Prohibitionist Drug Policy in South Africa— Reasons and Effects

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Abstract

The moral approach that has been used to interpret and implement the *Single Convention on Narcotic Drugs* exacerbates the health burden faced by people who use drugs. Drawing on our experience in research, programming and policy relating to drug use and health in South Africa, we illustrate the negative consequences prohibition has had for the health of people who use drugs in our country. We argue that South Africa illustrates how approaches that stigmatise people who use drugs are morally justified at the expense of human rights and public health outcomes. We highlight how South Africa is perpetuating prohibitionist approaches on international platforms and question why this has endured. Conflicting health and law enforcement policies, local conservatism and donor conditionality have thwarted harm reduction expansion and evidence-based drug policy development, resulting in notable harms. Persistent morally-based perspectives contribute to stigma and discrimination in healthcare facilities and negatively affect treatment-seeking by people who use drugs. Criminal justice responses have increased TB exposure and entry into correctional centres that do not offer evidence-based drug treatment services. Encouragingly, progressive health and HIV policy affecting people who use drugs has recently been developed, and the recent decriminalisation of cannabis opens a door for policy debate. We recommend that to improve health, the *Single Convention on Narcotic Drugs* should be challenged to prioritise rights and health and that the personal use of drugs be decriminalised. We also highlight the need for mechanisms to hold health and other actors accountable for ensuring that the health and rights of all people are prioritised and strengthened.

1 Introduction

It was early evening when Taariq, aged 30, arrived at the emergency room of a public hospital in Cape Town, South Africa. He had recently transitioned from smoking to injecting heroin. Due to inexperience, had missed the vein, and injected into the surrounding area. His arm was swollen and

painful, and he was scared. He revealed his drug use and explained what had happened to the healthcare worker, who said he would have to wait to see the doctor. Through the night he was kept waiting, watching staff assist people who arrived long after him. The doctor, who eventually saw him the next morning, opened with a volley of assault, 'There are other people out there with real sicknesses, and now I must sit here with you?' The doctor did not touch him, barely looked at his swollen arm, prescribed antibiotics and said, 'If your arm turns blue, come back. We will have to look at amputation.' Taariq was sent away, fearful of engaging with the healthcare system again.

People who use drugs face a range of health risks, including those directly related to their substance use, as well as the social and structural risks related to the use of illegal substances. The majority of countries in the world, including South Africa, criminalise the non-medical use of scheduled drugs (Csete et al., 2016). Our starting point is that, internationally and locally, prohibitionist policy is deeply rooted in the moral and political past. The United States (US) and selected Western European countries, and more recently the Russian Federation and China (IDPC, 2018b), have imposed their moral, political and prohibitionist agendas on sovereign nations (Alexander, 2008; Hari, 2015). Like many less powerful countries, South Africa has been drawn into, and continues to enact, these policies under the guise that they are for the international good, despite well-documented and significant harms (Csete et al., 2016; IDPC, 2018a). Even given recent moves in the country to decriminalise personal cannabis use (Parry et al., 2019), there are unlikely to be significant changes in drug legislation in the foreseeable future. However, as the opening vignette and the rest of this chapter show, prohibition-oriented policy has significant health and well-being ramifications in South Africa.

We begin by summarising the international public health consequences of prohibitionist policy, following this by a description of the socio-demographic, health and policy context in South Africa, as well as a historical perspective on local drug policy. We then turn to examining how these local policy dynamics were developed in South Africa in the context of international frameworks, before examining what the local ramifications of prohibitionist policies and approaches are. Finally, we note positive changes, towards more rights-centred approaches, that have recently taken place, before concluding with our vision for a better approach to drug policy and practice in South Africa.

In our approach, we include a focus on harm reduction, and the particular issues affecting people who inject drugs. We focus on this group of people because they are highly marginalised and at particular risk with regard to the

health and social consequences of drug policy and its implementation. A further reason for the focus on people who inject drugs is particularly relevant to this chapter: despite the predominance of smoking drugs and a historical absence of widespread injecting drug use, foreign donor funds have focused only on people who inject drugs as part of HIV prevention programming.

We draw on our reflections, discussions, reading and experience as researchers and practitioners in the realms of health and substance use in South Africa. Our collective experience reflects more than 30 years of involvement in HIV prevention and harm reduction, community-based quantitative research among people who use drugs, anthropological research on substance use, evidence-based substance use services and engagement around drug policy processes. Although we bring a wealth of experience to this chapter, we acknowledge that there are likely to be other perspectives and nuances linking the health of people who use drugs and drug policy, which we have not included. Furthermore, the political agenda, processes and actors that drive drug policy are not always clear (Gstrein, 2018). Nonetheless, we suggest that this chapter contributes to a global understanding of how and why standing drug policies continue to dominate, despite the failures and harms they have caused. This contribution to the literature also provides a concrete example of the health consequences that prohibitionist policies have had and continue to have in South Africa.

2 Prohibition and (Ill) Health

Overdose, hepatitis C, HIV and extrajudicial killings and torture illustrate some of the public health consequences of prohibitionist approaches. The largest public health impacts of overdose and infectious diseases are seen in the US, China and Russia, collectively home to 45 per cent of people who inject drugs (UNAIDS, 2019). In 2017, 70,237 people died from drug-related causes—mostly opioid-related overdoses—in the US (UNODC, 2019c). Approximately 1.4 million people who inject drugs in China live with hepatitis C (Liu et al., 2019; UNODC, 2019c). In Russia, 336,542 people who inject drugs are living with HIV, and HIV incidence is increasing (UNAIDS, 2019; UNODC, 2019c). Over the past decade, more than 4,000 people have been executed globally for drug offences (Girelli, 2019). In the Philippines, there have been more than 27,000 extrajudicial killings since President Duterte came to power (IDPC, 2018a). High levels of torture, disappearances, forced treatment and rights violations linked to the drug trade are reported in low- and middle-income settings (IDPC, 2018a).

