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PRIORITIZING PUBLIC HEALTH RESPONSES IN NIGERIAN DRUG CONTROL POLICY

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ABSTRACT

Nigeria's drug control policy, a throwback to colonial dangerous drugs control legislations, is remarkable for its reliance on severe sanctions to curb drug offences. The establishment of the National Drug Law Enforcement Agency (NDLEA) in 1990 took drug control in Nigeria to a crescendo. The agency amalgamates the functions of supply control and demand reduction in a highly-centralized bureaucracy. Although it has been successful in the seizure of drugs and arrest and punishment of offenders, its impact on drug use and related problems is negligible. the success is tainted by rampant corruption and the cost of law enforcement. The development of a comprehensive drug policy which prioritizes demand reduction through public health measures such as prevention and treatment is hampered by the bureaucracy of drug law enforcement, whose direction cannot be changed without altering the structure of the organization. The devolution of functions through the creation of a new agency on drug demand reduction is a step in the right direction.

Keywords: drugs, policy, public health, law enforcement, Nigeria

INTRODUCTION

There has been significant concern over the availability and use of illicit psychoactive substances in Nigeria in recent times, but the problem is by no means new. The distribution and consumption of illicit drugs in Nigeria have a relatively long history (Obot, 2004). The use of cannabis, for instance, predated formal independence from the British in 1960. The drug was introduced into Nigeria in the aftermath of the Second World War by military officers returning from the Middle East, the Far East, and North Africa (Asuni, 1964). Surveys conducted in psychiatric hospitals in western Nigeria in the 1950s indicated that most of the patients who presented with schizophrenia, anxiety disorders and other mental health

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problems had a history of alcohol or drug abuse (Lambo, 1965).

The 1980s witnessed the entry of cocaine and heroin into the Nigerian drug market. The drugs came into the country as a result of the involvement of Nigerians in international drug trafficking. Heroin reportedly entered the country when Nigerian naval officers undergoing training in India smuggled it into the country on their return. Cocaine came into Nigeria through South American drug traffickers who used West African countries, including Nigeria and Ghana, as a passage into the European and North American drug markets (Akyeampong, 2005; Ellis, 2009). Initially these drugs were mostly used by affluent residents of Nigerian cities. The earliest reports of cocaine use included 'cocaine parties' organized by some wealthy Nigerians in Benin City (Pela & Ebie, 1982). The use of these drugs has increased, while other drugs such as amphetamine-type stimulants have been added to the list (UNODC, 2012).

psychoactive substances use is correlated with mental disorders. It is also associated with increase in the burden of disease, disability, mortality, crime and other social problems. But these issues are hardly considered in drug control policy, which is focused on controlling the supply of illicit drugs. The focus of the National Drug Law Enforcement Agency (NDLEA) is on interdiction of drugs in airports and seaports, eradication of narcotic cultivation and arrest and prosecution of drug offenders. There is a Drug Demand Reduction (DDR) unit within the NDLEA, but the effectiveness of the unit is hampered by poor staffing and funding. This paper discusses the development of drug control policy in Nigeria, and highlights the neglect of public health measures. It contends that the bureaucratization of drug control has retarded the development of public health responses to drug problems.

GLOBAL DRUG CONTROL

International drug control efforts are guided by the three UN treaties, namely the Single Convention on Narcotic Drugs of 1961 (amended by the 1972 Protocol), the Convention on Psychotropic Substances of 1971, and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. They seek to "eliminate the non-scientific and non-medical production, supply and use of narcotic and psychotropic drugs" (Bewley-Taylor, 2012, p. 49). As stated in the preamble of the 1962 Convention, the rationale is that "addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind". The drug control system (often referred to as the global drug prohibition regime) is built on the assumption that controlling the market for illicit drugs through prohibition-oriented supply-side measures will reduce the problems associated with the use of illicit drugs. This involves the development of a growing list of substances considered dangerous and subject to legal controls (Klein, 1999). Substances such as cocaine, heroin and cannabis are dangerous drugs to be controlled, while others such as tobacco and alcohol are regulated differently. Signatory states to the conventions are expected to adopt relevant measures to prohibit the production, consumption and trade in these controlled substances within their domain.

The different aspects of the drug control system are administered by specialized

agencies of the United Nations (UN) system. The development of policy is the responsibility of the Commission on Narcotic Drugs (CND), which is made of the 53 member states. The World Health Organization (WHO) and the International Narcotics Control Board (INCB) provide technical support for the CND. The INCB also serves as an independent judicial control body which assesses requirements for scheduling substances and monitors compliance with the conventions by member states. The United Nations Office on Drugs and Crime (UNODC) is the policy implementation organ of the drug control system. It is the duty of the UNODC to coordinate drug control activities and to provide technical and administrative support for the CND and the INCB in their respective functions.

