

West Africa drug policy training toolkit

Facilitation guide

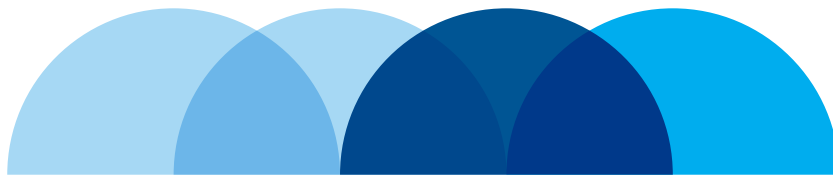
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1. <http://idpc.net/publications/2013/06/training-toolkit-on-drug-policy-advocacy>

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AQIM	Al Qaeda in the Islamic Maghreb
ATS	Amphetamine-Type Stimulants
AU	African Union
CND	Commission on Narcotic Drugs
CSO	Civil Society Organisation
CVE	Countering Violent Extremism
DEA	Drug Enforcement Administration
ECOSOC	Economic and Social Council
ECOWAS	Economic Community of West African States
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
EU	European Union
GCTF	Global Counterterrorism Forum
G-Youth	Garissa Youth Program
HIV	Human Immunodeficiency Virus
IDPC	International Drug Policy Consortium
IEC	Information, Education and Communication
INCB	International Narcotics Control Board
INPUD	International Network of People Who Use Drugs
KENPUD	Kenyan Network of People Who Use Drugs
KTI-E	Kenya Transition Initiative – Eastleigh
LAS	Legal Affairs Section (United Nations)
MUJAO	Movement for Oneness and Jihad in West Africa
NGO	Non-Governmental Organisation
NSP	Needle and Syringe Programme
OST	Opioid Substitution Therapy
SMART	Specific, Measurable, Achievable, Relevant, Time-bound
TANPUD	Tanzanian Network of People Who Use Drugs
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
USAID	United States Agency for International Development
WACD	West Africa Commission on Drugs
WENDU	West African Epidemiological Network on Drug Use
WHO	World Health Organisation



Introduction to the toolkit

Facilitators' note

To deliver every activity in this toolkit would take more than a full week – and it is very unlikely that you will have this much time for your training or workshop. As such, 'Facilitators' Notes' such as this one have been inserted throughout the toolkit to guide you on which activities complement each-other or overlap. We welcome any feedback you may have to improve these notes, which can be sent to contact@idpc.net.

Introduction to the toolkit

The West Africa drug policy training toolkit has been developed by the [International Drug Policy Consortium](#) (IDPC) to build the capacity of civil society organisations in the region and to help them engage with, and influence, drug policy making processes.

This toolkit allows IDPC and a wide range of organisations to deliver trainings and workshops on drug policy advocacy to their civil society partners and members. It covers the areas of drug policy, civil society advocacy, harm reduction, crime and security, and drug treatment and prevention. The Toolkit is intended as a comprehensive menu of activities and content – from which a facilitator can pick and choose the ones which best suit the context, audience and timeframe.

The West Africa drug policy training toolkit is based on a global drug policy training toolkit¹ that was launched by IDPC and [EHRN](#) in 2013. It was funded by the Open Society Foundations and USAID², via the Kofi Annan Foundation², as part of a project to maximise the impact and reach of the report and recommendations of the West Africa Commission on Drugs.³

About IDPC

The International Drug Policy Consortium (IDPC) is a global network of civil society organisations that come together to promote objective and open debate on drug policy issues. Its vision is that national and international drug policies are grounded in the principles of human rights and security, social inclusion, public health, development and civil society engagement.

For more information, visit <http://idpc.net/>

Why was this Toolkit developed?

Over the years, IDPC has received numerous requests to deliver trainings in countries around the world – often from local civil society partners with acute skills building needs in terms of advocacy and policy reform. This Toolkit was therefore developed to build the capacity of civil society organisations to better engage with, and influence, the policy making processes of national governments and regional and international agencies.

At the same time, West Africa has increasingly become a hub in the global drugs trade – particularly for the trans-shipment of narcotics from Latin America through West Africa to Europe and North America, although local production and consumption also continue to be significant concerns. These developments pose serious threats to good governance, peace and stability, economic growth and public health in West Africa, a region that has only recently emerged from decades of violent conflict. As attention turns to drug control policies in the region, and how these may be improved, there is an important role to be played by civil society in advocating for more balanced, effective and humane responses to drugs in the region.

1. <http://idpc.net/publications/2013/06/training-toolkit-on-drug-policy-advocacy>
2. <http://www.usaid.gov/>
3. <http://idpc.net/policy-advocacy/special-projects/west-africa-advocacy/disseminating-the-recommendations-of-the-west-africa-commission-on-drugs>

The Toolkit is the result of several years of work – building on drug policy advocacy trainings organised around the world. It fills an identified gap for a global training resource that focuses specifically on advocacy for drug policy reform.

The intention is to create an open access resource that can be used by facilitators and partners around the world – independently from IDPC, although we will also be using the toolkit for our own activities in the coming years.

How is this toolkit structured?

This toolkit is composed of six independent modules:

Module 1: The drug control system

Module 2: Balanced and effective drug policy - what needs to change?

Module 3: Effective drug prevention and treatment

Module 4: Harm reduction advocacy

Module 5: Best practice in tackling drugs, security and organised crime

Module 6: Civil society engagement in drug policy advocacy

Each of module contains:

Sessions, numbered in each module, either depicted as 'Presentations' or as 'Activities' so that the facilitator knows what type of session he/she will be facilitating.

We have suggested how much time the facilitator can allocate to each session, although this is flexible and will depend on time available for the overall training.

Each session starts with the description of its aims, followed by detailed instructions on the flow of the presentation/activity.

Throughout the training materials, the facilitator will also find 'Facilitators' notes' which are intended to help the facilitator with the overall flow of the training materials and to decide which sessions are more important than others in case of time constraints.

The aim and learning objectives of the module

A short introduction

Module 6 also includes text boxes entitled 'Shorter version if you have less time', which offer shorter alternatives to existing exercises in case of time constraints

For the 'Presentation' sessions: after the instructions, the facilitator will find a box entitled 'Information to cover in this presentation'. The amount of information to be covered by the facilitator during the actual presentation depends on time constraints and level of knowledge of the participants.

Each module ends with '**Handouts**' to distribute to the participants. These illustrate a certain topic with specific examples, or provide additional information on a specific issue. The facilitator can pick and choose which handouts they want to distribute to feed into the discussions. It is also up to the facilitator to decide when they prefer to distribute the handouts – at the beginning, during the training, or at the end.

How can this toolkit be used?

Because most trainings are just for a day or two – and some may only be for a few hours – the toolkit has been developed to allow facilitators to ‘pick and choose’ which modules, presentations, activities and handouts are the most relevant to their audience. This is particularly relevant for Module 6, which offers a wide range of exercises. The sample agendas below provide an idea of how this might work in practice:

Sample 1: When you have one day

9.00 – 9:15	Registration, coffee/tea, welcome, introductions, and objectives for the day
9.15 – 10.15	MODULE 1: THE CURRENT DRUG CONTROL SYSTEM Activity 1.2: overview of dominant international drug control approaches Presentation 1.6: West Africa has a drug problem
10.15 – 11.00	MODULE 2: EFFECTIVE DRUG POLICY: WHAT NEEDS TO CHANGE? Activity 2.2: the tree of balanced good drug policy
11.00 – 12.00	MODULE 3: EFFECTIVE DRUG PREVENTION AND TREATMENT Presentation 3.2: Objectives of drug prevention Presentation 3.5: The effectiveness and appropriateness of prevention interventions Activity 3.6: The availability of drug dependence treatment in West Africa Presentation 3.8: Minimum quality standards for drug dependence treatment
12.00 – 13.00	MODULE 4: HARM REDUCTION ADVOCACY Activity 4.1: Defining harm reduction interventions Presentation 4.3: Harm reduction in West Africa Presentation 4.5: Roadblocks to harm reduction
13.00 – 14.00	Lunch
14.00 – 15.00	MODULE 5: BEST PRACTICE IN TACKLING DRUGS, SECURITY AND ORGANISED CRIME Presentation 5.1: Setting the scene Activity 5.3: Corruption case studies
15.00 – 15.30	Break
15.30 – 16.45	MODULE 6: CIVIL SOCIETY ENGAGEMENT IN DRUG POLICY ADVOCACY Activity 6.1: what is drug policy advocacy? Activity 6.11: Creating an action plan
16.45 – 17.00	Discussion, questions and reflections on the training

Sample 2 :
When you have
two days

Day 1

9.00 – 9.15	Registration, coffee/tea, welcome, introductions, and objectives for the day
9.15 – 11.15	MODULE 1: THE CURRENT DRUG CONTROL SYSTEM Presentation merging 1.3 and 1.4: overview international drug policy and UN drug control architecture Activity 1.5: impacts and consequences of dominant drug control approaches Activity 1.6: film on international drug policy
11.15 – 12.00	MODULE 2: EFFECTIVE DRUG POLICY: WHAT NEEDS TO CHANGE? Activity 2.2: the tree of balanced good drug policy Presentation 2.3: principles to guide effective drug policy
12.00 – 13.00	Lunch
13.00 – 15.00	MODULE 3: EFFECTIVE DRUG PREVENTION AND TREATMENT Presentation 3.2: Objectives of drug prevention Presentation 3.5: The effectiveness and appropriateness of prevention interventions Activity 3.6: The availability of drug dependence treatment in West Africa Presentation 3.8: Minimum quality standards for drug dependence treatment
15.00 – 15.30	Break
15.30 – 17.30	MODULE 4: HARM REDUCTION ADVOCACY Activity 4.1: defining harm reduction interventions Activity 4.3: harm reduction in West Africa Activity 4.5: road blocks to harm reduction
	END OF DAY 1

Day 2

9.00 – 9.15	Recap on previous day and discussion
9.15 – 11.15	MODULE 5: BEST PRACTICE IN TACKLING DRUGS, SECURITY AND ORGANISED CRIME Presentation 5.1: Setting the scene Activity 5.3: Corruption case studies Presentation 5.4: Improving governance and political processes Presentation 5.7: Modernising drug law enforcement
11.15-13:0	MODULE 6: CIVIL SOCIETY ENGAGEMENT IN DRUG POLICY ADVOCACY Activity merging 6.1 and 6.2: what is drug policy advocacy and what are its objectives? Activity 6.3: the importance of planning drug policy advocacy Activity 6.5: selecting the issue or problem you want to address Presentation 6.10: identifying resources to address the selected advocacy issues
13.00 – 14.00	Lunch
14.00 – 15.30	MODULE 6 (continued) Interactive presentation 6.11: Creating an action plan
15.30 – 16.00	Break
16.00 – 17.00	Activity 6.13: Lobbying exercise
17.00 – 17.30	Discussion, questions and reflection on the training
	END OF DAY 2

Prior to the training ...

The facilitators should:

1. Develop the goals and objectives of the training and clearly communicate these to the participants prior to the workshop.
2. Determine participants' level of understanding of drug policy in order to adapt the training to their level of knowledge. This can be done with a short questionnaire sent to the participants prior to the training. When working in groups (which will often be the case in many of the activities presented in the toolkit), it can be useful to divide the participants into groups that contain both the experienced and the beginners to the field of drug policy. A sample questionnaire is available in Annex 5 of the Appendices.
3. Ensure he/she understands any specific local practices or customs with regards to trainings (i.e. the need to open or close with prayers in certain cultures, length of lunch breaks, start and end of day, etc.), and any other culturally specific needs that the participants may have.
4. Gather as much data and background information as possible from the country or region where the training is to be delivered, including:
 - Current and historic patterns of drug use, including recent increases in the supply/demand of certain substances or changes in the routes of administration
 - Relevant ratified UN conventions – e.g. relating to drug control and human rights
 - Relevant national and regional drug strategies
 - Policy response to drug use – measures adopted and funding allocated in the areas of criminal justice, treatment and prevention
 - Rationale and impact of current policies – regarding drug supply and demand, health-related indicators, etc. at the local/national level
 - Different policy options (if any) currently under discussion – e.g. recent proposals by government and / or any expressed desire for change
 - Upcoming opportunities for engagement with policy makers – e.g. forthcoming international meetings at which government and / or NGOs will be represented

This information can be gathered by issuing a questionnaire to the participants in advance of the training, and/or from some of the following online sources:

- <http://idpc.net/>
 - <http://www.wacommissionondrugs.org/>
 - <http://www.ihra.net/global-state-of-harm-reduction>
 - <http://data.worldbank.org/>
 - <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>
 - <http://idpc.net/policy-advocacy/regional-work/sub-saharan-africa>
 - <http://kofiannanfoundation.org/>
5. Ensure that all the materials and information are ready prior to the training in terms of:
 - Flow of the sessions and good understanding of the presentations and activities planned, and an understanding of everyone's role during the training (particularly relevant when there are several facilitators)
 - Preliminary research by the facilitator(s), which is necessary for some of the activities (this is indicated in facilitators' notes)
 - PowerPoint slides and other visuals
 - Printed copies of the handouts to be distributed to the participants

6. Assess the language skills of the participants. This Toolkit is available in English and French. However, if the participants' level of English or French is not good enough, the facilitator may choose to arrange for interpretation in another language (if so, plan for extra time if you choose to do consecutive interpretation, and make sure that the facilitator(s) speak slowly if you choose to do simultaneous interpretation). In addition, a follow-up questionnaire should be sent to the participants after the training to provide a 'post' assessment of knowledge to be compared with the initial questionnaire, as a way to measure changes in knowledge from the training.

If you are delivering the training in another language, you will also need to allocate a large amount of time (and often money as well) for translating the text, slides and hand-outs in advance. If you plan to have translators in the session itself, please allow extra time for each activity.

Thorough preparation is vital for this type of training – so please do not underestimate the time that this takes!

After the training...

At the end of the training, it is useful for the facilitator to ask the participants to evaluate the workshop quality and usefulness. A [template evaluation form](#) is available in Annex 7 of the Appendices of training materials. This form can be distributed to the participants at the end of the training to give them time to fill it in and to return it to the facilitator at the end of the training.

Experience has also shown that participants appreciate receiving a [certificate of attendance](#) at the training. A template of such a certificate is available in the Annex 8 of the Appendices of the training materials. The certificates can either be prepared in advance and distributed at the end of the workshop, or can be sent afterwards to the participants by email.

Who should be involved in the facilitation of the training?

Ideally, a minimum of two facilitators should be involved in delivering the training activities from this toolkit. They should both be present throughout the training itself, as the modules are linked to each other. It is advisable that at least one trainer has some experience in using participatory methods. At least one trainer should be familiar with drug policy issues.

It is always useful to keep a record of the discussions and outputs created during the training by taking pictures. This can easily be done if there are two facilitators at the training. However, should the facilitators wish to do so, they will first need to get the authorisation of the participants. For the purposes of IDPC's and EHRN's work, we would be grateful if the facilitators could send us some pictures of the trainings they have conducted based on these materials, at contact@idpc.net.

Training materials checklist

You will need to go through each activity to check which materials (e.g. flip charts, handouts, slides, etc.) are needed. These will likely include:

- Computer with PowerPoint
- Projector and screen (or blank wall)
- Flipchart stand(s) and paper (it is useful, if possible, to have one flipchart stand per group)
- Coloured marker pens
- Wall tack or tape (to fix flipcharts to the walls)
- Large rectangular post-it notes in different colours
- Printed copies of relevant hand-outs
- Microphones (depending on the number of participants)



Energisers / ice-breakers

Some facilitators like to open a training session with ‘energiser’ activities – also known as ‘ice-breakers’. These can prove useful to help participants to relax, and to allow everyone to get to know each other. They can also give participants greater enthusiasm for the training.

For a range of ‘energiser’ ideas, please read the International HIV/AIDS Alliance publication: *100 ways to energise groups* (<http://www.aidsalliance.org/publicationsdetails.aspx?id=146>).

At the very least, facilitators should allow time for a round of introduction for all participants.

Sample ‘energiser’:

Aim

- For participants to introduce themselves to each other
- To compare expectations and fears about the workshop with the training objectives.
- To clarify the workshop agenda and methodologies.
- To agree on ground rules for the training.

Methodology

- Presentation
- Introductory ice breaker
- Pair-work
- Group work

Time required

- Up to 1 hour

Materials needed

- Flip chart or PowerPoint slide with the workshop aims and objectives
- Flip chart or PowerPoint slide outlining the workshop agenda
- Post-it notes – 2 different colours
- Blank flip chart sheets
- Marker pens
- Photocopies of :
 - Agenda
 - Registration sheet
- Workshop aims and objectives

Preparation

- Prepare either a flipchart or a PowerPoint slide of the workshop programme
- Prepare either a flipchart or a PowerPoint slide of the workshop aims and objectives
- Prepare 2 flipcharts – one titled ‘expectations’ and one titled ‘concerns’

Activity: Find your pair

🕒 40 min

1. Welcome participants and introduce the workshop.
2. Address any housekeeping and logistical matters.
3. Provide each participant with one of the ‘Find your pair’ icebreaker cards (see: [Annex 1](#)), and ask them to walk around the room and find the person who is holding their ‘partner’ card (i.e. the person with ‘Day’ must find the person with ‘Night’).

4. Ask each person to introduce themselves to their partner by:
 - stating their name,
 - the organisation they are from, and
 - giving one example of something they enjoy doing outside of work.

In plenary, ask each pair to present their partner to the rest of the group.

5. Give 1 coloured post-it note to each participant and ask them to write one expectation about the workshop. Ask participants to stick these notes on pre-prepared flip charts placed on one of the walls in the room. One of the facilitators needs to quickly sort these into similar themes.
6. Present the training aims and objectives – either on a pre-prepared flip chart or on a PowerPoint slide. Compare these to participants' expectations and concerns and state how each will be addressed within the limits of the workshop.
7. Present the workshop agenda, explain the methodology that will be used and address any questions.
8. Spend five minutes brainstorming and agreeing on some basic ground rules or ways of working together during the training (e.g. listening to others without interrupting, etc.) and note these on flip chart paper to be stuck to the wall for the duration of the workshop.

Notes:



MODULE 1



The Global Drug Control System



Aim of Module 1

To describe and understand global drug policies, and to discuss how current drug policies across West Africa reflect these.



Learning objectives

Participants will gain an understanding of:

- the international framework that underpins drug control policies, the ideology behind these, and the history of the development of international drug control;
- the UN drug control system – the treaties and drug control bodies
- the tensions between drug control and human rights (health, development and legal issues);



Introduction

The roots of our current international drug control regime can be traced back more than 100 years, and are underpinned by the belief that a punitive approach would deter any involvement in the illicit drug market. This Module will provide a description and analysis of the global drug control system, as well as describe its consequences.

SESSION 1.1:

Activity: Setting the scene – what do we mean by drug policy

SESSION 1.2:

Activity: Overview of dominant drug control approaches

SESSION 1.3:

Presentation: Background to international drug policy

SESSION 1.4:

Presentation: United Nations drug control architecture

SESSION 1.5:

Activity: Impact & consequences of dominant approaches

SESSION 1.6:

Film clip: West Africa has a drug problem

MODULE 1



20 min

Session 1.1

Activity: Setting the scene - what do we mean by drug policy?



Facilitators' note

In case of time constraints, the facilitator may decide to present all definitions used in the training toolkit in this session (i.e. advocacy, harm reduction, etc.) This would mean reworking the sequence of sessions later on in the training and merely referring to the already agreed definitions rather than having participants come up with their own definitions.



Aim – To come to a shared understanding of the term “drug policy” and agree on a working definition to use during this training

1. Introduce the aim of the session.
2. Ask participants to brainstorm the key points for defining policy / drug policy.
3. Present the policy definitions below and ask participants if they know of other good policy definitions.
4. Depending on participants' knowledge, understanding and time available, you could also explore the term “controlled” – i.e. how much “control” does prohibition actually provide over certain drugs?



Examples of definitions

Policy

Policies can be defined as how societies and their institutions deal with issues. Policies may be formal and written (such as laws) or informal and/or unwritten (e.g. social etiquette or practice).

Controlled drugs

Psychoactive substances that are controlled under the three UN drug control conventions, and/or under national laws and regulations. These are widely referred to as “illicit drugs”.

Drug policy

The formal or informal policies that aim to affect the supply of drugs, the demand for drugs and/or the harms caused by drug use and/or drug markets. In practice, the term “drug policy” is most commonly used to describe laws and practices that target controlled drugs (rather than uncontrolled or pharmaceutical drugs).

Drug control

Drug control is a term used to indicate the overall system of laws, regulations, practices and institutions that focus on controlled drugs – at local, national, regional and international level.

War on drugs

The term “war on drugs” was made famous by US President Nixon in the 1970s, and has come to refer to the more punitive, repressive drug policies and a “zero tolerance” approach to drug use and people who use drugs.

Session 1.2

Activity: Overview of current drug control approaches



20 min



Aim – To review the dominant approaches taken by most governments to control drugs

1. Introduce the aim of the session.
2. Ask participants to brainstorm (without evaluating at this stage) the interventions used by governments to control the supply of, harms from, and demand for, controlled drugs. If they mention broader terms such as the “war on drugs”, ask them to break these down into the specific interventions that formed part of these approaches.
3. Note responses on a flip chart under three columns – **demand reduction**, **harm reduction** and **supply reduction** and control. The interventions that come under harm reduction will be discussed further in [Module 4](#).
4. Ask participants, based on their experience, how successful or not these interventions have been.



Examples of what participants may come up

Demand reduction

- School based educational programmes – ‘Just say no!’
- Schools based drug-testing
- Pragmatic drug user education
- Abstinence-based programmes
- Prevention programmes
- Incarceration of drug users
- Crackdowns on drug offenders
- Etc.

Supply reduction

- Crop eradication
- Crop substitution / alternative development programmes
- Efforts to stop the sale of drugs, including arrest & punishment of low level dealers engaged in the drug trade to fund their drug use
- Interventions against money laundering
- Interventions against diversion of chemical precursors
- Imprisonment and fines for producers and traffickers
- Seizure of drugs
- Etc.

Harm reduction

- NSP
- Peer outreach
- OST
- Heroin assisted treatment (HAT)
- Drug Consumption Rooms
- Overdose prevention / management
- Etc.

5. Put the flipchart up on a wall and explain that we will return to it at different points in the training.
6. Summarise by noting that the dominant strategy of reducing the scale of drug markets and use has been based on the **principle of deterrence** and focused on implementing **tough laws prohibiting** the production, distribution and use of drugs – referred to as **prohibition-led / prohibitionist / punitive** approaches. It was believed that this strategy, which seeks to deter any involvement in the illicit drug market with the threat of **punishment**, would reduce, and eventually eliminate, the global drug market and its associated health and social harms – it would lead to “a drug-free world” (which was the United Nations target for 2008!). These drug policies are underpinned by the international drug control system, which we will describe in the next session(s).



Retrieved from: <http://www.humanrightsanddrugs.org/category/images/>

Session 1.3

Presentation: Background to international drug policy



20 min



Aim – To provide participants with an overview of the international drug control system (which their governments have signed up to, and which informs drug policies at the national level)

1. Introduce the aim of the session.
2. Before starting the presentation, ask the participants what they know about when and why the international community first came together to discuss setting up a global system for drug control.
3. Present slides. The facilitator can refer to [handout “The UN drug control conventions”](#) for more information.



Facilitators' note

Depending on time available, the facilitator has a choice of either combining the presentations of Sessions 1.3 and 1.4 in one presentation, or to keep them in separate sessions.



Information to cover in this presentation:

The roots of the present global drug control system can be traced back 100 years, and therefore pre-dates the United Nations system itself. It was inspired by the realisation that no country could regulate drug use in isolation, since these commodities were so readily bought and sold across borders and jurisdictions. Control would require states to work together.

The beginnings of the international drug control system

At the instigation of the United States, a group of those countries most concerned about the drugs issue came to together in Shanghai in 1909 to devise an international system for controlling drugs. At the time, the widespread use of opium in China was the main concern. Although the drug control system is often presented in terms of humanitarian and health concerns, the movement was equally driven by economic and political forces. Although it had no legal powers, the Shanghai commission devised a system which was an early blueprint for today's international drug control regime.

Countries present in Shanghai met again at the Hague in the Netherlands, where they devised the 1912 International Opium Convention, a legally binding treaty that began the process of restricting the production, distribution and use of drugs to scientific and medical purposes. However, it was very difficult to persuade the major producing countries to sign up – Turkey and Germany for instance, leading producers of opium and cocaine respectively, were reluctant to enter into this agreement. They were, essentially, forced to do so when the Opium Convention was incorporated into the Treaty of Versailles which ended the First World War in 1919, which all the formerly warring nations had to sign in order to end hostilities. The system developed throughout the twentieth century, becoming gradually more restrictive.

Facilitators' note

'Illicit' drugs?

None of the drugs controlled in the international drug conventions were ever made 'illicit' in and of themselves – their production and trade were placed under tight control to limit use to medical and scientific purposes. It is therefore a behaviour (i.e. production, trade and consumption for non-medical purposes) that is illicit, rather than the substance itself. We therefore use the term 'controlled substances' or 'controlled drugs' in this training.

Today, three conventions with near universal ratification make up the **instruments of international drug control** that guide contemporary national drug laws and policies:

- **The 1961 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol)** – It formally established the current international drug control system that brought together and replaced all previous international agreements on drug control that had been signed since the 1912 Hague Convention. It established a universal system for limiting the cultivation, production, distribution, trade, use and possession of narcotic substances strictly to medical and scientific purposes, with special attention on substances derived from plants: opium/heroin, coca/cocaine and cannabis.
- **The 1971 Convention on Psychotropic Substances** – This convention extended international control to cover over a hundred synthetic psychotropic substances, but because of international pressure from European and North American pharmaceutical companies, the controls were much weaker than those imposed by the 1961 Single Convention.

NB – The preambles of the 1961 and 1971 Conventions state that the fundamental objective of these conventions is to protect the **"health and welfare of mankind"**.

- **The 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances** – This last convention was negotiated in response to massive increases in both demand and supply of cannabis, cocaine and heroin for non-medical use. The rapid growth of illicit trafficking fuelled a criminal black market worth billions. The 1988 convention provides special enforcement measures to reduce illicit cultivation, production and trafficking of drugs, and the diversion of chemical precursors. The Convention significantly reinforced the obligation of countries to apply criminal sanctions domestically. However, there is some flexibility in this convention which enables governments to implement national policies. We will explore those flexibilities in **Module 2**.

Summary Points

Controls in the UN drug control conventions apply to a variety of substances such as cocaine, methadone, oxycodone, diazepam (market name Valium), morphine and codeine, but these substances are placed in different schedules, each of which requires different control systems. Each of the treaties encourages, and in some instances requires, **criminal sanctions** to be put in place at the **national level** for certain types of drug-related offences. There are **two main aims to the drug control treaties**:

- to **prohibit the supply** of and **demand** for controlled substances for non-scientific or recreational/non-medical purposes, and
- to ensure **adequate access** to those substances for scientific and medical purposes.
- Traditionally the **overwhelming focus** has been placed **on the former, restrictive aspect**¹ – the various approaches which we will further review later on in this Module.

In addition, collectively, in more than 110 articles covering many areas that impact upon **human rights**, such as extradition, crop eradication and penalties, there is scarcely any reference to human rights, except in the preamble of the 1961 and 1971 conventions, which highlights that the conventions are concerned with the "health and welfare of mankind". We will also look at this in more detail later on in the training.

1. For more information, please read: International Centre on Human Rights and Drug Policy, *International drug control law*, <http://www.humanrightsanddrugs.org/international-law/international-drug-control-law/>

Session 1.4

Presentation: United Nations drug control architecture



30 min



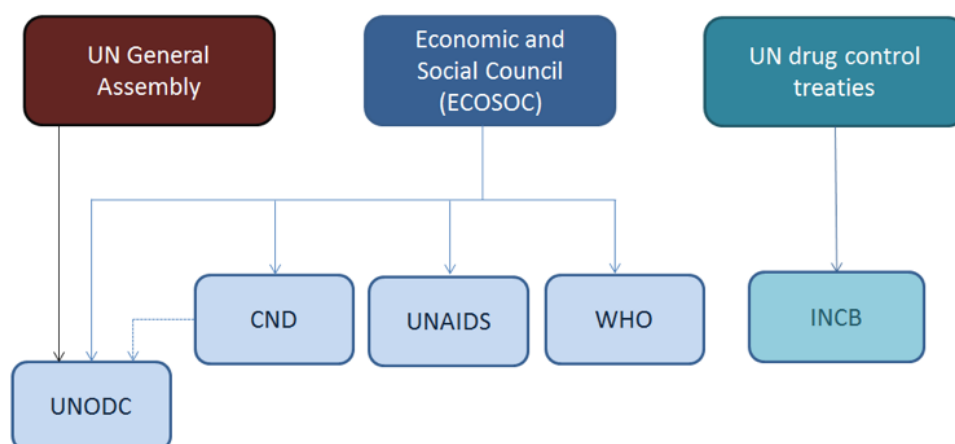
Aim – To provide an overview of the UN bodies that are responsible for overseeing the functioning of the international drug control system

1. Introduce the aim of the session.
2. Before starting the presentation, check with participants what they know about which UN bodies are involved in international drug control, what their mandates are and whether there is scope for civil society engagement. The facilitator can refer to handout [“The UN drug control bodies and how to influence them”](#) for more information.
3. Present slides.



Information to cover in this presentation:

The United Nations drug control bodies¹



Economic and Social Council (ECOSOC)

The Economic and Social Council is the central forum for discussing international economic and social issues, and for formulating policy recommendations addressed to Member States and the UN system. The UN Charter² (the organisation's founding document) entrusts ECOSOC with international economic, social, cultural, educational, health and related matters. In order to perform these functions, the Council established various functional commissions, including the Commission on Narcotic Drugs.

Commission on Narcotic Drugs (CND)

The CND is the central policy-making body for the UN drug control system. It meets every year for a week in March in Vienna, Austria, to discuss drug policy issues and adopt resolutions on the direction of international drug control for the coming year. It comprises 53 UN member States elected by ECOSOC, with a geographical distribution of seats. The Commission is mandated by the UN drug control conventions to consider all issues relating to the objectives of the conventions. Under resolution [1991/38](#) of the Economic and Social Council, the Commission was requested to give policy guidance to and to monitor the activities of the United Nations Office on Drugs and Crime (UNODC).³ The secretariat of the CND resides within the Division of Treaty Affairs of UNODC. The CND is the final decision maker on proposals by the World Health Organisation (WHO) to schedule, de-schedule or re-schedule a psychoactive substance (although it can only accept or reject the WHO proposal – see more information below on the description of WHO).

International Narcotics Control Board (INCB)

The INCB was created by the 1961 Convention (Article 9) to oversee the implementation of the drug control conventions. The second function of the INCB, of equal importance, is to ensure the availability of controlled drugs for medical and scientific research purposes. The INCB is made up of 13 members elected by ECOSOC, who serve 5-year terms, and is based in Vienna, Austria. The INCB has a secretariat that assists it in its functions. The INCB is the guardian of the treaties. As such, it monitors member states' compliance with the drug control treaties, and can raise the matter with individual governments if it judges them to be in contravention with the conventions. It is, however, supposed to approach such countries in a spirit of cooperation. It can also raise the matter with the CND and ECOSOC. In practice, the INCB has been one of the most conservative UN drug control bodies and has regularly criticised countries that sought to develop more progressive drug policies based on human rights and public health.

United Nations Office on Drug Control (UNODC)

UNODC is responsible for coordinating international drug control activities and is the public face of the drug control system. It assists member states in their responses to the challenges of illicit drug use and related crime. It was established in Vienna in 1997 through a merger between the UN Drug Control Programme and the Centre for International Crime Prevention. UNODC operates in all regions of the world through a broad network of field offices. In addition to drug control, UNODC is mandated to deal with security threats in the form of organised crime and terrorism. It has a three-pillar work programme:

1. Research and analytical work to increase knowledge and understanding of drugs and crime issues. This includes the production of documents such as the World Drug Report.
2. Normative work to assist States in the ratification and implementation of the international treaties.
3. Field-based technical cooperation projects to enhance the capacity of Member States to counteract illicit drugs, crime and terrorism.

World Health Organisation

WHO is the UN specialised agency for health, established in 1948. Its objective is the attainment by all peoples of the highest possible standard of health. Health is defined as a state of complete physical, mental and social wellbeing — not merely the absence of disease or infirmity. The WHO is the only treaty mandated body to conduct medical and scientific assessments of psychoactive substances and advise on their scheduling, and the WHO expert committee can recommend to upgrade or downgrade the classification of a substance between the four schedules of the 1961 and 1971 conventions, or recommend to remove a substance from the lists altogether. The CND can adopt or reject the WHO recommendation by vote

(simple majority for substances under the 1961 convention, two-third majority for substances under the 1971 convention) but not take another decision. However, lack of funding prevents the WHO expert committee from meeting on a regular basis, which results in some assessments being long overdue. For instance, cocaine, morphine and opium have never been reviewed by the WHO or any other entity since 1912, while cannabis and the coca leaf have not been reviewed since 1965.

UNAIDS

While UNAIDS is not a drug control body, it has a key relationship with the global drugs issue. UNODC and WHO are among the co-sponsors of UNAIDS, with UNODC taking the lead role in UNAIDS' response to HIV amongst people who use drugs and in prisons. To achieve the system-coherence needed by the UN as a whole, and to effectively and realistically address the HIV/AIDS epidemic, it is vital that the drug control policies are in line with the objectives and work of UNAIDS.

1. A full organisation chart of the UN bodies is available here: http://www.un.org/en/aboutun/structure/org_chart.shtml
2. Charter of the United Nations, <http://www.un.org/en/documents/charter/index.shtml>
3. For more information, please read: <http://www.unodc.org/unodc/en/commissions/CND/index.html?ref=me-nuside>

MODULE 1



90 min

Session 1.5

Activity: Impact & consequences of dominant approaches: The “tree of prohibition-led drug policy”



Facilitators' note

In case of time constraints, it is possible to conduct this activity at the same time as [activity 2.2](#) (the “Tree of good drug policy”) in Module 2, by splitting the participants into four groups and ask two groups to work on the tree of bad drug policy while the two other groups work on the tree of good drug policy. The discussions can then focus on comparing the findings of all groups on what they consider good and bad policies.

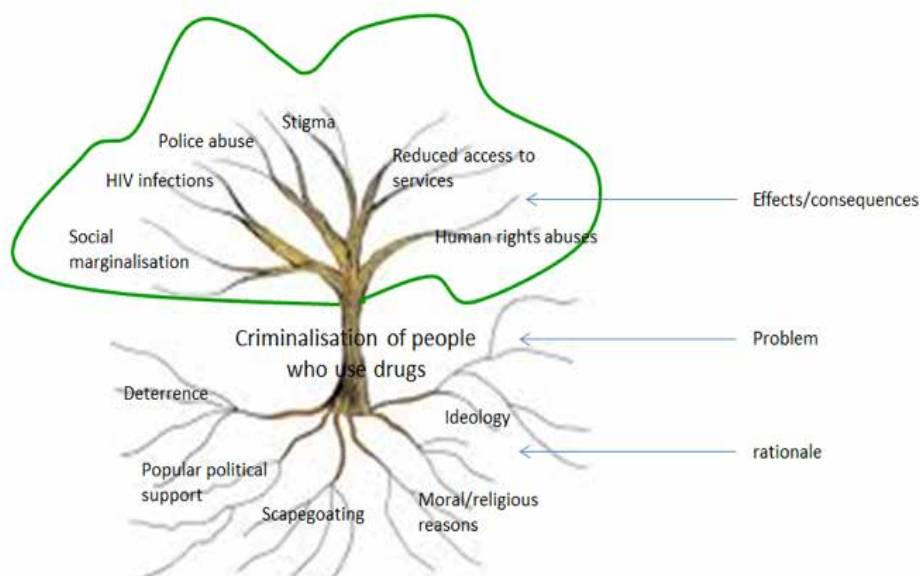
Please also note that Sessions 1.5, 2.2 and 3.9 include a similar activity (the “tree” exercise”). To avoid repetitions, we advise the facilitator to use this exercise only once during the training.

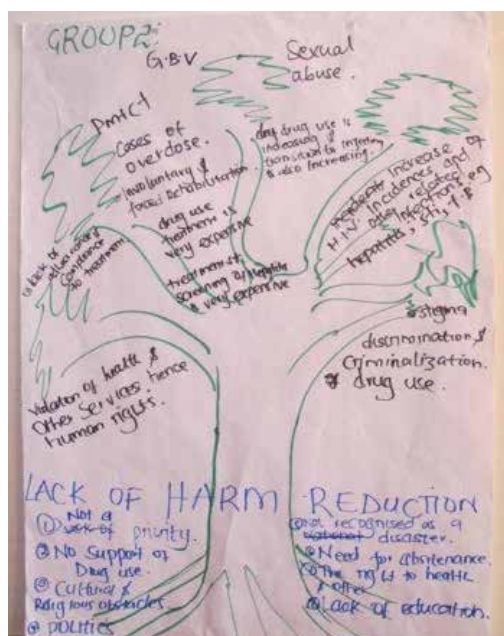


Aim – To explore the efficacy and consequences of prohibition-led policy and practice

1. Introduce the aim of the session.
2. Ask participants to work in small groups (three to five people) and to select one of the prohibition-led interventions or policies identified in the previous session that is relevant in their context – e.g. incarceration / criminalisation of people who use drugs, abstinence-based approach to drug use, compulsory detention, death penalty, disproportionate sentencing, inappropriate and badly sequenced alternative livelihoods, crop eradication, etc.
3. Give each group flipchart paper and coloured marker pens.
4. Ask each group to produce a large drawing of the trunk of a tree and write their chosen intervention on the trunk.
5. Encourage participants to identify the **rationale/justifications behind the intervention**. Draw these along the roots of the tree.
6. Next, encourage participants to identify the **main effects and consequences of the intervention** (both desired and undesired). Ask them to write each effect as a branch of the tree. Ask participants to pay particular attention to the consequences of the chosen intervention on the lives of people who use/transport/grow drugs (i.e. in terms of stigma, discrimination, social marginalisation or status, service uptake, livelihood and self-esteem).
7. When completed, ask each group to present and discuss what their tree shows. For example, how do the reasons for and the effects of the intervention relate to each other? Does the intervention have the desired effect as stipulated by the drug strategy rationale? What are the benefits of the policy? Are there harmful consequences? Can these be grouped – e.g. harms to public health, human rights, development?

Example of “tree of prohibition-led drug policy”





Example of "tree of prohibition-led drug policy" made during civil society advocacy workshop in Nairobi, Kenya, November 2012



8. In plenary, ask participants to consider why these traditional prohibitionist approaches to drugs have remained so predominant over the years.
9. For each of the approaches listed, ask what the rationale for governments pursuing this approach is – i.e. what are the perceived advantages? Add these in a column headed "advantages" to the right of the approach.
10. Next, ask participants to consider the negative consequences or disadvantages of each approach. Add these next to the advantages in a second column headed "disadvantages".
11. Provide a brief summary presentation (which will pave the way for subsequent sessions) along the following lines (present slides):



Example of what participants may come up with

Advantages

- Easily measured (e.g. numbers of arrests made, individuals incarcerated, narcotics seized)
- Offer images that are media friendly and ease public concerns
- Present a visible response to a complex, often hidden problem
- Assumption that not following such a hard line will invite criticism from other nations and organisations such as the United Nations

Disadvantages

- High costs of custody
- Breaking international human rights commitments, such as...
- Lack of evidence of effectiveness for drug education programmes
- Corruption
- Difficulties in border policing
- Environmental impact
- Increases in blood borne virus transmission
- Increased global organised crime



Information to cover in summary presentation:

There are two fundamental problems related to the current international drug control system. Firstly, when the 1961 Convention came into being over 50 years ago, and when President Nixon launched the US government's war on drugs more than 40 years ago, policy makers believed that harsh law enforcement action against those involved in drug production, distribution and use would lead to an ever-diminishing market in drugs such as heroin, cocaine and cannabis, and the eventual achievement of a "drug free world".

In practice, the **global scale of illicit drug markets** – largely controlled by organised crime – **has grown dramatically** over this period. While accurate estimates of global consumption across the entire 50-year period are not available, an analysis of the last 10 years alone shows a large and growing market.¹

Secondly, the current regime has led to a **number of serious negative consequences**. There is mounting recognition that the "war of drugs" approach has failed. This is a position now supported by many commentators, not least the Global Commission on Drug Policy² and the West Africa Commission on Drugs.³ The West Africa Commission's 2014 report – "Not Just in Transit" states:

We have concluded that drug use must be regarded primarily as a public health problem. Drug users need help, not punishment.

We believe that the consumption and possession for personal use of drugs should not be criminalised. Experience shows that criminalisation of drug use worsens health and social problems, puts huge pressures on the criminal justice system and incites corruption.

We abhor the traffickers and their accomplices, who must face the full force of the law. But the law should not be applied disproportionately to the poor, the uneducated and the vulnerable, while the powerful and well-connected slip through the enforcement net.

We caution that West Africa must not become a new front line in the failed "war on drugs," which has neither reduced drug consumption nor put traffickers out of business.⁴

According to the United Nations itself, the "unintended" consequences of the international drug control system include:

- A huge criminal black market that thrives.
- Funds and attention being drawn away from public health and into law enforcement.
- A "balloon effect" where tighter controls in one place produces increased drug production, trafficking or use in another place.
- "Substance displacement", whereby drug controls may encourage individuals to move from one drug to another – potentially more harmful – substance.
- The widespread perceptions of people who use drugs as criminals, and the associated social exclusion, human rights violations and marginalisation that they suffer.⁵

In addition drug policies have made drugs an explicitly political issue, which has resulted in organised crime exerting an undue influence in the political arena – resulting in the corruption of public servants, in particular those in the criminal justice system.

Thirdly, the regime is alarmingly **outdated**. The 1961 convention is now more than 50 years old, pre-dating the HIV epidemic, the internet and many of the characteristics of modern drug markets. Over the years, the system has not been able to adapt to new health and social realities.

The Global Commission, the West Africa Commission and a number of international advocates are now calling for:

- An open debate which acknowledges the failure of past policies, and looks for alternatives which differentiate between the harms caused by different drugs and acknowledge the human rights of those that take them
- A reduction of the harms caused by prohibitionist strategies
- The development of a new paradigm which treats drug use as a public health issue; reduces consumption through better information, education and prevention; and focuses repression on organised crime rather than drug users and subsistence farmers.
- Open up a larger public debate, through engagement of civil society, which considers previous policy shortfalls and considers alternatives.

The global drug control system is also being seriously questioned by a number of government officials, in particular in Latin America, where a call for reform from Mexico, Guatemala and Colombia has led to a UN General Assembly Special Session (UNGASS) on drugs in 2016 to review current strategies.

1. See, for instance: European Commission, Trimbos Instituut & RAND Europe (2009), *A report of global illicit drugs markets 1998-2007*, https://dl.dropboxusercontent.com/u/64663568/library/EU_Markets_Study_EN0409.pdf
2. To access the reports of the Global Commission on Drug Policy, please visit: <http://www.globalcommissionondrugs.org/>
3. To access the reports of the West Africa Commission on Drugs, please visit: <http://www.wacommissionondrugs.org/>
4. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
5. Costa, Antonio Maria (7 May 2008), *Making drug control 'fit for purpose': Building on the UNGASS decade – Report by the Executive Director of the United Nations Office on Drugs and Crime as a contribution to the review of the twentieth special session of the General Assembly*, E/CN.7/2008/CRP.17, http://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_51/1_CRPs/E-CN7-2008-CRP17_E.pdf

MODULE 1

Session 1.6

Film clip: West Africa has a drug problem

 20 min

Facilitators' note

The film is just over one minute long, and can be shown earlier in this module, or later on during the training, according to the facilitator's preference.

Facilitators' note

If time allows, there are several other films that could be shown to participants, including:

- West Africa Commission on Drugs – “West Africa Has a Drug Problem” (Longer Film) (https://www.youtube.com/watch?v=gMPqm3IE_GE)
- Open Society Foundations – “International Drug Policy: Animated Report 2009” (<http://www.youtube.com/watch?v=Do-RCrOrkpY>)



Aim – To showcase an animated film from the West Africa Commission on Drugs from 2014, which summarises the drug problem in the region and the need to review and reassess drug policies.

1. Introduce the aim of the session, and explain that this film was produced by the West Africa Commission on Drugs in 2014 to highlight some of the disastrous effects of drug policy in recent years and propose solutions for a way forward.
2. Provide the participants with some questions to consider while watching the film, in order to guide the discussions afterwards. For example, you could ask the participants to think about what the “stand out” point they take from the film – which of the facts or arguments was most impactful in their opinion, and why.
3. Allow some time for discussion (including of any issues raised in the film not previously explored), but contain discussions about the proposed solutions, explaining that these will be explored in the sessions that follow.
4. The film clip can be accessed online:

<https://www.youtube.com/watch?v=c5dz9d22NGw> (English)

<https://www.youtube.com/watch?v=hZXaB0m6a20> (French)

In areas where the internet is slow or intermittent, it is highly recommended that the facilitator streams the film prior to the session so that it is loaded on the computer.

Alternatively, the video can be downloaded from <http://vimeopro.com/afpservices/b-rolls-wacd/video/97953664>, and then played from a hard drive without the need for internet access.



Handout: The United Nations drug control treaties

The 1961 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol)

This convention formally established the current international drug control system that brought together and replaced all previous international agreements on drug control which had been signed since the 1912 Hague Convention. It established a universal system for limiting the cultivation, production, distribution, trade and use of narcotic substances strictly to medical and scientific purposes, with special attention on substances derived from plants: opium/heroin, coca/cocaine and cannabis. Importantly, “medical and scientific purposes” were not defined, though the implication is that only the modern western system is real medicine.

This convention contained new provisions that established the following:

- A harsher, prohibition-based system for the control of drugs
- Extended controls to include the cultivation of plants from which narcotic drugs are derived (this impacted directly on countries that traditionally produced plants such as opium¹ poppies, cannabis and coca)
- A ban on traditional practices that included traditional medicinal use of all three plants. Such use was defined as “quasi-medical” practices that had to be terminated within set time-frames. Opium was to be eliminated over a 15-year period, and coca and cannabis within 25 years
- The classification of more than a hundred substances under varying levels of control in four schedules according to their alleged level of dangerousness. Controversially, cannabis appears under the list of the most dangerous substances.

