Zimbabwe National Drug Master Plan

ZIMBABWE CIVIL LIBERTIES AND DRUG NETWORK
PITCH Partnership to Inspire, Transform and Connect the HIV response
aidsfonds
FRONTLINE AIDS
Ministry of Foreign Affairs
ARASA AIDS & Rights Alliance for Southern Africa

ZIMBABWE CIVIL LIBERTIES AND DRUG NETWORK
PITCH Partnership to Inspire, Transform and Connect the HIV response
aidsfonds
FRONTLINE AIDS
Ministry of Foreign Affairs
ARASA AIDS & Rights Alliance for Southern Africa

Zimbabwe National Drug Master Plan

Contents

FOREWORD

FOREWORD

The Zimbabwe National Drug Master Plan (2020-2025) offers both an integrated and comprehensive approach that will address a range of drug related issues. These include illicit and licit drugs.

There is need to address supply, demand and harm reduction as well as control of licit substances based on International Drug Control Conventions and in line with the principles of balanced approach to drug control.

Common substances of abuse in Zimbabwe are alcohol (both licensed and unlicensed brews), tobacco, cannabis and non-medicinal use of controlled medicines such as codeine containing cough medicines and benzodiazepines.

Currently approximately 60% of patients admitted in mental health institutions suffer due to drug related problems. Due to the socio-economic situation, Zimbabwe is facing increasing cases of depression, trauma and stress which has led to the increase in drug use. Hence as a nation there is need to have a concerted effort to address this menace. Alcohol, Marijuana, Crystal Meth (Mutoriro) and Broncleer among others are the main drugs being abused especially by youths. Excessive use of Alcohol and drugs damage the health of users and is linked to rises in addiction and non-communicable diseases including HIV and AIDS, cancer, heart diseases, psychological disorders and an increase in road traffic accidents.

There is great belief and optimism that the guidelines, strategies, and all that is contained within this National Drug Master Plan will pave way to strengthening responses on drug related issues in a positive way. It also strengthens prevention which is the most important leg of this Master Plan. The Master Plan also serves to strengthen, motivate, and educate users on drug related issues and their effects.

The program performance will be reviewed annually to see if the goals and objectives of the Drug Master Plan are being met. The annual reviews will also help in noticing the alleviation of drug use in Zimbabwe. In other words, this document is living.

All stakeholders are encouraged to embrace these guidelines on how to deal with drug use challenges and prioritize their actions in a way that will lead to the accomplishment of the Drug Master Plan's aim. Concerted effort is needed to protect youths which are the future of the nation.

I thank you.

Air Commodore (Dr) J. Chimedza
PERMANENT SECRETARY FOR MINISTRY OF HEALTH AND CHILD CARE
Harare 2020

List of Acronyms

HIV- Human Immunodeficiency Virus

AIDS- Acquired Immune Deficiency Syndrome

AU- African Union

AUC-African Union Commission

CID- Criminal Investigation Department

CND- Commission on Narcotic Drugs

CNS- Central Nervous System

GA- General Assembly

ICT-Information Communication Technology

IEC-information, education and communication

NSP - Needle & Syringe Programme

PWID - People who inject drugs

UN-United Nations

UNODC- United Nations Office on Drugs and Crime

UNGASS– United Nations General Assembly Special Session

STI- Sexually Transmitted Infection

TB-Tuberculosis

THC- Tetrahydrocannabinol

ZRP-Zimbabwe Republic Police

Acknowledgements

ACKNOWLEDGEMENTS

The Mental Health Services Department in the Ministry of Health and Child Care would want to acknowledge the effort put and support given by key Ministries and Partners in the production of the Zimbabwe National Drug Master Plan. It is hoped that the National Drug Master Plan will be used by all in addressing the challenges of drug control, demand, supply and harm in the country. Greatest appreciation goes to the following members who have attended consultative meetings on the development of the Zimbabwe National Drug Master Plan document:

Dr. S.M. Chirisa (Deputy Director, Mental Health Department, MOHCC)

Mr. F. Musoro (Mental Health Manager, Mental Health Department, Ministry of Health and Child Care)

Ms. E. Siyame (Retired Mental Health Manager, Mental Health Department, Ministry of Health and Child Care)

Ms. E. Tichawangana (Executive assistant, Mental Health Department, Ministry of Health and Child Care)

Dr. T. M. Chikwanha (Senior Lecturer, Department of Primary Health Care, University of Zimbabwe)

Mr. W. Box (Director, Zimbabwe Civil Liberties and Drug Network)

Mr. H. Nyamukapa (Program Manager, Zimbabwe Civil Liberties and Drug Network)

Mr. T. Chiweshe (Administration and outreach officer, Zimbabwe Civil Liberties and Drug Network)

Mr. B. Mufakwadziya (Occupational Therapist, District Therapist, Mazowe, Ministry of Health and Child Care)

Mr. W. Muroiwa (Senior Nursing Officer, Parirenyatwa Annex Psychiatric Hospital)

Miss. T. F. Chineka (Master in Social Work Intern, Mental Health Department, MoHCC)

Miss. S. Chahuruva (Master in Social Work Student, Mental Health Department, MoHCC)

Miss. M. Nhodza (Social Work Intern, Mental Health Department, Ministry of Health and Child Care)

Miss. R. Chakona (Social Work Intern, Mental Health Department, Ministry of Health and Child Care)

Miss. E. R. Chinhoyi (Social Work Intern, Mental Health Department, Ministry of Health and Child Care)

Mr. J. Chirinda (OPC, President's Department- Narcotics)

Mr. F. Marizani (K9 Officer, Zimbabwe Revenue Authority)

Ms. F. Bhunu (PAO, Ministry of Women Affairs, Community, Small and Medium Enterprises Development)

Mr. T. Chinyowa (Zimbabwe Republic Police, CID Drugs)

Ms. A. Verenga (CRO-LED, Medicines Control Authority of Zimbabwe)

Mrs. L. Antonio (Educational Psychologist, Ministry of Primary and Secondary Education)

Mr. B.Banga (Senior Economist, Ministry of Finance and Economic Development)

Mr. N. Saweto (Program Officer, Ministry of Public Service, Labour and Social Welfare)

Lexicon of alcohol and drug terms published by the World Health Organization

Absolute alcohol Ethanol containing not more than 1% by mass of water.

abstinence Refraining from drug use or (particularly) from drinking alcoholic beverages, whether as a matter of principle or for other reasons. Those who practice abstinence from alcohol are termed "abstainers", "total abstainers", or-in a more old-fashioned formulation-"teetotalers". The term "current abstainer", often used in population surveys, is usually defined as a person who has not drunk an alcoholic beverage in the preceding 12 months; this definition does not necessarily coincide with a respondent's self-description as an abstainer.

abuse (drug, alcohol, chemical, substance, or psychoactive substance) A group of terms in wide use but of varying meaning. In DSM-IIIR*, "psychoactive substance abuse" is defined as "a maladaptive pattern of use indicated by ...continued use despite knowledge of having a persistent or recurrent social, occupational, psychological or physical problem that is caused or exacerbated by the use [or by] recurrent use in situations in which it is physical1y hazardous".

