Drugs and Drug Control in Namibia

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Chapter 5

Drugs and Drug Control in Namibia

Lawrence Kazembe and Isak Neema

Introduction

Namibia is a Sub-Saharan country situated on the south western coast of Africa and has a surface area of about 824,116 square kilometers (or 318,192 square miles), which in Western terms is more or less twice the size of California. According to the 2011 Namibia Population and Housing Census, the Namibian population was estimated to be approximately 2.1 million people with an annual growth rate of about 1.4%. About 57% of the population is between 15–59 years old while the unemployment rate stood at 25% (Namibia Statistics Agency, 2012). According to the Namibian Demographic Profile of 2013, the racial breakdown of Namibia constitute of 87.5% blacks, 6% whites and 6.5% mixed-race. In addition, with respect to the demographic distribution of the ethnic groups, about 50% of the population belongs to the Ovambo tribe and 9% to the Kavangos tribe. Other ethnic groups include Herero and Damara, 7% each; Nama, 5%; Caprivian, 4%; San, 3%; Baster, 2%; and Tswana, 0.5% (Namibia Demographic Profile, 2013). As a result of the national policy of decentralization, Namibia is divided into 13 administrative regions: Caprivi, Erongo, Hardap, Karas, Kavango, Khomas, Kunene, Ohangwena, Omaheke, Omusati, Oshana, Oshikoto and Otjozondjupa (see the regional boundary map of Namibia in Figure 5.1). Furthermore, details of the regional populations, the size of each region in km^2 and the relative population densities measured by person per km^2, according to the 2011 Population and Housing Census, are presented in Table 5.1 below.

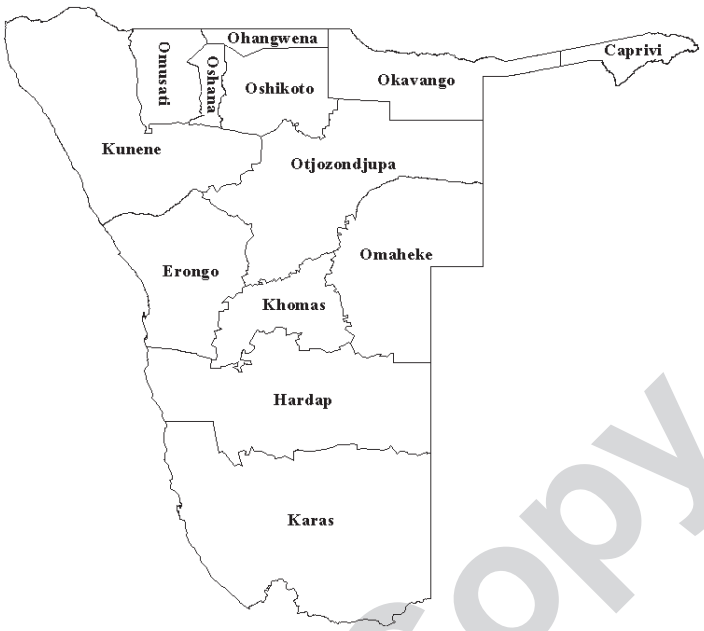

Figure 5.1 Regional Boundary Map of Namibia

Table 5.1 Regional Statistics per the 2011 Population and Housing Census

Region	Population	Area (km^2)	Density (person/km^2)
Caprivi	90596	14528	6.2
Erongo	150809	63579	2.4
Hardap	79507	109651	0.7
Karas	77421	161215	0.5
Kavango	223352	48463	4.6
Khomas	342141	37007	9.2
Kunene	86856	115293	0.8
Ohangwena	245446	10703	22.9
Omaheke	71233	84612	0.8
Omusati	243166	26573	9.2
Oshana	176674	8653	20.4
Oshikoto	181973	38653	4.7
Otjozondjupa	143903	105185	1.4

Source: Namibia Statistics Agency (2011).

It follows from the above table that the biggest regions in Namibia are Karas (161215 km^2) and Kunene (115293 km^2) while the northern regions of Oshana (8653 km^2) and Ohangwena (10703 km^2) appear to be the smallest. However in contrast, Ohangwena appears to be the most populated region with a population density of 22.9 persons/km^2 while Karas region is the least populated with a corresponding ratio of 0.5 person/km^2. In fact, it is important to point out that the top three most populated regions are in the north with only the central region of Khomas having a density exceeding 7 persons/km^2. This is expected as the northern regions account for about 62% of the Namibian population.

Namibia is one of the developing countries in sub-Saharan Africa, specifically in the SADC[1] region faced with a growing problem of drug abuse and drug trafficking. According to the Namibian police (2013), this situation has very serious implications for the Namibian population because it significantly contributes to social problems such as crime, domestic violence, road accidents, family disintegration, unwanted teenage pregnancies, suicides and health problems such as the spread of HIV/AIDS and other sexually transmitted diseases. Prevalence of HIV is also linked to injection drug users (IDU). A study among men who have sex with men, conducted in four African countries, including Namibia, showed a prevalence of 8% HIV among IDUs (Baral et al., 2009). Rape, general assault, assault with intent to do bodily harm, robbery, murder, and passion killing are examples of crimes that have featured prominently in the Namibian media over the years, and the majority of them have been attributed to the abuse of alcohol and related drug use. In general, developing countries tend to have high crime rates due to the unfavorable prevailing socioeconomic conditions, high unemployment rates and the lack of organized police and justice systems amongst others (Neema and Böhning, 2010). Desperate and unemployed Namibians are continuously being lured by drug syndicates with promises of easy money into becoming drug couriers.

This chapter examines the nature and trends of drug trafficking, and the epidemiology of drug use in Namibia. Namibia's approaches to drug control are also discussed. It is worth noting that, similar to many African countries, there are drug use and drug trafficking data reporting problems (for example, under-reporting and incomplete reports) in Namibia.

1 Southern African Development Community member states include: Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe

Nature and Trends of Drug Trafficking in Namibia

In the 2013 World Drug Report, the United Nations Office on Drugs and Crime (UNODC) (2013) estimates that annual profits derived from illicit narcotics amounts to U$600 billion. Up to US$1.5 trillion in drug money is laundered through the cover of legitimate enterprises and businesses. This amount is far more than the combined GDP of most of the SADC countries such as Botswana (US$5,965 million), Lesotho (US$851 million), Malawi (US$326 million), Mauritius (US$6,724 million), Mozambique (US$428 million), Namibia (4,267 million), Seychelles (US$8,688 million), South Africa (US$5,786 million), Swaziland (US$2,533 million), Tanzania (US$509 million), Zambia (US$985 million) and Zimbabwe (US$274 million) respectively. Table 5.2 below showcases the total distribution of illicit drugs seized in Namibia since January 2012 to July 2013, and their respective market value.

