harassment of PWUD by police, and denial of health services by medical staff, remain barriers to PWUD's access to health services. This continues to occur despite the recognition of the Mauritian government, in its HIV policy of 2012 and its National Action Plan for HIV and Aids (2017–2021), of the centrality of human rights to

the implementation of a health-oriented national policy response to drugs.¹⁴⁰

The evolution of the Mauritian drug policy to incorporate a strong health-focused approach was a significant moment in the evolution of African drug policy more widely. Its adoption was a measured response to the perceived immediate health implications of national drug use as it related not so much to the individuals involved as to the transmission threat of HIV and/or HCV from this smaller but expanding illicit drug-using population to the wider, 'normal' non-drug-using population.

With the threat of a PWID-driven HIV epidemic subsiding in the wake of initial health programming successes, PWUD in Mauritius continued to be marginalised. Recently they have seen their health services restricted or denied, as the country reconsiders its current drug policy approach in the wake of the Commission of Inquiry's findings and recommendations.

Thus, despite the earlier reformist rhetoric of a health and rights approach to drug policy, and in spite of the corrupt drug enforcement institutional infrastructure, drug use remains criminalised in Mauritius. The country's drug users are viewed increasingly as agents of influence of a new epidemic, i.e. drug trafficking.

That the Commission of Inquiry has exposed the enforcement apparatus as a principal enabling component of the illicit drug economy is of little solace, as it comes at the cost of a diminished, still-criminalised health and rights response to national drug policy; one which appears to be regressing in stature from its apex as an African pioneer.

In Tanzania, similar challenges are occurring. At UNGASS 2016 it was one of the few African states that did not elaborate a political position explicitly in support of the prohibition creed promoted by a majority of its peers. Instead, its ambassador, Tuvako Manongi, remarked more generally that 'we must promote a health and human rights approach to the drug problem'.¹⁴¹ It was a softer response, embracing concepts that have become core elements of the drug policy reform movement, and one that was aligned with the principles expressed in the AU CAP on drugs.

Drug use (particularly heroin injection) in Tanzania is widespread, and present in most urban and rural environments. Recent improvements in transportation infrastructure that opened up the country's marketplaces and decreased inter-provincial travel times, combined with persistent rates of poverty and economic disparity, have been key factors in the diffusion of heroin from its portside origins to the rural interior and beyond.¹⁴²

Heroin began arriving in Tanzania in increasing amounts in the mid-1990s, trafficked from Afghan poppy fields by South Asian organised criminal networks using traditional dhows as transport vessels. Intended to be repackaged and trans-shipped to European and American markets, its arrival coincided with the expansion of the tourism industry and the concomitant flows of international tourists.¹⁴³

The leakage of product to the local market was inevitable. As local consumption of heroin (and other drugs) increased in volume and geographic breadth, and the use of needle syringes became more prevalent, international research began documenting very high rates of HIV seroprevalence among communities of PWID in Zanzibar and mainland Tanzania.¹⁴⁴

Unlike many African countries, Tanzania has a history of implementing health programming targeting PWUD.

In 2007 the Tanzanian government began implementing an internationally funded harm reduction programme that included soft service provision such as targeted outreach, education of health providers, and HIV testing and counselling. This was expanded in 2011 to include the provision of methadone.

In the political context of health service provision in Tanzania, however, methadone was made available only in the context of preventing HIV, including as a means to assist in treatment compliance with HIV medicines by PWID. Its most common use – as a drug dependence treatment medicine to support recovery – was not referenced. This contextualisation of methadone (and harm reduction interventions more broadly) as a HIV-specific health intervention rather than as a drug dependence intervention more widely is not

uncommon in those few countries that have adopted these interventions.

Compartmentalising methadone (or buprenorphine and other OST medicines, for that matter) and intersecting it with HIV creates both a more politically palatable argument in support of these drugs and allows these interventions to be included in the larger HIV funding envelopes provided by international donors.¹⁴⁵

Unlike many African countries, Tanzania has a history of implementing health programming targeting people who use drugs

During this time Tanzania also appeared to embrace the health approach in its national drug policy, which seemed to be working. Despite its political link to HIV prevention, the limited methadone programme was successful in demonstrating positive impacts on the physical and mental health of the programme clients.¹⁴⁶ As morbidity and mortality decreased, and their lives became stabilised with the addition of methadone, many of these clients were able to find employment and accommodation. These factors in turn contributed to an increase in health-seeking behaviour among Tanzania's population of PWID.¹⁴⁷

Where the programmes fell short was in their ability to engender trust among women who used and injected drugs, and in organising programme approaches that enabled them to access these services in a manner that fostered trust rather than generated suspicion.¹⁴⁸

In general, while the programmes were limited in their geographic reach, they still showed some initial effectiveness in responding to the health and human rights needs of Tanzania's drug-using population, a core element of the modern drug policy reform agenda. This all changed in 2017.

In February 2017, following the appointment of a new commissioner of drugs, the Tanzanian government revived its 'war on drugs' approach, which was common in the initial years of the heroin influx.¹⁴⁹ Health programmes were closed or significantly reduced in scale and scope, an arrest campaign began targeting PWUD, and concerted efforts were made by security forces to return the country to a de facto 'drug-free' policy alignment.

The impacts appear to have been significant. While the government did identify suspected high-level drug traders against whom enforcement intervention was to be mobilised, local drug markets were still overseen by the same low-level corrupt security officials. Rotating enforcement campaigns resulting in the temporary dispersion of drug users and/or their arrest and detention – with their release pending an extorted payment to the detaining officer – have become common again. Additionally, access to previously provided health services has been restricted by way of their relocation to inaccessible locations and the dissolution or interruption of their funding.¹⁵⁰

The ineffective drug war politics of yore have usurped Tanzania's health-focussed policy platform of the previous 10 years, driven in part by the continued increase in heroin trafficked to and through Tanzania¹⁵¹ and the desire to generate political capital through a 'tough on drugs' agenda.

This political position is not uncommon on the continent or in the wider international drug policy environment. What is unusual is that it is a regressive response to drug control, likely a result of the growing number of increasingly repressive responses to antithetical political threats.

Where a number of African states are expanding their drug policy environments and exploring alternative approaches to address the community impacts of their respective illicit drug trade economies, Tanzania has begun to restrict its own policy approach, and re-invested in a more securitised vision of its future drug trade response.¹⁵² Appealing to some, it is a political counterpoint to the continental guardians of Africa's fragmenting consensus on drug policy. Whether

this policy change is a temporary aberration or a permanent political fixture remains to be seen.

State hold-outs to reform

A number of states have refused to discuss or pursue any drug policy reform measures. This collection of countries can be divided into two sub-groups. The first consists of those states that have taken a definitive, hard-line position on retaining prohibition measures and resisting policy change. The second consists of those states that have taken a weak position on drug policy reform (or none at all) and/or have not expressed unilateral support for the explicit retention of prohibition-only approaches. This policy reform inertia may be owing to several factors, including a lack of knowledge of policy alternatives, little desire for change, and technical, financial or human resource deficiencies, barriers or constraints.

Resistor states

Egypt is an example of one such state. It has had a long and complicated history of drug control rooted in its colonial and post-colonial histories, often driven, then as now, by the parochial state-centric interests of foreign bodies. Today Egypt remains a vocal drug prohibition stalwart.

In point of fact, it was the Egyptian ambassador who led the AG intervention at the most recent CND meeting.¹⁵³ There he reaffirmed – in contrast to the position expressed in the existing (and agreed) CAP on drugs – the continent's position as seeking a 'drug-free world'.

Two years earlier, at the 2016 UNGASS meeting, the head of the Egyptian delegation eschewed confederate calls for drug policy reform. In doing so he echoed earlier remarks by China when he declared that the interpretation of global drug prohibition from the three international drug conventions must be such that it maintained respect for 'national sovereignty, the territorial integrity of States and non-intervention in the internal affairs of countries ... [in order] to achieve a world free of drugs and societies free of drug abuse'.¹⁵⁴

Officially, Egypt has taken the position that effective drug control can only be achieved through better implementation of the existing drug prohibition strategies of the Vienna Consensus brokers. This is an agenda that it pioneered in the early days of drug control endeavours. Egypt's Anti-Narcotic General Administration (ANGA), the national body responsible for drug-related responses, was established in 1929, making it the oldest drug control agency in the world.

Egypt is a transit point for heroin originating from South-West and South-East Asia and destined for European, North American and domestic African markets. African cannabis and South American cocaine also transit the country. Domestic synthetic drug (methylenedioxyamphetamine [MDMA]) production was identified in 2004; the first such instance of synthetic drug production detected in the Middle East.¹⁵⁵

Cannabis remains the most commonly consumed illicit drug in the country.¹⁵⁶ Its domestic cultivation and production occurs year-round, and it has been a staple, subsistence livelihood crop since the 11th century.¹⁵⁷

The domestic presence of transnational organised criminal groups was identified as early as the 1890s,¹⁵⁸ and has been seen as a re-emerging threat since the early 1990s.¹⁵⁹ In addition to their core business of drug trafficking, today these groups are also involved in the illicit trade in arms, people, wildlife and cultural property, and licit goods, such as pharmaceuticals.

The 'drugs cause madness' narrative was used to promote 19th and 20th century Egyptian drug control efforts. Initially targeting cannabis resin (hashish) and its use, these early measures were aimed at the social control of groups on the fringes of 'normal' society. They were also a means through which government could exert more control over rural areas and peasants' use of the land.¹⁶⁰

The first decree criminalising cannabis came in 1800 by order of Menou in his capacity as general-in-chief of the French Army in the Orient.¹⁶¹ This hashish ban, arguably the first drug control measure in the world, was rescinded shortly after it was issued, as the French Army retreated from Egypt and local authorities

decriminalised the use of cannabis resin once again.¹⁶² Soon cannabis was banned and criminalised again via a series of decrees from 1868 to 1884.¹⁶³

At the Second Opium Conference in 1924, Egypt, diplomatically represented there for the first time by a national delegation headed by Mohamed El Guindy, proposed that the League of Nations include cannabis in its list of 'narcotics to control'. Arguing that cannabis was as dangerous a threat to society as heroin and cocaine, the proposal was successful.¹⁶⁴

Egypt continued to support increasing levels of drug prohibition and control over the years. It passed ever more stringent domestic drug laws with harsher penalties for offenders, was a strong proponent of the three international drug control treaties, and became a regular contributor at the AG and its input at the annual CND meetings.¹⁶⁵

Interestingly, however, within the fabric of its historically vigorous drug prohibition efforts, voices in favour of drug decriminalisation and legalisation approaches occasionally have featured. In 1892 the British Director General of Customs in Egypt, Caillard Pasha, proposed that the government consider legalising the trade¹⁶⁶ in cannabis by imposing a regulatory system of licences.¹⁶⁷ 'It has been abundantly proved that the vice of hashish smoking cannot be suppressed by legislation, whereas by a system of licenses it may be kept under control to some extent.'¹⁶⁸

While framing his suggestion in profiteering language, the director general's conclusion that legislated attempts at prohibition had proven unsuccessful is significant, as was his advocacy of legalisation as a better way of controlling the expanding illicit cannabis trade being exploited by thriving organised transnational trafficking networks.¹⁶⁹

Two decades later, in 1914, the British Counsel General, Lord Kitchener, echoed Pasha's sentiments and recommended the legalisation and regulation of cannabis as a more appropriate drug control solution in Egypt.¹⁷⁰ In fact, that year a law was drafted that would legalise and regulate the sale and use of cannabis in the country, but it was never promulgated.¹⁷¹

This illustrates the somewhat liberalised approach that colonial government officials took to Egyptian drug control; an approach that became far more conservative and stringent in the post-colonial era.

While Vienna-based Egyptian diplomacy continues to advocate 'try harder' prohibition approaches, a third proposal for the domestic decriminalisation of drugs has been made

Today, while Vienna-based Egyptian diplomacy continues to advocate 'try harder' prohibition approaches, a third proposal for the domestic decriminalisation of drugs has been made in the country. A draft law has been proposed in Parliament that would see drug users – specifically targeting Tramadol and cannabis users – referred to treatment programmes rather than prison, a model not dissimilar to that under consideration in Ghana.

Unlike Ghana, however, there appears to be significant vocal domestic political opposition to the proposal. Regardless, there is still the possibility that the first African country to criminalise drugs and then to legalise their production and use, might become one of the first finally to promulgate this (old, but new again) reform approach.

Several other states are resistant to any form of drug policy reform. Algeria has been, and remains, a strong proponent of drug control through prohibition. At the UNGASS, Algeria aligned itself with the AG position statement and rejected decriminalisation – particularly of cannabis – as a step backward in drug control policy development.¹⁷²

In fact, the minister of justice indicated that Algeria believed drug control prohibition policies to date, as outlined in the UN's 2008 Action Plan, have been too

weak.¹⁷³ Current drug policy in Algeria is prohibitionist. It is aligned with the positions advocated by the Russian-African Anti-Drug Dialogue (RADD), the Non-Aligned Movement (NAM), the Group of 77 (G77) and the AG.

In Rwanda, government institutions have taken a public prohibitionist position on drug control, and the country has aligned its drug policy approach with the AG position. The same is true for Uganda. It is a prohibitionist state, and has a strict domestic drug control policy regime even though it is a significant transit country for heroin to continental and European destinations, and possesses a strong West African organised drug trafficking network. Ethiopia, Algeria and Uganda share similar typologies in this regard.

Inertial states

Inertial states are those that may or may not be prohibitionist, but for varying reasons remain inactive in the wider discussion of drug policy assessment, revision and/or reform. In Djibouti, for example, khat dominates its drug use environments. It is estimated that Djiboutians spend US\$170 million annually on khat.¹⁷⁴ Each household is estimated to spend 40% of its income on khat chewing, and half of all men use it.¹⁷⁵

While a significant portion of the trade in khat is allegedly controlled by organised criminal groups, there is little evidence as to the extent of this claim. Further, as khat is not controlled by international drug conventions, the domestic and cross-border trade in and markets for khat are licit, although only loosely regulated. Djibouti



Djiboutians spend an estimated US\$170 million annually on khat

is notionally prohibitionist – with the exception of khat – but unlike many of its continental peers it has not pursued any broad agenda on either promoting or eschewing the general drug prohibition mantra.

As in neighbouring Djibouti, khat is the most common drug of use in Ethiopia. Like khat, cannabis is grown domestically as a livelihood crop by subsistence farmers. Most production is intended for the domestic market. However, there is also traffic to Eritrea, Djibouti, Sudan, Egypt¹⁷⁶ and the UK.

While Ethiopia, like Djibouti, is nominally a prohibitionist country, its enforcement approach to cannabis (and, of course, the legal khat) is more moderate than its drug control position might indicate. Like Djibouti, it is not a strong, principled advocate for prohibition, but neither has it entertained the prospect of further drug policy reform.

Namibia is in a similar position. It is a prohibitionist state, although its stand is less strident than that of continental peers. This is evidenced by its intervention at the UNGASS.

Namibia has indicated that it believes in a balanced – rights and health – approach to drugs. Drug trafficking networks use Namibia as a transit point, and it has a small but growing base of drug use. The use of and trade in cannabis is widespread. Namibia has the institutional and human resource capacity to support interventions, although it lacks the financial resources necessary for such endeavours.¹⁷⁷

In another example, taken from the UNGASS, Madagascar aligned itself with the positions of the AG, the International Organisation of the Francophonie (OIF) and the AU. A prohibitionist state, the Malagasy government admits, however, that it lacks any capacity to respond to the growing illicit trade in and consumption of drugs, or to undertake any prohibitionist intervention measures.¹⁷⁸ It can express prohibitionist sentiments but cannot ground these in domestic action.