acetaldehyde is a toxic substance, implicated in the alcohol flush reaction and in certain physical sequelae of alcohol consumption.

addiction Repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means.

agonist A substance that acts at a neuronal receptor to produce effects similar to those of a reference drug; for example, methadone is a morphine-like agonist at the opioid receptors.

alcohol in chemical terminology, alcohols are a large group of organic compounds " derived from hydrocarbons and containing one or more hydroxyl (-OH) groups. By extension the term "alcohol" is also used to refer to alcoholic beverages

alcoholic an individual who suffers from alcoholism.

alcoholic brain syndrome A general term for a range of disorders due to the effects of alcohol on the brain-acute intoxication, pathological intoxication, withdrawal syndrome, delirium tremens, hallucinosis, amnesic syndrome, dementia, psychotic disorder.

alcoholic cardiomyopathy (I42.6) A diffuse disorder of heart muscle seen in individuals with a history of hazardous consumption of alcohol, usually of at least 10 years' duration. Patients typically present with biventricular heart failure; common symptoms include

shortness of breath on exertion and while recumbent (nocturnal dyspnea), palpitations, ankle edema, and abdominal distension due to ascites.

alcoholic cirrhosis (K70.3) A severe form of alcoholic liver disease, characterized by necrosis and permanent architectural distortion of the liver due to fibrous tissue formation and regenerator nodules.

alcoholic fatty liver (K70.0) Accumulation of fat in the liver following exposure to hazardous levels of alcohol intake, with consequent enlargement of liver cells and sometimes hepatomegaly, abnormal liver function, nonspecific abdominal recurrent pain, anorexia, and-less commonly-jaundice.

alcoholic binge is characterized by mucosal erosions, which may bleed. Symptoms include pain in the upper abdomen, and there may be gastric hemorrhage.

alcoholic jealousy (F10.5) A type of chronic, alcohol-induced psychotic disorder, characterized by delusions that the marital or sexual partner is unfaithful.

alcoholic pancreatitis (K86.0) A disorder characterized by inflammation and necrosis of the pancreas, often accompanied by fibrosis and malfunction, related to the consumption of hazardous levels of alcohol.

alcoholism (F10.2) A term of long-standing use and variable meaning, generally taken to refer to chronic continual drinking or periodic consumption of alcohol which is characterized by impaired control over drinking, frequent episodes of intoxication, and preoccupation with alcohol and the use of alcohol despite adverse consequences progressive and fatal.

alcohol policy the aggregate of measures designed to control the supply of and/or affect the demand for alcoholic beverages in a population (usually national), including education and treatment programmes, alcohol control, harm reduction strategies, etc.

alcohol-related brain damage a generic term that encompasses chronic impairment of memory and of higher mental functions associated with the frontal and limbic system.

alcohol-related disabilities All problems, illnesses and other consequences secondary to alcohol use, intoxication, or dependence that diminish an individual' s capacity for physical, social, or economic activity.

alcohol-sensitizing drug a therapeutic agent prescribed to assist maintenance of abstinence from alcohol by producing unpleasant side-effects if alcohol is taken.

antagonist A substance that counteracts the effects of another agent. Pharmacologically, an antagonist interacts with a receptor to inhibit the action of agents (agonists) that produce specific physiological or behavioral effects mediated by that receptor.

aversion therapy A treatment that suppresses undesirable behavior by associating a painful or unpleasant experience with the behavior. The term refers to any of several

forms of treatment of alcohol or other drug dependence directed toward establishing a conditioned aversion to the sight, smell, taste, or thought of the misused substance.

biological marker A biological compound or attribute that provides evidence of the presence of, or vulnerability to, a specific disorder.

caffeine, which is a mild central nervous system stimulant, vasodilator, and diuretic. Caffeine is found in coffee, chocolate, cola and some other soft drinks, and tea.

cannabis A generic term used to denote the several psychoactive preparations of the marijuana (hemp) plant, Cannabis sativa. They include marijuana leaf (in street jargon: grass, pot, dope, weed, or reefers), bhang, ganja, or hashish (derived from the resin of the flowering heads of the plant), and hashish oil.

cocaine an alkaloid obtained from coca leaves or synthesized from ecgonine or its derivatives.

craving Very strong desire for a psychoactive substance or for the intoxicating effects of that substance.

decriminalization The repeal of laws or regulations that define a behavior, product, or condition as criminal. The term is used in connection with both illicit drugs and the crime of public drunkenness. It is sometimes also applied to a reduction in the seriousness of a crime or of the penalties the crime attracts, as when possession of marijuana is downgraded from a crime that warrants arrest and a jail term to an infraction to be punished with a warning or fine delirium tremens**.**

demand reduction A general term used to describe policies or programmes directed at reducing the consumer demand for psychoactive drugs. It is applied primarily to illicit drugs, particularly with reference to educational, treatment, and rehabilitation strategies, as opposed to law enforcement strategies that aim to interdict the production and distribution of drugs (supply reduction).

dependence (F1x.2.) As a general term, the state of needing or depending on something or someone for support or to function or survive. As applied to alcohol and other drugs, the term implies a need for repeated doses of the drug to feel good or to avoid feeling bad.

depressant Any agent that suppresses, inhibits, or decreases some aspects of central nervous system (CNS) activity. The main classes of CNS depressants are the sedatives/hypnotics, opioids, and neuroleptics. Examples of depressant drugs are alcohol, barbiturates, anesthetics, benzodiazepines, opiates and their synthetic analogues.

designer drug A novel chemical substance with psychoactive properties, synthesized specifically for sale on the illicit market and to circumvent regulations on controlled substances.

diagnostic instrument In general medical usage, any machine or instrument, and by extension-any clinical procedure or interview schedule used for the determination of an individual's medical condition or the nature of his or her illness. With respect to substance use and other behavioral disorders, the term refers principally to lists of questions oriented to diagnosis, including structured interview schedules that can be administered by trained lay interviewers.

diagnostic test A procedure or instrument used in conjunction with observation of behavior patterns, history, and clinical examination to help in establishing the presence, nature, and source of, or vulnerability to, a disorder, or to measure some specified characteristic of an individual or group.

disorder, psychoactive substance use A generic term used to denote mental, physical, and behavioral conditions of clinical relevance and associated with the use of psychoactive substances.

disulfiram (Antabuse) The prototypic alcohol-sensitizing drug, prescribed to assist in maintaining abstinence from alcohol.

drinking problem Drinking that results in problems, individual or collective, health or social. Earlier usages included drinking in response to a life problem.

drug A term of varied usage. In medicine, it refers to any substance with the potential to prevent or cure disease or enhance physical or mental welfare, and in pharmacology to any chemical agent that alters the biochemical physiological processes of tissues or organisms.

drug control The regulation, by a system of laws and agencies, of the production, distribution, sale, and use of specific psychoactive drugs (controlled substances) locally, nationally, or internationally.

Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights - it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support. It is also a range of public health policies designed to lessen the negative social and physical consequences associated with various human behaviors both legal and illegal.

intoxication is highly dependent on the type and dose of drug and is influenced by an individual's level of tolerance and other factors.

licit drug A drug that is legally available by medical prescription in the jurisdiction in question, or, sometimes, a drug legally available without medical prescription.

methadone A synthetic opiate drug used in maintenance therapy for those dependent on opioids. It has a long half-life, and can be given orally once daily with supervision.

misuse, drug or alcohol Use of a substance for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription medications. The term is preferred by some to abuse in the belief that it is less judgmental.

multiple drug use (French: polytoxicomanie) The use of more than one drug or type of drug by an individual, often at the same time or sequentially, and usually with the intention of enhancing, potentiating, or counteracting the effects of another drug.

multiple drug use disorder (F19) is one of the ''Mental and behavioral disorders due to psychoactive substance use" in ICD-I0, diagnosed only when two or more substances are known to be involved and it is impossible to assess which substance is contributing most to the disorder.

mutual-help group A group in which participants support each other in recovering or maintaining recovery from alcohol or other drug dependence or problems, or from the effects of another' s dependence, without professional therapy or guidance such as Alcoholics Anonymous, Narcotics Anonymous, and Al-Anon.

myopathy, alcohol- or drug-related (G72.0, G72.1) A disorder of skeletal muscle related to the use of alcohol and other drugs.

naloxone An opioid receptor blocker that antagonizes the actions of opioid drugs. It reverses the features of opiate intoxication and is prescribed for the treatment of overdose with this group of drugs.

narcotic A chemical agent that induces stupor, coma, or insensibility to pain. The term usually refers to opiates or opioids, which are called narcotic analgesics. It is often used imprecisely to mean illicit drugs, irrespective of their pharmacology.

needle-sharing The use of syringes or other injecting instruments (e.g. droppers) by more than one person, particularly as a method of administration of drugs. This confers the risk of transmission of viruses (such as human immunodeficiency virus and hepatitis B) and bacteria (e.g. Staphylococcus aureus).

neuroleptic One of a class of drugs used for the treatment of acute and chronic psychoses. Also known as major tranquillizers and antipsychotics.

nicotine An alkaloid, which is the major psychoactive substance in tobacco. It has both stimulant and relaxing effects.

opiate One of a group of alkaloids derived from the opium poppy (Papaver somniferous) with the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression. The term opiate excludes synthetic opioids.

1. Background

Drug use is a growing public health and security problem in Zimbabwe, regionally and all over the world. There is a continued increase in trafficking of almost all types of drugs and this is strongly linked to interpersonal violence, unintentional injuries, road traffic accidents, multiple medical complications as well as psychological and mental health complications. Alcohol and substance abuse are becoming a heavy burden to families, communities, the health and security systems as well as the national economy. There is need for a coordinated, multipronged approach to the drug use problem.

The African Union Commission has recommended that Member States set up national frameworks that address the drug use problem holistically addressing both supply reduction as well as demand reduction. This Drug Master Plan is balanced and integrated, involving various government and community stakeholders thus providing multipronged approach addressing both security, law enforcement, legislation in supply reduction as well as community awareness, early identification, treatment and rehabilitation as part of demand reduction. The drug master plan shall also address issues on human rights, public health, harm reduction and community involvement in addressing challenges posed by drug use in Zimbabwe.

The National Drug Master Plan 2020 to 2025 for Zimbabwe aims to provide a clear roadmap to addressing the cross cutting drug use problem and was developed through an inter- ministerial collaboration taking into account current measures in place to address the drug use problem and seeking to enhance and improve our response to it. This plan highlights a results based implementation matrix to better illustrate the roadmap as well as to ensure rigorous monitoring and evaluation.

According to UNODC (2020) World Drug Report, global drug use is rising and around 269 million people used drugs worldwide in 2018, which is 30 per cent more than in 2009, while over 35 million people suffer from drug use disorders, according to the latest World Drug Report, released today by the United Nations Office on Drugs and Crime (UNODC). The Report also analyses the impact of COVID-19 on the drug markets, and while its effects are not yet fully known, border and other restrictions linked to the pandemic have already caused shortages of drugs on the street, leading to increased prices and reduced purity.

Rising unemployment and reduced opportunities caused by the pandemic are also likely to disproportionately affect the poorest, making them more vulnerable to drug use and also to drug trafficking and cultivation in order to earn money, the Report says.

Cannabis was the most used substance worldwide in 2018, with an estimated 192 million people using it worldwide. Opioids, however, remain the most harmful, as over the past decade, the total number of deaths due to opioid use disorders went up 71 per cent, with a 92 per cent increase among women compared with 63 per cent among men.

Drug use increased far more rapidly among developing countries over the 2000-2018 period than in developed countries. Adolescents and young adults account for the largest share of those using drugs, while young people are also the most vulnerable to the effects of drugs because they use the most and their brains are still developing.

Up to 253000 deaths globally were a result of illicit drug use. Alcohol and drug use are also linked to HIV and Hepatitis infections through risk sexual behavior and injecting drug use. Cannabis is the most commonly abused illicit substance followed by Amphetamines and then opiates. Heroin, opioids and prescription opiates use are on the rise in Africa. Non medicinal use of prescription and non-prescription medications and over the counter drugs is increasingly becoming a problem worldwide.

In Zimbabwe it has been estimated that approximately 3% of the adult population (450 000 people) had either a drug or alcohol use disorder (WHO). In 2012, 75% (23 168 arrests) were connected to cannabis, 56% (17 396 arrests) were connected to illegal cough mixtures (ZRP CID). Alcohol and substance use related problems are one of the top 3 problems seen in mental health services in all 10 provinces (MOHCC). Over 40% of young people admit to regular drinking and 15% admit to regular cannabis use (Acuda 1999, Nkoma, 2014, Mazhandu, 2017). Young people admit to starting alcohol and substance use as young as 12 in Zimbabwe (Nkoma 2014). Common substances abused in Zimbabwe are alcohol (both licensed and unlicensed brews), tobacco, cannabis and non-medicinal use of controlled medicines such as codeine containing cough medicines and benzodiazepines.

2. Current Alcohol and Drug Control Activities

2.1. Demand Reduction

These interventions may also target those who have started using substances by facilitating early identification of those with drug use problems, having evidence-based treatment, rehabilitation and reintegration programs. Harm Reduction is also a component of Demand Reduction by reducing the damage that drug use has on individuals who use drugs. Strategies here may include testing for and treatment of common comorbid conditions as well as managing life threatening withdrawal symptoms overdoses. In terms of legal approaches, court diversion is also a recommended approach to demand reduction by directing those who use drugs who come into conflict with the law into treatment and rehabilitation rather than prosecution.