National drug control policies are formulated under the supervision of the INCB and with assistance from the UNODC. Until the 2016 UNGASS created a relatively open policy environment, member states had limited discretion in the formulation of domestic drug policies. As a result, local concerns were often lost in the pursuit of uniformity of policy goals and strategies. The international drug control system fosters a "background prohibitionist expectancy on nations regarding personal drug use" (Beweley-Taylor, 2012, p. 50). This involves imposing criminal sanctions on drug offences, including personal drug use. Drug prohibition is constructed as a moral necessity., West African countries are pressured to implement drug control measures. The pressure has arisen in response to the growth of illicit drug trafficking through the sub-region. Over the years there has been reported increase in seizures of illicit drugs in West Africa, enroute to European and American drug markets (Klantschnig, 2013), and this has contributed to the emergence of the region as an important site of international drug control activities.

West African countries have been pressured to strengthen law enforcement for the interdiction of drugs in air and seaports, and to repress domestic drug production. Failure to comply with the expectations of the international system attracts sanction in the form of loss of foreign aid. Thus, in the early years of the drug war the US would decertify countries that are deemed not to cooperate with its anti-drugs efforts, which meant withdrawal of aid or trade benefits. In 1994, Nigeria was decertified along with Myanmar, Iran and Syria, followed by Afghanistan in 1995. The sanction was an expression of the US displeasure over the growing role of Nigerians in the drug problem in the US. It proved successful in arm-twisting the Nigerian state to step-up drug law enforcement within its borders. Nigeria has since transformed into a model of drug law enforcement in the region, in the process earning itself a good reputation in the international community. But this means that law enforcement has become prominent in the response to drug problems, while demand reduction through public health programmes has been marginalized.

THE DOMESTIC SCENE

The control of illicit drugs production, distribution and consumption in Nigeria dates back to the colonial period when the British colonial government sought to introduce the control measures contained in the 1912 Opium Control Treaty in all her territories. In 1935, the Dangerous Drugs Ordinance was enacted in Nigeria

to control the production and consumption of substances considered dangerous. The major substance of abuse in Nigeria at the time was alcohol. The Ordinance is an illustration of the political transformation of social policy. Originally designed to protect 'inebriated natives' from the negative consequences of dangerous substances, the Ordinance morphed into a "system of tariffs and quotas on gins, schnapps and brandy imports" succeeded by "bans on distilled liquors, fermented beers, bottled beers and wine" (Klein, 1999: 54). It became an instrument for advancing the political and economic interests of the colonizers and served as the foundation of the colonial state.

Reflecting this history of prohibition, Nigeria's drug policies have contained some of the most draconian provisions ever applied to eradicate drug trafficking and use (Obot, 2004). The Indian Hemp (Cannabis) Decree of 1966 included death penalty or 21 years imprisonment for the cultivation of cannabis, 10 years imprisonment for trafficking in cannabis, and another 10 years for possession and/or smoking of cannabis. The Indian Hemp Act of 1975 abolished the death penalty and reduced sanction for cannabis smoking to 6 months and/or a fine. But the Indian Hemp (Amendment) Decree of 1984 reinstated stiff penalties for drug-related offences, while the Special Tribunal (Miscellaneous Offences) Decree of 1984 brought back death penalty by firing squad for "dealing in, buying, selling, exposing or offering for sale or inducing any person to buy, sell, smoke or inhale the drug known as cocaine or other similar drug" (Federal Military Government, 1984; cited in Obot, 2004).

The Special Tribunal (Miscellaneous Offences) (Amendment) Decree of 1986 finally did away with the death penalty. But it was substituted with life imprisonment, an equally severe sanction. Other clauses in the decree included forfeiture of assets and passport for those arrested for drug trafficking. The hallmark of drug control development came in 1989 with the enactment of Decree 48. The decree, which is now an act of parliament CAP N30 Laws of the Federation of Nigeria 2004, established the National Drug Law Enforcement Agency (NDLEA) and charged it with the responsibility of co-ordinating drug control activities in the country. The NDLEA amalgamates the functions previously discharged by different agencies of government, including the Nigeria Customs Service and the Nigeria Police (policy implementation), and the Federal Welfare Department (prevention, treatment and rehabilitation). Thus, a multi-sectoral approach to drug control was replaced by a highly centralized law enforcement bureaucracy. This has led to the ascendancy of supply control and the marginalization of demand reduction activities.

