

**Southern African Development Community Epidemiology
Network on Drug Use (SENDU): January – June 2004**



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***Contributors:** In preparing this report we have drawn heavily on the country reports prepared by Seloï Mogatle (Botswana), Teboho Khetsi (Lesotho), Immaculate Chamangwana (Malawi), Fayzal Sulliman (Mauritius), Eugenia Teodoro and Paula Simbine (Mozambique), Dinah Tjiho (Namibia), Nelisiwe Sikosana (Swaziland), Joe Mbatia (Tanzania), Ashbie Mweemba and Sharon Lesa (Zambia), and Dexter Tagwireyi (Zimbabwe), as well as our own report on South Africa.*

The Southern African Development Community (SADC) Regional Drug Control Programme makes provision for the establishment of a regional drug surveillance network (SADC Epidemiology Network on Drug Use – SENDU) in all SADC member states. The overall goal of SENDU is to improve the information base for policy makers in SADC member states to address the health and socio-economic burden caused by misuse of alcohol and other drugs. Between July 2000 and November 2004 a regional consultation meeting was held (in Pretoria), and technical support visits were undertaken to Angola, Botswana, the DRC, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, Swaziland, Tanzania, Zambia, and Zimbabwe. Regional report back meetings were held in April 2002 (Cape Town), November 2002 (Luanda), May 2003 (Johannesburg), November 2003 (Dar es Salaam), May 2004 (Johannesburg) and November 2004 (Cape Town).

Reports on data for January – June 2004 from Zimbabwe (Phase 1), Swaziland and Zambia (Phase 2), Tanzania (Phase 3), Malawi and Mozambique (Phase 4), Botswana and Namibia (Phase 5), Lesotho and Mauritius (Phase 6), and South Africa (Phase 16) are provided. This is followed by a comparison of data across these countries in terms of treatment demand, law enforcement and other indicators.

The report concludes with a summary of trends across countries (sites); a listing of policy implications, issues requiring further monitoring and research, suggestions for how monitoring systems could be strengthened; and an update on the way forward.

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1. INTRODUCTION

Figure 1: SADC member states



1.1 Background

The Southern African Development Community (SADC) was established in 1992 and comprises 13 member states (Figure 1). The Seychelles left SADC in 2003.

These countries differ greatly in land area, population, income levels, and official languages (Table 1). The region has a population of over 200 million persons with a landmass equal to that of the USA.

Table 1. Description of SADC member states on selected indicators¹

| SADC member state | Land area (sq kms) | Population (2003 est.) | GDP per capita* | Official language | Population 0-14 years (%) |
|-------------------|--------------------|------------------------|-----------------|-------------------------|---------------------------|
| Angola | 1 246 700 | 10 978 552 | \$1 900 | Portuguese | 43.5 |
| Botswana | 600 370 | 1 561 973 | \$8 800 | English | 39.2 |
| Congo (DRC)*** | 2 345 410 | 55 225 478 | \$590 | French | - |
| Lesotho | 30 355 | 1 865 040 | \$3 000 | English | 37.3 |
| Malawi | 118 480 | 11 906 855 | \$600 | English, Chichewa | 46.8 |
| Mauritius | 1 860 | 1 220 481 | \$11 400 | English | 24.8 |
| Mozambique | 801 590 | 18 811 731 | \$1 200 | Portuguese | 43.6 |
| Namibia | 825 418 | 1 954 033 | \$7 100 | English | 42.4 |
| South Africa | 1 219 919 | 42 718 530 | \$10 700 | 11 official languages** | 29.5 |
| Swaziland | 17 363 | 1 169 241 | \$4 900 | English, siSwati | 41.0 |
| Tanzania | 945 087 | 36 588 225 | \$600 | English, Swahili | 44.2 |
| Zambia | 752 614 | 10 462 436 | \$800 | English | 46.1 |
| Zimbabwe | 390 580 | 12 671 860 | \$1.900 | English | 39.4 |
| | 9 296 201 | 207 134 435 | | | |

*-purchasing power parity (2003 estimate); **-English predominates; ***2002 estimate

The South African Community Epidemiology Network on Drug Use (SACENDU) is an alcohol and other drug (AOD) sentinel surveillance system comprising a network of researchers, practitioners, and policy makers from six sites in South Africa. The network, managed by the Medical Research Council of South Africa (MRC), has been operational since July 1996. In 2000, with funding from the Southern African Development Community (SADC) via the European Commission, the MRC was contracted to establish sentinel or country surveillance systems in the 13 other SADC member states. The project forms part of the 5-year SADC Regional Drug Control Programme (SRDCP-I). The broader (regional) network has been named the SADC Epidemiology Network on Drug Use (SENDU).

This initiative has been driven by:

1. The view that the burden of harm from alcohol and other drug (AOD) use in Southern Africa is likely to increase with development and that conversely, the abuse of AODs can undermine development objectives.

¹ U.S. Central Intelligence Agency. *The World Fact Book 2004*. Washington, DC: Author, 2004.

2. The realisation that various factors, globally, regionally and locally have highlighted the need for monitoring substance use in Southern Africa at this time. At the global level, these include, for example, changes in drug use patterns, changes in production patterns, country-specific changes in supply reduction strategies, and armed conflicts and political/economic instability in certain SADC member states or countries neighbouring on the SADC region.
3. The SADC Drug Protocol, signed in 1996, which highlights the importance of information and research to inform interdiction and demand reduction activities.

The overall goal of SENDU is to improve the information base for policy makers in SADC member states to address the health and socio-economic burden caused by misuse of AODs. SENDU's immediate purpose is to develop and establish a substance abuse sentinel surveillance system in each of the SADC member states building on the SACENDU model operational in three cities and two provinces in South Africa.

1.2 Methods

The SENDU initiative has the following core components:

- Ongoing training and technical support.
- Establishment of site- or country-specific networks and the implementation of a "basic" surveillance system in each site and, if possible, additional components in some sites. The "basic" system comprises treatment demand data from specialist substance abuse treatment facilities (if available) and psychiatric hospitals; information from the police on arrests, seizures and drug prices; and data from NGOs on drug use among young people. Additional components might include school studies, mortuary or trauma unit studies, etc.
- Validation and collation of data during/after six-month country- and regional-report back meetings.
- Dissemination of findings via newsletters/reports, press briefings, and the establishment of a website.

A budget of € 430 000 over five years has been provided to "kick start" the process. The funds are being used for training/consultation meetings, technical support visits, transport for country representatives to attend regional meetings on a six-monthly basis, and to facilitate report writing and information dissemination.

A regional consultation/training meeting was held in Pretoria for four days during October 2000 attended by representatives from all 14 SADC member states. At this meeting:

- Country reports were delivered based on information provided using a standardised audit form.
- Agreement was reached on the initiative, broad indicators, and the way forward. In particular, it was agreed that approximately two countries would be added to the network every six months.
- Training was provided via lectures and participation in, and observation of, a national meeting of the SACENDU project.
- Teambuilding and networking exercises took place.

Between 2001 and 2004 technical support visits of four to seven days in length were undertaken to 13 SADC member states: Angola, Botswana, the DRC, Lesotho, Malawi, Mauritius, Mozambique, Namibia, the Seychelles, Swaziland, Tanzania, Zambia and Zimbabwe. The focus of these visits was to learn more about patterns of AOD use in the respective countries, meet with government officials to inform them about the SENDU initiative, assist countries in developing instruments to collect and collate secondary data on AOD use/associated consequences, provide technical support in other areas related to establishing and maintaining an AOD surveillance system, support country coordinators in running an initial meeting of potential members of an AOD surveillance network, conduct visits to agencies where data are to be collected, and identify other areas where technical- or other forms of support are required.

The focus of this report is on the findings of Phase 16 of the SACENDU Project, Phase 1 of the AOD abuse surveillance system established in Zimbabwe, Phase 2 of the surveillance systems established in Swaziland and Zambia, Phase 3 of the surveillance system established in Tanzania, Phase 4 of the surveillance systems established in Malawi and Mozambique, Phase 5 of the surveillance systems established in Botswana and Namibia, and Phase 6 of the AOD abuse surveillance systems established in Lesotho and Mauritius. This report covers the period January to June 2004, and preceding 6-month periods (if applicable).

Of these 11 countries, South Africa is the largest with a population of about 43 million. Lesotho has a population of 1.9 million, and the island state of Mauritius has a population of 1.2 million. The land-locked mountainous county of Swaziland has a similar sized population. Botswana and Namibia are situated in the central and western parts of Southern Africa, with populations of 1.6 million and 2 million respectively. Mozambique is situated on the east coast of Southern Africa and has a population of 19 million. The South African network (SACENDU) comprises six sentinel sites, four of which are large port cities (Cape Town, Durban, Port Elizabeth and East London) and the other two are provinces: Gauteng (a largely urban province which includes the cities of Pretoria and Johannesburg), and Mpumalanga (a largely rural province bordered by Swaziland and Mozambique). The South African sites cover just over one third of country's population of about 43 million. Tanzania is situated on the east coast of Africa, having a population of about 36 million. Malawi, Zambia and Zimbabwe are situated to the southwest of Tanzania and have populations of 10-13 million. The surveillance systems in Botswana, Lesotho, Malawi, Mauritius, Namibia, Swaziland, Zambia and Zimbabwe are country-level systems. In Mozambique the surveillance system has been established in Maputo, and in Tanzania in Dar es Salaam and Zanzibar.

A summary of the data sources accessed in the above countries during the first half of 2004 is indicated in the table below. The major sources of data came from specialist treatment centres and psychiatric hospitals and the police. With regard to detailed information on treatment demand, in the first half of 2004 data were obtained from 98 treatment centres in 9 countries (on 8 675 patients), up from 92 treatment centres (and 7 569 patients) in the second half of 2003.

Table 2. Data sources by sites: 1st half of 2004

| Source | Botswana# | Lesotho | Malawi | Mauritius | Mozambique | Namibia | S. Africa | Swaziland | Tanzania | Zambia | Zimbabwe |
|--|-----------|-----------|------------|------------|------------|-----------|--------------|------------|------------|------------|----------|
| Treatment centres (patients in period Jan-Jun '04) | N/A | 9 (63) | 7 (556) | 8 (596) | 5 (151) | 3 (54) | 58 (6680) | 2 (223) | 3 (169) | 3 (183) | N/A |
| Police drug data/forensic | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Psychiatric hospitals | N/A | * | * | Y | * | N/A | Y | * | * | * | N/A |
| Prisons | - | - | - | Y | - | - | - | - | - | - | - |
| Mortuaries | - | - | - | - | - | - | Y | - | - | - | - |
| Orthopaedic unit | - | - | - | - | - | - | - | - | Y | - | - |
| Surveys, studies | - | - | - | - | - | - | Y | - | - | - | - |
| Other health statistics | - | - | - | Y | - | - | - | - | - | - | - |
| Education Ministry | - | - | - | - | - | - | - | - | - | - | Y |

*-included with treatment centre data, #-no data were available as data collection system was being revamped

2. DRUG ABUSE PATTERNS AND TRENDS

2.1 By country

2.1.1 Botswana

Introduction

During the fifth phase of data collection for the Botswana Epidemiology Network on Drug Use (BENDU) information was received from Botswana police only, as data collection from psychiatric hospitals had to be re-launched with training workshops in 2004.

Key findings by substance of abuse

Cannabis

No arrests for dealing in cannabis were made in Botswana in the first half of 2004, however 89 arrests were made for possession of cannabis. This constituted 98% of all arrests for possession during this period. A total of 581 kg of cannabis was seized in Botswana in the first half of 2004.

Other drugs

During the 1st half of 2004 one arrest was made for possession of Mandrax (methaqualone) and one arrest for possession of Ecstasy. A total of 2784 Mandrax tablets were seized as well as 29 Ecstasy tablets.

Implications for policy

- Resources in the police force have to be increased in order for it to deal with the issues of substance abuse efficiently.
- The police need to be empowered to identify dealing/trafficking in drugs.
- Legislation empowering the police needs to be amended to assist them to undertake their duties effectively and efficiently.
- Data on drug-related crime needs to be included in the statistics. This will require more co-operation from the police.
- The public needs to be educated about the consequences of substance abuse, especially women.
- Poverty alleviation measures are important in addressing the issues of substance abuse.

2.1.2 Lesotho

Introduction

The Lesotho Epidemiology Network on Drug use (LENDU) has entered its sixth phase of the collection, collation and analysis of information on alcohol and other drugs. During January – June 2004 data were collected from one rehabilitation centre, eight psychiatric clinics, and the police department. All the data from treatment centres was combined and overall 63 people were treated in these centres during January – June 2004 for alcohol/drug problems.

Key findings by substance of abuse

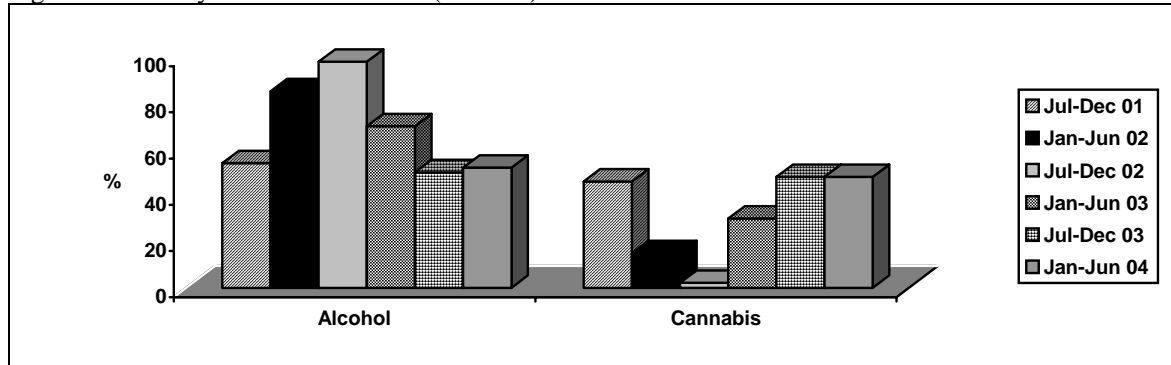
Alcohol

Overall, 52% of the patients treated for substance abuse had alcohol as their primary substance of abuse during the period January – June 2004 (Figure 2).

Cannabis (dagga)

Cannabis was reported as primary substance of abuse by 48% of the patients attending the treatment facilities during the period January – June 2004. During the period January – June 2004 over 7000 kg of cannabis was seized by Lesotho police. Of the 146 arrests made for dealing in cannabis, 71% of those arrested were male.

