Invisible Victims
Drugs, State and Youth in Liberia & Sierra Leone

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‘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. These policies have led to serious unintended consequences and often disproportionately impact upon the poor and marginalised, while creating a rich and powerful criminal market that undermines security of states. Therefore, we commit to strive for balance and proportionality at the local, national, regional and international levels.’

Executive Summary

The enduring images associated with the global war on drugs – which is now generally considered to be a catastrophic failure – come from Latin America where hooded, heavily armed soldiers preside over the incineration of drugs, or engage in battle with gangs belonging to cartels on the streets or in the jungles of Mexico and Colombia. On April 2, 2013 something eerily happened in West Africa, when the Vice-Admiral José Américo Bubo Na Tchuto, a powerful former head of Guinea-Bissau’s navy and a designated ‘drug kingpin’ by the US Treasury,¹ along with two of his aides were arrested in a sting operation by Drug Enforcement Administration (DEA) agents from the United States. Though Guinea-Bissau has long been considered a ‘narco-state’, this event was the first of its kind in West Africa.

As a result of counternarcotic policies adopted since the mid-2000s in reaction to a number of major interceptions of cocaine on transit to Europe from Latin America, less high-profile and dramatic raids by security agents have been routinely carried out all over the region. Unfortunately, the significant number of people rounded up as a result of these raids are primarily young adults from poor neighborhoods who smoke or sell marijuana and other narcotic drugs, rather than the ‘kingpins’. Hundreds of young men and women, arrested in these raids are subjected to long detention without trial.

This prohibitionist approach to marijuana, which is used as a medicinal drug in some countries, should be abandoned as a matter of urgency. The global medical consensus is that the physiological or behavioral harms related to the use of marijuana are mild. Certainly the costs related to the medical harm that it could cause are negligible when compared to the enforcement costs relating to its penalization. Moreover, thousands of people facing mental health challenges, often from causes unrelated to narcotic drug use, have nowhere to seek treatment, and are often derided as “drug addicts”. The purpose of this paper is to highlight the flaws of the current approach to the problem of narcotic drugs, particularly with respect to its impact on human rights and public health.

This paper, written based on research conducted in Liberia, Sierra Leone and Ghana on behalf of Open Society Initiative for West Africa (OSIWA) in

¹ David Lewis and Richard Valdins, ‘Capture of a ‘drug kingpin’,’ Reuters, 24 July 2013; also ‘Admiral of the White,’ Africa Confidential
October 2015, advocates for a more humane approach to the apparently growing problem of narcotic drug use in the region by decriminalising possession for personal use of some drugs, and making greater investments in harm reduction, demand reduction, and mental health programmes.

**West Africa and Drugs**

Until recently, the drug problem in West Africa has been discussed in the context of the region’s vulnerability to transnational organised criminal activity and as a transit point for the movement of cocaine from Latin America and heroin from Asia to Europe and North America. The concern has now widened to focus on the responses of governments to this threat, and to the implications of the increasing consumption of these narcotic drugs in the region. Thus, the 2014 report of the West Africa Commission on Drugs (WACD), *Not in Transit: Drugs, State and Society in West Africa*, had as it first recommendation the important point that drug use by individuals should be treated as a public health issue “with socio-economic causes and consequences” rather than as a matter for criminal justice. The report noted that the increased use of West Africa mainly as a transhipment point for cocaine (from South America) en route to Europe and North America by international drug cartels since the mid-2000s has exacerbated the problem of drug consumption.

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2 The author is grateful to Nancy Sesay in Freetown, Alphonso Quenneh in Monrovia, and Mohamed Adamu in Ghana for assistance during research for this paper. Thanks are also due to Michael Schulenburg, Eleanor Thompson, and Mathias Hounkpe for very helpful comments on an earlier draft.

3 This section draws from *Not Just in Transit: Drugs, State and Society in West Africa* (June 2014), the report of the West Africa Commission on Drugs.

4 UNODC’s 2005 report, “Crime and Development in Africa,” was the first to meticulously detail the issue. It noted that “drugs, crime and corruption are undermining development efforts” on the continent, and that “high levels of income inequality, a high share of youth in population, high rates of urbanization, low levels of criminal justice resources, firearms proliferation, wars and civil conflicts as well as weak controls over criminal activities leave Africa vulnerable to organised crime, drug trafficking, trafficking in human beings, money laundering and corruption.”

