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THE DRUG NEXUS IN AFRICA

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THE DRUG NEXUS IN AFRICA

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FOREWORD

It is often assumed that the illicit drug problem in sub-Saharan Africa is of minor concern. But there are two reasons to question that assumption. Firstly, we have an incomplete picture of the drug problem in Africa because data on illicit drug trends in the region have until now been relatively sparse. Secondly, there is reason for skepticism as recent economic, social and political instability throughout the continent has created needs that are clearly not being met by traditional societies or legal commercial markets. Rarely, if ever, has there been such a wide window of opportunity for the illicit drug trade. In view of the rapid pace of change in many African societies, UNDCP has prepared the present report to assess the present vulnerability of sub-Saharan Africa to illicit drug production, trafficking and consumption.

The study is meant to serve three purposes. Firstly, it provides a stronger empirical basis on which UNDCP itself can develop and refine its policy and operational involvement in the region. Secondly, it serves as an information resource available to Governments. Thirdly – and most importantly – it advances the policy dialogue on the illicit drug problem by highlighting the fact that the drug problem is not a self-contained phenomenon in and of itself, but that illicit activity both originates in, and has an impact upon, the process of human development.

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Only with a greater awareness of the multidimensional nature of the illicit drug problem – only with a firm grasp of the drug nexus – can we realistically aspire to developing and carrying out the actions needed to prevent its further spread. Let there be no mistake: we have a unique opportunity – and a responsibility – to pre-empt the spread of the problem in sub-Saharan Africa. The involvement of development agencies, humanitarian aid organizations and others will make the difference between fulfilling this responsibility or watching the problem spiral beyond control. It is with this aim in mind that the following report should be read.

Pino Arlacchi
Under-Secretary-General
Executive Director, United Nations Office for Drug Control and Crime Prevention

CONTENTS

OVERVIEW **PAGE 11**

I. INTRODUCTION **PAGE 15**

A. INTRODUCTION

B. GOALS AND METHODOLOGY

C. RESULTS AND LESSONS LEARNED

II. ILLICIT DRUGS IN AFRICA **PAGE 19**

A. INTRODUCTION

B. PREVALENT ILLICIT DRUGS
1. INDIGENOUS DRUGS
2. COCAINE AND HEROIN
3. SYNTHETIC DRUGS
4. OTHER DRUGS

C. ILLICIT DRUG PRODUCTION
1. CANNABIS PRODUCTION
2. PSYCHOTROPIC SUBSTANCES
3. KHAT

D. DRUG TRAFFICKING
1. CANNABIS DISTRIBUTION
2. INTERNATIONAL TRAFFICKING
3. EASTAFRICA
4. WESTAFRICA
5. SOUTHERN AFRICA

E. ILLICIT DRUG CONSUMPTION
1. EASTAFRICA
2. WESTAFRICA
3. SOUTHERN AFRICA

F. CONCLUSION

III. ECONOMIC CHANGE AND ILLICIT DRUGS IN AFRICA **PAGE 47**

A. INTRODUCTION
1. ILLICIT DRUGS IN AFRICA: THE INSTITUTIONAL CONTEXT

B. ECONOMIC INFLUENCES ON ILLICIT DRUG PRODUCTION AND DISTRIBUTION
1. RISK DIVERSIFICATION AND CANNABIS CULTIVATION
2. URBAN ECONOMIES AND ILLICIT DRUG DISTRIBUTION

C. ILLICIT DRUG MARKETS IN SUB-SAHARAN AFRICA
1. RETAIL PRICE IMPLICATIONS
2. TRADE-OFFS

D. SUPPLY REDUCTION
1. LAW ENFORCEMENT
2. DRUG CONTROLAND CORRUPTION

E. CONCLUSION
1. ZIMBABWE
2. KENYA
3. GHANA

IV. SOCIALCHANGE AND ILLICIT DRUGS IN AFRICA **PAGE 71**

A. INTRODUCTION

B. FUNCTIONAL CONSUMPTION AS AN INFLUENCE ON SOCIAL NORMS
1. CANNABIS CONSUMPTION
2. COCAINE AND HEROIN
3. PSYCHOTROPIC SUBSTANCES
4. KHAT

C. SOCIAL NORMS AND THEIR EFFECT ON DRUG CONTROL

D. VULNERABLE GROUPS: YOUTH
1. STREET CHILDREN
2. THE AFFLUENT YOUNG

E. DEMAND REDUCTION

F. CONCLUSION
1. CAMEROON
2. SOUTH AFRICA
3. NIGERIA

V. POLITICAL CHANGE AND ILLICIT DRUGS IN AFRICA **PAGE 93**

A. INTRODUCTION

B. POLITICAL TRANSITION AND DRUG CONTROL
1. EFFECTS ON DRUG POLICY DEVELOPMENT
2. ETHNICITYAND LOCAL GOVERNMENT

C. STATE-CIVIL SOCIETY RELATIONS AND PROSPECTS FOR THE RULE OF LAW
1. OBSTACLES TO EFFECTIVE POLICING
2. SEARCH AND SEIZE CAPABILITIES
3. CONVICTION AND SENTENCING

D. ARMED CONFLICT AND DRUGS
1. DEMOBILIZED COMBATANTS
2. WAR-AFFECTED CIVILIANS
3. STEPS FORWARD

E. POLITICAL FACTORS IN INTERNATIONAL DRUG CONTROL
1. POLITICAL CHANGE AND INSTITUTIONS
2. INSTITUTIONAL CONSTRAINTS

F. CONCLUSION

VI. RECOMMENDATIONS **PAGE 111**

A. SECTORAL RECOMMENDATIONS
1. POLICYAND INSTITUTIONAL DEVELOPMENT
2. LEGAL DEVELOPMENT, RULE OF LAW AND GOVERNANCE
3. NATIONAL LAW ENFORCEMENT STRUCTURES AND CAPACITIES
4. REGIONAL LAW ENFORCEMENT COOPERATION MEASURES
5. DRUG ABUSE PREVENTION
6. DRUG ABUSE REHABILITATION
7. INFORMATION, RESEARCH AND NETWORKING
8. PROVISION OF INTERNATIONALASSISTANCE

B. REGIONAL PRIORITYAGENDA
1. TOP-TIER PRIORITY COUNTRIES
2. SECOND-TIER PRIORITY COUNTRIES
3. THIRD-TIER PRIORITY COUNTRIES

BIBLIOGRAPHY **PAGE 119**

TABLES

CHAPTER II
TABLE 1. CANNABIS HERB SEIZURES, 1994 – 1996 29
TABLE 2. HEROIN SEIZURES, 1994 – 1996 29
TABLE 3. COCAINE SEIZURES, 1994 – 1996 30
TABLE 4. DRUG TRAFFICKERS ARRESTED IN ETHIOPIA, 1993 – 1997 31
TABLE 5. DRUG-RELATED ARRESTS IN NIGERIA, 1995 – 1997 32
TABLE 6. EXPECTATIONS OF FUTURE DRUG ABUSE TRENDS 35
TABLE 7. FIRST DRUGS OF ABUSE FOR DIFFERENTAGE GROUPS IN KENYA 35
TABLE 8. EXPECTED FUTURE TRENDS OF DRUG ABUSE IN KENYA 35
TABLE 9. PERCENTAGE OF SECONDARY SCHOOL STUDENTS WHO HAVE USED DRUGS IN ADDIS ABABA 35
TABLE 10. MAJOR SUBSTANCES OF ABUSE IN ADDIS ABABA 36
TABLE 11. EXPECTED TRENDS IN DRUG ABUSE IN NIGERIA 37
TABLE 12. PUBLIC EDUCATION CAMPAIGNS AND REHABILITATION PROGRAMMES IN NIGERIA 38
TABLE 13. FUNCTIONAL USE OF CANNABIS IN CAMEROON 38
TABLE 14. DRUGS EXPECTED TO INCREASE IN POPULARITY IN SOUTH AFRICA 40
TABLE 15. SOCIO-ECONOMIC REASONS FOR THE LIKELY INCREASE IN ADULT DRUG USE IN SOUTH AFRICA 40
TABLE 16. DRUG ABUSE PREVALENCE IN MOZAMBIQUE 41
TABLE 17. REASONS FOR LIKELY INCREASE IN DRUG USE IN ZIMBABWE 41
TABLE 18. DRUG ABUSE PREVALENCE IN HARARE AND ELSEWHERE IN ZIMBABWE 42

CHAPTER III
TABLE 1. AGRICULTURE VALUE ADDED 50
TABLE 2. AVERAGE CHANGE IN AGRICULTURAL PRODUCTION 51
TABLE 3. REASONS WHY THE DRUG PROBLEM IS LIKELY TO WORSEN IN GHANA 54
TABLE 4. OCCUPATIONAL CHARACTERISTICS OF DRUG OFFENDERS IN ETHIOPIA 54
TABLE 5. RETAIL PRICES IN URBAN CENTRES 58
TABLE 6. RETAIL PRICES OF DRUGS AND PER CAPITA INCOME 59
TABLE 7. DRUG AVAILABILITY IN URBAN CENTRES OF NIGERIA 61
TABLE 8. DRUGS USED IN MAPUTO 61
TABLE 9. DRUGS USED IN YAOUNDÉ AND DOUALA 61
TABLE 10. DRUG-RELATED ADMISSIONS OF NINE MENTAL HEALTH CENTRES IN NIGERIA 64
TABLE 11. HEALTH EXPENDITURE AND HEALTH CARE 64
TABLE 12. SUMMARY OF DRUG-RELATED ARRESTS IN NIGERIA 64
TABLE 13. NATIONAL PRISONER STATISTICS, GHANA 64

CHAPTER IV
TABLE 1. POLICE REPORTS ON THE OCCUPATIONAL CHARACTERISTICS OF DRUG OFFENDERS IN ETHIOPIA 72
TABLE 2. SOCIO-DEMOGRAPHIC PROFILES OF DRUG ABUSERS IN KENYA 72
TABLE 3. STATISTICS ON DRUG-RELATED PATIENTS FROM JAN TO DEC 1995, GHANA 72

CHAPTER V
TABLE 1. EFFECTS OF LAW ENFORCEMENT 99

FIGURES

CHAPTER III
FIGURE 1. NON-FUEL COMMODITY EXPORT PRICES OF DEVELOPING COUNTRIES, 1986 – 1996 50
FIGURE 2. LABOUR FORCE IN AGRICULTURE 51
FIGURE 3. PAVED ROADS 52
FIGURE 4. IRRIGATED LAND 53
FIGURE 5. URBAN POPULATION GROWTH AND LABOUR FORCE GROWTH 55
FIGURE 6. PRICE RATIO OF BEER AND COCAINE 58
FIGURE 7. PRICE RATIO OF BEER AND HEROIN 59

CHAPTER IV
FIGURE 1. POPULATION AGED 0 – 14 AND 15 – 64 81

BOXES

CHAPTER II
BOX 1. CANNABIS CULTIVATION IN MOZAMBIQUE 25
BOX 2. THE COST OF KHAT CULTIVATION IN NYAMBENE, KENYA 26
BOX 3. DRUG TRAFFICKING OUT OF ZIMBABWE 33
BOX 4. CANNABIS AND MENTAL ILLNESS 36
BOX 5. DRUG ADDICTION IN CAPE TOWN 41

CHAPTER III
BOX 1. MONEY LAUNDERING AND INSTITUTIONS IN SOUTH AFRICA 48
BOX 2. KHAT, THE EASTAFRICAN MARKET 52
BOX 3. THE EXPERIENCE OF CÔTE D'IVOIRE 53
BOX 4. GANGS IN THE WESTERN CAPE 62
BOX 5. CUSTOMS AND DRUG SMUGGLING IN SOUTH AFRICA 65

CHAPTER IV
BOX 1. SOCIAL CONTEXTS OF ILLICIT DRUG CONSUMPTION IN SOUTH AFRICA 76
BOX 2. EDUCATION IN KENYA 85

OVERVIEW

Chapter I. Introduction

The introduction describes the objectives and methodology for the present study, as well as the lessons learned during its preparation. This study provides a new and innovative model of analysis that assesses the vulnerability to illicit drug problems on the basis of an examination of processes of change not commonly associated with drug control, namely, economic, social and political change. Ten countries have been included: Cameroon, Côte d'Ivoire, Ghana, Ethiopia, Kenya, Mozambique, Nigeria, Senegal, South Africa and Zimbabwe. Given the number of countries and sectors covered – and the prominence of primary field-based research in a region of the world where initiatives of this nature are difficult to implement – the 10-month time-frame for this study was ambitious but, in the end, successfully adhered to.

The study is less concerned with the question of how illicit drug problems affect society – the conventional paradigm for drug control analysis – than with the question of how changes in society create vulnerabilities to illicit drug production, trafficking and consumption. In sub-Saharan Africa, where the illicit drug problem in most cases is still in its nascent phase of evolution, this latter question is certainly the more relevant. Strategies to prevent illicit drug activity must take into account causes and solutions that lie far beyond the immediate realm of drug control.

Chapter II. Illicit drugs in Africa

This chapter provides an overview of the illicit drugs presently available in sub-Saharan Africa; it also gives a detailed presentation of the survey data gathered during the study's preparation. In terms of production and consumption, cannabis is by far the most prominent drug in sub-Saharan Africa; cocaine and heroin are however also used in all 10 countries. Seizures of cannabis in Africa accounted for 12 per cent of global seizures in 1996. An interesting contradiction arises when comparing the relatively benign picture portrayed by official seizure statistics – which constitute the only consistently gathered form of official data on drug trends in Africa – with the survey data gathered for this exercise. The latter information, from survey questionnaires, interviews and focus group discussions, describes the bleak outlook that community members, practitioners and government officials have with regard to prospects to contain the illicit drug problem. In some countries, more than 80 per cent of respondents surveyed expressed the view that the illicit drug problem was likely to worsen henceforth; 98 per cent of the healthworkers interviewed in Kenya, for example, expected drug abuse trends to worsen in the foreseeable future. This pessimism contrasts sharply with the downward trend reflected in seizure statistics. The potential for the problem to escalate can be understood in terms of the economic, social and political problems faced by the 10 countries and the declining ability of States to apply the necessary controls.

Chapter III. Economic change and illicit drugs in Africa

This chapter identifies aspects of ongoing economic change in Africa that are influencing the supply and trafficking of illicit drugs throughout the region. It begins by describing the institutional context for drug control in Africa, noting that monitoring illicit drug transactions is a difficult task given the insurmountable challenge faced by Governments of monitoring legal trade. It concludes that assistance to farmers and urban employment generation must constitute central pillars of the drug control agenda in rural areas. The chapter describes how, owing to the endemic risk that attends licit cultivation in sub-Saharan Africa, rural households protect their consumption patterns through diversification into cannabis cultivation. Findings indicate that cannabis cultivation and retail drug distribution are at present supplementary income-generating activities. However, this is likely to change: in the urban sector, population growth and labour growth suggest that the relatively lucrative retail distribution

trade in drugs will expand henceforth, fueled primarily by unemployment. In most of the countries examined, cannabis is the cheapest psychoactive substance available – cheaper than even alcohol; also, heroin in most markets is at present less expensive than cocaine. Based on price data gathered in the field, the study concludes that there is already a firm foundation on which illegal drug distribution networks could evolve. The study has found that the retail price of heroin, in terms of its "real value", in Nairobi, Lagos and Abidjan has already fallen below the corresponding price in New York City.

Chapter IV. Social change and illicit drugs in Africa

This chapter describes the relationship between social norms and illicit drug consumption in Africa, focusing specifically on how the "functional use" of drugs has affected public perception of the drug problem and undermined the social norms that have limited consumption hitherto. National surveys indicate that generally those in the lower income brackets make up a disproportionately large share of drug abusers. The chapter considers how the shift in public perceptions of illicit drugs is relevant in the context of controlling drug abuse. It concludes that, generally, ambivalence is the most noteworthy attribute of the would-be collective front against cannabis consumption. The chapter also identifies social groups that appear particularly vulnerable to abuse, including street children. During this exercise, street children were observed to resort to drug use in order to allow them "the courage" to commit petty crimes; in this light, they personify the vulnerability to drugs created by economic and social dislocation, which shows little sign of abating in the foreseeable future. Family breakdown was found to be a key influence on drug consumption, particularly in Kenya, Mozambique and Zimbabwe; other factors included non-attendance and/or drop out from school, which was often due to increasing and unaffordable school fees imposed on families.

Chapter V. Political change and illicit drugs in Africa

This chapter is based on the basic assumption that any strategic assessment of a country's vulnerability to illicit drugs must take into account not only the extent of the problem per se but the ability of the Government to apply the necessary controls. It is due precisely to problems in the relationship between the State and civil society that many African countries are vulnerable to an outbreak in illicit drug activity; law enforcement authorities in particular do not enjoy the crucial support of the community in rooting out illicit activities. Armed conflict – political change in its most acute form – also creates certain vulnerabilities to illicit drug use. The study finds that demobilized combatants are turning to the drug trade for want of other viable employment. War-affected civilians seek psychological respite in drug abuse, for want of other means of medication. Finally, this chapter considers the viability of international cooperation regimes in drug control, taking into account political relations that have been powerfully shaped by colonialism, the cold war and economic reforms that are perceived to be externally imposed. It concludes that there is in many African countries relatively weak grass-roots support for cooperation in international drug control arrangements; in some cases, there is the perception that Africa's drug problems are due in no small measure to customs and behaviours imported from "the West".

Chapter VI. Recommendations

This chapter distils the policy-relevant material from preceding chapters and presents it in a more explicit manner. Key recommendations include:

Policy and institutional development

- Without a sufficient redefining of drug control in terms of economic, social and political development, and without ample international support for the implementation of policy, it is inevitable that the nascent drug problems in Africa will – probably in the next decade - grow to the point of crisis.

Legal development, rule of law and governance

- Responsibility for and oversight of seized drugs must be given to offices that can ensure that the drugs are handled properly (i.e. that they do not disappear). The disappearance of seized drugs, in addition to the acquittal of presumed major traffickers, has become one of the most profound influences on public opinion regarding the credibility of drug control institutions in sub-Saharan Africa.

National law enforcement structures and capacities

- Drug policy should focus on areas where transactions can be monitored. Strategy should seek to restrict supply at main ports of entry; selected ports should include those of the greatest importance to legitimate trade, which often acts as the

facade behind which illegal trade takes place. The most feasible option at present is to strengthen customs controls with far more rigorous profiling of international air passengers and more diligent checking of passengers at the major airports.

Regional law enforcement cooperation measures

- The most cost-effective means of strengthening customs control at international ports of entry is to improve intelligence exchange between African customs authorities and their counterparts in Europe and the Americas. There is a need for strengthened exchange within and between regional police and customs networks.

Drug abuse prevention

- Traditional leaders and traditional healers must be consulted and actively involved, especially in rural areas. Control efforts need to penetrate those sectors of society which are alienated from the State: *a)* rural communities with farmers of cannabis and; *b)* inner city/high-density areas where there is a risk of spill-over from international trafficking of hard drugs.

Drug abuse rehabilitation

- In many countries, abusers of cannabis and/or other substances make up the majority of imprisoned drug offenders. Consideration should be given as to whether imprisoning drug users is the optimal course of action, as it appears that prison conditions may in fact reinforce the vulnerabilities that gave rise to drug use. Many of those who may not have been chronic users prior to their imprisonment turn to more regular drug use when incarcerated.

Information, research and networking

- In addition to seizure data, other data need to be gathered in order for a comprehensive assessment of drug trends in Africa to be pieced together. Price and purity data are crucial for adequate monitoring of the consumer market in those countries.

Provision of international assistance

- International drug control assistance should be firmly integrated into multidisciplinary programmes that encompass the areas of economic and social development. Exceptions should be considered only in the context of law enforcement, customs control and legal assistance – though even interventions in those areas should be integrated as part of good governance programmes.

Regional priority agenda

The country prioritization in this section includes only the 10 countries included in the study; it is based on the analysis of the preceding chapters and is meant only as a suggestion for UNDCP policy purposes; in other words, it should not be perceived as a continent-wide ordering of “problem countries”.

Top-tier priority countries:
Kenya, Nigeria, Senegal, South Africa.

Second-tier priority countries:
Côte d’Ivoire, Ghana, Mozambique.

Third-tier priority countries:
Cameroon, Ethiopia, Zimbabwe.

CHAPTER I

INTRODUCTION

A. INTRODUCTION

Sub-Saharan Africa faces a host of challenges as it enters the twenty-first century; hitherto, illicit drugs have been seen as one of the less threatening. Yet as the following pages seek to demonstrate, this dichotomization – with drug-related problems on the one hand and the region's social, economic and political concerns on the other – is myopic, for it ignores the intricate linkages between societal change and vulnerabilities to drug abuse, trafficking and production. Those linkages have in other parts of the world proved that drug abuse, trafficking and production should be of concern not only to those directly involved in the field of drug control, but to a broader array of actors in areas such as development and state-building. It is for this broader audience that the present study has been prepared.

This study is meant to be of use also to those active in the field of drug control. Until now, much has been made within drug control circles of the impact that illicit drug activity has on society. For example, conventional wisdom has it that drug addicts often seek out criminal means to finance their habit. Drug use in this context leads to negative consequences in other areas of social and economic development; this unidirectional causality – from drugs to other problems such as crime – is often viewed as the sole basis for the relationship between drugs and other concerns. Less consideration has been devoted to the converse relationship, to the question of how societal problems contribute to involvement with illicit drugs. In the countries included in this study, street children are resorting to drug consumption as a means to allow them the "courage" to commit the petty crimes required to eke out a subsistence living. In this light, the relationship between drugs and poverty takes on a contrasting hue, with drugs serving unmet "functional" needs that arise in the spheres of economics and social development. Even less attention has been focused on the question of how drug abuse, once entrenched within such vulnerable societies, impedes the fragile process of human development. When the street child becomes dependent on drugs, what are the implications for his or her chances to proceed on the path toward self-empowerment that international development agencies see as their primary concern? When the cannabis farmer expands his illicit output of cannabis, what is the effect on his ability to access official aid or establish relations with licit traders and input providers? Once such questions are considered and the elusive answers to them identified, it becomes clear that drug control is not– cannot be – an issue unto itself, that both the causes and the solutions to illicit drug problems span the spectrum of social and humanitarian concerns. The aim of preventing or containing illicit drug activity should be of concern not only to so-called drug control specialists, but also to those involved in and working towards economic, social and political development. As this study seeks to demonstrate, drug abuse dims what prospects there are for human development. The causal relationship between drugs and economic, social and political change is, in short, a vicious circle and one that too often goes unrecognized.

B. GOALS AND METHODOLOGY

The overall goal of this exercise has been twofold. Its first and foremost aim has been entirely descriptive: to gather and provide information on illicit drug trends in sub-Saharan Africa. This information should assist policy makers both in the countries concerned and at the international level. Its second aim has been more conceptual: to interpret illicit drug trends from the perspective of the economic, social and political changes taking place in sub-Saharan Africa. The pursuit of this latter aim should result in the identification of shared interests – between drug control and social, economic and political development – that provide the basis for inter-agency drug control assistance at the country, regional and international levels.

The constraints that have prevented these aims from being fully met will be discussed shortly, but first a word on the methods and approaches used in their pursuit. Given that the chief objective of this exercise was fact-finding, the methodology consisted of literature review, field-based surveys and focus group discussions with key informants. This exercise was unusual in the sense that it involved a considerable number of research teams, both within the

countries examined as well as in London, Paris and Vienna. The rationale underpinning the focus on fact-finding by in-country, national research teams was quite simple: nationals in the countries examined would understand the trends of concern far better than visiting international consultants ever could. Due to language and cultural ties, their ability to access the required information would far surpass that of foreign visitors. Thus, research teams in each of the countries were identified and asked to gather and analyze the information based on a generalized research protocol prepared by the United Nations International Drug Control Programme (UNDCP). In Côte d'Ivoire and Senegal, specific teams were not identified because in both countries it was possible to mobilize the network of contacts established by the Observatoire Géopolitique des Drogues (OGD), which was an important counterpart involved in this study. With regard to the UNDCP research protocol, an effort was made to allow each national research team a considerable degree of flexibility in adapting the protocol to country-specific circumstances. While the broad parameters were identified in the UNDCP protocol, with an emphasis on survey questionnaires, focus group discussions and interviews, each research team developed its own detailed research plan for this exercise. It was recognized at the outset that this approach would ultimately complicate the comparability of findings among the countries involved, a task borne by UNDCP and the University of London School of Oriental and African Studies (SOAS). Nonetheless, it was also considered important to steer away from assumptions that the countries included in this study were somehow alike or in any significant way homogenous: by allowing each national team the opportunity to develop the protocol according to country-specific constraints and attributes, it was that much more likely that we would have a clear picture of the situation without the distortions that attend a universally applied protocol.

Countries examined in this study were selected according to several criteria: *a)* their strategic importance in the context of drug control in general and UNDCP country/regional frameworks in particular; and *b)* the likelihood that the local infrastructure – informational, communications, etc. – would allow the necessary data to be gathered in the limited time available. On that basis, the following countries were selected:

West Africa: Côte d'Ivoire, Ghana, Nigeria, Senegal
East Africa: Ethiopia, Kenya
Central Africa: Cameroon
Southern Africa: Mozambique, South Africa, Zimbabwe

Each of the national teams, as well as OGD, carried out its field research and prepared a report on its findings; in this regard, the present study represents a compilation and synthesis of individual country reports. Each team had a total of five weeks to gather the requested data and prepare an analysis, prior to the visit of a team of international experts who would remain in each country for one week to meet with key informants. The latter team consisted of economists and social development experts from SOAS and a team leader from UNDCP, which carried out the political analysis. The SOAS and UNDCP experts visited eight countries during the months of November 1997 and February 1998. For the other two countries, Côte d'Ivoire and Senegal, OGD carried out its field visits in February 1998. The week long visits allowed a first-hand exchange of information between the national teams and the experts from London and Vienna. These visits also allowed the international experts an opportunity to see the trends and activities that they were to address from the perspectives of African economic, social and political change. The week long visits included interviews with governmental and non-governmental contacts, law enforcement specialists, medical practitioners, teachers, youth organizations, religious and community leaders, central bankers and others. They were organized primarily by UNDCP and the national research teams.

C. RESULTS AND LESSONS LEARNED

The results of this exercise must be seen in the light of the ambitious timeframe chosen by UNDCP in the summer of 1997. It was decided in June of that year, at a UNDCP meeting held at the headquarters of the Economic Commission for Africa in Addis Ababa, to launch a study that would provide an empirical foundation on which drug policy in sub-Saharan Africa could be based. However, in subsequent discussions in Vienna, the dearth of available information on illicit drug trends in Africa made clear that the data-gathering would have to take place in stages, with an initial "snapshot" assessment that would serve as the basis for subsequent, more in-depth national fact-finding. A study prepared within, say, a span of six to eight months could provide a timely, initial basis for UNDCP to identify the major problem areas that could be addressed with more rigour at the country level. This study represents that first step. The holistic perspective is meant to serve as a foundation for future policy and operational developments. The summer of 1998 was identified as a target date, ideally with a synopsis or summary made available for the General Assembly at its special session on the world drug problem, which was held in June 1998.

As regards the principal goal of gathering and providing information on illicit drug trends in the 10 countries selected, this exercise has against the odds made encouraging progress as evidenced most clearly in the next chapter on "Illicit drugs in Africa".

The ambitious timeframe did, however, lead to some complications. Each of the country teams, as well as the teams from London and Paris, expressed frustration at the time constraints which prevented important logistical and conceptual planning. Often, the national teams had to launch their survey work before receiving their research grant. In Zimbabwe, for example, the national team's report states:

> "The greatest problem encountered in this study was the delay in receiving the first installment. This resulted in the local team losing the original and the more experienced research assistants who had been thoroughly trained and who had participated in designing and validation of the questionnaire."[1]

In Nigeria, the national team writes:

> "The feedback from all the study sites revealed that time constraints seriously limited their output. More time was needed to study and refine the methodology, to conduct a pilot study, to seek official approval at different levels, to fully penetrate the relevant target groups at each site, and to articulate the findings and do a comprehensive write-up. Perhaps the idea of the study designers was to obtain a snap shot bird's-eye view of the situation, but all researchers agreed that more time is needed in future similar studies."[2]

It should be emphasized, however, that in no country did either the time constraints or the delay in payment become a reason for the national team not to proceed in good faith. In all the countries, the national teams cooperated to the full extent possible; it is to their credit that the field-level phase of this exercise was completed on schedule.

The key to success for a multidisciplinary initiative such as the present one is to bridge spheres of analysis by interpreting trends that are not always within the expert's immediate field of specialization. In this exercise, many of the national teams of experts were specialized in areas that could be subsumed under the rubric of drug control. It was thus appropriate for those teams to provide the raw data that could be interpreted and analysed by the international experts who were intentionally selected not from disciplines of obvious relevance to drug control but from others – social, economic and political development. In short, the richness, if not the utility, of this study hinged on the interaction between the national teams and the international experts. The outcome was less than entirely successful due primarily to difficulty in bridging diverse approaches and diverse disciplines– this outcome is, in and of itself, suggestive of the tremendous challenges that await the crucial broadening of the policy horizons in drug control. The final reports provided by the international experts required re-engineering in order to be consistent with one another as presented in this study and in order to reflect more clearly the extensive work done by the national teams.

There were some pleasant surprises. For example, one team of experts from SOAS– the so-called "social change" team consisting of eight members of the University of London faculty – provided an exceptional and detailed analysis of illicit drug trends that is arguably one of the most comprehensive of its kind done in Africa thus far. For a team of experts specialized in areas such as anthropology and developmental history, it could not have been foreseen that the team's report would provide such rich detail on the specifics of the drug trade. Entitled "Social change and illicit drugs in Africa", the report was used to the maximum extent possible during the editing process, with parts of its content allocated to virtually every chapter in this study. The economic analysis, carried out by a team of economists from SOAS, proved far more daunting, as the field visits and national reports provided too little information that could be interpreted by the economists involved. As a result, the economic analysis as completed by SOAS had to be significantly revised, with the result being a chapter in this study that does not reach the level of empirical detail and analytical innovation that could have been possible with more time.

Several caveats follow from the problems raised above. Firstly, this study cannot be mistaken for a rigorous, in-depth analysis of drug trends in Africa; the short timeframe, the number of countries covered and the number of actors involved in fact-finding and analysis limited the output of this exercise to a brief snapshot; that snapshot can, nonetheless, give some clues as to where Africa stands today both in terms of the reach of the drug problem and the scale of efforts being launched in response.

This study sought to examine the range of possible contributing factors that have, in other parts of the world, influenced society's use of illicit drugs – a medical exam, which has unfortunately gone no further than asking how the patient feels. It will fall on others to follow up on the study, the purpose of which has been to call attention to a range of issues not commonly recognized for their importance as causes of illicit drug activity. While a continent of such diversity and historical richness could never be adequately examined in one study, it is hoped that what follows will prove to be one step in redefining the dialogue on drug control in Africa, such that a greater awareness of the drug problem's complexity and the region's drug control needs comes about.

One other caveat applies to the observations and conclusions that follow. In any study that seeks to develop generalizable conclusions based on findings from a sub-set of the relevant subjects, there is a risk of over-simplification. While some effort has been made to avoid sweeping generalizations that ignore the cultural diversity that defines the countries in sub-Saharan Africa, it must be acknowledged that this effort has been only partly successful. As a result, important distinctions between regions, between countries and between communities have been overlooked. With more time and resources, it would have been possible to undertake more detailed country-specific analyses; it is anticipated, however, that this overarching region-wide study may provide useful parameters that can shape more detailed reports in future.

Lastly, a word of appreciation to those who assisted in this exercise, specifically the national expert teams, the University of London School of Oriental and African Studies and the Observatoire Géopolitique des Drogues. The national research teams involved were the following: the Centre for African Studies and Development (CASSAD), Ibadan; the Department of Sociology, University of Ghana, Legon; the Department of Psychiatry, University of Nairobi and Ramwe Consultancy and Development Services, Nairobi; the Faculty of Medicine, Addis Ababa University; the Cameroon Ministry of Public Health, Yaoundé; the Human Sciences Research Council, Pretoria, and the Medical Research Council, Cape Town; the Centro de Estudios da Populaçao (CEP), Universidade Eduardo Mondlane, Maputo; and the Department of Psychiatry, University of Zimbabwe, Harare.

The general findings of the study were presented to the representatives of the African States at the United Nations in May 1998; comments and views of the representatives were solicited at that time and are reflected in the study and the findings presented below.

In order to keep citation to a minimum and to increase the accessibility of this final report, we have cited the national reports directly only where it has seemed strictly necessary to do so – typically where a controversial or debatable opinion has been reported. Information gathered from interviews in November 1997 and February 1998 have been cited where appropriate.

Finally, appreciation is expressed to the Swedish International Development Cooperation Agency for its extensive support for this study; the Government of Italy also provided assistance that was crucial for the completion of this initiative.

Notes

1 National research team (Zimbabwe) report, p.72.
2 National research team (Nigeria) report, p.5.

CHAPTER II

ILLICIT DRUGS IN AFRICA

A. INTRODUCTION

Seizure statistics are the most widely and consistently gathered source of information on illicit drug trends in Africa. While they thus comprise one of the most important indicators for the development of drug policy, they can also be misleading due to certain constraints that manifest themselves with unusual clarity in the African context. As elsewhere, there is the inherent uncertainty as to whether seizure information reflects actual changes in illicit drug trends or rather extraneous changes in resources, commitment, technical capability or luck of the authorities. But due to the extent to which those constraints manifest themselves in sub-Saharan Africa, the wisdom of using seizure statistics as the sole basis for drug policy development is especially questionable. Other sources of data are clearly required.

The problem is that the gathering of other such data is not only costly but impeded by myriad economic, social and political obstacles that complicate the smooth exchange of information on sensitive issues such as abuse and cannabis cultivation. In order to circumvent those obstacles, the present exercise has resorted to means that target accessible groups that are: *a)* familiar with the general trends of immediate interest; and *b)* willing to express their opinions on the issue. In-country surveys, focus group discussions and first-hand observations by research teams have all aimed at providing a fuller picture of the drug problem in sub-Saharan Africa. That picture will, in subsequent chapters, be interpreted from the perspectives of economic, social and political change.

A word on the general approach to fact-finding that has underpinned this exercise. The inherent difficulty in monitoring activities that are illicit, clandestine and criminal creates the need to consider the views of those affected rather than those carrying out the activities at hand. Members of the local community are likely to be able to tell us at least as much about drug problems affecting the community as a whole as can official statistics on the volume of drugs seized at the border. In this regard, while the survey results provided in this chapter document subjective opinions, it is hoped that the quantitative scope of the surveys allows them to serve as a useful source of empirical information. To emphasize the caveat made in the introduction, such a multi-faceted, multi-country exercise, undertaken in a matter of several months, should be seen as a "snapshot" of the drug problem in Africa. It is meant as a first step.

The following scenario gives some reason to conclude that the problem, beneath the surface, is more pervasive than was at first assumed. On balance, it is possible to conclude that African lay persons, as well as those working in the drug-related fields of health, education and others, are concerned by what they see as a crisis waiting to happen. The consensus view in each of the 10 countries examined in this study is that illicit drug production, trafficking and consumption have all increased in the last 10 to 15 years and, ominously, that these worrying trends are likely to continue into the foreseeable future.

B. PREVALENT ILLICIT DRUGS

This section introduces the substances that form the basis for discussion in the remainder of the study. It is broken down into the following categories: indigenous (principally cannabis), cocaine and heroin, synthetic (methaqualone, amphetamine, LSD, Ecstasy) and other (including licit substances such as solvents used for narcotic purposes).

1. Indigenous drugs

Cannabis is grown and consumed in all 10 countries examined. The most common mode of consumption of cannabis is smoking, though it is also processed into cannabis paste (by pounding the plant and adding water), "hashish" (by scraping the resin off the leaves and then compressing) and cannabis oil (distilled from the seeds). Processed cannabis derivatives are added to various foods and beverages in Ghana, Nigeria and Zimbabwe, including local gin or *akpeteshie* in Ghana to give a narcotic version of "bitters" (the generic term for *akpeteshie* flavoured with herbs). In Zimbabwe, particularly in the Binga area where

consumption is traditional, cannabis can also be taken as an infusion. Marijuana is also smoked in a mixture with cocaine, crack cocaine or heroin in Cameroon, Ghana, Nigeria and South Africa. In South Africa it is also mixed with crushed methaqualone tablets – known as "white pipe" – a practice that now appears to have spread to Mozambique. Cosmetic (especially for hair) and medicinal preparations using cannabis are reported for Cameroon and Nigeria.

Iboga (Tabernanthes eboga) is an indigenous plant used in the religious rites of the so-called Mbwiti cult of the Fang people of Cameroon and Gabon. Consumed as a brew, it has hallucinogenic properties with similar effects to LSD. In the historical development of Mbwiti during the colonial period, *iboga* was adopted to replace *alan* (Strychnes icaja), another indigenous plant with similarly hallucinogenic properties. *Iboga* is grown on a large scale as a cash crop in the south-eastern region of Cameroon, destined not only for Mbwiti adherents in Yaoundé but also for pharmaceutical use abroad; recent clinical research has suggested *ibogaine*'s utility in drug therapy to reduce the consumption of narcotics, stimulants, alcohol and nicotine.[1]

Mudzepete is a plant-derived hallucinogenic drink used by traditional healers in Zimbabwe and taken by male elders in the rural areas. The roots of the plant are boiled and the extract diluted before drinking.

2. Cocaine and heroin

Cocaine and heroin are known and used in all 10 countries, being most widely used in South Africa and least used in Ethiopia. The cheaper crack cocaine is also consumed in Ghana, Nigeria, South Africa and Zimbabwe. Commonly used terms for those drugs in Nigeria, Ghana and Zimbabwe are the following:

Nigeria
cocaine – charlie, white, koko, coke, crack
heroin – brown, gabana, biko ("recycled" burnt remnants of heroin, said to be very powerful)

Ghana
cocaine – (Thai) white
crack cocaine – rock, goju, African Karate
heroin – brown

Zimbabwe
cocaine – cox, coke
crack cocaine – crack

The most common mode of consumption is smoking with tobacco or cannabis. More elaborate modes of smoking, using home-made equipment, are described for Nigeria ("stemming" and "bunkering", which is smoking through filtered water) and are no doubt known and employed in South Africa as well (which has the most sophisticated experimental drug culture of the 10 countries). Also in Nigeria, fumes are sniffed from heroin heated on foil ("chasing the dragon"), or from a mixture of cocaine and heroin – a practice known as "speedballing". Injection is much less common and is reported only for Nigeria, South Africa and Zimbabwe. Generally associated with elite consumers who acquired the knowledge and taste of the practice overseas, it is said to have originated in Kenya, specifically along the coast and in Nairobi, serving as an attraction in the tourist industry. Generally speaking, however, injecting tends to be viewed as "un-African".

3. Synthetic drugs

Methaqualone ("mandrax") is more widely used in South Africa than in the other countries studied, though it also has a strong if smaller consumer base in neighbouring Zimbabwe and Mozambique, where it is relatively inexpensive and easily available. In South Africa it is mixed with cannabis and smoked as "white pipe" (see above). In Ghana methaqualone is dissolved in beer and drunk as "blue blue". In Mozambique and Zimbabwe it is also commonly taken mixed with alcohol and its use is also widely reported from Kenya.

Amphetamine-type stimulants (ATS) are known and used in many of the countries observed, including Côte d'Ivoire and Nigeria. According to a UNDCP study, diversions of ATS have declined in the 1990s.[2] However, according to the study, ATS are still among the three or four most abused substances in Côte d'Ivoire, Ghana and Senegal. In Nigeria methamphetamine is known as *kwaya* and *paya,* and is most commonly found in the northern part of the country. The abuse of ATS in southern and eastern Africa is, compared with west Africa, relatively low.

Ecstasy as a new "designer" or "club" drug has entered Mozambique, Nigeria, South Africa and Zimbabwe in the 1990s. However, at present, Zimbabwe has not yet listed the substance as illicit.

LSD is known and used in Nigeria, if not as widely as in South Africa, where it is reported to be manufactured as well. There is evidence that it has more recently become available in Kenya and in Zimbabwe. South Africa has the capacity to produce illicit synthetic drugs like methaqualone and LSD. In Ghana, Nigeria and South Africa, the processing of crack from cocaine base takes place through simple "kitchen" technologies. There is a large and little explored area of concern in relation to the mixing and in some cases counterfeiting of pharmaceuticals that reach and endanger large numbers of people who are both desperate and gullible.

4. Other drugs

Solvent abuse – particularly the inhalation of petrol, methylated spirits, glue and other industrial solvent products – occurs in Cameroon, Ethiopia, Kenya Mozambique, Nigeria, South Africa and Zimbabwe. In Nigeria it is known as *shalishaw* and said to be a new practice. Solvent abuse is particularly associated in Kenya with street children, who inhale solvents very openly in the streets of Nairobi and other large towns. In Zimbabwe, solvents known by the names *fembo* and *genkem* are also widely taken by street children. The abuse of

pharmaceutical drugs also occurs in the countries examined. These drugs include barbiturates obtained over the counter from pharmacies (Nigeria, South Africa) and/or accessed through "informal" (and often illicit) circuits of distribution (Kenya, Mozambique, Zimbabwe). The sedatives Roche 5 and Rohypnol have been widely available in Kenya, especially on the coast, where they are a popular cure for insomnia among consumers of khat. Other medical drugs that are used – typically by small groups of practised consumers of cocaine, heroin, methaqualone and other synthetics – include Wellconal[3] tablets in South Africa, which are crushed, dissolved and injected ("pink"), and Alabukun in Nigeria, a powdery salicyate analgesic. This is obtainable over the counter, is cheap and widely used as medicine. Heroin users claim that it is a good substitute for heroin and can be similarly "run" on foil and be inhaled.

Addiction to benzodiazepines is reported from Zimbabwe among middle and upper class urban households. The Medical Control Council there also acknowledges that a number of medical staff are addicted to pethidine, which they acquire from hospital supplies. *Maragado* is the local name for the sedative chlorpromazine, which is available in the Harare area and almost certainly "leaks" into the market from official medical supplies.

In Cameroon, there is a market in "*comprimés*", capsules filled with various combinations of licit drugs (that can be bought in street markets) to produce narcotic effects. One kind is known as "*oui, oui*" ("yes, yes") because its effect is to induce an inability to make informed decisions, thus leading to manipulation by others. This is one particular example of a much wider problem in many African countries where demand for (cheap) medicines and popular beliefs in panaceas meet a supply of licit drugs that is largely unregulated (as well as a supply of illicit drugs). This suggests that the abuse of (including possible addiction to) licit drugs – with both stimulant and sedative effects – often occurs unwittingly, especially on the part of consumers. They are thereby exposed to potentially health-endangering cocktails of licit drugs into which illicit drugs may be introduced.

C. ILLICIT DRUG PRODUCTION

1. Cannabis production

Cannabis is in terms of area and volume the most widely produced drug in Africa. In all 10 countries covered in this study, cannabis is both consumed and cultivated domestically. In Cameroon, Ethiopia, Mozambique, South Africa and Zimbabwe cannabis has probably grown wild and perhaps been cultivated and used for narcotic purposes, for hundreds of years. In Zimbabwe it has long been used as medication by traditional healers and has important ritual uses among spirit mediums and in a variety of cultural ceremonies, most notably among the Tonga-speaking peoples.

In Ghana and Nigeria the introduction of cannabis for narcotic use, and its subsequent expansion as a commercial crop, is traditionally dated from the end of the Second World War, with the return of West African soldiers from service in South Africa. The South Asian provenance of cannabis is suggested by the common (and official) term of Indian hemp in the two countries. The name *bhanga* (of Hindi derivation) was used by marijuana smokers in Ghana in the 1950s and 1960s (*bhangi* is the generic Kiswahili term for marijuana in east Africa, and *banga* is widely used in the vocabulary of Cameroon today). Two regions in particular seem to account for the bulk of the continent's supply: southern and western Africa.

As noted, cannabis is the only illicit drug produced on a significant scale in all 10 countries. This section therefore focuses primarily on cannabis.

(a) East Africa

Cannabis cultivation in Kenya has a long tradition in the western parts of the country, but in recent years it has moved from being a minor crop grown to supply a limited local market to becoming a commercially significant crop produced for profit on a large scale. Good-quality (i. e. high THC content) *bhang* is said to come from the Kakamega, Vihiga and Busia districts in the Western Province, and from the remote Gwassi Hills area, and from the Kuria, Migori, Homa Bay and Kisii districts in Nyanza Province. Some of the *bhang* marketed in those areas is in fact grown in Uganda and is sold in Kenya to gain exchange rate advantages. More recently – over the past decade or so – the Coastal Province has also become a major producer. Here the Malindi district is the centre of activity, with most growers located in the valleys of the Sabaki and Athi rivers, where conditions are favourable. Land consolidation has moved ahead more slowly in this region, and farmers in remote areas can more easily find suitable land on which to cultivate the crop with little concern about detection. Large-scale commercial plots of cannabis are also reported from the Kilifi district and in the Chyulu Hills. Other supplies reach the coastal market from the fertile uplands of Taita-Taveta. Here again, as in the west, some of the *bhang* reaching the Kenyan market is grown across the border, in the neighbouring United Republic of Tanzania. There is a large market for *bhang* among the urban populations of the coastal towns, but tourists provide another and potentially very lucrative market. Reports indicate that cannabis is also now being grown on an increasingly large scale in many other parts of the country, often on forest land near urban markets. A recent police report cites the destruction of a huge cultivated area of cannabis in the Nandi Hills as one example of this trend.[4]

In October 1989, Kenyan law enforcement officials exposed the first opium poppy cultivation operation in east Africa: over 30,000 plants were being cultivated.[5] The authorities identified another area of poppy cultivation in 1992; since then, the Government has reported evidence of poppy cultivation in parts of the Central Province.

In Ethiopia, cannabis cultivation is well established in the countryside. It has traditionally been grown on Ethiopia's monastic estates, being used by monks to enhance relaxation and meditation. Its strong associations with religious use leads many people to view it as a benign

substance, its effects bringing enlightenment and tranquillity.

Reports from the Ethiopian police indicate that cultivation of cannabis has greatly expanded in recent years.[6] The first cannabis eradication campaign was carried out in 1996, when 320 hectares were reportedly destroyed by the Counter-Narcotics Unit and 21 individuals arrested. The crackdown on cannabis cultivation has triggered a response among many farmers: production is increasingly diffused into parts hitherto untouched by drug production. Cannabis cultivation has in effect been scattered into areas that are more difficult to monitor (more on this subject below and in chapter III, on economic change and illicit drugs in Africa). Increasingly, Ethiopian farmers with some land to spare are being paid by cannabis producers to devote a small area of their farmland to cannabis cultivation. This development has already begun to complicate efforts by the Counter-Narcotics Unit to monitor trends in cannabis cultivation.

Between 1993 and 1997, cannabis plants were seized from farmers in many parts of the country, including the Alemaya district of eastern Hararghe, the Shebendia district of Sidamo and in many parts of the Oromia region, especially Shashamene. The recent discovery of commercial farming of cannabis at the Debrilbanos monastery, 110 kilometres north of Addis Ababa, raises the possibility that the traditional centres of cannabis cultivation for religious purposes may now be opening up to wider market forces. Users in Addis Ababa confirmed that supplies of good quality cannabis have been reaching the city from the Debrilbanos monastery. Although evidence was taken from monks belonging to the Debrilbanos community, it is not clear whether this development is the consequence of individual opportunism or whether it reflects a collective pattern of commercial enterprise. Connections with dealers who visit the monastery from Addis Ababa were admitted, which suggests a process of commercialization.[7]

These recent trends aside, most Ethiopians associate the commercial supply of cannabis with the Jamaican Rastafarian community settled at Shashamene, on land granted to them by Emperor Haile Selassie. This settlement now comprises no more than 40 families, who are known to have grown cannabis for their own use for many years. They constitute an energetic and productive community, which sustains a relatively prosperous return from their agricultural holdings.

The cannabis from Shashamene is believed to be of higher quality than other cannabis produced in Ethiopia and it is in high demand. Many Ethiopians assume that this cannabis is grown and marketed by the Jamaican community. However, evidence from field visits clearly indicates that Ethiopian farmers are now actively pursuing cannabis cultivation. Under the Mengistu Government the Jamaican settlers lost a large portion of their land. This loss, combined with the connections forged by Jamaicans who subsequently married into the surrounding Ethiopian community of Shashamene, has built up greater linkages with local farmers, many of whom have taken up cannabis cultivation.

To some extent this development has been deliberately fostered by the "out-farming" of cannabis by the Jamaican community, an initial response to their land loss and more recently to increased police surveillance of their farms. In the words of one Shashamene Jamaican resident, "We taught them how to farm it and helped them with their problems".[8] Aware of the possibility of police interference, farmers plant cannabis far from the roads and conceal it in the midst of other crops. There are, as yet, no large-scale fields of cannabis in the area, but the local police readily admit that the increase in cannabis cultivation among local farmers is widespread.

There is little information available on the distribution of Ethiopian marijuana. The local police tend to assume that the Jamaican community at Shashamene was behind the marketing of cannabis into Addis Ababa and that the cultivation was done by Ethiopian farmers. Interviews with dealers and consumers, and among the Jamaican community themselves, confirmed that distribution is also in the hands of Ethiopians. The police believe that cannabis is moved to Addis Ababa in the lorries that take khat to markets, but discussions with dealers and users in Addis Ababa suggest that transport is on a smaller scale, with couriers bringing relatively small quantities into the city themselves, dealing or delivering to other dealers. Distribution throughout the city of Addis Ababa appears to be divided among a very large number of small-scale dealers.

(b) West Africa

In the case of west Africa, available data point to Ghana and Nigeria as significant producers of cannabis. In Nigeria generally low-grade (low THC content) cannabis is grown widely in the southern and Middle Belt states, including Anambra, Benin, Delta, Kogi, Ogun and Ondo, on farms of up to 20 hectares. Cannabis production is now spreading to the north and the west. Marijuana from Akure and Delta states is said to be of higher quality, fetching higher prices. As the country with by far the largest population in the region, Nigeria is assumed to be the largest producer of cannabis in west Africa. The scale of destroyed crop acreage suggests that overall output could be substantial. The National Drug Law Enforcement Agency of Nigeria continues its eradication campaign ("Burn the Weed") after having reorganized its zonal command structure. According to the Agency, over 430 tons of cannabis were destroyed between the launch of Operation Burn the Weed in 1994 and 1997.[9] According to Interpol, seizures for 1994 and 1995 were respectively 7 tons and 19 tons.[10]

The second largest producer is Ghana, which produces high-quality marijuana prized throughout west Africa. Ghana's sub-equatorial climate is ideal for cannabis growing. In the 1940s and 1950s, cultivation began in areas of the Eastern Region close to Accra, and thereafter expanded in a north-westerly direction to the new growing areas of Ashanti, the Afram plains and Brong Ahafo. Cannabis today is grown both in pure stands, typically in remote clearings, and intercropped with cassava, tomatoes and okra, which serve to conceal cannabis plants (which also benefit from irrigation applied to vegetables). A size

of 0.4 – 0.8 ha is said to be fairly standard for fields of pure stands, with 3 ha being the largest size of a farm estimated by OGD.[11] Recent press reports have referred to the destruction of larger than average farms: one of 3 ha near Wenchi[12] and another of over 2 ha.[13] While hidden from the authorities (generally outsiders), it is likely that cultivation is known about, assisted and protected in farming communities.

Traders who supply seeds and often advance cash or consumer goods against the crop typically contract farmers in Ghana. Growing times, between 3 – 5 months, vary with conditions. Harvesting is done when the leaves start to drop and the plant is then cut and dried. Drying can be a problem in deep forest areas where the best cannabis tends to grow, which may contribute to patterns of seasonality in supply (see below). When dried the cannabis is bagged – in "anto" bags (3.5 – 4.5 kg), medium-sized fertilizer bags (up to 10 kg) or "maxi-bags" (50 kg cocoa sacks) that can hold up to 25 kg of dried cannabis. The only form of on-farm processing is compressing cannabis into "bricks" (using presses for making concrete blocks) for easier transport.[14] This compressing, it should be noted, was observed as far south as Mozambique and is clearly a means of facilitating the long-distance traffic of cannabis.

A trader (well informed about cultivation and trade in the south, but not in the north) identified the following types and sources of cannabis in Ghana, in descending order of quality:

"no seed dope":
: grown in the most fertile soils, often marshy and deep inside forests, on the Afram plains, in Ashanti and Brong Ahafo, with marijuana from Wenchi, especially prized

"taffeta":
: dense leaves and very small (concealed) seeds, grown in the Volta Region

"seed dope":
: which grows anywhere

"area dope":
: grown close to Accra and cut early to avoid detection, giving the lowest-quality marijuana.

That farmers sell their crop in the field to traders[15] is probably accurate in general, although there are press stories about farmers arrested off-farm trying to transport bags of cannabis themselves.

Producer prices are difficult to report with precision. OGD[16] gives presumably "average" farm-gate prices in mid-1995 of 50 – 60,000 cedis (at that time, $42 – 50) for a "maxi-bag" of 25 kg. However, producer prices are likely to vary by area (and distance from consumption destinations), quality, season and relationships and negotiation between farmers and traders. Two sets of figures obtained from interviews (with a farmer and a trader) both refer to seasonal variations and probably apply to medium- to low-grade "seed dope".[17] The farmer reported C 50 – 60,000 ($21 – 26) per "maxi-bag" after harvest, and C 80 – 90,000 at times of strong demand. The trader said he paid growers C 60 – 80,000 or C 80 – 100,000 according to market conditions.

There seems little doubt that cannabis cultivation is lucrative to farmers, although the potential for high returns has to be weighed against the risks of detection, destruction of farms and severe prison sentences. OGD[18] calculates that farmers can gain an annual gross income of C 1 – 1.2 million ($520) per hectare, assuming a yield of 250 kg, two harvests a year and a producer price of C 50 – 60,000 a maxi-bag. OGD also suggests that many cocoa farmers have diversified into cannabis cultivation. This is impossible to assess, but certainly some of the main supply areas (of high-quality cannabis) are in classic cocoa zones like Brong Ahafo. Discussions with cannabis cultivators and middlemen made clear that the industry is thriving, with the use of charcoal-carrying lorries as a key means of transport from rural growing to urban consumer areas.

As in other countries in the region, although there are numerous police checkpoints between the rural growing areas and the urban markets, the transporters are well aware of the right time of day to run the risk of bringing their goods into town. Either they wait until a hiatus between police shifts, or the small-scale deliveries are actually carried by foot through the forest until they can be picked up again after the checkpoint.[19] A series of intermediary transactions then takes place, with not only the drugs, but sometimes only information on the next pick-up point, being exchanged.[20]

While the current level of commercial cannabis cultivation in Côte d'Ivoire is still relatively low, recent pricing trends for other cash crops give reason to speculate on the likelihood of an increase. Côte d'Ivoire has struggled to deal with the collapse of cocoa and coffee prices in the 1988 – 1992 period. Today, cannabis is grown and concealed in cocoa plantations in the southern, eastern and western areas of Côte d'Ivoire, mainly for local consumption.[21] According to a survey undertaken by the OGD between 1994 and 1995, two thirds of cannabis farmers in the country began cultivating in response to the price collapse of cocoa and coffee.[22] Cannabis farmers earn about CFA 500,000 for a sack weighing 20 – 25 kgs: CFA 20 – 25,000 per kilo. When crop yields are taken into account, a farmer who devotes 0.1 ha to cannabis cultivation can earn the equivalent of 30 – 40 ha of cocoa cultivation.