Prohibition precludes the safe supply of drugs, contributing to poisoning and death (IDPC, 2018a; Karamouzian et al., 2018; CTV News, 2019). Criminalisation

results in clandestine use in hostile environments (Belackova and Salmon, 2017) and unintended injury (Kaushik et al., 2011; Hartogsohn, 2017). Prohibition limits access to evidence-based health services. Less than 1 per cent of people who inject drugs globally have access to sufficient and required levels of needle and syringe programmes and opioid substitution therapy services (Csete et al., 2016; UNODC et al., 2017; WHO, 2018; International AIDS Society, 2019; UNAIDS, 2019). Even fewer people who use drugs have access to overdose prevention and management services (Harm Reduction International, 2018). Current drug policy also contributes to inequitable distribution of and access to opioids for pain relief—less than 0.5 per cent of morphine-equivalent opioids are distributed to low-income countries (Knaul et al., 2018).

As a result of the criminalisation of drug use, many people come into contact with law enforcement and are incarcerated (Dolan et al., 2016). Medications for the management of withdrawal or replacement therapy while in police custody are seldom available (UNODC, 2019b). People in prison who use drugs, particularly in low- and middle-income settings, face a significant risk of contracting TB and other infectious diseases (Dolan et al., 2016). Outside of high-income settings, most prisons have poor living conditions and violence is common, increasing the risk of trauma and mental illness (Baranyi et al., 2019). Few prison services provide the recommended package of evidence-based health services for people who use drugs or the appropriate mental health services (UNODC et al., 2013; Fazel et al., 2016). Incarceration has profound adverse effects on the physical health of people and their dependents (Wildeman and Wang, 2017). Post-release, unemployment is inevitable, and there are high risks of recidivism and associated consequences (Baranyi et al., 2019).

People of colour, women and the poor are at greater risk of experiencing the harmful consequences of drug use in the context of prohibition (Taylor et al., 2016; Mitchell and Caudy, 2017; Muehlmann, 2018). This is highlighted in the US, where the levels of incarceration (Carson, 2018), likelihood of arrest for a drug-related offence (Carson, 2016), and likelihood of receiving a higher sentence (Rehavi and Starr, 2014) are significantly higher among African American males than among their white counterparts. The racial disparity in policing the war on drugs has also been well documented in the United Kingdom (Eastwood et al., 2013).

3 Responding to Drug Use

The dominant models of 'treatment' for people who use drugs in the US are abstinence-based and focus on 12-step facilitation as the primary intervention

(Fletcher, 2013). Belief in the all-or-nothing approach has caused great harm to some people (Moos, 2005), and can prolong drug dependence (Miller, 2008). Medical explanations of addiction have recently challenged the moral explanation for dependent drug use (Leshner, 1997). The 'brain disease' theory, promoted by the United States National Institute on Drug Abuse, supports the need for medically assisted therapy, but pays little attention to contextual and other factors that contribute to drug use and its effects (Hammer et al., 2013). As an alternative to abstinence and incarceration, harm reduction provides a less rigid response to problematic drug use. This public health-inspired approach focuses on concerns and interventions at community and individual levels, rather than on the causes of drug use and ways to stop it. It aims to maximise health through beneficent, equitable and fair means while limiting harm. It is also pragmatic, involves precise planning to meet clearly defined goals, and includes the evaluation of outcomes (Single, 1995; Pauly, 2008).

4 South Africa

In 1994, after almost 50 years of apartheid rule, and hundreds of years of colonialism, both of which sought to maximise the power and opportunities of the white minority population, South Africa became a democracy. The transition to democracy was marked by the development of one of the world's most progressive constitutions. In contrast to the regime that preceded it, the constitution prioritises human rights and dignity for all and puts extensive protections in place for citizens (Cock, 2003). It emphasises that all people have the right to freedom from discrimination based on 'race, gender, sex, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language or birth, amongst others' and guarantees the right to equality, dignity, life and access to healthcare services (South African Government, 1996). State institutions and ministries were tasked with improving the lives of the previously disadvantaged population in a context of widespread poverty, a stagnated economy, and infrastructure (including the health system) designed for a minority of the population. Needing new systems and funding, the government turned to international and donor bodies, institutions, and frameworks to structure local policy (Coovadia et al., 2009). The newly designed health policies drew directly on World Health Organization (WHO) recommendations, except for the response to HIV, which became a contested area in the years of President Mbeki (Fassin, 2007).

Currently, South Africa's population stands at 59 million (2019), 51 per cent of whom are female, while 80 per cent are black African and Christian

(Schoeman, 2017; Statistics South Africa, 2019a). Despite efforts to mitigate the effects of colonialism and apartheid, they continue to shape society. Though South Africa is considered an upper-middle-income country, with a gross domestic product of USD 368 billion, it has one of the highest levels of socio-economic inequality in the world: half the population lives in poverty and a third of adults are unemployed (Statistics South Africa, 2019b; World Bank, 2019). Massive disparities in socio-economic status continue to play out along racial lines. Many people face considerable challenges in exercising their constitutional rights and—as we show in what follows—the context with regard to inequality has a significant impact on health outcomes (Ataguba, Akazili and McIntyre, 2011).