Similarly, although Comoros lacks significant domestic drug cultivation or production, limited research indicates that the islands are used regularly for the trans-shipment of illicit drugs, mainly from Madagascar

and continental Africa.¹⁷⁹ It would seem an intra-regional drug trafficking pattern links Kenya, Tanzania, Madagascar, Mauritius, Seychelles and the Comoros.¹⁸⁰

Yet the islands are unable to respond to the changing Indian Ocean drug trafficking industry, particularly as trans-oceanic routes from South Asia to East Africa regularly adapt in the face of coalition maritime interdiction efforts under the aegis of JTF-150.¹⁸¹ It often quietly aligns with the stance of continental drug prohibition stalwarts, but in doing so also expresses the need for financial and other support if it is to take national action.

States incapable of enacting reform

The fifth typology characterises those states that are, as yet, structurally and/or institutionally incapable of enacting or enforcing any drug policy prohibition or reform measures for reasons of structural and institutional irrelevance, frailty or collapse.

States classified as failed or failing often fall in this category, as do states considered to be corrupted or captured by criminal elements, and those that are in open conflict or shifting into a post-conflict period of consolidation and rebuilding. Such classification is temporal, and largely based on the systemic vulnerabilities that exist in such states as a result of these environmental influences.

Somalia is one example of an incapable state. It is classified as a failed state, ranking second in the Failed State Index (FSI), and is also a state in conflict.¹⁸² The country has been torn apart by protracted foreign and internecine conflict, and tensions continue to exist. Competing NSVAs control large swaths of state territory, as well as the illicit trades that transit and transact within their areas of influence.

In principle, Somalia is a drug prohibitionist country, but it lacks any ability to interfere in the illicit drug economy. Khat is the most common drug of use, as Somalia is one of the original African khat cultivation countries. It is consumed in vast quantities and the domestic trade in khat also supports a significant cash-based economy, with subsistence farmers benefitting from livelihood

production in the absence of state-sponsored support and investment.

The Somali diaspora, both continentally and globally, represents a significant export market for local khat producers, and a potential foreign exchange channel. Drug policy reform is a non-issue in the country as it struggles with absent institutions, innumerable structural and systemic vulnerabilities, and a lack of effective, peaceful governance.¹⁸³

The Somali diaspora represents a significant export market for local khat producers, and a potential foreign exchange channel

Mauritania is a fragile state.¹⁸⁴ It is a major trans-shipment point for illicit drugs and other commodities feeding into the Sahel-Sahara trafficking network. In addition, it lies at the western point of the enormous so-called 'Arc of Instability', has a strong al-Qaeda in the Maghreb (AQIM) and other NSVA presence and threat potential, and maintains a weak security infrastructure that could easily be overwhelmed by these often better trained and equipped NSVAs.¹⁸⁵

When considering Mauritania and its neighbours it is important to note that the contested territories of the Sahel and Sahara are riven by ideological and personal divisions.¹⁸⁶ The maintenance of formal governance systems and structures is difficult across most areas, and ephemeral at best. To even begin to respond to the criminal economies so pervasive here would require a recognition of the roles that intense poverty, governance disjunction, and social disunion play in exacerbating structural instabilities and the vulnerabilities of the state's socioeconomic fabric.

With the current international focus on terrorism or mineral extraction, shifting the ideological focus of

development actors from the political attraction of counter-terror to societal instability will be a difficult task. A solution must be found to the extensive and varied illicit economic market structures in the Mauritanian and wider Sahel-Sahara socioeconomic landscapes if continental approaches to drugs and drug policy are to have a chance to succeed.¹⁸⁷

Burundi is a fragile, unstable country. It is ranked 17th on the 2018 FSI, and 184 out of 188 on the UN Development Programme's (UNDP) Human Development Index.¹⁸⁸ Currently, it is in the midst of a multi-faceted socioeconomic crisis.¹⁸⁹ Following recent uprisings and a failed 2015 coup, the country has a failing economy, deteriorating living conditions, increasing loss of access to basic services, worsening poverty and unemployment, and an unstable and incapable political governance and institutional environment. In terms of its response to drugs and criminal economies, it takes a prohibitionist approach but lacks the institutional, human resource and financial capacity to effectively respond to related illicit economy and drug-use environmental factors.

Eritrea is another example of the drug policy complexities found within the framework of a fragile state. In fact, Eritrea has a fragility ranking similar to that of Burundi.¹⁹⁰ While the level of illicit cross-border drug traffic transiting or targeting Eritrea is unknown, it is believed that the country does not have a significant domestic market for illicit drugs, nor is it likely to be a continental transit point.¹⁹¹

While a staunchly prohibitionist country in terms of its position on illicit drugs and their control, Eritrea has a limited regulatory structure, poorly resourced government institutions, and an economy that is largely cash-based with high levels of underground remittances. Its increasing levels of institutional corruption, coupled with its geographic proximity to conflict-affected neighbouring regions where NSVAs and transnational organised criminal groups are heavily invested, increases its perceived vulnerability to illicit markets, and in particular the market for the regional transit of illicit drugs.¹⁹²

Guinea-Bissau has often been identified as a prototypical narco-state in Africa. It got this label

in the mid-2000s when its government embraced trafficking organisations from South America, allowing them to use the country as a transit point for cocaine and heroin trafficked in partnership with Nigerian traders and destined for Europe.¹⁹³ Guinea-Bissau has been classified as a captured, criminalised state.

Post-revolutionary Libya is a failing state,¹⁹⁴ and a ripe environment for organised criminal groups. With rival governments competing for control, significant conflict displacement, a collapsed economy, and a shortage of basic services, it lacks the basic systems, structures and institutions needed to address socioeconomic and human security vulnerabilities. This has exposed it to exploitation by organised criminal groups. Drug use rates have risen, the supply of illicit drugs has increased and price has decreased, and there are fears that an HIV epidemic is inevitable.¹⁹⁵

Libya's illicit economy rests on the four interconnected markets for arms, migrants, drugs (including pharmaceuticals, like Tramadol) and smuggled licit goods. It also has a well-organised and -armed criminal protection system. While domestic conflict remains common, and often is driven by competition over these illicit markets, it is the criminal economy (rather than government structures) that currently binds the country and its regions together.¹⁹⁶

Libya is an important continental entry and departure point for illicit goods that travel the Sahel-Sahara trafficking routes to and from West and Central Africa, and beyond.¹⁹⁷ It has also become a growing hub for terrorist financing in the Trans-Sahara.¹⁹⁸

Addressing the criminal economy, and the illicit drug trade in particular, will require cooperative intervention – less on justice and security reform and more on carefully calibrated political management – aligned with targeted socioeconomic development assistance designed to increase the institutional capacity of dormant state structures and undermine the influence of criminal markets.¹⁹⁹ Responding to, and resolving, the crisis in Libya is of paramount importance to the success of neighbouring and regional initiatives targeting illicit drug economies on the continent.

In general, it is clear that a diversity of drug policy approaches, positions and perspectives is shaping Africa's national sociopolitical environments. The traditional prohibitionist response to drugs and their consumers is changing, particularly in the wake of the UNGASS 2016 debate but also in the face of growing evidence in support of such change.

More African states are questioning the efficacy of a strict prohibitionist approach to drug policy

More African states are questioning the efficacy of a strict prohibitionist approach to drug policy, particularly in the context of the rapidly developing global cannabis industry, and what has been a failed 20-year UN global plan of action against drugs, within a broader century of global drug control failure.

All of this is occurring within a wider political environment of competing policy positioning and prescription across the continent, domestically as well as regionally.

The confounding role of regional economic communities

It is evident that a growing and diverse array of individual states is considering and reconsidering their national approaches to drug policy and, by extension, the political capital opportunities and expenses within the fragmented continental consensus of prohibition.

There is growing recognition of emergent domestic political and bureaucratic pressures across the continent's national drug policy environments, in particular owing in many instances to political pressure from civil society in favour of policy reconsideration and reform. At the same time, various continentally recognised regional political and economic bodies also function as policy influencers.

Despite these regional economic communities (RECs) being endorsed by the AU, their collective political positioning on drug policy and reform is neither uniform nor derivative of the CAP on the subject. In fact, much like the fluid variability of approaches that characterise the fragmented drug policy environment across African member states, the approaches advocated by RECs are equally diverse.

This inconsistent alignment of drug policy positioning between multiple RECs, the AU and its many member states is a further indication of the political turmoil that characterises continental drug policy environments. These additional, competing channels of policy advice are further complicated by the fact that 39 African states are formal members of at least two different RECs, and 12 states are formal members of at least three or more RECs. This contributes to the thematic disarray and political noise of the continental drug policy environment.

The AU recognises eight RECs on the continent. These are the Arab Maghreb Union (UMA); the Common Market for Eastern and Southern Africa (COMESA); the Community of Sahel-Saharan States (CEN-SAD); the East African Community (EAC); the Economic Community of Central African States (ECCAS); the Economic Community of West African States (ECOWAS); the Intergovernmental Authority on Development (IGAD); and, the Southern African Development Community (SADC).

Created by the Lagos Plan of Action for the Development of Africa (1980) and the Abuja Treaty (1991), the role of these RECs is to facilitate economic integration between members of the respective region and the wider African Economic Community (AEC). In fact, the RECs are intended to be the foundation for the promotion and achievement of wider African developmental integration, with a view to a future in which the social and economic development of the continent is fully integrated. As such, they can play an influential role in the development and implementation of national policies, and the generation of consensus on issues deemed important to regional members.

The relationship between the AU and RECs is mandated by the Abuja Treaty and the AU Constitutive Act (2000), and guided by the Protocol on Relations Between

RECs and the AU (2008)²⁰⁰ and the Memorandum of Understanding (MOU) on Cooperation in the Area of Peace and Security Between the AU, RECs and the Coordinating Mechanisms of the Regional Standby Brigades of Eastern and Northern Africa (2008).

Coordination between RECs remains weak, however, and despite AU (and some national state) attempts to foster greater policy coherence, cooperation and integration between RECs, there is only infrequent formal cooperation outside of official AU forums.

Mauritius highlighted this lack of regional (and by extension, bilateral) cooperation and coordination through its unsuccessful attempts to pursue documented drug trafficking intelligence leads with neighbouring states, which were met with inaction and entangled in red tape.²⁰¹

Coordination between RECs remains weak and there is only infrequent formal cooperation outside of official AU forums

A second example relates to the Force Commander of Combined Task Force 150 (CTF-150),²⁰² who was tasked with intercepting vessels in the Indian Ocean off the eastern coast of the continent with the intention of seizing heroin shipments before they reached their Kenyan, Tanzanian and/or Mozambican port destinations. To do this he had to seek direct political engagement with each relevant East African nation to request its military and security forces' cooperation in patrolling their own coastal waters in order to assist CTF-150 with its work.²⁰³ However, he found that none of the states approached was willing to commit its own assets, or to cooperate with its neighbours in creating a coalition coastal response.²⁰⁴

In fact, regional cooperation and integration in matters as complex as 'drug control' often prove too challenging, as REC secretariats lack the institutional, financial

and human resource capital necessary to monitor and govern the regional partnership. Most operate on a tiny budget and/or with the in-kind assistance of member states, all operate on a consensus model of governance, and none has any regulatory, oversight or implementation authority unless it is provided to them by the consensus decision of their regional constituency.

State sovereignty remains the regional 'red line' for these RECs. Thus, while RECs convene and create consensual positions on a variety of subjects of interest to their constituent members, and develop implementation guides, plans and strategies for their membership, the implementation and enforcement of compliance with such commitments or positions remain subject to sovereign will.

RECs and their myriad drug policy orientations

REC positions on drug policy (where they exist) are outlined below, with a short description of the relevant circumstances and/or political positions of each REC.

Arab Maghreb Union (UMA)

The UMA was founded in 1989. Among its many founding objectives, the UMA was formed with the express purpose of coordinating and aligning regional members' development policies and strategies with the principles of sustainable development. Unfortunately, despite recent calls for it to help its members develop appropriate responses to the growing drug-related criminal economies of the region, the organisation has been dormant since 1994.²⁰⁵ As such, it has expressed no regional guidance or position on drug policy or drug-related approaches. Its members are Algeria, Libya, Mauritania, Morocco and Tunisia.

Common Market for Eastern and Southern Africa (COMESA)

COMESA was formed in 1994. Among its founding objectives is a commitment for members to cooperate in the promotion of peace, security and socioeconomic stability in order to improve economic development across the region. This cooperation pledge includes

joint efforts in addressing the growing organised criminal economies that are undermining the economic development and sustainability of its members. As such, COMESA advocates that its member states cooperate in the prevention of drug trafficking activities, and encourages them to engage in scientific research and development on drugs and medicinal plants (e.g. cannabis or khat), as is explicitly permitted in a soft interpretation of international drug conventions. COMESA has not taken a formal regional position on decriminalisation of drug use and/or possession, nor has it formulated a regional position on the legalisation of cannabis for medicinal purposes. However, some of its members are either in the process of considering the option of implementing such a reformed drug policy position nationally, or have already done so. Its members are Burundi, Comoros, the DRC, Djibouti, Egypt, Eritrea, eSwatini, Ethiopia, Kenya, Libya, Madagascar, Malawi, Mauritius, Rwanda, Seychelles, Somalia, Sudan, Tunisia, Uganda, Zambia and Zimbabwe.

Community of Sahel-Saharan States (CEN-SAD)

CEN-SAD was established in 1998. Its mandate was revised in 2013 to incorporate the development of cooperation around regional security and sustainable development. It is the largest of the RECs in terms of membership, and expresses a decidedly prohibitionist regional stance in its guidance on drug policy positioning.²⁰⁶ Through remarks at regional forums it seems the CEN-SAD membership supports the Vienna Consensus, and the restricted prohibitionist interpretation of the three international drug control treaties. Its members are Benin, Burkina Faso, the Central African Republic, Comoros, Côte d'Ivoire, Djibouti, Egypt, Eritrea, The Gambia, Ghana, Guinea-Bissau, Libya, Mali, Mauritania, Morocco, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo and Tunisia.