In Senegal, the major cannabis-producing area is the extremely fertile southern area of Casamance. The second largest is along the southern border with the Gambia, up to the Karone River islands, which is the south-west of the peanut-producing area. Peanut farming in Senegal, long a driving force for development, has in recent years been hard hit by adverse weather conditions and price falls on the world market. There have been reports of Ghanaian sponsors operating out of the Gambia, supplying seeds, supplies and a cut of the profit for the labour of Senegalese farmers. The cannabis is shipped to Dakar or exported abroad through the port.

Central Africa has also witnessed a rise in cannabis

cultivation in recent years, particularly in Cameroon and the Democratic Republic of Congo.[23] For Cameroon, there is little information on the history of cannabis cultivation (although the term *banga* may have arrived with Arab traders from the far distant east African coast), and little on current production. However, production is said to be widespread, not least in cocoa- and coffee-growing areas, given the fluctuating fortunes of those important export crops. Production also serves the export market to Europe. For example, 734.5 kg of cannabis originating in Cameroon was seized in France in 1994, while 100 kg coming from the Democratic Republic of Congo was seized in 1997 in Belgium.[24]

Nonetheless, it is likely that most of the cannabis consumed in Cameroon is of domestic origin; of the 972 respondents to the survey undertaken for this study, a full 65 per cent expressed the view that the cannabis consumed in their locales was of domestic origin. A study by OGD has found that marijuana in Cameroon sells, at wholesale, at a price 20 times that for coffee.[25] It estimates that cannabis cultivation earns profits of $0.50 – 2.00 per square metre, presumably per harvest, of which there are two per year. Annual income from cannabis ranges from $300 to $16,000, depending on price and quantity. Apparently, village leaders do not actively proscribe cannabis cultivation; on the other hand, along the border with Nigeria, more systematic control by state authorities does take place.

(c) Southern Africa

Until 1997, with some 80,000 ha reportedly under cannabis cultivation, South Africa was considered one of the major cannabis producers of the world and by far the most significant in sub-Saharan Africa. In 1997 that figure was significantly revised downward by the Government of South Africa, to a stated total of around 1,000 ha of cannabis cultivation. This sudden shift in measurement will statistically transform the scenario of cannabis cultivation not only in South Africa, but in Africa as a whole, given the country's prominence hitherto as a producer. There is, however, some reason to continue to view South Africa as a significant producer, as seizure statistics indicate a considerable volume of cannabis being produced in the country.

According to a 1995 South African Police Service report (based on aerial surveys), cannabis was grown in KwaZulu/Natal (2,547 ha), the Northern Transvaal Province (167 ha), as well as on a much greater scale in the Eastern Cape (Transkei) Province (80,000 ha).[26] Total production of cannabis from Botswana, Lesotho, South Africa and Swaziland would in this context amount to around 180,250,880 kg (175,396,080 kg for South Africa alone), with a total street value estimated at 54 billion rand or $15 billion, on an annual basis (at 1995 rand exchange rates).[27] As reported at the 1998 Meeting of Heads of National Drug Law Enforcement Agencies in Africa, held from 20 to 24 April 1998, South Africa is still considered "one of the world's largest producers".[28]

In South Africa, cannabis is mostly cultivated in mountainous and other inaccessible areas, and perhaps on a smaller scale on the fringes of large, historically white-owned farms. Two harvests a year are common in some locations, especially in KwaZulu/Natal. Much of the crop from South Africa has a high THC content. According to the South African Police Service, the cannabis grown in the Eastern Cape is transported from the mountainous areas and neighbouring Lesotho by individuals on horseback and on mules to lower-level staging areas where it is loaded onto vehicles and transported to consumer markets in Durban, Johannesburg and Cape Town.[29]

Popular varieties include "Durban Poison". Marijuana is also imported from Malawi (the prized "Malawi Gold") and Swaziland to supply South Africa's large and sophisticated market. There is a strong economic incentive to cultivate cannabis in the deeply impoverished rural areas of the former bantustans, even if farmers receive a small share of the final consumer price, in South Africa as elsewhere.[30]

Cannabis cultivation in Zimbabwe is widespread, mostly concentrated in the north of the country, around Lake Kariba and in the highlands, where climatic conditions are most favourable. The in-country research team reports that rural areas where cannabis is cultivated include Mutoko, Binga, Gokwe, Zhombe, Chipinge and Mt. Darwin. The *mbanje* grown in Zimbabwe is of only fair to poor quality, with a low THC content. Local supplies are inadequate to meet the demand for the drug, and it is estimated that only 30 per cent of the cannabis consumed in the country is supplied by domestic sources. High demand for the crop and a relative decline in the profitability of other cash crops are given as explanations for the increasing cultivation by farmers in recent years. The bulk of the cannabis imported into the country comes from Malawi ("Malawi Gold"), Mozambique and South Africa. Farmers disguise the crop by planting it in the midst of maize or tomatoes, or by growing it on land in forests or along riverbanks. Mutoko, lying in the north-east of the country on the road between Harare and the Nyamapanda border post to Mozambique, is a typical cannabis-growing area, with relatively easy access to urban markets for farmers via good transport infrastructure. Nowhere is cannabis the sole commercial crop, as most farmers see it as a means of securing a little extra income rather than as the mainstay of their economic well-being (see chapter III for details on supplementary income generation). It is also reported that Zimbabwean farmers have crossed the Mozambique border to cultivate cannabis in non-policed areas of Mozambique, utilizing Mozambican labour.

In Mozambique, the most important regions for cannabis cultivation are Angonia in Tete, Gorongoza in Sofala, Cimani-Mani in Manica and the higher- altitude areas of Nampula. These areas enjoy the best growing conditions and produce a crop with a high THC content. Varieties are identified by their region of origin, and domestic consumers are sensitive to quality differences.

Although no reliable statistics exist to test the hypothesis, circumstantial evidence suggests that Mozambique may be a major producer of marijuana in southern Africa. Cannabis is also exported on a significant scale from the Manica

Box 1.Cannabis cultivation in Mozambique

The Magude district is an important producer of cannabis in Mozambique. Surveys for this study tracked much of the cannabis consumed in Maputo back to Magude. It is thus significant that Magude is, despite its near total reliance on agriculture for the local economy, a net food importer. The lack of tools, which could conceivably fill the void left by cattle, is a concern that has prevented many farmers from greater productivity. Irrigation and fertilizer use are limited to major private holdings, but not to the subsistence farmers who make up the majority of the farming community in Magude.

region into Zimbabwe and from the Nampula region into Malawi.

Two principal types of grower can be identified. The smallholders who grow stands of cannabis in small patches are mostly women. Much of their crop is inter-planted with cassava to conceal the cannabis plants. They sell their harvest to itinerant traders, who then trade it through local markets. Most smallholders view the income earned as a useful addition to the household budget, but marijuana is not their principal agricultural activity.

There are some indications, however, that smallholders in some districts feel compelled to grow a stand of cannabis in order to meet the requirements of traders. The origins of this intimidation may be rooted in Mozambique's long civil war and in the presence of large numbers of Zimbabwean guerrilla fighters in the country during the 1970s, who consumed large quantities of marijuana and expected local communities to meet their requirements. Large, commercially oriented plantations produce the bulk of Mozambique's cannabis and many produce for export. These plantations are supervised by young men, drawn into cannabis production as a profitable enterprise; ex-guerrilla fighters who became involved with cannabis during the war; and foreigners, many from Malawi, who have crossed into Mozambique to grow cannabis in an environment where physical conditions are good and official surveillance is minimal. These farmers plant in large pure stands, hidden away deep in the forest, far from roads and the prying eyes of officials. The largest producers protect their fields with armed guards.

2. Psychotropic substances

The illicit manufacture of psychotropic substances in Africa, while emerging as a significant problem, is no more important than the diversion of licit medicines into illicit channels that result in medicines being used for misdiagnosed illness.

In its report for 1997, the International Narcotics Control Board notes, with particular reference to Africa, "that inadequate licit supply of some essential psychotropic substances can lead to their provision through informal distribution channels that are not subject to official control and do not provide adequate medical counselling to consumers".[31]

In all of the major regions examined for this study – southern, eastern, central and west Africa – it appears that both fake drugs and misprescribed drugs are resulting in higher levels of resistance and unnecessarily long bouts with the illnesses the medicines are meant to cure. In Ethiopia, several of the drugs mentioned as being smuggled from Kenya for illegal use include diazepam, valium and pethidine. In Zimbabwe, it appears that there are some weaknesses in the control of the prescription of medicines such that doctors are overprescribing either for their own benefit – for sales on the informal market – or for patients who have exceeded the maximum period of use for a given medicine.[32] Such diversion affects not only those who are given the wrong treatment but others in need of precisely the same medicines in other parts of the country. For example, in some of the outlying provinces of Zimbabwe, medics without recourse to other medicines are now reportedly prescribing to their patients the use of alcohol and cannabis as remedies against psychological illness.[33] In several of the countries included in this study, pethidine, in particular, was mentioned as being among the medicines diverted into the informal/illicit markets. This drug, a painkiller, has certain narcotic effects. Antibiotics are also being regularly sold illegally, and used improperly, thus raising resistence. According to one official in Zimbabwe, there is a need for greater information exchange between medical practitioners and monitoring authorities.[34] In recent years, methaqualone ("mandrax") laboratories have been discovered in southern Africa, and many suspect that countries in the region have acquired an important manufacturing capacity for psychotropic substances. One reason for the prevalence of methaqualone abuse in southern Africa is the tremendous demand in South Africa.

According to the South African Police Service, "a possible explanation for this phenomenon is that South Africa was the first country in which a sub-culture evolved where methaqualone was ground into a powder, mixed with cannabis and smoked as a concoction known as white pipe".[35] Unmet demand has triggered the domestic production of methaqualone in recent years.

Traditionally, methaqualone from laboratories in India has been transported by air and sea freight to either Kenya, Mozambique, the United Republic of Tanzania, Zambia or Zimbabwe, and then to South Africa. In recent years, however, the Indian authorities have cracked down on illicit methaqualone exports, giving rise to a classic case of the so-called "balloon effect", with domestic production in the southern African region intensifying. For example, Indian authorities, acting on intelligence supplied by the South African authorities, closed down a major methaqualone laboratory in Hyderabad, India, on 3 January 1995, confiscating 1.8 tons of the substance – enough for 3 million tablets – destined for the South African market.[36]

The first clandestine laboratory in South Africa was discovered in 1987 and, by 1995, nine laboratories had been closed down by the South African police in the KwaZulu/Natal, Western Cape and Gauteng Provinces. Since 1995, four additional clandestine methaqualone-manufacturing facilities have been dismantled in South Africa, along with one in Mozambique.[37] South African police are also currently investigating the possibility of large-scale Ecstasy manufacturing and have reportedly dismantled a number of clandestine laboratories producing that substance as well. Another related trend is the exchange of vehicles stolen in South Africa, for illegal drugs, especially methaqualone, in Kenya and other countries of the Southern Africa Development Community (SADC).[38]

The last trend related to methaqualone in southern Africa is the relationship between the markets for methaqualone and crack cocaine. In the major urban centres of South Africa, dealers of methaqualone are, in response to burgeoning demand for crack cocaine, switching their product line accordingly. Owing in part to the deteriorating quality of methaqualone and the increased supply of cocaine resulting from the expansion of South Africa's trade linkages with the world, the increased sale of crack has not only resulted in a lowering of prices for that drug (for details, see section E on "Illicit drug consumption"), but a concomitant rise in prices for methaqualone, at least in the Western Cape and Durban areas.[39]

In September 1997, an International Narcotics Control Board mission visited Nigeria, and in its 1997 report, the Board expressed its appreciation for the Government's strengthening of the import authorization system for psychotropic substances "and the increased cooperation of the competent authorities of that country with those of exporting countries and with the Board".[40] The Board observed that the tightening of controls over psychotropic substances in Nigeria had prompted traffickers to use neighbouring countries as transit points for smuggling the substances into Nigeria; during the first eight months of 1997, 715 kg of diazepam, 170 kg of chlordiazepoxide and 260 kg of pemoline were seized by Nigerian authorities – the Board notes that these "were among the most significant seizures of diverted psychotropic substances worldwide".[41]

3. Khat

In Ethiopia and Kenya khat cultivation is an important, legal industry and the daily export of multi-ton quantities of the product to Djibouti, Somalia and Yemen generates considerable economic benefits. The khat industry is now very important to the Ethiopian economy. Exports are significant and expanding, the principal markets being Djibouti, Somalia and Yemen. Khat is exported by air to Europe from Addis Ababa, and can be bought daily in Amsterdam, London and Rome. The crop is now estimated by the National Bank of Ethiopia to rank as the country's third most valuable export (after coffee and hides), its economic importance having risen sharply over the past three or four years. The economic value of the crop as an earner of foreign exchange is a significant factor in local debates about regulation and prohibition. The main centre of the trade is Dire Dawa.

In Kenya, where khat is not a controlled substance (and is locally known as *miraa*), cultivation in the highlands has reportedly taken place for centuries, with the most important growing areas in the Eastern Provinces, as well as in the Meru District. Although large-scale consumption is mainly limited to the Horn of Africa and part of the Arabian Peninsula, with the help of modern transportation means, the legal khat trade has acquired wide-reaching geographical, and thus economic, proportions in recent years. According to one khat farmer in Kenya, one rule of thumb for income expectation is that for each 1 shilling invested in khat cultivation, one can expect a return of 4 shillings in profit;[42] for the other major cash crop in the area, tea, the ratio is 1 to 2.5 shillings. The area under khat cultivation has grown considerably as a result, mainly in Ethiopia and Kenya, often at the expense of other cash or food crops.

D. DRUG TRAFFICKING

A number of African countries have become increasingly important transit points for international drug trafficking in the 1980s and 1990s. The principal drugs involved are cocaine from Latin America, especially Brazil, and heroin from South Asia, especially from India, that transit African countries with couriers (and sometimes by post) en route to destinations in Europe and North America.

Box 2.The cost of khat cultivation in Nyambene, Kenya

In the Nyambene district of Kenya, one of the most bountiful areas of khat production in the world, district agricultural workers are at present trying to encourage farmers to diversify, specifically into more food crops: despite being one of the wealthiest agricultural areas in Kenya, Nyambene is a net food importer.[43] With regard to competition from other farmers, which has resulted from more entrants into the market, it appears that there is little impact on the revenues of the farmer. It is significant that one common reason for beginning khat production – likely to be a key barrier to entry – is the inter-generational provision of the farmland: many of the khat farmers are cultivating trees that were planted by distant ancestors. In the view of the district workers, the main reasons why the farmers should diversify are the following: *a)* it is risky from an investment perspective to have such a concentration in the production of one and only one crop; *b)* khat cultivation displaces many of the traditional food crops; and *c)* the profits for this activity are too often spent on alcohol consumption, or sent to other parts of the country, that is, there is very little productive reinvestment in the region– thus the extreme poverty that is manifest throughout Nyambene. One other drawback is the impact on children, particularly young boys. The boys earn a considerable income and yet this has the effect of preventing them from attending, or even wanting to attend, school. Illiteracy is entrenched. Another important reason is that the farmers themselves are earning so little compared with the traders; interestingly, it appears that the farmers are prevented from uniting to increase their bargaining power, as the traders have successfully kept up one-on-one business ties, which have effectively kept the farmers divided, subject to the whims of the traders and the weather. While the farmers themselves acknowledge these disadvantages, it is clear that there is no question as to whether to remain involved.

According to a UNDCP report, Africa has in recent years "become a major transit point for illicit drug trafficking to markets in Europe and North America, as evidenced by the spread of international operations, mainly by West African trafficking groups, in recent years".[44] The report provides a useful overview of trafficking trends in Africa:

> "Reports in the past indicated that cannabis was the most preponderant drug in the region, though most of this was either growing wildly or was for local traditional use. This situation was changing rapidly in recent years and cannabis has become a cash crop, grown not only to supply the increasing market of the youth in major cities of the continent but also for export, mainly to Europe and North America. Countries in Africa are responsible for a quarter of the herbal cannabis and one tenth of the cannabis resin seized worldwide. It is mainly South Africa and Morocco that account for the bulk of the African share in global (cannabis) seizures. Although the volume of heroin seized in African countries is still small by international standards, there are indications of expansion of international trafficking links to both Europe and North America. Since the 1980s, west African trafficking organizations have gained control of trafficking in heroin from the source countries in Asia to markets in Europe and the North America. The same established heroin routes have also been increasingly used to smuggle cocaine from Latin American sources to Europe".

1. Cannabis distribution

Not much is known about the organization of cannabis distribution within African countries, with the exception of Ghana, where field research for this study has led to some insight into distribution modalities. In Ghana, traders collect, transport and sell cannabis wholesale, thereby linking downstream activity to the processing and retailing levels. There as elsewhere, farmers receive only a small proportion of the final consumer price.

In Ghana, traders buy from farmers with whom they have contracted, or with whom they have relations of trust. Bagged cannabis is trucked to distribution and consumption centres concealed in loads of other produce, commonly charcoal (transported in massively loaded trucks) and sometimes fruit (e. g. pineapple), which conceals its distinctive odour. Bags of cannabis are sometimes carried in taxis or private cars, with a corresponding risk of detection at the police posts on all main roads, unless arrangements can be made in advance. According to the Commissioner of Police in charge of the Narcotics Unit in Ghana, shipments are stored at well-concealed "warehouses" on the outskirts of towns and cities, whence they are distributed along a chain of three or four intermediaries to street (retail) sale. Arrests at street level are much more common than at the source of the distribution chain, although there are occasional raids on warehouses, as at Maamodi, Accra, in October 1996, when over 300 kg of marijuana was seized.[45]

Nima is a poor and congested residential area of some 170 – 200,000 people. It is known for its large population of northern Ghanaians and immigrants from other west African countries. Sociologically, it presents some contrasts with the downtown and beachside centres of drug dealing and consumption in Accra. One informant said that Nima had 9 or 10 spots for buying and smoking marijuana, with 5 or 6 dealers operating at each.[46] These spots are located near public utilities (e. g. public toilets and wash-houses), with access to quick escape routes through the dense networks of alleyways.

There is no precise or generalizable price information, including mark-up, along the distribution chain. One trader interviewed claimed that his mark-up on loads bought from farmers was 20 – 25 per cent. The dealer interviewed in Nima had brought his half kilo of seed dope for C 10,000, on which he would make C 30,000 when it was sold in individual wraps at C 300. Assuming an initial producer price of C 2,000 per kilo, this gives a price spread of C 3,000 per cent from farm gate to the consumer. OGD[47] gives a price of C 100 a wrap in mid-1995,[48] suggesting a three-fold inflation in the consumer price in the intervening two and a half years (with much lower increases in producer prices, see above). However, consumer prices vary with quality: higher-value wraps contain the best leaves and flowers of higher-quality types of marijuana (see above). The leaves with highest THC content are known as *shasha* ("huff and puff" in Hausa) or *swali* (in Kumasi), lesser-quality leaves (from the main stalks) as *bukata* ("better than nothing" in Hausa) or *boka* (Kumasi). Street prices are also likely to fluctuate with supply conditions. Another informant (a former smoker in Kumasi) said that in his experience there was always one reliable source of supply in any town or city quarter when marijuana was generally scarce. The inference is that there is a particularly well-placed or pre-eminent wholesaler in every urban area.

In South Africa, street dealing in the townships (and some inner city areas like Hillbrow and Yeoville in Johannesburg) is usually associated with neighbourhood gangs supplied by older established men. The link between youth gangs and gangsterism at various points in the distribution chain appears more pronounced in South Africa than in the other countries, with the exception of Mozambique.

In Nigeria, "area boys" – young men who have grown up together in the same neighbourhood – are incorporated into gangs based on age grades. There is strong peer pressure to take up drug consumption and it is an often short step from there to street selling for local "barons" (and with experience and proven qualities, possible recruitment as international couriers). Such networks of dealers operating from local distribution centres (drug houses) provide an especially important sociological channel through which cocaine, crack and heroin have been added to marijuana distribution. In Ghana too, raids on drug houses in Accra and Kumasi in recent years have encountered groups of 40 or more young male consumers/dealers and quantities of cocaine and heroin as well as marijuana.

The Zimbabwean police estimate that some 70 per cent of the cannabis consumed in Zimbabwe is imported, much of

it from neighbouring countries such as Malawi and Mozambique. "Malawi Gold", with its high THC content, fetches a premium price and is highly prized by Zimbabwean consumers. Supplies from Mozambique are of lower quality, but is said to be more potent than the locally produced *mbanje*. The movement of cannabis across the border into Zimbabwe appears unrestrained. Much of it enters through the Nyamapanda border post with Mozambique in the north-east of the country. Zimbabwe's 1,231 km of borders are difficult to patrol and thus overland smuggling even by foot is an easy and relatively risk-free enterprise. Well-known urban venues for cannabis purchases in Harare include sports clubs, bars and nightclubs in the residential suburbs and in the central business district of the city. The majority of *mbanje* sales occur in the lower- income suburbs. Mbare is particularly known as an area where cannabis can be bought. This former squatter township has the highest density of settlement in the city, with many squatter huts crowded onto small plots, with a busy informal economy, a large concentration of street children and a high level of unemployment (see chapter III, section B, for further details on the relationship between informal urban economies and drug peddling). Here, as elsewhere, it is common for small quantities of *mbanje* to be sold as "twists" – enough cannabis for a small cigarette, wrapped in cigarette-paper, and "twisted" into a round, easily managed unit of sale. Street selling is common in Highfield, a middle-income suburb to the south of the city. This was the centre of political activity in Harare during the long struggle for majority rule, and it is an area with a radical tradition. One residential street in Highfield, popularly known as the Beira Corridor, is renowned for cannabis trading, with drug dealers purchasing *mbanje* directly from truckers and other traffickers and selling it to consumers. Small-time or opportunistic traffickers also come to this street to sell directly to users. The area's name derives from perceptions that both the sellers and the products sold originate in Mozambique.

In Maputo itself, one area of the city, the military quarter, where drug dealing is concentrated, is known as "Colombia". Soldiers are said to be involved in street dealing in *suruma*, organizing distribution and protecting dealers. Their involvement intimidates many concerned Mozambicans into silence and it is thus difficult to find out even the most basic details about cannabis marketing and consumption within the country.

2. International trafficking

Seizure statistics are the most widely gathered source of drug data in sub-Saharan Africa and this section provides an overview based on those data. However, the caveat made at the outset of this chapter with regard to the reliability of seizure statistics should be borne in mind. Africa accounted for about 12 per cent of global cannabis seizures in 1996[49] (see table 1).

According to a UNDCP report, South Africa, along with the United States of America, continues to rank among the countries with the largest annual seizure quantities of herbal cannabis.[50] The volume of heroin seized in Africa (see table 2) is small by international standards, accounting for only 1 per cent of worldwide seizures in 1996.[51] Nonetheless, this could have as much to do with insufficient resources for border control as it does with the actual extent of trafficking. Cocaine seized often originates in Brazil, with shipments destined for Abidjan, Lagos and Johannesburg.[52] In southern Africa, shipments also arrive in Angola, for onward transit either by land – through Botswana, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe – or by sea – directly or via Mozambique – to South Africa.

In west Africa, cocaine trafficking is currently undergoing major shifts, largely in response to the intense crackdown being waged by the Nigerian authorities. Nonetheless, Africa's location makes it an ideal transit point for heroin from Asia destined for Europe. During the 1990s, Egypt, Kenya, Nigeria, Senegal and Zambia reported the largest volumes of heroin seized in Africa. The overall amount of cocaine seized in Africa (256 kg in 1995, 386 kg in 1996, see table 3) is insignificant in comparison to the worldwide amount in 1996 of over 300 tons.[53]

The International Narcotics Control Board in its 1997 annual report states "there are signs that, due to strengthened control measures, illicit traffickers are using seaports and airports in Nigeria for the trans-shipment of cocaine and heroin less frequently than in the past".[54] Between 1994 and 1996, the key trend of significance was a shift in the bulk of seizures from Nigeria to South Africa, the latter of which seized the largest annual quantity of cocaine in the two-year period. Again, this is probably due to the law enforcement intensification in Nigeria and the integration of South Africa into major trading and travel networks. Several relevant international factors can be added to the above account of drug trafficking in Africa.

The extensive land frontiers and coastlines of all the countries make effective border control and policing difficult in relation to inward and outward movement of drugs. South Africa alone has 96 ports of entry as well as 36 designated international airports (many of which are understaffed or even unstaffed outside peak times). To the pressures that extensive and permeable land frontiers and coastlines impose on the capacities of States to control them must be added the effects of historic and still important trading, social and cultural ties across international boundaries. In South Africa, such ties include those across the borders with Botswana, Lesotho, southern Mozambique, Swaziland and southern Zimbabwe. In Nima (Accra) respondents pointed out that official national identities like "Nigerian" or "Togolese" meant little in so mixed a population, typified by continuous mobility, interaction, patterns of settlement and intermarriage and kinship across borders.

Regional immigration has several implications for international drug trafficking. Changes in South Africa since 1990 have accelerated immigration from within the region and from more distant countries in Africa. Police and immigration officials have estimated between 2 and 8 million "illegals" in South Africa. More reliable recent research suggests about 1 million "illegal" immigrants, many of whom stay for short periods like cross-border traders and seasonal agricultural labour migrants.

Table 1. **Cannabis herb seizures, 1994 – 1996 (kilograms)**

	1994	1995	1996
Cameroon	491	9.7	581.9
Côte d'Ivoire	634	536	1 483
Ethiopia	668	312	2
Ghana	28	209 506	903
Mozambique	-	-	-
Kenya	4 146	2548	8 238
Nigeria	19 733	15 258	18 604
Senegal	1 392	79 775	212
South Africa	268 652	238 813	203 354
Zimbabwe	1 086	3 935	2 429
Africa (Total)	**355 000**	**643 600**	**321 300**
World	2 200 000	3 000 000	2 500 000

Source: Annual Report Questionnaires, ICPO/Interpol[55]

Table 2. **Heroin seizures, 1994 – 1996 (kilograms)**

	1994	1995	1996
Cameroon	-	-	-
Côte d'Ivoire	-	5.4	4.5
Ethiopia	10	4	27
Ghana	0.1	6	0.4
Mozambique	-	-	-
Kenya	23 – 33	29	15
Nigeria	91	30	19
Senegal	78	15	0.3
South Africa	25	6	0.8
Zimbabwe	7	0.3	-
Africa (Total)	**348**	**320**	**169**
World	29 000	31 000	28 000

Source: Annual Report Questionnaires, ICPO/Interpol[56]

Nonetheless, the extent of underemployment and poverty in South Africa and the massive pressure on housing and services in its cities have generated xenophobia against people from other African countries, who are often scapegoated.

For example, because of the oft-aired accusations of involvement of Nigerians in international trafficking of cocaine and heroin through transit points in Africa, they are strongly associated with the drug trade (and especially imports) in South Africa, as well as in other countries. In Ghana, for example, one newspaper report suggested that there were 300 Nigerians in the drug business in that country in 1996.[57] They are said to find it easier to operate from Ghana, especially in the face of the "war on drugs" of General Bamayi's National Drug Law Enforcement Agency in Nigeria from 1994.

If the figure of 300 cited is at all accurate, it would still represent only a small proportion of the probably tens of thousands of Nigerians resident in Ghana and Ghanaians of Nigerian origin.

Table 3. **Cocaine seizures, 1994 – 1996 (kilograms)**

	1994	1995	1996
Cameroon	-	0.2	-
Côte d'Ivoire	0.1	2.9	33
Ethiopia	-	-	-
Ghana	7	18	0.8
Mozambique	-	-	-
Kenya	0.1	0.4	3.4
Nigeria	91	16	6
Senegal	12	2	2
South Africa	69	187	106
Zimbabwe	4	0.1	1
Africa (Total)	**192**	**256**	**386**
World	319 000	289 000	316 000

Source: Annual Report Questionnaires, ICPO/Interpol[58]

3. East Africa

In east Africa, Kenya has progressively become a significant transit point for heroin and hashish destined for Europe or North America, and for methaqualone originating from India and re-exported to other southern African countries.[59] The rise in trafficking is easily explained when one considers both the geographical location as well as the importance of the country as a commercial and transportation hub. Mombasa harbour is the only major commercial shipping port on that part of the coast, and, as such, serves many of the neighbouring countries. It therefore constitutes an ideal point of entry or transit for controlled substances. Its recently acquired status as a free trade zone has served to reinforce this trend by further complicating the work of the authorities attempting to control drug trafficking in the port.[60] As one of the biggest air platforms for freight export to European capitals, the Jomo Kenyatta International Airport is also an important entry and exit point for drugs destined for the region or transiting through it. Kenya has become an important transit point for south-east and south-west Asian heroin. In response to increased law enforcement at the Nairobi airport, heroin traffickers are flying to Uganda and the United Republic of Tanzania and bringing the heroin into Kenya by road or small air carrier. The heroin is then trafficked to Europe and sometimes to the United States.

Although cannabis is grown on a large scale throughout east Africa, it is believed that most of the production is destined for the domestic market, although some individuals have been arrested abroad with small amounts of cannabis herb originating from the region.[61] In Kenya, up to 50 per cent of locally grown cannabis is reportedly exported to neighbouring and European countries.[62] The Kenyan Narcotics Bureau reckons that approximately 20 per cent of available cannabis in the country originates from Uganda, after being smuggled to Kenya by road.[63] The trafficking of cannabis resin is reportedly also on the increase, smuggled mainly from Pakistan via Zanzibar (the authorities estimate that 80 per cent of all available hashish originates from this source). Although much of it is only transiting on its way to the European markets, recent seizures show that important quantities nevertheless seem to make their way to the local market.[64]

In recent years, Ethiopia has also emerged as an important trafficking hub for south-east and south-west Asian heroin en route to Europe and America, via west African destinations. This situation is not surprising given the strategic location the country occupies on the Horn of Africa, its relative proximity to west Asia and its long, porous, under-patrolled borders. Moreover, the country's extensive air links to west Africa and the rest of the world make it an ideal entry point for illegal drugs. Most of this traffic is believed to be carried out through the international airport in Addis Ababa, although overland routes could also be used.

This inevitably results in the "spillage" of heroin to local consumers in Addis Ababa. Between 1993 and 1997, Ethiopian police and customs officials apprehended 127 foreign drug traffickers, most of those persons being in transit through Bole International Airport. Two nationalities predominated: Nigerians (80 of the 127) and to a lesser degree Tanzanians (20 in total). Of the remaining 27, 13 came from west African States other than Nigeria, 9 from Europe and North America and 5 from the Red Sea region (Eritrea, Saudi Arabia, Yemen). The provision of an Ethiopian immigration law that allows transit passengers up to 72 hours' stay in Addis Ababa without a visa is designed to maximize the potential for making flight connections through Bole Airport on Ethiopian Airways,

Table 4. **Drug traffickers arrested in Ethiopia, 1993 – 1997**

Country of Origin	Number	Male	Female	Percentage
Nigeria	80	74	6	70.1
U. R. of Tanzania	20	20	1	17.5
France	5	4	1	4.4
Gambia	4	4	–	3.5
Liberia	3	3	–	2.6
UK	2	2	–	1.8
Total	**114**	**107**	**7**	**100.0**

Source: Ethiopian Police Record

but also affords considerable opportunities for heroin in transit to west Africa to find its way onto the streets.

Little is known about the extent of cannabis exports from Ethiopia. The Ethiopian police Counter-Narcotics Unit believes that cannabis cultivation is spreading, particularly among farmers in the north of the country, perhaps with a view to supplying export markets into the Sudan and Saudi Arabia (via Eritrea). Located at the junction of five main highways linking all the southern and central regions of the country, and with a busy through traffic, the main production centre around Shashamene is well placed for the distribution of cannabis to regional markets. The Ethiopian police are aware that cannabis is exported to Saudi Arabia and have made arrests of smugglers along this route. Some of this export trade may emanate from Shashamene, but the staff in the Counter-Narcotics Unit believe that cultivators closer to the trafficking routes are supplying the main exports. The poor quality of much Ethiopian cannabis is likely to restrict the opportunities for export.

In the Horn of Africa, modern transportation and infrastructure have literally changed the face of the khat trade. In fact, as the drug must be consumed within 48 hours of being harvested in order keep its potency, the financial benefits derived from the trade very much depend on the speed with which transporters can deliver their product to the consumer market.

Thus, whereas before fresh khat was only available in or near the areas of production, with the help of paved roads and airplanes the traders have now set up entire networks, which take care of harvesting (during the night), transporting and delivering the drug to the main consumer countries (Djibouti, Ethiopia and Somalia).[65] As several million people are reportedly regular khat users in east Africa, its economic importance to some rural areas is on the increase, especially as modern transportation means now make it possible to reach more customers.[66] Although small but growing quantities of the drug have been seized in Europe and the United States, the fact that khat must be consumed soon after harvest rules out large-scale khat penetration of both of those markets in the short and middle term.

4. West Africa

In west Africa, Nigeria has for over a decade been seen as a significant country in terms of the role its nationals play in international drug trafficking. But there is reason to believe that Nigeria's role in trafficking may be undergoing significant change. Recent arrest figures indicate an intensification of law enforcement efforts in the country, albeit an intensification that has focused most heavily on cannabis-related offenses (see table 5). As mentioned, the efforts of the National Drug Law Enforcement Agency seem to have succeeded in the sense that Nigerian traffickers who in the past used Nigeria as a transit point are believed to be using other countries as their springboard into Europe and North America. This has several implications. Firstly, the now-falling prices for crack cocaine and heroin in Lagos are likely to change course in the near future due to smaller volumes of trafficked drugs entering the country, and accordingly less spillover into the domestic market. At the same time, because of greater risk, higher prices will translate into more profits for syndicates catering to domestic demand.

Of the other countries, more information is available for Ghana, especially from extensive newspaper coverage during the 1990s (encouraged by the Narcotics Control Board as part of its mission of balanced supply and demand reduction). Ghana became a significant transit route in the late 1980s. Cocaine and heroin are carried by couriers using various air routes, with journeys also made by overland transport into and out of Ghana. Cocaine and heroin are also smuggled by post as arrests in Ghana[68] and the United States[69] show. The former case involved a "drug baron", George Bonsu (also known as Benjillo) who was sentenced in 1997,[70] and the latter case a major Ghanaian international trafficker sentenced to 20 years in the United States for trying to import heroin worth $25 million via Ghana.[71]

The involvement of Ghanaians as organizers, and especially as international couriers, is indicated by seizures and arrests at Kotoka International Airport in Accra (and at border posts), in source locations (especially Thailand, where 50 or more Ghanaians are serving long sentences) and at destinations in Europe and North America. Between

Table 5. **Drug-related arrests in Nigeria, 1995 – 1997**

Drug	1995	1996	1997
Cocaine	47	40	91
Heroin	68	66	138
Cannabis	660	1 004	2 143
Total	**775**	**1 110**	**2 372**

Source: Nigeria Drug Law Enforcement Agency[67]

1991 and 1995, at least 231 Ghanaians were arrested for drug offences in other countries.[72] The Narcotics Control Board (NCB) in Ghana estimates that 50 per cent of domestic cannabis production is exported. This is impossible to confirm, although there is no reason to doubt the large scale of the export trade, which the Director of NCB considers to be increasing.[73] Marijuana is exported in herbal form and in compressed form as cannabis "slabs" or oil. A local form of hashish is manufactured by crushing mature (strong) leaves into a powder that is then compressed to make slabs.[74] Oil is extracted from the seeds in a more sophisticated process, likened to the distilling of *akpeteshie*. A "huge quantity of hashish oil" for export was seized in April 1997,[75] in fact 34.7 kg of hashish and hashish oil.[76]

Ghanaian marijuana is highly prized in neighbouring countries, with exports by road facilitated by the proximity of cultivation areas to the borders with Burkina Faso. OGD suggests that the organization of exports to Côte d'Ivoire and Togo draws on networks previously used to smuggle cocoa out of Ghana.[77] Maritime export uses both major ports and the many fishing villages along the coast, where it is said to provide an important source of income, given the fluctuating fortunes of the fishing industry.[78] The ocean traffic is destined for African countries further to the west and east (Angola) and for Europe. The scale of shipments is suggested by major, if infrequent, seizures: a load of nearly 2 tons in the small fishing village of Komenda in 1993,[79] and 5.7 tons at Takoradi in May 1996, packed in 119 plastic drums.[80] In Europe, large consignments of Ghanaian marijuana, often concealed in loads of timber exports, included 0.5 tons seized by Belgian customs in 1995 on the border with France,[81] in February 1997, 3 tons in Rotterdam in a container of Ghanaian timber planks and in November 1997 2.5 tons in Germany.[82] Air freight is less used in export, but marijuana was found in 47 cartons of yams awaiting air freight at Kotoka International Airport and is also said to be air freighted in loads of pineapples and coconuts.[83]

According to the 1998 US State Department International Narcotics Control Strategy Report:

> "Trafficking of cocaine and heroin through the Kotoka International Airport has gone down considerably due to intensified security checks but the same cannot be said of the western and eastern borders, both at Elubo at the border with Côte d'Ivoire and Aflao at the border with Togo."[84]

Ghanaian traffickers reportedly control production in some neighbouring countries (Senegal and the Gambia, as well as southern Burkina Faso along the rivers Sisili and Nahouris). As a result of this geographical spread, it is often difficult to trace the "national" origin of cannabis seized in Europe. Nevertheless, a substantial amount of cannabis originating in Ghana is exported to Europe, particularly Spain and the United Kingdom. This traffic to Europe is mostly carried out by boat transiting the Canary Islands (Las Palmas). An amount of 6.1 tons of cannabis destined for Europe was seized in Ghana in 1996, while Ghanaian cannabis traffickers have been arrested in five European countries.[85]

Senegal is the mainland sub-Saharan African country closest to both the Latin American producer regions and North American consumer markets. Because of its geographical location and a relatively developed transport infrastructure, Senegal is another key transit country in west Africa. Between 1993 and 1997, more than 30 tons of hashish and 5 tons of cocaine passing through Dakar were seized or detected worldwide. According to OGD, in 1997, the trafficking route most often used in Senegal was the Bogota-Caracas-Lisbon-Dakar-Paris route. It reports that, while heroin had until recently been trafficked along the Bombay-Addis Ababa-Dakar route, that route had expanded to include Cape Verde.

5. Southern Africa

The two drugs that are widely trafficked within the southern African region are cannabis and methaqualone. With regard to cannabis, southern Africa appears to be distinct from other cannabis- growing/consuming areas such as west Africa in that there is considerable intra-regional trade among the countries in the region. Cannabis trafficking reportedly takes place in particular among Malawi, Mozambique and South Africa.[86]

As for hashish, seizures suggest that the transiting of large quantities of the drug destined for third countries is commonplace, especially through Mozambique and South Africa. This is not to imply that intraregional drug trade in west Africa does not exist; but it does seem that, at least as regards to cannabis, the extent of overlapping markets is greater in southern Africa, with products from

Box 3.Drug trafficking out of Zimbabwe

For Z$ 50,000 (US$ 2,800), a residence permit in Zimbabwe can be purchased. These permits often are bought by drug traffickers who present themselves as traders. Such "traders" pay a considerable duty on imported clothing and other wares at the border upon arrival; they then sell the goods in Zimbabwe, and ultimately end up purchasing or renting homes, often in residential areas. Those homes are walled and heavily secured with electronic alarms, thus making it difficult for the police forces to seize drugs such as cocaine before the drugs are eliminated, frequently by being flushed into the household plumbing system. Security forces must increasingly seal off sewage ducts prior to making raids on these heavily fortified residences. Sao Paulo seems to be a key source for cocaine, with some routes going from Sao Paulo to the United Kingdom or the Netherlands then down to Zimbabwe before returning to Europe. Traffickers bringing drugs into or through the country are, curiously, going first to Europe, which is often the ultimate destination of the drugs. The reason is that these travellers do not go through European customs– they use the transit gate, only then arriving in southern Africa under far less scrutiny than if they were to come directly from the source countries. Being Zimbabweans, they are also under less scrutiny when bringing the drugs back into Europe. One possible solution is to strengthen security at transit gates.

neighbouring countries being traded more extensively and more "commercially". Bearing in mind the extensive smuggling of commodities that has traditionally characterized west Africa, one must question why there appears to be a far more active intraregional cannabis trade in southern Africa.

One possible explanation is the geographical diffusion of cannabis production in west Africa, where countries such as Ghana, Nigeria and others have relatively developed cannabis cultivation capacity in each country. In the south, by contrast, only South Africa has large-scale, widespread cannabis cultivation; others such as Zimbabwe, while home to cannabis production, must settle for smaller-scale industries in limited, specific geographical locations such as Binge in Zimbabwe and Tete in Mozambique. It is perhaps this limited-scale production that has given rise to geographically associated consumer preferences, with each product taking on real or perceived quality attributes.

The considerable reduction in methaqualone supply in the region seems to have triggered an intraregional reallocation of existing supplies, with the result being more intraregional trade in that product. However, with increasing prices, methaqualone is likely to give rise to further domestic production, a trend likely to reverse the current growth in intraregional methaqualone trafficking.

With regard to heroin and cocaine, the southern African region is not only a transit point for drugs destined for European and North American consumer markets, but, increasingly, a consumer market in its own right, with rising demand fueled by the economic weight and social problems of post-apartheid South Africa. Heroin smuggled from Asia has made its way to South Africa in recent years, often at the hands of west African syndicates, or ethnic Chinese, Pakistani or Indian groups. According to one of the leading sources of drug data in South Africa, the South African Community Epidemiology Network on Drug Use, heroin is also being trafficked into South Africa from Colombia.[87] The size of the South African market, combined with the relatively high buying power of its citizens, ensures that a wider variety of drugs are available on its streets than probably anywhere else in Africa.

One South African police official involved in alien investigation has been quoted as saying that, of the 3,000 Nigerians who applied in 1996 for asylum in South Africa, 90 per cent ultimately came under suspicion of being involved in the drug trade.[88] The long process of verifying asylum applications – up to a year – apparently makes South Africa a choice destination in this regard; each applicant is granted a temporary permit (so-called "section 41" permits) allowing a three-month stay in the country before the case is heard.[89]

Unlike other countries in the region, South Africa has resources to maintain an informant network for the key tip-offs that enable law enforcement authorities to break up drug trafficking transactions. According to one official, dealers often provide information on a particular incoming shipment.[90] If successfully seized, the informant receives a percentage of the seized assets; sometimes this amount can be substantial. Traffickers within the Johannesburg area typically make their transactions within the major hotels in the city; for this reason, the hotels are important "stake-out" areas for the authorities.

As a result of the reopening of Mozambique's two main trade corridors (Beira and Maputo) following the end of the civil war in 1992 and the ensuing increase in cross- border trade, Mozambique has become an important transit point for both legitimate goods as well as drugs and other illicit products, such as weapons and stolen vehicles. A number of relatively important seizures, both in Mozambique and in Europe, point to an increase in the amount of cocaine presumably transiting through Mozambique, especially as couriers attempt to bypass tighter airport controls in South Africa and Kenya.

The lack of basic facilities for freight and cargo screening at Mozambique's ports of Maputo and Beira means that, in effect, they are unregulated entrepôts to the wider markets of southern Africa. In recent years Mozambique has accordingly become a corridor for the smuggling of heroin, hashish and methaqualone from south and south-east Asia. It is believed that a sizeable amount of the methaqualone smuggling takes place at the commercial seaport of Maputo, where most of the freight goes unchecked due to the lack of proper equipment and manpower; the methaqualone is then taken by road or rail to South Africa via Swaziland. In 1993, the Indian authorities seized 1.4 tons of methaqualone in a freight shipment consigned for Mozambique.[91] Methaqualone is also smuggled by air cargo or couriers through Maputo airport, or directly overland, hidden in vehicles, between Kenya and South Africa, via other countries. In recent years, methaqualone-manufacturing facilities catering to the South African market have been operating in Mozambique. This trend was revealed in 1995 when one large-scale methaqualone production facility was discovered and destroyed.

According to reliable sources, courier services are responsible for a considerable volume of drugs trafficked to and through Mozambique.[92] Another emerging trend in Mozambique is the increased use of the shoreline as a depot for drug shipments that are offloaded in the shallow waters just off the coast by major cargo carriers and picked up manually in small fishing boats. In 1997, several tons of cannabis were found along the coastline near the city of Maputo, apparently abandoned after being picked up at sea by fishing boats. Cash smuggling to and from Mozambique of dollars is apparently rampant as well. Some observers believe that Dubai is emerging as a springboard for illegal commerce going to and through Mozambique.[93]

There is known to be regular transit traffic through both Mozambique and Zimbabwe, much consigned for South Africa. With a well-developed transport infrastructure, Zimbabwe offers an attractive alternative to South Africa for those wishing to smuggle long-distance. Heroin now finds its way to Zimbabwe by air from south-east Asia, and by sea via the ports of Beira and Dar es Salaam and then onwards by road or rail, and eventually into South Africa. There is also evidence of some smuggling of cannabis in air cargo and in passenger luggage through Harare International Airport to Europe, although air trafficking is more commonly used for higher-cost illicit drugs. Based on interviews with officials in the country, Nigerians are believed to control much of the smuggling of hard drugs through Zimbabwe, although this perception is not supported by the limited number of arrests for hard drug offences in recent years. Apart from Harare International Airport, Zimbabwe has 11 other airports that offer easy and quick links to neighbouring countries. Customs controls at these points, and at similar small airports in South Africa, are not rigorous.

E. ILLICIT DRUG CONSUMPTION

The explanatory limits of seizure statistics in the context of sub-Saharan Africa are particularly self- evident when seen alongside survey information on consumption trends. Whereas the seizure information in tables 1 – 3 provided a somewhat equivocal scenario of trafficking trends from 1994 to 1996, the surveys undertaken for this study indicate a very different development, one of a secular rise in consumption in the countries visited.

For example, table 6 indicates survey responses in five countries to the question of what respondents expect of drug abuse trends in the future. It is clear that, except for Nigeria, there is deep pessimism, suggesting a worsening of the drug situation in those countries, an assessment that is not as self-evident in the context of seizure information.

1. East Africa

A variety of drugs are abused in Kenya. Apart from the traditional intoxicants, socially and culturally accepted by large segments of the population, such as alcohol, tobacco, cannabis and khat, a number of new substances such as methaqualone and heroin have progressively come to permeate Kenyan society in the last two decades. A rapid assessment undertaken for UNDCP in 1995 indicated that the drug abuse problem was greater than expected and had permeated all strata of Kenyan society, with youth being the group most at risk.[94] Khat is culturally acceptable to many communities, especially Swahili. The abuse of a wide array of depressants has been reported in connection with khat consumption (as khat causes insomnia, many users resort to the use of depressants in order to sleep). Cannabis, despite being illegal, is both cheap and widely available, and appears to be used by a growing number of younger and older men (but few women).[95]

In a survey undertaken for this study in Kenya, (see tables 7 and 8) ex-street children, rural and urban secondary school students, university students and rural and urban hospital patients were asked questions on their familiarity with the problem of drug abuse.[96] A total of 365 respondents replied; of this sample, 63 (17.5 per cent) were regular drug abusers. The drugs most used were cannabis (8.3 per cent), volatile substances (4.7 per cent), cocaine/cannabis combination (1.1 per cent), amphetamine/cannabis combination (0.6 per cent), cocaine (0.3 per cent), cocaine/amphetamine/cannabis (0.3 per cent) and cocaine/methaqualone (0.3 per cent). The majority of drug users were under the age of 30 (76.2 per cent). Of the 63 drug users, 32 (50.8 per cent) were aged 10 – 19 years, 16 (25.4 per cent) were 20 – 29 years, 11 (17.5 per cent) were aged 30 – 39, 3 (4.8 per cent) were between 70 and 79 and 1 (1.6 per cent) was between 80 and 89.

Other findings from Kenya include the following: 32.8 per cent of the 67 secondary school teachers responded that drug abuse was a problem in their schools; 67.2 per cent believed that drug abuse was not a problem in their schools. Of 50 health workers, 98 per cent expressed the view that illicit drug use would increase in the future; the drugs cited as those most likely to be a problem in the future were cannabis, diazepam and heroin, in that order.

All 32 community leaders interviewed in Kenya felt that illicit drug use was a problem in their communities, with the main drugs of concern being cannabis herb, cannabis resin, cocaine, heroin, methaqualone, home-brew and amphetamines, in that order. In the past decade, heroin abuse has spread rapidly throughout the coastal towns of eastern Kenya, principally Malindi and Mombasa and, to a lesser extent, to the islands of Zanzibar, Tanga and Lamu.[98] One characteristic of this abuse pattern is that heroin tends to penetrate predominantly Swahili communities. Some authors have established links between the increase of heroin abuse in coastal Swahili communities, the important growth of the tourist industry in and around those communities (with the associated consumer values) and the rise of Muslim revivalist groups, created partly as a response to the spread of heroin abuse.[99]

It is to be noted that the Muslim groups appear to have acquired a rising influence among the communities from which they stem. In fact, their stance is not only against heroin abuse but against other drugs (such as more culturally acceptable cannabis, khat or alcohol) as well. The report on the rapid assessment mentioned earlier concluded that solvents (glue, detergent, petrol) were abused either by streetchildren or to increase the potency

Table 6. **Expectations of future drug abuse trends (percentage of respondents)**

	Illicit drug use will increase	Illicit drug use will decrease	Don't know
Kenya (N = 365)	78	21	–
South Africa (N = 47)	67	12	21
Mozambique (N = 426)	67	22	11
Cameroon (N = 972)	69	10	13
Nigeria (N = 701)	19.7	23.3	44.9

Table 7. **First drugs of abuse for different age groups in Kenya (percentage of each age group that began with cited substance (N = 63))**

Age	Glue and solvents	Cannabis	Psychotropics (methaqualone, amphetamine)	Cocaine
0 – 9	75	25		
10 – 15	40	31		
16 – 20		73	13	
21 – 25		75		
26 – 30		67		33

Table 8. **Expected future trends of drug abuse in Kenya (percentage)**

Respondents	Expect improvement	Expect worsening	Expect stabilization
Secondary school teachers (N = 71)	12.7	87.3	–
Health workers (N = 50)	2.0	98.0	–
Community leaders (N = 32)	12.9	83.9	3.2
Religious leaders (N = 29)	13.8	82.8	3.4
Law enforcement officers (N = 30)	36.0	54.0	9.0

Table 9. **Percentage of secondary school students who have ever used drugs, Addis Ababa, January 1998[97]**

	Public government owned school (N = 196)	Private school (N = 45)
Alcohol	17.9	57.8
Khat	9.2	48.9
Tobacco	5.1	35.6
Cannabis	1.0	31.1
Psychotropics	5.1	22.2

Table 10. **Major substances of abuse in Addis Ababa, January 1998**

	Health workers mentioning substance (% of 47)	Teachers mentioning substance (% of 50)
Tobacco	94	76
Alcohol	92	60
Khat	89	50
Cannabis	62	20
Heroin/opiate	9	4
Cocaine	10	2

of local brews. UNDCP also reports that, while methaqualone use seems on the decline, benzodiazepine abuse is on the rise in the country.[100]

The most widely used drug in Ethiopia by all accounts is khat (see tables 9 and 10). Although it has been consumed for centuries, recent years have witnessed a significant increase in the consumption of the product, or at least its diversification into groups that were traditionally seen as non-users: Christians, women and children. As for cannabis, its use is reportedly increasing, especially among young people, and in urban areas. In a survey undertaken for this study, 98 per cent of the 122 khat farmers interviewed identified khat as the main drug causing dependency in their community.[101] Indeed, 20 per cent admitted that they had developed a dependency to khat.[102]

In Ethiopia, total acreage under cannabis cultivation in the country is increasing. Although most cannabis consumption is for recreational purposes, Ethiopia has a long tradition of ritualistic and religious consumption as well (Rastafarians and monasteries). Groups particularly exposed to drug abuse are taxi drivers, bus drivers and, increasingly, students. Reports point to increased consumption of drugs by students, especially during examination periods. Some students reportedly use khat and alcohol as well as stimulants, though incidence of heroin and cocaine use is very rare.[103]

A UNDCP rapid assessment study completed in Ethiopia in November 1995 found that 93 per cent of the nearly 2,000 social, medical and public health workers surveyed considered drug abuse a very serious problem in the country.[104] The study showed 82 per cent of street children, commercial sex workers and street vendors as having used addictive drugs or substances. Khat, alcohol, hashish, tobacco and solvents were the most abused substances according to the law enforcement officers interviewed. Table 10 shows the results from a survey of health workers and teachers undertaken for this study on the substances abused.

The Ammanuel Hospital, the sole medical institution in Ethiopia with a drug rehabilitation component, treated three heroin cases in 1997 – a small number, but striking as heroin consumption had until then been assumed to be a problem of other countries.

In general, therefore, a cautious prognosis of the drug abuse situation in Ethiopia would reflect the following: at present the consumption of khat is the predominant drug concern in the country. In recent years, the consumption of khat has expanded beyond the traditional group of elderly, Muslim men.

Consumption now cuts across age groups, with children increasingly involved; across gender groups, with more women; and, perhaps most importantly, across the religious spectrum, with orthodox Christians consuming in growing numbers.

Indeed, this last point – the expansion of khat consumption beyond the Muslim community – could explain in part the khat-related concerns, sometimes expressed as hysteria, of the Christian community, whose members are some of the most vociferous advocates of drug control in the country.

Box 4.Cannabis and mental illness

The World Health Organisation, in a 1997 study, states that at present "there are important gaps in knowledge about the health consequences of cannabis use".[105] The study points out that "chronically there are selective impairments of cognitive functioning, and dependence syndrome may develop. Chronic cannabis use may also exacerbate schizophrenia in affected individuals. On the other hand, several studies have demonstrated therapeutic effects of THC for nausea and vomiting in advanced stages of cancer or AIDS and studies on the other therapeutic uses are under way." The uncertain impact of cannabis might lead some observers to question whether the prevalence of cannabis use in Africa warrants concern. Discussions with medical practitioners in the countries visited during preparations for this study indicated a consensus that there is. There is a widely held view among medical specialists in African cities that cannabis can precipitate– not necessarily cause– the onset of mental illness such as schizophrenia. Doctors in Zimbabwe, for example, conclude that, if and when compulsive cannabis use triggers psychological problems in youth, the end result is that drug abuse causes a hiatus in social development at a very pivotal phase in the child's life. Again, this theory has yet to be empirically proved, but throughout field visits undertaken for this study, when asked what effects cannabis had on mental health, medical experts gave similar answers.

Table 11. **Expected trends in drug abuse in Nigeria (percentage of respondents)**

N = 701	Cannabis	Heroin	Cocaine
Increase	31.0	18.3	19.7
Decrease	30.7	24.8	23.3
No Change	6.0	3.4	7.0
Don't know	28.0	48.4	44.9

In early 1998, 43 per cent of patients with psychiatric disorders at the psychiatric hospital in Addis were khat addicts.[106]

2. West Africa

According to the authorities in Côte d'Ivoire, although cannabis is the main drug of abuse in the country, the consumption of heroin, cocaine and psychotropic substances constitutes a cause for concern.[107] The risk lies primarily in the "spillover" potential resulting from the country's – particularly Abidjan's – role as a transit point in the international trade in cocaine and heroin. Among the psychotropic substances abused within the country are methamphetamine, barbiturates, rohypnol and valium. These substances are reportedly in transit and end up on the streets of the country, often consumed as a means of self-medication. In order to identify in greater detail the illicit drug consumption trends in the country, UNDCP and the Government of Côte d'Ivoire plan to undertake a rapid assessment study of abuse trends in 1998.