4.1 *Health Context*

South Africa has more people living with HIV (7.9 million) than any other nation, with the highest proportion of new infections among young, black women aged 15 to 25 (Human Sciences Research Council, 2018). It also has one of the world's highest TB incidence rates, with 301,000 active cases in 2018 (WHO, 2019).

Non-communicable diseases account for half of all deaths (260,000 annually). A third of South Africans will develop a mental illness in their lifetime (Herman et al., 2009). Violence is ubiquitous: 40 per cent of children are exposed to or have been victims of violence, a quarter of women have been raped, and the homicide rate is 33 per 100,000 people (Day, Gray and Ndlovu, 2018). In 2018, South Africa's score for Universal Health Care coverage¹ was 66 (of a maximum of 100) (Day, Gray and Ndlovu, 2018) in comparison with a global average of 65 (range 22–86) (Hogan et al., 2018).

4.2 *The South African Health System and Financing*

The South African health system is sharply divided between a highly sophisticated private healthcare system, supported by the extensive use of private medical insurance (covering less than a quarter of the population), and a public healthcare system that provides care and treatment (including HIV and TB treatment) free of charge or on an income-based scale to the majority of the population (Health Policy Project, 2016). In addition to public facilities, the Department of Correctional Services has primary health facilities and programmes for HIV, TB, sexually transmitted infections (STIs) and primary health

1 Score based on 16 indicators, four each for reproductive, maternal, newborn and child health; infectious diseases; non-communicable diseases; and service capacity and access.

conditions (Department of Correctional Services, 2018). Overall, public health resources largely remain distributed along previous apartheid-informed lines, with previously advantaged historically white areas, which are often physically and practically inaccessible to the economically excluded black majority, hosting the most comprehensive, quality services (Harris et al., 2011; Coovadia et al., 2009). A substantial portion of healthcare, particularly for marginalised populations and as part of the HIV response, is now provided by civil society organisations (South African National AIDS Council, 2017).

Health expenditure in South Africa comes from three primary sources. The government finances approximately half of all expenditure (in 2017/18 this was approximately USD 12.8 billion). In the 2017 Medium Term Budget Policy Statement, USD 0.3 billion was allocated to National Health Insurance over three years to establish a national health insurance fund and to enhance health technology assessment capacity, with additional investments planned (Day, Gray and Ndlovu, 2018). Donor investments account for a small proportion (2.4 per cent) of overall health spending, and the remaining financing is from the private sector (Day, Gray and Ndlovu, 2018). In 2016/17, approximately half of the government's total health budget was allocated to the HIV/TB response, and 5 per cent to mental health (Docrat et al., 2019), of which services for people who use drugs form a small part.

After the Government of South Africa, the US President's Emergency Plan for AIDS Relief (PEPFAR) has been the largest investor in the HIV/TB response (over USD 5.6 billion since 2004), accounting for a quarter of costs (United States Embassy and Consulates, 2017), followed by the Global Fund to Fight AIDS, TB and Malaria (Global Fund). Apart from a project in the city of Tshwane, no other harm reduction services are funded by the South African Government (Scheibe et al., 2018). Between 2016 and 2019, South Africa's Global Fund programme for HIV prevention allocated 1 per cent of its budget to people who inject drugs (Global Fund, 2015). PEPFAR and the Global Fund have projects for people who inject drugs that will run until September 2021 and March 2022, respectively. As a middle-income country, South Africa's support from PEPFAR and the Global Fund, if it continues, is likely to be significantly reduced. As others have pointed out, like international drug policy, these stakeholders are important external forces shaping how South Africa responds to drug use (Hearn, 2000).

4.3 *Drug Use*

The number of people who use drugs in South Africa is unknown, which is inherent in a system where the illegality of drugs precludes accurate assessment (Larney et al., 2017). The substances most used in South Africa include

cannabis, methaqualone, methamphetamine, and heroin (Dada et al., 2018). It is estimated that over 75,000 people inject drugs (Setswe et al., 2015; Haysom, 2019), but the most common way to consume drugs in South Africa is through inhalation. Cannabis most likely came to the region from Asia via Arab traders and has been cultivated and used for centuries (Du Toit, 1975). Methaqualone was introduced as a sleeping tablet and was made illegal in 1977 after it became widely used outside medical contexts (Standing, 2006). Post-apartheid investigations revealed that methaqualone was being used in covert experiments related to crowd control (Gould and Folb, 2002). Methamphetamine use, previously uncommon, increased at the turn of the millennium, as more relaxed border controls increased availability either through direct imports or imports of precursor substances (Standing 2006). Heroin has been available since the 1980s, but limited international trade and apartheid policies that discouraged black Africans from seeking employment in South Africa allowed for tighter border controls and fewer transnational syndicates, reducing supply, keeping prices high, and limiting use to a small portion of the (largely white) population (Haysom, 2019). Since the 1990s, the heroin trade routes from Afghanistan have shifted down the East Coast of Africa, resulting in increased availability and a threefold reduction in the price of heroin (Haysom, Gastrow and Shaw, 2018). Locally, heroin² of varying quality is often smoked with cannabis or nicotine.