The 1971 Convention on Psychotropic Substances

This treaty extended international control to cover over a hundred synthetic psychotropic substances, such as amphetamines, barbiturates, benzodiazepines and psychedelics under four schedules. However, due to pressure from European and North American pharmaceutical companies the controls were much weaker than those imposed on plant-based drugs in the 1961 Convention.

Under the treaty, “street drug” hallucinogens are most tightly controlled while pharmaceutical products have much weaker controls, reflecting the interests of those countries with powerful pharmaceutical interests (such as the United States, United Kingdom, Canada, Federal Republic of Germany, Switzerland, The Netherlands, Belgium, Austria and Denmark).

Note: The preambles of the 1961 and 1971 Conventions states that the fundamental objective of these conventions is to protect the “health and welfare of mankind”.

The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic substances

This last convention was negotiated in response to massive increases in both demand and supply of cannabis, cocaine and heroin for non-medical (therefore illicit) use. Demand had dramatically increased for these substances in Western countries during the 1970s

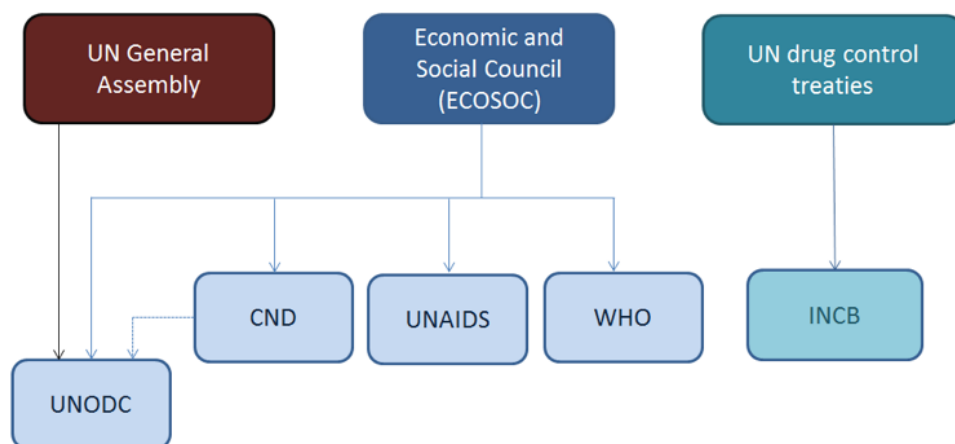
and 1980s, and large-scale illicit production took place in the traditional producer countries to meet that demand. Prior to the 1961 Convention, this demand for non-medical use had been met partly through leakage from licit production, and partly through illicit cultivation and production. However, by the 1980s, globalised organised crime groups had established an international industry to handle illicit supply.

The rapid growth of illicit trafficking of these drugs fuelled a criminal black market worth billions. This development led the international community to negotiate the 1988 convention to provide special enforcement measures focused on reducing illicit cultivation, production and trafficking of drugs, and the diversion of chemical precursors. The treaty also made provisions for mutual legal assistance including extradition for such offences, mechanisms to combat money-laundering, and so on.

The important point about the 1988 Convention is that it 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. However, there is some flexibility in this convention which enables governments to implement national policies, such as decriminalisation and alternatives to imprisonment.

1. "If in those days the opium-producing countries had been as concerned about alcohol as Western countries were concerned about opium, we might have had an international convention on alcohol", remarked the former head of the WHO Section on Addiction Producing Drugs.

Handout: The UN drug control bodies and how to influence them



Economic and Social Council (ECOSOC)

ECOSOC serves as the central forum for discussing international economic and social issues¹, and for formulating policy recommendations addressed to Member States and the United Nations system. The UN Charter entrusts ECOSOC with international economic, social, cultural, educational, health and related matters. In order to perform these functions, the Council established various functional commissions, including the Commission on Narcotic Drugs

Scope for CSO engagement – ECOSOC can grant what is called “consultative status” to NGOs working on drug-related issues, which enables them to obtain access to certain institutions and events relevant to the international drug control system, some of which are illustrated below.

Commission on Narcotic Drugs (CND)

The CND is the central policy-making body for the UN drug control system. It meets every year for a week in March in Vienna, Austria, to discuss drug policy issues and adopt resolutions on the direction of international drug control for the coming year. It comprises 53 UN member States elected by ECOSOC, with a geographical distribution of seats. The Commission is mandated by the UN drug control conventions to consider all issues relating to the objectives of the conventions. Under resolution [1991/38](#) of the Economic and Social Council, the Commission was requested to give policy guidance to and to monitor the activities of the United Nations Office on Drugs and Crime (UNODC).² The CND is the final decision maker on proposals by the World Health Organisation (WHO) to schedule, de-schedule or re-schedule a psychoactive substance (although it can only accept or reject the WHO proposal – see more information below on the description of WHO).

Scope for CSO engagement – The CND is mandated by the UN Charter (article 71) to facilitate NGO and civil society participation in its work. There are formal provisions for NGOs which have ECOSOC consultative status to attend the CND as observers; and a small number of NGO representatives have been able to deliver statements at the CND’s Plenary session. More importantly, the informal sessions at which member states meet to negotiate disputed draft resolutions are closed to civil society.

A more efficient channel of influence consists of NGOs liaising directly with their own government's delegation at the CND in the "corridors" of the meeting. In some cases, NGO representatives can even be included in government delegations, but this will of course depend on the governments' willingness to do so. In any case, as member states are best placed to achieve policy changes at the CND, advocacy directed at national delegates constitutes an effective tool for promoting drug policy reform

International Narcotics Control Board (INCB)

The INCB oversees the implementation of the drug control conventions. It is made up of thirteen members elected by ECOSOC, who serve 5-year terms, and is based in Vienna. The INCB was created by the drug controls treaties (Article 9 of the Single Convention) 1- to be the guardian of the treaties and 2- to ensure the availability of controlled drugs for medical and scientific research purposes. As "guardian of the treaties", the INCB monitors member states' compliance with the drug control treaties, and can raise the matter with individual governments, the CND and ECOSOC when it judges some governments to be in contravention with the conventions. In practice, the INCB remains one of the most conservative UN drug control bodies and has regularly criticised countries that seek to develop more humane and progressive drug policies.

Scope for CSO engagement – The INCB has traditionally not been receptive to engagement with civil society, citing the "need for security of information" as a justification. However, in the face of extensive criticism from NGOs working in the drugs field and subsequent negotiations between the INCB and the Vienna NGO Committee on Drugs (VNGOC – see below for more information), it has recently made some concessions, in particular the possibility for NGO participation during the INCB country missions. As a result, it is now possible for NGOs to apply³ to meet INCB representatives when they undertake visits in member states to examine the drug control situation (a number of these visits are made in various countries each year). At the international level, the INCB chair now meets every year with NGOs at the informal dialogue organised at the CND.

United Nations Office on Drug Control (UNODC)

UNODC is the UN agency responsible for coordinating international drug control activities, and is the public face of the drug control system. It was established in Vienna in 1997 through a merger between the UN Drug Control Programme and the Centre for International Crime Prevention. UNODC operates in all regions of the world through a broad network of field offices. The UNODC is also mandated to deal with security threats posed by organised crime and terrorism. It has a three-pillar work programme:

1. Research and analytical work to increase knowledge and understanding of drugs and crime issues. This includes the production of documents such as the World Drug Report
2. Normative work to assist States in the ratification and implementation of the treaties
3. Field-based technical cooperation projects to enhance the capacity of member states to tackle controlled drugs, crime and terrorism.

Scope for CSO engagement – The primary mechanism for civil society involvement with UNODC and the other international drug control bodies is the Vienna NGO Committee on Drugs (VNGOC). Formed in 1983, the VNGOC has a Board of 7 officers, and is made up of international, national and local NGOs. The Vienna NGO Committee works to provide information about NGO activities, draw attention to areas of concern, build partnerships between governmental and non-governmental organisations, and enhance civil society involvement in the formation and development of international drug policies. Beyond 2008, an initiative of the VNGOC in partnership with UNODC, provided a platform for civil society to contribute to the review of the 1998-2008 United Nations General Assembly Special Session on Illicit Drugs. NGOs can apply for membership of the VNGOC through its website⁴. UNODC has established a "Civil Society Team" which is coordinating collaboration with NGOs. In addition, the UNODC is directly engaged in informal consultations with a number of NGOs, including IDPC.

World Health Organisation (WHO)

WHO is the UN specialised agency for health, established in 1948. Its objective is the attainment by all peoples of the highest possible standard of health. Health is defined as a state of complete physical, mental and social wellbeing — not merely the absence of disease or infirmity. The WHO is the only treaty mandated body to conduct medical and scientific assessments of psychoactive substances and advise on their scheduling, and the WHO expert committee can recommend to upgrade or downgrade the classification of a substance between the four schedules of the 1961 and 1971 conventions, or recommend to remove a substance from the lists altogether. The CND can adopt or reject the WHO recommendation by vote (simple majority for substances under the 1961 convention, two-third majority for substances under the 1971 convention) but not take another decision.

Scope for CSO engagement – The importance of civil society engagement is embedded in the WHO constitution. A number of public health NGOs have formal relationships with the WHO and are permitted to speak at governmental meetings. While no drug policy NGOs presently enjoy such relations, numerous NGOs involved in harm reduction, for example, are engaged in informal dialogue with the WHO. In 2001, the Civil Society Initiative was set up to examine the state of civil society participation in the body. The initiative concluded that a new policy was necessary to guide WHO's relationships with civil society. This has yet to be approved by the WHO governing body.

1. For more information, please visit: <http://csonet.org/>
2. For more information, please read: <http://www.unodc.org/unodc/en/commissions/CND/index.html?ref=me-nuside>
3. For more information, please visit the INCB Watch page: <http://idpc.net/incb-watch>
4. For more information, please visit the website of the Vienna NGO Committee on Drugs: http://www.vngoc.org/details.php?id_cat=7&id_cnt=26

MODULE 1

Handout: Drug control and human rights violations

The tables below, adapted from the [IDPC Drug Policy Guide](#), 2nd Edition, highlights examples of international human rights violations caused by current drug control efforts. If you would like to learn more about drug policy and human rights advocacy, please read:

- Harm Reduction International (2011), *The UN human rights system and harm reduction advocacy: A training package for civil society organisations*, http://www.ihra.net/files/2011/03/29/IHRA_Training_Pack_Final.pdf
- Kaplan, K. (2009), *Human rights documentation and advocacy: A guide for organizations of people who use drugs* (New York: Open Society Institute Public Health Program), http://www.opensocietyfoundations.org/sites/default/files/hr-doc_20090218.pdf

Human right	International human rights convention	Violations in the name of drug control
Right to life	<ul style="list-style-type: none"> • Article 4 of the Universal Declaration of Human Rights, 1948 • Article 6 of the International Covenant on Civil and Political Rights, 1966 	<ul style="list-style-type: none"> • Use of the death penalty for drug offences¹ • Extra-judicial killings by law-enforcement agencies²
Right to be free from torture, cruel and inhuman punishment	<ul style="list-style-type: none"> • Article 5 of the Universal Declaration of Human Rights, 1948 • Article 7 of the International Covenant on Civil and Political Rights, 1966 • Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1975 • Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984 	<ul style="list-style-type: none"> • Arbitrary detention of people who use drugs • Abuses in compulsory centres for drug users³
Right to be free from slavery	<ul style="list-style-type: none"> • Article 4 of the Universal Declaration of Human Rights, 1948 • Article 8 of the International Covenant on Civil and Political Rights, 1966 	<ul style="list-style-type: none"> • Use of forced labour in the name of drug treatment⁴
Right to health	<ul style="list-style-type: none"> • Constitution of the World Health Organisation (WHO), 1944 • Article 25 of the Universal Declaration of Human Rights, 1948 • Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966 	<ul style="list-style-type: none"> • Restricted access to essential medicines for pain relief⁵ • Restricted access to the means to prevent disease transmission and restricted access to appropriate forms of humane drug dependence treatment programmes
Social and economic rights	<ul style="list-style-type: none"> • Article 22 (and next) of the Universal Declaration of Human Rights, 1948 • Articles 6 and 7 (and next) of the International Covenant on Economic, Social and Cultural Rights, 1966 	<ul style="list-style-type: none"> • Implementation of forced crop-eradication campaigns, leaving many farmers with no means of subsistence⁶

Human right	International human rights convention	Violations in the name of drug control
Right to be free from discrimination	<ul style="list-style-type: none"> Article 7 of the Universal Declaration of Human Rights, 1948 Article 26 of the International Covenant on Civil and Political Rights, 1966 International Convention on the Elimination of All Forms of Racial Discrimination, 1965 Convention on the Elimination of All Forms of Discrimination Against Women, 1979 	<ul style="list-style-type: none"> Discriminatory application of drug control laws, notably towards minority ethnic people,⁷ indigenous people, young people and women
Right to privacy	<ul style="list-style-type: none"> Article 12 of the Universal Declaration on Human Rights 	<ul style="list-style-type: none"> Practice of stopping and inspecting people, including school children, suspected of carrying drugs Sharing of confidential medical information of a person under drug dependence treatment with the police
Right to be protected from illicit drug use	<ul style="list-style-type: none"> Article 33 of the UN Convention on the Rights of the Child 	<ul style="list-style-type: none"> Denial of harm reduction services targeted at young people⁸

References

¹ In 2010, 33 countries retained the death penalty for drug offences: Harm Reduction International (2010), *Complicity or abolition? The death penalty and international support for drug enforcement* (London: Harm Reduction International), http://idpc.net/sites/default/files/library/IHRA_DeathPenaltyReport_2.pdf

² Haugaard, L. & Nicholls, K. (December 2010), *Breaking the silence: in search of Colombia's disappeared* (Washington DC: Latin America Working Group Education Fund & US Office on Colombia), <http://lawg.org/storage/documents/Colombia/BreakingTheSilence.pdf>

³ Open Society Foundations (June 2011), *Treatment or torture? Applying international human rights standards to drug detention centers* (New York: International Harm Reduction Program, Open Society Foundations), <http://idpc.net/sites/default/files/library/Treatment-or-torture.pdf>; Nowak, M. (February 2010), *Report of the Special Rapporteur on torture and cruel, inhuman or degrading treatment or punishment* (United Nations General Assembly A/HRC/13/39/Add.5), http://idpc.net/sites/default/files/library/A.HRC_13.39.Add_5_en.pdf; Wolfe, D. & Saucier, R. (May 2010), 'In rehabilitation's name? Ending institutionalised cruelty and degrading treatment of people who use drugs', *International Journal of Drug Policy*, 21(3): 145–148, <http://www.ijdp.org/article/PIIS0955395910000095/abstract?rss=yes>

⁴ Human Rights Watch (January 2010), *'Where darkness knows no limits' – incarceration, ill-treatment, and forced labor as drug rehabilitation in China* (New York: Human Rights Watch), http://idpc.net/sites/default/files/library/hrw_china_darkness%20knows%20no%20limits.pdf

⁵ WHO estimates that approximately 80% of the world's population has either no or insufficient access to treatment for moderate or severe pain: World Health Organization, Access to Controlled Medications Programme (2007), *Improving access to medications controlled under international drug conventions* (Geneva: World Health Organization), http://www.who.int/medicines/areas/quality_safety/access_to_controlled_medications_brnote_english.pdf

⁶ Mansfield, D. (2011), *Assessing supply-side policy and practice: Eradication and alternative development* (Geneva: Global Commission on Drug Policy), <http://idpc.net/sites/default/files/library/crop-eradication-and-alternative-development.pdf>

⁷ For example, in the USA, African-American individuals are 10 times more likely than whites to enter prison for drug offences: Human Rights Watch (2008), *Targeting blacks: drug law enforcement and race in the United States* (New York: Human Rights Watch), <http://www.hrw.org/en/node/62236/section/1>

⁸ Harm Reduction International & Youth RISE. *Drugs, Harm Reduction and the UN Convention on the Rights of the Child: Common themes and universal rights*, <http://www.ihra.net/child-rights>

Handout: Resources / Further reading

Full texts of the three UN Drug Control Treaties

Single Convention on Narcotic Drugs, 1961, as amended by the 1972 protocol, <http://www.unodc.org/unodc/en/treaties/single-convention.html>

Convention on Psychotropic Substances, 1971, <http://www.unodc.org/unodc/en/treaties/psychotropics.html?ref=menuaside>

United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, <http://www.unodc.org/unodc/en/treaties/illicit-trafficking.html?ref=menuaside>

Discussion and analysis of the drug control system

West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf

Global Commission on Drug Policy (2014), *Taking Control: Pathways to Drug Policies That Work*, <http://www.globalcommissionondrugs.org/reports/>

Global Commission on Drug Policy (2013), *The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic*, <http://www.globalcommissionondrugs.org/reports/>

International Drug Policy Consortium (2012) *Drug Policy Guide* (2nd Edition), <http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition>

Global Commission on Drug Policy (2012), *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic*, <http://www.globalcommissionondrugs.org/reports/>

Organization of American States (2012), *Scenarios for the drug problem in the Americas 2013 – 2025*, www.oas.org/documents/eng/press/Scenarios_Report.PDF

Bewley Taylor, D. & Jelsma, M. (2012), *The UN drug control conventions: The limits of latitude* (International Drug Policy Consortium & Transnational Institute), <http://idpc.net/publications/2012/03/un-drug-control-conventions-the-limits-of-latitude>

Global Commission on Drug Policy (2011), *War on Drugs: Report of the Global Commission on Drug Policy*, <http://www.globalcommissionondrugs.org/reports/>

Jelsma, M. (2011), *The development of international drug control: Lessons learned and strategic challenges for the future*, <http://www.druglawreform.info/en/publications/legislative-reform-series-/item/1158-the-development-of-international-drug-control>



MODULE 2

Balanced and effective drug policy – what needs to change?



Aim of Module 2

To introduce the principles of a balanced and effective drug policy that is based on health, human rights and social inclusion.



Learning objectives

Participants will gain an understanding of the principles of cost-effective policies based on evidence, human rights, development and health and identify and discuss key barriers hindering the implementation of these principles.



Introduction

In Module 1, we concluded that under the global drug control system currently being implemented around the world, the scale of drug markets and levels of use have not declined, and prohibition-led drug policies been associated with violations of human rights and negative consequences. In light of these observations, it is necessary to rethink the objectives of balanced and effective drug policy. This module will explore the objectives and principles of balanced and effective drug policy, as well as possibilities for reform.

SESSION 2.1:

Activity: Objectives of balanced and effective drug policy

SESSION 2.2:

Activity: “The tree of balanced drug policy”

SESSION 2.3:

Interactive presentation: Principles to guide effective drug policy

SESSION 2.4:

Activity: Key elements of a balanced drug policy

SESSION 2.5:

Presentation: Recommendations from the West Africa Commission on Drugs

SESSION 2.6:

Presentation: Flexibilities in the UN drug conventions – what is allowed in the international drug control framework?

MODULE 2



15 min

Session 2.1

Activity: Objectives of balanced and effective drug policy



Aim – To explore what participants consider to be the high-level objectives of more balanced and effective drug policy

1. Introduce the aim of the session.
2. Ask participants to work in pairs and identify five objectives that could be achieved by a balanced and effective drug policy, allowing 5 minutes for this.
3. Ask each pair in order to put forward one of the objectives that they have identified, writing the ideas on a flipchart. For each objective, ask other groups if they also identified a similar objective (this can be done by a show of hands) – noting where there is broad consensus among the participants.
4. Repeat this process until all the identified objectives have been exhausted, or until the available time has elapsed.



Example of what participants may come up with

- Protecting health
- Protecting human rights
- Preventing discrimination
- Promoting socio-economic development
- Ensuring social inclusion
- Increasing citizens security
- Ensuring adequate access to justice
- Etc.

Session 2.2

Activity: "The tree of balanced drug policy"



60 min



Aim - To explore the positive outcomes and potential barriers to the development and implementation of effective and balanced drug policies

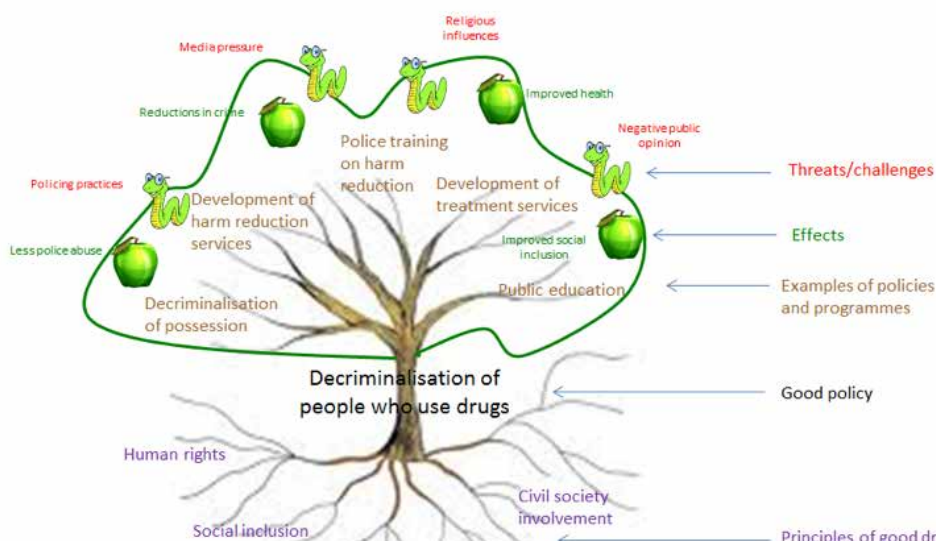
1. Introduce the aim of the session.
2. Ask participants to work in small groups (3-5 people) and give each group flip-chart paper and coloured marker pens.
3. Ask each group to draw a large tree with roots, a trunk, and branches. Explain to the participants that this time the tree represents "balanced drug policy". This tree will focus on an alternative to the "prohibition-led policy" on which the participants focused in [Session 1.5](#); i.e. if we focused on criminalisation, we could focus on decriminalisation; if we focused on crop eradication, we would focus on sequenced alternative livelihoods; if we focused on compulsory treatment, we would focus on evidence-based drug dependence treatment; etc. However, if they prefer to do so, groups may choose to focus on an issue that is not necessarily related to their previous tree of bad drug policy.
4. Explain that the roots are the beliefs and ideals that "feed" the tree – in this context they represent the principles of "balanced drug policy" (human rights, public health, harm reduction, etc.).

Facilitators' note

In case of time constraints, it is possible to conduct this activity at the same time as [activity 1.5](#) (the "Tree of prohibition-led drug policy") by splitting the participants into four groups and ask two groups to work on the tree of bad drug policy while the two other groups work on the tree of good drug policy. The discussions can then focus on comparing the findings of all groups on what they consider good and bad policies.

Please also note that Sessions 1.5, 2.2 and 3.9 include a similar activity (the "tree" exercise"). To avoid repetitions, we advise the facilitator to use this exercise only once during the training.

Example of tree of balanced drug policy



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Session 2.3

Interactive presentation: Principles to guide effective drug policy



30 min



Aim - To introduce principles for developing effective drug policy and to explore how these can be applied, or already apply, to national and international responses

1. Introduce the aim of the session linking it to the work done by participants in the previous session.
2. Present slides by making a strong link to the principles included in the trees drawn by the participants.
3. Explore the participants' understanding of these principles and what they think about them.
4. Explore how they might apply to the local context.
5. Explain that these principles underpin this training and will provide a useful source of reference throughout, particularly in the sessions where participants will be encouraged to set their own advocacy goals.



Facilitators' note

You may want prepare for this session by reading Chapter 1 of the IDPC Drug Policy Guide: <http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition>



Information to cover in this presentation:

This session considers a set of principles for the review, design and implementation of effective drug policies. Each country will need to develop drug policy responses that are relevant to their specific needs, cultural context, and available resources. However, IDPC has developed core principles, which have been developed in response to the failure of prohibition-led policies to impact meaningfully on the problems caused by drug use and drug markets.

IDPC high-level principles¹

1. Drug policies should be developed through a **structured and objective assessment of priorities and evidence**: These priorities and objectives should flow from an assessment of which consequences of drug markets are the most harmful to society. Civil society organisations are key to identify those. Governments then need to define which activities, based on evidence, will be most effective to achieve those objectives, which government departments should be involved, which resources should be articulated, and how the strategy will be evaluated and reviewed.
2. All activities should be undertaken in full **compliance with international human rights law**: A number of the most common elements of prohibitionist policies, in criminal justice settings (e.g. the use of disproportionate punishment) and elsewhere (e.g. lack of access to or the punitive application of treatment and care), are in direct contravention with the obligations of all governments with regard to the promotion and protection of human rights. Compliance with these obligations should be at the heart of any review and development of drug policy. All drug policies should focus on promoting public health, development and human security.

3. Drug policies should **focus on reducing the harmful consequences** rather than the scale of drug use and markets. This may include policies that seek to reduce corruption, insecurity and organised crime associated with drug supply chains (see Module 5 for further exploration of this topic). It may also include harm reduction measures to reduce the health, social and economic harms of drug use and drug markets on individuals, communities and the overall population. These are pragmatic approaches in which we recognise that the reduction of the scale of drug markets and use is not the only, or even the most important objective of drug policy. It is therefore necessary that governments start by assessing the drug-related harms that have the most negative impact on their citizens, and then start designing strategies that tackle those specific problems.
4. Policy and activities should seek to **promote the social inclusion** of marginalised and vulnerable groups: Harsh living conditions and the associated trauma and emotional difficulties are major factors in the development of drug problems, and for low-level involvement in drug markets. Evidence shows that programmes focusing on harsh criminal sanctions have had little deterrent effect, and only serve to increase the exposure of people to health harms and other risks, and to criminal groups.² The same phenomenon can be observed when harsh penalties and systematic crop eradication campaigns are conducted against subsistence farmers – these interventions simply exacerbate their poverty, social marginalisation, and access to services. IDPC promotes an approach that challenges the social marginalisation and stigmatisation of individuals at higher risk, in particular women and young people, who face specific social and cultural stigmas.
5. Governments should build **open and constructive relationships with civil society** in the discussion and delivery of their strategies: NGOs, especially those representing people who use or grow drugs, are an invaluable source of expertise because of their understanding of drug markets and drug-using communities. They have extensive experience and expertise on these issues and play a major role in analysing the drug phenomenon and in delivering programmes and services. Governments should therefore engage meaningfully with these groups.

1. These policy principles are detailed on the IDPC website at: <http://www.idpc.net/policy-principles> and on the IDPC Drug
2. See, for example: Stevens, A. (March 2013), *Applying harm reduction principles to the policing of retail drug markets* (London: International Drug Policy Consortium), https://dl.dropboxusercontent.com/u/64663568/library/MDLE-report_3_applying-harm-reduction-to-policing-of-retail-markets.pdf; UK Drug Policy Commission (October 2012), *A fresh approach to drugs – The final report of the UK Drug Policy Commission*, <http://www.ukdpc.org.uk/wp-content/uploads/a-fresh-approach-to-drugs-the-final-report-of-the-uk-drug-policy-commission.pdf>

Session 2.4

Activity: Key elements of a balanced drug policy



60 min



Aim - To introduce principles for developing effective drug policy and to explore how these can be applied, or already apply, to national and international responses

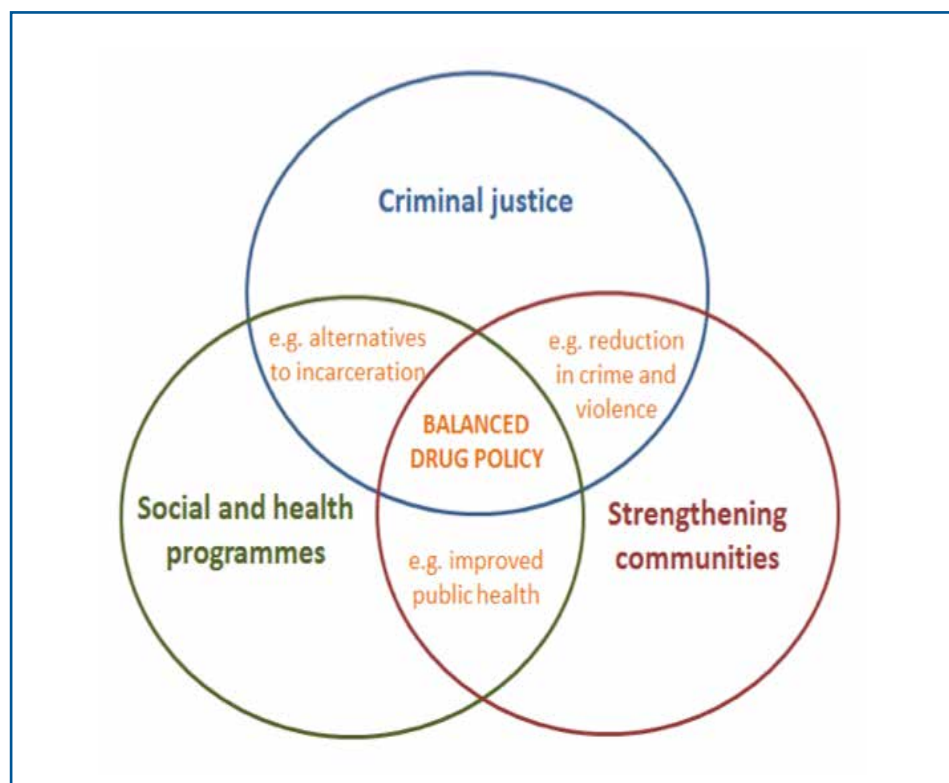
1. Introduce the aim of the session.
2. Split the participants into three groups.
3. Give each group two of the case studies included in the handout "[Case studies to be used for Session 2.4](#)", ideally giving each group one "positive/balanced policy" case study, and a "prohibition-led" one on similar policy issues (for example: Portugal/Russia on HIV prevention; Plan Colombia/Thailand on producing issues, etc.). Ask each group to read the case studies and respond to the following questions:
 - What is the focus of this policy?
 - What are the positive elements of this policy?
 - What are the negative elements of this policy?
 - Do you think that the policy is respectful of the five IDPC policy principles?
4. Back in plenary, each group will present their two case studies to the wider group, on the basis of the questions above. Allow time for discussions.
5. Drawing from the conclusions of each group, present the information below, allowing time for participants to feed into the discussion.



Information to cover in this presentation:

While criminal justice interventions tended to dominate over much of the last 100 years, there has recently been a growing recognition that effective policies require a re-balancing away from an over-reliance on law enforcement tactics and toward a greater role for health, social and development components. Experience has shown that three main component can be balanced adequately to ensure that drug policies are based on the high-level policy principles presented earlier. These include:

Criminal justice activities are centred on interdiction, prosecution and punishment. Traditionally, criminal justice activities have focused primarily on mass arrests and severe punishments of people who use drugs, crop eradication campaigns, arresting drug mules, etc. We are proposing here that these activities are re-focused to be more effective and less harmful, while fully integrating the other two core components – social and health interventions and community strengthening. Criminal justice can, for instance, focus on high-level, high-impact cross-border cooperation to target the elements of the drug market and organised crime that are the most dangerous, violent and/or corrosive to good governance, rather than targeting low-level dealers,



drug mules and people who use drugs (indeed, the United Nations (UN) drug conventions do not require that governments impose criminal sanctions against people who use drugs – this will be discussed in Session 2.5 below). In other cases, people who are considered to be dependent on drugs and are arrested for other crimes are no longer sent to prison but diverted to treatment services. In other countries, however, governments continue to be reluctant to move away from repressive approaches towards people involved in the drug trade, in particular people who use drugs.

Health and social programmes are directed primarily at people who use drugs, in order to provide them with harm reduction, counselling, drug dependence treatment, and other services that they may need to respond to overdoses, HIV and hepatitis C, for example. Such programmes are now widely developed around the world, and are now being scaled up in countries such as Malaysia, China, Mauritius or Tanzania, in order to respond to the high increase in HIV infections among people who use drugs. Countries are increasingly moving away from criminal sanctions with regards to people who use drugs in order to ensure adequate access to these programmes, without fear of arrest.

Strengthening communities focuses on wider social and economic development strategies to reduce the harms associated with drug markets, and to prevent people becoming engaged in drug markets – as low-level dealers, “drug mules” and/or consumers. In some countries, such as in Brazil, this had led governments to move away from militarised law enforcement and towards community policing, social and economic opportunities, education, employment, housing, etc. In some drug producing countries, crop eradication campaigns have been replaced by alternative livelihoods strategies that aim at providing viable alternative sources of income to subsistence farmers involved in the drug trade, including aid to develop new forms of agriculture, sequenced reduction in illicit crop production, access to infrastructure and markets, etc.

It is therefore important that drug policies demonstrate a coherent mix between these three complementary components, but that these are adequately balanced to respond to the various issues related to drug markets (i.e. production, high level trafficking, low level dealing, drug use, etc.).

One interesting example of an attempt to balance a modern drug policy comes from the Africa Union (AU). In 2012, the AU approved its “Plan of Action on Drug Control 2013-2017”, which focuses on four “priority areas”:

- Continental, regional and national management, oversight, reporting and evaluation.
- Evidence-based services to address health and social impact of drug use.
- Countering drug trafficking and related challenges to human security.
- Capacity building in research and data collection.¹

The Plan of Action (and the accompanying Implementation Matrix²) commits member states to – among other things – conduct baseline studies on drug use, deliver policy advocacy campaigns, implement “the UN comprehensive package on HIV prevention, treatment and care” for people who inject drugs (also widely referred to as the “harm reduction package”), and provide alternatives to incarceration. Speaking at the time, Dr. Jean Pierre Onvehoun (the AU Commissioner for Human Resources, Science and Technology) stated that drug use is a public health issue, and that law enforcement efforts should focus on high-level organised criminals rather than people who use drugs. Advocating for the balanced approach contained within the Plan of Action, Dr Onvehoun reminded the participants that some African countries “have been quietly implementing evidence-based programs that deal with the harms of drug use... the war on drugs is shifting fronts”.³

1. African Union Plan of Action on Drug Control (2013-2017), p. 4, <http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20English.pdf>
2. <http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20Implementation%20Matrix%20-%20English.pdf>
3. Bridge, J. (21 December 2012), *African Union agrees: “Support. Don’t Punish”*, IDPC Blog, <http://idpc.net/blog/2012/12/african-union-agrees-support-don-t-punish>

MODULE 2



30 min

Session 2.5

Presentation: Recommendations from the West Africa Commission on Drugs



Aim – To present and discuss the findings of the West Africa Commission on Drugs

1. Introduce the aim of the session.
2. Present slides.



Facilitators' note

See [Session 1.6](#) for a selection of related videos from the West Africa Commission on Drugs, which may be shown alongside this activity if time allows.



Information to cover in this presentation:

Deeply concerned by the growing threats of drug trafficking and consumption in West Africa, Kofi Annan, the former Secretary General of the United Nations, convened the West Africa Commission on Drugs (WACD) in January 2013. The Commission's objectives are to:

- mobilise public awareness and political commitment around the challenges posed by drug trafficking
- develop evidence-based policy recommendations
- promote regional and local capacity and ownership to manage these challenges.

Chaired by former President Olusegun Obasanjo of Nigeria, the Commission comprises a diverse group of West Africans from the worlds of politics, civil society, health, security and the justice sector. The Commission is an independent body and can therefore speak with impartiality and directness. Their report – “Not Just in Transit”¹ – is the culmination of one and a half years of engagement by the Commission with national, regional and international parties including the African Union (AU), the Economic Community of West African States (ECOWAS), and the United Nations Office on Drugs and Crime (UNODC). Based on this research, the Commission have made the following recommendations for drug policies in West Africa:

1. Treat drug use as a public health issue with socio-economic causes and consequences, rather than a criminal justice matter.

1.1 Adopt drug treatment policy frameworks in line with the core principles and the minimum legal and policy standards referenced in this report such as the expansion of drug treatment and related health services and facilities and the establishment of community-based prevention programmes and decentralised treatment.

1.2 Adopt harm reduction approaches in order to minimise the worst harm relating to drug consumption, while also ensuring that they are integrated into national development strategies.

2. Actively confront the political and governance challenges that incite corruption within governments, the security services and the judiciary, which traffickers exploit.

2.1 Support the establishment of inter- and intra-party platforms to discuss the impact of drug trafficking and illicit party funding on political systems in the West African region with the aim of establishing mechanisms to buffer these systems from illicit funding.

2.2 Strengthen the oversight role of parliaments with regard to the drafting and implementation of drug legislation.

2.3 Support the conduct of national, regional, or inter-regional (South-South) meetings of independent electoral bodies or electoral tribunals to discuss avenues to protect electoral processes from drug trafficking, and share lessons on building resilience against drug trafficking (and other forms of organized crime) into the electoral system. Existing networks of electoral management bodies should be encouraged to take on this issue.

2.4 Support efforts aimed at developing the capacity of civil society, media and academia to monitor and assess the links between drug trafficking and party and campaign financing, while also providing them with the relevant safeguards.

2.5 Actively explore options for the establishment of a panel or a special regional court to investigate or try high-target offenders, including state and security officials suspected of being complicit in, or facilitating, drug trafficking. Such efforts should not replace the need to ensure that national justice systems have the independence, specialised expertise and the resources to prosecute these kinds of cases.

3. Develop, reform and/or harmonise drug laws on the basis of existing and emerging minimum standards and pursue decriminalization of drug use and low-level non-violent drug offences.

3.1 Ensure that efforts to develop, reform and/or harmonise drug laws are carried out on the basis of existing and emerging minimum standards in which the protection of the security, health, human rights and well-being of all people is the central goal.

3.2 Pursue decriminalisation of drug use and low-level non-violent drug offences through reform of national legislation as a means to reduce the enormous pressures on overburdened criminal justice systems and protect citizens from further harms.

4. Strengthen law enforcement for more selective deterrence, focusing on high-level targets.

4.1 Support further efforts to develop vetted units within specialised agencies, while also ensuring that safeguards are put in place to protect these units against infiltration by organized crime or abusive practice.

4.2 Improve intelligence gathering and processing techniques; and develop more sustainable operational mechanisms for sharing intelligence within and between regions.

4.3 To ensure more effective integration of anti-narcotics efforts with anticorruption and anti-money laundering efforts in the region, and achieve a better alignment of resources, further strengthen efforts to review the patterns, priorities and effectiveness of external assistance while ensuring that significant action is expended in understanding what specifically has not worked in terms of external assistance to date, and precisely why. This will require investment in developing ECOWAS capacity to monitor and assess results; and ensuring that the outcome of efforts by partner organisations and countries to assess progress and setbacks are shared and discussed with a broader range of actors straddling the security, development and governance fields, and civil society. Information about who is doing what in the region should be centralized in one entity at the regional and national levels, and made publicly available.

5. Avoid militarisation of drug policy and related counter-trafficking measures, of the kind that some Latin American countries have applied at great cost without reducing supply.

6. Ensure that the shared responsibility of producer, transit and consumer countries is translated into operational strategies, including the sharing of experience among leaders from affected countries within and beyond West Africa.

6.1 Seek humane ways to reduce demand for those drugs, especially for nations whose citizens consume large amounts of illicit drugs.

7. Balance external assistance between support for security and justice efforts on the one hand, and support for public health efforts on the other, particularly with regard to the provision of treatment and harm reduction services.

8. Invest in the collection of baseline data and research on drug trafficking and drug consumption.

8.1 Ensure sustained support of initiatives such as the ECOWAS West African Epidemiological Network on Drug Use (WENDU) and deepen research (and strengthen regional research capacity) on the different impacts – security, governance, development – of drug trafficking and drug consumption in the region.

1. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf

Session 2.6

Presentation: Flexibilities in the UN drug conventions – what is allowed in the international drug control frameworks?



30 min



Aim - To understand what types of reforms are possible within the current UN drug control system, and be able to use this knowledge in national advocacy strategies

1. Introduce the aim of the session.
2. Split the participants into three groups.



Information to cover in this presentation:

As explained earlier in this Module, a growing number of countries have started exploring the development of policies that shift away from prohibition-led approaches. However, when developing these new strategies, governments must pay close attention to the UN drug control system to ensure that they do not violate their international obligations.

To understand the flexibilities¹ within the drug control treaties, it is necessary to break down drug offences into two types:

1. Cultivation, trafficking and possession offences on a **commercial basis**
2. Cultivation, production, purchase, possession and even importation for personal use, consumption, and social supply or the sharing of drugs

Under the conventions, the first type of offences should be criminalised and punished with imprisonment and confiscation. However, there is **considerable flexibility**, or “wiggle room”, within the UN drug control treaties that enable governments to adopt alternative policies for the second type of offences. This session applies a “traffic light” analogy to explain which of these policies and programmes are currently possible within the drug control framework.

Policies considered to operate inside the UN drug control obligations

• Decriminalising the consumption and possession of drugs for personal use

The main obligation under the conventions is to “take such legislative and administrative measures as may be necessary... to limit exclusively to medical and scientific purposes the production, manufacture, export and possession of drugs”. However, this article does not include any specific obligation for governments to criminalise **drug use**, as confirmed by a Commentary on the 1988 Convention (Commentary E/CN.7/590).

Drug consumption is predicated upon **possession**. Here again, there is some flexibility in the treaties. The 1961 Convention makes a distinction between possession for



red, stop or challenge the conventions
orange, proceed with caution; and
green, please proceed



personal use and trafficking. For trafficking, the convention clarifies that possession should be criminalised, but nothing is indicated for possession for personal use.

In addition, article 3, para 2 of the 1988 Convention states that: "Subject to its constitutional principles and the basic concepts of its legal system, each party shall adopt such measures as may be seen necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention".

Therefore, the UN drug conventions allow governments to **decriminalise** (i.e. remove activities from the realm of criminal law; e.g. in Portugal) or **depenalise** (i.e. offences continue to be criminalised, but penalties are reduced; e.g. in the UK) drug consumption, or drug possession for personal use.

Finally, article 3, para 4 of the 1988 Convention offers the possibility to impose, "either as an alternative to conviction or punishment, or in addition to it, measures for the treatment, education, aftercare, rehabilitation and social reintegration of the offender". This gives **considerable flexibility** for governments to establish **diversion mechanisms from prison to treatment** for people dependent on drugs. There is therefore some scope to provide health care or social support instead of punishment for people caught up in minor offences.



- **Provision of harm reduction services**

There is some "wiggle room" in the treaties because of the lack of clear definition of what constitute "medical and scientific purposes". It is widely argued, for example, that interventions such as opioid substitution therapy (OST) can be considered as drug use for medical purposes. In a 2002 report by the Legal Affairs Section of the then UN International Drug Control Programme (the predecessor of UNODC) concluded that most harm reduction measures, including OST and needle and syringe programmes, were in line with UN drug control treaty obligations.² The most common harm reduction measures can therefore operate lawfully within the UN drug control system – and are in fact openly endorsed by the UN itself through a "comprehensive package" of interventions for people who inject drugs³ Harm reduction services will be further discussed in Module 4.

Although safer injecting facilities (or drug consumption rooms) have been heavily criticised by the INCB, most of the jurisdictions that have introduced them have justified that they were in accordance with their international obligations. In Germany, for example, it was concluded that these facilities were compatible with the conventions so long as they did not permit the sale and acquisition of drugs, and responded to risk reduction. In Canada, the Federal Supreme Court also ruled in favour of Insite, Vancouver's drug consumption room. The 2002 UN Legal Affairs Section report also supports these services. However, their use remains controversial in some countries which have sought to build a legal case against this practice.⁴

Contested policy options under the current treaty system

- **Medical cannabis**

The INCB has also been very critical of medical cannabis policies and systems – such as those that are commonplace across the USA. According to the international conventions, all controlled drugs can be used for medical purposes, and what constitutes medical use is left to the discretion of the state parties. The 1961 Convention requires that, where medical marijuana schemes are in operation, a government agency must award all licences and take "physical possession" of all crops. Most countries allowing medical marijuana abide by these procedures.





- **Indigenous coca production**

Additional legal tensions exist between the drug control conventions and other international legal obligations, such as those stemming from indigenous rights. This is the case for Bolivia, which is the first country to have ever withdrawn from the 1961 Convention to protect the right of Bolivians to chew the coca leaf (a drug that is widely used in Bolivia for indigenous, spiritual, medicinal and traditional purposes). Bolivia later re-joined the convention with an additional “reservation” that allows for coca production and sale in the country. Although the conventions themselves do not seem to permit such a market for coca leaf in Bolivia, their formal “reservation” (one of a large number of “reservations” that several countries inserted when they signed up to the conventions) seems to have been an effective mechanism to overcome this. Impermissible policy options under the current treaty system

Impermissible policy options under the current treaty system

- **Regulated markets for non-medical purposes**

It is clear under the UN drug control conventions that a regulated market for the non-medical use of controlled substances is not an option, and that this would require a drastic revision of the international drug control framework. However, since 2013, we now have exactly this kind of market for cannabis in Uruguay and several parts of the USA – which is stretching the current treaty system to its limit.

Both Uruguay and the USA claim to not be contravening the treaties – citing clauses on national sovereignty and, in the case of the USA, the fact that cannabis remains illegal under national law even if it has been legalised in some States. This debate is ongoing, and the INCB has spoken out on several occasions⁵ against both countries (although in a notably more reserved way when addressing the USA!).

