3. DRUG SITUATION

3.1. Cultivation and Production

Opium and coca: There is no cultivation of either opium poppy or coca bush in South Africa.

Cannabis: There is large-scale cultivation of cannabis. Most of the cannabis cultivation takes place in small, remote plots in the following provinces (by order of importance): Eastern Cape, KwaZulu-Natal, Limpopo (formerly Northern Province) and Mpumalanga. Cannabis is usually cultivated in mountainous or otherwise inaccessible areas, and – on a smaller scale – on the fringes of large, historically White-owned farms. In both the Eastern Cape (essentially the former "independent" Republic of Transkei) and in KwaZulu-Natal, a large number of rural families supplement their cash income with cannabis production. Almost all are Black/African small farmers who are poor. They supplement their subsistence agriculture with cannabis as a cash crop. Unlike other countries in the subregion, there is no evidence of plantation style cultivation in South Africa (Aziz 2001).

A considerable amount of cannabis is also imported into South Africa from Lesotho (ARQ 1998, Strydom 2000, OGD 1998a). Smaller quantities are also brought in to satisfy domestic demand from Swaziland and Malawi. Major domestic consumer markets are the metropolitan areas of Durban, Johannesburg and Cape Town.

Most of the cannabis consumed in the country is of South African origin. Authorities estimate that excess production enabled exports to grow from 15% of total production in 1991 to 70% of total production by 1996. Although the cultivation and wholesaling at domestic level is in the hands of rural Black/African communities and middlemen, much of the international

Brief history of cannabis in South Africa
The use of cannabis, known as *dagga* in South Africa, dates back to the 15th century AD. Arab as well as Persian and Indian merchants are reported to have been responsible for its spread along the eastern coast of the African continent in the 13th century. By the 15th century, Swahili merchants in East Africa and some Bantu tribes in Central and Southern Africa co-operated in bringing the plant to Southern Africa where it was later also cultivated. Cannabis gained in popularity in the 18th and 19th century (OGD 1996a). In 1928, authorities in South Africa introduced the first drug legislation concerning cannabis (Wright 1991). Historically, the controlled use and consumption of cannabis among the African population was ubiquitous throughout Southern Africa (MacDonald 1996). Cannabis was an integral part of the culture of traditional communities. Strict rules and values governed the circumstances under which it could be used. Availability was usually controlled by tribal elders. However, in the context of a modernizing, increasingly urbanized society, where traditional community controls are breaking down, the use of cannabis has now become the domain of the younger user and the poly-drug user. In South Africa, cannabis use is now often associated with alcohol and mandrax use. Over the past few decades cannabis use has also gained in popularity among all ethnic groups.

cannabis trafficking to Europe is reportedly in the hands of British and Dutch expatriates living in South Africa, working in conjunction with South Africans. Western Europe in general, and the United Kingdom and the Netherlands in particular, are the main final destinations. For example, within the past two years, based on seizure and arrest data as well as other sources of information, the UK has reclassified South Africa upward as the most significant source of herbal cannabis smuggled into that country, far outranking any other.[8]

Several neighbouring countries also report South Africa as a source country for the cannabis they seize. Authorities in Namibia, for instance, claim that 80% of the cannabis consumed within that country is from South Africa (ARQ[9] 1996).

Estimates on the extent of cannabis cultivation in South Africa are made regularly. They are based largely on aerial surveys. These have been undertaken either by the South African Police Service's Aerial Application Unit or subcontractors. Both are related to crop eradication efforts. The resulting estimates have fluctuated significantly over the years, and there have been some apparent inconsistencies in reporting (see Table 1 below).

Table 1. Estimates on area under cultivation of cannabis in the Republic of South Africa, 1992-2000, in hectares (Ha)

	1992	1993	1994	1995	1996	1997	1998	2000
Reported change of area under cultivation versus previous year (ARQ)	stable	stable	down	up	stable	down	down	stable
Estimates of areas under cultivation (ARQ)	6,000	5,000	2,140	82,000 (1)	1,200	2,000	1,300	1,247 (3)
Other sources (see below)	n.a.	20,000 - 30,000		83,000		n.a.	n.a.	
Exported (in % of total domestic production) (ARQ)	15% (2)	25%		70%		n.a.	n.a.	n.a.

(1) – later reported to UNDCP to have been a gross over-estimate.

(2) – 1991.

(3) – SANAB directly (not yet reported via ARQ).

Other sources: US Drug Enforcement Agency, the French Observatoire Geopolitique des Drogues, German Bundeskriminalamt, UK Home Office.

In 1992, cannabis cultivation was estimated at 6,000 Ha by the South African authorities (ARQ 1992). For the next two years, South African authorities reported to UNDCP

8 In May 2001 alone, 16 persons (11 South Africans and 5 European citizens) were arrested at London's Heathrow airport inbound from Johannesburg International Airport. Each was carrying an average of 28 kg of compressed herbal cannabis. The gender breakdown among the South Africans was 9 males and 2 females. The racial breakdown among the same group was 7 White, 3 Black/African and 1 Coloured.

9 ARQ means "Annual Reports Questionnaire". This is an official report which the UN Commission on Narcotic Drugs requests each UN Member State to complete on an annual basis and return to ODC HQ in Vienna. It is divided into three sections: (a) legislative and administrative measures, (b) drug abuse, and (c) illicit supply of drugs.

that there was a decline in cultivation. By contrast, the US Drug Enforcement Administration, based on information received from South Africa, estimated an expansion of cannabis cultivation to between 20,000-30,000 Ha in 1993-94 (DEA 1996). If correct, this would have been more than all cannabis cultivation in Latin America (16,000-17,000 hectares) in the period 1993-94 according to US estimates (INCSR 1999). This high level of cultivation was subsequently also reported by the South African Police Service (SAPS). In the mid-1990s, an official SAPS report identified 56,000 acres under cannabis cultivation (equivalent to 22,700 Ha or 0.1% of the arable land) in 1994 (SAPS 1995).

Thereafter, estimates went even beyond levels that could be considered realistic. For 1995, South African authorities estimated the area under cannabis cultivation to have increased to more than 82,000 Ha, which would amount to 0.5% of arable land (SAPS 1996). These high figures did not go uncontested within the police force. The South African Narcotics Bureau (SANAB) continued to estimate that only about 2,200 Ha were being dedicated to cannabis cultivation,[10] in contrast to the higher figure (see also Oosthuysen 1998) which pegged cultivation at 82,734 Ha. SANAB claimed that the higher figure had been the result of a calculation error. This claim was subsequently proved correct, but only following publication of the figures. Nonetheless, based on the higher figure, the authorities – applying a yield of 2,120 kg/Ha – estimated total cannabis production to amount 175,000 tonnes. This figure was subsequently also quoted for several years by other international organizations, including Interpol, INCB and various national organizations such as the UK Home Office and the German Bundeskriminalamt (BKA). Such a level of production would have meant that South Africa would have been – by far – the world's largest producer of herbal cannabis. However, the estimate has not withstood the process of verification and critical validation.[11]

In 1997, SAPS officially informed ODC that the 1995 estimate had been too high. Estimates were subsequently lowered from more than 80,000 Ha to levels of around 2,000 Ha, while the extent of cultivation was considered to have remained stable. The figure for 1998 estimates cultivation at 1,300 Ha reflecting some decline over the previous year. Based on South Africa's standard yield of 2,120 kg/Ha, cannabis output was thus estimated at 2,760 tonnes in 1998 (roughly equivalent to some 830 tonnes of marijuana). The cultivation figure reported by SAPS for 2000 is 1,247 Ha.[12] A recent unpublished ODC study of the cannabis

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[10] SANAB (1998) Arrest and seizure data. Pretoria, (Unpublished statistics).

[11] First, the yield figures used in South Africa do not appear to reflect cannabis herb (marijuana) production but the overall weight of dry cannabis plant material, and are thus not directly comparable with cannabis herb production figures, as used in many other countries. In official South African publications it is mentioned that only 30% of cannabis production is "for smoking", suggesting that cannabis herb accounts for about 30% of cannabis production (SAPS 1995). The actual marijuana yield would thus fall from 2,120 kg/ha to 636 kg marijuana per hectare -- a figure in line with yields reported from Latin America (some 660 kg/ha on average). Even taking this into account, South Africa would have still produced some 53,000 tonnes of cannabis herb in 1995. Considering the reported export rate of 70%, the actual amount for consumption in South Africa would have amounted to 16,000 tonnes of cannabis herb. The question therefore arises whether such levels of consumption are possible, as consumption in South Africa would have been six to ten times higher than overall marijuana consumption in the USA (1,600-2,400 tonnes p.a.) even though South Africa's population is considerably smaller.

[12] South African Police Service, "Today's Situation: Globalization and the Risk of Transnational Organizations" paper presented by S. Superintendent George Mason, at SACENDU report back session October 2000.

situation in South Africa indicated that the current SAPS estimate of 1,000-1,200 Ha appears to be accurate (Aziz 2001). This study found, *inter alia*, the following:

- The average size of a cannabis field in South Africa is 300 square meters. A good quality field of this size will yield approximately 10 kg of flowering tops and leaves and approximately 25-30 kg of poor quality marijuana (Majat). If the farmer sells the marijuana immediately after the harvest, the revenue will be approximately R700 for the top quality and approximately R500 for the remaining poor quality marijuana.
- Extrapolating to a hectare size field, the returns will be R40,000 from a total mass of between 1,155-1,320 kg of "usable" plant comprising 330 kg (flowering tops) plus 825-990 kg (dried leaves).
- In the cannabis growing areas of Eastern Cape and KwaZulu-Natal, the cannabis farmers are almost exclusively subsistence farmers, farming small plots of poor quality land. Cannabis is usually the only cash crop that they grow. The average annual household cash income from cannabis ranges between R1,200-2,000.

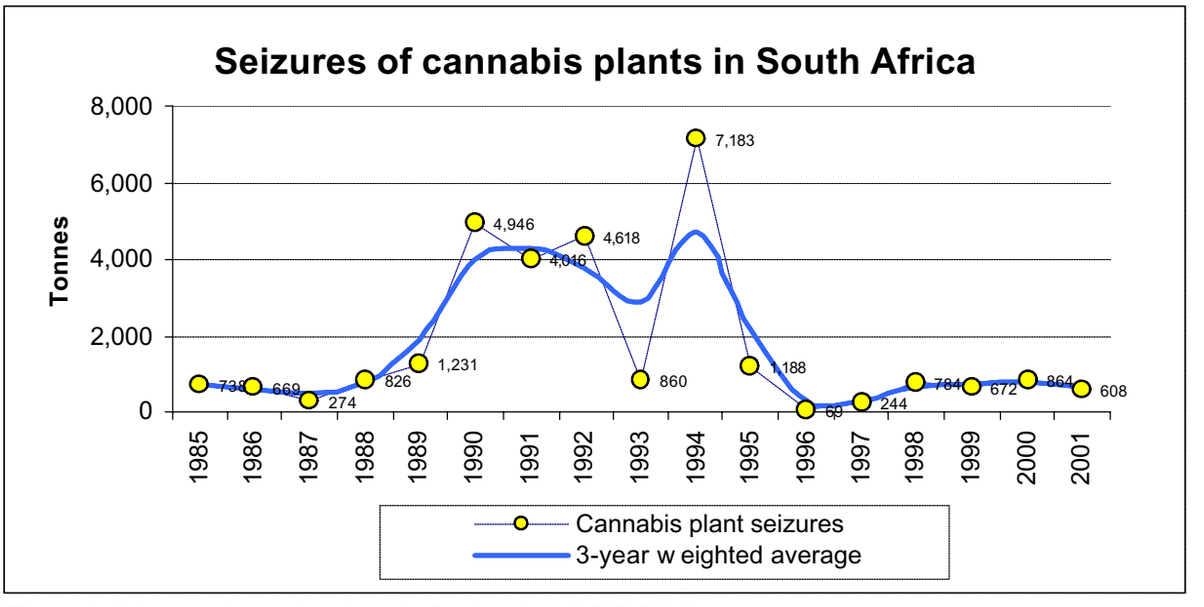

Figure 1: Seizures of cannabis plants in South Africa (1985-2001).
Sources: ARQs; SAPS. Note: While the remainder of the seizure statistics used in this report have been sourced from the records of the SAPS Forensic Science Laboratory, this is not the case for cannabis. Unlike other illicit drugs, cannabis seizures represent a low-value, high-bulk product. As a result, only a small percentage of cannabis cases are actually forwarded to the National Forensic Science Laboratory for analysis. For this reason, the cannabis statistics used in the above graph have been supplemented with information available from the South African Narcotics Bureau (SANAB).

The precise amount of land dedicated to cultivation remains a matter of dispute, as is the total quantity of cannabis produced, in view of the varying estimates of the number of crops harvested per year (typically between two and four). While intermittent eradication operations conducted by the SAPS do provide accurate details on the scope of these operations themselves[13], they do not actually go further to indicate the totality of what is occurring with regard to cannabis cultivation in South Africa. Nonetheless, even at currently reported levels,

13 See for example, SAPS 1999 for details on Operation Motokwane (October - December 1999). More recently, cannabis eradication operations were conducted in the Umtata and Lusikisiki areas of Eastern Cape (October 2001).