4.4 *The Burden of Disease among People Who Use Drugs*

Emerging data point to a notable burden of infectious diseases, deaths, and mental illness among people who use drugs, as well as health issues of particular importance for youth, women, and incarcerated people who use drugs. HIV prevalence among people who inject drugs is estimated at 21 per cent (Scheibe et al., 2016; University of California San Francisco, Anova Health Institute and National Institute for Communicable Diseases, 2018; Scheibe, Young, Moses, et al., 2019), and hepatitis C at 55 percent (UCSF and Anova Health Institute and National Institute for Communicable Diseases, 2018; Scheibe, Young, Moses, et al., 2019). Local data has highlighted that without appropriate and acceptable services, people living with HIV who use substances experience challenges in adhering to antiretroviral treatment, and, due to anxiety and depression, are less likely to report psychological distress (Kader et al., 2015). There are no accurate estimates for TB, but people who use drugs are defined as a population at increased risk (South African National AIDS Council, 2017).

2 Several local names are used to describe heroin, specifically Unga (Swahili for *n*: flour; *v*: to sprinkle) and the derivative Whoonga, and Nyaope (Swahili for 'be afraid').

Furthermore, the burden of infective endocarditis among people who inject drugs is increasingly being documented (Meel and Essop, 2018; De Villiers et al., 2019). The burden of disease among people who use drugs who are in prison settings has not been quantified (Dos Santos et al., 2014; Booyens and Bezuidenhout, 2015; Luyt and Moshoeu, 2017).

Data on drug-related deaths are limited by the large number of medical–legal autopsies that should be carried out (ca 70,000 per annum) in the context of limited forensic pathology and toxicology services (Du Tooit-Prinsloo and Saayman, 2012). Under-reporting is likely another factor. For example, the 2019 World Drug Report shows that the latest reported mortality data from South Africa is from 2012, and is limited to the city of Pretoria: 10 drug-related deaths, with opioids ranking as the most common cause (UNODC, 2019c). Between 2016 and 2019, at least 13 people who inject drugs who accessed harm reduction services in two South African cities died as a result of overdose.³ None of these deaths, however, were captured and reported in the country's formal surveillance system. Moreover, people who use drugs often die prematurely from other causes, often linked to lack of access to appropriate services (Shelly et al., 2017).

Moral reflections on drug use are associated with self-stigmatisation and poor self-esteem among people who use drugs, which further contribute to mental illness (Luoma et al., 2007). People who use drugs in South Africa report persistent and extensive human rights violations. Between July 2015 and May 2019, 1,105 rights violations were reported by 403 people across three cities as part of the human rights reporting system implemented by TB HIV Care—54 per cent (598) due to the confiscation or destruction of sterile injecting equipment by law enforcement officers,³ resulting in significant trauma.

The high prevalence of childhood adversity among South African youth increases the likelihood of developing substance use problems and mental illness, as well as HIV infection (Jewkes et al., 2010). Recent research has identified high levels of violence and trauma among women who use drugs (UNODC, 2019a). The prevalence of HIV and TB among incarcerated adult males is notably higher than among males in the general population (2 percent versus <0.5 per cent and 23 per cent versus 15 per cent, respectively), with higher levels probable among incarcerated people who use drugs (South African National AIDS Council, 2017; Human Sciences Research Council, 2018).

3 Personal communication with Zara von Homeyer, monitoring and evaluation coordinator for TB HIV Care's projects for people who use drugs, on 11 October 2019, Durban, South Africa.

4.5 *South Africa's Post-apartheid Legislative and Policy Frameworks*

The post-apartheid government inherited policies influenced by international drug policy frameworks. South Africa was (and remains) a signatory to the *Single Convention on Narcotic Drugs* (UN, 1961). The maintenance of these prohibitionist perspectives is evident in subsequent legal documents, including the Drugs and Drug Trafficking Act 140 (1992) (Gray, 2019), which draws overtly on the *Single Convention* in that it aims 'To provide for the prohibition of the use or possession of, or the dealing in, drugs and of certain acts relating to the manufacture or supply of certain substances or the acquisition or conversion of the proceeds of certain crimes [...]'. This conservatism has continued in subsequent policies such as the Prevention and Treatment of Drug Dependency Act (Act 70 of 2008), which describes the national response to the use of internationally scheduled drugs.

This overarching conservatism and attachment to a punitive approach continues within a fragmented government environment in relation to drugs. The development and implementation of local drug policy frameworks is the responsibility of the national Department of Social Development. This Department houses the Central Drug Authority, the institution tasked with issuing a guiding policy document—the National Drug Master Plan—approximately every five years.

The first National Drug Master Plan (1999) aimed to address 'health risks and other damages associated with drug misuse, including the spread of communicable diseases, related injuries and premature death'. Despite the stated desire to minimise harm and promote human rights, there was no explicit focus on harm reduction, and the plan primarily supported supply reduction and a criminal justice response to drugs, as well as prevention strategies focused on treatment and rehabilitation (Geyer and Lombard, 2014). With each subsequent version, there has been increasing emphasis on punishment or the need to 'rehabilitate' people who use drugs. The most recent National Drug Master Plan (2019–24), however, illustrates a partial shift towards harm reduction through its five key principles: human rights, scientific evidence, 'inter-sectionality', person-centred approaches, and the inclusion of people who use drugs.⁴ While the latest National Drug Master Plan was accepted by parliament on 1 November 2019, it was publicly released on the 26th of June 2020.

