

## **HARM REDUCTION – THE RIGHT POLICY APPROACH FOR AFRICA?**

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### **ABSTRACT**

African policy makers find themselves confronted by a phenomenon of rising substance use particularly in urban areas. The knowledge base in terms of prevalence rates, medical consequences, patterns and cultures of consumption remains patchy. Responses are largely driven by imported models advocated by drug control agencies and development partners. There are two inherent flaws to this – first, many of the methods from treatment modalities to drug enforcement techniques were designed for completely different social and cultural scenarios. Secondly, the mode of operation is that of a ‘war on drugs’, where the problem is inherent to the drug itself. The consequences of such a policy can be even more devastating than the drug use itself. The harm reduction paradigm that takes drug use as a fact of modern life, but addresses its problems with regulative intervention provides a policy orientation that is more promising. Existing drug cultures – khat, kola, iboga – that originated and are unique to Africa should be understood within both traditional and quickly evolving modern contexts. A system of regulation should be advocated against vested professional and organizational interest.

**KEY WORDS:** Harm reduction, harm minimization, drug policy, Africa, drug conventions

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### **INTRODUCTION**

Far from being a marginal, export activity, drug use is becoming a fact of life for many African communities, and there is an urgent need for discussing what is to be done about it. This article argues that African drug experts in their policy deliberations have to make careful assessments of (i) the history and context of drug control legislation, (ii) cultures of drug consumption, and (iii) capacity and consequences. All these questions have to be asked against the backdrop of another discussion – what is the overarching objective of policy.

While the Single Convention seeks to prevent and combat this evil, the purpose of this and subsequent control instruments (the 1971 Convention on Psychotropic Drugs, and the 1988 Convention on Drug Trafficking) according to the International Narcotics Control Board is to “reduce harm” (INCB, 2003)

For any reader familiar with the ‘harm reduction’ debate this is a surprising, though little known observation. There is no doubt that given the tenor of INCB pronouncements on drug policy under the presidency of the Nigerian chemist Philip Emafo this was not to be mistaken as an endorsement of methadone

maintenance. But it opened up ground for a crucial reconciliation between the different wings in a polarised debate over the future of drug control. Before returning to this, however, it needs to be recognised that harm reduction itself has become a term that is politically contentious. The United Nations Office on Drugs and Crime (UNODC) secretary general, Antonio Costa, did regrettably concur with the view of the US emissary that ‘harm reduction’ was sending the wrong message, and ordered the term to be deleted from all UNODC documents.<sup>1</sup> During the Bush era harm reduction was largely written out of US drug treatment provision and research. The National Institute on Drug Abuse, an ostensibly scientific institute bound to the ideal of objectivity, refused to publish articles on harm reduction interventions. The previous chief of the United Nations Drug Control Programme (UNDCP – predecessor of UNODC), the Italian criminologist Pinot Arlacchi accused harm reduction advocates of acting as a Trojan horse for drug legalisation, and his successor has called drug policy reformers the “pro-drug lobby”. Much of this furore is not directed at the set of practices that are normally associated with harm reduction, but the underlying philosophical disposition of ‘living with drugs’ (Gossop, 2007). The tacit recognition that drug use has spiralled since 1961, that the problems of drug use are not properly addressed by drug control policies, and that there is a need for service provision for drug users to enhance their health and wellbeing without dissuading them from their drug use, is seen as an existential challenge to some drug control agencies. Yet, drug control should always be dictated by the needs of public health, not the interests of professional groups or ideological dictates. The call for policy to be evidence based has to be continuously reformulated, because it remains in most countries an aspiration at best.

In Africa too there is the danger of a policy formulated by rhetoric, ideology and fear. One

former chief of the Nigerian National Drug Law Enforcement Agency, Ibrahim Bamayi, would pepper his speeches with phrases like the ‘scourge of drugs’, ‘immorality’, and the ‘bane of the young’. Yet as he candidly admitted, his own knowledge of the subject was minimal. “I was not appointed to head the NDLEA because of my knowledge of drugs, but because of my leadership” he once said in a conversation with the author. These hopes were well rewarded, after the agency was overhauled, one third of its operatives sacked and professional standards much improved. Yet the approach taken was one of militarization, with roadblocks, attacks on villages with marijuana farms, and gruesome interrogation methods of suspects. The general had taken the ‘war on drugs’ literally and launched a crusade that earned him the accolade “the fear of Bamayi is the beginning of wisdom.”