While the international community often focuses on Nigeria in terms of its trafficking role, Nigerians themselves appear no less concerned with the problem of drug abuse. Indeed, more than other countries such as Ethiopia and Kenya, Nigeria appears to have developed a serious abuse problem in response to the spillover of drugs originating elsewhere. There also seems to be a rise in the misuse of solvents (glue and petrol). Out of 701 respondents interviewed for this study, a total of 87 (12.4 per cent) said they had experimented with illicit drugs; 83.6 per cent had never done so; and 4 per cent did not respond.[108] A total of 12 (1.7 per cent) used drugs at least once a week; 9 (1.3 per cent) used some type of illicit drug at least once a day.

Amphetamine use seems to be on the rise, particularly in northern parts of Nigeria. The abuse of hard drugs such as heroin, cocaine or LSD seems low beyond the urban centres. The in-country research team reports that cannabis is often provided at retail level by dealers who operate from so-called "joints" or nightclub-like establishments where drugs are freely available. The original source of the drug is from plantations within the country. A total of 64.8 per cent of the respondents in Nigeria expressed the view that cannabis was available.[109] With regard to heroin and cocaine, dealers can be found in most of the downtown areas of Lagos Island and the mainland. Table 11 shows survey results on expected trends.

Two possible explanations lie behind the prominence of the "don't know" response. The first possibility is that the drug problem, largely through the efforts of the law enforcement authorities, is contracting. Indeed, particularly for heroin and cocaine, many respondents expressed the view that the abuse of those substances had subsided. The other possibility, however, is that a considerable portion of respondents are reluctant to express their views on the matter. In both the retrospective and future-oriented questions, the high proportion of non-committal responses is in this light significant. One often heard criticism of the National Drug Law Enforcement Agency's (NDLEA) efforts has been that the Agency emphasizes supply reduction efforts at the expense of demand-side interventions. Informed observers note that although governmental and non-governmental organizations carry out anti-drug public awareness campaigns, these are usually sporadic.

Table 12 gives reason to believe that NDLEA is making some progress in raising awareness of drug abuse issues in the country. The high profile of these demand-side interventions could well be due to the overall profile of drug control efforts, again a consequence of the intensification of law enforcement that has taken place since 1994.

In Ghana in 1997, 6 per cent of patients admitted to the central psychiatric hospital in Accra were regular cannabis users. The figure used to be much higher, but officials at the hospital believe that the reduction is due to a growing stigma attached to admittance to an institution where drug addiction is seen as a mental illness on a par with schizophrenia and manic depression. Heroin and cocaine are widely available, especially in the tourist areas along the beach, but their price range still prevents the average Ghanaian from using these drugs. Most of the misused licit medications, some of which are produced domestically, are obtained informally through hospitals and pharmacies.

Cannabis is the main drug of abuse in Senegal, though heroin and cocaine abuse are increasing rapidly particularly in Dakar among the middle class and unemployed. Reports that crack cocaine is available and its use spreading have surfaced since 1991.[110] Drug abuse among youth is pervasive, particularly that of solvents. In 1998, UNDCP and the Government of Senegal will undertake a rapid assessment of drug abuse trends in the country. The last comprehensive assessment was undertaken in 1988 by the United Nations Educational, Scientific and Cultural Organization (UNESCO), which

Table 12. **Public education campaigns and rehabilitation programmes in Nigeria (N = 701, percentage)**

	Anti-drug public education campaigns	Treatment and rehabilitation programmes
Awareness:		
Yes, aware	70.8	40.4
No, not aware	20.8	50.1
No response	8.4	9.5
Perceived effectiveness:		
Very Effective	16.7	8.1
Moderately Effective	35.0	18.5
Ineffective	18.1	13.1
Counterproductive	2.6	1.4
Don't know	**6.8**	**17.8**

Table 13. **Functional use of cannabis in Cameroon (N = 972)**

Functional use of drug	Percentage of respondents familiar with use
To increase agricultural output:	38
As a pesticide	13
As a fertilizer	13
To enhance performance in sport:	82
"Improve efficiency"	59
A stimulant	35
"Courage"	4
To increase artistic abilities:	80
Reduce stress	46
"Inspiration"	16
Enhance endurance	9
For traditional – religious rites:	16
Traditional medicine	7
Increase "mystic power"	5
Sacrificial ceremony	3
To enhance sexual experience:	58
Enhance performance	36
Enhance sensation	11
Hygiene (and use as prophylactic against sexually transmitted disease)	5
"Bewitchment"	3
Other (cannabis):	12
Hair-growth enhancer	5
Antidote against filaria	4

found that 12 per cent of girls and 10 per cent of boys interviewed in Dakar had used drugs, specifically tranquillizers, and that 2 per cent were regular users.[111] In Cameroon, a UNDCPrapid assessment study completed in January 1995 showed that cannabis, amphetamine-type stimulants, cocaine, solvents and benzodiazepines were the most commonly abused substances (in order of importance), accounting for 91 per cent of all substances abused by the respondents.[112]

The rapid assessment found that drug use was often more "utilitarian" than recreational in the sense that individuals turned to drugs to carry out specific tasks or to deal with the stress and difficulties induced by a particular lifestyle or professional occupation. These findings were confirmed and amplified during the data-gathering for the present study. Cameroon was exceptional in the sense that cannabis, in particular, seems to be perceived as fulfilling a myriad of functional uses. Of the 972 respondents – of whom 54 were farmers – 34 per cent expressed the view that cannabis was used to enhance agricultural output.[113] A full 80 per cent of respondents expressed the view that drugs could be used in sports to enhance performance.[114] About 80 per cent confirmed the use of drugs to enhance artistic ability. A total of 58 per cent of respondents expressed the view that drugs in Cameroon were used to enhance sexual performance, with 37 per cent unaware of such practices.[115] Table 13 provides more information on the phenomenon of multi-functional use in Cameroon that was not documented elsewhere. Despite these common perceptions, however, law enforcement officials are concerned by increasing illicit consumption, particularly of heroin and cocaine. There are signs that some of the trafficked drugs are increasingly spilling over into an emerging consumer market in Cameroon. Law enforcement officials are particularly concerned by a still small but growing volume of heroin sent by post to destinations in Cameroon – suggesting nascent consumer demand within the country. Indeed, despite table 13, of those interviewed for this study, 74 per cent deemed drug abuse to be a serious problem, against only 9 per cent who believed it was not.[116]

3. Southern Africa

In South Africa, recent research points to a general increase of drug abuse, particularly in the younger population, while the structure of demand patterns seems to be changing as well. New drugs are entering the market and heretofore unaffected segments of the population are likely to witness a rise in consumption.

Cannabis is the most extensively used drug in the country; it has been grown for local consumption for over 500 years, when it was first introduced in southern Africa by Arab traders and nomadic Bantu-speaking tribes.[117] With an average retail price of R 6 per gram, it is the cheapest of all available drugs. Further underlining this pattern is the fact that the local production of cannabis is widespread, while retail outlets have multiplied in urban areas, spreading to shopping malls and other popular places.[118]

According to sources in Pretoria, the retail price of cocaine has collapsed in recent years, as has that of Ecstasy; indeed, the authorities have noted a constant fall in crack cocaine prices from R 300 ($50) per gram in 1992 down to R 180 ($30) per gram in 1996.[119] Interviews with police officials indicate that since 1996 prices have continued to fall. Conversely, the purity of cocaine has gone in the opposite direction, towards an increase. In November 1997, Ecstasy at retail level was priced at R 65 ($10.8) per pill.[120] LSD on the other hand seems to have become more expensive. At the so-called "rave" scene, LSD costs approximately R 40 ($6.7) in Pretoria. Today, cocaine at retail level costs about R 250 ($49), with crack selling for R 70 ($11.7) per "rock".[121] Although heroin consumption is reportedly on the rise, the drug has not yet penetrated the domestic market to any significant extent.[122]

The authorities attribute the low demand for heroin to the prevalence of the drug called Wellconal ("Pinks"), which has dipipanone as an active ingredient and which has similar effects to heroin. Wellconal, a prescription painkiller, is often used by terminally ill patients[123] and thus has the potential to reach into even the least privileged socio-economic groups in the country's so-called "raves".

The South African police estimate that no fewer than 70 per cent of attendees are using Ecstasy at the raves; 90 per cent of these users fall into the 14 – 16 age group.[124] It is less expensive than heroin and its purity is consistently high, as it is produced in sterile laboratory conditions. In South Africa, surveys for this study were held with 47 key informants, including specialists in criminal justice (29.8 per cent), health (14.9 per cent), welfare and drug rehabilitation (51.1 per cent), youth organizations (2.1 per cent) and business (2.1 per cent). The respondents were either national or provincial representatives, with 66 per cent identified as government-affiliated and 34 per cent as non-governmental.

Table 14 provides their view of what the drugs most likely to increase in popularity will be in South Africa. Records on drug-related arrests (dealing/possession) in South Africa indicate that there was a decline in cannabis and methaqualone-related arrests between 1992 and 1995 and an increase in cocaine-related arrests during the same period.[125] The majority of respondents – 89 per cent – believed that, among the reasons likely to fuel crack cocaine abuse, increased availability was the most significant, followed by peer pressure and public tolerance and media projection of drug use as acceptable. A full 91.8 per cent of respondents identified increased supply and media influence as likely to contribute to increased designer drug use. Generally, it is expected that the prevalence of illicit drug use among adults will increase, particularly in urban areas, in low socio-economic groups, among middle age groups, among women and possibly in the top socio-economic groups as well.

The national research team reports:

> "Available information also suggests that a major sector of South African adults find themselves in a social environment conducive to drug use, i. e., an environment in which there is a fair degree of social support for drug use, exposure to such use and limited discrimination against it."[126]

Table 14. **Drugs expected to increase in popularity in South Africa**

Substance (N = 47)	**Key informants citing substance (percentage)**
Designer drugs (Ecstasy)	90.9
Crack cocaine	71.4
Cocaine	66.7
LSD	65
Heroin	45

Table 15. **Socio-economic reasons for the likely increase in adult drug use in South Africa**

Reason	**Key informants citing this reason (percentage)**
Weak policing and law enforcement	15.6
Weak border control	14.5
Economic pressure	14.5
Insufficient services (drug treatment facilities)	10.8
Demographic pressures	10.2
Decriminalization advocacy	9.7

With regard to children, there is an expected increase in the number of drugs used as well as the frequency and volume of intake. The increase is likely to pertain to older youths, among relatively new entrants into the consumption market, including girls in the lower socio-economic sectors (informal settlements), urban dwellers and historically disadvantaged groups.

Table 15 cites some of the main "socio-economic" reasons for an expected deterioration in South Africa's drug problem. Note that the main reason was a purely political factor, namely, policing and law enforcement weakness, due not least to the legacy of the apartheid system (this issue is examined in further detail in chapter V).

Apart from traditional uses of cannabis and psychotropic drugs, Mozambique has not yet developed a serious abuse problem.[127] Nevertheless, new illicit drugs have reportedly appeared on the market, especially methaqualone, heroin and cocaine, most likely as a spillover from the drugs transiting the country. With regard to cannabis consumption, the in-country research team observed that:

> "The cultural context of traditional consumption of cannabis has been destroyed. Regulations imposed by elders and chiefs have been lost due to the liberalization and commercialization of cannabis."[128]

As reflected in table 16, of the 1,070 respondents in Mozambique interviewed for this study, 18 per cent said that they used drugs regularly.

Predictably, the highest percentage of users were found in the urban neighbourhood areas of Maputo: of the 305 respondents in Maputo, 26 per cent were drug users.[129]

At present Zimbabwe appears to have a relatively limited illicit drug problem. While a highly developed transport infrastructure and looming economic, social and political challenges on the horizon leave it vulnerable to worse in the future, it is noteworthy that Zimbabwe has in place certain safeguards that limit domestic consumption and trafficking. The limited scale of the problem at present should not overshadow the potential for an escalation fueled by the spread of AIDS and its impact on family structure. Table 17 shows some of the reasons cited by survey respondents as likely causes for the expected rise in abuse. Table 18 shows perceptions of availability of drugs in various parts of the country. The recent drug-related development of most concern to many within Zimbabwe is the increasing use of cannabis among the country's youth. Whereas cannabis has been consumed traditionally by elders for centuries, particularly in the provincial district of Binga, the regularly consuming population has in the past decade expanded to include young children. At this point in time the abuse of hard drugs such as cocaine and heroin is negligible in Zimbabwe, at least among the African majority. Within the minority white population the abuse of hard drugs, including that of Ecstasy and methaqualone, seems to be more prevalent. A recent study of drug use among secondary school students in Zimbabwe found that the highest risk factors for drug use among students were high parental income, education and drug use by parents, siblings or friends.[130]The survey undertaken for this study,

Table 16. **Drug abuse prevalence in Mozambique**

	Number of respondents	Male (percentage)	Female (percentage)	Current users (percentage)
Public schools	346	50	50	11
Private schools	322	53	47	18
Neighbourhoods	305	74	26	26
Infulene Psychiatric Hospital	64	45	55	25
Total	**103.7**	**56**	**44**	**18**

Table 17. **Reasons for likely increase in drug use in Zimbabwe in the next five years (N = 200)**

Reasons for increase	Number of responses	Rank of response	Percentage
Economic hardship	72	1	36.0
Increasing availability	19	3	9.5
Population growth	9	4	4.5
Increase in number of orphans	7	6	3.5

with 200 key informants in Harare and other sites, indicates, generally, an increase in drug use. The survey included interviews with key informants from the local community. Eight focus group discussions were also held, and the findings below from the survey are generally consistent with the qualitative results from those exchanges. With an estimated 1993 average street price per gram of between Z$ 1 ($0.06) in the north and Z$ 5 in the capital, cannabis is the cheapest and most readily available drug in Zimbabwe.[131] In the northern regions, cannabis consumption is apparently well integrated into the local culture, especially within the Tonga ethnic group.[132] However, the non-traditional use of the drug is spreading, especially among youth in large urban centres. Alcohol consumption, as in all the countries examined in this study, is by far the major substance-related issue.

In Zimbabwe, the binge consumption of homemade brews such as "*katchasu*" takes place not only in makeshift bars throughout downtown Harare but in the provinces as well. Alcoholism is the more explicit consumption problem despite the considerable price differential between a pint of homemade brew (Z$ 4.5) and a "twist" of cannabis.

F. CONCLUSION

The above information allows several conclusions. Firstly, the available information at the country and regional levels suggests that at present the main drug of concern in sub-Saharan Africa is cannabis. However, this is likely to change, as other drugs, most notably cocaine and heroin, have begun to emerge in certain pockets of the region.

Box 5.Drug addiction in Cape Town

The Counselling Centre in Cape Town is the leading centre for drug rehabilitation in the Western Cape region. During interviews in November 1997, its staff provided an overview description of its patients. In 1996, 22 per cent of its patients were adolescents, a figure that rose to 26 per cent in 1997. Two thirds of the addicts who seek treatment at the Centre are under 30.

Other characteristics:

1. 70 per cent of addicts seeking treatment at the Centre began using drugs in their teens.
2. It is estimated that addicts spend between 26,000 – 36,000 rand ($4,300 – 6,000) each year on drugs.
3. It is estimated that for each 100 persons successfully treated, the costs to the social service system are between R 2 – 10 million ($330,000 – 1.7m) per year.
4. According to the Centre's staff, the main contributing factors for child drug abuse are absent fathers; chemically dependent parents (especially alcoholics); deterioration in the school system due to many teachers and administrators resigning; and the pressures created by uncertainty and post-apartheid political change. The most significant factor, according to the staff, is the growing availability of drugs. For the wealthier children, the rave scene seems to introduce many to Ecstasy, as many in that class seem to associate "fitting in" with taking drugs. But in the lower income groups, methaqualone and cannabis are the major drugs of abuse, again to fit in, but this time in neighbourhood gangs. Peer pressure seems to affect both groups.
5. Cape Town is not a city of widespread injecting.
6. The number of patients addicted to crack has skyrocketed from 0 per cent in 1995 to 8 per cent in 1996 to 35 per cent in 1998.
7. The main consequences of addiction appear to be divorce, job loss and income loss.

Table 18. **Drug abuse prevalence in Harare and other sites in Zimbabwe**

Region	Number interviewed	Percentage ever used	Percentage current User
Binga	48	29	6
Harare-City Centre	25	36	8
Harare-Mbare	50	70	28
Harare-Highfield	39	51	0
Mutoko	38	63	21
Total	**200**	**51**	**14**

Secondly, the consumption of cocaine, crack cocaine and heroin is principally an urban phenomenon, confined to large cities; its use has been underpinned by a growing availability at lower cost. The third point to be emphasized, however, is that the above observations provide only a part of the picture. The above information has provided a benchmark, or a qualitative baseline. The consistent forecasts of worsening drug-related problems need to be substantiated on the basis of a broader, multidisciplinary analysis. This is the aim and objective of the next three chapters.

Notes

1 Lotsof, H.S., Smith, C.A., and Bastiaans F. and J., *Ibogaine, Trauma and Abreaction in Treatment of Chemical Dependence*, International Institute on the Prevention and Treatment of Dependencies, 1996, ICAAAmsterdam.
2 UNDCP Technical Series No.3. Vienna, *Amphetamine-type Stimulants: A Global Review*, 1996, p. 117.
3 Wellconal is obtainable as a tablet which contains the anti-emetic, cyclizine, in addition to dipipanone. Wellconal is, however, rarely taken orally by abusers, but is rather crushed, dissolved in water and injected. This is done to obtain a marked high . . . the intravenous injection of a medicine which is produced in tablet format, leads to special problems. Apart from the dangers attached to self-injecting . . . the injection of tablet ingredients is undesirable. This may lead to anaphylactic reactions, damage to heart, lung and muscle tissues, and local tissue reactions at the sites of injection. (Information provided by David Bayever, Director, Drug Wise, P. O. Box 95123, Grant Park 2051, South Africa.)
4 C.I.D.Kenya report of 12 November 1997.
5 DEA. Kenya country profile: 1996.
6 Interview with officers from the Counter-Narcotics Unit, Addis Ababa. February 1998.
7 Interviews with users, Addis Ababa. February 1998.
8 Interview, Shashemene district. February 1998.
9 NDLEA. 1997. *Battle Against Drug Scourge: Bamaiyi's Magic Wand*. Lagos.
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11 Observatoire Geopolitique des Drogues (OGD). 1995. *West Africa: In-Depth Assessment Study on Drug Production and Local Trafficking, in particular related to Cannabis Cultivation.* Paris: OGD (Report to the European Commission, D-Afr/94/01) p. 36.
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13 *Ghana Times 24.10. 1997.*
14 Observatoire Geopolitique des Drogues (OGD). 1995, *op. cit.,* pp. 36and 37.
15 Observatoire Geopolitique des Drogues (OGD). 1995, *op. cit.,* p. 37.
16 Ibid.
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18 Observatoire Geopolitique des Drogues (OGD). 1995, *op. cit.* p. 37.
19 Interview with trader, Accra. February 1998.
20 Interviews in Ghana including police officials. February 1998.
21 U.S. Department of State, International Narcotics Control Strategy Report, March 1998, Bureau for International Narcotics and Law Enforcement Affairs. Washington: Department of State, March 1998.
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27 Ibid., p. 7.
28 UNDCP HONLEA Africa, *Current Situation with Respect to Regional and Sub-regional cooperation,* Abuja 20 –24 April 1998. Report UNDCP/HONLEA/1998/CRP.1, p. 7.
29 South African Police Services. 1996. *The Extent of Drug Trafficking in South Africa*. Pretoria: SANAB and CIMC. p. 5.
30 Atkins, A. 1997 *The Illegal Drugs Trade and Development in South Africa: Some Observations.* London: Catholic Institute for International Relations (CIIR).Ryan, T. 1997. *Drugs, Violence and Governability in the Future South Africa*. Halfway House: Institute of Security Studies, ISS Papers No 22 Rocha-Silva, L.1998. *Drug Use Within the Context of Other Socioeconomic Conditions in South Africa,* A Report for the United Nations International Drug Control Programme (UNDCP). Pretoria: South Africa.
31 INCB. 1998. *Report of the International Narcotics Control Board for 1997*. New York: United Nations. pp. 30 – 31. "The Board urges Governments of the countries concerned to re-examine their needs for psychotropic substances and to ensure adequate supply of those substances for medical purposes. The Board invites WHO to support those countries in those endeavors".
32 Interview with R.Hove, Medicines Control Authority of Zimbabwe, Nyanga. 26 November.
33 Interview with A. P. Reeler, clinical director at Amani Trust, Harare. 27 November.
34 Interview, with R.Hove, of the Medicines Control Authority of Zimbabwe, Nyambe. 26 November.
35 South African Police Service. 1996, *op. cit*., p. 7.
36 Ibid.
37 Presentation by Superintendent J.J. Van Aarde: the extent of drug trafficking in South Africa and the nexus between drugs and crime: workshop on the illegal narcotics trade in Southern Africa: 5 – 6 June 1997, University of Witwatersrand, Johannesburg.
38 South African Police Service. 1996, *op. cit*., p. 7.
39 Ibid.
40 International Narcotics Control Board, *Report of the International Narcotics Control Board for 1997*. New York: United Nations. 1998. p. 34.
41 Ibid.
42 Interview with khat farmer, Nyambe/Meru District of Kenya. 5 November 1997.
43 Interview with district agricultural officers, Meru/Nyambene. Kenya, 5 November 1997.
44 UNDCP Technical Series No.7. Vienna, 1996. Supply Reduction and Law Enforcement Section. 1998. *Supply of and trafficking in narcotic drugs and psychotropic substances*, p. 17 and 18.
45 *Daily Graphic 10.9. 1996.*
46 Interviews with residents of Nima and street dealers, Accra. February 1998.

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[48] Observatoire Geopolitique des Drogues (OGD). The World Geopolitics of Drugs, 1995/1996. Paris, Washington and Madrid: OGD, September 1997.
[49] UNDCP Technical Series No.7.Supply Reduction and Law Enforcement Section. 1998, *op. cit.*, p. 20.
[50] Ibid.
[51] UNDCP. HONLEA Africa, *Current Situation with Respect to Regional and Sub-regional cooperation*, Abuja 20 –24 April 1998. Report UNDCP/HONLEA/1998/CRP.1, p. 18
[52] Ibid., p. 15.
[53] UNDCP Technical Series No.7.Supply Reduction and Law Enforcement Section. 1998, *op. cit*., p. 80.
[54] INCB, 1998, *op. cit.*, p. 35.
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[56] Ibid.
[57] *The News*, 1. 7. 1996
[58] UNDCP Technical Series No.7.Supply Reduction and Law Enforcement Section. 1998.
[59] DEA. Kenya country profile: 1996
[60] OGD, *The Geopolitical Drug Dispatch*, N.55, May 1996, p. 7.
[61] DEA. Ethiopia country profile: 1996.
[62] DEA. Kenya 1996 country profile: 1996.
[63] ARQ. Kenya 1996, Part III: Illicit traffic.
[64] Ibid..
[65] Ibid.
[66] US Department of Justice, Drug Enforcement Administration, Intelligence Division. Khat Fact sheet. December 1993.
[67] For 1995 – 1996 figures, see NDLEA; *Battle against Drug Scourge: Bamaiyi's Magic Wand*. For 1997 figures, the Guardian (Lagos) January 211998, reporting on press conference by NDLEAchairman – figures for cocaine and heroin arrests in 1997 are estimates.
[68] *Ghana Times*, 29. 3. 1996.
[69] *Ghanaian Chronicle*, 28.9. 1992.
[70] *Ghana Times*, 1.5. 1997.
[71] *Ghanaian Chronicle*, 28.9. 1992.
[72] Statistics supplied by NCB in February 1998.
[73] February 1998 interview, Accra.
[74] Interviews with traders, Accra, February 1998.
[75] *Ghana Chronicle*, 23.4. 1997.
[76] Ghana, Narcotics Control Board. 1997
[77] Observatoire Geopolitique des Drogues (OGD). 1995, *op. cit.*, p. 39.
[78] Observatoire Geopolitique des Drogues (OGD). 1995, *op. cit.*, p. 40.
[79] Observatoire Geopolitique des Drogues (OGD). 1995, *op. cit*., p. 41.
[80] *Ghana Times*, 10.2. 1997.
[81] OGD. 1997.
[82] Narcotics Control Board. 1997. *Annual Report of the Narcotics Control Board*, (Ghana).
[83] *Weekend Spectator* 27.3. 1997.
[84] U.S. Department of State, International Narcotics Control Strategy Report, March 1998, Bureau for International Narcotics and Law Enforcement Affairs (Washington: Department of State, March 1998).
[85] DEA. Ghana country profile: 1996.
[86] DEA. Mozambique country profile: 1996.
[87] SACENDU. 1997. *Monitoring Alcohol and Drug Abuse Trends: July-December 1996.* Cape Town: Medical Research Council. p. 16.
[88] Captain Giacomo Bondesio, of the SAPS Aliens Investigation Unit, quoted in the Sunday Independent of 22 June 1997.
[89] This situation has parallels with the emerging trafficking problem in Ethiopia, where transit passengers are allowed to stay in Addis Ababa for up to three days, without visas, as long as they exchange their passport for a so-called "pink card". According to police officials in Addis, this privilege is being thoroughly exploited by traffickers who are using the three-day stopover to make drug deliveries and pick-ups.
[90] November 1998 interview, Johannesburg.
[91] DEA. Mozambique country profile: 1996.
[92] 18 November 1997 interview with Peter Atkinson of Crown Agents, the entity entrusted by the government with the task of revitalizing the customs and excise capabilities of the country.
[93] Ibid..
[94] UNDCP. 1995. *Rapid Assessment of Drug Abuse in Kenya: A National Report*. Vienna: UNDCPp. 4.
[95] ARQ. Kenya 1996, part II: Drug Abuse.
[96] In-country research team (Kenya) report, p. 1.
[97] A total of 196 students from public schools, and 45 students from private schools were surveyed in Addis Ababa. The gender ratio in the public school was 63.7 per cent male, 36.3 per cent female. The gender ratio in the public school was 55 per cent male and 45 per cent female.
[98] See for example Beckerleg, Susan 1995. "Brown Sugar" or Friday Prayers: Youth Choices and Community Building in Coastal Kenya. *African Affairs* (1995) 94, pp. 28 – 38 and: Susan Beckerleg, Maggie Telfer, and Abudi Kibwana Sizi. 1996. ,Private Struggles, Public Support: rehabilitating heroin users in Kenya. *Drugs: education and policy*, vol. 3, No.2, 1996.
[99] Susan Beckerleg, Maggie Telfer, Abudi Kibwana Sizi. 1996. Private Struggles, Public Support: rehabilitating heroin users in Kenya. *Drugs: education and policy*, vol. 3, No. 2, 1996. pp. 160 – 161.
[100] UNDCP *East and Southern Africa: Subregional Programme* Framework, p. 6.

[101] In-country research team (Ethiopia) report, p. 45.
[102] Ibid.
[103] UNDCP. 1995. Country Drug Abuse and Treaty Implementation Profiles, International Drug Abuse Assessment System; Ethiopia. January 1995. UNDCP Vienna.
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[106] Interview with Dr. Meshfin Araya, Ammanuel Hospital, Addis Ababa. 3 February 1998.
[107] Statement by Commissioner Krowah Elabo Jean Claude, of the Police Directorate on Narcotic Drugs in Côte d'Ivoire, "Situation actuelle du trafic illicite des stupefiants et des drogues en Côte d'Ivoire, HONLEAAfrica, 16 – 20 June 1996, Cairo Egypt.
[108] In-country research team (Nigeria) report, p. 30.
[109] Ibid., p. 19.
[110] DEA. Senegal. Country Report, 1996.
[111] Cited in *Projet de plan d'action national de lutte contre l'abus et le trafic illicite de drogue (1997 – 2000)*, Ministere de L'Interieur, Republique du Senegal, Commission Nationale de Stupefiants, p. 4.
[112] Wansi, Emmanuel et al. 1996. *Rapid Assessment of Drug Abuse in Cameroon.* UNDCP – WHO Project AD/RAF/93/795 – 976, January 1996, p. 59.
[113] In-country research team (Cameroon) report p. 13.
[114] Ibid., pp. 15 – 16.
[115] Ibid., p. 20.
[116] Ibid., p. 4.
[117] Macdonald, D.1996.`Drugs in Southern Africa: An Overview', *Drugs: Education, Prevention and Policy*, vol. 3, No.2, pp. 127 – 144. *op cit*. pp. 132.
[118] ARQ, calendar year 1996, part II; note however, the major downward revision by the South African authorities in the area of commercial cannabis cultivation in the country, from the previous assessment of more than 80,000ha (pre-1997) to a present assessment of 1000ha.
[119] Interview with SANAB superintendent Van Aarde, and other constables working the Johannesburg, Hillbrow area, 11 November 1997.
[120] In-country research team (South Africa) report p. 44; October 1997 in-depth interview with drug dealer.
[121] Ibid.
[122] South African Police Services. 1996. *The Extent of Drug Trafficking in South Africa*. Pretoria: SANAB and CIMC. p. 12.
[123] Ibid.
[124] Ibid., p. 13.
[125] In-country research team (South Africa) report, p. 20, citing Crime Information Management Centre 1996 (SANAB) findings.
[126] In-country research team (South Africa) report, p. 27.
[127] For an interesting example of traditional use of psychotropic drugs in Mozambique, see: Grob de Rios. 1992. Adolescent Drug Use in Cross-Cultural Perspective, *Journal of Drug Issues,* vol.22, N.1 (Winter 1992), pp. 121 – 138.
[128] In-country research team (Mozambique) report, p. 7.
[129] Ibid. It should be acknowledged however that this group was gender-biased towards males, with men comprising 74 per cent of interviewees. The overall gender balance for the 1070 respondents was 56 per cent male, 44 per cent female.
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CHAPTER III

ECONOMIC CHANGE AND ILLICIT DRUGS IN AFRICA

A. INTRODUCTION

This chapter identifies aspects of ongoing economic change in Africa that should be taken into account during any assessment of Africa's vulnerability to illicit drug problems. While it does not examine those aspects in detail it does call attention to specific indicators of key relevance, indicators that should be seen not only as measurements of economic activity per se but also of the vulnerability to illicit drug production and distribution.

Several economic trends are of particular significance in the context of illicit drugs in Africa: as regards illicit production, the key economic changes to focus on include rural income generation, commodity pricing trends and, relatedly, the terms of trade in the agricultural export sector. With regard to illicit drug distribution, the changes to focus on include the processes of urbanization and urban employment generation.

This chapter is organized as follows. The rest of section A considers institutional aspects of drug control in Africa. Section B considers the economic factors behind illicit drug production and distribution. Section C analyses the potential for illicit drug markets to expand in sub-Saharan Africa, as well as the trade-offs should they ultimately do so. In section D certain aspects of supply reduction and law enforcement are briefly considered. Section E offers some conclusions.

1. Illicit drugs in Africa: the institutional context

The nature of the illicit drug problem and the question of what Governments can – and should – do in the area of drug control is to an extent determined by a country's level of economic development. If South Africa is excluded from the discussion, every sub-Saharan country has the majority of its population in rural areas; the 10 countries treated in this report have levels of urbanization below the average for the region. Most of the labour force works in agriculture or in other rural-based activities. Since in all of the countries large-scale agriculture accounts for a small share of employment, most people earn their livelihoods on medium and small holdings (in some cases as wage labourers) and rural micro-enterprises.

This pattern of livelihood has two implications for drug control in sub-Saharan Africa. Firstly, as elsewhere, the problems confronted by rural producers go far towards explaining the appeal of illicit crop cultivation. This exercise has found that cultivating cannabis, the one illicit substance widely produced in Africa (see chapter II, section C), is largely a response to market failure in the legitimate sector.

Secondly, as a result of the rural, small-scale character of production and distribution, most illicit drug transactions go unmonitored by the authorities. Even legal transactions are virtually impossible to measure directly, much less monitor for purposes of taxation. Therefore, the difficulties faced by the State in monitoring cannabis cultivation are merely an extension of the challenge of accounting for market transactions in the rural sector. Since Governments at best can obtain only rough estimates of the production of legitimate crops such as maize, it takes little effort for producers of cannabis to hide their activities from the authorities.

One reflection of the strength of a State is its capacity to tax, which is closely related to development indicators such as per capita income, urbanization and the degree of industrialization. Sub-Saharan economies are predominantly agricultural; small and micro-enterprises typically dominate their urban centres. These two attributes suggest that the scope for effective taxation and revenue collection is limited. At present, in many African countries the two main domestic sources of public revenues are foreign trade and taxes on large commercial enterprises (most commonly in mining and other extractive industries). Yet over the last 15 years, lending arrangements with the international financial institutions have fostered tariff reduction and the elimination of export taxes. As a result, countries without major mineral resources have less taxation potential than that of the past. In this regard, it could be argued that the key institutional constraint on the development and implementation of drug policy in many African countries is not, as is commonly

Box 1.Money-laundering and institutions in South Africa

South Africa has a highly developed financial sector; indeed, some of its financial institutions are among the largest in the world, operating in the major money markets. On the one hand, the sophistication of the financial system makes the monitoring of financial flows considerably easier than in other sub-Saharan countries; on the other, drug-related money transfers can easily be hidden in the relatively large daily movements of cross-border finance. In 1989, the Bank of International Settlements issued a directive calling for central banks throughout the world to take cognizance of money laundering. In response to this, the Reserve Bank of South Africa initiated discussions with the country's commercial banks about measures to control illegal flows of funds. In that context, the Law Commission began research on money laundering in the country and joined with the Financial Action Task Force to draft legislation. The relevant legislation is before Parliament, which will create the mechanisms for detection and enforcement.

Under apartheid, the Reserve Bank developed considerable expertise in monitoring capital flows, the purpose of which was to prevent capital flight in response to international sanctions. One trend with likely influence on money laundering in South Africa is the incremental process of capital account liberalization, which has been implemented by the ANC Government. Officials from the relevant government institutions, the Reserve Bank, the Ministry of Finance and the Attorney-General's Office, all agree that capital account liberalization will make the monitoring and detection of money-laundering more difficult. The decision by the Government to assign enforcement to the Ministry of Finance and to remove exchange controls is related. Exchange controls, administered by the Reserve Bank, represented the "first line inspection" of capital flows. Removal of exchange controls, in effect, reduces the ability of the Reserve Bank to intervene.

It goes without saying that estimates of the size of illegal money flows are conjectural. However, the Reserve Bank's best guess is that the quantity of illegal money is sufficiently large to have a substantial effect on the economy. Specifically, it is estimated that drug-related money flows at several points over the last few years have been sufficiently large to counter the effect of Reserve Bank monetary actions. This occurs when the Reserve Bank seeks to manage the domestic money supply through "open market" operations in government securities: selling them to reduce liquidity in the economy and buying to increase it. If illegal money flows are sufficiently large, they can overwhelm such actions by the Reserve Bank. Thus, monitoring and control of money laundering is of major importance to economic management. Effective control of illegal money flows would improve economic policy, with considerable benefits and limited political cost.

asserted, the technical or technocratic deficiencies of personnel, though those deficiencies are significant. It is the practical limit set on generating revenue for drug policy in a political environment in which public priorities other than drug control often, if not always, take precedence– all the more reason why international actors have an important role to play in filling the financial shortfall at the country level.

The contrast with developed economies is instructive. In developed countries, the relatively large-scale nature of production activities, and the fact that most people are salaried employees, allows the Government to collect tax efficiently; indeed, in most developed economies, the tax system is a key lever for the identification of criminal activity. Even in the agricultural sector, where income flows are difficult to monitor, land titling, subsidies, extension services and taxation systems facilitate the monitoring of what is produced. In many low-income countries this information is not automatically generated. Indeed, in sub-Saharan countries the only accurate data on agricultural production are those on the export of certain crops – and even those data are heavily distorted due to smuggling.

Such difficulties in monitoring rural production apply to the monitoring of urban production as well. Many exchanges in Africa's urban areas are carried out in small, informal markets, almost entirely in cash. These attributes are not conducive to the generation of information on transactions available for official monitoring purposes. It is for these reasons that value added taxes have proved impractical in the sub-Saharan region. In Europe, where value added taxes play a major revenue-generating role, countries have identified a minimum turnover level that acts as a threshold for the imposition of value added tax, below which enterprises are exempt. The exemption is practical, for the cost of monitoring small enterprises would exceed the revenue collected. In the sub-Saharan region, most transactions involve economic units with turnover well below the minimum threshold levels for exemption in Europe.

The implication for drug control is obvious: if the authorities have only a rough estimate of the size of legitimate trade, there is little likelihood of effectively monitoring illegal activities with models and approaches shaped according to conditions in developed countries. The above is not meant to imply that attempts at drug monitoring are futile. It suggests only that monitoring methods must be appropriate to the nature of African economies. It is in this context that an analysis of economic change in Africa is relevant to discussion on the most cost-effective drug control interventions.

Monitoring methods must also conform to the capabilities of public institutions. Except for a few countries (most notably Ethiopia), the sub-Saharan region has a short history of central government. The contrast with parts of Asia is instructive. In China, India and Viet Nam, for example, central Governments have raised armies, collected taxes at the village level and implemented massive public works for centuries. Today's public bureaucracies derive in great part from a long history of strong States. In the sub-Saharan region, in contrast, the influence of central authority in the countryside is often weak, if not altogether non-existent; even in urban centres, popular commitment to state rule is often thinly spread.[1] Thus, the relatively high degree of autonomy of rural communities vis-à-vis the State characteristic of the pre-colonial, colonial and post-independence periods sets a limit to the monitoring, surveillance and enforcement potential of Governments. Again, limited state influence in Africa does not imply that no effective drug policy is possible; however, policy must be designed in the context of Africa's institutional and economic constraints.

B. ECONOMIC INFLUENCES ON ILLICIT DRUG PRODUCTION AND DISTRIBUTION

Frequently cited definitions characterize drug-related activities as manifestations of moral decay or reprehensible because they are inimical to law-abiding behaviour. The value-laden discourse on drugs precludes open

acknowledgement that, often, involvement in illicit drug activity comes about as a result of legitimate needs – whether economic or psychological – that go unmet in more conventional contexts of social exchange. At least in the context of sub-Saharan Africa, illicit drug production and distribution are to a large extent manifestations of an emerging survival strategy, one that is likely to grow in acceptance and use, parallel to the ongoing process of economic decline.

As reported in chapter II, the cultivation of cannabis in Africa is widespread. National research and fact-finding visits undertaken for this exercise allow for the conclusion that the illicit cultivation of cannabis in sub-Saharan Africa, at this point in time, is a supplementary income-generating activity. South Africa, as is so often the case, may prove to be the exception in this regard, and the national research team in Zimbabwe also found otherwise,[2] but certainly for the other eight countries examined, it appears that cannabis cultivation has yet to become the exclusive source of income for the rural inhabitants engaged therein. Income from peddling also appears to be a financial supplement, rather than the sole source of income for those involved.

The current status of illicit drug activity as a secondary source of income-generation could change, however. Unstable markets create favourable conditions for an increase in the production and peddling of drugs. In Nigeria, during national surveys undertaken for this study, economic reasons (as opposed to production for own consumption) were cited as the key factor motivating illicit drug production (70 per cent of respondents) and peddling (84 per cent of respondents) in the country. In Ethiopia, the national research team found that, of those drug offenders whose occupational status had been recorded, nearly 50 per cent had been jobless prior to involvement in drug-related activity. In Kenya, a survey for this study was undertaken of 30 law enforcement officials; when asked what the key motivation was behind production and peddling, 28 respondents cited economic reasons in the case of production (93 per cent) and all 30 cited economic reasons in the case of peddling.

These and other observations from the national teams suggest an economic incentive for an expansion in illicit drug activity.

1. Risk diversification and cannabis cultivation

The concept of risk is central to an understanding of means of insurance against shocks to legitimate productive enterprise. Producing in a high-risk environment over time raises the risk threshold for producers such that involvement in illicit productive activities may appear relatively less risky than to those involved in more predictable trades. Indeed, both within and beyond the agricultural sector, field visits undertaken for this study repeatedly faced concerns regarding the "get-rich-quick" mentality that was said to attend illicit drug activity.[3] In the context of Africa, the perceived risks of cultivating cannabis are much lower than in other parts of the world simply because the scope of law enforcement is relatively limited, especially in the rural areas. In this regard, the agricultural producers in sub-Saharan Africa face a very different risk scenario than in other parts of the world, one that is likely to allow for more wide-scale involvement in the illicit drug sector.

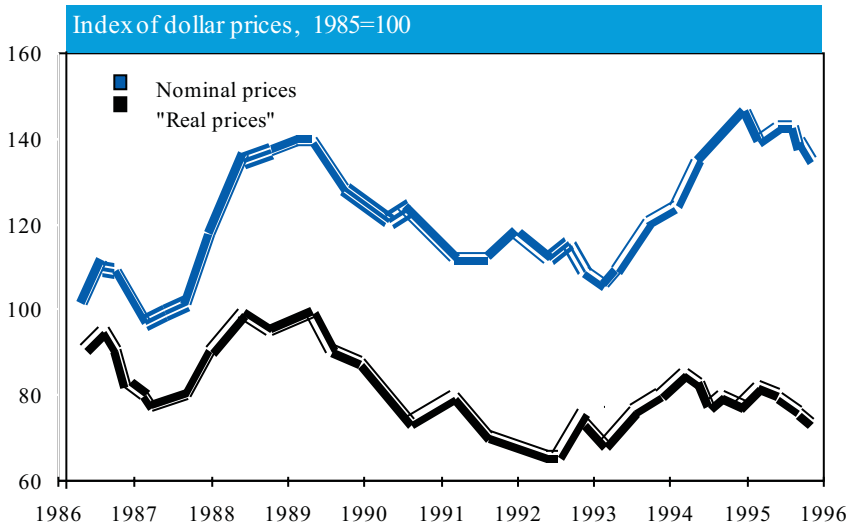
What are the risks facing legitimate agricultural producers? The two most prominent are (a) the risk of crop failure due to inconsistent rainfall, disease and pestilence, and (b) the risk of unsustainably low financial return due to inadequate market access, lack of support to farmers and price volatility. In both senses, the rural agricultural sector in many parts of Africa is distinctive due to exceptional vulnerability to external shocks. The region as a whole, for example, experienced a 3.6 per cent annual fall in its terms of trade for the period 1981 – 1993.[4] As many studies show, under these conditions agriculture is confined to subsistence cultivation with no market for permanent labour.[5] Land policies and scarcity of cattle preclude credit markets from using these as collateral. One other constraint on small-scale agricultural development is the limited availability of rural credit schemes.[6] In the face of high risk, the absence of credit markets compels private agents to seek out diversification to maintain consumption levels.[7]

In 1997 primary commodities still accounted for 88 per cent of all exports; African exports continue to be shipped overwhelmingly to developed economies, which absorbed 78 per cent of African exports in 1996, with Europe being the region's largest trading partner.[8] Trade with the United States has grown rapidly in recent years, especially for Côte d'Ivoire, Ethiopia, Ghana, Kenya, Nigeria, South Africa and Zimbabwe. The United States Administration in 1997 proposed legislation to Congress that would establish a free trade zone between the United States and sub-Saharan African countries in some goods and reduce trade barriers on others.[9] South African exports have increased rapidly in the 1990s, a trend largely responsible for growth in Africa's exports to eastern and southern Asia, which have increased from 1.5 per cent of total exports in 1990 to nearly 6 per cent in 1996.[10]

In short, for the 10 countries covered in this study, there was significant export growth in 1986 – 1990, reversing the downward trend of the earlier period. For the period 1991 – 1992 export earnings fell by 2.2 per cent but increased by 2.5 per cent in 1994. At the other extreme, however, countries damaged by conflict and political unrest, Ethiopia and Mozambique did not perform well in the initial years of the 1990 s, though they recovered in the mid-1990 s. The increase in export earnings, which took place despite a one-third fall in the terms of trade over the same period, was due primarily to an increase in export volume.

Figure 1 shows the fluctuation in non-fuel commodity export prices of developing countries between 1986 – 1996; note the trend of lower real prices (nominal prices deflated by unit value of manufactured exports of developed economies). The outlook for the future is uncertain. As a result of the Uruguay Round of multilateral trade negotiations and the new rules of the World Trade Organization, many of the trade preferences previously enjoyed by African countries have been abolished.

Figure 1. **Non-fuel commodity export prices of developing countries, 1986-1996**



Source: United Nations World Economic and Social Survey, 1997

Furthermore, less trade than ever before is being conducted under price stabilization schemes; only the International Natural Rubber Agreement has survived thus far and its future is uncertain at best.

Table 1 reflects the value added of the agriculture sector in several of the countries examined, indicating some fluctuation faced in the past decade. Note that while annual value added was generally positive, the rates at which growth occurred varied considerably from year to year. Uncertainty at the international level ultimately trickles down, having an impact on the individual household. Given the instability in agricultural revenue, most households choose to fragment their holdings into many plots, often for the legitimate as well as the illicit crop. Typically, households grow many different crops.

Field visits and research by the national teams confirms that cannabis cultivation is one diversification method rural households employ. The cultivation of cannabis, for instance, enables the household to cope with shocks and to smooth consumption over the life cycle. Farmers in Ethiopia and Kenya treat khat as a supplementary crop with coffee and tea being the major products. During the 1992 drought in Zimbabwe households responded to the fall in food production by increasing consumption through livestock sales, wage employment and remittances from urban household members. Most rural households today have highly diversified sources of income, including those beyond the agricultural sector.[11]

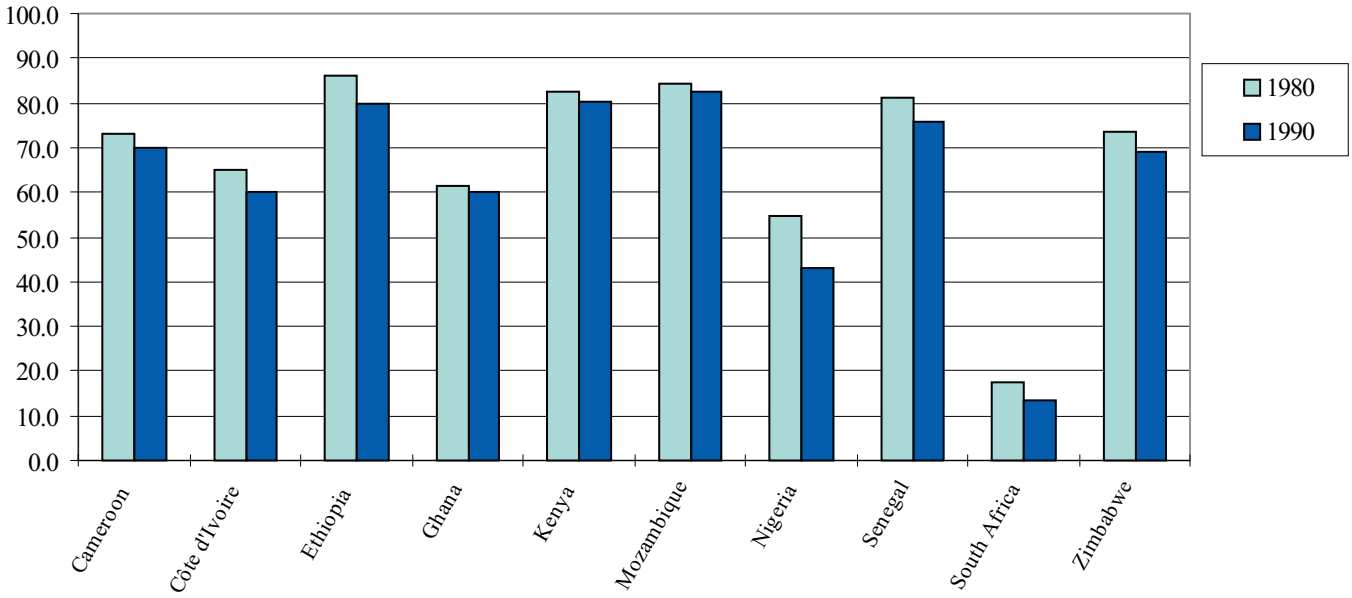
During times of crisis, households choose to protect their consumption level through diversification into durable and

Table 1. **Agriculture value added (annual percentage growth)**

	Cameroon	Ethiopia	Ghana	Kenya	Mozamb.	Nigeria	South Africa	Zimbabwe
1986	6.1	16.3	3.3	4.9	0.7	9.2	6.6	-6.2
1987	0.5	18.2	0.0	4.2	5.6	-3.2	2.5	-18.1
1988	-12.7	-2.3	3.6	4.6	7.2	9.8	2.8	25.4
1989	7.1	-0.1	4.2	4.1	3.7	4.9	14.7	-0.8
1990	-1.0	5.2	-2.0	3.6	1.1	4.2	-6.8	-6.7
1991	-4.0	2.8	4.7	-0.8	-4.0	3.5	3.8	3.1
1992	5.0	-4.6	-0.6	-3.3	-11.3	2.1	-27.2	-24.4
1993	2.0	6.4	2.8	-3.2	21.3	1.4	17.2	48.5
1994	4.0	-1.9	2.6	3.1	5.0	2.4	8.6	NA
1995	2.0	3.6	4.2	4.9	NA	2.8	3.2	NA

Source: World Bank, 1997

***Figure 2*. Labour force in agriculture (percentage)**



Source: World Bank, 1997

quick profit-generating techniques, one of which is illicit cultivation of cannabis. Because cannabis is widely produced in Africa, analyses of the agricultural sector can provide useful insight into the nature of and underlying motivations for this activity. On aggregate, the agricultural sector contributes approximately 30 per cent to GDP and provides employment for more than 60 per cent of the labour force in the 10 countries examined. A significant proportion of the poor live in rural areas, which are dependent on agriculture, agro-industries and agricultural marketing. Senegal appears to have the smallest proportion of its domestic product devoted to agriculture, which constituted only 17 per cent of GDP in 1994, with services making up over 60 per cent.[12]

Nonetheless, the proportion of its labour force in agriculture is still considerable, as shown in figure 2. It is clear that, while the proportion of labour involved in agriculture has declined, it has done so only marginally, and in absolute numbers it has continued to expand.

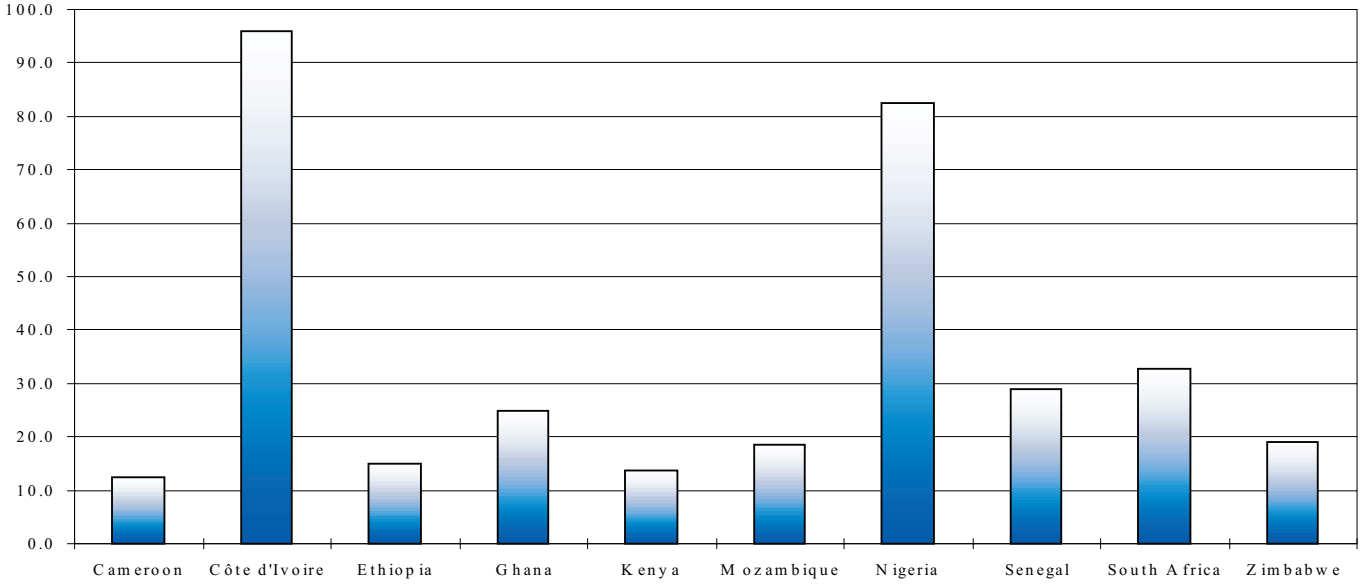
The sector has performed to varying degrees in the 10 countries under study. Table 2 shows the average growth rate of agricultural production in a few of the countries. It can be seen that in Nigeria and Ghana, for example, there has been sustained growth in the agricultural sector throughout the 1990s. The other countries, however, have fared rather poorly. The agriculture sectors that perform well have been those characterized by price and tax regimes sensitive to market signals. They are also the ones in which the private sector has been allowed to play a significant role in marketing, processing and input supply. Private sector development of horticulture production in Kenya and Zimbabwe, pineapple in Cameroon and coffee in Kenya are a few encouraging examples. Food crop marketing in Ghana and Nigeria by private marketing agents is another example of impressive achievement. In general, however, these cases of progress are noteworthy because they have been achieved despite considerable obstacles to growth. The absence of roads connecting farmers and retailers, for example, is a key impediment to development of the agricultural sector. In the countries under study, on average, less than 33 per cent of the total road network is paved. Such impediments, including ineffective marketing strategies, have raised the relative appeal of crops that can sustain long periods of time

***Table 2*. Average change in agriculture production (average annual percentage growth)**

	Cameroon	Ghana	Kenya	Mozambique	Nigeria	South Africa	Zimbabwe
1971-1980	1.91	-0.74	2.99	-0.56	-0.64	3.73	4.16
1981-1990	1.95	2.28	4.66	-0.23	4.82	0.91	3.51
1991-1995	1.78	11.84	0.86	1.85	6.42	-2.26	-2.25

Source: World Bank, 1997

***Figure 3*. Paved roads (as a percentage of the total road network)**



Source: World Bank, 1997

between harvesting and consumption. Farmers are also isolated from the source of improved inputs and equipment, which is located in towns and cities. Côte d'Ivoire and Nigeria have the largest network of paved roads, with about 96 per cent and 84 per cent, respectively, of their road networks paved (figure 3). One other constraint on rural productive expansion is the absence of basic social services such as health, education and water; public investment in such services has not yet reached most rural areas and this limits the expansion of agricultural production.

For instance, in Ethiopia, only 150,000 200,000 ha of land is under cultivation out of a potential area of about 3 million ha.[13] Demographic pressures intensify the effects of limited productive capacity in rural areas. Rapid population growth has put pressure on limited natural resources such as water. Time requirements created by such obstacles, as well as limited access to agricultural credit, land and extension, have given many women farmers in particular little choice but to continue practising traditional low-input, low-productivity farming.