South Africa is still one of the world's largest producers (UNODCCP 2001 and UNODCCP 2002). Though production estimates for other countries also have to be interpreted with considerable caution, South Africa's importance in the cultivation and production of cannabis internationally can be extrapolated from the huge quantity of seizures the country makes each year (see section 3.4). According to Interpol, South Africa is among the world's top four source countries for herbal cannabis (Interpol 2001).

3.2 Manufacture

After the Second World War, mandrax emerged as another important psychoactive substance. Following the identification of its abuse potential, mandrax was removed from the legal market and classified as a prohibited dependence-producing drug in part I of the schedule of the South African narcotics law (Act 41 of 1971). However, following its official withdrawal from the local market, mandrax tablets were diverted from international distribution channels – mostly originating in India and China. In recent times, they have also been illicitly manufactured in neighbouring African countries as well as in South Africa itself. Abuse was originally primarily concentrated in South Africa's ethnic Indian/Asian population. However, it is has since spread to other ethnic groups, notably the Coloured community, but also the country's Black/African population. There is hardly any use of this substance reported among Whites. In geographical terms, its use is heavily concentrated in the Western Cape province where there is a large Coloured population base.

Mandrax is today the second most widely abused illicit substance in South Africa after cannabis (SACENDU: all reports). Its use started to become a general problem for South African society in the late 1980s. There is evidence that the apartheid state promoted drug use as a form of chemical control ("pacification") against the democratic resistance (Leggett 2001, especially Chapter 4). During the late 1980s and early 1990s, apartheid agents reportedly produced one thousand kilograms of both mandrax and MDMA (henceforth ecstasy)[14], and diverted massive amounts of the former drug from law enforcement seizures, allegedly for use in "crowd control". The Truth and Reconciliation Commission has expressed the view that these drugs were ultimately sold on the streets.[15] There have been indications from the Truth and Reconciliation hearings that a "cosy relationship" existed between the apartheid government and certain criminal groups and that the apartheid government may have acquiesced in, if not encouraged, the trafficking in narcotics to some ethnic groups as a means of social and political control (INCSR 1999). Finally, allegations have also been made that, among the groups opposing the apartheid regime, some may have been involved in the trafficking of mandrax in the late 1980s and early 1990s to finance weapons purchases.[16]

Although South Africa does not currently appear to be a major manufacturing site for illicit drugs, there is firm evidence that clandestine manufacturing of illicit drugs has been taking place in the country for more than a decade. The trend is increasing.

14 MDMA is 3,4-methylenedioxymethamphetamine, commonly known as ecstasy.

15 TRC 1999, Volume 2, Chapter Six.

16 These allegations concern some groups linked to the Pan African Congress which are reported to have imported mandrax via Mozambique into South Africa (OGD 1996).

Manufacture of illicit drugs was originally limited to mandrax. The first clandestine mandrax laboratory was shut down by police in 1987. However, domestic production of mandrax has reportedly increased since then and continues to gain in importance. Laboratories were originally identified primarily within Gauteng. By 2000, laboratory seizures were taking place in all major metropolitan areas.

In recent years, the range of detected laboratories has also broadened to include facilities manufacturing amphetamine-type stimulants (ATS) including ecstasy and methamphetamine, as well as kitchen-type laboratories for the manufacture of crack cocaine. A laboratory manufacturing GHB (gamma hydroxy butyrate) was detected in 1998 (ARQ, 1998). GHB has, since November 2000, come under strict control in South Africa.[17]

Table 2. Laboratories detected and dismantled in South Africa

	1987	1990	1996	1997	1998	1999	2000	2001	2002(*)
Mandrax	1	4	2	1	3	2	4	4	8
Ecstasy group			1	1		3	2	6	1
Crack cocaine					3		2		2
Methamphetamine					1	2			
GHB					1				
MDP2P / MDA						1			2
Cannabis processing								2	1
Methcathinone								1	9
Total	1	4	3	2	8	8	8	13	23

Sources: SAPS Forensic Science Laboratory (Pretoria), South African Police Service – "Dwelmmiddelanalise Seksie Pretoria: Klandestine Laboratorium Ondersoeke (2000), SAPS Sanab, ARQ Data.

(*) First 9 months.

About three laboratories per year were dismantled over the 1987-97 period (see Table 2 above). During the period 1998-2000, the average number increased to eight per year, reflecting an underlying trend of increased domestic drug manufacture. Of the eight labs dismantled in 1999 two of these were dual- or poly-capacity laboratories.[18] The upward trend continued with 13 labs being dismantled in 2001. For the year 2002, at the end of September, a total of 23 labs had been closed down in a similar fashion by the SAPS. Of interest is the recording, in 2001, of the first methcathinone lab used to synthesize what is known as 'Cat' in South Africa.[19] By September 2002, a total of 9 methcathinone labs had been closed down for the year. The United Nations Office on Drugs and Crime is not aware of any significant emerging trends concerning methcathinone elsewhere, and the sudden upsurge of clandestine laboratories in South Africa would seem particular to this country.[20]

17 GHB was scheduled as a Class I substance (highest restriction) in the US as of 1 April 2000. Since 11 November 2000 it has been included in Schedule 8 ("undesirably dependence-producing substances") under South Africa's Medicines and Related Substances Act (Act 101/65).

18 South African Police Service – Forensic Science Laboratory report 1999.

19 The chemical term for the drug known as 'cat' is methcathinone. It is an amphetamine which is synthesized from the *khat* (or catha edulis) plant, typically grown in East Africa and the Arabian peninsula.

20 There is continuing illicit manufacture of the substance in United States, but at very low level, certainly compared to methamphetamine. Similarly, there is ongoing clandestine manufacture in Russia and Central Asia.

3.3. Diversion of Precursors

Clandestine manufacture of drugs in South Africa is also reflected in seizures of precursor chemicals. Important seizures of **anthranilic acid** and of **N-acetylanthranlic acid**, the two main precursors for mandrax manufacture, were reported in 1995 and have continued in and around South Africa ever since. Approximately 70% of all seizures of **mandrax precursors** worldwide took place in South Africa in that year. During 2001, at the request of South Africa, the authorities in France stopped a shipment of 25 tons of anthranilic acid to Mozambique when it was determined that the consignment was to have been transshipped through Mozambique to South Africa, where it would be used in the illicit manufacture of mandrax.[21] During December 2001, South Africa conducted a controlled delivery of 5 kg of **sassafras oil** from France to South Africa which led to the detection and dismantling of an illicit laboratory which manufactured methamphetamine and MDMA (UNDCP 2002; SAPS 2002b).

Trafficking groups capable of handling such large consignments are well-established and possess well-organized networks in order to transport, store and utilize such a large quantity of precursors (INCB 2001). In December 2001, another ten tonnes of anthranilic acid was seized in Maputo harbour in Mozambique en route to South Africa from Mumbai, India. In July 2002, in two linked enforcement actions, South African police and forensic experts raided warehouses in Gauteng and seized, inter alia, more than 100 metric tons of chemicals (principally anthranilic acid and acetic anhydride) which could be used to produce 90 million mandrax tablets. Precursor chemicals for the production of ecstasy were also recovered in these busts.

In addition to these typical mandrax precursors, a number of other chemicals have also been seized in South Africa, including acetic anhydride, hydrochloric acid, toluene, acetone, ethyl ether and sulphuric acid. Each of these chemicals can be used in the manufacture of mandrax. They also, however, may be used for licit industrial purposes as well as the manufacture of other drugs – thereby posing a problem for effective functioning of chemical monitoring programmes. It is becoming evident that foreign trafficking groups have started to target South Africa's chemical industry as a supplier of precursors. The magnitude of such attempts, as examples from the late 1990s have shown, has been considerably higher than domestic seizures of precursor chemicals in South Africa itself. The INCB highlighted in its 1999 annual report on precursors that large quantities (approximately 25 tonnes) of **methyl ethyl ketone (MEK)**[22] originating in South Africa were shipped via Europe to Colombia. This may have resulted in the subsequent tightening of chemical controls in the United States and in Europe. Around this time, and following the revelation of the real reason for the strong MEK demand in Colombia, South African industry began working with the national authorities to prevent future diversion.

21 In the Mozambican operation referred to above, Mozambican and South African police also recovered 30 tonnes of chemicals and precursors – sufficient to make 7.5 tonnes of mandrax tablets.

22 MEK is one of the key substances in the manufacture of cocaine hydrochloride. It is used to extract and purify the cocaine.

There have also been some important attempts to import precursor chemicals into South Africa for illicit uses. In March 1998, for instance, China stopped a suspicious shipment of the enormous amount of 20 tonnes of **ephedrine**, the main precursor for the manufacture of methamphetamine, to a South African company. Global seizures of ephedrine in 1997 amounted to a mere 8 tonnes. A quantity of 20 tonnes of ephedrine would have been sufficient to produce 13 tonnes of methamphetamine, equivalent to more than 430 million doses of methamphetamine. While **phenylacetic acid** is not currently being seized on a large scale at illicit laboratories, the authorities in South Africa and the United Kingdom successfully carried out a controlled delivery of the substance during 2001, resulting in the dismantling of an illicit laboratory for the manufacture of methamphetamine and the arrest of those responsible for the import and diversion of the substance (INCB 2001).

In 1999, the SANAB established its Chemical Monitoring Programme. Since then there have been no seizures of the listed chemicals in terms of Section 3 of the Drugs and Drug Trafficking Act and Article 12 of the 1988 UN Convention. Thus, in the relatively short period since its inception, this unit has established an effective relationship with the chemical industry and receives regular reports from the latter regarding irregularities and possible diversion. During 2001, the Chemical Monitoring Programme dealt with 174 import notifications of precursor chemicals into South Africa as well as 89 export notifications. A total of 80 chemical and pharmaceutical companies were visited during 2001 (UNDCP 2002, SAPS 2002b).

3.4 Trafficking

Over the better part of the past decade, two distinct trends can be identified. First, a gradual decline in drug-related cases was followed, since, 1998, by a recent upsurge. Second, there has been an overall and sustained shift by law enforcement away from a heavy concentration in cannabis and mandrax-related arrests and seizures toward other drugs.

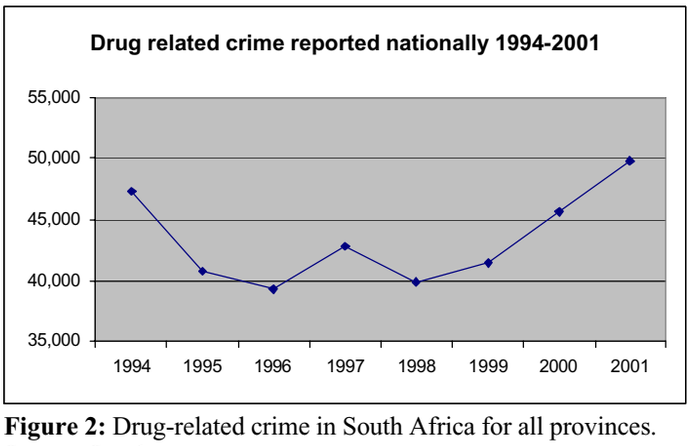

Figure 2: Drug-related crime in South Africa for all provinces. Source: Sanab.

Regarding the first trend, police statistics for the country as a whole show that there were 47,323 drug-related cases reported in 1994. Figure 2 demonstrates how this figure declined to a low between the years 1996-98. Following 1998, the number of drug-related cases started to rise

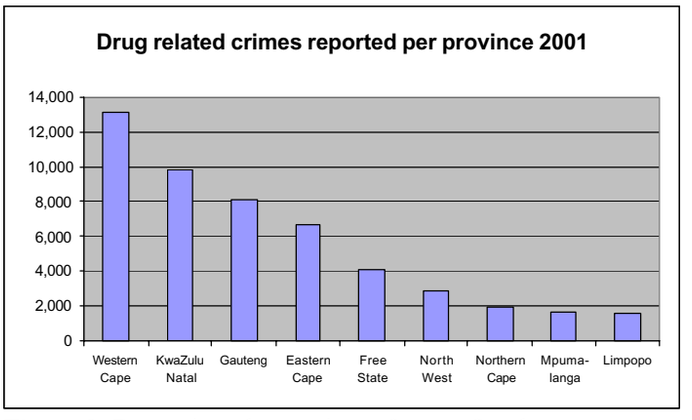

Figure 3: Drug crimes by province. Source: Sanab.

again. In 2001, the number stood at 49,839 (SAPS 2002). This constitutes an average of 4,153 cases per month or 135 cases per day. On a geographical basis, statistics prepared by the Crime Information Analysis System concerning drug-related occurrences during the year 2001 indicate that the highest number of drug-related crimes occurred in Western Cape, the province which contains Cape Town. Incidences of drug-related crime in that province in 2001 accounted for about one-quarter (26.4%) of all such crime in the country (SAPS 2002 see Figure 3). The next highest province in terms of drug-related crime is KwaZulu-Natal which contains Durban (19.8%). Gauteng (encompassing Johannesburg and Pretoria) has the third highest incidences of drug-related cases in 2001 (16%).