Primary prevention consists of:

- Community Awareness
- School Programs
- Workplace Programs
- Programs for at risk/ Special Groups

Secondary Prevention consists of:

- Current treatment norms and standards for alcohol and drug use problems
- Current screening and early identification programs
- Programs for special groups

2.2 Supply Reduction

Involves approaches that seek to reduce the amount of drugs available in the community through legislative changes, law enforcement and monitoring systems for controlled medicines and drugs of abuse. Legislative approaches include changes to counter illicit trade. Law enforcement can be enhanced through capacity building, dealing effectively with drug related violence, drug trafficking and money laundering. Monitoring systems for controlled medicines and training of health care workers in rational prescribing are also key components of supply reduction.

2.3 Harm reduction

This refers to an overarching strategy that aims to prevent and reduce the harms associated with the use of illicit substances in the community.

Harm reduction strategies:

- Needle and Syringe Programs (NSP) also referred to as syringe services programs (SSP) or Needle-syringe programs (NSP) which are community-based programs that offer free sterile needles and syringes. Syringe/needle exchange program (NEP) is a social service that allows people who inject drugs (PWID) to obtain hypodermic needles and syringes at little or no cost. It is based on the philosophy of harm reduction that attempts to reduce the risk factors for diseases such as HIV, viral hepatitis and other blood borne infections.

- Naloxone Overdose Reversal- naloxone is a medication designed to rapidly reverse opioids overdose. It is an opioid antagonist meaning that it binds to opioids receptors and can reverse and block the effects of opioids. It can very quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of overdosing with heroin or prescription opioids pain medications. Families that use heroin or other opioids may consider keeping naloxone in their homes in case of overdose.

- Opioid substitution therapy (OST) refers to the administration of a prescribed daily dosage of opioid medicines with long-lasting effects to clients with opioid dependence, under medical supervision and supported by psychosocial interventions.

- Psychosocial interventions include counselling, motivational interviewing, cognitive-behavioral therapy, case management, group and family therapy and relapse prevention. They offer support to users as they attempt to manage and overcome their drug problems, and they are the main form of therapy for users of stimulant drugs, such as cocaine and amphetamines.

- OST is recognized as an effective tool to prevent HIV among people who inject drugs (PWID) and to increase adherence of eligible people living with HIV/AIDS to antiretroviral therapy (ART). It is recognized as a cost-effective strategy, which allows for the achievement of high retention rates of PWID in therapeutic programmes, a significant reduction of illegal opioid use and a reduction of injecting risk behavior (WHO, 1998; WHO/UNODC/UNAIDS, 2004; WHO, 2005; WHO 2009).

- Opioid substitution therapy is part of the “essential” core package of services and interventions which are proven to prevent HIV transmission among PWID and from them to their sexual partners and children. These interventions are supported by scientific evidence, and summarized by WHO/UNODC in Evidence for Action technical papers and policy briefs and in the joint ECDC/EMCDDA guidance (ECDC/EMCDDA, 2011)

- Needle and syringe programmes (NSP)
- Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
- HIV testing and counseling
- Antiretroviral therapy (ART)
- Prevention and treatment of sexually transmitted infections (STIs)
- Condom programmes for PWID and their sexual partners
- Targeted information, education and communication for PWID and their sexual partners
- Vaccination, diagnosis and treatment of viral hepatitis
- Prevention, diagnosis and treatment of tuberculosis (TB)
- Health promotion
- Targeted delivery of services

- Moderation Management is a voluntary support group for non-dependent alcohol users who do not necessarily want to stop drinking but moderate their amount of alcohol consumed to reduce its detrimental consequences.
- Consequences Caucus is a mutual help harm reduction support group for alcohol drinkers. It aims to eliminate risks like road traffic accidents, violence, loss of balance, STIs, mixing drugs, drowning, burns and hypothermia.
- Designated driver is a peer support program that restricts one team member from drinking alcohol for a particular night, so as to ferry all other peers who have gone beyond the alcohol intoxication level permitted by road traffic laws.
- Methadone Maintenance Treatment (MMT)- is a comprehensive treatment program that involves the long-term prescribing of methadone as an alternative to the opioids on which the client was dependent. Central to MMT is the provision of counselling, case management and other medical and psychosocial services. Methadone is a long-acting opioid agonist that is prescribed as a treatment for opioid dependence and the management of chronic pain. MMT addresses only the treatment of opioid dependence. It is an effective tool in managing heroin and other types of opioid dependences, but can cause some unpleasant side effects for example, nausea, constipation, sedation etcetera if the dosage is not clearly adhered to.

3. Current Legislation for Alcohol and Drug Control in Zimbabwe

Zimbabwe's legislation on drug control centers on the United Nations International Conventions. These are as listed below.

- The Single Convention on Narcotic Drugs, 1961
- The Convention on Psychotropic Substances, 1971
- The Convention against Illicit Trade in Narcotics and Psychotropic Substances of 1988 (Vienna Convention)

The following legislation has been put in place towards drug control in Zimbabwe;

- Criminal Law (Codification and Reform) Act (Chapter 9:23)
- Dangerous Drugs Act (Chapter 15:02)
- Dangerous Drugs Regulations RGN (Rhodesia Government Notice) 1111 of 1975
- Dangerous Drugs (Production of Cannabis for Medicinal and Scientific Use) Regulations, Statutory Instrument 62 of 2018
- Dangerous Drugs (Production of Cannabis for Medicinal and Scientific Use) (Amendment) Regulations, Statutory Instrument 178 of 2018
- Medicines and Allied Substances Control Act (Chapter 15:03)
- Medicines and Allied Substances Control (General) Regulations, Statutory Instrument 150 of 1991
- Medicines and Allied Substances Control (Import and Export of Precursors and Certain Chemical Substances) Regulations, Statutory Instrument 56 of 2008

Monitoring and Evaluation

- Each ministry has a role to play (multipronged approach)
- Continuous Research on drug use
- Data collection and data management system on Drug Use

4. International and Regional Institutions on Drug Control

4.1 United Nations Commission on Narcotic Drugs (CND)

The Commission on Narcotic Drugs (CND) was established by Economic and Social Council (ECOSOC) resolution 9(I) in 1946, to assist the ECOSOC in supervising the application of the international drug control treaties. In 1991, the General Assembly (GA) expanded the mandate of the CND to enable it to function as the governing body of the UNODC. ECOSOC resolution 1999/30 requested the CND to structure its agenda with two distinct segments: a normative segment for discharging treaty-based and normative functions; and an operational segment for exercising the role as the governing body of UNODC.

The CND meets bi-annually; in March/April, when it considers and adopts a range of decisions and resolutions. Inter-sessional meetings of the CND are convened in October/November to provide policy guidance to UNODC. Towards the end of each year, the CND meets at a reconvened session to consider budgetary and administrative matters as the governing body of the United Nations drug programme.

The three major international drug control treaties cited above are mutually supportive and complementary. An important purpose of the first two treaties is to codify internationally applicable control measures in order to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes, and to prevent their diversion into illicit channels.

4.2 UNODC

The United Nations Office on Drugs and Crime is a United Nations office that was established in 1997 as the Office for Drug Control and Crime Prevention by combining the United Nations International Drug Control Program and the Crime Prevention and Criminal Justice Division in the United Nations Office at Vienna. UNODC offers practical assistance and encourages transnational approaches to action. UNODC does this in all regions of the world through their global programs and network of field offices.