5 WACD, *Not Just in Transit: Drugs, State and Society in West Africa* (June 2014), 19. It states that “criminalising drug use will overburden already over- burdened criminal justice systems. It can also incite corruption within the judiciary and the police; provoke violence and human rights violations, while also blighting the future prospects of those detained for relatively minor offences. Lastly, it can drive major disease epidemics such as HIV and hepatitis C. In the light of these unintended consequences, the current practice of criminalising every aspect of the drug trade should be abandoned.”

The United Nations Office on Drugs and Crime (UNODC) World Drug Report for 2013 cites estimates reported by governments of cocaine use in West Africa and Central Africa as likely significantly higher than the global average when adjusted for population size; the estimated absolute number of people who used cocaine in the region was 1.6 million in 2012, with no data provided for Liberia and Sierra Leone. The 2013 report also noted an emerging market for methamphetamine in Africa. Seizures in Asian and European countries show large quantities of methamphetamine to have been trafficked from Benin, Côte d'Ivoire, the Gambia, Ghana, Guinea, Mali, Nigeria, Senegal and Togo.

In West Africa, however, cannabis is overwhelmingly the drug of choice, particularly among young people. According to UNODC reports, the estimated prevalence of cannabis use in the adult population is highest in West and Central Africa, at 12.4 percent, compared to the African average of 7.5 percent and 3.9 percent globally.

**A War on Drug Users**

When in July 2009, the UNODC issued a grim report entitled Transnational Trafficking and the Rule of Law in West Africa: A Threat Assessment, anxiety rose particularly about fragile post-war countries like Liberia and Sierra Leone, which were seen to be particularly vulnerable. The report placed the two countries at the top of the table of countries at the highest risk of instability, not necessarily as a result of the drug trade (Liberia at number 5 and Sierra Leone at number 6, just below Afghanistan, Iraq, Niger and Ethiopia.)

Elaborating on the report’s findings, Antonio Maria Costa, Executive Director of UNODC, said in October 2009 that the entire West African ruling elite was complicit in narco-trafficking. In a speech at Praia, he implicated members of the region’s ruling elite in “this bloody trade, because of greed and as an insurance policy for hard times when power will be lost.” We are aware, he said, “that major trafficking rings are run from places of power, while counter-narcotic operations (run by low paid, junior officers) are compromised by corrupt, high-level interference… It is up to you – the leaders of West Africa – to turn the tide. To launch a counter attack against drugs and crime you need expensive hardware from abroad, as well as inexpensive software already at your disposal: political will, leadership, and integrity… Yes, you are victims of a global trade – caught in the crossfire of drug suppliers to the West and
drug consumers to the North. But traffickers are targeting your countries because of conditions that enable them to operate with low risk. And many of these wounds are self-inflicted.”

This was, in effect, a call to begin a new war on drugs, this time in West Africa. Costa’s bombastic statement resonated widely. Ghana, which he claimed was being rapidly transformed into a ‘coke coast,’ had become a particularly attractive target for drug traffickers, in part because Ghanaians had long been active in the drug trade, and the country had direct flights to Europe and the United States, as well as a functioning banking system. Ghana has long being a favored transit point for illicit drug trafficking. United States records show a number of arrests of Ghanaians, including of a Member of Parliament, in the US for smuggling drugs into the country. In July 2004, a ship allegedly carrying more than two tons of cocaine was seized off the coast of Ghana by a French warship. On inspection, cocaine with a street value of at least $50m was found on it. The most notorious case of such seizure was that involving the Ghanaian ship, MV Benjamin, in April 2006, when Ghana’s Narcotics Control Board (NACOB), following a tip by British and American intelligence, apprehended the drug-laden ship, which was headed towards its port at Tema. The drugs on aboard were worth hundreds of millions of dollars. A significant proportion of the drugs vanished apparently in the custody of security agents.