Regarding the second trend, while arrests and seizures in South Africa still remain overwhelmingly linked to **cannabis,** there has been a noticeable increase in the number of other drugs featuring in the arrest records (Figure 4) aside from mandrax. Approximately three-quarters of all people arrested for drug trafficking and abuse and 99% of all seizures in volume terms (if transformed into dosage units) are annually linked to cannabis herb (marijuana). Trafficking in cannabis resin (hashish) within South Africa is still limited due to the small consumer base for this substance.[23] The next two most widely trafficked illicit drugs are **mandrax** and **cocaine.** Just under 20% of all people arrested for drug possession and dealing in 2000 were arrested for mandrax and 5% for cocaine-related offences. Since 1999, a larger percentage of all reported drug-related arrests have been related to **ecstasy** as compared with cocaine. Arrests for ecstasy have gained in magnitude over the last few years rising from nil in 1993 to almost 350 in 2000. The importance of **amphetamine type stimulants** in the South African drug market is still limited. Arrests for possession/dealing in **heroin** have increased eight-fold since the product emerged in a very low-key manner onto the South African drug scene in the mid-1990s. However, the absolute number of arrests for this substance is still relatively low.

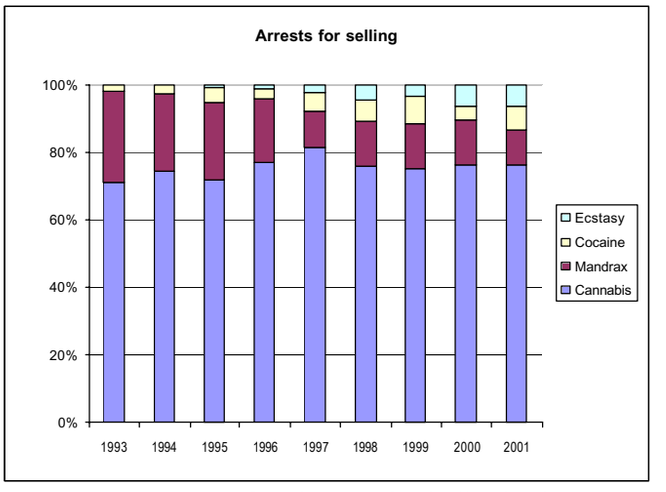

Figure 4: Percentage of total arrests for dealing by drug type in 2000. Source: SANAB. Note: this chart features only those drugs for which there have been significant numbers of arrests, hence the absence of heroin arrests.

The shift away from a predominant focus on cannabis and mandrax in arrests for dealing and possession may, in part, be explained by the re-prioritization of resources towards targeting new drug threats and more formidable criminal networks which do not yield immediate arrest results that would come from a strong emphasis on traditional street-level

23 South Africa and Mozambique nonetheless witness much transshipment traffic in hashish. In October 2000, Durban's joint port drugs unit seized 11metric tons of containerized hashish en route from South West Asia to Canada. It was being transshipped via South Africa. This proved to be the country's largest drug seizure worth over 1 billion rand (equivalent, at the time, to US$150 million). Significant hashish hauls have occurred over the past decade in Mozambique, most recently involving 15 tonnes near the coastal city of Inhambane in August 2000. None of this appears intended for domestic markets in either country.

buy/bust operations. Reports from the SACENDU network[24] over the past four years (Table 3) are also able to look at the police data from a different perspective and on a provincial level. Across all the sentinel sites surveyed, there has been a decline in the number of persons arrested for cannabis-related offences as well as a corresponding increase in arrests for cocaine, heroin and ecstasy.

Table 3. Arrests for dealing (January 1997 - December 2001)

Area	Period	Cannabis	Mandrax	Cocaine	Ecstasy	Heroin	LSD	Meth.	Other	Total (N)
Cape Town	1997a	54%	27%	10%	4%	<1%	3%	1%	0%	236
	2001b	29%	26%	26%	15%	1%	2%	1%	0%	255
Durban	1997a	66%	9%	11%	9%	0%	0%	5%	<1%	227
	2001b	27%	40%	23%	4%	0%	0%	0%	5%	162
Gauteng	1997b	70%	12%	14%	2%	<1%	1%	<1%	0%	417
	2001a	29%	16%	33%	11%	2%	8%	1%	0%	567

Source: SACENDU 2002b. Note: Gauteng is the province containing Johannesburg and Pretoria. 1997a indicates first half of 1997; 2001a indicates first half of 2001; 2001b indicates second half of 2001.

A drugs / crime nexus

Within the past three years, ground-breaking research work by the South African Medical Research Council and the Pretoria-based Institute for Security Studies has confirmed a high positive correlation between drug use and crime even though the chain of causality remains unclear in many respects. Results of the 3-Metros Arrestee Study (in Gauteng, Cape Town, Durban) conducted between August 1999 and September 2000 among a representative sample of arrestees (n=2,859) have revealed much about the drugs / crime link in South Africa.[25] The study found that the percentage of arrestees testing positive from urinalysis for at least one drug was 46%. Positive tests for cannabis, mandrax and cocaine occurred in 40%, 21% and 4% of the cases, respectively (Parry, Louw and Pluddemann 2001). Arrestees under the age of 20 were most likely to test positive for some substance (66%). Those testing positive for a substance (51%) were more likely than those who tested negative (29%) to have been arrested before (ISS 2002). The research suggests a very strong link between drug use and various crimes. For example, the percentage of arrestees testing positive for any drug (excluding alcohol) in connection with housebreaking, motor vehicle theft and rape was, respectively, 66%, 59% and 49%. Up to one-third of arrestees who indicated that they were under the influence of substances at the time of the crime took place stated that they had used

24 The SACENDU (South African Community Epidemiology Network on Drug Abuse) system monitors trends in alcohol and drug abuse, using multi-source information from 46 specialist treatment centres, psychiatric hospitals, mortuaries, trauma units, the SAPS, and from research conducted in schools, with sex workers, street children, patients attending primary health care clinics, arrestees and persons attending rave parties. The main benefit of this network is the facilitation of an evidence-based approach to local and national policy formation. Since 1997, the SACENDU network has compared arrest and seizure trends across the major population sites in South Africa on a semi-annual basis.

25 The study followed closely the methodology used by the Arrestee Drug Abuse Monitoring (ADAM) project in the United States and related projects worldwide.

substances to assist them committing the offense. The research also highlighted major differences between ethnic groups in terms of levels of drug use and different kinds of substances of abuse. For example, a much higher proportion of Coloured arrestees (64%) tested positive for drugs as compared with Black/African arrestees (38%) with Indians/Asians and Whites other two groups falling somewhere in between. The drug/ethnic segmentation nexus was found to be linked to income. White arrestees (most likely to be in the highest income group), for example, were most likely to test positive for cocaine (43% as compared to 3% for Blacks/Africans) (Parry, Louw and Pluddemann 2001).

Linkages to organized crime

Trafficking of illicit drugs has increased dramatically in South Africa over the last decade. Aside from the fact that drugs are highly associated with dependency or addiction and thus the frequently desperate search for instant cash – often through prostitution or acquisitive crime – there are other obvious links to criminal activity. Drug trafficking is an extremely profitable enterprise for organized crime syndicates which are often otherwise heavily engaged in the trafficking of stolen vehicles, illegal firearms, precious metals, endangered species and human beings. For example, organized crime syndicates have also become involved in stealing vehicles and trading them across South Africa's land borders in exchange for drugs (INSCR 2001, Shaw 2001).

Drug trafficking and organized crime have unquestionably grown in a symbiotic relationship in South Africa since the mid-1990s. In 1997, the SAPS conducted a survey which demonstrated the existence of 192 organized crime groups operating in South Africa of which 92 were focused primarily on the international smuggling of drugs. This survey formed the basis of the SAPS Organized Crime Threat Analysis (OCTA) system. The current SAPS OCTA (early 2002) shows 238 listed threats. Criminal violence associated with drug trafficking is particularly visible in Cape Town (especially in the Cape Flats and Mitchells Plain areas[26]) where drug trafficking groups fight over market share.[27] The level of violence is reduced in Durban where the drug market is more strongly structured and controlled (Leggett 2000). In broad anecdotal terms, the level of drug-related violence in Johannesburg would sit somewhere between these two extremes.

Money laundering

South Africa's position as the major financial center in Southern Africa and its relatively sophisticated and unprotected banking and financial sector make it vulnerable to organized crime activities, including money laundering.[28] At this stage, there are no statistics

26 Arrest reports and other information available on the situation in the gang-dominated Cape Flats and Mitchells Plain areas support almost exclusive Coloured gang control of the distribution of crack and mandrax in these areas and beyond. The "Americans", "Hard Livings" and other gangs dominate. Some efforts at Nigerian encroachment have been met by market sharing deals.

27 Responding to such in-fighting, an Islamic vigilante group, called People Against Gangsterism and Drugs (PAGAD) has declared war on gangs and drug dealers but has itself been allegedly involved in violence against the state, leading the Minister for Safety and Security to denounce its activities in 2000. See Garson 1997 and Galant & Gamieldien 1996. See also Section 8.3 of this Country Profile.

28 See also *International Narcotics Control Strategy Report*, U.S. Department of State, March 2002.

available on money laundering in South Africa. Furthermore, there have to date been no prosecutions for money laundering. This does not, however, mean that money laundering does not occur in South Africa. From the statistics available on organized crime and its growth, it can be deduced that money laundering is taking place and is likely to increase in the coming years.[29] In addition, the work of the Asset Forfeiture Unit of the National Directorate for Public Prosecution (NDPP), particularly the high number of proceedings initiated for the confiscation or forfeiture of the proceeds and instruments of criminal activity and the large value of the assets involved, gives an indication as to the high volume of proceeds from criminal activity finding their way into the South African economy. In December 2001, the Financial Intelligence Center Bill became law. This law should substantially increase the Government's capacity to combat these crimes. Money laundering is dealt with, in particular, under chapters 2, 3 and 4 of the Act. The law provides for the establishment of a Financial Intelligence Center to coordinate policy and efforts to counter money laundering activities and to serve as a centralized repository of information. In August 2002, South Africa signed the Memorandum of Understanding of the Eastern and Southern African Anti-Money Laundering Group which is open to 14 countries in Eastern and Southern Africa.

Foreign criminal networks

Just as the South African drug abuse market is highly culturally and economically segmented, so too is the drug trafficking related to it (Leggett 2000; ISS 2002). Of particular prominence in the drug trafficking market is the presence of West African criminal networks. Most of these have become established since the early 1990s. The operations of these groups – centering principally, but not exclusively, on Nigerian criminal networks – are central to the illicit drug economy of South Africa.[30] Their role in this industry and its links to other criminal activities – primarily but not exclusively advance fee fraud (the so-called 419 scams[31]), kidnapping, cheque and credit card fraud, dealing in stolen vehicles, and trafficking in and smuggling of human beings – have been analyzed in detail elsewhere (Allen 1999, Gastrow 1999, Leggett 1999c, Leggett 2000, SAPS 2001, Shaw 2001). During 2001, South African police conducted 39 **controlled deliveries** with foreign anti-narcotics agencies (UNDCP 2002). As an indicator of South Africa's profile in the context of international trafficking, the majority of South African citizens in **foreign prisons** have been incarcerated for drug smuggling (SAPS 2001).

Johannesburg International Airport

The vulnerability of Johannesburg International Airport to trafficking opportunities is central to developing countermeasures for the trafficking in high-value, low-volume drugs into

29 Pieter Smit, Clean Money- Suspect Source: *Turning Organized Crime against Itself*, ISS Monograph Series, No. 51, Institute for Security Studies, January 2001.

30 The extent of penetration of the heroin trafficking networks by Tanzanian organized criminal syndicates since 2001 has become a law enforcement concern in South Africa. The operations of Chinese Triads in South Africa have also, at times, involved the smuggling of mandrax into the country within the last three years.

31 The "419 Scam" is named after Section 419 of the Nigerian Penal Code which deals with advance fee fraud. The scheme is operated by a fraudster who is usually a member of a criminal syndicate. Such individuals lure victims into false money schemes with the promise of huge returns – instead they are typically robbed of their money and sometimes kidnapped and murdered.

South Africa. A review of cocaine and heroin seizures by Johannesburg International Airport SANAB during 2000 versus drug quantities seized by all other SAPS components nationally is striking, as shown in Table 4.

Table 4. Prominence of Johannesburg International Airport in Drug Trafficking in South Africa (2000)

Drug	Total Quantity Seized	Quantity Seized by JIA SANAB	% seized by JIA SANAB
Cocaine	91.2 kg	59.4 kg	65 %
Heroin	15.4 kg	13.7 kg	89 %
ATS (incl. ecstasy)	297,021 tablets	195,679 tablets	66 %

Source: South African Police Service.