As reflected in figure 4, less than 2 per cent of total arable land is irrigated in Cameroon, Ethiopia, Ghana, Kenya and Nigeria. The proportions are higher in Côte d'Ivoire, Senegal and South Africa. Because of structural rigidities, economies continue to be vulnerable to economic shocks and possible downturns; in this context, the farmer's decision to seek other safety nets is, from a purely economic perspective, entirely rational. The drug trade provides a safeguard in an uncertain economic environment in which the demand for exports of the sub-Saharan region is unstable. It is clear that creating a more

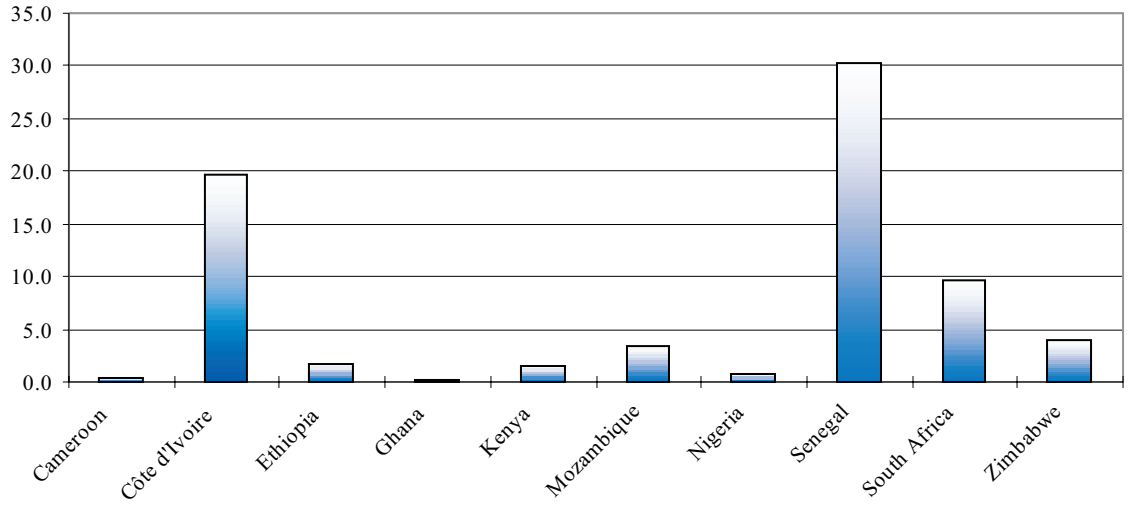
Box 2.Khat, the east African market

The khat ("*miraa*") trade is unique to east Africa and particularly Ethiopia and Kenya. In both countries khat is produced, distributed and consumed legally. In Ethiopia khat (locally known as chat) is the third largest export earner after coffee, hide and skins. Khat of Kenyan origin is available as far away as Europe and North America.

In both countries, khat is increasingly becoming an integral element in economic relations. The khat trade now provides employment and income for many, mainly the pickers, packers and watchmen. The involvement of children in the khat trade in Kenya is very illustrative. Pupils are not only engaged in consumption of khat, but the market provides broad scope for income generation. Children sell *maua* (leaf used for wrapping khat) and receive payment for tying the *miraa* into bundles and delivering to customers. These activities are especially prevalent among school children, whose parents' income is insufficient to provide the basic necessities and where state social service provisions are non-existent. According to one newspaper commentary, if the "ban on *miraa*-growing is granted, the Government would have to be prepared to distribute famine relief to a region which cannot otherwise feed itself".

Similarly, visits to the major khat market in Addis Ababa revealed that the involvement of children in the retail trade is significant. They are key to the packaging, loading and distribution phases. The khat industry, as shown above, provides a steady income to many people, not least children, who are often migrants from rural areas. The harsh reality is that the current level of expenditure on social services does not allow children to concentrate on their education and leave income earning to their parents. Increasingly, children must fill the gap left by the State and their parents by seeking out such means to support themselves.

***Figure 4*. Irrigated land (as a percentage of arable land) 1994**



Source: World Bank, 1997

favourable environment for rural producers must be a key element of any drug strategy in the region. Efficiency and diversification in agricultural production, marketing and processing will become increasingly important if African farmers are to remain competitive in the coming years.

Interviews in Ethiopia confirmed that many women had turned to cannabis cultivation simply because the legitimate sector was not able to support them and their families.[14]

The national research team in Zimbabwe found that, contrary to police reports that the majority of illicit drugs used in Zimbabwe came from other countries, the illicit drugs in Zimbabwe came mainly from within the country itself, particularly the rural areas. The common reason for producing and selling mentioned by all groups was economic need.

Recurring responses from focus group discussions in Zimbabwe's cannabis-growing areas included: "people need money and the drugs are in demand". Where there were alternatives it was felt that drug producing and selling was a better option because "drugs can be produced throughout the year unlike growing maize, which is seasonal". Other common responses were, "drugs are always in demand", and "we choose to sell *mbanje* (cannabis) because it needs very little start-up capital".[23] In Mozambique, the national research team captured a sentiment observed in the other countries as well:[24] "The

Box 3.The experience of Côte d'Ivoire

Côte d'Ivoire is the world's leading producer of cocoa (900,000 metric tons in 1995, or about one third of world production). During this decade, cocoa has accounted for more than 50 per cent of the country's GDP despite efforts at diversification under the various structural adjustment initiatives since 1981.[15] In 1988, there were approximately 700,000 cocoa and coffee plantations in the country, supporting some 4.8 million people (almost 40 per cent of the population).[16]

Due to expansion in the industry, Ivorian forest reserves became exhausted in the mid-1980s, mostly as a result of cocoa and coffee planting. While forests covered 12 million ha. in Côte d'Ivoire at independence, only 2 million ha remained in 1990 and they were put under strict protection by the authorities.[17]

The late 1980s witnessed a severe collapse in cocoa prices. Between 1988 and 1992, the price of cocoa at the farm gate fell by 50 per cent (officially from CFA 400 to CFA 200 per kilogram, but buyers often actually paid only CFA 150) and the price of raw coffee fell by 75 per cent (from CFA 200 to CFA 50)[18]. The credit system collapsed, and in 1988 1989, at the height of the "cocoa war", and again in 1993, planters discovered they were unable to sell their produce. Food production became the priority of planters and family members, often the only workers left on the plantation. The use of insecticide was sharply reduced and in some cases simply abandoned. As a result, cocoa yields dropped by 20 50 per cent between 1988 and 1992. During that period, planters' revenue fell by about 60 per cent.[19]

An OGD field investigation of 41 cannabis growers in south-western Côte d'Ivoire between April 1994 and June 1995 documented the existence of a strong correlation between these trends and the "massive boom in the production of cannabis".[20] Approximately two thirds of the people interviewed said they started growing cannabis after 1990, while only 8 per cent said they started earlier. Moreover, more than 33 per cent of those interviewed stated that their motivation for becoming involved in cannabis was the fall in cocoa and coffee prices. A full 50 per cent of interviewees began to cultivate cannabis at the prodding of cocoa plantation owners and wholesalers. Among those farmers who started growing cannabis at their own initiative, financial and land problems were cited as motivations by 62 per cent.[21] Prices recorded in the south-west in 1995 showed that the annual production of 0.1 hectare of cannabis sold wholesale at the farm gate earned as much as the output of 30 to 40 hectares (15 to 16 tons) of cocoa. In other words, cannabis brings 300 to 400 times more revenue than cocoa, and for much less work, in the Ivorian agricultural sector.[22]

Table 3. **Reasons why the drug problem is likely to worsen in Ghana (N = 1272)**

Reason	Number	Percentage
Unemployment	242	19.0
Moral decay	210	16.5
Profit-seeking	208	16.4
Youth curiosity	150	11.8
Weak public education	135	10.6
Inadequate penalties	90	7.1
Weak policing	90	7.1
Negative foreign influences	85	6.7
Economic liberalization	62	4.9
Total	**1 272**	**100**

Table 4. **Occupational characteristics of drug offenders in Ethiopia (N = 287)**

Occupation	1993		1994	
	Number	Percentage	Number	Percentage
Unemployed	49	17.1	60	20.1
Students	40	13.9	30	10.0
Traders	4	1.4	30	10.0
Immigrants (refugees)	2	0.7	7	2.3
Professionals	1	0.3	6	2.1
Unknown occupation	191	66.6	166	55.5

Source: Gebre Selassie and Gebre, 1995

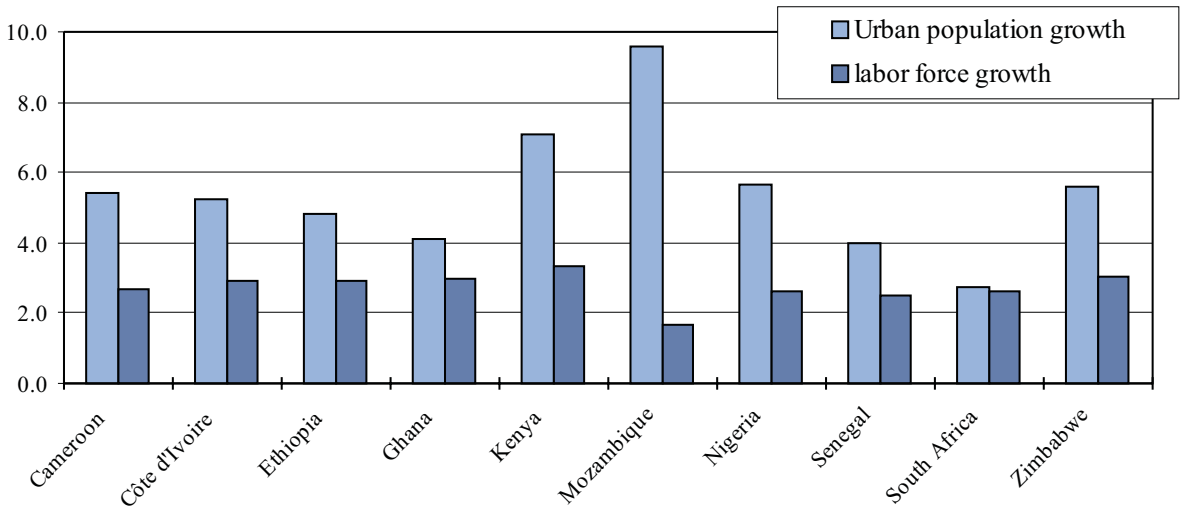
local production of drugs is considered to be a business with good profits. Respondents considered profit as the first reason to engage in production (76 per cent of 695 respondents), and survival strategies as the second most important (15 per cent). Local production of cannabis is considered to be a good market option because prices of agricultural products are low, deteriorate easily, and there are too many controls."

2. Urban economies and illicit drug distribution

Whereas the last section considered the relationship between rural agriculture and illicit crop cultivation, this section examines the link between urban employment and illicit drug distribution. That link is manifested most obviously in the vulnerability of the unemployed and underemployed to drug-related employment. Surveys undertaken for this study, in Ghana, for example, found that unemployment was generally perceived to be the key factor likely to influence illicit drug trends in the future (see table 3). While widespread unemployment is an attribute of rural communities as well, its significance as a catalyst to illicit income generation is greater in the urban centres due to various factors addressed in this section. As will be discussed, the foundations for an "industry" of illicit drug trading in African cities appear to be in place.

Table 4, taken from a UNDCPrapid assessment undertaken in 1995 in Ethiopia, shows the prominence of the unemployed among drug offenders. Note that the 20.1 per cent figure generally matches the figure in table 3, with unemployed individuals comprising 19 per cent of those arrested for drug-related offences. There is a perception in many rural areas that people who reside in urban areas are better off, that more jobs are available in cities. Rural-urban migration has mainly been caused by the income differential between urban households and rural ones. The concentration of social services such as education and health in the urban areas has proved to be an additional factor spurring migration. This last point provides the intellectual ballast to structural adjustment programmes that aim to reverse urban bias in developing countries.[25]

***Figure 5*. Urban population growth (average annual percentage) and labour force growth (average annual percentage), 1980-1995**



Source: World Bank, 1997

Figure 5 shows the considerable growth between 1980 1995 of the urban population as a percentage of overall population. This takes on added significance when trends in urban employment generation are considered. One feature of industrialization in the sub-Saharan region is that industries are located in urban areas. Firms are set up where infrastructure facilities are available. Significantly, however, industrial growth has not kept up with the growth of the urban labour force.

The average growth rate of the labour force between 1980 and 1995, except for Mozambique, equalled or exceeded 2.5 per cent per annum. Clearly, one contributing factor to growth in the labour force has been urban population growth. For all of the countries, except South Africa, the urban population grew during this period by an average of 5.8 per cent (see figure 5). Parastatals, which have so far been the largest employers in the formal sector, are undergoing major restructuring and downsizing. It is the inability of the industrial sector to absorb excess labour supply in the urban sectors that creates a class vulnerable to drug abuse and drug-related employment.[26]

Investment is one means to create new jobs, but the record on this front has been less than encouraging, at least with regard to investment from non-public sources. Excluding Côte d'Ivoire and Senegal, gross domestic investment, as a percentage of GDP, declined from around 24 per cent in 1985 to 22 per cent in 1993, though these figures are heavily skewed due to the exceptionally high proportion in Mozambique.

In Côte d'Ivoire and Senegal, the rate of annual gross domestic investment fell by 75 per cent and 41 per cent respectively in 1993 compared to 1992. In those countries where investment has grown, the increase has been due primarily to public investment. For example, public investment in Ghana was about 40 per cent of total investment in 1994. The low level of private investment is one characteristic of many African countries, an aspect due in part to constraints on domestic resource mobilization.

In 1994, Ethiopia, Ghana and Mozambique had savings rates below 5 per cent. Only Kenya and Nigeria have substantial savings rates, due in part to the developed nature of the financial sector. The manufacturing sector in the 10 countries under study accounts, on average, for about 16 per cent of GDP.

As with other economic parameters, however, there are wide country variations in both the size and growth potential of the sector. In South Africa and Zimbabwe, the share of manufacturing in GDP is about 35 per cent. In Côte d'Ivoire, manufacturing constitutes about 25 per cent of GDP. In Ethiopia and Mozambique the figure is less than 12 per cent. In all 10 countries, the informal small-enterprise sector, which is not accounted for in most national accounts, is significant, absorbing the majority of the labour force.

In Senegal, some 100,000 young people enter the job market every year, including approximately 40,000 in urban areas.[27] But the formal sector of the economy, including the public sector, generates less than 5,000 jobs a year. Increasingly, women are also seeking formal work, putting further pressure on the job market. While 34 per cent of women worked for pay in 1970, 54 per cent did so in 1991.[28] In the meantime, employment opportunities

have remained stable or have fallen. According to an official study, 30 per cent of Senegalese households were living below the poverty line in 1991. Some 300,000 people, or 30 per cent of the active population, were unemployed in Dakar in 1991.[29] It is now well documented that adjustment policies that aim to reduce government budget deficits have hit the urban sector hardest. The policies of the last and the present decade have reduced the income of the urban sector and further deepened the hardship of the urban poor.[30] One of the repercussions of the "rural bias" has been to cause the gap between food prices and urban wages to widen.

This is not exclusively because wages have fallen but also because price liberalization has led to explosive increases in food prices. For countries in the so-called franc zone, the January 1994 devaluation of the CFA franc has led to a further loss of purchasing power for the urban population; this is so because food, which makes up more than 50 per cent of household expenditures, registered some of the largest price increases. As such, the relatively high real wages that once prompted rural-urban migration appear to be a thing of the past.[31] On the contrary, urban centres are now home to some of the most glaring examples of deprivation.[32] These trends give reason for concern insofar as urban squalour and urban unemployment create vulnerabilities to drug abuse and drug-related employment. It appears that in most of the cities visited – Addis Ababa being perhaps the only exception – drugs such as cannabis, heroin and cocaine are already widely available, suggesting the foundations for an industry that could expand in response to economic needs. The increase in the urban population has also put pressure on housing. Dense urban slums are increasingly becoming a feature of urban life. In most cases, slums emerged as a result of colonial policies: laws physically segregated the local population from the white settlers or invariably made African acquisition of property in the white enclaves very difficult.

In Ghana, the most populous of such slum areas is Nima, which originally started as a squatter camp for demobilized Gold Coast soldiers at the end of the Second World War. It is inhabited by people of various ethnic groups from Ghana and other countries in the subregion. In this environment, the social system survives through an intricate balance between legality and illegality. According to the national research team in Ghana, "drugs are thus sold often with the connivance of law enforcement agents".[33] Residents in Kiamaiko (Nairobi), Chamankulo (Maputo) and other urban centres were resigned to the fact that urban squalour and drug peddling often went hand in hand, due not least to high demand for drugs. The insecurity most people in these environments face contributes to social tension, not least due to simple over-crowding and lack of privacy. In the face of fiscal austerity, public housing programmes are less feasible from the point of view of policy makers. With fixed limits on land, property rents are now rising beyond the reach of the low-income groups. As the leader of a mosque in Cape Town aptly put it, "drug dealers exploit the deprivation of the grass-roots".[34] The Ghana research team reports: [35]

> "In the urban areas the youth either emigrate or engage in criminal activities. In many urban communities today, residents can identify people whose houses or cars were acquired through the drug trade. Clearly, in Ghana as elsewhere, people's decision to engage in the drug trade, though personal, finds its expression in the social structure of society".

A full 93 per cent of key informants in Zimbabwe said peddlers sold drugs to generate income.[36] The majority of drug distributors were either unemployed or employed in low-income sectors. Two coping mechanisms in response to urban poverty include urban migration and resort to informal sector employment.[37] As shown in figure 5, the urban population has increased substantially in all 10 countries, most significantly in Mozambique, where rural population growth for the period 1980 – 1995 was negative. The second survival strategy is related to the growth in the informal sector, for instance, street vending. Many individuals are entering the informal sector selling legitimate commodities. Other new types of coping mechanism include urban small-scale farming and petty commodity trade.[38] The informal sector's success is based on its flexibility and ability to adapt rapidly to changing circumstances, in particular its ability to supply goods and services cheaper and more efficiently than the formal sector.

The existence of multitudes of informal traders is a feature of many African cities. In Ghana, the informal sector is by far the fastest growing sector in terms of employment creation (6.5 per cent per annum, compared to 1 per cent in the formal economy).[39] The International Labour Organization (ILO) estimates that the informal sector absorbs as much as 80 per cent of the annual increase in the urban labour force in that country.[40] The national team reports that cannabis in the urban centres of Ghana is sold mainly in the "ghettos while the planned residential areas are said to be the sources of cocaine, heroin, crack, hashish and pethidine".[41]

Informal traders are at a particular disadvantage because they cannot use the court system to enforce contracts, they are unable to insure themselves against risk and they cannot acquire secure property rights.[42] Informal traders, including those in the streets, make up a class that has little to do with laws and regulations. Participants in the informal economy are citizens alienated to the extent that risk-taking has become a fundamental aspect of daily life.

In Côte d'Ivoire, after the CFA devaluation in January 1994, goods imported from Europe became unaffordable to most of the population, and commercial links were thus strengthened with African countries like Nigeria and South Africa, Latin American countries such as Brazil and Colombia, Asian countries like Thailand, and Arab countries like Morocco[43] and Lebanon. Although trade with those countries makes up a small proportion of overall registered (and therefore visible) exchanges, these contacts have multiplied opportunities to become involved in narcotics trafficking since the countries also serve as sources of illicit drugs. Moreover, informal trading networks are also often smuggling networks that import goods without any form of control.

In Senegal the informal sector is booming. Currently, it is estimated that informal activity constitutes over 60 per cent of GDP, employing some 700,000 people, 45 per cent of whom live in Dakar.[44] Since the beginning of the 1980s, many of the Senegalese who entered the urban job market have joined the informal sector in activities such as trade, handicrafts, transport, clothes making, metal work, woodwork and services. A significant proportion of the informal activity is controlled by the Mouride Sufi Muslim brotherhood. In Dakar the brotherhood controls a large proportion of the recycling of metals, wood, plastics, tiles, refrigerators, cars and so on. According to the Senegalese Drug Law Enforcement Office (OCRTIS),[45] the majority of those sentenced to prison for selling illicit drugs (marijuana, heroin and crack) in the street are Mourides.[46] From 1 January to 31 October 1997, 205 Senegalese citizens were arrested in Italy on drug trafficking or selling charges, compared to 150 in 1994 and 167 in 1995. The involvement of Mourides in drug distribution abroad was confirmed by a study carried out in Perpignan, France, and Barcelona, Spain, by Alain Tarrius, a French anthropologist.[47]

C. ILLICIT DRUG MARKETS IN SUB-SAHARAN AFRICA

This section examines the potential for illicit drug markets to expand in urban centres. Based on the findings in chapter II and the above overview of rural and urban trends, a rational weighing of the costs and benefits of drug control intervention in sub-Saharan African countries would lead to the conclusion that, at present, the urban centres are more vulnerable to the negative externalities that surround illicit drug activity and as such more deserving of policy attention. Field visits to the 10 countries were, it should be acknowledged, focused primarily on urban centres, and thus this assessment could be due simply to the "urban bias" that characterized the study methodology. And yet, it should also be stated that the national research teams devoted considerable time and energy to gauging trends in rural areas; their assessments clearly indicated greater potential for drug-related problems in the cities.

The national teams in each country examined both large and medium-sized urban centres. The major cities examined included: Nairobi and Mombasa (Kenya); Pretoria, Johannesburg and Cape Town (South Africa); Maputo (Mozambique); Harare (Zimbabwe); Addis Ababa (Ethiopia); Yaoundé and Douala (Cameroon); Abidjan (Côte d'Ivoire); Lagos (Nigeria); and Dakar (Senegal). Each of the cities is characterized by high rates of urbanization, limited employment opportunities, expansive informal sector exchange and, as will be examined in the next chapter, an erosion of so-called traditional values and family cohesion. If there is one chain of causality to monitor closely in coming years it is the one in which the process of urbanization leads to higher rates of unemployment in the cities, which itself exacerbates the social and economic pressures that underpin both the illicit supply and demand for drugs, all in an informal environment that state authorities are unable to monitor, let alone effectively penetrate.

1. Retail price implications

Information gathered by the national teams and during field visits by the international experts gives some reason to believe that there is already a firm foundation on which an expansion in urban drug markets could take place. Specifically, retail price information has provided useful insight into the scope and dynamics of the urban drug markets. While it should be acknowledged that myriad factors influence price, one important factor is scarcity. Others include risk perceptions of producers and dealers; the presence and effectiveness of law enforcement authorities influence these perceptions. Another key determinant of price is demand. And central to a full appreciation of the significance of prices is purity – a crucial category of information that could not be sufficiently examined during this exercise. Thus, to read into retail prices too much significance would be inadvisable at present. At best, the information presented below can provide a basis only for informed speculation.

If other factors are taken into account, however, the price information below may prove more telling than is obvious at first sight, particularly in view of the qualitative data gathered for this exercise. Those data point to several important attributes of the urban markets: firstly, drug policing has not been effective; thus, risk perceptions in the urban centres are at present not likely to have an important upward effect on price, though this may be changing in some cities such as Lagos. Secondly, the national teams concluded that there was broad-based demand, especially for cannabis, in the urban centres, where cannabis has become a cheap substitute for alcohol.[48] Other observations and interviews suggest (a) that there are established drug distribution networks in nearly all the high-density suburbs and slum areas visited; (b) that drugs are transacted openly in densely populated places such as Chamankulo and Colombia (Mozambique), Mbare (Zimbabwe) and Tudo, Avenor, Nima, Abraka-Shara, Circle and Labadi in the city of Accra; (c) that urban distribution networks for cocaine and heroin receive their sustenance from the spillover of the international trade; and (d) that the domestic distribution of cannabis – the major domestically consumed illicit drug – is at present a supplementary activity.

Table 5 provides retail price information gathered in some of the urban centres visited for this study. Prices have been kept in local currency units in order to avoid distortions that accompany simple conversion into US dollar units. For comparison, the prices of a 1-way (under 10-kilometre) bus fare and a bottle of average grade domestically produced beer are also included. Bottled beer, it should be emphasized, is considered a relatively "upscale" consumer item in view of the widespread availability of cheaper home-brews.

The volume of 0.1 gram of heroin and cocaine was chosen as a proxy to constitute a "dose" of each drug that could be comparable in terms of a unit to a bottle of beer. Measuring the heroin and cocaine against the price of beer would allow for a crude estimation of the "real" price of those substances as well, at least in relation to alcohol. It should be emphasized however that the factors that affect the retail

Table 5. **Retail prices in urban centres**

	1-way bus fare	1 bottle of beer	1 stick cannabis	0.1g heroin	0.1 g cocaine
Abidjan	CFA 160	CFA 200	CFA 40-50	CFA 1000	CFA 3000
Dakar	CFA 170	CFA 200	CFA 200	CFA 2500	CFA 2500
Accra	600 cedi	2000 cedi	500 cedi	4500 cedi	6500 cedi
Addis Ababa	1 bir	3 bir	1 bir	50-80 bir	NA
Harare	Z$4	Z$7	Z$2	Z$75	Z$50
Lagos	N20	N45	N10	N200	N400
Johannesburg	R3	R3	R3	R30	R25
Nairobi	KS 30	KS 54	KS1-10	KS 100-200	KS400

price of alcohol have, significantly, not been considered; thus possible distortions cannot be ruled out.

In each of the cities, cannabis was either less expensive or equal in price to a bottle of beer. This point is significant in and of itself, as it exposes a key feature that makes cannabis a drug of choice: low prices, even compared to alcohol. In Zimbabwe, cannabis was less expensive than the local home-brew, *katchasu*. Another general characteristic is that in most of the countries, heroin at present appears to be less expensive than cocaine. Exceptions include Johannesburg, where in recent years the influx of cocaine specifically crack cocaine has led to a reduction in retail prices. Cocaine in Harare also appears to be less expensive than heroin, perhaps as a result of the increasing transit trade that officials in Zimbabwe are concerned about.[49] Other findings are consistent with field-level interviews and observations. For example, the very high price for heroin in Addis Ababa was consistent with findings that the market for this drug had not yet reached critical mass prices still resemble those of the drugs as consumed in the major consumer markets in Europe and the United States. In contrast, the relatively inexpensive price of heroin in Nairobi is consistent with the presumed increase in heroin abuse throughout those countries' urban centres.

Figure 6 provides a comparison of prices of cocaine and beer. Figure 7 does the same for prices of heroin and beer. For present purposes, the ratio of these prices can be defined, albeit crudely, as the "real" price of these drugs, or the price of these drugs in terms of a local product their "real" value as determined by the market forces. As an additional basis for comparison, the corresponding ratio for New York City has been included as well.[50] The selected price of beer in New York was $3, which would reflect the price of a medium-upscale beer purchased in a restaurant or bar not altogether dissimilar from the way a bottle of

Figure 6. **Price ratio of beer and cocaine**

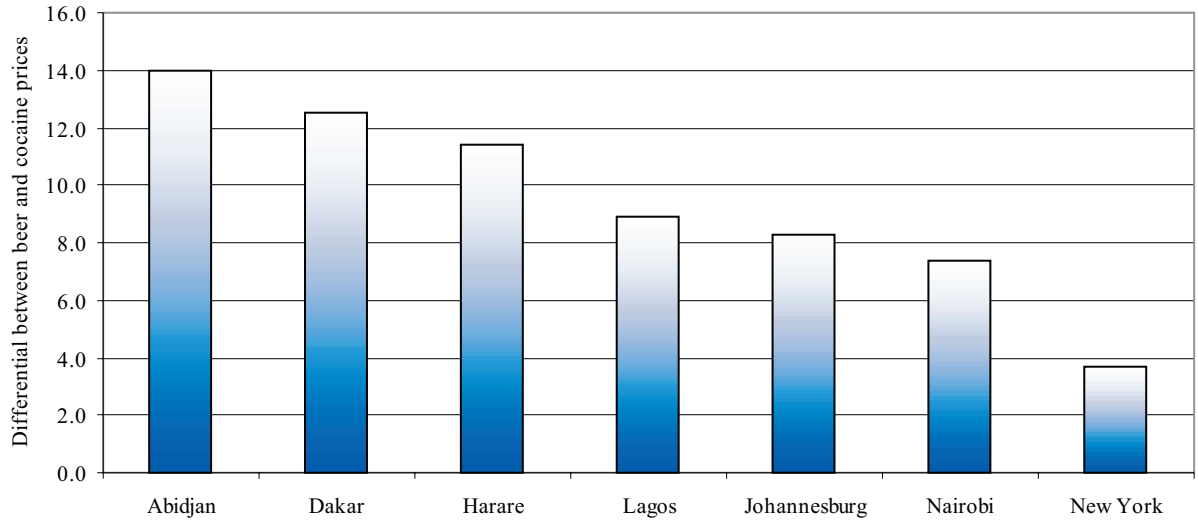
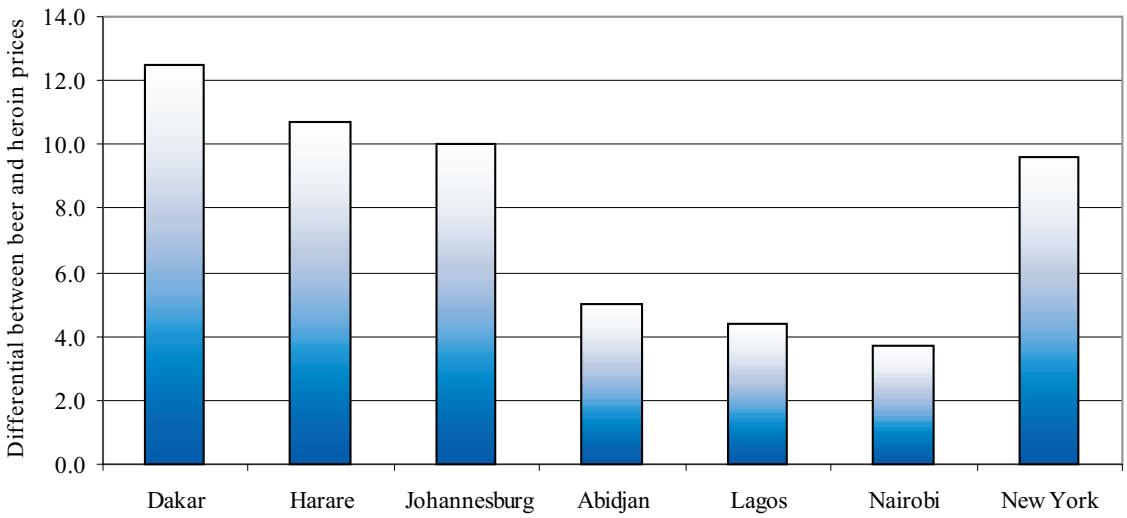


***Figure 7*. Price ratio of beer and heroin**



medium-scale domestic beer would be seen from the point of view of alcohol drinkers in the above-mentioned cities, who would have access to much less expensive alcohol. Note in figure 6 that in six cities compared to New York, the "real" price of cocaine is higher than that in New York.

In comparison, the price differences are not as considerable and, in some cases, the "real" price of heroin has in fact sunk below that in New York. Based on these comparisons, the real price of heroin in Nairobi, Lagos and Abidjan would appear lower than in New York. Nonetheless, given the limited amount of empirical data on which these comparisons are made, it is premature to read too much into the figure other than the fact that in Abidjan, Lagos and Nairobi, the retail price of heroin is much closer to that of bottled beer than is the relationship in New York, Johannesburg, Harare and Dakar. What this says about the market for illicit drugs in these cities is ambiguous, but the relatively low price of heroin could suggest one of two possibilities. Either the supply of the product is relatively ample or demand is negligible.

This study has been unable to rigorously address the question, but some additional information gives reason to believe that both factors are at play. A team of economists from SOAS participated in the various field visits as

***Table 6*. Retail prices of drugs (per gram) and per capita income (US$)**

	Cannabis	Cocaine	Heroin	Purchasing power parity GNP per capita
Ethiopia	0.8	-	125.00	450
Mozambique	0.93	68.18	34.09	810
Nigeria	2.32	56.82	28.41	1220
Kenya	1.82	123.21	44.64	1380
Ghana	0.90	88.08	66.06	1990
Zimbabwe	0.49	107.14	71.43	2030
Cameroon	0.99	110.66	-	2110
South Africa	2.27	111.11	65.56	5030
United Kingdom	-	111.17	136.33	19260
United States	-	100.86	338.33	26980

members of the international research team. Their price information is reflected in table 6, together with figures for purchasing power parity per capita income for some of the countries included in this study. The first three columns showed the prices of cannabis, cocaine and heroin. The last column refers to purchasing power parity GNP per capita. Several points about the table are worth explaining. Firstly, the prices for cannabis, cocaine and heroin have been converted directly into US dollars and, more importantly, the price figures especially for cannabis are considerably higher than those reflected in the national research reports and the preceding tables.

The disparity is due to different calculations used by the economists to estimate the price of a gram of cannabis based on a single unit of consumption ("stick", "chunk", etc.). Table 6 reflects variations in drug purchasing power parity.[51] Ethiopia, for instance, has a relatively high price (US$ 125 per gram) for heroin, almost the same as the price in the United Kingdom. This may not be surprising given the negligible amount of heroin consumption in the country. This could also be due to lack of competition in the local market. The overall trend shows that countries with high per capita income have high prices for cocaine and heroin.[52] The drug market is distinctive in one important respect, namely, the relationship between prices and the level of income. According to the table only a small proportion of the society can at present afford to purchase imported drugs. Comparable prices with the United States and the United Kingdom indicate that consumers in the sub-Saharan region are constrained by income and not prices.

While it is not possible to arrive at any firm conclusions regarding the drug markets in these cities, the above observations give some reason to speculate that the chief constraint at present on widespread consumption of cocaine and heroin is low income. The logical correlate is that, as incomes rise, the potential for more widespread demand for cocaine and heroin will grow. National surveys undertaken for this study reveal public perceptions that the drugs in question are already available and used in the countries concerned.

Tables 7–9 show respondents' perceptions of drug availability in Cameroon, Mozambique and Nigeria. Noteworthy findings of the surveys in Nigeria (table 7) are (a) the high number of responses indicating that heroin and cocaine were available in Lagos, and (b) the perceived widespread availability of amphetamine-type stimulants in Kaduna. In table 8, cocaine appears to be the second most prevalent substance after cannabis. Similarly, in Cameroon, table 9 shows that, after cannabis, which was cited as the leading substance of abuse in terms of prevalence, cocaine was cited more often than heroin, glue and psychotropic substances. The findings in table 9 result from a survey undertaken in Yaoundé and Douala (with about 972 respondents).

Several scenarios could result based on this initial assessment. Any improvement in urban income growth will have contending influences on supply and demand. On the supply side, it will relieve pressure on urban job markets, thus possibly raising the costs of hiring based on a smaller pool of willing and needy recruits for distribution. On the demand side, however, it is likely that higher incomes may lead to an increase in the consumption of drugs such as cocaine and heroin.

Another possible scenario is one in which urban income stagnates. This would increase the number of unemployed in the cities and cast greater appeal on involvement in illicit income-generating activities. But the converse of income growth on demand cannot be easily asserted. Indeed, whereas a rise in income may shift consumption into cocaine and heroin, a reduction in income likely expands consumption of cannabis and possibly the cheaper variants of cocaine, namely, crack.

These issues are examined in chapter IV. This section can conclude with the overall assessment that the drug markets in Africa are far more developed than presumed, and even though it is obvious that their evolution henceforth will be determined by urban economic advance, it appears that even income growth will open up new sectors of middle-income earners in particular to the abuse of substances such as cocaine and heroin. Importantly, the drug markets do not respond passively to economic trends, for dealers and peddlers are actively promoting and marketing their wares.

In South Africa, the Crime Information Management Centre in Pretoria has undertaken qualitative research on the gang phenomenon and a summary of that research states that "the gang culture is actually something of a survival mechanism in a world of poverty and unemployment and this phenomenon will never be eradicated by prosecution of the crimes committed by the gangs alone. Socio-economic reformation combined with a process of re-socializing is necessary to address the problem". The summary has the following points of relevance in the present context:[53]

> "A culture of gang-related violence and the selling and smuggling of banned substances has become embedded in the community.
>
> "The areas suffering the most from gangsterism are mainly poorly developed, with little or no recreational facilities. In areas like the Gaat in Helenvale, for example, social deprivation is obvious. Basically all areas where regular shootings occur are inhabited by poor communities.
>
> "Shacks are rented out to families needing shelter and some of the gang members act as banks, lending money to members of their communities on a monthly basis.
>
> "Many families having to cope with insufficient government grants are forced to borrow money. These people will not testify against gangsters, because they know that they receive a service from the gangs. At the same time, a strong fear factor is present within the community.
>
> "Gang leaders often pay peoples' rent, water and electricity bills in return for using their homes

Table 7. **Drug availability in urban centres of Nigeria**
(Percentage of respondents who responded "yes" when asked "Are these drugs available in your area?")
(N = 701)

	Cannabis	Heroin	Cocaine	LSD	ATS	Pethidine
Lagos (N = 152)	53	41	40	8	12	7
Kaduna (N = 201)	64	17	25	10	31	10
Port Harcourt (N = 117)	76	37	44	10	9	11
Ilorin (N = 231)	68	30	36	13	19	17
Total	**65**	**20**	**35**	**11**	**19**	**12**

Table 8. **Drugs used in Maputo**
(N = 1070)

Drug	Number of responses	Percentage of respondents
Cannabis	584	55
Cocaine	396	37
Methaqualone	196	18
Heroin	191	18

Table 9. **Drugs used in Yaoundé and Douala**
(N = 972)

Drug	Number of responses	Percentage of respondents
Cannabis	856	88
Cocaine	280	28
Glue	233	24
Heroin	65	7

to hide drugs. Homeowners' legally registered firearms are also often hired to commit crimes."

2. Trade-offs

Despite ostensible economic gains, the strategy of diversification through illicit activities has drawbacks due primarily to the need to hide the activities and defend them. Under such circumstances, asset accumulation actually increases the risk of exposure. Such illegal activities can be sustained only if farmers produce so little that raiding becomes unattractive or, as is more often the case, if they retreat to the bush to avoid detection. As experience shows, the existence of small, scattered plots of cannabis plants, as well as their location behind the "front-line", is a security strategy. Such strategies, however, can be costly: agents have to forego specialization or engage in small-scale production to avoid confrontation with law enforcement agencies.

It was noted in the previous chapter, for example, that cannabis producers in Ethiopia have been contracting out cannabis cultivation, partly in response to increased police surveillance of their farms. Farmers there, it will be recalled, plant cannabis far from the roads and conceal it in the midst of other crops. If the drug trade can be viewed as a means of private accumulation in Africa, it must also be

Box 4.Gangs in the Western Cape

In 1996, according to the South African Police Service, there were 481 organized crime syndicates. Many of those syndicates, 136, engage in drug trafficking, 112 in vehicle theft and 85 in commercial crime.[54] Gang activities in South Africa at present are an issue of major public concern. The link between drugs and gangsterism in South Africa, however, is a relatively new phenomenon. Informants and community members conveyed the impression that the main current activities of gangs in the area are now linked to drugs and related crimes. The Mitchells Plain police estimate that there are 30 gangs with 80,000 members, which is 11.6 per cent of the population in the Western Cape (note that there are only 350 police officers in the area).

Since the late 1970s, the Cape gangs have moved gradually from utilitarian to business-oriented activities. Gangs are now associated with the drug industry as well as *shebeens* (local drinking bars, often unregistered). One of the popular gangs, known as "The Firm", in Lavender Hill, is estimated to have a turnover of 1.7 million rand ($380,000) a day. Its main activities are trading in methaqualone, which costs R 35 to 45a tablet. According to the local police, a gang member can earn R 500 ($111) a day. There are few employment opportunities or recreational activities for the local youth. Between 1976 and 1988,25,000 people lost their jobs from the textile and clothes industry alone. Today, in the Western Cape, 69 per cent of the adult population is unemployed; the national unemployment rate is 33 per cent.[55]

Because of their established organizational structures, gangs can monopolize local markets and organize efficient distribution systems. In the jargon they benefit from economies of scale. One way to protect a market, establish monopoly position or minimize competition is to put resources into violence, invest in weapons and threaten potential entrants or competitors.

Gangs face a constraint in their operations. Since contracts are enforced outside of the legal framework, they have no incentive to merge or expand (transaction costs are high). The larger the organization, the more difficult it is to enforce contracts among members and clients become costly. The existence of numerous small gangs, distinguished either by location or functional specialization, in the Western Cape is indicative of a rational decision. Gangs also maximize profits through collusive agreements with one another, like a producers'cartel. But again, contract enforcement poses a problem. Whereas the breakdown of a legal cartel may lead to a price war, the breakdown of collusive agreements among illegal gangs tends to result in violence.

seen as a sub-optimal solution from the perspective of long-term sustainable development. People's dependence on the production of illicit crops, for instance, turns farmers into vulnerable groups and alienates them from mainstream policy interventions by and assistance from the Government.

Another drawback is that the income from drug-related activity is neither smooth nor cumulative, but fragmented and episodic.

One of the problems in drug economies is the scope given to corruption. The illicit drug trade triggers the search for favours by traffickers who depend on privileges for access to markets and often monopoly markets. The uncertainties of illegitimate trade and criminal patronage and of the broader economic environment make them averse to the long-term risks of productive investment, while immediate consumption, moneylending and the like hold greater promise of immediate profit, especially for those with the proper connections.

The drug traders constitute an illicit class, who are informal, privileged and uncontrolled, while other legitimate businesses, rooted in more productive activities, find themselves at a competitive disadvantage. Drug-related activities constrain development through their alienation of productive resources and distrust of laws and regulations. The emergence of such a class – unwilling to take risks in licit investment, fully dependent on official favours and engaged in myopic production – is an obstacle to long-term economic development. While often weak and operating on a modest scale, such a class has begun to form in all of the countries covered in this study, even in those where the drug industry is at an embryonic stage. The following summarizes the negative externalities associated with the drug trade.

- *Lack of access to agricultural extension services*: Once farmers begin growing cannabis as a supplementary activity, their access to state or NGO-sponsored extension services becomes limited and difficult. This may have an adverse impact on their long-term development, which, however, will not be taken into account in the decision to grow cannabis, given its positive utility in the context of an immediate survival strategy. Moreover, diversification into illicit cultivation can be costly. The opportunity for learning by doing in licit farming is reduced.

- *Potential for the creation of cannabis trading networks*: Once the growth of cannabis as a supplementary activity increases, there is scope for the creation of a trading network that seeks to "push" the product in wider markets. In-country surveys undertaken of drug users in Kenya found that nearly 60 per cent of the 139 self-declared users were convinced that peddlers were resorting to increasingly sophisticated methods to target potential buyers such as school children.[56] Middlemen as well are finding it worth while to experiment with producing more marketable varieties of cannabis and provide finance to do so.

- *Transaction costs:* Every contract between economic agents presupposes a set of activities for its implementation, such as information gathering, bargaining, monitoring and contract enforcing. All these activities generate transaction costs.[57] In the drug industry transaction costs are raised by several factors such as judicial scrutiny, extra expenditure on security and constant retreat from the public eye. Other factors include the process of identifying potential collaborators as well as customers. The need to conceal cannabis production raises the transaction costs of overall production for the small producer. Drugs are often interspersed with other crops or "hidden" within a field in which legitimate crops are grown around the cannabis plants to evade detection. This raises the costs of monitoring agricultural output and distorts optimal cropping patterns. The growth of cannabis in remote

and undetectable areas requires more family labour to be spent in journeying to those areas and in escaping detection in the process. Producers and distributors will attempt to internalize upstream and downstream competitors to minimize the costs. Distributors, who seek contractual enforcement, would have a motivation to collude to internalize transaction costs, thus increasing the degree of monopoly formation.

- *Short-term investment horizon*: Opportunity costs result from the speculative and unstable nature of illicit crop cultivation. The reinvesting of profits over the long term is constrained by the ever-present fear and insecurity that attend engagement in illegal activities. Illicit crop cultivators cannot enjoy the benefits that accrue to long term investment strategies.

- *Criminalization of legitimate trade*: Economic growth along the southern and western African borders is likely to spawn a proliferation of drug smuggling because customs inspectors are less likely to scrutinize shipments from bonded enterprises and increased trade flows. Vast amounts of drugs are already spirited in and out of countries in commercial vehicles hidden in containerized shipments, in false panels beneath crates of vegetables and fruits, in boxcars, in hidden compartments and in fuel tanks. With the trade increases anticipated over the next few years, especially after the approval of SADC and ECOWAS, the volume of illegal drugs crossing borders is likely to rise. The shipment of drugs with legitimate commodities raises the need to scrutinize legitimate trade flows, with attendant delays to legitimate cross-border trade. This increases the cost of conducting legitimate trade and opens up the opportunity for seeking favours from public officials.

- *Cost of rehabilitation and treatment*: At the national as well as the local levels resources are devoted, in the health sector, to the rehabilitation of drug users. From the point of view of low-income economies, the problem is not only that they undermine law and order but that they divert resources away from other health expenditure.

  As shown in table 10, drug-related admissions in 1992 in nine mental hospitals in Nigeria reached 416 patients, or about 7 per cent of the total. In the same year, only 67 per cent of the population had access to health care (table 11). Today, Nigeria has five rehabilitation centres throughout the country: Lagos, Minna, Benin City, Kano and Maiduguri.

  Similarly, 25 per cent of patients in Accra Psychiatric Hospital were cannabis-related, although currently the figure has dropped to 5 per cent. The hospital now has six psychiatrists catering for 1,200 in-patients and 4,000 outpatients, while only 25 per cent of the population have access to health care.[58]

  In contrast, there are no rehabilitation centres in Ethiopia. The only psychiatric hospital in the country confirmed that there have been only three heroin cases reported.[59] In fact government officials in the Ministry of Health believe that rehabilitation is expensive and prefer prevention and treatment as drug control policies. The drug unit, whose main concern is monitoring pharmaceutical products within the ministry of health, is also responsible for monitoring illicit drug trends. The unit has 22 professionals, 7 administration staff and 2 inspectors dealing with the issue of drugs and pharmaceutical products.

- *Cost of law enforcement*: Expenditure on law enforcement could also be seen in the same light. While police departments require expenditure on other aspects of policing, port surveillance, border patrol, payment to informants, court procedures and administration consume resources. The figures in table 12 shows the intensification of enforcement efforts by the Nigerian authorities.

The Ghana Police Headquarters has 35 staff in the drug unit, and it made 94 and 116 convictions in 1996 and 1997, respectively. As at 25 February 1998, 250 prisoners (out of 1,700) convicted at Nsawam Medium Security Prison were drug-related.

The Narcotics Control Board (NCB), the central coordinating body in Ghana is responsible for law enforcement, expert development, intelligence, education and prevention. It must be said that NCB is unique in that it strikes the right balance between law enforcement and preventive education. It encourages and, in some cases, has set up drug-free clubs and rehabilitation and treatment centres. According to NCB, the decline in the number of prisoners at Nsawam prison, as shown in table 13, is an indicator of the success of those programmes. In part assisted by UNDCP and other bilateral donors (United States, United Kingdom and Germany), most of NCB funding comes from public coffers.

As funding requirements are growing, NCB is currently proposing the introduction of an asset seizure law. Such schemes seek to lighten the financial burden on the treasury.

D. SUPPLY REDUCTION

One policy question hitherto not fully investigated in the sub-Saharan region is how a Government should allocate its drug control expenditure in order to achieve the highest return. The first basic principle of allocation is that Governments should avoid placing priority on activities that are beyond their capacity to effectively carry out. As mentioned in the introduction to this chapter, what a Government can do effectively is in part a function of the level of development of the country. The level of development affects both what is “intrinsically” possible and what the public sector has the capacity to implement.

Generally speaking, one central objective of development policy is poverty reduction. Prompted primarily by the international financial institutions, and as part of the process of restructuring their economies, a number of African Governments have entered into policy-based borrowing arrangements with international financial

Table 10. **Drug-related admissions of nine mental health centres in Nigeria compared with total admissions, 1992**

Health institutions	Total admission	Drug-related admissions
U. C.H Ibadan	470	16
Unilorin Teaching Hospital	164	16
Neuro-Psychiatric Hospital, Aro	1 124	73
Psychiatric Clinic Kware, Sokoto	156	35
Psychiatric Hospital, Yaba	1 352	67
Yola Psychiatric Hospital	1 266	103
Luth, Lagos	124	2
Kano, Rehabilitation Centre	234	8
Uselu Psychiatric Hospital, Benin City	822	96
Total	**5 712**	**416**

Source: Adetula (1995)

Table 11. **Health expenditure (percentage of GDP) and health care (percentage of population with access)**

	Expenditure 1994	Access 1992
Cameroon	1.0	15.0
Ethiopia	1.1	55.0
Ghana	1.0	25.0
Kenya	1.9	–
Mozambique	4.6	30.0
Nigeria	–	67.0
South Africa	3.6	–
Zimbabwe	2.1	71.0

Source: World Bank, 1997

Table 12. **Summary of drug-related arrests in Nigeria**

	Male suspects	Female suspects	Convictions	Acquittals
1994	632	61	67	20
1995	732	66	333	10
1996	1 099	88	537	13

Source: NDLEA, 1997

Table 13. **National prisoner statistics, Ghana**

Reason for arrest	1992	1993	1994	1995	1996
Theft	5 200	8 500	7 000	7 000	5 000
Assault	682	1 300	1 151	1 000	580
Murder	356	335	277	281	27
Drugs	525	556	476	482	97

Source: Nsawam Medium Security Prison, Ghana

institutions. The general thrust of those programmes has been to reduce government regulation of markets and decrease the size of the public sector. While those programmes cover a wide range of economic and social policy, they have not yet addressed drugs to any significant degree. This is noteworthy, for while many goals associated with official lending may have little impact on the drug problem, some, such as trade liberalization and reform of the customs system, certainly have direct effects on monitoring and enforcement capacities. Conversely, it is clear that the illicit drug trade, in some countries, has a powerful impact on economies far beyond the production sites.

Thus, at the international level, one element of institutional consolidation is to integrate drug control components more centrally into the work of the international financial institutions, beginning with the involvement of UNDCP in international financial institution assessment missions.

1. Law enforcement

In very low-income countries, such as Ethiopia and Mozambique, the pattern of urban settlement is not particularly conducive to effective policing: there is probably no reliable registry of residents, many dwellings are temporary and there is considerable turnover of population. Training of police or improvement of law enforcement equipment might in this context not be the most effective strategy to pursue.

The current public debate on decriminalization/ legalization of cannabis in South Africa is the result of concerns over the capacity of the Government to fight the drug trade (cannabis has been illegal in South Africa since 1903).[60] The Land and Agricultural Policy Centre is calling for legalization of industrial hemp production use, but not of cannabis consumption. The Rastafarian community demands legalization on religious grounds.

The Minister of Correctional Services commented that decriminalization/legalization of cannabis "would save millions of taxpayers' money".[61] The Secretary of Safety and Security also questions the viability of arresting consumers and advocates a strategy that focuses on seizures and big traders.[62] What is clear– at least in the case of South Africa – is that seeking to enforce legal sanctions against small-scale distribution and individual consumption may not be the most cost-effective option. Of possibly greater net benefit would be measures to restrict supply farther back in the distribution chain. While this policy has proved ineffective in many developed countries, the institutional constraints in Africa suggest that it may be the most cost-effective approach. For imported drugs, the obvious point of focus would be ports of entry and channels of clandestine traffic. This approach has several advantages for a low-income country:

- Firstly, it avoids the intractable problem of street enforcement in urban areas.
- Secondly, it facilitates the concentration of control efforts at strategic points, thereby economizing on scarce skilled personnel.
- Thirdly, it allows the Government to consider ways of treating a growing portion of its population as other than criminals (i. e. individual drug producers, distributors and consumers).

The approach described above must be at a regional level. If not, the prospect of increased law enforcement, for instance, NDLEA's successful crackdown on imported and exportable drugs in Nigeria, is that the internal market will shift to neighbouring countries – the "balloon effect". The impression conveyed by informants is that trade in illicit drugs can easily be relocated. Field interviews suggest that as a result of NDLEA's success, most drug traders from Nigeria have shifted their operations to Cameroon, Ghana and other countries in the region. According to officials in

Box 5. Customs and drug smuggling in South Africa

In sub-Saharan Africa, South Africa has the most sophisticated customs and excise institutions. However, officials complain about the lack of resources, pointing out that there are only 1,500 customs officials assigned for 19 border posts and 10 airports.[63] The Ministry of Finance estimates illegal cross-border movement of smuggled goods to be endemic (estimated to be 1 million rand per working hour). In terms of definition, smuggling is of two types: (a) clandestine entry of otherwise legal commodities, with the purpose of avoiding payment of taxes or import and export licenses; and (b) shipment of illegal commodities. The major commodities of the first type are consumer durable imports (particularly electronics) and diamond exports. Drugs are the only illegal commodities of any quantitative importance. Officials estimate that the value of drug imports exceeds that of illegal import of other commodities. Evidence from drug seizures by the police suggests that most of the importation is through established ports of entry (i. e. not via clandestine air, sea and land transport).

The Government has sought to limit the scope for drug smuggling by reducing the number of official ports of entry. This policy should make enforcement more effective, even if it has the effect of increasing clandestine transport. An increase in clandestine drug movements would prompt a corresponding increase in seizures, by increasing the probability of the police apprehending traffickers. The principal limit to enforcement is lack of personnel, which reflects the budget constraints of both customs and excise and the South African police. If the government wishes to reduce smuggling of drugs into the country, there is no alternative to increasing the number of customs and excise inspectors. Some small gains in efficiency of drug control could be obtained through reallocation of staff within customs and excise. This would have a cost, since reallocated officials would require specialized training (as would new officials if the number of inspectors was increased).

"Street enforcement" of drug distribution and use is quite expensive, being highly labour-intensive. It also can prove provocative in the racially divided urban areas of South Africa. More effective border control, through improved customs inspection and interdiction of clandestine traffic, is likely to be more cost-effective. If effective, the reduction of supply has an automatic mechanism for discouraging drug consumption. The consequent increase in the street price would shift consumption to high-income groups, where monitoring becomes feasible. As with customs and excise, specialized training would be required to effect such a change in enforcement priorities and the social return to a shift at the margin from street enforcement to interdiction is likely to be high.

Lagos, this trend is facilitated by the settlement of Nigerian communities in other countries.[64] Similarly, more effective law enforcement in other countries may lead to the "dumping" of expensive drugs at prices significantly lower than prevalent in other countries in the region and world markets, thereby causing temporary demand increases, which may become permanent.

2. Drug control and corruption

There is a widely held perception in the countries under study that one can be caught selling or abusing drugs, but all one has to do is to give a bribe to go free. Others say that although anti-narcotic groups have been formed, they exist only in theory and in effect are "toothless".[65] The implication is that institutional weakness and corruption are significant barriers to effectively combating the illicit drug trade through conventional law enforcement interventions. In this context, it should be pointed out that the recent proliferation of anti-drug units and other law enforcement agencies in Africa, while clearly an encouraging sign of prioritization, may from a purely economic perspective also lead to a collusive form of bribe-seeking. Domestic distributors and traffickers of drugs no longer need to bribe as many customs, police or other officials, but rather only officials from a central drug enforcement agency. One illustrative phenomenon is the assignment of central law enforcement agents at airports, ports and at the district level. Another example is the discontent voiced by many customs officials, as observed in Mozambique, Nigeria and South Africa, that they have been stripped of a major law enforcement task: drug interdiction.