Table 5.2 Total Distribution of Illicit Drugs Seized in Namibia—January 2012 to July 2013

Drug type	Quantity	Market value (N$[1])
Cannabis	2,254,903kg	1,764,709.00
Cocaine powder	2,446.7kg and 2 moons	1,347,100.00
Crack Cocaine	1,888 units	188,800.00
Ephedrine powder	20,190kg	1,290,000.00
Methcat	20 g	5,000.00
Mandrax tablets	3,353 tablets	167,650.000

Source: Namibian Police, 2013.

As shown in Table 5.2, cannabis, cocaine and ephedrine powders are the most common illicit drugs seized in Namibia, having the highest market value of well over a million dollars. Similarly, crack cocaine and mandrax tablets, although not common, contributed to over US$150,000 worth of seized drugs, while a relatively small quantity (20 kg) of methcat was also seized in Namibia. Consistent with the above results, a 2006 report by the International Narcotics Control Board (INCB, 2006) highlights cannabis as the main drug of abuse in Africa. The drug is widely smuggled and trafficked at national, sub-regional, regional and international levels.

Namibia is not a significant producer of cannabis nor is a producer of other illicit drugs, or precursor chemicals as no drug production facilities have ever been discovered in the country over the past years. However, illicit drugs still find their way into the country. Namibia is a drug transit haven for drugs that are destined for other lucrative markets particularly in the SADC region and in

Africa in general. According to the Head of the Drug Law Enforcement Sub-Division, Chief Inspector Hermie Van Zyl, in conversation with the Namibian Sun Newspaper in 28 February 2011, most drugs are impounded from, amongst others, houses, drug dealers, trucks, drug mules, vehicles and even holes in the ground. He also pointed to the city of Windhoek, the coastal towns of Walvis Bay and Swakopmund, and the northern town of Oshakati as key areas where drug dealing is most rampant. Print and electronic media have reported that cannabis cultivation on small plantations in the North is on the increase. Chief Inspector Van Zyl identified cannabis, smuggled into the country mostly from other Southern African countries, as the most commonly used illegal drug in Namibia. Another drug which is also common is cocaine, which in many cases is smuggled into Namibia from South America and more specifically, Brazil.

Although drug trafficking is a male-dominated illegal business in Namibia, Namibian women have slowly become involved in the trade as drug dealers are targeting women as couriers and drug mules. According to the Head of Namibian Police (NAMPOL) Public Relations division, Deputy Commissioner Edwin Kanguatjivi, 12 Namibian women aged 29–36 years were serving time in foreign prisons for drug-related cases in the period 2009–2011 (Namibian Police, 2012). Among these, six were in Brazil, five in South Africa while one was in Dubai. Although Namibian men are also incarcerated in foreign prisons, figures are not available at this point. In Namibia, the distribution of individuals imprisoned for illicit drug possession and trafficking from January 2012 to July 2013 is presented in Table 5.3 below. Ninety percent of the individuals imprisoned in Namibian prisons for a drug offense were Namibians, with only 10% of foreigners being imprisoned in Namibian prisons for a drug offense.

Table 5.3 Distribution of Imprisoned Namibians and Foreign Nationals from January 2012 to July 2013

Nationality	Number	%
Namibian	1,298	90
Foreign nationals	141	10
Total	**1439**	**100**

Source: Namibian Police, 2013.

The bar graph shown in Figure 5.2 below presents the distribution of reported drug trafficking related cases in Namibia during the 2008/9 through to 2012/13 financial years. The figures indicate a fluctuating increasing trend between the 2008/9 and 2011/12 financial years, while a marked decrease is shown during the 2012/13 financial year. At the regional level, both Karas and Khomas regions reported the highest number of drug trafficking related cases during

the financial periods under study, while regions such as Erongo, Hardap and Otjozondupa have also reported a substantial number of drug trafficking related cases for each of the financial years under consideration (see Figure 5.3 below). The region with the lowest number of reported drug trafficking related cases during the period under study was the northern region of Omusati.

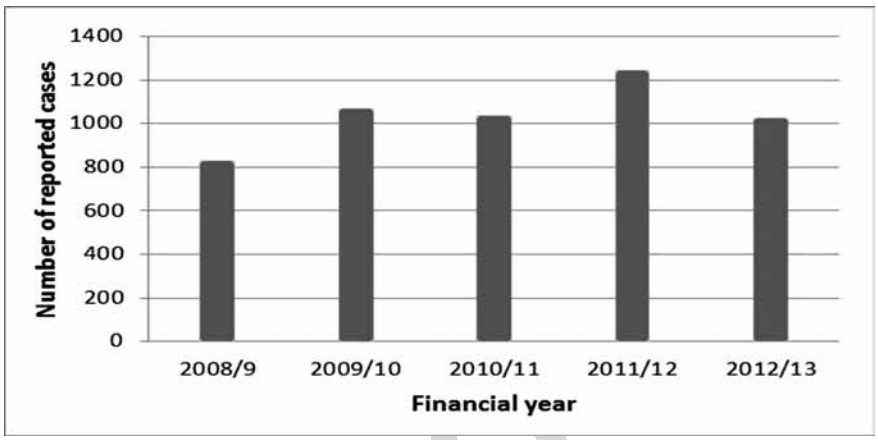

Figure 5.2 National Reported Drug Trafficking-related Cases for the 2008/9–2012/13 financial years

Source: Namibian Police, 2013.

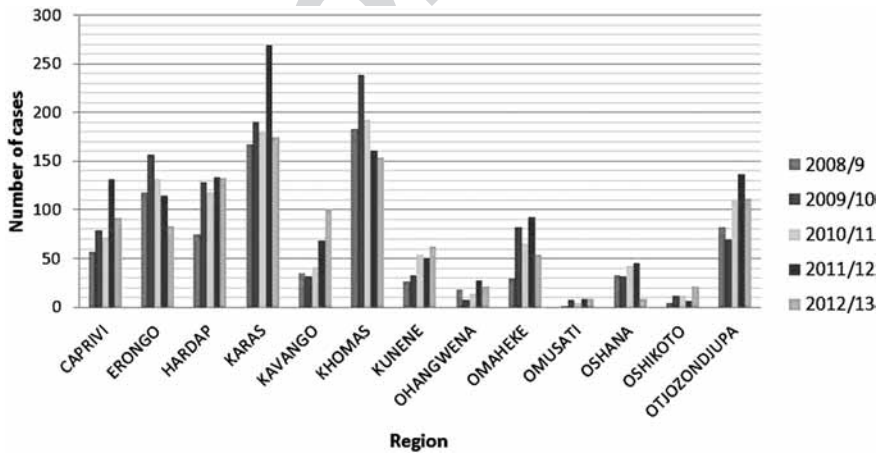

Figure 5.3 Distribution of Regional Reported Drug Trafficking-related Cases for the 2008/9 2012/13 financial years

Source: Namibian Police, 2013.

