



# SENDU UPDATE

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## **UPDATE FROM THE REGIONAL CO-ORDINATOR**

This Update includes a brief report on the technical support visit to Zimbabwe undertaken in September 2003, a short description of the 4<sup>th</sup> Regional SENDU Report Back Meeting held in Dar es Salaam in November 2003, as well as a review of the key regional trends from treatment and law enforcement data from countries for which data are available. We envisage both treatment demand and law enforcement data from Swaziland, Tanzania, and Zambia also being available for the next reporting period. We hope that data collection will start in Zimbabwe at the beginning of 2004. Steps have been taken to facilitate increasing the number of patients on whom treatment demand trends are reported as well as increasing data from other sources, particularly from NGOs working with youth. Technical support visits to the DRC and Angola are planned for the 1st half of 2004.

## **4<sup>th</sup> REGIONAL MEETING**

The fourth regional meeting for the SENDU project was held in Dar es Salaam from 18-21 November 2003. The meeting was held in conjunction with the SADC Drug Control Committee (SDCC) meeting. SENDU country co-ordinators from Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe attended the meeting. Also in attendance was the SADC Drug Control Officer (Dr Strijdom), as well as the SDCC representatives for the SADC countries. The meeting was opened by the Honourable William Lukuvi, Minister of State, Office of the President and Ambassador William Hannah, of the European Commission in Tanzania. At the meeting representatives from Botswana, Lesotho, Mauritius, Malawi, Mozambique, Namibia, and South Africa presented the data collected during January – June 2003 in each of the respective countries, as well as available trend data. The country co-ordinators from Swaziland, Tanzania, Zambia and Zimbabwe gave an update on the progress of their data collection. On the second day of the meeting Dr Parry gave a summary of the latest trends and findings of SENDU regionally. A team of consultants from the EU also provided feedback on their evaluation of the SADC Drug Control Programme, including SENDU. On the 3<sup>rd</sup> and 4<sup>th</sup> days of the meeting Dr Parry and Mr Plüddemann discussed issues related to data collection and reporting with the SENDU country co-ordinators and provided a training session on data analysis with SPSS.

## **TECHNICAL SUPPORT VISIT TO ZIMBABWE**

The technical support visit to Zimbabwe was conducted from 8-12 September 2003. Below is a list of stakeholders and agencies contacted in Zimbabwe.

## **Stakeholders contacted:**

1. Minister and Permanent Secretary of Home Affairs
2. SADC Contact Point, Ministry of Foreign Affairs
3. Ministry of Education representative
4. Ministry of Health representative
5. Psychiatrist, Parirenyatwa Hospital
6. Commissioner of Police & colleagues
7. Deputy Commissioner of Prisons, the Director of Prison Medical Services & colleagues
8. Acting Matron, Harare Central Hospital Psychiatric Unit
9. Asst. Director of Social Statistics, Central Statistics Office
10. Director of SHAPE (an NGO) & colleagues
11. Director, Ministry of Public Service, Labour & Social Welfare

## **Other activities:**

The focus of Day 2 was a half-day workshop on establishing an AOD surveillance network in Zimbabwe. The workshop was attended by over 30 stakeholders from a number of sectors, including health, law enforcement, prison services, education, central statistics, foreign affairs, social services, media and NGOs. The meeting was also attended by representatives of the University of Zimbabwe and the Medicines Control Authority.

## **The situation with regard to AOD use in Zimbabwe**

The main substances abused are alcohol (including home brews), cannabis, and solvents/glue. Heroin, Mandrax, cocaine, Ecstasy, and over-the-counter and prescription medicines are also abused, but to a far lesser extent.

## **Readiness to collect data:**

In summary there appears to be sufficient infrastructure available to support the establishment of a drug information system in Zimbabwe. All the main persons/agencies likely to be able to access the data needed to sustain an ongoing AOD surveillance system in Zimbabwe, were seen. The team was able to present the idea of the need for setting up such a system and the methodology to be used to a broad range of stakeholders in both one-on-one and large-group meetings.

## **REGIONAL TRENDS: BOTSWANA, LESOTHO, MALAWI, MAURITIUS, NAMIBIA, MOZAMBIQUE, & SOUTH AFRICA**

## **Treatment demand data**

Information on primary drug of abuse reported at specialist AOD treatment centres<sup>1</sup> is provided in Table 1. To facilitate country comparisons, data for South Africa are averaged over the five sentinel sites in the country.

