

A dense, repeating pattern of light green icons on a dark teal background. The icons include medical supplies like syringes, pills, and bandages, as well as symbols associated with drug use such as marijuana leaves, syringes, and pills.

"DON'T TREAT US AS OUTSIDERS"

2019

Drug Policy and the
Lived Experiences of People
Who Use Drugs in Southern Africa

ARASA
AIDS & Rights
Alliance
for Southern Africa

Support.
Don't
punish.

About ARASA

The AIDS and Rights Alliance for Southern Africa (ARASA) was established in 2002 as a regional partnership of civil society organisations working in 18 countries in southern and East Africa. Between 2019 and 2021, the partnership will work to promote respect for and the protection of the rights to bodily autonomy and integrity for all in order to reduce inequality, especially gender inequality and promote health, dignity and wellbeing in southern and East Africa.

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The background of the entire page is a light green pattern of various icons related to medicine, drugs, and health. These icons include syringes, pills, capsules, medical crosses, umbrellas, and stylized plant leaves, scattered across the white background.

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Acronyms

ADSU	Anti-Drug and Smuggling Unit
AU	African Union
AUPA	African Union Plan of Action on Drugs
CAP	Common African Position
CND	Commission on Narcotic Drugs
COSUP	Community Orientated Substance Use Programme
CSR	Corporate Social Responsibility
CUT	Collectif Urgence Toxida
DDA	Dangerous Drugs Act
EuroNPUD	European Network of People who Use Drugs
GCDP	Global Commission on Drug Policy
GCHL	Global Commission on HIV and the Law
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDPC	International Drug Policy Consortium
INPUD	International Network of People who use Drugs
KANCO	Kenya Aids NGO Consortium
M&E	Monitoring & Evaluation
MSF	Médecins Sans Frontières
MOHQL	Ministry of Health & Quality of Life
NPS	New Psychoactive substances
NSP	Needle and Syringe Programme
OST	Opiate Substitution Therapy
PE	Peer Educator
PWID	People who Inject Drugs
PWUD	People who use Drugs
SADC	Southern African Development Community
SADC-PF	Southern African Development Community Parliamentary Forum
SDP	Support Don't Punish
SANPUD	South Africa Network of People who Use Drugs
SC	Synthetic Cannabinoids
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WACD	West African Commission on Drugs
WHO	World Health Organisation
WOCACA	Women's Coalition Against Cancer
ZCLDN	The Zimbabwe Civil Liberties and Drugs Network

Executive Summary

Since the 1960s, the “War on Drugs” had started to take shape, not just in the US, but globally. By 1988, the United Nations Member States had ratified 3 major conventions that have fuelled criminal and repressive approaches to many forms of drug use. The War on Drugs has become a conflict of enforcing prohibitionist policies on the manufacture, distribution, and consumption of “illegal drugs.” However, now, after more than forty years of a militaristic approach to a public health problem, there continues to be an increase in narcotics production in the so-called “global south” and rising rates of consumption particularly in northern economies. Even more importantly, in recent years, there have been grave concerns about the global response to drugs; it has become more than clear that the War on Drugs not only perpetuated, but fuelled, severe human rights abuses towards people who use drugs, was not effective in its stated goals to curb drug use, and only worsened public health issues, especially in the context of HIV.

In the past decade a growing movement for reform of the outdated punitive approach has started to gain traction. Not only local, regional, and global civil society organisations, but also UN agencies are speaking out more and more in favour of drug policy reform and the need to provide people centred and rights-based harm reduction services to people who use drugs. The harms of a continuing punitive approach that effectively criminalises people who use drugs are inconsistent with basic human right principles. In 2019 the UN System Task Team’s published a report entitled “What we have learned over the last ten years” speaks out strongly against the violent consequences of the War on Drugs.

Unexpectedly, global drug policy has influenced the African region significantly. Criminalisation of the possession of drugs for personal use remains across the southern African region and in many places harm reduction policies are not available; in places where policies are available to provide harm reduction services, implementation is often still lacking. In 5 countries where this report has done focus groups with people who use drugs it shows clearly that repressive policies lead to an environment of impunity of violence by the police, government stakeholders, and the wider community. Extreme levels of stigma are fuelled by criminalisation of drug use and possession within the communities that people who use drugs live. Even more worrying is the added burden of people who use drugs who live with HIV, who struggle to access ART, and of women who use drugs who face added issues of gender-based violence. Through linking the prevailing laws and policies with the lived experiences of people who use drugs this report provides clear evidence of the dehumanising effects of the continuing repression.

There are some positive developments, however. The Southern African Development Community (SADC) has adopted a key population strategy that includes people who use drugs; the SADC Parliamentary Forum is working on minimum standards for key populations; and the African Commission on Human and People’s Rights has produced a report that endorses the human rights of people who use drugs.

Furthermore, growing trends towards decriminalisation of cannabis in several countries the region is helping shift both the political and the public debate.

The role of civil society has been essential, not only in assisting people who use drugs where government has failed, but to advocate for drug policy reform. Additionally, networks that are led by people who use drugs show a growing movement of community led activism that strengthens the voices of people who use drugs.

However, as is stated by the global campaign started by the International Drug Policy Consortium, continued action is needed to ensure that people who use drugs will be able live within a world that continues to deny their rights. Their annual global day of action on the 26th of June strategically coincides with the International Day Against Drug Abuse and Illicit Trafficking as a counter voice against the War on Drugs and for drug policy reform. It has started in 2013 and continues to grow globally, and strongly calls out: SUPPORT, DON'T PUNISH.

Part I: Understanding and Contextualising Drug Policy in Africa

Global Drug Policy

A mind-altering substance that has been used for ages

When having a look at the earliest use of psychoactive substances, evidence shows that drugs have been around for ages, with documented use of alcohol (7,000-6,600 B.C), hallucinogens (8,600 and 5,600 B.C.), opium (mid-sixth millennium B.C), coca leaves (6,000 B.C.), tobacco (2,000 B.C.)¹, and cannabis² (8,000 B.C.) What is more recent however is the modern response to drug use, traditionally known as the “War on Drugs.”

Modern responses to drug use

Definition of the War on Drugs⁸

The U.S.-led global War on Drugs refers to the conflict and violence produced by the enforcement of prohibitionist policies on the manufacture, distribution, and consumption of banned substances commonly known as “illegal drugs.” After forty years of a militaristic approach to a public health problem, studies continue to report higher records of narcotics production in so-called southern nations, and rising rates of consumption particularly in northern economies. It is thus common for institutional reports, journalistic articles, and academic studies to declare the complete “failure” of the War on drugs. However, despite the lack of results and the human cost of still-increasing incarceration and violence, governments and intergovernmental organizations around the world continue to invest in a global war on the production and distribution of illegal narcotics.

The “War on Drugs” was popularised by the media after a speech by Richard Nixon in 1971.³ This war was expanded in the United States in the early 80’s, during the Reagan era and coined the controversial slogan “Just Say No!”⁴ However, this perspective was also transferred at global level, and, by 1988, the United Nations Member States had already ratified the 3 UN drug Conventions:

1961: The United Nations Single Convention on Narcotic Drugs.⁵

1971: The United Nations Convention on Psychotropic Substances.⁶

1988: The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychoactive Substances.⁷

Even though these three conventions states that their the objectiveas being the “health and welfare of mankind”, all three conventions have

been implemented with a repressive and criminalisation approach. The 1988 Convention specifically, has significantly reinforced the obligation of countries to apply criminal sanctions domestically to combat all the aspects of illicit production, possession and trafficking of drugs. It is arguably the most prescriptive and punitive of the three conventions.⁹ The 3 UN convention have been a stepping-stone for the drafting and implementation of national drug legislations in most countries.

It is worth mentioning that none of the controlled drugs have been declared 'illicit' per se by the 3 conventions, but the different substances have been classified according to different schedules that determine the level of control imposed on each substance. The 1961 and 1971 conventions come with 4

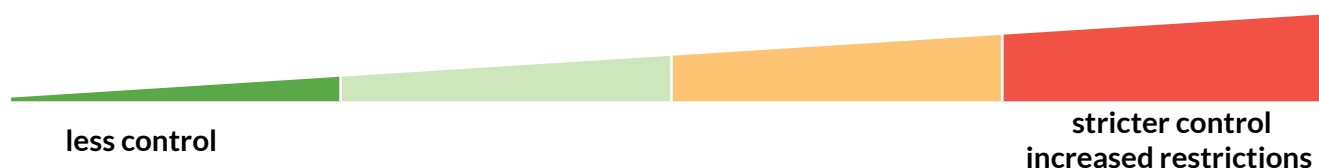
Table 1: Schedules of the 1961 and 1971 UN Drug Conventions¹¹

1961 Convention on Narcotic drugs

Schedule III	Schedule II	Schedule I	Schedule IV
Pharma-ceutical preparations containing low amounts of narcotic drugs Unlikely to be abused	Substances that are less liable to abuse and to produce addiction than those of Schedule I	High Liability to Abuse and to provoke addiction Precursors directly convertible into a drug similarly addictive and liable to abuse	Already listed in schedule I Particularly dangerous properties, especially liable to abuse and to produce ill effects Little or no therapeutic value, or a substantial therapeutic value that is also possessed by another drug not listed in schedule IV
Example: preparations with less than 100mg of codeine	Example: codeine	Example: Cannabis, opium, coca leaf, heroin, cocaine	Example: Cannabis, heroin

1971 Convention on Psychotropic Substances

Schedule IV	Schedule III	Schedule II	Schedule I
Regular liability to abuse Small but significant risk to public health From little to great therapeutic value (s)	Regular liability to abuse Substantial risk to public health Moderate to great therapeutic value (s)	Regular liability to abuse Substantial risk to public health Little to moderate therapeutic value (s)	High liability to abuse Especially serious risk and threat to public health Very limited or no therapeutic value (s)
Example: tranquilizers, diazepam	Example: Barbiturates, buprenorphine	Example: THC, amphetamines	Example: LSD, MDMA, Cathinone



different schedules each - summarized in table 1. As for the 1988 Convention, it has led to the adoption of more repressive measures, and includes 2 tables listing precursor chemicals, reagents and solvents which are frequently used in the illicit manufacture of drugs.¹⁰

In terms of global response, a high level meeting of the Commission on Narcotic Drugs (CND) was held in 2009, where Member States agreed to a Political Declaration and Plan of Action¹² for the period 2009-2019, calling for Member States to establish 2019 'as a target date for states to eliminate or reduce significantly and measurably' the illicit cultivation, production, trafficking and use of internationally controlled substances, the diversion of precursors, and money-laundering' at Article 36.

A growing call for Drug Policy reform

In recent years, there have been concerns about the global response, and the fact that we were very far from reaching the goals of the UN 2009 Plan of Action,¹³ but mostly that this approach has led to a series of "unintended consequences", as per Antonia Maria Costa, former Executive Director of the United Nations Office on Drugs and Crime (UNODC)¹⁴. Other, unintended, health and social related consequences of the war on drugs were documented in a series of publication by the Global Commission on Drug Policy¹⁵ (GCDP), namely its general impact,¹⁶ its impact on HIV/Aids,¹⁷ on the Hepatitis C Virus (HCV),¹⁸ and on the pain medication crisis.¹⁹ The War on Drugs has also been highly criticized for the unequal outcomes across racial groups, through racial discrimination by law enforcement and for its disproportionate impact on communities of colour.²⁰ In 2019 the UN System Task Team's produced a damning report "What we have learned over the last ten years" regarding the impact of the War on Drugs.²¹

These concerns that have been raised regarding this repressive approach have led to several initiatives calling for drug policy reform. These include, among others, the creation of the International Drug Policy Consortium (IDPC)²² in 2006, a global civil society network of 182 organisations engaged in drug policy initiatives, as well as the International Network of People Who Use Drugs (INPUD),²³ a global network advocating for the rights of People Who Use Drugs (PWUD). In 2011, the Global Commission on Drug Policy was created comprising of former heads of state or government, as well as other experienced and well-known leaders from the political, economic and cultural arenas, whose objective is to advocate for drug policies based on scientific evidence, human rights, public health and safety, for all segments of the population. Furthermore, in 2012, the Global Commission on HIV and the Law²⁴ (GCHL) published a ground-breaking report²⁵ where they also recommended decriminalisation of drug use, and similar recommendations have been brought forward in their more recent report in 2017.²⁶

Unintended Consequences of the War on Drugs

1. The creation of a huge 'criminal black market', along with all its attendant problems.
2. 'Policy displacement', through which scarce resources are redirected from health to law enforcement.
3. The 'balloon effect', whereby, rather than eliminating drug production, transit and supply, enforcement measures just shift it somewhere else.
4. 'Substance displacement', whereby, rather than eliminating drug use, enforcement measures just cause users to consume other substances.
5. Stigmatisation and discrimination, which prevents People who use drugs accessing treatment and support.

All these initiatives have at least one common vision: that people who use drugs should not be incarcerated for their drug use; some of these initiatives are pushing for a public health approach with more harm reduction measures, others for a regulated market, or for the rights of PWUD.

What is Harm Reduction?

As per Harm Reduction International (HRI), Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights - it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support. (It) encompasses a range of health and social services and practices that apply to illicit and licit drugs. These include, but are not limited to, drug consumption rooms, needle and syringe programmes, non-abstinence-based housing and employment initiatives, drug checking, overdose prevention and reversal, psychosocial support, and the provision of information on safer drug use.²⁷

By UN standards, Harm Reduction is referred to as the Comprehensive Package of interventions for the prevention, treatment and care of HIV among people who inject drugs (PWID),²⁸ whose priorities are:

1. Needle and syringe programmes (NSPs) : programmes aiming at ensuring access to clean injecting equipment for PWID.
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment: medicated assisted therapies aiming at substituting the use of opiates like heroin for example, with medications like methadone so that the user is not in heroin withdrawal. This programme aims at protecting opiate users from health consequences like HIV or HCV, while aiming at social, and professional insertion. While methadone can be gradually decreased to ease off the person from the programme, WHO recommends treatments to be on a long period rather than short scale.²⁹
3. HIV testing and counselling (HTC) : specifically aiming PWID.
4. Antiretroviral therapy (ART) specifically aiming PWID.
5. Prevention and treatment of sexually transmitted infections (STIs).
6. Condom programmes for PWID and their sexual partners.
7. Targeted information, education and communication (IEC) for PWID and their sexual partners.
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis for PWID.
9. Prevention, diagnosis and treatment of tuberculosis (TB) for PWID.

As per WHO 2016 guidelines³⁰, overdose prevention is included as a new recommendation in terms of Harm Reduction interventions. This measure includes specifically the availability of Naloxone. Naloxone is a medication aimed at reversing the effects of opioid overdose. As such, if someone is experiencing an overdose on heroin for example, administering Naloxone as quickly as possible to that person is likely to save him/her from dying of that overdose. Naloxone is however available in hospital settings only in most countries. It is thus recommended that Naloxone be available in the community with peers, family members and friends of people who use opiates, including PWUD themselves as they are more likely to be the ones witnessing an overdose, thus saving their peers' lives. WHO thus recommends the availability of community Naloxone.

It is to be noted that Harm Reduction is not limited to injecting drugs, nor to the prevention of HIV or other blood-borne infections. It is thus not limited to the UN Comprehensive package, but has a broader scope as highlighted by HRI above.

There have been some UN entities that have also called for decriminalisation of drug use, among which the World Health Organisation (WHO), and UNAIDS.³¹ More recently, the Chief Executives Board of the UN, representing 31 UN agencies, has adopted a common position on drug policy that endorses decriminalisation of use and possession for personal consumption.³²

Since States often have difficulties to navigate between their obligations as per UN Drug treaties and Human Right obligations, a recent publication by the International Centre on Human Rights and Drug Policy endorsed by UNAIDS, WHO and UNDP ensures human right compliance within national drug policies. This initiative aims at highlighting the “compatibility between the promotion of human rights and the stated object and purpose of the drug control conventions, that of promoting the ‘health and welfare of mankind.’”³³ It is also worth noting that the WHO’s Expert Committee on Drug Dependence (ECDD) has published a report,³⁴ recommending the reclassification of cannabis under the UN drug treaties, following a lengthy review process. The report is considered as progressive, though too limited to the usefulness of medical cannabis.³⁵

Several global campaigns have also been organized by civil society, asking for drug policy reforms, one of them being the Support Don’t Punish (SDP) Campaign. SDP is a global advocacy campaign calling for better drug policies that prioritise public health and human rights. The campaign aims to promote drug policy reform, and to change laws and policies which impede access to harm reduction interventions.³⁶ SDP was organized for the first time in 2013 and was celebrated in 41 cities globally,³⁷ and subsequently each following year. In 2018, it was celebrated in 220 cities globally in nearly 100 countries.³⁸

The UNGASS on Drugs (2016) and the UN High level Ministerial segment (2019)

Some governments have acknowledged that a new approach to drugs is fundamental, with countries such as Mexico, Guatemala and Columbia calling for a United National General Assembly Special Session (UNGASS) on drugs. The UNGASS on drugs was convened in 2016³⁹ in New York and provided an opportunity for civil society to be vocal and push forward instrumental advocacy initiatives,⁴⁰ including statements for drug policy reform.⁴¹ One of the pivotal outcomes of the UNGASS on drugs was the formation of the UNGASS Outcome Document.⁴² This document, though not questioning the “drug-free” goals of the conventions and global plan of action, included some progressive statements about proportionality of sentences, harm reduction, overdose prevention, and controlled pain medication.



Women in Malawi taking action for Support Don't Punish. (photo credit: WOCACA)

2019, marks the end of the UN Plan of Action 2009-2019, which has seen a UN High level Ministerial segment⁴³ prior to the Commission on Narcotic Drugs (CND) annual meeting in Vienna. This high-level meeting has issued a declaration⁴⁴ that has disappointed many organisations. Organisations such as the GCDP⁴⁵ and IDPC⁴⁶ have issued statements express their concern. The arguments are that the progressive points in the UNGASS Outcome Document have not been carried forward in the new declaration by the CND, and that the targets of the UN Plan of Action (2009-2019) have neither been questioned, nor evaluated. For many the concerns are that the new declaration will have an impact on the global drug

policy for the 10 years to come, despite lack of clear language towards drug policy reform.

Drug Policy in the African region

Global drug policy continues to shape policy and practice within the African continent. Lugard Abila, a Kenyan Drug Policy Reform activist, has pointed out that “the international drug control system was shaped at a time when African states focused on models of development which were propagated by European imperialism, scientific racism, concepts of moral responsibility and the legacy of colonial legislation.

So while in the early 1950s African states were focused on developing their economies and societies, by the 1960s legal arrangements for drugs were inherited from the colonial powers by the newly independent states. Although drugs were originally not an issue, they have since been identified as a ‘development impediment’ for which prohibition is the only answer.” This is despite the fact that “Africa has a history of drug use that precedes contact with Europe.

From a genesis in pre-colonial times before the scramble for Africa, and before the foundation of drug prohibition was laid, some of these drugs were used as a tool for accessing other psychological, cultural and spiritual dimensions, and they were typically found in the domain of the sacred, other the medical and some for recreation.”⁴⁷

Africa has a prohibitive approach in terms of drug policy, with 5 countries in the region applying the death penalty for drug-related offences,⁴⁸ namely, the Democratic Republic of Congo (DRC), Egypt, Libya, South Sudan and Sudan, with the latter having a mandatory death penalty for such offences.

The drugs response in the region has largely been based on a punitive approach. Even if there are some sub-regional initiatives to be potentially developed in the future with a human rights and public health-based response in mind, policy change remains a challenge because of the lack of reliable data in many countries in the region pertaining to drug use and PWUD.⁴⁹ A review of drug legislation in Western Africa also reveals that despite some interests to review drug policies in the sub-region, “existing drug laws and approaches are rooted in the prohibitionist interpretations of the international drug conventions.”⁵⁰

The birth of Harm Reduction initiatives in Africa

HIV has had a catastrophic impact on People Who Inject Drugs (PWID) in Africa. Countries, such as, Egypt, Morocco, Mauritius, and South Africa have reported harm reduction interventions like the Needle and Syringe Programme and/or Opiate substitution Therapy (OST) since 2008.⁵¹ Soon thereafter, HIV started affecting the PWID community in different countries within the African region, and small initiatives, including pilot projects started to be launched with limited funding in other countries.

It was however clear that these were too limited, and voices started to be raised for the need to scale up these initiatives and bring about the policy changes required to make it possible. An article in the International Journal of Drug Policy read: “The time for small pilot harm reduction programmes in priority countries in Africa, and elsewhere, has gone. The virus is not waiting. It is imperative for countries to rapidly mobilize both their core resources and partners’ funding and adopt a systematic public health approach for large, high volume and low threshold harm reduction programmes for HIV prevention as against small, low volume and high threshold ones.”⁵²

After more than 10 years, these services are reported in only 12 countries within the region, while 13 more countries are reporting data on PWID.