The time series plot presented in Figure 5.4 below compares monthly trends of illicit drugs trafficking related arrests of Namibians and foreign nationals from January to December 2012. There is a consistent high proportion of Namibians arrested in comparison to foreign nationals during the 12 month period under consideration. The highest numbers of these arrests occurred in March with a recorded total number of 106 arrests, and in October where 97 individuals were arrested for dealing in illicit drugs. A cyclic pattern is also observed whereby the number of Namibian arrests decreases sharply between March and May as well as between October and December, while foreign national arrests show an increasing trend between September and November with a slight decrease in December.

There are sex variations in the outcome of the monthly distribution of arrested Namibians and foreign nationals respectively (see Figures 5.5 and 5.6 below). Figures for the Namibian groups show a consistent higher number of arrested Namibian males in comparison to their female counterparts. The highest number of male arrests was made in March (slightly over 90 arrests) and in October (approximately 86 arrests). The series for the Namibian female group indicates a rather uniform trend for the number of female arrests during the 12 months (January to December 2012) period under study. For foreign nationals, the resulting trends indicate that the number of arrests for male foreigners was higher than that for female foreigners throughout the period under consideration.

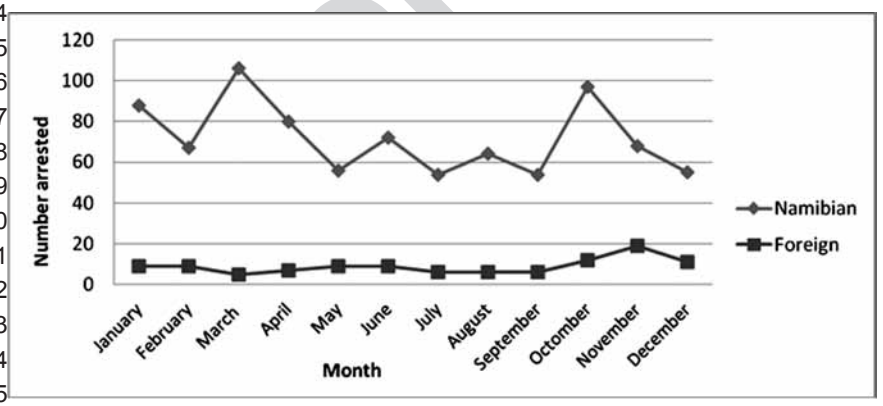

Figure 5.4 Monthly Trends of Arrested Namibians and Foreign Nationals from January to December 2012

Source: Namibian Police, 2013.

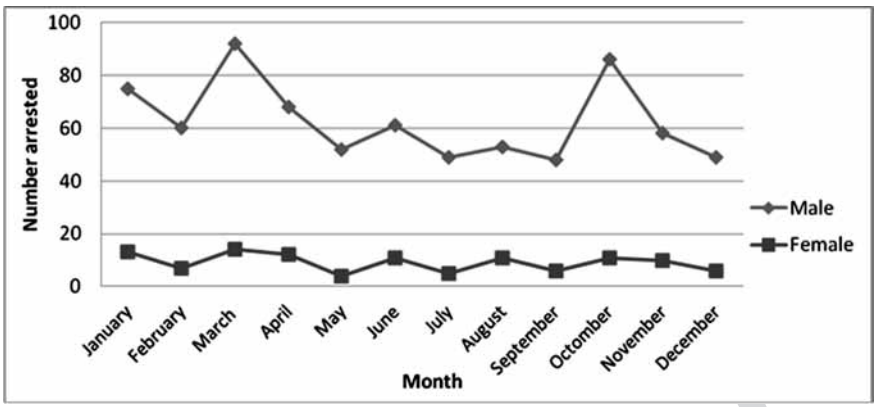

Figure 5.5 Monthly Trends of Arrested Namibians by Sex from January to December 2012

Source: Namibian Police, 2013.

The lowest number of foreign male arrests was 3, which were recorded in the month of March, while the highest number was 14 arrests recorded in November. The result further indicates a fluctuating increasing trend of foreign male arrests while that for females shows a steady trend with a sharp increase in the number of female arrests in the month of November.

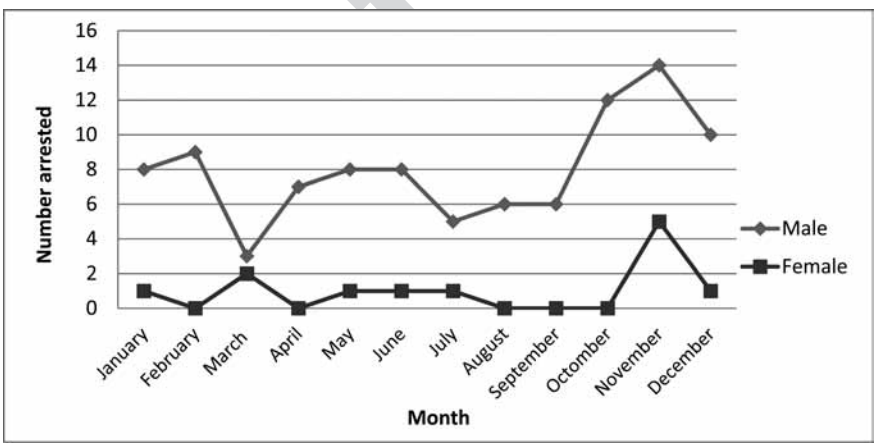

Figure 5.6 Monthly Trends of Arrested Foreign Nationals by Sex from January to December 2012

Source: Namibian Police, 2013.

In order to determine the nationality of foreigners who were arrested in Namibia for trafficking in illicit drugs, a tabulation of arrests by sex of the offender and the country of origin was undertaken and the results are presented in Table 5.4 below. The table shows that the highest number of foreigners arrested in Namibia for drug trafficking were Zambians (35.2%), Angolans (21.3%) and South Africans (13.9%) while the least arrested offenders were the Americans, Germans, Nigerians, Rwandans, Sierra Leoneans as well as Ugandans each with a 0.9% of the total foreigners arrested in the country.