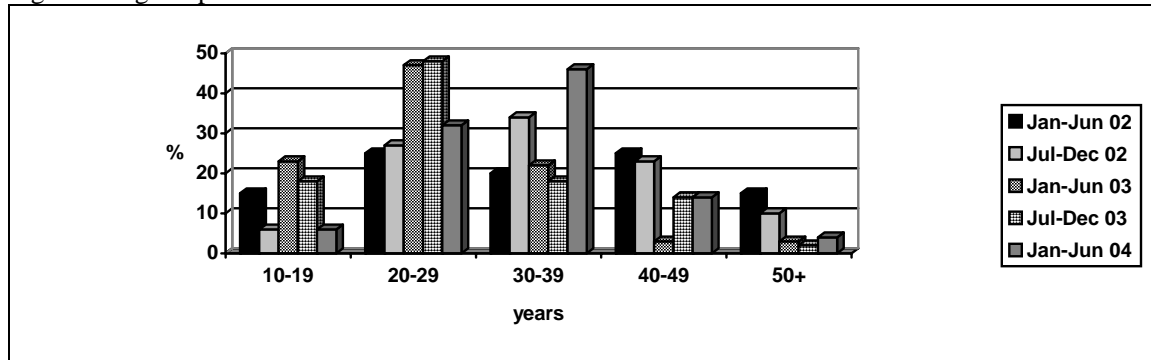
Figure 2: Primary substance of abuse (Lesotho)



Other key findings

Of the patients seen in treatment 61% were employed (full-time or part-time), more than half had a secondary or tertiary level of education, and 54% were never married. Most of the patients were in treatment for the first time (81%). Almost half (46%) of patients were aged 30-39 years. The proportion of patients in the younger age groups appears to be decreasing (Figure 3).

Figure 3: Age of patients in treatment - Lesotho



Issues related to strengthening the surveillance system

- There is a need to intensify data collection at a central point so as to obtain a national picture of the drug problem in Lesotho.
- Information from several critical centres is still not available i.e. the Youth and Juvenile Training Centres.
- There is a need for further training, monitoring and evaluation of data collectors so that they have the ability to capture relevant information.
- There is a need to strengthen capacity at a central point where the national data is compiled.

Implications for policy

- Intensify health promotion more specifically with a focus on drug use at all levels of society.
- The current legislation regulating the sale, handling and use of different categories of drugs and substances of abuse needs to be in place and, more importantly, enforced.
- Development and implementation of policies relating to the management of alcohol and drug related issues in the workplace.

2.1.3 Malawi

Introduction

Malawi has completed its fourth phase of data collection. For the period January – June 2004 data were collected from the Zomba Mental Hospital, the Lilongwe Psychiatric Unit, and the St John of God treatment centre. In addition data were collected from the Machinga, Ntchisi and Mulanje District Hospitals, as well as Drug Fight. A total of 556 forms were completed across these centres. Data on arrests and seizures has also been compiled.

Key findings by substance of abuse

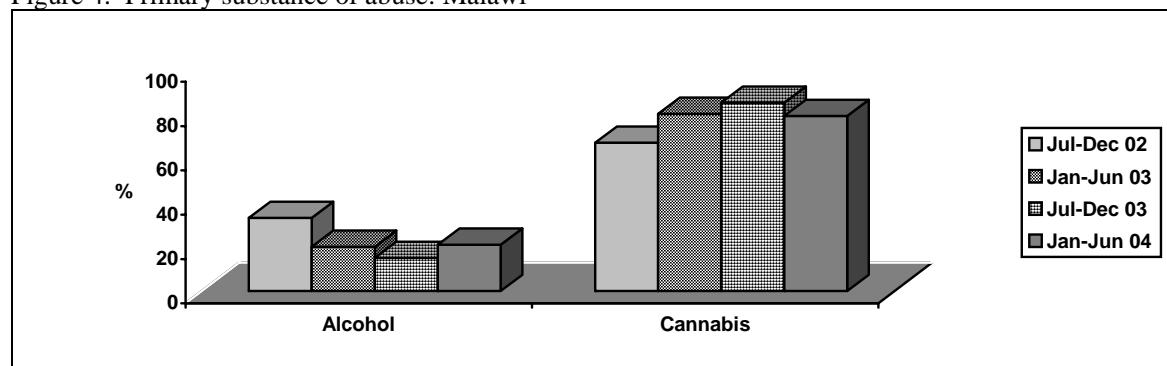
Alcohol

Alcohol is the second most common substance of abuse for patients seen at all the facilities, accounting for 21% of patients treated for substance abuse disorders during January – June 2004, a slight increase from 15% in the previous period (Figure 4). All these patients were males with an average age of 27 years. The most common form of alcohol used is traditionally brewed beer (*kachasu, masese, and kuchekuche*).

Cannabis (chamba)

Cannabis was the most common primary substance of abuse among patients attending the treatment facilities during the period January – June 2004, accounting for 79% of the patients, compared to 85% in the previous period. The mean age of the cannabis patients was 24 years and 94% were male. During the period January – June 2004 over 7807 kg of cannabis was seized by Malawi police. A total of 355 arrests for dealing in cannabis and 350 arrests for possession of cannabis were made, a substantial increase over the previous period. No arrests were made for dealing in, or possession of, other substances.

Figure 4: Primary substance of abuse: Malawi



Other key findings

Just over half of the patients were treated as outpatients (51%) versus 31% in the previous period and 58% were admitted for the first time. Over 63% were unemployed and 84% had a primary school education or less. Furthermore over 58% of the patients were under 25 years of age (Figure 5).

Implications for policy

- Intensify mental health education to general public.
- There is a need for rehabilitation centres in the various regions in Malawi.
- Involve NGOs in addressing alcohol and other drug abuse.
- There is a need to train health workers in the management of mental health issues.

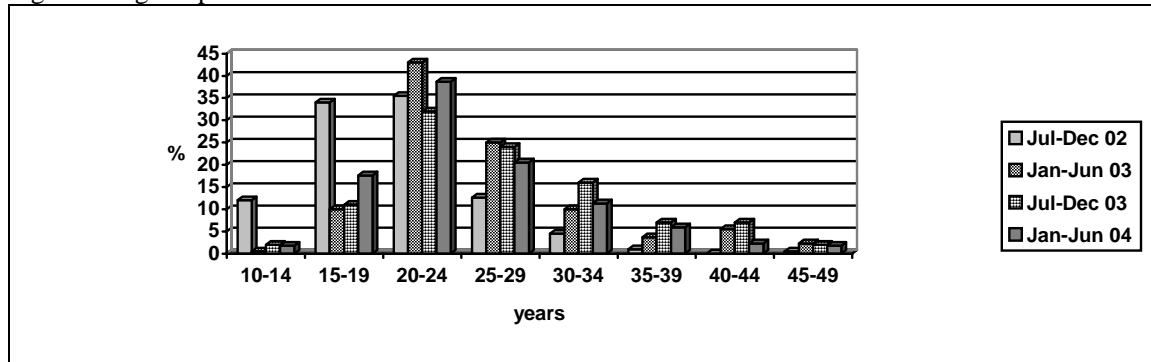
Questions for further research

- Conduct surveys in schools, prisons and colleges (nationwide).
- Impact of AOD use on mental health.
- Reasons for AOD use among young boys and girls.

Issues relating to strengthening the surveillance system

- To further increase the number of district hospitals and NGOs involved in data collection.
- Obtain drug-testing kits to facilitate diagnosis.

Figure 5: Age of patients in treatment – Malawi



2.1.4 Mauritius

Introduction

During its sixth phase the Mauritius Epidemiology Network on Drug Use (MENDU) collected data on treatment demand from eight NGOs that treat and rehabilitate substance abusers. A total of 596 data forms were analysed for the period January – June 2004, a slight increase over the previous period. Data on admissions and discharges from the Brown Sequard Mental Health Care Centre (BSH), data from the forensic science laboratory, HIV routine statistics and arrests and seizures on illicit drugs from the Police Force (ADSU) were also collected.

Key findings by substance of abuse (see Figure 6)

Alcohol

Alcohol is still the second most common primary substance of abuse (28% of treatment demand), declining compared to the previous period. Patients with alcohol problems had a mean age of 41 years (similar to the previous periods) and are mostly Christians and Hindus who visit the Help – De Addiction Centre and the Centre de Solidarité. Patients are married, being self-referred or referred by their friends and families. Most patients with alcohol as their primary substance of abuse are males who come from the districts of Plaine Wilhems and Port Louis. Most are manual workers, artisans or unemployed. Most alcohol patients are treated as outpatients and seek treatment for the first time. Patients started drinking alcohol during their mid twenties. Of the 2424 admissions to the Brown Sequard Mental Health Care Facility during January – June 2004, 52% were alcohol related.

Cannabis

Cannabis (gandia) was the primary substance of abuse for 7% of patients, compared to 6% in the 2nd half of 2003. They are mostly males aged between 15 and 40 years (mean = 32), coming mainly from the districts of Port Louis, Plaine Wilhems and the southern region. They were self-referred or were referred by friends and family. Most of them were treated as outpatients. Most were Muslims and Hindus who presented for treatment for the first time. Of the 199 arrests made for dealing in drugs 37% were for dealing in cannabis and 25% of the 710 arrests made for drug possession related to cannabis. These proportions remained fairly stable. A total of 39.2 kg of cannabis was seized during the period January – June 2004. A gram of cannabis sells for about 300 MUR (10 US\$).

Heroin (see also White Lady)

Heroin/Brown Sugar was the most common primary substance of abuse (41%) among patients seen at substance abuse treatment centres, and 94% of these patients reported injecting as primary mode of use. These proportions have remained fairly stable when compared to the previous period. Numerous patients visited the Dr I. Goomany Centre or the Centre de Solidarité, being either referred by

courts/correctional services, family, friends or self-referred. Most were single males from Port Louis and Plaine Wilhems. Most were either unemployed, manual workers, artisans or hawkers. They were treated as outpatients. Treated on average at the age of 35, they started using drugs during their teens or youth. Most were Christians or Muslims, seeking treatment for the first time. Just under half of patients with heroin as their primary drug reported needle sharing. A total of 125 persons were arrested for dealing in heroin during the period January – June 2004, constituting 63% of all arrests for dealing. A further 485 persons were arrested for possession of heroin, making up 68% of all arrests for possession of drugs. Overall 2.4 kg of heroin was seized during the period January – June 2004, compared to 0.5 kg in the previous period. The price of heroin is estimated at 10 000 MUR/gram (334 US\$). The average purity of heroin tested between January and June 2004 was 51%. It was higher than compared to previous phases.

White Lady²

Of all the patients 18% reported White Lady as their primary drug of abuse, compared to 13% in the previous period. These patients were mostly aged between 15 and 24 years (Mean age = 32) and were mostly males, single and sought treatment from the Centre de Solidarité, the Dr I. Goomany and Sangram Seva Sadan Centres, being self-referred or were referred by families or friends. Most came from Port Louis and Plaine Wilhems with a low level of education and were manual workers, hawkers or unemployed. They were treated as outpatients. They were mostly Christians and Muslims who sought treatment for the first time.

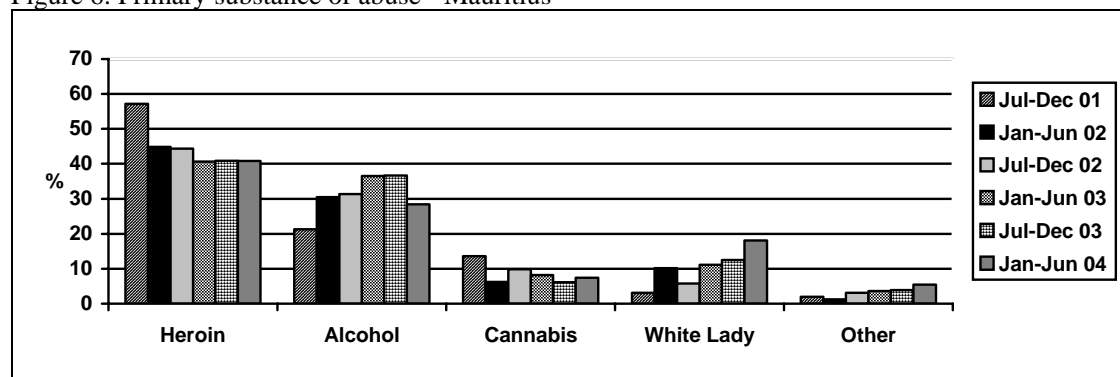
Other drugs

Other drugs reported as primary substances of abuse during January – June 2004 included Subutex (Buprenorphine), psychotropic drugs, solvents, codeine, and opium.

Other key findings

The highest proportion of patients in the current period was in the 45-49 year age group, a slight change over previous periods (Figure 7). About 4% were under 25 years of age. Over 75% of HIV cases detected during January to June 2004 were related to intravenous drug use.

Figure 6: Primary substance of abuse - Mauritius

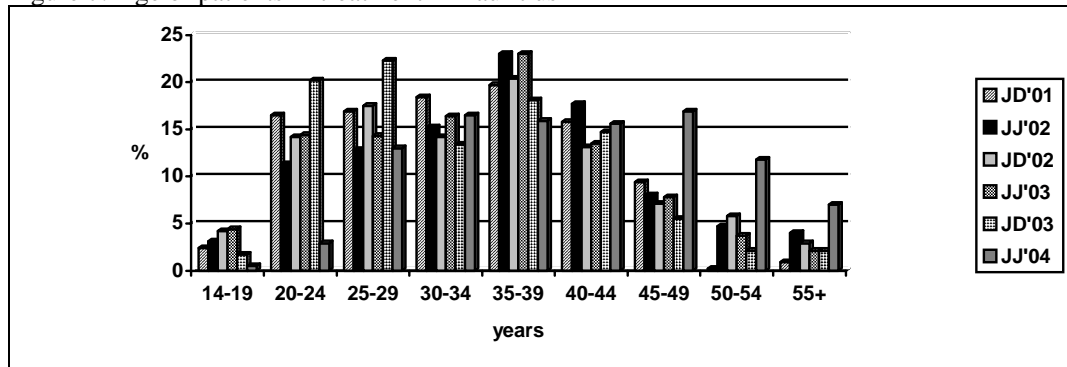


Issues to Monitor

- AOD use related to domestic violence.
- Death related to drug overdose.
- Poly-drug use.

² ‘White Lady’ is a white form of heroin, but is still reported separately by the treatment centres.

Figure 7: Age of patients in treatment – Mauritius



Issues for Further Research

- The incidence of HIV, HCV, HBV among injecting and non-injecting drug users.
- The effectiveness of prison based treatment programmes.
- Barriers to females accessing treatment services.
- Strategies to combat inhalant use among children.