Table 2: African countries with reported data on PWID and Harm Reduction Services

Country with reported injecting drug use	People Who Inject Drugs	% Prevalence among PWID			Harm Reduction Response (detailed with number of sites)	
		HIV	Hep C	Hep B	NSP	OST
Algeria	21,050	6.5	Not Known	Not Known	No	No
Benin	Not Known	5.1	Not Known	Not Known	No	No
Côte d'Ivoire	500	5.3	1.8	10.5	No	Yes (12)
DRC	3500	13.1	Not Known	Not Known	No	No
Egypt	93,000	2.4	NK	Not Known	Yes (9)	No
Ghana	6314	Not Known	40.1	Not Known	No	No
Kenya	30,500	42	16.4	5.4	Yes (19)	Yes (7)
Lesotho	2,600	Not Known	Not Known	Not Known	No	No
Liberia	457	3.9	Not Known	Not Known	No	No
Libya	6,800	87.1	94.5	4.5	No	No
Madagascar	15,500	4.8	5.5	5	No	No
Mali	Not Known	5.1	Not Known	Not Known	Yes (1)	No
Mauritius	11,667	45.5	97.1	6.1	Yes (46)	Yes (42)
Morocco	3,000- 18,500	7.1	57	Not Available	Yes (6)	Yes (7)
Mozambique	29,000	46.3	67.1	Not Known	Yes (1)	No
Nigeria	44,515	3.4	5.8	6.7	No	No
Rwanda	2,000	Not Known	Not Known	Not Known	No	No
Senegal	1,324	9.4	38.9	Not Known	Yes (5)	Yes (1)
Seychelles	2,560	12.7	76	1	No	Yes
Sierra Leone	1,500	8.5	Not Known	Not Known	No	No
South Africa	76,000	14.2	54.7	5	Yes (4)	Yes (<11)
Tanzania	30,000	35	57	1.1	Yes	Yes(6)
Tanzania (Zanzibar)	3,000	11.3	25.4	5.9	No	Yes
Togo	2,500	Not Known	Not Known	Not Known	No	No
Tunisia	11,000	3.9	29.1	3.0	Yes (25)	No
Uganda	Not Known	17-20	Not Known	Not Known	Yes (2)	No

Data taken from the Global State of Harm Reduction 2018⁵³

It is to be noted that there is no community Naloxone (medication used to reverse an opiate overdose), and no drug consumption room either in the region.

Africa at the 2016 UNGASS

At the regional level, it looks like there is no consensus among member states on the direction that has to be taken in the drug policy debate. Prior to the 2016 UNGASS on drugs, there were two opposite declarations made by Africa,⁵⁴ a more conservative one from the Africa Group⁵⁵ (a small and non-transparent grouping of the 11-or-so African countries that have a permanent diplomatic presence in Vienna, and therefore dominate African representation at the CND⁵⁶), and the other from the African Union (AU).⁵⁸ The AU document, commonly referred to as the Common African Position (CAP) is more progressive, and more participatory, as it includes all African members States inputs. This document asks for human rights and public health approaches towards the drug policy debate. This dichotomy probably reflects the situation in the region where in some countries, health services are available for PWID, and in others, they are not even acknowledged as key population needing health services.

The African Union

It is interesting to note that the African Union Plan of Action (AUPA) on Drug Control (2013-2017)⁵⁹ has been worked out with a strong human rights perspective. The human rights component in the AUPA is seen throughout the objectives, as it focuses, not only on the drug supply, but mostly on evidence-based response “to address the social and health impact of drug use”. Also, the drug trafficking response is in accordance with “fundamental human rights principles and the rule of law.” The need for more effective data collection in the response has been enhanced, the lack of data being a major issue in the region.

Finally, the accessibility to controlled medicines for medical and scientific purposes has been included, thus addressing, among other things, the issue of lack of pain medication in the region. It is worth mentioning that in 2014, at the Sixth Conference for African Ministers for Drug Control (CAMDC6), the biennial meeting of the region’s ministers and civil servants responsible for drug control, where the AUPA progress was reviewed, the conference theme was: “Drugs Kill, but Bad Policies Kill More: Scaling up balanced and integrated responses towards drug control in Africa”,⁶⁰ thus echoing the famous Koffi Anan quote that “drugs have destroyed many lives, but wrong government policies have destroyed many more”.⁶¹

The AUPA has then been extended to 2019 in an AU Meeting,⁶² in order to incorporate the progressive statements of the UNGASS 2016 Outcome document and the UNGASS CAP. The AUPA is now to be evaluated through an implementation progress report.⁶³ At the 2019 CND, AU stated that they were planning to approve a new Plan of Action in 2019, for 2019 to 2023 – building on the seven operational pillars of the 2016 UNGASS on drugs.⁶⁴

Global Commission on HIV and the Law

Another impactful drug policy reform initiative has been the organization in 2011 of an African dialogue by the Global Commission on HIV and the Law. The dialogue’s objectives was to discuss gaps and opportunities for change in the law, practices of law enforcement, issues with legal aid and access to redress, including a focus on law as well as law enforcement practices and access to justice in relation to HIV and in relation to key populations at higher risk of HIV exposure. In terms of drug policy, one of the major outcomes was that “68.8 % of countries in Southern and East Africa have laws which place barriers on providing harm reduction services such as the accessing of clean needles. Furthermore, individual drug possession and use is a criminal act throughout Africa. In most countries service providers are unable to provide users with access to clean needles or other harm reduction services without aiding and abetting a criminal offence. Recommendations were made for law review and reform to decriminalise sex work, sex between men and injecting drug use.”⁶⁵

African Commission on Human & Peoples' Rights (ACHPR)

The ACHPR published a report in 2017 on HIV, the Law and human rights in the African Human Rights system,⁶⁶ its first report on HIV, the law and human rights. The report looks at different thematic areas around human rights and HIV, as well as different key populations. When it comes to people who use drugs, the report makes it clear that "A human rights-based approach to drug use requires a move away from criminalisation towards harm reduction and support. The UN Committee on the Rights of the Child, the Committee on ESCR and the Special Rapporteur on the Right to Health have all endorsed a harm reduction approach, as has the Human Rights Council, UN General Assembly and the OHCHR".

This is an example of another African body advocating for drug policy reform, which is a progressive move, considering the fact that advocacy around decriminalisation of key populations in the region have, in the past, mostly focused on the LGBT community and sex workers, drug use advocacy in the region being more recent.

Civil Society Responses towards Drug Policy Reform in the African Region

On civil society's side, there have been progressive moves from Western Africa. One of these was the creation of the West Africa Commission on Drugs (WACD),⁶⁷ comprised of a group of distinguished West Africans from the spheres of politics, civil society, health, security and the judiciary. In line with the GCDP, they advocate for drug policy reform, and have formulated a ground breaking report in 2014, stating "that the consumption and possession for personal use of drugs should not be criminalized," and asking for "political leaders in West Africa to act together to change laws and policies that have not worked".⁶⁸

They have even gone further by publishing a Model Drug Law for West Africa,⁶⁹ which provides concrete legal templates that Western African countries can adapt to reform their drug legislation, including legal provisions and how they relate to international legal obligations. The WACD is thus in line with the Global Commission on Drug Policy's initiatives. It is worth mentioning that 2 ancient heads of State from the SADC region have recently joined the Global Commission on Drug Policy, namely from South Africa and Mauritius.⁷⁰

Another dynamic initiative has been the creation of the West Africa Drug Policy Network,⁷¹ a budding coalition of more than 600 CSOs from the 16 West African countries, that supports drug policy reform in West Africa by building the capacity of local CSOs to address the impact of drug markets on democracy, governance, human security, human rights and public health.

A series of drug policy trainings has also been organised in Western Africa,⁷² based on a training toolkit⁷³ adapted specifically to the Western Africa context, and developed by IDPC, in collaboration with WACD. In Senegal, these trainings have been carried out in collaboration with Senegalese universities.⁷⁴

Moreover, there have been a number of conferences organized by civil society in the region with international participants/speakers, addressing drug use with a perspective of human rights, health, harm reduction, or drug policy reform, by organisations like the African Centre for Research and Information on Substance Abuse (CRISA)⁷⁵ in Nigeria, as well as others organized in Eastern and Southern Africa by organisations like TB HIV Care in South Africa, Collectif Urgence Toxida (CUT) in Mauritius, and Kenya Aids NGO Consortium (KANCO) in Kenya, and that are developed further down.

Civil Society is gradually getting more on board with drug policy reform. An example is the fact that IDPC had its first African member in 2012, from Mauritius.⁷⁶ Today IDPC has 20 members in the region.⁷⁷ Additionally, the Support Don't Punish campaign was organised in 3 countries across Africa when it was launched for the first time in 2013, namely Tanzania, Mauritius and Kenya.⁷⁸ Today this number has expanded nearly tenfold and as of 2018, there were 29 countries in Africa where SDP campaign was organized as shown on the map taken from SDP website.⁷⁹

The regional drug user network was originally initiated by the Kenyan Network of People who Use drugs (KeNPUD) in 2012,⁸⁰ followed by the Tanzanian Network of People who use drugs (TaNPUD) in 2013⁸¹ and (Real Activist Community Tanzania) in 2014,⁸² respectively. Following the formation of these structures similar initiatives sprouted throughout the region: in South Africa with the South African Network of People Who use Drugs (SANPUD), Cameroon (Empower Cameroon),⁸³ Senegal (Santé, Espoir, Vie – SEV), Cote d'Ivoire (Foyer du Bonheur – La relève), Morocco (AHSUD),⁸⁴ Nigeria (Equal Health & Rights Access Advocacy Initiative -EHRAAI),⁸⁵ Zimbabwe (Zimbabwe network of People Who Use Drugs - ZimPUD),⁸⁶ as well as Mali and Burkina Faso.

With the aid of the Global Fund regional grant for East Africa, networks have been/are being developed:⁸⁷ in Mauritius (Mauritius Network of People who Use drugs – MauNPUD),⁸⁸ Seychelles (Drug User Group Seychelles-DUGS), Zanzibar (Zanzibar Network of People Who Use Drugs – ZaNPUD), and Burundi (Burundian Association of People who Used Drugs-BaPUD). There is also the African Francophone network of people who use drugs (RAFASUD – Réseau Africain Francophone d'Auto-Support d'Usagers de Drogue)⁸⁹ registered in Cote d'Ivoire in 2017 and AfricaNPUD,⁹⁰ a Sub-Saharan network.”*

Drug Policy in southern Africa

Drug Control Regime and health responses

Within the SADC region, not only have countries ratified the international treaties, but most of the SADC countries have also ratified the SADC Protocol on Combating Illicit Drug Trafficking 1996⁹¹ that aims at “assist(ing) in reducing and eventually eliminating drug trafficking, money laundering and abuse of drugs through cooperation among enforcement agencies.”⁹²

All countries in SADC have reported ratifying it with the exception of Angola (that has signed but not ratified it) and DRC, Madagascar and Seychelles.⁹³ The protocol is a “legally binding document committing Member States to the objectives and specific procedures stated within it.”⁹⁴ The protocol urges member States to promulgate and adopt domestic legislation which shall make illegal “drug trafficking, money laundering, diversion of chemical precursors, (...) and drug abuse,” drug abuse not being defined in this specific document. The document also urges Member States to make the following sentencing for these acts: “maximum custodian sentences which will serve both as punishment and deterrent and would include provision for rehabilitation.”

Drug use and possession is thus prohibited in all SADC countries (Ref table opposite). However, this has not prevented drugs from being used, and reports of the use of opiates like heroin as far back as the early 80's has been noted in Mauritius.⁹⁵ The country has thus launched harm reduction services like OST and needle and syringe programmes as from 2006.⁹⁶ Other countries in the SADC region or around have

*Although not all People who use drugs groups are documented, these information have been obtained through INPUD, RAFASUD, in country partners, and other partners involved in People who use drugs group's initiatives.

gradually followed afterwards with similar services, like South Africa, Kenya Tanzania, Mozambique and Uganda.⁹⁷ Moreover, people who inject drugs are now recognized as key populations in HIV/Aids National Strategic Frameworks in 12 countries within the SADC region (See table 3).

Table 3: An overview of drug legislation, and health policies/interventions for PWID

SADC Countries	Drug possession criminalised	Specific provisions in national drug legislations (developed further down)	PWID identified as key pop in HIV/Aids national plans ⁹⁸	Needle and syringe programmes and/or OST ⁹⁹
Angola	✓ ¹⁰⁰			
Botswana	✓ ¹⁰¹			
Comoros	✓ ¹⁰²		✓	
DRC	✓ ¹⁰³		✓	
Lesotho	✓ ¹⁰⁴	Medical cannabis cultivation approved by Government in 2018	✓	
Madagascar	✓ ¹⁰⁵		✓	
Malawi	✓ ¹⁰⁶	Parliament is discussing a proposed bill in Parliament for the legal production of hemp, and cannabis for medical use		
Mauritius	✓ ¹⁰⁷		✓	✓
Mozambique	✓ ¹⁰⁸	There is a draft bill that would allow for production of cannabis for medical and scientific purposes, as well as decriminalization of a small amount of drugs	✓	✓
Namibia	✓ ¹⁰⁹		✓	
Seychelles	✓ ¹¹⁰	No criminal offence for drugs possession, with minimum amounts specified as personal use (conditions apply)	✓	✓
South Africa	✓ ¹¹¹	Sep 2018 ruling stated that an adult person is allowed to possess, use or cultivate cannabis in private	✓	✓
Swaziland	✓ ¹¹²		✓	
Tanzania	✓ ¹¹³		✓	✓
Zambia	✓ ¹¹⁴		✓	
Zimbabwe	✓ ¹¹⁵	Zimbabwe has approved production of medical and scientific cannabis in 2018		

As mentioned in Table 3, there are few countries where there have been some initiatives in terms of drug policy reform, though most of them are around cannabis.

Lesotho: has also made some legal amendments¹¹⁶ in 2018 and has been the first African State to allow legal production of cannabis for medical purposes.¹¹⁷ However, licences have been attributed only to foreign companies so far,¹¹⁸ and it looks as if the protocols surrounding the production control makes it out of reach for nationals.¹¹⁹



Malawi: A proposal for a bill allowing for the cultivation, production and possession of industrial hemp and marijuana for medical use was approved by Parliament in December 2018. The bill is supported both by Government and opposition.¹²⁰ While Parliament is still discussing the bill, it gave the go-ahead for industrial hemp trials.¹²¹

Mozambique: A bill has been drafted in 2018, the Anteprojecto de Revisão da Lei nº. 3/97, that would allow, in Article 34, for the cultivation of cannabis for medical, veterinary or scientific research purposes, provided authorisations are obtained. Moreover, article 36 would allow for the possession of a small amount of drugs for personal use without being sentenced to jail.



Seychelles: The amendments made to the drugs legislation in 2016 brought the following provisions:

- A difference made in the law between a drug user and a drug dependent person
- A drug user caught with limited amount of drugs (10 grams /3 plants of cannabis or 0.1 grams of heroin or cocaine) shall not be convicted/ or if convicted, not incarcerated (however, this is conditional that the person has not more than 2 cautions within 12 months)
- In the case of a drug dependent person, the objective of the court will be to make treatment, education, rehabilitation, recovery and social reintegration services accessible. (However, no freedom of choice with that respect for the person caught).
- The possibility to appeal under the 2016 legislation, through a tribunal, if one person has been charged with harsher sentences under previous law (Misuse of drugs act 1990)
- In essence, drug use and possession is still criminalized in Seychelles, but only under certain conditions as mentioned above, which can be seen as a form of partial decriminalisation.

South Africa: In 2018, the Constitutional Court ruled in a judgement that the criminal prohibition of possession, use or cultivation of cannabis by an adult person for personal consumption in private is an infringement of the right to privacy of an adult person and constitutionally invalid. The court gave parliament 24 months to change the law to reflect its ruling.¹²³ This ruling came after cases launched by Gareth Prince, as well as Julian Stobbs and Myrtle Clarke, known as the “Dagga couple”, who have created the not-for profit organization *Fields of Green for All*. In the meantime, this organisation has published a bill proposal for the legal regulation of Cannabis in South Africa.¹²⁴



Zimbabwe: Amended the section 6 of the Dangerous Drugs Act,¹²⁵ through the Dangerous Drugs (Production of Cannabis for Medical and Scientific use) Regulations 2018¹²⁶ to allow Zimbabwe citizens/residents or companies managed by same to grow cannabis. Licences have already been issued.¹²⁷ Zimbabwe Civil Liberties and Drug Network (ZCLDN) has been advocating for drug policy reform for a while.¹²⁸

However, as much as there are some drug policy reforms in the region, not much of these directly impact the lives of people who use drugs and specifically, those who inject drugs. Those last years have seen numerous reports of human rights violations of people who use drugs in the region. In Uganda, arbitrary arrests of PWUD, including peer workers were reported from the Uganda Harm Reduction Network (UHRN) as from 2015,¹²⁹ and more recently as well in 2019.¹³⁰ In Tanzania, cases of stigma and discrimination towards key population, including people who use drugs have also been reported,¹³¹ and PWID in South Africa have suffered arbitrary detention, assault, extortion and confiscation of their medical supplies according to reports from the Step-Up project.¹³² As for cannabis users, despite the fact that there has been a constitutional judgement about cannabis in South Africa, and cannabis-related arrests have gone down, some over-zealous police officers are still arresting them.¹³³

SADC Key Populations Regional Strategy

SADC has also elaborated the Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations.¹³⁴ This publication provides guidance for SADC Member States aiming at operationalising global and regional commitments by providing a framework to develop programmes for key populations. Among other recommendations, this strategy pushes for “essential activities for successful interventions to address legal and policy barriers (including) training and sensitizing key populations about relevant laws, their human rights and how to access justice; advocating for reviewing and reforming laws and policies”, “developing and strengthening key population-led organizations and networks; supporting capacity building and mentoring of key populations to enable them to participate in all levels of a programme; strengthening the management and capacity of key population organizations”, and “ensuring the availability of (...) harm reduction.”

SADC Parliamentary Forum

Another initiative is the SADC Parliamentary Forum (SADC-PF). This platform is an autonomous institution of SADC, established in 1997 in accordance with Article 9 (2) of the SADC Treaty. It is a regional inter-parliamentary body composed of Members of Parliament from 14 SADC countries.¹³⁵

From 2014-2018, the SADC-PF has run the Sexual and Reproductive Health and Rights (SRHR), HIV and AIDS and Governance program through seven SADC countries (Zambia, Zimbabwe, Tanzania, Mauritius, Seychelles, Lesotho and Namibia). The aim was to strengthen the capacity of SADC National Parliaments so that they can advocate and influence policies related to SRHR and HIV/Aids within their parliaments and other national platforms.¹³⁶ Through this initiative, HIV/Aids has been an entry door to discuss key populations including PWUD, as well as drug policy.

Other initiatives of the SADC-PF was the organization of a symposium with ARASA (AIDS and Rights Alliance for Southern Africa) to discuss the theme of criminalisation of key populations with regional Members of Parliament. CSO like CUT and ZCLDN could thus speak about themes like decriminalisation of key populations including people who use drugs,¹³⁷ and the speaker of Seychelles National Assembly also talked about the importance of removing legal barriers for key populations, including PWUD, and thus talked about the Misuse of Drugs Act in Seychelles that provides for a form of decriminalisation for PWUD.¹³⁸

Civil Society Initiatives

There has been a growing interest within civil society in the region as far as Harm Reduction and Drug Policy is concerned. It is worth mentioning that the first initiatives in terms of Harm Reduction in Africa were led by civil society in Mauritius as from 2006.¹³⁹ Advocacy has also been echoed by CSOs in Kenya,

Tanzania, South Africa, Seychelles, the countries that were primarily concerned by injecting drug use since then. CSOs have been implementing actors or partners of harm reduction services, as well as advocates. There has thus been several initiatives, including through the Global regional grant for Eastern Africa, for high level advocacy initiatives with members of parliaments.¹⁴⁰

As previously mentioned, several drug user groups are also organising themselves within the sub-region, though some of them were done through the Global Fund regional grant that has come to an end, and the sustainability of these initiatives might be an issue.