East African Community (EAC)

The current iteration of the EAC was founded in 1999. Among its founding principles is members' commitment to promote peace, security and socioeconomic stability within and across the region. It also aims to pursue – with the partnership of local CSOs – the sustainable

Table 1: Relative drug policy position of AU Regional Economic Communities

Group	Membership	Drug policy position	Reference
Arab Maghreb Union (UMA)	5	UMA has been inactive since 1994.	Elabdi, F. (2018) It's time to revive the Maghreb Union, <i>The Turban Times</i> , 19 August. Retrieved from: https://www.theturbantimes.com/2018/08/19/its-time-to-revive-the-maghreb-union/
Common Market for Eastern and Southern Africa (COMESA)	21	Advocates member cooperation in the prevention of drug trafficking; and, encourages member states to engage in research and development on drugs and medicinal plants. No explicit position on decriminalisation of drug use/possession or legalisation of cannabis, though some members are engaging in internal debate on these issues and/or have legalised cannabis cultivation, possession, and/or use.	Article 118, Chapter 14, <i>Treaty of the Common Market for Eastern and Southern Africa (COMESA)</i> , December 1994.
Community of Sahel-Saharan States (CEN-SAD)	23	Advocates a prohibitionist-focussed securitised response to drugs, and criminalisation of drug use/possession. No support for decriminalisation or cannabis legalisation policy measures.	<i>Statement by Dr. Souley Hassane on behalf of CEN-SAD</i> , High-Level Event on Strengthening Partnerships for Peace, Security and Stability in Africa, 11 October 2016, New York.
East African Community (EAC)	6	Advocates members work together in the control and eradication of trafficking and consumption of illicit or banned drugs; but is considering a policy promoting the implementation of harm reduction services for people who use drugs. No explicit position on decriminalisation of drug use/possession or legalisation of cannabis, though some members are engaging in internal debate on these issues.	Article 110, <i>Treaty for the Establishment of the East African Community</i> (as amended on 14 December 2006 and 20 August 2007); <i>EAC Regional Policy on Harm reduction Services for People Who Use Drugs</i> [draft], East African Community (EAC), October 2017.
Economic Community of Central African States (ECCAS)	11	Advocates cooperation among members in a regional, securitised response to drugs. No explicit position on decriminalisation of drug use/possession or legalisation of cannabis, though some members are engaging in internal debate on these issues.	<i>ECOWAS-ECCAS Joint Communiqué</i> , Joint Summit of ECOWAS and ECCAS Heads of State and Government on Peace, Security, Stability and the Fight Against Terrorism and Violent Extremism, 30 July 2018, Lomé.
Economic Community of West African States (ECOWAS)	15	Current Regional Action Plan advocates for member state use of alternatives to incarceration for people who use drugs; establishment of harm reduction services; treatment of drug use as a health issue rather than a criminal matter; and, advocates member state partnership with civil society to support national drug responses. Some member states are engaging in internal debate on policy options of decriminalisation of drugs and/or legalisation of cannabis.	<i>ECOWAS Drug Action Plan to Address Illicit Drug Trafficking, Organised Crime and Drug Abuse in West Africa (2016–2020)</i> , ECOWAS Commission, Abuja.

Group	Membership	Drug policy position	Reference
Intergovernmental Authority on Development (IGAD)	8	Advocates criminalisation of drug use/possession and a stronger, securitised response to drugs in the region. No support for decriminalisation or cannabis legalisation policy measures.	IGAD (2016) <i>Regional Strategy (2016–2020): Vols 1 & 2</i> , IGAD Secretariat, Djibouti.
Southern African Development Community (SADC)	16	To reduce and eventually eliminate drug trafficking, drug use, and production of drugs in the region. Advocate criminalisation of drug use/possession, though some members are engaging in internal debate on this issue and/or have legalised cannabis cultivation, possession, and/or use.	<i>Protocol on Combatting Illicit Drug trafficking in the Southern African Development Community Region</i> , 24 August 1996, Maseru; UNODC & SADC, <i>Making the Southern African Development Community (SADC) Region Safer from Crime and Drugs: Regional Programme: 2013–2020</i> (as amended in 2017), UNODC Regional Office for Southern Africa, Pretoria.

- Policy position embraces measures of drug policy reform
- Policy position is neutral towards measures of drug policy reform
- Policy position rejects measures of drug policy reform

socioeconomic and political development of its member state populations. The EAC has been among the most active RECs in terms of the generation of discussion and debate around the nature of effective drug policy, and the role of drug policy and organised criminal economies in undermining the development of the region. It is on track to become the first REC to establish and adopt a regional policy promoting member states' adoption of harm reduction health services targeting their drug-using populations. It has partnered with a drug policy reform-oriented CSO consortium²⁰⁷ and has expressed the intention of establishing a regional drug policy network, a move that will lay the political groundwork for the establishment of a regional East African Commission on Drugs, intended to be similar in form, function and philosophy to the West Africa Commission on Drugs (WACD), located in the ECOWAS region. Despite being a small REC with limited institutional, financial and human resource capacities, the EAC has demonstrated strong regional leadership on the subject of advocating for its membership to address more effectively the health impacts of their prohibitionist drug policies and programmes. As a continental REC, it may well be one of the most reform-minded in terms of its political perspective on the drug policy positioning of

its members. Its members are Burundi, Kenya, Rwanda, South Sudan, Uganda and Tanzania.

Economic Community of Central African States (ECCAS)

ECCAS was founded in 1983, but entered the AEC in 1999 following a number of years of intra-regional conflict and REC dormancy. In its founding principles, ECCAS did not address in any way the issues of peace, security or regional stability. It later adopted the Protocol on Peace and Security in 1999, which then established the Security Council in Central Africa (COPAX) in 2004, which led to the creation of the Central African Multinational Force. ECCAS also adopted the Protocol Relating to the Strategy to Secure ECCAS's Gulf of Guinea (2009) and the Declaration of Heads of State and Government on Maritime Safety and Security (2013). The last two lay the foundation for joint maritime security measures by ECCAS members, an issue of particular relevance to the region given the almost regularised flow by sea of cocaine and heroin into and through the Central African region. While it has no formal regional policy position, through its adopted security-related policy architecture ECCAS can be seen to advocate an informal position favouring drug control prohibition

and supply interdiction, particularly in the context of undermining illicit financial flows to, and illicit market penetration by, indigenous violent non-state actors. Its members are Angola, Burundi, Cameroon, Central African Republic, Chad, Republic of Congo, the DRC, Equatorial Guinea, Gabon, Rwanda, and São Tomé and Príncipe.

Economic Community of West African States (ECOWAS)

ECOWAS was established in 1975. Among its many founding principles is the objective to promote the balanced socioeconomic development of the region, with particular attention to overcoming the 'special problems' of individual member states that may affect their ability to achieve the intended regional balanced development standard. The illicit drug trade is one such 'special problem'. Perhaps the most active REC in terms of recognising and responding to the national threats and impacts of regional illicit drug economies, ECOWAS has developed its own health and human rights-focused regional policy position on drugs,²⁰⁸ as well as the ECOWAS Drug Action Plan to Address Illicit Drug Trafficking, Organised Crime and Drug Abuse in West Africa (2016–2020). The current action plan replaced the earlier Political Declaration Against Illicit Drug Trafficking, Abuse and Organised Crimes (2008), the ECOWAS Regional Action Plan Against Illicit Drug trafficking, Abuse and Organised Crimes (2008–2015), and the Operational Plan on Illicit Drug Trafficking, Organised Crime and Drug Abuse in West Africa (2009–2012). These earlier instruments were developed in the wake of the CND's approval in 2008 of its Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem and shared common approaches and goals. Following the failure of these prohibition-based approaches to counter the regional 'drug problem', in the new action plan law enforcement shifts its focus away from drug users and instead targets mid- and high-level drug traffickers. It also advocates for incarceration alternatives for low-level drug offenders; emphasises the need for member states to identify income replacement and livelihood alternatives for subsistence farmers who cultivate

cannabis; and stipulates a suite of harm reduction and drug treatment service alternatives targeting PWUD. While the policy approach and positioning of ECOWAS is progressive in its political orientation, it does neglect to address several core drug-related issues. Despite being the home of the WACD, and with at least one member state shortly to decriminalise all drugs, ECOWAS has expressed no position on decriminalisation (or legalisation). Furthermore, despite the health and rights content of its new action plan, ECOWAS has not explicitly addressed the reality that PWUD face significant stigmatisation and often are barred from accessing public health services. This is a violation of their fundamental human rights, and a significant barrier to access the health service programming prescribed in the action plan. However, the fact that such reform-oriented drug policy developments have occurred with the ECOWAS region should be regarded as an achievement in its own right. After all, the region has presented its regional body with a collection of significant, recurring and regularly emerging security threats, many of which are fundamentally entwined with the endemic organised criminal economies of its development landscape. Its members are Benin, Burkina Faso, Cabo Verde, Côte d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.

Intergovernmental Authority on Development (IGAD)

IGAD was created in 1996. Its mission is to assist and complement member state efforts on cooperation to achieve, among other things, peace, security and the sustainable development of the region. IGAD advocates a drug policy position that is aligned with the criminalisation of drug use and possession, and a stronger regional, securitised and militarised response to drug economies and their consumers.²⁰⁹ As it is an REC with many regional challenges to address, IGAD and EAC foreign ministers in 2013 began exploring the possibility of merging IGAD with the EAC. As the EAC has recently pursued a revised, reformed approach to drugs and drug control matters, it would be interesting to monitor the outcomes of the inevitable epistemological conflicts from such a political merger.

Its members are Djibouti, Ethiopia, Eritrea, Kenya, Somalia, Sudan, South Sudan and Uganda.

Southern African Development Community (SADC)

SADC was founded in 1992. One of its principle aims is the cooperative commitment of member states to regional integration and poverty eradication achieved through socioeconomic development and the assurance of peace and security. SADC is one of the largest RECs in terms of membership. However, apart from the dormant UMA, SADC is also one of the more disappointing RECs in terms of its recognition of and commitment and response to illicit commerce and the drug trade more specifically, as well as the health and rights of PWUD. A

study conducted on the SADC region 10 years after its inception concluded that even in this period, at the cusp of the rapid intra-continental expansion of West African (among others) criminal groups, organised indigenous criminal groups from South Africa, Zambia and Zimbabwe (among others) had already established 'solid market penetration' across the region.²¹⁰ Its members are Angola, Botswana, Comoros, the DRC, eSwatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe.

The influence of global alliances

In addition to the fragmented policy influences and requirements imposed upon African states by their

Table 2: Relative drug policy position of selected global alliances and bodies with African member state membership

Group	African membership	Drug policy position	Reference
League of Arab States (LAS)	10	Advocates for members to provide an integrated package of services to people who inject drugs, including harm reduction programmes, and programmes in prison settings; and, to review laws and regulations in relation to drug use and HIV to promote comprehensive and evidenced based programming focusing on the health aspect in service provision rather than the punitive dimension. Decriminalisation of drug possession/use not explicitly rejected.	League of Arab States (2014) <i>Arab Strategic Framework/or the response to HIV and AIDS (2014–2020)</i> , Social Affairs Sector, Directorate of Health and humanitarian Aid, Technical Secretariat of the Council of Arab Ministers of Health, March.
Organisation Internationale de la Francophonie (OIF)	30	Supports drug prohibition principles of the international drug control treaties & the approach of the related Vienna-based institutions. Reference human rights & health approaches as necessary tools for states to employ according to their situations, but to be done so in the context of a broader prohibition approach to drugs. Does not openly support decriminalisation or legalisation off cannabis, even for medical purposes.	<i>Statement of H.E. Omar Hilale on behalf of the Organisation de la Francophonie Member and Observer States</i> , 30th UNGASS, 2nd Plenary meeting, 19 April 2016, Document A/S-30/PV.2, pp15–17.
Africa Group of the UN (AG)	54	Supports the drug prohibition principles of the international drug control treaties & the prohibitionist approach of the related Vienna-based institutions. Rejects decriminalisation, legalisation and harm reduction approaches. Supports increased prohibition-focussed initiatives to achieve a 'world free from drugs'.	<i>Statement of Egypt on behalf of the Group of African States</i> , 61st Session, Commission on Narcotic Drugs, Plenary session, Vienna, 12 March 2018.

Group	African membership	Drug policy position	Reference
Organisation of Islamic Cooperation (OIC)	13	Advocates a prohibitionist approach to drugs. Members commit "to cooperate in combatting terrorism in all its forms and manifestations, organised crime, illicit drug trafficking, corruption, money laundering and human trafficking". Decriminalisation and legalisation are rejected as drug policy alternatives.	Chapter 1, Article 1, Objective 18, <i>Charter of the Organisation for Islamic Cooperation</i> ; Member statements to CND Sessions, and the UNGASS (2016).
Non-Aligned Movement (NAM)	53	Supports the drug prohibition principles of the international drug control treaties & the strict prohibitionist approach of the related Vienna-based institutions. Decriminalisation and legalisation are rejected as drug policy alternatives.	International Institute for Non-Aligned Studies (2018), NAM highlights the significance of international instruments for drug control, <i>New Delhi Times</i> , 14 August. Retrieved from: https://www.newdelhitimes.com/nam-highlights-the-significance-of-international-instruments-for-drug-control/
Group of 77 and China (G77)	54	Supports the drug prohibition principles of the international drug control treaties & the strict prohibitionist approach of the related Vienna-based institutions.	<i>Statement of Ecuador on behalf of the Group of 77 and China</i> , 61st Session, Commission on Narcotic Drugs, Plenary session, Vienna, 12 March 2018.
Pompidou Group (PG)	1	Advocates that drug users should enjoy the same rights under the existing international human rights instruments as all other persons; that the application of the death penalty for drug-related offences does not accord with human rights obligations; the application of inhumane punishment and torture for drug-related offences does not accord with human rights obligations; and, drug-users have an uncontested right to equitable access to health-care services for their drug addiction and other drug- or non-drug-related health problems.	<i>Statement of H.E. Bent Høie, Minister of Health and Care Services of Norway, on behalf of the Pompidou Group</i> , 30th UNGASS, 1st Plenary meeting, 19 April 2016, Document A/S-30/PV.2, pp24-26.
International Conference of "Parliamentarians against Drugs" partners (PAD)	2	Advocates a continuation of prohibition measures to support progress towards a "drug free environment" in order to "protect society from the drug challenge".	<i>Declaration of the International Conference of "Parliamentarians against Drugs"</i> , 04 December 2017, Moscow.
Russian-African Anti-Drug Dialogue partners (RADO)	54	Advocates increasing the securitization of global responses to drugs; rejects drug policy responses that deviate from the international drug conventions – including decriminalisation efforts and the legalisation of cannabis in any form – and advocates a unified stance at UNGASS & other global fora.	<i>The Banjul Declaration</i> , Russian-African Anti-Drug Dialogue, 23 July 2015, Banjul, Gambia; <i>The Durban Declaration</i> , Second International Conference, Russia-Africa Anti-Drug Dialogue, 09 March 2016, Durban, South Africa. [Note: <i>The Durban Declaration</i> was debated but not adopted by members due to the withdrawal of South Africa]

- Policy position embraces measures of drug policy reform
- Policy position is neutral towards measures of drug policy reform
- Policy position rejects measures of drug policy reform

domestic bureaucracies and RECs, many states hold membership in a collection of global alliances and groups that proffer drug-related policy advice, positioning, and/or political requirements. In addition to these global alliances are bilateral and multilateral political pressures exerted directly; through indirect channels such as temporary dialogue mechanisms; and institutionally through entities such as the UN and other international political forums.

Much like RECs, several global alliances count many – and in some cases, all – of the African states among their members

It is important to understand the political space that international alliances and institutions occupy, as it leads to further fragmentation of the continental drug policy environment.

International alliances

Much like RECs, several global alliances count many – and in some cases, all – of the African states among their members. Their influence and political pressure toward a common approach further prejudice continental drug policy orientation, with some alliances espousing a nuanced reformist position and others a more prohibitionist perspective.

For example, the League of Arab States (LAS) was founded in 1945 and is headquartered in Egypt. It counts 10 African countries among its members. In terms of drugs, it advocates that member states provide an integrated package of services to PWUD, including harm reduction services and programmes supporting those drug users in prison.²¹¹ It also recommends that member states review their laws and regulations in relation to drugs in order to allow comprehensive and evidence-based domestic programming focused on supporting the health and rights of PWUD.²¹²

Like the LAS, the Community of Portuguese Language Countries (CPLP), founded in 1996, advocates a human rights- and health-oriented approach to drugs, and universal access to health services for PWUD. Some CPLP members advocate the complete decriminalisation of drugs.²¹³ There are six African countries among its members and observer states.