Implications for Policy

- Increase treatment and prevention programmes focussing on high-risk groups.
- Pilot testing of harm reduction strategies among high-risk groups.
- Revisiting the drug treatment facilities within the prison system.
- Providing additional facilities for women drug addicts to come into treatment.
- Ensure provision of affordable, accessible treatment options.
- Substance abuse prevention approaches need to target children at a young age (primary school) with particular attention to tobacco, alcohol and cannabis.
- A multi-pronged strategy is required to reduce alcohol use in the population at large with particular emphasis on the workplace.

2.1.5 Mozambique

Introduction

Mozambique joined SENDU in the second half of 2002. During the current phase (January – June 2004), data includes information from Maputo Central Hospital, more specifically, from CERPIJ (a psychological and rehabilitative unit for children and young people) and from the Acute Psychiatric Care Unit. Data from the Infulene Psychiatric Hospital are also included, as well as data from the military hospital and the REMAR treatment centre.

Key findings by substance of abuse

Alcohol

Alcohol was the primary substance for 39% of the 151 patients on whom data was captured during January – June 2004 (Figure 8). Most of the patients were male (95%). Of all the patients 37% reported Shangana as their home language and 18% reported Ronga as their home language. The average age of these patients was 36 years. Overall 88% of the patients reported alcohol as either a primary or secondary substance.

Cannabis

Cannabis was reported as primary substance of abuse by 19% of patients. 97% of these patients were male and 36% reported Shangana as their home language. The average age of these patients was 25 years. Overall 28% of all the patients reported using cannabis as either a primary or secondary substance. Forty arrests for possession or dealing of cannabis were made in Maputo City and Maputo

Province in the 1st half of 2004 and one person was arrested for trafficking. Over 22 kg of cannabis was seized. The price of cannabis is very low (0.2 US\$ per unit).

Cocaine

Thirteen patients (9%) reported cocaine as primary substance of abuse, while 20% reported cocaine as a primary or secondary drug of abuse. The average age of the cocaine patients was 26 years and most were Portuguese or Shangana speaking. No arrests or seizures of cocaine were made in the first half of 2004.

Heroin

Thirty-three percent of all the patients reported heroin as their primary substance of abuse, an increase over previous reporting periods. 98% were male and their average age was 28 years. Most (80%) reported Shangana, Portuguese or Ronga as their home language. Although most reported smoking heroin (75%), 23% reported injecting. A number of patients reported heroin as a secondary substance of abuse, with 41% reporting it as either a primary or secondary substance of abuse. No arrests or seizures related to heroin were made in Maputo City in the 1st half of 2004.

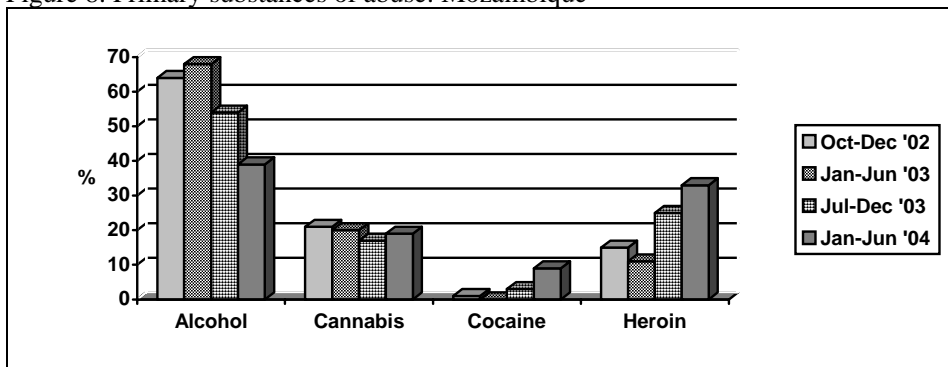
Other substances

One person reported using LSD in the first half of 2004.

Other key findings

Most of the patients treated at the various centres were treated for the first time (69%) and 78% were treated on an inpatient basis. Of all the patients 57% were unemployed and 76% were single. Just over a third (38%) of the patients had some secondary education. Over 30% of the patients were younger than 25 years (Figure 9). The mean age of all the patients was 31 years.

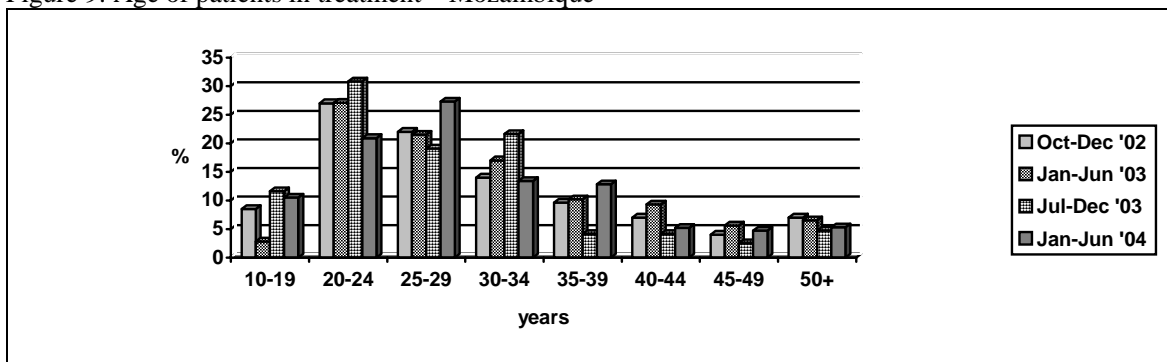
Figure 8: Primary substances of abuse: Mozambique



Implications for policy, issues to monitor and further research questions

- See July – December 2003 report (no new information provided for January – June 2004)

Figure 9: Age of patients in treatment – Mozambique



2.1.6 Namibia

Introduction

The Namibian Epidemiology Network on Drug Use (NENDU) started to collect data from the 1st of January 2002. The data sources for January – June 2004 were treatment and rehabilitation centres (Etegameno Rehabilitation and Resource Centre, Nova Vita Rehabilitation Centre and the Walvis Bay Alcohol Rehabilitation Centre) and police statistics (arrest for possession and dealing).

Key findings by substance of abuse

Alcohol

Alcohol still appears to be the main substance of abuse, but this appears to be declining. At the three treatment centres where data were collected during the 1st half of 2004, of the 54 patients, 54% had alcohol as their primary drug of abuse (Figure 10). The majority were males (93%) and their average age was 39 years.

Cannabis/Mandrax (methaqualone)

The cannabis/Mandrax combination was the 2nd most common primary substance of abuse in the 1st half of 2004, accounting for 26% of the patients. Cannabis alone was reported as primary substance of abuse for only 7% of the patients. Treatment demand related to Mandrax use increased substantially. Most of these patients were male, with only two females reporting Mandrax as their primary drug of abuse. The average age of the Mandrax patients was 27 years, while the cannabis patients were 22 years on average. Police arrests indicate that cannabis accounted for 64% of the 355 arrests for dealing and possession of drugs, while Mandrax accounted for 18%. Over 433 kg of cannabis was seized in Namibia during January – June 2004 and 1 185 Mandrax tablets were seized. Mandrax seizures decreased, while cannabis seizures increased compared to the previous period. Cannabis sells for about 5 N\$ per gram and Mandrax for about 50 N\$ per tablet.

Cocaine

Seven patients in treatment (13%) had cocaine/crack as their primary drug of abuse. They were all male with an average age of 23 years. The police data showed that 44 people were arrested for dealing in/possession of cocaine during this six month period (12%), and 15 kg of cocaine and 141 crack pieces were seized, another increase over previous periods. Cocaine powder sells for about 450N\$ per gram and 150N\$ per crack rock.

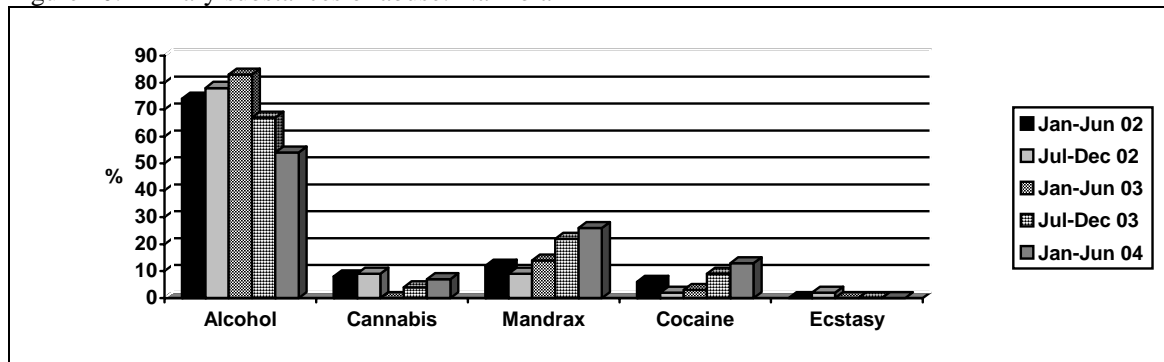
Heroin

One arrest for possession of heroin was made during the first half of 2004 and 2 g of heroin was seized.

Club drugs (Ecstasy, LSD, etc.)

Nineteen arrests for dealing in/possession of Ecstasy were made in the 1st half of 2004 (5% of arrests) and 169 tablets were seized. One Ecstasy tablet sells for about 120N\$. No treatment demand for problems related to Ecstasy use was noted.

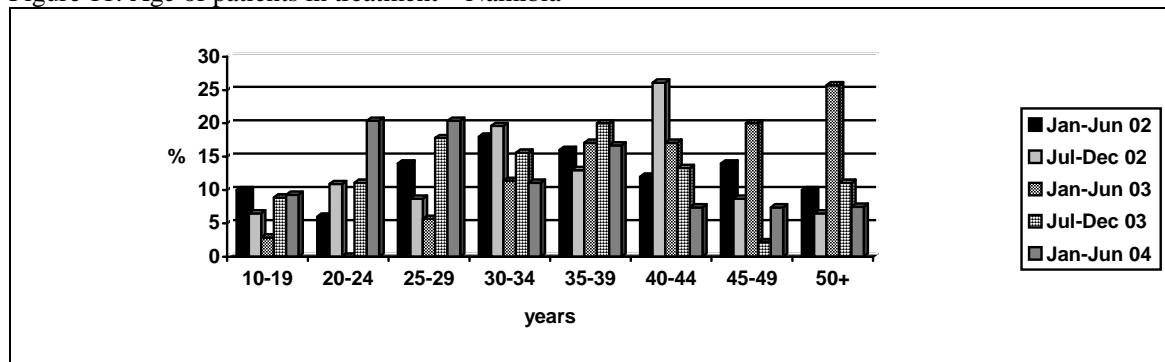
Figure 10: Primary substances of abuse: Namibia



Other key findings

Most of the patients treated at the two specialist treatment centres were treated for the first time (83%) and all were treated on an inpatient basis. Over 46% were unemployed. Only 9% of the patients were younger than 20 years (Figure 11). The mean age of all the patients was 32 years.

Figure 11: Age of patients in treatment – Namibia



Implications for policy

- Strengthening of treatment and rehabilitation services.
- Strengthening the law enforcement services (police and customs).
- There is a need to review the Liquor Act.

Issues to monitor

- Effectiveness of rehabilitation programmes.
- Penalties for drug offenders.
- Implementation of the National Drug Control Master Plan (NDCMP).

Issues requiring further research

- Link between substance abuse and mental health.
- Reasons women do not use rehabilitation services.
- Increase in abuse of hard drugs by the youth.

2.1.7 South Africa

Background

The SACENDU Project is an alcohol and other drug (AOD) sentinel surveillance system operational in Cape Town, Durban, Port Elizabeth (PE), East London (EL), Mpumalanga, and Gauteng (Johannesburg/Pretoria). The system, operational since July 1996, monitors trends in AOD use and associated consequences on a six-monthly basis from multiple sources. Data are collected from over 50 specialist treatment centres, psychiatric hospitals, mortuaries, and the police Forensic Science Laboratories (FSL). Other data sources (e.g. community studies) are included when available. At the time of completing this report mortuary data for 2003 was only available for Cape Town and Durban. Unless noted otherwise data refer to the 1st half of 2004.

Key findings by substance of abuse

Alcohol

Alcohol remains the dominant substance of abuse across sites. Between 53% (Cape Town) and 72% (Mpumalanga) of patients in treatment have alcohol as a primary or secondary drug of abuse. The proportion reporting it as a primary drug of abuse has decreased over time. In all sites the proportion of patients older than 20 having alcohol as a primary drug of abuse is substantially greater than for younger patients (Table 3). Between 40% (Durban) and 50% (Cape Town) of all non-natural deaths in 2003 had blood alcohol concentrations (BACs) $\geq 0.05\text{g}/100\text{ml}$. BACs were particularly high for transport-related deaths and homicides, with 51% of homicides and 53% of transport-related deaths in

Cape Town having BACs at that level, compared to 40% and 47% respectively in Durban. BAC levels in Durban appear to be increasing annually.

Table 3. Primary drug of abuse (%) for all patients and patients under 20 years – selected drugs (2004a) – South Africa

| | Age | CTn | Dbn | PE | EL | Gtg | Mpum |
|----------|-----|-----|-----|----|-----|-----|------|
| Alcohol | All | 38 | 60 | 48 | 55 | 50 | 64 |
| | <20 | 5 | 17 | 10 | 17 | 7 | 16 |
| Cannabis | All | 12 | 23 | 15 | 20 | 19 | 19 |
| | <20 | 33 | 60 | 43 | 57 | 54 | 54 |
| Methaq. | All | 17 | 12 | 24 | 18 | 8 | <.1 |
| | <20 | 23 | 13 | 37 | 23 | 20 | 0 |
| Cocaine | All | 10 | 5 | 5 | 4 | 9 | 4 |
| | <20 | 4 | 7 | 2 | 3 | 3 | 10 |
| Heroin | All | 9 | 0 | 2 | <.1 | 7 | 8 |
| | <20 | 8 | 0 | 1 | 0 | 6 | 11 |

Cannabis

Use of cannabis (“dagga”) and Mandrax (methaqualone) alone or in combination (“white-pipes”) continues to be high. Across sites between 22% (PE) and 40% (Durban) of patients attending specialist treatment centres had cannabis as their primary or secondary drug of abuse, compared to between 4% (Mpumalanga) and 30% (Cape Town) for Mandrax. In the 1st half of 2004 treatment demand for cannabis as a primary drug decreased in all sites except PE. Treatment demand for Mandrax (white-pipes) declined in Cape Town, PE and Gauteng, but increased in Durban (by 8 percentage points). Treatment demand for both cannabis- and Mandrax-related problems is generally higher for persons under 20 years than older persons (Table 3). Treatment demand for cannabis by persons under 20 years increased substantially in Durban and PE. While there was an increase in the proportion of police cases relating to Mandrax handled by all FSLs except the Western Cape, all labs reported a decrease in the amount of Mandrax seized. Nationally the equivalent of 592 968 tablets was reported as seized. Findings from a University of Pretoria study of substance use among adolescents (Gr. 8) at 3 schools in Pretoria North found that 6% had used cannabis in the past 30 days (and 14% reported binge drinking).