<sup>1</sup>For Botswana and Malawi information comes only from psychiatric hospitals

In summary, in Mauritius, Mozambique, Namibia, and South Africa there appears to be demand for (and supply of) treatment for a greater range of substances of abuse than in the other countries, where alcohol and cannabis are the primary drugs of abuse reported (Table 1). Specifically, based on treatment demand data South Africa has a greater range of substances available than in other SADC countries for which SENDU data are available. South Africa also has the largest number of treatment centres (in general, and included in the SENDU project) and the largest number of patients going to substance abuse treatment facilities.

With regard to specific substances:

**Alcohol** is the primary substance of abuse most likely to be reported by patients seen at specialist substance abuse treatment centres in SADC countries, ranging from 20% in Malawi to 84% in Botswana. On average 58% of patients across the seven countries had alcohol as a primary drug of abuse. Increases were noted in four countries.

The proportion of patients coming to treatment centres with **cannabis** as their primary drug of abuse varied greatly in the first half of 2003, ranging from 0% in Namibia to a high of 88% in Malawi. In most countries this ranged between 15% and 30% (mean = 26%). Over time it does not appear to be increasing substantially, except in Malawi. As several treatment centres were added to the data collection system in Lesotho it would at this stage be premature to infer anything from the increase in treatment demand relating to cannabis in this country.

Treatment demand for problems related to the use of **Mandrax** (methaqualone) is confined to Namibia and South Africa, with both countries reporting a slight increase in demand in the latest period.

Similarly, treatment demand for problems related to the use of **cocaine** is confined to Namibia and South Africa, with both countries reporting a slight increase in demand in the latest period.

Treatment demand for problems related to the use of **heroin** is confined to Mauritius, Mozambique, and South Africa, with treatment demand increasing in the latter in the first half of 2003. However, Mauritius has by far the greatest proportion of patients in treatment whose primary drug of abuse is heroin (over 50%). Over the past five to seven years treatment demand for heroin as a primary drug of abuse has increased substantially in Cape Town and Gauteng province (South Africa) from a low of under 1% to over 6% of all patients in treatment.

During the first half of 2003, **Ecstasy** (methylenedioxymethamphetamine) was only reported as a primary substance of abuse in treatment centres in South Africa.

**Over-the-counter and prescription medicines** (primarily benzodiazepines and analgesics) were only reported as primary drugs of abuse in Mauritius and South Africa.

**Other drugs** included khat, methcathinone (CAT), LSD and inhalants (e.g. glue, petrol).

Across countries and sites the proportion of patients in treatment who are under 20 years of age ranges from 3% (Namibia) to almost 30% in Lesotho. Mauritius appears to be experiencing a slow, but steady increase in the proportion of patients in treatment aged 20 years or less. Increases in the proportion of patients under 20 years was also noted in

Botswana and Lesotho, but caution is urged in reading too much into data presented for these two countries (and Namibia) given the small number of patients on whom data are presented.

With the exception of Mauritius, across sites the predominant mode of ingesting substances is by swallowing or smoking. In Mauritius, however, over half of persons in treatment injected their primary drug of abuse. In this country heroin is primarily used intravenously. In contrast, in South Africa most heroin is smoked ('chasing the dragon'), but a large proportion of patients with heroin as their primary drug of abuse report some injection use (49% in Gauteng and 38% in Cape Town). This proportion appears to be increasing over time in Gauteng (from 36% in the 2<sup>nd</sup> half of 2001). The only other country (on board the SENDU project) where intravenous drug use was reported was Mozambique.

#### Law enforcement data<sup>2</sup>

Information on the proportion of police arrests for dealing in different drugs is given in Table 2. In Lesotho, Malawi and Mozambique (Maputo) in the 1<sup>st</sup> half of 2003 all arrests for drug dealing involved cannabis. For South Africa information on cannabis arrests is not available, but information on police cases (by drug) for drugs other than cannabis is available from the police forensic science laboratories. The highest number of arrests for dealing in cannabis in the first half of 2003 was noted in Tanzania (2 318). Arrests for dealing in Mandrax were only made in Namibia, South Africa and Tanzania during this period. In South Africa cases increased by almost a thousand as compared to the previous three reporting periods.

Arrests for dealing in cocaine were made in Namibia, South Africa and Tanzania. The number of cases related to dealing in cocaine in South Africa has remained fairly stable over the past four reporting periods at around 800 per six months. In Mauritius over 50% of arrests for drug dealing involved heroin. This was substantially greater than in Mozambique, South Africa, and Tanzania. However, the quantity of arrests is substantially greater in South Africa (169 cases), but decreased substantially as compared to the previous two reporting periods.