Table 5.4 Percent Distribution of Arrested Foreign Nationals According to Country of Origin and Sex from January to December 2012

Country of origin	Arrested (N)	Percent	Male (%)	Females (%)
Angola	23	21.3	20.4	0.9
Botswana	5	4.6	4.6	0.0
Burundi	2	1.9	1.9	0.0
Democratic Republic of Congo (DRC)	9	8.3	8.3	0.0
Germany	1	0.9	0.9	0.0
Nigeria	1	0.9	0.9	0.0
Rwanda	1	0.9	0.9	0.0
Sierra Leon	1	0.9	0.9	0.0
South Africa (SA)	15	13.9	4.6	9.3
Tanzania	5	4.6	4.6	0.0
Uganda	1	0.9	0.9	0.0
United States of America (USA)	1	0.9	0.9	0.0
Zambia	38	35.2	35.2	0.0
Zimbabwe	5	4.6	3.7	0.9
Total	108	100	88.9	11.1

Source: Namibian Police, 2013.

As already noted, Namibia is not a producer of illicit drugs with the exception of scanty production of cannabis. However, it a transit route for drugs supplied from other countries. Figure 5.7 below presents the major routes of cannabis and cocaine seized in the country, particularly from the neighboring countries in the SADC region such as Angola, Botswana, Zambia and South Africa, with Democratic Republic of Congo and Swaziland being the only other sister member countries in the SADC region. Malawi, Tanzania, South Africa, Swaziland and Zambia are among the main producers of cannabis in

the SADC region (Eastern and Southern Africa Anti Money Laundering Group (ESAAMLG), 2011).

Figure 5.7 Major Routes of Cannabis and Cocaine Seized in Namibia from other SADC countries

Source: Namibian Police, 2013.

The Epidemiology of Drug Use in Namibia

Namibia is gradually developing from a transit country to a drug-consuming country. However, the exact extent of drug use remains largely unknown, as data on arrests for drug use is never made available. In 1993, the United Nations (UN) reported about 20,000 annual users or about 10,000 daily users of cannabis. Cannabis was followed by methaqualone (in the form of mandrax preparation) with an estimated 16,000 annual and 7,000 daily users; and volatile solvents (1,500 persons annual and 300 daily users). Drugs such as LSD, cocaine and heroin have been unknown in Namibia before independence but surged thereafter (Heads of National Drug Law Enforcement Agencies (HONLEA), 1993). A recent UN report suggests that cannabis, as in other countries in sub-Saharan Africa, is the most prevalent illicit drug, with its consumption estimated at an average prevalence of 60% (UNODC, 2010). Cocaine, opiates

and amphetamine-type stimulants (ATS) are below 10%, although opiate consumption has continued to rise in recent years.

A relatively detailed picture of legal and illegal drug use can be found in a number of earlier and recent surveys. Results from a 1992 sample survey of 600 school children and 600 parents indicated that tobacco was the most common drug of abuse among parents (42% daily), followed by alcohol (9.5% daily), traditional brews (5.5% daily), cannabis (or "dagga") (3% daily) and synthetic narcotic analgesics (3% daily). Among school children, alcohol was the most commonly abused drug (41% daily), followed by tobacco (13.27% daily) and synthetic narcotic analgesics (1.3% daily). About 0.5% of the school children abused mandrax on weekends and 3.3% abused it occasionally. Table 5.5 below gives a summary of the top five drugs reported in the 1992 study.

Table 5.5 Pattern of Drug Usage in Namibia in 1992

	Abstainers	Occasional use	Weekend use	Daily use
Tobacco				
adults	53.8	3.0	1.2	42.0
(chldren)	(83.2)	(1.4)	(2.2)	(13.27)
Alcohol				
adults	49.3	13.8	27.3	9.5
(children)	(80.2)	(6.5)	(12.3)	(41.0)
Traditional brews				
adults	84.7	5.8	4.0	5.5
(children)	(94.7)	(3.7)	(1.3)	(0.3)
Cannabis				
adults	91.8	2.8	2.0	3.3
(children)	(93.0)	(3.7)	(2.7)	(0.7)
Methaqualone				
adults	95.7	3.3	0.7	0.3
(children)	(96.2)	(3.3)	(0.5)	-

Source: UNODC (1992).

As of 1998, a country profile reported Namibia as mild consumer on drugs use and alcohol (World Health Organization, 2004). This was based on a 1998 national survey report on Namibia's drug use among a sample of 2823 individuals aged 18 years and above (males $n = 1012$ and females $n = 1811$). Among a sub-sample of 1402 alcohol consumers (males $n = 732$ and females $n = 670$), the estimated mean value (in grams) of pure alcohol consumed per day was a total of 11.6g, with 13.0g for males and 10.3g for females. A sub-sample of 1,186 alcohol consumers (males $n = 547$ and females $n = 639$) found the rate of heavy drinkers to be a total

of 2%, with 2.1% for males and 1.9% for females. Heavy drinking was defined as consuming six or more drinks on one occasion at least once a week (data apply to drinkers only). Youth drinking constituted about 5.4% of those surveyed. Male youth by far had the highest prevalence rate.

Respondents were asked about their experiences of alcohol-related problems over the past three months and over their lifetime. The "past three months" questions constituted a part of the Alcohol Use Disorders Identification Test (AUDIT) questions, which have been developed to detect early stages of alcohol dependence (examples include: unable to stop drinking, feeling of remorse or guilt after drinking, difficulties getting alcohol out of mind, etc.). The "lifetime" questions covered separate topics such as getting injured, breaking up with friend or spouse and seeking treatment. Results from the survey indicate that altogether, nearly half of the male and one-fourth of the female respondents reported experiencing at least one of the seven problem options during the past three months. About 9% of male drinkers and 5% of female drinkers had experienced all of the seven problem options at least once during the last three months. Among both men and women, feelings of remorse and guilt after drinking are the most common harmful experiences of all the listed alcohol problems in the past three months. Twenty-five percent of male drinkers and 12% of female drinkers had been injured at least once in their lifetime as a result of their drinking, and 19% of male drinkers and 10% of female drinkers had ended a relationship with a friend or spouse as a result of their drinking (Mustonen et al., 2001).

Also informative is the 2004 school survey, which was conducted within the spectrum of Global School Health Surveys (GSHS) and carried out in several countries in the world under the auspices of the U.S. Centers for Disease Control and Prevention (CDC) and WHO. The 2004 Namibia GSHS found that alcohol was the most consumed legal psychotropic substance in Namibia (32.8%), followed by tobacco products other than cigarettes (31.1%). About a third of the students sampled indicated that they had used drug in their lifetime (28.8%). Cigarette smoking was also reported, but not quite common with a national prevalence of 16%. National consumption rate shows a slight sex variation in alcohol consumption (see Figure 5.8 below). Regional comparisons show that the north eastern region had the lowest prevalence (19.1%), while the north western region had prevalence higher than the national average (36.9%), with males being the highest consumers of alcohol (41.2%). Figure 5.9 below shows regional variations in cigarette smoking: the north western region also reported prevalence rates higher than the national average (17.5%). Again, male students recorded the highest rate for cigarette smoking (21.0%).

