Civil Society Task Force (CSTF) on the UNGASS 2016 Country Consultations for South Africa

The Newlands Sun Hotel, 7 Main Road, Newlands, Cape Town, South Africa

1. CSO consultation (February 1, 2016)

Civil Society Taskforce present: Nathalie Rose (Mauritius) & Eze Eluchie (Nigeria)

The audience was made up of 17 people from CSOs working in different fieldS : Health services, recovery users, harm reduction, school-based interventions, cannabis movements, and in and ou tpatient treatment centres, rights movement, research, as well as the Central Drug Authority (CDA)-(Attendance sheet attached)

The consultation started by an introduction to the UNGASS, its processes, the CSTF, including a presentation of the CSTF Zero Draft Survey by thematic areas.
The participants were then organised in different groups to discuss each thematic area, and reporting was done after lunch.

Details about each thematic area is included in the table below. However, there were some points that were strongly put forward during the discussions, independently of the thematic area, in relation with the context of South Africa:

- There need to be more synergy between different stakeholders : CSO, provincial level, governmental level
- Funding should be redirected to health and social response of drug use instead of policing
- Research in the local context of drugs is paramount as international evidence-based interventions often do not incorporate national/traditional realities and contextualised responses
- The language used by some stakeholders is stigmatising (terms like “drug addict” needs to be replaced by more neutral language)
- There is a strong link between drug use and poverty
- Marginalised populations already vulnerable, and on top of that, drug laws and policies affect them in a way that give rise to human right abuses
- There needs more inclusion of CSOs in drugs and drug policy debate
- Policing efforts should be re-directed towards health and social services
- Criminalisation does not work. It puts people who use drugs more at risk, and alternatives like regulation should be discussed.

GROUP 1	DRUGS and HEALTH
	Need for evidence-based or evidence-informed drug prevention • Evidence: Integrated ground work and research – Marring of processes • Government limited in research approaches and funding • Implementation of programmes (lack of funding, so tap into UN resources) • NGOs need to have a unified voice (planned, provincial representatives) • Lack of information, prevention and presentation of issues • Youth Access to information (Implementation and access to free internet/ Education syllabus) – contextualize programme, experimental approach to best practice • Presentation of information in an accessible manner (who and how) • Integration of medical research, specialists
	Adoption & Availability of harm reduction • Needle exchange should be widely available • NGO Provide access, pilot projects, but these are not yet mainstream • Drug replacement programmes difficult for extremely marginalized populations (homeless people, harm reduction homeless OST, psycho-social aspects, specific populations). There is a need to look at various structures that will enable the provision of OST for specific sub PWUD populations • Harm reduction should not push for OST only • We should also look into the Endocannabinoid system (ECS): [Definition is a group of endogenous cannabinoid receptors located in the mammalian brain and throughout the central and peripheral nervous systems, consisting of neuromodulatory lipids and their receptors]
	Funding concerns • Re-direct policing efforts/ rather spend time on larger targets/ before court • Re-direct funding to prevention, Tx and other services rather than policing • Re-direct to Tx programmes rather than report to specialized community drug courts (i.e. one being piloted in Cape Town since 2008) • Look at Law Assisted Diversion Programmes (U.S.A example)
	Universally available evidence-based and culturally-appropriate drug dependence tx • Western Cape has made good efforts in addressing these issues • Limitation to implementation is funding • Challenge in e.g. translating documentation • Cultural sensitivity, population groups, women, children, youth, religious, socio-economic • Tailoring programme • Therapists need to be flexible • Evidence based models need to be contextualize and adaptable
	Health Response to drug use: • Don't see enough of it • Discussion of the terminology: THE FOCUS IS ALL WRONG: • Criminalisation of the user is entirely wrong: For instance, small time users are harassed, while traffickers are getting away with crimes. The focus on getting the big guys and suppliers is not even there, the police focus on small users to reach their targets. • The government does not have the ability to regulate and govern this // this should be a 'health-focused issue' and not just a *'justice matter or a quota issue for the police'* • *Legalise regulation is the only way to go….* • Terminology is critical: Legalization, regulation of drugs, Distinction between user and dealer/ Classification of legal v.s. illegal / Cost of regulation / funding of monitoring / regulation of chemicals used to manufacture drugs / capacity to regulate / regulation of OTC drugs (only 3% - under represented / pharmaceuticals/ doctors)