Cocaine

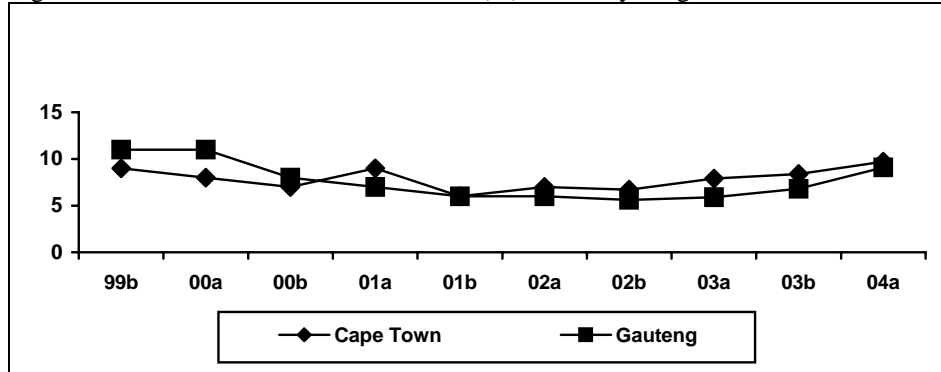
The stabilisation in treatment demand for cocaine-related problems over time reported earlier for Cape Town and Gauteng has not continued and there continues to be a slight increase in treatment demand in these sites (Figure 12). Currently between 8% (EL) and 22% (Cape Town) of patients in treatment have cocaine as a primary or secondary drug of abuse. Some demographic shifts in treatment populations were reported (e.g. a decrease in the age of patients with cocaine as a primary drug of abuse in Durban, and an increase in patients from groups other than the white population in PE, Gauteng and Mpumalanga). FSL cases involving cocaine increased in all sites, and by 51% nationally (to 1399 cases) with increased seizures being noted by the KwaZulu-Natal (KZN), Western Cape and Eastern Cape labs. However, nationally seizures declined from 188 kg in the 2nd half of 2003 to 46 kg in the 1st half of 2004.

Heroin

Over time, there has been a large increase in treatment demand for heroin as a primary drug of abuse in Cape Town, Gauteng and Mpumalanga (Figure 13). Most heroin is smoked, but of patients with heroin as their primary drug of abuse in Cape Town, Gauteng, and Mpumalanga, 28%, 55% and 32% respectively report injection use. This reflects a 16 percentage point decline in Cape Town compared to an increase of 6 and 2 percentage points in Gauteng and Mpumalanga respectively. Under 3% of patients in Durban, PE and EL have heroin as a primary or secondary drug of abuse, compared to 9% for Gauteng, and 11% for Cape Town and Mpumalanga. A five percentage point increase in the proportion of patients under 20 years having heroin as their primary drug of abuse in Mpumalanga was noted between the 1st half of 2003 and the 1st half of 2004, mainly comprising white persons (Table 3).

In Cape Town it was noted that 86% of heroin patients reported daily use. Demographically an increase in Coloured patients was noted.

Figure 12. Treatment demand for cocaine (%) - Primary drug of abuse – South Africa



A quantitative study of heroin users carried out in July and August 2004 by the MRC estimated that there could be 12 000 – 18 000 heroin users in Cape Town. It found that 23% of study participants injected heroin in the past 12 months and 86% of injectors shared a needle in the past 30 days. A third had at least one heroin overdose. Nationally there was a 24% increase in FSL cases involving heroin (271 cases) and seizures increased from 2.2 to 13.7 kg (mainly noted by the Pretoria FSL).

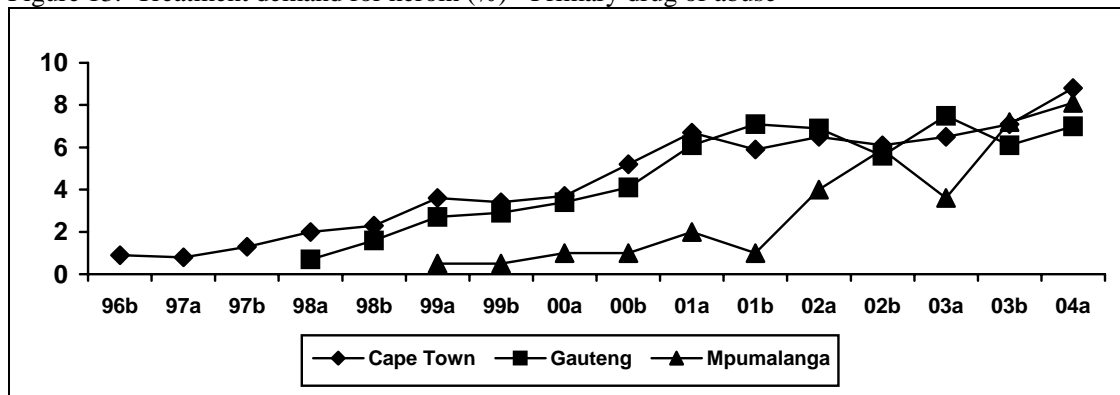
Club drugs and methamphetamine

Treatment demand for Ecstasy, LSD or methamphetamine as primary drugs of abuse is low except in Cape Town. However, between 4% (EL, Mpumalanga) and 11% (Cape Town) of patients had Ecstasy as a primary or secondary drug of abuse. An increase in the proportion of patients who have Ecstasy as a primary drug of abuse who were Asian was noted in Cape Town (9% of all patients) and an increase in Coloured patients abusing Ecstasy was noted in Gauteng (14% of all patients). A dramatic increase in treatment demand for methamphetamine was noted in Cape Town in the 1st half of 2004, especially among patients under 20 years. 1 in 5 patients in Cape Town now have methamphetamine as a primary or secondary drug of abuse, and 41% of users report daily use. Methamphetamine use in Durban and EL was also reported. All FSLs reported an increase in cases involving amphetamine type stimulants, with there being a 36% increase nationally (to 1785 cases). However, all FSLs reported a decline in seizures (to the equivalent of 76 407 units nationally). Across sites indicators for LSD use were low.

Over-the-counter (OTC) and prescription medicines

The abuse of over-the-counter (OTC) and prescription medicines such as slimming tablets, analgesics, and benzodiazepines (e.g. diazepam and flunitrazipam) continues to be an issue across sites. Treatment demand as a primary or secondary drug of abuse was between 2% (EL) and 8% (Cape Town, Gauteng). Abuse of diphenhydramine and Welconal (dipipanone) and poppers (amylnitrate) was also noted.

Figure 13. Treatment demand for heroin (%) - Primary drug of abuse



Inhalants and other substances

Inhalant/solvent use among young persons continues to be an issue across sites. Methcathinone use in Gauteng was also reported, as was magic mushrooms in several sites. Poly-substance abuse remains high, with 49% and 33% of patients in specialist treatment centres in Cape Town and Gauteng respectively indicating more than one substance of abuse. It was reported that methamphetamine is being used in combination with heroin in Cape Town.

Other key findings

Except for Cape Town all sites showed a drop in treatment demand by persons less than 20 years of age and all sites except Durban showed a decrease in the proportion of Black African patients in treatment (Table 4). The increase in treatment demand by younger persons in Cape Town is largely due to methamphetamine use and the increase in Black African patients in Durban is largely due to referrals by employers.

Table 4. Changes in age and race of patients over time

| | % of patients in treatment < 20 years of age | | % of patients in treatment who are Black African | |
|------------|--|-------|--|-------|
| | 2003b | 2004a | 2003b | 2004a |
| Cape Town | 22 | 25 | 11 | 7 |
| Durban | 27 | 22 | 22 | 62 |
| PE | 18 | 17 | 29 | 28 |
| Gauteng | 26 | 22 | 38 | 34 |
| Mpumalanga | 21 | 13 | 45 | 41 |

Selected implications for policy/practice

- Intensify efforts to reduce methamphetamine use in Cape Town among youth and prevent the spread to other areas.
- Ensure that emergency room personnel are adequately trained to deal with heroin and methamphetamine cases.
- Increase the synergy between substance abuse and mental health services.
- Reduce alcohol-related violence in or around bars and *shebeens*, and educate public that abuse of alcohol can put them at risk of being the victim of a violent assault.
- Consider harm reduction strategies among heroin users to prevent risk of infectious diseases and overdoses.
- Implement policy of toxicology screening for all MVA driver deaths and improve the monitoring and reporting of drug overdose deaths.

Selected issues for monitoring/research

- Changes in the demographic profile of drug users, especially the drop in black African patients, and changes in the age of persons abusing different drugs.
- Changes in mode of heroin and other drug use.
- Factors promoting methamphetamine use in Cape Town.
- Individual, contextual, and programmatic barriers to persons entering drug treatment.
- Strategies for reducing alcohol-related pedestrian injuries.
- Appropriateness of treatment models for adolescents.
- Differences between the marketing and use of methamphetamine in Cape Town with methcathinone in Gauteng.
- Reasons for the decrease in younger patients and Black Africans in several sites.

2.1.8 Swaziland

Introduction

Data collection commenced in Swaziland in July 2003. During January – June 2004 data were collected from the national psychiatric centre, the police (drugs unit) and COSAD (a specialist treatment centre). A total of 208 forms were completed at the national psychiatric centre and 15 forms were completed by COSAD.

Key findings by substance of abuse

Alcohol

Alcohol was the primary substance for 62% of patients treated at COSAD and the psychiatric hospital (Figure 14). Almost 90% of the alcohol patients were male.

Cannabis

Cannabis was the second most common substance of abuse, accounting for 36% of patients treated at COSAD and the psychiatric centre. Of the patients treated for cannabis-related problems, 97% were male. During January – June 2004, 467 arrests were made for possession of cannabis and almost four tons of cannabis was seized. Cannabis sells for about 13 US cents per gram.

Other drugs

One person reported heroin as their primary substance of abuse at the national psychiatric centre and one person reported cocaine as their primary substance of abuse at COSAD. Stilpain (an analgesic) was also reported as primary drug by one person at COSAD. A small amount of heroin was seized by Swazi police (0.047 g) and one arrest for possession was made. A gram of heroin sells for +/- 77 US\$.

Other key findings

Most of the patients reporting at the national psychiatric centre were referred by ‘self/family/friends’ (59%) or police (36%) and were unemployed (64%). Most had some secondary education. Overall 9% of patients were younger than 20 years (Figure 15).

Implications for policy

- There is a need to review legislation and policy with regard to drugs and drug abuse.

Issues to monitor

- There is a need to establish the extent to which socio-economic factors contribute to drug abuse and influence policy.
- Although hard drugs are not yet common in Swaziland, a strategy to curb the problem should be designed.

Issues for further research

- Research should be done on the relationship between drug abuse and the spread of HIV/AIDS in Swaziland.

Figure 14: Primary substance of abuse: Swaziland

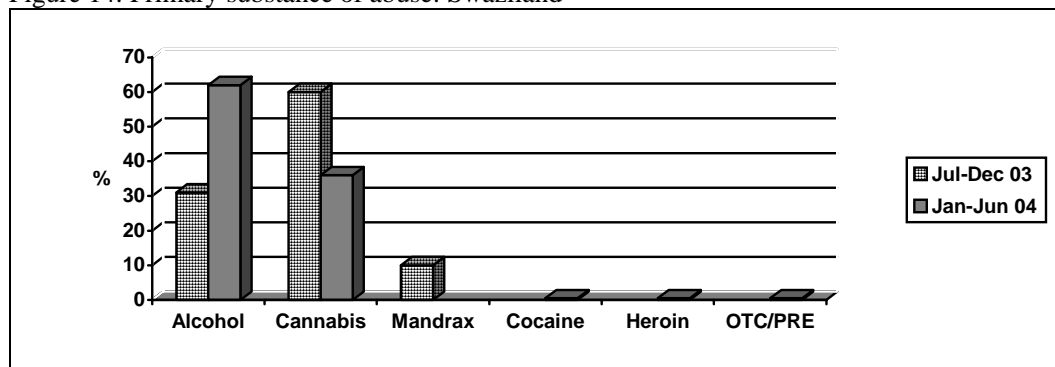
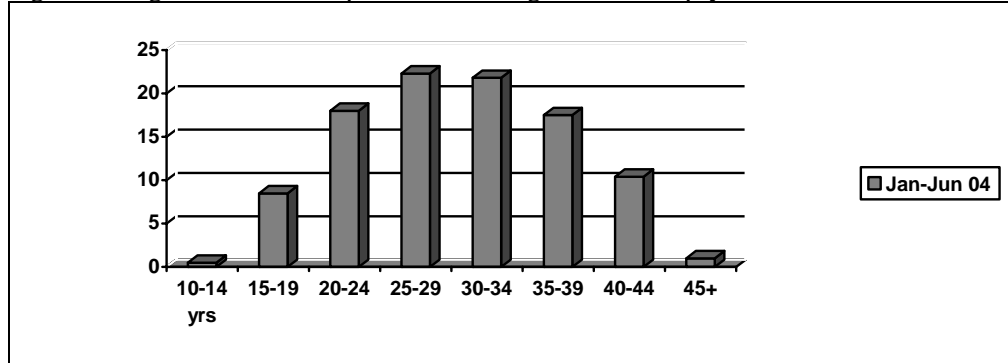


Figure 15: Age distribution of patients attending the national psychiatric centre and COSAD



2.1.9 Tanzania

Introduction

Data collection commenced in July 2003 in Dar es Salaam and Zanzibar. Data sources for the period January - June 2004 included the Muhimbili Orthopaedic Institute, three psychiatric hospitals (Department of Psychiatry Muhimbili National Hospital, Kidongo Chekundu Mental Hospital in Zanzibar and Isanga Forensic Psychiatric Hospital), data from the Government Chemist Laboratory Agency on seizure samples, as well as police data on arrests and seizures.

Alcohol

Alcohol was the primary substance for 18% of the 169 patients admitted with substance abuse related disorders to the three psychiatric facilities (Figure 16). Most of these patients were male (83%). Out of 3144 patients admitted to the Muhimbili Orthopaedic Institute during January – June 2004, 1% had a serious alcohol use problem.

Cannabis

Cannabis was the primary substance for 50% of the patients admitted with substance abuse related disorders to the three psychiatric facilities. Most of these patients were male (98%). A total of 71 cannabis samples were received by the Government Chemist Laboratory (86% of arrests for dealing) and 2219 people were arrested for cannabis-related offences. A total of 234 042 kg of cannabis was seized in Tanzania during January – June 2004.