The Nigerian experience raises the many problems of drug control in countries where experience is shallow, resources scarce and information patchy. Working at the hard end of drug law enforcement, agencies and policy makers are tempted to import solutions proffered by development partners. Yet in spite of regular lip service to adapting policies to local needs, some of the key players – the US Drug Enforcement Administration, the UNODC and European Commission – continue to subsume national particularity to universal drug control principles. Clichéd phrases, like not reinventing the wheel, are often used to justify this knowledge transfer, but they also ignore what one member of the Mini-Dublin group<sup>2</sup> in Lagos said in a candid moment during a meeting in 1999– “there is little that Europe or the Americans can celebrate when it comes to drug control.”

If there are indeed no models of how to successfully contain drug use at an acceptable cost, we can still draw some lessons: (i) that

1 Letter from Antonio Costa to Robert Charles, 11, November, 2005 [http://www.tdpf.org.uk/MediaNews\\_LatestNews\\_25\\_01\\_05.htm](http://www.tdpf.org.uk/MediaNews_LatestNews_25_01_05.htm)

2 In most drug producing and transit countries law enforcement agents and diplomatic staff from developed countries meet to exchange information in an informal setting known as the Mini Dublin Group

there are severe limitations of what policy can achieve in the containing and controlling of human behaviour, (ii) the need for clear policy objectives, and (iii) the urgency of well informed debate.

### ALCOHOL AND THE HISTORY AND CONTEXT OF DRUG CONTROL LEGISLATION

In that spirit, I would like to propose that the first thing that is required is a sense of origin of drug control in Africa. The point needs to be stressed that African governments inherited drug control legislation at independence from the former colonial administrations. These were designed either in the spirit of benign paternalism, or mere extensions of metropolitan legislation. Important for the discussion is therefore the regulation of Europe's favourite drug – alcohol.

From the 17<sup>th</sup> to the 19<sup>th</sup> century, alcohol like rum, gin, and brandy were important trade items in the Atlantic trading triangle. Yet while European merchants had been happy to ply Africans with hard liquor, and colonial administrators depended on revenue from alcohol and tobacco taxes, colonial policy became ever more disapproving (Akyeampong, 1997; Pan, 1975). Prohibitions on liquor sales to African subjects were introduced across the continent. Some of the best known examples are from white settler colonies in Southern and Eastern Africa where beer halls were located outside settlements to prevent social protest (Ambler 1990). The 1892 Brussels General Act, the outcome of the two year conference of European powers engaging in the process of carving up the African continent, provided the first instance of a drug control regime established by international agreement. The effect of these restrictions on the importation of alcohol was to stimulate African production, a case study in import substitution.

While the brewing of different beers and the fermentation of wines, particularly from the palm tree, is historically recorded as an ancient tradition, the technique of distilling was

established in the late 19<sup>th</sup> century. It quickly became an important cottage industry, particularly for urban women. The challenges that the relatively sudden availability of home distilled and relatively low priced liquors posed to the traditional assumptions about its proper use are well documented (Akyeampong, 1997). Social tensions along the lines of age and gender, key organising principles in African (and any) society, were subverted by the market. Many traditionalists who saw access to alcohol as a privilege of age rather than a prerogative of purchasing power regarded the availability of alcohol to young men as a grave offence to the proper order of things. In East Africa the alarm caused by alcohol was “a question of the age and gender of the drinker; and the absence or presence of particular categories of persons.... it was ‘joint drinking’ which challenged ideas of propriety” (Willis, 2002). There was equal concern over the role played by women, but this has once again been explained as stemming from the perceived financial independence of distillers, which was in essence no different from the financial independence of other market women.