	Stigma and Re-integration: *Same drug, different stigma* • Injectors vs. smokers: (i.e. when people are smoking *nyaope* (heroine concoction in townships of South Africa), they are still considered as community-members, while when they start injecting, they are immediately stigmatized from the community) • Abuser (service abuser) / Addict: (someone who is addicted to drugs) • Changing language will change Tx and status • Not abuser, rather disorder, medical conditions, patient, etc
	Access to controlled medicines: • Potential of over-control, over-regulation of useful medication to general public can hinder access • Over-scheduling of medicines is also problematic

GROUP 2	DRUGS and CRIME -
	Concerns around the unequal enforcement of policies and sentencing • Diversion programmes exist, but should be mainstreamed • Drug courts need to be 'standardised' • All 11 Ministries should be represented on the Central Drug Authority • We call for overarching review of the national drug master plan 2018 – an inclusive policy that brings about synergies • Exchange visit programs to 'higher functioning' countries to be implemented
	Harms of traffic and its associated violence and exploitation • Cybercrime exacerbates trafficking • Synergy between supply reduction and harm reduction – conversation between various bodies / training and education is critical for police, teachers, Health Care Workers etc
	An evaluation of whether the current system is cost-effective and making society safer • Provincial review/ survey that should be consolidated to give a national overview, as a national survey is not sufficient • M&E needs to be rigorous and the template should not be standardized for all CSOs
	Allowing for greater policy experimentation by member states • Group addition: Better documentation by communities of functional models • Community dialogues, to identify community needs (e.g. local drug action committee)

GROUP 3	HUMAN RIGHTS, WOMEN, CHILDREN & COMMUNITIES
	Death Penalty • Not applicable in South African context, but participants were strongly against this.
	Human Rights Violations • Drug policies and practices criminalise drug use and/or poverty, and intersectionality of drug use and poverty is key • Human rights of PWUD violated by police, health service providers and members of public • Apart from being a cruel injustice, criminalisation and abuse are counterproductive to their stated aims of reducing drug use and homelessness
	The Right to Care If we are saying that drugs come with major problems, and we know from overwhelming evidence that OST and NSPs are effective, it is unethical to deny these services and instead continue to spend money on ineffective prohibition efforts.

	Women Challenges faced by women who use drugs: no legal protection from rape or GBV, OST discontinued after child delivery, they have no access to child care resources, stigma hinders access to services. • Tradition & religion influence the daily reality of women/women who use drugs/ more than laws and policies. More effort needs to be made to bring legal and practical reality together • Intersection of drug use and sex work – double criminalisation and vulnerability.
	Children • Support/services for children of drug users (in terms of the psychosocial and health impact). Children of women who use drugs are either removed or left to develop in a potentially toxic environment – no/inadequate support for family units. • The discussion around the protection of the child was discussed in the larger group, and it was observed that a legal regulation of drugs was a way of legally controlling children's access to drugs in a more effective way that when it is controlled by the black market's drug cartels.
	Other Marginalised Populations • Populations like prison inmates, or old people who use drugs should receive proper health and social services as well. • Chronic pain: Access to these medications should not be hindered by strict control protocols. However, more mandated healthcare provider support is needed when dispensing powerful painkillers • Marginalisation and lack of resources increase risks of drug use, leading to increased criminalisation and marginalisation, with ineffective access to services that are needed to address drug problems on an individual level
GROUP 4	NEW CHALLENGES, THREATS & REALITIES IN ADDRESSING THE WORLD DRUG PROBLEM
	New psychoactive substances (NPS) : • Criminalization does not work / no point putting 'new' substances on the 'list' • Most substances deemed to be 'new' are either existing and/ or pharmaceutical products • More autonomy needs to be given to the organisations dealing with these substances at user level. Currently in the hands of the police and funds/ information on the substances are not constructively used • "'Synthetic cannabis is the result of Cannabis prohibition"'
	Diverse views on the conventions • Disconnect between CDA(Central Drug Authority) representing South Africa at UNGASS, and views of CSOs and those working in the drug field • Timeline for local policy is not in line with the UNGASS process (E.g. New National Drug Master Plan possibly coming out before UNGASS) • Participants felt no confidence that the CDA was going to reflect the view of the people: There are portfolios/ areas for CSO intervention ("How will CDA include CSOs in these processes and at UNGASS level?") • No scope for the reduction of the influence of the CDA
	Diverse views on recent decriminalization and regulation trends • Harms of prohibition far outweigh perceived harm. Need to learn from other countries • Need to look to oversee models for current hard reduction system
GROUP 5	DRUGS & ALTERNATIVE DEVELOPMENT
	• Some South Africa CSO signatory to the Heemskerk Declaration which outlines all the issues around farmers and alternative development • Alternative Development has to involve organizations on the ground • Aerial spraying of cannabis crops by law enforcement agencies in South Africa by harmful products like Kilomax (Glyphosate) destroys various crops, including maize and other essential crops, and has a devastating environmental impact.