The situation with regulated cannabis markets in the USA has forced their government to redefine its position on international drug control – which is now captured within a “four-pillar” approach set out by Ambassador William Brownfield: (Assistant Secretary of State for International Narcotics and Law Enforcement):

1. Respect the integrity of the existing UN Drug Control Conventions.
2. Accept flexible interpretation of those conventions, as “Things have changed since 1961” [when the first of the three drug conventions was passed].
3. Tolerate different national drug policies, to accept the fact that some countries will have very strict drug approaches, while other countries will legalize entire categories of drugs.
4. All these countries must work together in the international community, striving for agreement and consensus that, whatever our approach and policy may be, we all agree to combat and resist criminal organisations.⁶

This represents a major shift in discourse from the USA, which had previously been one of the key proponents of the “war on drugs” approach – and is an attempt to reconcile “a treaty breach it does not wish to admit within a system it wishes to protect”.⁷ While welcomed by some, this new four-pillar approach concerns for others – perhaps appearing to embrace reform while actually changing nothing of substance. For example, it is notable that the flexibility and tolerance does not stretch to Bolivia’s attempts to allow indigenous coca leaf production and sale at the domestic level – which has been openly criticised by the USA, who also attempted to block their withdrawal and re-ascension to the 1961 convention.⁸



1. Information and traffic light analogy adapted from: Bewley-Taylor, D. & Jelsma, M. (2012), *TNI/IDPC Series on Legislative Reform of Drug Policies Nr. 18 – The UN drug control conventions: The limits of latitude*, http://dl.dropbox.com/u/64663568/library/limits-of-latitude-tni-idpc_0.pdf
2. Legal Affairs Sections, UNDCP (2002), *Flexibility of treaty provisions as regards harm reduction approaches* (Decision 74/10), <http://www.tni.org/sites/www.tni.org/archives/drugsreform-docs/un300902.pdf>
3. http://www.who.int/hiv/pub/idu/targets_universal_access/en/
4. For more information about drug consumption rooms, please read: Schatz, E. & Nougier, M. (2012), *IDPC Briefing Paper – Drug consumption rooms: Evidence and practice* (London: International Drug Policy Consortium), http://dl.dropboxusercontent.com/u/64663568/library/IDPC-Briefing-Paper_Drug-consumption-rooms.pdf
5. Barrett, D., Jelsma, M. & Bewley-Taylor, D.R. (18 November 2014), 'Fatal attraction: Flexibility doctrine and global drug policy reform', *Huffington Post Blog*, http://www.huffingtonpost.co.uk/damon-barett/drug-policy-reform_b_6158144.html
6. Ibid

Handout: Case studies to be used for Session 2.4

Introduction



The following selected case studies provide examples of drug policies that have been developed around the world, some of which continue to be anchored in the principles of deterrence and harsh penalties towards people involved in the drugs trade, others that seek to move towards greater emphasis on human rights, public health and/or social inclusion, and others that have shown positive moves towards reform but continue to impose severe punishments towards vulnerable groups involved in the drug trade.

These case studies constitute a basis for discussions among the participants in Session 2.4 on the need to achieve a balance between the complementary demands of criminal justice, health and social programmes, and community.

The facilitator can choose from these case studies (or use their own examples) in order to adapt the exercise to the participants' local context. Each case study is accompanied by a key reference in case the facilitator and/or the participants need more information.



Portugal

In 2001, Portugal introduced a new national law that decriminalised the illicit possession of all controlled drugs for personal use. Instead of being considered as a criminal offence, the possession of controlled drugs for personal use is now an "administrative offence". Drug supply remains a criminal offence. When individuals are caught in possession of small amounts of drugs (defined as a maximum of 10 doses of a particular drug), they are referred to a Dissuasion Commission. Each region in Portugal has its own Commission, composed of a medical professional, a legal advisor and a social worker supported by a team of technical experts.

The Commissions provide an individually tailored response, and their primary objective is to dissuade people from drug use, promote social inclusion and employment opportunities, and to encourage access to health care and drug dependence treatment for those who need it. Although administrative penalties such as fines, and community orders can be imposed, referral to the Commissions does not result in a criminal record.

This policy has led to reductions in drug-related health harms, including lower levels of HIV and hepatitis B and C transmission among people who inject drugs, reductions in overdose deaths, and a significant reduction in prison overcrowding. This has also enabled the police to focus law enforcement efforts towards major drug traffickers in the country.

Key resource: Hughes, C. and Stevens, A. (2010), *What can we learn from the Portuguese decriminalization of illicit drugs?* <http://kar.kent.ac.uk/29910/1/Hughes%20%20Stevens%202010.pdf>

Scotland

The Scottish National Diversion from Prosecution scheme was established in 2000-2001, and is designed to prevent relatively minor and non-violent offenders from entering the criminal justice system. Once an individual is reported by the police, a prosecutor is responsible for identifying whether or not they are suitable for diversion into social work interventions. The scheme targets primarily people who use drugs, young people and women.

Those diverted away from the criminal justice system can access individual and group sessions to address their drug use, as well as social skills, education, employment, training and problem-solving. Considerable success has been achieved, particularly in the reduction of youth re-offending.

Key Resource: Scottish government website, <http://www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/offender/community/examples/6827>



Bolivia

Bolivia has a long tradition of coca chewing for social, medicinal and spiritual purposes, although coca chewing is internationally banned under the 1961 Single Convention on Narcotic Drugs. In 2009, the Government and President Evo Morales decided to enshrine the practice of coca chewing within its new constitution, with an obligation to “protect native and ancestral coca as a cultural patrimony”. The banning of coca by the 1961 Convention was driven largely by Western geopolitics and ideology, and marginalised the cultural practices of native Amerindian people. After a failed attempt to remove the ban on coca chewing from the 1961 Convention, the Bolivian government formally withdrew from the 1961 Convention, before re-joining in 2013 with a reservation that allows the traditional use of coca within the country’s territory (despite the attempts of the INCB and the USA to prevent it doing so). Today, the Bolivian government has adopted a strategy that ensures the cultivation, trade and use of the coca leaf within its territory for traditional purposes, and has engaged in a community-led approach to reduce the illicit coca market.

Key Resource: The Transnational Institute’s Drugs and Democracy programme, <http://www.undrugcontrol.info/en/home/tag/2-bolivia>



Switzerland

In 1994 the Swiss government adopted a new drug strategy that integrated public security, health and social cohesion objectives. This strategy comprises four pillars: prevention, treatment, harm reduction and law enforcement. The strategy was developed on the basis of consultations with members from the law enforcement, public health and community sectors, and continues to have strong backing among the general public.

The Swiss Four Pillars Policy is one of the best examples of a balanced, integrated drug policy (both in policy and implementation) that meets the demands of law enforcement (directed at major criminals involved in violence and/or trafficking), while also supporting health and social programmes. As a result, Switzerland has a comprehensive harm reduction approach that includes drug consumption rooms and the prescription of pharmaceutical heroin for treating drug dependence.

The progressive implementation of this policy resulted in a significant decrease in harms related to drug consumption. For example, the drug related death toll fell by 50 per cent between 1991 and 2005.

Key Resource: Csete, J. (2010), From the mountaintops: What the world can learn from drug policy change in Switzerland (Open Society Foundations Global Drug Policy Program), <http://idpc.net/publications/2010/11/from-the-mountaintops-switzerland>

Malaysia

Malaysia has been a longstanding supporter of incarceration and the use of capital punishment for drugs offences and the compulsory detention of people who use drugs. In 2010, Malaysia reconfigured its drug policies – initiating a major transformation toward voluntary services through a “Cure and Care” model. This move acknowledges the need for a range of treatment approaches for different individuals. Treatment options now include Opioid Substitution Therapy (OST), and clients can access services without conditions and choose their own objectives against which treatment progress is measured.

Needle and Syringe Programmes (NSPs) were also developed in Malaysia. However, fear of arrest constitutes a significant barrier to accessing these services, as drug use and the possession of clean needles are still heavily criminalised in the country.

Key Resource: Tanguay, P. (2011), *Policy responses to drug issues in Malaysia* (International Drug Policy Consortium), <http://idpc.net/publications/2011/06/policy-responses-to-drug-issues-in-malaysia>



Brazil: Rio de Janeiro

Rio de Janeiro has a long history of high levels of violence associated with the illicit drug market, organised crime and police repression. The drug trade is concentrated in the city's favelas (slums), where social and economic disadvantage and poverty are endemic. In 2008, the city of Rio introduced a new response, starting in the favela of Santa Marta: the Unidades de Polícia Pacificadora (UPP), or “Pacifying police units”. The deployment of these units takes place within a public security policy that combines law enforcement with social, economic and cultural interventions to tackle the violence associated with the drugs market. They are focused on areas where the market is at its most harmful, and acknowledge that some level of trafficking will be tolerated elsewhere. The process of ‘pacification’ entails four steps: invasion, which deploys military force to “retake” the territory; stabilisation, in which the military forces remains until community policing (i.e. the UPPs) is established in the territory; occupation, whereby the UPPs seek to restore the rule of law through community policing; post-occupation, in which relations of trust are forged between the community and the UPPs, based on social programmes that bring educational and employment opportunities. However, criticisms have been raised about the fact that this strategy remains small scale (there are over 900 favelas in Rio, and less than 20 of them have been pacified). Others have also criticised the fact that large police forces did remain within the favelas after the UPPs had been pacified. Finally, concerns have been raised regarding corruption among police forces involved in the UPP process.

Key Resources: International Drug Policy Consortium (2012), *Drug Policy Guide, 2nd Edition*, <http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition> ; Washington Office on Latin America (June 2011), *Tackling urban violence in Latin America: reversing exclusion through smart policing and social investment* (Washington, DC: Washington Office on Latin America), http://idpc.net/sites/default/files/library/WOLA_Tackling_Urban_Violence_in_Latin_America.pdf



Cannabis regulation in Washington and Colorado

In November 2012, the US states of Washington and Colorado voted for the legal regulation of cannabis production, sale and consumption, even though cannabis is banned under the 1961 Single Convention on Narcotic Drugs and under US federal law. The two states are now working on the complex set of rules and regulations that will define how cannabis is grown, transported, advertised, sold and consumed. The reform was aimed not only at protecting consumers from life-altering criminal penalties and prison sentences, but also reducing incentives for violence associated with unregulated markets. Profits from marijuana consumption will also benefit legitimate economies, rather than fuel violence in producer or transit countries. Finally, the measure seeks to promote drug dependence treatment for those who need it without fear of arrest, stigma and discrimination. Additional US states have now turned to similar policies on cannabis. Although it is too soon to assess the impact of this policy, preliminary results in Colorado show a decrease in crime rates, in traffic fatalities, an increase in tax revenue and economic output from retail cannabis sales, as well as an increase in jobs.

Key resource: Open Society Foundations (2012), *The implications of marijuana legalization in Colorado and Washington*, <http://idpc.net/alerts/2012/11/the-implications-of-marijuana-legalization-in-colorado-and-washington>; Drug Policy Alliance (2015), *Status report: Marijuana legalization in Colorado after one year of retail sales and two years of decriminalisation*, <http://idpc.net/publications/2015/01/marijuana-legalisation-in-colorado-after-one-year-of-retail-sales-and-two-years-of-decriminalisation>



Thailand

In 1969 the Thai government adopted policies that sought to tackle high levels of opium cultivation, by integrating highland communities into mainstream national life, rather than through traditional crop eradication campaigns. Opium cultivation and use was a tradition amongst some of these communities, and any development plan therefore required an alternative livelihoods component. The integration of the crop replacement element into broader national and local development projects, which included social programmes (e.g. education and healthcare) and economic infrastructure (e.g. transport and water) lay behind the successes of this approach. Local communities were also involved in the design and delivery of these policies.

A key factor in Thailand's pattern of alternative livelihoods was the adequate sequencing of these measures: poppy crop reduction only commenced in 1984, 15 years into the programme. Poppy cultivation was reduced only when new sources of income were established, thus avoiding the problem of re-planting. This developmental process took more than 30 years, but the results appear to have been sustained.

Key Resource: Youngers, C. & Walsh, J. (2010), *Development first: A more human and promising approach to reducing cultivation of crops for illicit markets* (Washington Office on Latin America), <http://idpc.net/publications/2009/12/development-first-wola-report>



United States: Plan Colombia

Beginning in 2000, “Plan Colombia” involved the US government spending around US\$ 8 billion to support the Colombian government’s attempt to suppress the production of cocaine and heroin. The project was overwhelmingly centred on law enforcement, with the heavy involvement of the Colombian military. Cocaine use among US citizens (considered to be a key driver of the Colombian market), was not considered as a priority in this strategy, with little money going into drug demand reduction.

While the USA argues that it succeeded in reducing violence and cocaine production, the project generated severe negative consequences. Extending the government’s presence across the country translated in practice into a military presence, which was associated with a large rise in extra-judicial killings and human rights violations. As crop eradication was not accompanied by sufficient attempts to provide alternative livelihoods, the resulting social and environmental destruction focused disproportionately on Afro-Caribbean and indigenous minorities. Coca farmers responded to crop spraying by moving into remote areas, leading to deeper social marginalisation and additional destruction of fragile ecosystems.

Key Resource: Haugaard, L., Isacson, A., Stanton, K., Walsh, J. & Vogt, J. (2005), *Blueprint for a new Colombia policy* (Washington Office on Latin America, Latin America Working Group Education Fund, Center for International Policy, US Office on Colombia), http://www.wola.org/sites/default/files/downloadable/Andes/Colombia/past/blueprint_new_colombia_0305.pdf



Indonesia

Indonesia’s rapidly expanding HIV epidemic has been largely driven by the sharing of needles and injecting equipment. The Indonesian government has traditionally responded with harsh law enforcement measures, resulting in overcrowded prisons where drugs continue to be used, and injecting equipment to be shared. Local activists and UN agencies pressed the government to respond to drug use as a health issue rather than a criminal justice one, and their advocacy has led to the development of harm reduction measures (including Opioid Substitution Therapy (OST) and Needle and Syringe Programmes (NSP)) directed at people who use drugs. However, drug use remains heavily criminalised under Indonesian drug laws and people who use drugs constitute a large proportion of Indonesia’s prison population. Under national laws, people dependent on drugs should report themselves to Indonesian authorities to enter treatment or are imposed a prison penalty or a fine. Relatives of a person dependent on drugs are also obliged to refer that person to authorities.

As a result of the increased drug use in prison and high levels of harms associated with drug use in closed settings, Indonesia has started to develop harm reduction interventions in prisons. The Kerobokan prison in Bali led the way, becoming the first prison to offer methadone treatment in 2005. By 2009, it had treated 322 patients, combining OST with a range of harm reduction measures including needle and syringe exchange, bleach for cleaning equipment, and condoms. However, these and other OST and harm reduction interventions need to be scaled up, as they presently only accessible for a small minority of the drug using population. In the Banceuy prison, Bandung, for example, harm reduction is less integrated into the prison programme, and only 9 patients accessed OST between 2007 and 2009. Nonetheless, the introduction of these measures represents a positive direction away from exclusive reliance on law enforcement toward the inclusion of health and social programmes and community measures.

Key resource: Lai, G., Asmin, F. & Birgin, R. (2013), *Drug policy in Indonesia* (International Drug Policy Consortium), <http://idpc.net/publications/2013/01/idpc-briefing-paper-drug-policy-in-indonesia>

Russia

Russia's drug policy is focused overwhelmingly on law enforcement efforts and severe punishments handed out by the courts. Although there are drug treatment services in Russia, they have inherited the "narcology" approach from the former Soviet Union – with the objective of achieving rapid detoxification (often under conditions that resemble prison rather than medical treatment facilities). Contrary to medical evidence accepted by the global scientific community, Russia's government and much of its medical profession claim that OST with methadone or buprenorphine is not an effective treatment. Methadone and buprenorphine remain prohibited under national laws. The country remains committed to the principle that severe punishments against drug use will deter potential users from starting to consume drugs.

It should be noted that Russia has very high levels of drug use: there are an estimated 1.8 million people who inject drugs in the country – 37 per cent of whom are living with HIV and 72.5 per cent of whom are living with hepatitis C.

Key reference: Human Rights Watch (2004), *Lessons not learned: Human rights abuses and HIV/AIDS in the Russian Federation*, <http://www.hrw.org/sites/default/files/reports/russia0404.pdf>



China

China has a long history of drug use. Today, there are an estimated 2.3 million people who inject drugs in the country, the majority of whom inject heroin. The government has responded to drug use and trafficking through tough drug law enforcement efforts and severe sanctions against people involved in the drug trade, ranging from the compulsory detention of people who use drugs (which includes forced labour, beatings and humiliations) to the use of the death penalty for drug trafficking offences. Every year, China celebrates the International Day against Drug Trafficking and Drug Abuse with the execution of major drug traffickers to deter people from involvement in the drug trade.

For years, injecting drug use has been a major HIV transmission route. This has led the government to review its policies towards people who use drugs to reduce risks of infection and of drug-related deaths. This includes Needle and Syringe Programmes (NSPs), Opioid Substitution Therapy (OST) and overdose prevention. China has made significant progress in scaling up harm reduction programmes, with 753 methadone maintenance treatment clinics in 28 Chinese provinces and 941 NSPs in 19 provinces. More than 98 million syringes having been distributed since NSPs started operating in 1999.

Today, methadone maintenance treatment clinics function alongside compulsory detention centres, which the government is seeking to phase down and replace with community based treatment centres. People who use drugs also continue to be registered as drug users in government and police registries. Harsh penalties continue to be imposed on people involved in drug production and trafficking.

Key reference: Li, J., Ha, T.H., Zhang, C. & Liu, H. (2010), *The Chinese government's response to drug use and HIV/AIDS: A review of policies and programs*, <http://www.harmreductionjournal.com/content/7/1/4>; Data from IDPC scoping visit to China, February 2013



Mauritius

Mauritius has one of the highest prevalence of drug use per capita, with high rates of heroin injection. The government has responded to drug use with harsh punitive sanctions against users and drug offenders. The 2000 Dangerous Drugs Act punishes people caught for drug use with a maximum of 2 years' imprisonment and/or a fine of a maximum of 50,000 rupees (USD 1,640). Data shows that this has not led to a decrease in drug use, while a number of negative consequences have emerged, in particular in terms of public health – in 2005, 92% of new HIV infections in Mauritius was among people who inject drugs.

To respond to this worrying trend, some NGOs opened the first needle and syringe programme (NSP) in the country – illegally at the time, since the possession of a syringe is considered as a criminal offence under Mauritian drug laws. The first methadone maintenance treatment programmes also opened in 2006. That year also marked a change in the country's legislation, with the adoption of the HIV and AIDS Act which officially supported NSPs, and providing that a person should not be criminalised on the basis only of possession of a syringe, if the syringe was obtained from an accredited NSP facility. Today, a number of NGOs, as well as the Ministry of Health, are offering a range of harm reduction services across Mauritius.

These harm reduction services have been effective at responding to the public health challenges caused by drug use. In 2013, the incidence rate of new HIV infections among people who inject drugs had already fallen at 44% (from the high levels of 92% only eight years earlier).

However, many challenges remain. Biggest among those is the fact that there is a clear contradiction between the harm reduction approach promoted by the HIV and AIDS Act and the repressive approach adopted by the Dangerous Drugs Act – and therefore, many people continue to be arrested and sent to prison for simple drug use while caught in possession of a syringe, despite the HIV and AIDS Act.

Key reference: Nougier, M. (2013), 'Drug policy and harm reduction in Mauritius: Some progress but challenges remain', *IDPC Blog*, <http://idpc.net/blog/2013/12/drug-policy-and-harm-reduction-in-mauritius-some-progress-but-challenges-remain>



Handout: Resources/Further reading

Full texts of the three UN Drug Control Treaties

Single Convention on Narcotic Drugs, 1961, as amended by the 1972 protocol, <http://www.unodc.org/unodc/en/treaties/single-convention.html>

Convention on Psychotropic Substances, 1971, <http://www.unodc.org/unodc/en/treaties/psychotropics.html?ref=menuseide>

United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, <http://www.unodc.org/unodc/en/treaties/illicit-trafficking.html?ref=menuseide>

Discussion and analysis of the drug control system

West Africa Commission on Drugs (2014), *Not Just in Transit: Drugs, the State and Society in West Africa*, <http://www.wacommissionondrugs.org/report/>

Global Commission on Drug Policy (2014), *Taking Control: Pathways to Drug Policies That Work*, <http://www.globalcommissionondrugs.org/reports/>

Global Commission on Drug Policy (2013), *The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic*, <http://www.globalcommissionondrugs.org/reports/>

International Drug Policy Consortium (2012) *Drug Policy Guide (2nd Edition)*, <http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition>

Global Commission on Drug Policy (2012), *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic*, <http://www.globalcommissionondrugs.org/reports/>

Organization of American States (2012), *Scenarios for the drug problem in the Americas 2013 – 2025*, www.oas.org/documents/eng/press/Scenarios_Report.PDF

Bewley Taylor, D. & Jelsma, M. (2012), *The UN drug control conventions: The limits of latitude* (International Drug Policy Consortium & Transnational Institute), <http://idpc.net/publications/2012/03/un-drug-control-conventions-the-limits-of-latitude>

Global Commission on Drug Policy (2011), *War on Drugs: Report of the Global Commission on Drug Policy*, <http://www.globalcommissionondrugs.org/reports/>

Jelsma, M. (2011), *The development of international drug control: Lessons learned and strategic challenges for the future*, <http://www.druglawreform.info/en/publications/legislative-reform-series-/item/1158-the-development-of-international-drug-controls>



MODULE 3

Effective drug prevention and treatment



Aim of Module 3

To define, understand and analyse the objectives and desired results of evidence-based drug prevention and drug dependence treatment, as part of a comprehensive health-based approach to drug use.



Learning objectives

Participants will be able to:

- Understand the principles and potential results of drug prevention, and assess evidence for effectiveness
- Understand the objectives of different forms of drug dependence treatment
- Assess the cost-effectiveness of prevention and treatment interventions in resource poor settings.



Introduction

As drug use is increasing in West Africa (see Session 3.1 below), it is becoming urgent that governments establish evidence-based policies to respond to this phenomenon. Despite growing concerns, however, few countries in West Africa have a national drug policy that covers treatment and prevention, nor one which outlines clear and measurable goals and strategies. In the region, drug policies have tended to focus predominantly on law enforcement, in some cases with severe punitive measures towards all people involved in the drug trade, including people who use drugs. As discussed in previous

modules, harsh punishments and the implementation of punitive drug laws have been ineffective at curbing the levels of drug use and have led to a number of serious health and social consequences for people who use drugs.

A number of politicians, NGOs, academics and UN agencies are now calling for drug use to be considered as a health issue, rather than a criminal one, and that consumption issues be tackled through a comprehensive health-centred strategy. Indeed, the West Africa Commission on Drugs, in its “Not just in transit” report, called on governments in the region to: “Treat drug use as a public health issue with socio-economic causes and consequences, rather than a criminal justice matter”.¹ Such a strategy encompasses three main components – drug prevention and drug dependence treatment (which will be the focus of this Module), and harm reduction (which is discussed in [Module 4](#)).

A myriad of interventions have been developed over the years in the fields of drug prevention and treatment. But not all have been effective, and some have even been counter-productive and unable to reduce the health and social harms related to drug use. This module aims to capture the key objectives, characteristics and outcomes of evidence-based prevention and treatment interventions, and how these can be adapted to the context of West Africa.



MODULE 3

SESSION 3.1:

Presentation: Setting the scene: Drug use in West Africa

SESSION 3.2:

Presentation: Objectives of drug prevention

SESSION 3.3:

Presentation: Defining the different types of drug prevention

SESSION 3.4:

Presentation: Minimum quality standards for drug prevention

SESSION 3.5:

Activity: The effectiveness and appropriateness of prevention interventions

SESSION 3.6:

Activity: The availability of drug dependence treatment in West Africa

SESSION 3.7:

Activity: Defining the objectives of drug dependence treatment

SESSION 3.8:

Presentation: Minimum quality standards for drug dependence treatment

SESSION 3.9:

Activity: Key elements of an effective drug dependence treatment programme

SESSION 3.10:

Activity: Referrals to treatment: The limits of coercion

1. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf

Session 3.1

Presentation: Setting the scene: Drug use in West Africa



15 min



Aim – To offer the latest data around patterns of drug use in West Africa

1. Introduce the aim of the session.
2. Present the information below (present slides).
3. Explain to the participants that the first half of this module will focus on drug prevention, and the second on drug dependence treatment (with the next session focusing on defining these two concepts).



Information to cover in this presentation:

There is much concern today about illicit drug use in West Africa; but the problem is not a new one. As far back as the late 1950s there was already clear evidence that cannabis was being grown and consumed in several West African countries.¹ According to estimates by the United Nations Office on Drugs and Crime (UNODC), between 22 and 72 million adults use drugs in the region, with a prevalence rate in the range of 3.8 and 12.5%.

The pattern of illicit drug use in the region is characterised by a high prevalence of cannabis use, and low but increasing rates of cocaine, heroin and amphetamine use.^{2, 3} In 2010, around 12.4% of adults in West Africa (aged 15-64) had used cannabis. Cocaine and heroin are newcomers in the illicit drug scene in West Africa, and were relatively unknown before the early 1980s. Although there is a lack of data related to the use of these drugs, many small surveys of heroin and cocaine use have been conducted in several West African countries. These studies show an estimated all-African average of 0.4% - but of 0.7% in West Africa, which is equal to the global average.⁴ As for amphetamine-type stimulants (ATS), in particular methamphetamine, it has become a popular drug among traffickers in West Africa, and local production has increased in the region. Although ATS use has been recorded in the region for many years, the effects of these drugs are only now beginning to be felt.⁵

Studies conducted in several West African countries show that the numbers of people who inject drugs vary from a few hundred to several thousands.⁶ As far back as 1998, injecting drug use was reported in five countries in the region, namely Nigeria, Cote D'Ivoire, Gabon, Ghana and Senegal.⁷ Three rounds of UNODC-funded rapid assessments in Nigeria show that out of the 1,147 street-based people who use drugs recruited into the survey, 90 (8%) were current injectors, while 145 (13%) had injected at least once in the past.⁸ The drugs most injected are heroin, cocaine, pentazocine⁹ and speedball.^{10,11}

Prevalence of drug use in different regions of Africa (adults 15-64, 2011)¹²

Region	Cannabis	Opioids (synthetic narcotics)	Opiates (naturally occurring narcotic)	Cocaine	ATS
East Africa	4.1	0.17	0.2	-	-
North Africa	4.4	0.25	0.3	0.02	0.6
South Africa	5	0.41	0.3	0.8	0.7
West/Central Africa	12.4	0.44	0.4	0.7	-
Africa	7.5	0.33	0.3	0.4	0.9
Global	3.9	0.7	0.4	0.4	0.7

Source: UNODC World Drug Report 2013

1. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa*, WACD Background Paper No. 2 (West Africa Commission on Drugs), <http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf>
2. Lim, S.S. (2012), 'A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: A systematic analysis for the Global Burden of Disease Study 2010', *The Lancet*, 380: 2224-2260
3. World Health Organisation (2010), *ATLAS on substance use 2010: Resources for the prevention and treatment of substance use disorders* (Geneva: WHO)
4. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa*, WACD Background Paper No. 2 (West Africa Commission on Drugs), <http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf>
5. Ibid
6. Harm Reduction International (2014), 'Sub-Saharan Africa', *The global state of harm reduction*, www.ihra.net
7. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa*, WACD Background Paper No. 2 (West Africa Commission on Drugs), <http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf>
8. Adelekan, M., & Lawal, R. (2006), 'Drug use and HIV infection in Nigeria: a review of recent findings', *African Journal of Drug and Alcohol Studies*, 5(2): 118-129; <http://www.sahealthinfo.org/admodule/afjour/afjour-drug2006.pdf>
9. Pentazocine is a synthetically-prepared prototypical mixed agonist-antagonist narcotic (opioid analgesic) drug of the benzomorphan class of opioids used to treat moderate to moderately severe pain
10. Speedball refers to heroin and cocaine used together in a cocktail
11. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa*, WACD Background Paper No. 2 (West Africa Commission on Drugs), <http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf>
12. Table drawn from: Asare, J.B. & Obot, I.S. (2013), *Treatment policy for substance dependence in West Africa*, WACD Background Paper No. 8 (West Africa Commission on Drugs & Kofi Annan Foundation)

Session 3.2

Activity: Objectives of drug prevention



20 min



Aim – To understand what the objectives of drug prevention interventions are

1. Introduce the aim of the session.
2. Ask the participants to brainstorm around a definition and the objectives of drug prevention and note the responses on a flipchart.



Example of what participants may come up with

- Reducing the overall prevalence of drug use
1. Reducing drug use among certain groups (e.g. young people, pregnant women, etc.)
 - Reducing the levels of problematic drug use and dependence
 - Reducing the frequency and/or quantity of use
3. Present the information below (present slides), adding up to what has already been said during the brainstorming session.



Information to cover in this presentation:

Drug prevention is an activity aimed at preventing, delaying or reducing drug use and/or its negative consequences in the general population or sub-populations. Prevention interventions can be realised in different settings and with different methods and contents. The duration can vary between one-off activities and long-term projects running for several months or more.

Some form of drug prevention interventions have been developed in most West African countries.¹ The challenge to policy makers and professionals is to develop and implement prevention programmes that are based on evidence of effectiveness, and that respond to the specificities of local needs. But the first challenge, before measuring effectiveness, is to define what the objectives of these interventions are – what are we trying to achieve?

The primary objective of drug prevention is to help people to avoid or delay the initiation of drug use (or, if they have started already, to avoid their drug use becoming problematic). However, the general aim of an effective, holistic prevention programme is broader than this: it contributes to the positive engagement of children, young people and adults with their families, schools,

workplace and community, and seeks to build important life skills and personal capacity in individuals.

One common misconception about drug prevention is that it consists merely of informing (generally warning) young people about the effects (most commonly the dangers) of drug use. Prevention is then often equated with scare tactics and mass media campaigns. However, there is currently no evidence to suggest that this approach has an impact on drug use behaviours, or that mass media campaigns are cost-effective. In reality, the challenge of prevention lies in helping people **to adjust their behaviour, capacities, and wellbeing** in fields of multiple influences such as social norms, interaction with peers, living conditions, and their own personality traits.²

Prevention science in the last 20 years has made enormous advances. As a result, practitioners in the field and policy makers have a more complete understanding about:

- What makes people more vulnerable to experiencing problems with drug use – the so-called “**risk factors**” – at both the individual and environmental levels. The evidence points to the following powerful risk factors: biological processes, personality traits, mental health problems, family neglect and abuse, poor attachment to school and the community, favourable social norms and conducive environments, and growing up in marginalised and deprived communities.
- What makes people less vulnerable to experiencing problems with drug use – the so-called “**protective factors**” – include psychological and emotional well-being, personal and social competence, a strong attachment to caring families, and schools and communities that are well resourced and organised.³

Some of the factors that make people vulnerable (or, in contrast, more resistant) to starting drug use, differ according to age – with risk and protective factors evolving through infancy, childhood and early adolescence (e.g. family ties, peer pressure, etc.). At later stages of the age continuum, schools, workplaces, entertainment venues and the media are all settings that may contribute to make individuals more or less vulnerable to drug use and other risky behaviours. Needless to say, marginalised youth in vulnerable communities with little or no family support and limited access to education in school, are especially at risk. So are children, individuals and communities torn by war or natural disasters.

Therefore, if governments invest in prevention activities expecting to achieve a **reduction in the overall level of drug use** in society, they are likely to be disappointed as very few prevention programmes evaluated so far have been able to show such impacts. If, however, the objective is to **delay the onset of drug use, strengthening individuals’ ability to avoid drug problems, or increasing their knowledge of risks**, then some prevention programmes can achieve the desired results.

1. See: World Health Organization (2010), *ATLAS on substance use 2010: Resources for the prevention and treatment of substance use disorders* (Geneva: WHO)
2. European Monitoring Centre on Drugs and Drug Addiction (2011), European Drug Prevention Quality Standards, <http://www.emcdda.europa.eu/publications/manuals/prevention-standards>
3. United Nations Office on Drugs and Crime (2013), *International standards on drug use prevention*, http://www.unodc.org/documents/prevention/prevention_standards.pdf

Session 3.3

Presentation: Defining the different types of drug prevention



30 min



Aim – To understand the various models and components of drug prevention programmes

1. Introduce the aim of the session.
2. Present the information below (present slides).
3. Distribute the “[The drug prevention cards](#)” previously cut from the handout and ask the participants to sort them out in the following categories:
 - a. Universal prevention
 - b. Selective prevention
 - c. Indicative prevention
 - d. Environmental prevention
4. Distribute the handout “[The different types of drug prevention](#)” and ask the participants if they have any more questions.



Information to cover in this presentation:

In order to strengthen protective factors and mitigate risk factors at the different stages of an individual's life, drug prevention activities need to be carefully designed and targeted – both in terms of who the target audience is, and what setting is best to use to reach that audience. Prevention practitioners usually categorise prevention interventions into four broad groups:¹

1. **Universal prevention – i.e. intervening on *populations*:** this is the broadest approach to prevention, targeting the general public without any prior screening for their risk of drug use – these interventions assume that all members of the population are at equal risk of initiating use. Universal prevention interventions target skills development and interaction with peers and social life and can be implemented in schools, whole communities, or workplaces. Available evidence shows that these interventions have not been effective at reducing levels of use, and at times, have even proved to be counter-productive. We will turn back to effectiveness later in this session.
2. **Selective prevention – i.e. intervening on (vulnerable) *groups*:** these interventions target specific sub-populations whose risk of developing drug use or problematic drug use is significantly higher than average. Often, this higher vulnerability to drug use stems from social exclusion (e.g. young offenders, school drop-outs, marginalised ethnic minorities, etc.). Selective interventions therefore usually target the social risk factors (that is, the living and social conditions) that make this specific group more vulnerable to drug use.
3. **Indicated prevention – i.e. intervening on (vulnerable) *individuals*:** these programmes target high-risk individuals who are identified as having minimal

but detectable signs or symptoms that may put them at greater risk of experiencing problems with drug use (e.g. mental illness, social failure, antisocial behaviour, hyperactivity, etc.). The aim of indicated prevention is not necessarily to prevent initiation of drug use, but rather to prevent the (fast) development of dependence or problematic use.

4. **Environmental prevention – i.e. intervening on *societies and systems*:** these programmes are aimed at altering the immediate cultural, social, physical and economic environments in which people make their choices about drug use. This perspective takes into account the fact that individuals do not become involved with drugs solely on the basis of personal characteristics, but rather that they are influenced by a complex set of factors in the environment, what is expected or accepted in the communities in which they live, national rules or regulations and taxes, the publicity messages to which they are exposed, and availability of drugs.

1. O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.) (2009), *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*, National Research Council and Institute of Medicine of the National Academies (Washington, D.C.: The National Academic Press)

Session 3.4

Presentation: Minimum quality standards for drug prevention

15 min

**Aim – To present and discuss the minimum quality standards set out in the region and beyond**

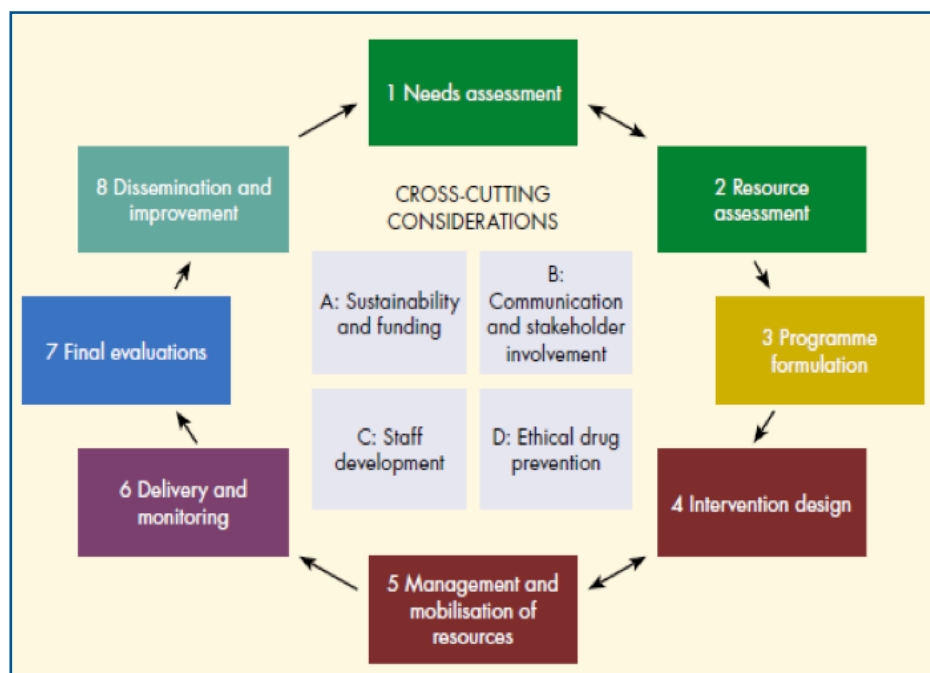
1. Introduce the aim of the session.
2. Present the information below (present slides). Ask the participants if they have any questions and whether their country has similar quality standards in the field of prevention.

**Information to cover in this presentation:**

There are several documents made available by the United Nations (UN) and other bodies that provide minimum quality standards in the field of drug prevention. Among those, the “Minimum quality standards in drug prevention” adopted by UNODC in 2013 provides useful information about how prevention interventions and policies should be developed and implemented, based on available evidence.¹ According to the report, “An effective national drug prevention system delivers an integrated range of interventions and policies based on scientific evidence, in multiple settings, targeting relevant ages and levels of risks”, which include:

- A supportive policy and legal framework
- Scientific evidence and research
- Coordination of multiple sectors and levels (national, sub-national and municipal/local) involved
- Training of policy makers and practitioners
- A commitment to provide adequate resources and to sustain the system in the long term.

The EMCDDA Minimum Quality Standards on Drug Prevention manual also offers a set of tools on prevention interventions, based on the following prevention project cycle:²



The first step for an intervention to meet the quality standards is a **needs assessment** – that is, an assessment of drug use and community needs. This includes a thorough understanding of the targeted population or group (i.e. a mapping of the risks and protective factors in that particular group). While the needs assessment indicates what the programme should aim to achieve, the **resource assessment** offers important information on whether and how these aims can be achieved – this second step therefore provides a realistic understanding of the desirable type and scope of the programme. The **programme formulation** outlines the programme content and structure and provides the necessary foundation to allow for detailed, coherent and realistic planning. In the next stage, “**intervention design**”, the contents of the intervention will be developed to ensure quality and effectiveness, as well as activities tailored towards the target population, taking into account evaluation requirements. A drug prevention programme consists not only of the actual intervention, but also requires good **management and mobilisation of resources** to ensure that it is feasible. At the stage of **delivery and monitoring**, the plans developed are put into practice; where there needs to be a balance between fidelity toward the original project plan, and flexibility to respond to emerging new developments. After the intervention has been completed, **final evaluations** assess outcomes and processes of delivery of the intervention. These evaluations will form the basis for **dissemination** of current results and **improvement** of our interventions for future prevention programmes.

Issues to consider in designing prevention strategies

There are a series of issues that need to be considered when designing an effective prevention strategy, some of which have already been mentioned above:

- What are the **objectives** of the drug prevention strategy? It is important not to be too ambitious – prevention programmes on their own cannot bring down overall levels of drug use significantly, but they can change the behaviours of some young people by delaying or preventing drug use, improving decision making and resistance, preventing problematic use, and encouraging safer choices.
- What is the **target group** for prevention programmes? While it is easier to reach the largest number of young people with mass campaigns through the media or schools, the delivery of simple information and messages about risks to a mass audience does not seem to have a big impact on behaviour. Planners also have to be clear on what age group they are targeting – interventions before the average age of initiation will focus on information, protective factors and resistance skills; while prevention in later years will focus more on minimising risky behaviour.

- What is the best **setting** for prevention messages to be delivered? This will depend very much on the age and breadth of the target group, but there are a number of options. Prevention interventions can be organised through families, community or religious networks, or health and social services structures. Two key factors need to be considered in deciding the setting for prevention – the extent to which the target group will engage with and trust the information provided and, particularly in resource-poor environments, the relative cost of any initiative (prevention programmes, depending on the design, can be very cheap or very expensive).
- What will be the best prevention intervention based on **available resources**? In resource-poor environments, it is important to avoid rushing into eye-catching campaigns that show immediate action, but will have little short- or long-term impact.
- Does the general **policy and regulatory framework** have an impact on my prevention interventions? Drug prevention is but one of the fundamental components of a health-centred system, alongside evidence-based drug dependence treatment and harm reduction. In this respect, an effective national system would be: 1- Embedded in a comprehensive and health-centred system of drug control focused on providing treatment, care and rehabilitation of drug dependence, and, preventing the health and social consequences of drug use (e.g. HIV/AIDS, hepatitis C, overdoses, etc.); 2- Based on the understanding of drug dependence as a complex health condition with a mix of biological, psychological and social causes; 3- Linked to a comprehensive national public health strategy; 4- Mandated and supported at the national level by appropriate regulation, including national standards for policies, interventions and practitioners; as well as requirements for schools, workplaces and health and social agencies to implement relevant prevention interventions; and 5- Supported by a local and national monitoring and evaluation systems to identify emerging substance use patterns and inform prevention strategies.
- Is the prevention intervention based on **scientific evidence and research**? Interventions and policies should be chosen on the basis of an accurate understanding of the situation. To this effect, a data collection system should be in place to provide information on drug use prevalence, drug use initiation and vulnerabilities. A formal mechanism should regularly feed the data generated by the information system into a systemic planning process. This data should be used to prioritise evidence-based programmes and carefully adapt our interventions without necessarily modifying the core components of the programme, but by making it more relevant to the new socio-economic/cultural context.
- Finally, the **effectiveness and cost-effectiveness** of delivered interventions and policies should be evaluated – programmes need to include a scientific monitoring and evaluation component to assess whether interventions result in the desired outcome.

1. United Nations Office on Drugs and Crime (2013), *International standards on drug use prevention*, http://www.unodc.org/documents/prevention/prevention_standards.pdf
2. European Monitoring Centre on Drugs and Drug Addiction (2011), *European drug prevention quality standards*, <http://www.emcdda.europa.eu/publications/manuals/prevention-standards>

MODULE 3



1 h

Session 3.5

Activity: The effectiveness and appropriateness of prevention interventions

Facilitators' note

The handout "Examples of drug prevention interventions" includes two copies of each intervention – one to be distributed to the group of participants and that only includes a photo/snapshot of the intervention, and a second copy to be kept by the facilitator and includes key information about each intervention to feed into the discussions during the exercise.



Aim - The effectiveness and appropriateness of prevention interventions

1. Introduce the aim of the session.
2. Explain to the participants that they will work in groups of 4-5 people (each group will need to nominate a note taker and a rapporteur). Give each group an example of a drug prevention programme – either as a handout (see the handout "[Examples of drug prevention interventions](#)"), or on pre-prepared slides. Based on what has already been discussed during this module, each group will respond to the questions below:
 - a. What type of prevention programme is this? What do you think were its primary objectives?
 - b. Do you think that the prevention programme was effective? Why?
 - c. Would this programme be effective in your country? Would it be practically possible to implement it in your country?
3. Ask each group to present their case study and their findings to the rest of the participants (if possible, display the prevention interventions on PPT slides). Leave time for the participants to discuss each case study with the rest of the group.
4. Present the information below (present slides).
5. Ask the participants if they have any questions, explaining that this is the last session on drug prevention, and that the rest of the module will discuss drug dependence treatment.



Information to cover in this presentation:

A review of effectiveness

Major reviews¹ of drug prevention programmes have led to the following evidence-based conclusions:

- Mass media strategies are generally not effective except if delivered in coordination with community involvement interventions
- School-based prevention programmes that teach social and coping skills have a slight positive effect by delaying initiation when compared to provision of information about drugs and their effect
- Interventions that seek to change the school environment and classroom management are better than trying to change individual behaviour because factors that predict drug use also predict school failure

- Reducing criminal penalties for some drugs does not seem to increase drug use, but instead significantly reduces the health and social costs related to criminal penalties, especially incarceration.²

Therefore, the interventions that are the most effective have two main characteristics:

1. they focus on early intervention with their close social environment (i.e. family, classroom), and
2. they address issues other than drugs by focusing on social and behavioural development.³

A review of cost-effectiveness

Investing in evidence-informed drug prevention not only reduces the harms associated with drug abuse experienced by individuals, their families and communities, but it can also greatly reduce costs to society. A growing body of evidence over the last 20 years demonstrates that prevention can have significant cost-benefit savings. It has been shown that, for every dollar spent, good programmes for the prevention of drug use among youth can save up to 10 dollars.⁴

1. Hawks, D., Scott, K., & McBride, M. (2002), *Prevention of psychoactive substance use: a selected review of what works in the area of prevention* (Geneva: WHO)
2. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa*, WACD Background Paper No. 2 (West Africa Commission on Drugs & Kofi Annan Foundation), <http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf>
3. Babor, T., Caulkins, J., Edwards, G. et al. (2010), *Drug policy and the public good* (Oxford: Oxford University Press)
4. United Nations Office on Drugs and Crime (UNODC), "Prevention" <http://www.unodc.org/unodc/en/prevention/>; Canadian Centre on Substance Abuse, "A Case for Investing in Youth Substance Abuse Prevention", 2013 [http://www.ccsa.ca/Resource%20Library/2012-ccsa-Investing-in-youth-substance abuse-prevention-en.pdf](http://www.ccsa.ca/Resource%20Library/2012-ccsa-Investing-in-youth-substance%20abuse-prevention-en.pdf); Miller, T., & Hendrie, D. "Substance abuse prevention dollars and cents: a cost-benefit analysis," Center for Substance Abuse Prevention, SAMHSA (2009) <http://store.samhsa.gov/shin/content/SMA07-4298/SMA07-4298.pdf>; Lee, S., Drake, E., Pennucci, A., Miller, M. & Anderson, L. "Return on investment: Evidence-based options to improve statewide outcomes". Olympia: Washington State Institute for Public Policy, 2012

MODULE 3



20 min

Session 3.6

Activity: The availability of drug dependence treatment in West Africa



Aim – To establish the availability of treatment services in the region

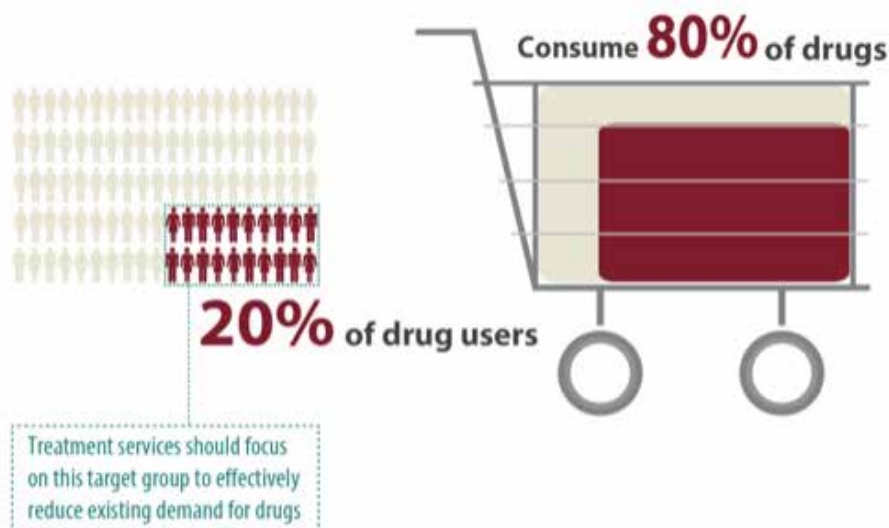
1. Introduce the aim of the session.
2. Reiterate that the rest of this module will now focus on drug dependence treatment.
3. Ask the participants what kinds of drug treatment are available in their country/region, and whether they think these are appropriate.
4. Present the information below (present slides) and distribute the handout “[Data on the availability of drug treatment services in 14 West African nations](#)”.