In July 2008, a small aircraft bearing fake Red Cross insignia and carrying over 600 kilograms of cocaine worth hundreds of millions of dollars along with arms and ammunition landed at Sierra Leone’s Lungi Airport and was impounded by officials. The government, with critical support from the United Nations and the UK, quickly passed the very repressive National Drugs Control Act No 10 of 2008 (as amended), under which it tried 18 people, including three Colombians, two Mexicans, a Venezuelan and an American (subsequently finding 16 guilty, fined and sentenced.) In April 2009, after months of negotiation, Sierra Leone expelled three of the foreign nationals into U.S. custody to face charges there. A senior government minister was implicated in the cocaine scandal. In Liberia, a successful

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8 ‘Cocaine Coast,’ Africa Confidential, 14 March 2008
9 Author’s interview with Mr. Yaw Akrasi-Sarpong, head of Ghana’s Narcotics Control Board (Accra, 21 April 2011)
11 Sierra Leone Judiciary, THE STATE AND GEREGE ARTISTIZABEL ARCHILLA and 17 Others (Trial judgment is in the author’s possession.)
collaboration between DEA officials and the country’s National Security Agency (NSA) in May 2010 led to the arrest of traffickers attempting to bribe the NSA’s head with $400,000 to allow 700 kilos of cocaine worth hundreds of millions of dollars to land safely in Liberia. Those arrested included a Russian pilot, a Nigerian narcotics broker, a Colombian cocaine supplier and a Ghanaian maritime expert with expertise in sea routes that might help in evading law-enforcement radar. Another of the defendants and his associates were part owners of a large commercial airline operating in the region. The alleged traffickers were suspected of intending to use passenger flights departing from Monrovia to move cocaine out of the country.12

The result of these high-profile interceptions was the enactment of a rash of new laws which imposed stiff penalties mainly on low-level distributors and traffickers as well as users, and a substantial increase in the arrest and detention of minor users mainly of cannabis, the drug of choice for the region’s poor, particularly youth. As early as 1990, Ghana passed the Narcotics Drugs Enforcement and Sanctions Law, PNDCL 236, providing the legal framework for combating drug trafficking, production, and use; it has since characterized the use of narcotics as a public safety and security issue, not a public health issue. A draft amendment of this law is currently being considered by Parliament.

Sierra Leone only passed its National Drug Control Act in 2008, following the apprehension of the cocaine plane, and in order to try those arrested in connection to it, retroactively. Like the Ghanaian law, the Sierra Leone National Drug Control Act 2008 takes a punitive approach to both drug use and drug trafficking. It prescribes life imprisonment for anyone convicted of producing or cultivating drugs, including cannabis, as well as selling or attempting to tranship them. This means that a peasant farmer cultivating an acre of marijuana or even a smaller plot, who is arrested in the occasional police raids, may be jailed for life. This has economic livelihood, as well as security and human rights implications. The law states that a drug user “is liable on conviction to a fine not less than thirty million leones or to a term of imprisonment not less than ten years.” It adds that “the court may in addition to the penalty prescribed for that offence, make an order requiring the offender to undergo measures such as treatment, education, aftercare, rehabilitation or social reintegration.” The law clearly encourages imprisonment because the majority of drug users (particularly petty drug users, most of them young

people using cannabis) cannot afford the minimum fine of Le30m (equivalent to almost $6,000) - making imprisonment in most cases is the only option.

On paper at least, the law affects to be lenient on minors – defined as anyone under the age of 18 – for whom if convicted of the offences above “the court may order as an alternative to the penalty prescribed for that offence, that the minor undergoes treatment, education, aftercare, rehabilitation or social reintegration, as the circumstances may require.”¹³ Since, however, there are no existing facilities for such treatment, education, or social reintegration, this provision is essentially meaningless or moot.

The absence of such facilities underlines the fact that it takes much more than legislation to enforce a harm reduction approach to drugs.

Liberia enacted its “Controlled Drugs and Substances Act” as an addendum to its penal code under the title “offenses involving danger to the person” in December 2014. The law states that “Except permitted or authorized by law, a person who consumes or uses controlled drugs or substances… shall be guilty of a first degree misdemeanor, and if apprehended for the second time, a third degree felony.” Those convicted may be subjected to long prison sentences; but the law provides for an alternative to conviction or punishment: the “court may order that such user undergoes measures of treatment, education, aftercare, or rehabilitation.”

The problem is that, as in Sierra Leone, there is no facility in Liberia for treatment, education, after-care and rehabilitation of drug users, making this apparently humane provision of no effect. In fact, many of those arrested so far for drug use and minor possession of even cannabis for personal use in both countries face long detention without trial, and when finally tried and convicted, are often left forgotten in prisons.