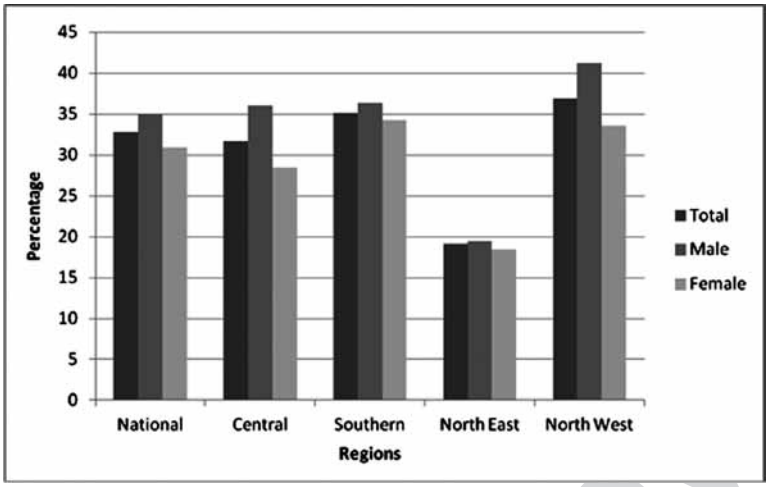

Figure 5.8 Alcohol Use among School Children. Regional Variations of Use by Sex of Respondents

Source: (Ministry of Education (MoE), Centres for Disease Control and Prevention (CDC) and World Health Organization (WHO), 2004).

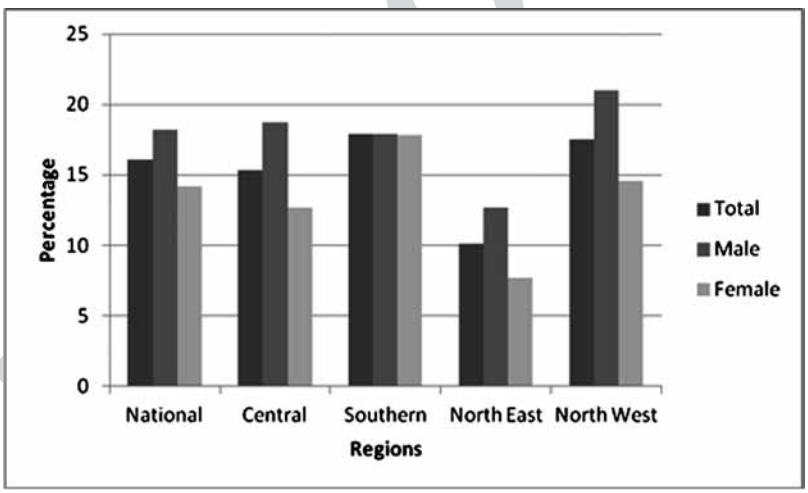

Figure 5.9 Cigarette Smoking among School Children: Regional Variations of Use by Sex of Respondents

Source: MoE, CDC and WHO, 2004.

Regional variations on lifetime use of drugs or tobacco-related products among school children are given in Figures 5.10 and 5.11. The North-West had the highest prevalence for both male and female students compared to the national average (45.5% and 37.9% for male and female respectively). The southern region registered low prevalence (regional rate of 13.7%), while the rate for males was 16.3% (Figure 5.10). The pattern of use of tobacco-related products, other than cigarettes showed little difference between male and female students (33.5% for males and 30.1% for females) however, there was a substantial regional variation. The lowest substance use was reported in the southern region, while the highest was in the North-West region (Figure 5.11).

The Namibian Demographic and Health Surveys (DHS) of 2000 and 2006 provide additional details on drug use particularly on alcohol consumption and tobacco products (smoking and chewing) in the general population. Table 5.6 below shows summaries of self-reports of alcohol consumption based on the questions "Ever gotten drunk from drinking alcohol," followed by "Number of days got drunk last months." The table also reports on cigarette smoking and use of other tobacco products.

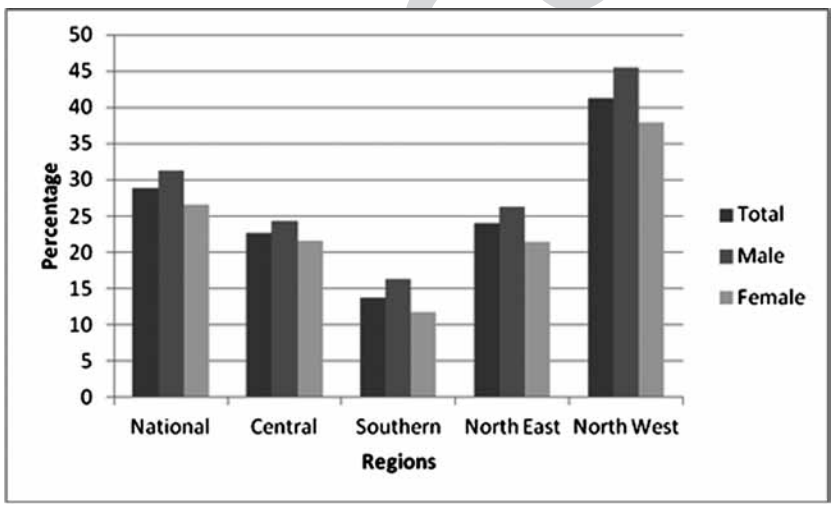

Figure 5.10 Drug Use in lifetime Among School Children: Regional Variations of Use by Sex of Respondents

Source: MoE, CDC and WHO, 2004.

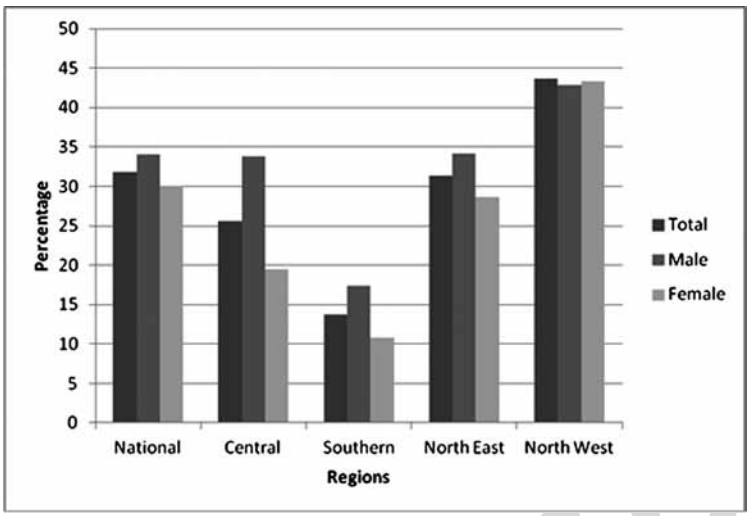

Figure 5.11 Other Tobacco-related Products Other Than Cigarettes among School Children: Regional Variations of Use by Sex of Respondents

Source: MoE, CDC and WHO, 2004.