Information to cover in this presentation:

Drug dependence treatment refers to a wide range of support services (such as opioid substitution therapy [for more information about OST, please refer to Module 4 on harm reduction], psychosocial support, mutual aid support groups, abstinence-based treatment, etc.) for individuals experiencing serious problems related to their drug use. It is important to understand that treatment interventions are appropriate only for those who are diagnosed as dependent, or whose drug use is causing significant risks to themselves or others. Too often, scarce treatment resources have been directed at people who do not experience significant problems. This is a wasteful use of scarce resources, but also unnecessarily stigmatises a large number of people who use drugs as being incapable of looking after themselves.

Figure: The 20/80 rule of thumb



Source: Kleiman, Caulkins and Hawkins, 2011. Drawn from: <http://www.wacommissionondrugs.org/report/>

The gap between drug dependence and the availability of treatment services is significant and expanding as the prevalence and diversification of drug use increases in different countries across West Africa. A recent global survey of treatment resources shows a general lack of resources (facilities, personnel, training, etc.) for treating people with drug dependence across the world, but much more so in Africa, and particularly in West Africa.¹

Across the region, most services are provided in psychiatric hospitals and traditional faith-based facilities which tend to be overcrowded and characterised by abuses of the rights of the clients seeking treatment. Those facilities also tend to be poorly funded, and lack personnel, skills and experience in the field of evidence-based treatment. This situation is caused, in part, by the lack of treatment policies that regulate the delivery of services in these facilities, but also by the fact that people who use drugs are often heavily stigmatised and are deemed as not deserving the expenditure of state resources. A snapshot of the availability of drug dependence treatment services across the region is available on the table below:

Country	SA Policy exists	Govt. Unit for SUD	Budget Line	Financing Method	Usual Treatment Setting	Medical detox for DUD	SMT available	Specialized Tx available	3 Most important professionals	National data collection
Benin	Drugs	Y	Y, drugs	Tax-based	Gen health	Y	N	N	Psych, GPs, Nurses	Y
Burkina Faso	N	Y, alcohol	N	Out-of-pocket	Gen health	N	Y	N	—	N
Chad	N	Y	N	Out-of-pocket	MH service	Y	N	N	Psych, Nurses, GPs	N
Cape Verde	N	MH	N	Insurance	MH service	Y	N	N	GPs, Psych, Psy	N
Cote d'Ivoire	Y/MH	MH	N	Out-of-pocket	MH service	N	N	N	Psych, GPs, Nurses	N
The Gambia	N	Y	N	Tax-based	Gen health	Y	N	N	Nurses, PHC workers	N
Ghana	N	MH	N	Insurance	MH service	Y	N	N	Psych, Counsellors, GPs	N
Guinea	Y/MH	N	N	Out-of-pocket	MH service	Y	N	N	Psych, GPs, Psy	N
Mali	N	MH	N	—	MH service	Y	N	N	Psych, Psy, Nurses	N
Niger	N	MH	N	External grant	MH service	Y	N	N	Addictologists, Psych, Nurses	N
Nigeria	N	Y	Y/MH	Tax-based	MH	Y	N	Y	—	N
Senegal	N	MH	N	—	MH	—	—	N	—	N
Sierra Leone	Y	MH	Y	NGOs	MH	N	N	N	Psych, Nurses, PHC	Y
Togo	N	Y	Y/MH	Out-of-pocket	MH	Y	N	N	GPs, PHC, Psych	N

Notes:

Y = Yes, available N = No, not available

MH = mental health Psy = psychologists Psych = psychiatrists PHC = primary health care workers GPs = general practitioners

SMT = Substitution maintenance therapy

Source: World Health Organisation (2010), *ATLAS on substance use 2010: Resources for the prevention and treatment of substance use disorders* (Geneva: WHO)

1. See: World Health Organisation (2010), *ATLAS on substance use 2010: Resources for the prevention and treatment of substance use disorders* (Geneva: WHO)

MODULE 3

 30 min

Session 3.7

Activity: Defining the objectives of drug dependence treatment



Aim – To understand who treatment is for, and what the expected outcomes of effective treatment should be

1. Introduce the aim of the session.
2. Ask the participants to brainstorm on what the objectives of drug dependence treatment should be. Note the responses on a flipchart.



Example of what participants may come up with

- Becoming abstinent
- Reducing levels/quantity of drug use
- Achieving a stable life
- Obtaining a job or continuing one's studies/training
- Reductions in petty crimes committed by people dependent on drugs to purchase drugs
- Reductions in public health threats

3. Reflect on what the participants have said, presenting the information below (present slides).



Information to cover in summary presentation:

It is important to remember that people who use drugs are a heterogeneous population, most of whom do not experience problems with their drug use. Only a minority will experience multiple and complex difficulties. It is therefore important to focus treatment interventions on those who are experiencing the greatest problems and have the greatest need. Forcing treatment on all people who use drugs (irrespective of the nature of their use) has led to a misdirection of resources, as well as the development of models of treatment that are ineffective and that breach the human rights of the patients.

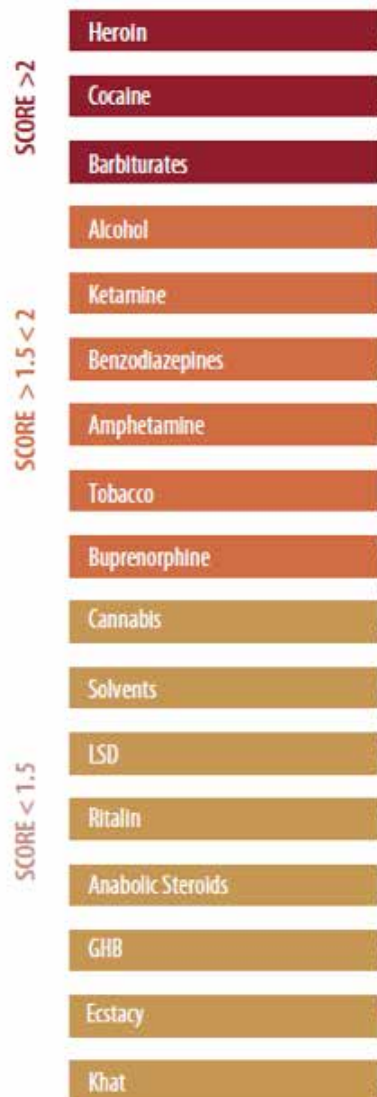
Most young people who experiment with drug use do not become frequent users, and most who become frequent users do not become dependent. For example, it has been estimated that approximately 32% of people who use tobacco will become dependent, with a prevalence of 15% for alcohol, 23% for heroin, 15-16% for cocaine, 11% for amphetamines and 8% for cannabis.¹ Based on these numbers, it seems clear that there is no correlation between the addictive nature of a substance and whether it is legal or illegal. In fact, significant research has shown that international (and national) scheduling and control are scarcely

based on evidence. This graph displays the levels of harms caused by a substance compared to its levels of control to illustrate this point.

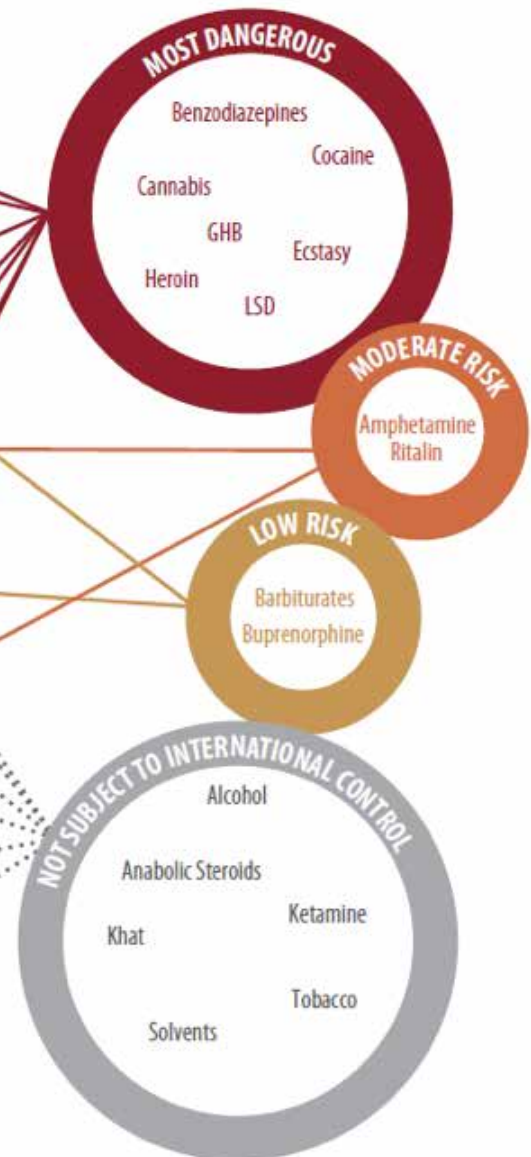
CLASSIFICATION OF DRUGS

LEVELS OF CONTROL VS. LEVELS OF HARM

INDEPENDENT EXPERT ASSESSMENTS OF RISK LEVELS OF HARM



UN CLASSIFICATION OF DRUGS LEVELS OF CONTROL



Data sources: Global Commission on Drug Policy, June, 2011. War on Drugs Report.
Nutt, King, Saulsbury and Blakemore, 2007, 'Development of a rational scale to assess the harm of drugs of potential misuse' The Lancet.

Source: <http://www.wacommissionondrugs.org/report/>

The key elements of dependence are the loss of control over use, and continued use despite awareness of problems caused or exacerbated by the using behaviour. The high risk of harm to individual users and the community of dependent and problematic use make this population the legitimate focus for treatment services. Because of its nature as a chronic relapsing health disorder, drug dependence requires long-term treatment and care.

The objectives of drug dependence treatment can therefore be categorised on three levels:

1. For the **individual**, the objective is the achievement and maintenance of physical, psychological and social well-being. This may be through reducing the risk-taking associated with drug use, through reducing levels of drug use, or through complete abstinence from drug use – dependent on the individual. Because of the chronic relapsing nature of drug dependence, and the need to address social and psychological dimensions, achieving abstinence is often a lengthy and difficult (or even undesirable) goal for some people. The provision of “stepping stones” or “stabilising strategies” in the form of more achievable interim goals helps to define and structure progress and also to reduce drug-related harms.²
2. For the **family or community**, the most important objective is that the person dependent on drugs is able to integrate and interact positively with those around them.
3. For the **wider society**, treatment aims to reduce health and social problems, including rates of early and accidental death, public health concerns such as HIV or hepatitis infection, or drug dependence-related crime. At a national level, many countries have reported falling crime rates, reduced levels of overdose deaths, and averted HIV epidemics, that can be attributed to drug dependence treatment strategies.³ As will be shown below, all of these objectives can be successfully achieved through well designed and delivered treatment and harm reduction interventions (see [Module 4](#)).

When setting up a drug dependence treatment programme, policy makers must address three key questions. These will be further discussed during the rest of this training:

- **Who the treatment is for?** An assessment needs to be made of the current (and possible future) populations of users in a country and, critically, which subsets of these users are most problematic and in need of treatment. Care should be taken not to target or impose treatment or controls on individuals who are causing no social problems, as this would be a waste of limited resources. Mechanisms for identifying, making contact with, and motivating individuals to want to accept treatment need therefore to be carefully designed – although care should be taken to avoid unnecessarily coercive measures.
- **What the treatment is aimed at achieving?** In any given setting, the objectives of a treatment system will be a mixture of maximising recovery from dependence, and minimising the related crime, health and social problems. In practice, there will be different priorities which drive the need to develop or expand treatment, but a well-designed system and evidence-based interventions have been shown to achieve positive outcomes in all of these domains.
- **What mix of interventions and services are provided?** We have described above how research has shown that several treatment methods are particularly effective. Treatment planners need to offer a “menu” of services and settings, as no single model can be suitable for a group of patients using different drugs in different ways, with different emotional and psychological challenges, and in a variety of socio-economic and cultural contexts.

1. For more information, see: Wagner, F.A. & Anthony, J.C. (2012), ‘From first drug use to drug dependence: developmental periods of risk of dependence upon marijuana, cocaine, and alcohol’, *Neuropsychopharmacology*, **26**(4): 497-88, <http://www.ncbi.nlm.nih.gov/pubmed/11927172>; National Institute on Drug Abuse (October 2014), *Drugfacts: Heroin*, <http://www.drugabuse.gov/publications/drugfacts/heroin>; Anthony, J.C. & Echeagaray-Wagner, F. (2000), ‘Epidemiologic analysis of alcohol and tobacco use’, *Alcohol Research and Health*, **24**(4), <http://pubs.niaaa.nih.gov/publications/arh24-4/201-208.pdf>; World Health Organisation Western Pacific Region (2011), *Harm reduction and brief interventions for ATS users*, http://www.who.int/hiv/pub/idu/ats_brief2.pdf
2. World Health Organisation (2006), *Evidence for action: Effectiveness of drug dependence treatment in preventing HIV among injecting drug users*, http://www.who.int/hiv/pub/idu/drugdependence_final.pdf?ua=1
3. International Drug Policy Consortium (2012), ‘Chapter 3.3: Drug dependence treatment’, *Drug Policy Guide*, <http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition>

Session 3.8

Presentation: Minimum quality standards for drug dependence treatment



30 min



Aim – To understanding and compare what the minimum quality standards for drug dependence treatment are in Africa, and elsewhere.

1. Introduce the aim of the session.
2. Present the information below (present slides).
3. Ask the participants whether the treatment programmes in their country/region



Information to cover in this presentation:

As for drug prevention, a wide range of quality standards have been developed in the field of drug dependence treatment to ensure the effectiveness of available programmes.

According to the African Union (AU) *Continental minimum quality standards for treatment of drug dependence*,¹ drug dependence treatment should respond to the following standards and principles:

- Addiction is complex but treatable. It affects brain function and behaviour.
- Treatment needs to be readily available. Forcing someone who needs addiction treatment to wait for it when he or she is ready for it may mean losing that person to care.
- Matching treatment settings, interventions, and services to an individual's particular problems and needs is essential to the end-result and recovery.
- Effective treatment attends to several needs of the individual, not just drug use. To be effective, treatment must address the individual's drug use and any related medical, psychological, social, vocational, and legal problems. Treatment must also be tailored to age, gender, and culture.
- Recovery from drug addiction is a long-term route and frequently requires multiple instalments of treatment. Therefore, remaining in treatment for a sufficient period of time is critical, as is allowing patients to have as many rounds of treatment as necessary.
- Counselling and other social therapies are the most universally used forms of drug use treatment. Participation in group therapy and other support programmes during and following treatment assists abstinence.
- Medications are often a core element of treatment, in particular when linked with counselling and other social therapies. Treatment of opiate addiction using methadone, for example, even over a long period, is highly effective for many patients.
- Individual treatment plans must be evaluated frequently and adapted as required.

- Accessible and affordable treatment for mental disorders may be crucial to ensure effectiveness of treatment for drug dependence.
- Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Patients should be encouraged to continue drug treatment following detoxification. Ongoing support, motivation and encouragement must also be included.
- While the voluntary nature of treatment is a central principle, family, friends and colleagues can often help by urging and encouraging entry into treatment.
- Drug use during treatment must be monitored to prevent lapses.
- Treatment programmes should assess patients for infectious diseases and provide support and counselling to help patients modify activities that place them at further risk.
- Treatment and rehabilitation services should play a key role in reducing the social stigma and discrimination against drug users and supporting their reintegration into society as healthy and productive members of the community.

In Europe, the European Union has worked on developing minimum quality standards on demand reduction.² Those related to treatment include the following standards:

- accessibility
- physical environment (adequate spacing, separate rooms for individual counselling, safety)
- indication criteria (i.e. diagnosis)
- staff education and composition (multi-disciplinary)
- assessment procedures (drug use and treatment history, somatic and social status, psychiatric status)
- individualised treatment planning
- informed consent
- written client records (e.g. assessment results)
- confidentiality of client data
- routine cooperation with other agencies.

1. African Union (2012), *Proposed continental minimum quality standards for treatment of drug dependence*
2. Uchtenhagen, A. & Schaub, M. (2012), Minimum quality standards in drug demand reduction EQUS, http://www.emcdda.europa.eu/attachements.cfm/att_231087_EN_INT09_EQUS_2012.pdf

Session 3.9

Activity: Key elements of an effective drug dependence treatment programme



1:15h



Aim – To understand and discuss the key aspects that constitute an effective and evidence-based drug dependence treatment programme

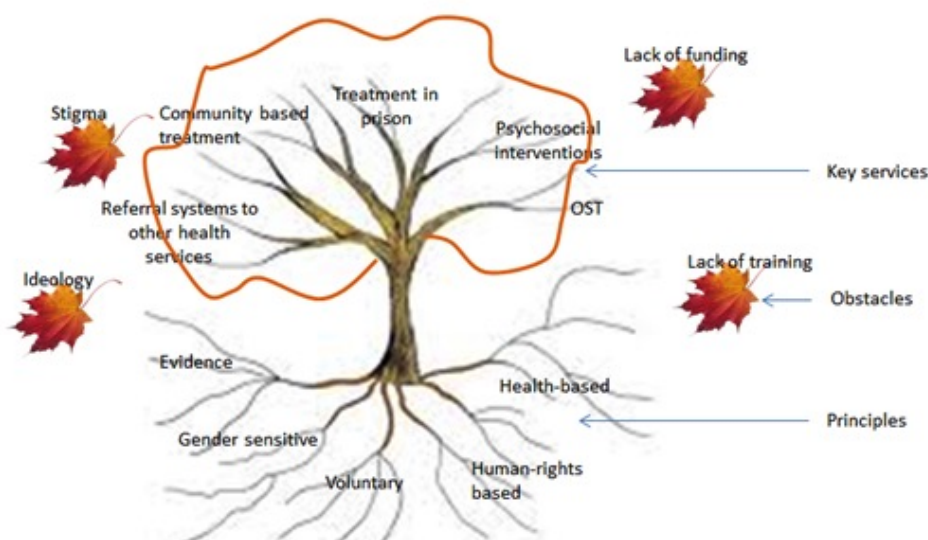
1. Introduce the aim of the session.
2. Divide the participants into four groups (each group will nominate a note taker and a rapporteur), give them a flipchart and marker pens.
3. Explain to the participants that they will produce a “tree of effective drug treatment”.
4. Ask the participants to draw a trunk with roots and branches.
 - a. Ask the participants to think of the basic underlining principles of drug dependence treatment, and note them along each root of the tree (can include evidence, human rights, gender-based, voluntary, etc.).
 - b. Ask the participants to think of the key services that need to be offered as part of a comprehensive drug treatment programme (can include setting such as community, residential and prison, forms of treatment such as OST, psychosocial interventions, etc.).
 - c. Ask each participant to use falling leaves (see Annex 5) to characterise the obstacles to evidence-based treatment.



Facilitators' note

This exercise is similar to those proposed in Sessions 1.5 and 2.2. To avoid repetitions, we advise the facilitator to use this exercise only once, either here or in Modules 1 and/or 2

Example of tree of effective drug dependence treatment



5. Ask each group to present their tree to the rest of the group. Leave time for the participants to comment on other groups' trees.
6. Present the information below (present slides), and distribute the handout "[Key resources on drug prevention and treatment](#)"



Information to cover in this presentation:

Treatment for drug dependence can come in different forms: specialised services, psychiatric care, the general medical care system, criminal justice/prisons, social welfare system and the voluntary or NGO sector. In addition, treatment can also take place in traditional and religious healing sites – the latter accounts for a high proportion of people who seek treatment in Africa.¹ It is therefore important to consider the key aspects that characterise what is an effective drug dependence treatment strategy.

Treatment methods

The complexity of drug dependence is such that the response, setting and intensity of the treatment need to be tailored to each person. A menu of services should therefore be made available to suit the differing characteristics, needs and circumstances of each person. Below is a list of the most common methods used for drug dependence treatment – these are often used in combination and along other health and social services, whenever appropriate:

- **Detoxification:** defined by WHO as “the process by which an individual is withdrawn from the effects of a psychoactive substance” and “as a clinical procedure, the withdrawal process is carried out in a safe and effective manner, such that withdrawal symptoms are minimised”. Detoxification is therefore the first stage of drug dependence treatment, and often needs to be followed by longer-term treatment to keep individuals from using drugs.
- **Opioid substitution therapy:** the prescription of a substitute drug for which cross-dependence and cross-tolerance exist, and used to minimise the effects of withdrawal or move the patient from a particular means of administration. There is significant evidence from around the globe that shows the effectiveness of OST. The most common drug substitutes include methadone, buprenorphine and naltrexone. In West Africa, OST is not widely used, mainly because opioid use is not common in the region. But consultations with experts in the region also suggest that there is a fear among health practitioners that OST would simply “substitute one addiction with another”. Currently, OST is available in two West African countries – Burkina Faso and Senegal.
- **Psychosocial treatment:** counselling – individual or in groups – and other behavioural therapies including peer support. These activities vary in their focus and may involve addressing a patient’s motivation to change, providing incentives for abstinence, building skills to resist drug use, improving problem solving skills, facilitating better interpersonal relationships, etc. There is good evidence that these approaches, especially cognitive behavioural therapy (in particular motivational interviewing, contingency management and multidimensional family therapy), are associated with reduced drug use, as well as a decrease in drug-related problems, criminal activity and infections.
- **Rehabilitation:** aims to help people adjust to society and to overcome the many social problems associated with their drug use. It is important to manage family life, impart social skills and satisfy educational needs, as well as help solve employment and accommodation problems. Rehabilitation programmes ensure continued involvement of the client with treatment systems and should be viewed as an integral part of service delivery.²

Treatment settings

As well as offering a range of interventions, an effective treatment system should also deliver interventions in a range of environments. These can be broadly categorised as street-based (e.g. outreach, drop-in centres), community-based (e.g. regular attendance at a clinic, counselling, etc.) and residential.

In resource-poor settings, residential treatment programmes are often expensive and sometimes use unnecessary or unacceptable practices – they might, for instance, apply overly rigid treatment pathways to all clients irrespective of their individual

needs, use coercive or abusive practices, expect the clients to pursue particular sets of religious or community beliefs or isolate the clients from their families or friends. On the contrary, community-based treatment centres are generally more cost-effective, they usually have more capacity to deal with more patients, can be better integrated with other health and social support services, and can make better use of family and community support. The individual's recovery is also likely to be more robust if achieved in the community, as opposed to the rather artificial setting of a remote residential centre.

As many people who use drugs end up in prison (either because drug use continues to be heavily criminalised, or because the consumer has committed a crime), the rates of drug dependence amongst the prison population are high – and often significantly higher than among the general population. Prisons are therefore an important setting for drug treatment. Many of the principles of effective treatment in the community also apply in prison – the need for a range of services, incorporating clear assessment of need, motivational work, the availability of general health and specific harm reduction services, and voluntary access into both substitution and abstinence-based treatment pathways – but services need to be designed to fit in with the realities of prison conditions, ensuring that security is protected, taking into account the varying sentence lengths of participants, and working with the restrictions on movement of prisoners. Notwithstanding these restrictions, well designed and delivered prison-based treatment services can go a long way to protecting the health of prisoners, and preventing a return to drug dependence, risks of overdose deaths and crime after release.

Respecting human rights and the principle of individual choice

No matter what treatment method or setting is being used, treatment programmes must be respectful of human rights and the principle of individual choice to enter a treatment programme or not, and whether to comply and continue with it. This not only fulfils human rights obligations, but also ensures the effectiveness of the programme. Evidence shows that long-term behaviour change only comes about when individuals decide to change of their own free will. Treatment systems therefore need to be organised so that they encourage individuals to accept treatment and lay down the rules and expectations for programme compliance, but do not cross the line into coercion. We will examine the issue of coercion in the next session. Treatment programmes that use torture, cruel and inhuman punishment, humiliation, sleep and food deprivation, forced labour and other such practices also violate human rights and are ineffective strategies.

Ensuring cost-effectiveness

Drug dependence treatment is less expensive than alternatives, such as not treating or simply incarcerating people dependent on drugs. According to several conservative estimates, every \$1 invested in evidence-based drug dependence treatment programmes yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1.³ According to several studies, drug treatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment. OST has been shown to decrease criminal behaviour by as much as 50 percent amongst the patients. Research also shows that OST reduces risks of overdose deaths, as well as the risk of HIV infection – this form of treatment is much less costly than that of treating HIV-related illnesses. Finally, treatment can improve the prospects for employment.⁴

1. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa*, WACD Background Paper No. 2 (West Africa Commission on Drugs & Kofi Annan Foundation), <http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf>
2. Ibid
3. Harm Reduction International, International Drug Policy Consortium & International HIV/AIDS Alliance (July 2014), *The funding crisis for harm reduction*, <http://idpc.net/publications/2014/07/the-funding-crisis-for-harm-reduction>
4. National Institute on Drug Abuse (2007). *Understanding drug abuse and addiction: What science says. Section IV.6*, <http://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iv/6-cost-effectiveness-drug-treatment>

MODULE 3

 45 min

Session 3.10

Activity: Referrals to treatment: The limits of coercion

 **Aim – To assess what are acceptable levels of coercion into treatment**

1. Introduce the aim of the session.
2. Explain to the participants that many governments across the world, but also in the region, have relied on some form of coercion to push people to enter treatment.
3. Divide the participants into four groups and distribute flipchart paper and marker pens to each group.
4. Ask the participants to divide the flipchart paper into two, in the length of the page. The left column will be entitled “Acceptable referrals/pressure”, the right “Inacceptable referrals/pressure”, and ask them to list all the methods they can think of that have been used to refer/push dependent users to a treatment programme.

Example of what participants may come up with

Acceptable referrals/pressure	Inacceptable referrals/pressure
Informed orientation of a person arrested by the police to a health facility	Police raids to arrest people who use drugs and send them to compulsory detention/treatment
Referral by an administrative body that has the health and social skills to do so	Referral by community members without the consent of the person
Drug courts	
Informed referral via a doctor or other health professionals	Mandatory drug testing
Self-referral	Referral by family member without the consent of the person
Voluntary access to treatment in prison	

5. In plenary, ask the participants to present their work to the rest of the group and explain why they categorised each method in a certain column.
6. Present the information below (present slides).



Information to cover in this presentation:

Another challenge is to be able to identify people who use drugs and encourage them to engage with social and healthcare services. As this population is often hidden, useful gateways can be established through which they can approach these services. However, these need to be careful not to fall into the “coercion into treatment” trap.

There are a number of routes through which people can access treatment:

- **Self-referral by the individual** – people who use drugs should therefore be aware of the types of treatment programmes available and how to reach them without fear of arrest. This can be facilitated through outreach services, in particular peer outreach programmes (see below)
- **Identification through general health and social service structures** – this necessitates that health professionals are adequately trained on issues related to drug dependence (often a challenge in some West African countries) and are aware of existing treatment facilities. It also requires a certain level of trust between the healthcare professional and the client, without fear of stigma and discrimination
- **Identification through specialist drug advice centres and outreach services** – these services can offer a range of services ranging from food, temporary housing, harm reduction services, etc. The existence of drop-in centres with a flexible and informal approach is a useful tool to provide a gateway for those caught up in drug dependence
- **Identification through the criminal justice system** – as mentioned before, people who use drugs regularly come into contact with the criminal justice system. The justice system can therefore play an important role in identifying dependent users and motivate them to access treatment. Treatment may then be offered as an alternative to arrest (in the UK, for example), or incarceration during court proceedings. In Nigeria and Mali, drug laws state that a person can be referred to treatment upon judgement, instead of conviction or punishment (in Nigeria, this is only for minors – for adults, treatment can be offered in addition to punishment). Although this has not been used in practice, it is a move away from a punishment-based approach to drug dependence. But, the question remains – what level of coercion is deemed to be acceptable?
 - › In Asia, the practice of compulsory detention of people who use drugs has been condemned by many governments, UN agencies and NGOs. The practice involves arresting any person using drugs and coercing them to attend and stay in treatment programmes that often rely on physical and psychological abuse, rather than healthcare and support. This is an unacceptable practice.
 - › The use of drug courts is also being extensively discussed worldwide, including in Nigeria and Mali in West Africa. Although this may be a useful way to refer people into treatment, there are a set of guidelines that should be respected to ensure that the mechanism works adequately: ensuring that those sent to treatment are dependent, that the assessment is done by trained medical professionals, that the individual has a choice to enter treatment or not, that those sent to the drug courts are not there for simple drug use (drug use itself should not be punished by criminal sanctions) but are people dependent on drugs who have committed other crimes, etc. Such a system is also fundamentally flawed by the fact that relapse into drug use constitutes an infraction leading to a prison sentence – this is against the scientific position that drug dependence is a chronic relapsing condition.

- › Less extreme forms of compulsion have been applied in many countries, such as the use of mandatory drug testing as a measure of compliance into treatment.³⁴ Such a mechanism has, in practice, often resulted in mistrust between patient and treatment service provider, while not having a deterrent effect in levels of relapse, and should therefore be avoided.

It is very important, in designing assessment and treatment systems, that any external pressures and conditions applied to drug dependent individuals are justified by established criminal justice principles of due process and proportionality, and do not undermine the principle of self-determination.

1. For a full discussion on drug courts, see: Guzman, D. (2012), Drug courts: Scope and challenges of an alternative to incarceration (London: International Drug Policy Consortium), <http://idpc.net/publications/2012/07/idpc-briefing-paper-drug-courts>



Handout: The drug prevention cards

UNIVERSAL PREVENTION	SELECTIVE PREVENTION	INDICATED PREVENTION	ENVIRONMENTAL PREVENTION
Mass information campaigns	Prevention education children in foster care	Brief intervention for a child diagnosed with hyperactivity	Taxation of alcohol
School-based interventions	Peer support groups for children whose parents have a drug problem	Training for parents of a child with disruptive behavioural disorders	Publicity ban on tobacco
Education targeted at physicians on illicit use of prescription drugs	Skills training for unemployed people	Skills building programme for a teenager diagnosed with a mental illness	Ban on pentazocine by the national government

MODULE 3

Handout: The different types of drug prevention

	Universal	Selective	Indicated	Environmental
Developmental	Social/life-skills programmes to provide young people with skills to cope with social influences, classroom behavioural management to socialise children	Family/parenting programmes with families among vulnerable communities in a city/region/country	Individual counselling programmes with young male teenagers with impulse control problems	Legislation to prohibit drug use, suppression of international supply routes, taxation policies on certain substances
Informational	Mass media campaigns to raise awareness of the risks of drug use	Informational interventions targeted at young males in vulnerable communities with strong gang cultures	Normative feedback interventions for individuals who screen positive for drug use	Publicity bans, information on where substances can/ cannot be used (for tobacco, alcohol & cannabis in USA/ Uruguay)

Handout: Examples of drug prevention interventions

Prevention campaign against the use of new psychoactive substances in Romania



"The difference between a user of illicit plants and a cow is that the cow knows what it uses. Drug use kills!"

Prevention campaign against the use of new psychoactive substances in Romania:

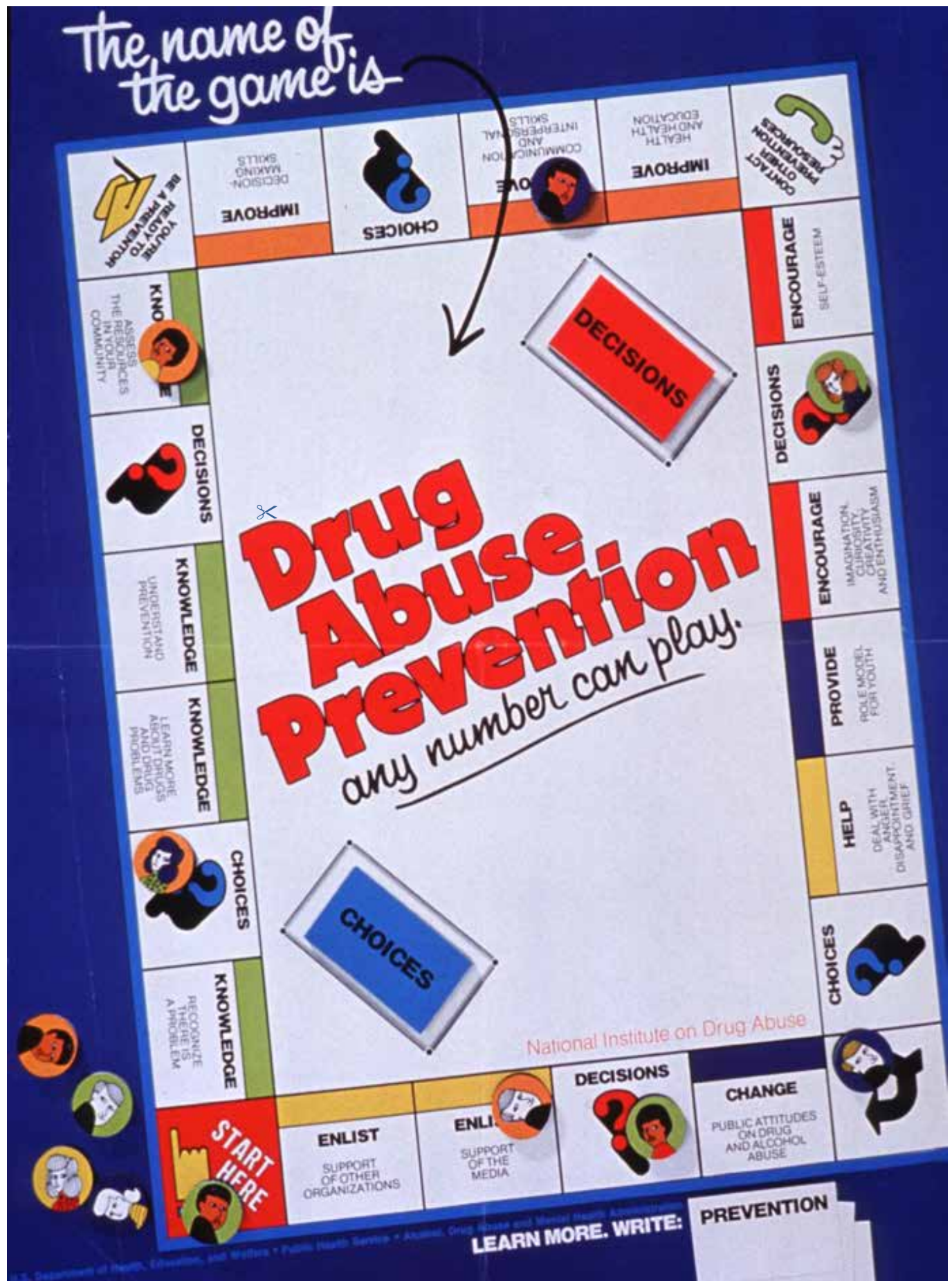


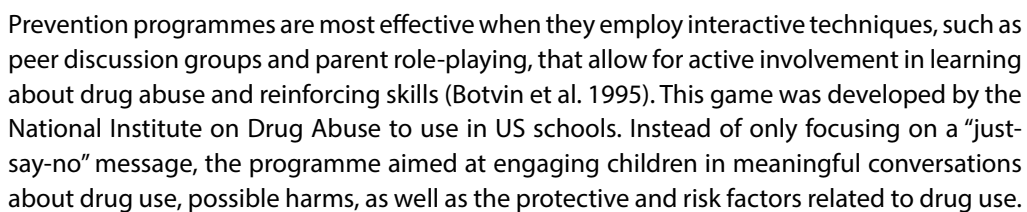
"The difference between a user of illicit plants and a cow is that the cow knows what it uses. Drug use kills!"

Recently, Romania has experienced a fast increase in injecting new psychoactive substances (see: <http://www.emaramures.ro/stiri/55999/CAMPANIE-ETNOBOTANICE-Ministerul-de-Interne-raspunde-care-este-diferenta-dintre-un-consumator-de-etnobotanice-si-o-vaca-VIDEO->).

This has happened in parallel with the economic crisis, which has led many harm reduction services to close down – leading to a fast growing HIV epidemic among people who inject drugs. Instead of adopting a public health approach to the problem, the government has conducted bans on local stores selling NPS and has produced numerous drug prevention campaigns in the same spirit as this photo. In a country where drug use is particularly stigmatised, such campaigns can be more harmful than beneficial and can deter people who use drugs from accessing the health, harm reduction and treatment services they need.

Prevention campaign developed by the National Institute on Drug Abuse in US schools:





UNODC video released on the International Day against Drug Abuse and Illicit Trafficking in 2013 (international)



Video available at: https://www.youtube.com/watch?v=jJGw_d5nqi4

UNODC video released on the International Day against Drug Abuse and Illicit Trafficking in 2013 (international)




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These mass media campaigns are very frequent across the world. A recent systematic review of all scientific evaluations of anti-drug public service announcements has found that these interventions had been largely ineffective, and may in fact encourage drug use and exacerbate the social stigma associated with drug use.

See: Werb, D., Mills, E.J., DeBerk, K., Montaner, J.S.G. & Wood, E. (2011), 'The effectiveness of anti-illicit-drug public-service announcements: A systematic review and meta-analysis', *Journal of Epidemiology & Community Health*, 65(10): 834-840

Unplugged prevention programme in schools (international)



Lesson 11

Problem solving and decision making

A problem can stand before you like a block of concrete, impossible to move. It may paralyze you and keep you from thinking, working or going on in any way. The five step model you will learn about in this lesson is a strategy to prevent such frozen situations.

CHOOSE ONE OF THESE PROBLEM SITUATIONS OR CREATE ONE YOURSELF

Rachel is always late for school because she sleeps in past her alarm time. *How can she overcome this problem to be on time for school?*

David failed his last math test and needs to pass the next one in order to maintain his school average. He has set a goal that he would like to work in some math-related field and therefore places great importance on passing every test. *What should he do?*

Nicole lives in a home where her parents smoke all of the time. She know that second-hand smoke is bad for you and does not want to continue breathing it. *What can she do?*

Daniel gets a hold of a package of cigarettes. He is very curious about trying them but wants others to try with him. He asks Michael among others in the class. *Michael has decided he does not want to try, what does he do?*

Amanda has decided that she does not want to drink. Amanda is invited to a party and she knows that people will be serving alcohol mixed with juice and soda. *What does she do?*

42

Which of the following statements is correct?

- A. The use of cocaine now and then doesn't cause dependence
- B. The use of cocaine enhances school performance
- C. After the use of cocaine you feel strong and calm for a long while
- D. None of the above statements is correct

42

It is possible to get addicted to cocaine

You can become addicted to cocaine especially because you are feeling that bad after the flush that you want to use the drug directly again to feel strong and assertive again.

CORRECT ANSWER: D

29

Which one of the following statements is true?

- A. It is less dangerous to smoke one joint than one cigarette
- B. Smoking joints and cigarettes are often related
- C. Smoking one cigarette is equally harmful as smoking one joint

29

It is not less harmful for the body to smoke hashish than to smoke cigarettes

Since the smoke of cannabis (which is mixed with tobacco) usually is inhaled more deeply and kept for a longer time in the lung compared to the smoke of cigarettes (we are now only talking about the effect of the smoke!). However, most people smoking cannabis also smokes cigarettes, thus enhancing the harm.

CORRECT ANSWER: C

Unplugged prevention programme in schools (international)

29

Which one of the following statements is true?

- A. It is less dangerous to smoke one joint than one cigarette
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CORRECT ANSWER: C

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CORRECT ANSWER: C

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CORRECT ANSWER: D

42

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Lesson 11

Problem solving and decision making

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Nicole lives in a home where her parents smoke all of the time. She know that second-hand smoke is bad for you and does not want to continue breathing it. *What can she do?*

Daniel gets a hold of a package of cigarettes. He is very curious about trying them but wants others to try with him. He asks Michael among others in the class. *Michael has decided he does not want to try, what does he do?*

Amanda has decided that she does not want to drink. Amanda is invited to a party and she knows that people will be serving alcohol mixed with juice and soda. *What does she do?*

Unplugged is the first school-based prevention programme developed in an international collaboration in Europe and evaluated in a multi-centre cluster randomised controlled trial. It is based on the comprehensive social influence approach, and includes training of personal and social skills with a specific focus on normative beliefs. Unplugged was developed by a European expert group as a standardised package and includes the following components: social skills, personal skills, knowledge and normative education. The core programme consists of 12 1-hour sessions to be delivered weekly by class teachers who previously attended a 3-day training course.

It is a strongly interactive programme and follows a standardised package programme. The programme has been evaluated in the EU-Dap study, a large European collaborative study conducted between September 2004 and May 2007 in seven European countries: Austria, Belgium, Germany, Greece, Italy, Spain and Sweden, and involving 143 schools, 345 classes and 7 079 students. The evaluation showed that Unplugged reduced the use of tobacco and cannabis, and the episodes of drunkenness among pupils receiving the programme versus pupils of the usual curriculum control group.

At post-test, significant intervention effects were detected for daily use of cigarettes, frequent and sporadic drunkenness episodes and cannabis use. The effect on drunkenness episodes and cannabis use was maintained at 18 months follow-up. In a second phase of the EU-Dap project, the teacher handbook was largely revised, mainly based on teacher feedback information. Moreover, to complement the new teacher's handbook, a student's workbook was developed, intended as a personal workbook of the student, and containing activities that students are to work through during the Unplugged units.¹

¹ EMCDDA Best Practice Examples Database, http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=IT&tab=overview; http://www.eudap.net/Research_Publications.aspx

Handout: Data on the availability of drug treatment services in 14 West African nations*

Country	SA Policy exists	Govt. Unit for SUD	Budget Line	Financing Method	Usual Treatment Setting	Medical detox for DUD	SMT available	Specialized Tx available	3 Most important professionals	National data collection
Benin	Drugs	Y	Y, drugs	Tax-based	Gen health	Y	N	N	Psych, GPs, Nurses	Y
Burkina Faso	N	Y, alcohol	N	Out-of-pocket	Gen health	N	Y	N	–	N
Chad	N	Y	N	Out-of-pocket	MH service	Y	N	N	Psych, Nurses, GPs	N
Cape Verde	N	MH	N	Insurance	MH service	Y	N	N	GPs, Psych, Psy	N
Cote d'Ivoire	Y/MH	MH	N	Out-of-pocket	MH service	N	N	N	Psych, GPs, Nurses	N
The Gambia	N	Y	N	Tax-based	Gen health	Y	N	N	Nurses, PHC workers	N
Ghana	N	MH	N	Insurance	MH service	Y	N	N	Psych, Counsellors, GPs	N
Guinea	Y/MH	N	N	Out-of-pocket	MH service	Y	N	N	Psych, GPs, Psy	N
Mali	N	MH	N	–	MH service	Y	N	N	Psych, Psy, Nurses	N
Niger	N	MH	N	External grant	MH service	Y	N	N	Addictologists, Psych, Nurses	N
Nigeria	N	Y	Y/MH	Tax-based	MH	Y	N	Y	–	N
Senegal	N	MH	N	–	MH	–	–	N	–	N
Sierra Leone	Y	MH	Y	NGOs	MH	N	N	N	Psych, Nurses, PHC	Y
Togo	N	Y	Y/MH	Out-of-pocket	MH	Y	N	N	GPs, PHC, Psych	N

Notes:
Y = Yes, available N = No, not available
MH = mental health Psy = psychologists Psych = psychiatrists PHC = primary health care workers GPs = general practitioners
SMT = Substitution maintenance therapy

* World Health Organisation (2010), *ATLAS on substance use 2010: Resources for the prevention and treatment of substance use disorders* (Geneva: WHO)



MODULE 3

Handout: Key resources on drug prevention and treatment

Prevention

United Nations Office on Drugs and Crime (2013), *International standards on drug use prevention*, <http://www.unodc.org/unodc/en/prevention/prevention-standards.html>

World Health Organisation (WHO), *Prevention publications*, http://www.who.int/substance_abuse/publications/prevention/en/

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European Monitoring Centre on Drugs and Drug Addiction, *Prevention of drug use*, <http://www.emcdda.europa.eu/topics/prevention>

European Monitoring Centre on Drugs and Drug Addiction (2011), *European drug prevention quality standards*, <http://www.emcdda.europa.eu/publications/manuals/prevention-standards>

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Treatment

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United Nations Office on Drugs and Crime (2014), *Community based treatment and care for drug use and dependence – Information brief for Southeast Asia*, http://www.unodc.org/documents/southeastasiaandpacific/cbtx/cbtx_brief_EN.pdf

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MODULE 4



Harm reduction advocacy



Aim of Module 4

To build strategies and arguments that promote the existence, or support the adoption, of drug policies that protect people who use drugs from infections, discrimination, overdose and other preventable harms.



Learning objectives

Participants will be able to:

- Understand and explain the meaning and principles of the harm reduction approach
- Recognise how harm reduction principles can contribute to an effective, balanced drug policy
- Identify potential opportunities for policy development and barriers to success
- Agree short, medium, and long term actions to encourage a harm reduction approach in their own countries



Facilitators' note

Before the session, the facilitator should gather local data on drug-related harms and harm reduction service coverage (e.g. overdose rates, trends in spread of HIV and hepatitis B or C, prevalence in the general population and among people who inject drugs, rates of incarceration) to add local context to the session. Data can be sought through questionnaires sent to participants prior to the training, or found through some of these resources below:

- HRI's 'Global state of harm reduction': <http://www.ihra.net/global-state-of-harm-reduction>
- UNAIDS' 'AIDS Info' database: <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>
- West Africa Commission on Drugs (2013), Not just in transit: Drugs, the State and Society in West Africa, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
- Mathers et al (2008) The global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet*; **372**(9651):1733–45
- Mathers et al (2010) HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet*; **375**(9719): 1014–1028
- The World Bank's database: <http://data.worldbank.org/>

Introduction

This module examines the set of practices and principles which make up what is known as harm reduction.