4 Information obtained from a presentation by the Central Drug Authority during a meeting held in Tshwane on 11 February 2020. Further confirmed by an advance copy of the National Drug Master Plan, forwarded to the authors in February of 2020 by members of the Central Drug Authority.

Resistance around harm reduction are, we suggest, partly due to challenges the Central Drug Authority faces in providing clear leadership and direction. Firstly, the institution has been set up to be inter-sectoral and it is made up of representatives from 21 government departments and 13 experts, not all of whom come to the table with the same mandates or requirements. As the institution itself has noted, 'The broader Central Drug Authority contains many civil servants representing different government departments and reporting to their ministers, each of whom may have different positions on aspects of policy related to alcohol, tobacco, cannabis and psychoactive substance use' (Stein, for the ECCDA, 2016).

Departments focused on law enforcement are concerned with international legal frameworks. For example, at the 2019 United Nations Commission on Narcotic Drugs, South Africa committed to strengthening relationships with other international law enforcement agencies and confirmed that its response to drug use is guided by the three major drug policy conventions, with law enforcement at the forefront (UN CND, 2019). In contrast to the principles of the constitution, South Africa abstained from the vote supporting the Resolution on Contribution to the Implementation of the Joint Commitment to Effectively Addressing and Countering the World Drug Problem with Regard to Human Rights (OHCHR, 2018). In these moves, South Africa appears to be adopting and promoting prohibition as a policy choice.

In contrast, health-orientated institutions tend to lean more towards harm reduction. The Department of Health, which is responsible for managing medical emergencies, medical complications, detoxification, and co-morbidities relating to drug use,⁵ is developing a more public health-oriented approach to drug use. This is evident, for example, in the National Hepatitis Action plan and the Health Sector Drug Master Plan, which provide support for increased coverage by harm reduction services (National Department of Health, 2018a) and opioid substitution therapy for people who use drugs (National Department of Health, 2018b). The policies of the South African National AIDS Council support efforts to reduce stigma and discrimination, to increase coverage of harm reduction services, and to protect human rights, and support legislative reform (South African National AIDS Council, 2017, 2019b). The Department of Health has a policy to support access to opioids for the management of pain (see Box 15.1).

5 See the National Mental Health Policy Framework and Strategic Plan (2013–20) and National Health Mini Drug Master Plan (2011/12–2013/14).

BOX 15.1 Access to opioid medications for pain

South Africa has greater access to opioids for pain relief than other African countries (Drenth et al., 2018) and had the highest levels of prescribed opioid consumption in Africa, with a defined daily dose of 338 per million people per day, in 2011–13, compared to an African average of 41 and a global average of 3,027 (Berterame et al., 2016). Increased access to opioids for chronic disease and cancer-related pain was driven largely by the palliative care movement (Drenth et al., 2018). A National Policy Framework and Strategy on Palliative Care (2017–22) exists (National Department of Health, 2017), and standard treatment guidelines for the management of acute and chronic pain that includes tramadol and morphine exist for use at the primary care level (National Department of Health, 2018). Access to these medications in South Africa is partially limited by their scheduling and the requirement of a doctor's prescription. In Africa more broadly, this limitation is mostly linked to challenges with sourcing from industry and importation (Berterame et al., 2016).

Differences are sometimes even evident within departments and institutions. Despite the Central Drug Authority being housed within the Department of Social Development, these two institutions have not always presented a uniform perspective. Some of the tentative shifts towards harm reduction seen in Central Drug Authority position statements (Stein, for the ECCDA, 2016a; Stein and Manyedi, 2016) have been publicly countered by the Minister of the Department of Social Development. For example, in the Minister's statement at the Commission on Narcotic Drugs in March 2019, she said that the event was 'a clear illustration of the political will of our Governments to give practical effect to the implementation of the Three Drug Conventions in order to fulfil the desire and aspirations of our people to rid society of the scourge of drugs' (Shabangu, 2019, 3). The Department of Social Development also illustrated its preference for an abstinence-based approach in the framing of an International Substance Abuse Conference (November 2019) it hosted and that aimed to 'review prevention, demand and harm reduction, including law enforcement strategies and to address new and emerging trends as well as mitigation of the impact of the scourge of alcohol and substance abuse on families' (South African Government, 2019). Notably, organisations that implement needle and syringe and/or opioid substitution therapy programmes were not invited to participate in the conference.

Fragmented government perspectives are accompanied by varied implementation processes. Within departments, policy implementation is distributed to the nine provincial government structures, which vary between provinces, districts, and municipalities, depending on the dominant perspective in the region (Department of Planning Monitoring & Evaluation, 2016). This means that policy and action can be discrepant. Between departments differences in perspective can result in conflicting actions. For example, law enforcement agencies frequently challenge the legality of needle and syringe services, harass or arrest outreach workers, and continue to confiscate and destroy injecting equipment (TB HIV Care Association, 2017; Dada et al., 2019). Overall, prohibition-inspired approaches continue to dominate the local implementation landscape.