Trafficking in cannabis

Seizures of cannabis herb in South Africa in volume terms, as reported to ODC have been subject to major annual fluctuations over the last decade (see also Figure 1 in Section 3.1). Once the data are smoothed, the overall seizure trend from the mid-1990s is steeply downwards, stabilizing at a lower level with minor fluctuations in that lower range. The magnitude of South Africa's cannabis production and its related enforcement measures nonetheless testify to the country's importance in international trafficking terms. As Figure 5 demonstrates, in 2000 – the latest year for which comparative figures exist – South Africa's cannabis herb seizures accounted for almost 68% of all cannabis herb seizures in Africa. At the global level, South Africa's cannabis herb seizures were almost 16% of the world total. In the year 2000, South Africa (718 metric tons) ranked second behind Mexico (2,050 mt) in terms of cannabis tonnage seized (UNODCCP 2002). In Africa, only Malawi (312 mt) and Nigeria (212 mt) came close.

Cultivation and domestic transport of cannabis herb from the farm gate to the distribution centres within South Africa are generally controlled by rural Blacks/Africans with links to both the farm gate and the urban market. Domestic trafficking in cannabis is also mainly in the hands of Blacks/Africans (Leggett 2000; ISS 2002). The large Black/African former "townships" (sometimes referred to as "disadvantaged communities" and especially the hostels located there) tend to serve as cannabis storage and redistribution centres (e.g., Soweto and Alexandra in Johannesburg, Bambayi in Kwa-Zulu-Natal, Inanda and KwaMashu in Durban, and Gugulethu in Cape Town) (see also OGD 1997, OGD 1998).

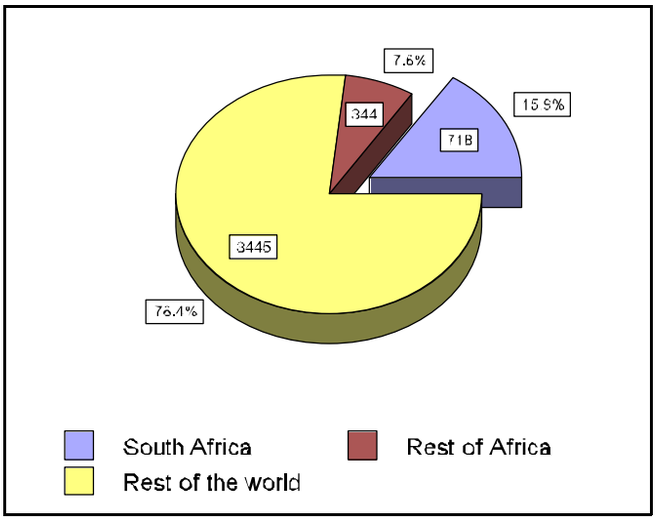

Figure 5: World cannabis herb seizures in 2000 (figures in metric tons). Source: UNODCCP 2002.

While South Africa is an important exporter of cannabis, the country is also a significant importer. Cannabis is transported to South Africa from countries such as Malawi, Zambia, Lesotho and Swaziland (MRC 1998, OGD 1997, Aziz 2001) often with overseas exporting as the express purpose. In particular, Swaziland and Malawi have specialized in the production of cannabis varieties with a reportedly high THC[32] content, known as "Swazi" and "Malawi Gold".[33]

Given the need for large-scale exporters of cannabis to have business connections with the shipping community and courier contacts in the UK and Netherlands, the controllers of this traffic are unlikely to have a profile similar to those who run domestic production and trafficking operations. For example, the majority of couriers currently trafficking herbal cannabis into the UK are White South Africans. The significant penetration of the South African organized criminal world by Nigerian criminal organizations has also meant that such groups have managed to forge an effective, but not dominant, link to the trade in cannabis (SAPS 2000; Shaw 2001). During the period 1999-2000, the UK reported the seizure of multi-tonne consignments smuggled from South Africa by way of containers, indicating a preference for this manner of maritime trafficking. Available evidence is inconclusive regarding whether South Africa is a net importer or exporter of cannabis.

In the recent past, the bartering of South African cannabis for European ecstasy and LSD had been reported (OGD 1997; OGD 1998; Leggett 2001). Cocaine and heroin, however, now also appear to be part of bartering arrangements. Information available to police and other sources inside South Africa points to a strong link between the syndicates exporting cannabis from South Africa and the import of cocaine, heroin and club drugs from overseas. This, coupled with the relatively low price in South Africa of club drugs, heroin and cocaine – at a time when the rand is weak – has reinforced suspicions of a direct link in the trafficking of these drugs into and out of the country (see also Leggett 2001; ISS 2002).

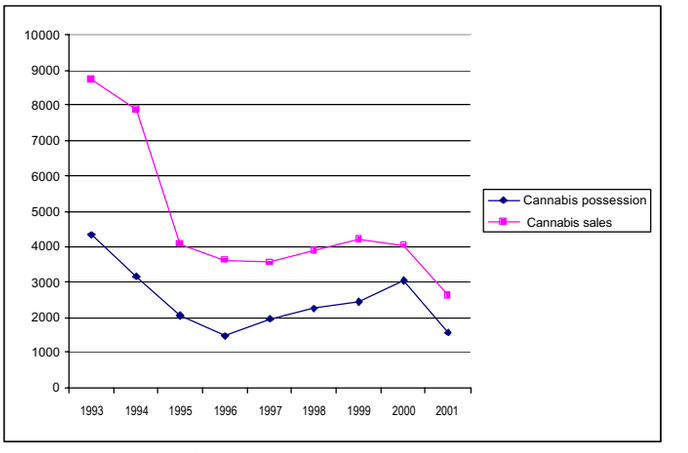

Figure 6: Cannabis arrest data 1993-2001. Source: SANAB.

The cannabis seizure pattern described above has also been paralleled, in general terms, in arrest data for the better part of the past decade. In other words, a significant decline during the mid-1990s leveling off at the lower level with smaller fluctuations to 2001 (see Figure 6). It is unlikely that the overall decline between 1993 and 2001 reflects a shift in the dynamics of the cannabis market within South Africa. The market appears as robust as ever. A number of other factors are probably more relevant in explaining the decline. First, some of the earlier large seizures were actually due to the fact that cannabis seized in containers in ships transiting

32 Tetra-hydro-cannabinol, the active ingredient in cannabis.

33 A cannabis enforcement operation conducted in Swaziland in 2000 yielded compress machines which produced blocks of herbal cannabis for export to the UK.

South Africa (including cannabis resin from Pakistan and cannabis herb from Colombia en route to Europe) were included in the statistics (OGD 1997, OGD 1998). As a result, the figures, though officially recorded in the seizure statistics, are not directly comparable. Second, but perhaps more significantly, is the noticeable shift in enforcement priorities (Leggett 2000). The emergence of other highly dangerous drugs in the South African market over the past decade has clearly prompted the authorities to target them with greater vigour.

Trafficking in mandrax (methaqualone)

In many respects, the extent and trend of the illicit consumption of mandrax in South Africa is unique in the world. Anecdotal evidence from the law enforcement and treatment communities within the country indicates that South Africa is by far the world's leading consumer of the drug. Some estimates suggest that as much as 80% of worldwide clandestine production of mandrax may be destined for the South African market (Venter 1998). In 1998, the South African Association of Retail Pharmacists claimed that South Africa consumed between 70-90 per cent of the world's production of mandrax (CIIR 1998).

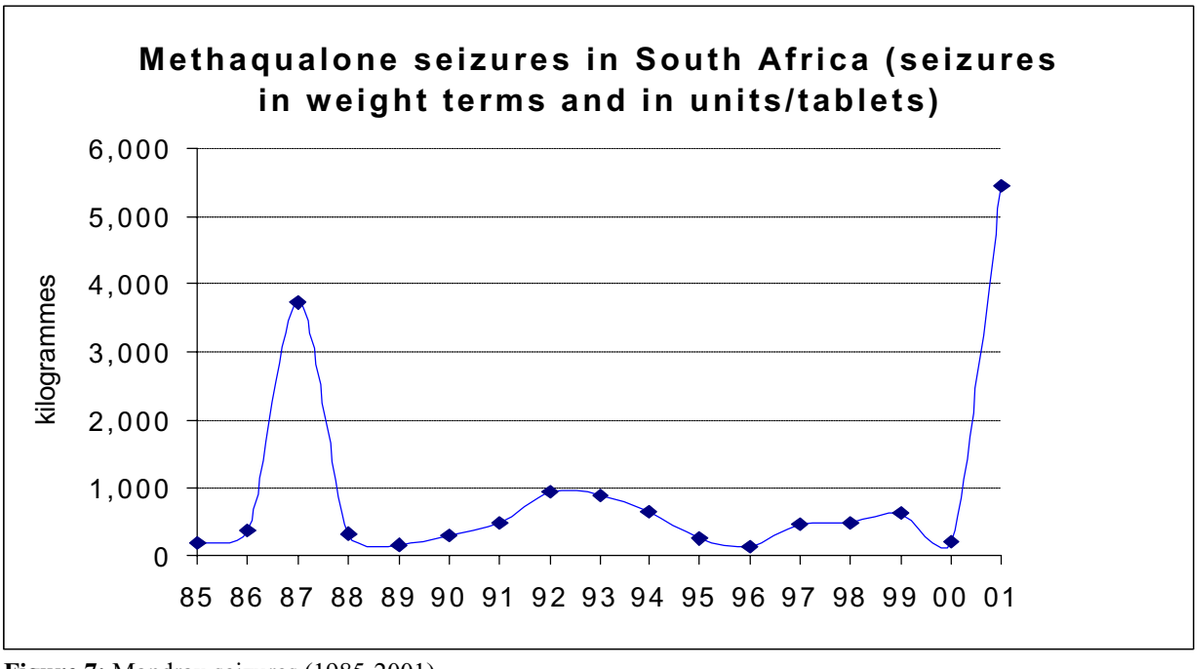

Figure 7: Mandrax seizures (1985-2001).
Sources: UNDCP, ARQs; SAPS Forensic Science Laboratory (for 1999 and 2000-to-October figures).
Note: The analysis of seizure data is complicated by reporting practice. Mandrax seizures are reported overwhelmingly in terms of units (tablets), but reports also are made in weight terms (kg). In order to gain an overall picture, the two measurements have to be combined even though the results are then only rough approximations and have to be interpreted with caution. In addition, it is normally the case that a transformation ratio is used to reflect pure methaqualone as opposed to the weight of the tablet/mass which contains other additives. The numbers used in this diagram reflect a standard Roussel® transformation ratio of 250 mg of methaqualone per unit (tablet) and 500 mg per powdered gram. Thus, for example, the seizure figure for the year 2001 was arrived at in the following manner. Seizures of tablets = 1,280,224 tablets x 0.25 = 320,056 g = 320.056 kg + Seizures of powder = 10,231.276 kg x 0.5 = 5,115.638 kg. Total = 5,435.695 kg.

For many years mandrax use was widespread among the Coloured and Indian/Asian communities. However, since the late 1980s and early 1990s, its use has also started to spread to the Black/African community. Although some of the mandrax tablets are produced locally

(the precursors for which are generally imported), most of the tablets seized on the streets in South Africa have been imported. The main source countries are India and China, with the latter eclipsing the former in recent years as the primary source of supply. Within the last three years, the number of significant seizures of mandrax originating in China has proven a source of concern for South African law enforcement officials. The February 2000 seizure and dismantling of the largest mandrax laboratory in the southern hemisphere in Maputo indicates the extent to which South Africa is seen as a lucrative market for organized criminal groups operating in Mozambique.[34] Moreover, there have been reports in Zambia (Grove 1994, van Aarde 1997, SAPS 1998) and known cases in Mozambique of the production of mandrax for export to South Africa.

The pattern of mandrax seizures in South Africa has tended to reflect massive busts followed by periods of sparse enforcement success between – as well as within – successive years (see Figure 7). The data suggests that mandrax seizures rose in the late 1980s – with what was then a record high reported in 1987 following the dismantling of the first large mandrax laboratory in the country. Following gradual increases over the 1989-1992 period, seizures fell during 1992-1996. They started rising again during the 1996-1998 period, reaching the levels of the early 1990s, again, on account of large factory-type seizures. Such patterns may not reflect shifting enforcement priorities but rather successful police work which simply resulted in large busts. The seizure figures for 2001 show a steep increase following the seizure, during the second quarter, of 2.1 tonnes of powdered mandrax inbound from China. This trend will certainly increase in 2002 with the seizure of significant numbers of mandrax tablets and precursor chemicals from India.

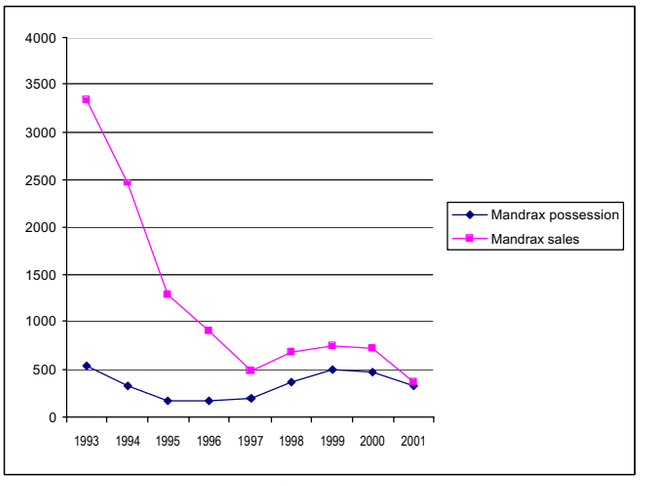

Figure 8: Mandrax arrest data 1993-2001. Source: SANAB.