With independence legislative arrangements were normalised, and brewers and distillers led the way in the industrial processing sector. But concerns over the commercialisation of alcohol remained, as had happened in earlier in Europe. The Ugandan informants interviewed by Willis, for instance, lament that people do not drink like they used to, that the alcohol is stronger and more widely available, and that people tend to misbehave.

Colonial authorities applied a system of multiple standards, where white settlers and merchants had free access to range of beverages deemed too dangerous for natives, who according to a British delegate at the Brussels conference ‘knew no moderation’ (Klein, 1999). However, the drug control legislation introduced from the 1930s onwards introduced blanket bans. Only opium and cocaine, two of the substances that were brought under control, were largely unknown in Africa. Legislation had little to do with local need, and everything to do with the obligations of

the metropolitan country to the League of Nations that had organised the drug control conventions. In successive conferences held at Geneva in 1920, 1925, 1928 and 1931, the restrictions on the production and distribution of these three plant-based substances grew ever tighter. While the League was blown apart by the Second World War it re-emerged in the shape of the United Nations in 1946. It is a little known fact that drug control was one of its immediate concerns, and an area where the organisation could play an influential part and align itself with the foreign policy outlook of its most powerful member, the USA. Drug control proved a rare instance of super power accord, and all three conventions enjoyed support from the General Assembly.

Though the US government supported eradication measures in countries as diverse as Jamaica, Belize, Mexico and Thailand at an early date, drug control was primarily a domestic and law enforcement issue until the 1990s. In the following decades, in the absence of state level rivalry, security agencies began identifying non-state actors as threats to national security (Andreas and Nadelman, 2007; Klein, 2008; Feiling, 2009). Throughout the 1990s the US Drug Enforcement Administration sharply accelerated its programme of building operational bases across the continent, to gather intelligence, pressurize African governments, and provide training and equipment to selected partner agencies. At a different level the European Commission, emerging as the largest single donor agency, included accession to the three UN drug conventions as an aid conditionality. To be eligible for development assistance countries had to introduce legislation that criminalised drug production and use even where these were part of a well established tradition. Given that most policy makers have little interest in and knowledge about drug policy, they find it easy to agree on some global principle that drugs are deleterious to the well being of the young, and have no clear understanding of the unintended consequence of a drug control programme. Across Africa the passage of drug control measures into national legislations has proceeded apace over the past

twenty years, accompanied by the passage of so called Drug Master Plans. In the Southern African Development Community, European development funds have prompted the drafting of a SADC Drug Protocol. The reasoning is that drug trafficking undermines governance by fostering corruption. This is only partially correct, as traffickers are only in the business because of the combined factors of powerful market demand and strict prohibitions. The Drug Master Plans that are drafted with assistance by the UNODC are rarely a planning instrument for national governments as most of the listed activities remain on paper only. They are at best aspirational statements, that are not owned by the governments in whose name they are published.

For the most part then, drug policies in Africa are a response to external pressure – by US and European government agencies, and by the appearance of drugs and traffickers from abroad. Yet the implications of drug control policy go well beyond the crack down on white powders flowing in from Latin America and the Far East.

### **TRADITIONS OF NON-ALCOHOLIC DRUG CONSUMPTION IN AFRICA**

According to the UNODC, traditional patterns of use should be exempt from prohibitionist interventions, provided that these are regulated by tradition and phased out for younger generations (UNDCP, 1997). What exactly constitutes ‘traditional’ drug use does remain contested, given the preponderance of an ideology based policy-making approach in this field. My second contention is therefore that recognition be given to evidence of traditional use, and particularly the scholarly work on historical and contemporary patterns of drug use. We can start by tracing the century old history of cannabis use in many parts of Eastern and Southern Africa, documented in the magisterial work by du Toit (1980). Though this scholarship suggests diffusion from India, there is no doubt that over several centuries the herb became accultur-

ated. Among many different population segments, including the Twa in Rwanda, cannabis use has become integrated and normalised. He further describes the use of cannabis by Zulu, Sotho and Swazi warriors to build up courage and suppress scruple, a tradition that is reportedly continued by soldiers across the continent today. There are further reports of medical application, for example during child-birth. It is reported that in many sub-groups cannabis use is seen as normal and adaptive behaviour.