5 Historical Insights into Drug Policy Development and the Health of People Who Use Drugs

A historical analysis illustrates the extent to which drug prohibition in South Africa has been directly tied to concerns about controlling labouring people (Waetjen, 2019). Cannabis is an exemplar of this. In 1870, cannabis became a prohibited drug in the Colony of Natal (now part of South Africa). This ban expanded to the Cape in 1891, and in 1922 came to cover the area that now constitutes South Africa when the 'Customs and Excise Duties Amendment Act prohibited the cultivation, sale, possession and use of cannabis, cocaine and a number of opiates' (Paterson, 2009, 52). Cannabis prohibitions were tied to concerns that it was undermining the discipline and obedience of South African labour, and encouraging people of different races to interact through trade. In 1923, South Africa requested that the Council of the League of Nations' Advisory Committee on the Traffic in Opium and Dangerous Drugs include cannabis as an internationally banned substance. In 1925, the League of Nations listed cannabis as a dependence-forming substance, thus justifying South Africa's ban.

During apartheid (from 1948) the church played a variety of roles—both in justifying apartheid and as a core location for the development of resistance (Prozesky, 1990). The most powerful church was the Dutch Reformed Church. A notably conservative institution, it was closely tied to the government and—though not uniformly so—supported notions of racial purity and white superiority, and shaped conservative social laws (Kuperus, 1999). In this respect, international prohibitionist approaches aligned with local political views during the apartheid period, supporting their adoption.

5.1 *The Long Reach of International Moral Conservatism*

Globally, the framing of drug use as evil serves to justify any approach to excise drugs and their use, at the level of national and international practice (Lines, 2010). Deployment of armed forces and the militarisation of police forces and training are all justified by 'the war on drugs', an approach originating in the US, and serve to increase the influence of the Northern powers in the global South. In 2016, the US Department of Defense requested more than USD 1 billion for international drug control activities (Office of National Drug Control Policy, 2016). The economic benefits to industry and businesses are massive, and most of the money from the illicit drug trade is laundered through Northern banks (Esquivel-Suarez, 2018). Pursuit of this Northern agenda, particularly the global control policies of the US, has been described as a form of neocolonialism or 'narcocolonialism' (Oliver and Cottle, 2011).

The agendas of other superpowers such as China and Russia have played out locally through the partnership between Brazil, Russia, India, China and South Africa (BRICS). Russia's increasing influence, due to the economic incentives it has provided to South Africa, has led to its undue level of influence in the African setting, as evidenced by the Russia-Africa Anti-Drug Dialogue (RAADD). In a speech to the 2016 RAADD, Lieutenant General Ntlemenza of the South African Police Service made this clear: 'The Russia Africa Anti-Drug Dialogue has one aim which is to achieve a drug-free society'. He added that the proliferation of drugs was fuelled by increased international trade and because money laundering was made easy by the 'free movement of people' (Lt. Gen. Ntlemenza, 2016). What is critically missing is an analysis of who trades and uses drugs, when, and how, and—importantly—who does so in a way that is visible to the broader public. There is, therefore, no recognition that the people who make and use drugs in publicly discernible ways are often those who have limited alternative opportunities to craft meaningful lives in which their basic needs are met (Adler and Aniskiewicz, 2003; Bourgois and Schonberg, 2009).

As South Africa is heavily reliant on international funders, their agendas also shape local health policies in ways that are not necessarily aligned with local needs. This has been particularly evident in the HIV response (Johnson, 2008). Investments in the health of people who use drugs have been relatively small and focused on HIV prevention. For example, PEPFAR supported staffing and infrastructure for needle and syringe services in three cities from 2014 (Scheibe et al., 2017a; Scheibe et al. 2017b), but PEPFAR funds cannot be used to purchase needles and syringes (United States Centres for Disease Control, 2016). Needles and syringes for these initial services were purchased with support from the Ministry of Foreign Affairs of The Netherlands through the NGO Mainline. In 2016, PEPFAR focused support on priority districts, and two of

their support sites transitioned to being funded by the Global Fund, which also established two additional sites in the same year and started two small opioid substitution therapy pilots shortly thereafter (Global Fund, 2019). In 2019, four additional harm reduction sites were established in different health districts: three through the Global Fund and one through PEPFAR (Dada et al., 2019). To date, donor support has been insufficient to enable the provision of the full WHO package of services, with neither naloxone nor hepatitis services available.

The ongoing controversy and policy disharmony around harm reduction and the health of people who use drugs is best highlighted by the closure of the needle and syringe programme in Durban (see Box 15.2). Below, we turn to how morally inspired policy prevents the attainment of health for people who use drugs.

BOX 15.2 Enacting inaction

The needle and syringe programme in Durban (KwaZulu-Natal province) started in 2015 to address an unmet need (Scheibe, Shelly, et al., 2017). Initially, the programme was supported by PEPFAR, and in 2016 it transitioned to the Global Fund (Global Fund, 2017), with consistent support from Mainline and the Dutch Ministry of Foreign Affairs (Mainline and TB HIV Care, 2017). From its inception, individuals within the municipal and provincial departments of health contested the effectiveness of needle and syringe programmes, and highlighted their potential to increase drug use.⁶ These officials supported the then Deputy Mayor's decision to halt the needle and syringe service in May 2018 (van Dyk, 2018a). This was sparked by needles and syringes that washed up on one of the city's beaches and received media coverage (Mbanjwa, 2018). Later, claims were made of insufficient consultation preceding project implementation, followed by a request to obtain a trading license to distribute and collect injecting equipment (eThekweni Municipality, 2018). Efforts by the local network of people who use drugs to voice their concerns and demand access to this service were unsuccessful (Walford, 2018). Many meetings took place, several with ward councillors who were opposed to harm reduction and whose positions did not shift despite attempts to engage them on the public health benefits and supporting science (van Dyk, 2018b). After 24 months of negotiations, the implementing service

6 A full listing of the correspondence documenting the engagement between project implementers and the eThekweni Municipality and the provincial and national Departments of Health are available from the authors upon request.

provider received authorisation from the provincial and local Departments of Health, and the service restarted on 29 June, 2020 (KwaZulu-Natal Department of Health, 2020). People who inject drugs have grown increasingly desperate as well as frustrated with the harm reduction service provider (van Dyk, 2018b). Reports have been documented of increased needle and syringe sharing and an increased prevalence of infections (UNODC, 2019a). A repeated HIV and HCV prevalence survey has not been conducted since the closure of the service, but it is likely that infections have been widely transmitted.