A Sierra Leone police data for 2014, which was later reviewed in October 2015 – showed that the police arrested over 100 people for marijuana possession and use, confiscated 2898 kilograms of it, and convicted 38 people for those offences. Many of them were given the maximum sentence of 10 years in prison under the National Drugs Controlled Act 2008. In the first

¹³ Government of Sierra Leone, National Drugs Control Act 2008, Section 8.
quarter of 2015, the Sierra Leone courts convicted 40 people for marijuana possession and use, and confiscated 1438 kilograms of marijuana. The total number of those arrested during that short period was 85, of whom all but three of them young Sierra Leoneans. In October 2015, civil society activists in Sierra Leone were agitating for the release of 32 mentally ill young men and women who are in prison after being rounded up on the streets and ghettos of Freetown for possession of drugs meant for personal use.\textsuperscript{14} In the absence of rehabilitation and treatment facilities, the Sierra Leone courts can hardly utilize the discretion that the law provides with respect to an alternative disposition to a prison sentence.

In May 2011, the Sierra Leone police announced the seizure of three tons of marijuana with an estimated street value of some $10 million. In 2012, the Sierra Leone police announced that they had destroyed over 100 acres of marijuana farms in the immediate vicinity of the capital Freetown. This operation was facilitated by funding from, curiously, the Government of the Netherlands, which itself recognizes cannabis use as legal.\textsuperscript{15} The farms are small scale, many of them no larger than one acre, and shortly after the destruction, more of such farms emerged in the same areas. Destroying marijuana farms is a particularly destructive and counterproductive policy – directly affecting the livelihood of peasants and many unemployed young people – that must be abandoned as a matter of urgency.

The Liberia DEA records for 2013 show that 142 were arrested for possession of drugs, of which 74 were for cannabis, 32 were found in possession of cocaine, and 36 of heroin. The agency also reported the destruction of four marijuana farms and the arrest of two farmers, who were charged to court. A notorious case that year related to the 9 November 2013 interception by Liberia’s Transnational Crime Unit of 10 bags of cannabis with a street value of $36,618 in Monrovia in the Grand Cape Mount County. The drugs were intercepted while being trafficked from Sierra Leone in a vehicle bearing the official insignia of one of the Liberian National Police’s Presidential Escort, and one of those arrested in it was Superintendent Perry Dolo, the police chief of presidential escort. Dolo and his accomplices were charged in court for possession and trafficking in narcotic drugs. It subsequently emerged that the seized drugs mysteriously disappeared in the custody of the court. Nevertheless, Dolo and four others were found guilty of the charges, and were

\textsuperscript{14} Interview with activists in Freetown, October 2015.
\textsuperscript{15} Email communications from Michael von der Schulenburg, then UN Secretary-General’s Executive Representative in Sierra Leone and head of the UNIPSIL.
sentenced to prison terms in August 2014. They have since appealed. When in December 2013 the Liberia National Police launched Operation Pyramid it claimed to have arrested 167 drug dealers and users, almost all of them for possession of cannabis. Police data for the first half of 2014 showed nearly 100 people arrested for drug possession. The Liberia National Police appeared to have been less active in this regard for the rest for 2014 and much of 2015, probably because of the crisis of the Ebola Virus Disease.

In both Sierra Leone and Liberia, no major seizures of cocaine, heroin or amphetamine-type stimulants (ATS) has been made in the past five years, and the zeal of the authorities seemed to be more directed at minor dealers and users, many of them poor young people. Reports of significant seizures and even state penetration by drug traffickers continue in neighbouring countries. However, it is possible that, after the initial interceptions, and particularly the significant interventions by US, Britain and the UN in the counternarcotic efforts of these countries, large cartels may have decided for the moment to avoid using them to transit their drugs. However, the danger remains that traffickers are rarely, if ever, deterred by the counternarcotic strategies of even powerful states.

**Harm Reduction, Treatment and Rehabilitation**

The African Union *Common African Position* on UNGASS 2016, agreed in Addis Ababa on 13-17 April 2015, noted that the fundamental goal of drug policies “should be to improve the health, safety, security and socio-economic well-being of people by reducing drug use, drug-related harms, illicit trafficking and associated crimes.” It stated that effective drug policies “are those that achieve a balanced and integrated approach, with appropriate and proportional focus on… evidence-based services to address the health and social impacts of drug use.”