The 1989 Decree assigns 18 major functions to the NDLEA. This includes investigation, arrest and prosecution of drug offenders, confiscation and/or seizure of the property or proceeds of drug-related offences, eradication of illicit cultivation of narcotic plants and interdiction of drugs at entry points into the country. Of the 18 functions, only 2 may be considered drug demand reduction functions. These include functions related to prevention and research. There is no mention of treatment for drug use disorders. Furthermore, there is heavy reliance on criminal sanctions to curb drug offences. For example, the Decree states that any individual or organization colluding with offenders to perpetrate a drug offence or to conceal

proceeds from illicit drug trade is liable on conviction to a term of 25 years imprisonment or two million Naira fine.

The NDLEA has special commands in all borders, airports and seaports in the country to seize drugs trafficked into and out of the country, and to arrest offenders. Officials of the agency make use of special full body scanning machines to identify smugglers and couriers moving drugs such as cocaine and heroin through Nigeria to western markets. Between 2006 and 2008 officials of the agency arrested 12, 663 suspected drug dealers and seized over 418.8 metric tons of various hard drugs. In July 2009 a female courier was arrested on board a KLM flight at the Kano International airport. She excreted 42 wraps of cocaine weighing 585 grams. In September of the same year a Guinean woman was arrested at the Lagos international airport going from Brazil to Europe with 6.350 kilogram of pure cocaine. The agency has also been involved in the eradication of illicit narcotic drug cultivation. In September 2009 the NDLEA reportedly destroyed 24 hectare of cannabis plantation in a forest reserve in Osun state. Other plantations have been destroyed in Ogun and Edo states.

Going by conventional standards such as figures of arrests and drug seizures the NDLEA has been successful. The agency has also achieved recognition for its progress in counter narcotics and for effective cooperation with the US in tackling drug-related crimes and money laundering in West Africa. But the impact of the agency's operations on illicit drugs consumption and in addressing drug-related problems has been marginal. Beyond the much vaunted success in drug interdiction operations there exists a gruesome reality of drug consumption, dependence and harm in the population. Treatment services for problem drug users are inadequate. Drug users make up the bulk of prison inmates in many prisons in Nigeria.

Furthermore, drug interdiction exacts enormous toll on the economy as funds are doled out to counter narcotics operations. Drug law enforcement activities cost the Nigerian state millions of naira annually, and the total cost has been rising consistently over the past decade. The problem is pernicious because funding for law enforcement activities limits the availability of funds for healthcare services, housing, clean water and other social services that can improve the quality of life of the Nigerian populace.

Drug control is also associated with corruption. It is now common knowledge that law enforcement officials loot funds, property and even exhibits recovered from arrested drug dealers. There have also been reports of the complicity of judges and security (police, military, customs and prisons) officials in illicit drug trade. Chieftains of the drug agency have been dismissed following allegations of corrupt practices.

DRUG CONTROL AND THE NEGLECT OF PUBLIC HEALTH

Drug control in Nigeria has throughout its history been motivated by the need to combat drug trafficking. This has justified overzealous law enforcement activities. Drug problems are generically defined as criminal offences subject to generalized and severe penalties, and drug users are punished more than traffickers. Law enforcement has not reduced drug use, and may have exacerbated it along with the associated problems. It has also increased

the risks involved in drug dealing, making the trade lucrative on account of increase in the market price of drugs. It also pushes drug users into "adopting more dangerous practices – stronger drugs replace moderate drugs, consumption moves to riskier settings where social controls are weak, and more dangerous methods of administration (smoking crack as opposed to snorting cocaine) are adopted" (Klein, 2011, p. 65). "A drug user", says Klein, "stands to suffer far greater harm from arrest, interrogation, imprisonment and a criminal record than he or she would have from using the drug" (p. 65).

law enforcement will remain the dominant approach to drug problems so long as the NDLEA remains the only agency coordinating drug control activities. This is so because, as McAllister (2012, p. 12) points out, "extant structures exert a major influence on the trajectory of events". The NDLEA was set up as a law enforcement agency, and it is impossible to change its direction without altering its overall structure. Let's quote McAllister on this:

> Bureaucracies are… hard to kill. They have built in constituencies and budget, and the capacity to generate political support if an existential threat materializes. Also, obviously, bureaucracies tend to do what they are created to do and not something else. Therefore, one of the reasons those seeking to reform or liberalise drug policy often find themselves frustrated is because they are relatively few assets devoted to prevention, intervention and treatment. In the era when these organizations were created, the overwhelming emphasis was on supply control, and hence the extant agencies are designed and staffed to accomplish that purpose. Bureaucracies can be redirected, or 'repurposed', but doing so is always difficult because the existing organs are likely to adopt new terminologies without changing the fundamental focus of their mission, or because existing organization may simply add a branch to deal with a previously unmandated function without altering their overall focus (McAllister, 2012, p. 12).