5.2 *Discrimination and Hindrance to Healthcare*

Equivocal non-acceptance of harm reduction in policy allows for the continued moral—rather than rights-based—approach to drug use. Relevant policy, such as the National Drug Master Plan, frames the key aim of drug treatment as ‘reintegration’ into society. The assumption seems to be partly that people who use substances are not already and consistently part of communities, and partly that the communities they are part of are not deemed worthy of being called ‘society’. Yet anthropological work has shown that drug use is part and parcel of its fabric (Garcia, 2010; Saris, 2013). Even people who use drugs, live on the streets, and may appear to passers-by as ‘external’ to communities are part of families and social networks that often straddle street life and the communities they come from. This conceptual segregation, we suggest, serves not only to shape treatment modalities, but also to justify the lack of attention to the needs and health of people who use drugs by framing them as external and unworthy. This approach has undermined access to, and the quality of care for, people who use drugs.

Healthcare providers in South Africa tend to come from the communities they serve and are often representative of dominant moral positions around drug use. They are neither sensitised nor equipped to manage the realities and needs of people who use drugs (TB HIV Care and StopTB Partnership, 2018; Duby et al., 2019). Consequently, stigma and discrimination towards people who use drugs is widely accepted in healthcare facilities. This includes denial of care, conditional access to care, shaming, lack of confidentiality and privacy and being made to wait disproportionately long periods for services (Shelly et al., 2017; Versfeld et al., 2020). Moreover, there are currently no effective accountability mechanisms within healthcare facilities to manage these rights abuses, nor is there easy access to legal recourse for people who use drugs whose rights have been violated (TB HIV Care and StopTB Partnership, 2018).

Stigma does not have to be personally experienced to impact on individuals. Peers' experiences of stigma are powerful disincentives for individuals to access healthcare in South Africa. Stigma in the healthcare system also reinforces low self-worth, which in turn inhibits health-seeking behaviour (Versfeld et al., 2020). An assessment of TB and people who use drugs found that of the eight people who use drugs and acknowledged that they had received TB diagnoses, only one had started treatment (while incarcerated), only to cease on release from prison (TB HIV Care and StopTB Partnership, 2018). In a recent viral hepatitis study among 1,200 people who use drugs across three cities, less than 1 per cent of participants diagnosed with hepatitis C were linked to treatment. Fears of the public health sector were some of the reasons for not accessing care (TB HIV Care et al., 2018; Scheibe, Young, et al., 2019). Earlier dialogues with people who use drugs revealed that emergency services frequently discriminated against people who use drugs—either not arriving for an overdose if reported, or arriving only after several hours (Shelly et al., 2017).

5.3 *Continued Support for Non-evidence Based Approaches*

Nationally, the programmatic responses to drug use are seldom evaluated, and when they are, the results tend to be poor. In the Western Cape, the Matrix Model outpatient programme for people who use stimulants (Center for Substance Abuse Treatment, 2006) was adapted to include people who use opioids. However, after 12 weeks, only 7 per cent of people using opioids were retained at 'graduation' (Magidson et al., 2017). The City of Tshwane is an exception, and the city funds South Africa's largest methadone programme. However, even after demonstrating early successes, the project is unlikely to expand.⁷ One factor is limited political effort to reduce the high price of methadone⁸ (Herrmannsen, 2015). Fear of diversion is a second factor (Adult Hospital Technical Sub-Committee of National Essential Medicine List Committee, 2019), and the favoured models informed by American policy often impose a level of social control (Bourgois, 2000) in an attempt to prevent diversion. Along with others (Harris and Rhodes, 2013), we argue that a more effective approach is to ensure that there is sufficient coverage through low threshold community-based services.

⁷ During a review of the COSUP Programme attended by the University of Pretoria on 12–13 March 2020, the City expressed a reluctance to expand the programme and some members of City Management wanted to cut the programme.

⁸ Methadone in South Africa is 10–30 times more expensive than in other low and middle-income countries.

Despite the absence of data, there is continued government support for expanding the availability of abstinence-based drug rehabilitation (Zulu, 2019) to the exclusion of a wide range of interventions that can prevent escalation or achievable alternatives for people wanting to change patterns of use (Miller, 1998).

6 Windows of Opportunity

Despite the overwhelming influence of prohibitionist policy and approaches in South Africa, some progressive changes have taken place in terms of the law, policy, practice and evidence. While some have notable limitations, these, as we describe below, also open important opportunities for transformation.

In 2018, the South African Constitutional Court handed down a judgement that effectively decriminalised the possession and use of cannabis in private spaces (Minister of Justice et al. 2018). While this is cause for celebration, it comes with limitations. The judgement still referred to cannabis as a 'great social evil' and people who do not have 'private space' where they can consume cannabis, effectively remain criminalised for their use. Parliament is further required to determine arrest thresholds as well as the mechanisms for legal regulation within 24 months of the judgement. Furthermore, possession, growing or production of cannabis remains illegal. This continues to justify the persecution of rural populations who, for generations, have relied on cultivation for survival. These same growers stand to lose out in the future if the government issues production licenses to global cannabis businesses.