Table 5.6 Prevalence (%) of Alcohol Use and Tobacco Consumption, Namibia Demographic and Health Surveys 2000 and 2006 by Demographic and Socioeconomic Variables

	Year 2000						Year 2006					
	Women			Men			Women			Men		
Socioeconomic/ Demographic factors	Alcohol *(n=2496)*	Cigarette *(n=497)*	Other tobacco *(n=300)*	Alcohol *(n=1240)*	Cigarette *(n=542)*	Other tobacco *(n=431)*	Alcohol *(n=3680)*	Cigarette *(n=515)*	Other tobacco *(n=337)*	Alcohol *(n=2503)*	Cigarette *(n=891)*	Other tobacco *(n=120)*
Place of residence												
Rural	33.7	3.7	6.8	71.4	10.3	23.4	48.4	3.6	4.7	72.5	22.5	4.8
Urban	40.9	11.7	1.6	82.5	28.1	4.0	54.9	7.3	1.8	75.6	23.1	0.8
Age												
15–19	24.1	3.5	0.6	70.6	9.5	3.6	21.8	2.0	0.5	65.8	8.1	0.7
20–24	33.3	5.2	1.7	78.0	19.2	10.5	35.9	3.9	1.4	72.2	23.3	1.2
25–29	37.6	7.8	3.2	78.6	22.1	13.5	36.8	5.3	2.1	76.0	27.7	3.1
30–34	43.5	8.6	5.4	75.5	21.1	17.4	34.7	5.8	3.3	80.2	27.0	3.6
35–39	43.3	9.4	8.1	86.3	23.3	21.8	38.3	7.5	6.1	74.0	29.6	5.5
40–44	46.1	10.9	10.9	78.7	23.1	20.5	42.7	9.3	6.5	74.2	29.3	7.7
45–49	48.8	13.7	9.6	74.7	21.4	24.7	41.7	9.0	11.7	76.6	30.6	5.6
Education level												
None	40.6	5.3	18.2	78.4	9.5	39.7	67.4	8.4	17.3	80.6	27.3	10.6
Primary	38.1	5.0	6.1	77.8	12.7	17.5	55.2	4.7	6.0	71.9	21.7	3.7
Secondary	35.0	9.1	0.6	73.1	25.2	5.6	47.8	5.1	0.8	73.9	23.3	1.5
Higher	48.1	9.8	0	75.8	21.9	1.6	36.8	5.2	0.4	72.7	15.1	0.1
Marital status												
Never married	30.0	5.1	1.2	76.8	14.6	7.8	44.8	3.2	1.2	70.6	17.7	2.1
Currently married	42.6	9.4	7.8	76.0	22.1	20.2	56.3	7.8	6.2	76.7	28.8	4.4
Formerly married	52.4	11.4	7.4	86.4	27.1	40.0	62.6	8.5	6.7	92.4	52.8	7.3

Source: Ministry of Health and Social Services, MoHSS and Columbia Research Corporation (CRC) Macro (2001, 2008)

Alcohol consumption has increased between the two DHS survey periods for both men and women, however, consumption rate is higher for men. Alcohol drinking was comparatively highest in urban than in rural areas, and increased with increasing age. Consumption rates for persons of low education levels and formerly married (widowed or divorced) were slightly higher than those for other groups. Figure 5.12 below shows regional variations in alcohol consumption for men and women. For both men and women, the level of alcohol consumption has increased across all regions, however, among men there was a slight decrease in Khomas (from 91.7% in 2000 to 78.8% in 2006) and Erongo (from 88.4% in 2000 to 68.0 in 2006) regions respectively, whereas for women, there was a decrease in the northern region of Ohangwena (from 39.7% in 2000 to 26.6% in 2006). The highest increase in use of alcohol among women was observed in Omaheke (from 29.8% in 2000 to 76.6% in 2006) and Kunene (from 41.1% in 2000 to 75.5% in 2006) regions respectively.

Cigarette smoking was almost below 10% across all socioeconomic groups for women, but considerably high for men. In 2000, it was found that rural women smoked more than women in urban areas, but this changed in 2006. Smoking also increased with increasing age in women in both survey years. With respect to education level, more educated women were likely to engage in cigarette smoking than those with no education in 2000, however, this was reversed in 2006. For marital status (see Table 5.6 above), the pattern of use remained the same for both 2000 and 2006, with formerly married women using more tobacco products including smoking cigarette. In relation to men, an average of 20% of sampled men reported cigarette smoking in the two surveys. Urban men were almost three times more likely to smoke cigarette than rural men in 2000, but the proportions were almost equal in 2006, with an increase in the rural men reporting smoking (see Table 5.6 above). Age was an important factor in cigarette smoking, with the youth reporting 9.5% in 2000 and 8.1% in 2006, but the level of use increased with age. Education level was not a major distinguishing factor for smoking, except when "other tobacco" use is considered (see Table 5.6 above). Marital status was a major factor, with formerly married men being more likely to smoke cigarette or use other tobacco products than others within marital status (see Table 5.6 above). Figure 5.13 below shows regional variations in cigarette smoking. There is clear upward shift in smoking in some regions, for example, in Hardap, Kunene and Otjozondjupa for men. As for women, there is some decline in use between 2000 and 2006.

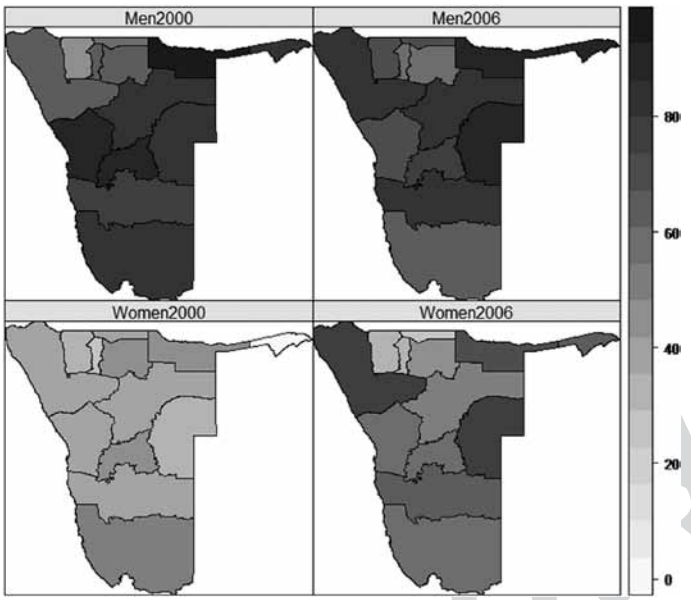

Figure 5.13 Maps Showing Regional Variation in Smoking Cigarette between Men and Women, in the Years 2000 and 2006

Source: MoHSS and ORC Inc. (2002, 2008).