With regard to Ecstasy, a substantial number of cases relating to dealing have been reported in South Africa over the past four reporting periods, increasing to almost a thousand in the first half of 2003. One arrest was made for dealing in Ecstasy in Namibia. In contrast to Botswana, Lesotho, Malawi and Mauritius, in Namibia, South Africa and Tanzania persons were arrested for dealing in a much greater spectrum of substances.

Police seizures are indicated in Table 3. The highest seizures of cannabis during the 1<sup>st</sup> half of 2003 were noted in Tanzania (Dar es Salaam), while the greatest amount of heroin was seized in South Africa (16 kg) and Mauritius (15 kg). This represented a substantial decline in South Africa but an increase in Mauritius. The drop in Mandrax (methaqualone) seizures noted in the 2<sup>nd</sup> half of 2002 in South Africa continued in this reporting period. The only other countries listed in Table

<sup>2</sup> Law enforcement data was available for Tanzania for this period (Dar es Salaam)

3 in which Mandrax seizures were made were Namibia and Tanzania. A large increase in cocaine seizures was noted in South Africa. The only other countries (sites) listed in Table 3 in which cocaine seizures were made were Mozambique (Maputo), Namibia and Tanzania. A large amount of seizures of amphetamine type stimulants (mainly Ecstasy) was noted in South Africa in the 1<sup>st</sup> half of 2003 (256 927 tablets). A small quantity of LSD was seized in South Africa and just less than 1.5 kg of khat was seized in Tanzania (Dar es Salaam).

Cannabis is clearly very cheap in South Africa at under 15 US cents per joint. One explanation for this is that cannabis is widely cultivated in certain parts of South Africa. Heroin is also significantly cheaper in South Africa as compared to Namibia and especially Mauritius where it sells for over 330 US\$ per gram.

### **Summary**

While cannabis and alcohol dominate treatment demand and community concern in most SADC countries, there is evidence of substantial use of other drugs such as Mandrax (methaqualone), heroin, cocaine and amphetamine type stimulants (such as Ecstasy) in certain countries and trafficking of these drugs in many countries (not just those where use has been reported).

- Heroin use is particularly high in countries in the south and east of the region, including South Africa, Mozambique, Tanzania and Mauritius. Almost 35 kg of heroin was seized in these countries in the first half of 2003. In Mauritius roughly 40% of the patients seen by the island's eight specialist drug treatment centres had heroin as their primary drug of abuse.
- Treatment demand and law enforcement indicators for cocaine and Mandrax are highest in South Africa and Namibia. Cocaine arrests and seizures were also made in Tanzania.
- Use of amphetamine type stimulants is growing in South Africa, with police seizures increasing substantially every 6 months over the past two years to over a quarter of a million tablets in the first half of 2003.

In almost half of the countries for which data were available, over one in five patients receiving treatment for substance abuse were under twenty years of age.

The most alarming finding reported was the high level of HIV/AIDS cases directly associated with intravenous drug use in Mauritius, increasing from 7% of all HIV cases among intravenous drug users in 2001 to 27% in 2003. In this country over 50% of patients in substance abuse treatment report injection drug use. Also alarming was the dramatic increase in treatment demand related to methamphetamine use in one of the South Africa sites, Cape Town. Methamphetamine use has been linked to violent crime in the USA and other countries.

### **Policy Implications**

Among the *general* policy implications raised in the country reports for January to June 2003 were that:

- Substance abuse prevention approaches need to target children at a young age. Particular attention should be

given to alcohol, tobacco, cannabis and methaqualone (where applicable).

- Countries need to consider implementing alternative development projects to counter the growing of cannabis.
- Strategies are needed to counter the myth that prevails in many countries that smoking cannabis is good for studying.
- Roadside testing of drivers for alcohol needs to be expanded and to include testing for other drugs.
- A multi-pronged strategy is required to reduce alcohol-related HIV infection.
- Affordable, accessible treatment options (from detoxification to long term rehabilitation and community support groups) need to be instituted.
- Barriers to women accessing treatment need to be overcome.

