

**OPINION**

## Time for a humane and radical rethink on drug policy in South Africa

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Nyaope addicts - Madelene Cronje

About 275 million people have used drugs, up by 22% from 2010, according to the United Nations Office on Drugs and Crime in 2021. By 2030, demographic factors project the number of people using drugs to rise by 11% around the world, and as much as 40% in Africa alone.

In countries such as South Africa, characterised by high unemployment rates, economic and social disparities and growing poverty, drug use disorders are on the increase. Drugs have become a solution to underlying structural problems.

Punitive drug laws that impose disproportionate criminal sanctions are the main driver of imprisonment, having led to an estimated 2.2 million people worldwide in prison for drug offences. Out of these 2.2 million people, 22% (470 000 people) have been imprisoned for drug possession for personal use.

As we regrettably watch the increasing numbers of deaths by overdose, unnecessary incarceration for minor drug-related offences, as well as the constant stigma, marginalisation and criminalisation of people who use drugs, we witness yet again the failure of the existing drug regulatory system.

Punitive and draconian drug control systematically leads to human rights violations and abuses: discrimination targeting already marginalised communities, disproportionate drug sentences, arbitrary detention, ineffective compulsory treatment programmes, and restricted access to controlled medicines for the treatment of pain. All of this exacerbates a severe lack of health-seeking behaviour on the part of the drug-using community.

## **The role and relevance of science and harm reduction**

Treating problematic or dependent drug use is a key responsibility of governments. The Global Commission on Drug Policy reiterates that drug treatment should be a matter for health professionals working in the health sector.

Coercing people into treatment through the threat of a criminal sanction is wholly unethical and counterproductive. Harm reduction interventions are not only more effective in treating drug use disorders but are also more cost effective than punitive approaches or simply leaving the problem to “self-resolve”.

In contrast, relapse rates for people released from compulsory drug detention centres are very high. For example, high relapse rates have been reported in Cambodia and China, with more than 90% of people who use heroin relapsing after release. The same is true in South Africa in “treatment centres” such as the Newlands Rehabilitation Centre in Durban which has a “success rate” (determined by abstinence) of 7%.

## **There is cause for optimism though.**

Over the past decade, we have seen drug reform based on scientific evidence gaining traction around the world at national and sub-national levels. More and more countries are decriminalising drug use, and adopting innovative programmes based on public health and human rights. The most recent country to do this is Australia, where in the Australian Capital Territory possession of small amounts of all drugs will be decriminalised.

Additionally, a recent report released by Harm Reduction International indicated that for the first time in nearly a decade the provision of harm reduction interventions such as needle and syringe services programmes (NSPs), medically supervised drug consumption rooms and substitute opioid agonist therapy (OAT) such as methadone or buprenorphine for heroin users, were on the increase globally.

The biggest growth has occurred in sub-Saharan Africa. Nigeria, Burundi, Côte d’Ivoire, Democratic Republic of the Congo, Guinea and Uganda (plus new data on Seychelles) have all introduced NSPs in the past two years and during the same period Algeria, Mozambique and Uganda have welcomed OAT initiatives.

But South Africa lags far behind these countries with no state-funded harm reduction services available. OAT or opioid substitution therapy (OST) medication, as it is sometimes referred to, is not on the essential drugs list (EDL) list in Southern Africa

which means that there are supply chain issues, costs are high and health insurance does not cover those costs.

We also have to do more than NSPs to support and address the needs of people who use drugs. We need better infrastructure in the region that links this community to health services (including mental health services) as well as improving relationships with law enforcement officials, recognising the inextricable link between public health and public safety.

## **The changing drug landscape in Southern Africa**

Having said this, we need to take a critical look at our drug policy in South Africa and in the South African Development Community (SADC) region. With drug use on the rise in the Global South, it is imperative that we work toward reducing harm to our health, our economy, our societal fabric, and our health systems.

South Africa has become one of the global capitals of methamphetamine use which is also affecting other countries in the region. The response to this phenomenon should be guided by sound evidence-based policy, one that acknowledges that most of the drug use is through smoking and not injecting drug use (IDU).

The number of users who smoke powerful drugs is growing and creating a range of societal consequences that we have witnessed in other countries over the years and we urgently need to address it.

That means confronting the disease-specific funding of the donor community. While donors are familiar with many of the social and health problems in the Global South, their funding decisions are informed by experiences in the Global North when determining who and what should be funded.

While the focus on injecting drug users is fundamental because of the link between injecting drug use and the transmission of HIV and hepatitis, the reality is that a range of behaviours and contextual issues are determinants for the spread of HIV — often a very different reality from the Global North. Governments, the public and donors need to be cognisant of the fact that if we are able to intervene early with drug users, we can prevent the transition to injecting with all the individual and societal harms that this modality brings.

## **Essential medicines**

We also need a rethink on other essential medicines under control, such as morphine; in many countries on the continent, essential medicines are unavailable to people who need it for palliative care and for treating pain, not because there are shortages but because such a drug is classified as an opioid along with heroin, and therefore banned.

The immensity of suffering and pain experienced by millions of people in late-stage cancer is not only horrific but totally unnecessary. Where is the scientific evidence behind this kind of decision-making? There is none.

The restrictions put on access to these medicines originate from the political choice to focus the international drug control framework on preventing misuse rather than to “promote the welfare of people”, which was the initial objective stated in the preamble of the 1961 Convention on Drugs.

It is time for a radical rethink of what we are currently practising, and for recrafting policies that are dated, discriminatory and exclusionary. These policies include national directives, but also include discriminatory by-laws that are drafted at the local municipal level.

Getting to where we need to requires evidence-based advocacy, activism and solidarity – important lessons learned from the journey with HIV about treatment access. It is this evidence-based advocacy role that we are committed to as we strive toward a truly progressive and humane approach to dealing with drug use, drug markets, and drug policy.

**The views expressed are those of the author and do not reflect the official policy or position of the Mail & Guardian.**



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