Arrest data for mandrax (see Figure 8) also mirror, to a degree, the seizure data with a significant fall from the peaks of the early 1990s. There has been a tendency to plateau off at the lower level from 1996. This may support the contention that policing priorities were readjusted to tackle the more addictive drugs which were then entering the South Africa drug scene.

Until very recently, informed opinion held that, of the amount of mandrax consumed within South Africa, slightly less than half was produced locally.[35] Given the sizeable

34 In February 2000, South African police provided support to the Mozambican government in this operation which resulted in the seizure of 292 kg of mandrax tablets.

35 Local production was argued to be increasing substantially to meet local demand. A causal connection was even surmised in respect of the crackdown on mandrax production in India in the early 1990s as it was argued that this then resulted in increased domestic production (OGD, 1997/98).

quantities being seized at South Africa's ports of entry, this assumption may need to be revised downward. The overwhelming bulk of mandrax is still seized in "units" (i.e., tablets or end-product) and not in weight terms (normally reflecting powder seizures at the site of clandestine laboratories). However, even here there is room for debate because the 2.1 tonne mandrax seizure in 2001 was evidently destined for pill presses located inside South Africa itself which would convert the drug into the tablets normally bought on the street.

On mandrax, then, it is possible to conclude with two points. First, because of its political history, the origins of mandrax's introduction into South Africa will perhaps always remain shrouded in mystery. Second, mandrax remains a commodity much in demand, as judged by the continued alarmingly high level of seizures. These trends weaken the explanatory power of an earlier contention that mandrax use had been supplanted by the introduction of crack cocaine since the mid-1990s.

Trafficking in cocaine

Cocaine used to be classed as a drug only consumed by small sections of the South African White upper class. When consumed as cocaine hydrochloride (i.e., cocaine powder), this claim largely remains accurate. However, since 1995, crack cocaine has emerged as a significant feature of the South African drug market and, along with cannabis, crack is the drug most consumed on a trans-ethnic basis.

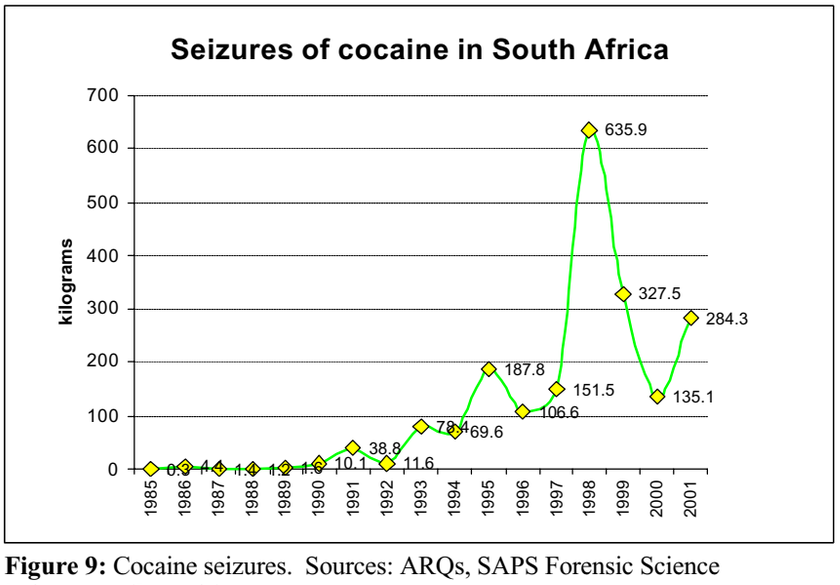

Figure 9: Cocaine seizures. Sources: ARQs, SAPS Forensic Science Laboratory (Pretoria).

While South Africa initially served mainly as a point of transshipment for cocaine leaving the Andean countries en route to Europe, it has – in recent years – started to emerge as an important market in and of itself. Most of the South African-bound cocaine from the Andean region still leaves mainland South America via Venezuela or Brazil (SAPS 2000). From there it enters South Africa either directly or via other African countries. The latter may either have a language connection to Brazil (e.g., Angola and Mozambique) or a perceived proximity advantage (e.g., Zimbabwe).[36] During the early to mid-1990s, almost all of the cocaine entering South Africa was couriered from Brazil directly into Johannesburg by air. However, following enforcement successes countering this smuggling route, a number of alternative routes emerged, including flights to Cape Town and flights to other African

36 SAPS and other reports in 2001 speak of South African couriers bringing cocaine from Brazil in transit via Johannesburg International Airport en route to Harare. From Harare the drugs are placed in vehicles and smuggled back into South Africa by overland route.

countries and then overland to South Africa, including from Mozambique, Angola, Zambia, Zimbabwe and Namibia (OGD 1997, OGD 1998).

South African police statistics show that 65 per cent of all cocaine seizures in South Africa in the year 2000 occurred at Johannesburg International Airport. The utilization of air passenger couriers is still the dominant mode of smuggling cocaine into South Africa, although smuggling via air freight occurs regularly. A cocaine smuggling ring among employees of South African Airways was discovered in 2000. Seizure statistics for 2001 show increases owing primarily to two large seizures of cocaine by Cape Town enforcement officials (in July and August) aboard ocean going vessels originating in Latin American ports and destined for China. In March 2002, SAPS seized 350 kg of cocaine hidden in a container vessel in Cape Town harbour with a street value of approximately US$10 million which was destined for onward shipment to Lome, Togo.

On the strength of these trends, South Africa is demonstrating itself to be an important – perhaps even the most significant – market for cocaine within Africa.[37] According to the most recent comparative analysis (for the year 2000) more than 21% of all cocaine seizures on the African continent took place in South Africa, up from a share of just 5% in 1993 (UNODCCP 2002). In 1999, South Africa accounted for 82% of Africa's cocaine seizures (UNODCCP 2002). These statistics point to a shift in the balance of African cocaine trafficking from Nigeria in today's terms (currently 13%, UNODCCP 2002) from where it stood in 1993 (well over 90% of all African cocaine seizures, ARQ 1993). The shift from Nigeria to South Africa does not, however, reflect a loss of influence of Nigerian drug trafficking groups (Shaw 2001). Police and other data show a strong correlation between the migration of Nigerian nationals into South Africa starting in 1992 and the introduction of high quality cocaine into the country (Venter 1998a). The immediate result was a dramatic price fall for the drug within a short time. South African estimates put the percentage of its cocaine trade in the hands of West African trafficking organizations, notably Nigerians, to be in the vicinity of 80% (Drug Advisory Board 1998, Leggett 2000, SAPS 2001).[38] Police and other sources report that since 1993 the bulk of the trafficking has been in the hands of Nigerian organized crime syndicates (SAPS all reports, Leggett 2001, Shaw 2001).

Even omitting the year 1998 – which witnessed an unusually large seizure[39] – data for the 1990s (see Figure 9) shows an overall increase in the seizure levels of cocaine. The escalating trend is also noted in the generally rising arrest figures (Figure 10). While the picture regarding arrests and seizures is uneven, the overall trend increase is nonetheless clear. Not depicted in either the seizure or arrest statistics, but still of significance, is the fact that there is a very definite shift towards dealing in crack cocaine as opposed to cocaine powder.

37 South Africa's level of cocaine seizures is still relatively small when measured globally. For example, in 1998, it accounted for 0.2% of global cocaine seizures.

38 The perception of Nigerian domination of the trade has been challenged. See for example: Tangeni Amupadhi and Miepje Commandeur "Blame it all on the Nigerians", electronic *Mail & Guardian*, April 18, 1997. For more recent critiques see Aminu 2001 and Chukwuma and Alemika 2001.

39 This was due to a single seizure of a container in which approximately 300 kg of cocaine (suspended in liquor) was concealed.

This change in the pattern of consumption indicates that increasing numbers of users are choosing crack – probably because of its potency combined with its affordability.[40]

There can be no doubt that trafficking in cocaine has exhibited a strong increase in recent years whether one looks at arrest data or seizure figures. Whichever indicator is used, over the past few years cocaine powder and crack cocaine have both been making inroads into the South African drug market scene. The upward trend is reflected in seizure and arrest data. There has been a strong increase in cocaine seizures in recent years which, arguably, cannot be accounted for exclusively in terms of increased law enforcement efforts.[41] Violence related to the cocaine market tends to be related more to acquisitive violent crime (mainly robbery) associated with the crack market than to competition for market share.

Ethnographic research within South Africa indicates that the growth in the cocaine market did not simply happen, but was actively developed by organized drug trafficking groups, often through free give-aways to sex workers in exchange for their assistance in promoting and distributing cocaine (especially crack-cocaine) among their clients (Leggett 1998 and 1999c). Foremost among these have been Nigerian criminal groups which have thus developed the market. This market is now maintained through a rather sophisticated system in which addicts have the option of paying either in cash, or in kind. This means that they can pay with stolen goods which are then re-sold again to individuals in disadvantaged communities at relatively low prices.

Some of the cocaine imports from Latin America for "White" rave clubs are allegedly controlled by individuals and groups associated with the Italian mafia (notably the Cosa Nostra). Following the crackdown on the mafia in Italy, a number of mafiosi took up refuge in South Africa and started their new careers with both legal and illegal activities. Illegal activities include involvement in the cocaine trade and in money laundering operations (OGD 1998).

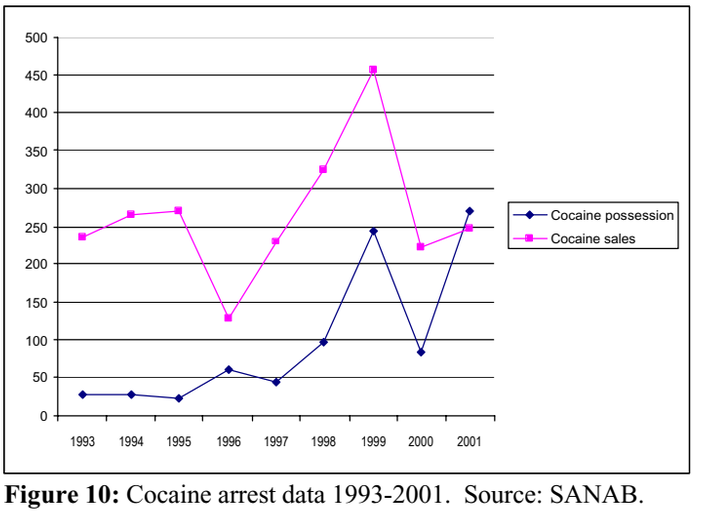

Figure 10: Cocaine arrest data 1993-2001. Source: SANAB.

Some of the crime and violence in South Africa would appear to be linked to the need to pay for cocaine consumption as well as to the fights among gangs trying to increase their market share of this particular drug (Leggett 2001, Parry, Louw and Pluddemann 2001). Cape Town has been affected by such gang wars. Cape Town and Gauteng remain the largest

40 The price of one rock (1g) was, on average, R50 = US$5.00 in April 2002.

41 Note: for a discussion of the issue of whether or not increased seizures reflect a greater volume of trafficking, see UNODCCP 2000, pp 36-37, "Following the tracks: Using seizures to identify trends". The report concludes that "seizure statistics – even without additional information – are a relatively good indicator for the identification of trafficking trends once longer periods are investigated."

cocaine markets in South Africa. Acquisitive violent crime (robbery) is also related to the crack market in the Hillbrow district of Johannesburg (ISS 2002).

Trafficking in heroin

Over the past decade, perhaps the most disturbing trend in the South African drug market has been the alarming rise in heroin trafficking and consumption. Figures 11 and 12 depict this sustained upward trend. The broad pattern in the arrest and seizure data is mirrored in the consumption data.

During the 1990s, in marked contrast to South Africa's role as an important transshipment point and market for cocaine, the extent of heroin trafficking could reasonably be termed modest. However, recently it has increased markedly. Even though the quantities involved are still small – with earlier significant seizures in 1990 and 1994 of heroin adding incongruous blips to the overall trend line (Figure 11) – seizure data for the past half decade show a sustained and strong trend increase. Arrest data for both possession and dealing since 1993 also depict a similar steeply upward trend.

Although the transshipment – via South Africa – of heroin destined for the US and Europe has been detected, it is clear that the majority of the heroin trafficked into South Africa is intended for domestic consumption. Most worryingly, its use is spreading rapidly in the school-going population, especially, but not exclusively, among those whose income base permits experimentation in this substance. A growth of evidence, both from sentinel surveillance sites (MRC 2001a) as well as anecdotal sources, points to significant increases in heroin consumption predominantly among White suburban school-going youth. However, even this trend is changing as cheaper heroin becomes available to the poorer residents in disadvantaged communities (e.g., Langa in Cape Town and Hammanskraal north of Pretoria).