The OIF was founded in Niger in 1970. It has 30 African countries among its members and observer states. In regard to drugs, the OIF supports the principles of the three international drug control treaties and the drug prohibition approaches expressed by the Vienna-based drug control institutions. While the OIF has acknowledged human rights and health approaches as being necessary tools for member states to employ according to each state's specific circumstances, such efforts are to take place in the context of a broader prohibitionist approach to drug control.²¹⁴

Similar to the OIF in its conservatism, the NAM supports the drug prohibition principles of the international drug control treaties and the strict prohibitionist approach of the related Vienna-based institutions.²¹⁵ It does not support decriminalisation or legalisation approaches as viable interpretations of the drug control conventions. The NAM was founded in 1961 and counts almost every African country (53) as a member.

There is also the G77 and China. It was founded in 1964, and every African country belongs to it. The G77's position on drug policy closely parallels that of its affiliated partner, China, as well as the OIF and the NAM. The G77 supports the drug prohibitionist principles and measures of the international drug control treaties, as defined by the Vienna-based UN drug control institutions.²¹⁶ It does not support decriminalisation or legalisation approaches as viable interpretations of the drug control conventions. Several of its members also advocate for the use of capital punishment as a deterrent for drug crimes, and use the argument of state sovereignty to shield themselves from drug policy consensus exercises that refer to human rights and state obligations.

International institutions

In addition to international alliances, international institutions have also contributed to the fragmentation of the continental drug policy consensus. Similar to the complicated relationship between African states and their RECs, international institutions also see strong African state membership. As is the case with RECs, there is often overlapping membership by states across two or more of these bodies with their diverse and often competing policy positions, objectives, and political orientations.

In June 2011 the newly created Global Commission on Drug Policy (GCDP), chaired by Fernando Henrique Cardoso, a former president of Brazil, issued a landmark report entitled *War on drugs*.²¹⁷ The report contained a scathing indictment of the negative consequences of the global drug prohibition regime, and called for a new approach. This publication was followed by new reports released each of the following years.

When combined, these documented and defined the failures of the global war on drugs, and lay the blueprint for a new, decriminalised global approach to drug policy.²¹⁸ This initial publication by the GCDP, and its second in 2012, began to galvanise drug policy reform sentiments among civil society groups across the globe by providing them with a collection of rigorous, evidenced, political texts with which to rebut the traditional Vienna-based prohibition discourse on drugs.

The publications of the GCDP provided a strong evidence base for questioning prohibitionist status quo approaches to continental drug policy. They also sparked debate among CSOs and drug-using communities across Africa, most particularly in the coastal states of the East, West and South.

As a direct result of the work of the GCDP, and in particular the leadership of its African commissioners,²¹⁹ the WACD was founded in 2013, acting as a de facto regional body of the GCDP. The WACD advocates with African states on the evidence supporting a transition in drug policy approaches to one that is founded on the principles of decriminalisation and legalisation.²²⁰

Similar in message to the GCDP is the Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (the Pompidou Group [PG]). The PG was founded in 1971 and has one African country (Morocco) in its membership. The PG advocates that PWUD should enjoy the same rights under the existing international human rights instruments as all other persons; that the use of the death penalty for drug-related offences is inconsistent with human rights obligations; that inhumane punishment and torture for drug-related offences do not accord with human rights obligations; and that PWUD have an uncontested right to equitable access to healthcare services for their drug addiction and other drug- or non-drug-related health problems.

The drug policy stance of the PG is progressive, and in line with much of the recent drug policy reform discussion that has been contributing to the fragmentation of the Vienna Consensus.

A thematically different influencing institution is the International Conference of Parliamentarians Against Drugs (PAD). The PAD was convened in December 2017 in Moscow, Russia. It was sponsored by the Russian Parliament, and included two African states (Guinea and Morocco) among its partners. The PAD was undertaken in conjunction with the UN, as UNODC Executive Director Yury Fedotov, a former Russian ambassador, delivered an address at the event.

The Declaration of the International Conference of PAD was included as an official document and agenda item of the 61st session of the CND in March 2018.²²¹ The PAD Declaration appears to be aligned with the conservative Russian and Chinese positions on drug policy that support only interpretations of the international drug conventions that advocate for a continuation of drug prohibition measures toward the goal of a 'drug-free environment' for the 'protection of society from the drug threat and to come out in favour of promoting healthy lifestyles'.²²²

The RADD pursued a similar message as the PAD. The first Russia-Africa Anti-Drug Conference was held in The Gambia in July 2015. Every African state was invited to send delegates. The stated purpose of the event was to advocate a drug policy position aligned with

the traditional prohibition orientation of the Vienna Consensus, perhaps as a means to counter the growing soft defections of CND member states and reinforce this position with African state assistance.²²³ As a concluding milestone of this event, the Banjul Declaration was adopted. In this 13-paragraph document the RADD delegates pledged, among others:

- To support the international drug conventions
- To support a securitised response to drugs
- Not to pursue legalisation of drugs in any manner
- To take a unified position on these principles at UNGASS 2016²²⁴

Parties to the declaration, therefore, were committing themselves to align their political position on drug policy with that of the Russian Federation and other prohibitionist states strongly opposed to the emerging drug policy reform debate and, in particular, the increase in decriminalisation and cannabis legalisation policy approaches.

In April 2016, days before the UNGASS meeting in New York, a second RADD was held, this time in Durban, South Africa. While receiving strong support from the host, the South African Police Service (SAPS), the Russian Federation delegates were unable this time to achieve delegate consensus agreement on a proposed second statement, the Durban Declaration.²²⁵

Ironically, it appeared that while the SAPS was a willing host of the event, national assent to the draft declaration was overruled by another arm of government, this one led by the deputy minister of the Department of Social Development (DSD). The DSD is the government entity responsible for most drug matters in South Africa, and Hendrietta Bogopane-Zulu happened to be preparing for her CAP presentation to the UNGASS 2016 meeting in New York at that very time. As a result, it was her remit to oppose the country's assent to the so-called Durban Declaration on the grounds that the conditions of the declaration contradicted the consensus points already agreed by South Africa in the CAP.

Without a consensus, the document faded into the background. Shortly thereafter the Russian Federation, under the leadership of Foreign Minister Sergei

Lavrov, reached an agreement with AU Commission Chair Nkosazana Dlamini-Zuma on the creation of a permanent AU–Russia Working Group to Combat Drug Trafficking. This was a shrewd solution to the consensus debacle. It allowed for the continued promulgation of Russian-backed drug prohibitionism on the continent, and extended its diplomatic reach deeper into the previously occupied ideological margins of the continent.²²⁶

The Organisation of Islamic Cooperation (OIC) was founded in 1969. It counts 13 African states among its members. The OIC advocates a prohibitionist approach to drugs in line with the Vienna Consensus, and commits its members 'to cooperate in combating terrorism in all its forms and manifestations, organised crime, illicit drug trafficking, corruption, money laundering and human trafficking'.²²⁷ Decriminalisation and legalisation are rejected as drug policy alternatives.

In addition, one should not underestimate the influence of UN bodies on the continental approach to drugs and drug policy. After all, there is no 'One UN' position on drug policy among the assorted collection of UN agencies, funds and programmes. Despite the mantra of the UN reform movement's being imposed across the development and humanitarian spaces of the previous decade, and its desire for 'One Voice' across organisations, the topic of drug policy and, in particular, the polarisation that has become endemic in its discussion has seen a significant split within the UN across its various organisations.

This political divide is far from equal in its distribution. With regard to drug policy, there is clear internecine conflict in that the majority of UN organisations retain a policy position that directly contravenes the position espoused by the three Vienna institutions. The CND, UNODC and INCB are the only UN organisations/institutions that hold a strict prohibitionist position on drugs.




The drug policy schism within the UN

Twelve UN entities openly advocate for the complete decriminalisation of drug use and possession of drugs for personal use.²²⁸ Even the UN secretary general

Table 3: Formal drug policy position of UN organisations and entities, where such a position has been declared

	Entity	Drug policy position	Reference
UNDP	UN Development Programme	Advocate for the decriminalisation of drug use and possession of drugs for personal use.	<i>Joint United Nations Statement on Ending Discrimination in Health Care Settings</i> , June 2017. Retrieved from: https://www.who.int/gender-equity-rights/knowledge/ending-discrimination-healthcare-settings.pdf
WHO	World Health Organisation		
OHCHR	UN Office of the High Commissioner for Human Rights		
UNFPA	UN Population Fund		
UNAIDS	UN Joint Programme on HIV/AIDS		
UNHCR	UN High Commission for Refugees		
UNICEF	UN Children's Fund		
WFP	World Food Programme		
UNWOMEN	UN Entity for Gender Equality & the Empowerment of Women		
ILO	International Labour Organisation		
UNESCO	UN Educational, Scientific & Cultural Organisation		
IOM	International Organisation for Migration		
UNSG	UN Secretary General	Advocates for the decriminalisation of drug possession for personal use.	<i>Secretary-General Cites General Assembly Special Session in Message on International Day against Drug Abuse, Illicit Trafficking</i> , Document SG/SM/19105-OBV/1802-SOC/NAR/963, 25 June 2018. Retrieved from: https://www.un.org/press/en/2018/sgsm19105.doc.htm
UNGA	UN General Assembly	Consensus support of health-oriented programming for people who use drugs, but majority position remains in favour of drug prohibition. A growing minority of members support decriminalisation of drugs and/or legalisation of cannabis.	<i>S-30/1 – Our joint commitment to effectively addressing and countering the world drug problem</i> , Resolution adopted by the General Assembly on 19 April 2016, New York.
CND	Commission on Narcotic Drugs	A fragmenting consensus advocating for total prohibition, with a growing minority membership in support of decriminalisation and/or legalisation approaches.	CND (2018) <i>Report on the 61st Session (8 December 2017 and 12–16 March 2018)</i> , Report E/2018/28-E/CN.7/2018/13, Vienna.

	Entity	Drug policy position	Reference
UNODC	UN Office on Drug & Crime	Advocates for implementation of the commitments made by CND member states to address and counter the world drug problem, in a balanced manner, under the framework of the international drug conventions & the UNGASS; and, to encourage member states to incorporate HIV interventions for people who use drugs and those in closed settings into national drug policies & plans.	UNODC (2018) <i>Activities of the United Nations Office on Drugs and Crime: Report of the Executive Director</i> , 61st Session, Commission on Narcotic Drugs, Report E/CN.7/2018/2-E/CN.15/2018/2, Vienna.
INCB	International Narcotics Control Board	Advocates for continued, complete drug prohibition. Critical of those that promote or adopt decriminalisation or legalisation measures of any kind under any circumstance.	INCB (2018) <i>Report of the International Narcotics Control Board for 2017</i> , Report E/INCB/2017/1, Vienna.

-  Policy position embraces measures of drug policy reform
-  Policy position is neutral towards measures of drug policy reform
-  Policy position rejects measures of drug policy reform

himself favours the complete decriminalisation of drug use and possession.²²⁹ This institutional fragmentation across UN bodies, and the broken consensus that normally permeates any UN approach to a subject, is also representative of the current continental disaggregation of approaches to drugs.

The political isolation of the Vienna-based institutions illustrates the anachronistic space that they occupy within the wider UN community and the growing body of global drug policy. That the Vienna organisations constantly appear to need to reinforce their political position (see the UNGASS remarks of INCB Chair Werner Sipp, for example) at the expense of rejecting those held by others, is a political survival instinct designed to reinforce (or force) the maintenance of an illusion of consensus.

This, however, does not mean that the institutions themselves are uncontested spaces. For example, in October 2015 a remarkable situation transpired at the International Harm Reduction Conference held that year in Kuala Lumpur, Malaysia.

These biennial conferences are a focal point for sharing knowledge about harm reduction²³⁰ practices, philosophy, promotion and networking, especially in

relation to drugs and people who use them. They attract a large number of CSOs, human rights and public health workers, and politicians, among many others. The UNODC is a regular participant.

Twelve UN entities openly advocate for the complete decriminalisation of drug use and possession of drugs for personal use

On this particular occasion the UNODC was represented by the head of its HIV/AIDS Unit, Dr Monica Beg. In the months prior to this conference, Beg had organised the drafting of an internal briefing paper designed to address the issue of decriminalisation in the context of HIV programming. The intention of the piece was to outline, through a soft interpretation of the international drug conventions, that decriminalisation was not inconsistent with its terms.²³¹ The resulting briefing paper, entitled 'Decriminalisation of drug use and possession for personal

consumption', opened with the following extraordinary statement: 'Decriminalising drug use and possession for personal consumption is permitted by the international drug control conventions and is a key element of the HIV response among people who use drugs.'²³²

It was a remarkable development, to have a UNODC publication openly advocate a flexible interpretation of the conventions. To have it released and presented for discussion at a meeting of harm reductionists was a dramatic, forward-thinking shift in organisational political orientation. This was certain to galvanise the sentiments of reformist member states of the CND, and challenge those in its prohibition status quo.

The night before the conference was to begin, however, UNODC HIV staffers desperately tried to retract the paper, even though it had already been submitted to the conference and informally circulated among its delegates. Following the negative reaction of a single mission²³³ in Vienna to the paper's embrace of decriminalisation, the UNODC distanced itself from the briefing's content and attempted to have it retracted. However, the political damage was done.

Upon learning of this organisational volte-face by the UNODC, the paper was leaked to the media by Virgin founder Richard Branson²³⁴ and its content was hailed as a 'turning point in drug policy reform'.²³⁵ What was now a UN 'ghost paper' on decriminalisation had been released into the wilds of the Internet, and the world soon realised that the cracks in the Vienna Consensus extended into the institutional drug control machinery of the once 'iron triangle'.²³⁶

It also demonstrated that, in spite of the UN's international drug policy framework being defined in the halls of the CND, and the fact that the political position of many other UN agencies, funds, and programmes was diametrically opposed to that of the CND, and by extension, the UNODC, the Vienna institutions would continue to protect and promote their consensus position, no matter how compromised.²³⁷

It is important to note that the political isolation of the UN's drug policy agents and their drug prohibition stance is further evidence that the faded African position

on prohibition, for so long a derivative of this global stand, is equally isolated, particularly among many of its international development partners.

Role of the African Union

The AU is meant to be the seat of continental drug policy positioning. It is the home of the AU Specialised Technical Committee on Health, Population and Drug Control, under which the subject of drug policy falls; the convenor of the regular AU Conference of Ministers in Charge of Drug Control; and the custodian of the AU Plan of Action on Drug Control (2013–2020).

This Plan of Action is considered to be a positive instrument, representing the continent's determination 'to tackle the growing problem of illicit drug use and drug markets, and the associated criminal, social and health problems'.²³⁸ It outlines a moderately progressive approach to drug control on the continent, and embraces within its revised strategic approach several elements consistent with policy measures advocated by the global drug policy reform movement. Every African state is a member of the AU, and each has assented to this consensus Plan of Action.