4.3 African Union

At AU level, the "Common African Position for the UN General Assembly Special Session (UNGASS) on the World Drug Problem noted that the overall goal of drug policies should be to improve the health, safety, security and socioeconomic well-being of people by reducing drug use, drug-related harms, illicit trafficking and associated crimes and also noting that drug policies which focus entirely or disproportionately on law enforcement, incarceration, punishment and repression have not succeeded in eradicating supply, demand and harm caused by illicit drugs on the Continent.

Operational recommendations include:

- Demand reduction and related measures, including prevention and treatment, as well as other health-related issues
- Ensuring the availability of and access to controlled substances exclusively for medical and scientific purposes, while preventing their diversion
- Supply reduction and related measures.
- Effective law enforcement and responses to drug-related crime.
- Countering money-laundering and promoting judicial cooperation
- Cross-cutting issues included: drugs and human rights, youth, children, women and communities evolving reality, existing trends, emerging and persistent challenges and threats, including new psychoactive substances.
- Strengthening international cooperation based on the principle of common and shared responsibility
- Regional, interregional and international cooperation on development-oriented, balanced drug control policy.

Member States are called upon to establish the National Coordinating Bodies with the following functions:

- Establishment of operational inter-sectoral drug coordinating committees.
- Development and implementation of detailed national Plans of Action with clear objectives, milestones, roles and responsibilities of all stakeholders and development partners and indicators using the AU Plan of Action on Drug Control (2019-2023) as a guideline.
- Compilation and submission of drug related questionnaires, baseline studies, drug use epidemiology reports, and treatment data.
- Launching drug policy advocacy campaigns.
- Adopting and implementing minimum quality standards for drug use prevention and treatment.
- Strengthening legal and policy frameworks.
- Provision of necessary national services, and support to civil society organizations in favor of victims of drugs and crime; and
- Biannual preparation and submission of national progress reports (to the AUC).

5. Proposed National Drug Master Plan and Implementation Matrix

Introduction

In implementing this drug master plan, priority shall be given to improvement of public wellbeing and public health as top priorities of the plan and that all proposed interventions will be in line with international human rights standards.

Why the need for a Drug Master Plan?

Due to the cross-cutting nature of the interventions needed to reduce demand and reduce supply, there is a need for:

- Coordinated inter-ministerial efforts on tackling drug issues,
- Conform to regional, international standards where each Member State is required to have national guideline e.g. African Union Plan of Action (2019-2023)
- Give guidance to interventions by stakeholders
- Comprehensive integration
- National response on the people using drugs

This implementation Matrix is a result-based plan that illustrates the roadmap to drug demand and supply reduction through several objectives. It provides clear direction to monitoring and evaluation through clearly defined performance indicators and the implementing parties within the stated timeline.

Vision: To establish a coordinated, holistic and a proactive response to the drug use challenges in Zimbabwe

where all people lead healthy and prosperous lives.

Mission: To reduce the demand, supply, and harm of substance use through a multipronged approach.

Guiding Principles

- Promoting safe, conducive environment that fosters development
- A humane, non-discriminatory, non-punitive approach to people who use drugs
- Inter-ministerial collaboration
- Promotion of public health

Objective	Activities & Outputs	Performance Indicators/Targets	Responsible party	Resources needed	Timeline
DEMAND REDUCTION					
Reduce Demand for drugs in the community through primary prevention	Community Awareness through community leader consultations and community workshops Community awareness through community campaigns, social media campaigns, traditional media campaigns, development and distribution of information, education and communication material (IEC) on alcohol and drug use Provision of alternative activities to drug use in the community	National focal person for community awareness Number of community leader consultations held Structured media and community awareness agenda for alcohol and substance use awareness Number of community awareness campaigns carried out as per structured agenda Number of social media (Facebook/twitter/Instagram) awareness messages developed as per structured agenda and Number of views for social media pages Number of television and radio shows developed as per agenda Number of print newspaper articles written for awareness as per agenda IEC material developed as per agenda	National Drug Control Committee Ministry of Health Ministry of Information Media Stakeholders Ministry of Youth, Sports and Recreation Community stakeholders Ministry of Women Affairs	Technical expertise to develop content Technical expertise to produce IEC material Logistical support for content development and community campaigns	Commencing January 2020 running continuously

School Based Alcohol and Drug Use Awareness	Number of school based and higher learning centre awareness campaigns carried out Alcohol and substance use education incorporated in the curriculum Number of schools with alternate activities available Peer to peer programs	National Drug Use Control Committee Ministry of Primary and Secondary Education Ministry of Higher and Tertiary Education Ministry of Youth, Sports and Recreation Ministry of Health and Child Care	Technical expertise to develop content Logistical support for content development and campaigns Sports and recreation facilities	Continuous from January 2020
Workplace Education Programs	Number of work based awareness campaigns conducted as per national agenda Number of workplaces with alternate activities (sports/recreation) to drug use Annual sporting programs	National Drug Use Control Committee Business community/ Private stakeholders Ministry of Health and Child Care Ministry of Public Service, Labour and Social Welfare Ministry of Youth, Sports and Recreation	Technical expertise to develop content Logistical support for content development and awareness campaigns Sports and recreation facility set up costs	Development of Content by 3rd quarter 2020 Campaigns from 3rd quarter 2020 continuous
Family Support programs to increase awareness and prevent substance use	Number of families who have received training in strengthening families, parenting skills and drug abuse prevention	National Drug Use Control Committee Ministry of Health (Mental Health and Family Health) Ministry of Public Service, Labour and Social Welfare Ministry of Primary and Secondary Education Church and religious body stakeholders Community stakeholders	Technical experts for content development/adaptation of training materials Logistical support for content development and trainings	Content development/adaptation by 3rd quarter 2020 Training from 1st quarter 2021

Prevention programs for at high risk and special populations (Pregnant women, Sex Workers, Trans,MSM)	Number of pregnant women engaged and given information on alcohol and drug use at maternity visits Number of sex workers, key population community members engaged and given information on alcohol and drug use in targeted awareness campaign	National Drug Use Control Committee Ministry of Health- Department of Family Health Ministry of Public Service, Labour and Social Welfare Community Stakeholders	Technical expertise to develop content Logistical support for content development and awareness campaigns	Starting 1st quarter 2019 continuous
Secondary Prevention: Establish and disseminate National Treatment guidelines for alcohol and substance use disorders School Programs (Guidance and counselling, special assemblies, essay writing competition discussing effects of using drugs, debates, quiz, inviting resource person to address learners)	National Treatment guidelines document developed using regional and international guidelines Dissemination of guidelines to primary care clinics, district, provincial and tertiary level hospitals and private health care facilities Those dropped out due to drug use, Number of teachers trained, awareness campaign held, lessons and sessions on guidance and counselling delivered.	Min of Health (Taskforce for Establishing treatment guidelines) Health Stakeholders Universities (Medical Schools)	Technical expertise to develop guidelines Logistical support for meetings to develop guidelines, pilot guidelines and disseminate guidelines	Guidelines developed by 1st quarter 2020 Guidelines piloted by 2nd quarter 2020 Dissemination of guidelines by 3rd quarter 2020
Support activity for secondary prevention: Improve training of health workers in management of alcohol and drug use problems	Number of health workers trained in management of alcohol and drug use problems using the national treatment guidelines	Ministry of Health Ministry of Higher and Tertiary Education Health Education stakeholders	Technical experts in health education Logistical support for training	mhGAP training of health workers on going Training of health workers using alcohol and substance use treatment guidelines 2nd quarter