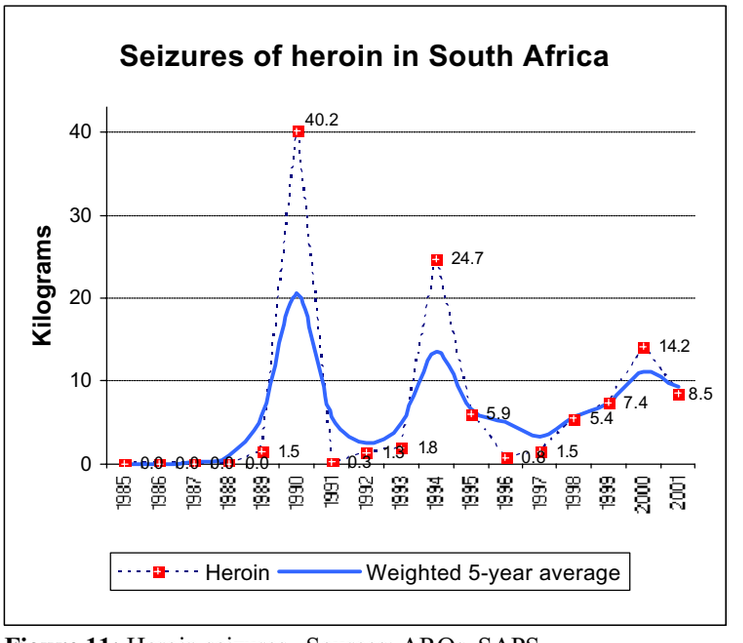

Figure 11: Heroin seizures. Sources: ARQs, SAPS.

Like cocaine, the heroin entering South Africa is mainly imported by air, principally via Johannesburg International Airport (see section 3.4 above). It comes from South East Asia and to a much lesser extent, South West Asia. There is increasing evidence of heroin originating in South West Asia entering South Africa overland via Kenya, Tanzania and Mozambique.

As is the case for cocaine trafficking, Nigerian criminal syndicates are heavily involved in trafficking heroin into and within South Africa (DEA 1996, Klein 1999, Leggett 2000, INSCR 2001). According to SAPS, most Nigerian immigrants – including many of those who have entered South Africa illegally – are law-abiding. Yet this diaspora also has attracted significant criminal elements who move from one country to another where the risk of law enforcement is perceived to be lower and opportunities for new forms of criminal entrepreneurship greater (SAPS 2000, SAPS 2001). The centre of cocaine and heroin smuggling operations has been located in the residential hotels located in the Hillbrow district of Johannesburg. Since mid-2001, largely due to enforcement activity by the SAPS, these operations have become more decentralized. Recent evidence from Cape Town and elsewhere also would suggest that while the cocaine and heroin trade is still largely in the hands of Nigerian syndicates, there appears to be prominent involvement in the heroin trade by nationals from Tanzania, Burundi, Kenya and Ethiopia, often under the misnomer "West African Nationals".

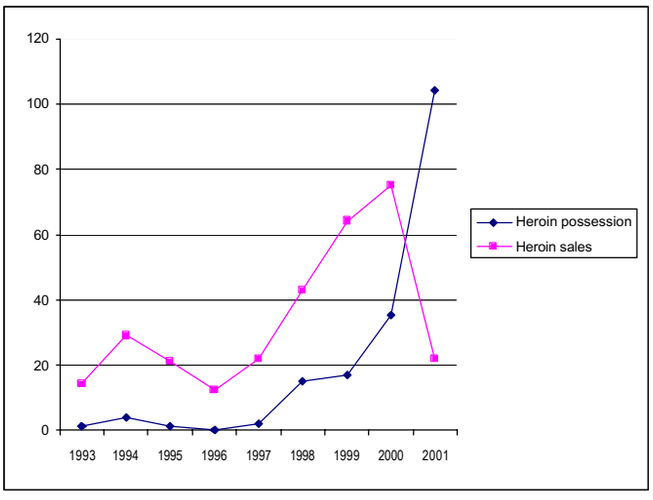

Figure 12: Heroin arrest data 1993-2001. Source: SANAB.

Trafficking in ecstasy, LSD and amphetamines

Mirroring trends in Europe, **ecstasy** has become a significant drug of abuse in recent years in South Africa. Similar also to the situation in Western Europe, use of ecstasy has been closely associated with rave parties and the club scene. In parallel with the increased popularity of this drug, seizures have also grown steadily. In 1998, South Africa had by far the highest number of ecstasy seizures of any African country and ranked 9th at the global level. Compared with Europe, however, the spread of ecstasy occurred rather late. Effectively it started only in 1994 following the opening up of South Africa to the outside world associated with the country's new democratic era. Rave parties can bring together an average of nearly 10,000 people at least twice a month in South Africa's largest cities (Johannesburg, Cape Town and Durban). Reports from the late 1990s estimated that on average 70% of youths attending these parties were taking synthetic drugs of which the preferred drug was ecstasy (OGD 1998). In 2000, a RaveSafe[42]

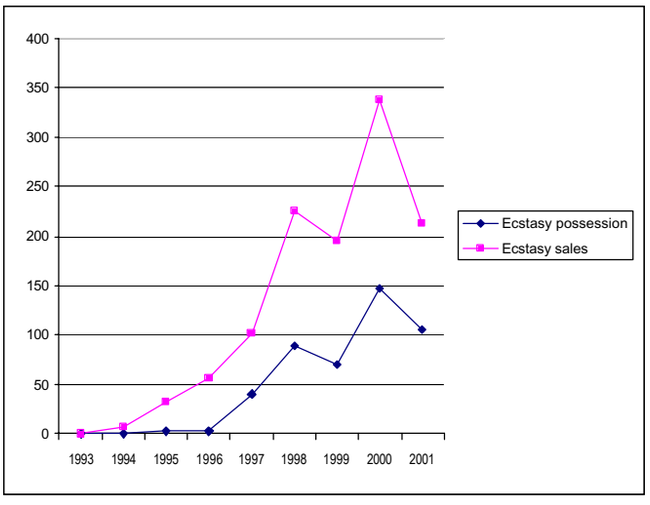

Figure 13: Ecstasy arrest data 1993-2001. Source: SANAB.

42 RaveSafe is an independent, South African non-profit organization run by volunteers whose stated objective is to inform ravers about how to avoid unnecessary danger when using drugs. They have stands at most big raves and distribute informational literature and provide advice.

study in Gauteng found that 88% of respondents had tried ecstasy at least once, and of these, 23% were using it weekly (SACENDU 2001).

Combined data on arrests for possession and dealing in ecstasy (Figure 13) show a steep rise, especially between 1999 (280) and 2000 (just under 500). Corresponding seizure figures are depicted in Figure 14. Year to date figures as of October 2002 indicate an increase in the number of tablets seized in that year over 2001. Although a few ecstasy laboratories have been seized in South Africa (see section 3.2 above), the bulk of what is consumed in the country is imported from Europe, notably from the Netherlands and the UK (SAPS 2000). Consumption and trafficking, until recently, have tended to be in the hands of White South African syndicates (the so-called "bouncer mafias") as well as some Europeans (notably from the UK and the Netherlands) (Leggett 2000). Within the past two years, however, and owing to their dominance of the trafficking market in cocaine and heroin, control of the market chain for the supply of ecstasy has, to a degree, shifted into the hands of organized criminal syndicates from Nigeria (SAPS 2001).

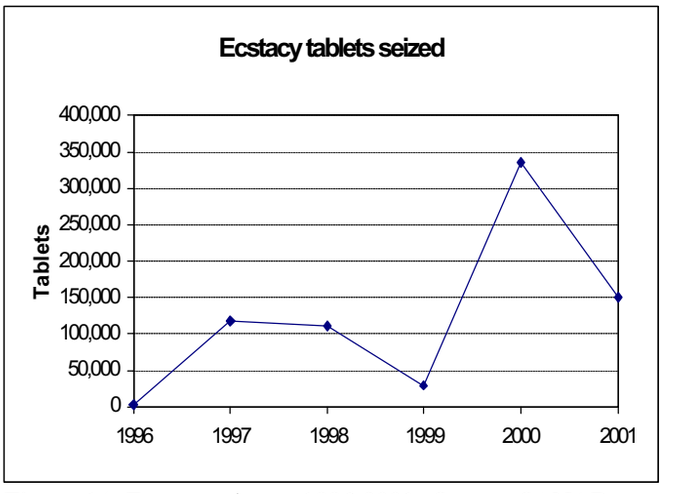

Figure 14: Ecstasy seizures 1996-2001. Source: SANAB.

For product being imported into the country, the preferred mode of transport continues to be the postal system and fast courier services (SAPS 2000). South Africa's role in the international trafficking in club drugs – this time as a transshipment point – was underlined in May 2002 when 36,000 tablets of ecstasy were seized in a shipment en route to New Zealand.[43] The syndicate allegedly involved in this deal had a prior record of smuggling compressed cannabis from South Africa into Europe in barter deals for club drugs.

The consumption and trafficking of **LSD** is still largely in the hands of White South Africans. The popularity of LSD, and thus trafficking in this substance, is generally less significant than that of ecstasy. Nonetheless, seizures of LSD were the largest in Africa and the 15th largest worldwide in 1997, the most recent year for which comparative data is available.

Easy availability of **speed (methamphetamine)** has been reported from South Africa. Speed is frequently trafficked together with ecstasy or together with LSD (MRC 1999). However, large scale availability is not – as yet – reflected in South African seizure data reported to ODC. It is also important to note that what is often reported as "speed" in the South African context is not actually methamphetamine, but ephedrine. Thus, the seizure reports have to be treated with caution.

43 Report in *Pretoria News* 14 May 2002, confirmed by SANAB.

Trafficking in other drugs

Wellconal (dipipanone hydrochloride), a synthetic opiate, is still considered to be a "White" drug. It served, for many years prior to the opening up of South Africa, as the *de facto* substitute for heroin which was not readily available in the country. Trafficking in this substance seems to have diminished in recent years, with most illicit supply deriving from the forgery of doctors' prescriptions. As is the case in many other countries, **benzodiazepines,** including **diazepam (Valium)**, have gained in popularity in recent years and is illegally obtained over the counter (OTC).

3.5 Diversion of Drugs

In addition to the trafficking of drugs from illicit sources, there is also some diversion from licit channels. Traditionally, diversions concerned mainly synthetic opiates such as **Wellconal, morphine or pethidine**. More recently, diversions were also reported for **benzodiazepines**, notably **diazepam (Valium)** (ARQ 1998 and previous years). There also have been cases of diversion of **flunitrazepam (Rohypnol),** another benzodiazepine. The overall extent of diversions, however, seems to be less significant if compared to many other African countries. Up to 5% of patients seen at specialist treatment centres across a number of sentinel surveillance sites in Cape Town, Durban, Port Elizabeth and in the provinces of Gauteng and Mpumalanga, during the period January to July 2001, reported over-the-counter medicines or prescription medicines as their primary substance of abuse (SACENDU 2002).

3.6 Drug Prices

In line with reports of the general availability of illicit drugs in South Africa, drug prices have remained relatively stable in rand terms or have even declined. However, once they are translated into US dollars, the impact of South Africa's currency depreciation in recent years yields a strong downward price trend. For example, according to information provided by the South African authorities in response to UNDCP's Annual Reports Questionnaire (ARQ), heroin prices – if expressed in US dollars terms at the then current exchange rates – fell by more than 75% between 1992 and 2001 (see Figure 15). Cocaine prices fell by approximately the same margin over the same period (see Figure 16).

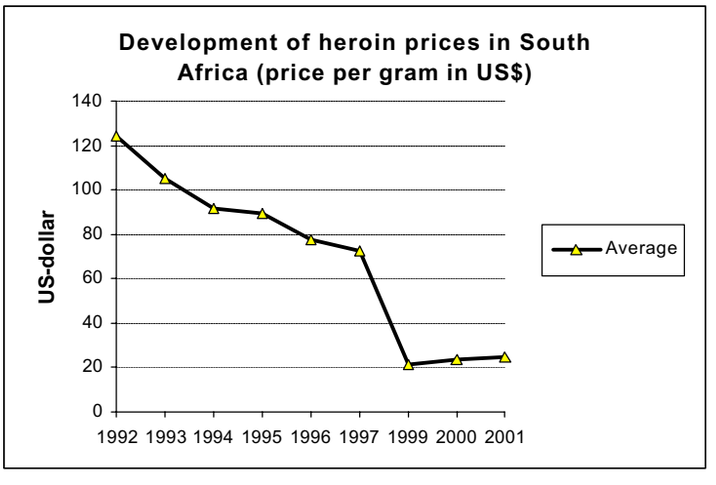

Figure 15: Heroin prices (price per gram in US dollars).

In rand terms, the values have remained stable or have declined somewhat. Lower prices, especially for crack cocaine, and, very recently, heroin, have made both drugs

affordable to a far broader range of people, including youth, than was the case previously. Measured in dollar terms, unit prices for both heroin and cocaine in South Africa are now substantially lower than in North America or Western Europe.