In addition, at the sixth session of the AU Conference of Ministers in Charge of Drug Control, AU member states mandated the development of the CAP on drugs. The resulting CAP consensus document created by the AU Commission had been requested by member states in their Addis Ababa Declaration on Scaling Up Balanced and Integrated Responses Towards Drug Control in Africa decision of 2014, and subsequently was developed through many months of rigorous consultation across the continent.²³⁹

The resulting position statement, while not as strong on 'reform' points as some would have preferred,²⁴⁰ nevertheless was seen by many as an agreeable, progressive stand. It highlighted the failure of the status quo drug prohibitionist approaches of the past, and laid out numerous human rights- and public health-oriented drug policy commitments that member states agreed to pursue, moving away from the securitised and militarised drug control approaches still so common on the continent. However, many African

Table 4: Outline of the AU Common African Position (CAP) on drugs (2015)

AU member states commit to the following:

- The fundamental goal of drug policies should be to improve health, safety, security and socioeconomic well-being of people.
- Effective drug policies are those with appropriate and proportional focus on the four priority areas of the AU Plan of Action on Drug Control (2013–2020), including using evidence-based services to address the health impacts of drug use, and doing so in accordance with fundamental human rights principles and the rule of law.
- Drug policies which focus entirely or disproportionately in law enforcement, incarceration, punishment and repression have not succeeded in eradicating supply, demand and harm caused by illicit drug on the continent.
- Drug use and drug dependence must be treated as a public health issue. People who use drugs must be offered support, treatment and protection, rather than be faced with punishment and a criminal record.
- Financial resources should target capacity building for local communities, as well as healthcare workers and law enforcement officials.
- Drug policies should be harmonized and law enforcement resources should be directed towards more selective deterrence.
- Undertake policy and legal reforms to adequately address drug use and drug trafficking in all its forms, including reducing harm associated with drug use, including increased vulnerability to HIV.
- To ensure the provision of opiates and other essential and controlled medicines for palliative care and pain relief.
- Call for an open, transparent and inclusive debate on drug control, including participation of civil society and affected populations.
- Support the restructuring of the UN's Political Declaration and Plan of Action to reflect Africa's collective health goals.

governments were heavily invested in these protean, authoritarian approaches to drug control, and wanted them to continue.

Importantly, the CAP was intended to be a continental policy instrument outlining the evolving continental consensus on drug policy within the AU membership, and to be presented to the UNGASS in 2016. It was a significant step toward a coordinated continental definition of the drug control problems affecting member states, and contained nuanced, 'new' approaches to contribute to national drug policy resolutions.

Yet despite this unanimity, the politics of African drug control presented additional complications. Regardless,

on April 2016 in New York, Bogopane-Zulu, South Africa's Deputy Minister of Social Development and Chairperson of the First AU Specialised Technical Committee on Health, Population and Drug Control, presented the CAP on drugs to UN member state representatives gathered at the UNGASS.

This consensus statement was delivered on behalf of all AU member states, and publicly established 10 commitment points for continental drug policy.

Some of these points were so unpopular with a large subset of the AU membership²⁴¹ that late the previous year, some of these dissatisfied states had deposited a rival, secret submission with the UN in its place.

The African Group of the UN

Since the UNGASS 2016 discussion, and leading up to the 61st CND meeting in March 2018, there had been significant and growing political disruption fomenting across the otherwise conservative establishment that is the UN's drug policy mechanism.

Twelve new countries had undertaken soft defections from a prohibitionist reading of the conventions and adopted legislation legalising cannabis for medical purposes. Two more countries had decriminalised cannabis use, including Austria, the country in which the CND is based. In Africa, Lesotho had gone ahead and legalised cannabis production for medical purposes the year before, and Morocco and eSwatini were now considering following Lesotho's approach. Ghana had been circulating a decriminalisation bill since the end of 2017, and it seemed like it would be adopted.

The reformist threat blossomed in the halls of Vienna, and now on the soil of Africa

Even though the iron triangle²⁴² of global drug control machinery had weathered previous attempts at pushing the philosophical, legal and sociocultural bounds of its drug convention trinity, the sense of unease was growing. The reformist threat blossomed in the halls of Vienna, and now on the soil of Africa.

A response came in the form of a cadre of African foreign affairs bureaucrats, and their desire to resist the thematic changes that the consensual contents of the continental CAP had thrust upon their political portfolios.

In 2015, between June and December, the 15 members of the AG²⁴³ in Vienna gathered to develop a document outlining a competing continental position on drugs. It is claimed that in late 2015 the ambassador of South Africa to Austria, Tebogo Seokolo, then the chair of the AG, submitted this document to the UN on behalf of the

group, to be disseminated as the African 'position' at the UNGASS the following April.

In doing so, it was claimed that he held back the CAP document sent to him by the AU Commission some time earlier, substituting it in the UN catalogue with the AG submission.²⁴⁴ Soon after, political chaos ensued.

Sometime after the AG document had been submitted, concern was raised within the AU Commission about its 'missing' CAP submission. The AU Commission confirmed, through internal verification processes, that the CAP document had been sent to the South African mission in Vienna for its onward official submission to the UN, but somehow it had not been passed on.

An AU Commission delegation was sent to Vienna in December 2015 to determine what had happened, and to seek answers from the South Africans and the AG. It returned to Addis Ababa some days later, unsatisfied. Unfortunately, the AU Commission was unable to take this issue any further, given that the AU's member states hold the organisation's power, and not the commission itself. Yet the deception had apparently been uncovered.

For its part, the South African Department of International Relations and Cooperation (DIRCO) defended its mission in Vienna, stating that its ambassador and the AG had not known of the CAP development process undertaken by the AU. It proposed that the existence of the AG paper – developed in parallel but independently – was nothing but an unfortunate misunderstanding. A spokesperson for DIRCO, Nelson Khwete, even went so far as to add:

The Chairperson of the African Group [SA Ambassador Seokolo] is accountable to the African Group in Vienna and promotes the agreed positions and interests of the Group. There is no formal relationship between the African Group in Vienna and the African Union Commission.²⁴⁵

Of course, since DIRCO staff attended the sixth session of the AU Conference of Ministers in Charge of Drug Control in Addis Ababa, where it was decided that the AU Commission would develop this CAP document, there was concern about this denial. Further to the point was the fact that the person responsible within

the AU for spearheading the CAP's development was none other than South Africa's own Deputy Minister, Bogopane-Zulu.

Khwete later stated that in fact the South African embassy in Vienna had received the CAP document from the AU Commission, but that upon reading it the membership of the AG 'collectively decided that the draft CAP could not be forwarded to the UNGASS Board because the Group felt that there was a need for further consultation on some of the elements contained in the CAP'.²⁴⁶

It is interesting to note Khwete's use of the adjective 'draft' in his explanation. Of course, the CAP document was not a draft, but the final product of months of consensus-building consultation among member states. That the South African government would refer to it as anything but final demonstrates either the diplomatic employment of a linguistic distinction in order to save face or, more likely, an inadvertent revelation of how such critical political positioning is brokered within the privileged, closed-door confines of the UN system.

Eventually, the correct CAP document was submitted to the UNGASS Board, and the AG position paper removed but not retracted.

Shortly thereafter the situation intensified when an African icon stepped into the fray.

On 22 February 2016 an opinion piece was published in *Der Spiegel* newspaper.²⁴⁷ Kofi Annan, the author of the piece, had selected this venue in order to present his argument in favour of the legalisation and regulation of all drugs, and to appeal for global support for his cause. Not only was Annan a former UN secretary general, but in January 2013 he had inaugurated – through his Kofi Annan Foundation – the WACD, a sub-regional variation of the GCDP, which he also chaired.²⁴⁸

In addition, Annan was a Nobel laureate and chairperson of The Elders. This is an exclusive NGO established by Nelson Mandela, tasked with seeking solutions to some of the world's most intractable conflicts.²⁴⁹ Global drug policy was one such conflict, and Annan carried considerable weight among his continental colleagues.

The timing and venue of this opinion piece's publication were equally important. The CND was to meet two weeks later to consider a draft of the Outcome Document²⁵⁰ that was to be considered for adoption at the UNGASS. The UNGASS 2016 delegates were to convene in New York the following month to discuss the global illicit drug problem and to decide on the final version of this document.

Thus, in the weeks before the 2016 CND meeting not only had Africa apparently taken a more flexible position with regard to drug prohibition, in the form of the CAP, but now one of its leading statesmen had gone so far as to advocate openly for the legalisation of all drugs. This was a significant development for the conservative AG membership, and one that required political intervention if its progress was to be arrested.

In March 2016, the 59th session of the CND was held in Vienna. The purpose of this session was to discuss the UNGASS, which was to take place the following month in New York, and create an outcome document for this event. Debate was passionate, lengthy and often rancorous.

The CAP of the AU was presented by Bogopane-Zulu, and promoted across member state delegations. While not enthusiastically supported by members of the AG, it was nevertheless accepted – despite a contrarian AG statement – as representative of the continent's contribution to the UNGASS.

Bogopane-Zulu presented the CAP to the UNGASS some weeks later. It was at this event that the mild, reformist position of the AU appeared to change.

It is relevant to observe that at this time South Africa was undergoing a significant and extended leadership crisis. Its president, Jacob Zuma, was facing numerous charges of corruption and other criminal behaviour.²⁵¹ His African National Congress party was facing declining confidence and riven with internal successional battles, and newspapers were headlining these issues daily.

Interestingly, one of the candidates being touted at the time as a potential replacement for Zuma – should he be forced out – was Dlamini-Zuma, the Chairperson of the AU.

Whether the South African government approached Bogopane-Zulu directly in the weeks between the CND session and the UNGASS, or through her compatriot and chairperson Dlamini-Zuma, is not known. What is known, however, is that Bogopane-Zulu went from delivering a speech at the CND in March in which she put forward the reformist public health and human rights policy vision of the CAP, to a Tuesday afternoon in New York where she remarked that the AU 'remain[s] committed to doing everything in our power to create a drug free continent'.²⁵²

This deliberate reference to the continental 'drug free' goal championed by the AG, yet so decidedly absent from the CAP's language, appeared to be a calculated capitulation to what had been a torrent of criticism at the general debate sessions of both the 2016 CND session and UNGASS.

Before her remarks that Tuesday afternoon, the leaders of the CND, UNODC and INCB had taken turns reinforcing the unbending nature of both the drug conventions and the Vienna institutions. Werner Sipp, president of the INCB, was forthright in his criticism of reform-minded approaches and their advocate states, proclaiming that while the drug conventions 'provide for flexibility' in the interpretation of sanctions, this flexibility had its limits.²⁵³ He ended with a declaration that resonated across the previous 18 years of the UNGASS:

The future of global drug policy is not a false dichotomy between a so-called war on drugs, on the one hand, and legalisation and/or regulation of non-medical use, on the other. It is also unnecessary to seek so-called new approaches. In fact, we do not really need new approaches to the global drug policy. Quite to the contrary, what we need is to better implement the principles of the drug control treaties ...²⁵⁴

In that moment Sipp eschewed the new and embraced the old. It was the ultimate 'we must work harder' rejoinder. His defiance was echoed by various member states, including nearly every African member that raised a voice.

Nigeria's Deputy Prime Minister Geoffrey Onyeama stood before the assembled delegates and declared his

country committed to the goal of a 'society that is free of drug abuse'.²⁵⁵ Senegalese Minister of Foreign Affairs Mankeur Ndiaye reaffirmed his country's investment in the 'cornerstone' Vienna institutions and their prohibitionist approaches.²⁵⁶

South African Minister of Police Nkosinathi Nhleko (amid the political contradiction of a domestic public health system promoting and implementing 'harm reduction' services alongside a prohibitionist foreign policy stance) joined the chorus. He rejected any deviation from the status quo and declared his country fully vested in achieving 'a society free of substance abuse'.²⁵⁷

Kenyan Cabinet Secretary for Interior and Coordination Joseph Nkaissery, representing a country that would soon begin providing methadone to its opioid-using populations, declared that 'the overall objective of drug control should be to eliminate the availability and use of illicit narcotic and psychotropic substances ... Kenya is determined to be a drug-free nation'.²⁵⁸

Algeria, Angola, Burkina Faso, Cabo Verde, Egypt, Libya, Madagascar, Morocco, Niger, Sudan, Togo, Tunisia and Zambia all rejected the calls for drug policy reform, and re-committed themselves to the policy-making 'cornerstone' of the Vienna Consensus and its pyrrhic 'drug free' goal.²⁵⁹

To ensure there was no misunderstanding, Sudan delivered the position statement of the AG to the UNGASS. The content was not surprising. The AG reaffirmed its commitment to the 'cornerstone' Vienna drug control institutions and approach; and declared its membership universally invested in 'the achievement of a drug-free continent'. It stressed its belief that 'effective drug policies are those that achieve a balanced and integrated approach towards supply reduction, demand reduction, and international cooperation ... in order to achieve a society free of drug abuse'.²⁶⁰

Health and rights language could be included in continental drug policy, he intimated, but only in so far as it contributed to the ultimate development goal of 'a drug-free continent'.²⁶¹ Having failed in their attempt to bury the CAP of the AU prior to the UNGASS, the most conservative voices within the AG membership, through

coordinated efforts at the CND and the marshalling of member state inputs at the UNGASS, succeeded in undermining the 'soft' continental consensus drug policy position expressed in the CAP.

Yet not all African interventions were so fundamentalist in their affirmation of the global prohibition status quo. Tanzanian Ambassador to the UN Tuvako Manongi took a decidedly centrist position. 'We must promote a health and human rights approach to the drug problem,' he said. 'We should not permit ourselves to become divided over policy preferences with regard to applicable penalties.'²⁶²

The Africa Group reaffirmed its commitment to the 'cornerstone' Vienna drug control institutions and approach

Namibian Ambassador Simon Maruta was also more tempered in his submission to the debate, advocating for the abolishment of the death penalty for drug-related offences; a critical attribute of the reform agenda. This was a direct challenge to the 16 retentionist member states (including Egypt, Sudan and Yemen) that had declared earlier that there was no international consensus on abolition in order to defend their use of the death penalty as a drug policy tool.²⁶³

Benin made a similar intervention on the death penalty, and also expressed 'concern' that the current approach to the global drug problem was not working.²⁶⁴ Uganda invoked the principle of 'dual balance' in its remarks, taking a more centrist approach to the debate than its continental peers.²⁶⁵ Cameroon and Ghana spoke of the flexibility needed in the drug conventions, and the need to raise global drug policy stewardship responsibilities beyond the Vienna institutions.²⁶⁶

Despite the plethora of reformist positions expressed by a number of member states, and the defection

by several African states from the language of the dominant, fundamentalist AG position, Bogopane-Zulu and the CAP appeared to have been isolated by the AG and its factional rhetoric. In her statement on behalf of the AU to the assembled delegates, she seemed to deviate from the position she had taken at the earlier CND session in Vienna and to respond to the polarised orientation of the assembled AG membership.

'Representatives will also appreciate that member states think differently about drugs,' she said.²⁶⁷ She described the AU as an institution that presented a forum where 'different approaches can be openly discussed – one member state cannot prescribe to all the others – and, most important, member states follow democratic approaches to include those affected by decisions that concern them'.²⁶⁸

It is unclear whether this closing comment was an acquiescence to the fundamentalism of the AG member states and their remarks during the special session and at the CND session, or Bogopane-Zulu's offering an opening to her continental foes for reconciliation discussions.

Whatever the case, her words were deliberate, measured and, for some, dispiriting. In addition, they may have illustrated the fact that in Africa, while nascent reform positions are evolving with respect to the organisation and implementation of continental drug policy approaches, prohibitionism and its correlated 'war on drugs' mentality remains the dominant structure.

The CAP existed, yet, like many policy documents developed before, with consensus adoption but without consensus implementation it was nothing more than a 'paper lion' – an appealing but toothless instrument.

The fragmenting continental consensus on drugs

It should be clear that the AG's continued attempts at shepherding African drug policy around a prohibition base speaks to the disconnect between the politics within and among the AU's members, and between the spirits of consensus and unity.

It also demonstrates the difficulties that democratic approaches encounter in changing the privileged, basal political positions of some African member states on crucial socioeconomic topics such as the 'war on drugs'. After all, drug prohibition has long been a core component of domestic policy and practice in many states on the continent, and continues to be a major source of financial and political currency therein.

In Africa, drug policy has grown alongside the development and expansion of wider illicit continental economies

In Africa, drug policy has grown alongside the development and expansion of wider illicit continental economies, and has been shaped as much by the forces of economic development and human insecurity as by the political intervention of states, both foreign and domestic.