Tertiary: Establish rehabilitation programs from community level – this needs to be broken down into activities; what will happen in those rehabilitation centres? • Relapse prevention • Family / support network engagement • Vocational training • Psychosocial counselling • Mental health support	Development of rehabilitation guidelines based on international standards Development of ICT material in line with national agenda Number of community rehabilitation centers established/refocused in line with international standards Number of rehabilitation focal persons trained in keeping with international standards Number of community members engaged through rehabilitation centers and receiving appropriate standards in line with international standards	Ministry of Health Ministry of Public Service, Labour and Social Welfare Community rehabilitation stakeholders	Technical experts in community rehabilitation Logistical support for training, implementation and support SOPs and guidelines for rehabilitation centres Quality control on centres and their activities	Guidelines developed by 1st quarter 2020 ICT material developed by 1st quarter 2020 Focal persons trained/sensitized by 2nd quarter 2020 Community Rehabilitation centers established/refocused by 3rd quarter 2020
Engage high risk/special groups in establishing challenges associated with drug use.	Profiling of high risk/special groups carried out in accordance with international standards Development of engagement protocols/guidelines for specific high risk/special groups in line with international standards Establishment of coordination teams for specific high risk/special groups in line with national agenda Number of persons in high risk/special groups engaged in line with international standards Establishment of research hubs for high risk/special groups in line with national agenda	Ministry of Health Ministry of Home Affairs Ministry of Public Service, Labour and Social Welfare High risk/special groups' stakeholders Ministry of Women Affairs	Technical expertise to carry out profiling Technical experts support for developing engagement guidelines/protocols Logistical support for establishing coordination teams	Profiling of high risk/special groups by 1st quarter 2020 Guidelines developed by 1st quarter 2020 Engagement initiated and ongoing by 2nd quarter 2020 Research hub established and ongoing from 3rd quarter 2020

Secondary prevention (harm reduction): 1. HIV testing & treatment 2. NSP 3. OST 4. TB screening & treatment 5. Viral hepatitis testing & treatment 6. STI screening & treatment 7. Overdose management 8. Education (on safer drug use, safer sex, HIV, TB, HCV, OD, etc) – written (IEC materials) & verbal (group & individual counselling) 9. Distribution of condoms and lubricants 10. Psychosocial & mental health support 11. (Legalization of cannabis use for medicinal and scientific research. Tertiary prevention: drug treatment	Development of guidelines and protocols in line with international harm reduction standards Number of stakeholders engaged and sensitized on appropriate harm reduction strategies in line with international standards Number of clients accessing harm reduction services in line with the national agenda Monitoring and evaluation of harm reduction activities in line with the national agenda	Ministry of Health Ministry of Social Welfare Ministry of Home Affairs Harm reduction stakeholders	Technical expertise to develop guidelines and protocols Logistical support for engaging and sensitization Logistical support for monitoring and evaluation	Guidelines and protocols developed by 1st quarter 2020 Stakeholders engaged and sensitized by 2nd quarter 2020 Harm reduction services ongoing from 3rd quarter 2020 Monitoring and evaluation ongoing from 4th quarter 2020

Reduce demand for drugs through Court Diversion programs, where minor offenders are referred for support programs rather than punishment or to health care system	Sensitization of judiciary structures	ICT material developed reflecting international diversion standards Number of meetings/sessions for sensitization Number of structures/personnel sensitized Standard Operation for a Case Management for guidance	Ministry of Health and Child Care Ministry of Home Affairs Ministry of Justice Judicial stakeholders Ministry of Public Service, Labour and Social Welfare	Technical expertise for developing ICT material Logistical support for sensitization meetings/sessions	ICT material developed by 1st quarter 2020 Sensitization meetings/sessions ongoing by 2nd quarter 2020
SUPPLY REDUCTION					
Supply reduction through Legislative changes	Review current legislation for illicit drug trafficking in line with regional and international recommendations	Number of legislation reviewed in line with regional and international recommendations	Ministry of Health and Child Care Ministry of Justice Ministry of Home Affairs Ministry of Public Service, Labour and Social Welfare Universities Illicit drug use and trafficking stakeholders	Technical expertise to review legislation Logistical support to review legislation	Reviewing of legislation ongoing from 2nd quarter 2020

Supply reduction through strengthening of Law enforcement	Improve capacity of law enforcement for drug screening at entry ports Improve capacity for forensic drug testing Improve skills of law enforcement in combating drug trafficking	Screening guidelines developed in accordance with international standards ICT material for drug screening developed reflecting international standards Number of training sessions conducted Number of law enforcement officers adequately capacitated	Ministry of Home Affairs Ministry of Health Drug screening stakeholders	Technical expertise to develop screening guidelines Technical expertise to develop ICT material Logistical support for training sessions	Screening guidelines developed by 1st quarter 2020 ICT material developed by 1st quarter 2020 Training sessions ongoing from 2nd quarter 2020
Supply reduction through strengthening monitoring systems for controlled substances	Consolidate aspects of the supply chain /? use of electronic systems for controlled substances Training of health workers in laws and regulations, policies, standards for rational drug use and risks of non-medicinal use of drugs	Guidelines for monitoring of controlled substances developed in line with international standards ICT material on relevant legislative and regulatory frameworks Number of training workshops conducted	Ministry of Health and Child Care Ministry of Justice Ministry of Home Affairs Medicines Control Authority of Zimbabwe	Technical expertise to develop guidelines Technical expertise to develop ICT material Technical expertise to develop training material Technical expertise to facilitate trainings Logistical support to carry out trainings	Guidelines developed by 1st quarter 2020 ICT material developed by 1st quarter 2020 Training material developed by 1st quarter 2020 Training ongoing from 2nd quarter 2020
Implementation, Monitoring and Evaluation	Establish a formal alcohol and drug use control committee to guide the adoption, implementation and monitoring of the drug masterplan Develop and adopt regulations based on existing laws that give legal framework for implementation of the drug masterplan	Development of operational guidelines/protocols for the alcohol and drug use and control committee in line with international standards Development of regulatory guidelines for the control of alcohol and drug use in line with the national agenda	Ministry of Health Ministry of Public Service, Labour and Social Welfare Ministry of Home Affairs Medicines Control Authority of Zimbabwe Alcohol and drug use control stakeholders	Technical expertise for developing operational guidelines/protocols Technical expertise to develop regulatory guidelines Logistical support for the establishment of a formal alcohol and drug use committee Logistical support for the operation of the alcohol and drug use control committee	Operational guidelines/protocols developed by 1st quarter 2020 Regulatory guidelines developed by 1st quarter 2020 Alcohol and drug use committee established by 1st quarter 2020 Alcohol and drug use committee operational from 2nd quarter 2020