For the past 100 years, most drug control policies have been grounded in ideological perspectives which seek to create a “drug free society”, and West Africa has been no exception to the rule (see Module 1). Experience from around the world demonstrates that this objective is unlikely to ever be realised – historical evidence shows that virtually all known human societies have experienced some levels of drug use. We have seen in Module 3 that in West Africa the absence of drug dependence treatment systems poses significant public health risks, potentially aggravating existing challenges such as the spread of HIV. This is particularly concerning when evidence shows that the transit of cocaine, heroin and amphetamine-type stimulants (ATS) has led to increased drug use in the region, especially among young people.

The harm reduction approach is increasingly being considered as a political necessity in West Africa, as a way to work practically and compassionately with people who use drugs.

Fundamentally, harm reduction recognises that:

- there are positive aspects of drug use for many people
- many people are unwilling or unable to stop using drugs, even when there are negative consequences associated with drug use
- many harms associated with drug use are preventable.

Harm reduction strives to respond to each individual's unique experience of drug use by providing accessible information and support, and integrating services with

primary care and specialist medicine, drug treatment, housing services, the criminal justice system, and other relevant areas. When adopted, harm reduction approaches tackle drug use as a health, rather than a criminal, issue. This, in turn, can reduce some of the harms of punitive criminal justice approaches to drug use, which exacerbate stigma and discrimination and drive vulnerable individuals away from life-saving harm reduction services. Harm reduction seeks to protect the human rights of people who use drugs, particularly for vulnerable populations such as women who use drugs, young people, etc.

This module looks in detail at some of the specific interventions that characterise harm reduction, as well as the overall concept and values of harm reduction and the common challenges for implementation in West Africa. This will form the basis of the development of effective harm reduction advocacy interventions.

SESSION 4.1:

Activity: Defining harm reduction interventions

SESSION 4.2:

Presentation: Why is harm reduction important?

SESSION 4.3:

Activity: Harm reduction interventions

SESSION 4.4:

Presentation: Harm reduction in West Africa

SESSION 4.5:

Activity: Road blocks to harm reduction

SESSION 4.6:

Activity: Peers, patients, prisoners, or partners?

SESSION 4.7:

Activity: Responding to concerns about harm reduction

Session 4.1

Activity: Harm reduction advocacy



30 min



Aim - To share experiences and perspectives on harm reduction, come to a shared understanding of what the approach encompasses, and agree on a working definition to use during this training and in subsequent advocacy work

1. Introduce the aim of the session.
2. Divide the group into groups of three or four people.
3. Cut out and distribute the series of cards included in the handout "[Harm reduction cards](#)".
4. Ask the participants to sort the cards into three categories:
 - a. the UN "comprehensive package of HIV prevention interventions among people who inject drugs"¹
 - b. other harm reduction services
 - c. non-harm reduction services.
5. Participants should be encouraged to discuss any disagreements or questions they may have – with the facilitator playing a key role in validating, clarifying and filling in any gaps in knowledge. The facilitator should ask the participants if there is any other harm reduction intervention that is not included in the list of interventions provided during the exercise.
6. Present the accompanying slides and the definition below, and ask participants if it matches the outcome of the activity above and if it works for them as a definition.
7. For more information, facilitators can give the participants copies of the handout "[Principles of harm reduction](#)".



Facilitators' note

The concept of harm reduction is most commonly associated with the protection of public health and human rights as they relate to drug use. The harms of drug use and drug control are broad – from blood-borne viruses such as HIV and hepatitis, to the mass incarceration of people who use drugs, to the damage caused to farmers and their families by crop eradication projects. As such, the term harm reduction has been used broadly by some groups. For the purposes of this module, the facilitator should use his/her judgement about whether to apply a broader or narrower definition of harm reduction, provided it fits firmly within the principles listed below.

1. See: World Health Organisation, United Nations Office on Drugs and Crime & United Nations Joint Programme on HIV/AIDS (2012), *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* – 2012 revision, <http://idpc.net/publications/2013/01/who-unodc-unaid-technical-guide-for-countries-to-set-targets-for-universal-access-to-hiv-prevention-treatment-and-care-for-injecting-drug-users-2012-revision>

Information to cover in this presentation:

“Harm Reduction” refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits drug users, their families and the community. The harm reduction approach to drugs is based on a strong commitment to public health and human rights.

The fundamental principles of harm reduction are that it:

- **is targeted at risks and harms** – harm reduction begins from the standpoint of identifying what specific risks and harms are occurring with an individual’s or population’s drug use, defining the causes of those risks and harms, and determining what can be done to reduce – if not eliminate – them.
- **is evidence based and cost effective** – harm reduction approaches are founded on public health science and practical knowledge, and employ methods that are most often low cost and high impact.
- **is incremental** – harm reduction seeks to achieve any positive change in individuals’ lives through interventions that are facilitative rather than coercive, and that take practical, achievable steps to reduce immediate harms associated with drug use.
- **is rooted in dignity and compassion** – harm reduction views people who use drugs as valued members of the community, as well as friends, family members and partners, and consequently rejects and challenges discrimination, stereotyping and stigmatisation.
- **acknowledges the universality and interdependence of human rights** – harm reduction fully respects international human rights principles.
- **challenges policies and practices that maximise harm** – many factors contribute to drug-related risks and harms: the behaviour and choices of individuals, the environment in which they use drugs, and the laws and policies designed to control drug use. Harm reduction seeks to address all of these factors in order to protect the human rights and health of affected individuals.
- **values transparency, accountability and participation** – harm reduction staff, donors, public officials, and other relevant people are ultimately accountable to people who use drugs. Harm reduction seeks to ensure accountability by prioritising participation and leadership by people who use drugs in the design and implementation of policies and programmes that affect them.
- **responds to the specific needs of a diverse range of vulnerable groups**, rather than offering a one-size-fits-all solution.

Session 4.2

Presentation: Why is harm reduction important?



20 min



Aim - To explore the rationale for a harm reduction approach

1. Introduce the aim of the session.
2. Remind participants that in Session 2.3 we saw that one of the high-level principles for effective drug policies is that “*drug policies should **focus on reducing the harmful consequences** rather than the scale of drug use and markets*” and in Session 1.5 we identified some of these harmful consequences.
3. Present the information below and corresponding slides.



Information to cover in this presentation:

HIV through use of non-sterile injection equipment, overdoses, and the exacerbation of existing mental or physical illnesses. In many settings, these harms are exacerbated by repressive and punitive drug policies that deter individuals from accessing health care and advice. Harm reduction interventions seek to minimise these health harms.

Harm reduction is equally concerned with the **harms caused by public policies and attitudes** directed at people who use drugs. In most countries, the policy environment leads to the criminalisation and incarceration of people who use drugs – affecting access to healthcare, their chances of employment, housing, social support and even child custody. As a criminalised population, people who use drugs are also often subjected to discrimination in medical settings or denial of health care. Some groups of people who use drugs (such as women, young people and ethnic minority groups) experience additional social and cultural stigma. The harm reduction approach seeks to challenge these cultures of marginalisation. As such, harm reduction is often conceived as both a public health and a human rights concept.

The following data demonstrate why harm reduction is a vital approach in West Africa:

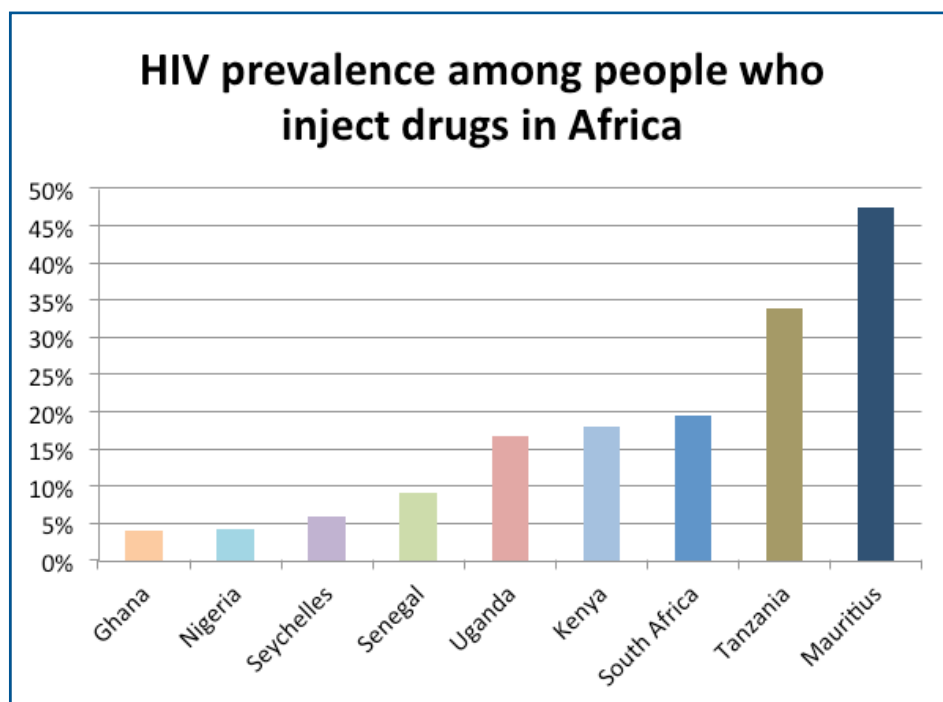
- There are estimated to be 12.7 million people inject drugs worldwide, more than 13% of whom are living with HIV.¹
- In Sub-Saharan Africa, an estimated 1 million people inject drugs. Of these 1 million people, between 5 and 10% are estimated to be living with HIV.² Although the Joint United Nations Programme on HIV and AIDS (UNAIDS) has reported a decline of 34% in the annual number of new HIV infections among adults in Sub-Saharan Africa since 2001,³ there are risks that the gains in tackling HIV in the region may be lost if HIV among people who inject drugs is not addressed rapidly. In several Sub-Saharan African countries, HIV prevalence among people who inject drugs is on the increase:



Facilitators' note

Please replace with/add as much local data as possible when presenting this information.

- 4% in Ghana
- 4.2% in Nigeria (where 9.1% of all new HIV infections are now attributed to injecting drug use)
- 9.1% in Senegal (compared to under 1% among the general population)
- 16.7% in Uganda
- 18% in Kenya
- 19.4% in South Africa
- 33.9% in Tanzania
- 47.4% in Mauritius⁴.



Source: Global State of Harm Reduction, 2014

- HIV prevalence in a number of countries (Senegal, Tanzania and others) tends to be significantly higher among women who inject drugs than among men – with HIV prevalence among women who inject drugs being between 5 and 15% higher than their male counterparts in Nigeria, and between 55 and 68% higher in Tanzania. In Senegal, the prevalence rate was at 21.1% among women, compared to 7.5% among men. This can be explained by the fact that some women who inject drugs participate in highly risky injecting practices because of gender inequality, dependence on male partners and their possible involvement in sex work.⁵
- Globally, there are an estimated 10 million people who inject drugs who are also living with **hepatitis C** – indicating a prevalence among this group of more than 60 per cent. Approximately 800,000 of these people are in Sub-Saharan Africa.⁴ In many countries in Eastern Europe, the Middle East and Asia, HIV and hepatitis C transmission are mainly driven by injecting drug use. Injection-related transmission has also recently become an important part of HIV epidemics in sub-Saharan Africa, where the prevalence of injecting drug use now approaches the global average. In Senegal, hepatitis C prevalence among people who inject drugs reached over 23%.⁶
- **Drug overdose** is a major cause of mortality in many parts of the world.
- **Non-injecting drug** use can also be associated with negative health outcomes. Many parts of the world, including West Africa, have seen an increase in the use of cocaine and ATS, and in the non-medical use of pharmaceutical medications:

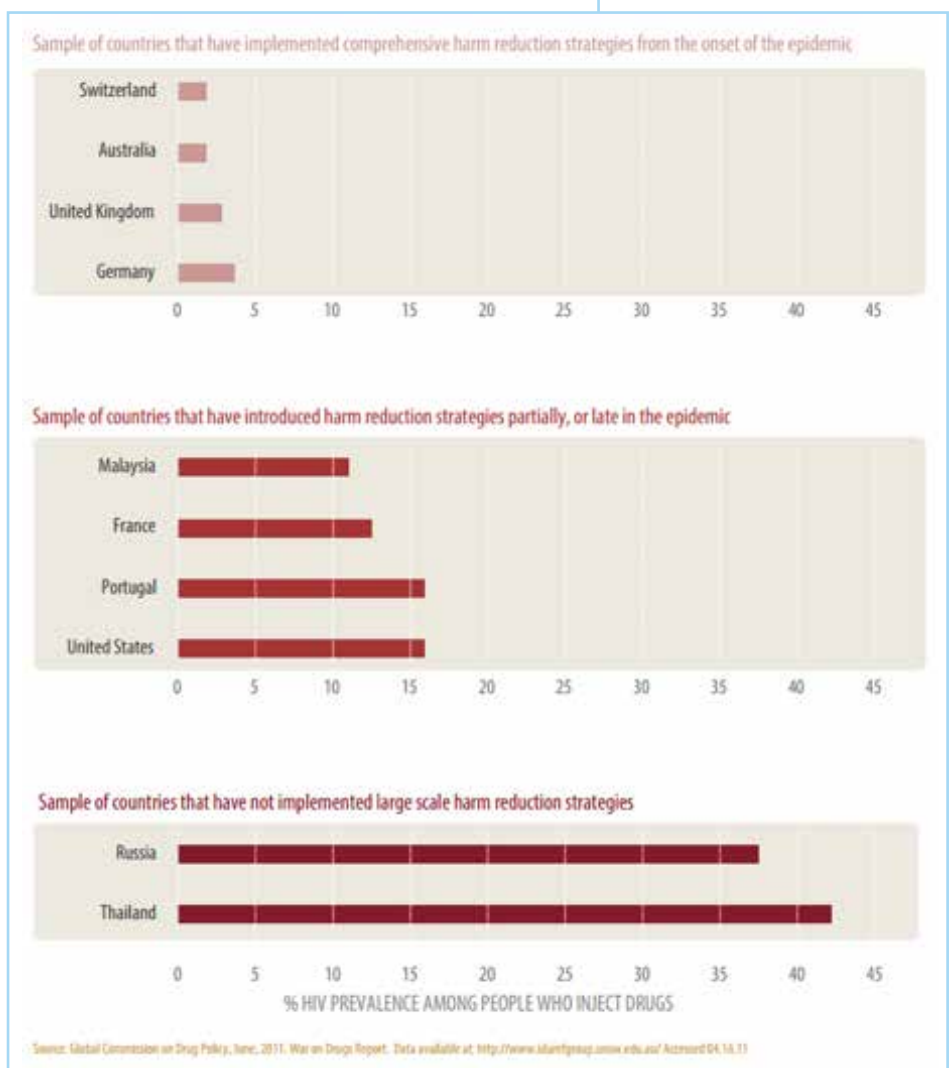
- o Non-injecting drug use can be associated with an increased risk of sexual transmission of HIV in some contexts. This can be explained by the fact that people who use cocaine, ATS or other substances may be less likely to use a condom while under the influence of the substance,⁷ but also that some dependent users may turn to trading sex for drugs or money to feed their drug dependence, making them more vulnerable to HIV infection and other STIs
- o Sharing drug smoking paraphernalia may increase risks of hepatitis C transmission
- o Stimulant drugs may cause hyperthermia, acute psychiatric disorders, dehydration and other harms
- o Inhaled drugs may cause lung infections and other health complications (including cancers).

Evidence in support of harm reduction interventions

There is a wealth of evidence from around the world that supports the effectiveness of harm reduction interventions. In 2011, the Global Commission on Drug Policy produced the three graphs that show the prevalence rates of HIV among people who inject drugs in:

1. countries that have consistently implemented comprehensive harm reduction services from the onset of their HIV epidemic;
2. others that have adopted harm reduction strategies partially, or later on in the epidemic; and
3. those countries that are resisting the implementation of such strategies.

The graphs show that the HIV prevalence rates are significantly lower in the first group of country, compared to the second group, and more drastically compared to group three.⁸



1. United Nations Office on Drugs and Crime (2014), *World Drug Report 2014*, <http://www.unodc.org/wdr2014/>
2. Harm Reduction International (2014), *The Global State of Harm Reduction 2014*, www.ihra.net
3. Joint United Nations Programme on HIV and AIDS (2013), *2013 Global Report*, <http://www.unaids.org/en/resources/campaigns/globalreport2013/globalreport>
4. Harm Reduction International (2014), *The Global State of Harm Reduction 2014*, www.ihra.net
5. Nelson, P.K. et al (2011), 'Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: Results of systematic reviews', *The Lancet*, **378**(9791): 571-83, <http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736%2811%2961097-0.pdf>
6. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
7. See: African Union Plan of Action on Drug Control (2013-2017), p. 4, <http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20English.pdf>
8. Global Commission on Drug Policy (2011), *War on Drugs: Report of the Global Commission on Drug Policy*, <http://www.globalcommissionondrugs.org/reports/>

MODULE 4



40 min

Session 4.3

Presentation: Harm reduction in West Africa



Aim – To explore the range and accessibility of harm reduction services available in West Africa

1. Introduce the aim of the session.
2. Ask the participants to brainstorm on which harm reduction services are available in their country/region and note them on a flipchart.
3. Ask the participants to discuss the availability and quality of existing services.
4. Present slides and distribute the handout “The state of harm reduction in Sub-Saharan Africa”.



Facilitators' note

As the situation regarding harm reduction is constantly evolving, if participants present information that contradicts what we have below – please let us know so that we can update our records.



Information to cover in this presentation:

Globally around 90 countries and territories support the harm reduction approach in policy or in practice (2014 data). In some regions, harm reduction services have expanded in scale and in range, with innovative services now available to prevent a number of drug-related harms.¹

We saw in Session 4.2 that the use of heroin, cocaine and ATS – which is increasing in West Africa – has been associated with a number of health harms. Yet access to harm reduction interventions in the region remains limited. Indeed, only a few African countries have some form of harm reduction programmes:

Reference to harm reduction in national policy documents	Kenya, Mauritius, Tanzania
Opioid Substitution Therapy (OST)	Burkina Faso, Kenya, Mauritius, Senegal, Seychelles, South Africa, Tanzania
Needle and syringe programmes (NSP)	Kenya, Malawi, Mauritius, Senegal, South Africa, Tanzania
Heroin Assisted Treatment	N/A
Safer injecting facilities	N/A
Take-home naloxone programmes to manage overdose emergencies	N/A

No West African country currently has national policy documents that explicitly refer to harm reduction, and only two West African countries offer OST – Burkina Faso (through private services only) and Senegal (since 2014). Only Senegal provides sterile needles and syringes to people who inject drugs (also since 2014), although a pilot is being proposed in Nigeria as well. Other services, such as heroin assisted treatment, safer injecting facilities, and medicines to reverse opioid overdoses are not available in any Sub-Saharan African country.

Across the world, even when harm reduction interventions are in place, global coverage remains woefully low. It has been estimated that worldwide just two needles and syringes are distributed per person who injects drugs per month. Only 8% of people who inject drugs have access to OST, and just 4% of those in need receive antiretroviral therapy.¹ Access to these services is often limited by the fact that people who use drugs are often stigmatised, criminalised and denied access for ideological reasons.

Regional documents supporting harm reduction in Africa

- **The African Union Plan of Action on Drug Control (2013-2017)²**

For the first time, the African Union (AU) adopted a plan of action in October 2012 that highlighted the need to “pay greater attention to health and other social consequences of drug use”, in addition to law enforcement approaches. As such, one of the four key priority areas of the Plan of Action is the development of “Evidence-based services scaled up to address health and social impact of drug use in Member States”. Although the Plan of Action does not refer explicitly to “harm reduction”, it mentions, as a key output, “comprehensive, accessible, evidence-informed, ethical and human rights based drug use prevention, dependence, treatment and aftercare services implemented”. In addition, the accompanying ‘Implementation Matrix’ calls on member states to provide the United Nations (UN) “comprehensive package on HIV prevention, treatment and care among injecting and non injecting drug users (IDUs), most at risk populations and in prison settings” (see Output 2.4.3).³ Although the documents are non-binding, they are an important acknowledgement of the need for harm reduction interventions in the region.

- **The ECOWAS Regional Action Plan to Address the Growing Problem of Illicit Drug Trafficking, Organised Crimes and Drug Abuse in West Africa (2008-2011) – extended until the end of 2014**

The ECOWAS Regional Action Plan calls for drug policies and HIV policies to be harmonised at regional levels, as well as for programmes to be implemented to integrate drug and HIV prevention services. The plan also requests the establishment of integrated health services to address mental health and HIV/AIDS and drug use. Similarly, Output 15 in the ECOWAS regional action plan is framed as follows: “A network of treatment centres is established and best practices on drug abuse treatment, including HIV prevention for vulnerable groups, are implemented in selected West Africa countries”.

- **The Abuja Declaration – Political Declaration on the Prevention of Drug Abuse, Illicit Drug Trafficking and Organized Crimes in West Africa, 2008**

The Abuja Declaration also raises concerns over the increasing health harms related to drug use, and calls for governments in the region to “Take appropriate steps to make health care and social support available, affordable and accessible to those who abuse drugs and those dependent on drugs”.

Case study: Harm reduction in Senegal

Senegal is emerging as a pioneer in the provision of government-supported harm reduction services in West Africa. A survey conducted in 2011 showed that although HIV prevalence remained low (0.7%) in the general population, prevalence among people who injected drugs was as high as 9% and hepatitis C prevalence reached over 23%.⁸ HIV prevalence among women who injected drugs was significantly higher than among men (21.1% compared to 7.5%). Needle sharing was also frequent in this population.⁹ Generally, people who use drugs in Senegal faced a very high mortality risk. Seeing the danger of a possible injection-linked HIV epidemic, the government included injecting drug use as a priority in its 2011-2015 National AIDS Programme. The government project Usagers de Drogues au Senegal (UDSEN) mobilised teams of outreach workers to begin sensitising people who use drugs to the need for safer use practices. In 2013, NSPs began on a small scale, and in 2014, a major national centre for treatment of drug dependence opened and includes the provision of methadone maintenance therapy. The Senegal experience is an interesting example for other West African countries as the extent of injection drug use in the sub-region becomes clearer.¹⁰

1. For more information, see: Mathers, M.B. et al (2010), 'HIV prevention, treatment, and care services for people who inject drugs : A systematic review of global, regional, and national coverage', *The Lancet*, **375**(9719): 1014-1028, <http://www.lancet.com/journals/lancet/article/PIIS0140-6736%2810%2960232-2/abstract>
2. African Union Plan of Action on Drug Control (2013-2017), <http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20English.pdf>
3. AU Plan of action on drug control and crime prevention (AUPA) (2013-2017) – Implementation matrix, <http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20English.pdf>
4. Regional action plan to address the growing problem of illicit drug trafficking, organised crimes and drug abuse in West Africa (2008-2011), <https://www.unodc.org/westandcentralafrica/en/ecowasresponseactionplan.html>
5. Economic Community of West African States, Political declaration on the prevention of drug abuse, illicit drug trafficking and organised crimes in West Africa, <https://www.unodc.org/westandcentralafrica/en/ecowaspoliticaldeclaration.html>
6. Raguin, G., Leprêtre, A., Ba, I. et al (2011), 'Drug use and HIV in West Africa: a neglected epidemic'. *Tropical Medicine and International Health*, **16**: 1131-33
7. Retrieved from: West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
8. Maynard, M., Ba, I. & Leprêtre, A. (2012), *Accès aux soins du VIH et des hépatites B et C des usagers de drogues injectables dépistés dans le cadre d'une enquête menée à Dakar* (ANRS 12243 UDESIN). AFRAVIH 2012, 6^e Conférence Francophone VIH/SIDA, Geneva
9. Raguin, G., Leprêtre, A., Ba, I. et al (2011), 'Drug use and HIV in West Africa: a neglected epidemic'. *Tropical Medicine and International Health*, **16**: 1131-33
10. Retrieved from: West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf

Session 4.4

Activity: Prioritising harm reduction interventions



40 min



Aim - To explore participants' knowledge about, experience of, and attitudes towards different harm reduction measures. To describe the main harm reduction interventions based on global evidence.

1. Introduce the aim of the session.
2. Ask participants to work in small groups of three or four and give each group some flipchart paper and different coloured marker pens.
3. Ask each pair / group to note as many harm reduction interventions as they can think of and once they have done so to rate them from 1 to 5 (*acknowledge that some may already be implementing some of these*)
 - first (*in one colour*) – in terms of how effective they would be (or are) in the local context
 - second (*in a different colour*) – in terms of how achievable it would be to set them up in the local context.
4. Ask participants to present their work and explore the reasons for their ratings.
5. Present the information below.
6. Give participants copies of the Handout on "[Harm reduction interventions](#)".



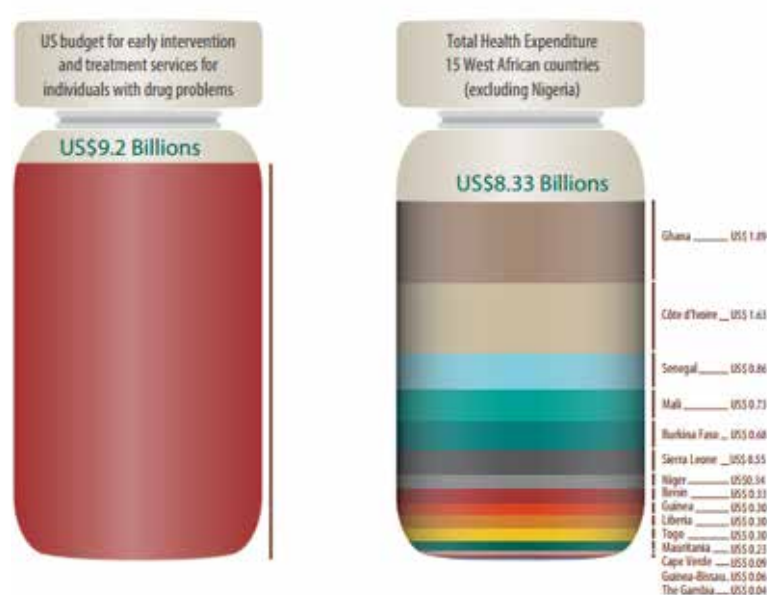
Information to cover in this presentation:

Although harm reduction services should be considered as comprehensive and mutually reinforcing, many governments may be unable to develop all nine interventions of the UN "comprehensive package" – let alone all 19 interventions listed on the handout – because of resource constraints. It is paramount to prioritise the interventions that will be most effective in reducing harms according to the specific local contexts. As such, the UN Technical Guide emphasises that "To successfully address HIV where injecting drug use occurs, countries should prioritise implementing NSPs and evidence-based drug dependence treatment (specifically OST)".¹

Harm reduction interventions should also adapt to different patterns and trends of drug use. In countries where drugs are mostly snorted or smoked, other harm reduction interventions will need to be prioritised. If people who were traditionally smoking cocaine or heroin are suddenly turning to injection, new harm reduction interventions should be developed and prioritised to ensure that the risks associated with these new patterns of use are minimised.²

Policy makers often tend to place a low priority on harm reduction interventions, in particular in settings where even the most basic drug-related health services are scarce. However, research has consistently shown that investments in harm reduction services can lead to significant economic and social benefits which far exceed the resources invested.³ For example, a study of the available evidence by the United Nations Office on Drugs and Crime (UNODC), UNAIDS and World Health Organisation (WHO) concluded that: “According to several conservative estimates, every dollar invested in opioid dependence treatment programmes may yield a return of between US\$4 and US\$7 in reduced drug-related crime, criminal justice costs and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12:1.”⁴ Part of the massive expenditure on drug law enforcement, policing and interdiction therefore needs to be urgently redirected towards harm reduction interventions.⁵

US SPENDING ON DRUG TREATMENT VERSUS WEST AFRICAN NATIONAL HEALTH BUDGETS (CIRCA 2011) (US\$ BILLIONS)



To ensure their effectiveness, harm reduction interventions should be scaled up as much as possible – while also taking into account local resource constraints – to ensure that those in need have access to these services.⁶ If these services are not available widely enough for people who use drugs, they will not be able to reduce harms. For example, the UN guidance states that more than 200 needles and syringes should be distributed annually for each person who injects drugs, and that more than 40% should have access to OST. As we explained earlier, services implemented in West Africa are far from reaching these numbers.

The quality of services is also essential to their effectiveness, and refers to the scope, completeness, effectiveness, efficiency, safety and accessibility of interventions. One way to promote service quality is to involve people who use drugs in service design, development and delivery. Even simple mechanisms such as anonymous feedback forms and client surveys can help to obtain valuable feedback about a service. The UN guidance provides several options for measuring quality, including how many clients are provided with additional services (such as psychosocial support, information and education, or adherence support).

Because a large number of people who use drugs end up in prison (either because drug use remains criminalised or because of other related crimes), harm reduction interventions should be provided both in the community and in prison settings. The “principle of equivalence” articulates that prisoners should not be denied health care that would have been available in community settings – and this includes harm reduction interventions.

Case study: Harm reduction in Tanzania⁶

Until the 2000s, Tanzania's drug policy focused on reducing supply, with little emphasis on treatment or harm reduction services for people who use drugs. During the late 1990s and early 2000s, researchers documented a rapid escalation in heroin use and a simultaneous rise in HIV among people injecting heroin. On World AIDS Day 2006, medical researchers met in Dar-es-Salaam to discuss the links between injection drug use and the rising HIV rates in the country. The government subsequently commissioned a study that estimated HIV prevalence in the general population at 5.6%, but an alarming 42% among people who inject drugs in Dar-es-Salaam. One study of residual blood from syringes used for drug injection found that 57.4% of the syringes tested positive for HIV. Subsequent studies showed that 45% of men and 72% of women who injected heroin were HIV positive. Supported by the US Centers for Disease Control and Prevention, the Tanzanian authorities began implementing a methadone maintenance programme in Dar-es-Salaam despite the fact that the existing drug law was not supportive of the intervention. One NSP was started with support by non-governmental organisations around the same time. The national Drug Control Commission, operating from the Prime Minister's Office, helped coordinate the police, health and social sectors in these activities. Today, the OST programme, launched in February 2011, is the largest government-run methadone programme in Sub-Saharan Africa. By early 2013 more than 1,200 patients were receiving methadone; outreach workers made contact with over 20,000 people who use drugs; some 25,000 needles and syringes were distributed monthly; and the police in some communities are constructively involved in the outreach programmes and in directing people dependent on drugs to treatment programmes rather than detaining them.⁷

1. World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2013), *WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision* (Geneva: WHO), <http://idpc.net/publications/2013/01/who-unodc-unaidst-technical-guide-for-countries-to-set-targets-for-universal-access-to-hiv-prevention-treatment-and-care-for-injecting-drug-users-2012-revision>
2. Bridge, J. (2010), 'Route transition interventions: Potential public health gains from reducing or preventing injecting', *International Journal of Drug Policy*, 21(2): 125-128, <http://www.ijdp.org/article/S0955-3959%2810%2900012-5/abstract>
3. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
4. World Health Organization, Joint United Nations Programme on HIV/AIDS & United Nations Office on Drugs and Crime (2004), *Position paper: Substitution maintenance therapy in the management of opioid dependence and HIV prevention* (Geneva: United Nations), <http://www.unodc.org/documents/hiv-aids/Position%20Paper%20sub.%20maint.%20therapy.pdf>
5. Harm Reduction International, International Drug Policy Consortium & International HIV/AIDS Alliance (2014), *The funding crisis for harm reduction*, <http://idpc.net/publications/2014/07/the-funding-crisis-for-harm-reduction>
6. Joint United Nations Programme on HIV/AIDS (2005), *Intensifying HIV prevention: UNAIDS policy position paper*, http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf
7. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
8. Based on a presentation to the WACD by Yovin Ivo, Drug Control Commission of Tanzania

MODULE 4



45 min

Session 4.5

Presentation: Road blocks to harm reduction



Aim – To explore the range and accessibility of harm reduction services available in West Africa

1. Introduce the aim of the session.
2. Divide the group into smaller groups of 3 or 4 people and distribute four A4 cards to each group.
3. Ask each group to identify:
 - Two barriers to the adoption of harm reduction interventions in their country/region (e.g. resource constraints, not seen as a priority on the political agenda, ideological resistance, scepticism from influential religious leaders, and laws criminalising drug use and/or possession of drug paraphernalia).
 - Two possible barriers that people who use drugs might face even when these services are available (e.g. distance of services, opening hours, fear of arrest).
4. Ask the participants to fold their A4 cards in half and draw or write one barrier on each card.
5. Place the cards in a row on the floor, so that they look like a series of road blocks. While doing so, try and group identical / similar barriers together (i.e. “ideological barriers” and “religious barriers” could be discussed together).
6. Walk along the road blocks, and discuss why each barrier has been identified, and how it might be overcome.
7. Encourage the participants to identify the most important barriers of those discussed.
8. Present slides.
9. Allow time to explore each of these sets of issues and how they relate to the local context with participants, ask the participants whether and how they have been confronted to these barriers.



Information to cover in this presentation:

Economic and technical resource issues

As explained earlier in this training, in most West African countries, the coverage of harm reduction services remains extremely low or non-existent, hindering their ability to respond efficiently to drug-related harms. This is often due to the fact that the issue remains low on the political agenda, as well as national resource constraints and/or lack of international funding. Globally, there is a huge funding gap for harm reduction – with the available resources from governments and international donors falling far short of the estimated need.

UNAIDS estimates that US\$2.3 billion is required annually to fund HIV prevention among people who inject drugs, but only US\$160 million are currently invested by international donors – that is, only 7% of what is required. In comparison, globally, at least US\$100 billion is invested in drug law enforcement.¹

This is despite evidence that these interventions are generally highly cost-effective. In fact, a powerful economic case can be made in favour of harm reduction, since a relatively modest outlay can often prevent very significant costs accumulating in the longer term. For example, costs incurred in the on-going treatment of conditions such as HIV and hepatitis C, or the very large sums spent on criminal justice measures such as imprisonment, can be avoided by the timely scale up of harm reduction interventions that prevent infection and help people to avoid the criminal lifestyles often associated with the funding of drug dependence.²

In Africa, although both ECOWAS and the AU policies address some of the prevention, treatment and harm reduction needs in the region, investment in these areas have remained marginal in comparison to investments related to security and drug law enforcement efforts – highlighting an urgent need to re-balance expenditure from interdiction towards public health measures. Recently, some external partners have started expressing a growing interest in the area. For example, the United States and France are supporting a joint UNODC and WHO programme on drug dependence treatment and care aimed at increasing the reach and quality of treatment services for people dependent on drugs. The programme includes the establishment of National Drug Observatories and a Specialised Reference Treatment Centre in Senegal, which will host the first methadone programme for people dependent on opioids in West Africa. The EU, the Nigerian government and UNODC are also supporting the establishment of a National Drug Observatory in Nigeria. Meanwhile, discussions are continuing with the EU, ECOWAS and UNODC to support a specific component of the ECOWAS Operational Plan on drug use epidemiology (surveys and data collection), drug prevention and treatment. These are important, yet still small steps towards a better balancing of resources invested in drug-related health services in the region.³

Policy and legislative barriers

- **International drug control and harm reduction**

It has previously been argued that harm reduction practices fall outside the terms of the three UN drug control conventions to which most countries are signed up. The debate prompted the Legal Affairs Section (LAS) of the UN Drug Control Programme, now part of the UNODC, to examine the legality of harm reduction interventions. In 2002, the LAS provided a nuanced response to the INCB. It drew attention to the fact that the treaties do not define either the “scientific and medical” purposes to which drugs are to be restricted, or the nature of the “treatment” and “social reintegration” that states parties are allowed (and encouraged) to provide. This means that there is an inherent flexibility within the drug control treaties, of which member states can make use. The LAS found that OST, drug consumption rooms, and NSPs fall comfortably within the measures allowed by the treaties and subsequent UN resolutions. However, the LAS found that drug quality control interventions (such as the testing of drugs and tablets at clubs or festivals) run “contrary to the spirit of the Convention” – although even here it noted a lack of any *intention* to induce or facilitate the use or possession of drugs (the intent that would be necessary for informal drug-testing to constitute a legal offence). Across much of the world, harm reduction concepts and practices are now an established element of policies aiming to manage drug use, and are widely supported by many countries, and UN agencies, including WHO, UNODC and UNAIDS.⁴

However, in some countries, it has proved difficult to roll out interventions even though they fall within the provisions of the international drug control treaties. For instance, the overregulation of substances, such as methadone and buprenorphine, does not allow the development and scale up of OST programmes in certain countries. In Africa, methadone and buprenorphine are only available in a handful of countries. In others, such as Mauritius, although methadone maintenance treatment is well established, buprenorphine remains illegal and therefore inaccessible for OST programmes. The argument that is sometimes brought forward against OST is that substitution treatment “merely replaces one addictive drug with another”, and therefore does not qualify as a medical treatment. This is, however, a very reductive argument that fails to acknowledge the enormous impact that the provision of a safe, quality-controlled and legal alternative to heroin has on the stabilisation and quality of life of people dependent on opioids. It also wilfully ignores the considerable evidence-base supporting the use of medications such as methadone and buprenorphine, which can produce clear and demonstrable improvements in health and social function.

- **The criminalisation of people who use drugs**

Across the world, the criminalisation of people who use drugs presents a direct barrier to the effective provision of harm reduction services. If the police arrest, or are widely perceived as targeting people going to harm reduction and treatment facilities, this will deter many individuals from seeking support and accessing these life-saving services. The experience of countries that have decriminalised drug consumption and the possession of small amounts of drugs for personal use have reported positive health outcomes with a reduction in overdose deaths, of new HIV and hepatitis C infections, as well as an increase in people accessing treatment and employment.

People who use drugs run a high risk of spreading HIV and/or hepatitis through the sharing of contaminated equipment. The criminalisation of injecting or smoking paraphernalia is also a significant barrier to the effectiveness of harm reduction services such as NSPs and the distribution of crack pipes. In Mauritius, the government passed the HIV and AIDS Act in 2006 to remove criminal sanctions for people enrolled in NSPs and caught with a syringe by the police. However, conflicts between the 2006 Act and the 2000 Dangerous Drugs Act (which criminalises people who use drugs and the possession of drug use paraphernalia) persist and people caught with a used syringe routinely continue to be processed in the criminal justice system. Nonetheless, this example constitutes an interesting attempt at protecting harm reduction services.

Additional barriers exist where drug services are perceived as being too closely linked to law enforcement agencies – for example, where people who use drugs must be added to police registries before accessing support.

Institutional and socio-cultural issues

Often, cultural and ideological assumptions can represent the greatest obstacles to the design and implementation of harm reduction programmes. The notion that providing NSPs, for example, “is likely to encourage drug use” is entirely unsupported by scientific evidence, but is a familiar argument.

At their most basic, social and cultural barriers include prejudicial, stereotypical images of people who use drugs, and harm reduction programmes must address these attitudes and misconceptions among the general population and policy makers. An education-oriented advocacy intervention that addresses these beliefs and prejudices among public opinion is, therefore, an essential element of harm reduction.

1. Harm Reduction International, International Drug Policy Consortium & International HIV/AIDS Alliance (2014), *The funding crisis for harm reduction*, <http://idpc.net/publications/2014/07/the-funding-crisis-for-harm-reduction>
2. Harm Reduction International (2011), *Harm reduction: A low-cost, high-impact set of interventions*, <http://dl.dropbox.com/u/64663568/library/Harm-reduction-low-cost-high-impact.pdf>
3. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
4. See, for example: https://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf

MODULE 4



30 min

Session 4.6

Activity: Peers, patients, prisoners, or partners?



Aim – To explore common perceptions of people who use drugs and discuss their importance to the harm reduction approach, and drug policy reform more generally.



Facilitators' note

If time allows, the facilitator can also show the complete version or extracts of this 6-minute video on drug user involvement in drug services:

<https://vimeo.com/aldp/review/61355076/5f8ee8995f>

1. Introduce the aim of the session.
2. Divide the participants into four groups. Provide each group with flipchart pads and pens.
3. Ask the participants to consider four terms: “peers”, “patients”, “prisoners” and “partners”. Using the flipcharts, ask the participants to do a brief word association exercise of the four terms – writing what words and images each term creates in their minds.
4. Back in plenary, discuss some of the words that have been used. Encourage the participants to think about how each of these labels might impact on a person's own self-image and their likelihood to access services or talk to practitioners. Ask participants to also think about what terms are more commonly used in the country/region to characterise people who use drugs, and what impact this has on public perceptions.
5. Present the information below and distribute the handout “[The Vancouver Declaration](#)”.



Information to cover in this presentation:

In the 1970s, two of the first drug user organisations were created:

- The “JunkieBond” was developed by people who use drugs in the Netherlands in order to lobby politicians and the media about their treatment and misrepresentation.
- The Committee of Concerned Methadone Patients and Friends (CCMP) was formed by Methadone patients in New York.

These groups were both engaged in drug user-led, grassroots activism and played a key role in advocating for effective and quality treatment. They also focused on conflict resolution within drug using communities in order to portray positive identities and engender a sense of community. JunkieBond are also widely accredited with opening the world's first NSPs – in response to sudden Hepatitis B epidemics among their friends and colleagues.

The emergence of HIV and hepatitis led to a growth in drug user organising, particularly among people who inject drugs. The Australian IV and Illicit Drug Users League (AVIL) began to run NSPs, undertake social marketing campaigns

and produce magazines. Similar groups were also developed in Europe and North America – sometimes officially and sometimes “underground”. More recently, similar models have been adopted across Asia, Eastern Europe and Africa.

Over time, many drug user organisations have developed a human rights discourse in addition to continuing public health work. Adopting a rights-based approach has even allowed people who use drugs to take legal actions against governments in order to gain access to services.

The [International Network of People who Use Drugs](#) (INPUD) was established in 2006 at the International Harm Reduction Conference in Vancouver, Canada. It aims to represent the interests of people who use drugs on the world stage – advocating for their rights, engaging with decision makers, support regional and national networks, promoting harm reduction, and building alliances with other organisations (including those representing sex workers, people living with HIV, and men who have sex with men). INPUD’s founding statement is known as the “Vancouver Declaration”, and the organisation is now accepted as a legitimate partner by the relevant UN agencies.

Drug user networks are now flourishing both at regional and national level. As of 2014, the Kenyan Network of People Who Use Drugs (KenPUD), REACT (Tanzania), and the Tanzanian Network of People Who use Drugs (TanPUD) have all recently been established in Africa – although no such networks exist yet in West Africa (as far as we are aware).

MODULE 4



30 min

Session 4.7

Activity: Responding to concerns about harm reduction



Aim – To practice responding to concerns about harm reduction from groups that may often not understand or approve of this approach.



Facilitators' note

The audience in this exercise will be chosen depending on the participants and the local/national/regional context at hand.

This exercise can be adapted to the international context, using audiences such as the INCB chair, the UNODC Executive Director, CND delegations, etc.

1. Introduce the aim of the session.
2. Split participants into three groups and give them the scenario below:
You/your organisation are invited to meet with [NAME THE TARGET]. They want to know more about your organisation and about some harm reduction interventions that are being implemented. They have some concerns about the concept of harm reduction and ask some questions. You have a short amount of time to answer the questions below:
 - *Doesn't harm reduction send out the wrong message – promoting drug use or making it look safe?*
 - *Surely we must enforce the law, and that means that drug users have to be punished?*
 - *I hear that outreach workers help people use drugs. Are outreach workers assisting and encouraging illegal acts?*
 - *Why would you offer methadone? Are you saying that we should replace an addictive drug with another?*
3. Give each of the group a different audience to whom they must respond (e.g. the police, the head of the national drug control agency, the Minister of Health, a religious leader, a community leader, the media, etc.).
4. In each group, one of the participants will be the targeted audience, and another participant will be the advocate defending harm reduction, as a role play exercise.
5. After 10 minutes, encourage each group to swap roles so that each participant has a chance to respond to concerns on harm reduction. The facilitator should encourage the participants to tailor their responses to the specific audience. For example, senior police officers will want to hear about reduced crime, while religious leaders will prefer to hear about humane responses in line with their own beliefs, community strengthening, etc. If you have time, you can ask each group to do a 3 minute role play in front of the whole group.
6. At the end of the exercise, encourage the participants to share any challenges or thoughts they may have – and reflect back on some of the arguments you have heard while walking around the room.

Handout: Harm reduction cards (to cut out and distribute)

The United Nations “comprehensive package”

Needle and syringe programmes	Opioid substitution therapy	Voluntary HIV testing and counselling
Antiretroviral therapy for people living with HIV	Treatment of sexually transmitted infections	Condom distribution
Information, education and communication	Hepatitis vaccination, testing and treatment	Tuberculosis prevention, testing and treatment



Other harm reduction interventions*

Crack pipe and smoking foil distribution	Safer injecting facilities	Outreach services
Advocacy for drug policy reform	Provision of alternative livelihoods	Overdose prevention and management
Drug user organising and peer-led advocacy	Legal services and legal aid	Psychosocial support
	Drug checking and pill testing	



Non-harm reduction interventions*

Crop eradication	Police efforts to arrest drug dealers	Compulsory / forced detention
Mass-media campaigns against drug use	Imprisonment of people who use drugs	Abstinence-based programmes**



*Although the nine interventions in the UN “comprehensive package” are clearly defined, there may be more disagreement in the group in terms of what else is a harm reduction intervention or not. There are no right or wrong answers here, and discussion should be encouraged in order to reach agreement. The comprehensive package is available at: World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2013), *WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision* (Geneva: WHO), <http://idpc.net/publications/2013/01/who-unodc-unaid-technical-guide-for-countries-to-set-targets-for-universal-access-to-hiv-prevention-treatment-and-care-for-injecting-drug-users-2012-revision>

** Although abstinence-based programmes are not typically included as a harm reduction intervention, whether they should be considered as such can be discussed and agreed upon by the participants.