2. ADVOCACY MEETING

The consultation was organised one day before the South Africa Drug Policy Conference, and during the conference, Ms Rose, CSTF Rep, could meet with a Government representative. Mr Zane Dangor, Special Advisor to the Minister of Social Development, will be in the South African Delegation for the UNGASS. The following themes were discussed with him:

1. The African Position Papers for UNGASS: He was aware of the 2 African positions for the UNGASS: The one of the Africa Group of the CND that was done with no involvement of other African Union(AU) countries, and the Common African Position (CAP), circulated by AU Secretariat, that was widely disseminated and discussed among African Government representatives. He said that the necessary was being done to get the CAP to the UNGASS.

2. The CSTF: The zero draft was presented to him, and he was already aware of its content. He has been made aware of the final version of this document that would soon be available, and he wanted it to be sent to him when available

3. The civil society hearing in New York: He was not aware of this event, and asked more information about this. All the details were sent to him by email soon afterwards

4. CSO Representative at the UNGASS: He said that the SA delegation was opened to the presence of a CSO representative, and that those interested could get in contact with him.

This report was drafted by Nathalie Rose
CSTF Representative
8 February, 2016

3. Annex:

List of Attendance at CSO consultation meeting:

Name	E-mail	Organisation	Nature of Organisation
David Fourie	david@sancawc.co.za	SANCA	National treatment provider for substance abuse
Ashley Potts	ashley@drugcentre.org.za	Cape Town Drug Counselling Centre	Local treatment provider - out patient
Dawie Nel	neld@out.org.za	OUT Wellbeing	Operate a harm reduction clinic
Andrea Schneider	Andrea@tbhivcare.org	TBHIV Care Association	HIV, PWID health services
Rudolph Bassan	rudolph@tbhivcare.org	TBHIV Care Association	HIV, PWID health services
Lynette Mabote	lynette@arasa.info	ARASA	Rights organisation
Nelago Amadilha	nelago@arasa.info	ARASA	Rights organisation
Shuaib Hoosain	hoosainshuaib333@gmail.com	Sultan Bahu Centre	OST Treatment centre
Alison Carsten	alison.carstens@gmail.com	Mudita Foundation	School based intervention
Dr Liezl van Pletzen-Vos	liezlvpv@gmail.com	Mudita Foundation	School based intervention
Jurgens Smit	jurgens@favor.org.za	FAVOR SA	Faces and voices of recovery
Marlon Germon	marlymarlmd@gmail.com	Fields of Green for All	Cannabis Movement
Myrtle Clarke	myrtle@fieldsofgreenforall.org.za	Fields of Green for All	Cannabis Movement
Theresa Rossouw	trossouw@toevlug.org	Toevlug	In patient centre
Frances Bantom	fbantom@toevlug.org	Toevlug	In patient centre
Chanelle Lombard	research@farrsa.org.za	Foundation for Alcohol Research	Research
Evodia Mabuza-Mokoko	evodiam@gmail.com	Central Drug Authority	Central Drug Authority
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