### **Issues for monitoring or further research**

Across countries various issues requiring further monitoring or more in depth research were raised, including:

- Demographic/social class shifts in patterns of drug use (South Africa).
- Strategies for reducing injuries caused by drunk pedestrians (Mauritius, South Africa).
- The impact of AOD use on mental health (Malawi, Mauritius), HIV/AIDS and other infections (Namibia, Mauritius), crime and road traffic injuries (Namibia), and domestic violence (Mauritius).
- Strategies to combat glue sniffing by street children (Namibia, Mauritius).
- Overdose deaths related to drug use (Mauritius).
- Abuse of over-the-counter and prescription medicines and club drugs (Mozambique).
- Evaluation of effectiveness of prison substance abuse treatment services (Mauritius, Namibia).

At the SENDU regional meeting various suggestions were put forward for how data collection efforts could be strengthened. Among other things site facilitators indicated the need for increased access to other data sources (besides treatment and law enforcement): district hospitals and other NGOs (Malawi), schools, colleges, and prisons (Malawi), private hospital casualty departments (Namibia), and youth and juvenile training centres (Botswana, Lesotho). With regard to additional resources required, the following were mentioned: drug testing kits (Malawi, Namibia) and computers to facilitate computerisation of data at source (Namibia).

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Table 1: Treatment demand data (%): Primary drug of abuse (row % add up to 100)

Country	Period	Alcohol	Cannabis	Methaqualone (Mtq)	Cocaine	Heroin	Ecstasy	OTC/Pre*	Other	N	# centres
Botswana	Jan-Jun '02	70.3	23.8	0.5	0.5	0.0	0.0	0.0	4.9	188	9
	Jul-Dec '02	69.6	29.0	0.0	0.0	0.0	0.0	0.0	1.5	72	5
	Jan-Jun '03	83.6	16.4	0.0	0.0	0.0	0.0	0.0	0.0	73	4
Lesotho	Jul-Dec '01	54.3	45.7	0.0	0.0	0.0	0.0	0.0	0.0	45	6
	Jan-Jun '02	85.0	15.0	0.0	0.0	0.0	0.0	0.0	0.0	20	5
	Jul-Dec '02	97.8	2.2	0.0	0.0	0.0	0.0	0.0	0.0	46	3
	Jan-Jun '03	70.2	29.8	0.0	0.0	0.0	0.0	0.0	0.0	67	7
Malawi	Jul-Dec '02	32.7	67.3	0.0	0.0	0.0	0.0	0.0	0.0	445	3
	Jan-Jun '03	19.6	79.4	0.0	0.0	0.0	0.0	0.0	0.6	361	5
Mauritius	Jul-Dec '01	21.8	14.1	0.0	0.0	70.7	0.0	1.3	1.5	467	8
	Jan-Jun '02	32.7	6.6	0.0	0.0	59.3	0.0	1.1	0.2	452	8
	Jul-Dec '02	33.0	10.3	0.0	0.0	52.9	0.0	2.8	0.5	427	8
	Jan-Jun '03	36.5	8.2	0.0	0.0	51.7	0.0	3.2	0.4	561	8
Mozamb.	Oct-Dec '02	63.7	20.5	0.0	0.9	15.0	0.0	0.0	0.0	234	7
	Jan-Jun '03	68.3	20.2	0.0	0.0	10.5	0.0	0.0	1.0	104	4
Namibia	Jan-Jun '02	74.0	8.0	12.0	6.0	0.0	0.0	0.0	0.0	50	2
	Jul-Dec '02	78.0	8.7	8.7	2.2	0.0	2.2	0.0	0.0	46	3
	Jan-Jun '03	82.9	0.0	14.3	2.9	0.0	0.0	0.0	0.0	35	2
South Africa	Jul-Dec '01	52.2	21.4	10.1	5.1	5.1	1.1	3.1	1.6	5667	48
	Jan-Jun '02	54.0	19.3	10.3	5.7	5.3	1.0	3.1	1.2	6108	50
	Jul-Dec '02	54.1	21.0	9.5	5.3	4.6	1.1	2.7	1.7	5830	50
	Jan-Jun '03	51.7	18.2	12.6	5.8	5.5	0.9	3.1	2.1	5886	52

\*includes psychotropic medicines

Table 2: Police arrests for drug dealing (row % add up to 100)