What is more controversial is how cannabis use has been spreading over the past fifty years to areas where it was hitherto unknown, particularly in West Africa. More complex still is the question of how the use of cannabis and all other psychoactive substances have taken hold in the fast growing African cities. The proviso that 'traditional use' be acceptable is difficult to transfer to the entirely different environment of the modern city. Yet it is precisely in the urban context that drug use is taking off in Africa, as it is in other regions, and has of course in European history.

Urbanisation has been proceeding at break-neck speed across the continent. A majority of people are now living in cities lacking in many basic services, including the rarely considered need for entertainment and the building of community, two areas where substance use comes to the fore. The need for leisure and pleasure where people can relax, and where the community of strangers can mix across ethnic boundaries and social distinctions, is well served by the provision of locally produced vegetable based drug products of moderate potency (Klein and Beckerleg, 2007).

Given their international treaty obligations, African government may have to tread softly when licensing cannabis cafes similar to the coffee shops found in the Netherlands, or the Medical Marijuana cooperatives of California, though both provide a model worth exploring. Less contentious but equally challenging is the regulation of drugs that are culturally embedded in particular regions where they are rarely recognised as drugs, but are spreading to new areas. There are three of these cultural complexes of significance in Africa.

### (i) The khat belt

Historically khat consumption was confined to the areas of khat production, because of the instability of the psychoactive alkaloids contained in the leaves of the shrub. These leaves are harvested, collected into bundles some 200-300 grams in weight, and chewed in regular chewing sessions held in private houses, or increasingly in mafrishes<sup>3</sup> or khat cafes. Until the introduction of road, rail and air transport, which have facilitated the emergence of khat as a global commodity, its use was confined to parts of Ethiopia, the Meru mountains of Kenya and the highlands of northern Somalia (Klein, 2009). Historical sources report a well regulated pattern of consumption in urban areas like Harar (Anderson et al., 2007), and the integration of khat chewing into the rhythm of life in rural areas (Gebissa, 2004). Khat is best described as a stimulant that has little impact on the well being of the chewer when used in moderation. And yet, there is growing concern in Ethiopia and Kenya over the spread of khat to areas where it was hitherto unknown and to new groups of users like students. Even more contentious is the spread of khat use to countries inside and outside Africa where there is no history of consumption at all. Some, like Uganda, are deliberating over the pros and cons of this phenomenon, while others like Rwanda and Tanzania have taken a prohibitionist approach.

### (ii) Kola nut

This caffeine containing nut is chewed with enthusiasm in Burkina Faso, Ghana, Niger, Nigeria, and Mali, where it provides for the vertical integration of forest and savannah (Lovejoy, 1985). At the risk of generalisation, one can record a marked difference in the pattern of consumption that has emerged between these two ecological regions. While southern consumers integrate kola in rituals of hospitality as a religious offering, or in a more profane context, combine it with alcohol

3 From the Arabic; as Beckerleg notes, Yemenis are often pioneers in the introduction of khat to new areas.

when socialising, northern kola chewers display more extensive patterns of use. Northern Nigeria and Ghana are predominantly Muslim, and most people abstain from alcohol, leaving kola as “one of the few stimulants permitted by the Koran” (Abaka, 2005). The long term consequences of heavy kola use are particularly evident in poor oral health, but also in symptoms of self neglect, the prioritisation of kola use over other activities, and the central importance that kola use has in the lives of regular chewers. These are all symptoms of addiction listed by the International Classification of Diseases (ICD-10), yet the only country that has recognised the risk of immoderate kola use is Saudi Arabia where it is classified as a controlled drug. For the time being African governments are more concerned about the missed opportunity of turning kola into an export commodity, but the implications of heavy use and the extensification of use will require a response in the future.

