The war on drugs and social policy in Tanzania

Crackdowns, prohibition and control

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This thesis is dedicated to people who use drugs, in Tanzania and elsewhere. You have all deserved far better for far too long. Tupo Pamoja.

Abstract

In February 2017, Tanzanian President John Magufuli publicly declared a war on drugs, an unexpected change in policy in a country previously leading the way in harm reduction in Sub-Saharan Africa. The war on drugs, a set of policies aimed at reducing drug supply and use through the punishment, forced treatment and criminalization of drug users, is a part of Magufuli's strategy to 'clean up' Tanzanian society. Prior to his election, the Tanzanian government largely ignored treatment and drug policy, and foreign NGOs, in partnership with local activists, funded and implemented harm reduction interventions.

This thesis seeks to understand a puzzling reversal from harm reduction to repression, posing the questions: 1) How did the Tanzanian government implement a war on drugs that went against the goals of a number of powerful foreign actors funding services for drug users? 2) What have been the outcomes for drug users in Tanzania as a result of the drug policies and programming implemented since the election of Magufuli? 3) How does Tanzania's war on drugs shape international and domestic approaches to drug use and drug policy in the country?

In the fall of 2018, I interviewed foreign and local NGO workers, officials from major international organizations and former drug users and activists in Dar es Salaam, Tanzania. Using interviews and observations during this fieldwork, I explore the realities on the ground underlying both the drug policy changes towards drug users implemented over 2016/17, and the more public crackdown on drug use in 2017. I rely on a constructivist methodology to challenge and interrogate the narratives being produced by the Tanzanian government, which echoed harsh, war on drugs ideology but also boasted about comprehensive harm reduction programming, a contradictory position I also explore in this thesis.

In answer to my first research question, I argue that the Tanzanian government evaded donor pressure or interference in pursuing an anti-drug user agenda through strategies of appeasement, intimidation and the exploitation of a neglected policy area. The Tanzanian government touted its harm reduction program at the international level to produce a narrative of continued support for drug users, appeasing donors and foreign agencies while, in reality, narrowing the scope of treatment to the detriment of people who use drugs. The government also used intimidation tactics, threatening the work of foreign NGOs working with vulnerable population, which chose to stay and provide limited services rather than risk being kicked out of the country. The Tanzanian government, with limited resources, took advantage of donors' focus on HIV/AIDS and lack of commitment to drug users, to maneuver and achieve a repressive policy agenda without interference.

I build on this argument using the evidence I gathered during fieldwork to answer to my second research question. I argue that the outcomes of the Tanzanian drug war agenda were increased police harassment, higher drug prices and fear of punishment among drug users which led to riskier drug use, greater difficulty in accessing services and greater economic vulnerability. Drug users had to go farther, spend more money on drugs and face harassment as they tried to avoid dopesickness. Policy changes resulted in the closure of harm reduction centres frequented by drug users, limited access to needle exchange and limited the outreach efforts of local and international NGOs, making life much more difficult for people who use drugs.

During my research, I found that, contrary to some of the literature I read which posited the war on drugs as a Western strategy of political control, the Tanzanian government was actually producing

war on drugs narratives, and using these narratives to justify its repressive policies. This finding supports the answer to my third research question. I argue that the Tanzanian government produced narratives of drugs hindering development, causing corruption and threatening national unity. I also argue that donors such as the United Kingdom, and foreign agencies working in HIV/AIDS, are reproducing these narratives and are following an agenda, set by the Tanzanian government, that does not meet the needs of drug users and supports the centralization and repression of the Magufuli regime. Foreign agencies shifted from supporting drug users, to instead following an agenda that does not meet their goals in reaching drug users. Donors did not notice or prioritize the increased abuse of drug users' human rights at all, accepting the provision of methadone as evidence of support for drug users and continuing to provide general budget support to the Tanzanian government and even providing specific funding to limit drug supply in the country.

The effectiveness of Tanzania producing such narratives, and enacting the repressive policies war on drugs narratives justify, reveals global antipathy towards actually supporting people who use drugs and advancing the rights of people who use drugs. In upholding old war on drugs narratives and implementing policies that attack people who use drugs, Tanzania is contributing to an international consensus that the war on drugs is justified as long as basic treatment is provided. This thesis, using the voices of activists and advocates on the ground, deconstructs the Tanzanian war on drugs. I argue for the inclusion of those with lived experiences in shaping and changing the repressive drug policies and epistemologies that are being produced by the Tanzanian state and are being accepted by the international community.

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List of Acronyms

ART – Anti-Retroviral Therapy

AU – African Union

CCM – Chama Cha Mapinduzi (Party of the Revolution)

CDC – US Center for Disease Control and Prevention

CSOs – Community Service Organizations

DCEA – Drug Control and Enforcement Authority

Global Fund – Global Fund to Fight AIDS, Tuberculosis and Malaria

FDI – Foreign Direct Investment

HIV/AIDS – Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

INCB – International Narcotics Control Board

INGOs – International Non-governmental Organizations (foreign agencies)

Jhpiego – John Hopkins Program for International Education in Gynecology and Obstetrics

KVP – Key Vulnerable Populations. In the context of HIV/AIDS prevalence and transmission, KVP include populations more vulnerable to infection including People Who Inject Drugs (PWID), female sex workers and men who have sex with men.