It is worth mentioning that ARASA that works with several CSOs across the Southern/Eastern region, also has drug policy reform as a key advocacy priority now. This has led to capacity building and advocacy activities specifically around drug policy with CSO partners and decision makers in the region, as previously mentioned. ARASA and its partners have also published a Statement from the Southern African Drug Policy Reform and Harm Reduction Advocacy Network on police violence in the sub region.¹⁴¹

The sub-region has also seen the organisation of 9 conferences with the participation of international partners those last 10 years, all of them being civil society initiatives: In Mauritius, CUT has organized 3 conferences: one in 2009, one in 2011,¹⁴² and one in 2017.¹⁴³ In South Africa, TB/HIV Care has organised 3 SA Drug Policy Weeks: In 2016,¹⁴⁴ 2017¹⁴⁵ and 2018, and *Fields of Green for All* has organised a Clinical Cannabis Convention¹⁴⁶ in 2017. Finally, in Kenya, KANCO has organized the Eastern Africa Harm Reduction Conference in 2018.¹⁴⁷ There was also the organization of a pre-conference on drug use and HIV, prior to the South African Aids conference in Durban in 2015.¹⁴⁸

These initiatives have also led to declarations and demands in favour of harm reduction and drug policy reform: The Nairobi Declaration,¹⁴⁹ the South Africa Drug Policy Week 2018 Declaration,¹⁵⁰ as well as the eThekweni Demand,¹⁵¹ the latter being specifically about the obstruction to needle and syringe programme by the authorities in an area in Durban.

There are also national civil society initiatives including high level meetings, capacity building interventions, advocacy, and lobby, though these have not been documented.



Focus group discussion session at Bridge View Hotel in Lilongwe facilitated by Mat Southwell - CoAct Consultant (photo credit: WOCACA)

Part II: Perspectives and Experiences from People who Use Drugs

Background

In order to bridge policy discussions and conversations with the lived experiences of people who use drugs, it is essential that the experiences and perspectives of people who use drugs are included in any conversation regarding drug policy. In order to give voice to people who use drugs and to ensure that their experiences of policies and harm reduction services are included, focus groups were facilitated by CoAct in 4 countries: Malawi, Mozambique, South Africa, and Zimbabwe. CoAct is a Technical Support agency specialising in work with people who use drugs. They work with policy-makers, programme implementers, service providers and drug user groups, supporting the adoption of models of community mobilisation, harm reduction and drug treatment with people who use drugs.

The CoAct Consultant facilitated focus groups and openly acknowledged his personal experience as a person who uses drugs. This helped participants explore their attitudes towards drugs and allowed them to consider different non-stigmatising identities as People Who Use Drugs (PWUD). The variety of choices that individual PWUD made around their personal drug use were respected and valued. It also gave participants the chance to test knowledge and beliefs about drug use and people who use drugs. The CoAct Consultant positively reinforced the individual choices made by the different drug using participants about their use of abstinence from drugs. This models a commitment to non-judgemental facilitation and the right to self-determination. However, it is also notable that drug using participants became more open and balanced in their views as this process was explored.

The assessment in each of the southern African countries covered four elements:

1. Drug user experiences of drug policy
2. Drug user experiences of harm reduction
3. Drug user experiences of human rights violations

Methodology

The Country Mapping Exercise generally engaged three different audiences depending on the stage of development of people who use drug organising in each country:

1. **Drug user organisers** – the collective leaders of the local drug user group or country drug user network.
2. **Drug user activists, members or potential members** – people living active lives as daily people who use drugs who would join for a 3 hour focus group focussed on peer experiences of drug policy, harm reduction and human rights.

3. Harm reduction or other NGO partners – particularly in settings where drug user groups or networks are being conceived or in the early stages of development, the more structural questions about the context, stage of development and capacity for community mobilisation may need to be answered by professional partners.

Focus groups were organised through organisations that were either PWUD led, or were working actively to assist PWUD to organise themselves.

In South Africa the focus group participants were recruited through PWUD led networks. 6 members of Drug Users of Gauteng (DUG) as well as 2 PWUD activists from Cape Town and Durban participated in the focus group.

In Malawi the focus groups were attended by 15 participant – of which 4 were women - including PWUD as well as representatives from NGOs who work with PWUD through the country.

In Mozambique the first day of the consultation focussed on a mixed group of PWUD peer workers and harm reduction practitioners and managers from UNIDOS. The peer workers had formed a drug user group called Solidarios. The harm reduction practitioners and managers also took part in the consultation given the early stage of development of Solidarios and the close relationship between the new drug user group and UNIDOS. Over a 2-day consultation 45 people participated.

In Zimbabwe a total of 18 of PWUD, including 11 women who use drugs, attended the focus group. Additionally, 4 members of the Zimbabwe Civil Liberties and Drug Network were present.

In Mauritius the focus group hosted a total of 28 PWUD were recruited, a third of which were women who use drugs.

The following four country case studies were developed using the Coact Country Mapping Tool - Drug User Experiences of Drug Policy, Harm Reduction, Human Rights and Community Mobilisation. The profiles cover the following countries which were each visited by the Coact Consultant:

- South Africa
- Mozambique
- Zimbabwe
- Malawi

A high value was placed on collaboration with PWUD drugs and NGOs that work with them. The main aim to ensure sound qualitative information from focus groups, with groups being limited in size and allowing for as much engagement as possible. Focus groups and engagement took place over two days.

In addition to the work done in Malawi, Mozambique, South Africa and Zimbabwe, a additional review was undertaken in Mauritius to focus specifically on harm reduction. A 2-day focus group led by CUT was to undertake a mapping exercise with people who use drugs, (most of them being specifically PWID). The goal was to assess the current challenges they experience on a daily basis within the Mauritian context, especially in light of the long-standing harm reduction programme in Mauritius that has often been used as an example of a best practice in the region.

Particular emphasis was placed on the drug situation, Needle and Syringe Programme, Methadone Substitution Therapy, access to health care, stigmatisation, human rights violations and role of police authorities among others.

People who Use Drugs (PWUD) vs People who inject drugs (PWID)

It is acknowledged by UN partners that Harm Reduction is an effective way of curbing HIV within the community of people who inject drugs. However, Harm reduction is not just about commodities to address HIV and other blood-borne viruses. It encompasses a range of health and social services, policies and approaches that address the harms of illicit drug use and drug policy.¹⁵² UNODC acknowledges some risks faced by PWUD with a broader scope than just injecting drug use:¹⁵³

- Stimulant drug use, non-injecting and injecting, has been associated with sexual transmission of HIV, particularly among men who have sex with men and sex workers.
- People who use drugs are highly stigmatized and discriminated, and are often unable or unwilling to access HIV services for fear of arrest or harassment.
- People who use drugs are overrepresented in prisons with low access to HIV services.
- However, the global response, including the funding have been largely limited to people who inject drugs because of the higher HIV risk actor. What is being referred to as Harm Reduction by UN partners is a set of 9 interventions addressing mainly injecting drug use. Countries having drug use, but limited or no injecting drug use have less access to funding to address the needs of PWUD, an example throughout the countries included in this report being Zimbabwe.

As pointed out by OSF, "Harm reduction is not just about responses to HIV and hepatitis C. It covers a range of public health and social interventions that aim to improve quality of life, and to uphold human rights and dignity. The use of amphetamine-type stimulants is reportedly rising worldwide, particularly in Asia, and countries are not adapting to this trend. The availability of information on safer use and safer smoking kits, for example, is scarce."¹⁵⁴

Thus, understanding Harm Reduction with a limited scope of HIV/HCV prevention, or a limited scope of PWID vs PWUD is a risk factor for PWUD who do not inject as they have less access to services "that aim to minimise negative health, social and legal impacts associated with drug use."¹⁵⁵

Thus, "PWUD", "drug users", or "peers" are terms used in this report to include all categories of drug use. When the context requires specific interventions aiming at injecting drug use, the term PWID is used.



Drug Policy Environment

Overarching drug policy

Central focus = zero tolerance with beginnings of harm reduction. The war on drugs is experienced as a war on people who use drugs. As it has been observed in other parts of the world, in the name of the 'war on drugs' implementation, the emphasis is not upon the development of appropriate rehabilitative models, but upon prevention, prohibition and punishment. It has subsequently subjected PWUD to a process of stigmatisation, marginalisation and social exclusion, and prevented many of them from recovery by hindering their re-integration into the wider social and economic community.¹⁵⁶

Drug laws

Drugs are criminalised and PWUD face significant pressure from the police including routine corruption and violations of human rights without any recourse to justice. One of the reasons for this pressure is the way police performance is measured. With regards to drug possession, police are required to increase the number of arrests by 47.36% in 2019.¹⁵⁷ In the meantime, politicians are discussing cannabis regulation due to a high profile legal test case. Given that the majority of drug possession arrests involved cannabis, and that the Constitutional Court ruling¹⁵⁸ of this high profile case has made arrests for cannabis possession much harder, the police will look for targets of people who use drugs other than cannabis in order to meet their quotas, and these people who use drugs will experience the full effects of zero-tolerance.

Social welfare

South Africa does not provide welfare support to people who are unemployed or chronically unwell and does not have specialist welfare support for PWUD.

Security and governance

People who use drugs are very poorly treated by the police and government officials and have not benefited from the introduction of the democracy and human rights that followed the end of apartheid. People who use drugs are routinely targeted by the police and are subjected to corruption and rights violations that allows for the continuation of 'apartheid-style policing.'¹⁵⁹

Development

South Africa is has the largest economy in the African region.¹⁶⁰ This is reflected in the range of available drugs, which are comparable with the drugs used in much of Western Europe and North America.¹⁶¹ The economy has faltered in part due to the accusations of corruption and incompetence surrounding the President and his allies. The history of apartheid underpins the income disparity in the country compounded by the current economic setbacks. The impact of the country's renewal has been slow to benefit those living on the margins of society.¹⁶² There is a strong correlation between drug use and poverty and HIV and marginalisation.¹⁶³ The potential economic benefits of cannabis legalisation and the need to respond to the impact of HIV on other key populations are part of the national discourse. The re-routing of drug trafficking routes via the ports of East and Southern Africa is also bringing high quality heroin and cocaine to the country which is a new driver for the HIV epidemic.¹⁶⁴

Human rights

The SA Constitution provides protections on gender and sexuality that are unrivalled in the region. As for sex work, there has been a long debate over the decriminalisation of sex work, with the South Africa Law Reform Commission (SALRC) working on a report for about 10 years, which was meant to be promising for recommendations around decriminalisation. However, when the report was released in 2017,¹⁶⁵ it pushed for partial decriminalisation, which, according to sex workers advocates, was a no-brainer, and brought them back to where they were 20 years back.¹⁶⁶ Concerning PWUD, they continue to face the full impact of severe drug control regulations. The drug control regime also provides a framework for systemic and institutional discrimination, corruption and rights violations against PWUD.¹⁶⁷ They currently sit outside the protections of SA's strong human rights laws and constitution.

The rights violations reported by people who use drugs illustrate the South African Police Service operating with impunity. People who use drugs report that they are:

- being stopped and searched without cause,
- being detained and searched with excessive violence,
- being beaten,
- being stripped naked and searched in the street,
- being held until they were in opiate withdrawals or craving drugs in order to extract a confession or bribe,
- being threatened and intimidated with a gun,
- having plastic held over the face so they could not breathe during interrogation.

This undermines the rights-based constitution that South Africa is justly proud of. It has to be noted that the Constitution¹⁶⁸ and Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA)¹⁶⁹ prohibit unfair discrimination on any ground, and this includes a long list of specific grounds, like race, sex, gender, sexual orientation and religion. This list is however non exhaustive. The court can thus recognise new grounds on which discrimination can occur, as it has been the case in 2000 when the Constitutional Court recognised that discrimination could occur on the ground of HIV status – despite the fact that HIV status is not listed in the Constitution as a ground of discrimination. The court thus acknowledged that HIV positive people are a vulnerable minority, as the impact of HIV discrimination was devastating.¹⁷⁰ In the same line of thought, a transgender inmate brought a case in front of the Equality Court in late 2018, where the court will have to confirm whether South Africa's laws prohibit unfair discrimination against transgender persons. This case is seen as having the potential to revolutionise the treatment of transgender prisoners in South Africa.¹⁷¹ As other cases of people being stigmatised are being addressed by the Courts, PWUD do not feel that their rights are being respected, and this leaves a feeling of anger, disillusionment and fear, according to the discussions.

The policing of the drugs trade and drug using community creates substantial opportunities for corruption. People who use drugs reported and gave numerous personal examples of the police simultaneously profiting from the drug supply trade and extorting people who use drugs. They describe how the effect of prohibition, particularly for people of colour, the homeless and poor, is to extend the era of apartheid-style policing. People who use drugs describe how they were denied the rights available to other citizens. They believe that they have no recourse to justice or redress within the law. People who use drugs argued that they were usually better off paying bribes or agreeing to other inducements if they encountered the police. This reinforces the effective position of People who use drugs as outsiders to the legal system. People who use drugs illustrated how this made them vulnerable to corruption, violence and in the case of women who use drugs, sexual exploitation.




“The police routinely plant drugs on people.”

“If I am caught with three items, the police officer may ask me what I want to be prosecuted for. This means if I pay a bribe I will only get prosecuted for one item and the police officer will use or sell the other two items.”


“If I asserted my rights during arrest, the police would kick the shit out of me and lock me up and throw away the key!!”

Within such a system, money and connections help insulate more affluent People who use drugs from the worst excesses of this criminal ‘justice’ system. This means that it is mostly “black and coloured” People who use drugs who experience the full impact of prohibition and apartheid-style policing.



“If you have money and are arrested, you won’t withdraw in the police station. The police will call a dealer to come and sell to you. If you have money, you have a much smoother ride.”

Homeless people were targeted by police officers with systematic cruelty designed to exploit and increase their vulnerability:



“The police would wake us up in the night or early in the morning by hosing us with water or throwing buckets of water over us. They would take or burn our possessions including our blankets. This was something that happened regularly to us as street dwellers.”

“The Captain stood by with a big smile on his face. This wasn’t just a few bad apples.”

Of particular concern were reports from People who use drugs that the police removed harm reduction commodities such as needles and syringes from PWUD. Participants also reported the police taking their Anti-Retroviral Treatment (ART). This is in line with the Step-Up Human Rights report who states that: “A total of 683 violations were recorded for the 2016 reporting period (...)81% of reported violations involved the illegal removal of unused injecting equipment” There were also 5 cases of medications being taken away.¹⁷²



“The police officer took my ARVs and stamped on them in front of me!”

This repressive and hostile context undermines HIV prevention. When the police target areas where people buy or use drugs, People who use drugs are driven towards faster and higher-risk drug using practices and do not have the time to check what they are buying.

The participants translated a local saying to explain the experience of PWUD. “Big dog eats a small dog” illustrates how the vulnerable can be preyed on by those with more power. The rule of law should protect the human rights of the vulnerable, and specifically in South Africa that has a rights-based Constitution. However, when the police are the primary rights violators and people who use drugs have no right of redress, then big dogs rule.

The context for PWUD in South Africa is very difficult with the hostile legal environment and corrupt policing compounding the public health challenges faced by the drug using community. However, it is important to also note the signs of hope arising alongside the developing harm reduction system. The use of peer workers by OUT¹⁷³ and TB HIV Care provides a pathway into structured volunteering and employment for drug user organisers. These peer workers provide the heart of the developing South African Network of People who Use Drugs (SANPUD). Two drug user activists also hold management roles in OUT and TB HIV Care which provide important insights, access and capacity for the drug user groups.

In Pretoria, peer workers have built a working relationship with a senior police officer who has become a champion for harm reduction. This senior officer is offering to be a partner in combatting rights violations against PWUD and ensuring the smooth development of harm reduction. This has resulted in a high-level commitment to end the targeting of PWID carrying injecting equipment. This is a key partnership given the current negative impact of policing on harm reduction and drug user rights.

In addition, Community Orientated Substance Use Programme (COSUP) has developed a new initiative with a private housing provider to include social housing and a drop-in centre in a private housing development in Festival Street in Hatfield. This initiative has been supported by the local authority and the private developer is encouraged to include social components in their development through planning regulations and their own social commitment. This provides an interesting model for managing perceptions of ‘social cleansing’ by collaborating with the private sector to achieve social benefits.

It is to be noted that COSUP is a programme whose goal is to: “develop an inclusive, non-punitive harm reduction response to drug use in the City of Tshwane using the Community Oriented Primary Care model of community-based health service provision. Those seeking assistance choose from a menu of services that include screening and brief interventions, health screening, psycho-social services and support, provision of sterile injecting equipment, opioid agonist therapy and skills development.”¹⁷⁴ COSUP is funded and supported by the city of Tshwane that provides funding, in conjunction with the University of Pretoria (Family Medicine Department) that provides the logistics.

High level advocacy from TB/HIV Care, and exposed at the SA Drug Policy Week in Cape Town prior to the 2016 UN General Assembly Special Session on Drugs (UNGASS) on drugs,¹⁷⁵ led the South African Minister of Social Development to make a positive statement¹⁷⁶ in support of harm reduction and community mobilisation with PWUD at the UNGASS held in 2016 in New York. The 2016 UNGASS was held as some Member States were asking for a meeting to discuss the world drug problem, and whether a new approach was necessary, prior to 2019, that would mark the end of the 10 year UNODC Political declaration and plan of Action on drugs,¹⁷⁷ and probably the setting up of a new 10 year plan of action.¹⁷⁸

The statement made from South Africa was a progressive statement, asking for “comprehensive, accessible, evidence-informed, and ethical and human-rights based drug use prevention.” The statement also pushed for the Common African Position¹⁷⁹ of the African Union for the UNGASS that was also grounded in human

rights and evidence-based health interventions semantics. This highlights the potential of empowering the health leadership of the drugs response in South Africa. There is a potential to build on the South African rights-based constitution and to link the rights violations against PWUD with the national momentum against high level corruption.

There is also a growing recognition of the importance of engaging key populations in order to effectively respond to HIV. In line with the GIPA principle (Greater involvement of people living with HIV/Aids), PWUD have also pushed for a greater involvement of their community when it comes to designing, developing, implementing, monitoring and evaluating policies and programmes related to them. It is in this spirit that the Meaningful Involvement of People who Use Drugs, the MIPUD principle, has been set-up, following the Vancouver declaration.¹⁸⁰ Commitments around community involvement is now growing, as there is a wider recognition of civil society organisations work, and more specifically community-based movements. Through the UNGASS document,¹⁸¹ Member States have committed to “support networks for prevention and treatment, care, recovery, rehabilitation and social reintegration in a balanced and inclusive manner.”

The legal protections provided to other key populations could be cited in favour of removing criminal sanctions against PWUD (decriminalisation). There is a national debate on drug policy following a high court challenge to the criminalisation of cannabis, whose judgement was made public in September 2018,¹⁸² and allowing for less stringent laws around cannabis, which further adds to the sense of a country in transition.

Harm Reduction Interventions

International funding and technical support is allowing for the introduction and modelling of harm reduction. However, further work is needed to create the required legal enabling environment, investment and reach of harm reduction services. South Africa is a target country in the Dutch funded international development consortium led by Mainline International. The involvement of the International Network of People who Use Drugs (INPUD) in the consortium has also ensured that community mobilisation with PWUD is a key component in developing HIV response in three South African cities – Pretoria, Cape Town and more recently Durban. Engaging the South African Government is key to creating the policy environment and domestic investment to support a comprehensive harm reduction system.