MODULE 4

Handout: Harm reduction interventions for people who inject drugs*

The World Health Organisation (WHO), the Joint United Nations Programme on HIV and AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) have developed a comprehensive package of nine interventions to prevent HIV among people who inject drugs:

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy
5. Prevention and treatment of sexually transmitted infections
6. Condom programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication for people who inject drugs and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis

In addition to these nine interventions, the International HIV/AIDS Alliance have also described some further interventions that comprise a harm reduction approach:

10. Sexual and reproductive health services, including the prevention of mother-to-child transmission of HIV
11. Behaviour change communication
12. Basic health services, including overdose prevention and management, including the distribution of naloxone
13. Services for people who are drug dependent or using drugs in prison or detention
14. Advocacy
15. Psychosocial support
16. Access to justice / legal services
17. Children and youth programmes
18. Livelihood development / economic strengthening.

Finally, the IDPC Drug Policy Guide adds a final harm reduction intervention to this list:

19. Drug consumption rooms / safer injecting facilities

* World Health Organisation, United Nations Office on Drugs and Crime & United Nations Joint Programme on HIV/AIDS (2012), *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision*, <http://idpc.net/publications/2013/01/who-unodc-unaid-technical-guide-for-countries-to-set-targets-for-universal-access-to-hiv-prevention-treatment-and-care-for-injecting-drug-users-2012-revision>; International HIV/AIDS Alliance (2011), *Good practice guide: HIV and drug use: community responses to injecting drug use and HIV*, http://www.aidsalliance.org/assets/000/000/383/454-Good-practice-guide-HIV-and-drug-use_original.pdf?1405520726; International Drug Policy Consortium (2012), 'Chapter 3.2: Harm reduction', Drug policy guide, 2nd edition, <http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition>

Handout: Principles of harm reduction*

Harm reduction is targeted at risks and harms.

It begins from the standpoint of identifying what specific risks and harms are occurring with an individual's or population's drug use, defining the causes of those risks and harms, and determining what can be done to reduce them.

In Ukraine, for example, this has led services to identify reproductive health and risks as important issues for women who use drugs. In response, they have developed innovative services for this population....

Harm reduction is evidence based and cost effective.

This approach is founded on public health science and practical knowledge, and employ methods that are most often low cost and high impact.

New evidence on the efficacy of syringe-cleaning methods, for example, has led to renewed attention to how to support people who reuse syringes. There is a growing body of literature on the cost effectiveness of harm reduction interventions – particularly regarding NSPs and OST.

Harm reduction is incremental.

As Harm Reduction International (HRI) explain, "Harm reduction practitioners acknowledge the significance of any positive change that individuals make in their lives. Harm reduction interventions are facilitative rather than coercive, and ... are designed to meet people's needs where they currently are in their lives".

This principle plays out in countless ways in the day-to-day work of harm reduction service providers, from working with individuals to reduce immediate harms associated with chaotic crack cocaine use in Rio de Janeiro, to helping people who use drugs to find housing in New York.

Harm reduction is rooted in dignity and compassion.

This approach views people who use drugs as valued members of the community, as well as friends, family members and partners, and consequently rejects discrimination, stereotyping and stigmatisation.

Harm reduction acknowledges the universality and interdependence of human rights.

The former UN High Commissioner for Human Rights, Navanathem Pillay, declared that, "People who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment".

Harm reduction challenges policies and practices that contribute to harm.

Many factors contribute to drug-related risks and harms: the behaviour and choices of individuals, the environment in which they use drugs, and the laws and policies designed to control drug use. Harm reduction seeks to address all of these factors in order to protect the human rights and health of affected individuals.

In much of Western and Central Europe, for example, this insight has led governments to decriminalise drug use to various extents. In Portugal, a decriminalisation approach has resulted in substantial gains in reductions in HIV and hepatitis B and C infections and overdose deaths, a decrease in prison overcrowding, a reduction in drug-related crime, an increase in people accessing drug dependence treatment and employment, etc.

Harm reduction values transparency, accountability and participation.

Harm reduction principles encourage open dialogue, consultation and debate. A wide range of stakeholders must be meaningfully involved in policy development and programme implementation, delivery and evaluation. In particular, people who use drugs and other affected communities should be involved in decisions that affect them.

For example, in North America, people who use drugs played a central role in conceiving and building harm reduction movements as a practical response to the harms being experienced by their peers. The 2006 “Vancouver Declaration” outlines this approach and laid the foundation for the International Network of People Who Use Drugs (INPUD).

* For more information, please see: International Drug Policy Consortium (2012), ‘Chapter 3.2: Harm reduction’, Drug policy guide, 2nd edition, <http://dl.dropbox.com/u/64663568/library/IDPC%20Guide%20HTML/Chapter-3.2.pdf>

Handout: The state of harm reduction in Sub-Saharan Africa

Country/ territory with reported injecting drug use	People who inject drugs	HIV prevalence among people who inject drugs [%]	Hepatitis C (anti- HCV) prevalence among people who inject drugs [%]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs [%]	Harm reduction response	
					NSP ⁱ ■	OST ⁱⁱ ■
Burkina Faso	nk	nk	nk	nk	x	✓ ⁽¹⁾
Côte D'Ivoire	nk	nk	nk	nk	x	x
Djibouti	nk	nk	nk	nk	x	x
Gabon	nk	nk	nk	nk	x	x
Ghana	nk	nk	nk	nk	x	x
Kenya	18,327 ⁽²⁾	18 ⁽²⁾	51.4 [42.2–60.6] ⁽³⁾	6.4 ⁽²⁾	✓ ⁽¹⁰⁾ ⁽²²⁾	x
Malawi	nk	nk	nk	nk	x	x
Mauritius	10,000 ⁽⁴⁾	44.3 ⁽⁴⁾	97.3 ⁽⁵⁾	9 ⁽³⁾	✓ ⁽⁵²⁾ ⁽⁴⁾	✓ ⁽¹⁶⁾ [M, 0]
Nigeria	11,692	4.2 ⁽⁶⁾	nk	nk	x	x
Senegal	1,324 ⁽⁷⁾ iii	9.1 ⁽⁸⁾	nk	nk	✓ ⁽¹⁾	x
Seychelles	345 ⁽⁹⁾	5.8 ⁽⁹⁾	53.5 ⁽⁹⁾	0.1 ⁽⁹⁾	x	✓ ⁽⁹⁾
Sierra Leone	nk	nk	nk	nk	x	x
South Africa	67,000 ⁽¹⁰⁾	19.4 ⁽¹⁰⁾	nk	nk	✓ ⁽¹⁾ ^v	✓ [M, B] ^v
Tanzania	30,000 ⁽¹¹⁾	33.9 ⁽¹¹⁾	28 ⁽¹¹⁾	nk	✓ ⁽⁷⁾	✓ ⁽³⁾ [M, 0]
Uganda	nk	16.7 ⁽¹²⁾ iii	nk	nk	x	x
Zambia	nk	nk	nk	nk	x	x

Source: Harm Reduction International (2014), *The Global State of Harm Reduction*, <http://www.ihra.net/>



MODULE 4

Handout: Countering common misbeliefs and negative attitudes*

“There is no problem” – This is a common argument in countries with few recorded cases of (or inadequate data on) HIV or hepatitis C infections among people who inject drugs.

REPLY: We know from experience that every country with injecting drug use is at risk of HIV, hepatitis B and/or hepatitis C epidemics among people who inject drugs and their partners, and that these epidemics can expand rapidly in the absence of prevention measures. Prevention that starts early is much less expensive and much more effective in saving lives than prevention efforts developed after an epidemic is established. Rapid assessment should be done immediately to determine the extent of injecting drug use, related risk behaviour, HIV and hepatitis. Based on these data and/or the experiences of community-based organisations, action should be taken immediately at a scale large enough to prevent epidemics among people who inject drugs, or to bring an existing epidemic under control.

“Drug users do not matter” – Some people believe that people who use drugs are “bad”, “immoral” or “evil” people, and therefore should not be provided with health services.

REPLY: People who use drugs are members of society, and the health of all people in a society is important and must be protected: no one deserves to die simply because they use drugs, especially as we know how to prevent HIV and hepatitis C infections and how to prevent and manage overdoses.

The vast majority of people who use drugs do so in a non-problematic way with no health or social consequences – for example, people who use drugs are young people experimenting with substances in the context of their personal development. Drug use and drug-related problems can affect anyone, and the reasons for drug use are many and complex.

“There are more important health problems” – This is a very common argument, especially in developing and transitional countries. It is also often true, at least in the short term.

REPLY: The truth about HIV and hepatitis C epidemics is that they overwhelm health systems several years after the initial epidemic has occurred. Unless they are brought under control, massive waves of related illnesses can occur. The only way to prevent this from happening is to prevent blood-borne transmission now, as part of a balanced health response that also tackles other acute health issues such as malaria, tuberculosis or other diseases.

“Needle and syringe programmes and opioid substitution therapy encourage drug use and drug injecting” – This is a particularly reactionary attitude that is easily debunked with the available evidence and international experience.

REPLY: This is simply not true. Harm reduction activities have been studied extensively to determine specifically whether they lead to any negative consequences such as increased drug use or increased injecting. In no research has this been shown to occur. In fact, the effect is often the opposite, with people who use drugs being engaged in services that

“Police must enforce the law and drug users have to be punished” – This is a very common argument.

REPLY: Across the world, it is common practice to enforce the law with some discretion. Although police cannot directly amend the law, they can determine whether to enforce certain laws more or less vigorously, in which areas to focus their resources, and on what crimes they will concentrate. Evidence shows that fear of arrest by the police is often stronger than fear of acquiring HIV or hepatitis C, so that people who use drugs are likely to take greater risks in injecting drugs when they fear arrest. They will also not seek out support or information if there is a perceived risk of arrest or police harassment. Health workers need to be able to communicate and build up this trust with people accessing services so that information on harm reduction can be conveyed and taken on board.

“Needle syringe programmes and opioid substitution therapy send the wrong message” – This is extremely common, especially from politicians, in almost every country. It means that the government is committed to “fighting drugs” and being “tough on drugs”, and that they regard harm reduction as contradicting this.

REPLY: Implementing harm reduction interventions does not imply “weakness” or being “soft on drugs” – quite the opposite. This argument can be easily turned around: the weakest approach to take is to persist with punitive policies that have been proven not to work. Countries that implement harm reduction also continue to have strong policies on reducing drug supply and demand. A balanced approach is needed that allows a government to maintain control over drug use by its citizens, while also preventing harms such as HIV and hepatitis epidemics among people who use drugs.

“The laws are fixed, and I cannot change them” – This is especially common among bureaucratic policy makers.

REPLY: In this circumstance the law may not need to be changed. There may be regulations that can be amended while legal review or change is pending. There may be policy statements that can be changed, which can put pressure on legislators to change laws. It may also be possible to negotiate local agreements with police or prosecuting authorities to circumvent restrictive laws (such as laws prohibiting the possession of needles and syringes).

“Drug users should not receive special assistance”

REPLY: Harm reduction activities do not mean that people who use drugs receive special assistance. Rather, they are just providing basic standards of care and protection to a population that otherwise has unequal access to health care. It means that a society gives priority to disease prevention among this group, in order to protect the health of all members of society and prevent the over-burdening of health systems.

“Ideas from Western countries are unsuitable in this country” – This is a common argument even from health professionals, lawyers and especially police and politicians in some countries.

REPLY: Harm reduction has been proven to work across a broad range of settings – including low, middle and high income countries in every region of the world, for example in Tanzania and Mauritius. It may be that local policy makers prefer to start

* Adapted from: World Health Organisation, Joint United Nations Programme on HIV/AIDS, United Nations Office on Drugs and Crime (2004), *Advocacy Guide: HIV/AIDS prevention among injecting drug users* (Geneva: WHO), <http://www.who.int/hiv/pub/advocacy/en/advocacyguideen.pdf>

Handout: The 2006 “Vancouver Declaration”

Why the world needs an international network of activists who use drugs

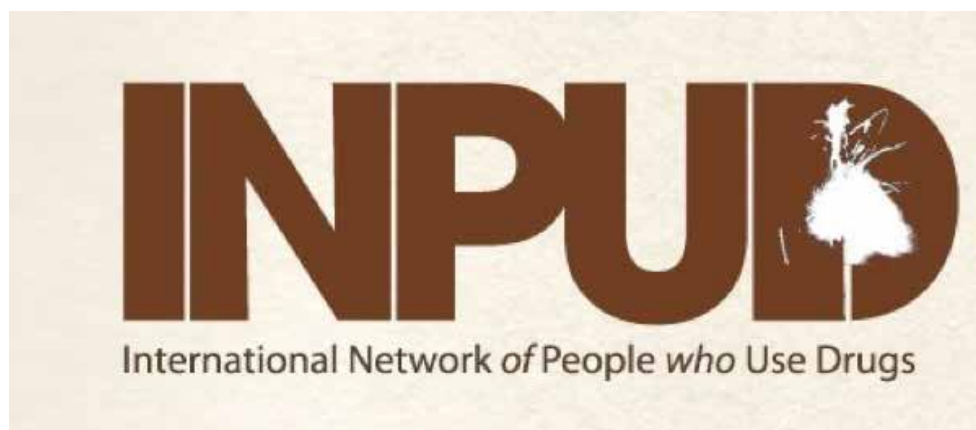
We are people from around the world who use drugs. We are people who have been marginalized and discriminated against; we have been killed, harmed unnecessarily, put in jail, depicted as evil, and stereotyped as dangerous and disposable. Now it is time to raise our voices as citizens, establish our rights and reclaim the right to be our own spokespersons striving for self-representation and self-empowerment:

- To enable and empower people who use drugs legal or deemed illegal worldwide to survive, thrive and exert our voices as human beings to have meaningful input into all decisions that affect our own lives.
- To promote a better understanding of the experiences of people who use illegal drugs, and particularly of the destructive impact of current drug policies affecting drug users, as well as our non-using fellow-citizens: this is as an important element in the local, national, regional and international development of these social policies. To use our own skills and knowledge to train and educate others, particularly our peers and any other fellow-citizens concerned with drugs in our communities.
- To advocate for universal access to all the tools available to reduce the harm that people who use drugs face in their day-to-day lives, including, i) drug treatment, appropriate medical care for substance use, ii) regulated access to the pharmaceutical quality drugs we need ii) availability of safer consumption equipment, including syringes and pipes as well as iii) facilities for their safe disposal, iv) peer outreach and honest up-to-date information about drugs and all of their uses, including v) safe consumption facilities that are necessary for many of us.
- To establish our right to evidence-based and objective information about drugs, and how to protect ourselves against the potential negative impacts of drug use through universal access to equitable and comprehensive health and social services, safe, affordable, supportive housing and employment opportunities.
- To provide support to established local, national, regional, and international networks of people living with HIV/AIDS, Hepatitis and other harm reduction groups, making sure that active drug users are included at every level of decision-making, and specifically that we are able to serve on the boards (of directors) of such organizations and be fairly reimbursed for our expenses, time and skills.
- To challenge the national legislation and international conventions that currently disable most of us from living safe, secure and healthy lives.

Well aware of the potential challenges of building such a network, we strive for:

- Value and respect diversity and recognize each other's different backgrounds, knowledge, skills and capabilities, and cultivate a safe and supportive environment within the network regardless of which drugs we use or how we use them.
- Spread information about our work in order to support and encourage development of user organizations in communities/countries where there are no such organizations.
- Promote tolerance, cooperation and collaboration, fostering a culture of inclusion and active participation.

- Democratic principles and creating a structure that promotes maximum participation in decision making.
- Maximum inclusion with special focus to those who are disproportionately vulnerable to oppression on the basis of their gender identity, sexual orientation, socioeconomic status, religion, etc.
- To ensure that people who use drugs are not incarcerated and that those who are incarcerated have an equal right to healthy and respectful conditions and treatment, including drug treatment and access to health-promoting supplies such as syringes and condoms and medical treatment or at least equal to that they would receive outside.
- To challenge execution and other inhuman treatment of people who use drugs worldwide.
- Ultimately, the most profound need to establish such a network arises from the fact that no group of oppressed people ever attained liberation without the involvement of those directly affected by this oppression. Through collective action, we will fight to change existing local, national, regional and international drug laws and formulate an evidence-based drug policy that respects people's human rights and dignity instead of one fuelled on moralism, stereotypes and lies.



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<http://inpud.net/en/vancouver-declaration>

Notes:



MODULE 5

Best practice in tackling drugs, security and organised crime



Aim of Module 5

To discuss and explore how drug markets impact upon public security and organised crime, and what the best responses to this problem are.



Learning objectives

Participants will gain an understanding of:

- the evidence and experience of the nexus between drugs, security and organised crime in West Africa
- an understanding of the context and underlying causes of this nexus
- an understanding of the existing responses, and some ways in which these could be improved or enhanced in order to reduce harms



Introduction

Much has been made in recent years of the increase in drug trafficking in West Africa, but the production, smuggling and use of drugs is nothing new to this region. However, in their 2014 report, the West Africa Commission on Drugs state “The drugs trade in West Africa is worth hundreds of millions of dollars, in a region where the majority of countries are still among the poorest in the world. The growth in drug trafficking comes as the region is emerging from years of political conflict and, in some countries, prolonged violence. This instability has left a legacy of fragile state institutions and weak criminal justice systems that are vulnerable to infiltration and corruption by organized crime, and

are hard pressed to keep up with the quickly adapting skills of the traffickers”.¹ This Module will address these complex issues, and explore the options that may be available for the region’s governments.

SESSION 5.1:

Presentation: Setting the scene

SESSION 5.2:

Activity: Motivations for criminality

SESSION 5.3:

Activity: Corruption case studies

SESSION 5.4:

Presentation: Improving governance and political processes

SESSION 5.5:

Activity: Insecurity and violence

SESSION 5.6:

Presentation: Organised crime and terror

SESSION 5.7:

Activity: Modernising drug law enforcement

1. West Africa Commission on Drugs (2013), Not just in transit: Drugs, the State and Society in West Africa, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD-report_June_2014_english.pdf

MODULE 5

Session 5.1

Presentation: Setting the scene



20 min



Facilitators' note

If you have not already done so, this session is also a good opportunity to show some of the videos produced by the West Africa Commission on Drugs presented in Session 1.6.



Aim – To provide an introduction to the related issues of drug markets, public security and organised crime

1. Introduce the aim of the session.
2. Present the accompanying slides and the information below.
3. Encourage questions and discussions from the participants.



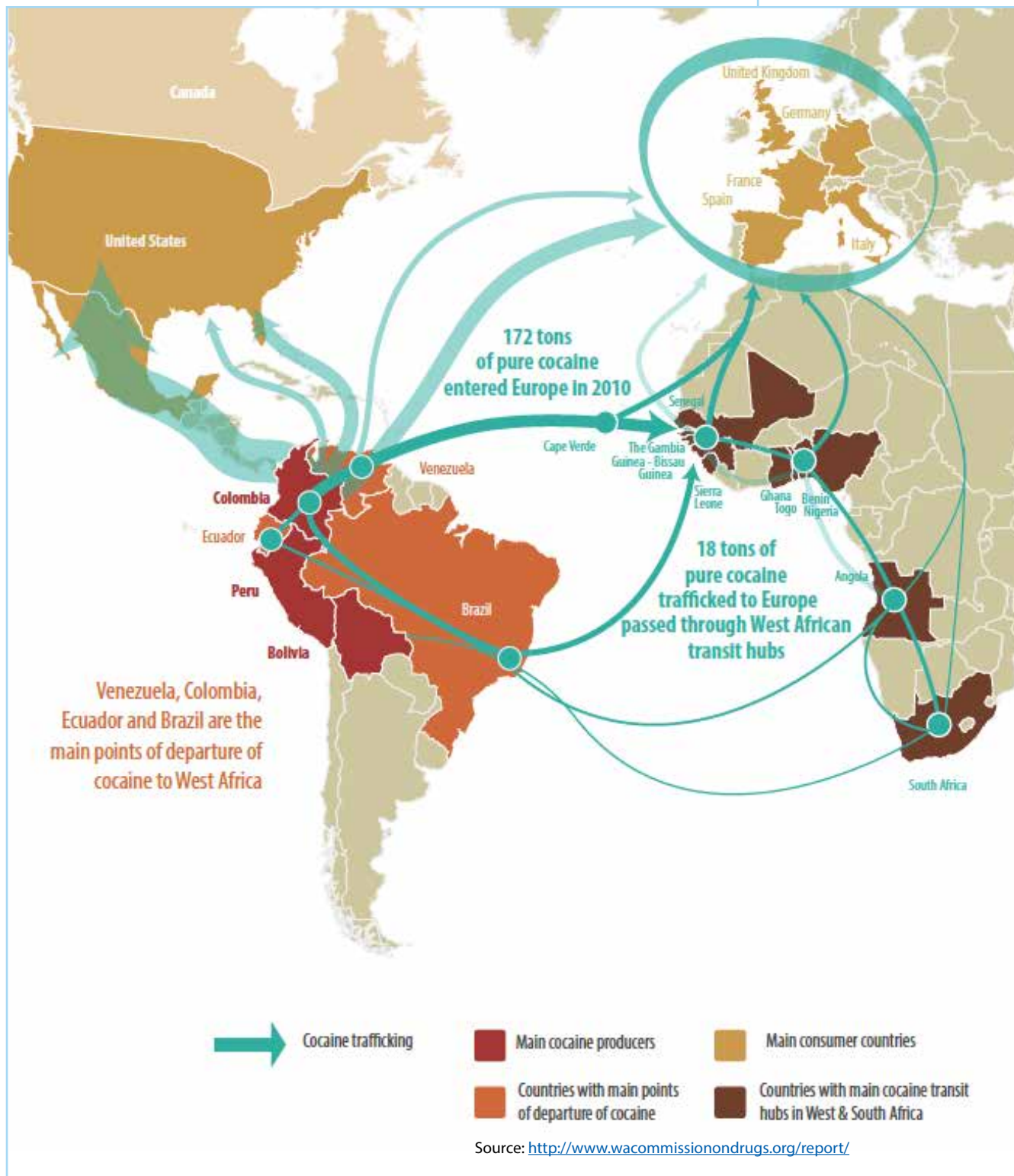
Information to cover in this presentation:

The international drug policy landscape has evolved significantly in the past few years. The surge in drug-related killings in Mexico from 2007 onwards has shed light on the pervasive nature of drug trafficking and organised crime, and their destabilising human, economic, social and institutional effects, including through corruption and violence. New routes, substances and challenges have emerged. Increasingly, experts and officials are pointing to the ineffectiveness and potentially damaging impacts of current drug policies.

This has led some commentators to point out that the drug policy debate “has evolved more in the past three years than in the previous three decades”.¹ In 2013, the Organization of American States (OAS) became the first multilateral organisation to openly challenge the status quo and explore alternative policy options.² The African Union (AU) Plan of Action on Drug Control 2013-2017 stresses the importance of the socio-economic and health dimensions in the drug problem, and notably recommends the development of alternatives to incarceration for minor offences.³ The Economic Community of West African States (ECOWAS) has also begun to build up its institutional efforts to tackle these growing challenges.⁴ In parallel, actual reform has taken place, with decriminalisation policies in Portugal and several other countries⁵, and legally regulated cannabis markets operating in Uruguay and in several US states.

West Africa has emerged in this international landscape as a transit area increasingly affected by the transatlantic cocaine trade. While the cocaine trade seems to have declined since 2007 following an earlier sharp increase, the United Nations Office on Drugs and Crime (UNODC) points out that drug traffickers may have adapted their techniques, moving to smaller shipments from Brazil dispatched by local actors in West Africa, and therefore making drug law enforcement more difficult. In addition, there are indications that the trafficking of heroin and methamphetamines may be on the rise.⁶

Flow of cocaine through West Africa, 2010



As a consequence, there is increasing evidence that the region is becoming an important market for the consumption of drugs as well as for producing drugs (notably methamphetamines). In June 2014, the West Africa Commission on Drugs (WACD), chaired by former President Olusegun Obasanjo of Nigeria, produced a ground-breaking report on the drug problem in the region, highlighting key challenges and making a number of policy recommendations to “respond humanely, effectively and pre-emptively to these problems”.⁷ The report includes the following specific recommendations related to the impacts of drug trafficking and counter-narcotics policies on security and governance in West Africa:

- Actively confront the political and governance challenges that incite corruption within governments, the security services and the judiciary, which traffickers exploit.
- Strengthen law enforcement for more selective deterrence, focusing on high-level targets.
- Avoid militarisation of drug policy and related counter-trafficking measures, of the kind that some Latin American countries have applied at great cost without reducing supply.
- Balance external assistance between support for security and justice efforts on the one hand, and support for public health efforts on the other.

Barriers in understanding the nature of drug trafficking

Understanding the nature of drug trafficking suffers from the fact that important information about key participants and their support networks in governments are largely unavailable. Drug trafficking takes place in an atmosphere of secrecy, rarely leaving any paper trail. Where available, the information tends to be inconclusive because it is open to denial and possibly legal challenge. The problem is compounded in West Africa by the frequent overlap between licit and illicit spheres in economic and political systems, which often operate through informal networks. This makes it extraordinarily difficult to acquire accurate information about both drug trafficking and drug consumption in West Africa. However, while it is hard to acquire data on the drug trade that can be regarded as utterly reliable, it is nonetheless possible to amass information – through a range of different official sources as well as expert intelligence – that can help to produce a fairly accurate picture.

The gradual entrenchment of the drug trade may have long-term effects on society, creating a culture of criminality appealing to the youth with few alternative role models and lifestyles to aspire to. The examples of “Narco-cultura” in Mexico⁸⁻⁹ and gang culture in the USA and Central America may very well be replicated across West Africa, with young individuals aspiring to the “Cocainebouyou” way of life – marked by luxurious houses, cars and jewellery. Endemic levels of corruption and/or government incompetence may push individuals away from mainstream activities and towards more adventurous, appealing and seemingly rewarding groups.

Policy burden and economic impact

Drug trafficking weakens the state through budgetary and institutional pressures on structures that are already suffering from a lack of resources. It also creates tensions between the need to respond to crises as soon as they occur, and sustainable approaches to address the root causes of the problems. Foreign development aid makes a much-needed and positive contribution, but is rarely a sustainable solution.

Drug trafficking and organised crime have four main destabilising economic impacts:

1. They drain scarce resources: while organised criminal groups make billions of dollars from drug markets each year, more than half of the region’s population lives on less than US\$1 per day.¹⁰ At the same time, money and effort spent by individuals involved in the drug trade and related organised crime activities (e.g. money laundering) in the region are not spent on legal activities or collected as taxes. In some contexts, organised criminal groups can sometimes provide much-needed services to the local population – filling a governance vacuum with jobs, social services, healthcare, infrastructure, protection, etc. However, these pale quantitatively and qualitatively in comparison to what the functioning states would be able to offer without such a large-scale diversion of resources.

2. Distorting economic indicators and prospects through money laundering, which can contribute to disproportionately inflating the financial, real estate and construction sectors in particular – with negative impacts for the local population, and investments and consumptions that are not conducive to long-term development.¹¹
3. Discouraging foreign companies from investing in West Africa, as drugs and organised crime tend to reflect broader social instability and therefore likely higher costs of doing business. Corruption is often listed as the number one obstacle to development in the region.¹² Tourism has also been particularly affected by crime and instability.¹³ Recent research conducted by USAID also suggests that “inflows of illicit profits may inflate the currency, rendering legitimate exports less competitive.”¹⁴
4. Spoiling the region's social and human capital, forcing workers to move abroad, hampering education, employment and personal economic success, affecting citizens' health, and creating a climate of fear across society that obstructs economic growth and human development.

In addition, drug trafficking is by nature a cross-border issue, which breaks up traditional and legal conceptions of frontiers. It requires highly challenging and complex transnational and regional policy cooperation. Countries in the region face challenges that easily migrate from a country to another, highlighting the need for stronger regional cooperation – for instance, via bilateral agreements and broader multilateral programmes.

1. Gomis, B. (2014), *Illicit drugs and international security: Towards UNGASS 2016* (Chatham House), <http://www.chathamhouse.org/publications/papers/view/197070>
2. Organization of American States (2013), *Scenarios for the drug problem in the Americas 2013-2025*, http://www.oas.org/documents/eng/press/Scenarios_Report.PDF
3. African Union Plan of Action on Drug Control (2013-2017), <http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20English.pdf>
4. See for instance: European Union (2013), *Support to ECOWAS Regional Action Plan on illicit drug trafficking, related organised crime and drug abuse in West Africa*, http://ec.europa.eu/europeaid/documents/aap/2013/af_aap-spe_2013_west-africa_p4.pdf
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7. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
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12. World Bank (2010), "Quiet corruption" undermining development in Africa, <http://go.worldbank.org/TOK9PZ01V0>
13. United Nations Office on Drugs and Crime (2005), *Why fighting crime can assist development in Africa: Rule of law and protection of the most vulnerable*, https://www.unodc.org/pdf/research/Africa_Summary_eng.pdf
14. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf

MODULE 5

Session 5.2

Activity: Motivations for criminality



30 min

Facilitators' note

It may be helpful to keep the accompanying slide for this activity projected onto the wall/board throughout – to remind participants of the three scenarios.



Aim – The flow of drugs, other commodities and money through West Africa has corrupted many government, military and police officials. This session will explore the reasons why people may become engaged in drug trafficking, in order to better understand the appeal and existence of this problem

1. Introduce the aim of the session.
2. Participants will work individually on the first part of the activity – but assign each person to one of the three scenarios below. This can most easily be done by either dividing the room into three parts (assigning one scenario to everyone sat in one part), or going around the room calling out “1, 2, 3, 1, 2, 3...” to give each person a number.

Scenario 1: You are an entry-level customs official. You have been working there for a few years, but are frustrated at the lack of respect you receive from your managers, who you know are also receiving side payments from some of the major transporters, and the fact that you have not had a pay rise since you started.

Scenario 2: You are a newly-elected member of parliament. Your election campaign was expensive, and has left with debts. You have strong political ambitions to climb the ladder within your government, but do not get the attention that you feel you deserve as you are young and new to the system.

Scenario 3: You are a police officer, and have been working for the police for several years. You have been promoted up to the level of sergeant, and are now responsible for the work of around 30 officers in your local, coastal town.

3. Ask the participants to “put themselves into the shoes” of the character that they have been assigned, and think about what might lead that person to begin engaging with the drug trade.



Example of what participants may come up with

- Favours owed to those who have helped you in the past
- Loyalty to family and relatives approaching you for favours
- Corrupt superior orders you to participate
- Money or other material benefits (for example, the average annual salary of a civil servant in Guinea Bissau is around US\$ 5,000 – an amount dwarfed by the value of illicit drugs and other goods smuggled through the country)

- Political power
- Political donations and support
- Fear of, or threats of, violence if the person refuses
- Protection
- The offer of promotions and other benefits
- Blackmail or coercion by organised crime groups using violent tactics and threats
- Naivety or ignorance about what is happening

4. After a few minutes, ask participants to share their ideas with the group – writing the response on a flipchart.
5. Ask the participants to add any other factors that they can think of, and then ask them what the implications of these factors would be for an effective policy response. Summarise by emphasising the range of different reasons for engaging in the drug trade – and that it is not always necessarily down to the greed of the individual, but can also be because of threats, fear and coercion. Such factors need

MODULE 5

Session 5.3

Activity: Corruption case studies



20 min



Facilitators' note

If time is limited, you could distribute the handout and discuss the case studies in one large group.



Aim – To discuss real cases of drug-related corruption in West Africa

1. Introduce the aim of the session.
2. Split the participants into between five and seven groups, assigning each group to one of the case studies in the handout "[Corruption case studies](#)".
3. Ask each group to read and discuss the case studies, answering the following questions:
 - What does this case reveal about the levels of corruption in the country?
 - What was the outcome? Was it deserved?
 - What factors do you think influenced these individuals to do what they did?
 - What factors do you think influenced the outcomes of the case?
 - What impact do you think this case had on the broader drug market?
4. If there is time, ask each group to briefly present their thoughts to the rest of the participants. If not, encourage participants to read the whole handout after the workshop, and to consider the same questions for the other case studies.
5. Present the accompanying slides and the information below.



Information to cover in this presentation:

These types of cases create an overwhelming impression that corruption is all-pervasive, regardless of the often more nuanced reality, as discussed in Session 5.2. Nonetheless, the current situation presents a number of policy implications for West Africa:

1. Foreign governments and agencies (especially the USA) are likely to remain involved in the capture, extradition and prosecution of key drug traffickers. The US criminal code, for example, "authorizes US agencies to pursue and prosecute drug offences outside the US if a link to terrorism is established", and gives their Drug Enforcement Administration (DEA) "extraterritorial jurisdiction over drug offenses with some link to the US, even if there is no actual entry into US borders by the drugs at issue".¹ Policy cooperation with the USA – as well as other Western countries with security interests in the region, including the UK and France – may be potentially highly effective, in particular to tackle the issue of corruption. However, in itself, this type of involvement does not provide a comprehensive and durable response to the challenges related to drug trafficking in West Africa and the broader African continent.

2. Given the transnational nature of the problem, policing strategies to tackle the current challenges must include regional collaboration. This may involve bilateral agreements among neighbouring countries, trans-regional cooperation mechanisms between West Africa and the likes of Europe, South Asia and the Middle East (who are all affected by the flow of drugs transiting through West Africa), efforts to build the capacity and legitimacy of existing regional bodies (including ECOWAS and the AU), and enhanced cooperation with relevant international organisations (such as UNODC).
3. A number of measures may help mitigate corruption, as the World Bank have highlighted through the example of Georgia: “exercising strong political will; establishing credibility early; launching a frontal assault; attracting new staff; limiting the state’s role; adopting unconventional methods; coordinating closely; tailoring international experience to local conditions; harnessing technology; and using communications strategically”.² As has also been pointed out with regard to Sierra Leone, potentially effective efforts also include the creation of institutions specifically dedicated to tackling corruption, and the development of oversight processes led by civil society, parliamentary committees or the judiciary. In order to be most effective, these may focus on education, accountability and transparency, especially regarding asset disclosure and political party financing – and should engage the private sector.³
4. It is also important to remember that illicit drugs are just one category of commodities being trafficked. Tackling corruption only related to illicit drugs may simply lead to officials shifting to focus on other commodities (such as cigarette smuggling – against which countries often have more lenient laws and a more passive law enforcement strategy).⁴

1. Csete, J. & Sánchez, C. (2013), *Telling the story of drugs in West Africa: The newest front in a losing war?* <http://www.swansea.ac.uk/media/GDPO%20West%20Africa%20digital.pdf%20FINAL.pdf>
2. World Bank (2012), *Fighting corruption in public services*, <http://elibrary.worldbank.org/doi/book/10.1596/978-0-8213-9475-5>
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MODULE 5

Session 5.4

Presentation: Improving governance and political processes



20 min

Facilitators' note

Civil society has an important role to play in ensuring greater transparency from governments – but this is beyond the scope of this document. Instead, you may wish to look at, or direct participants to, the Transparency International “Corruption Fighters’ Toolkit” for more information

[\(http://www.transparency.org/whatwedo/tools/corruption_fighters_toolkits_introduction/2/\)](http://www.transparency.org/whatwedo/tools/corruption_fighters_toolkits_introduction/2/).



Aim – To provide an introduction to the related issues of drug markets, public security and organised crime

1. Introduce the aim of the session.
2. Present the accompanying slides and the information below.
3. Encourage questions and discussions from the participants.



Information to cover in this presentation:

It is clear, from evidence around the world, that weak state institutions create environments that facilitate the illegal drug trade. As discussed elsewhere in this Module, the spoils and strength of the drug market are often used to corrupt political figures, but they can also infiltrate and undermine political processes themselves – such as elections and judicial safeguards. Weak governance therefore needs to be considered as one of the most urgent priorities for the region.

In order to be effective, the work of drug traffickers is facilitated by a wide range of people outside of the informal sector – business executives, politicians, the military, police and customs, and members of the judiciary. Connecting with people who have legitimate influence means that the drug market can establish complex networks and avoid detection – but it can also reshape relationships between and among political and security actors, the general public, the religious community and the business community.¹ This places obvious strain on political systems in the region, which are already vulnerable in many countries – dramatically increasing the risks of polarisation and violence around electoral contests.²

According to the West Africa Commission on Drugs, “One key source of weakness is that elections – key instruments of democratic politics – are not publicly funded in most of West Africa. In many cases, candidates tend to “own” parties, funding them from their private resources or raising support from friends, regional allies or from their ethnic base. Moreover, though some electoral systems in West Africa require asset disclosure and impose ceilings on campaign spending and restrictions on campaign funding, mechanisms to verify and monitor such measures are limited. Where they do exist, they do not always expose new means of cheating the system, and in many cases the absence or weakness of access to information laws makes monitoring by civil society difficult. These flaws make West Africa’s electoral processes vulnerable to corruption by drug money.”³

The Commission’s recommendations therefore include:

“Actively confront the political and governance challenges that incite corruption within governments, the security services and the judiciary, which traffickers exploit.

- Support the establishment of inter- and intra-party platforms to discuss the impact of drug trafficking and illicit party funding on political systems in the West African region with the aim of establishing mechanisms to buffer these systems from illicit funding.
- Strengthen the oversight role of parliaments with regard to the drafting and implementation of drug legislation.
- Support the conduct of national, regional, or inter-regional (South-South) meetings of independent electoral bodies or electoral tribunals to discuss avenues to protect electoral processes from drug trafficking, and share lessons on building resilience against drug trafficking (and other forms of organized crime) into the electoral system. Existing networks of electoral management bodies should be encouraged to take on this issue.
- Support efforts aimed at developing the capacity of civil society, media and academia to monitor and assess the links between drug trafficking and party and campaign financing, while also providing them with the relevant safeguards.
- Actively explore options for the establishment of a panel or a special regional court to investigate or try high-target offenders, including state and security officials suspected of being complicit in, or facilitating, drug trafficking. Such efforts should not replace the need to ensure that national justice systems have the independence, specialised expertise and the resources to prosecute these kinds of cases.”⁴

1. West Africa Commission on Drugs (2013), Not just in transit: Drugs, the State and Society in West Africa, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
2. Aning, K. & Pokoo, J. (2013), Drug trafficking and threats to national and regional security in West Africa: WACD Background Paper No.1, <http://www.wacommissionondrugs.org/wacd-commissioned-papers/>
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4. Ibid

MODULE 5

Session 5.5

Activity: Drug market-related insecurity and violence



30 min

Facilitators' note

The correct answers for the handout are:

Annual prevalence of cannabis use:

- West & Central Africa = 12.4% of population
- North America = 11.2%
- Europe = 5.7%
- Caribbean = 2.5%

Cocaine seizures (% of the global total):

- Latin America = 71.10%
- Europe = 10.26%
- Africa = 0.47%
- Asia = 0.21%

Homicide rates (per 100,000 population):

- Southern Africa = 30
- Latin America = 22
- West Africa = 14
- Eastern Europe = 6

Prisoners (per 100,000 population):

- Caribbean = 376
- Southern Africa = 205
- Western Europe = 98
- West Africa = 46

Corruption Perceptions Index (lower score indicates greater corruption):

- Sub-Saharan Africa = 33 out of 100
- Middle East & North Africa = 38
- Asia = 43
- Europe = 66



Aim – To explore some of the drug-related data for West Africa and put it into a global context, and to discuss the levels of drug-related insecurity and violence in the region

1. Introduce the aims of the session, and tell the participants that there has been much focus on drug-related violence and insecurity in West Africa. Although violence has not yet become a major feature of the drug trade in the region, the risk is that West Africa may well face such challenges in the future.
2. Split the participants into groups of 3 or 4 people, and distribute the handout [“Drug-related data: putting West Africa in context”](#).
3. Ask participants to match the drug-related violence data to the region.
4. Walk around the room, passing from group to group to see how they are doing. Discuss with them the correct answers, and discuss how their answers differ (if at all), and why this might be the case. Perhaps the situation in West Africa has been over-reported, or the situations in other parts of the world have not received the same attention?
5. Bring the participants back together for a short brainstorm activity, and discuss the factors that might increase or reduce drug-related violence in a region or country, and the policy implications of these. Note these factors on a flipchart.
6. Present the accompanying slides and the information below, highlighting where issues have already been written on the flipchart(s).



Information to cover in this presentation:

The levels of violence associated with the drug trade depend on a number of factors:

1. **The presence of weapons:** According to UNODC, while two thirds of homicides were carried out with firearms in the Americas, only less than a third were related to firearms in Africa.¹ Many analysts have shown that a greater availability of weapons in a geographical area is likely to lead to more violent deaths. The case of Mexico is telling in this regard. Over 250,000 guns are smuggled from the USA to Mexico annually.² While West Africa holds a large number of weapons as well, the region has nowhere near the same levels of violence as Latin America – however, the smuggling of an estimated 10,000-20,000 firearms from Libya has certainly contributed to instability in Northern Mali.³

2. **Law enforcement measures and strategies:** An aggressive crackdown on drug trafficking organisations can result in overcrowded prisons and more violence – as the organisations may fight back aggressively and other groups may violently compete for newly available market shares. This can cause significant collateral damage for the civilian population. Furthermore, the capabilities of some drug cartels can simply outweigh those of a country’s law enforcement forces, rendering it powerless to stop the violence associated with the trade.
3. **Corruption:** Corruption can influence the levels of violence, but it can play out in different ways. In Japan, the Yakuza are a very successful organised crime group, with an estimated 79,000 members divided among 22 groups and involved in a number of activities including legal businesses (e.g. construction) and illegal ones (such as extortion, money laundering, financial fraud, black-mail and racketeering).⁴ However, the country holds one of the lowest homicide rates in the world (less than 0.5 per 100,000, according to the UNODC). One of the reasons for this apparent contradiction is the level of enabling and collusion from politicians and police officers, which reduces the need for the Yakuza to resort to violent measures.⁵ Kenya’s homicide rate is above the global average of 6 per 100,000 inhabitants,⁶ while it is perceived as one of the most corrupt countries in the world, ranking 136th out of the 177 reviewed by Transparency International.⁷
4. **The type of drug market:** In Canada, the province of British Columbia is one of the world’s largest producers of marijuana. Yet the illegal production and trafficking of this drug (often to serve domestic markets) is not associated with any significant violence and insecurity. It is commonly the case that the longer the “supply chain” for a drug (i.e. from cultivation and/or production, through to sales and consumption) and the higher the profits and income to be made – the higher the risk that the trade will create some level of violence, through the involvement of a wider range of actors.
5. **Balance of power:** The balance of powers within a drug market is a key factor that can lead to more or less drug-related violence. For example, a clear hierarchy and division of labour between drug trafficking organisations, or a market that is strongly led by an organisation keen to avoid the use of force, may lead to more “peaceful” situations, at least in the short-term.
6. **How drugs are sold:** It is being increasingly hypothesised that online sales – which are emerging as an important market development, especially in North America and Europe – may create less violence than street dealing, as they limit face-to-face interactions: “with Silk Road [one of the most infamous online drug marketplaces, which is currently in its third version after having been shut down twice by law enforcement authorities] functioning to considerable degree at the wholesale/broker market level, its virtual location should reduce violence, intimidation and territorialism”.⁸ However, the immediate impact of online drug marketplaces similar to Silk Road on West Africa is unlikely to be significant, as most consumers do not have access to online drug markets. In addition, while online markets may reduce violence in the country of sale, the true impact on producing and transit countries remains unknown.
7. **Local contexts:** Other factors that may contribute to the levels of drug-related violence include demographic factors such as the age of criminal bosses, the geographic concentration of minority groups, and levels of poverty.⁹ Another crucial determinant is the strength of a country’s institutions. In order to control and mitigate levels of violence within a country, the state must be present and in charge of all of its territory. This can then translate into economic opportunities, social services, a solid education system, law enforcement forces maintaining order while respecting the rule of law, and an effective judiciary – all of which are crucial drivers for peace and security. “Most crises take place in areas with weak regional organizations that have limited capacities to prevent and manage conflict”.¹⁰

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Session 5.6

Presentation: Organised crime and terrorism



30 min



Aim – To critically explore the narrative linking drugs and terrorism in West Africa and beyond

1. Introduce the aim of the session.
2. Present the accompanying slides and the information below.



Information to cover in this presentation:

Drug trafficking is one source of funding for, and therefore helps to empower, organised crime groups in many parts of the world. But these groups are rarely focused solely on drugs – their portfolio of criminal activities may also include human trafficking, robberies, smuggling of other substances and items, racketeering, extortion, “milking” (oil theft), mining, logging, online or credit card fraud, and money laundering. This creates complex and opportunistic overlaps between the illegal and legal economies. In addition, drug trafficking may lead to an increase in drug production in transit areas – as has been the case in Mexico, Guatemala and other Central American countries. Some West African countries appear to be following similar patterns, with methamphetamine production reportedly increasing (i.e. in Nigeria and Ghana)^{1, 2, 3}

Given the wide range of illegal and legal activities most organised crime groups are involved in, it is clear that policy reform must go beyond tackling only the illicit drug trade – otherwise criminals may simply diversify and shift towards other sources of revenue. A comprehensive approach focusing on violence reduction and addressing the conditions that allow organised crime to flourish in the first place (in particular poor economic and social prospects, and weak institutional support) would help create lasting conditions for peace and development.

Links between the drug trade and terrorism / extremism

There is some overlap between organised crime groups and terrorist and extremist groups operating in West Africa. Field research suggests that MUJAO (Movement for Oneness and Jihad in West Africa) is directly involved in smuggling, while AQIM (Al Qaeda in the Islamic Maghreb) has provided protection to drug convoys in exchange for a fee, and facilitated and financially benefited from smuggling in general.^{4, 5, 6}

However, there is a lot of misinformation, over-simplification and exaggeration on the connections between drug traffickers and terrorists, insurgents, extremists and rebels – often further blurred with simplistic terms such as “narco-terrorism” and the “drug-terror nexus”. This stems from a widespread obsession over terrorism, which often sparks irrational fears and disproportionate levels of attention and policy responses. Drug traffickers and terrorists often have very different goals and

modus operandi: organised criminals aim to remain discreet and focus on financial gains, while terrorists seek publicity to share their political or religious messages.