MEFADA – Methadone Family Against Drug Abuse

MDM – Médecins du Monde

MRC Sober House – Morogoro Recovery Community

MSM – Men who have sex with men

MUKIKUTE – Mapambano ya Kifua Kikuu na Ukimwi Temeke (Struggle against Tuberculosis and AIDS Temeke

NGOs – Non-governmental Organizations

ODA – Official Development Assistance

PEDDEREF – People with Drugs Dependence Relief Foundation

PEPFAR – The President's Emergency Plan for AIDS Relief

PWID – People who Inject Drugs

TACOSODE – Tanzanian Council for Social Development

TANPUD – the Tanzanian Network of People Who Use Drugs

UN – United Nations

UNAIDS – Joint United Nations Program on HIV/AIDS

UNGASS – United Nations General Assembly Special Session on Drugs and Crime

UNODC – United Nations Office on Drugs and Crime

USAID – United States Agency for International Development

Africa has recently become a focus of drug trafficking and illicit use, posing a new challenge to international counter-narcotic efforts. Drug trade generates organized crimes, including human trafficking, terrorism, money laundering, dissemination of weapons and cybercrimes. On the other hand, combating drugs will have a huge impact not only in the fight against drugs but also reduction in other organized crimes.

- *Tanzanian Prime Minister Kassim Majaliwa, September 2018*

Narcotic addiction is a major contributor to crime. Untreated narcotic addicts do not ordinarily hold jobs. Instead, they often turn to shoplifting, mugging, burglary, armed robbery, and so on. They also support themselves by starting other people-young people--on drugs.

We are not without some understanding in this matter, however. And we are not without the will to deal with this matter. We have the moral resources to do the job. Now we need the authority and the funds to match our moral resources.

The final issue is not whether we will conquer drug abuse, but how soon.

- *President of the United States Richard Nixon, June 1971*

Chapter 1 - Introduction

Introducing the war on drugs

The war on drugs is one of the most enduring and widespread policy frameworks to emerge in the 20th century[1]. While the history of using mind-altering substances is long, the 20th century saw the birth of a global project aimed at limiting the supply of drugs and punishing those who use them. The spread of globalization and capitalism afforded the war on drugs a truly global reach over the past decades as a framework of policy practices that has proven remarkably adaptable and useful for governments to score political points and utilize as a tool of control. The dream of a drug-free world, a notion posited by the United Nations and many states pursuing their own drug wars, has been reiterated through numerous policies, agreements and protocols since President Richard Nixon famously coined the phrase in the early 1970s. Although Nixon and his successors used the war on drugs to punish and discipline African Americans, their governments also helped create and firmly establish the idea of drugs as criminal, threatening and inherently evil, epithets that also came to define those who use drugs.

The epistemic linkage of drugs with criminality, the disaffection of youth, corruption and poverty make the idea of eliminating drug use a way to create a world without these problems. The assumption that war on drugs policies are the way to create a better world is still the backbone shaping drug policies in most countries around the world, despite evidence of increased drug use and availability across the globe due to these policies. The focus on the need to eliminate drugs among many governments and at the international level is so pervasive that there is little questioning of the realities of drug use, and the larger socio-economic situations that shape the ways in which drugs are sold, perceived and used.

The huge amount of resources devoted to enforcing the dream of a drug free society by Western donors and governments has not stopped drug use. The idea of drugs impacting poorer countries and impeding development is also now a commonly accepted idea, justifying aggressive

[1] The war on drugs is a term associated with policies of criminalization and prohibition, with the aim of creating a drug-free world. Policies associated with this approach are often referred to as supply side interventions which focus on eliminating drugs or limiting their availability through policies including increased border control and policing, harsh punishments for users and traffickers, treating drug use as a criminal issue and raising fears, real and false, as to the realities of drug use (Herschinger 2011).

measures to ensure supply is reduced in these countries. However, as the global war on drugs spread, poorer, producing countries have only increased production and drug user continues to grow. In the Western world, dangerous opioid analogues such as fentanyl are now common and, across the globe, new and different supply routes have appeared for other drugs such as heroin and cocaine. Further, despite well-established evidence that policies such as abstinence, prohibition, incarceration and the militarization of borders have clearly failed, priorities for most countries and the United Nations have not changed and remain resolutely focused on reducing the supply of illicit drugs. The few treatment options available for people who use drugs are implemented in the midst of these repressive and costly policies which often significantly reduce drug users' access to basic services.

The lasting power of war on drugs policy is the construction and distillation by a number of domestic governments and international organizations, based on disparate threads of prohibition and moral panic, into a coherent political agenda transferable across cultural and political contexts. These policies, which conservative American governments initially constructed and put in place internationally in the 1970s and 1980s, are now supported more broadly by a number of international organization and governments, such as China, Russia and the African Union. While the Western world is facing the results of decades of failed drug policy, including unprecedented rates of overdose deaths, countries previously considered peripheral to the global drug war are also facing greater numbers of drug use and overdose.

Yet, the continued presentation of drugs as an inherent threat at the international level by numerous countries, for the most part, persists in shaping governmental policy and international agreements. Decades of activism to oppose this idea and present people who use drugs in a more compassionate light and advance limited harm reduction supports continue, but are often hindered by a better resourced and supported campaign to maintain the status quo[2]. The assumptions of a war on drugs ideology, which I show in this thesis as being promoted and reified by governments and international organizations, serves as the continued basis for domestic drug policies across the globe.

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[2] Harm Reduction aims at treatment of addicts rather than punishment, focused on reducing harms associated with drug misuse, and not necessarily forcing abstinence. This practice is controversial, with policies such as needle exchanges, safe injection sites, provision of clean drug paraphernalia and Opioid Replacement Therapy (ORT), being seen by proponents of the war on drugs as encouraging drug use (HRI 2016).

The war on drugs and Tanzania

The increased supply of drugs such as heroin, and the interdiction efforts aimed at combatting trafficking, have had the contrary effect of increasing supply and leading to a proliferation of trafficking routes from Afghanistan. A major route for heroin trafficking developed through East Africa in the 1990s, increasing supply in the region and resulting in significant drug use in coastal towns such as Mombasa and Dar es Salaam. Yet, despite the increase in drug use in East Africa countries, global war on drugs policies and their connections with the developing world, save for producing countries, is relatively under-theorized. The lack of scholarly and political interest in the war on drugs in countries such as Tanzania creates the semblance that these states are not engaged and active in shaping policy and contributing to international arguments about how to deal with drugs. In this thesis, I position Tanzania within the global war on drugs described above to show not only the country's active role in shaping narratives around drug use, but also its role in prolonging the failed war on drugs.