McAllister's insightful analysis is aptly describes the Nigerian situation. The NDLEA was established at the peak of the drugs war. The content of the Decree which established it reflects the mood of the era. That is why the agency is fully focused on law enforcement, and not demand reduction. Although a Drug Demand Reduction (DDR) Unit has been appended, demand reduction activities such as prevention and treatment are not necessarily coextensive with law enforcement. In most commands of the agency, DDR Units reek of poor staffing and underfunding. As McAllister cogently observed above, the terminology of demand reduction has been adopted, but the overall focus of the agency remains intact.

PREVENTION AND TREATMENT

Nigeria's drug policy needs to prioritize prevention and treatment, which are recognized as effective measures for reducing the demand for psychoactive drugs. A variety of risk factors for drug use exists at the individual, family, peer group, and community (school, workplace and the neighbourhood) levels (Rhodes et al.,

2003). These factors suggest multiple pathways to drug use to the effect that drug use involves the interaction of multiple risk factors at different levels. Drug use prevention involves addressing the risk factors that predispose people, especially youths and young adults, to the use of psychoactive drugs. The use of multiple strategies at different levels to address risk factors for drug use within the same program enhances the effectiveness of prevention programs (Schaps et al., 1981).

Interventions designed to prevent drug use and transition to problem drug use should target 'vulnerable' or 'at-risk' youths such as school drop-outs and street children, in order to minimize risk factors and enhance protective factors. This could be approached through the provision of information on the effects of drug use through media campaigns, lectures, films and printed materials (flyers, posters and stickers) (Shoemaker, 1989). Educational programs designed to build social and psychological skills (e.g refusal skills), improve interpersonal communication, and promote self-understanding and acceptance can help in building capacity to deal with social influences to use drugs.

Further, emphasis should be placed on the prevention of early initiation into drug use, since early initiation increases the likelihood of problematic drug use (Daugherty & Leukfeld, 1998; Lloyd, 1998). This will involve targeting families, since familial factors such as family structure, relationship quality and parental and/or sibling drug use are important risk factors for drug use, including problem drug use (Wells & Rankin, 1991; Ripple & Luther, 1996; Swadi, 1988). Community factors such as availability of psychoactive drugs, sociocultural norms, and social and economic deprivation should also be addressed as part of a multi-level program to prevent drug use. And since the effectiveness of prevention programs depends, among other factors, on the evidence-base on risk factors associated with drug use (Rhodes et al., 2003), research should be encouraged and funded in order to shore up the scientific evidence-base for programs.

Drug abuse treatment services in Nigeria, mostly available in tertiary health facilities (e.g., psychiatric hospitals), are grossly inadequate to meet existing needs. Treatment services should be expanded and funded adequately, including community-based drug abuse treatment programs which provide services on outpatient basis. The United Nations Office for Drugs and Crime (UNODC) is currently implementing a model program in partnership with Community-Based Organizations (CBOs) in the different geo-political zones of the country. This project could be adopted, incorporated into a national drug demand reduction strategy that includes prevention components, and expanded in order to widen the coverage of treatment services.

CONCLUSION

The paper discussed drug policy in Nigeria, highlighting the ascendance of supply control and the neglect of demand reduction. The focus on supply control arises from a misplaced confidence in the capacity of law enforcement operations to curb illicit drug trafficking and consumption. This explains the imposition of severe criminal penalties on drug offenses, the logic being that harsh penalties are capable of deterring potential drug offenders. This confidence has collapsed in the face of hard evidence pointing to

the contrary. It is increasingly being acknowledged that the best approach is to manage drug problems, and this involves prioritizing drug use prevention and treatment for users. Expediency demands the separation of supply control and demand reduction functions through the creation a new agency of government to co-ordinate the latter. Thus, the recent establishment of the Drug Demand Reduction unit within the Federal Ministry of Health is a welcome development. But this should go beyond agency creation to genuine devolution of functions, adequate funding and staffing of the agency to discharge its functions. There is also need to involve civil society organizations in the national response to drug problems.

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