It is clear that drug enforcement is becoming highly centralized. In general, this is a positive development, but it should also be recognized that corruption by collusion may also be facilitated, for it creates an opportunity for people to engage in the drug industry via reduction in the price of services. The concentration of drug law enforcement in one central agency allows its members to demand higher bribes because of their "ownership" of the law and new-found lack of competition in bribe-seeking. In this situation the drug trader would prefer a fragmented approach to law enforcement. Further research is required to determine the actual effect of either concentration or decentralization of law enforcement. However, it is clear that the decision to hand over the task of drug law enforcement to a single agency or to a multitude of agencies should take place in full view of the possibility that a particular incentive structure will be formed.

E. CONCLUSION

This chapter concludes with excerpts from the reports of the national research teams of Zimbabwe, Kenya and Ghana, led by Dr. Stanley Acuda, Dr. Halima Mwenesi and Dr. Kojo Senah, respectively. While the following texts were written with specific regard to the three countries, they tie together many of the themes covered in this chapter:

1. Zimbabwe

"This was the first major study to focus on illicit drug problems among adults and the community in Zimbabwe. All previous studies had been done on adolescents in schools. This was also the first study to examine the social, economic, and political aspects of illicit drugs in Zimbabwe. Although the study confirmed the findings from previous studies on the type of illicit drugs which are currently available and are being used in Zimbabwe, this study has gone further and has indicated strongly that the magnitude of the problem may be much more serious than had previously been thought and seems to be linked to the current adverse socio-economic situation in the country.

"Both the key informant interviews and the focus group discussions identified the main reasons for the production, trafficking and abuse of drugs in Zimbabwe as being largely socio-economic. The study has shown quite clearly that the majority of people who grow cannabis in rural areas and who brew and distil *katchasu* (home-brew) in rural and urban areas are doing so as the major and perhaps the only source of income for themselves and their families.

"The majority of people who are involved in distribution of illicit drugs are either unemployed or have very low incomes. They are reported to indulge in drug peddling also as a means of gaining or supplementing their incomes. Unemployment among the youth is currently estimated to be around 40 per cent. It is claimed that they use illicit drugs in order to forget their problems, which are also largely socio-economic."

2. Kenya

"(In Kenya) the factors that influence the abuse of drugs are: poverty, rural urban migration, and its concomitants such as living in slums, unemployment, single parenthood, the availability of drugs, lack of adequate controls, peer pressure; print and electronic media advertisements and the persistence of multinational firms that produce alcohol and tobacco. The abuse and dealing in drugs is a vicious cycle. Negative economic and social factors lead many of the users and peddlers into the drug web and then involvement therein leads to other economic and social repercussions. The young man is forced to the streets due to poverty and harassment at home. Once in the streets he has to take drugs to survive and in order to buy them he steals and robs people to get money. As for the peddler, it could be a man or a woman who is jobless and has a family to fend for. He gets into drug peddling and in order to succeed he has to create a market by introducing the drugs to young

people and perhaps bribing corrupt officials to avoid arrest.

"Kenya is one of the most highly populated countries in the world. The concomitants of this phenomenon include unemployment, food scarcity, and pressure on the economy. It is also one of the developing nations on a developmental and social-political crossroads. As more airlinks with other parts of the world open, so does the level of narcotics finding their way into the local market increase. The spillover effect becomes a consumer-driven phenomenon. The production of cannabis takes place in the fringes of forests and deep in the rural areas where its control is hampered by lack of resources and as repeated by most respondents, corruption by law enforcement agents."

3. Ghana

"Adequate policy formulation requires an assessment of people's opinion on the future direction of the drug problem. Thus the question was put to respondents: 'Do you think the drug problem is likely to improve or worsen in the future?' In response to this all respondents predicted a bleak future for the nation.

"Respondents' views touch on both macro- and micro-level issues. That unemployment and moral degeneration top the list is not surprising. The popular view is that the devil finds jobs for idle hands. The large number of young unemployed persons on the streets in urban areas who are engaged in all manner of activities including drug use is visible enough to attract public concern. What is even more frightening is that the situation appears to worsen each year. Today we are faced with graduate unemployment, a phenomenon unheard of a decade ago. Today we have an army of juveniles who work and sleep on the streets. Population pressures in the face of dwindling national resources have had an impact on society. The speed of social change has caused disruption in the norms and value system of a largely traditional society like Ghana. Today in Ghana the home and the school are at each other's neck as to who should be blamed for the moral decay in society. This decay is also blamed on foreign influence (tourists, films, television, etc.), which piques the imagination of the youth.

"In a country where material poverty is the most democratized item, it is difficult to convince the farmer to plant cassava when he can obtain more for less effort if he plants weed (cannabis). In the same vein, the courier who succeeds in bringing home dollars to build a house for herself and for her extended family members will not be condemned by all: at least she is a heroine to her family even if she is a topic for community gossip. The point being stressed here is that considerations for financial rewards are gradually blunting the societal need to uphold morality. At least in Ghana, this issue has not reached the level of public debate yet and this is the more reason why we will need to improve the social and material conditions of our people. In a country where 30 per cent of the population lives below the poverty line, preaching morality is an exercise in futility. Indeed, one commercial vehicle owner has philosophized the whole point thus: 'Money be Man.''In Ghana, money makes a person what he is.'Of course, it may be argued that economic prosperity per se does not automatically lead to a reduction in the use of drugs: it may indeed exacerbate the problem. At least the experience of the developed economies is proof of this. This fact notwithstanding, in the Ghanaian context, drug use appears to be a function of poverty.

"Generally, the belief is that once the factors likely to worsen the problem are identified and seen to, the drug problem will be contained. For instance, it has been argued by many (62.3 per cent of survey respondents) that once youth are given employment opportunities, their tendency to engage in the drug business will decrease. Other suggestions of considerable importance are the need to intensify public education (21.2 per cent), the need to properly equip the police and other law enforcement agencies (10.5 per cent) and the need for stiffer punishment for drug-related offences (6 per cent). What is interesting from these suggestions is the mix of control measures and their respective weights. Basically, respondents favour both repressive and non-repressive measures. However, it appears that more weight is given to non-repressive measures such as widening employment opportunities and intensifying public education.

"Drug problems require multifaceted solutions to the extent that they are a function of individual psychosocial needs which are themselves offshoots of the social structure of society. For this reason, solutions must focus on demand and supply reduction strategies which employ both the stick and the carrot: helping the farmer to grow food crops which he can readily sell and earn enough to take care of himself and members of his family is as important as instituting both repressive and non-repressive measures which discourage the demand for drugs."

Notes

1 More on this in chapter V, "Political Change and Illicit Drugs in Africa".

2 The Zimbabwe research team, led by Dr. Stanley Acuda and Essie Machamire, concluded that "the majority of people who grow cannabis in rural areas and who brew and distil (homebrew) katchasu in rural and urban areas are doing so as the major and perhaps the only source of income for themselves and their families". Quoted on p. 74 of the National Report.

3 For example, the national research team in Zimbabwe reports: Key informants have reported that drugs sell quickly; it is a way of making quick money and there is demand for drugs. Producers and distributors of drugs are therefore able to take the various risks. . .in order to make quick money." National report, p. 52.

4 World Bank. Trends in Developing Economies, vol. 3: Sub-Saharan Africa 1995. Washington, World Bank, 1995 p. ix.

5 See Binswanger, H. and McIntire, J., "Behavioural and Determinants of Production. Relations in Land Abundant Tropical Agriculture", *Economic Development and Cultural Change, 1987,* vol. 36, pp. 73 – 99, for a thorough discussion of this point.

6 As explained by Udry, C., "Credit Markets in Northern Nigeria: Credit As Insurance in a Rural Economy", in Hoff, K., Braverman, A. and Stiglitz, J.E. (eds.) *The Economics of Rural Organisation: Theory, Practice and Policy*, Oxford, Oxford University Press, 1993. Where collateral is not used in the credit system, both the lender and the borrower share risk.

7 See Deaton, A., "Saving in Developing Countries: Theory and Review", *Proceedings of the World Bank Annual Conference on Development Economics 1989, World Bank Economic Review Supplement*, 1990, pp. 61 – 96, for a discussion of "consumption smoothing" through diversification.

8 United Nations, World Economic and Social Survey 1997, Trends and Policies in the World Economy. New York, United Nations 1997, p. 47.

9 Office of the U.S. Trade Representative, "AComprehensive Trade and Development Policy for Africa: A Report Submitted by the President of the Untied States to Congress" , 20 February 1997.

10 United Nations. 1997, *op.cit.*, p. 47.

11 This is measured by the amount of time farmers spend farming as a proportion of their working hours. It has been found that Asian and Latin American farmers spend more time farming than African farmers and that the average share of non-farm income is significantly greater (Reardon, T. et al., "Is Income Diversification Agriculture-led in the West African Semi-Arid Tropics? The Nature, Causes, Effects, Distribution and Production Linkages of Off-Farm Activities, in Atsain, A., Wangwe, S. and Drabek, A.G. (eds), *Economic Policy Experiences in Africa*, Nairobi: African Economic Research Consortium, 1994.

12 World Bank, *Trends in Developing Countries,* Washington: World Bank, 1996.

13 According to official reports, some 600,000 farmers are at present benefiting directly from the Government"s agricultural extension programme. The overall agricultural development plan envisages an annual surplus production of 100,000 kg beyond food self-sufficiency. Estimates maintain that in a few years time Ethiopia will need no foreign food assistance.

14 February 1998 interview, Shashamene District, Ethiopia.

15 Sogodogo, A., "Dévaluation, croissance et équilibres macro-économiques: le cas de la Côte d'Ivoire", in Contamin, B. and Memel-Fotê, H. (eds), *Le modèle ivoirien en questions, crises, ajustements, recompositions*, Paris. Kathala-ORSTOM, 1997, p. 140.

16 Observatoire Geopolitique des Drogues, *West Africa: In-Depth Assessment Study on Drug Production and Local Trafficking, in particular related to Cannabis Cultivation,.* Paris, OGD (Report to the European Commission, D-Afr/94/01), 1995, p. 52.

17 Ibid., p. 54.

18 Ibid., p. 55.The CFA franc is pegged to the French franc. US$ 1 = CFA 600 approximately, according to the exchange rate in Abidjan at the time of the field study (mid-January 1998).

19 Ibid., pp. 54 – 57.

20 Ibid., p. 60.

21 Ibid.

22 Ibid., p. 74.

23 National research team (Zimbabwe) report, pp. 47 and 61.

24 National research team (Mozambique) report, p. 7.

25 From a political point of view, one popular argument *a la* Bates (Bates, R.H., *Markets and States in Tropical Africa: The Political Basis of Agricultural Policies,* University of California Press, Bates, R.H., "Governments and Agricultural Markets in Africa*",* in Bates, R. H. (ed.), *Toward a Political Economy of Development: A Rational Choice Perspective,* University of California Press, 1988, emphasized the prevalence of state-induced distortion in urban prices, particularly food prices.

26 During the field visits community leaders, the police, government officials and others emphasized that vulnerability to drug use resulted from "idleness".

27 Agir ici-Survie, *France-Sénégal, une vitrine craquelée,* Paris, L'Harmattan, 1997, p. 10.

28 Duruflé, G., *Le Sénégal peut-il sortir de la crise?* Paris, Karthala, 1994, pp. 21 – 23.

29 Ibid., pp. 24 – 26.

30 See Jamal, V. and Weeks, J., "The Vanishing Rural-Urban Gap in Sub- Saharan Africa", *International Labour Review*, vol. 127, No. 3, 1998; and Jamal, V. and Weeks, J., *Africa Misunderstood: Or Whatever Happened the Rural-Urban Gap*? London, Macmillan, 1994.

31 For instance, Jamal, V. and Weeks, J.,1988, showed that the wage premium in the urban sector had declined significantly in the last decade.

32 Recent studies of poverty in Ghana reveal that poverty in the urban sector has worsened (Ghana, 1996, and World Bank, 1995).

33 National research team (Ghana) report, p. 32.

34 November 1998 interview with Imam Rashid Omar, Cape Town.

35 National research team (Ghana) report, p. 39.

36 National research team (Zimbabwe) report, pp. 74 and 51.

37 See Potts, D. and Mutambirwa, C.C., "Rural-Urban Linkages in Contemporary Harare: Why Migrants Need Their Land", *Journal of Southern African Studies*, vol. 16, No.4,1990, pp. 676 – 698.

38 See Gilbert, A.,"Third World Cities: Poverty, Employment, Gender Roles and the Environment During a Time of Restructuring", *Urban Studies*, vol. 31, No.4/5, 1994, pp. 605 – 633.

[39] UNDCP, Ghana Human Development Report, Vienna, UNDCP, 1997, p. 46.

[40] ILO/JASPA, *From redeployment to sustained economic generation. Challenges for Ghana"s programme of economic recovery and development,* Addis Ababa, ILO, 1989.

[41] National research team (Ghana) report, p. 5.

[42] Institutional underdevelopment is one feature of economic underdevelopment. In other words, the difference between the developed and developing countries can be found in transaction costs or the cost of the law. In developed countries, transaction costs are low relative to national income, while the opposite is true in developing countries (see North, 1990).

[43] Interview with an economic adviser to the Prime Minister, Abidjan, 20 January, 1998; see also the series of articles on business opportunities in Morocco in the government newspaper *Fraternité Matin*, Monday, 19 January, 1998, pp. 2and 3.

[44] Duruflé, G.1994, *op. cit*., p. 6.

[45] Interview with the Director of OCRTIS in Dakar, 11 January 1998.

[46] Ibid.

[47] Taurus, A., *Fin de siècle incertaine à Perpignan*, Université de Toulouse-Le Mirail, 1996.

[48] On the extent of alcohol consumption in the region see Macdonald, D., "Drugs in Southern Africa: An Overview", *Drugs: Education, Prevention and Policy*, vol. 3, No.2, 1996, pp. 127 – 144. and Rocha-Silva, L., *Drug Use within the Context of Other Socioeconomic Conditions in South Africa,* A Report for the United Nations Drug Control Programme (UNDCP). Pretoria, South Africa, 1998. In Zimbabwe, for instance, cheaper alcoholic substitutes have been invented in response to decline in purchasing power. Low-income consumers can seldom afford beer and resort to *kachasu* and *chibuku* (illicit brews).

[49] 24 November 1997 interview with the Interpol Subregional Bureau for Southern Africa, Harare. One important trend is the increasing use of prostitution networks by international cocaine traffickers, who store cocaine shipments at the residence of the prostitutes.

[50] The price for heroin and cocaine in New York is that reported in the UNDCPAnnual Report Questionnaires.

[51] It is important to note that prices of illicit drugs very much depend on purity. For this reason, the data must be taken as rough indicators rather than absolute figures.

[52] This is on the assumption that the prices for heroine and cocaine in Ethiopia and Kenya respectively, are special cases.

[53] Crime Information Management Centre (CIMC), National Detective Service, *The Incidence of Serious Crime between 1 January and 31 March 1997*, 13 June 1997, pp. 21and 22.

[54] South African Police Service, *The Incidence of Serious Crime. Quarterly report*. Pretoria, CIMC, 1996.

[55] Ibid.

[56] National Research Team (Kenya 1) Report, p. 17.

[57] Whenever production costs are lower than transaction costs, producers will find ways to go around market operations through the expansion of additional activities. Conversely, a decline of transaction costs will reduce the scope of production vectors and producers will be compelled to refocus their capabilities on those production lines that remain profitable. In other words, the relationship between transaction costs and production costs suggests the convenient degrees of output diversification.

[58] One special feature of rehabilitation in Africa is the fact that the institutions responsible for the treatment of drug-related patients are government-owned psychiatric hospitals. For instance, there are three psychiatric hospitals rehabilitating addicts in Ghana, a country divided into 10 regions, all of them concentrated in the southern regions and established in 1905, 1906 and 1975, respectively.

[59] The resource need in Ethiopia and Mozambique cannot be over emphasized. Hospitals today turn away patients because of lack of basic materials. Patients in some hospitals are required to bring their own medication, such as syringes and plasters. In Ethiopia, health expenditure as a percentage of GDPwas only 1.1 per cent in 1994 and only 55 per cent of the population had access to health care in 1992. The statistics for Mozambique are even more telling. Although health expenditure as a percentage of GDPwas 4.6 percent, only 30 per cent of the population had access to health care.

[60] The success rate of the South African Police Service is limited. In 1995, of the 20 couriers INTERPOLsupplied information on, the police were able to apprehend 5 couriers, with 36.50kg of cocaine. In 1996, out of the 56 known couriers, only 6 were arrested with 14 kg of cocaine (South African Police Services, *The Extent of Drug Trafficking in South Africa*, Pretoria, SANAB and CIMC, 1996).

[61] Ryan, T., *Should South Africa Decriminalise Dagga?* South Africa, South African National Council on Alcoholism and Drug Dependence, 1997.

[62] *Sunday Tribune,* 20 July 1997.

[63] November 1998 interviews in Johannesburg, Pretoria and Cape Town.

[64] February 1998 interview, Lagos.

[65] See Mwenesi, H.A., *The Drug Nexus in Africa: Kenya*, A Report for the United Nations International Drug Control Programme (UNDCP), Nairobi,1998.

CHAPTER IV

SOCIAL CHANGE AND ILLICIT DRUGS IN AFRICA

A. INTRODUCTION

Chapter III considered the relationship between economic change on the one hand and illicit drug production and trafficking on the other. Pointedly, chapter III did not address the question of consumption. This chapter does, recognizing the importance of cultural attitudes and social causes. It attempts to identify social groups in each of the 10 countries who are affected by drugs and to highlight trends that may alter future patterns of use. It also offers a sociological picture of those participating in drug activities in the 10 countries under review: Cameroon, Côte d'Ivoire, Ethiopia, Ghana, Kenya, Mozambique, Nigeria, Senegal, South Africa and Zimbabwe.

Attitudes toward drugs vary across the 10 countries and between social groups within each. Important cultural factors affect public reactions to illicit drugs; variations in the perceived morality of drug use are evident in different parts of the continent. This chapter avoids assuming that African society is homogenous; it instead emphasizes the particularities of culture and place and the distinctions that must be drawn between different drugs. While it is often asserted that Africa's drug problem is a new phenomenon, it is important not to ignore the historical experience of drugs within African societies. Traditional religious and medicinal uses of cannabis in Ethiopia and Zimbabwe, for example, influence society's responses to the modern-day manifestations of illicit drug consumption.

A comprehensive analysis of drug consumption from the perspective of social change would need to consider the following questions:

- *Poverty* – how does economic need influence consumption patterns?
- *Public perceptions of drugs* – does consumption influence cultural attitudes toward drugs; how do these attitudes affect collective support for demand reduction initiatives?
- *Youth and education* – to what extent is the younger population able to gain access to education; what perceptions are held locally by and about younger city dwellers, and to what extent may they be perceived as vulnerable; how serious is the problem of street children; how representative are they of a specifically vulnerable group?
- *Religion* – what role do religious bodies play in the provision of social welfare; how well-equipped are such bodies to meet emerging challenges in relation to drug issues, how are such bodies viewed locally and to what extent are they able to maintain authority at the community level?

The motivations for drug abuse are many; one useful analogy is that of a bipolar spectrum, with recreational use and so-called "functional" use comprising the two poles. It is argued here that the more consumption in a given context swings to the latter, the more likely those social attitudes and norms against drug use will be weak. Without the support of local communities, demand reduction measures are unlikely to be effective in the longer term (the next chapter, on political change, examines the importance of public support in the context of supply reduction). It is for this reason that section B devotes considerable attention to public perceptions of illicit drugs. Section C considers the implications for drug control of the changing nature of public perceptions of drug consumption. Section D examines the key groups who are vulnerable to illicit drug consumption. Section E, on demand reduction, highlights the importance of raising public awareness of drugs issues and fostering public debate on drug abuse.

B. FUNCTIONAL CONSUMPTION AS AN INFLUENCE ON SOCIAL NORMS

In the conventional discourse on the key motivations of drug use, "peer pressure" is considered to be among the most prominent causes in western, industrialized societies. Peer pressure emerged in some of the national surveys for this study– most prominently in Nigeria and South Africa – but otherwise did not figure prominently as a contributing factor to drug abuse. In this regard, while the "social pressure" underpinning drug abuse in sub-Saharan Africa

Table 1. **Police reports on the occupational characteristics of drug offenders in Ethiopia**

	1993		1994	
	Number	**Percentage**	**Number**	**Percentage**
Unemployed	49	17.1	60	20.1
Students	40	13.9	30	10.0
Traders	4	1.4	30	10.0
Immigrants (refugees)	2	0.7	7	2.3
Professionals	1	0.3	6	2.1
Unknown Occupation	191	66.6	166	55.5

Source: Gebre Selassie and Gebre (1995)

Table 2. **Socio-demographic profiles of drug abusers in Kenya (male: 353, female: 30)**

Age	**Status**	**Occupation**	**Drug abused**
5 to 9 – 29	Free adult – 220	Unemployed – 123	Cannabis – 350
11 to 29 – 100	Student 72	Employed – 80	Khat – 100
20 to 29 – 100	Prisoner – 58	Homeless – 100	Heroin – 24
30 to 39 – 104	Probationers – 25	Student – 80	Cocaine – 19
40 + to 50	Non- Kenyan – 8		Methaqualone – 19
			Hashish – 7
			Other – 100

Source: Mwenesi (1995)[1]

Table 3. **Statistics for drug-related patients from January to December 1995 in Ghana (male: 881, female: 44)**

Age group	**Educational level**	**Type of drug**	**Region**	**Occupation**
15 to 20 – 80	1st Cycle – 550	Cannabis – 573	Greater Accra – 403	Unemployed – 437
20 to 30 – 495	2nd Cycle	Alcohol – 153	Easter – 126	Artisans – 158
31 to 40 – 242	3rd Cycle	Heroin – 14	Volta – 98	Farming – 103
41 to 50 – 71	Illiterate	Cocaine – 5	Ashanti – 98	Student – 70
51 to 60 – 33		Multiple	Central – 94	Civil Servant – 51
61-to 70 – 3		Pethidine – 4	Western – 40	Trading – 47
71 to 80 – 1		Unspecified – 71	Bong Ahafo – 28	Labourer – 25
			Northern – 18	Fishing – 10
			Upper East – 10	Enforcement – 8
			Upper West – 4	Security Officer – 4
			Togo – 1	Other – 8
			Benin – 4	
			Nigeria – 1	

Source: NCB (1997)

is no less significant in the countries under study, its manifestation and origin appear to be distinct from those in other parts of the world. For rather than emanating from social contexts in which individuals urge their peers to consume illicit drugs, the social factor of greatest significance in the context of many of the countries examined takes the form of a weakening of social norms against drug abuse, a process driven by the functional use of drugs, which emanates from the sphere of economics. In the present context, it is argued that due primarily to economic deprivation, the widespread emergence of the functional use of drugs has begun to undermine the social constraints on abuse that have long characterized African societies.

National surveys have found that those generally in the lower-income brackets make up a disproportionately large share of drug abusers. What makes cannabis consumption the ideal coping mechanism is the low price of the drug, an attribute that should be kept in mind for the other substances as well, considering that continued spillover from trafficking is likely in future to lower their retail prices. The unemployed make up a large proportion of marijuana users. Of the 553 offenders arrested in Ethiopia between 1993 and 1997, for example, 50 per cent were unemployed.[2] These findings generally confirmed those discovered during a UNDCP rapid assessment of the drug abuse situation in 1995 (see table 1). Similarly, in Kenya the profile of drug users shows that the unemployed make up the majority (see table 2). In South Africa, 36 per cent of drug users under treatment at the Cape Town Drug Counselling Centre in 1996 were unemployed.[3] A total of 60 per cent of drug patients at the Accra Psychiatric Hospital are unemployed: of the total (925) drug-related patients admitted to the Ankaful Psychiatric Hospital (Ghana) in 1996, 47 per cent were unemployed (see table 3).

1. Cannabis consumption

The first point of note is that cannabis, being widely grown and readily available in all 10 countries, is cheap: it should be recalled from chapter III that a "joint" typically costs less than a corresponding "dose" of alcohol, certainly in Ghana, Mozambique and Nigeria. In Nigeria a joint costs N 2 – 5 ($0.02 – $0.06) in Ilorin, N 5 – 10 in Port Harcourt and N 10 – 20 in Lagos. In Mozambique, where supplies are usually abundant, cannabis prices range from 250,000 meticais ($22) per "cob"– a tightly packed bundle of about 0.5 kilogram of high THC-content cannabis. In Harare, cannabis is available for as little as Z$ 2 ($0.12) a "twist" for locally produced varieties, and double that price for the much-prized "Malawi Gold". Regular consumers, except the very poor, are able to buy larger quantities (at discounted prices) to store for use over a longer period. In Zimbabwe, larger quantities are also referred to as a "cob", tightly wrapped in a banana leaf, retailing for Z$ 20 to 30, depending on the source.

Historically, in the countries covered, cannabis consumption has been principally a male practice, though this is starting to change (particularly in Nigeria and South Africa), with consumption now reaching increasingly into different gender, age and religious groups. The key question, for which at present there is no empirically proved or provable answer, is why? One finding of this study has been that at least part of the expansion of consumer groups is due to the rise in "functional" drug use. The "functional" use of cannabis includes abuse by:

- Those doing physically demanding or dangerous work.
- Those confronting social danger, which applies to work that involves transgression of taboos, whether formal (legal) or more widely social and cultural.
- Those wishing to escape conditions of social and/or personal misery.

The first category includes consumption by construction and other labourers, dockers, drivers, farmers and farm labourers, whose "functional" reasons for using cannabis are that it enables them to stay awake, to work longer without eating and that it generally enables them to carry on – reasons that are also given for particular patterns of alcohol consumption by the working poor.[4] The prevention of hunger is an attribute of cannabis much emphasized by users in Mozambique.

The second category includes occupational groups like soldiers and police who are often exposed to danger. Soldiers, followed by police, were the earliest consumers of cannabis in Ghana and Nigeria, and continue to be extensive users of the drug.[5] In Ethiopia, Mozambique and Zimbabwe cannabis consumption was widespread amongst the forces fighting in recent civil wars. Fighters brought large quantities of *mbanje* into Zimbabwe from neighbouring Mozambique and Zambia and it was well known that the guerrilla forces expected to be regularly supplied with *mbanje*. During the liberation struggle, the rural supply of *mbanje* thus came to be important for communities in the war zone. Many war veterans are reported to have continued consumption in the years following, either because of addiction or as a means of psychological relief from the trauma of war-time memories (chapter V, section D, considers this issue in further detail).

Other occupational categories confronting taboos and attendant dangers include sex workers, criminals and street children. During national data-gathering in Ethiopia, Ghana and Kenya, in particular, it became clear that street children use cannabis (and other drugs) to cope with inhibition and fear that results from the need to commit petty crimes in order to survive.

The third category of users includes many sections of the urban underclass: the populations of South Africa's townships and the slums and other poor areas of the cities of the other countries, where the incidence of cannabis consumption is at its highest (among men).[6] In such conditions of congestion, high unemployment, poverty and often personal insecurity and danger, the "functional" use of drugs provides a form of release or escape not only for the large numbers of unemployed (especially young men) who may also feel they are unemployable, but for the precariously self-employed of the burgeoning informal sector as well. It is in those major social zones of

contemporary Africa that the boundaries between licit and illicit activities in the informal sector are blurred.

The above does not suggest that functional consumption is the only model with which to view illicit drug consumption in Africa, for there is clearly a broad base of recreational consumption as well, especially in the higher-income groups. One high-profile category of recreational use/users is musicians and artists (Ghana, Kenya, Nigeria, South Africa, Zimbabwe), whose rationale is inspiration and creativity and the need to overcome social inhibition when performing publicly. Drug consumption by musicians in this regard demonstrates how functional and recreational uses of cannabis can become blurred and difficult to distinguish. The venues at which they perform are some of the major public sites at which "recreational" use of cannabis (and other drugs) is concentrated, and sometimes flaunted (Nigeria, South Africa and Zimbabwe especially). Otherwise, "recreational" use on a more private, or at least secluded, pattern is found among students and more elite social groups – at private parties, in people's homes (much more rare in underclass use) and in specific social contexts like secret student societies in Nigerian universities and some secondary schools in Ghana.

There are no reliable figures on the extent of cannabis consumption for any of the countries in this study, although 5 – 10 per cent of the population seems a plausible estimate of regular users, with the highest incidence among young men from their mid-teens to 30s – a figure supported by survey data from South Africa and Nigeria, and more impressionistic evidence from Ghana.[7] In Ghana an officer of the police narcotics unit estimated regular and occasional consumers as 15 per cent of the population, which OGD put at 2.5 million people in 1995 and 3 million in 1997.[8]

Surveys by the Human Sciences Research Council in South Africa report over 20 per cent of households in (black, and in the Western Cape also "coloured") townships containing regular cannabis consumers and 30 per cent of all blacks convicted (of all crimes) as being regular consumers.[9] Estimates from Zimbabwe suggest that 27 per cent of the population are cannabis users, with an emerging higher incidence of consumption among the young and among urban women.[10] In Zimbabwe cannabis use is by no means confined to the urban population, and in those rural populations where consumption is traditional, such as the Binga district, anecdotal evidence suggests that use may be even more widespread and regular. In Mozambique, as reflected in table 16 of chapter II, current users represented 18 per cent of the 1,070 respondents interviewed for this study in that country.

Studies of drug use among Ethiopian adolescents suggest that while cannabis is consumed by some school children, its use is not yet widespread or regular for most consumers. Among Addis Ababa school children only 1 per cent of those questioned in government schools had experimented with the drug, but in private schools (with students from wealthier backgrounds) this figure climbed to 31 per cent.[11] These figures are similar to those reported for Harare in the 1980s, where 32 per cent of male students questioned, aged 16 to 19, admitted having used cannabis, but one in four of those had tried the drug on only one occasion.[12]

Outside Addis Ababa and Harare, figures for cannabis use among adolescents fall dramatically. Even in rural Butajira, an area of Ethiopia where it is said that cannabis is grown, only 3 per cent of the school children surveyed admitted to any direct experience with the drug. Few students questioned claimed to have taken cannabis in the two weeks prior to being interviewed for this study. Similar figures were reported from rural secondary schools in Zimbabwe in 1989, with 8 per cent of students questioned having taken cannabis in the week prior to the study.[13] A more recent Zimbabwean study,[14] taking in a larger sample and including a mixture of rural and urban schools, showed no increase in the extent of cannabis use when compared with earlier studies. The Zimbabwe and Ethiopia studies suggest that use and experimentation with drugs among adolescents increases with age, and is more prevalent in higher income groups (incidence of use being invariably higher in private schools than in government schools). However, it must be stressed that the sample sizes for all of the reported studies were too small to draw firm conclusions about trends or wider patterns of use.

Although there is some awareness of the use of cannabis as medication in all the countries studied, it is particularly widespread in Zimbabwe, where *mbanje* is taken as self-medication for a number of ailments, including headaches, mental illness (both anxiety and depression) and relief from trauma or social stress. Traditional healers, many of whom are licensed by the Ministry of Health, commonly advocate the use of *mbanje* for all these complaints and as a general painkiller. Senior health professionals do not support such practices, arguing that longer-term adverse effects outweigh any short-term benefits through the relief of symptoms.[15] *Mbanje* is also renowned for its apparent capacity to reduce the extent and rate of weight loss among AIDS sufferers.

2. Cocaine and heroin

In Kenya, the abuse of heroin and to a lesser extent cocaine appears – at least in the coastal areas – to have emerged in parallel with the growth of certain social enclaves that depend for their economic survival on the tourist industry. At present the use of heroin is concentrated in the coastal towns of Mombasa and Malindi, and in Nairobi, but is also reported in other urban centres. Heroin use was first reported from Nairobi in the early 1980s and on the coast in the mid-1980s.[16] Some observers, both in Government and in the wider community, link the ready availability of heroin on the coast to the arrival of an Italian community, who acquired properties in Malindi and other coastal towns at that time.[17] The market has subsequently expanded and now thrives on a rising number of local consumers as well as tourists. European tourists on the coast ask local guides and other tour company staff to provide them with drugs; dealers consequently target tourist hotels and the locals who work in the tourist industry. Evidence from studies of heroin use on the coast indicate that many Africans who take heroin began to do so while working in some connection with the tourist industry. The industry is

currently experiencing its first serious decline in 30 years. As tourism accounts for a large slice of the service sector, which currently generates no less than 54 per cent of GDP, the effects upon the economy of any downturn in tourist trade could be severe, with a consequent expansion in the drug trade that caters to domestic demand.

In August 1997, there was an outburst of violence and killing between various political and tribal groupings in the Likoni district of Mombasa. The political violence resulted in many casualties and, as a result, many children lost parents, many parents their jobs. According to local sources, drugs played a functional role in allowing the perpetrators to commit brutal acts of killing.[18]

The Likoni incidents had a powerful impact on the tourist industry and the drug trade, which is highly dependent on it. The precarious dependence of the local economy on tourism, as well as the drug trade's potential to expand in response to economic and social adversity, were self-evident during field visits to the area, as various drug sellers and users openly admitted that they were accordingly compelled to expand their involvement in the drug trade due to lack of work opportunity in tourism.[19] With a contracted clientele base among foreign tourists, furthermore, street dealers focused more intensely on addicts within the local population.

In Nigeria, imports of cocaine followed by heroin also began in the early to mid-1980s, in Ghana four to five years later. The chronology for South Africa and Cameroon is not known, but elite consumption of cocaine and heroin in South Africa at least coincides with, and probably predates, their use in Nigeria. In Nigeria and Ghana it is assumed that domestic consumption began with the return of middle- and upper-class citizens from residence (e. g. as students) or extensive travel overseas, where they acquired a taste for the drugs. There was probably also a demonstration effect from cocaine and heroin use by foreign residents, who mix socially with the local elite, and visitors (tourists). This generated an initial, albeit elite (hence small), source of domestic demand. As cocaine and heroin became more available through spillover or leakage from the international transit traffic through the countries in question, their consumption expanded across sections of the social spectrum.

In Cameroon, cocaine and heroin use are also perceived at present as limited to elite consumption, especially young people from rich families, plus artists and musicians. The same categories of elite, wealthy users are described for Ghana. However, it may be that their use by at least some underclass groups in Ghana is spreading to constitute an important source of demand. This is suggested by seizures of large quantities of so-called "wraps" (small paper parcels of drugs) in poor urban areas – for example, 731 wraps of cocaine and heroin seized from a single dealer in Kumasi[20] and 436 wraps seized in Nima, Accra;[21] by the fact that cocaine is peddled as a "performance enhancing" drug to long-time functional users of cannabis, like dockworkers and fishermen; and by the already extensive vernacular jargon for (different types of) cocaine, crack and heroin. Street children in Accra, many of whom are regular cannabis users, are reported to buy crack or heroin when they have a windfall earning or when they pool their money for this purpose – a practice also noted in South African townships. In Nigeria, one senior drug official observed that cocaine had moved from the government reserved areas, where civil servants live, to the slums, but this seems to be much more the case in Lagos than other major cities.

In Ethiopia, the past five years have seen only five Ethiopians arrested by the authorities for possession of heroin, but the police admit that there is potential for a regular supply of heroin reaching the more affluent citizens of Addis Ababa who can afford it. The Ethiopian Counter-Narcotics Unit says that whereas demand for heroin was first rooted in the expatriate (largely European) community, it has now begun to affect Ethiopians. They anticipate that demand will increase, particularly if (as anticipated) there is growth in the country's tourist industry over the next few years.

3. Psychotropic substances

Methaqualone has long been used as a sedative in South Africa. In 1976, the Government banned imports (principally from India). Since then, imports have been routed illegally through neighbouring countries in the region (Mozambique and Zimbabwe) and further north (Kenya). A fairly rudimentary production plant was destroyed in Mozambique in the early 1990s. Zimbabwe is also an established market for the drug, with an estimated 5,000 regular consumers, mostly among better educated teenagers and younger adults in the age range 14 to 27, who pay up to Z$ 50 per tablet. But South Africa is said to be by far the largest market for methaqualone in the world, with a different pattern of consumption from that in Zimbabwe. Amphetamine-type stimulant (ATS) abuse is associated with different groups in the various countries. It is consumed by sections of the extensive and diverse drug culture in South Africa, and by street children in the main cities of Cameroon. In Nigeria, such occupational groups as casual labourers, farmers, soldiers and long-distance truck drivers use ATS for "performance enhancement".[22] Its functional use is probably longstanding, as it is consumed across all adult age groups (though more commonly men), especially in northern Nigeria. Supply to the north comes from the south or through cross-border smuggling, and drug hawkers, roadside traders and some pharmacies distribute ATS. In Ghana, the use of ATS is associated with secondary school (and perhaps university) students, who dissolve it in beer. In this case, then, it is the same as methaqualone use by category of consumer and mode of consumption, though the effects are in fact completely different.

Ecstasy is the latest designer drug to penetrate the African market, where it has become popular in South Africa and Zimbabwe, above all in the principally white "rave" scene in the major cities of Johannesburg, Pretoria, Cape Town, Durban and Harare. As full a range of drugs (and combinations of their uses) seems to be available in these places as in any North American or European city, with similarly sophisticated knowledge of varieties, qualities

Box 1.Social contexts of illicit drug consumption in South Africa

In South Africa, in line with other African countries, illicit drug use rates tend to differentiate socio-economically and demographically, with differences varying across drug types. Generally in line with licit drug use patterns in South Africa and illicit drug use in other African countries,[23] illicit drug use appears to be a male phenomenon. However, in contrast with figures in the United States (1994 National Household Survey on drug abuse),[24] available South African data point to an "overrepresentation" of females among users of prescription drugs, e.g. tranquillizers, amphetamine-type stimulants and, to some extent, sedatives. This may be attributed to female ill health and/or low socio-economic status. The female use of cannabis may also be associated with ill health and socio-economic deprivation,[25] especially as cannabis use has generally seemed to be quite common among persons living in poor socio-economic conditions (e.g. residents in informal settlements).[26] Bearing in mind *(a)* the findings of a recent income and expenditure survey (Central Statistics 1997 : 51 – 52) that African female-headed households are generally poorer than African male-headed ones . . . [and that] African households have the lowest average annual income in the country, as well as *(b)* international indications that persons of low socio-economic status tend to be risk-prone in terms of initiation into drug use,[27] African women may be particularly risk-prone.

In the light of US experience[28] and socio-economic patterning of licit drug use in South Africa (e.g. a high frequency of licit drug use concentrates in the lowest and highest socio-economic categories (defined in terms of, for example, income, occupation, education and place of residence)), the frequent use (e.g. at least once a week) of cannabis, may be particularly prevalent in low socio-economic categories as well as in comparatively high socio-economic categories (possibly with respect to especially older age groups, i.e. those more or less 35 years and older). Available South African information is, however, too scant to verify this assumption. Available information generally coincides with experience in the rest of Africa: illicit drug use tends to concentrate in urban areas. (However, solvent use among African adults in South Africa seemed to be particularly common in deep-rural (former self-governing) areas.) The use of club drugs (e. g. Ecstasy), although seldom reported in national surveys, has been reported by drug-related treatment centres in metropolitan centres, suggesting that such use is not uncommon among hard-core users in urban areas.

At present illicit drug use is substantially less common than licit drug use among adult South Africans. This is, for example, illustrated when comparing the past-year prevalence of illicit and licit use, focusing on the substances most commonly used and the largest adult sector in the South African population; indeed, the ratio for alcohol to cannabis use seems to be about 10 : 2 and the ratio for tobacco to cannabis use about 10 : 3;[29] also, a comparison of available figures for South Africa and 1994 figures for the United States suggest that past-year prevalence of cannabis may be somewhat higher in South Africa than in the United States,[30] at least among a major sector of adult South Africans.

An increase in illicit drug use (at least in terms of past-year use) may be expected (or may have emerged) among certain sectors, namely, (a) adults in the lowest socio-economic category in urban areas, especially with regard to the use of cannabis and possibly particularly marked among middle-aged groups (among women this increase may be quite marked especially with regard to amphetamines, sedatives, tranquillizers and (possibly) cannabis); and (b) adults in the higher socio-economic categories in urban areas, especially with regard to the use of cannabis (and, possibly, cocaine).

and prices, and a well-organized supply system to and within Western-style nightclubs and bars in the scene.

LSD is widely used in South Africa, where it is also manufactured (so-called "dipping operations"). Its adoption in South Africa probably followed closely on the emergence and fashion of psychedelic drugs in the US and western Europe in the 1960s. If young South African whites who travel introduced it, its use seems to have permeated wider sections of drug users in South Africa in the three decades or so since. Instances of LSD use are reported for Zimbabwe (Harare) and Nigeria (Lagos), but not for Cameroon or Ghana.

To varying degrees, pharmaceutical drugs find their way onto illicit markets in all the countries studied. In Maputo a wide range of pharmaceutical drugs are sold at market stalls throughout the city, these being a major source of pills for middle-class youths. It is believed that the stalls are mainly owned and supplied by hospital staff, who take drugs from the hospital pharmacies to supplement their incomes. The drugs they supply are commonly taken in combinations, or mixed with alcohol or soft drinks. Their consumption forms a part of the social life of the clubs and discos of the Maputo youth scene. In Ethiopia the Ministry of Health runs an efficient audit system for prescribed drugs and there is no significant problem of theft or misappropriation of such medicines. However, in the southern districts pharmaceutical drugs smuggled across the border from Kenya are said to be readily available and can be purchased in local markets.

These drugs cover a wide variety of substances, but include tranquillizers, which are in demand with habitual khat chewers who find difficulty in sleeping. Medical staff in Addis Ababa report that addiction to sedatives is a recognized problem in those Muslim districts where khat is most frequently taken.

In Côte d'Ivoire, one reported consequence of economic hardship has been an increase in the use of diverted medicines such as benzodiazepines (mostly diazepam) and barbiturates. These substances are the most widely abused after cannabis, far ahead of cocaine and heroin, and they are equally prevalent in both rural and urban areas according to sources. Seizures of valium average 1 million tablets a year.[31] The use of these diverted medicines can largely be explained by the widespread practice of self-medication, due largely to unaffordable cost of proper medical attention– another example of so-called functional use driving the illicit market.

In Côte d'Ivoire, 7.1 million Ivorians, more than half the population, are thought not to have access to health services.[32] Moreover, illiteracy is high – only 50 per cent of men and 30 per cent of women were considered to be literate in 1995.[33] Most people recognize medicines by associating the colour of the tablets, their prices and their effects. For example, the young drug users and street children interviewed for this study in Côte d'Ivoire all knew that "Tof" is a small yellow tablet that makes you sleep and costs CFA125 for three, while "Sans migraine" (literally "without headache") is a white pill "that makes you feel strong at CFA100 for one".[34]

4. Khat

Khat, more so than any other drug addressed in this study except cannabis, has deep traditional roots in some Africa

societies. It is thus particularly significant that an intense debate within these societies has in recent years exposed a widening divergence in opinion on the merits of its consumption – a development that would have been unthinkable a decade ago. Such is the shifting – i. e. expanding – pattern of consumption that what was not long ago considered beyond judgement has increasingly drawn the ire of growing portions of particular countries. It is in this light that this section on khat – despite its focus on a legal, uncontrolled substance – provides further insight into how new patterns of abuse have had an impact on long-accepted norms of drug consumption.

In Ethiopia, Somalia and Yemen, and to a lesser extent in Kenya, there is an emerging debate on the adverse social and economic effects of khat consumption, in which khat is commonly presented in conjunction with a range of illicit drugs, to imply its detrimental effects on personal health and contribution to processes of social breakdown.[35] Because of these close associations with illicit drugs in public discourse on khat, an examination of the socio-economic dynamics of khat production and consumption is revealing for attitudes toward other illicit substances that people are often more reluctant to discuss in direct and open terms.

Khat consumption has a long history in Ethiopia and the surrounding region, extending back at least 500 years. Its stimulant effects are said to ease the tedium of hard labour and so it has been widely used by manual labourers and as an appetite suppressant. Principally, khat chewing is a leisure activity. A number of social conventions govern its consumption in Ethiopia and it is not uncommon to see khat used in a public workplace, although in Kenya there are not the same conventions as in Ethiopia. Consumption has never been solely restricted to males in either country, although it is predominantly a male activity. It is customary for groups to gather to consume khat in a private home, in a room set aside for the purpose. Historically, khat consumption is strongly identified with the Muslim community in Ethiopia, and in Kenya with the Meru people in particular, although its use is now widespread throughout both countries. Those who use khat regularly emphasize its social dimensions, bringing relaxation and enhancing social interaction among friends.[36]

Kenyan Muslims are mostly Shafi Sunnis, but can be divided into two broad groups, one of which has incorporated Sufi elements into its observances, and an opposing reformist group, which calls for stricter observance. Both groups disapprove of the use of any substance that alters consciousness; Friday sermons broadcast from the larger mosques sometimes contain warnings against the dangers of *miraa*, heroin and cannabis. Nonetheless, some Muslim scholars argue that *miraa* is permitted.[37] Whatever the orthodox religious view of the matter may be, it is apparent that *miraa* is widely consumed among Kenya's Muslim and non-Muslim populations alike.

The centre of Kenyan *miraa* production is the Nyambene district, close to Mount Kenya, where it dominates the local economy and its historical production and usage has no apparent connection with the Muslim community. The Meru people say that they have always grown *miraa* and that it has traditionally been used as part of bride price payments made by a man to the family of his prospective spouse. It is also customary to give *miraa* as a gift on important occasions and as a token of respect when settling a dispute. Until recently, Meru people have held a monopoly of *miraa* production, distribution and retailing throughout Kenya. Child labour is widely used in *miraa* production. Agricultural extension workers report that young boys are employed to climb the trees to harvest the stems and that children do the bulk of the sorting and tying of the *miraa* into bundles – their small nimble fingers working quicker and more delicately than those of adult workers. The extensive use of child labour in the *miraa* industry is given as the explanation for the very low school enrolment in Nyambene district.

The commercial potential of *miraa* is widely recognized in Kenya. Fuelled by an apparently expanding consumer base, *miraa* is now cultivated in other areas also. Since 1995, Somali middlemen have assumed an important role in domestic distribution and marketing, moving the crop from Meru through wholesaling outlets in Nairobi and Mombasa. *Miraa* is also transported by airfreight to Europe and North America, where mainly Somali refugees and expatriate communities reportedly consume it.

Ethiopian production is on a larger scale and commercially more important than in Kenya. In Ethiopia a sophisticated system of brokerage and wholesaling exists for the purchase and distribution of the crop, organized principally through several associations of khat growers and brokers based in Hararghe (Dire Dawa) and Addis Ababa.[38] A recent report in the *Ethiopian Herald*[39] claimed that one such exporting company earns $1.4 million per year from the trade. A large wholesaling market operates from the Mercato district of Addis Ababa and khat is reported to be on sale in all major towns throughout the country, including the northern regions, where it was not easily available until the last few years. Khat is relatively cheap, a bundle costing only a few birr in local markets and shops, and so is readily obtainable by all sectors of the population.[40]

The Ethiopian national team found widespread usage of khat among school pupils and tertiary students, but with some regional variations in the intensity of consumption; among school children in Addis Ababa, around one third appear to be khat users.[41] In areas to the south and south-east consumption is higher, rising to 60 per cent of all school children surveyed.[42] In other rural areas, for example Butajira, surveys indicate that 57 per cent of secondary school children have taken khat, but do not distinguish the regularity of use. Among tertiary-level students, principally those at Addis Ababa University, it is reported that 68 per cent of students take khat and that more than half that number are regular or heavy users. Both male and female students consume khat, but the frequency and intensity of use were found to be greater among males. Use of khat by university students is associated with examination periods. In the Hararghe region consumption is believed to extend across 75 per cent or more of the population, children first taking up the habit from age 10.

The samples surveyed in these studies are all small and it is

difficult to draw general conclusions from the results. Nonetheless, the studies generally reinforce concerns about the detrimental effects of khat chewing. Many health professionals, including those in the Ministry of Health Narcotics Unit, and senior academics in the Psychology Department of Addis Ababa University, advocate prohibition, even though they admit that the substantive evidence to show that addiction to khat has significant adverse effects upon physical or psychological health is sparse.[43]

Rather than health, current concerns over khat appear to be located more in the domain of cultural representation and social behaviour. It is argued that until recently khat was consumed by the Muslim community and then only by men. Muslims represent between 40 and 50 per cent of the population, so this was already a significant consumer base, but it is generally held that consumption is now spreading into non-Muslim areas, particularly the north, where khat was previously unknown. In the towns of the north, notably Bahir Dar and Gondar, khat shops are proliferating. It is apparent that the crop is now being marketed more effectively and that opportunities for export earnings have attracted farmers in many areas of the country where khat was not grown before.

Supply side explanations are sometimes given to account for the apparent broadening of the consumer base and there is some evidence to suggest expanding supply is indeed a factor. But the few available studies of consumers suggest that sociological factors are important as well. Youths see khat consumption as a form of rebellion against parental control.[44] Field-level data gathering for this exercise came across cases where parents had expelled teenage children from the home for persistent khat abuse, as well as cases where children admitted to taking up khat consumption only after leaving parental supervision. The relatively high number of broken families in the larger urban areas, most notably in Addis Ababa, appears to contribute to this, although there is insufficient research to draw firm conclusions.

To some extent present concerns about khat reflect anxieties about challenges to the previous dominance of a Coptic Christian highland culture, represented in the authority of the Coptic Church. Many people in the Amharic and Tigrinya highlands, exposing young Christians to other aspects of Islam, view khat as a cultural symbol of Muslim influence, as a pollutant. Khat consumption thus represents a loss of parental control and undermining of cultural values for the people of the central and northern highlands. Paradoxically, the more liberal policies of the current Government toward regional autonomy may also have played a part in fuelling the cultural defensiveness of those living in the Amharic and Tigrinya-speaking northern highlands. The debate about khat use is therefore infused with a number of religious and cultural issues, which, though not directly related to concerns about drug use per se, can often serve to reinforce and justify certain perceptions and biases.

Through the Ministry of Health, a small but persistent media awareness campaign on drugs has been developed over the past two years, utilizing local radio and newspapers. Khat has featured prominently in this public discourse. Emphasis is given to the potential for khat consumption to undermine the family: through loss of economic purchasing power diverted to khat, through the loss of productive labour time and the breakdown of family relationships among habitual khat chewers.

Finally, in discussions about drug consumption in Ethiopia there is seldom any attempt to differentiate the effects of different substances. Even health professionals tend to assume a common chain of consumption linking alcohol-tobacco-khat-cannabis-heroin, which is not supported by social observations in Ethiopia. Ethiopian Muslims do not consume alcohol and for them khat is an acceptable alternative. There is a strong association between khat chewing and tobacco smoking, but no evidence of any connection between khat and cannabis. Reports from the Hararghe region, where khat is chewed with greatest frequency and intensity, suggest that some consumers find difficulty in sleeping after consuming khat and then seek sedatives.[45] Among non-Muslim khat users, alcohol can fulfil this purpose, but Muslims must seek other forms of relief. The "bundles" of substances consumed therefore tend to be influenced by cultural and sociological factors, a fact that is ignored in the local debate on drug use. The failure to distinguish types of drug and their social effects may have implications for public attitudes toward the prohibition and control of substances other than khat.

While senior officials in the Narcotics Unit of the Ministry of Health and Addis Ababa University argue for the prohibition of khat, others stress that this would not meet with general support in Ethiopia. The majority of people view khat as a relatively harmless substance and consider its effects to be less detrimental to society than alcohol abuse, for example. Moreover, the crop is economically important to farmers as a source of cash income and to the Government as a valuable export earner.

Such issues have not emerged in the same way in Kenya, but there is a social stigma attached to the use of *miraa* and a similar tendency to link its consumption with a range of other drugs. Many people in Kenya, particularly those from areas where *miraa* has not been consumed historically, appear to regard *miraa* as a highly dangerous substance, which can contribute significantly to social breakdown. They claim that heavy use may affect libido and sexual performance and there is concern about the use of tranquillizers by *miraa* chewers to induce sleep. While Kenya's Somali and Swahili groups, who have lived with *miraa* use in their communities for decades, acknowledge that excessive use may cause harm, they are more concerned with the detrimental effects of other, more potent drugs.

C. SOCIAL NORMS AND THEIR EFFECT ON DRUG CONTROL

How drug abuse influences public perceptions of drug abuse was considered above; this section considers the converse, how the shift in attitudes is relevant in the context of controlling drug abuse. Among the features of drug abuse outlined above are the consumption of cannabis across most segments of the social spectrum and the association of consumption of other drugs with groups at

one end (male urban youth, especially the unemployed and marginally employed, street children, particular groups of the working poor) and the other (the rich and powerful): corresponding, albeit crudely, to functional and recreational use, respectively.

Fact-finding undertaken for this study allows for the tentative conclusion that there is a high degree of popular awareness of drugs in all 10 countries, which contains inaccurate views about, and contradictory attitudes towards, their use. In fact, views about drugs easily become a vehicle for sentiments (of anxiety, fear and envy) generated by economic and social pressure, further fuelled by cynicism about official authority. Drug supply and use are often represented in sensationalized ways, both positively (films, music) and negatively (official media, religious organizations). Of the 10 countries, South Africa is the only one where there is a thriving campaign for, and public debate about, decriminalization of cannabis. This is due in part to the widespread perception that illicit drug consumption is expanding and will continue to do so, aided by growing tolerance towards drugs and ineffectual law enforcement. Such perceptions are easily attached to xenophobic views that the "swamping" of the country by illegal drugs compounds – or in extreme cases creates – its economic and social problems, thereby adding to currents of moral panic about drug use as a vehicle of more general fears.

In Ghana and Nigeria it is sometimes believed that drugs – most commonly cannabis – cause madness, violence and other anti-social and criminal behaviour. There is a specific stigma, which may reflect, in part, the relatively recent narcotic use of cannabis (and for older people, its negative association with the army in the 1950s and 1960s). This contrasts with attitudes to alcohol, as a valued substance, which can be used properly or improperly. Alcohol has a long history of indigenous production and specified cultural and social uses (Akyeampong, 1996). The massive consumption of alcohol and resulting drunkenness on social occasions such as funerals is generally regarded with amused tolerance, rather than disapproval. (The notable exception is those evangelical churches that equate alcohol – and indeed tobacco – use with drug use.) The use of cannabis by many petty criminals (and urban underclass males more generally) no doubt reinforces the stigma attached to it. It is striking how newspaper reports of crime – and especially erratic or random acts of violence – assume or speculate that it is caused by drug (typically cannabis) use.

There are some similarities with social attitudes in Zimbabwe, although here cannabis consumption is of considerable historical standing. Psychiatric staff in Harare believe that use of *mbanje* can trigger, worsen or perpetuate mental illness, such as schizophrenia, paranoia, depression and anxiety (see chapter II, box 4). However, there appears to be little in the way of empirical evidence to substantiate such claims. Accusations of an association between *mbanje* use and anti-social or violent behaviour were also largely anecdotal, but seem to be widespread.

Family breakdown and the undermining of traditional values by global cultural influences were constant themes in the evidence drawn from Kenyan, Mozambican and Zimbabwean informants when asked to explain the increasing consumption of drugs by the young. Anxieties over the loss of parental discipline and control implicit in these concerns were shared everywhere and were applied to those enjoying wealth and financial security as much as to families blighted by poverty and desperation. In fact, "traditional" family and community structures were always more fluid, complex and contradictory than their cultural representations (and nostalgia for them) suggest and have always changed and adapted (thereby continuously refashioning "tradition"). Nonetheless, the dislocations of sustained socio-economic and political crisis in the last 20 – 30 years (punctuated by the volatile fortunes of the oil economy in Cameroon and Nigeria and by war in Ethiopia, Mozambique and Zimbabwe) have had an impact on people's lives in many ways, for which drug supply and use – and the easy wealth and anti-social behaviour widely attributed to it – became emblematic.