This thesis addresses important gaps in literature on Africa and the war on drugs, and the case study of Tanzania provides a fresh perspective on African agency and the lack of attention to, and understanding of, drug policy and use in the country. While some scholarly works pay attention to Africa and drugs, they are not always accurate and comprehensive in describing the realities faced by people who use drugs. As noted by Carrier et al. (2012), war on drugs rhetoric in regard to Sub-Saharan Africa is alarmist, focusing on societal degradation, corruption of youth and increasing flows of drugs being used to fund criminality and terror. Scholars are often concentrated more on the security aspects of the growing drug trade in Africa, the control of traffic and the potential violence of this trade, as illicit flows have increased over the past two decades through both East and West African ports on their way to destinations in Europe and North America. A few scholars have focused on injection drug use in East Africa as the practice became more common, especially along the Swahili coast (McCurdy 2013, 2016, Reid 2009, Dimova 2016). However, there are no major studies on drug policy in these countries, nor any studies that consider the international and domestic relationships informing their creation and implementation.

I use the case study of Tanzania as, in 2016 and 2017, the new President there, John Magufuli, recreated crisis narratives surrounding drug use by echoing the language of the war on drugs and declaring an all-out 'war' on substances, drug traffickers and users (Apolinairi 2017, *Famagusta Gazette* 2017, *Xinhuanet* 2016). While drug use was not new in the country, the government highlighted the use of drugs as a major factor impeding development, damaging youth and causing corruption. Despite the use of heroin in the country dating back several decades, the Tanzanian government developed policies and narratives around this use that served to erase the larger socio-economic context underlying addiction and place the blame for societal problems such as corruption on drug users themselves.

The framing of the drug war attempted to focus popular anger against insidious drug use as the agent of the long standing issues of corruption and poverty, reducing the linkage of these problems to the ruling party. The war on drugs in Tanzania, in the inflammatory language used by the President and the reactionary approach to harm reduction, was outdated, in contrast with the milder language now being used by donor countries and the United Nations Office on Drugs and Crime (UNODC). Repressive language, which justified mass incarceration, police harassment and, in the end, did little to hinder drug supply in the country, went largely unremarked upon by international and domestic observers, however, showing how normalized attacking drug users still is.

As I show in this thesis, the rhetoric and crackdown against drug users were only part of a concentrated effort to reduce access to services for people who use drugs and deny their human rights. The rhetoric and public war marked a reversal as Tanzania initially implemented and supported some harm reduction policies beginning in 2011. While pursuing more performative, public acts against drug users, the government of Tanzania was also working to dismantle, through policy change, intimidation and obfuscation, the limited harm reduction supports that were being developed to reduce Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) among drug users and provide some basic medical and social care. As with 1980s era United States under Ronald Reagan, the drug war in Tanzania is marked not only by fear-mongering rhetoric and increased legal discrimination, but also efforts to reduce social services, marginalize already vulnerable people and focus public attention on a constructed crisis.

Tanzania is an example of how the domestic political motives of the ruling party, particularly the President, interact with larger, international policy frameworks promoted by more powerful actors such as the UN, and produce a patchwork of policies inclusive of treatment but favouring criminalization, punishment and security. Tanzanian activists and NGOs, along with international donors with an interest in harm reduction such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, have driven the implementation of methadone and the limited supports available for people who use drugs. The government methadone program, funded by donors, was mainly aimed at reducing particularly high rates of HIV/AIDS among injection drug users. However, the focus of the Tanzanian government in reversing this progress since 2016 resulted in the methadone program remaining in place with little support amidst policies reflecting a harsh punitive stance. The semblance of harm reduction in Tanzania, and donor partnership in helping drug users is, in reality, a continued denial of human rights for people who use drugs driven by the Tanzanian government.

Based on my fieldwork, the promotion of treatment and harm reduction is now being touted by many governments throughout the world, and Tanzania, at UN gatherings and harm reduction conferences is one of them. The reality, however, is quite different, showing either a basic misunderstanding of what harm reduction and actually supporting drug users means, or a lack of political will to truly provide this support. As I show in this thesis, the language of Tanzanian representatives, as well as that of donor countries, does not reflect in a real commitment to policy change.

The global shift towards more progressive and humane responses to drug use is not evidenced in funding from major donors and non-governmental organizations (NGOs), which is still biased towards war on drugs policies aimed at reducing supply. Medical journals have raised alarm at the growing rates of HIV infection rates among people who inject drugs (PWIDs), and have called for enhanced harm reduction policies (see Tan et al. 2015), but little work has been done to examine the implementation of policies within African countries, and why the punitive policies that have failed in controlling drugs in the West still hold sway for governments like Tanzania. The focus of donors, notably the United States, on the security aspects of the drug trade in Africa overshadows understandings of addiction and social policies within African countries even as social and medical concerns are increasing.

The rising traffic of drugs in countries such as Tanzania coincides with a number of domestic cultural and social beliefs around drug use and its harms, including dominant government messaging in which drugs are a great evil to be eradicated. As Western countries appear to be moving towards less punitive, health focused approaches to managing drug use, Tanzania enacted repressive tactics to worsen the lives of people who use drugs with little interference or opposition. Some donors, such as the United States Agency for International Development (USAID), are supportive of these approaches as a way to support development. In reality, there is little evidence that limiting drug supply leads to development and policies stigmatizing drug use and promoting prohibition and punishment often lead to increased government control and deny the human rights of people who use drugs.

In this context, I illustrate how Tanzania, while influenced by international aid and by non-governmental interventions, is driving policy towards people who use drugs. The country received some media attention for the public crackdown on drug users in 2016/17, but the policy changes governing how to support Key and Vulnerable Populations (KVP) implemented at the same time were top-down and government driven and received much less attention. My thesis explores the ways in which Tanzania is impacted by western discourses but is also developing its own strategies for dealing with drugs and influencing how the issue is framed in the country.