Heroin

Heroin was the second most common primary substance of abuse accounting for 30% of all the patients (Figure 16). All but two of these patients were male. The Government Chemist Laboratory reported receiving 2112 samples of heroin. A total of 257 arrests for heroin related offences were made during January – June 2004 (10% of all arrests for dealing) and 10.7 kg were seized.

Cocaine

About 0.6 kg of cocaine was seized by Tanzania police during January – June 2004, and 3 arrests were made (all in Zanzibar).

Other drugs

Over 250 kg of khat was seized in Tanzania in the 1st half of 2004 and 110 arrests were made. The Government Chemist Laboratory reported receiving 467 Mandrax samples for analysis. One person was arrested and half a kg of Mandrax was seized.

Other key findings

Almost half of the patients (47%) were unemployed. Most patients were aged between 20 and 29 years (66%), while 4% were younger than 20 years (Figure 17).

Figure 16: Primary substance of abuse: Tanzania

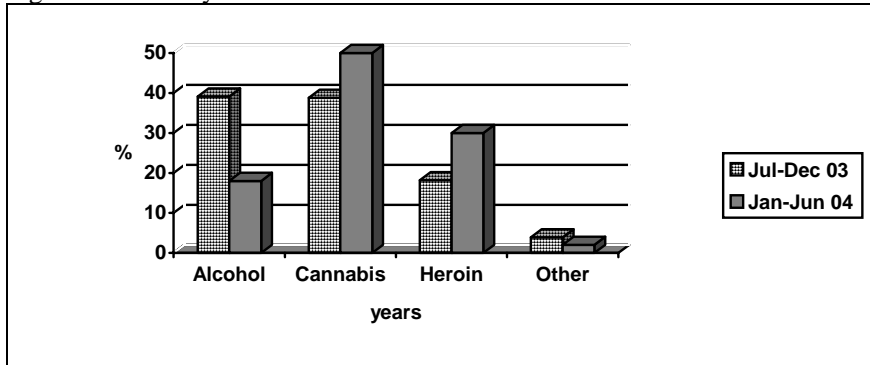
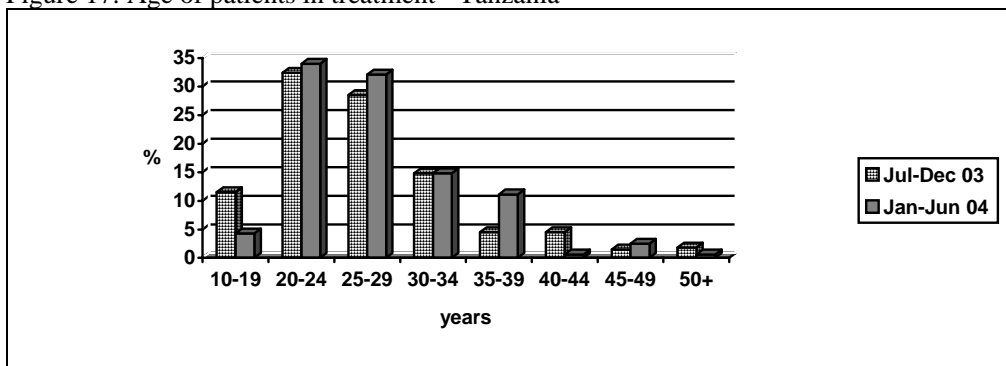


Figure 17: Age of patients in treatment - Tanzania



Implications for policy & issues to monitor

- There is a need to monitor and address intravenous drug use and needle sharing in order to avoid HIV and other infections.

2.1.10 Zambia

Introduction

Data collection commenced in Zambia in August 2003. Data were collected from Chainama Hills Psychiatric Hospital, the University Teaching Hospital and Maina Soko (the Military Hospital) during the period January – June 2004. Forensic data on confirmed drug analyses were obtained from the Food and Drug Control Laboratory and arrest and seizure data from the Drug Enforcement Commission (DEC). Seven police stations were also selected to provide data on the number of drug-related offences.

Alcohol

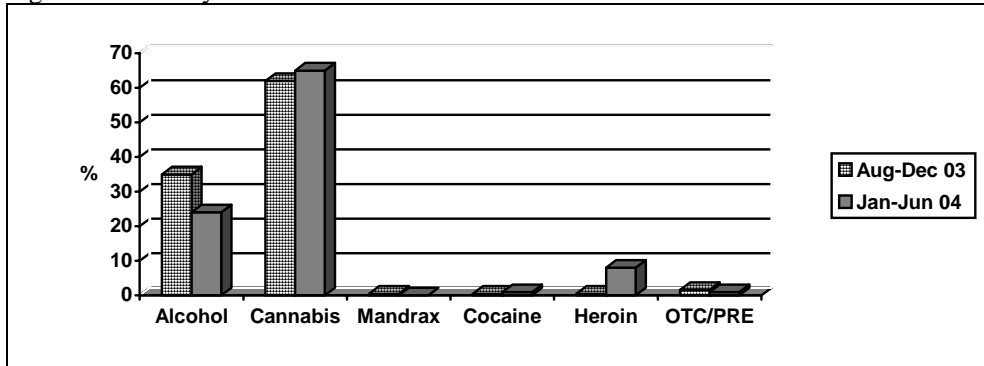
Alcohol was the primary substance of abuse for 24% of the 183 patients on whom data was collected from January – June 2004. Most of these patients were male (95%). Overall 72% of all the patients reported using alcohol either as a primary or secondary substance. Alcohol was the second most common primary substance of abuse (Figure 18).

Cannabis

Cannabis was the most common primary substance of abuse amongst patients reporting to the various centres between January and June 2004, accounting for 65% of the patients. All but three of these patients were males. Overall 70% of all the patients reported using cannabis as either a primary or secondary substance. Most of the 1487 arrests made by the DEC during the period January – June

2004 related to dealing in cannabis (96%). A further 74 arrests were made for possession of cannabis and 2.5 tons of cannabis was seized. Cannabis is very cheap at less than 10 US cents per gram.

Figure 18: Primary substance of abuse: Zambia



Cocaine and Heroin

Fifteen patients reported heroin as their primary substance of abuse (8%), a large increase from the previous period. Two patients reported cocaine as primary drug of abuse. Seven arrests for dealing in heroin were made by the DEC (0.5% of arrests) and seven for dealing in cocaine (0.5% of arrests). Five arrests for possession of heroin and four arrests for possession of cocaine were also made. 1.5 kg of heroin was seized and 0.7 g of cocaine.

Other drugs

Two patients reported pethidine as their primary substance of abuse and six patients reported petrol as a secondary substance of abuse. Other seizures made by police also included 35 kg of amphetamines (the equivalent of about 70 000 tablets).

Other key findings

Most patients were referred by “self/family/friends” (87%) and were either students or unemployed. Over 66% had some secondary education. Over a quarter (28%) were younger than 20 years of age (Figure 19). The age of patients in treatment appears to be increasing.

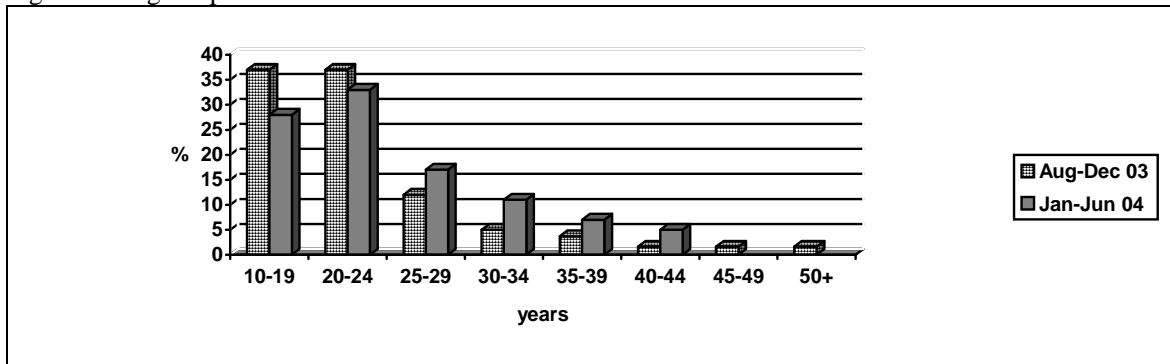
Implications for policy

- Provision of more treatment options (building of treatment centres).
- There is a need for more awareness amongst the general public regarding drug related issues.

Issues to monitor

- Drug use in relation to HIV/AIDS.

Figure 19: Age of patients in treatment - Zambia



2.11 Zimbabwe

Introduction

Data collected in Zimbabwe for the period January – June 2004 was limited to police arrests and seizures (national) and alcohol or other drug-related school expulsions.

Alcohol

During the period January to June 2004, 25 learners were expelled from schools across Zimbabwe due to alcohol-related problems. This represented 36% of all substance abuse related expulsions.

Cannabis

All but one of the 568 arrests made for dealing or possession of drugs related to cannabis. Almost 555 kg of cannabis was seized as well as 877 cannabis plants. Cannabis sells for about 0.30 US\$ per gram in Zimbabwe. Thirty-seven expulsions across schools in Zimbabwe were related to cannabis in the first half of 2004. This constituted 54% of all substance abuse related expulsions.

Other drugs

During January to June 2004 one arrest for possession of cocaine was made and 0.7 g was seized.

Issues to monitor

- Cocaine seizures – will they increase?
- Drug abuse amongst the street children population.

Questions for further research

- Prevalence of substance abuse amongst school-going youth.

2.2 Regional (cross-national) trends

2.2.1 Treatment demand data

Information on primary drug of abuse reported at specialist AOD treatment centres³ is provided in Table 5. Unless stated otherwise data presented relate to the period January to June 2004. To facilitate country comparisons, data for South Africa are averaged over the six sentinel sites in the country (namely Cape Town, Durban, Gauteng Province, Mpumalanga Province, Port Elizabeth and East London), and treatment data for Tanzania are averaged over Dar es Salaam and Zanzibar.

In summary, in Mauritius, Mozambique (Maputo), Namibia, South Africa, Swaziland, Tanzania and Zambia there appears to be demand for (and supply of) treatment for a greater range of substances of abuse than in the other countries (i.e. Botswana, Lesotho, and Malawi), where alcohol and cannabis are the primary drugs of abuse reported (Table 5). 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 21% in Malawi to 62% of admissions in Swaziland. Averaging across the nine countries for which data are available, just over a third (38%) of patients had alcohol as a primary drug of abuse. This is a decrease of 7 percentage points compared to the second half of 2003. Decreases were noted in six of the nine countries for which comparative data were available. The implication of this is that there is an increase in the demand for treatment for substances other than alcohol in these countries.
- The proportion of patients coming to treatment centres with **cannabis** as their primary drug of abuse varied greatly in the first half of 2004, ranging from 7% in Mauritius and Namibia to 79% in Malawi. Over the nine countries just over a third (37%) of patients had cannabis as a primary drug of abuse. This is similar to the previous reporting period. The increase over time reported previously for Malawi has not continued. An increase in treatment demand for problems related to cannabis use was noted in Tanzania, while conversely a decrease was noted in Swaziland as compared to the previous reporting period.
- Treatment demand for problems related to the use of **Mandrax** (methaqualone) is confined to Namibia and South Africa. In the previous reporting period treatment demand for problems related to Mandrax use was noted in Swaziland and Zambia, but this was no longer the case in the first half of 2004. Over the past three reporting periods an increase in treatment demand related to this drug was noted in Namibia, whereas in South Africa there appears to be no discernable trend.
- Treatment demand for problems related to the use of **cocaine** is mainly confined to Mozambique, Namibia and South Africa, and to a lesser extent in Zambia, with increases being noted in all four countries.
- Treatment demand for problems related to the use of **heroin** is confined to Mauritius, Mozambique, South Africa, Tanzania, Zambia, and to a much lesser extent Swaziland where it appeared in the treatment demand data set for the first time since data were collected in Swaziland as part of SENDU. Mauritius has by far the greatest proportion of patients in treatment whose primary drug of abuse is heroin (over 50% if “White Lady” is included). An increase in treatment demand related to heroin use was noted in all six countries, especially in Mauritius, Mozambique, Tanzania and Zambia (by at least five percentage points since the second half of 2003).

Table 5: Treatment demand data (%): Primary drug of abuse (row % add up to 100)

³For Botswana, Malawi, Tanzania and Zambia information comes from psychiatric hospitals/units only