Core UN Recommended HIV Prevention Interventions for People who Inject Drugs

Intervention	Summary for South Africa	PWID experience & advocacy issues
Needle and Syringe Programme	<p>Needle and Syringe Programme are provided by NGOs in Cape Town, Durban Johannesburg, Tshwane and Port Elizabeth. Limited funding restricts amount of syringes to be given out, and number of sites being operational. As such, additional Needle and Syringe Programme sites are needed to reach into drug using hotspots.</p> <p>Needle and Syringe Programme provide injecting equipment, alcohol wipes, cotton wool filters, water and disposal bins.</p> <p>Not available for free from pharmacies – non-PWUD sent in to buy syringes for PWID. Public hospital pharmacies with a COSUP project linked to it will however provide needles and syringes for free.</p> <p>Secondary Needle And Syringe Programme is not officially supported, as PWID are requested to show up on a needle and syringe programme to collect their equipment. Secondary distribution involves the distribution of injecting equipment by peers to their community members who are unwilling or unable to show up at a Needle and Syringe Programme. This is part of UNAIDS/WHO manual on Needle and syringe Programme, and is a technique that has also been used by peers. On existing Needle and Syringe programmes there, PWID are sometimes allowed to take extra equipment on behalf of another peer, but no secondary distribution per se is taking place.</p>	<p>PWID are often prosecuted for carrying injecting equipment even if provided officially via a Needle and Syringe Programme. However, advocacy in Pretoria by TB HIV Care and through dialogues between law enforcement and South African People who use drugs movements has resulted in high level police support – build on positive example.¹⁸⁵</p> <p>Police use carrying of injecting equipment as reason for stop and search and opportunity for a bribe.</p> <p>It is essential that an enabling environment is developed to pilot and demonstrate the role of secondary Needle and Syringe Programme in scaling up HIV prevention with PWID.</p>
Voluntary HIV Counselling and Testing	Available through general HIV services as well as harm reduction services.	Stigma and discrimination within general HIV services impact the access to these services for PWID. Harm reduction services need to be expended to provide more access.
Opioid Substitution Therapy (OST)	<p>Methadone available on a private basis but hard to access and expensive. Suboxone and Subutex available but very expensive.</p> <p>Sponsored community methadone programme provided for free via COSUP.</p>	<p>Develop methadone advocate group among consumers of new OST service to create quality management relationship through effective consumer feedback.</p> <p>Methadone advocates can also speak in favour of OST supporting the general public to understand and appreciate the value of OST.</p>
Anti-Retroviral Therapy (ART)	<p>Available through general HIV services.</p> <p>Challenges of sustaining engagement in ART given limited access to OST. ART services not targeted at PWUD.</p>	As per UN Guidelines, delivery needs to be “drug-user specific.” ¹⁸⁶ Since it is not specifically the case, a review needs to be done on the effectiveness of ART for PWUD, specifically regarding the access and retention to ART.
Naloxone	No access	There needs to be further clarity to understand barrier to implementation – cost, essential medicine, political will – and a concerted effort to address the lack of access.



Drug Policy Environment

Central focus = zero tolerance

The Lei 3/97¹⁸⁷ makes the possession of drugs illegal. However, there is a draft bill¹⁸⁸ that, if enacted, would allow for cultivation of cannabis for medical/scientific purposes, and allow decriminalisation of a small amount of drugs for personal use.

Overarching drug policy

Harm reduction activities remain illegal so it is not possible to run Needle and Syringe Programme due to the fact that paraphernalia is illegal under Article 44 of Lei 3/97, thus limiting harm reduction outreach and peer education. This is despite the fact that 46.3% of people who inject drugs in Mozambique are estimated to be living with HIV and 67.1% of PWID living with HCV.¹⁸⁹ However, UNIDOS recently reported having developed a small scale pilot Needle and syringe programme in Maputo, project that was launched after the country visit of the Coact Consultant.

Drug laws

People who use drugs experience extreme levels of criminalisation, particularly in the high intensity drug using area called Mafalala. Possession of injecting equipment is a criminal offence and People who use drugs face systematic repression and corruption from the police. The drug dens are regularly raided by the police even though they operate in a defined geographic area in houses, clubs and yards behind closed gates away from public attention. These police actions and the lack of harm reduction services fail to realise the potential of using the community networks in Mafalala to promote safer drug use, access to harm reduction commodities and self-support systems.

Social welfare

Welfare support in Mozambique is very limited according to local partners.

Security and governance

The criminalisation of PWUD, the legal barriers to the distribution of harm reduction commodities and the corruption of the police create conditions that severely disadvantage PWUD. People who use drugs are punished as criminals and provided with little or no support. PWUD in Mozambique feel disregarded and persecuted by their Government in the midst of HIV and HCV epidemics that are unfolding unchecked. As reported by the IBBS (Integrated Behavioural and Biological Survey) among PWID in Mozambique, "The low capability to provide specialized services for PWID also results from the lack of information regarding their general health, like risk of coinfection by HBV and HCV. Approximately 65.3% of PWID in Maputo and 47.9% in Nampula/Nacala claimed they had never heard about hepatitis B and hepatitis C before (the IBBS) survey. This demonstrates a serious lack in the diagnosis and treatment of people who use drugs in Mozambique".¹⁹⁰

Development

As previously stated, Mozambique is experiencing serious HIV and HCV epidemics among people who inject drugs. These have the potential to place a health burden on the country by jeopardizing the national HIV/Aids response, despite the fact that the country has made remarkable progress against HIV, tuberculosis and malaria in the last decade according to the Global Fund.¹⁹¹ As it is the case at global level, HIV rates are growing within the PWID community.¹⁹² Mozambique already has a high prevalence rate estimated at 12.5% in the general population,¹⁹³ and if Harm Reduction services are not implemented, the national prevalence rate is likely to be impacted even more. The country has just acquired 6 Global Fund Grants.¹⁹⁴ However, according to local partners, the grants go to big/international NGOs, and it is difficult for the funding to cascade down to local NGOs. UNIDOS has reported that criteria for accessing grants were too high. However, they are hoping to be a sub-recipient in a Global Fund grant soon to provide Harm Reduction services to PWID, with a national NGO (FDC) as principal recipient. Médecins Sans Frontières (MSF) has initiated a programme supporting access to HIV testing and treatment in the capital Maputo.¹⁹⁵

Human rights

Human Rights are recognized by the Government,¹⁹⁶ but from the current drug legislation, PWUD are criminalized. Thus, the blunt criminalisation of PWUD creates a context within which the police are able to violate the rights of PWUD and to extort their money. (It is to be noted that UNIDOS has done advocacy work with the authorities, and as such a Memorandum of Understanding (MoU) on Human Rights (among other things) for PWUD is to be signed in April 2019).

The re-routing of drug trafficking routes via the ports of East and Southern Africa¹⁹⁷ is also bringing high quality heroin and cocaine to the country which is a new driver for the HIV epidemic.

The circumstances for people who inject drugs and those dependent on opioids in Mozambique are exposed, harsh and unsupported. Participants highlighted the vulnerability of using drugs in a context with a zero-tolerance policing approach, high levels of police corruption, and no harm reduction or drug treatment services.

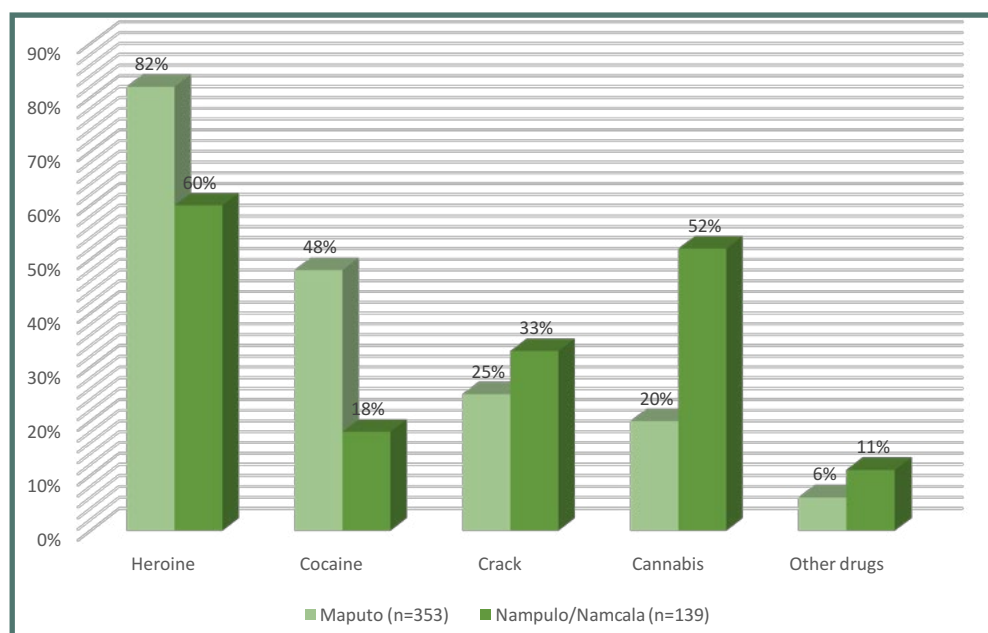


“We (people who use drugs) are treated as outsiders. If we are stopped by the police they take our money, drugs, mobile phones and other possessions. If we don’t have anything for the police to take, then they beat and imprison us.”

PWUD in Maputo have access to heroin number 4 (China White), cocaine powder, crack cocaine and cannabis. The drugs are of high quality but the dose in a normal packet of heroin is relatively small. The crack cocaine is good quality as it is washed up in a solution and not produced in a microwave. This avoids the sodium by-product created from the bicarbonate of soda during the conversion process which binds with the crack and bulks up the product.

The drugs available at the time of the country visit was in line with the IBBS report on PWID¹⁹⁸ as reflected in the graph on next page.

Figure 1: Drugs used by PWID, Mozambique (Maputo/Nampula) 2014



Categories of drugs listed are not mutually exclusive. Other drugs mentioned by PWUD include cocktail, Rohypnol®, ecstasy, inhalants and tranquilisers.

PWID reported the effects of multiple re-uses of a needle including barbed needles catching as they are withdrawn, having to press blunt needles against the skin with force until it pops through, and needles needing to be straightened before being re-used. Given the pattern of extensively re-using needles, PWID experience injecting related injuries. Heroin number 4 dissolves in water with only gentle warming of the water avoiding the damage of injecting heroin cooked up with an acidifier. PWID understand the risks they are taking but do not have the resources to apply harm reduction strategies.

Participants report knowing friends who have overdosed and survived and many had lost friends to opiate overdoses. Naloxone is not available and not known among local PWID. PWID apply myths such as injecting their friends with saline solution when they overdose or hitting or hurting people to try and bring them round. This highlights the instinct among PWID to rescue their friends but also the need for education.

PWID are well informed about the risks of sharing and the harms arising from re-using needles. However, they do not have the harm reduction commodities to implement safer injecting strategies. The Coact Consultant explained the USA history of promoting the cleaning of injecting equipment with bleach and water while Needle and Syringe Programme remained criminalised. The option of promoting 'bleach and teach' to PWID by distributing bleach tablets, which can be easily and safely, was discussed.

It is however to be noted that in October 2018, few months after the focus group discussions, UNIDOS launched a pilot programme where they provide clean needles and syringes in Maputo. They are now hoping to launch same in Mafalala in collaboration with MSF and FHI. This information has been obtained through discussions from UNIDOS National Coordinator.

Injecting drug use is not the dominant route of taking drugs in Mozambique. People inject heroin and some inject cocaine. Many others take a cocktail of drugs – usually heroin, cannabis and tobacco – in a joint while others smoke heroin on silver foil. Heroin number 4 is water soluble and therefore suitable for injection or snorting but it requires the heat created at the tip of a joint to become a vapour. Smoking on silver foil is very inefficient. Crack tends to be smoked in a homemade pipe made from a steel tube with a stainless-steel gauze or scrubber used to suspend the drug. This avoids the harms associated with the

type of pipes that use cigarette ash as a suspending agency (risking 'black lung') but the stainless steel gauze needs to be properly prepared to avoid pieces of hot metal being inhaled, burning the lips, mouth or even lungs.

People who use drugs buy and use their drugs in venues which are people's homes or the yards outside their homes or clubs or bars. These venues are well managed and have organised security. Small to large groups of People who use drugs congregate together. Different venues target different populations of People who use drugs. Some of the venues are enclosed spaces, which creates the conditions for the transmission of TB.

UNIDOS and their peer workers have good access to the drug using venues and are trusted by the People who use drugs, drug suppliers, venue security and peer leaders. The venues provide good access to PWUD that would allow for dynamic peer education. The injecting venues would be good sites for secondary needle and syringe programmes. UNIDOS' access to the drug using venues offers key opportunities to prevent HIV, promote harm reduction and mobilise PWUD.

Mafalala is both a high intensity drug using area and a location associated with criminality. The People who use drugs highlight the interwoven nature of the local community. Close to Mafalala is an open market called Estrela where people sell excess personal possessions, commercial products and stolen goods. The participants highlighted how the general community benefits from the savings from this semi-legal market while condemning PWUD for their criminality.

The police target Mafalala as a location known for its association with criminality and the sale and use of drugs. The police raid the drug using venues either late at night or in the early hours. They also use drugs as a reason to stop and search people in the street. Community leaders highlighted the abusive and hostile approach of the police to People who use drugs and their failure to address public health issues or to recognise that their actions compound the risks faced by PWUD.

Some People who use drugs described working to raise money through odd jobs for their family or the local community, by securing tips as street parking wardens, selling possessions, and other hustles to raise money without committing crime.



"My family will pay me to wash their cars, it's a way of supporting me and helping me avoid the problems involved in criminality. I also don't want to hurt my neighbours."


"I work as a tutor. I used to be a teacher but I can't sustain this role while being addicted to heroin. Tutoring is a way of earning money and using my skills."

Other people were rejected by their families and left unsupported.



"My family has nothing to do with me. They kicked me out. They are ashamed of me."

Others wanted to work but could not access employment due to stigma and discrimination and the lack of opioid substitution therapy (OST).




“There are no jobs and no-one employs addicts. So women end up selling sex and men commit crime.”

“People end up selling drugs because there is no alternative. How are we meant to live?”

Drug treatment is also highly under-developed. However, as of March 2019, UNIDOS were discussing the modalities of importing methadone in the country with government stakeholders, and while it yet available there is movement towards this in the future.

For now, the only treatment option is a Christian based residential rehabilitation service. This programme provides no pharmacotherapies to help people detoxify and the therapeutic programme is based on bible study and being kept away from the drug scene. Participants argued that the rehab does not comply with the evidence-base or human rights standards. According to UN publication, “Opioid dependence (is) a complex health condition that often requires long-term treatment and care(...). Drug dependence treatment is an important strategy to improve well-being and social functioning of people with opioid dependence and to reduce its health and social consequences, including HIV infection.” Opiate dependence treatment include (but is not limited to) methadone and buprenorphine.¹⁹⁹


Even knowing that the rehab does not comply with evidence-based standards, some People who use drugs had admitted themselves on more than one occasion as they have no other options. Local People who use drugs highlighted their desire to access much needed services that are not currently available in country.



“I used Methadone in South Africa. It is a very effective treatment. It is very sad that it is not available in Mozambique. It is tough living the life as an addict here!”

“The Christian rehabilitation centre is a work camp. There is no Methadone, no therapy and no help to change. You just stay there for months, working for them, being preached at and in the end you have to go back to the real world. I went there several times in desperation but it doesn't help.”

Once again women face particular vulnerabilities. They face sexual violence and exploitation from male People who use drugs and the general public. They are also vulnerable to sexual exploitation by the police on arrest as People who use drugs or sex workers.



“Women risk being raped and violated by two or three other people.”

“I saw a woman who was detained in a neighbouring cell being gang raped by police officers after she was arrested on a drugs charge.”

Harm Reduction Interventions

There is an urgent need to invest in the development of harm reduction services to respond to the escalating HIV and HCV epidemics among PWID. UNIDOS is being reactivated as a harm reduction service with the support of key international partners including ARASA and Frontline AIDS (working name of the International HIV/AIDS Alliance). The priority need is to advocate for the accessibility of funds (like those that have been recently made available to the country through Global Fund) to cascade down to local NGOs, as well as capacity building for CSO working to provide services for PWUD, including PWID, so that they can have access to available funds.

Non-injecting People who use drugs in Mozambique also encounter severe rights violations and face their own specific public health challenges without access to harm reduction information or services. They operate through the same or parallel drug using venues as PWID.

MSF also has an initiative in Maputo providing HIV testing and ARV treatment. The MSF programme also has peer workers and are interested in contributing to the development of community mobilisation with PWUD.

Two community leaders from Mafalala also attended the event. This reflected UNIDOS' engagement with the wider community in preparing for their harm reduction activities. The two community leaders were not People who use drugs but their willingness to attend the event is likely to indicate their sympathies. However, their understanding and compassion was still noteworthy. They were shocked witnessing the police violence and lack of compassion. They felt the police should look after, not persecute people who use drugs.



"I saw a drug user collapsed on the ground. The police just walked by them and ignored their plight. The police should look after all citizens."

"We live in this area. The People who use drugs are the sons and daughters of our community. The police should help address our community's problems not make them worse."

Core UN Recommended HIV Prevention Interventions for People who Inject Drugs

Intervention	Summary for Mozambique	Advocacy / Development Issue
Needle and Syringe Programme	<p>Needle and Syringe Programme is not available on a large scale in Mozambique despite high HIV and HCV rates among PWID. PWID report re-using injecting equipment for 15 – 20 times before selling them on. PWID also report renting injecting equipment to use in drug using dens.</p> <p>However, UNIDOS has launched a recent pilot project in Maputo, where they have a small NSP pilot component among other health services. They are now planning to launch a similar pilot project in Mafalala with MSF and FHI.</p>	<p>Advocacy is required to challenge the legal barriers to Needle and Syringe Programme and the carrying of injecting equipment by PWID, so that Needle and Syringe programmes can be up scaled and provided within a legal framework.</p> <p>Route transition interventions²⁰⁰ are required to support the practices of smoking heroin on silver foil or using cocktail joints of cannabis, tobacco and heroin to reinforce those using by non-injecting routes of administration. This will be an important counterbalance to the introduction of Needle and Syringe Programme.</p> <p>Safer cleaning strategies (bleach and teach) could be promoted as an interim strategy for supporting safer injecting. The distribution of bleach tablets and education about recommended cleaning practices would empower PWID to manage the risks of re-using and sharing before the introduction of Needle and Syringe Programme at a large scale. This would also provide a low threshold entry point to harm reduction with the Government and general public which could provide a stepping stone to Needle and Syringe Programme legal framework and upscaling.</p> <p>Advocates should highlight the ability of PWID to deliver secondary needle and syringe programmes to help cascade access to harm reduction commodities through drug supply and drug using settings. The role of peers to deliver injecting equipment and peer education into illicit peer networks should be established as part of the advocacy for Needle and Syringe Programme legal framework and upscaling.</p>
Voluntary HIV Counselling and Testing	<p>Available through MSF and health clinics.</p> <p>According to UNIDOS, there is stigma and discrimination within public health facilities.</p> <p>UNIDOS offers provision of TB, HBV and HCV as well as HIV/Aids follow-up through a pilot project in Maputo. They are now planning to launch a similar pilot project in Mafalala with MSF and FHI.</p>	<p>Advocacy to promote access to funds to CSO for them to provide health services including Harm Reduction in an enabling environment.</p>
Opioid Substitution Therapy (OST)	<p>Not available. OST has recently been approved by the authorities who are now discussing the modalities around its purchase and distribution to the community.</p>	<p>Advocacy to promote access to OST for it to be available in a user-friendly method.</p> <p>Testimony from those with experience of OST from South Africa will help in the advocacy.</p> <p>Advocacy to support PWUD to access HIV treatment and to manage treatment compliance without the support of OST that is not yet available.</p>
Anti-Retroviral Therapy (ART)	<p>Available through MSF internationally funded programme.</p> <p>In Maputo, MSF provide care for HIV patients who need second- or third-line ARV and treatment for co-infections such as Kaposi's sarcoma, drug-resistant TB and hepatitis. MSF also work with community treatment groups in Tete, and they are working to improve diagnosis, treatment and continuity of care in Maputo and Beira.²⁰¹</p>	<p>There needs to be further clarity to understand barrier to implementation – cost, essential medicine, political will – and a concerted effort to address the lack of access.</p>
Naloxone	Not available.	



Drug Policy Environment

Overarching drug policy

Central focus = zero tolerance

Harm reduction and drug law reform under discussion and potential funding for harm reduction services in Harare under discussion as well, though it is unclear as of now who will be funding these. The drugs mostly used are cannabis, village illicit alcohol, codeine-based cough medicines and pharmaceuticals such as Valium. Drug use is strongly linked with the country's economic crisis and 95% unemployment rate as the economic situation has led people into the drug trade.²⁰² The police are deeply complicit in the drug trade and also extort money and sexual favours from PWUD. Drug use is also mixed up in Zimbabwe's complex and volatile political situation. The complex political situation has led to an economy that has not been performing well for over two decades, and one of the results of this situation is that a lot of people are unemployed, and have turned to drug use to cope with the situation.²⁰³

Drug laws

According to ZCLDN, Zimbabwe does not provide welfare support to people who are unemployed or chronically unwell and does not have specialist welfare support for PWUD. Zimbabwe does not have specific medical facilities for PWUD. It has central hospitals for mental health services and detox, but no Harm Reduction services.