Epidemiological surveys in Nigeria and South Africa suggest that high proportions of drug consumers experienced especially difficult family circumstances as children. The decline in the quality of public education also contributes to anxieties about the loss of control over youth; blunted expectations and early disillusionment are considered by many as key factors that encourage experimentation with drugs among the young. In Kenya and Zimbabwe many parents point a finger at the inadequacies of educational systems in which drop-out rates are rising and teachers seem inadequately trained for the task. There is a growing perception that the academic focus of secondary education is ill-suited to job markets where practical and vocational skills offer greater employment opportunities. Also, the provision of school places has failed to keep pace with demographic trends and in many parts of Zimbabwe, for example, children attend school in shifts (as is the case in Ethiopia). When both parents may be at work or busy with the care of younger siblings, this leaves school-aged children unsupervised for a large part of the day.

The relatively minor use of cannabis by children in Ethiopia contrasts markedly with the anxieties of school teachers and parents in urban areas about the vulnerability of students to cannabis and other drugs (in rural areas cannabis was not seen as a problem at all). Health professionals questioned in Addis Ababa amplified this concern, with more than 60 per cent viewing cannabis use as a problem. It is conceivable that drug awareness, more manifest in teachers and professional health workers, is at least partly responsible for heightened anxiety about the effects of drug use.

Some of these anxieties are linked to the empowerment of youth in political ways. The township and especially student components of the struggle against apartheid in South Africa and social patterns of anti-colonial politics in Ghana (continuing after independence), for example, were marked by inter-generational conflict and the prominent role of urban male youths.

Attitudes are not uniform across social classes and groups in the countries observed. Interviews and focus group

discussions revealed a significant ambivalence to the castigation of casual cannabis consumption among adults. Indeed, in many countries visited, it appeared that the vehement opposition to cannabis consumption expressed by those groups directly involved with drug control issues was not shared by the public at large. Indeed, some groups went so far as to present cannabis as life-enhancing: good for ailments (asthma, appetite loss, insomnia), reading, contemplation, sense of self and sexual potency. In both Ghana and Nigeria cannabis smokers emphasized that it helped them cope with the frustrations of their lives and prevented, rather than stimulated, them from reacting aggressively and violently. This can be combined with a similarly ideologized rejection of other drugs (including alcohol) and a critique of the "Babylon" of concentration of wealth and arrogance of state power in their societies.

In rural areas where cannabis is widely grown – and smoked by (male) farmers and village youths – it may also be perceived differently, including in ways that express collective "resistance" to state authority. One could hypothesize further that in the more contained, socially regulated world of rural communities, the presence of older men who smoke cannabis all their adult lives encourages a less condemnatory attitude towards its effects, which seems to be the case in Mozambique and Zimbabwe (as in the historic centres of khat/*miraa* consumption in Ethiopia and Kenya).

On a different social position, those working with drug users like nurses and social workers are often less moralistic and observe links between drug use and common experiences of poverty, unemployment, lack of opportunities and desperation.

Educated individuals in Cameroon, Ghana, Kenya, Mozambique, Nigeria and Zimbabwe associate the use of cocaine and heroin with the children of wealthy families, to whose social world they are relatively closer and of which they are vicarious observers. They appear less aware of the growing use of those drugs among the underclass and poor. On the other hand, at a popular level there is a common assumption that those flaunting new or unexpected wealth – conspicuously consumed in the form of houses, cars or clothing – have obtained it from activity as drug couriers (Ghana, Nigeria) or other involvement in the drug economy (all countries).

In addition to official condemnation of drugs, religious organizations preach the dangers (and sins) of drug use. In Cape Town, a "vigilante" organization, People Against Gangsterism and Drugs (PAGAD), was established in the predominantly coloured Muslim community in 1985, registering frustration at police ineffectiveness in dealing with related problems of drugs, crime and violence in many townships. Headline-grabbing marches and demonstrations, as well as street patrols, gained substantial public support in affected areas, but by late 1996 direct confrontations with the police and with gangsters, in which one prominent gang leader was killed, raised concerns about their extrajudicial and even illegal methods. A spate of shootings, many of them fatal, apparently between the Hard Livings and American gangs as well as PAGAD, erupted in metropolitan Cape Town over the Christmas – New Year period at the end of 1997. Leadership struggles within PAGAD linked to these issues, as well as purported attempts by a shadowy radical Islamic movement, Qibla, to hijack the organization, have led to several prominent resignations, thus weakening the organization, which appears to have lost public support rapidly during 1997. Efforts to launch PAGAD in Gauteng and elsewhere have not met with significant success to date.

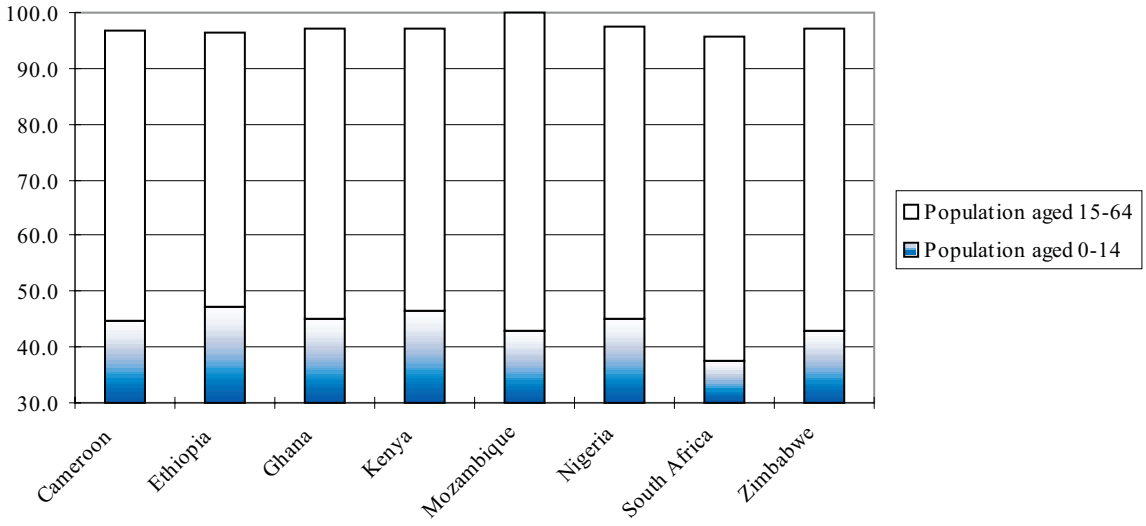
In general, therefore, based on fact-finding as well as interviews in each of the countries examined, it seems that, on balance, there is an ambivalence to cannabis use in particular – or at least a collective opposition that is less robust than is the case with other substances. In each country there is general consensus that an increase in drug abuse among youth in particular is not something that augurs well for the country as a whole. But at the grassroots level, ambivalence if not indifference is the most noteworthy attribute of the would-be collective front against cannabis consumption. It is noteworthy that self-described drug users were often the most vociferous in their denunciations of the decriminalization movement, often arguing that in countries where there were so many other problems, "why help people make life more difficult for themselves by allowing them to escape into drug abuse".[46] But public opinion more generally was not so clear cut, at least as shown in focus group discussions and interviews in the countries concerned. That said, while cannabis seemed to trigger more varied responses, when the issue came to drugs such as cocaine or heroin, or the abuse of cannabis by young children, there appeared to be clear opposition across all socio-economic groups.

D. VULNERABLE GROUPS: YOUTH

Given the rapid expansion in the relative proportion of youth in many African populations, as well as questionable prospects for employment, youth are a key group in the context of drug abuse in sub-Saharan Africa. Furthermore, youth also represent a high-profile target population that could, with effective policy guidance, serve to rally local populations as well as key service providers essential for multi-sectoral programmes in drug control. How to safeguard the welfare of children is a key goal in drug control; that fact opens up myriad synergies between drug control and other interests of the local and international community. On average, excluding South Africa, the population aged between 0 – 14 makes up 45 per cent of the total population, as shown in figure 1.

In Côte d'Ivoire, about half the population of the country was under 18 in 1996; the population grew by 3.4 per cent every year between 1980 and 1996. [47] An estimated 300,000 young people arrive on the job market every year. With the economic crisis, steady jobs have become hard to find and many young people are therefore under employed, mostly working on short-term contracts in the informal sector. For many young Ivorians this is a radical change from what their parents experienced during the economic boom (1960 – 1980) when there were opportunities, especially in the plantation economy and the public sector.

Figure 1. **Population aged 0-14 and 15-64 (as a percentage)**



The future is uncertain, as education no longer guarantees employment. Additionally, because school fees have increased during the recession, even education is no longer assured. UNICEF reports that only 33 per cent of boys and 17 per cent of school-age girls attended secondary schools in Côte d'Ivoire between 1990 and 1995, while between 1990 and 1993, 59 per cent of boys and 46 per cent of girls went to primary schools (against 61 per cent and 55 per cent, respectively, for sub-Saharan Africa as a whole).[48]

In rural areas, for instance, while young males used to obtain forest land cheaply, start their own plantation and get married, the crisis has pushed land prices up, and even land just good enough for food crops is beyond their means.[49]

In South Africa, a 1996 national study by the Human Sciences Research Council on the pre-incarceration history of prisoners (largely African adults) established with respect to the onset of drug use the following: by far the majority (69.7 per cent) of the respondents who said that they had used cannabis at some time in their life reported a starting age between 10 and 19 years.[50] Approximately one quarter (25.2 per cent) indicated an age in the higher category, namely, 20 29 years. (The median age of onset was 17 years and the mean age was 18 years.) Offenders who had smoked cannabis at some time in their life had mostly obtained their first cannabis from friends (63.4 per cent), but a substantial proportion (18.0 per cent) said that they had obtained it themselves. A fair proportion, namely, nearly one tenth (9.4 per cent), said that they had obtained their first cannabis from a drug dealer. Many prisoners in Western Cape prisons reported that they had obtained their first cannabis from friends. Respondents in Free Orange State and KwaZulu/Natal prisons who reported that they had obtained their first cannabis from friends who were older than they were included those who said that their parents had a drug problem.

Regarding reasons why they had started to use cannabis, experimentation (42.4 per cent) and, to a lesser extent, pressure from friends (15.5 per cent) and fun (12.9 per cent) were the most common reasons. Demographic analyses showed that in particular those who reported experimentation as a reason for starting to use cannabis included offenders in Western Cape and Gauteng prisons.

Offenders who said that pressure from friends was their reason for taking cannabis for the first time came primarily from KwaZulu/Natal, North West, Northern Cape and Northern Province prisons. Regarding white pipe (a mixture of cannabis and methaqualone), the survey found that although nearly half (49.8 per cent) of the offenders in the 1996 survey who said that they had used white pipe at some time in their life indicated that they had taken their first white pipe when they were between 10 and 19 years, almost as large a proportion (44.6 per cent) reported that they had started when they were older, namely, between 20 and 29 years.

Regarding solvents in South Africa, by far the majority (73.8 per cent) of the offenders who used solvents at some time in their life started to use solvents between the age of 10 and 19 years. However, a substantial proportion (20.5 per cent) started before the age of 10 years. (These findings coincide with those of a 1994 national study among youth (Rocha-Silva *et al*., 1996)). (The median age of onset was 12 years and the mean age was 13 years.) In line with alcohol, tobacco/cigarette and cannabis users, the solvent users mostly reported friends (41.5 per cent) and, to a lesser extent, themselves (27.5 per cent) as the suppliers of their first solvents. (These findings also parallel those in the mentioned 1994 study (Rocha-Silva *et al*., 1996)). Parallel with alcohol and cannabis users, the solvent users mostly (52.8 per cent) indicated that their first try at solvents was "nice", although a substantial proportion (35.9 per cent) said the opposite. (The fact that

the solvent users mostly experienced their first tries at solvents positively contrasts with the 1994 findings regarding African youth in the general population (Rocha-Silva et al., 1996)). Most of the solvent users cited experimentation (50.7 per cent) as their reason for starting to use solvents. Pressure by friends (19.7 per cent) and fun (18.3 per cent) were also fairly common reasons (as was the case with regard to drinking and the use of cannabis).

1. Street children

For many Africans, the emergence of street children as a feature of the urban landscape is a distressing indicator of social dislocation and the decline of welfare. Although orphans and child beggars, many migrants from rural areas, were seen on the streets of larger African cities in the late colonial period, the 1980s witnessed the beginning of a dramatic increase in their numbers and their visibility. Few city dwellers can avoid contact with street children. They will also know by repute that street children take cannabis and other illicit drugs as well.

Addis Ababa has a surprisingly large and highly visible population of street children and we can begin by giving a portrait of this "community". There has been no recent survey of their numbers, but based upon counts done in the early 1990s, workers for the Addis Ababa-based NGO Forum for Street Children estimate that there may be as many as 20,000 in Ethiopia as a whole and around 12,000 in the capital city itself.

Of this number, it is calculated that half are children of the street, who live on the streets with no other home to go to, and half are children on the street children who have homes in the city, but do not attend school and spend their days on the street. Given the size of Addis Ababa (population 2.1 million), this represents a remarkably large number of youths and it can be reasonably suggested that the street children problem here is as bad as in any other city of Africa.

There are several reasons contributing to the high number of street children in Addis Ababa. The most obvious explanation is that they are children who have migrated into the city from rural areas. Evidence from the larger NGOs working with these children suggests that maybe only one third are migrants, of whom most are older teenagers who came to the city to find employment. The vast majority are city children from Addis Ababa families. Many of those on the street simply stopped attending schools with the introduction of user fees, their parents being unable to afford the costs of schooling. But, more significantly, there is also a very high rate of family breakdown within the city. Separation and divorce appear to be very common and the majority of street children interviewed for this study came from broken families – a view confirmed by the workers in various street children welfare programmes.

The civil wars of the 1980s contributed to this pattern of family breakdown in important ways. Women were widowed by war and stepchildren were sometimes rejected, or felt rejected upon the remarriage of the mother. Also, many soldiers of the Derg's army, some 500,000 strong, were away from home for periods of five years or more, during which their wives sometimes gave birth, and returning soldiers then refused to share the costs of parenting. Lastly, with the repatriation of demobilized soldiers to the rural areas after 1994, some children elected to remain in the city.

Drug use appears to be the norm among Addis Ababa's street children. Higher rates of khat consumption and cannabis smoking are reported among street children than among secondary school students in the city. Inhalants are also commonly used, benzine being more widely used than glue. Many of the street children spoken with admitted taking inhalants. Their motives for drug use were: to gain warmth on cold nights (Addis Ababa is a mountain city); to gain courage to do things they might otherwise not wish to do, such as scavenging through rubbish or carrying out petty thefts; and to suppress hunger. Cannabis was also taken for reasons of relaxation and detachment, and camaraderie.

The high visibility of street children in the city puts them at the forefront of public concern over social issues relating to family structures. Street children are feared in some parts of Addis Ababa, but there is also widespread concern and pity at their plight. Most Ethiopians are often reluctant to admit that the problem is as bad as it is.

A similar link between the ravages of war and subsequent family dislocation has contributed to the increasing numbers of street children in Maputo. Here, again, there is a difference between those living on the streets and those making a living on the streets. The latter seem to be increasing, thrown into street life by family poverty and desperation. Though Maputo is a bustling city of new-found construction and entrepreneurship, its new status as such has prevented what community cohesion could have taken root because of the end of war. A key development that has attended the economic activity in Maputo is the contraction of the traditional extended family; with single-income earners now seen to be earning formal incomes, many find themselves besieged by members of the extended family. As a result, according to some sources in the city, there appears to be an inward contraction toward the nuclear family, with those long dependent on the core now faced with no reliable source of income.[51] The ones who suffer most from this contraction seem to be the children, sent increasingly into the streets by desperate parents. Many such children deal in cannabis as a means of making some money; most are also consumers. Glue and benzine sniffing are commonplace.

A noteworthy aspect of the plight of the street child in Maputo is the yearning for identity. For many children without homes, the identity card provided by organizations such as Médecins du Monde represents a precious possession, giving them a sense of belonging. In this light, drug abuse control efforts which seek to castigate the drug abuser, to marginalize or shame them into abstinence could arguably have the effect of actually reinforcing the inferiority complex that leads them into the abuse of drugs in the first place. The logical policy conclusion is the

following: drug control efforts should focus on building up self-esteem, to help the children feel better not worse about themselves. According to one NGO working in Maputo, maintaining the family unit would go far towards reducing the vulnerability of children to illicit drugs; support and counselling to the family as a unity will likely facilitate the reintegration of children back into the family that abandoned it.[52]

The extent and visibility of the problem of street children in Nairobi far exceeds that of Maputo. One NGO estimates that Nairobi may have as many as 10,000 street children, and there are known to be large and increasing communities building up in other towns also. Those who work with Nairobi's street children estimate that about half go home at night. Many of these children are believed to be the main provider for their family, which will characteristically be headed by a mother.

The poorer families in Nairobi cannot cover the school fees and thus the children drop out, often forced to search for money to help the family survive. One family visited in Nairobi was typical, in that it had a monthly income of 1,000 shillings (about $19).[53] The cost of rent alone was 300 shillings per month. The parents were unable to cover food and fuel expenses; fortunately, there was a local NGO that distributed small food rations to the families in the immediate area; under such circumstances, the family could not afford to send their children to school. In the community leaders' view, the overwhelming majority of children using drugs in the Kyamaiko slum area are illiterate. These children are seen by their families as the one means by which the family can earn a sustainable income– the main reason why the children are sent into the city centre each day to make some money, in any way, for the family. Scavenging, petty theft and whatever casual work they can obtain during the day will bring in a small income and most children will spend a part of this on solvents.

Glue sniffing is at the core of "street culture" in Nairobi. It has been estimated that 65 per cent of the children living in one area of Mathare – a large squatter shanty in the centre of Nairobi – regularly inhale solvents. Glue can be purchased with great ease and very cheaply from roadside cobblers, as well as from the many small hardware shops. In addition, a number of so-called "bars" and "video parlours" have sprung up where glue can be bought ready-packed in a small plastic bottle. Proprietors encourage the children to use the solvent on the premises, presumably so that they can recycle the bottles. More recently it is reported that the sniffing of paint thinners has become popular. This is equally cheap, and also easy to obtain, but has the advantage that a group of children can combine to buy a can and then share it between them. The paint thinner is applied to clothing – usually the sleeve – in small quantities, and can be sniffed without drawing attention to the activity. This is popular with children who wish to enter NGO projects where glue bottles are not allowed.

Among the wider urban community, the street children of Nairobi have come to be viewed as a social menace. Many have formed themselves into gangs, intimidating motorists and occasionally collectively robbing passers-by en masse. Tales of street child terrorism have become the stuff of urban myth in Nairobi, but there have been several very violent incidents, which have heightened public anxieties. Most notoriously, there have been a number of pitched battles between street children and the police, and in one recent incident it was reported that several children were seriously injured in a fracas between two rival gangs.

Many Kenyans say that street children sniff glue because they are idle, implying that they are not gainfully employed and are perhaps lazy. There is a feeling that not all of them need to be on the streets, but are delinquent. On the other hand, there is awareness that these negative images of street children may lead to a misunderstanding of the social circumstances that have brought about their predicament. In 1996, for example, lengthy television advertisements appeared to remind viewers of the Kenya Broadcasting Service that street children required love and care; and there are more NGOs working with street children in Nairobi than in any other African city. According to the Undugu Society, one of the leading NGOs working in Nairobi in the interests of street children, the one policy change that could make a difference in terms of keeping children off the streets – and thus off drugs – is to keep them in school.[54] Similarly, according to staff of the SOS Children's Village in Nairobi, more equitable policies on education and poverty alleviation would go far in preventing vulnerable youth from crossing the threshold into drug abuse and peddling.[55] According to these staff, when under the influence of drugs, the children have less self-restraint in the face of local police, who have a reputation for brutality against uncooperative street children.

In other cities a similarly complex picture of deprivation, anxiety and concern can be painted, although the precise configuration of contributory causes varies from place to place. A survey of street children in Harare and Bulawayo in 1995 gave their numbers as 500. Solvent abuse, particularly glue sniffing, and to a lesser extent smoking *mbanje*, is part of the daily experience of Zimbabwe's street children. These activities are presented as an important means of belonging to and being accepted by others on the streets and as a functional means of keeping warm and staving off the pangs of hunger. It is alleged that some children are pushed onto the streets of Harare by their parents, who view begging, scavenging and stealing as an effective strategy of survival in the face of social exclusion and desperate poverty. As elsewhere, some children in Harare live on the streets, while others return to homes in the evening. It is unclear what proportion of the total number of children on the streets may be migrants from the rural areas, but the marked increase in the visibility of street children in drought years suggests that urban begging is, for some at least, a temporary expedient.

Here, as elsewhere, the rising numbers of street children are viewed as an indication of wider social decay. People assert that traditional family values have been undermined by international influences and economic imperatives and that the welfare provisions of governmental, church and NGO agencies are inadequate to deal with the problem. A number of NGOs are active in this area, providing drop-in centres with educational facilities and training

programmes, arranging placements in state- and privately run orphanages and rehabilitation centres, and offering help with repatriation to rural families. An umbrella organization linking the various groups working in this field, known as the Harare Street Children Organization meets once a month to review policies and programmes. It is reported that this group has found it difficult to strike a balance between providing welfare for the needy and offering facilities that seem so attractive in so poor and under-resourced a community that they attract children onto the streets: for the poorest families, free education, free meals and a degree of training are critical resources. The inability of parents to meet school fees is known to contribute to the number of children found on the streets, as is the perception of declining job opportunities even for those with educational qualifications.

In Ghana various estimates of the numbers of street children in Accra include 10,000 and 17,000[56] and in Kumasi 1,000 – 1,500,[57] although as Anarfi rightly observes, [58] these are no more than guesses. Even so, the existence of (no doubt growing) numbers of street children confounds the views of some middle-class Ghanaians that "every child in Ghana has a family. . . this is not Brazil" (interviews). Both studies cited show that street children are economically highly active and self-reliant, in the typical range of informal sector "survival" occupations, both licit and illicit. Anarfi's survey of more than 1,100 street children in Accra found that the great majority migrated independently from rural areas and that most gave poverty as the reason. He also shows that street children are subject to extensive exploitation, both economic and sexual, including by the municipal police and others; that they experience a range of health risks, from poor nutrition to diseases including AIDS; and that they use drugs widely (commonly cannabis, cocaine and heroin when they can afford it).

A number of street children sleep in the streets of Abidjan. According to UNDP, there are some 14,000 street children in Abidjan alone (a city of 3 million). According to a Médecins du Monde representative interviewed for this study in early 1998, drug abuse is widespread among these groups.[59] Street children, the vast majority of whom are boys, have left their homes for a variety of reasons, because of violence, deprivation, or because their parents separated and they did not get on well with the new partner (50 per cent of cases approximately). A large number of Abidjan's street children are of foreign origin (Burkina Faso, Liberia, Niger) but the majority are Ivorian. The street children interviewed at one Médecins du Monde home in Abidjan reported widespread abuse of solvents and thinners (some reported drinking car fuel), widespread abuse of medicines (some use both solvents and medicines) and some cases of cannabis and "*koutoukou*", an Ivorian distilled spirit. Moreover, the children showed that they were very much aware of heroin and crack, could quote prices for doses and describe both the effects and the appearance of the "twins" in much detail when prompted.[60] But according to them and Médecins du Monde, cases of cocaine and heroin abuse are rare because the substances are too expensive. Even cannabis was described as a "luxury" drug, which remained out of reach most of the time and was only consumed when an opportunity arose (gifts from older kids, unusual income). A tin of the thinner they use the most costs CFA 400 and is available from shops. But those who do not have this kind of money may dip a piece of cloth into someone else's tin for CFA 50 a shot.

According to the children interviewed, inhaling thinners makes them unashamed to beg for money while significantly reducing their sensitivity to pain and augmenting their aggressiveness (giving them a "big heart" as they say, meaning they lose their temper rapidly and are not afraid to fight).[61] According to both the children and Médecins du Monde, violence is very much a part of their life. While fights occur among them, they report to be mostly the victims of older boys and adults.

In Senegal, the large migration movements set off by drought and the crisis of agriculture are translated into marked imbalances in the distribution of the population. About 63 per cent of urban and suburban dwellers occupy 18 per cent of the territory. According to a study carried out by the Dakar National School of Applied Economics made public at a conference in December 1997,[62] street children make up on average 13 per cent of all children aged 6 to 18 living in Dakar, Rufisque, Kaolak and Saint-Louis. But the street children/population ratio may vary across cities. It is very high in Saint-Louis and Kaolak, where the percentages are 38 per cent and 19 per cent, respectively, while Dakar has the lowest proportion, with 7 per cent. Girls only make up 7 per cent of street children but researchers think that this low figure is due to the secrecy surrounding the places where these girls carry on their main activity – prostitution.[63]

Apart from the economic phenomena described above (unemployment, crime and social isolation) urbanization has specific consequences in Senegal as well: Koranic schools. In many of the Muslim rural areas of Senegal, parents entrust some of their children, against payment in kind or cash, to marabouts or teachers who will make them familiar with the Koran. These children sleep at home and are not cut off from their families. But as the country has gradually become unable to provide for basic needs, the teachers have migrated to urban centres together with their pupils.[64] The latter obtain their own and sometimes even their teacher's daily food by begging in the street. They recite the Koran from 4 a.m. to 7 a.m. and sleep on the floor in squatted houses or buildings lent by some pious person. In order to tolerate such living conditions, the some 2,000 such children in Dakar inhale solvents (locally called "*guinze*"), sometimes "*pions*" (psychotropic medicines) or cannabis. The only epidemiological study on drug consumption among youths available in Senegal was done by UNESCO in 1990.[65] The sample comprised 7,675 young people aged 14 to 24 both in schools and universities (5,585 pupils and students) and out of school (2,090). The study showed that 39 per cent of young people routinely used at least one illicit drug. Another study made in controlled education centres has shown a constant rise in drug use among Senegalese youths.[66]

2. The affluent young

How drug use and users are represented in popular discourse, media representations and official government

literature and statements can profoundly affect public responses to policies and programmes mounted to deal with drug-related problems. Although lower-income groups, and in particular the poor, dominate among drug users in all of the countries encompassed within this study, there is a tendency in many places to view use of certain drugs as a concern only of the wealthier classes. This can serve to dampen public concern over abuse and limit the steps that Governments feel prepared to take in the provision of treatment and rehabilitation facilities. This section briefly examines the representation of heroin and cocaine use as confined to wealthy and better-educated sectors of the population in Kenya, Mozambique and Zimbabwe.

In Kenya the pressures of a highly competitive education system have been linked to the incidence of drug use among urban youth. Examinations at the primary level determine who can go on to secondary school. Even secondary school graduates may find it difficult to secure satisfactory employment for themselves and unemployment of university graduates is very high: it is estimated that half those completing degrees are unable to find employment in the first year after graduating.

The inability of the economy to absorb graduates contributes significantly to the pressures upon school pupils and university students to succeed academically. According to mental health practitioners in Nairobi, students from wealthy families often have difficulty coping with this highly competitive system. Many use drugs to escape these stresses, funded by the generous allowances they receive from their parents. They are influenced by global media culture and mimic the behaviour and fashions of western Europe and North America. Drug abuse among wealthy teenagers is said to be on the increase in Nairobi and it is acknowledged that cannabis, heroin and cocaine are available in private schools attended by children of wealthy families.

Similar circumstances affect the education system in Zimbabwe, where the consumption of cocaine and heroin is almost exclusively associated with the younger elements of the wealthy white community. It is reported that this was initially confined to ex-soldiers as a self-prescribed means of relief from their war-time experiences, but that it is now increasingly part of a youth sub-culture, influenced by South Africa and by global cultural commodities and images. Numbering less than 1 per cent of the total population, whites have privileges widely perceived as the illegitimate product of colonialism; accordingly, there is little sympathy for white drug addicts. This, coupled with a tendency to assume that use of cocaine and heroin will remain confined to whites, leads many Zimbabweans to dismiss it as a problem of minimal significance.

However, there is evidence that cocaine and heroin are already increasingly available at private parties held in the high-income suburbs of Harare attended by Africans and Asians as well as Europeans. It is also believed that these drugs, along with the cheaper and more widely consumed Ecstasy, form a part of the "rave" scene. Although the Government has recently banned rave parties from public land, they still take place on private land, for example in warehouses in the industrial area of Harare, and are increasingly popular with wealthier black youths.

Heroin consumption in Mozambique is also strongly associated with the younger elements of the wealthier classes. As in Zimbabwe, the club scene and private parties are the conduits through which heroin reaches these consumers. The numbers of people taking heroin remain very small, but the high status of their families gives their behaviour a peculiarly sharp political edge. Public discourse on the emerging problem of heroin addiction between the alleged complicity of senior government officials in the trade in drugs and the addiction of their own family members and their friends. A number of interpretations of this situation are revealed in the public imagination. Some people consider that senior officials feel compelled to look the other way because their children are implicated. Others see a more sinister intention among drug dealers to entrap the children of the politically powerful. Taking conspiracy theory one step further, some contend that the deliberate entrapment of the children of senior FRELIMO cadres is a plot to undermine the Government. These explanations may seem fanciful, but they are highly suggestive of the extent to which the Government of Mozambique is seen to be embroiled in the drug trade.

In Mozambique, as elsewhere in Africa, the more plausible reason for the targeting of the rich as consumers of hard drugs is strictly economic: in societies marked by widespread poverty, these small elite groups are the only people who can afford to sustain the habit. For the vast majority of people too poor to afford such expensive tastes, the misery of the rich heroin addict is viewed as a self-inflicted wound that is not worthy of public sympathy or amelioration. This has important consequences for wider

Box 2.Education in Kenya

Although the education system remains strong by comparison with other African countries, with illiteracy at only 22 per cent, there are clear indications of declining achievements. Primary school enrolment was estimated at 96 per cent in 1989, but had fallen to 75 per cent by 1997. NGOs working in Nairobi estimate that only 50 per cent of children in the city are regular school attendees – a figure far below official returns.[67] These changes are indicative of deepening poverty, lack of job opportunities for the educated which has contributed to parental disillusionment with investment in education, and the introduction of cost sharing in education as part of the structural adjustment programme. Kenyan parents do not pay school fees directly, but all school children must have uniforms and contributions are required to provide books and to support school building and maintenance programmes. Kenya's school system is highly competitive and over the 1980s the tertiary level intake was greatly expanded to meet public demand. There are now very high levels of unemployment among graduates.[68]

public attitudes in African countries to the provision of drug education programmes, treatment centres and rehabilitation facilities, all of which might divert precious resources away from other social programmes aimed at improving the lives of the poor. Wealth and education are as much a part of Africa's drugs problems, and how they are perceived, as are poverty and ignorance.

E. DEMAND REDUCTION

Demand reduction cannot be separated from the sociological picture and placed solely in the health domain, for this would be to deny the importance of public participation in the effectiveness of such measures. Without the wider support of local communities, such measures are exceedingly unlikely to be effective in the longer term. This survey of demand reduction is intended to highlight the importance of raising public awareness of drug issues and in fostering public debate on those questions relating to drug abuse.

While in many countries the principal emphasis continues to be on supply reduction through law enforcement, official recognition of the need for demand reduction through education, treatment and rehabilitation seems to be growing throughout the 10 countries studied, even if Governments are constrained from directing resources to such programmes. What is clear from the preceding two sections is that demand reduction in the context of the countries examined must be broadened to include measures more typically seen in the areas of education, family support and poverty alleviation, specifically with a view to safeguarding the welfare of vulnerable children.

In Ghana NCB is aware of the importance of demand reduction, but has few resources to carry out demand reduction initiatives. In Nigeria, the National Action Plan on drugs proposed in late 1997 features demand reduction and rehabilitation; a similarly comprehensive National Drug Master Plan framework was proposed in South Africa at the same time. The National Policy on Alcohol and Drug Abuse for Zimbabwe, dating from 1992, sets out steps to further national education on drug awareness and lays out an ambitious programme of treatment and rehabilitation facilities, neither of which has been implemented to date. In Kenya, the legislation enacted in 1994 provides for monies confiscated from convicts to be diverted to the establishment of treatment and rehabilitation services, but although the courts have accumulated funds through the act the reallocation of these monies requires treasury sanction in each case and to date no monies have been set aside.

Drug education activities aimed at young people in particular – in places of education (and to a much lesser degree residential neighbourhoods), through advertising and the government media – exist in all 10 countries, although their quality, the extent of their coverage and their effectiveness vary a great deal. In Ghana, NCB has expressed its frustrations with the progress of drugs education – the responsibility of the School Health Education Unit of the Department of Education – in secondary institutions. In Nigeria, the apparently greater success of drug education campaigns may reflect the resources devoted to them, and the vigour with which they are conducted, as well as links to the NDLEAenforcement offensive.

In Ethiopia, there is a programme to initiate drug awareness clubs in all secondary schools, for which success has been claimed in several large schools in the capital city. Plans to introduce drug education to the school curriculum in Zimbabwe have not yet been acted upon, although the Resource Centre for Drug and Alcohol Problems set up in Harare in 1989 has offered help to rehabilitate addicts, as well as extending drug-awareness education: through its activities, drug action clubs have been set up in the Mbare, Highfields, Tafara and Mabvuku suburbs of Harare, and further afield in the towns of Bulawayo, Mutoko, Kwekwe, Gweru and Mutare. In Kenya, drug awareness education is included within the primary school syllabus, but few teachers have the knowledge or training necessary to implement such a programme properly. A new handbook for teachers providing guidelines on drug prevention and education has recently been completed by the Kenya National Committee for Prevention of Alcohol and Drug dependency, but this handbook has yet to be widely distributed.

Alternative, or supplementary, to government drug education is that provided by religious organizations and NGOs. In the wake of events surrounding PAGAD (see above), an inter-religious Commission on Crime and Violence in the Western Cape was established in Cape Town in October 1997, bringing together prominent Muslim, Christian, Jewish and Hindu organizations and with a strong focus on drug-related dimensions of crime and violence. In Nigeria an NGOs Network for Drug Demand Reduction, was established in 1996, and NCB in Ghana encourages cooperation with several NGOs in drug education, as well as treatment and rehabilitation.

Historically, treatment of addicts and other drug users has been the responsibility of the public health service, notably in psychiatric hospitals, clinics and units that have typically suffered from the general deterioration in public health provision. Some specialized drug treatment (as well as rehabilitation) centres exist in South Africa, and a few in Nigeria. Here too the strain on the finances, capacity and performance of the public health service is alleviated, if only to a small degree, by NGOs, which often have a more comprehensive or social approach to treatment and rehabilitation than administratively demarcated departments of education, health and social welfare. These departments compete with each other for budget allocations and internally over the distribution of their funds between many areas of high priority. Wealthy families whose children have drug problems seek treatment for them in private clinics within the country or abroad.

There is a considerable stigma attached to treatment, especially residential treatment, in psychiatric institutions, and their families take most patients there if they display violent or otherwise disturbing behaviour. At the Accra Psychiatric Hospital in Ghana self-referred patients are usually unemployed men in their late teens to mid-30s who

use the hospital as a refuge when suffering from poor nutrition and dehydration, and who leave after a week or two when they feel better. The Hospital also receives batches of vagrants and destitute periodically rounded up by the metropolitan police in Accra and delivered for drug screening. As the Hospital does not have a regime of detention, except for patients certified as dangerous, there is a high rate of abscondment. Health professionals working at the Infulene Psychiatric Hospital in Maputo report similar experiences. Here, as in Ghana, addiction is viewed as a psychiatric problem yet the facilities provided by the psychiatric service are inadequate to treat properly those addicts admitted to the institution. Those Kenyans with addiction are also committed to psychiatric care if hospitalized, but neither Mathare Hospital in Nairobi nor any of the provincial institutions have adequate treatment facilities. A number of small private clinics in Malindi, Mombasa and Nairobi offer treatment to addicts who can afford their services. In Zimbabwe, an initiative was undertaken in 1989 to train social workers in drug counselling in the Mbare suburb of Harare, but as yet only very limited treatment facilities are available in government institutions and private clinics.

In the area of treatment, as in that of education, there are enormous gaps in provision, which some NGOs are trying to fill, increasingly with government approval. However, the commitment of NGOs cannot compensate for a lack of professional expertise. While some have the capacity to mount educational and awareness programmes and to provide basic welfare for those suffering ill effects from drug use, few are equipped to tackle the health-related issues that arise.

In Ethiopia, the lack of treatment facilities is particularly acute: no medical establishments currently exist in the country with facilities to treat addiction. Moreover, as the law is currently framed, doctors treating those addicted to prohibited drugs have no protection of confidentiality: anyone seeking medical help for addiction to an illegal substance is liable to arrest and doctors feel that they have to report such persons to the police. This matter is obviously an impediment to the proper treatment of drug addiction and needs to be urgently addressed.

It is probably in rehabilitation (combined with education) that NGOs can make their strongest contribution, because of their ability to adopt approaches that are more flexible as well as multi-purpose than those of government departments, and to locate their centres in areas where problems of drug use are most concentrated. Positive examples of NGO commitment and effectiveness exist in all 10 countries, alongside other less positive examples. The Bread of Life Rehabilitation Centre in Harare, for example, has been helping men with cannabis, methaqualone and other addictions since 1989. An average of 40 patients have passed through this Christian-run clinic every year. It has to be recognized, however, that the current and foreseeable scale of NGO activity can deal with only a small proportion of drug use and its associated social conditions in poor urban areas. NGOs can offer innovative approaches and complement and supplement public sector activity in demand reduction through education, treatment and rehabilitation, but cannot be regarded as a viable substitute for effective public provision of basic social services.

F. CONCLUSION

This chapter concludes with excerpts from the reports of the national research teams in Cameroon, Nigeria and South Africa, led by Dr. Félicien Ntone-Enyime, Dr. Lee Rocha-Silva and Professor A. G. Onibukun, respectively. While the following texts were written with specific regard to the three countries, they tie together many of the themes covered in this chapter.

1. Cameroon

"A total of 972 survey questionnaires were administered. Levels of education varied from primary school to post-graduate with various professions and different marital status category. With such a sample, we were able to obtain a perception of expectations of drug abuse trends.

"The surveys indicated a high degree of drug awareness. A large majority did confirm that drugs existed and was a serious problem facing society. The perceptions of drugs were many and varied. They had many properties according to respondents. One frequent response was that drugs were a narcotic, but they were also defined as stimulants for courage and for work. Other definitions were mentioned: medication in traditional medicine, fertilizer or pesticide.

"Although drug abuse is definitely seen as a problem in Cameroon (by 61 per cent of respondents) it is also necessary to mention that beyond addiction and trafficking issues, our focus group discussions, in-depth interviews and surveys make clear that while the consumption of drugs can be perceived as related to addiction or trafficking, there is consumption of a cultural character that is deeply rooted in common practices in agriculture, art, traditional rites, sexuality, and traditional medicine. Thus, drug abuse appears to be a very complex phenomenon, which, although able to cause harm to a developing country such as Cameroon, can also be seen as part of Cameroon culture."

2. South Africa

"Available information suggests that a major sector of South African adults find themselves in a social environment conducive to drug use, i. e., an environment in which there is a fair degree of social support for drug use, exposure to such use and limited discrimination against it. These social factors seem to be generally strengthened by certain psychological factors, namely tolerance

towards drug use, limited fear of discrimination against drug use and a personal need for or attraction to drug intake. In fact, this is illustrated in terms of the following patterns and trends regarding the reasons reported for drug use and the context of use:

"Illicit drugs are used in a fairly uncontrolled environment, namely in privacy, i. e. not in the company of other people (when it occurs in company, friends and/or relatives are mostly the company of choice) and at home (in the general population, public use mostly occurs in metropolitan centres and towns bordering these centres, with clubs/discotheques mostly the places of choice; among offenders, the street (in the case of cannabis) and the place of a drug dealer (illicit drugs other than cannabis) are fairly common places of use.

"Particularly common reasons for using illicit drugs (at least among people of African cultural background) seem to be mood-changing and coping; among people admitted to drug-related treatment, matters such as habit, lack of energy and sleeping problems seem to particularly motivate their drug use; solvent users in particular associate their solvent use with getting high and breaking the monotony of their daily life (indeed, the popularity of mood-changing and coping with hardships as reasons for illicit drug use among African groups and indications that African households (especially female-headed households) have the lowest average income in South Africa (Central Statistics 1997) substantiate the above conclusion that illicit drug use may increase among socio-economically marginalized sectors).

"Among offenders a somewhat different situation applies. Pleasure-seeking tends to be their primary motivation for using illicit drugs; the use of cannabis seems to be particularly associated with energy/stamina (especially among offenders whose parents experienced problems related to their drug use) and, among the less educated offenders in particular, cannabis seems to be associated with the ability to work, to have courage when mixing with people and because it has become a habit). Among offenders direct social pressure to use drugs (especially alcohol and *dagga*) seems to be a fairly common experience; offenders generally experience easy access to the substances that they commonly use (e. g. cannabis, tobacco and alcohol).

"Available data suggest that youthful drug use generally emulates adult patterns, although it is markedly more conservative (e. g. in terms of prevalence and frequency/quantity of use) than adult use, especially among African youth. However, in conjunction with the findings of earlier studies, the results of the first in-depth national study[69] on drug use among a major proportion of the South African youth (10 – 21 year-olds from historically disadvantaged African families) showed a fair degree of risk-proneness. It is clear that a major proportion of South African youth find themselves in a social environment in which there is a fair degree of social support for, exposure to and limited discrimination against drug use.

"Although youthful drug use is generally dominated by licit drug use (e. g. alcohol and tobacco), these drugs do not necessarily manifest as first-use drugs; indeed, illicit drug use may precede initiation into licit drug use,[70] although a 1994 study among 10 – 21 year-olds among Africans found that for alcohol, tobacco and cannabis, age of onset tended to be approximately mid-adolescence, with the onset of alcohol/ tobacco generally preceding that of cannabis, and solvent use that of alcohol/tobacco (practical difficulties prevented the collection of information on age-of-onset in respect of drugs other than alcohol, tobacco, cannabis and solvents).

"Furthermore, in the light of available findings suggesting that youthful drug use to some extent emulates adult patterns, it seems reasonable to assume (bearing in mind the expected patterns/ trends among adults) with respect to the future:

"An increase in the intensity of youthful drug use, i. e. an increase in the number of drugs used (e. g. illicit drugs such as cannabis, cocaine, LSD and heroin) and the frequency/volume of intake; differences in the proportions using various drugs may also diminish;[71] at the same time distinct preferences with regard to drug use may develop, especially among established users (the popularity of designer drugs or club drugs, such as Ecstasy, may intensify); injecting drug use may become more prevalent.

"The expected increases may be particularly marked *(a)* among older youth, *(b)* in the case of African youth, among those with family responsibilities (e. g. children) and isolated from social institutions (e. g. the family or church); *(c)* among relatively new entrants into the consumption market, such as females (especially in low socio-economic sectors (e. g. informal settlements); *(d)* among urban dwellers; and *(e)* among historically advantaged groups (note should be taken, though, that tobacco use among African youth seems to be particularly common in rural areas).

"The possibility of increased drug use among the youth is underscored by indications (at least among African youth and especially with regard to licit drugs) that drug taking generally is initiated and sustained within a supportive social context, serving various needs (not only providing escape from deprivation but also fun).

"Finally, the fact that the available data suggest that a major proportion of the South African youth

manifest, in terms of drug-taking practices and related attitudes, a fair level of risk-proneness has serious implications in terms of HIV-infection/AIDS. Of particular importance are the indications that a comparatively heavy alcohol intake is fairly common among youngsters. This is widely recognized as a risk practice in terms of HIV infection. (Some of the youngsters in the 1994 study among 10 – 21 year olds of African cultural background admitted that HIV had been identified in them).[72] Also, the possibility of the youngsters'being fairly at risk of contracting HIV is exacerbated by indications that they are fairly un/misinformed regarding the nature of HIV-infection/AIDS."[73]

3. Nigeria

"Treatment of drug-dependent persons in Nigeria takes place mainly in psychiatric hospitals, although some private hospitals, non-governmental organizations and traditional healers are known to also offer services.

"From the available reports, the treatment methods used in the psychiatric hospitals and the specialized drug units follow strictly the orthodox pattern and comprise mainly of *(*a*)* thorough investigation of the patient for physical, mental and social deficits; *(b)* detoxification, usually offered as an integral part of the treatment package; *(c)* various forms of psychotherapy and drug-free counselling; and *(d)* educational, occupational and social rehabilitation which is initiated at the start of the treatment with the active participation of family members. Treatment aims at total abstinence. Available reports[74] have identified several factors militating against successful treatment and rehabilitation of drug patients: *(a)* high rates of absconding from the hospital; *(b)* high default rates; (*c)* poor or no skill acquisition prior to presentation; *(d)* poor vocational or occupational rehabilitation equipment; *(e)* lack of follow-up services; *(f)* distance from the hospital to patients normal abode; and *(g)* poor chances of securing employment even after rehabilitation. The community-based approach is strongly advocated as a way of addressing some of these deficits. Traditional healers also attend to drug-dependent patients. They work on the belief that substance abuse problems, like mental health disorders, are caused by external agents, usually evil spirits or a curse by the enemy. Accordingly, the healer performs certain rituals designed to remove these afflictions.

"Unfortunately, the literature is very scanty on the methods used and the outcome of treatment of drug abusers by traditional healers. A major component of demand reduction activities is the implementation of prevention activities targeted at youths at risk, as well as the general public. However, many commentators on the Nigerian drug control strategy have noted the overemphasis on supply control and the relative neglect of preventive programmes. Although it would appear that the National Drug Law Enforcement Agency has been making efforts through its Demand Reduction Unit to correct this imbalance, the situation is still far from satisfactory. This could explain the dearth of literature on drug abuse prevention in Nigeria. Although a few governmental and non-governmental organizations carry out anti-drug awareness campaigns, these are usually sporadic. Furthermore, some of these programmes are known to employ unorthodox or scare tactics. Thus, there is a need to coordinate and standardize drug prevention programmes in the country and subsequently subject them to proper scientific evaluation.

"As the harsh economic conditions in the country in the past 10 – 15 years was identified as a key factor that could have pushed up drug activity, concerted efforts aimed at alleviating poverty, such as job creation, increasing purchasing power of workers, special support for at-risk youths and young adults, are urgently needed.

"Drug abuse prevention activities need to be community-based, should utilize community resources (personnel and equipment) and be sustainable year round. The target populations should be clearly defined, and the programmes delivered by trained personnel using standardized methods and campaign materials. The programmes should be centrally coordinated at the local, state and national levels. There should be an in-built systematic evaluation package for each programme."

Notes

1 The survey by Ndetei (1998) also reports that among the factors associated with drug use, unemployment and low-income status are significant.

2 See Kassaye, M., Sheriffe, H. T., and Fissehaye, G., *Illicit Drug Use in Ethiopia: A Pilot Project*, A report for the United Nations International Drug Control Programme Addis Ababa, Ethiopia, 1998.

3 Cape Town Drug Counselling Centre. *Statistics 1996.* South Africa.

4 Akyeampong, E., *Drink, Power, and Cultural Change. A Social History of Alcohol in Ghana, c.1800 to Recent Times.* London, James Currey, 1996.

5 Toit, Brian M du. 1980. *Cannabis in Africa. A Survey of its Distribution in Africa, and A Study of Cannabis Use and Users in Multi-Ethnic South Africa*. African Studies Centre, University of Florida, Rotterdam on this, and other basic historical data on cannabis in Africa.

6 Human Sciences Research Council 1997. *Drug Use and Other Socio-economic Conditions in South Africa*. Preliminary report, Pretoria: HSRC

7 For Nigeria: CASSAD. 1998*. Economic, Social and Political Analysis of Illicit Drugs Trends in Nigeria*. Centre for African Settlement Studies and Development (CASSAD). Ibadan: Nigeria. For South Africa. Atkins, A.1997 *The Illegal Drugs Trade and Development in South Africa: Some Observations.* London, Catholic Institute for International Relations (CIIR).

8 OGD. 1995. *West Africa: In-depth Assessment Study on Drugs Production and Local Trafficking, in Particular Related to Cannabis Cultivation*. Paris: OGD (Report to the European Commission, D-Afr/94/01)p. 26; OGD. The World Geopolitics of Drugs, 1995/1996. Paris, Washington and Madrid, OGD September 1997.

9 Human Sciences Research Council [HSRC]. 1997. *Drug Use and other Socio-economic Conditions in South Africa*. Preliminary report, Pretoria: HSRC

10 Figures derived from the statistical sampling in the Zimbabwe national report.

11 See table 10 in chapter II.Figures are from the national research team (Ethiopia) report.

12 See reports of earlier studies in Khan, N.1986 "Substance abuse among male secondary school pupils, its prevalence and concomitant problems" (MSc dissertation, University of Zimbabwe, Harare); Acuda, S. W. and A.H. Eide. 1994. "Epidemiological study of drug use in urban and rural secondary schools in Zimbabwe", *The Central African Journal of Medicine*, 40 (8): 207 – 212
Chalwa, S.1985., Drug abuse in Zimbabwe." In J.C. Ebie and E. Toungue (eds), *Handbook of the African Training Course on Drug Dependence.* Luassane: ICCA
Acuda, S. W., A.H. Eide, T. Butau et al. 1996. *Health Behaviour Among Adolescents in Zimbabwe: School Based Survey in Mashonaland and Matabeleland.* University of Bergen: Institute for Health Promotion.

13 Both figures derive from small surveys completed by the national research teams.

14 Acuda, S. W. and Eide A.H. 1994, op. cit.

15 Interviews, Harare, November 1997. See also, Acuda and Sebit (1997).

16 Mwenesi, H.A.1995. *Rapid Assessment of the Drug Abuse in Kenya,* A Report for the United Nations International Drug Control Programme.

17 November 1997 interviews, Nairobi, Mombasa, Malindi and Watamu.

18 November 1997 interviews, Likoni and Mombasa.

19 This insight was made possible by the excellent organizational efforts of the Omari project in Malindi, which arranged in November 1997 for the international research team to meet and talk openly with heroin addicts in the immediate vicinity.

20 *Ghana Times,* 16December 1995.

21 *Daily Graphic* (Accra, Ghana), 11 February 1997.

22 CASSAD, 1998, op. cit.

23 Selassie, G.B. and Gebre, A., A report on the rapid assessment of the situation of drug and substance abuse in selected urban areas in Ethiopia, (prepared for the Ministry of Health of Ethiopia and UNDCP, Nov 1995) 1995. Mwenesi, H. A.1995. US Dept of Health and Human Services, Public Health Service. 1996*. National household survey on drug abuse: Main findings 1994.* Rockville, MD: National Clearinghouse for Alcohol and Drug Information.

24 US Department of Health and Human Services, Public Health Service. 1996*, op. cit.,* pp. 1 – 3.

25 Obot (National Institute on Drug Abuse, US Department of Health and Human Services 1996. *Epidemiologic trends in drug abuse. Community epidemiology work group. June 1996. Volume II: Proceedings*. Rockville, MD: National Institute on Drug Abuse. p. 426) notes that „in eastern Nigeria, a survey of 640 women in farming, fishing, and other unskilled occupations showed very high rates of regular use of alcohol (94.4 per cent), tobacco (77.5 per cent), and cannabis (39.5 per cent) . Cannabis was used to relieve headaches, pains and the suppression of salivation during pregnancy. Among women who lived in the riverine areas, cannabis was also taken to get courage to fish at night and in turbulent waters." The findings of a 1995/1996 study among women (particularly single, low-income coloured women) attending selected antenatal clinics in the Western Cape (Croxford. J.1996. "A prospective analysis of alcohol ingestion in 636 pregnant women in rural and urban areas of the Western Cape". (Dissertation submitted in fulfilment of the requirements for the degree Bachelor of Science (Medicine), Honours.) Cape Town: University of Cape Town.) to some extent suggest that cannabis use may not be uncommon among patients attending antenatal clinics, especially those residing in metropolitan centres and of coloured cultural background.

26 Union of South Africa, Report of the Interdepartmental Committee on Drug Abuse of Dagga. Pretoria: Government Printer, 1952..
Rocha-Silva, L. 1991*. Alcohol and other drug use by black residents in selected areas in the RSA.* Pretoria: Human Sciences Research Council.
Croxford. J.1996, op. cit.
Rocha-Silva, L. and Stahmer, I.1996. *Research related to the nature, extent and development of alcohol/drug-related crime.* Pretoria: Human Sciences Research Council.

27 The 1994 US National Household Survey (US Department of Health and Human Services 1996 : 3), for example, found that „overall, receipt of welfare assistance, lack of health assurance, and family income below $9,000 were associated with the highest prevalence of drug use". Quite succinctly, Farmer *et al*. (1996 : 106) notes that „poverty destabilizes lives, crushes self-esteem, and creates an apartheid between those who have economic power and those who do not". When women „find themselves on their own raising children . . . forced to experience the pain and misery of poverty", prostitution, drug use and drug trafficking may become the most viable way of surviving (Farmer *et al*. 1996 : 107). Indeed, „the common denominator for poor, drug-using women appears to be their limited power to control the course of their lives. Women fare far worse than men not because of their gender, but because of sexism– unequal power relations between the sexes. More often than not, assertion of power (no matter what the context) is not an even option for poor

women“ (Farmer *et al.* 1996 : 99). (Farmer, P. Connors, M. and Simmons, J.1996. *Women, Poverty and AIDS. Sex, drugs and structural violence.* Monroe: Common Courage Press. pp. 91 – 123, and US Department of Health and Human Services, Public Health Service. 1996*. National household survey on drug abuse: Main findings 1994.* Rockville, MD: National Clearinghouse for Alcohol and Drug Information.p. 3)

28 The US1994 National Household Survey (*op. cit*., pp. 1 and 2) on drug abuse found, for example, that “marijuana use in the past year was proportionally more common among males, blacks, adults aged 18 – 25 and among the unemployed. For adults aged 35 and older, lifetime, past year and current marijuana use significantly increased with educational level, while for middle [this should possibly be young to middle] adults (18 – 34), past year and current use levels were the highest among those with less education”.

29 The figures refer to a 1990 survey (Rocha-Silva, L.1991. *Alcohol and other drug use by black residents in selected areas in the RSA..* Pretoria: Human Sciences Research Council.) among African males (14 years and older) in metropolitan centres and neighbouring towns and informal settlements in South Africa and a 1995 national survey in the general adult population (18 years and older) (Reddy, P., Meyer-Weitz, A. and Yach, D. 1996. “Smoking status, knowledge of health effects and attitudes towards tobacco control on South Africa”, *South African Medical Journal*, 86(11): 1389 – 1393.).

30 Indeed, the average 1990 rate (past-year use) was 15 per cent for cannabis among a major group of South Africans (male Africans, 14 years or older (93.0 per cent were 18 years or older)) (Rocha-Silva, L.1991 (*op. cit*.). The 1994 US rate for cannabis in the general population (persons 12 years or older) was 8.5 per cent (90.0 per cent of the surveyed population were 18 years or older), 13.7 per cent among black males, 11.4 pe rcent among white males, and 9.5 per cent among Hispanic males (US Dept of Health and Human Services, Public Health Service. 1996, (*op. cit*.).