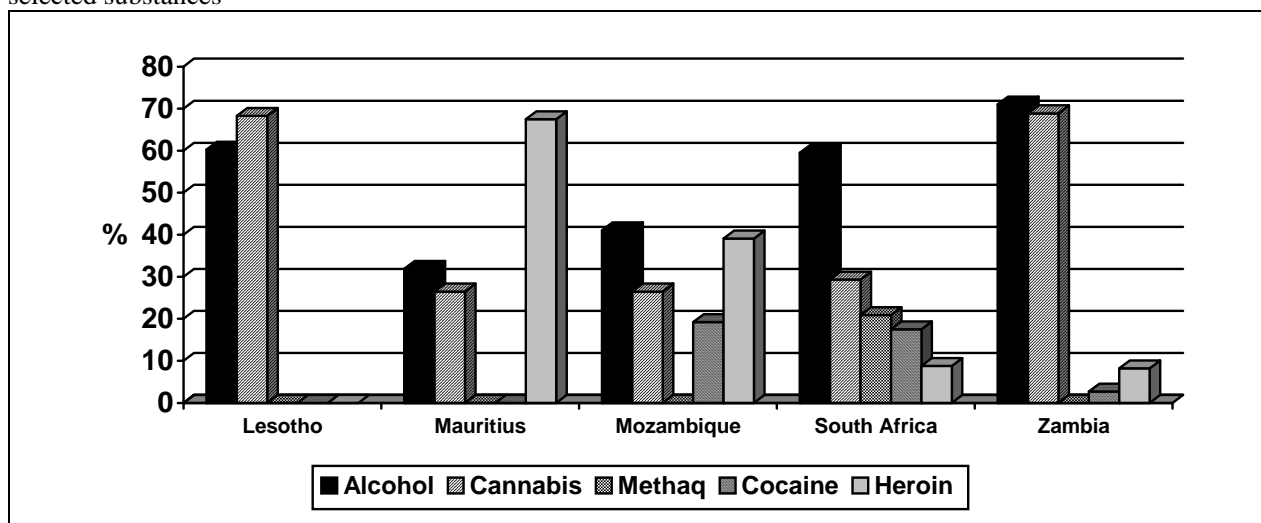
| Country | Period | Alcohol | Cannabis | Methaqualone (Mtg) | Cocaine | Heroin | Ecstasy | OTC/Pre * | Other | N | # tx. centres |
|--------------|-------------|---------|----------|--------------------|---------|--------|---------|-----------|-------|------|---------------|
| Botswana | Jan-Jun '02 | 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 |
| | Jul-Dec '03 | 73.7 | 26.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 19 | 4 |
| | Jan-Jun '04 | N/A | | | | | | | | | |
| 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 |
| | Jul-Dec '03 | 51.0 | 49.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 49 | 6 |
| Jan-Jun '04 | 52.4 | 47.6 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 63 | 9 | |
| 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 | 79.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.6 | 361 | 5 |
| | Jul-Dec '03 | 14.9 | 85.1 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 417 | 7 |
| | Jan-Jun '04 | 20.7 | 79.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 556 | 7 |
| 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 |
| | Jul-Dec '03 | 36.7 | 6.1 | 0.0 | 0.0 | 53.5 | 0.0 | 3.2 | 0.5 | 591 | 8 |
| Jan-Jun '04 | 28.4 | 7.4 | 0.0 | 0.0 | 58.9 | 0.0 | 4.2 | 1.2 | 596 | 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 | 10.6 | 0.0 | 0.0 | 1.0 | 104 | 4 |
| | Jul-Dec '03 | 54.3 | 16.5 | 0.0 | 3.2 | 25.2 | 0.0 | 0.0 | 0.8 | 127 | 6 |
| | Jan-Jun '04 | 39.1 | 19.2 | 0.0 | 8.6 | 33.1 | 0.0 | 0.0 | 0.0 | 151 | 5 |
| 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 |
| | Jul-Dec '03 | 66.7 | 3.7 | 22.2 | 7.4 | 0.0 | 0.0 | 0.0 | 0.0 | 54 | 2 |
| | Jan-Jun '04 | 53.7 | 7.4 | 26.0 | 13.0 | 0.0 | 0.0 | 0.0 | 0.0 | 54 | 3 |
| 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 |
| | Jul-Dec '03 | 48.7 | 18.9 | 14.1 | 6.2 | 5.2 | 0.8 | 2.8 | 2.3 | 5726 | 50 |
| Jan-Jun '04 | 47.9 | 16.6 | 11.9 | 8.2 | 6.2 | 0.8 | 2.9 | 5.0 | 6680 | 58 | |
| Swaziland | Jul-Dec '03 | 30.6 | 59.7 | 9.7 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 62 | 2 |
| | Jan-Jun '04 | 61.9 | 36.3 | 0.0 | 0.5 | 0.5 | 0.0 | 0.5 | 0.5 | 223 | 2 |
| Tanzania | Jul-Dec '03 | 39.1 | 38.8 | 0.0 | 0.0 | 18.2 | 0.0 | 0.0 | 3.9 | 330 | 3 |
| | Jan-Jun '04 | 17.8 | 50.3 | 0.0 | 0.0 | 30.2 | 0.0 | 0.0 | 1.8 | 169 | 3 |
| Zambia | Aug-Dec '03 | 34.6 | 61.8 | 0.5 | 0.5 | 0.5 | 0.0 | 1.6 | 0.5 | 191 | 4 |
| | Jan-Jun '04 | 24.0 | 64.5 | 0.0 | 1.1 | 8.2 | 0.0 | 0.0 | 2.2 | 183 | 3 |

*-includes psychotropic medicines

- Injection use of heroin is extremely high in Mauritius (over 90%), but is also high in the South African sites (28% in Cape Town, 55% in Gauteng, and 32% in Mpumalanga), in Maputo, Mozambique (23%), and in Tanzania (29%).
- During the first half of 2004, **Ecstasy** (methylene-dioxymethamphetamine) was only reported as a primary substance of abuse in treatment centres in South Africa (less than 1%).
- **Over-the-counter and prescription medicines** (primarily benzodiazepines and analgesics) were only reported as primary drugs of abuse in Mauritius, South Africa, and Swaziland, ranging between 0.5% and 4% of admissions.
- **Other drugs** reflected in treatment demand data included khat, methcathinone (CAT), LSD, methamphetamine and inhalants (e.g. glue, petrol). A dramatic increase in treatment demand for methamphetamine was noted in Cape Town (South Africa) especially in the first half of 2004, particularly among patients under 20 years. One in five patients in Cape Town now have methamphetamine as a primary or secondary drug of abuse, and 41% report daily use.

Figure 20 shows the percentage of persons in treatment who report any abuse (i.e. as primary or secondary drug of abuse) by country and per selected drugs. Such information was available from five countries. From this figure it is clear that patients are coming to treatment for a greater array of substances of abuse in Mozambique and South Africa as compared to Lesotho, Mauritius and Zambia. Overall treatment demand related to cannabis is highest in Lesotho and Zambia (at almost 70% of all treatment demand). For methaqualone treatment demand is highest in South Africa, whereas for heroin overall treatment demand in Mauritius substantially outstrips that of other countries in the region. Almost one in five patients in Mozambique and South Africa have cocaine as either a primary or secondary drug of abuse.

Figure 20: Treatment demand data: primary or secondary drugs of abuse (January – June 2004): selected substances



Across countries and sites the proportion of patients in treatment who are under 20 years of age averages 12% and ranges from 0.5% (Mauritius) to 27% (Zambia). This has declined substantially since the last reporting period, possibly reflecting the increase in certain countries of older patients whose primary drug of abuse is methaqualone, cocaine or heroin. It could also reflect a decrease in the availability of treatment slots for young persons. Over the last few reporting periods increases in the proportion of patients coming to treatment who are under 20 years of age have only been noted in Malawi whereas decreases have been noted in Lesotho, Mauritius, Swaziland, Tanzania and Zambia.

With the exception of Mauritius, across sites the predominant mode of ingesting substances is by swallowing or smoking (Table 7). In Mauritius, however, over half of persons in treatment injected their primary drug of abuse. Overall, only 3% of patients in treatment centres in the South African sites reported injection as their primary mode of ingesting their primary substance. The only other countries (on board the SENDU project) where intravenous drug use was reported were Mozambique, Tanzania and Zambia. Increases in intravenous drug use were noted in Mauritius, South Africa, Tanzania and Zambia.

In Lesotho, Mauritius, Namibia, and South Africa patients in treatment whose primary drug of abuse is alcohol are substantially older than persons having other primary drugs of abuse (Table 8). The mean age of patients whose primary drug of abuse is cannabis ranges from 22 years in Lesotho to 32 years in East London (South Africa) and Mauritius. Persons in treatment whose primary drug of abuse is heroin appear to be older in Mauritius than in Mozambique and in South Africa.

Table 6: Percentage of the population in treatment under 20 years of age

| Country | Period | % |
|--------------|---------------|------|
| Botswana | Jan-Jun '02* | 11.8 |
| | Jul-Dec '02* | 8.4 |
| | Jan-Jun '03 | 28.8 |
| | Jul-Dec '03 | 5.3 |
| | Jan-Jun '04 | N/A |
| Lesotho | Jul-Dec '01** | 40 |
| | Jan-Jun '02 | 15 |
| | Jul-Dec '02 | 2 |
| | Jan-Jun '03 | 29.7 |
| | Jul-Dec '03 | 18.2 |
| | Jan-Jun '04* | 6.1 |
| Malawi | Jul-Dec '02 | 45.8 |
| | Jan-Jun '03 | 10.6 |
| | Jul-Dec '03 | 12.7 |
| | Jan-Jun '04 | 19.4 |
| Mauritius | Jul-Dec '01 | 2.4 |
| | Jan-Jun '02 | 3.1 |
| | Jul-Dec '02 | 4.2 |
| | Jan-Jun '03 | 4.4 |
| | Jul-Dec '03 | 1.7 |
| | Jan-Jun '04 | 0.5 |
| Mozambique | Oct-Dec '02 | 8.5 |
| | Jan-Jun '03 | 2.8 |
| | Jul-Dec '03 | 11.6 |
| | Jan-Jun '04 | 10.5 |
| Namibia | Jan-Jun '02 | 10.0 |
| | Jul-Dec '02 | 6.5 |
| | Jan-Jun '03 | 2.9 |
| | Jul-Dec '03 | 8.9 |
| | Jan-Jun '04 | 9.3 |
| South Africa | Jul-Dec '01 | 22.7 |
| | Jan-Jun '02 | 22.6 |
| | Jul-Dec '02 | 22.8 |
| | Jan-Jun '03 | 21.7 |
| | Jul-Dec '03 | 23.5 |
| | Jan-Jun '04 | 22.0 |
| Swaziland | Jul-Dec '03 | 53.0 |
| | Jan-Jun '04 | 9.0 |
| Tanzania | Jul-Dec '03 | 11.5 |
| | Jan-Jun '04 | 4.3 |
| Zambia | Aug-Dec '03 | 37.2 |
| | Jan-Jun '04 | 27.6 |

*-under 20 years, **-under 23 years

Table 7: Primary mode of drug use by primary substance of abuse (%)

| Country | Period | Swallow | Smoke | Inject | Snorted | Other |
|------------|--------------|---------|-------|--------|---------|-------|
| Botswana | Jan-Jun '02 | 70.4 | 24.7 | 0.0 | 4.8 | 0.0 |
| | Jul-Dec '02 | 80.7 | 16.1 | 0.0 | 1.6 | 0.0 |
| | Jan-Jun '03 | 84.7 | 16.7 | 0.0 | 0.0 | 0.0 |
| | Jul-Dec '03 | 84.2 | 15.8 | 0.0 | 0.0 | 0.0 |
| | Jan-Jun '04 | N/A | | | | |
| Lesotho | Jul-Dec '01 | 52.1 | 47.9 | 0.0 | 0.0 | 0.0 |
| | Jan-Jun '02 | 85.0 | 15.0 | 0.0 | 0.0 | 0.0 |
| | Jul-Dec '02 | 97.8 | 2.2 | 0.0 | 0.0 | 0.0 |
| | Jan-Jun '03 | 70.2 | 29.8 | 0.0 | 0.0 | 0.0 |
| | Jul-Dec '03 | 14.9 | 85.1 | 0.0 | 0.0 | 0.0 |
| | Jan-Jun '04 | 52.4 | 47.6 | 0.0 | 0.0 | 0.0 |
| Malawi | Jul-Dec '02 | 32.7 | 60.3 | 0.0 | 0.0 | 0.0 |
| | Jan-Jun '03 | 19.6 | 79.8 | 0.0 | 0.6 | 0.0 |
| | Jul-Dec '03 | 51.0 | 49.0 | 0.0 | 0.0 | 0.0 |
| | Jan-Jun '04 | 20.7 | 79.3 | 0.0 | 0.0 | 0.0 |
| Mauritius | Jul-Dec '01 | 22.7 | 24.6 | 51.2 | 1.5 | 0.0 |
| | Jan-Jun '02 | 31.3 | 15.1 | 52.6 | 1.0 | 0.0 |
| | Jul-Dec '02 | 33.7 | 17.7 | 47.7 | 0.0 | 0.0 |
| | Jan-Jun '03 | 39.0 | 8.0 | 52.0 | 1.0 | 0.0 |
| | Jul-Dec '03 | 38.0 | 7.0 | 54.0 | 1.0 | 0.0 |
| | Jan-Jun '04 | 31.0 | 8.0 | 57.0 | 4.0 | 0.0 |
| Mozambique | Oct-Dec '02* | 5.0 | 80.0 | 8.3 | 6.7 | 0.0 |

| Country | Period | Swallow | Smoke | Inject | Snorted | Other |
|--------------|-------------|---------|-------|--------|---------|-------|
| | Jan-Jun '03 | 46.3 | 46.2 | 7.3 | 0.0 | 0.0 |
| | Jul-Dec '03 | 9.0 | 78.0 | 12.0 | 1.0 | 0.0 |
| | Jan-Jun '04 | 40.7 | 49.3 | 8.5 | 0.0 | 0.0 |
| Namibia | Jan-Jun '02 | 84.0 | 16.0 | 0.0 | 0.0 | 0.0 |
| | Jul-Dec '02 | 80.4 | 19.6 | 0.0 | 0.0 | 0.0 |
| | Jan-Jun '03 | 82.9 | 17.1 | 0.0 | 0.0 | 0.0 |
| | Jul-Dec '03 | 66.7 | 33.3 | 0.0 | 0.0 | 0.0 |
| | Jan-Jun '04 | 53.7 | 46.3 | 0.0 | 0.0 | 0.0 |
| South Africa | Jul-Dec '01 | 56.5 | 38.0 | 2.1 | 2.6 | 0.7 |
| | Jan-Jun '02 | 58.0 | 35.9 | 2.4 | 3.1 | 0.7 |
| | Jul-Dec '02 | 58.0 | 36.1 | 2.2 | 3.5 | 0.2 |
| | Jan-Jun '03 | 55.5 | 36.5 | 3.0 | 3.6 | 1.4 |
| | Jul-Dec '03 | 52.3 | 40.3 | 2.7 | 3.6 | 1.1 |
| | Jan-Jun '04 | 51.4 | 40.7 | 3.0 | 4.1 | 0.4 |
| Swaziland | Jul-Dec '03 | 30.6 | 69.4 | 0.0 | 0.0 | 0.0 |
| | Jan-Jun '04 | N/A | | | | |
| Tanzania | Jul-Dec '03 | 38.8 | 50.3 | 4.8 | 4.2 | 0.0 |
| | Jan-Jun '04 | 17.3 | 72.6 | 8.9 | 1.2 | 0.0 |
| Zambia | Aug-Dec '03 | 35.1 | 62.8 | 1.6 | 0.5 | 0.0 |
| | Jan-Jun '04 | 26.1 | 66.7 | 6.7 | 0.6 | 0.0 |