1.1 A statement of the problem, what this thesis seeks to address

This thesis was born out of a drastic, and somewhat confusing, change in policy by the Tanzanian government in 2016, from allowing foreign agencies such as the Global Fund to provide limited support to people who use drugs in collaboration with local NGOs, to outright attacking drug users who posed little threat to the power of the Tanzanian state. As with drug wars pursued by authoritarian leaders elsewhere, I assumed that it was measure of controlling the populace and a political ploy to instill fear. The small group of local and international NGOs, and the methadone program, seemed largely untouched and it appeared possible that the crackdown on drug use was simply a momentary effort, not seriously aimed at solving issues of drug use and trafficking. What I found surprising, however, was the length and extent the government went to control people who use drugs and reverse the limited advances drug users, in cooperation with International NGOs (INGOs) and donors, had made in accessing basic healthcare and human rights.

The problem I seek to address in this thesis is understanding how the Tanzanian government, despite its seeming limited involvement in the sector and few resources, was able to impose repressive policies in direct opposition to the foreign funded services being provided to drug users. I am less interested in the 'why' of the drug war, as drug wars are always implemented to control and discipline vulnerable populations. The 'how' of Magufuli's drug war stood out to me as a way in which to explore the agency of African states and efforts at political control. While drug policy in Africa is not subject to an extensive literature, there are works in African Studies on a number of areas, such as democratization and securitization, where narratives and policies seemingly imposed on Africa by the West are demonstrated to be produced and constructed by African governments for their own benefit.

Jonathan Fisher sums up the assumptions limiting African agency in the international sphere well:

> African governments arguably have less autonomy over their domestic policy agendas than any other group of state actors in the international system. Dependence on international aid flows, in particular, has historically provided many African regimes with limited room for maneuver in the design and implementation of national policies, given the frequent attachment by donors of highly prescriptive economic and political conditionalities to their much-needed aid disbursements since the 1980s. The necessity of accepting such aid 'with strings attached' has compelled many African governments to institute usually unwelcome, but wholesale, economic and political reform programmes, in order to secure continued international assistance (Fisher 2013:97).

As Brown and Harman note, African countries are often viewed as marginalized and inactive in international relations, 'victimised, chaotic, violent and poor' (Brown and Harman 2013:2). In this thesis, I follow their approach by placing an African government at the fore and 'focus on interaction, rather than one-way domination' (Brown and Harman 2013:2). Utilizing such a framework flips the script that I found in academic and policy works on drugs and development. It also allows exploration, not of the Tanzanian government having undue influence in the

international sphere, but of how they [the Tanzanian government] operate and act within it, and 'what might be done with room for maneuver' (Brown and Harman 2013:3).

While examples of securitization and democratization are high profile subjects of study, the war on drugs is an interesting case due to its relatively lower profile and the fact that, in many African countries like Tanzania, foreign funding supports services for people who use drugs, with little domestic funding provided at all. By analyzing Tanzania and the war on drugs, I intend to provide another case of African agency in shaping policy and contributing to narratives on development, drug use and prohibition.

1.2 The research questions and argument

In answer to the puzzle above, I wanted to analyze how the Tanzanian government went from being relatively uninvolved in drug policy, to taking an active role in governing the lives of drug users, from legal crackdowns to a concentrated series of drug policy changes. In order to answer how the government did so, despite these actions being opposed to the goals of foreign agencies involved in the sector, and which had such obvious negative outcomes for drug users, my first research question asks *1. How did the Tanzanian government implement a war on drugs that went against the goals of a number of powerful foreign actors funding services for drug users?*

I use the evidence from the interviews and observations I undertook during my fieldwork, to learn more about the outcomes of the crackdown and policy changes, posing the question *2. What have been the outcomes for drug users in Tanzania as a result of the drug policies and programming implemented since the election of Magufuli?*

Finally, during fieldwork, I came to understand the war on drugs as an ideology, a set of beliefs and policies being constantly shaped and re-shaped across the globe. Seeing the enactment of the war on drugs in Tanzania, I questioned what role a country like Tanzania could have in shaping perspectives on, and approaches to, drug policy domestically but also at the international level. In literature on the war on drugs and on African politics and international relations, drug policy is very under-theorized. In order to address this gap, I ask *3. How does Tanzania's war on drugs shape international and domestic approaches to drug use and drug policy in the country?*

Below, I answer each of these questions to show how Tanzania achieved its objectives of implementing a repressive war on drugs, shaping perceptions of drug use in the country and marginalizing drug users all while ensuring little attention would be paid by the international community as it undertook these actions.

Intimidation, appeasement and neglect – shaping the war on drugs in Tanzania

In answer to my first research question, I argue that the Tanzanian government evaded donor pressure or interference in pursuing an anti-drug user agenda through strategies of appeasement, intimidation and the exploitation of a neglected policy area. Over 2016/17 the Tanzanian government pursued a highly visible crackdown on drug users, changed legal and health policy for key vulnerable populations yet, at the same time, still promoted its comprehensive harm reduction programs at the international level. The continued promotion of its harm reduction program at the international level produced a narrative of continued support for drug users, appeasing donors and foreign agencies while, in reality, the government was narrowing the scope of treatment to the detriment of people who use drugs.

The Tanzanian government also used intimidation tactics, threatening the work of foreign NGOs working with vulnerable populations, which chose to stay and provide limited services rather than risk being ejected from the country. Individual employees I interviewed noted the real threats they felt in undertaking their work, concerned that they could be shut down completely and also facing threats of increased bureaucratic delays, increased surveillance and even harassment. While most organizations were ultimately not banned from the country, the threats and obstacles put in place by the Tanzanian government were real enough and many interviewees discussed arbitrary wait times for permits, increased oversight of their actions (including detailed reporting requirements) and being subject to inspections to enforce anti-harm reduction measures. The result is that organizations wanting to advance harm reduction, not wanting to draw attention to their work or further antagonize the Tanzanian government, were unable to oppose the repressive and ideological policies the Tanzanian government determined and implemented.