The *Common African Position* has been endorsed by every country in West Africa. However, except in Senegal, which has a rudimentary harm reduction programme, efforts are not being made in the region to integrate this progressive position into state policies, including legislations and health
In Liberia and Sierra Leone, where anecdotal evidence suggests that the use of harder drugs like heroin and cocaine is rather limited, the chief concern with respect to harm reduction relates to cannabis – and this more in relation to the brutal state policies towards the users, producers and dealers of the drug than in the medical harm caused by its use, which is generally believed to be mild. However, as interviews with psychiatrists and social workers conducted for this report in Sierra Leone, Liberia and Ghana indicated, a strong link is made between cannabis use and mental illness. Often a link is also made between cannabis use and violent behavior of young people. This position is most emphatically expressed by the lone psychiatrist in Sierra Leone, Dr. Edward Nahim, who has since 1976 headed the Kissy Mental Home in Freetown. He is a key member of the National Drug Law Enforcement Agency (NDLEA) and the consultant psychiatrist for the City of Rest rehabilitation Centre, which was founded and managed by Pastor Morie Sekiema Ngobeh.

The Kissy Mental Hospital was established in 1817, mainly to confine mentally ill repatriated slaves who were freed in Sierra Leone by the British colonial authorities. It is West Africa’s first, and for many decades only, Western-style mental hospital; and it remains Sierra Leone’s only psychiatric hospital. From the start it functioned largely as a place of detention for varied kinds of dependents and vagrants: it was, as an important study of the institution has noted, “a custodial facility – a place for the demented and dangerous people who were burdens and created trouble for family and society.” Though medical treatment has improved somewhat over the years, the hospital is still less a place for therapeutic help for mentally ill patients than one of forcible confinement and isolation for them. Patients – more accurately victims – live in deplorable conditions, as a visiting Sierra Leonean psychiatrist from the United States noted in 2011: “Life as a patient at Kissy Mental Hospital is… hard. If they could, most of the hospitalized patients would leave. Some cannot leave because they have been chained. Others simply have nowhere to go because family members no longer want them

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16 Interview with Dr. Nahim, Freetown, October 2015.

17 Leland V. Bell, Mental and Social Disorder in Sub-Saharan Africa: The Case of Sierra Leone, 1787-1990 (New York: Greenwood Press, 1991).
around. Very few patients come to Kissy Mental Hospital willingly.\textsuperscript{18} A visit there in October 2015 confirmed this impression. A total 104 patients – or ‘inmates’, as some refer to them – are housed at the hospital, of which 75 were men. Most of them are under age 40.

According to Dr. Nahim, 80 percent of the patients at the hospital suffer from drug use disorder, and have become psychotic as a result. Most patients take cannabis, though some have used cocaine, ‘brown brown’ (or crack cocaine) and heroin. As a result of this, he has sought to establish a correlation between narcotic drug use and mental illness. But this is not entirely convincing.

A study of mental health and substance abuse in post-conflict Sierra Leone in 2002 by Dr. Soeren Buus Jensen of the World Health Organisation – which Dr. Nahim facilitated – estimated that 400,000 people in Sierra Leone were suffering from mental health disorders like depression and post-traumatic stress disorder; only about 1 percent of the entire population of Sierra Leone (about 6 million) received treatment. This was shortly after the end of the country’s brutal civil war (1991-2002). The study noted that though the “frequency of severe traditional mental health problems in Sierra Leone is similar to most other countries,” many people in the country “were exposed to severe potentially traumatic events” which exacerbated the problem of mental health in the country. The report also noted that in Sierra Leone “there is a high frequency of people who never drink alcohol (85% of the random sample and 97% among secondary school students). \textit{Even less have tried or abused drugs.”} [My emphasis] Still, the “frequency of drug-induced psychoses in the mental hospital is very high (60% of the patients with drug-induced psychosis)”, noting that this problem necessitates the establishment of “a comprehensive mental health system.” The report described the mental hospital as particularly unfit for the purpose, since it is a worn out facility where a quarter of its patients were in heavy iron chains, lacked basic drugs, and many of the staff lacked adequate mental health training. The report also deplored the country’s lack of community based mental health care.\textsuperscript{19} Moreover, Kissy Mental Hospital is located in an overcrowded and somewhat uncongenial environment that is particularly unattractive to most professional health workers and doctors.