*-excludes alcohol

Table 8: Mean age of persons in treatment by primary drug of abuse

| Country | Period | Primary drug of abuse | | | | | | |
|--------------|-------------|-----------------------|----------|--------------|---------|--------|---------|-----------|
| | | Alcohol | Cannabis | Methaqualone | Cocaine | Heroin | Ecstasy | OTC/Pre* |
| Botswana | Jan-Jun '02 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Jul-Dec '02 | 37 | 23 | - | - | - | - | - |
| | Jan-Jun '03 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Jul-Dec '03 | 26-30 | 25 | N/A | N/A | N/A | N/A | N/A |
| | Jan-Jun '04 | N/A | | | | | | |
| Lesotho | Jul-Dec '01 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Jan-Jun '02 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Jul-Dec '02 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Jan-Jun '03 | 34.8 | 34.3 | - | - | - | - | - |
| | Jul-Dec '03 | N/A | N/A | - | - | - | - | - |
| | Jan-Jun '04 | 35.0 | 22.0 | - | - | - | - | - |
| Malawi | Jul-Dec '02 | 21 | 18 | - | - | - | - | - |
| | Jan-Jun '03 | 22 | 24 | - | - | - | - | - |
| | Jul-Dec '03 | 25.8 | 24.1 | - | - | - | - | - |
| | Jan-Jun '04 | 26.6 | 24.1 | - | - | - | - | - |
| Mauritius | Jul-Dec '01 | 38.2 | 31.4 | - | - | 32.7 | - | 26-28 |
| | Jan-Jun '02 | 41.0 | 31.9 | - | - | 24.9 | - | 24.6-31.2 |
| | Jul-Dec '02 | 38.3 | 28.7 | - | - | 33.6 | - | 27.6 |
| | Jan-Jun '03 | 38.7 | 27.8 | - | - | 32.0 | - | 28.3-34.2 |
| | Jul-Dec '03 | 40.3 | 28.5 | - | - | 32.9 | - | 30.2-37.3 |
| | Jan-Jun '04 | 40.8 | 32.1 | - | - | 34.6 | - | 33.0-41.0 |
| Mozambique | Oct-Dec '02 | 31.5 | 25.1 | - | 25.0 | 26.5 | - | - |
| | Jan-Jun '03 | 34.1 | 25.0 | - | 43.0 | 27.4 | - | - |
| | Jul-Dec '03 | 25.5 | 22.8 | - | 30.0 | 27.5 | - | - |
| | Jan-Jun '04 | 25.5 | 22.8 | - | 30.0 | 27.5 | - | - |
| Namibia | Jan-Jun '02 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Jul-Dec '02 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Jan-Jun '03 | 45 | - | 31 | 32 | - | - | - |
| | Jul-Dec '03 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Jan-Jun '04 | 39 | 22 | 27 | 23 | - | - | - |
| South Africa | Jul-Dec '01 | 37-41 | 19-23 | 20-30 | 29-30 | 23-24 | 17-22 | 30-37 |
| | Jan-Jun '02 | 37-41 | 19-23 | 21-28 | 27-36 | 23-25 | 20-23 | 35-41 |
| | Jul-Dec '02 | 36-41 | 20-24 | 22-27 | 28-30 | 23-25 | 21 | 35-45 |
| | Jan-Jun '03 | 36-41 | 20-22 | 21-25 | 27-33 | 22-24 | 21-26 | 37-43 |
| | Jul-Dec '03 | 35-40 | 19-22 | 22-26 | 27-31 | 23-24 | 22-23 | 38-39 |
| | Jan-Jun '04 | 37-41 | 19-24 | 21-25 | 24-30 | 23-25 | 20-23 | 36-43 |
| Swaziland | Jul-Dec '03 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Jan-Jun '04 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Tanzania | Jul-Dec '03 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | Jan-Jun '04 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Zambia | Aug-Dec '03 | 24.3 | 23.5 | 21.0 | N/A | 23.0 | N/A | 25.0-30.5 |
| | Jan-Jun '04 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

*-includes psychotropic medicines

2.2.2 Law enforcement data

Information on the proportion of police arrests for dealing in different drugs is given in Table 9. In Botswana and Swaziland no arrests for drug dealing/trafficking were recorded in the first half of 2004. In Lesotho, Malawi and Mozambique (Maputo) in the first half of 2004 all arrests for drug dealing (trafficking) 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 2004 was noted in Tanzania (2 219), followed by Zambia (1 423). Increases in the number of persons arrested for dealing in cannabis were noted for five of the nine countries for which comparative data were available: Lesotho, Malawi, Mauritius, Maputo (Mozambique), and Zambia, but in all cases except Maputo there was no increase in the proportion of arrests for dealing in cannabis in the first half of 2004. Over the eight countries where arrests were made for dealing in cannabis (excluding South Africa), on average 85% of all arrests for dealing in drugs involved cannabis.

Arrests for dealing in **Mandrax (methaqualone)** were only made in Namibia, South Africa and Tanzania during this period: 63 arrests in Namibia (including arrests for possession), 4 829 cases in South Africa, and 1 arrest in Tanzania. The proportion of arrests for dealing in this drug stayed much the same in both Namibia and South Africa in the last two reporting periods. Arrests for dealing in **cocaine** were made in Namibia, South Africa, Tanzania, Zambia and Zimbabwe, though in the latter three countries the proportion of arrests for dealing in cocaine was less than one percent of all arrests. The largest increase was noted in Namibia, from 2.9% of all arrests to 12.4%. In Mauritius over six out of every 10 arrests for drug trafficking involved **heroin**. This is substantially greater than for Namibia, South Africa, Tanzania and Zambia, the only other countries where arrests for dealing in heroin were recorded. In these countries the corresponding proportions were 0.3%, 3.3%, 9.9% and 0.5% respectively. Increases ranging from 0.3 percentage points in Namibia to 6.3 in Tanzania were noted across these five countries.

With regard to **Ecstasy** and other **amphetamine type stimulants**, a substantial number of cases relating to dealing in Ecstasy and methamphetamines have been reported in South Africa over the past five reporting periods (now comprising 21.5% of all cases, n=1789 cases, in the first half of 2004). A large increase in arrests related to Ecstasy dealing/possession was also noted in Namibia. Of the 11 countries for which data on drug-related arrests were recorded as part of the SENDU project in 2004, only in South Africa were persons arrested for dealing in **LSD** (less than 1% in the first half of 2004). Arrests for dealing in prescription medicines were noted in Zambia and South Africa, and arrests for dealing in **khat** were reported in Tanzania (4% of all arrests) and in Zambia.

In Lesotho, Malawi, Mauritius, Mozambique and Zimbabwe, persons were arrested for dealing in a very narrow range of drugs (two distinct types or less), whereas in Namibia, South Africa, Tanzania and Zambia persons were arrested for dealing in a much greater spectrum of substances.

Police seizures are indicated in Table 10. The highest seizures of **cannabis** during the first half of 2004 were noted in Tanzania, 234 045 kg. No seizure information regarding cannabis is available for South Africa. Increased seizure amounts were noted in three countries and a decrease in four countries. Seizures of **heroin** were noted in Mauritius, Namibia, South Africa, Swaziland, Tanzania and Zambia. The quantity seized was, however, very low in most countries apart from Mauritius, South Africa, and Zambia. The amount seized over the 11 countries was 17.5 kg, with increases being noted in Mauritius, South Africa and Zambia (off a low base). Seizures of **Mandrax (methaqualone)** were noted in Botswana, Namibia, South Africa and Tanzania, with the equivalent of 592 968 Mandrax tablets being recorded by the four police forensic science laboratories in South Africa. Mandrax seizures were down in Namibia and South Africa but were substantially increased in Botswana and Tanzania. **Cocaine** seizures in the region overall (67 kg) were less than in the previous reporting period and were over ten kilogrammes only in Namibia and South Africa. Seizures of **amphetamine type stimulants** (mainly Ecstasy) were noted in four countries (the equivalent of 147 809 units in total), with the largest seizures being noted in South Africa and Zambia. A small quantity

of **LSD** was seized in South Africa and 251 kg of **khat** was seized in Tanzania, substantially less than was seized in the second half of 2003.

Table 9: Police arrests for drug dealing/trafficking (row % add up to 100)

| Country | Period | Cannabis or hashish | Mtq. | Cocaine or crack | Ecstasy/ATS | Heroin | Prescript | LSD | Khat | N |
|----------------------|--------------|---------------------|------|------------------|-------------|--------|-----------|-----|------|------|
| Botswana* | Jan-Jun '02 | 100.0 | 0.0 | 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 | 0.0 | - | 183 |
| | Jan-Jun '03 | 96.5 | 1.2 | 1.2 | 1.2 | 0.0 | 0.0 | 0.0 | - | 170 |
| | Jul-Dec '03 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 0 |
| | Jan-Jun '04 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0 |
| Lesotho | Jul-Dec '01 | 100.0 | 0.0 | 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 | 0.0 | - | 87 |
| | Jul-Dec '02 | 100.0 | 0.0 | 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 | 0.0 | - | 103 |
| | Jul-Dec '03 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 56 |
| | Jan-Jun '04 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 146 |
| Malawi | Jul-Dec '02 | 100.0 | 0.0 | 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 | 0.0 | - | 348 |
| | Jul-Dec '03 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 182 |
| | Jan-Jun '04 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 355 |
| Mauritius | Jul-Dec '01 | 47.0 | 0.0 | 0.0 | 0.0 | 53.0 | 0.0 | 0.0 | - | 156 |
| | Jan-Jun '02 | 37.0 | 0.0 | 0.0 | 0.0 | 63.0 | 0.0 | 0.0 | - | 125 |
| | Jul-Dec '02 | 59.1 | 0.0 | 0.0 | 0.0 | 40.9 | 0.0 | 0.0 | - | 149 |
| | Jan-Jun '03 | 46.0 | 0.0 | 0.0 | 0.0 | 54.0 | 0.0 | 0.0 | - | 153 |
| | Jul-Dec '03 | 41.0 | 0.0 | 0.0 | 0.0 | 59.0 | 0.0 | 0.0 | 0.0 | 122 |
| | Jan-Jun '04 | 37.2 | 0.0 | 0.0 | 0.0 | 62.8 | 0.0 | 0.0 | 0.0 | 199 |
| Mozambique (Maputo)* | Oct-Dec '02 | N/A | 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 | 0.0 | - | 4 |
| | Jul-Dec '03 | 0.0 | 0.0 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0 |
| | Jan-Jun '04 | 100.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 44 |
| Namibia* | Jan-Jun '02 | 84.4 | 14.1 | 1.0 | 0.5 | 0.0 | 0.0 | 0.0 | - | 397 |
| | Jul-Dec '02 | 84.9 | 9.3 | 3.5 | 2.2 | 0.0 | 0.0 | 0.0 | - | 226 |
| | Jan-Jun '03 | 88.9 | 9.6 | 1.0 | 0.5 | 0.0 | 0.0 | 0.0 | - | 208 |
| | Jul-Dec '03 | 79.8 | 16.5 | 2.9 | 0.8 | 0.0 | 0.0 | 0.0 | 0.0 | 491 |
| | Jan-Jun '04 | 64.2 | 17.7 | 12.4 | 5.4 | 0.3 | 0.0 | 0.0 | 0.0 | 355 |
| South Africa | Jul-Dec '01 | - | 65.7 | 16.2 | 13.8 | 3.0 | 0.0 | 1.3 | - | 4756 |
| | Jan-Jun '02 | - | 60.5 | 19.1 | 15.2 | 4.8 | 0.0 | 0.4 | - | 4818 |
| | Jul-Dec '02 | - | 61.3 | 16.5 | 16.8 | 4.6 | 0.0 | 0.8 | - | 5131 |
| | Jan-Jun '03 | - | 66.2 | 13.5 | 16.6 | 2.9 | 0.0 | 0.8 | - | 5910 |
| | Jul-Dec '03 | - | 59.9 | 12.0 | 24.5 | 3.0 | 0.0 | 0.6 | 0.0 | 7373 |
| | Jan-Jun '04 | - | 58.0 | 16.8 | 21.5 | 3.3 | 0.0 | 0.4 | 0.0 | 8321 |
| Swaziland | Jul-Dec '03 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0 |
| | Jan-Jun '04 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0 |
| Tanzania | Jan-Jun '03* | 85.8 | 0.2 | 0.7 | 0.0 | 5.7 | 0.0 | 0.0 | 7.5 | 2701 |
| | Jul-Dec '03 | 90.4 | 0.0 | 0.0 | 0.0 | 3.6 | 0.0 | 0.0 | 6.1 | 3418 |
| | Jan-Jun '04 | 85.7 | 0.04 | 0.1 | 0.0 | 9.9 | 0.0 | 0.0 | 4.2 | 2590 |
| Zambia | Aug-Dec '03 | 98.0 | 0.1 | 0.1 | 0.0 | 0.2 | 1.0 | 0.0 | 0.6 | 1247 |
| | Jan-Jun '04 | 95.7 | 0.0 | 0.5 | 0.0 | 0.5 | 2.0 | 0.0 | 1.4 | 1487 |
| Zimbabwe* | Jan-Jun '04 | 99.8 | 0.0 | 0.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 568 |

* 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

Information on drug prices is provided in Table 10. Cannabis is clearly very cheap in most SADC member states (excluding Mauritius), with at least four countries (Malawi, Mozambique, Swaziland and Zambia) being able to provide in excess of 50 joints of cannabis for US\$10. One explanation for this is that cannabis is widely cultivated in certain parts of southern Africa. Heroin is also significantly cheaper in South Africa as compared to Namibia, and especially Mauritius.