Social welfare

Zimbabwe's longstanding President Mugabe has been removed from office after 37 years. Young people in particular are now looking for economic and political reform. The country has been struggling with hyperinflation, 95% unemployment,²⁰⁴ a failing economy and international sanctions. The change of President offers the chance for change but many fear "new captain same boat". The death of the senior opposition figure Morgan Tsvangirai has left the opposition divided and lacking much needed leadership at a critical moment. The one positive feature of the security situation is Zimbabwe's strong gun controls,²⁰⁵ which, according to the discussions held with PWUD, has prevented the country from falling into civil war and political violence that have undermined other African countries. The Zimbabwe Firearms Act is restrictive in terms of gun control.²⁰⁶

Security and governance

Zimbabwe is facing an economic and political crisis after more than 30 years of President Mugabe's leadership. The country has faced international sanctions,²⁰⁷ economic stagnation and hyperinflation.²⁰⁸ The high rates of unemployment and poverty drive problematic substance use. Moreover, access to different ranges of drugs is limited to the most wealthy or well-connected People who use drugs. The collapse of the Zimbabwe currency makes the country reliant on the expensive USD (though the country has recently introduced its own currency, the RTGS (Real Time Gross Settlement) dollar).²⁰⁹ Thus, the drugs used are those that can be grown in country or purchased through local pharmacies. The limited prevalence of injecting means that Zimbabwe does not attract international HIV funding. The country's drug problems are interwoven with the country's economic crisis as are the solutions.

Development

Human rights violations against PWUD in Zimbabwe are not acknowledged or strategically responded to. The Zimbabwe Civil Liberties and Drugs Network (ZCLDN) has been lobbying politicians in favour of harm reduction and drug law reform. The low prevalence of injecting means that Zimbabwe has not benefited from HIV planning highlighting the human rights of PWUD. The links between drug trafficking and/or dealing and the political and policing system undermines good governance and human rights as shown in the discussions further down. As a land locked country, Zimbabwe does not benefit from the re-routing of drug trafficking routes via the ports of East and Southern Africa.

Rastafarians and traditional healers use cannabis as a spiritual aid and medicine.²¹⁰


As mentioned previously, Zimbabwe's drug laws are based strongly on zero tolerance. However, there is a substantial difference between the theory and practice of the drug laws. In reality the police are complicit in the drugs trade and their management of the drug laws is designed to ensure that the police maximise their potential profits from controlling the drugs trade.



"The laws we have are suppressive laws. The most people who benefit from drugs are the cops. They catch people using and selling drugs so they can get bribes or profit from re-selling the drugs."

"The police are corrupt. They are a cartel."


The overriding challenge for most respondents is the high rates of unemployment. This creates a sense of hopelessness and drug and alcohol use provide a relief from these negative feelings:



"We study hard to ready ourselves for the world of work. However, when we graduate we find there are no jobs. This makes us hopeless and many turn to drugs and alcohol in despair."

As such, the country's economic and political crisis is deeply mixed up in the country's problems with substance use. The use of drugs and village alcohol exposes marginalised people to police harassment and corruption, which increases their sense of exclusion and hopelessness. Breaking free from drug and village alcohol use can remove the substance user from this exposure but on becoming drug free, people are still left with nothing to do and no opportunities. A number of respondents described going to University to study as a journalist or learning a trade such as hairdressing but not being able to make use of this education or training. The current belief that education and hard work provide a pathway out of poverty and marginalisation does not apply in Zimbabwe.

Against this backdrop of restricted employment opportunities, selling drugs, cultivating cannabis and producing illicit alcohol all provide ways of earning an income. Drug suppliers can be found on many street corners in the high-density suburbs. At the same time participants noted that many of the sports and other youth services have been closed and the buildings stand empty



"In Farcose you can walk from area to area and see closed youth services and sports facilities. They once offered opportunities and activities for our young people. Now they have nothing."

This means youth have no alternative to alcohol and drugs. They have no positive focus in their lives and no access to diversionary activities.

Some people use codeine-based cough medicine (Bronclear), which is codeine suspended in strong medicinal alcohol. A bottle of Bronclear costs approximately \$4 and it can be used by 3 to 4 people who often mix it with village alcohol. Some heavy users of Bronclear may use 4 bottles on their own. Peers report becoming very sedated, out of control and experience short-term memory loss when using Bronclear, particularly when mixing it with village alcohol. When Bronclear is used in conjunction with village alcohol and cannabis, peers can become very 'out of it'. People who use drugs report being vulnerable to exploitation in this state whether from other People who use drugs or law enforcement officials.

People gather together in groups in secluded areas to drink alcohol, smoke cannabis and in some case drink codeine-based cough medicine. People who use village alcohol can become very drunk, loud and argumentative. This can create conflict with other local people and draw the attention of the police.

People who use drugs (PWUD) frequently describe their drug use in terms of disease, recovery and religious redemption. This is a familiar theme in a region where religious belief helps set the cultural and ethical values and faith and/or missionary style work is part of the motivation of some of the people stepping up to help PWUD.²¹¹ At times, relatively low level or recreational drug use is described in terms of addiction, but on further exploration many participants acknowledged ambivalent views of drug use or even admitted their enjoyment of drugs.

Those selling drugs have a 'big brother' in the police service who provides protection for their drug supply operation or their illegal drinking establishment. These corrupt police officers take a cut from suppliers to protect their business. Larger bribes are required to pay off the police if a cannabis cultivation site, drug supply or illicit drinking establishment is identified that has not paid off a big brother.



"The 'big brother' watches over you while you do your business (selling drugs) and the drug peddler pays a bribe so their business is protected and they are safe."


If the police catch suppliers or People who use drugs with drugs, the evidence-log will often show a lesser amount than the person was caught with. This benefits the drug user as they will be prosecuted for a lesser amount and the police will resell the drugs back through their protected supplier.



"The police take drugs from us and they give them to their drug peddler so they can sell the confiscated drugs."


"When you go to court the evidence log often shows a lesser amount of drugs. You do not complain because you get a lower sentence. BUT we also know what the police have done with these missing drugs!"

Only a minority of people caught with drugs will go to court. The majority will pay a bribe and have their case resolved outside the formal legal system. Some police even have mock receipt books for fines to make the process look official.




“The police have official looking receipt books so the payment of bribes looks official but really the money goes into the police officer’s pocket.”

The protection provided by the ‘big brother’ police officer also extends to their customers. One participant who is a cannabis users described an incident when she was arrested after buying some cannabis from her regular supplier:



“The big brother was not working that day, so my cannabis dealer was arrested by a different cop. I was taken to the police station and put in the cell. But then my supplier came and argued with the big brother explaining that I was a regular customer and that arresting regular customers was bad for business. The big brother intervened to protect me as the customer of the supplier he was protecting, and I was released.”

Women who use drugs face additional vulnerabilities given the hostile policing of drug use. Respondents reported being asked to have sex with a police officer in exchange for a drugs charge being dropped. Others knew of women who had been pressured to have sex after being caught in possession of drugs. One young women drug user explained a typical experience for women who use drugs:



“I had taken Bronclear and I went to a bar with my friends. It was OK to take drugs in this bar as long as the police do not catch you. I shared some marijuana with my friends and I only had a tiny amount left. The Narcotics CID arrested me and took me to the police station. I was asked to pay a bribe but I explained I had no money so I was kept in the cells overnight. The next morning the new shift police officer came to my cell and asked me for a \$20 bribe. Once again I explained that I had no money. The police officer proposed that I give him ‘love’ instead. He agreed a place for us to meet after his shift and I agreed to meet him and provide him with ‘love’ for my release. I gave him false information and got away but other women are not so lucky.”

“The police take advantage of women who use drugs.”

Sex workers have seen some meaningful improvement in their lives when a court order improved safety for them in the absence of decriminalisation.²¹² This provide a valuable precedent for reforming the legal environment to support HIV prevention with another key population. Many sex workers also use drugs and this intersection needs to be considered to address compounding HIV risks.

Nearly 25% of Zimbabwe's citizens work abroad, mostly in South Africa. A number of migrant workers have used a range of other drugs including cocaine, crack, heroin, ecstasy and methamphetamine while in South Africa. This varied from recreational to problematic drug use.

Zimbabwe was also preparing for new Presidential elections when the focus group was held. Participants reported the exploitation of drug and alcohol use by political candidates and their agents. One respondent had been an agent working for a Member of Parliament, so was able to describe the process from the inside, which was confirmed by other participants who had been on the receiving end of the political inducements. Different political activists would approach groups of people congregating together. Those using drugs or alcohol would be offered their preferred substances as inducements to attend political rallies and to vote in elections. This would also be accompanied with promises of future employment if the politician is elected. However, cronyism ensures that jobs go to the family and friends of the politician so the inducements are false. This creates a general cynicism about the political process and politicians:



“Political agents buy alcohol and Bronclear for people on the street to encourage them to attend rallies and to vote for the right candidate. This ensures that people fight among themselves and don't challenge the politicians. No-one has faith in the political process.”

Some of the People who use drugs were politically engaged and had attended a recent opposition rally but reported being frustrated and disillusioned by the in-fighting.

Around the period of elections, the police back off from raiding bars or drug using venues for fear of alienating potential voters. This was highlighted as another example of the corruption and collusion surrounding drug use.



“The police are not sent to raid illegal drinking dens or ‘shebeen’ (illegal drug dens) because they want the votes of the people using these establishments.”

Elections provide a potential flash point for violence, which is incited by political agents. However, gun control in Zimbabwe is very strong unlike other African countries. This has protected the country from the type of political violence and civil war that has blighted other countries in the region:



“In terms of security we have the best in Southern Africa because guns are very strictly controlled. However, the Government is not democratic. We live in a dictatorship. In the run up to elections we are promised jobs, money and change but, in reality, only the close friends and family benefit after the election of a politician. Corruption and cronyism is a blight on our country.”

People who use cannabis, Bronclear or street alcohol find it difficult to seek help from health clinics. If they approach these services for help the clinic staff will first ask if they have reported themselves to the police for their criminal behaviour.



“I was asked to first hand myself into the police station. If I could show I had been punished then I would be treated. This means we cannot access healthcare for problems with drugs and alcohol.”

In terms of development opportunities, participants discussed the potential for Zimbabwe to bring in much needed foreign currency by legalising the production of cannabis. This is potentially a significant cash crop that could be exported. Zimbabwe has already amended the law for the production of medical cannabis, namely the section 6 of the Dangerous Drugs Act,²¹³ through the Dangerous Drugs (Production of Cannabis for Medical and Scientific use) Regulations 2018²¹⁴ to allow Zimbabwe citizens/residents or companies managed by same to grow cannabis. The country is expecting to make substantial profits out of it.

Harm Reduction Interventions

Core UN Recommended HIV Prevention Interventions for People who Inject Drugs

Intervention	Summary for Zimbabwe	Advocacy / Development Issue
Needle and Syringe Programme	Needle and Syringe Programme is not available in country and this is not a priority given the absence of widespread injecting.	Monitor levels of injecting drug use by PWUD led organisations.
Voluntary HIV Counselling and Testing	Available through community health clinics	Test uptake and accessibility of HIV testing services to PWUD.
Opioid Substitution Therapy (OST)	There is no provision of OST in Zimbabwe. Wealthy People who use drugs can travel to South Africa to access private treatment.	It is not clear how many of codeine cough medicine users are physically dependent on opioids and using the drug every day. This would be something to test in a community consultation. This would inform whether there is a need for opioid maintenance or detoxification services using OST. If people are dependent on codeine based cough medicines, low dose opioids such as dihydrocodeine, buprenorphine or even opium tincture might be suitable pharmacotherapy treatment options.
Anti-Retroviral Therapy (ART)	ART available through municipal clinics but no specialist provision for PWUD	Test uptake and accessibility of HIV treatment services to PWUD
Naloxone	Naloxone not available or known about. Opioid overdose is not a major issue given the oral use of the relatively lower strength codeine.	Test are needed to understand if overdose is an issue in community consultations. Consider status of Naloxone in Zimbabwe and identify legal barriers to introducing this intervention if need is identified.



Drug Policy Environment

Overarching drug policy

Central focus = zero tolerance
Approach to drug use very limited and based on drugs prevention and criminal sanctions. Drug possession is criminalised according to the Dangerous Drugs Act.²¹⁵

Drug laws

Malawi is one of the poorest countries in Africa.²¹⁶ This means that there is no incentive for international traffickers to take the risk of smuggling large amounts of drugs into Malawi. As such the main drugs being used are cannabis and village alcohol. There are reports of injecting heroin use in the North of Malawi close to Tanzania, reflecting the seepage of Tanzania's drug trend across the border. Individual People who use drugs may bring drugs for personal use back to Malawi from South Africa or other countries and these cases sometimes come to the attention of human rights defenders, but these cases remain exceptional. The police take bribes to overlook the cultivation, sale or use of cannabis or the production, sale and use of village alcohol. They can also be bribed when People who use drugs are caught in possession of drugs.

Social welfare

Malawi does not provide welfare support to people who are unemployed or chronically unwell and does not have specialist welfare support for PWUD. The social welfare is coordinated through the Social-welfare department of Malawi through various policies.²¹⁷

Security and governance

The country is on a journey of political and economic reform. The country lived under a dictatorship for President Kamuzu Banda led Malawi to independence in 1964 until he was ousted in 1994 in the country's first democratic elections.²¹⁸ The new Government has seen improved democracy, stronger civil society but government institutions need further strengthening. The political environment is improved but the country faces a substantial development agenda.²¹⁹

Development

The country has suffered from droughts over the last few years, which also undermines the country's hydroelectricity system and industry.²²⁰ Malawi is investing in electrifying the country and reducing its reliance on coffee and tea as international cash crops and maize as the staple diet.²²¹ Cannabis legalisation has been discussed, given the potential to create a new cash crop that could attract international currency.²²²

Human rights

PWUD are vulnerable to being targeted by the police for bribes. The Rastafarian Church and community members are involved in the use and sale of cannabis. They use it as part of the religious practices. They are experienced at managing the police when they interfere in their commercial activities. Traditional healers also use and recommend cannabis as a medicine.

Malawi is one of the poorest countries in Africa, and it is land locked. As such, there is no commercial incentive for international smugglers to take the risk of trafficking drugs into the country. Therefore, for the majority, the only substances available are those that can be grown or produced in country – cannabis or village alcohol.

Wealthy People who use drugs do bring drugs back from South Africa or other third party countries. Occasionally people are caught crossing borders when transporting drugs through the country or into the country for personal use. The consequences is that they are tried, sentenced and jailed in Malawi under the Dangerous Drugs Act of Malawi. A lawyer present described providing legal assistance to someone caught with cocaine while transiting through Malawi.

Participants described their drug use in terms of addiction, disease and religious redemption. The health risks, social consequences and patterns of dependency that participants attributed to cannabis would have surprised many drug specialists. The range of effects and personal consequences would not have been unexpected if interviewing heroin, crack or methamphetamine users. This highlights the challenges of breaking past the dominant ideology and stereotypes surrounding drugs. Self-empowerment and separating myths from facts is an important part of community mobilisation and harm reduction. It was clear that at the start participants conflated community mobilisation with people who use drugs with drugs prevention. Peer education was seen as a strategy to persuade people to avoid or stop using drugs.

Professor John Booth-Davies' research into his students' engagement with studies into their use of drugs, showed that the students spontaneously adjusted their answers to match the perceived values of the researcher.²²³ Challenging prohibition as a drug user starts with questioning one's own engagement with drugs and equipping oneself to make informed choices. When invited and paid an incentive to take part in a meeting with professionals, it is easy for People who use drugs to believe that they have to conform to expected roles and beliefs. They also may not have the language or frameworks to describe the nuances of a rights compliant and evidence-based approach to drug policy and practice.

There was substantial confusion about the risks and benefits of using cannabis. The risks of cannabis are relatively low and needed clarification. It was clear that here is a body of knowledge about the risks and safer use of cannabis that is not widely known among People who use drugs in Malawi. The challenge will be introducing a peer education programme that challenges established beliefs. Asserting the rights of people who use cannabis and challenging myths that inflate or falsify the risks of cannabis brings with it challenges for the peer educators and the supporting NGO partners.

Cannabis is recognised to have a number of medicinal benefits, and as such, the World Health Organisation's Expert Committee on Drug Dependence (ECDD) has recommended the reclassification of Cannabis under the UN drug treaties, and this is seen as an overdue acknowledgement of the medical usefulness of cannabis by drug policy experts.²²⁴ One active cannabis user described how cannabis helped him to be calm and have balance. He felt irritable when he did not have cannabis. When he used village alcohol he reported becoming loud and aggressive, the very opposite to the effects of cannabis. He positively defended his cannabis use while acknowledging the costs and risks of being a cannabis user in Malawi.



“Cannabis helps me relax and be calm. Without cannabis I am restless and can become agitated. I am more comfortable and balanced when using cannabis. I do not see it as a problem. Alcohol just makes me more aggressive and loud. I prefer cannabis even if it is against the law.”

Cannabis is also used by members of the Rastafarian Church as part of their spiritual practice. Traditional healers also promote cannabis as a natural remedy. Both groups have a set of cultural and religious rules and rituals that help them embrace the medicinal values of cannabis while holding off the negative dominant ideology.



“Rastafarians understand how to use and sell cannabis and to manage the police. They can be arrested in the morning and will be back in operation by the afternoon.”

In light of this context, peer participants were supported to identify strategies for reaching people who use cannabis with peer education messages through a narrowcast advertising model. The professional partners undertook a risk assessment exercise to consider the challenges of promoting cannabis harm reduction and peer education within the current country context.

It is to be noted that after the Coact consultant talked openly about his personal experience with drugs, participants became more opened. This was helped by professional partners coming to a consensus that it was important to love and respect people who use drugs regardless of their personal choices around using or abstaining from cannabis or village alcohol.

Furthermore, the drug using participants talked differently about their use of drugs in formal sessions and on the side lines of the meeting. For example, the Coact Consultant showed pictures of high quality cannabis being grown in Southern Europe, which is the Coact Consultant's source of medicinal grade cannabis. There was great deal of interest and peer appreciation from the People who use drugs who had previously described drugs in such negative terms. One of the values of peer facilitation is that people who use drugs can review and reflect on the dominant ideology and develop their own views and values about drug use and being a drug user. This is also part of the power of peer education, as community members can use their privileged access and peer insights to talk about health and rights challenges in a balanced way so the target audience do not dismiss their advice as more anti-drugs propaganda. The exploration of this process helped professional colleagues and peers develop their partnership approach and mutual understanding.

The focus group discussions was thus a means of sharing, both for the consultant and the participants. However, people who use drugs might not have felt comfortable to talk openly about their drug use in front of the professional partners, which would explain their openness on the side lines of the meeting, thus showing the limitations of the focus groups discussions model for some aspects of the discussions.

There are reports of injecting drug use being identified during research conducted in the North of Malawi on the border with Tanzania. The Global State of Harm Reduction also mentions injecting drug use in Malawi.²²⁵ The development of harm reduction and drug law reform experience and capacity on a cannabis focussed project will help build expertise that can be applied at a later point once the issues in the North have been further explored. The proposed approach of using a community consultation to assess the needs of cannabis users and to mobilise them as members provides a development process that can be applied with different groups of PWUD.

Harm Reduction Interventions

Core UN Recommended HIV Prevention Interventions for People who Inject Drugs

Intervention	Summary for Malawi	Advocacy / Development Issue
Needle and Syringe Programme	Needle and Syringe Programme not available and not required given the absence of injecting other than on the border with Tanzania.	The pattern of injecting in the North of the country should be reviewed and monitored. Connections could be made with Tanzanian partners to help draw on their expertise in developing a response in the border area.
Voluntary HIV Counselling and Testing	Available through community health centres. PWUD can face stigma and discrimination when accessing health services. It sometimes depend on the medical professional.	Monitor stigma and discrimination in health care settings
Opioid Substitution Therapy (OST)	OST not available and no demand given absence of opioid dependency.	OST not available and no demand given absence of opioid dependency.
Anti-Retroviral Therapy (ART)	Available through general medical services. PWUD can face stigma and discrimination when health accessing services. It sometimes depend on the medical professional.	Monitor stigma and discrimination in health care settings.
Naloxone	Not available.	Monitor of opioid overdose rates in Malawi is needed. The lack of access to Naxolone need.



Picture from work done by CSOs in Malawi supported by ARASA for report (photo credit: WOCACA)



Focus groups and interviews with PWUD in Mauritius were conducted by the Collectif Urgent Toxida (CUT) with the assistance for a local consultant, as opposed to CoAct. The main focus was on the experience of PWUD towards the range and quality of harm reduction services. In light of the long standing harm reduction programme in Mauritius this was considered essential to highlight in addition to the broader scope in the four other countries. Thus the experiences of people who use drugs of drug policy and human rights was not directly covered. However, a summary of the drug policy environment was included to provide some context. The focus group hosted a total of 28 participants, and women made up a third of the group. It lasted two days, with the first dedicated to debates, testimonies and discussions relating to the field of drug use and harm reduction services, while the second was aimed at determining feasible solutions to the issues identified.