### (iii) **Iboga**

The only recorded instance of the use of heavy hallucinogens in Africa is the Bwiti cult found in Cameroon and Congo Brazzaville. This most powerful of substances is gained from root bark shaved off the iboga tree, used for visionary purpose. Members of the cult ingest varying dosages of the bark before embarking on a spiritual journey that takes place over several days. Accompanied by attendants from the cult, they engage in different ritual tasks all designed to help with the processing and interpretation of the powerful visionary and auditory hallucinations brought about by the psychoactive ibogaine. Strong doses are taken only on occasion by most adepts of the cult, and involve a painful ordeal of stomach cramps, vomiting, and the loss of physical control. There are regular cases of overdoses when administered inexpertly (Fernandez, 1982). The Bwiti cult strongly disapproves of iboga consumption outside the context of ritual, and there is little information about ‘recreational’ use. Given the strong physical reaction to iboga – fevers, sweating, and intense vomiting – it is an un-

likely candidate for extensive use. In recent years Ibogaine has been promoted as a treatment for drug and alcohol addiction. (Brackenbridge, 2010)

One of the regular refrains in the drug policy field is that there is not enough information for policy makers to move forward. This needs to be contested, as information abounds, but policy makers are either unaware, or reluctant to take note of politically controversial findings. When it comes to African drugs, information exists for the discussion to commence, but we need to update the picture on trends and developments. Critically, African drugs tend to stay off the radar as long as they remain confined to the continent, but once drug and drug habit are exported to Europe and North America they become a policy issue, as in the case of khat (Klein, 2009). Then decisions on the classification of substances with origin and distribution in Africa are taken to an international level, in fora where African policy makers and experts have little influence. A parallel example would be the classification of the coca leaf in the 1961 drug convention. Coca leaves are widely chewed across the Andes and have been part of a culture of consumption reaching back well before the pre-Columbian era. Yet the decision to class coca as a drug and agree on the elimination of use and the eradication of production was reached without consultation of farmers, users and traders, contributing to social unrest and instability that has plagued Bolivia, Peru and Colombia for the past thirty years (TNI, 2003). There is an urgent need for a good understanding of drugs and drug use in Africa to provide the background for policy discussion. This starts with the awareness that these drugs form a part of the cultural fabric of different societies, that there are spiritual as well as recreational uses, and that the cultural context in which drug use has already been normalised is dynamic and adaptable. The multiple questions of what drugs are about, who uses them, what should be the distinction of problematic and non problematic use, need to be given pride of place in drug control discussions.

## CAPACITY AND CONSEQUENCES

In terms of drug control one question that is never explored is what governments are actually capable of achieving. There is little point in passing legislation impossible to enforce or policies that cannot be implemented, as this only serves to bring the government into disrepute. The capacity of many African states is stretched already. Adding new responsibilities such as eradication domestic cannabis production without a thorough assessment of resources and capacities runs the risk of being counterproductive.

It is important to be very clear about the risk of unintended consequence in the drugs control field where the state moves to proscribe and prohibit certain forms of behaviour engaged in by sections of its own citizens. These are patterns of behaviour that are consensual and do not involve third parties. When the state interferes it has to work on the Hippocratic principle of first of all, doing no harm. It is arguable that a drug user stands to suffer far greater harm from arrest, interrogation, imprisonment and a criminal record than he or she would have from the use of the drug. A further consideration has to be that “one of the most pernicious and often forgotten side effects of prohibition is corruption. Illegal vice and police graft are two sides of the same coin” (Legget, 2002). Drug control legislation in societies where there is continuous demand for drugs has the potential to corrode the entire criminal justice system. At the street level patrolling police officers can hold up drug users and extort bribes; they can plant drugs on people for the same purpose as reported from Nigeria (Klein, 1999). At higher levels, senior officers can shield drug traffickers or even become involved in the trade itself. Bribes, often accompanied by violent threats, sway judges and prison officers. And the realisation of these practices quickly spreads, undermining the legitimacy of the government and the stability of the regime.