Table 10: Police seizures

| Country | Period | Cannabis (kg) | Methaqualone (tablets)* | Cocaine (g) | Amphetamine (tablets)* | Heroin (g) | LSD (units) | Khat (kg) |
|---------------------|-------------|---------------|-------------------------|--------------------|------------------------|------------|-------------|-----------|
| Botswana | Jan-Jun '02 | 1 471 | 0 | 0 | 0 | 0 | 0 | - |
| | Jul-Dec '02 | 1 471 | 0 | 0 | 0 | 0 | 0 | - |
| | Jan-Jun '03 | 1 189 | 5 | 1.77 | 31 | 0 | 0 | - |
| | Jul-Dec '03 | 1 359 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Jan-Jun '04 | 581 | 2 784 | 0 | 29 | 0 | 0 | 0 |
| Lesotho | Jul-Dec '01 | 19 671 | 0 | 0 | 10 045 | 0 | 0 | - |
| | Jan-Jun '02 | 4 154 | 0 | 0 | 0 | 0 | 0 | - |
| | Jul-Dec '02 | 4 417 | 0 | 0 | 0 | 0 | 0 | - |
| | Jan-Jun '03 | 5 380 | 0 | 0 | 0 | 0 | 0 | - |
| | Jul-Dec '03 | 2 020 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Jan-Jun '04 | 7 349 | 0 | 0 | 0 | 0 | 0 | 0 |
| Malawi | Jul-Dec '02 | 4 659 | 0 | 0 | 0 | 0 | 0 | - |
| | Jan-Jun '03 | 6 242 | 0 | 0 | 0 | 0 | 0 | - |
| | Jul-Dec '03 | 4 527 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Jan-Jun '04 | 7 808 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mauritius | Jul-Dec '01 | 30 | 0 | 0 | 0 | 22 441 | 0 | - |
| | Jan-Jun '02 | 23 | 0 | 0 | 0 | 4 995 | 0 | - |
| | Jul-Dec '02 | 44 | 0 | 0 | 0 | 6 973 | 0 | - |
| | Jan-Jun '03 | 9 | 0 | 0 | 0 | 15 432 | 0 | - |
| | Jul-Dec '03 | 34 | 0 | 0 | 0 | 517 | 0 | 0 |
| | Jan-Jun '04 | 39 | 0 | 0 | 0 | 2 357 | 0 | 0 |
| Mozambique (Maputo) | Oct-Dec '02 | N/A | N/A | N/A | N/A | N/A | N/A | - |
| | Jan-Jun '03 | 10 | 0 | 5 100 | 0 | 0 | 0 | - |
| | Jul-Dec '03 | 23 | 1 000 | 9 200 | 0 | 15 | 0 | 0 |
| | Jan-Jun '04 | 22 | 0 | 0 | 0 | 0 | 0 | 0 |
| Namibia | Jan-Jun '02 | 775 | 9 179 | 78 rocks | 10 | 0 | 0 | - |
| | Jul-Dec '02 | 147 | 679 | 189 rocks | 36 | 0 | 0 | - |
| | Jan-Jun '03 | 532 | 2 714 | 96 rocks | 14 | 0 | 0 | - |
| | Jul-Dec '03 | 96 | 6 426 | 55 | 162 | 0 | 0 | 0 |
| | Jan-Jun '04 | 434 | 1 185 | 15 350 + 141 rocks | 169 | 2 | 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 | - |
| | Jul-Dec '03 | N/A | 10 935 182 | 188 298 | 257 406 | 2 190 | 756 | 0 |
| | Jan-Jun '04 | N/A | 592 968 | 46 305 | 76 407 | 13 655 | 235 | 0 |
| Swaziland | Jul-Dec '03 | 8 463 | 473 | 3 832 | 0 | 0.02 | 0 | 0 |
| | Jan-Jun '04 | 3 919 | 0 | 0 | 0 | 0.05 | 0 | 0 |
| Tanzania | Jan-Jun '03 | 413 361 | 212 | 1,335 | 0 | 2 531 | 0 | 1 454 |
| | Jul-Dec '03 | 599 613 | 0 | 1 392 | 0 | 2 000 | 0 | 10 548 |
| | Jan-Jun '04 | 234 043 | 1000 | 620 | 0 | 10.65 | 0 | 251 |
| Zambia | Aug-Dec '03 | 1 322 | 8 | 0.1 | 69 152 | 55.5 | 0 | 0 |
| | Jan-Jun '04 | 2 510 | 0 | 0.7 | 71 204 | 1 446 | 0 | 0 |
| Zimbabwe | Jan-Jun '04 | 555 | 0 | 0.7 | 0 | 0 | 0 | 0 |

*or equivalent (calculated from powder seized): 1 g = 2 tablets

Table 11: Drug prices (January – June 2004) or latest available – in local currencies (1 April 2004)

| Country | Currency | Cannabis (g) ¹ | Mandrax (tablet) | Cocaine (g) | Crack (rock) ² | Ecstasy (tablet) | Heroin (g) | Khat (g) | Speed (unit) | Approx. local currency to 1 US\$ |
|--------------|-----------|---------------------------|------------------|-------------|---------------------------|------------------|------------|----------|--------------|----------------------------------|
| Botswana | Pula | 2 | 80 | 350 | 100 | 80 | N/A | N/A | N/A | 4.66 |
| Lesotho | Maloti | 6-8 ² | N/a | N/a | N/a | N/a | N/a | N/a | N/a | 6.28 |
| Malawi | Kwacha | 5 | N/a | N/a | N/a | N/a | N/a | N/a | N/a | 106.33 |
| Mauritius | Rupees | 300 | N/a | N/a | N/a | N/a | 10 000 | N/a | N/a | 26.40 |
| Mozambique | Metical | 3 000 | N/A | 700 000 | N/A | N/A | 600 000 | N/a | N/a | 23300.00 |
| Namibia | Dollar | 5 | 50 | 450 | 150 | 120 | 450 | N/a | N/a | 6.28 |
| Swaziland | Lilangeni | 0.8 | 50 | 212 | - | - | 180 | N/a | N/a | 6.28 |
| South Africa | Rands | 1-2 | 28-35 | 250-350 | 50-150 | 50-80 | 180-200 | N/a | 3-60 | 6.28 |
| Swaziland | Emlangeni | 0.5 | - | - | - | - | 455 | - | - | 6.28 |
| Tanzania | Shilling | 15 | 1 000/gm | 20 000 | N/a | N/a | 18 000 | N/a | N/a | 1082.30 |
| Zambia | Kwacha | 500 | 7000 | 170 000 | - | - | 140 000 | 3 500 | - | 4675.00 |
| Zimbabwe | Dollar | 2 000 | 50 000 | 300 000 | - | 80-100K | 250 000 | N/a | N/a | 4277.10 |

¹-0.5 g = 1 joint; ²-per small plastic bank bag; ²-depends on size

2.2.3 NGO and other data sources

Cross-national comparisons based on data collected from NGOs, prisons and other sources is not yet available. Information pertaining to other sources of data, by country, is provided in Section 2.1

3. CONCLUSION

3.1 Summary

This section summarises the situation with regard to the nature and extent of AOD abuse and associated consequences in the 11 SADC member states that are fully “on board” the SENDU project.

- Botswana
- Lesotho
- Malawi
- Mauritius
- Mozambique
- Namibia
- South Africa
- Swaziland
- Tanzania
- Zambia
- Zimbabwe

It should, however, be noted that information on drug treatment demand is not yet available for Zimbabwe.

Cannabis and **alcohol** continue to dominate treatment demand and community concern in most SADC countries. They independently comprise over one-third of the demand for drug treatment in the region. Across the region there continues to be strong evidence of the burden placed by alcohol and cannabis on health and law enforcement sectors and the number of persons arrested for dealing/trafficking in cannabis increased in over half of the countries. There is also evidence of substantial use of other drugs such as Mandrax (methaqualone), heroin, cocaine and amphetamine type stimulants (ATS) 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. In addition, use of heroin and dealing/trafficking in this drug increased in landlocked country of Zambia in the first half of 2004. Increases in treatment demand, seizures⁴, and the proportion of arrests for dealing/trafficking in heroin were noted in all countries where heroin use was reported.
- Treatment demand and/or law enforcement indicators for **cocaine** are highest in Mozambique, Namibia, and South Africa, i.e. in the coastal countries in the south and east of the SADC region. There was an increase in all countries where there was a demand for treatment for problems associated with cocaine use. Regionally, however, there was a decline in seizures for cocaine in the first half of 2004. One of the biggest changes noted was the increase in the proportion of arrests related to cocaine relative to other drugs in Namibia.
- Treatment demand and law enforcement indicators related to Mandrax (**methaqualone**) continue to be high in Namibia and South Africa. However, as compared to the previous six month period there appears to have been a shift in countries where there is less evidence of use of Mandrax and/or in dealing in this drug with such evidence no longer being noted in Mozambique, Swaziland and Zambia, but now being picked up in Botswana and Tanzania.

⁴ Except Tanzania. In addition it should be noted that the increase in heroin seizures in Swaziland was negligible.

- Treatment demand and law enforcement indicators indicate use of and trafficking in **amphetamine type stimulants** (ATS), especially Ecstasy and methamphetamine in South Africa. Trafficking of ATS was also noted in Botswana, Namibia and Zambia.
- The natural stimulant, **Khat**, continues to show up in treatment demand and law enforcement indicators in Tanzania.

Across sites, just over one in 10 patients receiving treatment for alcohol or drug related problems is under 20 years of age. This has shown a decrease over time and probably reflects the increase in older patients whose primary drug of abuse is methaqualone, cocaine or heroin. It could also reflect a decrease in the availability of treatment slots for younger patients.

The most alarming finding reported was the high level of HIV/AIDS cases associated with intravenous drug use in Mauritius, increasing from 27% of all HIV cases involving intravenous drug users in 2001 (with or without heterosexual contact) to 51% in the first half of 2004. In this country 57% 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 internationally to violence and other mental health problems.

A rough comparison of levels of substance use and associated consequences to society based on treatment demand and law enforcement indicators is provided in Table 12.

Street prices of illicit drugs vary substantially across countries, with the price of heroin in Mauritius being more than 10 times that in South Africa (in US dollar terms). For 10 US dollars one could purchase one cannabis joint in Mauritius as compared to more than 50 in Malawi, Mozambique, Swaziland and Zambia.

Table 12: Composite assessment of the use of various substances per SADC country and negative effect on health and social systems (January to June 2004) based on treatment demand (Tx-D) and law enforcement (Law-E) indicators

| Country | Cannabis | | Mandrax | | Cocaine | | Heroin | | ATS | |
|--------------|----------|-------|---------|-------|---------|-------|--------|-------|------|-------|
| | Tx-D | Law-E | Tx-D | Law-E | Tx-D | Law-E | Tx-D | Law-E | Tx-D | Law-E |
| Botswana | N/A | + | N/A | + | N/A | - | N/A | - | N/A | + |
| DRC# | ++ | + | - | - | - | + | - | + | - | - |
| Lesotho | +++ | +++ | - | - | - | - | - | - | - | - |
| Malawi | +++ | +++ | - | - | - | - | - | - | - | - |
| Mauritius | + | + | - | - | - | - | +++ | ++ | - | - |
| Mozambique | ++ | ++ | - | - | ++ | - | +++ | - | - | - |
| Namibia | + | ++ | ++ | ++ | ++ | ++ | - | + | - | + |
| South Africa | ++ | N/A | ++ | +++ | ++ | ++ | ++ | ++ | + | ++ |
| Swaziland | ++ | + | - | - | + | - | + | + | - | - |
| Tanzania | +++ | +++ | - | + | - | + | +++ | ++ | - | - |
| Zambia | +++ | +++ | - | - | + | + | ++ | ++ | + | ++ |
| Zimbabwe | N/A | ++ | N/A | - | N/A | + | N/A | - | N/A | - |

- substance either not used or not showing up substantially on indicators; + some evidence of use of drug and/or dealing in the country; ++ law enforcement and/or treatment demand indicators suggest moderate use of and/or dealing in substance; +++ substantial use and/or negative consequences indicated (e.g. arrests for dealing); #-from presentation by Mr Justin Ntambwa on Kinshasa (DRC)

Various policy implications were raised in the country reports for January to June 2004 and at the 6th SENDU Regional Report Back Meeting. These are indicated in Table 13 below, with reference to specific target groups and intervention approaches. Some of the recommendations are relevant to several or most countries, whereas others were made with reference to a particular country, but would in all likelihood have wider relevance.

Table 13: Selected policy implications

| Target | Intervention |
|--|--|
| Primary prevention | |
| Youth | Target children at a young age, focusing on gateway drugs such as alcohol, tobacco and cannabis (Mauritius). Focus particularly on children from broken homes (DRC). Intensify efforts to reduce methamphetamine use in Cape Town among youth and prevent the spread of use of this drug to other areas. |
| All | Step up efforts to alleviate poverty (Botswana). |
| All | Intensify AOD education broadly (Botswana, Malawi, Zambia). |
| Early intervention | |
| Intravenous drug users and heroin users in general | Pilot test harm reduction strategies to reduce infections and other problems such as overdoses (Mauritius, Tanzania, South Africa). |
| Sex workers | Intervene to address the abuse of drugs by sex workers (DRC). |
| Broader public, liquor suppliers, police | Reduce alcohol-related violence in and around liquor outlets and educate the public that abuse of alcohol can put them at risk for being a victim of a violent assault (South Africa). |
| Treatment/rehabilitation | |
| All (especially youth) | Increase the availability of affordable treatment centres, especially outside of the psychiatric system (Malawi, Mauritius, Namibia, Tanzania, Zambia). |
| Women | Provide facilities for female drug addicts (Mauritius). |
| Unemployed persons | Special interventions are needed that cater to the needs of unemployed persons (DRC). |
| Health workers | Increase training for health and social services workers in management of substance abuse and in mental health problems (Malawi). Provide training to emergency room (trauma unit) personnel to ensure that they are equipped to deal with cases involving heroin and methamphetamine (South Africa). |
| Workers | Increase treatment and prevention programmes aimed at workers (Lesotho, Mauritius). |
| Other | |
| Legislation | Review and increase the enforcement of drug trafficking legislation (Lesotho); Review legislation on drug abuse (Botswana). Review legislation regarding the carrying of syringes in public (Mauritius). |
| Resources | Ensure that police have adequate resources to enforce anti-drug legislation (Botswana, Namibia). |

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

- Reasons for use of AODs by youth (Malawi).
- Impact of AOD use on mental health (Malawi, Namibia), violence (Mauritius), overdose deaths (Mauritius), and crime (Botswana).
- Poly-drug use (Mauritius).
- Strategies to combat inhalant use among children (Mauritius).
- Incidence of HIV, HBV & HCV among IVDUs and non-IVDUs (Mauritius).
- The relationship between drug abuse and HIV/AIDS (Swaziland, Zambia)
- Barriers to treatment by women and other sectors of the population (Mauritius, Namibia, South Africa).
- Female drug traffickers (Botswana, Mauritius).
- Relationship between drug use, TB, and HIV/AIDS (DRC, Swaziland, Zambia).
- The relationship between patterns of drug abuse and expulsions from school (Zimbabwe).
- Treatment models for resource poor countries.

At the SENDU regional meeting various suggestions were put forward for how data collection efforts could be strengthened. Among other things site facilitators indicated that police need to be

empowered so as to increase arrests for dealing in drugs (Botswana). Various country coordinators highlighted the need for data to be collected from other sources such as youth and juvenile training centres (Lesotho), district hospitals and NGOs (Malawi), and clinics and private hospitals (Namibia). To strengthen the surveillance system a variety of logistical issues also need to be addressed, including the lack of computers (DRC) and drug testing kits (Malawi, Zimbabwe). In general, the need to add NGO data was indicated by several countries as was the benefits of linking SENDU activities more with National Drug Coordinating Committees and the implementation of national drug master plans.

3.2 Next steps and challenges facing the project

The first phase of the SENDU project is due to be completed at the end of June 2005. By the completion of this phase at least one six month data collection period should have been completed at each site.

Challenges facing the project continue to include:

- Getting all available treatment centres in the sentinel sites to contribute treatment demand data, and to continue participation in the network.
- Adding additional sources of data to complement existing sources (mainly treatment demand and law enforcement).
- Ensuring that data on the links between substance use and infectious diseases and crime are also collected. Improving the quality of written and oral reports, and particularly moving from more descriptive reporting to more analytical reporting.
- Getting the SENDU findings to have a greater impact on local, national and regional alcohol/drug policy and practice. In particular, it was felt that clear mechanisms are needed at the SADC Drug Control Committee (SDCC) level and at higher policy organs of SADC to ensure that recommendations made by SENDU are effectively responded to by policy makers.
- Ensuring the long-term sustainability and maturation of the national networks as well as SENDU as a whole.

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