31 Thiam, A. (CILAD General Secretary) 1997. “La Côte d’Ivoire et la lutte contre l’abus et le trafic illicite de drogues”, in *Unis contre la drogue*, ECOWAS/UNDCP, 1, Novembre 1997, p. 8.

32 Ette, J. and Ette, H.1997. “Itinéraire thérapeutique des `morts à domicile’. Incidences des facteurs socio-économiques et motivations des recours aux structures de soins publiques et privées”, in Contamin, B.& Memel-Fotê, H.*: Le modèle ivoirien en questions, crises, ajustements, recompositions*. Paris: Kathala-ORSTOM, quoting UNDP1994, p. 124.

33 UNICEF. 1998. *La situation des enfants dans le monde en 1998 (The State of the World’s Children 1998*), New York and Geneva: UNICEF, table 4, p.116.

34 Interview with young urban drug users, Marcory-Zone 4, Abidjan, 15 January, 1998; and street children at the Médecins du Monde House at Riviera, Abidjan, 15 January 1998.

35 Belew, Mesfin 1997. “Khat and its health, mental and nutritional effects”. (Thesis, Department of Community Health, Addis Ababa University).

36 For a recent historical survey of khat production, focusing upon the main producing area of Hararghe, see Ezekiel Gebissa (1997).

37 Interviews, Nyambene district and Mombasa, Kenya, November 1997.

38 Ezekiel Gebissa (1997).

39 *Ethiopian Herald*, 18 December 1997.

40 Visit to the main khat market at Mercato, Addis Ababa, February 1998.

41 Zein A. Z. 1984. “Polydrug abuse among college students, a symposium report”, In International Symposium on Khat Chemical and Ethnopharmacological Aspects of Khat, Proceedings, Addis Ababa, Ethiopia. and surveys conducted by the national research team, and reported in the Ethiopia national report.

42 Adunga, F. 1995. “Khat chewing among Agaro secondary school students, Agaro, Southwestern Ethiopia”, *Ethiopian Medical Journal:* 32.

43 Interviews, Addis Ababa, February 1998.

44 This paragraph draws upon a wide range of interviews conducted in Addis Ababa in February 1998.

45 Belew, Mesfin (1997).

46 November 1997 interviews in hospitals and/or prisons in Mombasa, Nairobi, Cape Town, Johannesburg, Maputo, Harare; February 1998 in Addis Ababa, Yaounde, Lagos, Accra.

47 UNICEF (1988), *op. cit*., table 5, p.120.

48 Ibid., table 4, pp. 116 –119.

49 OGD (1995), *op. cit.*, p. 64.

50 Rocha-Silva, L. and Stahmer, I. (1996), *op. cit*.

51 November 1997 interview with Médecins du Monde, Maputo.

52 November 1997 interview with the Director of the Escola da Rua School for Children, Maputo.

53 November 1997 visit to the Kyamaiko slum area, Nairobi.

54 November 1997 interview with the Director of the UDUGU Society..

55 November 1997 interview with the national coordinator of the SOS Children’s Village, Mombasa.

56 Anarfi, J.K. *Street Children in Accra: Sexual Behavioural Factors and HIV/AIDS*. Accra; Catholic Action for Street Children, 1996.

57 Korboe, D. A *Profile of Street Children in Kumasi*. University of Ghana, Legon; Centre for Social Policy Studies, 1997.

58 Anarfi, J.K., *op. cit*., p. 3.

59 Rough estimate by a Médecins du Monde official interviewed in Cocody, Abidjan, 14 January, 1998.

60 Interview with street children at the Médecins du Monde House at Riviera, Abidjan, 15 January, 1998.

61 Ibid.

62 Seck, A., *Enfants en situation particulièrement difficile*, École nationale d’économie appliquée, Dakar, p. 4.

63 “La vie tumultueuse des enfants de la rue”, in *Le Soleil*, jeudi 4 décembre l997, p. 11.

64 Interview with the Director of SOS Drogue (NGO), followed by visits of several Koranic schools in Pikine, a Dakar suburb, Dakar, January 161998.

65 Ndiappe, N.D., Guèye, M. and Sall M.: *Analyse explicative de la consommation des drogues chez les jeunes de 14 ans à 24 ans au Sénégal*, Ministère de l’Éducation nationale/UNESCO, Dakar, 1990.

66 Omais, M., *Particularité de la toxicomanie au Sénégal*, Dakar, Faculté de Medecine et de Pharmacie, 1982.

67 Interviews, Nairobi and Mombasa, November 1997.

68 The Second Participatory Poverty Assessment Study – Kenya, vol. 1 (1998).

69 Rocha-Silva, L., de Miranda, S. and Erasmus, R*., Alcohol, Tobacco and Other Drug Use Among Black Youth.* Pretoria; Human Sciences Research Council, 1996.

[70] In the 1996 national survey on the pre-incarceration drug use history of South African prisoners the median age of onset for various drugs was as follows: for solvents 12 years, for tobacco 17 years, for cannabis 17 years, for alcohol 18 years and for other illicit drugs 19 years (Rocha-Silva, L. and Stahmer, I. (1996), *op. cit*.).

[71] In fact, proportional differences in the prevalence of the most commonly used drugs, e.g. alcohol, tobacco and cannabis, may diminish. In terms of the data accumulated in the 1994 survey (Rocha-Silva, L., de Miranda, S. and Erasmus, R.1996.) among 10 – 21 year olds in African communities, the ratio for alcohol to cannabis use is about 10 : 1 and for tobacco to cannabis about 10 : 3.

[72] Rocha-Silva, L., de Miranda, S. and Erasmus, R.1996. *Alcohol, tobacco and other drug use among black youth.* Pretoria: Human Sciences Research Council.

[73] Ibid.

[74] See Makanjuola, J.D. "The Aro Drug Addiction Research and Treatment Centre: a first report", *British Journal of Addiction* 1986. 81 : 809 – 814, and Adelekan, M.L. and Adeniran, R.A. "Rehabilitation and follow-up issues in drug abusers managed at the Neuropsychiatric Hospital, Abeokuta, Nigeria", *West African Journal of Medicine 1991* 10(1): 354 – 360.

CHAPTER V

POLITICAL CHANGE AND ILLICIT DRUGS IN AFRICA

A. INTRODUCTION

Successfully controlling illicit drug production, consumption and trafficking depends on a close relationship between State and society. Myriad political factors mediate this relationship and by doing so affect whether or not drug control efforts will succeed. This chapter considers how ongoing political change in Africa is likely to influence *a)* the State-civil society relationship, *b)* the nature of the drug problem, and *c)* the ability of Governments to effect drug control measures.

Considering political change in the context of illicit drugs is analytically useful. However, in order to grasp its significance, one must never lose sight of how political change alters the social and economic environment in which illicit drugs emerge. To illustrate, South Africa's former system of apartheid in itself did not directly give rise to the burgeoning cannabis trade in the Transkei. Educational policies of apartheid did, however, deprive a generation of individuals of a chance to compete at the workplace. The system contributed to the disintegration of families, depriving children of a stable home environment. It bred intense animosity toward police and security forces, tainting anything related to law with an illegitimacy that will take years, if not decades, to dispel. Similar to the consequences of apartheid, the legacies of Africa's political past will influence the scope and nature of tomorrow's drug problem.

This chapter is divided into four parts. Section B, "Political Transition and Drug Control", describes developments likely to influence the political process through which drug control action must be taken. Section C, "State-Civil Society Relations and Prospects for the Rule of Law", is closely related, in that it describes the challenges faced by African Governments in their efforts to establish the rule of law. Section D, "Armed Conflict and Drugs", examines the process of post-war recovery. Section E, "Political Factors in International Drug Control", briefly discusses issues relevant to international cooperation. Section F offers some conclusions.

B. POLITICAL TRANSITION AND DRUG CONTROL

Modern political structures in Africa can be seen to have originated in the aftermath of colonialism, for most countries a period that coincided with the decade of the 1960s. That decade is often referred to as the "decade of independence", a period that, having begun with great hopes for pluralistic governance, ended with the democratic process under assault. As Adebayo Williams has observed:

> "By 1969, the great majority of African nations that started out at independence with one form of democratic governance or another had come under full-blown military dictatorship or some other variants of authoritarian rule."[1]

Williams cites five of the countries included in this study: Cameroon, Côte d'Ivoire, Ghana, Kenya and Nigeria. Interestingly, four of the other five countries – Ethiopia, Mozambique, South Africa and Zimbabwe – experienced armed conflicts. Of the 10 countries covered in this study, only Senegal seems to have maintained a somewhat steady, secular path toward pluralistic, democratic rule. Other countries examined in this study have sought, to varying degrees, to reverse the anti-democratic trend begun in the late 1960s, a trend, that accelerated and intensified in the 1970s. It is in this context of increasingly pluralistic political organization that this section examines the feasibility of effective drug control in sub-Saharan Africa.

1. Effects on drug policy development

The most noteworthy change in the nature of politics in sub-Saharan Africa in recent years has been the rise of multi-party democracy. In countries such as Ethiopia, Mozambique and South Africa, among others, the resolution of long-standing conflict has given birth to nascent, albeit fragile, systems of democratic decision-making. In South Africa, general elections were held in

April 1994, resulting in the assumption of power by a coalition of the African National Congress and the National Party. In Mozambique, after decades of brutal conflict, a peace accord was agreed by FRELIMO and RENAMO in 1992, leading to the country's first ever multi-party, democratic election in October 1994. Ghana made a democratic transition in 1992 after 10 years of military rule. In Kenya, 1992 saw the first multi-party election held, and in November 1997 a second took place.

Democratization, while desirable from the voter's point of view, brings with it new challenges insofar as drug control policy-making is concerned. With free and fair elections, traditional systems of patronage are transformed, driven not least by the new-found need to gain votes, and this transformation will result in new demands, new political needs, that can be met, it must be said, by illicit drugs and/or the revenues that accrue from their sale. The policy process is wrested free from the control of a monolithic political entity, but the right of its ownership falls on a still unclear mosaic of contending forces, each of whom must balance their calculations of the merits of a given drug intervention with considerations that have more to do with political survival in a precarious environment riddled with ethnic, tribal and geographical fault lines. In coming years, if and when the illicit drug problem continues to emerge as a sounding board for different ideologies and different beliefs as to the best way to solve it, these contending forces on the policy process at the national level will become more obvious as the embrace of democratic decision-making widens.

The transition to democratic rule alters the challenge of effective drug policy development, as a plethora of new policy influences enter the picture where only one player may have had a monopoly over the development, implementation and funding of drug policy in the past. With a greater say in the social and economic policies that affect their lives, and with more control over the finances and the leaders who handle them, individuals in the new democracies will likely have more opportunity to rectify the imbalances that for so many decades have deprived them of a real chance at human development. Poverty in these countries can be attributed to various causes, but certainly one of them is the past absence of government accountability to civil society.[2] But there are costs involved as well, particularly at the initial stages of transition. For one, with a democratic system of rule, one trade-off is the risk of a more drawn-out and unwieldy decision-making process.

The point to emphasize is that drug control is a political issue – there is no inherent truth or intrinsic logic to many of the actions it comprises. This leaves drug policy development and implementation particularly vulnerable to political wrangling. Given the high financial stakes and moral sanctions involved, and the fact that drug activity – whether production or consumption – is often seen to be driven by specific groups, the potential for policy to be derailed or altogether marginalized by political interests is considerable. In supply reduction, issues regarding crop eradication or legalization or prohibition of khat, for example, will have relevance only in certain geographically delineated parts of a given country, likely to be populated by a certain group or groups with representatives in Government from the same group. On issues of demand reduction, if drug abuse is a problem of the poor, then it is significant that socio-economic hierarchies are highly reflective of ethnic hierarchies as well. What this suggests is that politicians, newly confronted with the task of winning votes, may resort to that most conventional of vote-winning techniques, scapegoating.

2. Ethnicity and local government

As the processes of constitutional reform and democratization continue to transform politics in African countries, the role of local political organization will continue to grow in importance as the most critical threshold that drug policy must cross in order to reap its rewards in the form of a healthy, drug-free society. Attendant with the process of democratization and enhanced political pluralism is the growing importance of local representatives with political bases not in the ruling elite, but in ethnic or geographical constituencies.[3]

In some African countries, a range of ethnic groups is involved in illicit drug activities. The stigma attached to involvement in such activities is such that, should the ruling powers be associated with the same groups, there is the risk that no significant action will be taken due to reluctance to alienate one's so-called "in group". The close relationship between political elites and those directly involved in illicit drug activities, due either to ethnic or regional association, may contribute to selective application of the legal controls designed to minimize the illicit drug problem.

The introduction of pluralistic, democratic rule transforms this risk. In short, it dilutes the risk of selective application of drug control norms by devolving decision-making power to a cross-section of a country's ethnic and regional interests. While a representative from one part of a country known for cannabis cultivation may be reluctant to call attention to the region's top, albeit illegal, income earner, there may be other representatives, or a free press, that is willing to do so out of competing self-interest. In the context of drug control, it is the counter-scrutiny inherent in pluralistic politics that is the greatest advantage of democratic systems in the context of drug control.

The ethnic card came of age during the period of colonialism, when social classes were often manipulated and controlled by the State on a "tribal" basis and were able to access state resources on the basis of an unofficial hierarchy of "tribal" groups and through institutions such as the chieftancy.[4] Throughout, ethnicity was gradually entrenched in the process of economic and political resource allocation. In the post-colonial period, a direct relationship has emerged between ethnic division on the one hand and the fluctuating size of the State's resource base on the other.[5] Identifying a certain group as being involved in cannabis cultivation takes on added significance because of the resource implications of reducing the illicit drug supply. In the context of drug control, ethnic group competition is significant not in terms

of a struggle for the spoils of the State, but in terms of the effort to shield one's constituency from the stigmatization and economic penury that ensue after one's identification in illicit drug activity.

It is no less important that attention be focused at the local, community level – the key bridge between drug control decisions taken at the national level and their effective implementation. Akin Mabogunje makes an important distinction between the attitude of civil society to state structures and those toward community, non-governmental organizations, using the case of Nigeria as an example:[6]

> "There is some discrimination in the attitude to, on the one hand, the imposed structures of the 'modern' Nigerian State and, on the other, the inherited structures of traditional 'Nigerian' society. A good illustration is provided by the attitude to local governance. The popular reaction to existing local government councils is for most people to feel that they owe them no civic obligations, to try as much as possible to pay to them no taxes but rather to encourage or condone local councillors to misappropriate the funds meant for local services. On the other hand, the same citizens who would not pay tax to the local government would strain themselves to pay levies and contribute or donate generously to the coffers of their community development associations."

In Ghana, promising decentralization efforts began in 1989, when the Government of the Provisional National Defence Council (PNDC) created 101 district assemblies (DAs) with the stated objectives of greater participation, effectiveness and accountability. Various studies have pointed out several faults with the system: *a)* the dual role of the DA as a formal agency of local government and a community self-help development organization led to ambiguity; *b)* the main problems in terms of effectiveness were that obligations outstripped finances; *c)* as far as accountability was concerned, it was difficult for communities to remove elected members of the DAs; and *d)* appointed members, (one third of each DA), and the district secretary, (the highest position in the DA), could not be removed without the consent of the PNDC.[7] However, these same studies point out that the process of decentralization has moved forward a great deal since the people's defense committees and workers defense committees of the early 1980s. The programme has "awakened the spirit of voluntarism and 'awareness' among most sections of the communities", and the "elected DA members were for the most part genuinely 'representative'of their small electorates".

Ghana has taken steps to ensure that drug control policy development at the national level involves a two-way consultative process with local counterparts. Local assemblymen who receive their directives from national political entities consult with tribal elders and chieftains to ensure that economic, social and indeed drug policy are understood and fully consistent with traditional norms. The role of the Ghanaian assemblyman in drug control in many respects captures the extent to which effective drug control depends on broader political trends that take account of the views held by the local community. The establishment of district assemblies was a step taken in no small part because of a realization that the public sector faced insurmountable limits to what it could achieve in the realm of social development and welfare; the local district assemblies not only represent an effort to institute a "bottom-up" political system, but also an important two-way channel for the development and implementation of drug control efforts in Ghana.[8] Demand reduction efforts also make use of local government structure. NCB and the Ministry of Local Government and Rural Development are working with the district assemblies to include narcotics prevention in educational programmes.[9]

Nigeria has had a federal system since before independence. The federal structure was seen by both the colonial Government and independence leaders as the only feasible way to keep the disparate groups of the country together. During the years since independence, leaders have continually increased the number of states, largely in response to ethnic tensions and calls for the opportunities that state status entail. The diffusion of political power at the state and local levels is likely to facilitate the country's ongoing efforts to expand drug control efforts to outlying areas far beyond Lagos and Abuja. The recent establishment in the country of 99 "area commands" for drug control has taken place in the short span of three years, an accomplishment due primarily to administrative and political structures at the federal, state and local levels. Although there were in 1997 only five drug rehabilitation units throughout the country, it is likely the authorities will be able to exploit a developed institutional infrastructure to expand access to demand reduction services throughout the country. In this light, one reason for the governance difficulties in Lagos – its regional diffusion of political power – is also the main asset that Nigeria has at its disposal to address its burgeoning drug abuse problem.

Compare this situation to that of Ethiopia, a country whose political history has resulted in an acute concentration of political power and administrative know-how within the capital of Addis Ababa. Until the end of the civil war in 1991, this concentration of political power in a central core allowed the Derg regime an unparalleled degree of oversight within the capital and other urban centres of political or military significance. In this light, the former political regime in Ethiopia achieved a degree of all-encompassing rule that the Nigerian leaders of today have yet to enjoy. The Government of Ethiopia today faces a herculean task in decentralizing its political structures. State and local authorities are ill equipped to fulfil the many new administrative and institutional responsibilities being thrust upon them by Addis.

With the granting of regional autonomy, policing in Ethiopia is being reorganized. In that reorganization, the regional police will take responsibility for drug-related crime, and the centrally run Counter-Narcotics Unit will be unable to function outside Addis Ababa without the consent and cooperation of regional authorities. The regional police are poorly trained and currently operate lower admission criteria than the central police force based in Addis Ababa. It is planned to offer regional police training in drug

recognition, but at present the police admit that they lack the resources and expertise to accomplish this.[10]

It has been the argument of this section that democratic transitions will lead to effective drug control by making government officials and agencies more accountable to citizens and opening up discussions both within the Government and society. Equally important, the legitimacy of the Government is the foundation of a productive relationship between society and Government; it is that relationship which defines the parameters for the rule of law.

C. STATE-CIVIL SOCIETY RELATIONS AND PROSPECTS FOR THE RULE OF LAW

Whether in demand reduction or supply reduction, interdiction or treatment, drug control involves the State providing public goods with the aim of preventing or minimizing certain behaviours and promoting others seen as more beneficial to society at large. The key determinant of whether drug control aims are achieved is the relationship between the State and the target group, civil society.[11] One fundamental question is how the conduct of the State influences the collective will of civil society to abide by laws that proscribe illicit drug activity. It is a question we now ask in the context of sub-Saharan Africa.

The centrality of governance often goes unrecognized in the context of drug control, as though drug control norms could in themselves meet with their intended outcome despite the obstacles and constraints that the State must overcome in reaching out to civil society. In fact, the presence of comprehensive drug legislation, while crucial, is but one of myriad preconditions for effective drug control. Foremost among these is a State that has the credibility to elicit from civil society the collective will to abide by law. Akin Mabogunje has asserted that:

> "For a State to be strong, it must have the capacity and the capability to penetrate its society, regulate its social relationships, extract the resources it needs from the society and appropriate or use those resources in determined ways. The strength of the State is thus to be measured not by the unbridled wielding of coercive power but by its ability to make the citizens accept its laws as the standard to which they conform."[12]

1. Obstacles to effective policing

From the point of view of society, including the would-be drug offender, the police official is one of the most visible extensions of the State. The conduct of the police is thus significant not only as the most tangible "control" lever that the State has vis-à-vis civil society; its conduct, performance and image influence the collective will to abide by laws. If the law enforcement authorities are widely perceived to be corrupt or self-interested, the result is not only less efficient law enforcement but also less commitment on the part of individuals to respect the law as a constraint on their behaviour. Van Heerden has referred to the "tacit partnership in policing" when emphasizing that the "very basis of orderliness is the internalized inclination of every citizen to obey the law".[13]

This concept – that state credibility is a key precondition for eliciting support from civil society in matters of law enforcement – is fundamental to an understanding of the constraints facing sub-Saharan Africa in the area of drug control. Indeed, as mentioned in chapter III one formidable challenge of drug control in sub-Saharan African countries is monitoring illicit drug transactions in rural and urban areas. Owing to financial constraints and the extent of informal economic activity, police are effectively prevented from having immediate oversight of drug transactions. Without a physical presence of the police, it becomes all the more important that civil society be willing to fill the vacuum by means of moral sanctions as well as provision of information to state authorities who cannot be in all places all of the time. The problem is that this information for various reasons is rarely forthcoming in the African context. Thus, law enforcement institutions must often resort to costly and inefficient "search and seize" interventions such as roadblock inspections, neighbourhood raids and border checks – their role as a non-present deterrent is often marginalized because of poor credibility.

This latter point of deterrence requires further elaboration. Particularly where the illicit drug problem is today in its infancy, the role of the police is significant not only as a force to interrupt or expose activities such as illicit drug production, trafficking or abuse, but, perhaps even more importantly, as a deterrent. Indeed, if activities such as drug abuse, drug peddling and production can be defined as "victimless" crimes, the reporting of crimes often depends on moral, egalitarian considerations rather than a personal sense of loss. However, when police and state conduct give grounds for counterbalancing moral considerations, the end result is that no reporting takes place. In the case of many African countries, where past eras of political oppression and internal strife have weakened the ties that bind State to civil society, the information flow on illicit drug activity both within the community and between the community and the police may be especially sparse.

How the community perceives the police official is thus as important as how effective it is in apprehending those involved in the act of a given crime. It is in this context that Ethiopia, Ghana and Zimbabwe seem to be in a good position to stem the growth in the illicit drug trade at the street level. While street-level bribery is far from unknown in these countries, it does not yet seem to have reached systemic proportions that would taint the credibility of the police force as the standard-bearer of law and order. During interviews and focus group discussions for this study, it became clear that drug peddlers, abusers and others such as prostitutes and other groups of illegal entrepreneurs in these three countries have the perception that the police official cannot be easily bought off, or at least not cheaply.

As with all forms of corruption, that present in some police forces has much to do with insufficient resources to pay officials. In Nigeria, officers earn less than N 3,500 per month, which "cannot even transport some officers to

work".[14] Even groups who are wont to criticize the Nigerian legal institutions admit that the police forces have "low salaries and poor staff welfare, which occasions low morale and lack of confidence, encouraging corruption".[15] Bribing police officials takes place throughout the world, Africa being no exception. What distinguishes some countries from others, or some urban centres from those in other countries, is the extent to which bribery becomes institutionalized or systemic. In Accra, for example, it is widely believed that even though the street-level police official is far from averse to accepting a small pay-off, that pay-off is typically valid only for that one offence; if the offender is caught again, another payment – in cash or kind – is required to avoid arrest.[16] In other countries, on the other hand, bribery has become an institutionalized payment to the police. In Cameroon, for example, it appears that the pay-off may be valid for a period of time, say six months to a year, during which the police official will actually go so far as to shield the payer from other law enforcement officials.[17]

In Côte d'Ivoire, the illicit marketing of palm wine, or "*bangui*", during colonial times involved police cooperation.[18] Although prohibited since 1916, *bangui* was easily available in Abidjan as late as the 1930s. *Bangui* sellers were most often women, some of whom made alliances with law enforcement officers in order to market the beverage without interference. Le Pape stresses that this does not mean that "the functioning of illicit trading activities was absolutely submitted to alliances with law enforcement representatives", but rather that "small-time illicit activities mostly handled by women" were allowed to some extent by this system.[19] This colonial system laid the basis for similar current realities. According to small-time drug dealers and users in Abidjan, retail drug outlets, or "ghettos", which are often restaurants or bars, pay the police protection money on a monthly or fortnightly basis in order to operate unobstructed. This allows the managers of the ghettos, who are often Nigerian and Ghanaian women in Abidjan's working-class areas, to offer their clients absolute security while they are on the premises. The similarities with the colonial system described above are striking and suggest the existence of a long tradition of the sale and use of illicit substances in Abidjan.

The physical nature of the areas where illegal drug transactions take place also shed light on the importance of local involvement in and support for drug control efforts. The labyrinthine corridors of walkways and alleys of many urban centres provide ample scope for illicit drug sales to take place. The occasional police visitor, if he or she does not collude in the hope of augmenting a meager official pay, unknowingly sets off an alert system of neighbourhood runners that can inform the relevant parties far more quickly than the street official can walk or drive. Partly because of its congested environment, the high-density Mbare suburb of Harare has one of the widest ranges of available drugs in the country.[20] In South Africa, the Hillbrow area of Johannesburg is today a thriving centre of the illicit drug trade – due in part to the historical neglect during apartheid to police such areas adequately. Tourist areas also present challenges for the police; in tourist areas such as Malindi on the coast of Kenya and Labadi beach in Accra, the police presence is downplayed; and even if the police were present in those areas, it is doubtful whether they would arrest the foreign visitors who are the most sought out – and prolific – buyers on the retail drug markets.

The phenomenon, whereby illicit drug activity takes place in self-encapsulated enclaves detached from state surveillance or involvement, can be discerned with regard to illicit drug production as well. In South Africa, illicit cannabis cultivation is widespread in KwaZulu/Natal and the Eastern Cape, areas that were for decades sites of intense conflict with and animosity toward central governance structures. In Ethiopia today, cannabis found throughout the country often originates in the Shashamene region south of Addis Ababa, where the Emperor Haile Selassie gave land-holdings and virtual sovereignty to an enclave of Jamaican Rastafarians in the 1940s. Cannabis also grows on the property of monasteries, including those of Dire Dawa, areas where it is not only legally, but ethically, difficult for state authorities to intervene.[21]

Of the 10 countries examined in this study, South Africa has the police force with the most difficult political legacy to overcome in the eyes of its public.[22] South Africa's police force during apartheid carried out two primary functions. The first was the enforcement of laws that governed various aspects of peoples' lives, including the Pass Laws, the Group Areas Act and the Influx Controls. The second was the function of political policing, which was mandated by security legislation and involved monitoring the political and social activities of various groups. The need for a fundamental shift in the culture and mission of the force was aptly put by Mark Shaw of the International Institute of Strategic Studies in South Africa:[23]

> "In terms of the relationship between the public and the police, the latter have, in the past, functioned more as an army enforcing and maintaining a particular system of government rather than a legitimate agency protecting the rights of the country's citizens."

As mentioned in chapter III, many of South Africa's township areas, including those in the Cape Flats, are witnessing an upsurge in gang-related activity. Many of those gangs are heavily involved in illicit drug selling. Unofficial reports estimate the turnover in the Western Cape alone to be R 1 – 2 billion in 1995 ($170-340 million).[24] The revenues these groups earn are being used to expand their market share in the local drug trade, such that communities are, despite the increasing violence associated with the trade, growing increasingly indifferent to the gang activity.[25] This development, which contrasts with the highly publicized retaliation of groups such as PAGAD, demonstrates how the neglect of certain communities has played into the hands of cash-laden criminal groups. It has been reported that the Cape Flats gangs employ about 80,000 people.[26] The economic interests of the gang members and their families have yet to be countered by education about the ill effects of drug consumption.

Public education campaigns alone, however, will not be

enough to mobilize the public to cooperate in the arrest and prosecution of drug offenders. A working relationship between the police and the community depends on several key factors, one of which is community perception of the police as a credible and disinterested institution. When the police and drug enforcement agencies are perceived as more capable of arresting and bringing to prosecution drug producers, consumers and traders, there is an additional deterrent effect. Institutional capacity building requires that politicians recognize the importance of improving fiscal and human resources of the drug fighting bodies.

2. Search and seize capabilities

As mentioned above, without the active support from civil society, the police face formidable constraints in carrying out their duties in the area of drug control. But even when the police are successful in their search and seize operations, difficulties can subsequently arise during the processing of arrest cases. The credibility of law enforcement institutions can thus be reinforced or harmed not only by the way in which successful policing interventions are carried out but also by the way in which drug cases are subsequently handled. Perceptions of state conduct in this regard have a cumulative effect on the public's readiness to work with law enforcement.

Nigeria is in the midst of a major intensification of its drug law enforcement efforts, a process that is unlikely to slow despite the transition to civilian rule. Since the mid-1990s, the Government has intensified the monitoring and enforcement capabilities of NDLEA. While corruption continues to thrive at the street level, there has according to both Nigerian and international sources been a rooting out of corruption at higher levels.[27] By most accounts, NDLEA has met with unprecedented progress in its efforts to elicit greater compliance from civil society in the area of drug law. In 1993, the Agency went through a major process of retrenchment. For example, most of the staff at the Murtala International Airport in Lagos were replaced with others seen as less prone to corruption. Clearly there are merits to the assertive anti-drug campaign being waged by NDLEA under its chairman, Major-General Musa Bamaiyi. At the same time, though it has earned the respect of many sectors of Nigerian society for rooting out illicit drug activity to an extent unimaginable in the early 1990s, NDLEA has also prompted fears that illicit drug activity has merely been driven deeper underground, now thoroughly hidden within sectors of a society that has been galvanized by what it sees as an assault on its basic civil liberties. There exists a risk that the response of the Nigerian authorities may overshoot, not only sending illicit drug activity underground but erecting a wall of silence between the authorities and the communities that are the prime source of information essential for their work. Table 1 reflects findings from the survey undertaken by the national research team. As was repeatedly the case in survey questions in Nigeria, a considerable portion of respondents were unwilling to answer sensitive questions, even when their anonymity was guaranteed.

NDLEA today has the power to freeze bank accounts, impound personal property and monitor personal bank accounts, telephone lines and private gatherings. The high-profile tactics also include midnight raids, checkpoints, the suspension of flights by airlines popular with traffickers and couriers (Varig, Air India, Balkan) and the closure of privately operated telephone services (known as business centres), following reports by the US Drug Enforcement Agency that they were often used to organize trafficking schemes. NDLEA has also moved against cannabis cultivation in Operation Burn the Weed, with midnight raids on villages, destruction of cannabis farms and increasing arrests of farmers and cannabis dealers and consumers.[28] Since 1997, it has had the right to screen any politician seeking election into office. Between 1996 and 1997 the Nigerian authorities registered a 99.8 per cent increase in drug-related arrests, with more than 90 per cent of those arrests cannabis-related, and a total of 1,088 cases went to court, with only 16 acquittals.[29] In the sequence of enforcement, the next step is from arrest to charge, and from charge to remand or release on bail pending trial. These are also steps that can expose weaknesses of both the police and judiciary. It is often difficult to discern the rationale for decisions about remand or bail, or for the sums of bail imposed by courts.

Legal frameworks with comprehensive provisions that do not discriminate between types of drugs or categories of offences are susceptible to judicial practices that can require the same bail of petty dealers and consumers and cocaine and heroin couriers and "barons" who are charged.

When this happens in Ghana, for example, those unable to post bail can spend up to four years imprisoned on remand before trial, while others who can post bail often seek to postpone trial and indeed abscond. Together with sentencing (see below), bail conditions are often perceived by the public as evidence of collusion and deals between more substantial figures charged and police and judiciary or of more straightforward judicial corruption. In the case of Mozambique, many of the few cases of international trafficking that have come to court have resulted in the acquittal or direct release of the accused, fueling public suspicions that officials are complicit in the drug trade. While arrest figures provide no meaningful indication of the extent of drug distribution in any of the countries within this study, they are indicative both of the "mix" of drugs found in the country and the emphasis that local law enforcement officers choose to give drug-related crime. In Kenya, cannabis-related arrests have dominated since the early 1990s. Some 4,252 individuals were arrested for cannabis-related offences in 1992, and 4,283 in 1993. In 1994 this figure fell to 2,890, climbing again to 3,140 in 1995 and 3,990 in 1996. Almost all of those arrested were Kenyan nationals. In the case of heroin offences, the number of arrests have been remarkably stable over the period 1992 – 1996, averaging 32 per year. In contrast with those arrested for cannabis-related offences, almost two thirds of the convicts in heroin cases were foreigners.[30]

Insofar as the Ethiopian police are active in making arrests for drug offences, it is cannabis production, dealing and consumption that dominate. Of 553 arrests of Ethiopian nationals for drug offences noted in the police records for

Table 1. **Effects of law enforcement in Nigeria (survey responses, N = 701) (percentage)**

Relationship	Availability	Local price of drugs	Drug trafficking	Local dealing	Openness in use	Presentation of addicts at hospital
Reduces it	38.1	18.8	42.2	30.7	29.8	9.7
Increases it	3.7	11.8	0.1	4.4	5.8	7.8
No change	4.4	6.1	–	4.1	3.6	4.0
No response	53.8	63.2	57.6	60.8	60.8	73.8

the period 1993 – 1997, cannabis featured in all but 8 cases. (Note that these figures do not include foreigners arrested for international trafficking through Bole airport.) The charge-sheets record that some 50 per cent of those arrested were dealing in cannabis, including those said to be trafficking from Ethiopia to Saudi Arabia (approximately 70 arrests). The majority of those arrested were young males (495 males to 58 females), and 60 per cent of those arrested were aged 18 – 30, 12 per cent under 18.[31]

Of these arrests, 72 per cent were made in Addis Ababa. The police admit that drug awareness among law enforcement officers outside Addis Ababa is minimal. It is also apparent that law enforcement against cannabis trading and use has only taken effect since 1995, marked by a very sharp rise in arrests in that year and sustained each year since. The apparent contradiction between public awareness of the concentration of cannabis production in the Shashamene area and the lack of major arrests of farmers or dealers in Shashamene itself is striking.

In Zimbabwe, as in Ethiopia, most arrests are in response to tip-offs. Police carry out few speculative raids or searches, either at known selling points within the country or at known smuggling points. When a visiting customs official suggested that a bus be searched at the Nyamapanda border post, local officials related that a scramble ensued amongst the passengers and by the time the customs staff reached the bus it was surrounded by a variety of discarded packages, most of which were found to contain *mbanje*. From 1993 to 1996, when all other indicators suggest that drug trafficking and use became more prevalent, seizures and arrests by the Zimbabwean authorities declined. In 1993, there were 1,464 arrests for cannabis-related offences by the Drugs Division of the Harare Criminal Investigations Department, 1,334 in 1994, 826 in 1995 and only 763 in 1996.[32]

3. Conviction and sentencing

Similar problems exist in the areas of conviction and sentencing. The legal provision for substitution of fines for custodial sentences is sometimes seen, not surprisingly, as working to the benefit of the more substantial figures convicted. The general effect of such anomalies is to stimulate demand for harsher sentences for all convicted of drugs offences, rather than greater differentiation in sentencing policy and practices, as provided for in the Cameroon Law 109 of 1997.

In Ethiopia police admit that the slow procedures of the courts make it difficult to secure convictions, and that in these circumstances they often decline to prosecute known offenders. After arrest it is not unusual for cases to wait 12 to 18 months before being heard. The accused can be held in custody over the entire period, during which it is more difficult to store forensic evidence, keep in touch with crucial witnesses and ensure that perishable exhibits remain fit to be presented in court.[33] Cannabis farmers were aware that arrest and detention might not necessarily lead to prosecution, let alone conviction, as bribery could sometimes effect a swift release from an overburdened judicial system.[34]

For those who are prosecuted and convicted, inconsistencies in sentencing practices occur in many countries. In Ethiopia, the courts make no distinction between categories of cultivator, dealer and consumer, applying similar penalties across the board. For example, one of the traffickers interviewed in Addis Ababa's Central Prison, Mustafa, from Saudi Arabia, convicted of possession of 2 grams of cannabis, was sentenced to one year's imprisonment and a fine of 2,000 birr, while Mafengo, a Tanzanian convicted of heroin trafficking, received a sentence of one year and a 1,000 birr fine.[35] In these circumstances it is not surprising that youths and other users interviewed see no need to distinguish between different drugs in terms of any scale of criminality. It might be argued that this can have a generally deterrent effect, but it also tends to generate the view that there is no substantive difference between dealing in cannabis or heroin, or perhaps in consuming them.

In Zimbabwe, the courts differentiate between categories of drug when sentencing, but sentencing patterns reflect the fluctuations of local anxiety rather than any consistent view of criminal seriousness, social risk or economic value. Cannabis offences there carry a minimum Z$ 20 fine, but a maximum sentence of 10 years' imprisonment. Cocaine carries a statutory Z$ 1,000 fine, with six to seven years' imprisonment. Heroin offences carry the same prison term as cocaine, but without the fine, while mandrax possession

carries a 15-year sentence with a Z$ 15,000 fine. Prison sentences for those convicted of drug offences are usually given with hard labour and are served in typically harsh prison conditions.

Drug use in prisons in the 10 countries appears to be extensive (as elsewhere), with prison officers implicated in (and sometimes convicted of) supplying drugs. In Maputo, drugs are available within the Central Prison, while in Cameroon it is suggested that drug consumption by prisoners is often tolerated because it helps the prisoners cope with the difficulties of their lives rather than becoming violent (a somewhat different position to the standard view in west Africa that drug users are violent and dangerous). Rehabilitation programmes in prisons are typically absent.

D. ARMED CONFLICTAND DRUGS

The adage that "war is politics by other means" defines the underlying premise of this section, that armed conflict reflects political change in its most acute form. Illicit drug production, use and trade can be stimulated both during and after periods of war. Although during war illicit drugs can serve multiple roles (to be discussed briefly), the countries concerned in this section are dealing with the after-effects of armed conflict. The economic devastation resulting from conflict can make certain groups more susceptible to the lure of the illicit drug trade. Psychological trauma from prolonged exposure to violence and the disruption of normal life caused by displacement can make affected groups more tempted to seek relief in drug use.[36] Examples of these effects can be found in Ethiopia, Mozambique, South Africa and Zimbabwe and can provide useful insight into the relationship between conflict and illicit drugs.

During wartime, drugs provide a functional utility in three forms. Firstly, drugs serve a medicinal role, particularly for anaesthesiological purposes. The use of morphine during the Viet Nam war is the most well-known case of licit drug use during armed conflict, but other, less high-profile cases abound involving the use of cannabis, alcohol and natural hallucinogens. It is worth emphasizing in this context that the main risk of an escalation of drug use in Africa and beyond is the perception that drugs serve a valid role, a function; drugs are seen to offset, relieve or mitigate the ill effects of other problems faced by the individual. The second common use of drugs during wartime takes the form of consumption aimed at achieving psychological states conducive to effective performance. Cannabis and solvent abuse, particularly among children engaged in military confrontation, is believed to have been widespread during the Liberian and Mozambican conflicts. In this regard, the illicit consumption of drugs in times of war is little different from its use in times of peace: the consumer is often motivated by the belief that the drugs will allow the achievement of an otherwise unattainable state – whether it is relief, escape, courage or creativity. The third and final use of drugs during wartime, less documented and less in evidence, is the use of illicit drug revenues to augment military coffers. The use of drugs for financing militaries has been witnessed in places such as Afghanistan and Myanmar but not yet in the context of African conflicts. It is worth noting, however, that military financing of civil wars in particular is likely to increase in future, as official military assistance continues to diminish and rebel factions in particular find it difficult to support their cause because of increasingly rigorous controls on the clandestine import and export of conventional weaponry.

The functional use of drugs in post-conflict situations can be understood in terms of the supply of and demand for drugs, two dynamics that are driven by particular needs:

On the supply side, soldiers, for example, when demobilized and left without any real means of sustainable livelihood, can end up in the drug trade as couriers, street-level dealers or strongmen for the higher-ups.

On the demand side, the traumatized individual sees drugs as a source of psychological relief. When returned exiles, demobilized soldiers and the internally displaced experience the hardships of reintegrating into unfamiliar communities, the psychological pressures, compounded by the trauma of wartime experience, can be intolerable enough to force the individual to seek respite in drugs and alcohol.

1. Demobilized combatants

As a proportion of the general population, the number of soldiers who have left the military following the above conflicts is small. Yet owing to their military background, their familiarity with weaponry and in many cases their unfamiliarity with a stable, peaceful environment, demobilized soldiers have traits that would suit them well were they to choose a career in the illicit drug trade. The recent history of Afghanistan, the Middle East and Northern Ireland suggest that long-term involvement in situations of violent conflict can result in powerful inertial factors that contribute to a sense of alienation from peaceful existence within the ex-combatant community. Former soldiers when deprived of viable opportunities to reintegrate into civilian society have demonstrated what could be described as a resistance to return to the unfamiliar environs of peace. They have sought to support themselves and their families by resort to the only income-generating activity for which they have ever received training– the waging of war. While the analogy of war has been used to ill effect in the global anti-drug campaign, the illicit drug trade has in some cases taken on the form of violent conflict in pursuit of the limited spoils. How military conflict influences the illicit drug trade is a question that we now consider.

Observers have noted that not just in South Africa, but southern Africa as a whole, "the demobilization of military forces throughout the region- has influenced crime rates and arms proliferation".[37] The people of Mozambique have suffered a long uninterrupted period of armed conflict, which came to a welcome end in 1992.

The country's experience with armed struggle began in the mid-1960s. In September 1964, FRELIMO launched what

would become a 10-year, and ultimately successful, guerrilla struggle against colonial rule. Subsequent to Mozambique's independence in 1974, FRELIMO took charge of a fragmented nation, adopting Marxism-Leninism as its official doctrine. In the mid-1970s the civil war with rebel group RENAMO began. The war, during which 1 million lives were lost, formally ended in October 1992, with a Peace Accord signed in Rome. The demobilization of troops began in March 1994.

While precise figures are unavailable, it is believed that between 90,000 and 150,000 soldiers ended up leaving the army at the end of the conflict, many of whom have experienced serious obstacles reintegrating into civil society.[38] Demobilized soldiers received 6 months' pay from the Government and, in addition, 18 months of financial assistance from the international community, which pledged a total of $20 million. Payments ended in February 1996.[39]

The dearth of available statistics on even the most basic socio-political issues in Mozambique has prevented a precise measure of the level of unemployment among the former military, but several developments give reason to believe the situation is serious. OXFAM reports that "ex-soldiers' frustrations sometimes boiled over into riots and looting, as they raided warehouses, where aid supplies, meant for more vulnerable groups, were stored".[40] There is also fear that former soldiers in need of income have started to trade their weapons for cash at the border with South Africa. In January 1995, President Mandela of South Africa and President Chissano of Mozambique signed an agreement to increase cross-border police cooperation against illegal weaponry.[41]

These particular incidents suggest soldiers' willingness to commit crimes to relieve economic hardship; dealing in illicit drugs could be yet another way of coping. Military personnel in Mozambique were interviewed for this study on their views regarding the illicit drug trade. Of the 100 military personnel interviewed, 68 were present military personnel, 11 were former combatants, 8 were former combatants who had formally registered for demobilization and 13 were at present civil servants in defence-related ministries. When asked their views on who was actually transporting drugs to markets in Maputo, 14 per cent of respondents cited demobilized soldiers, nearly 17 per cent cited other military and only 13 per cent cited "traffickers". The general answer of "trafficking networks" was given by 41 per cent of respondents when asked who was selling the drugs. Again, former and present military were cited by 29 per cent of respondents, (6 per cent citing demobilized soldiers in particular) and "unemployed" accounted for 14 per cent. The major causes for involvement in the illicit drug trade were identified as unemployment, problems with reintegration, as well as the privatization of many social services.

There is also emerging anecdotal evidence indicating significant levels of drug use by former soldiers in Mozambique. In its 1997 report on reintegration of demobilized soldiers in Mozambique, ILO asserts that "drug and alcohol use are often found among former soldiers and are frequently indicative of deeper psychological disturbances".[42] In the above-mentioned interviews of military personnel, respondents were asked a range of questions on the illicit drug trade. A total of 61 per cent deemed that the illicit drug problem was very serious, 11 per cent deemed it to be a "medium" concern and 17 per cent believed it to be a minor problem. Of the 100 respondents, 10 were at present drug users and 11 were at present involved in the selling of illicit drugs. According to this group, the drugs being used, in order of magnitude, were: cannabis (28 per cent), cocaine (22 per cent), hashish (13 per cent), methaqualone (mandrax) (13 per cent) and diazepam (9 per cent).

In a related but quite different situation, South African combatants against apartheid have felt similar effects of violent conflict and some have tried to cope in much the same way as in Mozambique. Beginning around 1960, the main liberation movements in the country adopted a policy of armed struggle against apartheid. The first armed operations began in December 1961, led by the military wing of the ANC, Umkhonto we Sizwe. The conflict between the Government and the liberation movements was marked by events such as the 1960 Sharpeville massacre, the Soweto uprising in 1976, the killing of Steve Biko, leader of the Black Consciousness Movement, in 1977, the establishment of the bantustans and the attendant deprivation of blacks of their South African citizenship. Each stage of the conflict in South Africa further polarized the relationship between the Government and the country's black population, with approximately 4 million internally displaced due to forced labour or political belief.

The relatively smooth transition thus far from a plethora of apartheid-era military adversaries to a unified military force overshadows the difficulty faced by the individuals who have sought to reintegrate into society. The South African National Defence Force (SANDF) is to be pared down by the year 2000 by approximately 30,000, leaving a professional army of 75,000.[43] Although the system of apartheid has been abolished, jobs have been difficult to secure by those who have fought in the struggle against apartheid and decided to return to civilian life. In a 1994 survey undertaken in the Pretoria area, less than 24 per cent of returned exiles had succeeded in finding work. Of these, 46 per cent were employed in the formal sector and 36 per cent were looking for work again.[44] The unemployment rate for returnees was 70 per cent compared to that for the general population of 18 per cent.

In coming years, the reduction of the SANDF will magnify the problem of reintegration experienced thus far by the few who have already left either the government forces or the armed wing of the ANC. There are doubts as to whether the State has the capacity to support this costly transition to civilian life. By May 1996, the Service Corps programme, specifically aimed at military personnel who choose to leave the armed forces, had trained 885 people.[45] One problem has been the alienation of the so-called self-defence units of the ANC and the self-protection units of the Inkatha Freedom Party. Neither was initially included in the reintegration process and subsequent efforts to do so have met with only marginal success. For example, of the 2,000 SPU members in KwaZulu/Natal, only 20 had reported to the SANDF by early 1996.[46]

Focusing exclusively on military personnel would give a misleading picture of the vulnerabilities to drugs created by the South African conflict. For the war against apartheid was waged primarily on the basis of resistance supported far beyond formal military organization. For example, large segments of black and coloured students either participated directly in the anti-apartheid struggle or boycotted schools. In a sense, in the anti-apartheid struggle, they were the key soldiers fighting for their cause. But it is this same group of "demobilized" individuals who must now compete for limited jobs, on the basis of weak academic and professional credentials. Throughout the years of the resistance, children were seen by the apartheid regime as the vanguard of a societal conspiracy and many were imprisoned without any recourse to legal proceedings. Those children and the many adults who were deprived by the system of an education now find themselves with no marketable skills in a competitive work environment. They constitute the heart of the "demobilized" group, and their fate will influence the direction of the drugs and crime problem in South Africa.

2. War-affected Civilians

Civilians today are often seen as a key strategic component that can ultimately decide the outcome of a conflict; they are thus frequently and intentionally targeted.[47] Even when not targeted specifically, experiences during wartime can devastate a family economically and emotionally. Around the world, there are approximately 50 million people who, according to UNHCR, could be legitimately described as victims of forced displacement.[48] Seventeen million Africans have been internally displaced by violence, meaning 1 in 30 has fled his or her home.[49] While forced relocation of civilians has come to play a central part in modern war tactics, civilians who remain in their homes are also exposed to events that will torment them throughout their lives. Whether victims or observers, the experiences of torture and disappearances and the destruction of homes, communities and local economies can produce psychological pressures that may induce the search for relief in mind-altering substances. In the UNDCP World Drug Report, the theory behind some displaced person's resort to drugs is explained in this manner:

> "Feelings of marginalization, of non-identification with the cultural environment, are frequently the basis of broader drug use theories. Philosophical starting points include the concepts of alienation – in both the Marxist and the existential interpretations – and of anomie as defined by Robert Merton. According to Merton, anomie is the state, which exists when there occurs a weakening of the rules of conduct, which maintain social solidarity. The withdrawal from this conflict has been termed retreatism. Heroin addiction among US troops in Viet Nam in the 1970s was strongly related to feelings of acute loneliness and estrangement. In quite different circumstances, in Manipur, in the north-east of India, heroin use is fast becoming a cultural pattern of youths to counteract the extreme despair and frustration of a geographically captive population where education has lost its credentials, jobs are simply not available, the quality of life leaves much to be desired, insurgencies are commonplace and social-political stability the casualty. Joblessness creates vagrancy which has an immense potential for destruction and violence, and wayward youth with nothing positive to look forward to take to chemical euphoria as a catharsis of pent-up despair, anguish and suffering".[50]

With this definition in mind, below are some examples of available evidence of how civilians are affected by conflicts in Mozambique, South Africa and Zimbabwe.

In the surveys undertaken for this study in Zimbabwe, Professor Stanley Acuda and Dr. Essie Machamire concluded that youth in particular use illicit drugs in order to forget their problems, which are also largely socio-economical.[51] However, according to Dr. A. P. Reeler, the Clinical Director at the Amani Trust in Harare, another contributing factor for drug abuse in Zimbabwe is the need for medication to relieve psychological problems caused by the political violence of the early 1980s.

During the fight for independence from the British, the Zimbabwe African People's Union under the leadership of Joshua Nkomo (an Ndebele) and Robert Mugabe's (a Shona) Zimbabwe African National Union were unified in their mission. Despite this cooperation, independence in 1980 brought conflict between these groups, which resulted in violent civil strife in Matabeleland and the Midlands from 1982 until 1987, when a Unity Accord was signed. Troops were repeatedly sent to the areas to quell the unrest. A 1997 report by the Legal Resources Foundation and the Catholic Commission detailed the atrocities committed by these forces during that period.

In rural provinces, medics prescribe alcohol and cannabis as remedies for "psychological illnesses" most likely caused or exacerbated by this violence, which are frequently misdiagnosed. Alcohol use, especially among men, is a prevalent means to mitigate the effects of depression and anxiety. Based on a 1995 study of approximately 182 persons with psychological disorders and 57 survivors of organized violence in the Mount Darwin District of Mashonaland Central Province, Zimbabwe, "alcohol and substance abuse are often found in survivors of organized violence. This is frequently a form of self-medication."[52]

In Mozambique, between 1992 and 1996, 1.7 million Mozambican refugees returned from six neighbouring States: Malawi, South Africa, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe. The internally displaced persons number at least twice as many and are also believed to have returned to their homes.[53] By the end of 1994, it is believed that more than 90 per cent of Mozambique's refugees had returned home.[54]

Several war-related causes of psychological trauma hold particular relevance to a discussion of drug use: torture,

sustained exposure to violence and frequent military actions, and the disappearance of family members and friends. It is estimated that about 30 per cent of refugees have suffered some form of repressive violence or torture.[55] And yet, based on surveys of refugees, most survivors of organized violence do not receive treatment and only rarely are their illnesses detected. In the Mozambican refugee camps in Zimbabwe, for example, 60 per cent of refugees had a clinically severe psychological disorder, with 25 per cent of this group reporting some experience with violence.[56] Research on Mozambican children refugees has shown that 77 per cent of the children have witnessed murder and 51 per cent have been abused or tortured.[57] The disappearance of family members is particularly significant in view of religious beliefs regarding the importance of proper burial rites. When the dead are not or cannot be properly buried, some religious beliefs leave the family in the expectation of future misfortune. For many Mozambican refugees in Zimbabwe, concern that they had not had the chance to bury war dead properly when they fled into exile was a never-ending source of anxiety.

In South Africa, the number of internally displaced is about 4 million, though this number includes those relocated over a period of 30 years. In South Africa, refugees and political exiles began to return after the lifting of the ban on political organizations in February 1990. The Government announced guidelines for the return of exiles in November of that year. The initial procedures were criticized by political organizations and exiles because they required returnees to apply for pardon or immunity by filling in questionnaires requesting information on "offences" committed. UNHCR was requested to intervene in March 1991 and was ultimately entrusted with the task of organizing the repatriation operation. The Government decided to grant amnesty for political offences committed before 8 October 1990. Individuals granted indemnity could return without risk of arrest, detention, imprisonment or legal proceedings for such offences. Resettlement assistance was provided in the form of cash grants to returnees, including those who had arrived before the UNHCR involvement. By May 1993, nearly 11,000 South African refugees and exiles had registered for voluntary repatriation and the Government cleared nearly all of them. The international donor community provided $27 million through UNHCR to finance the repatriation.[58]

Dr. Lee Rocha-Silva of South Africa's Human Sciences Research Council has found that the two prominent reasons for using illicit drugs in South Africa are "mood changing" and "coping" with difficulties or hardships.[59] As pointed out above, there are essentially two types of hardships the war refugees or displaced must deal with, practical and psychological. To illustrate a practical issue, one of the pressures on returnees arises from the difficulty in finding housing. A study undertaken by J. Cock in 1993 found that only 11 per cent of returnees surveyed were living with their families and only 7 per cent were "happy with their living arrangements".[60] Obviously, lack of financial means is the key restraint to locating adequate housing. As a result, many are forced to move in with relatives or friends, or informal settlements. Of those who had found formal housing in the above survey, two thirds depended on family or friends for their accommodation, thus giving rise to tensions regarding overcrowding, confused lines of authority and financial responsibility. The survey in Pretoria observed the following:[61]

> "The impact of all these problems (i. e., lack of privacy, dependency on families, subordination to the authority of families, the loss of personal power, and the loss of status etc.) is that they lead to depression, and even personal deviance such as drinking and gambling."

Psychological assistance and drug abuse prevention are particularly difficult in post conflict situations considering that, according to the Amani Trust, a common consequence of war is a sustained climate of fear and silence in group situations. The "group silence" is a significant impediment to drug control efforts because a precondition for effective abuse prevention is an open, social discourse on the risks of abuse.

The need to break through this silence is widely recognized. In Zimbabwe, the national research team recommended an "increase in the awareness of the community on illicit drugs and the consequences of using them or dealing them so that those at risk can be deferred".[62] In South Africa, the national research team also concluded that one key element in primary prevention efforts must include "community-based information/ education programmes (at schools and other service agencies) to demystify beliefs concerning the `benefits'of drug taking".[63]

Another important cause for psychosocial instability is the difficulty experienced by women, who with children make up the majority of refugee and war-displaced civilians. ILO conducted a study in 1996 on the psychological problems experienced by ex-combatants, with a focus on gender differences.[64] It found that among the returnee population in Mozambique, over one third of women reported serious problems in family relationships (including financial stress and personal problems with partners or children), compared with only one fifth of men. At least 30 per cent of the women had failed to celebrate the traditional and crucial purification and reintegration rites that must be observed by the entire family at the place of origin – only 17 per cent of the men were still waiting to carry out this important step in the return to post-war life.