\textsuperscript{18} The psychiatrist was Dr. Mandy Garber, who spoke to the journalist Roland Marke, see: “Living in Chains: Sierra Leone’s Mentally Ill,” \textit{World Press} found at: http://www.worldpress.org/Africa/3750.cfm (accessed on 10 November 2015)
The *City of Rest* rehabilitation centre is in a far better shape, and appears to be more effective in a therapeutic sense. Its atmosphere is certainly far more salubrious. The centre is a well-secured three-acre gated compound at Grafton, a quiet village down the mountain slope of Freetown. The Government of Sierra Leone donated the land on which *City of Rest* is situated; and churches, as well as the embassies of United States and Germany, provided funding support for the construction of the buildings. *City of Rest* has 70 rooms. There were 43 patients at the centre, all between the ages of 15-45, in October 2015 when this writer visited. Each patient spends three months at the *City of Rest*; and social workers monitor the released patient while at home for another three months. Rehabilitated patients are then given a certificate celebrating their success. Though the *City of Rest* was founded as a Christian charity in 1985, its ecumenical spirit embraces people of other religious faith (there are several Muslims patients brought there by their relatives) as well as those who profess to no religion. It admits patients from Liberia, Guinea and elsewhere. The founder, Pastor Ngobeh, was himself a Muslim but converted to Christianity just before he founded the *City of Rest*. Patients who are Christian daily participate in group-prayers, but no one is apparently forced to do so. Dr. Nahim provides medical treatment for patients, and nurses on contract with the *City of Rest* provide therapeutic care; patients are regularly provided medication. The resources of the *City of Rest* are so modest, however, that often it has had to turn down patients. Its limited success is a reminder of the yawning gap in mental health capacity in Sierra Leone: over 30 percent of the patients admitted at the *City of Rest* suffer from depression or other forms of mental illness unrelated to drug use. *City of Rest*, which does not receive government funding, is currently not used as a referral for court-convicted drug users, including children, for the purposes of treatment and rehabilitation.

The available data for Liberia – which suffered a more prolonged civil war – are similar, if not worse. The Chief Medical Officer in October 2015 stated that 400,000 people (of a population of about 4 million) in the country suffer from various kinds of mental illness. A survey of 1,600 households in Liberia in 2008 revealed that about 43 percent of those surveyed meet the diagnostic criteria for serious depressive illness, major depressive disorder and post-traumatic stress disorder. Dr. Benjamin Harris, the country’s only psychiatrist, also said in an interview that there is a growing problem of drug addiction linked to mental illness among young people in Liberia: 27 percent of individuals surveyed had had “substance abuse related problems and
substance abuse issues are a growing problem in Liberia.” He warned that unless “something is done pretty quickly to try to address this problem, it is bound to get worse.”

Liberia has only one psychiatric hospital, in Monrovia, the capital, and no rehabilitation centre for drug users. It is called Esther Grant Hospital. The hospital was managed until 2010 on behalf of the Liberia’s Ministry of Health by Cap Anamur, a German NGO. It is now part of the government-owned John F Kennedy Hospital in Monrovia. The 80-bed hospital had 68 patients (48 male) in October 2015. Facilities are bare; and the atmosphere when this writer visited in October 2015 was one of sullen and brooding dereliction. Patients admitted at the hospital must show obvious signs of psychosis, and must be accompanied by their relatives. People with drug use disorders are not admitted, except if they are already psychotic and violent. When taken there, they are counseled and dismissed.

Though the deplorable statistics for Sierra Leone and Liberia – both of mental health and facilities for their treatment – are magnified by their recent experience of brutal conflict, they are fairly typical in the region. A report by Human Rights Watch in 2012 estimated that 2.8 million people in Ghana have mental health problems, of which 650,000 were thought to have severe mental disabilities. The report cited Dr. Akwasi Osei, director of Accra Psychiatric Hospital, that drug-related psychosis affected 8-10 percent of mental patients and epilepsy 5 percent of patients; 20-30 percent of patients are diagnosed with schizophrenia, 20 percent with bipolar disorder, and 15-20 percent with major depression. Ghana, with a population of 27 million, has three psychiatric hospitals; Human Rights Watch found them to be overcrowded and poorly resourced. Ghana has about a dozen psychiatrists. Many people suffering from mental illnesses were confined to so-called “prayer camps” where they were chained and subjected to other forms of abuses.