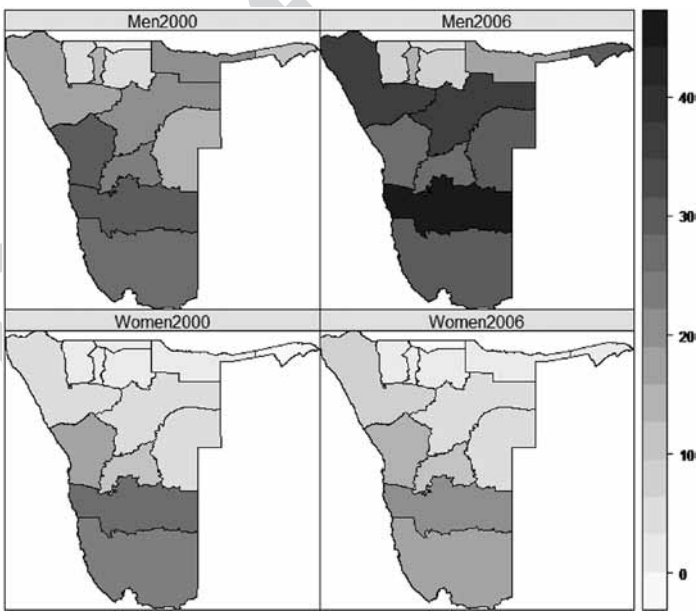

Figure 5.12 Maps Showing Regional Variation in Alcohol Consumption between Men and Women for the Survey Years 2000 and 2006

Source: MoHSS and ORC Inc. (2002, 2008).

Actions against Licit and Illicit Drugs in Namibia

The persistent flow of licit and illicit drugs into Namibia has not gone unchallenged as several actions and initiatives have been undertaken toward addressing this problem. Much of these efforts include the enactment of laws and policy initiatives, agreement, treaties and international cooperation initiatives, law enforcement efforts, and treatment and prevention programs—some of which are discussed here.

Laws, policy initiatives and law enforcement

At the international level, Namibia being a member state of the United Nations (UN) has ratified a number of UN conventions related to drug trafficking. Among these treaties are the 1961 UN single convention on narcotic drugs as amended, the 1971 UN Convention On Psychotropic Substance, the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, the 2000 UN convention against transnational organized crime as well as the 2003 UN Convention Against Corruption (ESAAMLG, 2011). At the national level, the Namibia anti-terrorism bill, and the drug control bill are still under consideration. However, once they are fully implemented and harmonized, they will allow for asset forfeiture and other related narcotic prosecution tools. Furthermore, Namibia is among the SADC member countries that have enacted the drug trafficking and money laundering related legislations. Among them is the Prevention of Organized Crime Act (POCA), which was passed by parliament in 2004 and entered into force in May 2009. The act is designed to combat organized crime and money laundering. Similarly, the Financial Intelligence Act (FIA) of 2007 gave rise to the establishment of the Financial Intelligence Unit which was operationalized in 2009. In 2006 a new law on drug abuse was submitted to parliament. The new law, which is aimed at combating the abuse of drugs, will effectively ban the trafficking, sale, possession and consumption of dangerous and dependence producing substances, and will provide for mandatory prison sentences. According to Brownfield (2011), this law, together with the FIA and POCA, is expected to pave the way for Namibia to accede to the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

There are policy and legislative initiatives that have targeted alcohol consumption and tobacco smoking, particularly in light of the growing problem of alcohol use among youths. For example, in January 2011 the Ministry of Health and Social Services (MoHSS) and Coalition on Responsible Drinking established the National Alcohol Traders Programme to help ensure compliance with regulations on alcohol sales and advertising. Further, the Namibia Tobacco Products Control Act (2010), parts of which are already

being enforced, provides for, among others, the reduction of demand for and supply of tobacco products, and protection from exposure to tobacco smoke.

In Namibia, narcotics enforcement is the responsibility of the Namibian Police (NAMPOL) Drug Law Enforcement Unit (DLEU). Namibia does partake fully in the regional law enforcement co-operations initiatives against narcotic trafficking especially through the SADC as well as the Southern African Regional Police Chief's Co-operative Organization (SARPCCO). In this case, the minister responsible for safety and security and other working-level police officials meet on a regular basis with counterparts from the SADC countries to discuss efforts to combat cross-border contraband shipments. These meetings and the sharing of information and ideas have proven to be a success as arrests and seizures of illicit drugs at borders have increased. Similarly, the acquisition of new high-tech scanning machine, which was procured by the Ministry of Finance through Customs directorate and commissioned at major ports and border posts as from 2009, enhances the capacity of border interdictions for illegal drugs and related contraband entering or leaving Namibia (Namibia Police, 2013).

Other initiatives include training of the police personnel on the Namibian narcotic drugs combating plan. Specifically, this training focuses on the formation of narcotic drug combating units with the aim of establishing regional and national crime intelligence structure in order to increase detection rate on drug-related cases by 50%. Crime intelligence gathering and analysis are aimed at the identification of syndicates, trafficking routes, modus operandi, dealers, couriers, means of transportation and concealment methods of illicit drugs. The above training also focus on the following: visibility of operations to detect drug-related crimes in order to reduce violent and property crimes; the application of the 2004 POCA as a seizing tool of all proceeds of drugs and other related crimes; building the capacities of investigating units to improve operational effectiveness and efficiency of the police in combating the scourge of drugs and to ensure that the DLEU structure is not less than 90% filled; and public awareness campaigns that educate the public on the dangers of narcotic drugs and formulation of demand reduction programs (Namibia Police, 2013).

In 2012/2013, the Namibian Police Force received a national public drug awareness and drug identification training, based on the following aims:

1. Reducing drug demand by public sensitization and education of dangers of

drugs and alcohol use;

2. Establishing of drug policies and peer guidance groups at schools and institutions of higher learning;
3. Introducing of drug policies at the workplace and the creation of anti-drug forums;
4. Conducting informative sessions to sensitize prosecutors and judicial officials on the complexity of drug investigations and the devastating effects of drugs on human life and the country; and
5. Training members of the Namibian Police, customs and immigration at boarder entry points and those at different police stations across the country.