Corruption is dogging drug enforcement the world over, as the UNODC recognise International drug control has produced several unintended consequences, the most formidable of

which is the creation of a lucrative black market for controlled substances, and the violence and corruption it generates.” But the corrosion of governance hits particularly hard where remuneration of law enforcement is low, supervision poor, and the capacity for internal reform is limited. By institutionalising rogue behaviour among front line officers, an unenforceable drug control law turns its objective of promoting law and order on its head. Once links between organised crime and senior officers have been made, a dangerous momentum is put into play that makes reform difficult and costly.

## HARM REDUCTION AS THE OVERRIDING POLICY PRINCIPLE

Most areas of life are ridden by the tensions between general principles, formulated with reference to universal rights and absolute values, and their application in the realm of practice. Nowhere is this more clearly in evidence than in the field of drug policy, where a system of restrictions, controls and punishments has been set up by international agreement to prevent the production, distribution and consumption of certain substances unless specifically authorized by government authority for medical or research purposes. Behind these prohibitions lie the best of intentions as laid out in the preamble to the 1961 UN Single Convention on drugs.<sup>4</sup> The treaty is “Concerned with the health and welfare of mankind” about the dangers of addiction to narcotic drugs and therefore imposes control on their availability as part of the signatories’ “duty to prevent and combat this evil.” Since it came into force nearly half a century ago, over 140 countries have acceded to the treaty and brought tough drug control legisla-

4 The Single Act was an amalgamation of several drug control treaties that had been developed under the auspices of the League of Nations during the 1920s and 30s. We can trace these drug control efforts back to the first international meeting at Shanghai in 1909.

tion onto their statute books. Yet the dispiriting reality is that in spite of these efforts drug use, far from becoming controlled has been expanding radically.<sup>5</sup>

Over ten years ago the UNDCP<sup>6</sup> published a study on drugs in Africa, where the continent was referred to as drug control's 'last frontier'. Following in the geographic determination of that report, this article will address Sub-Saharan Africa, leaving the discussion of North Africa for another time. Since then, successive World Drug Reports have reported that the use of illicit substances has been rising sharply in many African countries, at the very time as trends were stabilising in Europe and falling in the US. For many policy makers these reports came as wake up call, as they had regarded drug use as a symptom of developed country decadence from which Africa, for all its poverty, remained immune. One group of members of the Nigerian National Assembly, freshly convened after the return to civilian government in 1999, told the author that the trafficking syndicates making use of Nigerian airports to ship cocaine and heroin into Europe were no major concern of theirs. If Europeans wanted to import these substances and kill themselves let that be their problem, why should Nigeria invest precious resources to control this traffic. Such a disconnect from trends in the population is sadly reminiscent of the failure by African health researchers and epidemiologists to register the spread of HIV/AIDS during the 1980s. In this case too, cultural preconceptions overrode scientific evidence, as observed by James Chin, who ran a modelling seminar in Swaziland with leading African experts at a time when many participants rejected the pos-

sibility of an impending crisis, because AIDS was a western disease of homosexual and drug addicts (Chin 2007).

Considering the three salient features of drug use in Africa, (i) the history and context of drug control legislation, (ii) existing cultures of drug consumption, and (iii) the capacities of government institutions shaping drug control legislation's consequences for these institutions, harm reduction should be the overarching policy principle for African drug policy. It is based on the recognition that drugs play a part in most societies and that there are definite problems associated with certain patterns of use. The objective of policy is to use the various instruments at its disposal to reduce the risk of suffering harm to its citizens. Curtailing the influx of dangerous substances is as much a part of that as treatment for those whose pattern of use has slipped out of control. Whatever the policy mix, it has to be governed by the ideal of reducing risk and harm to the largest number of people.

The practices that are bundled together under the label 'harm reduction' and used in many different countries are not necessarily all applicable to African countries. The prevalence of injecting needle use reported in the last, continent wide Rapid Assessment Study by the UNDCP (UNDCP, 1998) was low. Since then, there have been dramatic changes in drug use behaviour. It seems that African countries, led by Mauritius are fast catching up with other parts of the world (Abdool et al., 2006). In addition, there is a high risk of hospital based infections, as exposure to small volumes of blood on unsterile instruments reused for invasive medical procedures is common, and critically understudied. Indeed, "Many AIDS prevention programs in Africa have set aside injection risks in their communications with the public, perceiving IDU as uncommon.... Africa's growing population of IDU are, in some communities, largely unaware that sharing needles carries a risk of transmitting HIV" (Reid, 2009).