The atmosphere at the section for the treatment of drug use disorders at Pantang Psychiatric Hospital in Accra when this writer visited in late October 2015 was, however, far more salubrious and professionally managed than found in the government-run treatment centres in Sierra Leone and Liberia. It

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21 HRW, Ghana: People with Mental Disabilities face Serious Abuse (October 2012); found at: https://www.hrw.org/news/2012/10/02/ghana-people-mental-disabilities-face-serious-abuse (accessed on 10 November 2015).
had 22 patients – it has a capacity for 30 – of which five were women; and each patient spends a minimum of six months (and a maximum of 18 months) before being released from the hospital. Each patient pays 1000 cedis – a prohibitive sum for many young people in the country – as admission fee at the hospital (which is then used to cover feeding), and patients buy their own medication. The hospital does not have the capacity for monitoring of patients after being released, however, and there have been countless cases of recidivism or relapse.

**Conclusion and Recommendations**

This report paints a grim picture, but it should be read in its proper context. Drug use is a global problem, not an African one, and experience from many countries suggests that the best way to tackle it is to treat it as a public health problem, not a criminal one. The United States National Institute on Drug Abuse defines drug addiction as “a chronic, relapsing brain disease that is characterised by compulsive drug seeking and use, despite harmful consequences.”

As the WACD report noted, “Every country has an interest in reducing drug demand and preventing new drug use. Yet, the experience of the past decades has shown that efforts are better expended by targeting problematic drug use, not least because it accounts for the largest share of the demand. Decriminalising drug use is one of the most effective ways to reduce problematic drug use as it is likely to facilitate access to treatment for those who need it. However, the absence of drug treatment policies in West Africa, notably for people with problematic use, poses significant public health risks, potentially aggravating existing health challenges such as the spread of HIV.” In order to be effective, however, decriminalisation must be accompanied by drug treatment and rehabilitation facilities. Unfortunately, in West Africa only Senegal currently has government-supported harm reduction services.

There is an urgent need for governments in the region to confront this problem humanely and responsibly. For countries like Liberia and Sierra Leone, the problem currently appears more acute with respect to mental health, though drug use is only one of the causes – or manifestations – of the problem, which was clearly exacerbated by the traumatic experience of brutal warfare. Sadly, this is also perhaps the most neglected public health concern in the region. For

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those two countries, neglecting this problem is both a human right violation, and a potential security risk – because the principal victims are mainly unemployed youth whose volatility was one of the drivers of the civil wars in both countries.

Where policy relating to narcotic drugs is concerned, the challenges to face are multifaceted, and they must be faced squarely. The first is to minimize the health risk posed to consumers, as well as to non-consumers. Police raids, arrests, and detention of drug users cannot minimize this risk; they will only exacerbate them. Only treatment, rehabilitation, and education can help minimize the risks. Certainly, prohibition cannot work, and has not been known to work anywhere. Enforcing the ban on particularly a traditional drug like cannabis is counterproductive. In both Pakistan and Iran it was the strict prohibition of opium, their traditional drug, in the 1980’s that drove many young people to heroin use. Cannabis is a traditional drug, the drug of choice for many young people, in Liberia and Sierra Leone. The urge to take drugs will not go away if a ban on this drug is enforced; it will only lead many of them towards possibly more dangerous drugs. The fact that cannabis provides livelihood for many people, including poor farmers, means that there is likely to be grave economic and possibly security and political consequences if the ban on it is enforced. Moreover, many studies have concluded that the medical harm associated with cannabis use is largely negligible, and that instead it has real medicinal value.

This report recommends that:

- The Governments of Liberia and Sierra Leone should amend their laws on narcotics or dangerous substances to bring them in line with the African Union Common African Position on UNGASS, which emphasises harm reduction over punitive measures against drug users. The new amended law should decriminalize cannabis use and possession of small quantities of all drugs for personal use.
- In line with their laws on narcotics and dangerous substances, the Governments of Liberia and Sierra Leone should establish rehabilitation and treatment centres for drug users, including those convicted for drug use.
- The Governments of Liberia and Sierra Leone should treat mental health as an important public health concern, and make greater
investment in that sector. They should establish community-based mental health care across their countries. It is important in this regard to provide incentives to medical students and nurses to train as psychiatrics by providing them scholarships and other incentives.

- The Government of Sierra Leone should relocate Kissy Mental Hospital to a more congenial environment.
- The Governments of Liberia and Sierra Leone should ensure that the law enforcement aspect of drug policies must focus on international and high-level traffickers, not users. It is also important that trial judges and magistrates are not only aware of the discretion that they have to prescribe treatment, education, after-care and rehabilitation, but also that there are social workers advising on such matters or available for the judiciary to consult on appropriate dispositions when presiding over drug offence cases.