Representatives of several Namibian law enforcement agencies such as customs and border protection, immigration and customs enforcement, prison services, police and anti-corruption commission, and prosecutors have participated in the International Law Enforcement Academy (ILEA) in Gaborone, Botswana where many of these training programs included counter-narcotic modules (ILEA, 2013).

Drug treatment and demand reduction

The Southern African Epidemiology Network on Drug Use (SENDU) report of 2004 (Parry and Plüddemann, 2004), based on data collected between January 2002 and June 2004, showed that alcohol appeared to be the main substance of abuse for those who sought treatment at three treatment centres in Namibia, although the pattern showed some decline in the trend, with 71%, 86%, and 54% for the years 2002, 2003 and 2004 surveillance periods respectively. The majority were male, with 86% in 2003 and 93% in the 2004 update. Data collected in 2003 by the Drug Awareness Group (DAG), a non-governmental organization that is involved in drug demand reduction activities mainly among the youth (in-school and out-of-school), showed that almost half of 17 clients (all under the age of 25 years) counseled during the first half of 2003 had an alcohol-related problem (Parry and Pluddemann, 2004).

During January to June 2003, there were 187 people arrested for drunk driving in the capital city (Windhoek), a 24% increase over the previous six months. All but two of the offenders were male and 16% were 17 to 25 years of age, while the majority was 26 to 45 years of age (63%) (Ibid.). Of 621 blood samples tested for alcohol by the National Forensic Science Institute, between January 2002 and June 2004, 85% tested positive (Parry and Plüddemann, 2004). Newspaper reports in Namibia have linked alcohol to domestic violence (Shivute, 2011). Although concrete research evidence of the alcohol consumption-domestic

violence connection is lacking in Namibia, the relationship has been established elsewhere (Brownfield, 2011; Parry and Plüddemann, 2004; Sloboda 2005).

In the SENDU report (2004), the cannabis/Mandrax combination was the second most common primary substance of abuse in the first half of 2004, accounting for 26% of the patients in Namibia. Treatment demand related to Mandrax use increased substantially. Most of these patients were male, with only two females reporting Mandrax as their primary drug of abuse. The average age of the Mandrax patients was 27 years, while the cannabis patients were 22 years on average. In the same report, seven patients in treatment (13%) had cocaine/crack as their primary drug of abuse. They were all male with an average age of 23 years (Parry and Plüddemann, 2004).

Drug treatment programs in Namibia are available in private clinics and to a lesser extent in public facilities such as the intermediate and referral hospitals. The vast majority of drug treatments handled at most of the clinics in Namibia are related to alcohol abuse, with cannabis, cocaine as well as mandrax to a lesser extent. Private clinics such as the Nova Vita Drug and Alcohol Rehabilitation Centre in Windhoek, Okanguarri Psychotherapeutic Centre in the vicinity of Outjo, My Wellness Centres in Swakopmund and Usakos, Etegameno Rehabilitation and Resource Centre as well as the Drug Rehabilitation Clinic of Omaruru, all offer rehabilitation services for alcohol and substance abuse (ibid.).

In regard to preventive measures, organizations such as the Blue Cross Namibia launched its integrated school prevention program in Windhoek in July 2009 as part of its youth activities. The program aims at providing young people with the facts they need to make informed decisions and to develop the "behavioral competence" to make preventive and protective choices against alcohol and illicit drug misuse. The core aspects of the program includes: daily life skill classes, and counseling and interactive educational activities. Other activities include the formation of support groups in affected communities such as the Coalition on Responsible Drinking (CORD) which include among its activities, awareness raising in marches, workshops, and mass media prevention activities; school programs; and drug treatment referrals and after care support.

Conclusion

Although alcohol abuse is one of the most prevalent drug problems in Namibia, this chapter also provides information on the status of illicit drug use in the county. Namibia as a country does not have a comprehensive database from which the illicit drug patterns can be evaluated; most of the information are currently paper-based or just incomplete, which makes it difficult to access timely and in an effective way. However the Namibian Police Drug Law

Enforcement Unit (DLEU) is in the process of formulating a comprehensive drug database from paper form to the electronic version. Thus, much of the efforts need to be dedicated to this noble yet important initiative in order to effectively capture various characteristics of drug offenders and drugs seized. The results presented in this chapter are drawn from available information that the authors were able to access at the time of writing this chapter.

An analysis of the Namibian situation of drugs and control shows a greater concentration and over-reliance of efforts on national institutions, for example, the use of Namibian police narcotics unit to combat drug trafficking. The Windhoek declaration, adopted in April 2006, spelt out efforts to counter drug trafficking. However, it also stipulated the under-capacity of the police force and the need to revamp the organization through training and resources, and support by appropriate legislation. For example, stiff legal recourse which requires that any drug-related offender should not be granted bail before appearing in courts is a good framework. However, national legislation and policy on drugs should mandate the need for drug users to attend compulsory rehabilitation therapy, as is carried out in western countries. Imprisonment, without complementary rehabilitation will not help address drug abuse. Unfortunately, rehabilitation centres are few and far apart.

There is a need to put in place targeted and proactive efforts aimed at attracting drug users to treatment. These should include scaling-up interventions or rehabilitation services at community level, primarily by engaging in peer-led interventions. Most informal settlements, where the poorest live, have a high concentration of *shabeens* or liquor outlets, which means that intervention should be targeted at these communities. For example, limiting *shabeen* and liquor outlet licenses should reduce their density in poor and disadvantaged communities. Long-term interventions for prevention of drug use and drug dependence treatment and care, along with supply reduction efforts are required. The African Drug Action and Control Advocacy has highlighted the need for providing a holistic substance abuse prevention training in member countries of the African Union, as a means to demand reduction, which is hoped will impact on the supply chain.

In line with the global alliance for prevention of drug use and dependence, Namibia needs to put in place or strengthen programs for monitoring and evaluating progress towards eliminating or reducing significantly the illicit manufacturing, marketing and trafficking of psychotropic substances. These efforts should extend beyond the jurisdiction of government departments, but must also involve NGOs to address drug abuse. There is general agreement among researchers that one must initiate the use of drugs before becoming a drug abuser or drug dependent. Both longitudinal and cross-sectional studies (Sloboda, 2005) show that only a proportion of those who initiate, will progress into drug abuse. Moreover, progression will depend on age, frequency of use,

and type of drug. Therefore, demand reduction programs should also aim at preventing initiation. The African Drug Awareness and Control Group, under the African Union, propagates early childhood education, parenting skills, and workplace prevention as some of the programs that would reduce demand for drugs. As postulated, is the use of NGOs to reach relevant groups in order to address health and socioeconomic burdens caused by the use/abuse of alcohol and other drugs.

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(Footnotes)

1 Namibian Dollars which is a Namibian currency