The continued low and even declining price of South Africa's imported illegal drugs during a period of steady decline in the value of the rand (from the mid-1990s to the present) is a complex phenomenon. It has occurred while the prices of legitimate imports have predictably increased as a result of the depreciating rand. A number of explanations have been proffered for this phenomenon, none of which — alone — is satisfactory.

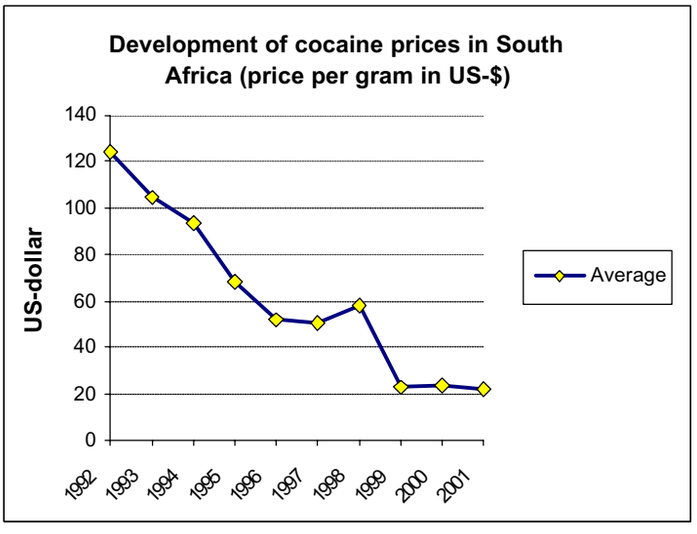

Figure 16: Cocaine prices (price per gram in US dollars).

First, it is a fact that illegal drugs like cannabis — or the results of other forms of criminal activity such as stolen cellphones, vehicles, and other property, etc. — are being exported under a form of barter arrangement for other imported drugs like ecstasy, cocaine and heroin. Such a barter arrangement, it has been argued, is a significant factor in the continued low price of these imported illegal drugs (Leggett 2001).

Second, there is the fact of greater 'competition', i.e., a larger number of smaller groups getting involved in importing drugs instead of a few big organizations. With unemployment relatively high and the economy far from booming, prospects to be able to generate sufficient legitimate income in the medium term are also limited. As a result, it is probable that individuals will be prepared to take more risk, without asking for more money. This will contribute to the price trend observed.

More speculative explanations have been advanced. One is the impact of a parallel decline in the international production cost of the various drugs. However, such a decline has not been consistently observed — at least in a manner that generally mirrors the South African rand-denominated stable or declining price trends.

Another possible explanation is declining purity levels. Declining purity would mean that drug producers and traffickers have lower costs for each unit of their drug, and this lower unit cost could be passed along to the drug user in the form of a lower price. Unfortunately, there have been no consistent surveys of drug purity in South Africa to permit a proper examination of this proposition.

Finally, a low price trend also could be accounted for by changes in the perception of risk by the trafficking organizations or other elements in the illegal drug market chain. Unlike the case for legitimate commodities, the element of perceived risk of law enforcement imposes additional costs to the eventual street price of any illegally-trafficked drug. If this perception of risk is high, the corresponding cost of trafficking the drug — and the resulting street price — will increase. If it is low, the reverse will be true.

Table 5. Street prices of illicit drugs in South Africa (national estimates) (at the current rand/dollar exchange rate)			
	1993 (in US$)	1997 (in US$)	2002 (in US$)
Mandrax (tablet)	9.3	6.8	4.0
Ecstasy (tablet)	18.6*	13.5	8.0
Heroin (gm)	52.4	42.3	18.0
Cocaine (gm)	50.7	42.3	25.0
Cannabis (joint)	0.2	0.2	0.1
Speed (unit)	8.5**	8.5	3.8
LSD (unit)	n.a.	8.5	4.2
Hashish (gm)	n.a.	0.9	n.a.
Cat (gm)	n.a.	n.a.	12.0

* 1994 ** 1996
Sources: SANAB, quoted in Charles Parry and Andreas Plüddemann (South African Medical Research Council), "Draft Country Profile: South Africa for UN World Drug Report", October 1998. SACENDU 2001. South African Community Epidemiology Network on Drug Use (SACENDU) *Research Brief Vol 4 (1), 2001*, covering the period July 1996 - December 2000, published by the South African Medical Research Council, 2001.

3.7 Demand

Prevalence in the general population

As is the case worldwide, the illicit – and therefore hidden – nature of drug use makes the collection of information on drug consumption particularly difficult. South Africa is no exception. Drug users are often reluctant to admit to their drug use due to fear of prosecution or, as illicit drug use is also a highly stigmatised activity in many societies, persecution. This difficulty may be compounded by the tendency for illicit drug use to often be prevalent among socially marginalised populations. Thus, many drug users are difficult to access and are often under-represented in household and school surveys. As a result, drug use prevalence data in most regions of the world is sparse at best, often relying on proxy indicators of use, such as treatment demand, rather than direct measures of prevalence such as population surveys. At a global level, the quality of drug use estimates available for each country is generally directly proportional to the level of development in that country.

For this reason, the best prevalence estimates currently available describe the drug use situation in Western Europe, North America and Australasia. In most developing countries, prevalence estimates either simply do not exist or where they do exist they are often of poor reliability and validity. While South Africa does not differ from the majority of developing countries in this regard, by developing country standards there is a reasonable amount of good quality information available describing demand for illicit drugs in the country.

An integrated drug information system, the South African Community Epidemiology Network on Drug Use (SACENDU) has been operational in South Africa since July 1996. This network provides information on drug demand trends based primarily on indirect

indicators such as demand for treatment (in treatment centres and psychiatric hospitals), drug-related arrests, drug seizures and drug-related mortality. Data from SACENDU is supplemented by ad hoc surveillance studies such as rapid situation assessments and school surveys. Very few estimates have been made of the prevalence of illicit drug use in South Africa, and to date no household surveys have been conducted.

The South African Medical Research Council (MRC) has arrived at the ranking of the prevalence of illicit drug use in South Africa given in Table 6, based on a comprehensive review of all existing studies and the findings. In terms of drug-related morbidity, i.e., adverse health consequences (as reflected in treatment data), the MRC ranks cannabis and mandrax as the primary and secondary drugs of abuse in South Africa, followed by cocaine/crack.

The findings of SACENDU suggest that, as in almost all other countries of the world, the most widespread illicit drug used in South Africa is **cannabis**. While SACENDU does not attempt to estimate prevalence, a previous study (HSRC 1991) conducted in 1990 reported an annual prevalence of cannabis use among Black/African males (14 years and above) of between 5.3% and 22.3%. This compares to an annual prevalence of cannabis use in the general population of the EU and the U.S. of approximately 5.5% and 9% respectively (average in the 1990s). Trend data from SACENDU suggests that the prevalence of cannabis use has remained relatively constant since this study was conducted. In the major urban centres of Gauteng province, Cape Town, Port Elizabeth and Durban, cannabis has been found to dominate drug-related arrests since the introduction of SACENDU sentinel surveillance. Similarly, cannabis is consistently the dominant illicit drug abused by those seeking treatment, and it is reported as the primary substance of abuse by between 10 and 20 percent of patients.

Table 6. Drugs of abuse in South Africa
Ranked according to estimated prevalence and morbidity (1997/98)

Extent of use Ranking		**Morbidity (as indicated by treatment data) Ranking**	
1	Cannabis	1	Cannabis
2	Mandrax (methaqualone)	2	Mandrax (methaqualone)
3	Other depressants (mostly benzodizepines)	3	Cocaine/crack
4	Inhalants (glue, thinners)	4	Other depressants (mostly benzodiazepines)
5	Cocaine/Crack	5	Heroin and other opiates
6	Amphetamine-type stimulants (ecstasy and speed)	6	Amphetamine-type stimulants (ecstasy and speed)
7	LSD	7	LSD
8	Heroin and other opiates	8	Inhalants (glue, thinners)

Source: South African Medical Research Council, Draft Country Profile, October 1998.

Cannabis used in conjunction with **mandrax** (methaqualone), a combination known as "white pipe", contributes to a further 5-15 percent of treatment admissions reported to SACENDU. The only data for this combination currently available suggest an annual prevalence of less than 4% among the male adult (14 years and above) population (Flisher

1998). This figure relates to a squatter settlement. It is likely that the figure for the general population is significantly lower. Treatment demand and arrest data suggest that this combination is more prevalent in the Cape Town and Durban regions. This may reflect the differences in the popularity of mandrax between cultures and regions. Between 10 and 50 percent of drug-related arrests are for mandrax.

Table 7. Treatment demand for illicit drug-related problems 1996-2001 (as % of total)

Location	Period	Cannabis	Cannabis mandrax	Cocaine/ Crack	Heroin	Ecstasy	OTC / PRE	Other drugs	Alco-hol
Cape Town	1996b	4	9	2	1	<1	2	2	81
	2001b	12	25	6	6	1	2	2	46
Durban	1996b	10	10	1	< 1	< 1	1	4	73
	2001b	26	7	8	< 1	1	<1	<1	58
Port Elizabeth	1997a	23		< 1	< 1	< 1	5	13	58
	2001b	36		1	0	1	4	<1	58
Gauteng	1998a	11	5	8	< 1	< 1	4	3	69
	2001b	24	5	6	7	<1	4	2	52
Mpumal-anga	1999a	13	1	3	< 1	< 1	3	2	76
	2001b	15	3	2	1	2	5	3	69

a/ January-June
b/ July-December
OTC = Over-the-counter drugs; PRE = prescription drugs
Source: SACENDU 2002b.

Although increasing ethnic integration in South Africa is evident, the drug markets of South Africa remain somewhat ethnically segmented. This is likely to be related to extreme income inequalities between the different broad ethnic segments which affect drug affordability and, with it, consumer choice. This has been underscored by recent research. For example, evidence from a recent study of arrestees (Parry, Louw and Pluddemann 2001) suggests that mandrax is most popular among the Coloured population. Nationwide, mandrax was the second most frequently detected illicit substance among those tested in police holding cells. In urinalysis, Coloured and Indian/Asian arrestees were approximately four times more likely to test positive for mandrax than Black/African and White arrestees, with 46% of Indian/Asian and 53% of Coloured arrestees testing positive, as compared with 12% and 13% of Black/African and White subjects respectively (Parry, Louw and Pluddemann 2001). These results do need to be interpreted with some caution however, as arrestees may not be representative of the broader population. In the Black/African population, mandrax appears to be most popular in former township communities where it has been associated with gangsterism. While mandrax continues to play a role as a "come down"[44] drug, it has been

44 The use of a drug to "come down" refers to the process of taking a drug – usually a depressant – to return the user to something similar to his or her original state following their preceding use of another drug – typically a stimulant – to get high.

suggested that it is being supplanted by crack to some extent among sex workers (Leggett 2000).

Treatment demand data suggest the emergence of **cocaine** as an important drug of abuse in South Africa (Table 7). From 1997 to 2000, the proportion of treatment centre patients reporting cocaine, in the form of both powder and **crack**, as their primary drug of abuse has increased from approximately 1% to between 5-10%. Regionally, treatment demand for cocaine is greatest in Gauteng, Cape Town and Durban, and it is still relatively uncommon in Port Elizabeth (Eastern Cape) and the predominantly rural province of Mpumalanga. Arrest data support this trend, with the proportion of arrests for cocaine in Gauteng, Cape Town and Durban increasing from approximately 10% to approximately 20% between 1997 and 2000. Data from the arrestees study suggests that cocaine use is more prevalent among the White and relatively more affluent communities. Arrestees testing positive for cocaine were disproportionately White, female and reported a higher average income. It is likely however that this result reflects the high proportion of sex workers among those arrested and is again unlikely to be representative of the pattern of use in the general population arrested.

Heroin use is an emerging trend in South Africa (Table 7). In Cape Town and Gauteng, heroin was reported as the primary drug of abuse by approximately 5% of treatment centre clients in 2000, having increased from approximately 1% in 1997. This trend is also apparent in arrest data for these regions, increasing from 1 to 5% of drug-related arrests between 1997 and 2000. Existing evidence suggests that the majority of heroin use occurs among the younger White middle class population in the major urban areas, namely Cape Town, Johannesburg and Pretoria. While the majority of heroin users are male, the ratio of males to females is lower than for other illicit drugs. The limited evidence currently available suggests a transition from smoking to injecting as a route of administration among some heroin users. For example, the most recent SACENDU findings report that "intravenous use by patients with heroin as their primary drug of abuse seems to be increasing with 51% of heroin patients in Cape Town reporting some injecting versus 36% in Gauteng" (SACENDU 2002b).

While arrests for **amphetamines** are rare – consistently comprising less than 1% of all drug-related arrests – arrests for certain amphetamine-type stimulants (e.g., ecstasy) have fluctuated significantly between years and across sites, ranging from 2% to 22% of all drug-related offences. As with arrests, treatment demand for amphetamine-type stimulants remains very low, accounting for less than 1% of treatment demand for the years 1997 to 2000. This may reflect the fact that users of these substances are generally under-represented among treatment populations, despite often having a relatively high prevalence of use.