Much of harm reduction is concerned with reducing the risks of needle injecting of which only sporadic incidence is reported from

5 Indeed in countries like the UK, where data on drug related deaths has been collected since the founding of the National Registrar in 1837 (Berridge and Griffiths, 1987), the tally has moved from a few hundred, to 3,301 in 2005 (Corkery, 2008). Different definitions on 'drug related death' compete – the figure cited was compiled by the Office for National Statistics

6 The United Nations Drug Control Programme changed its name to United Nations Office on Drugs and Crime in 2004.

Africa so far (Beckerleg, 1995; Deveau et al., 2006, Needle et al., 1996). On the other hand, we have good information on the risks run by governments that reject harm reduction for ideological reasons. Russia has refused to consider needle exchange programs or methadone maintenance, and now has a population of over 1 million people living with HIV or AIDS. The main vector for infection is the sharing or injection equipment, often inside the prison system. Predictably, infection rates have crossed over into the non-drug using population via sexual intercourse. There are early indications that this pattern of infection is about to repeat itself in Africa (Reid, 2009).

The warning signs are clear for all governments: intervention in human behaviour comes at a high price, and the consequences can be devastating. They impact the health of the people and the integrity of affected institutions. Many of the international agencies specialising in drug control point out these risks. Drug prohibitions push users into adopting more dangerous practices – stronger drugs replace moderate drugs, consumption moves to riskier settings where social controls are weak, and more dangerous modes of administration (smoking crack as opposed to snorting cocaine; injecting heroin as opposed to smoking or eating opium) are adopted. Yet these outcomes are not factored into control systems. Most importantly, the corruption of agencies involved in drug control, though well known and found in countries across the globe, is simply ignored by agencies like the International Narcotic Control Board.

Fortunately there is a rising body of knowledge not only about drugs and drug use, but also about drug policy and its impact. We have a better understanding of the efficacy of the drug programmes employed in different countries and can learn from over thirty years of waging a war on drugs. With the head of the US Office of National Drug Policy redirecting drug policy from war towards treatment, and with the directive by the Obama administration that the closure of Medical Marijuana centres is no longer a priority for law enforcement, we see a shift in approach among one of

the world's leading advocates of drug control. How this will play out in the mid term remains to be seen given the vested interests in the status quo. For Africa, the situation is at a different point.

Much of the international attention focuses on African countries as transit route for cocaine and heroin. This is neither new (Klein 1994), nor is it of major significance for drug markets in either Africa or importing countries. However alarming the shipment of cocaine via Guinea Bissau may appear to some commentators, closing down this route will not impact dramatically on European cocaine markets. There are simply too many alternative routes, and a host of amphetamine producers on stand by to fill in any temporary shortage. While the efforts by UNODC to support governance in West Africa are well intended they obscure the origin of the problem. African countries are victims of the 'sausage effect', where the closure of one trafficking route simply re-opens another. In this case, cocaine exporting cartels have relocated from the Caribbean to West Africa, with a raft of consequences for local law enforcement and property prices (UNODC, 2009).

What should be more important for African countries in the long term is finding a framework for the regulation of all psychoactive substances. This should take account of traditional substances like kola nut, khat, iboga, cannabis, and alcohol, as well as tobacco, prescription medicines and the new substances like cocaine and heroin. It may well be possible to enforce prohibitions on the latter as long as markets are tiny and the product is imported. But when it comes to plant based substances that are locally grown and sold, policy has to be governed by realism – what can be achieved. We therefore suggest that the idea of harm reduction become the overarching policy principle, with the clearly stated aim to contain the harm caused by all psychoactive drugs. Given the failure of the war on drugs in many other parts of the world, the risks of inappropriate interventions to the fabric of government, and the danger of unintended consequences, this seems to be the most promising foundation for African drug policy in the 2010s.

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