It has been suggested that there are three main reasons why narratives emphasising strong links between drug trafficking and terrorism have become so widespread throughout the region: the media's search for sensationalist stories; government (and civil society) perceptions that drawing a link between the two threats is likely to attract awareness and funding for their work; and diverting attention from the most important issue – corruption.⁷

In West Africa and the broader Sahel, actors in the drug trade and terrorist activities are largely connected through loose, local and evolving relationships, rather than robust regional networks. Moreover, drug trafficking only constitutes one – often minor – source of revenue among many others for smugglers and extremists of the region, alongside kidnapping, cigarette smuggling, human trafficking and extortion. The most important commonality between drug trafficking and terrorism in West Africa is actually their collusion with governments and other legitimate actors. Weak governance and failure to resolve long-standing political and economic issues are therefore the most urgent priorities for the region.

Counter-narcotics and counter-terrorism

Both drugs and terrorism have been tackled through heavy-handed law enforcement approaches as part of publically announced abstract “wars”. The “war on terror” and the “war on drugs” have become mutually reinforcing narratives in recent years, focusing on a blanket and reactive approach against all suspected offenders. Little emphasis has been placed on the motivations and grievances of actors, or on addressing the structural issues that underlie the problems of terrorism and drug trafficking in the first place. Yet it is crucial for West Africa not to replicate the ineffective and damaging drug policies put in place in Latin America decades ago.⁸

Drug trafficking and terrorism are two distinct types of threats that largely only interplay on a rare and opportunistic, ad-hoc basis. Policies to counter these two sets of challenges should therefore not be identical. However, both traffickers and terrorists often capitalise on state weakness and on poor economic and social prospects to recruit members to pursue their causes. Current talks of reform in the fields of counter-terrorism and counter-narcotics should therefore build on this refined understanding of the institutional and political roots of the problems. Effective policies must act upon these enabling factors (such as the lack of economic prospects, the absence of reliable social services, education, healthcare and welfare, the presence of inequalities and opaque political systems, widespread corruption, and disproportionate law enforcement actions) – rather than only addressing the symptoms.

Recent Countering Violent Extremism (CVE) initiatives have proved to be an initial step in the right direction, moving away from the “us versus them” mentality and focusing on prevention, community engagement and empowerment, the rule of law, human rights, and training and capacity building. USAID-funded programmes including the Kenya Transition Initiative - Eastleigh (KTI-E) and the Garissa Youth Program (G-Youth) in Kenya, the Somali Youth Livelihoods Program (SYLP), and other programmes under the auspices of the Global Counterterrorism Forum (GCTF), such as the Sahel Region Capacity Building Working Group, are important case studies to draw lessons from in this regard.^{9, 10, 11, 12}

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MODULE 5



30 min

Session 5.7

Presentation: Modernising drug law enforcement



Aim – To describe some of the negative impacts of traditional law enforcement responses to drugs, and how new thinking could yield better outcomes

1. Introduce the aim of the session.
2. Present the accompanying slides and the information below.



Information to cover in this presentation:

The “war on drugs” – comprising “tough on drugs” rhetoric, zero tolerance policing and high incarceration rates – has failed to curb drug use and markets around the world despite costing an estimated \$100 billion a year at least.¹ The zero-tolerance approach – with harsh punishments imposed on any activity related to drugs – has often led to widespread human rights violations, abusive policing practices, prison overcrowding, criminal justice overload, social stigmatisation, discrimination and marginalisation, and the channelling of resources towards the symptoms rather than the root causes of violence and crime. UNODC itself has acknowledged that the international drug control system has created a number of negative impacts – which they termed “unintended consequences” (see Module 1).²

A true cultural shift is needed to adjust the drug response to fit the modern world and manage drug markets in a way that minimises the harm to communities. In many settings, discussions are now focusing on how law enforcement powers can be used to beneficially shape, rather than entirely eradicate, drug markets.³

Selective law enforcement strategies

One promising option is “focused deterrence”, which is a more selective law enforcement approach that concentrates on:

- The most harmful groups (i.e. the most violent or corrupt drug trafficking gangs, or those smuggling the most dangerous drugs)
- The most harmful behaviours (i.e. executions, kidnappings, or terrorist activities)
- The geographical areas with the highest rates of violence.

The objective is to target the most harmful behaviours of certain criminal groups in order to deter other groups from resorting to similar actions. At its core, the strategy acknowledges that some level of drug trafficking will continue to exist, but that its most negative aspects will be mitigated⁴ This is often based on a

gradual approach – tackling targets one at a time rather than a blanket policy of trying to tackle everything at once. One of the first applications of this concept was Operation Ceasefire in Boston in the 1990s.⁵ The operational focus on the most violent gangs helped to reduce youth homicide by two thirds.⁶ To involve local community leaders, a coalition of religious groups hosted forums for gang members, police officers, church ministers and social service staff to discuss issues, and to give an opportunity for gang offenders to receive education and training in exchange for leaving the gangs. Similar initiatives in the USA and El Salvador have also proven to be effective.⁷

Selective targeting is not a magical solution to all drug problems. For example, in areas where violence is widespread, it may be difficult to identify which group(s) to prioritize on – so focusing on the most violent areas may be the best way forward. If corruption is pervasive, the implementation of the strategy will be flawed and less effective. Success also depends on the strength of the institutions, the number of law enforcement units and actors involved, the size of the territory, and of course the existence of economic and social prospects to steer individuals away from crime.⁸

Alternatives to incarceration

More often than not, a zero-tolerance approach results in dramatic increases in the prison population – which is problematic from several perspectives. Large prison populations are costly, morally undesirable, and do not have a convincing deterrent effect. In the USA, where federal and state prisons hold more than two million people, almost half of those released from prison are re-incarcerated within three years, either for a new crime or for a violation of conditions of their release.⁹ Prisons become overcrowded with non-violent drug offenders whose influence on drug markets is minimal – and these individuals then suffer long-term damage to their economic and social prospects as a result of their imprisonment. Ironically, this can make their participation in the drug market even more likely following their release, especially when rehabilitation and reintegration programmes are scarce or non-existent. Mass incarceration is also highly problematic from a public health perspective – placing individuals at elevated risk of HIV, viral hepatitis and tuberculosis – to name a few. These concerns are all particularly salient with regard to West Africa, as criminal justice systems in the region are already struggling and operating with limited capacities.

As the UNODC Executive Director Yuri Fedotov states: “a public health response to the drug problem should consider alternatives to criminalisation and incarceration of people with drug-use disorders.”¹⁰ Alternatives to incarceration have been widely implemented around the world, and may prove useful for West Africa. Indeed, the Africa Union Plan of Action on Drug Control (2013-2017) includes a recommendation to “Institutionalise diversion programmes for drug users in conflict with the law, especially alternatives to incarceration for minor offenses.”¹¹

Such programmes may include administrative sanctions (such as fines) instead of criminal ones for minor, non-violent drug offences. Other possibilities include the voluntary diversion of people who use drugs into treatment and support programmes as an alternative to prison sentences.¹² Potential benefits include lower costs for police and the criminal justice system, reduced stigmatisation of people who use drugs, increased uptake of drug treatment, and reduced rates of re-offending (especially among youth and first-time offenders).¹³

Nonetheless, challenges exist to this approach – not least in countries that lack a drug treatment system capable of handling large numbers of referrals from the criminal justice system. There is also a risk of “net-widening” whereby lower threshold punishments encourage the police to engage with greater numbers of people who use drugs (especially where performance indicators and financial

incentives encourage police officers to arrest as many people as possible).¹⁴ Additionally, referrals to treatment are an inappropriate use of resources for individuals who are not experiencing problems or dependence because of their drug use (see Module 3).

Proportionate sentencing

In the majority of countries around the world, drug offences attract the greatest criminal sanctions – with widespread incarceration, mandatory minimum drug sentences, and even the use of the death penalty (contrary to international law). One basic principle of a just and sustainable criminal justice response is that the sanctions imposed should be proportionate to the crime committed. Yet drug sentencing frameworks are often out-dated based on moral justifications that drugs are “bad” or “evil”.

Drug-related sentences should be comparable to those for other offences of similar motivation and impact. A number of factors should be considered when deciding sentences – the type of drug(s) involved, the scale of the illicit activity, as well as the motivations and the socio-economic background of the offender.¹⁵ Mitigating factors (such as a person’s motivation for involvement in the drug trade) must be given more prominence in sentencing decisions – particularly when involvement in the illicit drug market is driven by coercion, incapacity, vulnerability or basic subsistence needs.

Ultimately, the overarching objective of these modernised strategies should be the reduction of the levels of violence and harms associated with the drug trade, not the amount of drugs seized or the number of people arrested.

The dangers of vigilantism and militarisation

In some parts of the world, the ineffectiveness or unwillingness of the police to tackle drug trafficking may also lead to the emergence of self-defence groups and paramilitary groups taking the matter into their own hands. This challenge has not emerged in West Africa to any significant scale, but it may do in the future given the increased attention on drug markets there. In Mexico, vigilante members of unofficial self-defence groups have emerged^{16,17} – following on from the Sombra Negra (Black Shadow) death squads in El Salvador, Peru’s Rondas Campesinas (peasant patrols in the 1990s), paramilitary groups in Colombia, and justicieros in Brazil who publicise their punishments of petty criminals on social media.

Another major risk in the “war on drugs” is the use of the military to tackle drug trafficking organisations. Evidence shows that this approach can contribute to more violence in the short-term, the emergence of more drug trafficking organisations competing for market shares and territory, and violations of basic human rights on all sides. In Mexico, the military crackdown carried out under President Felipe Calderón has contributed to almost tripling the country’s homicide rate. Between 2006 and 2012, more than 60,000 people died in drug-related killings and more than 26,000 more people disappeared. Between 2007 and 2010, kidnapping increased by 188%, extortion by 100%, and aggravated robbery by 42%.¹⁸ While changes in the balance of powers between the six main drug cartels and other trafficking organisations in Mexico constituted another key factor in the increased violence in the country, the military response undoubtedly aggravated the situation on the ground. Military gains against one drug cartel only led to the emergence of a range of new, disorganised and highly violent groups competing for territory and power.¹⁹ More than 50,000 people were killed as a result of the war on drug cartels, launched in 2006 by former Mexican President Calderon.

This should serve as a useful lesson for West Africa. Guinea-Bissau is a good example of how the military having too much power can be counter-productive –

and how foreign assistance should first address the structural issues of corruption and underdevelopment. The country has the highest troop-to-population ratio of the whole region (twice as high as the region's average), and military personnel are heavily concentrated in the capital. The military is "old, top heavy, over-sized, and suffers from institutional sclerosis", and has "detained, brutally beaten, exiled or killed under mysterious circumstances" activists, business leaders, political candidates and journalists.²⁰

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Handout: Corruption case studies

Below are just some examples of the involvement of people in power in cases of drug trafficking and drug-related crime throughout West Africa in recent years.

Guinea Bissau: In 2009, João Bernardo “Nino” Vieira (the President of Guinea-Bissau) was murdered – hours after the assassination of the head of the country’s armed forces. There had been strong allegations that Vieira’s re-election campaign had been financed by Colombian drug traffickers and – while the two men were bitter political rivals – many argue that there was a direct link between the murders and the drug trade. In 2010, the USA placed Guinea-Bissau’s former Navy Chief and the Air Force Chief of Staff on their drug kingpin list – bringing the former to the USA for trial.

Mali: The infamous Boeing 727 dubbed “Air Cocaine” crashed in the northern part of the country in 2009, with between 7 and 11 tonnes of cocaine on board – most likely from Colombia. Although several Northern mayors were arrested due to allegations of linkages with Air Cocaine, the investigation of the case by the relevant authorities had reportedly been obstructed by the highest levels of authority in the country, and efforts by the prosecution gradually fell apart in a manner that indicates the extent of criminal collusion with the state. This has fuelled tensions and resentment in Mali: in 2013, a crowd of protesters nearly lynched two officials suspected of an active role in the case.

Sierra Leone: Mohamed Bashil Sesay (cousin of the former Minister of Transport and Aviation, Kemoh Sesay), was sent to two years in prison (although he eventually served his sentence in a hospital due to “health complications”) for his involvement in a cocaine trafficking scheme uncovered when a small aircraft carrying over 600 kilograms of cocaine landed without authorization at Sierra Leone’s international airport of Lungi. Others arrested included serving members of the national police force and airport authority. In 2011, Mohamed Bashil Sesay was released – three years before the end of his sentence – in exchange for a fine of approximately \$70,000. The judge in the case accused the government of obstruction of justice for preventing the investigation of Kemoh Sesay’s alleged involvement.

Ghana: In 2007, Eric Amoateng, the Member of Parliament for Nkuranza South, was convicted in a New York court on charges of conspiracy to distribute heroin in the USA. The case prompted an investigation by Ghanaian law enforcement officials into a former Minister of Energy on the grounds of his possible complicity via a charity foundation in the MP’s heroin trafficking venture. In June 2013, the head of airport security, Solomon Adelaquaye, was charged for conspiring to smuggle Afghan heroin into the USA – following a covert operation by Ghana’s Narcotics Control Board and the US Drug Enforcement Agency.

Nigeria: In 2013, the Nigerian Drug Law Enforcement Agency announced the arrest of a local politician who had swallowed more than 1 kilogram of cocaine at the Murtala Mohammed International Airport in Lagos – supposedly planning to smuggle the drugs into Europe and use the proceeds to fund his election campaign.

The Gambia: In 2013, a Special Criminal Court sentenced the former Inspector General of Police, and two former chiefs of the Gambia Armed Forces, to a 10-year jail term for a series of charges including drug trafficking (cocaine), corruption and theft.

Guinea: In 2009, Ousmane Conte, the son of President Lansana Conte, was arrested on drug trafficking charges – two months after the military took control of the country following his father's death. He spent 16 months in jail before being released, and was placed on the USA's drug kingpin list in 2010. His arrest coincided with the arrest of several other high-ranking officials from the country.

MODULE 5

Handout: Drug-related data: putting West Africa in context

For each of these sets of data below, try and match the statistics on the left to the regions on the right. The facilitator will then let you know the right answers – did you get them right? If not, why do you think this is: is the situation in West Africa over- or under-reported compared to other regions?

Example: Total Population (2013):

1,779 million people		West Africa
606.2 million people		Latin America and the Caribbean
505.8 million people		South Asia
330.7 million people		European Union

Source: Population Reference Bureau (2013) World Population Data Sheet

Annual prevalence of cannabis use (UNODC “best estimates”):

12.4% of the population	Western and Central Europe
11.2% of the population	Caribbean
5.7% of the population	West and Central Africa
2.5% of the population	North America

Source: UNODC (2014) World Drug Report 2014.

Cocaine seizures (2011-2012):

71.10% of the global seizures of cocaine
10.26% of the global seizures of cocaine
0.47% of the global seizures of cocaine
0.21% of the global seizures of cocaine

Western and Central Europe
Africa
Latin America and the Caribbean
Asia

Source: UNODC (2014) World Drug Report 2014

Homicide rate (2012 or latest year):

30 homicides per 100,000 population
22 homicides per 100,000 population
14 homicides per 100,000 population
6 homicides per 100,000 population

Southern Africa
West Africa
Caribbean
Western Europe

Source: UNODC (2014) Global Study on Homicide 2013.

Number of prisoners (2013 or latest year):

376 prisoners per 100,000 population
205 homicides per 100,000 population
98 homicides per 100,000 population
46 homicides per 100,000 population

Southern Africa
West Africa
Caribbean
Western Europe

Source: International Centre for Prison Studies (2013) World Prison Population List (tenth edition)

Corruption Perceptions Index – average scores per region (2014):

33 out of 100
38 out of 100
43 out of 100
66 out of 100

Asia Pacific
Middle East & North Africa
Sub-Saharan Africa
Western Europe

Source: Transparency International (2014) Regional Result Infographics, available from: <http://www.transparency.org/cpi2014/infographic>



MODULE 5

Handout: Key resources/ Further reading

Africa Union (2012), *AU Plan of Action on Drug Control (2013-2017)*, <http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20English.pdf>

Aning, K. & Pokoo, J. (2013), *Drug trafficking and threats to national and regional security in Csete*, J. & Sánchez, C. (2013), *Telling the story of drugs in West Africa: The newest front in a losing war?* <http://www.swansea.ac.uk/media/GDPO%20West%20Africa%20digital.pdf%20FINAL.pdf>

Gomis, B. (2014), *Illicit drugs and international security: Towards UNGASS 2016* (Chatham House), <http://www.chathamhouse.org/publications/papers/view/197070>

International Drug Policy Consortium (2012), *Drug Policy Guide (2nd Edition)*, <http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition>

International Drug Policy Consortium (2014), *Modernising Drug Law Enforcement*, <http://idpc.net/policy-advocacy/special-projects/modernising-drug-law-enforcement>

United Nations Office on Drugs and Crime (2013), *transnational organized crime in West Africa: A threat assessment*, <http://www.unodc.org/toc/en/reports/TOCTAWestAfrica.html>

USAID (2013), *The Development Response to Drug Trafficking in Africa: A Programming Guide*, http://www.usaid.gov/sites/default/files/documents/1860/Development_Response_to_Drug_Trafficking_in_Africa_Programming_Guide.pdf

Walker, S. & Burchert, E. (2013), *Getting smart and scaling up: The impact of organized crime on governance in developing countries: A desk study of Sierra Leone*, <http://r4d.dfid.gov.uk/Output/193543/>

West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf

West Africa: WACD Background Paper No.1, <http://www.wacommissionondrugs.org/wacd-commissioned-papers/>

World Bank (2012), *Fighting corruption in public services*, <http://elibrary.worldbank.org/doi/book/10.1596/978-0-8213-9475-5>



MODULE 6



Civil society engagement in drug policy advocacy



Aim of Module 6

To consider ways civil society can maximise its influence on drug policy and to develop work plans based on information provided during other sessions.



Learning objectives

Participants will be able to:

- Define advocacy as it relates to drug policy
- Identify general principles, goals and strategies for effective advocacy
- Develop a comprehensive advocacy plan
- Offer methods of monitoring and evaluation of advocacy tools and methods



Introduction

Modules 1 to 5 aim to give participants a general understanding of the international drug control system and its consequences, of examples of effective (and ineffective) drug policy reform movements, best (and worst) practice in tackling security issues and organised crime, and of the concepts of prevention, harm reduction and drug dependence treatment.

This module will use all the knowledge acquired in previous exercises and will aim to train the participants on designing solid advocacy strategies to promote reforms at local, national, regional and international levels.



Facilitators' note

This module includes a wide range of exercises to guide the facilitator and the participants through the design of an action plan. Previous experience has shown that it is best for the facilitators to pick and choose those activities that are most relevant for the training, based on the knowledge of the participants, issues already addressed in exercises from previous modules, priorities of the training, time constraints, etc. If the facilitator decides to skip some sessions, please note that for Sessions 6.5 to 6.11, the participants will work in the same group until the end of the Module.

For examples of how this module can be presented, please refer to the [sample agendas](#) at the beginning of the training. Some activities include both a long version and a shorter version that the facilitator can choose from in case of time constraints.

SESSION 6.1:

Activity: What is drug policy advocacy?

SESSION 6.2:

Activity: Objectives of drug policy advocacy

SESSION 6.3:

Activity: The importance of planning drug policy advocacy

SESSION 6.4:

Activity: Charting the national / regional drug response

SESSION 6.5:

Activity: Advocacy framework **Step 1** – Selecting the issue or problem you want to address

SESSION 6.6:

Interactive presentation: Interactive presentation: Advocacy framework **Step 2** – Analysing and researching the issue / problem

SESSION 6.7:

Interactive presentation: Advocacy framework **Step 3** – Developing specific objectives

SESSION 6.8:

Interactive presentation: Advocacy framework **Step 4** – Identifying targets for advocacy work

SESSION 6.9:

Interactive presentation: Advocacy framework **Step 5** – Identifying allies in achieving advocacy objectives

SESSION 6.10:

Interactive presentation: Advocacy framework **Step 6** – Identifying resources to address the selected advocacy issue

SESSION 6.11:

Interactive presentation: Advocacy framework **Step 7** – Creating an action plan

SESSION 6.12:

Activity: Advocacy exercise

SESSION 6.13:

Interactive presentation: Advocacy framework **Step 8** – Monitoring and evaluating drug policy advocacy

Session 6.1

Activity: What is drug policy advocacy?



20 min



Aim - To come to a shared understanding of the term “advocacy” (what it is and what it is not) and agree on a working definition to use during this part of the training

1. Introduce the aim of the session.
2. Ask participants to brainstorm on what we mean by advocacy for drug policy change. Ask participants to provide key words that define advocacy, and note them on a flipchart.

Note any answers that suggest activities that are not advocacy (e.g. information, education and communication (IEC) activities, community mobilisation, networking and partnerships, etc.) on a separate flipchart and, if you have time, review them at the end of the session.
3. Present the advocacy definition and the key characteristics – either on a pre-prepared flipchart or on the accompanying slides, and lead a brief discussion on how these fit with the participants’ outputs.

Advocacy is an on-going process to change values, attitudes, actions, policies and laws by influencing decision-makers and opinion leaders, organisations, systems and structures at different levels.

Adapted from a definition presented in ‘Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS’, International HIV/AIDS Alliance, 2003.

Key characteristics of drug policy advocacy

- On-going in nature
- Pragmatic and opportunistic
- Non-linear, incremental and dynamic to achieve a range of outcomes
- Aiming to achieve realistic results within a specific timeframe

4. Note that there is not one correct definition and, depending on the time available, review the handouts “[Examples of definitions and types of advocacy](#)” and “[What is and is not advocacy?](#)” with the participants. In case of time constraints, give them the handouts and ask them to review them in their own time.
5. Present slides on the theory of political advocacy.



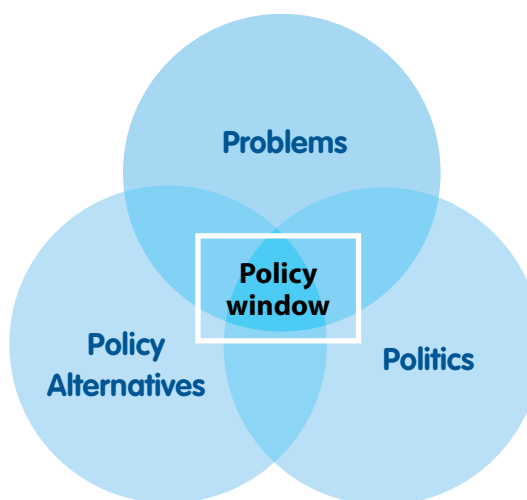
Facilitators’ note

Bear in mind that in some languages / countries there is no exact translation for “advocacy” and approximate terms can have different connotations. In China, for example, the term is considered too confrontational.

✓ Information to cover in this presentation:

There are several theories of how advocacy works in terms of changing policies and practices, but Simon Lenton has used Kingdon's "Multiple Streams Model" in a way that can be easily applied to drug policy.¹

This model states that brief opportunities for change ("policy windows") open and close over time, and are based on three inter-dependent and changeable factors: whether an issue is being perceived as a **problem**, whether easy **policy alternatives** exist, and the overall **political** environment. When these three factors converge, a "policy window" will open.



Effective advocacy efforts are those which manage to change these factors and are therefore able to open, and take advantage of, "policy windows". However, it is often impossible to predict when these "windows" will open, so a degree of opportunism and flexibility and patience is also important.

6.1 SHORTER OPTION IF YOU HAVE LESS TIME

🕒 10 min

1. Present the **advocacy definition**, the **key characteristics** and the **objectives of drug policy advocacy** – either on a pre-prepared flipchart or on the accompanying slides.
2. Discuss any questions or comments from participants

1. Lenton, S. (2007), *Beyond modelling and evidence: Bridging the gap between drug policy research and drug policy practice*, http://www.issdp.org/conferences/2007/papers/Simon_Lenton.pdf

Session 6.2

Activity: Why is harm reduction important?

10 min

**Aim - To reflect on the objectives of drug policy advocacy**

1. Introduce the aim of the session.
2. Ask participants to brainstorm the objectives of advocacy work and note these on a flipchart.
3. Summarise the key points from the discussion and highlight that drug policy advocacy usually aims at:

Objectives of drug policy advocacy

- Develop policies
- Place an issue on the policy agenda
- Adopt a new policy
- Block the adoption of a new policy
- Ensure the implementation of a policy
- Monitor and evaluate a policy
- Maintain a specific policy
- Reform of harmful or ineffective policies.

4. Note that civil society organisations constitute a key element for effective drug policy advocacy because:
 - they have extensive knowledge and understanding of local realities and issues
 - they have access to, and can represent, vulnerable population groups, including people who use drugs
 - they can bring an independent voice to the debate.

MODULE 6

 10 min

Session 6.3

Activity: The importance of planning drug policy advocacy



Aim – To enable participants to understand the benefits of planning their advocacy work systematically

1. Introduce the aim of the session.
2. Ask participants to contribute two or three reasons why planning drug policy advocacy work is important.
3. Present the advocacy planning framework on a pre-prepared flipchart or use the accompanying slides.

Advocacy planning framework

Step 1	Select an issue or problem you want to address ↓
Step 2	Analyse and research the issue / problem ↓
Step 3	Develop specific objectives for your advocacy work ↓
Step 4	Identify your targets ↓
Step 5	Identify your allies ↓
Step 6	Identify your resources ↓
Step 7	Create an action plan ↓
Step 8	Implement, monitor and evaluate

4. Explain that we will work in groups and practice this framework to design some drug policy advocacy interventions.
5. Explain that the framework can be adapted along the way of advocacy work. Highlight the importance of being creative and adaptable in advocacy interventions. Explain that the planning steps stop after Step 7 – as Step 8 covers implementation, monitoring and evaluation.
6. Discuss any questions or comments from the participants.

Session 6.4

Activity: Charting the national/regional drug response



20 min



Aim - To review a picture of the national / regional drug response, noting what and who is involved in, and responsible for, different aspects of this response. This will support work on the advocacy framework over the next sessions and provide a useful tool for participants' future drug policy advocacy

1. **Prior to the training**, the facilitator should send the table "[Charting the response](#)" to the participants and ask them to fill in as much as they can. If there are several participants from one organisation, ask them to work together and submit only one table. Before the training starts, the facilitator should compile the responses into one document and bring printed copies of the completed table at this session, as well as an electronic copy of the document to be projected so that the participants can see the table on the board as well.
2. Introduce the aim of the session and present the information below.
3. Distribute the completed "Charting the response" table. Explore how easy/difficult participants found it to complete the chart.
4. Ask the participants to review the contents and to add any missing organisations or stakeholders in the relevant columns. Note any gaps (i.e. where no organisation is working on a specific issue) and discuss what we would need to do to fill these gaps.
5. Make sure that all flipcharts with relevant outputs from the previous sessions (particularly sessions [1.5](#), [2.1](#), [2.2](#), [2.4](#), [3.2](#), [3.7](#), [3.9](#), [3.10](#), [4.3](#), [4.4](#), [5.2](#)) are also displayed on the walls and invite participants to review these.
6. Summarise and note how we can use the chart and other outputs in the next sessions.



Information to cover in this presentation:

The importance of understanding the drug response in your country

Before embarking on advocacy, it is important to map the situation in your country or region, and to note who the main stakeholders are. The following broad areas can be used to assess the response.

Each response is usually multi-sectoral; that is, it happens at different levels of society, from the **local** (such as community-based organisations, hospitals and clinics, schools and businesses) to the **national** (such as human rights institutions and national ministries), **regional** (such as ECOWAS and the African Union) and **international** (such as the UN and international NGOs).

MODULE 6

Session 6.5

Activity: Advocacy framework Step 1 - Selecting the issue or problem you want to address



30 min



Facilitators' note

The groups formed in this session will also work together on the next seven sessions in this Module.

It is important that groups document their work for each step as the steps are cumulative and outputs from each will feed into the work plan they will develop in Step 7.



Aim - To select an appropriate and realistic drug policy advocacy issue or problem

1. Introduce the aim of the session.
2. Explain to the participants that they will now **work in groups** on various exercises that will guide them to design an action plan.
3. Split the participants into three or four groups (either in a random manner, or if you know the participants well enough, assign them in groups to ensure variety of skills and level of knowledge – ensure that people from the same organisations do not end up in the same group). Participants will remain in the same groups during the rest of the training.
4. Explain that within their groups they will need a timekeeper, a writer and a presenter for the activities within each step of the advocacy framework. Ask the groups to document all their work to present to the whole group at a later stage.
5. Explain to the groups that each of them will choose an issue on which they would like to focus their advocacy work throughout the rest of the Module. Remind them of the issues and problems identified in earlier sessions of the training (e.g. [Session 1.5](#)) and the principles of drug policy ([Session 2.3](#)).
6. Using the following questions, ask each group to brainstorm a number of drug policy issues (e.g. tackling drug markets-related corruption, ensuring proportionality of sentencing for minor drug offences, developing targeted deterrence strategies in drug law enforcement, reducing the levels of violence associated with drug markets, decriminalising people who use drugs, developing and scaling up prevention, harm reduction and drug treatment, destigmatising drug users, etc.) that could be addressed through drug policy advocacy:
 - What are you trying to achieve? What is your final aim or goal?
 - What barriers or problems do you face in your work? Which barriers or problems could be overcome by drug policy advocacy?
7. When the groups have made a list of possible issues, ask them to select the best one for advocacy, using the matrix ranking below. They can rank issues using the following criteria:
 - To what extent can this issue be solved by drug policy advocacy?
 - How many people will benefit from the change?
 - Is the potential for success realistic?
 - Can people directly affected by the issue be involved in the drug policy advocacy work?
 - What are the personal / organisational risks associated with the change?
8. Go around the groups to ensure that they have all agreed on an appropriate issue to address. It is not necessary for the groups to present their work at this stage.



Facilitators' note

In case of time constraints, the facilitator can skip the matrix ranking table and only provide the participants with the guiding questions.

Example of matrix ranking of possible local advocacy issues

(using 1 for positive response – 0 for negative response)

Issues	Criteria			
	Can this issue be solved by advocacy?	Benefits for people affected by issue	Possibilities to involve those affected	Totals
Disproportionality of sentences for minor drug offences	1	1	1	3
Law enforcement efforts disproportionately focused on people who use drugs and low-level dealers, rather than high-level traffickers	1	1	0	2
Criminalisation of drug use	0	1	0	1
High levels of corruption linked to illicit drug markets	0	1	0	1
Adopting harm reduction policies	1	1	1	3

In this example, those advocacy issues most pertinent would be focusing on the disproportionality of sentences for minor offences, or promoting harm reduction policies and services. However, the decriminalisation of drug use or a reduction in corruption may be unlikely in the current context.

MODULE 6

Session 6.6

Interactive presentation: Advocacy framework Step 2 - Analysing and researching the issue / problem



90 min



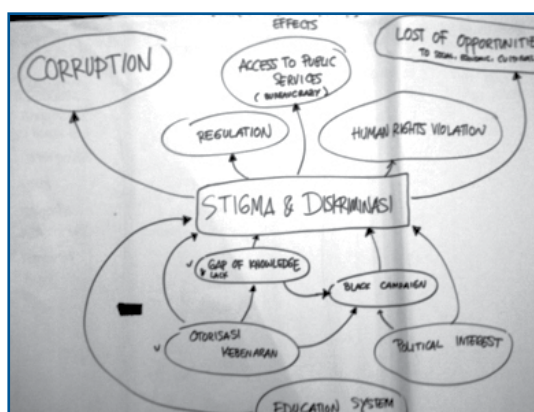
Facilitators' note

If the participants have already worked on the "Tree of prohibition-led drug policy" in [Session 1.5](#), we would recommend skipping this session here as it is covers much of the same ground. However, if time allows, this exercise may still be useful in determining the focus of advocacy actions.



Aim - To understand the issue or problem, identify advocacy solutions and gather information that supports the analysis

1. Introduce the aim of the session.
2. In plenary, present the accompanying slides and the information below.
3. Ask the participants to work in their assigned groups and to discuss their chosen issue or problem, noting that if it is one that came up from the work done in [Session 1.5](#), they can use this information to input into the following work.
4. Give each group flipchart paper and coloured marker pens and ask them to create a cause-and-effect flowchart, which will help understand the advocacy issue. Ask each group:
 - To write the issue or problem they have selected in the middle of the flipchart, to write "Effects" at the top of the flipchart and "Causes" at the bottom of the flipchart.
 - To draw or write two or three causes of the problem in the space below the problem. To then draw an arrow from each cause to the issue or problem in the centre. Causes can be people, organisations, attitudes, poverty, types of behaviour, lack of knowledge, etc.
 - To look at each cause and find deeper causes, by asking, "What causes that cause?" They should add these causes of causes, connecting them with arrows.
 - To write two or three effects of the problem at the top half of the flipchart. To then draw an arrow from the problem in the centre up to each effect.
 - To look at each effect and ask, "What further effect(s) will that have?" To add effects of effects, and connect them with arrows.
5. After the groups have completed their cause-and-effect chart, ask them to look at the causes, and circle the ones that could be changed or improved with the help of influential people or institutions (**i.e., the ones for which advocacy could be a solution**).



Cause and effects flowcharts, civil society workshop in Jakarta, Indonesia, October 2012

6. Ask the groups to select 2-3 possible advocacy solutions. When thinking of solutions, they can also use their previous experience or the experience of others who have worked on a similar issue or problem. Another way to identify solutions is to “reverse” a cause of the issue or problem – for example, if one cause of stigmatisation of people who use drugs is the silence of community leaders, a solution would be the opposite: for community leaders to speak publicly in support of people who use drugs.
7. In their groups, ask the participants to think of all the factors or criteria that would help them to select the priority solution to address. Make sure that they identify the following factors:
 - Do we have the legitimacy to advocate for change?
 - Are we the most appropriate NGO or coalition to advocate on the issue?
 - Are others already addressing the issue?
 - Can we access the kind of information we need as evidence?
 - Can/should those affected by the problem or issue be addressing the issue themselves?
 - Do we have the skills, time and resource to achieve the solution?
8. Ask the group to choose **one solution** that they would like to use when practising the planning framework together.

Facilitators’ note

Many of these factors are addressed in later steps in the planning process. Once participants are familiar with the whole planning framework, they will see how the steps are interrelated and build on each other as a thought process rather than sequence of steps.

Information to cover in this presentation:

We identified drug policy advocacy issues in Step 1 of the advocacy framework. The next step is to **analyse** the issue, find **information** about it and suggest possible **solutions**. All of this takes time, but it is time well spent.

- Analysis, documentation and information can be used:
 - to influence and inform targets and allies
 - to provide evidence for our position
 - to disprove statements from people who oppose our position
 - to change perceptions of a problem
 - to disprove myths, rumours and false assumptions
 - to explain why previous strategies have not worked.

Reliable data and evidence that will feed our advocacy work needs to be gathered from the locality/country/region targeted, and from the rest of the world to provide a point of comparison. The data and evidence will then need to be used and presented in a compelling way. There are a number of resources and websites that can be useful to access evidence and data on drug policy. See handout “[Compiling strong evidence to support advocacy interventions](#)”.

It is useful to create communication channels with other organisations to constantly share information on drug policy issues, both within and outside the locality/country/region.

It is also essential to involve people who are directly affected by the issue/problem at this stage. They will have an in-depth understanding of the problem and its effects, and will have ideas about how it can be solved. For example, participatory drama (involving a discussion with the audience) or a **cause-and-effect flowchart** can be used to analyse issues and identify solutions with those affected.

It is important to consider carefully the effects of any suggested solutions – some proposed solutions can cause more problems than they solve!

MODULE 6



20 min

Session 6.7

Interactive presentation: Advocacy framework Step 3 - Developing specific objectives



Aim - To develop an advocacy aim and objectives

1. Introduce the aim of the session.
2. Present the accompanying slides and the information below.
3. Ask the groups to write their chosen advocacy aim on flipchart paper.
4. Next, ask the groups to write detailed objective(s) for their advocacy work which describe how they will achieve their overall aim. Give the following guidelines for writing advocacy objective(s):
 - include the policy, practice or law that they want to change
 - include the influential individual, group or institution they are targeting
 - write SMART objectives.



Information to cover in this presentation:

It is important to have a clear vision of what we want to achieve. This can help us to decide what changes are necessary to reach a solution that will solve (or at least improve) the issue or problem we have identified.

Planning advocacy work is similar to planning other activities – it is easier to plan appropriate activities if we first identify aims and objectives.

We need to understand the difference between an aim, objectives and activities:

Aim / Goal	The long-term result that you are seeking to achieve
Objective	A short term target that contributes toward achieving the long-term aim; objectives describe the desired outcome or end result of activities
Strategy	The individual activities that will accomplish the objectives

Without a clear aim and objectives, it is very difficult to evaluate our work – unless you know your destination, you cannot know if you have arrived!

Objectives should be “SMART”!

Specific	Be precise about what you are trying to achieve and what you are going to do.
Measurable	Quantify your objectives to allow monitoring and evaluation.
Achievable	You should be able to achieve the objective with the available resources (financial, human and other). It should not be too ambitious. E.g., it may not be realistic for a small district council to advocate for a decision by the local council to introduce substitution treatment if the national government strongly opposes it.
Relevant	The objective must be useful to the overall process of working towards the goal.
Time-bound	When will the work be done and the objective achieved.

Advocacy aims can be achieved by objectives and activities which are not themselves advocacy – this is a common cause of confusion between advocacy, awareness-raising, information, education and communication, etc.

The groups will not have had enough time to gather information on their issue; therefore they may identify information-gathering tasks as objectives. Information gathering is not an advocacy objective. In some cases it could be an advocacy activity, but it is usually part of the advocacy planning and preparation process.

Examples of advocacy aims / goals:

- At the UN level – this could be mobilising member state representatives to call for the removal of criminal sanctions against people who use drugs
- At the regional level – this could be ensuring a balanced approach on drug control that includes a strong public health component (e.g. in line with the African Union Plan of Action 2013-2017)
- At the local / national level – this could be promoting more proportionate penalties for low-level drug offenders in a country, promoting more transparency in political financing to ensure drug money is not entering politics, reducing the high levels of violence associated with drug markets in a key locality, or starting the delivery of harm reduction services.

MODULE 6



45 min

Session 6.8

Interactive presentation: Advocacy framework Step 4 - Identifying targets for advocacy



Aim - To identify and prioritise targets (influential individuals, groups or institutions) for advocacy action

1. Introduce the aim of the session.
2. Before beginning the activity, ask the whole group to give examples of targets (direct and indirect) from their experience and from the drug response chart produced in [Session 6.4](#).
3. Present the accompanying slides and the information below.
4. Ask participants to return to their groups. Each group will choose one of the objectives they defined in [Session 6.7](#), and write it in the middle of a flipchart.
5. Next, they will write around the objective the names of all the groups, organisations, businesses, government departments, individuals, etc. that could be targeted to influence the changes identified in their objective. Encourage the groups to be as specific as possible – for example, “Minister for Home Affairs”, etc

The diagram should show:

- How much influence they have over the advocacy objective – place each name within a circle, the bigger the circle the more influential the target will be
- Whether they agree or not with your advocacy objective – underline the target if they agree or there is a good chance that they may agree
- Whether the target is direct or indirect – if direct, link the name to the objective with a full line, if indirect link the name to the direct target it relates to.

Example of “targets” diagram



6. Ask the groups to complete the [Targets information table](#) as in the example below:

Target information table

TARGET	Type of target (direct, indirect)	How to contact the target	Target's feeling about the advocacy issue	How to influence the target	Target's way of making decisions	Target listens to....

✓ Information to cover in this presentation:

Most organisations have limited resources available for undertaking advocacy work. Therefore it is important to focus advocacy efforts on the individuals, groups or institutions that have the greatest capacity to take action and to introduce the desired changes.

At national or international levels, these people are usually those with the power to make policy or programme decisions. At a local level there are often charismatic people who have power and influence at an informal level (e.g. peer leaders, respected older people, traditional healers, religious leaders) as well as those who have formal influential roles (e.g. local, provincial or national government officials).

Understanding the decision-making system is an important part of advocacy at all levels. Once the decision-making process is clear, it is possible that the most obvious target is not accessible and it is necessary to work through other targets to reach them. For example, it may be better to work with "those who can influence those with influence" and who have sympathetic views, rather than targeting the decision-maker directly, in particular in contexts where corruption is widespread. These people can be called indirect targets, rather than direct targets:

- Direct targets include decision-makers with the authority to directly affect whether and how an objective is achieved.
- Indirect targets are individuals and groups that can influence the decision-makers (direct target). These may include allies (people who support the advocacy objective), neutrals (those who neither support nor oppose) and opponents.

The key to effective advocacy is to determine which groups and individuals are likely to have the most influence over any decision and to try to persuade them to support the advocacy objectives. Identifying our targets will help us to plan strategically, and will also help us to choose the most appropriate methods or activities.¹

1. See: World Health Organisation (2004), *Advocacy guide: HIV/AIDS prevention among injecting drug users*, <http://www.who.int/hiv/pub/advocacy/en/advocacyguideen.pdf>

6.8 SHORTER OPTION IF YOU HAVE LESS TIME

🕒 20 min

1. Introduce the aim of the session and present the accompanying slides and the information above
2. Give each group a copy of the [Target information table](#) – either as a handout or on a pre-prepared flipchart.
3. Ask each group to choose one objective from the previous step.
4. Ask each group to then select three or four groups, organisations, businesses, government departments or individuals that could be targeted to influence the changes identified in their objective, and to complete the Target information table.

MODULE 6



30 min

Session 6.9

Interactive presentation: Advocacy framework Step 5 - Identifying allies in achieving advocacy objectives



Aim - To identify individuals, groups or institutions that can help in achieving our advocacy objectives

1. Introduce the aim of the session.
2. Working with the whole group, clarify the difference between a target and an ally, and how some allies can also be indirect targets.
3. Facilitate a discussion with participants to share their experiences of working in non-advocacy-related partnerships or coalitions for their work.
4. Focus the discussion on working in partnerships specifically for advocacy. Questions might include:
 - What are your experiences of advocacy work with others?
 - What were the main advantages and disadvantages you identified in working with others to undertake advocacy?
 - What are the differences and similarities between partnerships for advocacy and partnerships for other activities?
5. Present the accompanying slides and the information below.
6. Ask participants to return to their groups, and draw their potential allies on the same Venn diagram they used for [Step 4](#). Give them the following guideline questions:
 - Who else could have a positive impact on the issue that has been chosen? Who else is already working on this issue?
 - Who are usually your “natural” allies? Are they relevant allies for this issue?
 - Are they happy to work in a coalition?
7. Ask the participants to consider, for each ally:
 - What they will gain by joining your alliance
 - What they can offer to the advocacy work
 - What their limitations are.

Information to cover in this presentation:

In the previous step we identified our targets: who we advocate to. Now we will identify our allies: who we advocate with.

In some cases a coalition of people or organisations doing advocacy work can achieve more together than individually. However, coalitions take time and energy to develop and maintain because they involve building trusting relationships with other people and keeping people constantly informed and involved. Many advocates find this part of their work the most difficult and yet the most rewarding, both professionally and personally.

Coalitions can be short term or long term, and formal or informal. For example, in the short term they can take advantage of gatherings such as meetings, conferences and workshops to promote an issue and gather signatures for petitions. Alternatively, campaigns and actions can be undertaken over several years. Forming a coalition with allies to undertake advocacy work is not the same as being part of a network, but networks can also be useful to share information between organisations.

Examples of possible allies to form coalitions include:

- Other people directly affected by the issue or problem, such as people who use drugs, or small-scale subsistence farmers engaged in the production of drug-linked crops
- Other drug user service organisations, CSOs, NGOs, including human rights and health organisations
- Religious leaders and other community opinion formers
- Business people
- Local celebrities or public figures
- Known allies from within the law enforcement sector
- Supportive or sympathetic journalists
- Supportive local/national government officials who can lobby from inside
- Allies in other parts of the country, or other countries – counterpart organisations who could push from outside.

There is sometimes an overlap between allies and “indirect targets”, i.e. indirect targets may be sympathetic to your advocacy objective and may also have influence over influential people, but need some initial influencing to persuade them to support change that needs to be made.

6.9 SHORTER OPTION IF YOU HAVE LESS TIME

 20 min

1. Introduce the aim of the session and present the accompanying slides and the information above
2. Follow instructions 6 and 7 above, but instead of asking each group to add to the Venn diagram, ask them to simply list potential allies on a flipchart and to consider the guideline questions (displayed either on a pre-prepared flipchart or on a slide) for one or two of the listed allies.

MODULE 6



15 min

Session 6.10

Interactive presentation: Advocacy framework Step 6 - Identifying resources to address the selected advocacy issue



Aim - To identify existing resources available to address the selected advocacy issue

1. Introduce the aim of the session.
2. Ask the whole group to brainstorm what kinds of resources are useful for advocacy work. You could give the following examples if necessary:
 - People
 - Contacts
 - Information
 - Skills
 - Money
 - Equipment.
3. Present the accompanying slides and the information below.
4. Ask the three groups to identify all the resources available to address the advocacy aim and objectives selected in [Step 3](#).



Information to cover in this presentation:

Successful advocacy work requires resources such as people (human resources), money, skills and information. Human resources can include both staff and volunteers. Other resources can include access to the media and distribution networks – for example, newsletters, e-mail lists, etc. In [Step 5](#) we saw some advantages of working in coalition with allies – one major advantage is the possibility of sharing resources.

Once we have identified available resources, we can go on to [Step 7](#) – developing an action plan. It is best to plan only for activities that are possible with the resources we have. However, it is sometimes possible to fundraise for advocacy work – although this can be very difficult in some countries and for some issues.

Session 6.11

Interactive presentation: Advocacy framework Step 7 - Creating an action plan

60-90
mins

Aim - To develop an action plan of activities to achieve our advocacy aim and objectives

1. Introduce the aim of the session and explain that it will be in two parts.
 - **selecting** appropriate advocacy **activities**, and
 - making a **detailed plan** for those activities.

PART A: Selecting advocacy activities

2. Present the accompanying slides and the information below.
3. Ask the groups to decide which advocacy methods they want to use. They should look at:
 - the advocacy targets they identified in [Step 4 \(Session 6.8\)](#)
 - the information they gathered or identified in [Step 2 \(Session 6.6\)](#)
 - the list of advocacy methods on the handout "[Advocacy methods](#)"
 - the resources available.
4. Give them these guideline questions:
 - Why does each target support or oppose the advocacy solution?
 - How can each target be moved towards supporting the advocacy solution?