There are also some important regional differences in South Africa's drug market. Based on the proportion of people in treatment centres, with regard to their primary substance of abuse, data suggest (a) that Gauteng may be the largest market for cocaine, followed by Cape Town; (b) that Gauteng may be also the largest heroin market; and (c) that Durban is the largest market for cannabis, ahead of Port Elizabeth.

Data also appear to confirm that the strongest growth throughout South Africa in recent years was in cocaine, although there has also been an increase with regard to heroin.

Prevalence in the youth population

The most comprehensive school-based prevalence study conducted to date (Flisher 1998) generally confirms these patterns of use (see Table 8). However, among 11th grade pupils, inhalants (primarily glue) appear to be more popular than in the wider population, and the use of ecstasy exceeds that of crack cocaine. This study also confirms that drug consumption is two to three times more common among males than among females, as international experience would lead one to expect. The only exception to this pattern is for ecstasy use, where male abuse is only one third higher than abuse among females.

Table 8. Life-time prevalence of substance abuse among 11th graders in Cape Town in 1997 (n=2,770)

	Cape-Town			U.S. 1997
	Male	Female	Unweighted average	10th graders (Monitoring the Future study)
Cannabis	32.0%	13.1%	22.6%	42.3%
Glue / inhalants	15.8%	4.9%	10.4%	18.3%
"White pipe" (cannabis/mandrax)	5.7%	1.9%	3.8%	n.a.
Ecstasy	4.3%	3.1%	3.7%	6.9%*
Crack-cocaine	2.6%	1.0%	1.8%	7.1%
Other	3.9%	2.4%	3.2%	n.a.

* = figure for 12th graders.
Source: Flisher 1998.

According to preliminary results of research during 2000 regarding grade 7, 10 and 11 students from 35 secondary schools in Pretoria, conducted by the Department of Criminology and the Institute for Criminological Sciences of the University of South Africa, more than one quarter of the respondents had witnessed illegal drugs being sold on their school grounds, while 42% had personally seen illegal drugs being sold in their neighbourhood. When the results were broken down according to race, approximately 75% of Coloured students had witnessed illegal drugs being sold at school. This compares with 42% of Indians/Asians, 25% of Blacks/Africans and 13% of Whites. Approximately 83% of Coloureds, 55% of Indians/Asians, 42% of Blacks/Africans and 29% of Whites had observed drugs being sold in their neighbourhoods (Neser et. al. 2001).

The same survey revealed that when asked whether they knew a friend or classmate who had been using illegal drugs such as LSD, ecstasy, cocaine or heroin, the majority of Coloureds (79.3%) confirmed that they did. Of the other groups approximately 57% of Indians/Asians, 40% of Whites and 37% of Blacks/Africans answered in the affirmative. On the question of whether they thought their particular school was drug free, approximately 75% of Coloureds, 64% of Indians/Asians, 49% of Blacks/Africans and 46% of Whites answered that they thought it was not. One-third of the respondents admitted to having smoked cannabis, of which 23% were under the age of 12 and 34% were 15- and 16-year olds. One quarter of the respondents indicated that they had inhaled substances such as glue, petrol and

thinners, and 27% had consumed mandrax, ecstasy, LSD and 22% had smoked crack or cocaine and mandrax (Neser et. al. 2001).

A survey by Bridges — a Cape Town NGO engaged in prevention — of five high schools in the Cape Town metropolitan area during 2000 found that approximately 23% of the students had tried cannabis at least once with the highest proportion (35%) being grade 12 students. Ecstasy was found to be the second most common drug ever used (6% overall) with 12% of the grade 12 students having used the substance. The study also indicated that 36% of students who responded to the questions on drug abuse indicated that someone in their family was experiencing a drug problem (Fisher 2000). Using a larger catchment area, Bridges conducted a similar survey in 2002. Significantly, it was the first to monitor drug and alcohol use among primary school children in the Cape Town metropolitan area. The survey involved a total of 991 primary school and 387 high school pupils. Of the 20% who had tried drugs, 19% were still using them and the average age of first using drugs was 12.1 years. In high schools, 45% had tried any drug, and 32% were still using drugs (Fisher 2002).

The indicator data on prevalence among the youth would seem to suggest the following. Cannabis is the most common illegal drug being used by school children, followed by inhalants, mandrax, ecstasy and crack cocaine. A higher proportion of White adolescents report heroin, cocaine and ecstasy as their primary drug of abuse, with Coloureds and Indians/Asians most likely to report cannabis smoked with mandrax ('white pipe'). Black/African adolescents are most likely to report alcohol as their primary substance of abuse. While it is likely that cocaine — and especially crack — are still generally being used more often (and by more adolescents) than heroin, SACENDU data for Cape Town and Gauteng would seem to indicate that heroin may be overtaking cocaine in the adolescent age group. For example, in the second half of 2001, 9% of patients younger than 20 years in Cape Town treatment centres reported heroin as their primary substance of abuse compared with 3% for cocaine/crack. In Gauteng, 6% of patients younger than 20 years reported heroin as their primary drug of abuse compared with 2.5% for cocaine/crack in the same period (SACENDU 2002b).

Although it may not be possible to generalize national prevalence from statistics obtained in Cape Town and Gauteng, the lifetime prevalence estimates reported in these studies suggest that levels of drug abuse among high school students in South Africa nonetheless remain lower than those of students in the United States and Australia and on a par with those in much of Europe (UNODCCP 2002).

One of the only available studies examining risk and protective factors was undertaken during August 2001 by Research Surveys (Research Surveys 2001). It was conducted among 800 teenagers aged 13-19 years from major metropolitan areas throughout South Africa on their experiences with illegal drugs. The study found that 71% of the total sample had had a discussion with their parents about the risks of using illegal drugs. Whereas 83% of White parents had discussed the risks with their teenagers, only 59% of non-White parents had done so. The survey reported that 70% of White and 93% of Black/African teenagers had never been offered illegal drugs. When teenagers had been offered illegal drugs, two-thirds had been offered the drugs by a friend.

While this data would suggest that talking about drug use is linked to lower rates of experimentation, the fact that drug use is high among Whites in South Africa points to the need to further investigate other potential risk and protective factors in addition to family

functioning. Such factors would include disposable income, peer influence, educational prospects, socio-economic status and other environmental factors (e.g., the acceptability or non-acceptability of drug use among a particular social group).

3.8 Treatment Consequences

The adverse consequences of increasing rates of drug consumption are reflected in rising treatment demand. In the first half of 1998, a total of 4,500 patients were treated in Cape Town, Port Elizabeth and Johannesburg/Pretoria for drug abuse. Another consequence is drug-related violence as is reflected in drug-related injury statistics. A 1997 study of drug-related trauma undertaken by the South African Medical Research Council, found that 40% of injuries at a large hospital in Cape Town were drug-related. Chemical analysis revealed that 29% of the patients had THC in their urine, 10% had mandrax, and 2% had cocaine in their blood. Most patients (85%) were injured as a result of violence, which – at least indirectly – was drug-related (MRC 1998). The results of the 3-Metros (Johannesburg/Pretoria, Cape Town, Durban) study would appear to support this (Parry, Louw and Pluddemann 2001).

Another serious problem is the high rate of HIV infection. In 1997, a national survey of women attending ante-natal clinics (n=12,343) revealed that 16% had already tested positive for HIV, representing a 13% increase over the previous year, and subsequent studies have shown even higher rates. As indicated in Section 1.1 above, this figure is now estimated nationally to be in the vicinity of 24.8% (Department of Health 2000; Department of Health 2001; MRC 2001).

In South Africa, the Department of Welfare reported in 1999 that one in five of the economically active population was HIV-positive. The population of KwaZulu-Natal has already gone into decline as a result of AIDS-induced premature deaths.[45] As a result, the risk of a proportion of "AIDS orphans" growing up into criminal adulthood is to be considered a human security concern in South Africa (Schonteich 1999). Latest estimates from the South African-based Institute for Security Studies claim that some 300,000 children had already been orphaned by HIV/AIDS with projections that up to 3 million children would be orphaned under similar circumstances between 2002-2012. A burgeoning orphan population, growing up under extreme levels of poverty and without parental supervision will be likely, as a survival strategy, to "turn to crime, drugs, gangs and the sex trade".[46]

However, the question of delineating a clear chain of causality between drug abuse and HIV/AIDS remains complex. It is possible that the link goes in both directions. In other words, drug abuse is known to be a causal factor in the spread of HIV/AIDS, and HIV/AIDS is also believed to be a factor in causing drug abuse, although this second link needs to be investigated further.[47]

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45 As reported in 1999, the national antenatal average for women testing positive for HIV/AIDS was 23%. The provincial figure for KwaZulu-Natal was 32%.

46 Quoted in the *Sunday Independent*, 6 October 2002.

47 There are *prima facie* indications nonetheless that a relationship may exist, especially if the following two factors are considered. The first factor is a combination of the desperation and marginalization that people affected by HIV/AIDS suffer which could be one of the factors leading to drug abuse. For example, the findings

The following four points review the drugs-HIV/AIDS connection:

(a) Unprotected sex under the influence of drugs: In South Africa, the main mode of transmission of the HIV virus is unprotected heterosexual sex.[48] Non-injecting drug abuse is a significant factor that influences the sexual transmission of HIV. It has been demonstrated that unprotected sex is more common under the influence of drugs due to a loss of control. In other words, in the context of sexual intercourse, the main psychoactive effect of drug abuse is to: (a) alter an individual's judgment, (b) make it more difficult to say "no", and (c) make it harder to negotiate the use of a condom.

(b) Commercial sex work and drugs: Available research in South Africa[49] has demonstrated that drug-using sex workers report having much larger client volumes than non-users, as many as 9 clients on a "good night" working 7 nights a week, and even into the daylight hours. By comparison, sex workers who are not drug dependent have an average of 2-4 clients per night and generally work only 4-5 nights a week. Women who have been in the industry for some time complain that crack has increased the number of women on the street and driven down the median age. Increased competition also has driven down prices for commercial sex, forcing women to handle greater volumes of clients in order to maintain income levels. This also has led to an increase in demand for unsafe sex – such as condom-free sex and anal sex – as the competition among sex workers has reduced their ability to refuse business. These dimensions have clear implications for HIV transmission. In addition, crack has been blamed by some women for the increase in client violence. The problem of crack use therefore has worrying social health implications owing to its links with the spread of HIV/AIDS, mainly through its overall disinhibitory effect on safe sex practices.[50]

(c) Drug abuse and its consequences on people living with HIV/AIDS: The WHO has indicated that some psychoactive drugs may hasten the onset of AIDS by depressing immune functions.[51] This aspect needs to be further studied. It is known, for example, that there is a relationship between alcohol abuse and the weakening of the immune system. Drug abuse may also be a contributing factor in the development of AIDS from HIV. In the context of South Africa, if a connection were to be found between

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of a study conducted by a Tanzanian psychiatrist appear to demonstrate that some HIV/AIDS sufferers generally tend to (a) simply wither, (b) become religious, or (c) take drugs in order to escape their depression. (A variation on this theme is the so-called "Titanic phenomenon" for AIDS-induced drug taking – "why not enjoy the last few hours"? See Franzen 1998, pp. 27-29.) The second factor is the case of "AIDS orphans". The chain of causality in this situation is indirect. Orphans created by the AIDS-related death of their parents may be lured into illicit activities – possibly including aspects of the drug trade – in order to survive.

48 It is estimated that 85% of infections occurs through heterosexual transmission, 10% through mother-to-child transmission and the remaining 5% through same-sex transmission, injecting drug use and occupational exposure. See Parry and Karim 1999.

49 See, for example, Leggett 1999a.

50 Research in the U.S. has demonstrated that crack users exhibit seropositivity levels rivalling those of injecting drug users due to the unprotected sexual activity involved both in procuring the drug and in response to its effects.

51 "WHO Expert Committee on Drug Dependence", WHO Technical Report Series, Number 836, Geneva, 1993.

the abuse of cannabis (which is highly prevalent) and a weakening of the immune system, this would have major public health implications.

(d) Injecting drug use: IDU is not common in South Africa, but information on drug abuse is not complete, and the real situation may be more problematic than it currently appears. Recent evidence indicates that the injecting of heroin is increasing in South Africa. For example, 51% of heroin patients in Cape Town report some injecting. The figure for such patients in Gauteng is 36% (SACENDU 2002a and SACENDU 2002b). While efforts must therefore remain focused on addressing transmission via heterosexual sex, a failure to address IDU in South Africa may result in leaving open a space for the disease to affect the population by an additional route.

Research by the South African MRC into the link between substance abuse and the spread of HIV/AIDS is currently underway. The research correlates broadly with similar work undertaken in other countries in respect of the drugs-HIV/AIDS nexus where IDU is also not a principal vector of transmission. In general, the provisional MRC research findings indicate that adolescents who use alcohol and other drugs are more likely to engage in sex and in unsafe sex, than are adolescents who abstain from using alcohol and other drugs.