Drug Policy Environment

Overarching drug policy

The legal framework of drugs in Mauritius is governed by the Dangerous Drugs Act 2000,²²⁶ making it a criminal offence to produce, cultivate, sell, traffic, possess and consume drugs that are listed in the list of Dangerous Drugs by this Act into different *schedules*.²²⁷

Harm Reduction interventions like Needle and syringe programme and OST have been available since 2006, making Mauritius the first country in Africa to implement these services.

Drug laws

Drug Policy is based on repression, and even if Harm Reduction interventions are available, some of these programmes are still being implemented within a repressive perspective, as attested during the focus group discussions further down. In 2017, 74% of drug related arrests were linked to possession of drugs only.²²⁸

PWUD are also regularly targeted and persecuted by the police, and arrests due to possession of needles and syringes are still happening. As for methadone, it is now being distributed in front of police stations, with police often intervening in case of discontent from methadone users.²²⁹

Social welfare

Mauritius provides free healthcare, education and a basic retirement pension to all its citizens.²³⁰ There are also various other social support schemes, including social aid, medical support and unemployment support, but under specific conditions which hinder their access.²³¹ There is no specific welfare for PWUD, though harm reduction services are provided for free, as part of the free healthcare scheme available to all citizens.

Security and governance

Mauritius is a stable, multiparty, parliamentary democracy. Independence was acquired by the British Government in 1968, and the country became a republic in 1992. General elections take place every five years, based on universal adult suffrage for citizens over the age of 18.²³²

There was no war involved when the country accessed independence, and there has not been any war ever since, apart from riots occurring in 1968²³³ and 1999,²³⁴ none of them lasting more than 10 days, though having a strong racial basis, particularly in 1968.

Mauritius has been classified by some ratings as one of the richest in Africa.²³⁵

The country's economy has made great strides since independence in 1968, and Mauritius is now an upper middle-income economy. Key challenges include tackling inequality, which remains at moderate levels but is increasing, and adapting to the impacts of climate change.²³⁶

However, the disparity between rich and poor is growing, and between 2001 and 2015, the gap between the incomes of the poorest and the richest 10% of households increased by 37%.²³⁷

Development

In terms of drugs dynamic, the country has a specificity as compared to other countries of the region, as opium was available in the country since the early 70's and heroin as from the early 80's,²³⁸ and have thus been around for approximately 40 years now. This has gradually evolved into low quality brown sugar. New Psychoactive substances, namely synthetic cannabinoids have also been very popular these last 5 years, mainly with recent scarcity of cannabis and brown sugar, as reported by the focus group discussion further down.

In 2014, a new Prime Minister has been elected, and has clearly stated that he would launch a war on drug and People who use drugs, and launched a National Commission of Enquiry on drugs.²³⁹ The commission worked for 3 years before submitting its report²⁴⁰ to the Prime Minister.²⁴¹ 3 high level officials from the same Government were accused of drug trafficking and had to resign (including a Minister and the deputy speaker of the National Assembly).²⁴² Since the report revealed that cigarettes available for free on a quota basis to prison inmates were used by them to trade drugs, the Government has prohibited cigarettes in prison. This has given rise to cigarettes trafficking in prison, a pack selling via sexual exchanges, or at 170 USD,²⁴³ whereas the price on the regular market is around 5 USD.²⁴⁴ This is yet another means of putting prison inmates in a vulnerable situation, condoms not being available in prisons. The same Prime Minister (who is not PM anymore, but a 'Minister Mentor'²⁴⁵ in the Government), stated in 2018 that if it was up to him, he would re-instate the death penalty for drug related offences.²⁴⁶

Human rights

Despite the fact that human rights mechanisms like the Human Rights Commission²⁴⁷ and the Equal opportunities Commission²⁴⁸ exist, they do not seem to cater specifically for PWUD, as the latter have been exposing the human rights issues that they are facing in the group discussions, namely around police targeting, arrests for possession of syringes that are distributed by the Ministry of Health (and NGOs like CUT as well), and lack of transparency around methadone distribution.

Harm Reduction interventions

Due to the alarming HIV incidence rate among people who use drugs in the mid-2000's, with 92% in 2005, strong advocacy work was done by civil society, more specifically CUT, and Harm Reduction interventions like OST was made available in 2006 by MOHQL, and CUT started the Needle and Syringe Programme.²⁴⁹ The advent of the Global Fund lead to a considerable upscale of services as from 2010.²⁵⁰ However, considerable work needs to be done to improve the legal environment surrounding those services, in order to reach optimal service intake. Advocacy work around Harm Reduction has been led by NGOs like CUT, but with the recent registration of MauNPUD,²⁵¹ it is expected that PWUD will have a more meaningful engagement in the process.

Core UN Recommended HIV Prevention Interventions for People who Inject Drugs

Intervention	Summary for Mauritius	Advocacy / Development Issue
Needle and Syringe Programme	<p>35 sites managed by the Ministry of Health and Quality of Life, 11 sites managed by the NGO Collectif Urgence Toxida.²⁵²</p> <p>Irregular distribution on some sites.</p> <p>Inadequate quota of syringes distributed by MOHQL caravan.</p> <p>Lack of services in prison settings.</p>	PWUD activists to document and advocate for a more appropriate and user-friendly approach, including more participation of peers in service delivery.
Voluntary HIV Counselling and Testing	<p>Available through MOHQL public health centres, MOHQL Harm Reduction caravan, CUT caravan.</p> <p>Home-based testing and counselling should be up scaled.</p>	Advocacy requires additional capacity building, especially of PWUD activists, to receive training to be able to deliver community testing, including home-based.
Opioid Substitution Therapy (OST)	<p>Available on 42 sites,²⁵³ including in prison.</p> <p>Inconsistency of doses distributed.</p> <p>Dispensing points relocated to police stations within a restrained timeframe.</p> <p>Stigmatisation & discrimination among some members of the medical personnel and the police force present on OST site</p> <p>Application procedures to benefit from OST are tedious and lengthy</p> <p>No take home doses, not even for those who have been on the programme since the beginning (2006).</p> <p>OST users are not encouraged to gradually leave the programme, whereas some would like to move on after more than 10 years.</p>	<p>PWUD activists must monitor closely malpractices on OST sites involving stigma, discrimination, and human rights infringements of OST users on dispensing sites.</p> <p>Use of existing platforms, such as the Global Fund CCM, can be utilised by PWID direct representatives to constantly report on those malpractices.</p> <p>Advocacy is necessary to ensure inclusion of PWUD on national committee to discuss improvements to OST programme.</p>
Anti-Retroviral Therapy (ART)	Available through public hospitals	PWUD to receive capacity building on treatment literacy, so as to support community members who do not wish to attend treatment centres.

Naloxone	Available in hospital, as per Mauritius Essential Drugs List. ²⁵⁴ However it is not available in the community.	It is necessary to further understand barrier to implementation – cost, essential medicine, political will – in order to address the current problem. Furthermore, PWUD to receive training on how to administer Naloxone.
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Drug Scarcity, Quality and Price

The supply of injecting drugs has reached an unprecedented level of scarcity in Mauritius. In Tranquebar (a hotspot in the North of Mauritius), where the drug is known to be very accessible, PWUD of that locality have to go elsewhere to buy drugs. This situation has given rise to drugs of lower quality, which are being laced with unknown substances, to increase the quantity. PWID are aware that the products available contain little to no heroin at all, and are aware that no information is available on the nature of additives used to lace drugs. As a result of the poor quality of heroin, PWID are unable to obtain the usual high per dose, leading to an increase in the frequency of drug intake. Long-time users affirm that while one dose of injection used to be enough for a day, the heroin being sold at present requires repeated consumption throughout the whole day. In order to sustain the required high, PWID use other drugs in addition, like pharmaceuticals and synthetic cannabinoids (SCs), or what is believed to be SC, them being called “synthetics” in Mauritius. SCs being far more available and accessible than brown sugar, seem to be gradually supplanting the latter due to its scarcity. Consequently, PWID tend to develop aggressive behaviour and eventually surrender to the heavily addictive nature of SCs, according to the different testimonies.

The scarcity has led to a drastic increase in the price of injecting drugs. The cost of one dose of brown sugar ranges between 12USD and 30USD, depending on the dealer and market demand at a specific time. More recently, a new injecting drug has made its way on the Mauritian drug scene; commonly known as ‘Bat dan latet’ (Hit in the head). It appears to be of synthetic nature and produces a very strong high comparable to SCs. Sold in powder or in capsule form, it could possibly be a methamphetamine. Users have reported bad trips and feeling sick following injecting use of the drug.

A methadone traffic has been going on in hot spots. Mixed with products like Coffen or Benylin, it is often used in combination with SCs. There are numerous cases whereby PWID had begun to use street methadone way before officially joining the OST programme. Besides, this methadone traffic seems to be prospering due to the complex and lengthy enrolment process to access it through regular channel. Currently, street methadone is available at 15USD a dose, and does not entail the trouble of enrolment procedures.

The Emergence of Synthetic Cannabinoids

SC are readily available in varying classes of potency, quality and price all over the island. SCs usually come in powder form which end-users mix with tobacco to be smoked. However, they are also frequently dissolved in a solvent (thinner, acetone or benzene) to be sprayed on low-quality cannabis (or other types of) leaves before being made available on the market. Solvents employed are known to be carcinogenic. This poses a health hazard to unsuspecting consumers who would rather consume cannabis over SCs.

Cannabis being increasingly repressed and harder to come by in Mauritius, its price has soared over the past few years (between 35USD to 75USD per gram), rendering SCs a more accessible alternative to PWUD (average 15USD per gram). SCs are particularly popular among the younger population, and are customarily smoked by teenagers. In addition, SCs tend to be the first drug to which they are initiated on the streets or among peers. Several speakers have stated witnessing people as young as 10 years of age smoking SCs.

OST users suggest that methadone should be distributed in hospitals rather than in front of police station, while authorities use the argument that this would cause “nuisance” to other hospital patients. In support of this appeal, participants recalled that during the occurrence of cyclone Berguitta in January 2018, methadone was exceptionally and exclusively distributed in hospitals. OST users congregated to hospitals amidst the general crowd to benefit from the OST, in an orderly manner, without attracting attention, and without any incidence. This event acts as practical evidence that OST users are no different from other patients and deserve to benefit from equitable treatment from authorities.

Furthermore relocation of dispensing points to more appropriate venues, such as hospitals, dispensaries and health care centres, would link OST users to healthcare services, such as screening tests pertaining to drug use, ARV as well as medical and psychosocial follow-up.

SCs are extremely potent in terms of high, to such an extent that some types may cause a feeling of dissociation between body and mind. SCs effects vary between happy highs and severe bad trips, including loss of motor and sensory functions. 74 admissions in hospital for treatment due to SC use have been reported, and about 20 deaths from SC overdose over 15 months.²⁵⁵ Regular SC users are more than often unable to withdraw from them due to their addictive properties. In 2016, it was revealed by the Forensic Science Laboratory that the most common molecule contained in SCs found in Mauritius is MDMA-CHMICA. An extremely potent molecule, it has been flagged by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as constituting a serious risk of acute toxicity, and needing a risk assessment.²⁵⁶

Shortcomings in Harm Reduction Services: Opioid Substitution Therapy

There is inconsistency of methadone doses distributed. Users argue that their doses are being

diluted without informing them or the attending physician. This has led to a growing mistrust towards certain members of the healthcare personnel, and participants deplored the fact that methadone doses are no longer prepared with complete transparency (that is, within sight of patients), as the case used to be. In dispensing areas, it is not uncommon for individuals to claim their rights by voicing out that standard doses are not being respected, arguing that doses distributed on a daily basis frequently change colour and taste. The effects of current methadone doses merely last about 3 hours on average. This prompts OST users to resort to injecting drugs and/or other drugs to be able to carry on with their work and activities. Some patients are able to procure more methadone on the black market to compensate for their needs.

Authorities have relocated methadone dispensing points in front of police stations, with a restrained timeframe (6a.m. to 8a.m.), due to “overcrowding at dispensing sites and loitering in the vicinity of dispensing sites.”²⁵⁷ OST users regard this as a barrier, deeming the venue inappropriate, and deeming overcrowding and loitering being a result of inappropriate implementation. The starting time of distribution is often not respected, while the closing hour is strictly enforced. In addition, the imposed timeframe coincides with the work schedules of many OST users, some of whom have lost their jobs as a consequence. Participants disclosed that they suffered from impotency and lack of libido since on OST. This poses a threat to their private and family life with regards to their partners, while negatively impacting on their self-esteem. Understandably, this may act as a deterring factor for PWID to enter the OST programme or pursue their treatment properly. Participants testified that medical staff of the OST team sometimes reject the requests of patients asking to be transferred to other methadone dispensing sites closer to their homes, should they dislike them. Conversely, beneficiaries who get along well with the OST personnel are granted favourable treatment. For instance, they would still be given their methadone doses should they turn up after dispensing hours.

OST users are still subject to stigmatisation and discrimination among some members of the medical personnel and the police force present on site. Additionally, should patients reveal that they live with HIV, they are given lesser treatment from certain doctors who show reluctance to perform proper examinations on infected patients. This clearly indicates that the medical personnel is inadequately trained with respect to Harm Reduction best practices and HIV/AIDS. Application procedures to benefit from OST are tedious and imply going through a long waiting list of several months at times.

Some long-term OST users have testified that they are no longer satisfied with merely replacing their consumption of opiates with methadone. They want a complete release from the craving for opioids. As such, they are asking for more advanced detoxification and rehabilitation programmes. For this to happen, they suggest improving patient care through case by case follow-ups. Accordingly, resources should be assigned to assess and provide for regular psychological and social care of patients.

Needle and Syringe Programme

PWUD expressed mixed feelings concerning the Needle and Syringe Programme in Mauritius. Despite beneficiaries of the Barkly area affirming that the service has seen an overall improvement with respect to the Needle and Syringe Programme personnel and police force alike, a number of problems were raised that call for thoughtful consideration.

There has been a severe decline in the distribution of syringes in December 2017 in all regions. Subsequently, the growing demand for syringes on the streets has given rise to a syringe traffic in the hot spots of Mauritius. Syringes are being sold between 1USD to 3USD. According to PWID, those benefiting from this traffic do not even inject drugs, but they collect syringes from Needle and Syringe Programme dispensing points to sell the clean syringes as soon as the demand rises among PWID.

The syringe traffic is being indirectly supported by the limited quota of syringes allotted per beneficiary (3 per user daily) by the Ministry of Health & Quality of Life (MOHQL). With the low quality heroin sold on the market that inadequately caters to the needs of PWID, their frequency of consumption being intensified in order to maintain their required high. Participants declared that it was not unusual to inject up to 10 times a day, thus having to re-use or share needles because of their unavailability.

While the programme runs smoothly in some regions (like Barkly or Sainte-Croix), this is not the case in other regions (Tranquebar). This constrains PWID from regions of lower syringe distribution to procure their syringes in areas of higher supply. This has caused tension and feelings of discontent between local beneficiaries and those from other neighbourhoods.

PWID deplore that the MOHQL mobile caravans tend to show up on an irregular basis, usually when they are at work or at odd hours when they are unable to benefit from the service. They added that the personnel is generally unwelcoming and that running hours are not endorsed as they should be. The mobile caravan is sometimes stationed in areas of high influx of passers-by and students, and the driver refuses to relocate to a more appropriate spot in spite of requests by beneficiaries to do so.

The Need for Harm Reduction in Prison

Drugs are prevalent in the prisons of Mauritius.²⁵⁸ Of those who have attended the focus group, several have served prison terms and are thoroughly aware of the flourishing drug situation in local prisons. Drugs (brown sugar, heroin, cannabis and SCs among others) are more readily available inside than outside prison. Furthermore, the supply of drugs is in general of superior quality in prison, as compared to drugs in the community. Syringes are typically crafted from flip flops, pens and various plastic objects within the immediate surroundings of detainees. Since they are not entitled to the Needle and Syringe

Programme, these crafted syringes are being shared among PWID in prison. The price of cigarette has increased dramatically following cigarette prohibition in prison, inmates have reported selling sex for cigarettes (and also for drugs), as previously mentioned. All these are risk factors for HIV, HBV and HCV. PWUD who served time in prison pointed out that the young and newly convicted (who are generally in healthier condition prior to being detained) are most at risk to become infected. Many harm reduction interventions, such as the Needle and Syringe Programme and condom distribution, are not made available in prisons. While methadone is currently available in prison. Induction had been cancelled for some time for political reasons, including in prisons. However, with a new Health Minister coming on board, methadone induction was gradually introduced again in 2016.²⁵⁹

Health and social detriments

Most PWID in Mauritius resort to small jobs or short contracts, from being hawkers to construction workers, gardeners, plumbers and handymen among others. This is principally because they are currently unable to obtain a clear certificate of good character and moral standing due to former drug-related offences.²⁶⁰ PWUD who have served time in jail find themselves in a vicious cycle, whereby they cannot get a job because of their past offences. This eventually prompts them to resort to theft or illegal money-making activities such as drug-dealing, hence increasing their risk of going back to prison. Focus group participants have praised the ongoing initiative of providing rapid screening tests to PWUD, and the CSO home-based testing and counselling.

Anti-Drug and Smuggling Unit (ADSU) and Police Authorities

Participants of the focus group and other PWUD who were interviewed reside mostly in the hot spots of Mauritius disclosed that the ADSU and police authorities often patrol areas of drug affluence and dealing. Instead of pursuing heavy traffickers, they focus their attention and resources on mere consumers and lesser dealers. PWUD or those who are former drug users claim that they are repeatedly stigmatised, targeted and persecuted by the police and ADSU, especially if they have previously served sentences for drug possession or consumption. One participant, who stated having remained clear of opiates for more than 10 years testified that warrants are still issued on his name to this day as he systematically becomes a suspect in the eyes of authorities.

In hot neighbourhoods, PWUD are periodically subject to full body searches by the police in public, in sight of passers-by, and without consideration for their dignity or rights. Since methadone dispensing sites have been relocated to police stations, beneficiaries report that they are routinely threatened, and sometimes beaten if they dare to complain or speak out about the presumably lower (diluted) quality of the methadone doses. There are cases where patients have been threatened with guns, and even averted from obtaining their doses. OST users contended that some members of the OST personnel rally with police officers to oppress them, as well as participate in setting up the methadone traffic on the black market. Although PWID are taken in custody in the event that syringes are found on them (especially when returning them to the Needle and Syringe Programme sites), police officers appear to be showing more tolerance. Lesser penalties are imposed for the possession of syringes and PWID are sometimes released on parole should they be caught with a small dose of heroin or brown sugar.

Conclusion

It is imperative to note that most initiatives within the SADC region and few countries around in the field of Drug Policy Reform, Harm Reduction initiatives and People who use drugs group have been initiated by civil society. The first needle and syringe programmes in Mauritius were led by civil society since 2006, the first People who use drugs group were in Kenya and Tanzania. Also, among the civil society initiatives within Africa, the first NGOs to get on board with global drug policy movements like IDPC were CSO from SADC. Also, the first CSO that started advocacy with decision makers through Support Don't Punish were from Mauritius, Kenya and Tanzania (though other initiatives have happened elsewhere outside the scope of SDP). The first ones to challenge the law around drug policy reform, specifically around cannabis in the region were from South Africa, and it was a civil society initiative.

It is also to be noted that it is within the SADC region that countries are paving the way for some form of legal regulation of cannabis (though not only civil society initiatives) in South Africa, Lesotho, Zimbabwe and Malawi. There were also several Harm Reduction/drug policy conferences with international participants held in the sub-region, and all organized and led by civil society, and one of which, the South Africa Drug Policy week, has taken place every year since its first one in 2016.

In terms of initiatives and policies, SADC provides guidance for effective health and social services for key populations including PWID. The AU has adopted a very progressive perspective within its drug response as well. However, it is within the same sub-region that on one hand, Seychelles provides for some form of decriminalisation of drug possession for people who use drugs, and on the other hand, DRC can sentence the same people to the death penalty. Moreover, PWUD, and more specifically PWID are still being stigmatised, discriminated upon, harassed, and their human rights infringed.

Though there is a long way to go to get more civil society, and mostly decision makers on board, and have a significant impact on PWUD, the SADC and the surrounding regions have seen vibrant civil society initiatives that will hopefully gradually develop. For this to happen, networking, capacity building and resources for civil society would be the key for the further expansion of this movement.

Significantly the experiences documented in Malawi, Mozambique, Mauritius, South Africa, and Zimbabwe paint a very bleak picture: one of impunity fuelled by continued stigma and discrimination in an environment where people who use drugs continue to be criminalised. The extreme violence from policy is noteworthy and a clear symptom of the failures of the "War on Drugs" and those laws and policies that have been influenced by this punitive approach, in direct contradiction with basic human rights principles and sound public health policy. This reports highlights clearly that movements towards evidence based and rights based drug policy reform – away from the punitive and towards the supportive – is the only clear way forward in the Southern African region.