Much debate centres around post-traumatic stress disorder (PTSD), a term that is used to describe the onset of certain psychological problems resulting from a traumatic experience such as exposure to war-related violence. Some of the main symptoms of PTSD are the persistent reliving of the initial trauma; heightened arousal, as evidenced by difficulty falling or staying asleep; irritability or outbursts of anger; and an exaggerated startle response. The Epidemiological Catchment Area Survey undertaken in the United States in 1987 estimated lifetime prevalence of PTSD at about 1.3 per cent in the general population, but 3.5 per cent of those exposed to civilian or military violence; a rate of 20 per cent was found for Viet Nam veterans in the United States.[65] The National Viet Nam Veterans Readjustment Study reported lifetime prevalence

rates of 30.9 per cent for males and 17.5 per cent for females. For those exposed to high levels of war-related violence, prevalence reached 38.5 per cent for men and 17.5 per cent for women. Based on the 1995 study undertaken in the Mount Darwin District of Mashonaland Central Province, Zimbabwe, the prevalence of alcohol use was far higher among the survivors of torture and political violence (16.8 per cent) than among others with psychological illnesses (6.3 per cent).[66]

Given the prominent role played by women as the main household earner, it is thus especially significant when women experience acute forms of PTSD and again when they seek to remedy their ills through alcohol or illicit drug use. In Mozambique, the 1996 ILO study referred to above found that although men scored higher in terms of traumatic war-related experiences, it was the women who appeared more susceptible to moderate or severe cases of PTSD. This could be due to the reluctance of the men interviewed to admit to having psychological problems or their proclivity to maintain a hard exterior, but it could also be due to the higher degree of social isolation of women in urban areas, 85 per cent of whom live away from areas of origin, many with no family support. What this implies is that once basic survival requirements can be seen to, post-conflict reconstruction efforts would do well to target psychological needs, not least those of female-headed households. The ILO report on post-conflict Mozambique suggests, in particular, the establishment of gender-specific psychotherapy groups for demobilized soldiers, the setting up of self-help groups and more detailed research into traditional healing processes, their accessibility to men and women, and the possibility of local community support for such activities.[67]

3. Steps forward

The aim of this section has been to identify certain conflict-related trends that could prove to be significant in the context of illicit drugs, dynamics that could, if handled improperly or insufficiently, stimulate drug abuse and/or trafficking. The possible involvement of ex-combatants in drug trafficking and the resort to drug abuse by war-displaced civilians are relatively sensitive issues. The point should be reiterated that little evidence linking post-conflict recovery and drug abuse is available to date. The mental health status of refugees has been relatively neglected from a research standpoint, perhaps with some justification as the emphasis has been placed on the provision of material aid to mitigate the most pronounced and immediate physical problems. Of course, when resources are limited, aid objectives must be prioritized, meaning that food, basic shelter and other material assistance will most likely be provided first. However, organizations at both the national and international levels are beginning to consider that mental health issues should be addressed as soon as basic survival needs are adequately met. Increasingly, attention is being focused on the psychological health of war-affected civilians, seen as part of the continuum to recovery, which begins with physical stabilization. There is today greater recognition that physical and mental health cannot be disassociated, that they are interdependent.

Future research on the subject of drug abuse and post-conflict recovery should be careful to avoid stigmatizing these individuals, who, more than ever, need the help of national agencies and the international community. In other words, by identifying a potential cause for increases in Africa's illicit drug problem, this discussion is meant to emphasize the need for preventive action in the form of greater economic and psychological assistance to vulnerable groups, including former combatants and war-displaced civilians.

Although there may be more acceptance of the need for mental health assistance, drug abuse prevention in particular may be more difficult to implement in the extremely harsh conditions of, for example, a refugee camp. Considering the situation, drug abuse may not seem an urgent matter to organizations assisting the refugee population. But it is nonetheless clear that ultimately the individual abuser's prospects for full recovery are harmed by his or her dependence on drugs. Improved information on all drug-related problems will aid national agencies and international organizations to design comprehensive programmes for the economic stability, physical and mental health of beneficiaries.

E. POLITICAL FACTORS IN INTERNATIONAL DRUG CONTROL

Much of this chapter has looked at the major actors who have a role to play in drug control activities in sub-Saharan Africa: the State, civil society and particularly vulnerable groups therein. What it has not done hitherto is to consider the institutional context in which those actors must play their respective roles, the international frameworks, the regional forums, the laws, all of which have a bearing on the central axis for drug control, the relationship between State and society. Political change – at the country, regional, and global levels – gives rise to institutional changes of both direct and indirect relevance to drug control matters. This final part of the chapter considers these changes with a view to gauging their impact on the development and implementation of drug policy in sub-Saharan Africa.

1. Political change and institutions

In order for African countries to design and implement effective drug control programmes and thoroughly comply with international agreements, a substantive connection must exist between those agreements and the interests of each country's leadership and public. Although issues of non or partial compliance are often solely a question of lack of resources, other factors, such as historical relationships, can influence the actions of African Governments in making and meeting agreements as well as the willingness of civil society to contribute to international plans of action.

"International cooperation" on drug issues denotes myriad bilateral agreements such as extradition treaties, memorandums of understanding and multi-faceted regional agreements, in addition to international

conventions. At the global level, the international drug control conventions represent the most important legal institutions in drug control. Of the 53 countries in Africa, 43 are parties to the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol; 41 States are parties to the 1971 Convention on Psychotropic Substances; and 37 are parties to the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. Of the 10 countries included in this study, all are parties to the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol. All but Kenya are parties to the Convention on Psychotropic Substances of 1971. And all have either ratified or acceded to the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. According to the Organization of African Unity (OAU), "some countries have amended their domestic drug laws to be consistent with the provisions of these treaties. However many still need to adopt legislation on money-laundering and precursor control, as well as to adhere to their reporting obligations".[68]

At the regional level, recent years have witnessed the consolidation of important regional forums and organizations committed to tackling the drug problem through regional cooperation. Porous borders are often cited as major impediments to drug control (even in the richest most developed countries of the world) making regional cooperation imperative. The OAU signed a Memorandum of Understanding in 1994 with UNDCP to increase cooperation, provide for the exchange of information and expertise, provide the OAU with drug control reference materials and participate jointly in a number of drug control-related events and specific projects. Other projects have been developed with the Economic Community of Central African States, the Economic Community of West African States (ECOWAS) and with the Southern African Development Community (SADC).[69]

Among the member States of ECOWAS, cooperation is important due to the fact that travelling is facilitated by ECOWAS agreements, increasing transportation across borders. The Observatoire Géopolitique des Drogues has observed that the names and prices of drugs are suspiciously similar and that some drug traffickers even take advantage of slight price differences between countries by buying in one to sell in the neighbouring country.[70] This suggests a unity within the ECOWAS drug market that should be countered by tighter border controls and regional cooperation. ECOWAS is commended for adopting a political declaration and a plan of action for the period 1997 – 2001. This is a necessary beginning to tackling problems of cross-border traffic that even the most powerful nations find intractable.

The greatest potential for regional cooperation is developing in southern Africa. In that region, sophisticated routes have developed over decades for smuggling contraband (weapons, stolen vehicles, endangered species articles), which increasingly includes illicit drugs either produced domestically or imported from Asia. With the opening up of South Africa during the transition to majority rule, the resumption of transportation to the coast in Mozambique and the relative quality of transportation infrastructure in Zimbabwe, the increasing cross-border drug trade makes regional cooperation imperative.

The Government of South Africa has taken significant steps, including posting drug liaison officials in countries from which it receives illicit narcotics – its immediate neighbours as well as Brazil, India, Pakistan and Thailand. In 1995, SADC held a conference on cross-border trafficking. A protocol was ratified in 1996 to combat illicit drug trafficking and SADC States are considering an action plan.[71] All of these efforts have constituted the beginning of a key process of building regional cooperation but are not in and of themselves adequate to contain the growing problems of drug production, consumption and trafficking in Africa.

At the country level, the above processes of institutional consolidation at the global and regional levels have both triggered and been sustained by important institutional developments within each of the countries examined in this study. In this regard, one of the most tangible manifestations of the impact of political change on state capacity in drug control matters is reflected in legal and institutional reform that is undertaken in full view of the models shaped at the global and regional levels. A few encouraging examples are now provided as a means to cite how institutional vulnerabilities that apply to many of the countries included in this study are being addressed.

Cameroon, for example, is among those countries which have in recent years undertaken a major review of their legal instruments for drug control. The new law on licit and illicit drugs in Cameroon (97/109) defines cannabis, cocaine and heroin as illicit drugs of high risk. It distinguishes between possession of small quantities for personal use and trafficking in commercial quantities. The former carries sentences of one month to one year, and fines of CFA 25,000 – 500,000. The latter carries sentences of 10 to 20 years and commensurately larger fines.

This distinction is unusual in narcotics legislation in Africa and is absent, for example, from Ghana's Narcotics Drugs Law: PNDC Law 236 of 1990. The NCB in Ghana reviews Law 236 and proposes amendments. Current proposals (detailed in NCB, 1997) include a review of sentencing provisions to differentiate categories of offences and their relative gravity. The tenor of NCB's proposals, however, is to remove opportunities for "leniency" by the courts; to address anomalies, such as those found in the levels of fines specified in 1990, which have subsequently been overtaken by high rates of inflation; and to close perceived loopholes in the law, such as the seizure of assets of those convicted. In short, the NCB aim is to achieve more consistent enforcement of the law and a higher rate of conviction. NCB is also concerned to improve detection of money laundering, following the example of Nigeria's Money Laundering Decree No. 3 of 1995.

New legislation was implemented in Kenya during 1994 with the promulgation of the Narcotic Drug and Psychotic Substances (Control) Act. Under the terms of the act penalties for drug offences were greatly strengthened (life

imprisonment and fines of up to 1 million Kenyan shillings, or three times the value of drugs seized, whichever is found to be greater), and the courts were given powers to seize the property of convicts. In addition, the act provided for the establishment of treatment and rehabilitation centres, fostered international cooperation on drug cases and set up an advisory council to oversee aspects of drug policy. As part of this package of measures, the Government created an Anti-Narcotics Unit within the Criminal Investigation Directorate. Officers from this unit work with customs officials at all international port of entry and also investigate cases throughout the country.

Other countries have been slower to revise legislation in response to the evolving character of the drug problem. Current legislation in Ethiopia, for example, dates from 1948 and is a blunt instrument with which to tackle currently emerging problems. The law treats all illegal drugs as equivalent and rules only in terms of simple possession. The National Drug Policy promulgated in 1993 indicates how the Department of Health should administer particular drugs, but there is no clear organizational structure within Government for the formulation of policy on drug-related issues. Three bodies currently overlap: the Narcotic and Psychotropic Drug Control Unit, under the Ministry of Health, fulfils a supervisory role over medical drugs and carries out educational and publicity functions; the Counter-Narcotics Division of the police is responsible for enforcement of drugs laws within the country; and the Customs Department deals with the trafficking of drugs through ports of entry.[72] Cooperation between these groups on the ground appeared good, although all three bodies are understaffed and under-resourced.

At a higher political level, plans are in progress to create a working committee in Ethiopia to coordinate the activities of the various ministries with an interest in drug-related matters, but it was reported that there has been dispute over which ministry should lead this group. One of its duties is to review the statutory instruments governing illicit drugs.

A similar cross-ministerial structure has been created in Zimbabwe, as recommended by the committee that drafted the 1992 National Policy on Alcohol and Drug Abuse. The committee recognized the need for better coordination to generate effective programmes for demand reduction and supply reduction and proposed the formation of a Drug and Alcohol Commission, with representation from no fewer than 12 government Ministries, all interested NGOs, the Employers Confederation and the Zimbabwe Congress of Trade Unions. This body is to be financed from a special fund, drawing upon contributions from government and non-government sources. The Commission is launching efforts to implement the impressively broad programme set out in the National Policy document.

Anti-narcotics laws also establish agencies responsible for directing and coordinating supply (and in some cases demand) reduction activities: SANAB (South Africa), NDLEA (Nigeria), NCB (Ghana) and the Counter-Narcotics Unit in Ethiopia, which work with other state service organizations like the police (and in some cases the military), immigration, customs, the judiciary and prisons. The capacities and effectiveness of these bodies are, of course, the crucial variables that determine the extent to which legal provision is translated into enforcement performance.

2. Institutional constraints

The international drug control conventions and the regional organizations active in African drug control matters have provided a broad normative basis for institutional consolidation at the country level. But as discussed below, international influence can act in ways not so conducive to drug control progress at the country level. It is necessary to acknowledge that no matter how strong institutions at the international and regional levels may be, the viability of international drug control in Africa will depend primarily on institutional capacity at the country level.

Local communities are unlikely to cooperate in drug control efforts when only negative penalties are perceived to be the consequence of cooperation. Public information in Africa has not succeeded in addressing the benefits that accrue from drug control cooperation. At present, the negative results – reduction in rural income, imprisonment of community members – are widely recognized by the communities whose involvement in drug control is nothing less than essential, but the positive results are not.

Particularly harmful to international cooperation is the perception that the rise in domestic consumption is due in no small part to behaviours and values that have been "imported" from the industrialized North. In Kenya, 269 out of 330 respondents questioned for this study about the future of drug abuse in their country expressed the view that the problem was likely to worsen, with one of the most prominent causes cited as "Western" lifestyles. Such sentiments were common in many of the surveys undertaken for this study – in South Africa, "an influx of foreigners" was cited as one of the likely major causes of an escalation of the country's drug problems. Such views indicate not necessarily that the State-civil society relationship is weak, as described earlier, but, equally cause for concern, that there is widespread attribution of Africa's drug-related problems to causes found at the international level. Such perceptions are not altogether unfounded. More importantly, however, they demonstrate the legacy of failure to effectively define international drug control in terms of the interests of African society, as well as the legacy of decades in which the welfare of African countries has deteriorated alongside the relative advance toward prosperity of the rest of the world.

While the countries of this study have had vastly different experiences of colonialism, the economic, social and psychological legacies of these systems continue to have repercussions affecting the implementation of drug control legislation. As discussed in chapter II, the economic dependence on cocoa in Côte d'Ivoire, institutionalized during the colonial era, has left farmers destitute and searching for alternative crops. In Mozambique, colonial dispossession followed by two ravaging wars have resulted in a country where there is today little remnant of past traditions of civil organization independent of the ruling hierarchies. The colonial powers of Mozambique

suppressed the emergence of independent African organizations, banning trade unions, viewing grassroots efforts as inherently subversive. After independence, civil society continued to be dominated and controlled, with all potential opposition groups banned and, in their place, "organizations of the masses" created that were supposed to represent all interests and social groups: the Mozambican Workers' Organization, the Mozambican Women's Organization, and the Mozambican Youth Organization. Under the first national constitution, there was no legal room to create independent, civic organizations. While in recent years there has been an upsurge in the formation of such organizations, this process of grass-roots build-up will take time.

Combined with the colonial legacy, the perception that external powers have made their lives no better may figure prominently in the collective will to act against the illicit drug activities that may economically benefit their societies at the expense of other parts of the world. For many in African civil society, the cold war represented a period of unfettered concentration of power in the hands of political elites who were supported at any and all costs by external powers as long as they maintained the correct ideological posture. The pursuance of strategic goals of yesteryear has thus made the task of meeting tomorrow's strategic challenges – of which drug control is arguably one– all the more difficult. This century has, in this regard, represented an anomalous period in African political history, for it has proved in many parts of the continent to be a relentless concentration of political power in the hands of an elite few. Africa's distant past was different, characterized by extensive accountability of rulers to their followers, underpinned by a deep "distrust of the executive capacity as being all too able to upset the acquired balance with nature, or with society".[73] Basil Davidson writes:[74]

> "A well-built polity had to be a participatory polity. No participation had to mean no stability. In traditional Africa, this concept of an indispensable participation formed the hearth-stone of statesmanship. Standing on that, power would prosper, but not otherwise. . . The point here is a general one. These pre-colonial societies, or those that endured for centuries and were successful in mastering their historical processes and about which we consequently know a good deal, were centrally concerned in securing and sustaining their legitimacy in the eyes of their people. They endured because they were accepted. And they were accepted because their rules of operation were found to be sufficiently reasonable in providing explanation, and sufficiently persuasive in extracting obedience. What this says, in tremendous contrast with times during and after colonialism, is that these communities achieved an accountability of rulers to rule and, quite persistently, the other way around as well. Dissidence and protest might be frequent. The structures of accountability could well enough absorb them."

This century, however, has seen this accountability in some cases displaced or altogether eliminated. In many countries, the centralization of political power in a single entity was seen as a sine qua non for ensuring that society was shielded from ideological adversaries. Political entities such as KANU in Kenya, FRELIMO in Mozambique and ZANU in Zimbabwe were seen by external powers as key partners in a global ideological conflict, and in some contexts the problems of governance today are due in part to the difficulty in breaking from this past. It is those segments who today are the most vulnerable to the lure of illicit drug activity whose cooperation is essential for drug control progress.

The end of the cold war has left African countries in the unfamiliar position of having few foreign countries with an ostensible strategic interest in their ideological orientation. This dramatic shift in the global strategic environment has seen unquestioned international support for particular Governments replaced with heightened scrutiny into the conduct of the African State. The overarching criteria for external assistance is no longer ideological correctness but, seemingly, respect for human rights and individual liberties, democracy and free markets.[75]

During the 1980s, economic stagnation compelled many African Governments to turn to the Bretton Woods institutions for lending support; it was during this period that the International Monetary Fund (IMF) and the World Bank vastly increased their influence, as 36 of 47 countries in sub-Saharan Africa had by the end of the decade launched structural adjustment programmes.[76] Recent press reports of controversies involving the World Bank and IMF arrangement with the Governments of Kenya and Zimbabwe reinforce the impression that these institutions wield considerable influence in sub-Saharan Africa.[77] In Kenya, it was the decision of the country's major donors at Kenya's Consultative Group Meeting in November 1990 to withhold $1 billion worth of aid to the country for six months, and the subsequent criticism by the same group of the Government of Kenya in 1991 that many cite as important influences on KANU's decision to repeal the reference to the one-party State in the Constitution and to hold multi-party elections in 1992.[78]

Many African leaders and citizens perceive the conditions placed on loans and aid as interference in their sovereign affairs. The conditionalities are seen as a statement that Africans must be taught or forced to become democratic.[79] This view has bred considerable resentment, given the fact that traditional, pre-colonial African communities had many democratic aspects.[80] In addition, there is the widespread belief that the problems now faced in the social and economic sectors are due in no small part to the hardships that result from pressures resulting from structural reforms recommended by the Bretton Woods institutions.[81] The average civilian is most likely not well-versed in the intricacies of structural adjustment programmes or austerity measures and feels the emotional need to identify a scapegoat, to attribute the present level of economic misery to someone, be it the Government or IMF in many cases. In order to connect the international prioritization of drug control with popular support to join the campaign, there has to be a willingness to do so within that country's population and the Government. However, the perception that those external powers have made life no

better for African societies, combined with the view that drug production or trade economically benefits one's community, may generate a reluctance to act against illicit drug activities. It is these types of beliefs that need to be countered by educational campaigns on drug control benefits for society. There are some promising signs in certain countries, in particular.

Many southern African countries are beginning to recognize that drug trafficking threatens their societies – an important first step for addressing the problem. They realize that more and more of the drugs entering their region are for local consumption, not just transhipment to remote markets. They are beginning to get a sense of the ties between drug abuse and trafficking and increased violent crime, robbery and general lawlessness.[82]

F. CONCLUSION

An analogy with the global spread of disease may bring into relief the main focuses of this chapter. Earlier this century, in certain countries of the world, particular diseases when imported by foreign elements eliminated huge portions of the local population due to the absence of any indigenous resistance. The rapid and devastating spread of illnesses such as smallpox was due not only to the virulence of the diseases per se but also to the difficulty in identifying the required remedies; in the case of smallpox, once the response was developed the problem was globally eradicated.

The parallel with drugs is the following: sub-Saharan Africa is vulnerable to illicit drugs not because of some particularly pronounced proclivity to engage in illicit drug activity, but because the safeguards that could conceivably protect African societies from illicit drug problems are rarely in evidence. Chief among those safeguards is a healthy relationship between State and civil society; one could go so far as to assert that in few other major regions of the world is the State-civil society relationship in such disarray. The current state of affairs in this regard does not augur well, for the previous chapters of this study have described a scenario in which economic and social factors are likely to put upward pressure on illicit drug activity.

Indeed, inasmuch as the economic and social factors that exacerbate the illicit drug phenomenon can help us to understand the future of drugs in Africa, they are no more significant than the political factors that influence the ability of government to play its role as the arbiter of law and order. Only by assessing both the problem and the potential for an adequate response can one gauge the real magnitude of the threat at hand.

While Ghana suffers from many of the economic and social problems experienced by other countries in sub-Saharan Africa, it seems to have compensated for a historic alienation of the State with an intensification of outreach efforts to local political organizations. Despite accusations, Ghana has somehow avoided the level of crime and seeming lawlessness that today plague other countries of the region.

Violent crime is relatively rare in the urban centre of Accra. Drug use, while slowly on the rise, has yet to become endemic, particularly as regards cocaine and heroin.

In those countries where this type of State-civil society interplay is absent, or conversely, where the "delink" between State and society is complete, the signs of vulnerability to illicit drug production, trafficking and abuse are plentiful. In South Africa, the drug trade has surged most rapidly in those areas historically deprived or disenfranchized by the State – the thriving barter trade involving the exchange of drugs for weapons, ivory and gemstones raises important questions about the robustness of illegal markets in contexts where both supply and demand for illegal goods and services and resentment toward state structures thrive. Such scenarios shed light on the potential virulence of illegal market activities in the absence of credible state institutions.

In order to prevent the nascent drug problem in Africa from becoming an epidemic, it is clear that first and foremost the underlying causes in the economic and social fields, addressed in previous chapters, must be defused or mitigated: the analysis that began in earlier chapters of this study thus comes full circle. That said, however, parallel efforts in state building, particularly in the reform of state institutions, would go far toward nurturing a more robust capability to contain the illicit drug problem. Despite the simplicity of this admittedly banal conclusion, it must be stated that African Governments in many cases have yet to fully embrace its logic. Indeed corruption and the stop-and-go process of democratization evident throughout the continent suggest that, in the medium term, the African State will continue to suffer a credibility problem in the eyes of civil society. And all the while, drug traffickers and the wealthy purveyors of criminal activity will have freedom to bring vulnerable communities under their influence, similar to what has happened in other parts of the world where the State has been eclipsed by criminal forces that are responding, in their own opportunistic way, to the needs of the community.

This latter phenomenon – of lucrative criminal organizations seizing upon the needs of vulnerable groups in society – reintroduces the fundamental concept that drug control must be seen from a broader operational and policy perspective that is not limited to those in the field of drug control. Experience in other parts of the world suggests that, when organized crime and drug trafficking emerge at the early stages of democratization, subsequently extracting the criminal elements from the political process becomes extremely difficult. It is in this light that those involved in the state-building process in Africa need to come to terms with what is likely to continue to grow as a powerful influence and restraint on the democratization process. One proposal that logically follows from the above is that international efforts at state-building must devote more attention to civilian policing and the rule of law. At present there is debate on whether and how the policy horizon in the area of peace- building and peacekeeping can be expanded from purely military approaches to operational, civilian support in areas such as policing and judicial process. The above analysis would suggest that this debate, and the actions resulting therefrom, are nothing less than crucial.

Notes

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2 See, for example, Sandbrook, R.1993. *The Politics of Africa's Economic Recovery*. Cambridge, Cambridge University Press.

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7 Ayee, Joseph R. A.1996. "The Measurement of Decentralization: The Ghanaian Experience, 1988 – 1992" *African Affairs*, No 95. Tordoff, William. 1994. "Decentralization: Comparative Experience in Commonwealth Africa", *Journal of Modern African Studies*, vol. 32, No. 4.Crook, Richard C.1994. "Four Years of the Ghana District Assemblies in Operation: Decentralisation, Democratisation and Administrative Performance" *Public Administration and Development*, vol. 14.

8 See Lyons, Terrence. 1997. "Ghana's Encouraging Elections: A Major Step Forward", *Journal of Democracy,* vol. 8, No.2, April. and Gyimah-Boadi, E.1997. "Ghana's Encouraging Elections: The Challenges Ahead," *Journal of Democracy*, vol. 8, No.2, April 1997, p. 78.

9 International Narcotics Control Strategy Report, 1998. US Department of State, Bureau of International Narcotics and Law enforcement Affairs, p. 478.

10 Interviews with Counter-Narcotics Unit officers, Addis Ababa, February 1998.

11 It is recognized that the term "civil society" is controversial and complex. The meaning used in this section is that of Chabal (Chabal, P. 1986. *Political Dimensions in Africa– Reflections on the Limits of Power*. Cambridge: Cambridge University Press. p. 15): "What is not of the state becomes civil society. So that civil society, in so far as it can be defined, consists not just of what is obviously not part of the state but also of all who may have become powerless or disenfranchised; not just villagers, fishermen, nomads, members of different age groups, village councillors, or slum dwellers, but also professionals, politicians, priests and mullahs, intellectuals, military officers and all others who are, or feel they are, without access to the state. Civil society is a vast ensemble of constantly changing groups and individuals whose only common ground is their being outside the state."

12 Mabogunje, A.1995. "Institutional Radicalisation, Local Governance and the Democratic Process in Nigeria," *Governance and Democratisation in Nigeria* edited by Dele Olowu, Kayode Soremekun, and Adebayo Williams. Ibadan, Spectrum, p. 3.

13 Heerden, T. J. Van., *Introduction to Police Science*, Pretoria, University of South Africa, 1986. p. 131.

14 UNDCPCountry Report, Nigeria. February 1998, p. 26.

15 Nwankwo, Clement, Dulue Mbachu and Basil Ugochukwu. 1993. *Human Rights Practices in the Nigerian Police*, Constitutional Rights Project. Lagos, Constitutional Rights Project, p.80.

16 Interview with drug dealers in Accra, 24 – 26 February 1998. See *Street children in Accra, sexual behaviour factors and HIV/AIDS*, by John K.Anarfi in collaboration with Salvation Army Medical/Social Services Department, for Catholic Action for Street Children, Accra 1996.

17 Interview with commercial sex workers in Yaounde, 10 February 1998.

18 Le Pape, M.1997. *L'énergie sociale à Abidjan, économie politique de la ville en Afrique noire, 1930 – 1995*. Paris, Karthala.

19 Ibid., pp. 98 – 101.

20 National research team (Zimbabwe) report, p. 46.

21 National research team (Ethiopia) report, pp. 54and 55.

22 Recall that in chapter II, "weak policing" was cited as one of the top reasons for the expected worsening of drug trends in the country.

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24 "Jihad vs. Junkies", *Finance Week*, 15 – 21August 1996.

25 13 November 1998 interview with various Cape Flats community leaders.

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27 February 1998 interviews with NDLEAauthorities and law enforcement officials based at embassies in Lagos.

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29 *The Guardian* (Lagos), 21 January, 1998.

30 Kenya Police statistics appended in part to the Kenya national report, reported in part in Mwenesi (1995).

31 Figures supplied by Counter-Narcotics Unit.

32 Figures reported in the Zimbabwe national report.

33 These points were made quite explicitly in interviews by the police at Shashamene, Ethiopia, in February 1998.

34 Farmer interviews, Shashamene, Ethiopia, February 1998.

35 Interviews conducted with prisoners in Addis Ababa Central Prison, February 1998.

36 November 1997 interview with Dr. A. P. Reeler, Amani Trust, Harare Zimbabwe.

37 Rotberg, Robert I.1998. *War and Peace in Southern Africa: Crime, Drugs, Armies and Trade.* eds. Rotberg, Robert I. and Greg Mills. Washington, D.C., Brookings Institution Press.

38 International Labour Office. 1997. *"The Reintegration of War-Affected Youth: The Experience of Mozambique,"* August 1997, p. 6, citing discussions with Julio Joaquim Nimuire, President of AMODEG, 4 December 1996.

39 United Nations Institute for Disarmament Research. 1996. *Managing Arms in Peace Processes: Mozambique*. Geneva: United Nations Institute for Disarmament Research, p. 87.

40 Waterhouse, Rachel. 1997. *An Oxfam Country Profile: Mozambique: Rising from the Ashes.* Oxford, Oxfam, p. 17.

41 Cock, Jacklyn. 1996. "The link between security and development: The problem of light weapons proliferation in Southern Africa*," Africa Security Review*, Vol. 5, No. 5, pp. 15 and 16.

42 International Labour Office. 1997, *op. cit*., p. 29.

[43] *SIPRI Yearbook 1996.* 1996.Oxford, Oxford University Press, p. 350.
[44] Pretoria Returnees Project Committee and Human Sciences Research Council. 1994. *Together Let's Move Forward: Pretoria Returnees Needs Assessment.* Pretoria: Pretoria Returnees Project Committee and Human Sciences Research Council, p. 10.
[45] Oosthuysen, Glenn. 1996. *Small arms proliferation and control in Southern Africa*. Braamfontein, SA, South African Institute of International Affairs. p. 7.
[46] Ibid., p.6.
[47] See UNHCR, *The State of the World's Refugees 1997– 1998: A Humanitarian Agenda*, Oxford, Oxford University Press, 1998.
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CHAPTER VI

RECOMMENDATIONS

The preceding chapters of this study included observations and, in some cases, provided implicit recommendations that derived therefrom. This concluding chapter distils the policy-relevant material and presents it in a more explicit manner with a view to launching and shaping a long-overdue policy dialogue between practitioners in the fields of development and drug control. This study also serves as a basis for the UNDCPProgramme for Africa, which will take into account the findings and recommendations of this study.

In the following pages, various sectoral recommendations have been grouped into categories; these recommendations represent general policy guidelines that apply to a cross-section of the countries included in the study. After the sectoral recommendations, the subsequent section, entitled "Regional priority agenda", provides a streamlined action agenda, specifically highlighting the need for prioritization in the development and implementation of drug policy in sub-Saharan Africa. This regional priority agenda singles out particular countries for specific pilot initiatives.

The recommendations should be seen against the backdrop of a myriad of ongoing regional and international drug control policy developments. In July 1996, an OAU summit in Yaoundé adopted a Declaration and Plan of Action on Drug Abuse and Illicit Trafficking Control in Africa for the Period 1997 – 2001. Most recently, OAU States agreed on a Common Position on Drug Control at the ministerial meeting from 13 to18 April 1998.

Following a 1996 summit meeting in Abuja, ECOWAS held its third ministerial meeting in Praia, Cape Verde, in May 1997, where the ECOWAS Regional Plan of Action Against the Abuse and Illicit Traffic of Drugs and Psychotropic Substances in West Africa for 1997 – 2001 was adopted. The plan covers law enforcement measures such as laboratory development and the creation of centralized operational drug enforcement units and also assigns responsibility for implementation, coordination and mobilization of funds at both the regional and national levels.

SADC has in recent years launched a major planning initiative aimed at strengthening regional cooperation in drug control matters. In November 1995, SADC States met in Mmabatho, South Africa, and drafted a protocol on tackling the region's drug problems (SADC Protocol on Combating Illicit Drugs in the Southern Africa Development Community); the ratification process is expected to be concluded some time in early 1999. A programme to implement the protocol's recommendations was developed by the SADC secretariat and approved by the SADC Council of Ministers at a meeting in September 1998 in Mauritius.

A. SECTORAL RECOMMENDATIONS

1. Policy and institutional development

At present, many Governments in sub-Saharan Africa view drug control, in practice if not rhetoric, as a medium to low priority. This reality does not necessarily suggest neglect on the part of Governments – rather it reflects the extent to which many countries are confronted with a host of unmet resource-intensive needs. In a situation of limited resources – in some cases dwindling resources that are due to shrinking foreign aid budgets in other parts of the world – African Governments are fully justified in attaching less than top priority to drug control needs. But all the while, the drug problems that go unaddressed continue to increase in size and severity. The international donor community must in this light bear a greater burden of financing drug control activities in sub-Saharan Africa. One means to facilitate more support in the area of drug control is to define more effectively the drug problem in terms of what are in fact the top priorities of the countries concerned. Without a sufficient redefining of drug control in terms of economic, social and political development, and without ample international support for the implementation of policy, it is inevitable that the nascent drug problem in Africa will – probably in the next decade – grow to the point of crisis.

2. Legal development, rule of law and governance

So-called "rule of law assistance" must be seen and addressed as a key component of the drug control agenda in Africa. Where possible, donors supporting drug control

and Governments themselves should endeavour to strengthen the judicial system, laws and institutions not only in the interest of enforcing drug control laws but in the interest of supporting respect for the rule of law, thus deterring drug-related crime among the majority of citizens.

In terms of legislative development, rule of law assistance in the context of drug control should focus on how to establish or reinforce the independence of the legislature, particularly from the executive branch, as well as how to avoid local interference for political purposes in the introduction of draft laws.

Existing legislation in many countries does not distinguish between type of drugs or amount seized which results in unduly harsh penalties, further undermining the credibility of state legal institutions. The current practice should be reviewed, with the aim of assessing needs for more nuanced laws that distinguish between types of crime committed (possession vs. distribution), drugs (cannabis vs. cocaine) and quantities at hand. OAU members have, in a common position taken at Pretoria in April 1998, urged those members who have not already done so to legislate alternatives to incarceration for some categories of non-violent, first-time drug offenders who agree to undergo counselling and/or treatment for their drug dependencies.[1]

In terms of the application of law, controls need to be introduced to ensure the independence of the judiciary. The problem of state credibility in legal matters often comes down to selective application of the law, particularly as regards the relationship between those arrested and high-level state officials.

Responsibility for and oversight of seized drugs must be given to offices that can ensure that the drugs are handled properly (i. e. that they do not disappear). The disappearance of seized drugs, in addition to the acquittal of presumed major traffickers, has become one of the most profound influences on public opinion regarding the credibility of drug control institutions in sub-Saharan Africa. Penalties for lax oversight need to be developed and rigorously imposed. Accountability for seized drugs needs to be established more clearly.

3. National law enforcement structures and capacities

In the context of low-income countries, monitoring of drugs is problematic. This is because of the fragmentation of economic transactions. The rural sector is mainly small-scale and a large portion of exchange in urban areas is carried out in small, informal markets. Many transactions go unrecorded. Drug policy should focus on areas where transactions can be monitored. The strategy should seek to restrict supply at main ports of entry; selected ports should include those of greatest importance in legitimate trade, which often acts as the facade behind which illegal trade takes place. In this regard, it is important to differentiate clearly between illicit and licit drugs; indeed, improvements in the monitoring of the licit drug trade in Africa will be necessary for more effective control of illicit drugs.

The most feasible option at present is to strengthen customs controls, with far more rigorous profiling of international air passengers and more diligent checking of passengers at the major airports. Except for a few individual cases, passenger screening is not taking place, despite the presence of law enforcement officials and the equipment required to do the job; what is missing too often is the basic information and knowledge required to do the job effectively.

Many African countries do not have money-laundering legislation. Even for some of those which have, implementation can be impeded by human resource constraints. Another problem is that model legislation is often adopted without being adapted to the immediate contours of the financial system. External assistance in this regard is needed in areas such as the training and capacity-building of banks, not least central banks.

4. Regional law enforcement cooperation measures

The most cost-effective means of strengthening customs control at international ports of entry is to improve intelligence exchange between African customs authorities and their counterparts in Europe, Asia and the Americas. There is a need for strengthened exchange within and between regional police and customs networks. Similarly, more information exchange should be promoted and operationally assisted, particularly between authorities in southern Africa and Latin America on cocaine trafficking and in east Africa and Asia on heroin trafficking and psychotropic substances.

In the same light, efforts to contain retail drug distribution should rely, rather than on search and seize modalities, on intelligence networks that involve informants familiar with the illicit drug trade and its main entrepreneurs. The South African authorities – as well as those in Ghana and Nigeria – appear to have well developed networks of key informants and their expertise could, with international support, be channelled to law enforcement programmes in other countries. The World Customs Organization has established a useful precedent with its regional intelligence liaison offices, one of which is based in Nairobi; the ICPO-Interpol regional centres, in Nairobi and Harare, are also good examples to follow elsewhere.

5. Drug abuse prevention

The abuse of glue, benzine and other substances by street children is underpinned by desperation. Those programmes currently in place to assist street children should be sensitized to the fact that drug use is both a cause and consequence of the street child's problems. The physical "benefits" of warmth and hunger relief can ultimately be offset by deeper, long-term psychological and physical complications that result from chronic glue sniffing. More information-gathering is however required to identify where this trade-off begins to veer towards overall harm done to the child – where the immediate benefits to the child become outweighed. The local community, whose support is essential, will not embrace the perceived validity

of drug control efforts that appear merely to take from the street child what little means of respite he or she may have.

This study has found that children under the influence of such substances are emboldened to commit petty crimes – often the main reason why the children, seeking to survive economically, are consuming the substances in the first place. Such crimes bring the children into conflict with the police, raising the risk of violent clashes with law enforcement officials. Public information campaigns could help in sensitizing communities to the health impact, and rise in petty crime, attributable to glue sniffing. Public opinion could help to limit glue and other substance sales to children.

Non-governmental organizations involved in assisting street children should be supported with a view to integrating substance-abuse components into their basic survival strategies. In some cities – including Harare, Nairobi and Addis Ababa – it would be cost-effective to fund or indeed establish NGOs dealing specifically with drug-addicted street children. Assistance should focus not on the provision of room and board but on vocational and recreational activities.

Given the budgetary constraints facing Governments, recognition must be made of the limits on financing the rehabilitation of drug addicts. The task of rehabilitation and prevention should be seen as a key responsibility of community-based organizations. For the most part, however, NGOs lack the capacity and professional skills to operate such services effectively. Some further steps will need to be taken to build up NGO capacity if current trends in drug use continue. While proper screening is needed to ensure that NGOs are legitimately engaged in non-governmental activities for the benefit of the community, it is vital to remove unnecessary bureaucratic obstacles in NGO registration and regulation. It is equally vital to identify reliable NGO partners in each country – possibly on a pilot basis – and to work with those partners with a view to establishing a critical mass of community-based rehabilitation organizations. The key however is twofold: to ensure that prospective NGO partners are legitimate and to allow those which are to carry on with their work, with the necessary funding. Prospective NGOs need to be more rigorously vetted as it appears that in some countries the NGO in question exists only on paper. In coming years, the drug issue will draw growing attention and resources, raising the need to ensure that NGO operators are both reliable and fully detached from the state machinery.

Traditional leaders and traditional healers must be consulted and actively involved, especially in rural areas. Drug control efforts need to penetrate those sectors of society which are alienated from the State: *a)* rural communities with farmers of cannabis; and *b)* inner city/high-density areas where there is a risk of spillover from international trafficking of hard drugs.

6. Drug abuse rehabilitation

The current practice of treating drug-dependent individuals as psychiatric patients is not efficient. The stigma attached to the latter is a powerful deterrent against many would-be rehab patients seeking assistance in the public hospitals. In many such institutions, those seeking drug counselling are required to don highly visible psychiatric patient uniforms, labelling them as mentally unstable individuals; in this context, the real question is not why more drug addicts do not seek assistance, but why as many as at present actually do, despite such powerful disincentives. Separate rehabilitation and treatment centres should be set up; NGOs that play an important role in this field should be supported. WHO and UNDCPcould together consider how best to help Governments redirect drug treatment approaches away from psychiatric wards to smaller, less institutional, community-oriented facilities.

The concentration of medical facilities in Africa's urban centres has prevented many individuals with drug-related problems in peri-urban and rural areas from getting the help they need. Outreach efforts to those outlying communities are scattered across the region, but are clearly limited by resource constraints. In the case of available resources for outreach efforts more generally, additional funding to support rural counselling assistance, specifically with regard to substance abuse-related problems, could go a long way. UNDCP and WHO should take the lead in mobilizing support in this regard. NGOs should be encouraged to get involved; drug control education and counselling activities should be integrated into primary health care programmes.

In many countries, abusers of cannabis and/or other substances make up the majority of imprisoned drug offenders. Consideration should be given as to whether imprisoning drug users is the optimal course of action, as it appears that prison conditions may in fact reinforce the vulnerabilities that gave rise to drug use. Furthermore, according to interviews with prison inmates, drugs are widely available within prison compounds and thus many of those who may not have been chronic users prior to their imprisonment turn to more regular drug use when incarcerated. Drug counselling and rehabilitation services should be established in state penal institutions.

7. Information, research and networking

In addition to seizure data, other data need to be gathered in order for a comprehensive assessment of drug trends in Africa to be pieced together. The South African Community Epidemiology Network on Drug Use, of the South African Medical Research Council, represents a pioneering effort to monitor drug trends on the basis of a broader foundation of more reliable information; models such as this deserve to be applied to other countries in sub-Saharan Africa. First and foremost, there needs to be more consistency and rigour in the collection of basic data on all aspects of illicit drug markets. The abuse of indigenous drugs, as well as alcohol and tobacco, which have a far greater health impact than other substances addressed above, needs to be understood in greater detail. Price and purity data on illicit drugs are crucial for adequate monitoring of the consumer market. Seizure statistics, while the most widely gathered type of drug control data, should be recognized for their limits in terms of serving as

an indicator of the extent of the drug problem in Africa. As elsewhere, seizure statistics can give a misleading picture of drug trends in Africa, as they are influenced as much by the availability of resources as by the true extent of drug trafficking.

The association of heroin and cocaine with foreigners was widespread in most of the countries examined. While this reflects one important aspect of drug use and trafficking, there is a risk that problems of increasing use among the indigenous community within each country will be overlooked. This is particularly the case in South Africa, though in other countries as well there appears to be scapegoating of particular groups or regions; the Rastafarians in Ethiopia are another example.

This exercise has proved that there is a tremendous network of highly competent research institutions in the sub-Saharan African region, although those institutions may not at present be specialized in the gathering and analysis of drug-related data: many would require training and educational assistance in order to become key counterparts with Governments in the region as well as with UNDCP. In addition to strengthening the network of research partners in Africa, more attention needs to focus on price and purity data. Far more so than seizure statistics, price and purity data are likely to give a more accurate indication of the size and scope of consumer drug markets in the region.

8. Provision of international assistance

The organizational entities of the United Nations system need to clearly recognize that they have interests in drug control and that, conversely, drug control through the United Nations system requires their more active involvement. While UNDCP has thus far taken the lead in coordinating drug control efforts within the United Nations system, meeting with encouraging progress in specific cases, it is clear that without a greater commitment from other organizations, true inter-agency cooperation in drug control will remain a goal rather than a reality.

International drug control assistance should be firmly integrated into multidisciplinary programmes that encompass the areas of economic and social development. In other words, stand-alone drug control initiatives, except in a few limited cases, should be avoided, as they are unlikely to achieve the economies of scale required to make a difference. Exceptions should be considered only in the context of law enforcement, customs control and legal assistance – though even interventions in these areas should be integrated as parts of good governance programmes. Demand reduction initiatives, to the extent possible, should be launched only in the context of broader health and education programmes.

Two preventive elements of the supply reduction agenda in Africa need to be promoted and supported: assistance to farmers and urban employment generation. Sustainable reduction in illicit drug activity will in Africa depend largely on the extent to which these two development-oriented prerequisites for progress are satisfied.

Within the United Nations system, the long-sought goals of inter-agency cooperation in drug control matters remain largely unachieved, though disparate examples of progress are identifiable. One recommendation is to shift the policy dialogue away from high-profile, high-level forums and more towards country-level programming initiatives; this would require more regular and substantive in-country dialogue between UNDCP representatives in Africa and interlocutors from other agencies, including and especially the UNDP, WHO and UNICEF. The emerging arrangements within the framework of the UNDAF should facilitate this country-level programming, especially in view of the strengthening of the UNDCP field presence in the region.

Regional drug control cooperation is being actively pursued, particularly in southern and western Africa. These regional initiatives, led by SADC and ECOWAS respectively, are welcomed and should be supported. This study has identified some of the weaknesses constraining comprehensive drug control action at the country level. Unless and until these weaknesses are resolved, the regional programmes will be developed on the basis of unstable foundations at the country level, particularly as pertains to operational matters. As a policy, this study would recommend providing assistance at two levels: at the country level, support should focus on technical upgrading and capacity-building, while at the regional level, support should focus specifically on *a)* legal assistance aimed at harmonizing the drug legislation of neighbouring countries under the umbrella of the international drug control conventions; *b)* border patrolling cooperation and profiling, broken down into the five main regions of the continent; and *c)* information gathering and networking, including support to regional arrangements for advisory services in demand reduction and law enforcement.

In recent years, the international financial institutions have focused on issues such as poverty, the environment and post-conflict reconstruction. To incorporate concerns about drug policy into the design of stabilization and structural adjustment programmes would be a logical and natural extension of current practice.[2] One possibility could be for UNDCP to be included in country assessment missions to sub-Saharan countries where drug problems are judged to exist. In addition to integrating drug policy with economic policy, UNDCP participation would by extension involve officials of African Governments responsible for drug policy, thus triggering a process of drug policy diversification into areas of economic and social development.

It is apparent that supply reduction programmes are to some extent undermined by the lack of capacity on the part of the various law enforcement agencies. On one level this reflects lack of resources, limited training in drug-related matters and logistical difficulties. At another level, the general public has little faith in such agencies to control drugs effectively because they believe that corruption amongst police and customs officials can be exploited by those involved in the drug trade to avoid arrest and conviction. Thus, one overarching policy guideline is to seek ways to enhance state credibility in the areas of law enforcement and, particularly, street policing. It must be

recognized that without enhanced state credibility, all efforts to bolster official, state-implemented drug control efforts will be only minimally cost-effective.

Overcrowding, squatting and poor social services characterize slums in Africa. Experience also shows that such areas are breeding grounds for the drug trade. Governments should redirect resources to formally recognize urban slums, allocate expenditure in basic social services and provide legal protection – all measures that should be seen as relieving or pre-empting drug-related crime. International support should focus on raising awareness, within urban development institutions and urban renewal programmes, of the link between urbanization, urban poverty, unemployment and illicit drugs.

Family disintegration is contributing indirectly to drug abuse by youth. For example, divorce and then remarriage often result in the new parent rejecting the child, who must then fend for himself or herself on the street, often by committing petty crimes that are psychologically facilitated by drug use. For other children, family breakdown simply means the absence of important role models. Drug control assistance should take the form of raising awareness, particularly of mothers, of possible consequences regarding spousal rejection of the child; it should also focus on strengthening of vocational skills of children whose families have rejected them – with these skills the child is likely to be seen as an asset rather than a burden to the family. The most cost-effective first step in this regard would be for UNDCPto develop closer working ties with UNICEF and UNFPA with a view to assessing how best to integrate preventive drug messages into child assistance and reintegration initiatives.

Increasingly, families are faced with a dilemma about sending their children to school. Despite the widely heralded merits of education, the real benefits are too often eclipsed by high rates of unemployment as well as the immediate costs to the family of carrying a greater share of the educational budget, as foreseen by cost-sharing arrangements instituted under structural adjustment programmes. More research should be undertaken to identify the costs of drug abuse by children whose families cannot carry the financial burden of basic education – these costs should, once clearly assessed, be factored into cost-benefit analysis of cost-sharing arrangements. In addition, direct cooperation between IMF and UNDCPcould lead to means by which the latter focuses on means to identify and rectify drug-related problems that have emerged in partial response to austerity programmes.

In the immediate term, more attention needs to be focused on highlighting the merits of basic education as a means of keeping children in school, off the streets, away from the drugs. Recurrent parent-teacher curriculum reviews would help to sensitize parents to the merits of the educational programmes as well as allow them an opportunity to voice their preferences on the most cost-effective curriculum; as they are increasingly expected to pay for their children's education, it may be wise to allow them greater influence on curriculum development. UNDP, UNICEF and UNDCP could together promote basic education as a means to keep children in school and away from drugs.

UNDCPand UNESCO should, together, develop a strategy on how to sensitize African Governments to the need for flexibility in curriculum development as a means of pre-empting drug abuse among school dropouts. The two organizations should also develop a research agenda aimed at identifying the costs of drug abuse among school drop-outs and encourage Bretton Woods institutions to factor those costs into the cost-benefit analyses of structural adjustment programmes.

B. REGIONAL PRIORITYAGENDA

In addition to the above recommendations, which could be seen as applicable across most if not all the countries included in this study, one of the main conclusions of the study is that there is a need for a more systematic regional prioritization and, within specific regions, a more rational and streamlined sectoral prioritization. The priorities proposed below identify the study countries that are of top priority, an assessment that has taken into account the findings of this study. A general approach would be to focus in the short term on the top-tier priority countries and to apply the lessons learned during pilot interventions to operational and policy development in other countries.

The key term that should define drug policy development in the region is "prioritization." It appears that, in a context of limited domestic and international resources for drug control in Africa, efforts should focus first on trends in urban centres and only thereafter on rural production, which at present shows little sign of drugs other than cannabis. It is in the urban centres where the potential for illicit drug markets to emerge is greatest, with the attendant externalities of crime and illegality. In contrast, climactic, soil, as well as marketing factors are likely to contain the cultivation of coca and opium poppy for the foreseeable future. To emphasize, this study concludes that the first priority should be trends in urban centres.

This study has also called attention to the need to account not only for the threat potential of the illicit drug problem but the ability of civil society and Governments to respond. It is hereby recommended that a weighing of both the problem and the response capability result in a prioritization of regions and countries as well. While the timeframe and scope of this study prevent it from conclusively establishing a hierarchy, the following represent a tentative ordering of countries and the issues that should be addressed in each.

1. Top-tier priority countries

It should be emphasized that the following priority agenda represents an ordering only of the 10 countries included in this study.

(a) Southern Africa

South Africa

The drug problems in South Africa have implications not only for the country's citizens but also for those of the

southern African region and beyond. In addition, the institutional capacity to launch the necessary responses appears sound. In general, the country should be considered a priority for drug control interventions, at least in the southern African region.

Top priority issues in South Africa include:

(1) Law enforcement institutional reform, which should be developed as part and parcel of an overall programme of rule of law assistance. UNDP programmes in good governance should be seen as the overall assistance framework in which law enforcement assistance is integrated;

(2) Integration of demand reduction messages into school curriculum, specifically in the impoverished rural and urban areas. The key counterparts in this regard are the non-governmental organizations that are already involved in providing assistance to the marginalized regions of the country;

(3) Public information specifically on Ecstasy consumption among youths;

(4) Intelligence gathering on the crack trade in the urban centres. South Africa should also be enlisted to share its profiling and intelligence-gathering capabilities with neighbouring countries.

(b) West Africa

Nigeria and Senegal

Both of these countries appear to have emerging domestic abuse problems due to spillover from trafficking. Senegal has governmental institutions that appear well-placed to use externally provided drug control assistance; whether this trait applies to Nigeria is less explicit, although the magnitude of its drug problems warrant its positioning at the top of the region's priority agenda.

Top priority issues include:

(1) In the case of Senegal, information-gathering efforts should focus on gauging the extent of abuse in the country. In addition, there is a need for strengthening of border controls, specifically in the Casamance region where a low-intensity conflict continues to fuel cannabis cultivation, thus contributing to a regional problem. Senegal's geography leaves it especially vulnerable to trafficking, a problem that may intensify as a result of law enforcement intensification in the region's erstwhile transit country, Nigeria;

(2) In the case of Nigeria, prevention efforts should be expanded in the context of overall health assistance. Furthermore, given the rapid rise in cannabis-related arrests, consideration should be given, in the context of legal and penal reform, to means of helping the Government to refine its law enforcement efforts such that the major traffickers are imprisoned rather than the small-scale cannabis cultivators and/or users. Furthermore, mounting evidence to suggest interrelated trafficking patterns between the two countries now amply warrants cooperation between Nigeria and South Africa in law enforcement matters.

(c) East Africa

Kenya

More than most of the other countries examined in this study – with the exceptions of Nigeria and South Africa – Kenya appears to have a serious problem of heroin abuse. In addition, the abuse of other substances as well seems to be on the verge of escalation due to deep-rooted economic and social problems that are exacerbated by the country's political problems. On balance, despite the serious governance constraints in the country, Kenya should be considered the priority country in East Africa. The law enforcement machinery – specifically the Criminal Investigation Department – seems to be a reliable counterpart for international drug control assistance. Other sectors of the civil service, however, may not achieve the same levels of cooperation.

Top priority issues in Kenya include:

1) Demand reduction efforts, which should be intensified at the grassroots level, specifically through the existing network of NGOs, many of which would require training on drug prevention issues. Demand reduction efforts should focus first and foremost on the major urban centres, and thereafter on the coastal tourist areas;

2) Child drug abuse is a problem in Kenya: UNICEF and UNDCP should expand support to NGOs that are active in providing assistance to children, and specifically street children, with drug-related problems. The Sambamba Streetchild Organization appears to be a small entity with great promise; the UDUGU Society in Nairobi would appear to be an established, reliable counterpart in this regard as well;

3) With regard to work undertaken by UNDP in the area of rural community development, public information campaigns could be expanded and focused on slowing the rural-urban drift that is often due to misperceptions of the employment opportunities in the cities. By sensitizing rural communities to the unemployment in urban centres, these public information campaigns – thoroughly integrated into broader rural development programmes – could help relieve some of the social and economic pressures that contribute to illicit drug activity in the cities.

2. Second-tier priority countries

Mozambique

While the problems in this country – specifically drug trafficking – are as serious as in the countries listed above in the top-tier category, it ranks in this second-tier group due primarily to limited capacity at the state level to use drug control assistance effectively.

Ghana

With problems of lesser magnitude but excellent government capacity to execute drug control assistance, Ghana has the capacity to put drug control assistance to good use. The illicit drug problems in Ghana appear limited at present to cannabis production and trade, but nonetheless the seemingly high level of cost-effectiveness and commitment of the authorities suggest that Ghana would be an excellent partner for expanded drug control assistance. Ghana would likely be a good partner for information, networking and research in the West Africa region; it could serve as a model for law enforcement authorities in other countries.

Côte d'Ivoire

Sound governance structures and capabilities and an emerging spillover problem suggest that assistance should be aimed at demand side interventions, especially in the area of information gathering and analysis of drug abuse trends. It should, however, not be overlooked that the country's main drug problem at present is the growing influx of cocaine and heroin. Despite rapidly growing drug problems, it appears that the drug control institutions and the legislative constraints of the country warrant very careful planning for externally provided programmes of assistance.

3. Third-tier priority countries

Cameroon

A country with major economic and social problems, Cameroon is likely to witness an escalation in abuse in coming years. And yet the institutional capacity to absorb drug control assistance efficiently is at present non-existent. Absence of consensus within the Government and a weak foundation of non-governmental organizations in drug control matters are problems that must be taken into account during consideration of cost-effectiveness.

Ethiopia

Trafficking is a problem in this country, but it appears that authorities in the capital are well-placed to contain the trafficking problem, which has not yet spilled over into the domestic market. Trends could worsen, however, due to the country's leading airline industry and the airport's role as a transportation hub.

Zimbabwe

Zimbabwe has growing abuse problems along with its traditional cannabis cultivation, which appears to be emerging into a more commercial enterprise. Nonetheless, given the excellent state apparatus in law enforcement matters, the magnitude of the illicit drug problem does not warrant prioritization of the country at present.

Notes

1 Organization of African Unity, Common Position on Drug Control, adopted by the Ministerial Meeting held in Pretoria from 13 to 18 April 1998.

2 In this light a June 1998, executive-level meeting between the World Bank and UNDCP, which took place in Washington, D.C., holds particular significance. At the meeting, the World Bank President suggested that Bank activities in poverty reduction, health and education could be used to improve the overall quality of life in affected countries, reducing incentives to drug cultivation. It was also agreed to hold follow-up discussions between the Bank and UNDCP.

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