Local, regional and international collaborations	Inter-ministerial collaborations Engage and collaborate with local stakeholders, NGOs, religious organizations Engage and collaborate with the African Union Engage and collaborate with the UNODC and INTERPOL Engage and collaborate with WHO	Number of collaborative exercises/activities carried out in line with the national agenda Number of stakeholder engagements and collaborations carried out in line with the national agenda Number of engagements and collaborations undertaken with the UNODC and INTERPOL in line with international standards Number of collaborations carried out with WHO	Logistical support for collaborative activities	Ministry of Health and Child Care Ministry of Home Affairs DACZIM Alcohol and drug use control stakeholders	Collaborative activities initiated and ongoing from 1st quarter 2020

6. Concluding Remarks

The Zimbabwe National Drug Master Plan's aim is to help in strengthening responses to drugs in order to contribute to the enhanced health, security and well-being of all Zimbabweans. After the development of this Drug Master Plan and coordinated implementation and monitoring by all the stakeholders we hope to see an improvement in the treatment of people who use drugs and better awareness on drug challenge issues in Zimbabwe.

We would like to thank all the stakeholders for their effort in consolidating this document, which we hope is going to play a major role in the alleviation of alcohol and illicit substance use in Zimbabwe.

References

Acuda, S.W. (1999) Epidemiological study of drug use in urban and rural secondary schools in Zimbabwe. *Central African Journal of Medicine*, 40:207-212.

ECDC (2011) *ECDC and EMCDDA Guidance, Prevention and Control of Infection diseases among people who inject drugs*. Dublin: Grattan House

Nkoma, E. (2014) An exploratory study of alcohol use/abuse among first year students at Great Zimbabwe University. *Journal of Educational Policy and Entrepreneurial Research.* Vol.1, N0.4:38-47

UNAIDS (2004) *Report on the Global AIDS Epidemic*: 4th Global Report. Geneva: UN Press.

UNODC (2020) *UNODC World Drug Report 2020.* New York: UNODC Press.

WHO (2005) *Alcohol, Gender and Drinking Problems*: Perspectives from Low and Middle Income Countries. Geneva: WHO Press.

WHO (1998) *Global status report on tobacco*. Geneva: Substance Abuse Department Press

ANNEX 1: Classification of Drugs

Substances can broadly be categorized into Central Nervous System (CNS) depressants, CNS stimulants and Hallucinogens.

According to WHO, **DEPRESSANTS** are any agent that suppresses, inhibits, or decreases some aspects of central nervous system (CNS) activity. The main classes of CNS depressants are the sedatives/hypnotics, opioids, and neuroleptics. Examples of depressant drugs are alcohol, barbiturates, anesthetics, benzodiazepines, opiates and their synthetic analogues. Anticonvulsants are sometimes included in the depressant group because of their inhibitory action on abnormal neural activity. Disorders related to depressants use are classified as psychoactive substance use disorders in ICD-IO in categories FI0 (for alcohol), F11 (for opioids), and F13 (for sedatives or hypnotics).

Whilst **STIMULANTS** in reference to the central nervous system, are any agent that activates, enhances, or increases neural activity; also called psychostimulant. Included are the amfetamines, cocaine, caffeine and other xanthines, nicotine, and synthetic appetite suppressants such as phenmetrazine or methylphenidate. Other drugs have stimulant actions which are not their primary effect but which may be manifest in high doses or after chronic use; they include antidepressants, anticholinergics, and certain opioids.

Stimulants can give rise to symptoms suggestive of intoxication, including tachycardia, pupillary dilatation, elevated blood pressure, hyperreflexia, sweating, chills, nausea or vomiting, and abnormal behaviour such as fighting, grandiosity, hypervigilance, agitation, and impaired judgement. Chronic misuse commonly induces personality and behaviour changes such as impulsivity, aggressivity, irritability, and suspiciousness. A full-blown delusional psychosis may occur. Cessation of intake after prolonged or heavy use may produce a withdrawal syndrome, with depressed mood, fatigue, sleep disturbance, and increased dreaming.

In ICD-I0, mental and behavioral disorders due to use of stimulants are subdivided into those due to the use of cocaine (F14) and those due to the use of other stimulants, including caffeine (F15). Prominent among them are amphetamine psychosis and cocaine psychosis.

HALUCINOGENS

halucinogen A chemical agent that induces alterations in perception, thinking, and feeling which resemble those of the functional psychoses without producing the gross impairment of memory and orientation characteristic of the organic syndromes. Examples include lysergide (lysergic acid diethylamide, LSD). dimethyltryptamine (DMT). psilocybin, mescaline, tenamfetamine (3.4-methylenedioxyamfetamine, MDA), 3,4-methylenedioxymethamfetamine (MDMA or ecstasy), and phencyclidine (PCP).

Most hallucinogens are taken orally; DMT, however, is sniffed or smoked. Use is typically episodic; chronic, frequent use is extremely rare. Effects are noted within 20-30 minutes of ingestion and consist of pupillary dilatation, blood pressure elevation, tachycardia, tremor, hyperreflexia, and the psychedelic phase (consisting of euphoria or mixed mood changes, visual illusions and altered perceptions, a blurring of boundaries between self and non-self, and often a feeling of unity with the cosmos). Rapid fluctuations between euphoria and dysphoria are common. After 4-5 hours that phase may be replaced with ideas of reference, feelings of increased awareness of the inner self, and a sense of magical control.

In addition to the hallucinosis that is regularly produced, adverse effects of hallucinogens are frequent and include:

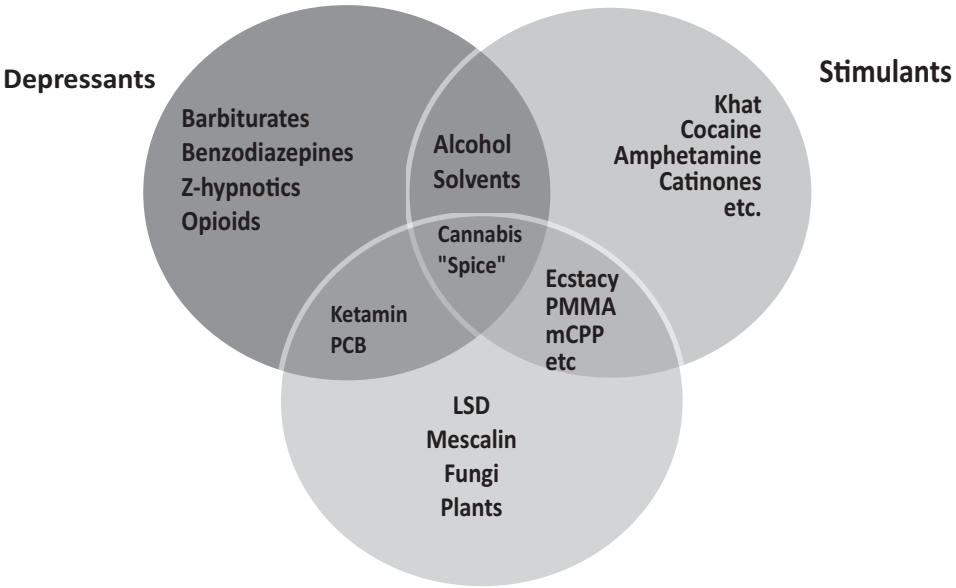
(1) Bad trips;

(2) Post-hallucinogen perception disorder or flashbacks;

(3) delusional disorder, which generally follows a bad trip; the perceptual changes abate but the individual becomes convinced that the perceptual distortions experienced correspond with reality; the delusional state may last only a day or two, or it may persist;

(4) affective or mood disorder, consisting of anxiety, depression, or mania occurring shortly after hallucinogen use and persisting for more than 24 hours; typically the individual feels that he or she can never be normal again and expresses concern about brain damage as a result of taking the drug.