References

- ¹<https://www.livescience.com/49666-prehistoric-humans-psychoactive-drugs.html>
- ²Tengwen Long; et al. Cannabis in Eurasia: origin of human use and Bronze Age trans-continental connections. Vegetation History and Archaeobotany (2017) https://www.researchgate.net/publication/304536111_Cannabis_in_Eurasia_origin_of_human_use_and_Bronze_Age_trans-continental_connections
- ³<https://www.encyclopedia.com/science/medical-magazines/president-nixon-declares-war-drugs>
- ⁴<http://www.drugpolicy.org/issues/brief-history-drug-war>
- ⁵United Nations, The Single Convention on Narcotic Drugs (1961) (as amended by the 1972 Protocol Amending the Single Convention) https://www.unodc.org/pdf/convention_1961_en.pdf
- ⁶United Nations, The Convention on Psychotropic Substances (1971) https://www.unodc.org/pdf/convention_1971_en.pdf
- ⁷United Nations, Convention against Illicit Traffic in Narcotic and Psychotropic Substances (1988) https://www.unodc.org/pdf/convention_1988_en.pdf
- ⁸<https://globalsouthstudies.as.virginia.edu/key-issues/global-war-drugs>
- ⁹IDPC, The International Drug Control System http://fileserv.idpc.net/library/IDPC-training-toolkit/Module-1_Rev-2017.pdf
- ¹⁰TNI, The UN Drug Control Conventions: A Primer (2015) <https://www.tni.org/en/publication/the-un-drug-control-conventions>
- ¹¹FAAT, The crimson papers #1 : The Schedules of the international drug control conventions (2017) http://faaat.net/wp-content/uploads/FAAAT_crimson_paper_1.pdf
- ¹²UNODC, Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (2009) https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_52/Political-Declaration2009_V0984963_E.pdf
- ¹³IDPC, Taking Stock: A Decade of Drug Policy. A Civil Society Shadow Report (2018) http://fileserv.idpc.net/library/Shadow_Report_FINAL_ENGLISH.pdf
- ¹⁴Maria Costa A, The 51st session of the Commission on Narcotic Drugs Speech (2008) <https://www.unodc.org/unodc/en/about-unodc/speeches/2008-03-10.html>
- ¹⁵<http://www.globalcommissionondrugs.org/>
- ¹⁶GCDP, The War on Drugs (2011) <http://www.globalcommissionondrugs.org/reports/the-war-on-drugs>
- ¹⁷GCDP, The War on Drugs and HIV/Aids : How the Criminalization of Drug Use Fuels the Global Pandemic (2012) <http://www.globalcommissionondrugs.org/reports/the-war-on-drugs-and-hiv-aids>
- ¹⁸GCDP, The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic (2013) <http://www.globalcommissionondrugs.org/reports/the-negative-impact-of-the-war-on-drugs-on-public-health-the-hidden-hepatitis-c-epidemic>
- ¹⁹GCDP, The Negative Impact of Drug Control on Public Health: the global crisis of avoidable pain (2015) <http://www.globalcommissionondrugs.org/reports/the-negative-impact-of-drug-control-on-public-health-the-global-crisis-of-avoidable-pain/>
- ²⁰<http://www.drugpolicy.org/issues/race-and-drug-war>
- ²¹<https://idpc.net/>
- ²²<http://www.inpud.net/>
- ²³<https://hivlawcommission.org>
- ²⁴GCHL, HIV and the Law: Risks, Rights & Health (2012) <https://hivlawcommission.org/wp-content/uploads/2017/06/FinalReport-RisksRightsHealth-EN.pdf>
- ²⁵GCHL, HIV and the Law: Risks, Rights & Health: Supplement (2017) <https://hivlawcommission.org/wp-content/uploads/2018/09/HIV-and-the-Law-supplement-FINAL.pdf>
- ²⁶HRI, What is harm reduction <https://www.hri.global/what-is-harm-reduction>
- ²⁷UNODC, UNAIDS, WHO, Technical Guide For Countries To Set Targets For Universal Access To HIV Prevention, Treatment And Care For Injecting Drug Users, (2012). https://apps.who.int/iris/bitstream/handle/10665/77969/9789241504379_eng.pdf;jsessionid=C57781B0D2E99116448FC22DA51EE357?sequence=1
- ²⁸WHO, Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009) https://www.who.int/substance_abuse/publications/Opioid_dependence_guidelines.pdf
- ²⁹WHO, Consolidated Guidelines On HIV Prevention, Diagnosis, Treatment And Care For Key Populations

(2016) <https://apps.who.int/iris/bitstream/handle/10665/246200/9789241511124-eng.pdf?sequence=1>

³⁰<https://www.talkingdrugs.org/infographic-un-agencies-drug-decriminalization>

³¹UN Chief Executives Board for Coordination, Summary of deliberations CEB/2018/2 (2019) <https://www.unsceb.org/CEBPublicFiles/CEB-2018-2-SoD.pdf>

³²ICHRDP, UNAIDS, WHO, UNDP, International Guidelines on Human Rights and Drug Policy (2019) https://www.undp.org/content/dam/undp/library/HIV-AIDS/HRDP%20Guidelines%202019_FINAL.PDF

³³WHO Expert Committee on Drug Dependence, Fortieth report (2018) <https://apps.who.int/iris/bitstream/handle/10665/279948/9789241210225-eng.pdf?ua=1>

³⁴<https://transformdrugs.org/who-says-reclassify-cannabis/>

³⁵<http://supportdontpunish.org/>

³⁶<http://supportdontpunish.org/day-of-action-2013/>

³⁷<http://supportdontpunish.org/day-of-action-2018/>

³⁸<https://www.unodc.org/ungass2016/>

³⁹<https://www.unodc.org/unodc/en/ngos/DCN13-civil-society-engages-in-ungass-2016-preparatory-process.html>

⁴⁰Civil Society Statement: The UNGASS Outcome Document: Diplomacy Or Denialism? (2016) http://files.server.idpc.net/library/UNGASS-shadow-declaration_FINAL.pdf

⁴¹UN General Assembly, Outcome Document Of The 2016 United Nations General Assembly Special Session on the World Drug Problem: Our Joint Commitment to Effectively Addressing and Countering the World Drug Problem (2016) <https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf>

⁴²<https://www.unodc.org/unodc/en/commissions/CND/2019/2019-high-level-ministerial-segment.html>

⁴³CND, Draft ministerial declaration on strengthening our actions at the national, regional and international levels to accelerate the implementation of our joint commitments to address and counter the world drug problem (2019) <https://undocs.org/en/E/CN.7/2019/L.11>

⁴⁴GCDP, Public Statement of the Global Commission on Drug Policy on the CND Ministerial Segment Declaration (2019) <http://www.globalcommissionondrugs.org/wp-content/uploads/2019/03/Statement-GCDP-on-CND.pdf>

⁴⁵IDPC, The 'Vienna consensus' stifles progress on UN drug policy : Statement from the International Drug Policy Consortium (2019) http://files.server.idpc.net/library/Public-IDPC-statement_FINAL.pdf

⁴⁶Abila L., No is not an Option. The Strangest Secret in the War on Drugs. <https://transformdrugs.org/no-is-not-an-option/>

⁴⁷HRI, The Death Penalty for Drug Offences: Global Overview 2017 (2018) <https://www.hri.global/files/2018/11/13/HRI-Death-Penalty-Report-2018-v2.pdf>

⁴⁸<https://www.swansea.ac.uk/gdpo/projectpages/drugpolicyinafrica/>

⁴⁹Bridge J and Loglo MG, Drug Laws in West Africa: A Review and Summary (International Drug Policy Consortium and West Africa Commission on Drugs 2017) http://files.server.idpc.net/library/Drug-laws-in-West-Africa_ENGLISH.pdf

⁵⁰International Harm Reduction Association, Global State of Harm Reduction 2008 <https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>

⁵¹Abdool R., Policy change towards implementing harm reduction in Sub-Saharan Africa (International Journal of Drug Policy 2016) http://files.server.idpc.net/library/Policy_change_towards_implementing_harm_reduction_in_Sub-Saharan.pdf

⁵²Harm Reduction International, Global State of Harm Reduction (2018) p 148,160 <https://www.hri.global/files/2019/02/05/global-state-harm-reduction-2018.pdf>

⁵³<https://www.health-e.org.za/2016/02/07/elite-african-group-in-vienna-undermines-au-drug-policy/>

⁵⁴https://www.unodc.org/documents/commissions/CND/Membership/CND_membership_January_2018.pdf

⁵⁵http://files.server.idpc.net/library/Zero_Draft_Africa_Group_Contributions_eng.pdf

⁵⁶https://www.unodc.org/documents/ungass2016/Contributions/IO/AU/Common_African_Position_for_UNGASS_-_English_-_final.pdf

⁵⁷AU, AU Plan of Action on Drug Control (2013-2017) CAMDC/EXP/2(V) https://au.int/sites/default/files/pages/32900-file-aupa_on_dc_2013-2017_-_english.pdf

⁵⁸<https://idpc.net/blog/2014/10/africa-union-meeting-drugs-kill-but-bad-policies-kill-more>

⁵⁹<https://www.kofiannanfoundation.org/changing-drug-policy/gcdp-geneva/>

⁶⁰AU, Second Meeting Of The Specialised Technical Committee On Health, Population And Drug Control STC-HPDC-2/MIN/RPT (2017) https://au.int/sites/default/files/pages/32900-file-ministers_report_-_stc-hpdc-2_final_sa19686_e_original.pdf

- ⁶¹AU, Call For Proposal – Individual Consultancy Services Consultancy Service To Compile A Progress Report On The Implementation Of The African Union Plan Of Action On Drug Control And Crime Prevention (2013-2019) https://au.int/sites/default/files/bids/35515-reoi_-compile_a_progress_report_on_the_implementation_of_the_african_uni.pdf
- ⁶²AU, 62nd Session Of The United Nations Commission On Narcotic Drugs (CND) Vienna International Centre, Statement By H.E Mrs Amira El Fadil Mohamed, African Union Commissioner For Social Affairs (2019) https://www.unodc.org/documents/commissions/CND/2019/2019_MINISTERIAL_SEGMENT/20March/African_Union_update.pdf
- ⁶³Global Commission on HIV and the Law, Report of the Africa Regional Dialogue of the Global Commission on HIV and the Law (2011) https://hivlawcommission.org/wp-content/uploads/2017/06/AfricaRD_ReportEn.pdf
- ⁶⁴ACHPR, HIV, the Law and human rights in the African Human Rights system: Key Challenges and Opportunities for Rights-based Responses (2017) http://www.achpr.org/files/news/2017/12/d317/africancommission_hiv_report_full_eng.pdf
- ⁶⁵<http://www.wacommissionondrugs.org/>
- ⁶⁶WACD, Not Just in Transit: Drugs, the State and Society in West Africa (2014) p 4-5. <http://www.wacommissionondrugs.org/wp-content/uploads/2014/11/WACD-Full-Report-Eng.pdf>
- ⁶⁷WACD, Model Drug Law For West Africa : A tool for policymakers (2018) <http://www.globalcommissionondrugs.org/wp-content/uploads/2018/08/WADC-MDL-EN-WEB.pdf>
- ⁶⁸<http://www.globalcommissionondrugs.org/press-release-motlanthe-uteem>
- ⁶⁹<https://wadpn.blogspot.com/>
- ⁷⁰<https://idpc.net/events/2018/07/5th-west-africa-executive-course-on-human-rights-and-drug-policy>
- ⁷¹IDPC, WACD, West Africa drug policy training toolkit (2015) <http://files.idpc.net/library/West-Africa-drug-policy-advocacy-training-toolkit.pdf>
- ⁷²<https://idpc.net/fr/events/2018/11/les-droits-humains-et-les-politiques-de-lutte-contre-la-drogue-en-afrique-francophone-cours-ouest-africain>
- ⁷³<http://www.crisafrica.org/about-crisa-2/what-we-do/>
- ⁷⁴<http://cut.mu/2012/12/27/achievements-in-2012-2/>
- ⁷⁵<https://idpc.net/members/directory>
- ⁷⁶<http://supportdontpunish.org/day-of-action-2013/>
- ⁷⁷<http://supportdontpunish.org/day-of-action-2018/>
- ⁷⁸<https://idpc.net/alerts/2012/07/kenya-network-of-people-who-use-drugs-now-officially-established>
- ⁷⁹<https://idpc.net/alerts/2013/02/launch-of-tanpud-a-new-network-of-people-who-use-drugs-in-tanzania>
- ⁸⁰<http://inpud.net/en/news/react-launch-tanzania>
- ⁸¹https://www.facebook.com/pg/empower.cameroon/about/?ref=page_internal
- ⁸²<http://hasnouna.org/>
- ⁸³<https://namati.org/network/organization/equal-health-rights-access-advocacy-initiativeehraai/>
- ⁸⁴ZCLDN, Apr 2018 Update, Issue No. 3. Vol.1 , p. 2-3 <http://files.idpc.net/library/ZCLDN%20News%20April%20Issue.pdf>
- ⁸⁵Global Fund KANCO Grant Performance Report http://docs.theglobalfund.org/program-documents/GF_PD_003_ac9a396a-fbb3-4a07-ac98-894b071c1063.pdf
- ⁸⁶<https://www.5plus.mu/guide-et-services/mauritian-network-people-who-use-drugs-moi-ancien-toxicomane-je-mengage>
- ⁸⁷<https://www.facebook.com/rafasud2017/>
- ⁸⁸INPUD, International Network of People Who Use Drugs Strategic Plan 2017-2020, p. 3 https://www.inpud.net/sites/default/files/Strategic%20plan_online%20version.pdf
- ⁸⁹SADC, Protocol on Combating Illicit Drug Trafficking in the SADC Region (1996) https://www.sadc.int/files/1213/5340/4708/Protocol_on_Combating_Illicit_Drug_Trafficking_1996_.pdf.pdf
- ⁹⁰<https://www.sadc.int/documents-publications/show/Protocol%20on%20Combating%20Illicit%20Drug%20Trafficking%201996>
- ⁹¹https://www.sadc.int/index.php/download_file/view/1836/681/
- ⁹²<https://www.sadc.int/about-sadc/overview/sa-protocols/>
- ⁹³CUT, Concept Paper – First Conference on Opiate Abuse and Harm Reduction Services in Mauritius: Let's Face it. (2009) p 7-8 <https://www.dropbox.com/s/c9139wghfx63n09/CUT%20Conference%20on%20opiates%20and%20Harm%20Reduction-%20Concept%20Paper.pdf>
- ⁹⁴<http://cut.mu/campaign/the-needle-exchange-programme/>
- ⁹⁵HRI, Global State of Harm Reduction (2018). Op. cit.
- ⁹⁶ARASA, HIV, TB and Human Rights in Southern and East Africa (2017)
- ⁹⁷HRI, Global State of Harm Reduction (2018) Op. cit.

- ⁹⁸No Angolan Drug framework could be accessed online, probably due to language barrier. However, press articles talking about arrests for cannabis possession and use tend to suggest that these acts are criminalised <https://sensiseeds.com/en/blog/cannabis-in-angola-en/>
- ⁹⁹Botswana Drugs And Related Substances Act (1992), Part III section 16 https://www.unodc.org/res/cld/document/drugs-and-related-substances-act-1992_html/Drugs_and_Related_Substances_Act_1992.pdf
- ¹⁰⁰Comores, Recueil des Textes Législatifs d'ordre Général 2005, Article 328. <http://comoresdroit.comores-droit.com/wp-content/dossier/recueil/RECEUIL%20DES%20TEXTES%20LEGISLATIFS.pdf>
- ¹⁰¹No DRC's drug legal framework could be accessed online. However, it is assumed that drug use and possession is criminalised due to the heavily criminalised regime. DRC provides for the death penalty for drug related offences. Moreover, Military Penal Code provides for death penalty in case of possession of drugs including cannabis on a military compound: <http://www.leganet.cd/Legislation/Droit%20Judiciaire/Loi.024.2002.18.11.2002.pdf>
- ¹⁰²Lesotho Drugs Of Abuse Act (2008), Part III 43(1) <https://lesotholii.org/ls/legislation/act/5/DRUGS%20OF%20ABUSE%20ACT%202008.pdf>
- ¹⁰³Madagascar, Loi n° 97-039 du 4 novembre 1997 sur le contrôle des stupéfiants, des substances psychotropes et des précurseurs, Titre III, Article 140. <http://www.justice.mg/wp-content/uploads/textes/1TEXTES%20NATIONAUX/DROIT%20PRIVE/Textes%20sur%20le%20penal/lois/Loi%2097-039.pdf>
- ¹⁰⁴Malawi Dangerous Drugs Act, Part IV (35), https://malawilii.org/system/files/consolidatedlegislation/3502/drugs_dangerous_drugs_act_pdf_15068.pdf
- ¹⁰⁵Mauritius Dangerous Drugs Act (2000), Part II (21) <http://apps.who.int/medicinedocs/documents/s18370en/s18370en.pdf>
- ¹⁰⁶Mozambique Lei No 3/97 (1997), Article (1,2,3 and 4); article 35 (1,2 and 3:a and b); article 36 (a and b); article 37 (1 and 2); article 38. <https://www.scribd.com/document/371709724/Lei-n-3-97-de-13-de-Marco-Drogas>
- ¹⁰⁷Namibia Abuse of Dependence-Producing Substances and Rehabilitation Centres Act 41 of 1971, Chapter 1 (2). <http://www.lac.org.na/laws/annoSTAT/Abuse%20of%20Dependence-Producing%20Substances%20and%20Rehabilitation%20Centres%20Act%2041%20of%201971.pdf>. New law on Drug Abuse was to be voted and enacted in 2006, but population opposed it as it was too harsh. No additional information was accessible online as to whether this law has been amended/enacted
- ¹⁰⁸Seychelles Misuse of Drugs Act (2016), Part II (8) (1) <https://seylii.org/sc/sc/legislation/Act%205%20of%202016%20Misuse%20of%20Drugs%20Act%20C%202016.pdf>
- ¹⁰⁹South Africa Drugs and Drug trafficking Act, no. 140 of 1992, Chapter II (4) https://www.gov.za/sites/default/files/gcis_document/201409/a1401992.pdf
- ¹¹⁰Swaziland Medicines And Related Substances Control Act (2016), Part V (39) <https://www.medbox.org/swaziland-medicines-and-related-substances-control-act-2016/download.pdf>
- ¹¹¹Tanzania Drug Control and Enforcement Act (2015) Part III (15) (1) (a) http://www.lrct.go.tz/download/laws_2015/ActNo-5-2015-Book-1-10.pdf
- ¹¹²Zambia Narcotic Drugs And Psychotropic Substances Act (1993), Part III (8) https://www.unodc.org/res/cld/document/zmb/narcotic-drugs-act-1993_html/NARCOTIC_DRUGS_AND_PSYCHOTROPIC_SUBSTANCES_ACT.pdf
- ¹¹³Zimbabwe Criminal Law (Codification and Reform) Act, Chapter VII (156) (1) <https://zimlii.org/zw/legislation/num-act/2004/23/Criminal%20Law%20%28Codification%20and%20Reform%29%20Act%20%5BChapter%209-23%5D.pdf>
- ¹¹⁴Lesotho Drugs of Abuse (Cannabis) Regulations of 2018
- ¹¹⁵<https://www.gov.ls/pm-launches-cannabis-cultivator/>
- ¹¹⁶https://en.wikipedia.org/wiki/Cannabis_in_Lesotho
- ¹¹⁷<https://www.bbc.com/news/world-africa-46288374>
- ¹¹⁸https://mwnation.com/house-allows-industrial-hemp-bill-drafting/?fbclid=IwAR1r4bW8xO8nOHfiriJ_Sk_HWI16VGXSmW-rS0v4yiqnzs_46APIQUgvcxvY
- ¹¹⁹<https://www.equaltimes.org/malawi-losing-millions-of-export#.XJpHwJgzblU>
- ¹²⁰<https://collections.concourt.org.za/handle/20.500.12144/34547>
- ¹²¹<https://www.bbc.com/news/world-africa-45559954>
- ¹²²Fields of Green for All, Proposal for the Legal Regulation of Cannabis in South Africa (2018) <https://fieldsofgreenforall.org.za/wp-content/uploads/2018/03/FGA-Outcomes-Discussion-Doc-March-2018-1.pdf>
- ¹²³Zimbabwe Dangerous Drugs Act (1956) <https://zimlii.org/zw/legislation/act/1956/28>
- ¹²⁴Zimbabwe Dangerous Drugs (Production of Cannabis for Medical and Scientific use) Regulations 2018 <http://www.cfuzim.org/images/cannabisregs.pdf>