During my fieldwork in 2018, fears persisted, resulting in the continued inability of progressive organizations to express disagreement with policies that reduced the ability of vulnerable populations to access services. Despite these organizations sometimes being large, well-funded entities providing the majority of HIV/AIDS support in the country, the Tanzanian government used tactics of intimidation and harassment, without attracting international attention, to silence any potential critics and achieve its war on drugs agenda.

The government framed narratives around drug use and policy in the country, presenting its methadone program at the international level as a comprehensive health and treatment package for drug users, appeasing donors or foreign agencies working in the sector. As methadone treatment was left intact, donors paid little attention to the policies and practices surrounding the provision of methadone treatment, such as increased police harassment, a decrease in harm reduction outreach and increased stigma preventing access to methadone. With treatment in place for drug users, foreign agencies involved in working in HIV/AIDS, shifted their focus to working with the general population and did not challenge the government's crackdown or policy changes. Donors did not notice the severity of the war on drugs or the increased repression and stigma drugs users' faced.

This study is the first to actually look at drug policy in Tanzania within the larger historical, social, legal and political context to show the realities of drug use in Tanzania and the policy changes and repression directed towards drug users. The Tanzanian government, with limited resources, took advantage of donors' focus on HIV/AIDS and their lack of commitment to drug users, to maneuver and achieve a repressive policy agenda without interference. The combination of appeasement and intimidation, in a neglected policy area that is not a major priority for the development community, silenced critics of the war on drugs and allowed the government to change the direction of drug policy in the country away from harm reduction and towards abstinence, punishment and prohibition.

Bad policy and bad outcomes – targeting vulnerable populations

The Magufuli government's policy changes and repression directly limited access to services for drug users, including those most at risk and living with HIV/AIDS. I argue in this thesis that, as a direct result of the Tanzanian government's policy changes and crackdown, drug users faced

increased police harassment, were forced into hiding, faced greater difficulties in accessing services and became the target of renewed stigma, systemically and in official rhetoric. While the Tanzanian government did not completely eliminate foreign funded supports for drug users, it narrowed it to a methadone program and actively hindered any greater social, economic or harm reduction services for drug users that would improve the lives of drug users.

In answering my second research question, I deepen the puzzle I seek to unpack in this thesis as the negative outcomes listed above were obvious to foreign agencies working in the sector. Many individuals I interviewed heard from clients that they were resorting to riskier drug use practices, such as needle sharing, were being arrested and harassed by police and had to pay more and go farther to find drugs and access treatment. Despite all of these issues increasing the risks of HIV transmission, and making a population with very high rates of HIV/AIDS harder to reach, organizations with a focus on reaching drug users and supporting them did not challenge the government. As I was told during fieldwork, in 2018 drug users still faced harassment, arbitrary detainment and lacked the outreach and services that they desperately needed.

Another lasting impact of the Tanzanian government's involvement in drug policy, as mentioned in the answer to my first research question, is presenting methadone as an example of comprehensive treatment and using the program to promote abstinence and cure drug use. This vision for drug treatment goes against the principles of harm reduction and does not meet the needs of many people who use drugs. Seen as a whole – from legal, social and health-based perspectives – Tanzanian drug policy is a continuation of the war on drugs and is having harmful effects on people who use drugs. In hindering the development of harm reduction supports and eliminating needed services for drug users, the Magufuli regime has delayed the development of better supports for people who use drugs and made life for people who use drugs in Tanzania much worse.

Shaping perspectives and justifying policy – the ongoing war on drugs and the role of Tanzania

In answer to my third research question, I argue that The Tanzanian government is producing the narratives of drugs hindering development and causing corruption to justify policies focused on the eradication of drugs in the country through abstinence and punishment. These narratives are being accepted and supported by donors such as the United Kingdom in the name of

development. Foreign agencies, working in HIV/AIDS in Tanzania, also accepted these narratives and were forced into a situation that required their obedience, even as these policies and crackdowns reduced their ability to reach the vulnerable populations they are trying to serve.

In answering this question, I describe the material and epistemic roots of the war on drugs, and focus on the dominant war on drugs narratives often applied to African countries in academic and policy literature – drugs as a hindrance to development, drugs as a security threat to be eradicated and drug users as a vector of disease, causing health crises. I illustrate that these narratives are being influenced and shaped by Tanzania and are, subsequently, contributing to the continued ideology that drug users still deserve punishment, harassment and limited access to needed services. In this ideological framework, treatment is a top-down option that does not reflect the perspectives of drug users themselves, harsh measures are justified to limit the supply of drugs in the country, regardless of whether human rights are respected, and incarceration and police harassment are needed to end the corruption drug use causes.

As with other areas where African governments have been shown to be contributing to agendas for their own benefit, such as the securitization of development, in the less prioritized area of drug policy, the Tanzanian government is shaping and determining policies aimed at reducing donor influence and denying human rights to people who use drugs. From the outside, it may appear Tanzania has a strong harm reduction focus given its status as a relatively poor African country. However, it is the framing of their program as comprehensive that supports an agenda of overall repression and control. As I show in later chapters, treatment in Tanzania is not comprehensive and, when coupled with the crackdown on drug users and the elimination of harm reduction services such as drop-in centres, is a model that does not support the needs of people who use drugs.

This thesis explores the discursive relationship between development discourses, the domestic discourses of the Magufuli government and the implementation of drug policy. The narratives of drugs hindering development are found in policy literature from major donors and international funding bodies yet, during fieldwork, I found this narrative coming from the Tanzanian government and not from any donors or foreign agencies in the country. Further, the Tanzanian government, in official rhetoric and policy, implies that drug users are a source of corruption and

vice. The government employs this narrative to both stigmatize drug users and justify its repressive actions, but also to obfuscate the greater challenges facing the Tanzanian state, such as poverty and corruption which are not caused by drug use.