Information to cover in this presentation:

The work done in Steps 1 to 6 will help to choose appropriate advocacy activities to achieve your aim. By now, you know what you are trying to achieve, who your targets are, who your allies are, and resources available. The handout "[Advocacy methods](#)" will also help in selecting activities.

When identifying activities it is important to consider who will be the beneficiary of the actions and involve them, if possible. For example, impact may sometimes be greater if a group of people who use drugs is supported to meet directly with a senior police officer, rather than an NGO representative attending the meeting on their behalf. However, this will largely depend on the local context, including the levels of stigma associated with drug use, and the potential risks of arrest or police abuse.



Facilitators' note

- Encourage participants to use their work from Steps 1-6.
- Encourage participants to co-ordinate their advocacy activities.
- Make sure activities are linked very closely to the objectives.
- Encourage the groups to be realistic when they estimate the time and resources needed.
- If a group finds action planning difficult, consider offering the example below as a guide or developing an example action plan together as a whole group.
- Do not worry if participants do not finish planning – it is more important for them to participate in the plenary discussion.
- Make sure that participants understand that action planning requires more time than they have been allowed in the workshop. Give the handout "[Advocacy methods](#)".
- Make sure participants include informal as well as formal activities – for example, taking opportunities to speak to targets and allies at meetings and other events.

Identifying advocacy methods

There are no simple rules for choosing the best advocacy methods. Your choice will depend on many factors:

- the target person/group/institution
- the advocacy issue
- your advocacy objective
- the evidence to support your objective
- the skills and resources of your coalition
- timing – e.g. external political events, when a law is still in draft form, immediately before a budgeting process, time of year, stage of advocacy process.

Developing and delivering a message efficiently

The message should use language that the target group will understand. It should be clear and simple, avoid technical terms, and use positive images rather than negative connotations.

The messenger is often as important as the message itself. Therefore, if the message is being disseminated via the press, it will be important to use a newspaper that is widely read and respected. If the target group is law enforcement officers, you can use a high-level police chief or retired police officer who will act as your spokesperson. If the message is targeted at a community where religion plays an important role, then a religious or faith-based group could be useful to disseminate the message.

Finally, the message will need to be delivered in a consistent way, through various channels, over a long period of time to be absorbed by the audience. Consistency is crucial, but the message may need to be delivered in various ways so that it does not become boring to the target audience.

PART B: Drafting an advocacy action plan

5. After they have decided on the advocacy methods (activities) to use, the groups should use the format suggested below to draft their advocacy action plan (*see next page*):
6. Ask participants to practise developing an action plan, so that they are familiar with the process. They can plan the activities they listed in Step 3 above. Ask the groups to present their action plans to the others, and encourage them to discuss the plans and ask any questions that they may have.
7. After they have practised action planning, go straight to a discussion with the whole group, without presentations:
 - What factors did you consider in planning advocacy work?
 - Outside this workshop, what needs to be done before writing an action plan?
 - What factors might require you to change your action plan?

Objective	Target	Activities	Resources required	Persons / organisations responsible	Timeframe	Expected outcome
Objective 1 - By July 2012, three influential members of parliament will make positive public statements supporting the decriminalisation of people who use drugs	Influential parliamentarians and their senior advisors Members of the public	Meetings with three parliamentarians	<ul style="list-style-type: none"> - Team leader, - Team to organise events and logistics - Volunteers - Access to the media - Funding - Venue for the meetings 	Team leader	By May	Positive support from three parliamentarians in public statements.

MODULE 6

Session 6.12

Activity: Advocacy exercise



60 min



Facilitators' note

Observe whether the group influencing the target is clear about exactly what it is they want and that they take full advantage of the cooperativeness of the target.



Aim - To allow participants to put into action some of the learning from the previous sessions by practising direct advocacy in a face-to-face meeting

1. Introduce the aim of the session.
2. Divide participants into groups of four to six people (new groups, rather than same ones used for the previous seven Sessions).
3. Provide them with the scenario below by displaying it on a pre-prepared flipchart, a slide or on a handout.

Background: A government-sponsored study in your province has just revealed that a large percentage of people incarcerated in that specific area were sent to prison for drug use or possession of small amounts of drugs for personal use. At the same time, a local politician who has been repeatedly alleged to engage in high-level trafficking has not been investigated. Your organisation wants the government to review its law enforcement practices to ensure that the police targets high-level offenders, instead of people who use drugs.

Aim: To gain government support for a review of policing and law enforcement practices in your province, and ensure that the police deprioritise targeting people who use drugs in their daily work.

Target: Your target is the chief aide to the provincial governor. You have just learned, through your research and advocacy planning, that the aide is a former senior staff member of UNODC who previously worked on developing focused deterrence strategies in drug law enforcement; he therefore fully understands the problem and the appropriateness of the solution. You know, through your advocacy partners, that this aide is in fact the most trusted advisor to the governor. The chief aide has agreed to meet with you for an hour, but due to an unexpected event, he/she can only give you five minutes of his/her time.

4. Ask each group to practice preparing to hold a face-to-face meeting with the target. Each group should identify two people to act as the “advocates” and two people to act as the target. Remind the “advocates” that they need to stress their point in less than three minutes.
5. Depending on the number of participants and the time available, either ask:
 - Some, or all of the groups to perform a short role-play of the face-to-face meeting they have prepared for the whole group, **or**
 - Each group to role-play their meeting without an audience. In this case, facilitators should circulate and observe the groups to assess how they are doing.

6. Lead a plenary discussion based on the following questions:
 - Who was more persuasive and why?
 - How could the advocates have improved their advocacy?
 - How might you follow up a face-to-face meeting?
 - What did you learn about face-to-face meetings from the role plays?
 - What are the advantages of having people directly affected by the issue at such a meeting?
7. Depending on time, invite any other comments or experiences of face-to-face advocacy.

MODULE 6



60 min

Session 6.13

Interactive presentation:

Advocacy framework Step 8 - Monitoring and evaluating drug policy advocacy



Aim - To review why it is important to monitor and evaluate advocacy work; to explore some of the challenges in doing so; and to decide on how to monitor and evaluate our advocacy work during and after implementation

1. Introduce the aim of the session and explain that it will be in three parts:
 - Understanding the importance of monitoring and evaluating drug policy advocacy
 - Challenges of evaluating drug policy advocacy
 - Deciding how to monitor and evaluate advocacy work

PART A – Understanding the importance of monitoring and evaluating drug policy advocacy ⌚ 15 min

2. Ask participants to form pairs with the person sitting next to them and to identify the main reasons for evaluating drug policy advocacy work.
3. After five minutes ask groups to report back and note their responses on a flip-chart.

Ensure that the main reasons identified below have been mentioned:

Example outputs - Reasons for monitoring and evaluating advocacy work

- To learn how to improve the capacity of advocates
- To demonstrate the quality and impact of our advocacy activities
- To review our progress and, if necessary, revise / adjust our strategies
- To inform the planning of future advocacy work, including funding cycles / proposals
- To demonstrate evidence-based approaches to drug policy advocacy
- To learn from our mistakes and our experience in advocating on a drug policy issue
- To improve our understanding of the issues and improve our strategy and programmes
- To account for funding and demonstrate results
- To demonstrate results to mobilise more resources for future advocacy work.

4. Summarise by noting that there is a growing interest in advocacy evaluation, both from advocates and donors. The reasons for this interest may differ between the two groups, but often overlap.

PART B – Challenges of monitoring and evaluating drug policy advocacy

🕒 15 min

5. Ask participants to form pairs with a new partner, and to share challenges they have faced or they imagine they might face in evaluating drug policy advocacy work.
6. Distribute handout “[Challenges of monitoring and evaluating drug policy advocacy](#)”.
7. Ask participants to share any additional challenges they identified in their pairs.

PART C – Deciding how to monitor and evaluate advocacy work

🕒 30 min

8. Facilitate a brief brainstorm on the difference between monitoring and evaluation.
9. Present the accompanying slides and the information below.
10. After the presentation, ask participants to brainstorm some examples of the following for the advocacy plan they have developed in the previous steps of the advocacy framework:
 - Short-term outcome indicators
 - Medium-term outcome indicators
 - Impacts.

✓ Information to cover in this presentation:

Monitoring and evaluation are distinct, yet complementary. The key difference between them is as follows:

- monitoring is a continuous process that tracks or records the activities we carry out (planned or not);
- evaluation is a periodic assessment of how we are doing things, if we are achieving our aims, or if we are achieving unexpected outcomes, and why we are achieving these.

Increasingly, advocacy evaluations focus on capturing the changes advocates make on the way to achieving their goals rather than the goals themselves. For example, for advocacy efforts aimed at achieving policy change, evaluations might not focus only on assessing whether policy change is achieved but also on **the key achievements along the way**, such as mobilisation to advocate more effectively, and the placement of the policy issue on the policy reform agenda. These changes are often referred to as **short- or medium term outcomes, interim outcomes** or **incremental measures of progress**.

Here is a standard programme logic chain that explains the difference between outputs and outcomes. Essentially, the outputs from a number of processes, if well implemented, will lead to the achievement of (short-term) outcomes.



In the logic chain, resources (inputs) are processed into goods and services (outputs). These result in knowledge and behaviour change, improvements in access to and use of services (outcomes), which, in turn, eventually produce changes in the socio-demographic or epidemiological profile of a population (impact).

This logic is applied to the example below:

A new national network of people who use drugs is being formed. Their medium-term aim is to “create a well-informed, organised and representative advocacy coalition able to respond strategically to new opportunities as they arise”, with the ultimate goal of “protecting the human rights of people who use drugs”. The outputs would be the specific processes leading to the creation of the network, with measures such as number of meetings held and attendance, the number of sub-regions represented in the network, and so on. The outcome measures would include the creation of the network, and might also explain what has been achieved, such as the participation of people who use drugs in national policy discussions. The impact, which would most likely happen over a number of years, and probably beyond the length of time of any funding agreement, would be the “protection of human rights of people who use drugs”.

The table below shows how this example relates to different parts of the logic model.

Inputs	Activities	Example output indicators	Example short-term outcome indicators	Example medium-term outcome indicators	Impacts
Time of network members, coordinators and volunteers, money, etc.	Organisation of coalition meetings Information sharing Partnership building Capacity building	Number of network meetings held Number of people attending meetings Briefing papers on people who use drugs	New relationships with influential champions Alignment of partners’ efforts and messaging Creation of a well-informed, organised and representative network	Changes in public perceptions of people who use drugs New policies that protect the rights of people who use drugs are introduced Mechanisms to address the rights abuses of people who use drugs established	Protection of the human rights of people who use drugs

When focusing on interim outcomes or incremental progress, the difference between an **output** and an **outcome** and their respective measures (indicators) can be confusing. The distinction between what counts as a **process indicator** (output) and what counts as a **result indicator** (outcome) will depend on your strategic vision for your advocacy work and what you consider to be significant achievements on the path to achieving your goals. This will be influenced by the **level of your advocacy goal** (or ambition) and the **timeframe** of the evaluation of you plan. For example, the creation of the network will be a significant outcome indicator of the first phase of the work, especially in countries where key people who use drugs are highly stigmatised and criminalised. However, once the network is established, work will focus on achieving longer-term outcomes, such as policy change or improved conditions. In this case, and over the longer term, the creation

and maintenance of the coalition would be an output, leading towards the desired policy outcome.

Summary points

Monitoring and evaluation in drug policy advocacy will therefore need to:

- Focus on interim/short-term outcomes
- Focus on “contribution” rather than “attribution”: Whereas **attribution** requires a cause-effect determination, **contribution** analysis focuses on identifying likely influences
- Prioritise areas of evaluation
- Develop new/creative outcomes and indicators of evaluation
- Take into account political sensitivities.

6.12 SHORTER OPTION IF YOU HAVE LESS TIME

 40 min

1. Introduce the aim of the session and present the accompanying slides and the information above.
2. You will need to include reasons for monitoring and evaluating advocacy work (see examples under Step 5 above), and the challenges of evaluating drug policy advocacy.
3. Select some examples from the handout “[Advocacy methods](#)” which you should also give to participants.

1. Adapted from: International HIV/AIDS Alliance & International Council of AIDS Service Organisations (2010), *Measuring up: A guide for learners – HIV-related advocacy evaluation training for civil society organisations*, <http://www.aidsalliance.org/resources/340-measuring-up-hivrelated-advocacy-evaluation-training-pack>

MODULE 6

Handout: Examples of definitions and types of advocacy

Examples of advocacy definitions

“Advocacy is an on-going process to change values, attitudes, actions, policies and laws by influencing decision-makers and opinion leaders, organisations, systems and structures at different levels”.¹

“Advocacy is a set of targeted actions directed at decision makers in support of a specific policy issue”.²

“Advocacy means putting across your message to other people to bring about wider public understanding about [specific] issues, changes in policies, laws, and services. Advocacy work can involve action at all levels, locally and through representation of national decision-making bodies”.³

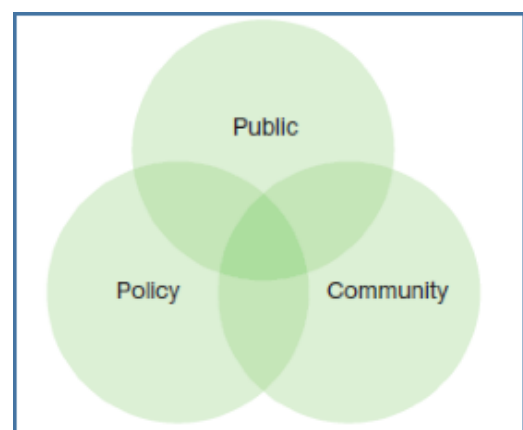
“Advocacy is not just about getting to the table with a new set of interests; it is about changing the size and configuration of the table to accommodate a whole new set of actors. Effective advocacy challenges imbalances of power and changes thinking”.⁴

“Advocacy is an action directed at changing the policies, positions, and programs of any type of institution”.⁵

Types of advocacy

The APCASO Advocacy⁶ Toolkit suggests another way of looking at the advocacy work we do. It notes three different types of advocacy that we probably do in our daily lives and which each overlap at a certain point and each can influence the other:

- Policy advocacy: to influence policy and regulations directly
- Public advocacy: to influence behaviour, opinion and practices of the public in order to influence groups and institutions which are involved in affecting change in policies
- Community advocacy: to influence groups and institutions that are involved in affecting change in policies by working with affected communities to influence behaviour and practices.



Levels of advocacy⁷

Advocacy work can target people with influence at all levels – from a local bar owner to the United Nations. Although there are multiple levels of advocacy work, for the sake of simplicity we can identify three key “levels” of advocacy:

- Local: village, district, city, state, etc.
- National: the whole country
- International: more than one country.

For example, if our advocacy issue is the reduction of the number of people incarcerated for the possession of drugs for personal use:

- **Local level:** Law enforcement officers must be aware of the ineffectiveness of incarcerating people who use drugs and of the harms caused by this practice (including the costs to the criminal justice system, the health harms, as well as the social stigma faced by people who use drugs). This will require significant advocacy work targeted at the police and others.
- **National level:** The government of the country in question is responsible for the legislative framework. For the intervention to be effective in the long term, the government will need to pass a law to remove criminal sanctions for people caught for drug use, in countries where current drug laws criminalise consumption.
- **International level:** Several UN agencies, including UNAIDS and the World Health Organization, have called for the decriminalisation of people who use drugs, while UNODC have made it clear that decriminalisation is permitted within the drug conventions.⁸ Representatives of these bodies may help in pushing for the policy to be adopted in national legislation.

In reality the problem or issue may have a combination of local, national and international causes, so the level of your advocacy work will depend on:

- The scale of the problem or issue (it may have a purely local cause)
- Where you can have the greatest impact on the problem or issue
- The resources of your organisation (i.e. different levels of advocacy take different amounts of staff time, skills and funds)
- Your organisation's networks and relationships (for example, one of your trustees may know the owner of the national hotel chain)
- The mission of your organisation (for example, your activities may be purely within one district).

Working together in coalitions can be a strength at every level, but becomes particularly important as you move from local to national to international level and face greater bureaucracy and power.

References

1. Adapted from a definition presented in: International HIV/AIDS Alliance (2003), *Advocacy in action: A toolkit to support NGOs and CBOs responding to HIV/AIDS*, <http://www.aidsalliance.org/publicationsdetails.aspx?id=142>, during the guide field-test workshop held in India
2. POLICY Project (1999), *Networking for change: An advocacy training manual* (Washington, D.C.: Futures Group/POLICY Project), <http://www.policyproject.com/pubs/AdvocacyManual.cfm>
3. Maasdorp, A. (1998), *Positive development: Setting up self-help groups and advocating for change—A manual for people living with HIV* (Amsterdam: Global Network of People Living with HIV/AIDS)
4. VeneKlasen, L. & V. Miller. (2002, reprinted 2007), *A new weave of people, power & politics: The Action guide for advocacy and citizen participation* (Washington, D.C.: Just Associates)
5. Sharma, R. (1997), *An introduction to advocacy: Training guide* (Washington, D.C.: Academy for Educational Development/Support for Analysis and Research in Africa (SARA) Project)
6. Asia Pacific Council of AIDS Service Organizations, with support from the Australian Federation of AIDS Organisations, *HIV advocacy from the ground up: A toolkit for strengthening local responses* (Kuala Lumpur: APCASO), http://www.afao.org.au/data/assets/pdf_file/0008/4796/Toolkit_3.pdf
7. Adapted from: International HIV/AIDS Alliance (2003), *Advocacy in action: A toolkit to support NGOs and CBOs responding to HIV/AIDS*, <http://www.aidsalliance.org/publicationsdetails.aspx?id=142>
8. See: TalkingDrugs (2014), Infographic: *Where UN agencies stand on drug decriminalisation*, <http://idpc.net/alerts/2014/08/infographic-where-un-agencies-stand-on-drug-decriminalization>

MODULE 6

Handout: What is, and what is not, advocacy?

Advocacy and other change-seeking interventions*

NOTE – Often, in order to achieve your advocacy overall goals, you will engage in activities that are not in themselves advocacy, but that are necessary to pave the path towards policy change.

	Advocacy	Information, education, communication	Community mobilisation	Networking & partnerships	Fundraising & resource mobilisation	Overcoming stigma & discrimination
What can it change?	Policies, implementation of policies, laws and practices	Awareness and behaviour	Capacity of communities to identify and address their problems	Isolation and duplication	Level of resources available	Level of stigma and discrimination against people involved in growing and consumption
Target group	Decision makers, people in positions of influence	Particular age group, gender, residents of an area, etc.	Members of a community	Individuals or groups who have a similar agenda	Communities, local councils, governments, donors	People who stigmatise or discriminate
Does it mainly target people who have influence over others	Yes	No	No	No	No	No
Typical indicators of success	Policies, implementation, laws or practices which improve the health, social and economic status and human rights of growers and users	Percentage of youth accessing harm reduction interventions, benefiting from alternative livelihoods programmes, etc.; changes in attitudes towards growers and users	A community problem is solved; more people attend community meetings focusing on drugs issues	Members of the network or partnership achieve more than they could if they had worked alone	Individual gives use of building for meetings, donor gives grant	Less cases of discrimination in accessing employment or healthcare at hospitals because of drug use

* Adapted from: Asia Pacific Council of AIDS Service Organizations, with support from the Australian Federation of AIDS Organisations, *HIV advocacy from the ground up: A toolkit for strengthening local responses* (Kuala Lumpur: APCASO), http://www.afao.org.au/_data/assets/pdf_file/0008/4796/Toolkit_3.pdf

Handout: Charting the national response*

	Government	Local or national CSOs and NGOs	INGOs and Networks (including networks of people who use drugs)	UN agencies/ regional organisations	Hospitals, Clinics and/or Universities	Other Groups
Surveillance and research on drug use, trafficking, production and harms						
Policy making and coordination of national and international stakeholders						
Drug prevention and drug education						
Harm reduction services						
Drug dependence treatment, care and support						
Crop eradication						
Criminal justice processes against people accused of drug offences/crimes						
Strategies against corruption & money laundering						
Promoting alternative development/ livelihoods for people who grow drugs						
Protecting the human rights of vulnerable groups						
Promoting drug policy reform						
Promoting the engagement of people who use drugs						

* Adapted from: Asia Pacific Council of AIDS Service Organizations, with support from the Australian Federation of AIDS Organisations, HIV advocacy from the ground up: A toolkit for strengthening local responses (Kuala Lumpur: APCASO), http://www.afao.org.au/data/assets/pdf_file/0008/4796/Toolkit_3.pdf

MODULE 6

Handout: The Support. Don't Punish campaign

"The heightened risks caused by the war on drugs can no longer be ignored. It is time to leave behind harmful politics, ideology and prejudice. It is time to prioritise the health and welfare of those affected, their families and communities".

Support. Don't Punish is a global advocacy campaign to raise awareness of the harms being caused by the war on drugs.

The Support. Don't Punish campaign aims to:

- The drug control system is broken and in need of reform.
- People who use drugs should no longer be criminalised.
- People involved in the drug trade at low levels, especially those involved for reasons of subsistence or coercion, should not face harsh or disproportionate punishments.
- The death penalty should never be imposed for drug offences.
- Drug policy in the next decade should focus on health and harm reduction.
- By 2020, governments should redirect a tenth of the resources they currently spend on drug control to harm reduction programmes – 10 per cent by 2020.

The campaign started in 2013 and has it been growing quickly around the globe, with the participation of many grass-root organisations, advocates, activists, policy-makers, celebrities and drug users. The campaign includes an interactive photo project where people can send their picture with the Support. Don't Punish logo to show their support:



The focus of the campaign, however, is the organisation of a Global Day of Action on 26th June – United Nations’ International Day against Drug Abuse and Illicit Trafficking – a day that is used by many governments to celebrate the war on drugs and to justify violent crackdowns and to promote harsh punishments. But June 26th is also the United Nations’ International Day in Support of Victims of Torture, and this campaign aims to help redefine what June 26th means, and how we look at drug policies around the world. In 2013, 41 cities across the world participated in the 1st Global Day of Action. 2014 was even bigger, with actions in 100 cities from all over the world, including in Nigeria, Senegal, Mauritius, Tanzania, Kenya and Zimbabwe:



Awareness raising march, speeches and press briefing in Senegal



Football tournament in Nigeria



Outreach visits to mobilise drug user households and communities, community dialogue forums and procession walks in Kenya



Open air cinema and event, speeches and information stand, as well as outreach to the media in Tanzania



Speeches from senior policy officers and drama performance by local community members in Zimbabwe



Bus tour to raise awareness about the campaign, distribution of leaflets, information, balloons, flags, etc. in Mauritius

For more information, please visit: <http://supportdontpunish.org/>

For a video on the 2014 Global Day of Action, please visit: <https://www.youtube.com/watch?v=NP-MebxLWYM>

MODULE 6

Handout: Advocacy Methods

Target	Methods of intervention	Information to consider	Examples of drug policy advocacy
Policy makers	<ul style="list-style-type: none"> Formal / informal meetings Letters (by individuals, organisations or a coalition of organisations) Documents, factsheets, brochures on a drug policy issue Videos Newspaper articles Broadcast commentaries 	<p>Messages should be short, concise and persuasive</p> <p>Thematic entry should be identified according to the local historical, cultural, political and socio-economic context:</p> <ul style="list-style-type: none"> Economic arguments Reducing violence associated with drug markets Reducing corruption Enhancing good governance Promoting public health Upholding human rights <p>Clearly communicate what action you want policy makers to undertake and who supports your proposal</p>	<p>At the international level: organisation of satellite events at international conferences (see: www.cndblog.org)</p> <p>At the national level: promotion of the IDPC Drug Policy Guide (http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition), meetings with government officials</p> <p>At the local level: training of public prosecutors or training of law enforcement officials on modernising drug law enforcement (harm reduction-based, focused deterrence, etc. see: http://idpc.net/policy-advocacy/special-projects/modernising-drug-law-enforcement)</p>
Other NGOs	<ul style="list-style-type: none"> Meetings with the organisation's leaders and staff Ready-to-use factsheets Graphs and illustrations Short Power-Point presentations Briefing meetings 	<p>Advocacy organisations need specific information to support their arguments. They will find research and data useful when presented in a clear and compelling way.</p>	<p>Short briefings and factsheets on drug policy reform (see: http://idpc.net/publications/2014/01/the-ungass-on-drugs-in-2016-a-milestone-for-hiv-aids-ngos-policy-in-africa)</p>
Press/media	<ul style="list-style-type: none"> Press releases Press conferences Briefings for journalists Factsheets or background papers Media packs/press kits Letters to the editor 		<p>Media information packs (see: http://idpc.net/publications/2011/02/idpc-media-information-pack-version-2)</p>
General public	<ul style="list-style-type: none"> Promotional items (badges, bracelets, pens, etc.) Banners Brochures, flyers Newspaper articles Radio or television shows and programmes 	<p>Messages must be attractive, clear and concise</p>	<p>Drug policy advocacy videos (see: http://supportdontpunish.org/videos/)</p>

Handout: Targets information table

TARGET	Type of target (direct, indirect)	How to contact the target	Target's feeling about the advocacy issue	How to influence the target	Target's way of making decisions	Target listens to....

Handout: Challenges of monitoring and evaluating drug policy advocacy

Challenges related to monitoring and evaluation of drug policy advocacy include*:

- Reluctance by some policy makers or opinion leaders to publicise or share results of successful advocacy around contentious outcomes
- Reluctance by some decision makers or key stakeholders to attribute success to advocates who they may perceive to be adversaries, particularly those representing people who use drugs who may be criminalised and stigmatised
- Changes in staff, values and policies of advocacy targets such as politicians, policy makers, opinion leaders and donors at all levels means that evaluating advocacy efforts over time can be challenging. This is because the challenges are constantly changing, and because there can be a loss of corporate memory, which makes it hard to assess contribution over the long term
- Lack of external resources for monitoring and evaluation, such as funding or partnership opportunities with experienced monitoring and evaluation organisations
- Difficulty in attributing policy change directly to advocacy work
- Difficulty in attributing success in advocacy work directly to one specific organisation or advocacy effort
- Stigma or criminalisation of people who use drugs can lead to a lack of secondary data or difficulty in accessing epidemiological data for baselines and indicator measures
- Reluctance of some advocates to claim contribution to successful change that they would prefer policy makers and opinion leaders to own
- Difficulty in involving beneficiaries in advocacy evaluations due to criminalisation, discrimination and stigma
- Fear that an advocacy initiative will fail if anticipated goals are not achieved
- Lack of flexibility on evaluation designs to capture unplanned achievements or the efforts to create or maintain stable advocacy partnerships and coalitions that are achievements along the way
- Advocacy work is often loosely planned as it can be difficult to predict and needs to be responsive. However, without clear planning it is difficult to evaluate using conventional evaluation approaches
- While funding cycles are usually time bound, much advocacy work is not
- Often drug policy advocacy has long-term objectives or goals that take longer to achieve than the duration of funding, so it is difficult to know what to track to show results
- In some contexts, monitoring and evaluation of advocacy is weak or limited because evaluation is not considered important so not planned or budgeted for; evaluating advocacy is considered too difficult or time-consuming for busy advocates; staff or volunteers have limited evaluation experience; or in some cases advocacy is considered a day-to-day activity not requiring specialist skills and not worth evaluating.

* Adapted from: International HIV/AIDS Alliance & International Council of AIDS Service Organisations (2010), *Measuring up: A guide for learners – HIV-related advocacy evaluation training for civil society organisations*, <http://dl.dropbox.com/u/64663568/library/measuring%20up.pdf>

Handout: Compiling strong evidence to support advocacy interventions

There are a number of resources which provide compelling data and evidence to support our advocacy intervention. These can include, but are not limited to:

- Publications from UN agencies, including from WHO, UNAIDS, UNODC, etc.
- Websites and key publications from NGOs working on drug policy issues (e.g. the IDPC Drug Policy Guide)
- Key quotes from UN officials or government representatives to illustrate your message.

Key Publications

West Africa Commission on Drugs (2013), *Not Just in Transit: Drugs, the State and Society in West Africa*, <http://www.wacommissionondrugs.org/report/>

West Africa Commission on Drugs, background paper series on drug policy: <http://www.wacommissionondrugs.org/wacd-commissioned-papers/>

International Drug Policy Consortium (2012), *Drug Policy Guide, 2nd edition*, <http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition>

International Drug Policy Consortium, Chatham House & the International Institute for Strategic Studies, Modernising Drug Law Enforcement Project and publications series, <http://idpc.net/policy-advocacy/special-projects/modernising-drug-law-enforcement>

Global Commission on Drug Policy (2014), *Taking Control: Pathways to drug policies that work*, <http://www.globalcommissionondrugs.org/reports/>

Global Commission on Drug Policy (2011), *War on drugs: Report of the Global Commission on Drug Policy*, <http://www.globalcommissionondrugs.org/reports/>

Harm Reduction International & Human Rights Watch (2009), *Building Consensus: A reference guide to human rights and drug policy*, <http://www.ihra.net/files/2010/06/01/BuildingConsensus.pdf>

Harm Reduction International (2014), *The Global State of Harm Reduction 2014*, <http://www.ihra.net/global-state-of-harm-reduction-reports>

Harm Reduction International, International Drug Policy Consortium & International HIV/AIDS Alliance (2014), *The funding crisis for harm reduction*, <http://idpc.net/publications/2014/07/the-funding-crisis-for-harm-reduction>

World Health Organisation technical guides and documents on drug use: <http://www.who.int/hiv/pub/idu/en/index.html>

UNAIDS publications: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries>

Key Websites

West Africa Commission on Drugs, <http://www.wacommissionondrugs.org/>

International Drug Policy Consortium, <http://idpc.net/>

Global Commission on Drug Policy, <http://www.globalcommissionondrugs.org/>

African Union, <http://sa.au.int/>

ECOWAS, <http://www.ecowas.int/>

United Nations Office on Drugs and Crime (West Africa Programme), <http://www.unodc.org/westandcentralafrica/en/index.html>

United Nations Office for West Africa, <http://unowa.unmissions.org/>

World Health Organisation, www.who.int

UNAIDS, <http://www.unaids.org/>

For more key websites, please visit: <http://idpc.net/about/relevant-links>

Handout Quotes from key international and West African actors



"We must have the courage to change policies that no longer fit reality."

OLUSEGUN OBASANJO
CHAIR OF THE WEST AFRICA COMMISSION
ON DRUGS

#ReformDrugLaws



"West African leaders and civil society must join forces to change policies that have not worked."

PEDRO PIRES
WEST AFRICA COMMISSION ON DRUGS

#ReformDrugLaws



"Drug traffickers must face the full force of the law, but the law must not be applied disproportionately to the poor & vulnerable."

DR. ALPHA ABDOULAYE DIALLO
WEST AFRICA COMMISSION ON DRUGS

#ReformDrugLaws



"Drugs are a public health issue."

CHRISTINE KAFANDO
WEST AFRICA COMMISSION ON DRUGS

#ReformDrugLaws

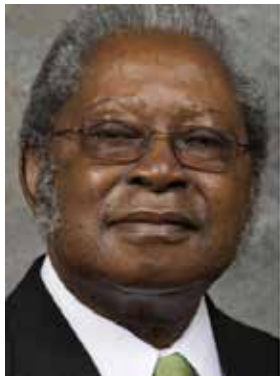




"West Africa must not become a new front line on the failed war on drugs."

DR. MOHAMMAD-MAHMOUD GULD
MOHAMEDOU
WEST AFRICA COMMISSION ON DRUGS

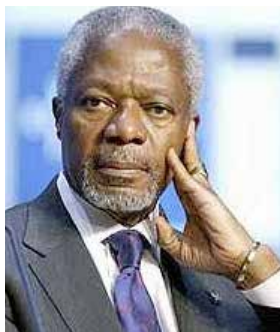
#ReformDrugLaws



"The criminalisation of drug use puts huge pressures on the criminal justice system."

JUSTICE BANKOLE-THOMPSON
WEST AFRICA COMMISSION ON DRUGS

#ReformDrugLaws



"Drugs may have killed many people. But I maintain that wrong governmental policies have killed many more, and we need to rethink."

Kofi Annan

President of the West Africa Commission on Drugs,
former UN Secretary General



"I urge all countries to remove punitive laws, policies and practices that hamper the AIDS response... In many countries, legal frameworks institutionalize discrimination against groups most at risk... We must ensure that AIDS responses are based on evidence, not ideology, and reach those most in need and most affected"

Ban Ki Moon, UN Secretary General

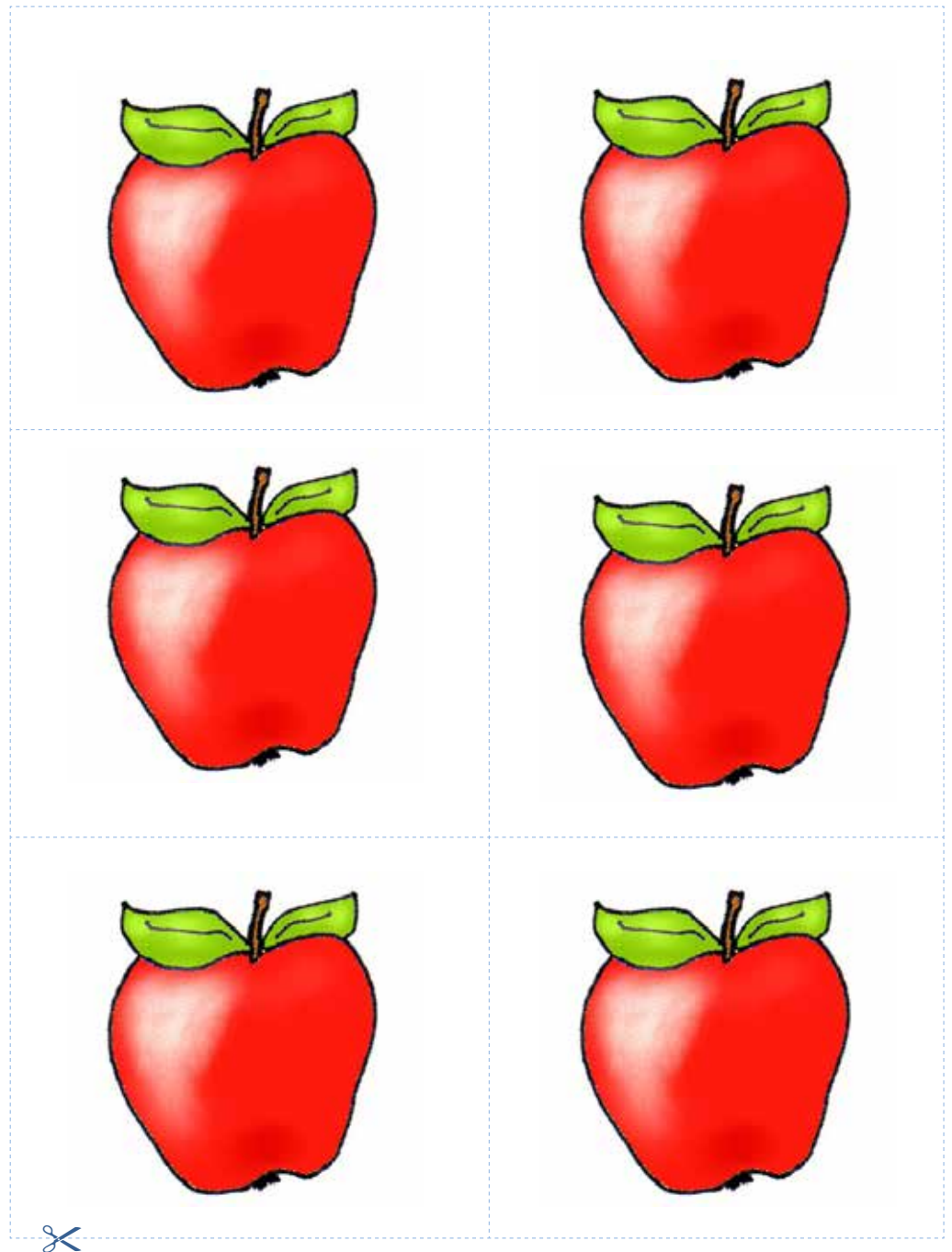
Message on World AIDS Day, 1st December 2009

Annex 1: Introductory icebreaker – Find your pair

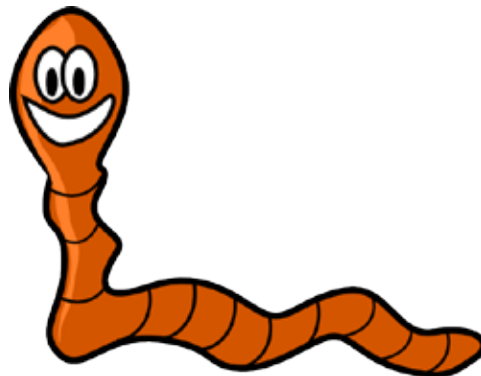
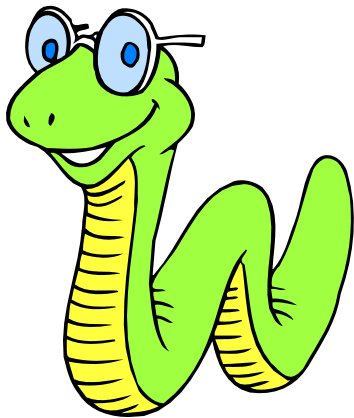
Cut word pairs into individual words. Fold up individual words and place in a bag ONLY when you know the number of participants taking part in this activity. Each participant takes one piece of paper and must then 'find their pair'.

'NIGHT'	'DAY'
'KNIFE'	'FORK'
'SUN'	'MOON'
'BLACK'	'WHITE'
'HIGH'	'LOW'
'SOCK'	'SHOE'
'TOOTHBRUSH'	'TOOTHPASTE'
'LOVE'	'HATE'
'HELLO'	'GOODBYE'
'WAR'	'PEACE'

Annex 2: Apples for tree of balanced drug policy (Session 2.2)

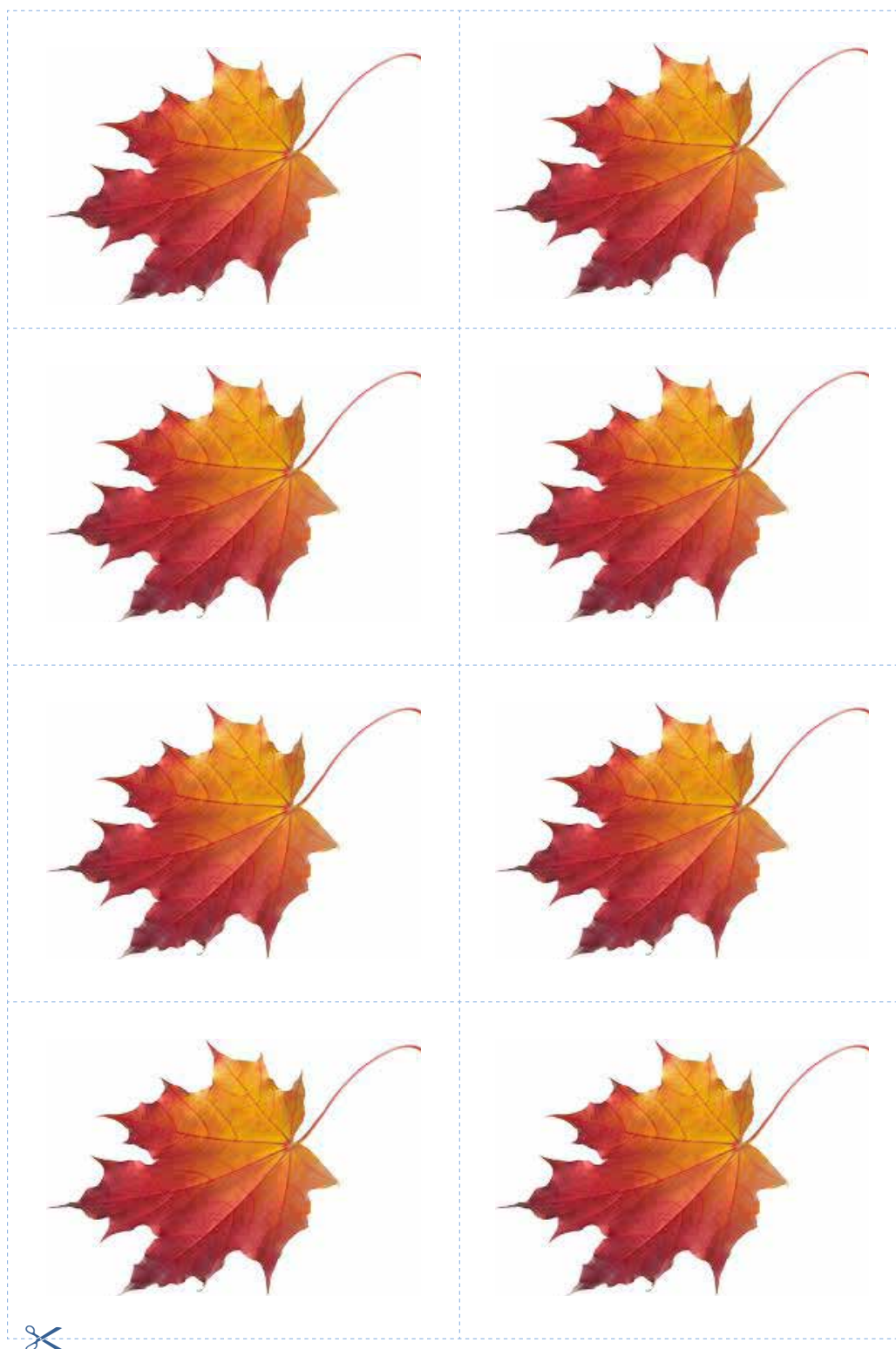


Annex 3: Worms for the tree of balanced drug policy (Session 2.2)



APPENDICES

Annex 4: Leaves for the tree of effective drug dependence treatment (Session 3.9)



Annex 5: Pre-Workshop Assessment Form

The objective of these workshops is to strengthen capacity to engage and advocate on issues of drug policy, drug prevention and treatment, harm reduction, security and governance in West Africa. In order to allow us to measure success, we would appreciate it if you could complete this short form before the event.

Name: _____

Question 1

On a scale from 1 (no understanding) to 10 (excellent understanding), how would you rate your knowledge on the **international drug control system**? Please circle one number below.

Don't know anything about it <<<

>>> Excellent understanding

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Question 2

On the same scale, how would you rate your knowledge on **harm reduction**?

Don't know anything about it <<<

>>> Excellent understanding

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Question 3

On the same scale again, how would you rate your knowledge on **drug prevention and drug treatment**? Please circle one number below.

Don't know anything about it <<<

>>> Excellent understanding

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Question 4

And finally, how would you rate your knowledge **on ways to advocate for policy reform**? Please circle one number below.

Don't know anything about it <<<

>>> Excellent understanding

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Question 5

Are you aware of the recommendations from the West Africa Commission on Drugs?

Yes	Not Sure	No
-----	----------	----

Question 6

Do you know about the UN General Assembly Special Session (UNGASS) on drugs?

Yes	Not Sure	No
-----	----------	----

APPENDICES

Annex 5: Post-Workshop Assessment Form

The objective of these workshops is to strengthen capacity to engage and advocate on issues of drug policy, drug prevention and treatment, harm reduction, security and governance in West Africa. In order to allow us to measure success, we would appreciate it if you could complete this form and hand it to the facilitators before you leave.

Name: _____

Question 1

On a scale from 1 (no understanding) to 10 (excellent understanding), how would you rate your knowledge on the **international drug control system**? Please circle one number below.

Don't know anything about it <<<

>>>Excellent understanding

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Question 2

On the same scale, how would you rate your knowledge on **harm reduction**?

Don't know anything about it <<<

>>>Excellent understanding

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Question 3

On the same scale again, how would you rate your knowledge on **drug prevention and drug treatment**? Please circle one number below.

Don't know anything about it <<<

>>>Excellent understanding

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Question 4

And finally, how would you rate your knowledge on **ways to advocate for policy reform**? Please circle one number below.

Don't know anything about it <<<

>>>Excellent understanding

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Question 5

Are you aware of the recommendations from the West Africa Commission on Drugs?

Yes	Not Sure	No
-----	----------	----

Question 6

Do you know about the UN General Assembly Special Session (UNGASS) on drugs?

Yes	Not Sure	No
-----	----------	----

Annex 6: Evaluation form template

For each of the following areas, please indicate your rating from 1 (poor) to 5 (excellent) by ticking the relevant column							
GENERAL CONTENT	☹	1	2	3	4	5	☺
The training covered useful topics							
The training was practical and useful to my needs and interests							
The training was well organised							
The training was presented at the right level of difficulty							
The activities were relevant and useful							
Training methods used were varied							
There was sufficient opportunity for interactive participation							
Visuals and handouts were useful							
The goals of the training were clearly defined							
The goals of the training have been met							
Time allowed for the training was sufficient							
PRESENTATION	☹	1	2	3	4	5	☺
The facilitator's knowledge was satisfactory							
The facilitator's presentation style was satisfactory							
The facilitator covered the materials clearly							
The facilitator responded well to questions							
OTHER COMMENTS							
How could this workshop be improved?							
Do you have any other comments or suggestions?							
Overall, how would you evaluate this training? (please circle)	Poor	Fair	Good	Excellent			



Annex 7: Template of certificate of attendance

[ADD LOGO
OF YOUR
ORGANISATION]

Certificate of Attendance

West Africa Drug Policy Advocacy
Workshop

We certify that [FULL NAME] has completed the Drug Policy Advocacy
Workshop, organised at [ADD LOCATION], on [ADD DATE OF TRAINING].

[ADD SIGNATURE OF DIRECTOR OF
YOUR ORGANISATION]

[ADD SIGNATURE OF TRAINER]

[ADD SIGNATURE OF TRAINER]

[ADD NAME OF DIRECTOR OF YOUR
ORGANISATION]

[ADD NAME AND AFFILIATION OF
TRAINER]

[ADD NAME AND AFFILIATION OF
TRAINER]



About IDPC

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

International Drug Policy Consortium

Fifth Floor, 124-128 City Road
London EC1V 2NJ, United Kingdom

Tel: +44 (0)20 7324 2975
Email: contact@idpc.net
Website: www.idpc.net

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Report design by Mathew Birch - mathew@mathewbirch.com

Design concept by Rudy Tun-Sánchez - rudo.tun@gmail.com