Adding to the increasing political challenges to the African position on prohibition is a growing evidence base of drug policy research documenting the human and economic costs of the failing 'war on drugs' approach.

The work of the GCDP aside, numerous 'alternative world drug reports' and other critical pieces have been published on the drug war.²⁶⁹ Civil society consultations, many documenting the human rights violations and other harms resulting from the domestic practices of 'drug control' in Africa and beyond, have been convened, giving voice to the once voiceless targets of continental drug policies.²⁷⁰

Refereed scientific papers have been published.²⁷¹ An expert John Hopkins-Lancet Commission on Drug Policy and Health has been undertaken,²⁷² and a landmark paper released that documents the specific harms of the Vienna status quo's prohibitionist approaches.²⁷³

The limited positive impact of prohibitionist policies on African states was a central component of many of these studies. The evidence base in favour of drug policy reform is growing, as is a civil society advocacy stream of political consciousness around health, human rights and correlated calls for a global drug policy framework founded on humans and communities, rather than on commodities (i.e. controlled drugs) and their consumers.

The contemporary African response to drugs is characterised by the strength of its security narrative, one very much aligned with the global narrative of 'drugs as threat'.²⁷⁴ This continental construct is grounded not just in the bellicose, existentialist argument of the Vienna consensus keepers but also in the violent, transactional criminal economies that have grown around the illicit drug markets of Africa.

While hardly uniform, there are many enabling conditions for the intersection of drugs, crime, corruption, arms and violence across the continent.²⁷⁵ These liminal intersections are exacerbated by the reformulation of state-based political structures and actors, in conjunction with emergent and interlocking criminal agents and groups, into transnational networks connecting Africa to international markets and institutions.

In the process, the market distinction between licit/illicit economic activities becomes blurred.²⁷⁶ In fact, among the transitional economies of many African nations, it could be argued that illicit drug markets have been both an effect and a cause of the economic transition to commodity modalities.²⁷⁷

Cause or effect, it is evident that the illicit economies connecting Africa are driven by fluid, diverse, opportunistic and evolving transnational criminal networks alongside 'violent entrepreneurs'²⁷⁸ whose infiltration structures and systems threaten the political stability and operation, in particular, of the continent's more fragile economies, cities and states.²⁷⁹

In addition to these fundamental challenges, the members of the AG had another reason to marginalise and undermine the AU-developed CAP, and to pledge

at the 2018 CND session that Africa would continue to pursue a 'drug-free' continental goal.

It was less than a year before the CND's 2019 review of the soon-to-end Action Plan's latest decade. Africa was no longer the bastion of prohibition that many within the AG wished it to be. The conservative AG membership had weathered an underwhelming UNGASS 2016 process through guile, aggressive posturing and misappropriated reformist rhetoric, and realised that it was leaking political capital as a result. Action was needed to try to curb the recent continental pushes for reformed drug policy positions.

It was also necessary to embolden the preferred continental consensus so as to regain political influence and the perception of credibility within the quid pro quo world of international diplomacy.

The AG felt that Africa needed to support the drug policy prohibitionist powers of the US, Russia and China. This made sense on many political fronts, as drug policy had proven in the past to be a viable foreign assistance bargaining chip.

However, unlike years past, the current policy environment appears far less amenable to the AG's foreign affairs manipulation in favour of old, failed approaches. Instead it is an environment increasingly populated by officials who appear to be far more responsive to discussions on policy options that may help states to overcome their structural vulnerabilities and more effectively pursue their wider development goals.

Why do we need to consider a new approach?

As discussed above, the political and scientific developments in recent years pose a growing threat to the continent's drug control establishment and its many beneficiaries. While foreign affairs and security institutions dominated the drug policy debate continentally and globally for many decades, health institutions and civil society voices are increasingly stoking political conflict around future drug policy directions.

They have presented clear proof that the continental consensus evidence base is, at best, flawed, and more so than anyone had believed. At worst, the continent's approach to drugs is the progenitor of a serious human rights and public health disaster.

At worst, the continent's approach to drugs is the progenitor of a serious human rights and public health disaster

As a result, a small number of member states have moved from quietly undertaking domestic drug policy changes that exploit 'softer' interpretations of the drug conventions, to openly and systemically contravening the conventions in the eyes of the AG and other stalwarts.²⁸⁰

In reviewing the market trade, policy, politics and developmental results, a number of challenges can be identified in regard to continental drug policy environments, and the impact of the current approaches to drugs.

Current policies based on strict drug prohibition are not working

As Africa and the world approach the end of the second decade of prohibition-oriented drug control approaches intended to achieve the goal of a 'drug-free continent', it is clear that the current approach is not working.

Today's consensus on the prohibition on drugs is a contrived, forced concept. The global illicit drug situation is, by a number of measures, worse than it was when the current decade of drug control action was launched (i.e. extended) through a consensus decision by the CND in 2008.

Globally, drug prohibition enforcement measures are estimated to cost US\$100 billion a year.²⁸¹ Yet today 72.5 million more people are estimated to use illicit drugs than in 2008.²⁸² Global cultivation of opium

poppy, cannabis and coca are at their highest levels in a decade, as are the production of heroin, cocaine and cannabis herb and resin.²⁸³ Alongside these traditional drug commodities, the production and use of new psychoactive substances have emerged in significant volume, as have the misuse and counterfeiting of pharmaceuticals.²⁸⁴

In fact, far from eliminating the use, production and supply of illicit drugs, the past decade of 'try harder' global prohibition measures has seen global drug markets expand from US\$153 billion/year at the start of the decade to an estimated US\$539 billion/year today.²⁸⁵ These policies' impact on Africa has been considerable.

Continentially, cocaine, heroin and cannabis supply is high, and their retail and wholesale prices are at some of their lowest average levels in a decade.²⁸⁶ Continental seizures of cocaine and cannabis herb are lower today than they were a decade ago, despite the growing supply and use of these commodities over the same period.²⁸⁷

Three-quarters of the total amount of heroin/morphine reported seized on the continent in 2016 occurred in one country – Egypt – with a mere 0.25 MT in total reported as seized across the remainder of the continent.²⁸⁸ The estimated number of people who use drugs today is higher than it was a decade ago.

African law enforcement bodies lack the organisational, institutional, technological and financial capacities to have a significant impact on organised drug trafficking markets. Most are staffed by under-trained, under-paid and demotivated personnel, whose performance measure of success is calculated according to the number of monthly arrests they make.

Naturally, this leads to a regular practice in many countries of rounding up 'perpetrators' from the most vulnerable sections in society: the poor, the homeless, and the politically disenfranchised. Many of these people use drugs, and it is on the basis of this distinction that they are placed in detention or forced to pay arbitrary 'fines' for their release; an exploitative practice that serves no evidentiary purpose in addressing drug-related crime.²⁸⁹

In short, the prohibitionist 'war on drugs' approach to Africa's illicit drug trades has failed. In the 67 years since the first international drug convention came into being, the use, production and trade in controlled substances across Africa have expanded significantly.²⁹⁰ The continent has transformed from being home to the geographically restricted and traditional plant-based drug economies of khat and cannabis, to become an industrial hub for the manufacture, production and trans-shipment of a variety of controlled drugs.

These drugs' related economies have significantly skewed the ability of some states to effectively manage the health and social impacts of these developments. The imposition of internationally defined and domestically attractive prohibition measures has been unsuccessful in arresting either the growth of these trades or the violence and institutional erosion that they engender.

This failure is not confined to Africa; rather, it is a product of global (and, by extension, continental) drug policy retentionists' myopic fundamentalism. It is also the evidentiary impetus for the recent extension of policy reform thinking and action.

That 45 countries around the world now have eschewed strict prohibitionist approaches and begun to liberalise, in varying degrees, their approach to the drug trade and the health and rights of its consumers, represents a significant *démarche*. That 11 African countries have also begun to embark on this path of reflection and reconsideration is equally remarkable, particularly when one considers that this has occurred in the brief 18-month interval since the conclusion of the UNGASS 2016 meeting.

Transnational organised crime is thriving on the continent

Despite decades of drug control programming, African and global drug markets continue to expand. The global area under opium poppy (420 000 ha), coca bush (213 000 ha) and cannabis cultivation has increased.²⁹¹ Production of opium (10 500 Mt), heroin (875 Mt) and cocaine (1 410 MT) is at record highs.²⁹²

While cannabis remains the most commonly consumed drug globally, with 192 million people having used it in 2016, the UN has identified the non-medical use and trafficking of prescription drugs as a new and major growing global threat.²⁹³

Illicit drugs are a ubiquitous tradeable 'dark commodity' in the new African economy, alongside people, wildlife and arms

African drug markets are becoming ever more sophisticated in their structural organisation, financial orientation and product commodification.²⁹⁴ New psychoactive substances are appearing (and disappearing) across the continent at a rapid rate.²⁹⁵ The illicit financial transactions of continental drug economies are increasingly taking advantage of secure innovations such as blockchain technology, cryptocurrencies and Darknet trading platforms.²⁹⁶

Organised criminal groups have become less geocentric in their placement, more transactional in their relationships, and increasingly specialised in their network linkages and innovations.²⁹⁷ Illicit drugs are, more than ever, a ubiquitous tradeable 'dark

commodity' in the new African economy, alongside people, wildlife, arms and anything else for which a demand exists or from which a profit can be made.

Today the global illicit drug trade is a US\$539 billion/year industry, and is the second largest global illicit market, behind only that for counterfeit goods.²⁹⁸ Its size equates nearly 1% of all global trade and its reach extends to every corner of the earth.²⁹⁹ In trade volume it is roughly 3.5 times larger today than when the current prohibition decade began in 2008.

Transnational organised crime is a business that continues to thrive, particularly as African environments of corruption and conflict continue to undermine the development of its systems, structures and peoples.

Underdevelopment and human insecurity are endemic vulnerabilities

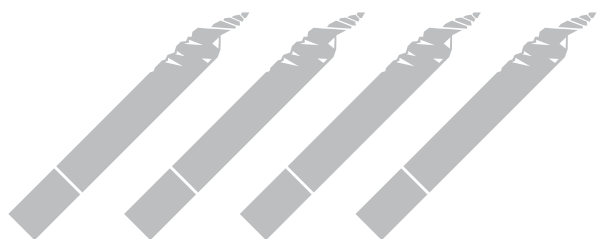
Many consider it to be self-evident that the drug trade 'problem' in Africa has become a 'crisis', is a regional 'security issue', threatens national development, fuels terrorism and terrorist groups, and threatens to corrupt and erode the democratic institutional foundation of states.³⁰⁰

The struggle of African states and their national institutions to understand and contain these substances, their markets, and the economies they generate and support, is a contentious issue that contributes to the evolution of the securitisation and militarisation of African drug control policies and approaches.

As one West African diplomat remarked when he addressed the UNGASS 2016 meeting: 'African countries in general, and those of West Africa in particular, have acute vulnerabilities relating to the drug problem that have socioeconomic, health and security impacts and, more important, threaten the very existence of certain states of the region.'³⁰¹

Drug control in Africa has been defined through a securitisation lens, leading to the militarisation of many of its security structures by external forces in order to improve the state's capacity to interdict.

Cannabis remains the most commonly consumed drug globally



192 million people used it in 2016

Where international actors feel that African efforts are inadequate, foreign military assets have been tasked to support continental drug prohibition efforts, including allowing these assets to execute drug interdiction measures on African territory.³⁰²

Yet these efforts have been unsuccessful in significantly impacting the continental drug trade. Further, some would argue that in fact it is the prohibition measures themselves that engender such violence and market expansion.³⁰³

Conflict has long been a useful tactic in African politics. Its impact has been exacerbated by the international community's engagement in the continent's fragile states through military intervention and peacebuilding approaches.³⁰⁴

Aligning development with reform

Moving forward, drug policy in Africa will most probably remain a complex puzzle. The continent's illicit drug trade is an evolving, enterprising socioeconomic and environmental entity 'aligned with structural vulnerabilities such as poverty, conflict, fragile social and political institutions, and particularly, militarised enforcement responses'.³⁰⁵

Far from controlling the trade, the continental policy approach over the past half-century of 'drug control through prohibition' has instead given rise to myriad economic opportunities and spaces that have proven susceptible to the promotion of transnational organised trade across the continent's illicit drug markets and their related geographies.

Endemic socioeconomic and environmental structural vulnerabilities in African societies and their constituent economies have facilitated the further exploitation of these opportunities.³⁰⁶ The emergence in the 1990s of politically fragile West African countries as large-scale *entrepôt* cocaine and heroin trade nodes linking Asian and Latin American suppliers with Arab, European and American consumers is a prime example of this structural continental exploitation.

We must acknowledge today that illicit 'shadow economies' such as the drug trade are significant

components of continental and national GDP. As such, reforming national drug policy and legislation alone is insufficient to foster effective, sustainable development solutions, or to reduce the pernicious influence of drug-related organised criminal groups and the corrosive impact of their illegal trade on national development efforts.

Far from controlling the trade, the continental policy approach of 'drug control through prohibition' has instead given rise to myriad economic opportunities

Solutions must mirror the illicit industrial environment in its structural complexity. They must also be designed to contribute to undermining the power and influence of these organised criminal groups and displacing their national and regional market economies for drugs and other commodities. They must be the product of a fundamental effort to undermine drug trade enablers from policy and programme angles beyond the intuitive 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 vulnerability and human insecurity would mark a positive, fundamental shift in continental drug policy approaches.

In Africa, the AU's Agenda 2063, coupled with continental commitment to achieving the 17 goals of the global Agenda 2030 for Sustainable Development, provides a relevant and timely opportunity for African states to integrate new drug policy responses into development agendas.

This also gives Africa as a political body the chance to take the lead in demonstrating a new continental consensus on drugs that places the human development and rights of its peoples above the fray of prohibition politics and the economic marginalisation of organised criminal markets.

But the question remains: is Africa prepared to pursue a new path? Such a path should advocate the reformulation of international drug policy objectives to develop the continent and its peoples by:

- Prioritising the health and human rights of all peoples and communities
- Ensuring universal access to essential medicines, particularly opioids
- Ending the criminalisation of drug use, and the incarceration of people who use drugs
- Refocusing continental drug control responses to target the structural vulnerabilities that are enabling organised criminal groups (instead of PWUD and those in possession of small amounts of drugs)
- Addressing conflicting 'continental' positions on drugs.

In so doing, drug policy reform measures may be aligned with sustainable and continental development goals as countries move to rectify socioeconomic vulnerabilities and imbalances and, by extension, complement and achieve a number of human security and people-centred goals.