Country	Period	Cannabis or hashish	Mtq.	Cocaine/crack	Ecstasy/ATS	Heroin	LSD	Khat	N
Botswana*	Jan-Jun '02	100.0	0.0	0.0	0.0	0.0	0.0	-	226
	Jul-Dec '02	100.0	0.0	0.0	0.0	0.0	0.0	-	183
	Jan-Jun '03	96.5	1.2	1.2	1.2	0.0	0.0	-	170
Lesotho	Jul-Dec '01	100.0	0.0	0.0	0.0	0.0	0.0	-	108
	Jan-Jun '02	100.0	0.0	0.0	0.0	0.0	0.0	-	87
	Jul-Dec '02	100.0	0.0	0.0	0.0	0.0	0.0	-	93
	Jan-Jun '03	100.0	0.0	0.0	0.0	0.0	0.0	-	103
Malawi	Jul-Dec '02	100.0	0.0	0.0	0.0	0.0	0.0	-	431
	Jan-Jun '03	100.0	0.0	0.0	0.0	0.0	0.0	-	348
Mauritius	Jul-Dec '01	47.0	0.0	0.0	0.0	53.0	0.0	-	156
	Jan-Jun '02	37.0	0.0	0.0	0.0	63.0	0.0	-	125
	Jul-Dec '02	59.1	0.0	0.0	0.0	40.9	0.0	-	149
	Jan-Jun '03	46.0	0.0	0.0	0.0	54.0	0.0	-	153
Mozambique (Maputo)	Oct-Dec '02	N/A	N/A	N/A	N/A	N/A	N/A	-	N/A
	Jan-Jun '03	100.0	0.0	0.0	0.0	0.0	0.0	-	4
Namibia*	Jan-Jun '02	84.4	14.1	1.0	0.5	0.0	0.0	-	397
	Jul-Dec '02	84.9	9.3	3.5	2.2	0.0	0.0	-	226
	Jan-Jun '03	88.9	9.6	1.0	0.5	0.0	0.0	-	208
South Africa	Jul-Dec '01	-	65.7	16.2	13.8	3.0	1.3	-	475
	Jan-Jun '02	-	60.5	19.1	15.2	4.8	0.4	-	481
	Jul-Dec '02	-	61.3	16.5	16.8	4.6	0.8	-	513
	Jan-Jun '03	-	66.2	13.5	16.6	2.9	0.8	-	591
Tanzania (Dar es Salaam)	Jan-Jun '03	85.8	0.2	0.7	0.0	5.7	0.0	7.5	270

\* Including possession. South African data refers to national cases seen by the Forensic Science Laboratory rather than arrests per se. These laboratories do not routinely analyse all cases involving seizures of cannabis.

Table 3: Police seizures

Country	Period	Cannabis (kg)	Mtq (tablets)*	Cocaine (gm)	ATS (tablets)	Heroin (gm)	LSD (units)	Khat (kg)
Botswana	Jan-Jun '02	147067.3	0	0	0	0	0	-
	Jul-Dec '02	1471.3	0	0	0	0	0	-
	Jan-Jun '03	1418.0	5	1.77	31	0	0	-
Lesotho	Jul-Dec '01	19 671	0	0	10 045	0	0	-
	Jan-Jun '02	4153.7	0	0	0	0	0	-
	Jul-Dec '02	4416.7	0	0	0	0	0	-
	Jan-Jun '03	5 380	0	0	0	0	0	-
Malawi	Jul-Dec '02	4 659.2	0	0	0	0	0	-
	Jan-Jun '03	6 242	0	0	0	0	0	-
Mauritius	Jul-Dec '01	30.0	0	0	0	22 441	0	-
	Jan-Jun '02	22.7	0	0	0	4995	0	-
	Jul-Dec '02	43.5	0	0	0	6 973	0	-
	Jan-Jun '03	8.9	0	0	0	15 432	0	-
Mozam. (Maputo)	Oct-Dec '02	N/A	N/A	N/A	N/A	N/A	N/A	-
	Jan-Jun '03	10.3	0	5 100	0	0	0	-
Namibia	Jan-Jun '02	774.6	9179	78 rocks	10	0	0	-
	Jul-Dec '02	147.2	679	189 rocks	36	0	0	-
	Jan-Jun '03	532.4	2 714	96 rocks	14	0	0	-
South Africa	Jul-Dec '01	N/A	12 872 000	191 143	121 562	1 856	6 632	-
	Jan-Jun '02	N/A	2 668 595	375 535	150 324	6 273	322	-
	Jul-Dec '02	N/A	750 099	67 148	275 362	77 041	1 303	-
	Jan-Jun '03	N/A	630 844	237 728	256 927	16 340	532	-
Tanzania (DAR, Zanz)	Jan-Jun '03	413 360.9	106g	1.335	0	2 531	0	1 454

\*or equivalent (calculated from powder seized)