As the global consensus on drug policy shifts to be more inclusive of treatment, the model presented by Tanzania, in appearing more inclusive and supportive of drug users is being accepted at the international level as valid and reasonable. The Tanzanian drug war still persists years after it was declared and the government is continuing to sideline donors in pursuit of an agenda that increases executive power. As the state encroaches more and more into areas of drug policy, and reduces access to essential services for drug users, the international community seems to accept this state of affairs, revealing a lack of commitment to actually protecting the health and welfare of people who use drugs.

In addition to the Tanzanian government crafting narratives around drug use in the country, this thesis highlights the structural aspects of policy implementation, including police harassment of drug users, the closing of harm reduction centres and the removal of basic health and social supports for drug users. I describe both the discursive relationship between war on drugs policies and the real world impacts of these policies which produce and reproduce the powerful epistemology behind the war on drugs. In analyzing the Tanzanian government's use of narratives and framing of drug use, I show how an aid-dependent country with seemingly little stake in the ability to influence international policy frameworks, is crafting a war on drugs ideology to justify domestic political goals and sideline more powerful actors.

Contrary to the idea that African governments do not have agency in shaping domestic policy, and influencing international policy norms, this thesis provides an example that supports the theory of African agency, showing how an African government is able to shape policy despite limited access to resources. As Jonathan Fisher notes, 'agency can be carved out by even the most aid-dependent African states' (Fisher 2013:97). I apply this idea to a highly aid-dependent state, Tanzania, and to the war on drugs, to provide an example of how the Tanzanian government 'carved out agency' in driving the development of policies and beliefs that surround drug use, as opposed to the foreign actors working with drug users in the country driving a more progressive agenda.

1.3 Contributions of this thesis

In this thesis, I seek to position Tanzania within the international context of drug policy debates and provide an insight into the impacts of drug policy on the ground. I also seek to address, through the use of concepts such as extraversion, the question of how policy is determined in a country that is highly aid dependent with a number of foreign actors involved in domestic politics. In examining this question, I use a relatively unexplored area, drug policy, to highlight the ways in which a government can maneuver and determine policy. I also add to the literature by studying a country that attracts little scholarly attention in terms of drug policy and where few works explore the realities of drug use.

Few studies also look at the formation of domestic drug policies and how these interact with global policy debates and norms. Studies on war on drugs policies, as they are practiced in many unique contexts, have not fully engaged with countries such as Tanzania, the domestic and international aspects of policy formation, and how unique historical and cultural contexts, as well as unique political moments, impact drug policy change. Questions remain as to why such a suite of defective policies are put in place by governments across the globe, yet few studies have sought to examine their implementation at the domestic level, their effects, and how international influence plays a role. Even fewer studies use the example of a country not considered relevant or important in such policy debates.

In the case of the war on drugs, Tanzanian policy interacts discursively with an evolving discourse on drug use which is adapting to calls for more progressive policy. This adaptation increasingly looks like the Tanzanian war on drugs – concessions to allow very basic treatment for people who use drugs, while continuing to limit access to services and deny the human rights of this population. The fact that Tanzanian government officials have spoken in support of harm reduction abroad while their president uses inflammatory language and imprisons and harasses people who use drugs challenges simple understandings of complex policy issues. Instead of substantive and meaningful change, change which would reverse decades of epistemic assumptions around drug use, war on drugs policies are being adapted and changed by government and international institutions. Harm reduction is increasingly integrated into a comprehensive drug control framework, which still includes all of the policies of the past.

The narratives of drug use have changed little and allow for the government of Tanzania, along with its counterparts, to implement basic health supports for drug users while targeting them legally, stigmatizing them and creating policies that do little to address their needs. As conservative authoritarian governments proliferate globally, there is a return to targeting vulnerable populations. In this context, understanding and promoting harm reduction, not as a simplified way to discipline and reform drug users, but as a policy change inclusive of the needs and desires of drug users is critically important.

While scholarly works have addressed African agency in relation to other policy issues such as democratization or securitization, the war on drugs has not been used as an example of how African countries can contribute to policy change and understandings. As mentioned, few studies consider the policies of African countries towards drug use at all. This thesis takes drug policy in an African country seriously in how it may shape narratives and influence global policy debates, while also showing how countries with few resources can manipulate and shape a global policy framework. Further, these arguments fill a gap central to this thesis, people who use drugs and their perspectives are at the heart of the study and reveal important gaps in how drug policy is currently developed.

Considering the context of Tanzanian politics and history, and the long relationship with donors and NGOs entering the country from outside, I also wanted to illustrate how policy and rhetoric were influenced by these international actors. Tanzania itself has long been donor dependent and while this dependency is decreasing, health care, and more specifically funding for HIV/AIDS interventions, remain largely funded by donors. The evidence I found of how the war on drugs impacts people who use drugs and how policy is implemented for these people shows that, despite the large number of foreign actors involved in this sector, these actors have done little to challenge the punitive policies of the Tanzanian government.

The government not only ignored donors, Magufuli runs a dangerous line between alienating them completely and using valuable resources to go after people with limited ability to challenge him. The Tanzanian war on drugs is not just an attempt to consolidate power, but is genuinely intended to discipline and order society along a strict moralistic vision. Magufuli's challenges to donors are answered at times with rescinded aid or threats of removing funding. For the most part,

however, donors continue to be along for the ride, supporting top-down and centralized government control in Tanzania, just as they did during the years of one-party rule. The moral nationalism and state power being promoted by Magufuli is a vision which is well suited to incorporate war on drugs ideology, an ideology rooted in decades of creating and re-creating the notion of people who use drugs as criminal, weak-willed and a vector for disease.