- ¹²⁵<https://www.zimlive.com/2019/02/25/zimbabwe-to-licence-37-cannabis-growers-after-over-200-apply/>
- ¹²⁶ZCLDPN, Apr 2018 Update, Issue No. 3 Vol 1. Op. cit.
- ¹²⁷UHRN, Compiled Cases of Drug User Arrests in Uganda (2014), <http://files.server.idpc.net/alerts/UHRN-cases-of-drug-user-arrests-in-Uganda.pdf>
- ¹²⁸<https://idpc.net/alerts/2019/01/uhrn-a-press-release-on-the-condemnation-of-the-human-rights-violations-against-people-who-use-drugs-by-state-operatives-in-uganda>
- ¹²⁹<https://www.gnpplus.net/civil-society-calls-for-rapid-international-response-to-the-human-rights-crisis-in-tanzania/>
- ¹³⁰Mainline, Human Rights Violations Among People who use Drugs in South Africa (2015) http://files.server.idpc.net/library/Mainlines_sober_facts_on_human_rights_violations_among_PWUD_in_South_Africa.pdf
- ¹³¹<https://www.dailymaverick.co.za/article/2018-10-08-following-concourt-ruling-saps-continues-to-arrest-people-for-possession-of-cannabis/>
- ¹³²SADC, Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations (2018) https://www.sadc.int/files/2715/3060/7629/SADC-regional-strategy-hiv-srhr-key-pops_FINAL.pdf
- ¹³³http://sadcpf.org/index.php?option=com_content&view=article&id=71&Itemid=89
- ¹³⁴http://www.sadcpf.org/index.php?option=com_docman&Itemid=150
- ¹³⁵<http://www.lusakavoice.com/2016/05/18/sadc-mps-discuss-drug-use-hiv-prevention/>
- ¹³⁶http://www.nationalassembly.sc/NAS/index.php?option=com_content&view=article&id=1623:the-speaker-calls-on-sadc-parliamentarians-to-help-contain-the-epidemic-of-bad-laws-affecting-public-health-in-the-region&catid=1:latest-news&Itemid=1
- ¹³⁷<http://cut.mu/campaign/the-needle-exchange-programme/>
- ¹³⁸<https://www.talkingdrugs.org/east-africa-parliamentarians-push-for-harm-reduction>
- ¹³⁹<http://www.arasa.info/news/statement-human-rights-violations-faced-people-who-use-drugs-southern-africa-62nd-ordinary-session-african-commission-human-and/>
- ¹⁴⁰<http://cut.mu/cut-harm-reduction-conference-mauritius/>
- ¹⁴¹<http://pils.mu/ouverture-de-la-mauritius-harm-reduction-conference-ii/>
- ¹⁴²<http://www.sadrugpolicyweek.com/run2016.html>
- ¹⁴³<http://www.sadrugpolicyweek.com/sadpw17-report.html>
- ¹⁴⁴<http://www.sadrugpolicyweek.com/>
- ¹⁴⁵<https://fieldsofgreenforall.org.za/clinical-cannabis-convention/>
- ¹⁴⁶<https://kanco.org/?p=1750>
- ¹⁴⁷http://mainline-eng.blogbird.nl/uploads/mainline-eng/1_Aids_conference_South_Africa.pdf
- ¹⁴⁸http://files.server.idpc.net/alerts/Nairobi_Declaration_EAHRC.pdf
- ¹⁴⁹<http://www.sadrugpolicyweek.com/declaration-2018.html>
- ¹⁵⁰<http://www.sadrugpolicyweek.com/ethekwini-demand.html>
- ¹⁵¹<https://www.hri.global/files/2018/12/10/GlobalOverview-harm-reduction.pdf>
- ¹⁵²https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/factsheet_Ending_AIDS_by_2030_for_people_and_with_people_who_use_drugs
- ¹⁵³<https://www.opensocietyfoundations.org/voices/overwhelming-evidence-favor-harm-reduction>
- ¹⁵⁴<https://www.hri.global/what-is-harm-reduction>
- ¹⁵⁵Buchanan J., The War on Drugs—a war on drug users? (Drugs: Education Prevention and Policy) (2010). https://www.researchgate.net/publication/228381416_The_War_on_Drugs-a_war_on_drug_users
- ¹⁵⁶<https://www.dailymaverick.co.za/article/2019-03-10-drug-bust-blues-ever-increasing-arrests-of-people-who-use-drugs-helps-fuel-crime-not-reduce-it/>
- ¹⁵⁷<https://collections.concourt.org.za/handle/20.500.12144/34547>
- ¹⁵⁸<https://www.opensocietyfoundations.org/voices/south-africa-still-fighting-apartheid-drug-war>
- ¹⁵⁹<https://www.fin24.com/Economy/sa-by-far-africas-richest-and-most-advanced-country-report-20180430>
- ¹⁶⁰Peltzer K, Phaswana-Mafuya N. Drug use among youth and adults in a populationbased survey in South Africa. S Afr J Psychiat. 2018 <http://www.scielo.org.za/pdf/sajp/v24n1/08.pdf>
- ¹⁶¹<https://worldpolicy.org/2015/07/07/inequality-in-south-africa-a-post-apartheid-analysis/>
- ¹⁶²<https://city-press.news24.com/Voices/drug-policy-is-race-based-20190125>
- ¹⁶³UNODC, World Drug Report Booklet 3, Analysis of Drug Markets: Opiates, cocaine, cannabis, synthetic drugs (2018). https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_3_DRUG_MARKETS.pdf , <https://idpc.net/alerts/2015/01/east-african-states-are-being-undermined-by-heroin-smuggling>
- ¹⁶⁴SALRC, Report Project 107. Sexual Offences Adult Prostitution (2015) <http://www.justice.gov.za/salrc/>

- reports/r-pr107-SXO-AdultProstitution-2017-Sum.pdf
- ¹⁶⁵<http://www.sweat.org.za/2017/05/26/release-report-little-late/>
- ¹⁶⁶Step-Up, Human Rights Violations Report (2017) p.2 http://mainline-eng.blogbird.nl/uploads/mainline-eng/STEP_UP_HUMAN_RIGHTS_REPORT_TBHIV_CARE_2017.pdf
- ¹⁶⁷<https://www.gov.za/sites/default/files/images/a108-96.pdf>
- ¹⁶⁸https://www.gov.za/sites/default/files/gcis_document/201409/a4-001.pdf
- ¹⁶⁹<https://www.dailymaverick.co.za/opinionista/2018-11-07-groundbreaking-case-on-transgender-rights-could-create-a-legal-precedent/>
- ¹⁷⁰<https://www.globalcitizen.org/en/content/jade-september-transgender-prisoner-south-africa/>
- ¹⁷¹Step-Up, Human Rights Violations Report (2017) p.4. Op. cit.
- ¹⁷²OUT provides direct health services to the lesbian, gay, bisexual and transgender (LGBT) community, MSM, sex workers, and injecting drug users, including HIV testing, counselling, treatment and general lifestyle advice and support.(<https://www.out.org.za/>)
- ¹⁷³<https://www.researchgate.net/project/Community-Oriented-Substance-Use-Program-COSUP>
- ¹⁷⁴<https://www.health-e.org.za/2016/02/07/elite-african-group-in-vienna-undermines-au-drug-policy/>
- ¹⁷⁵<http://statements.unmeetings.org/media2/7657368/s-africa-on-behalf-of.pdf>
- ¹⁷⁶UNODC, Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (2009) <https://www.unodc.org/documents/ungass2016/V0984963-English.pdf>
- ¹⁷⁷<https://idpc.net/policy-advocacy/the-un-general-assembly-special-session-on-drugs-ungass-2016>
- ¹⁷⁸https://www.unodc.org/documents/ungass2016/Contributions/IO/AU/Common_African_Position_for_UNGASS_-_English_-_final.pdf
- ¹⁷⁸<http://inpu.net/en/vancouver-declaration>
- ¹⁷⁹General Assembly, Our Joint Commitment to Effectively Addressing and Countering the World Drug Problem (A/RES/S-30/1) ('UNGASS Outcome Document') (2016), Paragraph 1(q). <https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf>
- ¹⁸⁰<https://collections.concourt.org.za/handle/20.500.12144/34547>
- ¹⁸¹UNAIDS, WHO, Guide to Starting And Managing Needle and Syringe Programmes (2007) https://www.who.int/hiv/idu/OMSEA_NSP_Guide_100807.pdf
- ¹⁸²http://co-act.info/images/pdf/PeerNSP_Case4.pdf
- ¹⁸³T. Fleetwood, T. Howell, A Versfeld, S. Shelly, Dialogues with Durban Law Enforcement: An overview of discussions on the policies, approaches and effects of the policing of street level drug use. Cape Town, TB/HIV Care, 2017
- ¹⁸⁴UNAIDS, WHO, UNODC (2012). Op. Cit. Pg 27 (3.1. Monitoring "drug-user-specific" versus "general population" interventions)
- ¹⁸⁵Mozambique Lei No 3/97 (1997), Article (1,2,3 and 4); article 35 (1,2 and 3:a and b); article 36 (a and b); article 37 (1 and 2); article 38. <https://www.scribd.com/document/371709724/Lei-n-3-97-de-13-de-Marco-Drogas>
- ¹⁸⁶Anteprojecto de Revisão da Lei nº. 3/97 (2018)
- ¹⁸⁷Harm Reduction International, Global State of Harm Reduction (2018) p 160 <https://www.hri.global/files/2019/02/05/global-state-harm-reduction-2018.pdf>
- ¹⁸⁸MISAU, INS, Final Report: The Mozambique Integrated Biological and Behavioral Survey among People Who Inject Drugs, 2014 (2017) <https://globalhealthsciences.ucsf.edu/sites/globalhealthsciences.ucsf.edu/files/pub/pwid-final-report-20180329.pdf>
- ¹⁸⁹<https://www.theglobalfund.org/en/news/2018-02-08-mozambique-and-global-fund-launch-new-grants/>
- ¹⁹⁰UNAIDS, Health, rights and drugs: harm reduction, decriminalization and zero discrimination for people who use drugs (2019) p 2. http://www.unaids.org/sites/default/files/media_asset/JC2954_UNAIDS_drugs_report_2019_en.pdf
- ¹⁹¹<http://www.unaids.org/en/regionscountries/countries/mozambique>
- ¹⁹²<https://www.theglobalfund.org/en/news/2018-02-08-mozambique-and-global-fund-launch-new-grants/>
- ¹⁹³<https://www.msf.org/mozambique>
- ¹⁹⁴Constituição da República de Moçambique de 1975 e de 2004; 2. Lei de Trabalho 8/85 de 14 Dezembro; 3. Decreto 14/87 de 20 de Maio; 4 Decreto numero 17/88 de 27 de Dezembro; 5. Decreto presidencial numero 01/2000 de 17 de Janeiro.
- ¹⁹⁵UNODC, World Drug Report Booklet 3, (2018) Op.cit., <https://idpc.net/alerts/2015/01/east-african-states-are-being-undermined-by-heroin-smuggling>
- ¹⁹⁶MISAU, INS, Final Report: The Mozambique IBBS among PWID, 2014. (2017) Op. Cit.

- ¹⁹⁷WHO, UNODC, UNAIDS, Position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention (2004) https://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf
- ¹⁹⁸Route transition interventions~ (RTIs) are interventions that can be used to reduce injecting and its associated harms. It concerns the prevention of injecting among existing non-injecting drug users and the promotion of transiting away from injecting among current injectors.
- ¹⁹⁹<https://www.msf.org/mozambique>
- ²⁰⁰<https://www.thestandard.co.zw/2016/09/04/harare-dangerous-drugs-time-bomb/>
- ²⁰¹ZCLDN, A pilot study on the attitude of Zimbabweans towards drug users (2018)
- ²⁰²<https://www.forbes.com/sites/timworstall/2017/03/05/congratulations-to-robert-mugabe-zimbabwes-unemployment-rate-now-95/#4c240148244c>. This figure is however questioned by the International Labour Organisation, and analysed further : <https://www.bbc.com/news/business-42116932>
- ²⁰³<https://www.gunpolicy.org/firearms/region/zimbabwe>
- ²⁰⁴Zimbabwe Firearm Act 1957 http://psm.du.edu/media/documents/national_regulations/countries/africa/zimbabwe/zimbabwe_firearmsff_act_1972.pdf
- ²⁰⁵<https://www.reuters.com/article/us-zimbabwe-politics/zimbabwes-mnangagwa-calls-for-end-to-western-sanctions-idUSKBN1E812U>
- ²⁰⁶<https://www.iol.co.za/news/africa/zimbabwe-inflation-hits-high-of-290-says-economist-18991292>
- ²⁰⁷<https://www.bbc.com/news/world-africa-47361572>
- ²⁰⁸<https://globalpressjournal.com/africa/zimbabwe/illegal-healers-zimbabwe-use-cast-spirits-heal-people/>
- ²⁰⁹<https://www.churchtimes.co.uk/articles/2018/23-november/features/features/africa-s-time-mission-across-the-continent>, http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S2305-08532016000100014
- ²¹⁰Buzsa et al., Good news for sex workers in Zimbabwe: how a court order improved safety in the absence of decriminalization (Journal of the International Aids Society) (2017) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5515058/>, <https://lawhubzim.org/is-sex-work-prostitution-illegal-in-zimbabwe/>
- ²¹¹Zimbabwe Dangerous Drugs Act 1956 <https://zimlil.org/zw/legislation/act/1956/28>
- ²¹²Zimbabwe Dangerous Drugs (Production of Cannabis for Medical and Scientific use) Regulations 2018 <http://www.cfuzim.org/images/cannabisregs.pdf>
- ²¹³Malawi Dangerous Drugs Act, Part IV (35), https://malawilii.org/system/files/consolidatedlegislation/3502/drugs_dangerous_drugs_act_pdf_15068.pdf
- ²¹⁴<http://worldpopulationreview.com/countries/poorest-countries-in-africa/>
- ²¹⁵Malawi Growth and Development Strategy, Poverty Reduction Strategy paper, Malawi National Social Support programme, National disability mainstreaming strategy, National policy on equalization of opportunity for persons with disabilities.
- ²¹⁶<http://thecommonwealth.org/our-member-countries/malawi/history>
- ²¹⁷<https://www.bbc.com/news/world-africa-13864367>
- ²¹⁸<https://www.theguardian.com/world/2017/dec/08/malawi-blackouts-drought-hydro-power>
- ²¹⁹FAO, Agwa, COMESA, National Investment Profile. Water for Agriculture and Energy: Malawi (2015) http://www.fao.org/fileadmin/user_upload/agwa/docs/NIP_Malawi_Final.pdf
- ²²⁰<https://malawi24.com/2018/12/07/malawi-parliament-approves-drafting-of-bill-to-legalise-chamba/>
- ²²¹Pr John Booth-Davies, Drugspeak: The Analysis of Drug Discourse (1997) <https://epdf.tips/drugspeak-the-analysis-of-drug-discourse.html>
- ²²²<https://transformdrugs.org/who-says-reclassify-cannabis/>
- ²²³Harm Reduction International, (2018) p 160, Op. Cit. : " HRI also found data on injecting drug use in Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Djibouti, Ethiopia, Gabon, Gambia, Guinea, Malawi, Mali, Niger, Rwanda, Sierra Leone, Somalia, Togo, Zambia and Zimbabwe, but did not find verified data to include on these countries."
- ²²⁴<http://apps.who.int/medicinedocs/documents/s18370en/s18370en.pdf>
- ²²⁵<http://cut.mu/legal-aspects/>
- ²²⁶Ministry of Health & Quality of Life, National Drug Observatory Report (2018) http://health.govmu.org/English/Documents/2018/NDO_MOH_FINAL_JOSE_VERSION_05July_2018_Brown.pdf
- ²²⁷http://www.coalitionplus.org/wordpress/wp-content/uploads/2018/07/MAURICE_EN.pdf
- ²²⁸<https://defimedia.info/basic-retirement-pension-and-free-healthcare-should-rich-benefit-welfare-state-0>
- ²²⁹<http://socialsecurity.govmu.org/English/ServicesMenu/Pages/Social-Aid--Unemployment-Hardhip-relief.aspx>

- ²³⁰<http://thecommonwealth.org/our-member-countries/mauritius/constitution-politics>
- ²³¹https://en.wikipedia.org/wiki/1968_Mauritian_riots
- ²³²https://en.wikipedia.org/wiki/1999_Mauritian_riots
- ²³³<http://www.africaranking.com/richest-countries-in-africa/3/>
- ²³⁴<https://www.worldbank.org/en/country/mauritius/overview>
- ²³⁵<https://www.worldbank.org/en/country/mauritius/publication/mauritius-addressing-inequality-through-more-equitable-labor-markets>
- ²³⁶CUT, Concept Paper – First Conference on Opiate Abuse and Harm Reduction Services in Mauritius: Let's Face it. (2009) p 7-8 <https://www.dropbox.com/s/c9139wghfx63n09/CUT%20Conference%20on%20opiates%20and%20Harm%20Reduction-%20Concept%20Paper.pdf>
- ²³⁷<http://www.rfi.fr/afrique/20150105-ile-maurice-premier-ministre-Anerood-Jugnauth-decide-lutter-trafic-drogue-corruption-politique>
- ²³⁸Commission of Inquiry on Drug Trafficking, The Commission of Enquiry on Drug Trafficking Report (2018) <http://cut.mu/wp-content/uploads/2018/12/Commission-of-Enquiry-on-Drug-Trafficking-Report-optimized.pdf>
- ²³⁹<http://www.govmu.org/English/News/Pages/Report-of-the-Commission-of-Inquiry-on-Drug-Trafficking-contains-some-460-recommendations,-says-Prime-Minister.aspx>
- ²⁴⁰<https://www.africanews.com/2018/07/28/mauritius-minister-resigns-after-commission-of-inquiry-on-drugs/>
- ²⁴¹<https://www.lexpress.mu/article/345234/cigarettes-rs-6-000-en-prison-massages-et-autres-petites-gateries-en-echange>
- ²⁴²<https://defimedia.info/budget-2017-18-decouvrez-les-nouveaux-prix-des-cigarettes>
- ²⁴³https://en.wikipedia.org/wiki/Minister_Mentor
- ²⁴⁴<https://www.lemauricien.com/article/criminalite-en-hausse-la-politique-des-drogues-du-gouvernement-lepep-pointee-du-doigt/>
- ²⁴⁵<http://nhrc.govmu.org/English/Pages/default.aspx>
- ²⁴⁶<http://eoc.govmu.org/English/Pages/default.aspx>
- ²⁴⁷CUT, Note on Harm Reduction Services for People Who Inject Drugs in Mauritius (2015) <http://files.server.idpc.net/library/Harm%20Reduction%20position%20paper%20CUT-2015.pdf>
- ²⁴⁸<https://www.theglobalfund.org/en/portfolio/country/?k=01ee1f53-5dd8-4797-811f-84989e8d452f&loc=MUS>
- ²⁴⁹<http://ionnews.mu/tag/mauritian-network-of-people-who-use-drugs/>
- ²⁵⁰HRI (2018) Op. Cit. p 160.
- ²⁵¹HRI (2018) Op. Cit. p 160.
- ²⁵²MOHQL, Essential Drugs List (2017) <http://health.govmu.org/English/Documents/Drug%20Formulary.pdf>
- ²⁵³<https://www.lexpress.mu/article/285182/drogues-synthetiques-74-personnes-brown-sequard-22-morgue>
- ²⁵⁴CUT, Mauritius Harm Reduction Conference Summary Report (2017)
- ²⁵⁵UNODC, Compendium of Good Practices on Drug Use Prevention, Drug Use Disorders Treatment and Harm Reduction in Africa (2018) <http://files.server.idpc.net/library/Compendium%20of%20Good%20Practices%20on%20Drug%20Use%20Prevention,%20Drug%20Use%20Disorders%20Treatment%20and%20Harm%20Reduction%20in%20Africa%2007032018.pdf>
- ²⁵⁶Commission of Inquiry on Drug Trafficking, The Commission of Enquiry on Drug Trafficking Report (2018) Op.cit.
- ²⁵⁷<https://defimedia.info/lutte-contre-la-drogue-anwar-husnoo-annonce-la-reintroduction-de-la-methadone>
- ²⁵⁸The Certificate of Character Act (2012) <http://dpp.govmu.org/English/Documents/Legislation/certchar2012.pdf>