Prioritise the health and human rights of all peoples and communities

- Undertake an ACHPR human rights compliance inventory by REC
- Agree to a moratorium on the use of the death penalty for drug crimes
- Ensure fundamental 'right to health' principles are implemented in practice
- End compulsory drug treatment
- Ensure universal access to harm reduction services for PWUD

- Require access to all health services by PWUD
- Develop a continental harm reduction position and strategy, and disseminate it by REC

Ensure universal access to essential medicines, particularly opioids

- Develop and implement a pharmacovigilance strategy for essential medicine supply assurance
- Revise the existing continental common procurement strategy to strengthen the supply chain for opioids
- Develop a consensus continental list of essential medicines
- Include OST and overdose prevention medicines in the list of essential medicines

End the criminalisation of drug use, and the incarceration of PWUD

- Advocate for continental decriminalisation of drug use and possession for personal use
- Develop a common continental position on decriminalisation thresholds
- Provide amnesty for those arrested for drug use and possession
- Ease continental prison overcrowding by releasing those incarcerated for drug use or possession offences
- Expunge criminal record convictions for drug use and possession
- Legalise and regulate the cultivation, production and distribution of cannabis and khat
- Develop and fund a continental livelihoods strategy for subsistence cannabis and khat farmers
- Establish a continental regulatory framework for cannabis and khat
- Revise the mandate of the African Medicines Agency to include cannabis and khat oversight
- Develop a continental regulatory and oversight framework for cannabis and khat, including quality assurance standards for production and trading

Refocus continental drug control responses to target the national and regional structural vulnerabilities that are enabling organised criminal groups

- Research national and regional illicit criminal markets and trafficking flows to identify vulnerabilities and threats
- Develop a continental monitoring framework and vulnerability index for African illicit trafficking flows
- Develop REC-specific state criminal market vulnerability indices
- Develop REC cooperation strategies to address regional and national drug-related structural vulnerabilities
- Support revisions to national drug laws and criminal codes
- Remove national scheduling of cannabis and khat (where existing)
- End mandatory minimum sentencing for drug offences
- Adopt the principle of proportionality for drug-related criminal offences

Address conflicting 'continental' positions on drugs

- Develop and agree on one consensus CAP on drugs
- Ensure diplomatic and communication adherence to the CAP by AG and AU entities
- Develop REC communication and implementation strategies for the CAP
- Develop and support national civil society organisations and structures to contribute to continental drugs and health programming

It's time for Africa to lead

In reflecting on the influences and complexities of the drug policy environments in Africa, it should not be lost that this nascent continental trend towards more liberal drug policies has evolved through states' relationship with cannabis.

In particular, it is increasingly becoming the prevailing view that cannabis, although scheduled, is less harmful (the 'soft drug' thesis) and potentially more beneficial to African society from a socioeconomic, sustainable continental development perspective if it were decriminalised or legalised, rather than prohibited.

In many countries, cannabis has become a mainstream – yet illicit – consumer commodity, alongside tobacco and alcohol. Its consumer base has evolved to incorporate a cross section of recreational middle-class users. It has been rebranded from a drug of the marginalised to a vice of the mainstream. The potential financial benefits afforded to the state from regulating trade in this renewed criminally ambiguous substance has proven to be a motivating factor in its legal transition.

The addition of health- and human rights-focussed criteria to the drug policy reform debate has aided in the further acceptance of policy reform, particularly in the health institutions and systems of the continent.

Unfortunately, the securitisation of drugs remains the predominant lens through which a (declining) majority of African governments view cannabis and other drugs. It is a lens through which international assistance continues to be provided by external forces – often directly to domestic security institutions – that wish to influence the promotion and retention of traditional prohibition-oriented programming.

Furthermore, we must accept that for many years to come forces will be vested in the promotion and maintenance of a restrictive, prohibition-based continental drug policy framework. The governments of a number of African states are rigidly opposed to any deviation from reform measures, let alone consideration of drug decriminalisation or legalisation scenarios.

In some, this opposition goes further to embrace political positions that oppose the implementation of rights- and health-related programming or services for PWUD in their countries. Such positions are inconsistent, however, with the now-evolving continental drug policy environment characterised by fragmented African positions and typologies on drugs and drug policy reform.

Article 16 of the African Charter on Human and Peoples' Rights guarantees every African's right to enjoy the best attainable state of physical and mental health. The provision of harm reduction and other health services for PWUD should not be seen as a special, praiseworthy circumstance. If the charter is to be respected, the creation of a drug policy that includes – even as an extraordinary measure – provision of healthcare services for PWUD should be a normal duty of care act by member states.

Importantly, there are African institutions and structures that can assist in the development of a new continental consensus on drug policy. Most AU member states have ratified the nine core international human rights conventions. The political foundation for drug policy reform is thus already in place. It is a matter now of exploiting it.

Yet, moving forward on a new continental consensus for African drug policy also entails new challenges that must be addressed and, if possible, overcome.

'Evidence-based approaches' to drugs – that phrase so often appropriated by drug prohibition proponents in Africa to frame any number of traditional, politically motivated, drug demand and supply reduction intervention measures – are now firmly behind the ascent of a new and growing continental drug policy counter-dialogue.

The reconsideration of entrenched approaches, particularly ones that have been used successfully for years to serve political and security-driven domestic

narratives, requires action that goes beyond the realm of drugs policy. It requires investment in wider socio-environmental change beyond simplistic language revisions to legislation and policy instruments.

It also requires a changing of perception, and active measures to develop and maintain the fundamental human rights duties and responsibilities of African member states. Most importantly, however, is the requirement for leadership.

Long-term sustainable solutions to effectively interdict the continental drug trade and its corrosive embeddedness within African 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 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 such commitments has already been laid by Africa's leaders. This can be seen in their assent to both Agenda 2030 and Agenda 2063's development goals.

The alignment of continental drug policy reform in the context of these complementary human development frames could see Africa grasp a global 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 instead as a fundamental, long-term social and rights development duty.

Notes

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- 13 N Carrier and G Klantschnig, Illicit livelihoods: drug crops and development in Africa, *Review of African Political Economy*, 43, 2016, 174–189; LL Gezon, Drug crops and food security: the effects of khat on lives and livelihoods in northern Madagascar, *Culture, Agriculture, Food and Environment*, 34, 2012, 124–135.
- 14 UNODC Regional Office for Southern Africa, unpublished data.
- 15 Author interviews with prison officials, health officials and judiciary officials from Malawi, Namibia, Nigeria, Tanzania, Uganda, Zambia and Zimbabwe (July 2016; July 2017; May 2018).
- 16 Anecdotal accounts from author interviews with civil society programme officers, and members of people who use drugs networks, Malawi, South Africa, Tanzania and Zimbabwe (July 2017; May 2018).

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- 28 Ibid.
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- 42 UNODC, *Cocaine trafficking in Western Africa: situation report*, Vienna: UNODC, 2007; UNODC, *Global synthetic drugs assessment: amphetamine-type stimulants and new psychoactive substances*, Vienna: UNODC, 2014.
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- 44 UNODC, *Global synthetic drugs assessment: amphetamine-type stimulants and new psychoactive substances*, Vienna: UNODC, 2014.
- 45 AN Bybee, The twenty-first century expansion of the transnational drug trade in Africa, *Journal of International Affairs*, 66, 2012, 69–84.
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- 52 California, Massachusetts, Michigan, Nevada, Vermont.
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- 228** These entities include the UNDP, WHO, OHCHR, UNFPA, UNAIDS, UNHCR, UNICEF, WFP, UNWOMEN, ILO, UNESCO and IOM. See WHO, Joint United Nations statement on ending discrimination in health care settings, June 2017, <https://www.who.int/gender-equity-rights/knowledge/ending-discrimination-healthcare-settings.pdf>
- 229** UN, Secretary-General Cites General Assembly special session in message on International Day against Drug Abuse, Illicit Trafficking, Document SG/SM/19105-OBV/1802-SOC/NAR/963, 25 June 2018, www.un.org/press/en/2018/sgsm19105.doc.htm
- 230** It is important to note that the term 'harm reduction' appeared in no CND, INCB or UNODC official publications or statements. The politics around its use, particular as opposed by member states such as the US, meant that while some of the tools of harm reduction were mentioned (e.g. opiate substitution therapy) the phrase itself was absent. Nevertheless, this linguistic sensitivity did not stop the HIV/AIDS Unit of the UNODC becoming one of the world's largest advocates for, and implementers of, harm reduction programming for PWUD. The irony of this should not be lost here.
- 231** In fact, during this time there was a rumour within UNODC staff circles that a confidential INCB legal briefing note had been prepared that argued the same case. Perhaps it was on the basis of this 'ghost note', which has since been disavowed (if it ever, in fact, existed), that the HIV/AIDS Unit felt it had the grounds to make its own case.
- 232** UNODC, Briefing paper: Decriminalisation of drug use and possession for personal consumption, UNODC HIV/AIDS Section, paper submitted to the International Harm Reduction Conference, Kuala Lumpur, Malaysia, 2015, 1. Note that this citation identifies the document as it was when it was released. We must stress that this is not a UNODC publication, has no relationship to the organisation, and was retracted from the conference.

Despite this, the genie could not be put back into the bottle, as numerous copies still exist online.

- 233** While never formally identified, it was alleged that this aggressively dissenting nation was a large, well-known supporter of the Vienna Convention and its prohibitionist approach. Further for the record, the UNODC denied that it retracted the paper because of the reaction of one member state.
- 234** Notably, Branson was (and still is) a member of the GCDP.
- 235** N Morris, UN 'shelves report calling for decriminalisation of all drugs after pressure from one government', *The Independent*, 20 October 2015, <https://www.independent.co.uk/news/world/politics/un-shelves-report-calling-for-decriminalisation-of-all-drugs-after-pressure-from-one-government-a6700771.html>.
- 236** Perhaps that was Beg's plan all along.
- 237** A similar instance occurred in March 2018 in Nigeria, where a UNODC official was reported as having delivered a briefing to the government endorsing the legalisation of cannabis, a position that was then aggressively retracted by the UNODC following its having been reported. See K Awosiyan, Medicine: Nigeria should legalise use of marijuana – United Nations, *Silverbird TV*, 2018, <http://silverbirdtv.com/health/41964/medicine-nigeria-legalise-use-marijuana-united-nations/>; Nigeria Health Online, We didn't tell Nigeria to legalise cannabis – UNODC, 27 March 2018, <http://nigeriahealthonline.com/2018/03/27/we-didnt-tell-nigeria-to-legalise-cannabis-unodc.nho/>
- 238** IDPC, *Recommendations for the African Union Plan of Action on Drug Control (2013–2017)*, Advocacy Note, London: IDPC, 2012, 5.
- 239** See AU, *Addis Ababa Declaration on Scaling Up Balanced and Integrated Responses Towards Drug Control in Africa*, Document no. CAMDC/MIN/Decl.(VI), decision point 8, 2014, 3.
- 240** There was some desire among a small number of civil society groups and individuals who participated in the development of it to have the document address the issue of decriminalisation in an explicit manner.
- 241** For the CAP statement and its 10 commitment points see AU, *Common African Position (CAP) for the UN General Assembly Special Session on the World Drug Problem, April 19–21 2016*, Document no. STC/EXP/DC/3(I), 3–4. For the statement of Bogopane-Zulu to the UNGASS in New York, see AU, *Statement by Hon. Hendrietta Bogopane-Zulu, Deputy Minister of Social Development, South Africa, and Chairperson of the First AU Specialised Technical Committee on Health, Population and Drug Control to the UN General Assembly Special Session on the World Drug Problem*, 2016, <http://www.sadrugpolicyweek.com/uploads/6/6/2/3/66238155/s-africa-on-behalf-of.pdf>.
- 242** The term 'iron triangle' is used to describe the UN drug prohibition machinery of the Commission on Narcotic Drugs, the UNODC, and the INCB. The phrase's use is credited to the founding director of the Global Drug Policy Observatory, David Bewley-Taylor, and discussed in J Sischy and J Blaustein, Global drug policy at an impasse: examining the politics of the 2016 United Nations General Assembly Special Session, *International Journal of Drug Policy*, 60, 2018, 74–81.
- 243** The African Group in Vienna comprises Algeria, Angola, Burkina Faso, Côte d'Ivoire, Egypt, Kenya, Libya, Morocco, Namibia, Nigeria, South Africa, Sudan, Syria, Tunisia and Yemen. All are members of the AU.
- 244** Discussion between the author and two AU officials, March 2016.
- 245** See K Cullinan, Elite 'African Group' in Vienna undermines AU drug policy, *Health-E News*, 7 February 2016, from: www.health-e.org.za/2016/02/07/elite-african-group-in-vienna-undermines-au-drug-policy.
- 246** Ibid.
- 247** K Annan, Kofi Annan on why it's time to legalise drugs, *Der Spiegel*, 22 February 2016, <http://www.spiegel.de/international/world/kofi-annan-on-why-drug-bans-are-ineffective-a-1078402.html>.
- 248** It was envisaged by Annan and others that the establishment of the WACD in 2013 would be the first of several to be inaugurated across the political regions of the continent. To this day, however, it remains the only one, although there have been unsuccessful efforts recently to raise a second commission in East Africa.
- 249** Kofi Annan was UN secretary general from 1997–2006. Jointly with the UN, he shared the Nobel Prize for Peace in 2001. Annan was chair of The Elders until his death in August 2018.
- 250** The process of drafting this Outcome Document prior to CND consideration was fraught with division and acrimony among member state delegates. Intersessional meetings ended with increasingly conflicted views as a minority of member state delegations pushed the use of progressive reforms in the language, conflicting with those of more conservative, status quo delegations. Intersessionals broke down into 'informals' (bilateral language negotiation meetings between member states) that

- further deteriorated along status quo lines. Importantly, all of these negotiations occurred behind closed doors, and only between members of the Vienna-based missions. As a result, the March 2016 CND session to consider the draft outcome document was expected to be a significant event.
- 251** These included allegations related to his use of state funding for personal upgrades to his personal residence ('the Nkandla affair'); allegations of facilitating state capture ('the Gupta affair'); and various other corruption-related allegations. Jacob Zuma resigned as president in February 2018.
- 252** UNGASS, Remarks by Hendrietta Bogopane-Zulu on behalf of the member states of the African Union, Document A/S-30/PV.2, 2nd Plenary, New York, 19 April 2016, 11-12.
- 253** UNGASS, Remarks by Werner Sipp, President of the INCB, Document A/S-30/PV.1, 2nd Plenary, New York, 19 April 2016, 6-9.
- 254** Ibid., 8.
- 255** Ibid., 16.
- 256** UNGASS, Document A/S-30/PV.2, 2nd Plenary, New York, 19 April 2016, 8.
- 257** UNGASS, Document A/S-30/PV.1, 2nd Plenary, New York, 19 April 2016, 16.
- 258** Ibid., 31-32.
- 259** See member state debate remarks in the UNGASS Official Records, A/S-30/PV.1 – A/S-30/PV.6.
- 260** UNGASS, Document A/S-30/PV.2, 2nd Plenary, New York, 19 April 2016, 18-20.
- 261** In their statement, the AG conflated the need for strong adherence to drug prohibition with the achievement of the Agenda 2063 aspirational goal of a peaceful and secure Africa. Agenda 2063 is an AU framework for the socioeconomic development of the continent over a 50-year period.
- 262** UNGASS, Document A/S-30/PV.5, 5th Plenary, New York, 21 April 2016, 16.
- 263** UNGASS, Document A/S-30/PV.1, 2nd Plenary, New York, 19 April 2016, 13-15.
- 264** UNGASS, Document A/S-30/PV.6, 6th Plenary, New York, 21 April 2016, 15-16.
- 265** UNGASS, Document A/S-30/PV.2, 2nd Plenary, New York, 19 April 2016, 23.
- 266** UNGASS, Document A/S-30/PV.3, 3rd Plenary, New York, 19 April 2016, Cameroon (18-19) and Ghana (19-20).
- 267** UNGASS, Document A/S-30/PV.2, 2nd Plenary, New York, 19 April 2016, 11.
- 268** Ibid.
- 269** Produced by the Transform Drug Policy Foundation through its 'Count the Costs' initiative, and detailing the harms caused by a 'drug war' approach to drug policy, *The alternative world drug report* (2nd edition) can be found at Count the Costs, *The alternative world drug report* (2nd edition), <http://www.countthecosts.org/alternative-world-drug-report-2nd-edition>.
- 270** See, for example, A Scheibe et al., *A national community consultation with people who inject drugs*, unpublished report, Pretoria: UNODC, 2015; Step-Up Project, *Human rights report: 15 August to 15 November 2015*, Cape Town TB/HIV Care Association, 2015; A Ogunrombi, West Africa: a new frontier for drug policies?, *International Journal on Human Rights*, 21, 2015.
- 271** For example, the *British Medical Journal* published an analytical piece decrying the negative impacts to society of the 'drug war' criminalisation approach and argued that the more effective approach to drug policy was one based on a transition to a regulated drug market. See S Rolles, An alternative to the war on drugs, *British Medical Journal*, 340, 2010, c3360. The London School of Economics convened an Expert Group, including five Nobel Laureates, that examined the costs of prohibition-based drug policy approaches, and presented its findings, critical of the drug war approach, in a series of 10 papers. See J Collins (ed.), *Ending the drug wars: report of the LSE Expert Group on the economics of drug policy*, 2014, <http://www.lse.ac.uk/ideas/Assets/Documents/reports/LSE-IDEAS-Ending-the-Drug-Wars.pdf>
- 272** The *Lancet* is one of the world's pre-eminent medical journals with an impact factor of 53.254, second only to the *New England Journal of Medicine*.
- 273** See J Csete et al., Public health and international drug policy, *The Lancet*, 387, 2016, 1427-1480.
- 274** For a detailed examination of the securitisation of drugs and its role in the maintenance of the global drug prohibition paradigm, see E Crick, Drugs as an existential threat: an analysis of the international securitisation of drugs, *International Journal of Drug Policy*, 23, 2012, 407-414.
- 275** V Felbab-Brown and JJF Forest, Political violence and the illicit economies of West Africa, *Terrorism and Political Violence*, 24, 2012, 787-806.
- 276** S Ellis and M Shaw, Does organised crime exist in Africa?, *African Affairs*, 114/457, 2015, 505-528.