A final, but important point underlying my approach in this thesis is that new policies and epistemologies are needed to support drug users. While the war on drugs has already attracted a number of critiques that I review in the next chapter, few studies consider the deep roots of why these policies are trapped within an epistemic framework that pervades even progressive approaches to drug use such as harm reduction. A new approach that considers the inherent human rights of drug users, their needs and the systemic factors that prevent them from getting the supports they need is important and this study is intended as just one of a growing number of works that advances a new approach.

1.4 Research design and thesis plan

In this thesis I adopt a qualitative approach, utilizing participant observation and interviews with a number of individuals in Dar es Salaam directly involved in issues of drug use and policy. I use Tanzania as a case study as it is an example of a surprising policy reversal and the full context of drug use and policy in the country had yet to be explored. My past experiences in Tanzania also influenced my choice, as I studied the popularity of the ruling party there in 2013. Since that time, the ruling party underwent a challenge to their power in the 2015 elections and went on to undertake a number of controversial decisions including reforming drug policy. Finally, while there are studies on the methadone program in Tanzania and on drug use, few of these studies explore the experiences of drug users and the policies being enacted by the government.

I use the evidence gained from my fieldwork in fall 2018 to question the narratives on drug use in the country and to show the realities of drug use. Using qualitative methods allowed me to dig deeper into issues of drug use, moving beyond statistics or the numbers of attendees at methadone clinics to show how people who use drugs experience and understand the policies governing their lives. I use a constructivist approach to better understand how a war on drugs ideology develops and

the deeper, epistemological constructs that influence how policy is implemented and understood. I designed my research and fieldwork to align with the need to recognize the perspectives of people who are directly involved, on the ground, in drug use and to challenge how narratives are crafted.

In the next chapter, I set the basis for my arguments above by explaining my methodology and describing my fieldwork. As mentioned, I apply a constructivist lens to the war on drugs and set my arguments within the works of Stephen Brown, William Brown, Jean Francois Bayart and Jonathan Fisher, all of whom highlight the agency and strategies of African governments to participate and influence larger global systems and policy debates. In exploring these works I was particularly influenced by how countries such as Uganda and Kenya framed narratives to suit their needs, leading donors to misunderstand the full and complex political picture of the country and participate in undermining their own goals, such as democratization or fighting terror. I found that drug policy, while not as high a priority, is similarly reduced in its complexity and, despite donor involvement, pursued in a way opposed to donor goals. Applying extraversion to the war on drugs is a novel approach that highlights how a country such as Tanzania positions itself within a global policy framework and, despite its subordinate position, is able to pursue its own policy agenda. I set up the theoretical framework to also show how, in pursuing its war on drugs, Tanzania is influencing how drug policy is understood in the region.

In chapter 3, I review the existing literature on the war on drugs and drug use in African countries. I review how the war on drugs policies were initially crafted, creating a powerful epistemology that persists in preventing alternative approaches to people who use drugs. I then define and place harm reduction within this context, to show how difficult it is to overturn decades of failed policy and try to see people who use drugs as deserving of human rights. This chapter sets the stage for my later arguments which show how harm reduction, as it is being pursued in Tanzania and many other countries, is in fact still subordinate to a larger war on drugs approach. Finally, I look at the literature on drugs in Africa to show that gaps still persist in how drug policy is understood, particularly in considering people who use drugs, drug policy and how it shaped, and the interaction of domestic drug policy with the international.

In chapter 4, I build on the previous chapter to illustrate the actual structures that upholds a war on drugs ideology, through governance, funding and international consensus. The structural

aspects of the drug war are important, as it is not simply an abstract ideology, but rather a set of policies with devoted resources that are aimed at criminalizing drug use and are upheld by international structures of policy development and consensus building. I then turn back to Africa to show how the broad implementation and understanding of drug use is governed by three narratives that are often been applied to drug policy in African countries – drugs as a cause of security crises, drugs as a threat to development and drugs as a public health crisis. I illustrate how the use of these narratives by the Tanzanian government justifies increased war on drugs style policies that do not lead to better supports for people who use drugs.

Chapter 5 provides a background on Tanzania as my case study. In alignment with my approach that considers the social, cultural and historical context shaping drug policy, I argue in this chapter that of particular importance to Tanzania's drug policies are its history of aid dependence, authoritarianism and moral socialism all of which, to some extent, are a legacy of the country's first president. These factors all influence how Tanzania is currently dealing with its drug policy, sidelining donors, using moral and inflammatory rhetoric against those who do not belong and using repressive policies to bolster the centralized power of the ruling party.

Chapter 6 delves deeper into drug use in Tanzania, highlighting drugs users' experiences, policy gaps and funding shortfalls prior to the election of John Magufuli in 2015. This chapter sets the stage for chapter 7, where I show the impacts of policy changes and crackdowns on people who use drugs. I argue in chapter 7 that the government of Tanzania undertook both high profile crackdowns while also working to change policies towards abstinence-based approaches. Despite the large number of NGOs and donors working in the sector and trying to oppose these changes, the government was effectively able to determine how drug policy should change and hinder the activists, NGOs and INGOs whose work was impacted by these changes for the worse. Chapters 6 and 7 demonstrate the extent to which policy is determined by the Tanzanian government in ways that violated the health and human rights of people who use drugs.

In chapter 8, I use the evidence established in chapters 6 and 7 to position Tanzania and the war on drugs as a telling example of African agency in the face of donors with greater resources. I argue that the Tanzanian government crafted policies and narratives that not only determined how drug use is dealt with in Tanzania, but also that it implemented policies that are reflected in an

evolving international consensus determined at the United Nations, and agreed upon by member states, on how to deal with people who use drugs. In this chapter I show the efforts of the Tanzanian government to frame approaches to drug use in Tanzania and contrast these efforts with the challenges and obstacles faced by international organizations in overturning policies opposed to their goals in reaching vulnerable people. I illustrate here how Tanzania frames drug use as a problem to be eradicated and dealt with through abstinence, justifying repressive policies that hurt drug users and exist within continued understandings of drug users as criminals and drug use as a disease.