In terms of policy, the South African National AIDS Council has recently overtly supported a call for the decriminalisation of drug use (South African National AIDS Council, 2019b). Furthermore, the National Drug Master Plan 2019–2024 and the National Strategic Plan on HIV, TB and STIs 2017–2022, explicitly support the evidence-based comprehensive package of HIV prevention, treatment, care and support services for people who inject drugs, as recommended by the WHO. Together, these policies provide the scaffolding for harm reduction to take place and to contest people and institutions that perpetuate prohibitionist agendas.

In terms of practice, attempts at inter-sectoral collaboration around drug use are taking place at the local and national level. This includes the development of technical working groups that include members of the South African Network of People Who Use Drugs, which have informed national policy (Shelly and Howell, 2018), and the participation of networks of people who use drugs in some regional and local drug action committees (Scheibe, Shelly

et al., 2020). These relationships can be nurtured to influence future policy. The South African Network of People Who Use Drugs is a sub-recipient of a Global Fund grant and other philanthropic grants. This will support the development of people to champion the rights of people who use drugs. The funding of the largest opioid substitution therapy programme in South Africa by the City of Tshwane is an important step towards investing in effective interventions. While the remaining harm reduction interventions remain donor-funded, it is possible that another round of PEPFAR and Global Fund support for HIV prevention for people who inject drugs and harm reduction will be available and provide the opportunity to plan for the transition towards government support.

Data is also improving. The effects of the criminalisation of drug use, including the negative health consequences, are being better quantified and qualified (Harm Reduction International, 2018; UCSF and Anova Health Institute and National Institute for Communicable Diseases, 2018; Scheibe, Young, et al., 2019; South African National AIDS Council, 2019a). Furthermore, community-based harm reduction services are now included in the national accounting of services, as documented in the South African Community Epidemiology Network on Drug Use since 2018 (Dada et al., 2019).

7 Conclusion and Recommendations

Racial discrimination in South Africa played a significant role in the history of prohibition. Despite the negative consequences for the health of people living in the global South, South Africa's (home-grown) prohibitionist perspectives and policies continue to reinforce the 'war on drugs' approach. Critical reflection on the ways the past and the current policies impact on the rights and health of South Africans is essential for a rights-based approach and should inform and motivate new policy directions.

State entities must challenge the application of the *Single Convention on Narcotic Drugs*. Policymakers must rethink the dominant law enforcement and criminal justice approach, and encourage an emphasis on the rights, health and well-being of people who use drugs. Perhaps most importantly, the moral and stigmatising language, particularly the framing of drug use as 'evil', must be addressed.

The decriminalisation of the possession and use of drugs will immediately reduce the burden on marginalised communities. Reducing the number of people who use drugs that enter the criminal justice system will reduce exposure to TB, HIV and other health consequences of incarceration and post-release

economic exclusion. Reallocation of financial resources from supply reduction and the criminal justice system towards community development and a continuum of evidence-informed prevention and harm reduction services would strengthen communities. Healthier communities with better social integration and opportunities will ultimately reduce the levels of problematic drug use as well as many of the associated harms.

While there is a need for people who use drugs to be able to access appropriate health services—free of stigma, within the community—it is also essential to avoid the over-pathologisation of people who use drugs. The solution is not a simple health response to drug use, but a more comprehensive inter-sectoral response that looks at systemic and contextual issues. Mechanisms are required to enhance accountability around violations of the human rights of people who use drugs. Locally, strategic litigation against the state, institutions and individuals should be instituted where the health and well-being of people who use drugs are violated.

Stigma is pervasive. It ranges from the stereotypes portrayed in the media to the dismissive treatment of people who use drugs by healthcare workers, and it needs to be addressed. Following the principle of ‘nothing for us without us’, people who use drugs should actively be involved in, and consulted on, the design and implementation of research, service delivery, the training of health professionals and journalists, and the development of drug policy.

The inequitable access to services and issues of spatial discrimination can best be addressed by locating services within communities and providing services to people who use drugs along a continuum of medical and social services. Policy needs to support a range of evidence-based interventions that would cater for drugs commonly used and the methods people use them. Examples include harm reduction services for people who smoke stimulants and drug consumption rooms.

The human resources required to provide harm reduction services need to be capacitated. In addition, policy and practice needs to allow for task shifting, with increased health services provided by trained peer outreach workers, counsellors, registered nurses and other cadres of health professionals.

Harm reduction services should be created with a sense of inclusion and social integration, both geographically and ideologically. We would suggest that there are lessons to be learned from the City of Tshwane Community Oriented Substance Use Program that provides integrated interventions for drug use as part of a community-oriented primary healthcare approach.

Countries, communities and organisations that rely on donor funding that is restrictive and only funds a narrow set of prescriptive interventions and

programs should advocate for non-restricted funding, and insist on support for evidence-based interventions for substance use.

Countries from the historical global South, specifically South Africa, must re-evaluate their drug policies and look to approaches based on the science and needs of their communities. There are windows of opportunity that need to be used to protect the rights of all people and provide opportunities for all to enjoy health. Perhaps all that is needed is that our policies align with our constitution, the highest law of the land.

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