- 277 J Fitzgerald, Illegal drug markets in transitional economies, *Addiction Research and Theory*, 13, 2005, 563–577.
- 278 See M Shaw and P Mahadevan, *When terrorism and organised crime meet*, Policy Perspectives 6/7, ETH Zurich: Centre for Security Studies, 2018.
- 279 P Miraglia, R Ochoa and I Briscoe, *Transnational organised crime and fragile states*, Development Cooperation Working Paper 3/2012, Paris: Organisation for Economic Cooperation and Development (OECD), October 2012. For a specific example on drug crime and state fragility, see Global Initiative Against Transnational Organised Crime (Global Initiative), *The nexus of conflict and illicit drug trafficking: Syria and the wider region*, Geneva: Global Initiative, 2016.
- 280 J Sischy and J Blaustein, Global drug policy at an impasse: examining the politics of the 2016 United Nations General Assembly Special Session, *International Journal of Drug Policy*, 60, 2018, 74–81.
- 281 S Rolles et al., *The alternative world drug report, 2nd edition*, London: Transform Drug Policy Foundation, 2016.
- 282 The UNODC estimated there were 155 million to 250 million people (mean = 202.5 million) who used drugs in 2008, and an estimated 275 million in 2017. See UNODC, *World drug report 2011*, Vienna: UNODC, 2011; UNODC, *World drug report 2018*, Vienna: UNODC, 2018.
- 283 UNODC, *World drug report 2018*, Vienna: UNODC, 2018.
- 284 UNODC, *Understanding the synthetic drug market: the NPS factor*, Global Smart Update 19, Vienna: UNODC, March 2018.
- 285 For the 2008 figure a cumulative estimate was derived from the global market values estimated by Kilmer and Pacula for cannabis, cocaine and opiates, and converted from EUR to US\$ at the rate of exchange prevailing when the report was written. See B Kilmer and L Pacula, *Estimating the size of the global drug market: a demand-side approach*, Technical report 2, Santa Monica: RAND Corporation, 2009. The 2017/18 figure is drawn from Global Financial Integrity (GFI), *Transnational crime and the developing world*, Washington DC: GFI, March 2017. The GFI estimated the global illicit drug market value at US\$426–US\$652 billion (mean estimate = US\$539 billion).
- 286 See UNODC drug price data for cocaine, heroin and cannabis (herb & resin) data compiled from its Annual Reports Questionnaire (ARQ) data sets, and available at UNODC, Retail and wholesale drug prices, dataunodc.un.org/drugs/prices. The datasets are limited to the years 2012–2016, and limited in scope, as member state submission of responses is voluntary. Given the commitment made by all African states in 2008 to implement and report against the programming of the UN drug control 10-year strategy, annual reporting of such price, use and seizure data could be seen as a proxy measure of how serious a state sees its political responsibility to meet this reporting commitment as a party to the grander consensus vision of a ‘drug-free world’. In point of fact, most African countries rarely respond to the ARQ request for annual data.
- 287 While data on drug use and behaviour across the continent remains limited, we may extrapolate from data discussed in the UNODC *World drug report 2018*, as well as from anecdotal accounts, of drug use increases as indicated in continental reporting such as that for the AU, including AU, *Progress report on the implementation of the AU Plan of Action on Drug Control (2013–2017) for the period 2014–2016*, Second meeting of the Specialised Technical Committee on Health, Population and Drug Control (STC-HPDC-2), Addis Ababa, 20–24 March 2017. National drug use population size estimates, such as those for South Africa and Tanzania, are also helpful proxies for drug use numbers. See A Scheibe et al., HIV prevalence and risk among people who inject drugs in five South African cities, *International Journal of Drug Policy*, 30, 2016, 107–115; NACP, *Consensus estimates on key population size and HIV prevalence in Tanzania*, Dar es Salaam: Ministry of Health and Social Welfare, July 2014.
- 288 See UNODC, Global seizures of drugs, dataunodc.un.org/drugs/global_seizures.
- 289 This practice has been documented through personal communication with police officers and PWUD in Kenya, Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe. Claims exist of its practice in numerous other countries, particularly in West and North Africa.
- 290 AU, *Progress report on the implementation of the AU Plan of Action on Drug Control (2013–2017) for the period 2014–2016*, Second meeting of the Specialised Technical Committee on Health, Population and Drug Control (STC-HPDC-2), Addis Ababa, 20–24 March 2017.
- 291 UNODC, *World drug report 2018*, Vienna: UNODC, 2018. The figure for cannabis cultivation (2017) is not indicated in report; however, cannabis cultivation was 420 900 ha (mean) in 1997, and 520 000 ha in 2007. See UNODC, *2008 world drug report*, Vienna: UNODC, 2008; UNODC, *World drug report 2011*, Vienna: UNODC, 2011. There is no indication that global cannabis cultivation has done anything but increase, particularly

- as the UNODC indicates substantial increases in current global use and seizures in its most recent world drug report (2018).
- 292** UNODC, *World drug report 2018*, Vienna: UNODC, 2018.
- 293** Ibid. Cannabis remains the most commonly consumed illicit drug in Africa.
- 294** S Ellis, *This present darkness: a history of Nigerian organised crime*, London: Hurst, 2016.
- 295** UNODC, *Global synthetic drugs assessment: amphetamine-type stimulants and new psychoactive substances*, Vienna: UNODC, 2017.
- 296** M Tzanetakis, Comparing cryptomarkets for drugs: a characterization of sellers and buyers over time, *International Journal of Drug Policy*, 56, 2018, 176–186; J Broséus et al., A geographical analysis of trafficking on a popular darknet market, *Forensic Science International*, 277, 2017, 88–102; T Groshkova et al., *Black hands and onion channels: a study of drugs on non-English language darknet markets*, EasyChair Preprint 441, 17 August 2018.
- 297** A Idler, Exploring agreements of convenience made among violent non-state actors, *Perspectives on Terrorism*, 6, 2012, 63–84.
- 298** Global Financial Integrity (GFI), *Transnational crime and the developing world*, Washington DC: GFI, March 2017. The GFI estimated the illicit drug market at US\$426–US\$652 billion (mean estimate = US\$539 billion). The market for counterfeit goods was estimated at US\$923 billion–US\$1.13 trillion.
- 299** This is based on a global GDP for 2017 estimated at US\$80 trillion and the high-end estimated drug market size of US\$652 billion. The global GDP figure is from World Bank, GDP (current \$), <https://data.worldbank.org/indicator/NY.GDP.MKTP.CD>
- 300** UNODC, *Crime and development in Africa*, Vienna: UNODC, 2005.
- 301** UNGASS, H.E. Jean-Francis Zinsou, Permanent Representative of Benin to the United Nations, remarks made to the UNGASS general debate, Document A/S-30/PV.6, 6th Plenary, New York, 21 April 2016.
- 302** See, for example, the work of the Combined Task Force 150 (CTF-150) operating in the Indian Ocean, along the eastern coast of Africa; and the tasking of military assets by US Africa Command for the purposes of active counternarcotic field operations under the banner of Operation Enduring Freedom – Trans Sahara (OEF-TS), now called Operation Juniper Shield, covering the Sahara/Sahel region of Africa; and Operation Enduring Freedom – Horn of Africa (OEF-HOA), to which CTF-150 is related.
- 303** For example, see E-U Nelson, Police crackdowns, structural violence and impact on the well-being of street cannabis users in a Nigerian city, *International Journal of Drug Policy*, 54, 2018, 114–122; V Felbab-Brown and JJF Forest, Political violence and the illicit economies of West Africa, *Terrorism and Political Violence*, 24, 2012, 787–806. The issue is also threaded throughout the work of N Carrier and G Klantschnig, *Africa and the war on drugs*, London: Zed Books, 2012.
- 304** L Lombard, *State of rebellion: violence and intervention in the Central African Republic*, London: Zed Books, 2016.
- 305** GCDP, *Regulation: the responsible control of drugs*, Geneva: GCDP, 2018, 33. In the text, this GCDP quote was in reference to the global situation; however, the structural vulnerabilities referenced by the GCDP are especially true in respect to the situation in Africa. As such, its description is employed in this manner.
- 306** Ibid.



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Issue 04 | June 2018

Tackling heroin trafficking on the East African coast

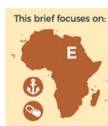
Simone Hayson, Peter Gastrow and Mark Shaw

Summary

In recent years, the volume of heroin shipped from Afghanistan along a network of maritime routes in East and Southern Africa appears to have increased considerably. An integrated regional criminal market has developed, shaped and shaped by political developments. Africa is now experiencing the sharpest increase in heroin use worldwide, and a spectrum of criminal networks and political elites in East and Southern Africa are substantially enmeshed in the trade. New policy approaches are urgently needed.

Key points

- Responses should address the challenge as a cross border criminal system.
- Progressive action should be targeted in major drug hubs along the southern route, focusing on vulnerable areas and potential sources of regional instability, such as northern Mozambique.
- The relationship between politics, business and organised crime must be adequately researched and addressed.
- Vetted private sector actors should be engaged to prevent or reverse the criminalisation of key ports.
- Support must be increased for community-based initiatives that mitigate the effects of drug use.
- Programming interventions to reduce violence in the most vulnerable communities affected by the heroin trade in Southern and East Africa should be considered.



POLICY BRIEF



Issue 04 | June 2018

The heroin coast

A political economy along the eastern African seaboard

Simone Hayson, Peter Gastrow and Mark Shaw

Summary

In recent years, the volume of heroin shipped from Afghanistan along a network of maritime routes in East and southern Africa appears to have increased considerably. Most of this heroin is destined for Western markets, but there is a spin-off trade for local consumption. An integrated regional criminal market has developed, both shaping and shaped by political developments in the region. Africa is now experiencing the sharpest increase in heroin use worldwide and a spectrum of criminal networks and political elites in East and southern Africa are substantially enmeshed in the trade. This report focuses on the characteristics of the heroin trade in the region and how it has become embedded in the societies along this route. It also highlights the features of the criminal-governance systems that facilitate drug trafficking along this coastal route.

Recommendations

- The East African heroin market forms an integrated regional criminal economy based on the transit of heroin from Afghanistan to the West.
- The transit economy relies on international ports and other infrastructure, and high levels of political protection.
- There is a rapidly growing consumer drug market in the region – one that is much larger than is commonly acknowledged.
- Despite some positive trends in drug users' ability to access health services in several locations in the region, there are nevertheless gaps in appropriate drug treatment interventions.



RESEARCH PAPER



Issue 06 | November 2018

The rise of counterfeit pharmaceuticals in Africa

Robin Cartwright and Ana Barić

Summary

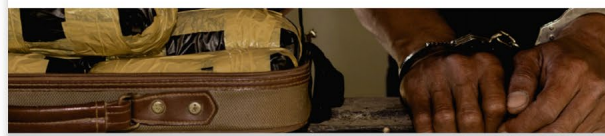
Sustainable Development Goal 3 (SDG 3) places significant emphasis on populations' health, and sub-target 3.8 specifies access to safe, effective, quality and affordable essential medicines and vaccines for all. Yet, remarkably missing from the discourse around achieving this goal is the need to address the growing phenomenon of counterfeit medicines, which disproportionately affects developing countries. Counterfeit medicines put people's lives at risk, finance criminal groups and cause profound public health challenges. The full scale of the challenge in Africa is not fully understood, but research suggests that the problem and its impact are severe. If the continent is to make headway in achieving SDG 3, the issue of counterfeit medicines must move higher up on policy agendas. Experience elsewhere suggests that there would be scope for significant positive results.

Key points

- Addressing counterfeit medicines in Africa may help prevent widespread loss of life, including an estimated 64 000-158 000 avoidable deaths from malaria alone, as well as mitigating other public health and public safety risks.
- Much greater prioritisation of the issue by African states and continental or regional bodies is needed. The response should include a substantial overhaul of the analytical, legal, educational, regulatory and enforcement systems around medical supply chains. The legal and regulatory frameworks for combating medicine fraud will need strengthening.
- These responses would need to be coordinated within a global effort, including setting up a database of intelligence on counterfeits, and improved awareness-raising and training campaigns. National medicines regulation authorities should investigate mass serialisation forms of track-and-trace.



POLICY BRIEF



Issue 05 | June 2018

Analysing drug trafficking in East Africa

A media-monitoring approach

Clara Aucoin

Summary

By analysing drug-related incidents reported in the media in three key East African nations over the past decade, this paper provides insights into drug trafficking in the region. This includes the different drug types in circulation across Kenya, Tanzania and Uganda, the quantities and trafficking methods used, as well as the origin, transit, and destination hubs. The report also suggests patterns in the actors involved, the nature of state responses and the reporting styles of the African and foreign press. The potential for improved sourcing using this methodology, and for greater public awareness of drug trafficking-related harms, lies in the development of stronger and more capable journalism in the region.

Key points

- East Africa plays an increasing role in the continent's illicit drug trade, particularly as a corridor for flows of heroin and cocaine.
- Media monitoring is an innovative way of gathering data to help illustrate trends in transnational organised crime, including drug trafficking trends.
- Findings show interesting patterns in reporting on major harmful drugs in the region, and the many challenges faced by journalists in investigating and publishing drug trafficking stories.
- The paper calls for greater press freedom and increased training and financial support for investigative journalism in East Africa, and across the continent more generally.



RESEARCH PAPER



About the author

Jason Eligh is a senior expert at the Global Initiative Against Transnational Organised Crime. He is an illicit drugs trade and policy analyst who has worked for the United Nations, and has researched, developed and led technical cooperation and assistance initiatives addressing illicit drugs for numerous African and East Asian governments. His expertise focuses on understanding the myriad contexts influencing illicit drug use behaviour and the resilience of drug trade environments, particularly as these factors relate to the development and sustainability of harm.

About ENACT

ENACT builds knowledge and skills to enhance Africa's response to transnational organised crime. ENACT analyses how organised crime affects stability, governance, the rule of law and development in Africa, and works to mitigate its impact.

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