Hallucinogens have been used for insight therapy in psychotherapy, but this has been restricted or even banned by legislation See also: hallucinogenic plant



(https://www.google.com/url?sa=i&source=imgres&cd=&cad=rja&uact=8&ved=2ahUKEwj2uL7E6PbkAhXdAGMBHVtUA3AQjB16BAgBEAM&url=https%3A%2F%2Fwww.fhi.no%2Fen%2Fop%2Fhin%2Flifestyle%2Falcohol-and-other-psychoactive-subs%2F&psig=AOvVaw0UM7IPDpfYPqlx9nSPhhtR&ust=1569873466535217)

Table showing locally available drugs

Depressants	Stimulants	Hallucinogens	Inhalants
Alcohol	Cocaine	Lysergic Diethylamide	Petrol
Benzodiazepines	Crystal Meth (Mutoriro/Guka)	Mescaline	Thinners
Narcotic analgesic	Amphetamines	Proactive mushroom	Glue
Opiates	Ecstasy	Cannabis (Mbanje)	Nail polish remover
Barbiturates		Peyote cacti	
Spirits (zed, tegu tegu, soldier, double punch, ranger, saints, blue diamond, first choice)			
Cannabinoids			

ANNEX: 2. Causes of Substance Abuse

- Poverty
- Trauma
- Mental illness
- Relationship problems
- Stress
- Chronic pain or medical conditions
- Poor social skills or lack of social support structure
- Peer pressure

2. Effects of substance abuse

Unsafe use of drugs or bad drug policies affects the individual, their family and community and the nation at large. The effects of unsafe drug use are as follows:

3. Physical effects

- Stroke
- Respiratory problems
- HIV/AIDS
- Disease contraction such as hepatitis B and C
- Several types of cancer
- Road traffic accidents

4. Psychological effects

- Changes in appetite
- Loss of coordination
- Sleeplessness
- Depression
- Anxiety
- Difficulty maintaining personal hygiene
- Panic disorders
- Paranoia
- Hallucinations
- Dependence

5. Social complications

- Relationship problems
- Unsafe neighborhoods and criminal activity through drug trafficking and drug use itself.
- Burden of treatment to care givers
- Gender-based violence
- Increase in divorce rate
- Unwanted pregnancies
- Suicide

6. Economic effects

- Affects an individual's capacity to work and earn a living thus may not be able to contribute economically to the nation.
- High unemployment rate
- Money laundering
- Costs from labor non-participation
- Costs from treatment participation, hospitalization, incarceration and premature mortality
- Inflation

Current drug cultivation and production in Zimbabwe

Zimbabwe legalized the cultivation and production of cannabis for medicinal and scientific use through the introduction of the Dangerous Drugs (Production of Cannabis for Medicinal and Scientific Use) Regulations, Statutory Instrument (SI) 62 of 2018. The following measures have been put in place to avoid diversion of cannabis and its related products;

(i) The applicants go through vetting for the purposes of security clearance to rule out their involvement in money laundering, human trafficking, and drug trafficking etcetera.

(ii) A licensed producer's site shall be designed in such a way that prevents unauthorized access.

(iii) The perimeter of the licensed producer's site shall be visually monitored at all times by visual recording devices to detect any attempted or actual unauthorized access. These devices should be capable of making a visible recording of any attempted or actual unauthorized access.

(iv) The perimeter of the licensed producer's site shall be secured by means of an intrusion detection system that operates at all times and that allows for the detection of any attempted or actual unauthorized access to or movement in the site or tampering with the system.

(v) A licensed producer shall ensure that the records, documents and information are kept in a manner that will enable an audit of them to be made in a timely manner and are available at their site.

The maximum yield quantity is as indicated below;

(i) Cannabis oil shall not exceed a maximum yield quantity of 30 mg of delta-9-tetrahydrocannabinol (THC) per milliliter of the oil in the immediate container, taking into account the potential to convert delta-9-tetrahydrocannabinolic acid into delta-9-tetrahydrocannabinol.

(ii) If cannabis oil is in a capsule or similar dosage form, each capsule or unit of the dosage form shall not exceed a maximum yield quantity of 10 mg of delta-9-tetrahydrocannabinol, taking into account the potential to convert delta-9-tetrahydrocannabinolic acid into delta-9-tetrahydrocannabinol.

These measures are important to safeguard the health of the public. Numerous studies have demonstrated that using cannabis prior to the age of 15-18 significantly increases the risk of developing psychotic symptoms (Pierre, 2017). The risk is dose dependent and increases with greater frequency of use and with higher potency THC. A landmark study out of the United Kingdom analyzed 780 adults, ages 18-65, 410 with their first psychotic episode versus 370 matched healthy controls. They found that the use of high potency THC > 15% resulted in a three times increased risk of psychosis, and if the use was there daily there was a five times increased risk. Those who used cannabis with < 5% THC did not exhibit psychotic symptoms (DiForti et al, 2015).It is important to note that the use of cannabis for medicinal purpose is not yet approved in Zimbabwe and this would require regulations and dialogue with medical profession.

ANNEX 3: Alcohol Policy Within Zimbabwe

The National Alcohol Policy recognizes the social and economic role alcohol plays in Zimbabwe and its consequences, that is, its significant capacity, when misused, to impose unacceptable costs on individuals and the community as a whole. It seeks to establish the basis for the place of alcohol in the lives of Zimbabweans, moving consumers of alcohol to safer drinking patterns in shaping the future. It is the overarching framework for the implementation of measures aimed at minimizing the health and social harms from the abuse of alcohol.

The current laws of Zimbabwe which apply to all alcoholic beverages which are sold or manufactured for sale in Zimbabwe include:

The Liquor Act [Chapter 14: 12]

The Traditional Beer Act [Chapter 14:24]

The Road Traffic Act (BAC) of 2001

The Shop Licenses Amendment Act [Chapter 14:17] of 2018

The Finance (No. 2) Act (ZIMRA Licenses' and Approval) of 2019

The Children's Act [Chapter 5:06] of 2002

Food and Food Standards (Alcoholic Beverages) Regulations 2001 (S.I. 25 of 2001)