Chapter 2
Theoretical Framework and Methodology

2.1 Introduction

The narratives surrounding illicit drugs provide a fascinating example of how economic and moral values are attached to substances, which are seen as a major threat to almost all aspects of society. In international relations, dominant positivist approaches attach a high level of meaning to drug use, and to people who use drugs, in which the drug itself is seen as a threat to security, economic stability and development. The people who use these substances are likewise crafted as threats and failures, unable to contribute to development or be constructive members of society.

In this thesis, I rely on a more critical, constructivist approach to disassemble the dominant narratives surrounding drug use and interrogate 'the empiricism and positivism that underpin the dominant theorizations' (Ayers 2008:4). A critical framework seeks to position the construction of illicit drugs as an inherent threat in terms of socio-economic context and historical moments. This framework also shows how illicit drugs and drug use have linkages to production, economies and power, with the narratives surrounding them constructed and re-constructed at different times in order to serve a number of different purposes. In this chapter, I outline this constructivist theoretical framework and my methodology to examine how the war on drugs is being constantly negotiated and renegotiated with deep ontological roots that make it profoundly difficult to reverse.

Constructivist approaches do not take 'institutions and social and power relations for granted but [call] them into question' (Cox 1981:129). Drugs themselves, as substances, are well positioned for a constructivist approach as positivist or strictly materialist approaches attribute material forces 'with intrinsic meanings and causal powers that in fact they enjoy only in virtue of the contingent social relations in which they are embedded' (Wendt 2000:169). In his work reviewing critical approaches to international relations, Alexander Wendt emphasizes the structuralism of a constructivist approach, and how constructivists see structures not as strictly material but produced by 'shared knowledge, material resources and practices' (Wendt 2000:73). In other words, the materiality of the war on drugs is mutually constituted by ideology and narrative building. The example of the Tanzanian war on drugs is a novel example of how the Tanzanian state, through its

practices and its framing of drug use in the country, is able to participate in 'processes of interaction [that] produce and reproduce social structures' and 'shape actors' identities and interests' (Wendt 2000:81). The inclusion of Tanzania in a global order of states participating in the war on drugs, which states continue to support both materially and ideologically, allows examination of African agency in a new context.

While I do not intend to delve deeply into debates on agency at the international level, it is important to note how structure and agency construct and reconstruct the global drug war and how states like Tanzania, participating in this global order, utilize their limited agency to influence these structures. A constructivist approach relies on examining material structures that are shaped discursively by ideas and narratives, opening opportunities for African states to participate in framing narratives and influencing policy structures. As Jonathan Fisher notes, 'in analyses of African agency at the global level, "structure" and "agency" are understood as being mutually constituted with structures being malleable and open to reform or reconstitution on the basis of their interactions with key actors' (Fisher 2013:538). Too often, African state actors are left out of analyses of international policy structures and, in work on the war on drugs at the international level, few studies have included how African states interact discursively with the global policy consensus continuing this failed war.

In traditional international relations approaches, drugs are considered an existential threat and states are rational actors seeking to reduce a legitimate danger to their country. This formulation leaves out much greater complexity behind how drugs enter countries, whom they impact and how they interact with the state. A constructivist approach highlights the constructed nature of drugs as a threat, and the structures and outcomes produced by state and non-state actors that perpetuate this epistemology. The continued ideological support for the war on drugs by states domestically and internationally likewise justifies repressive policies. As Dominic Corva argues, with reference to the Americas, 'narco-disorder has been scripted into global space, justifying illiberal modes of intervention inside and outside of the U.S.' (Corva 2008:182).

A theoretical approach that does not consider how the war on drugs is used to support illiberal interventions, can serve to justify this war itself or prop up the ongoing crisis narratives surrounding drug use. State-level analysis and the drugs' threat to society remain dominant in

informing policies around drug use, even as the impacts of these policies on drug users have become clearer. At the international level, as Emily Crick states, 'the global drug prohibition regime continues to remain pre-eminent despite the wealth of unintended consequences it causes' (Crick 2012:407).

In this thesis, I assume that the global war on drugs is a construct, a policy discourse that serves a variety of purposes and is intimately tied to social, economic and political interests. A constructivist approach, while acknowledging the materialism of the drug and economies and practices surrounding drug use, lends more emphasis to the social construction of the material as a threat, how the drug itself, and reactions to it, are shaped socially. Or, in the words of Alexander Wendt, how identity and interest formation take place (Wendt 1992). This approach deconstructs casual theoretical assumptions such as drugs being a threat to development, drugs corrupting youth and drugs causing criminality. My objective in using Tanzania as a case study is to 'assess the causal relationship between practice and interaction…the relationship between what actors do and what they are' (Wendt 1992:424). In Tanzania, this approach involved understanding the outcomes on the ground and how policy discourses and practice constitute an identity and reality of Tanzania as a moral, strict, developmental state in which drug use is non-existent. Deconstructing common narratives reveals that drug policies are the actual causes of corruption and criminality.

This thesis also seeks to expand upon the role of international norms and policy frameworks at the domestic level, where narratives are contested and transformed by state and non-state actors operating on the ground. In comparative politics, constructivist approaches attempt to illustrate the ways in which framing, constructed narratives and ideas are used as tools by the state to develop and maintain power. As Timothy Mitchell notes, 'we need to examine the detailed political processes through which the uncertain yet powerful distinction between state and society is produced. The distinction must be taken not as the boundary between two discrete entities, but as a line drawn internally within the network of institutional mechanisms through which a social and political order is maintained' (Mitchell 1991:78). Assuming the state is constructed means the policies enacted by it rely on ideology and narrative framing as much as the use of force to create and maintain state power.

In an authoritarian country such as Tanzania, where material resources are low, the use of narratives and ideas has enabled a relatively weak state to exercise some power over its citizenry, from major top-down projects such as Ujamaa, to the war on drugs in the present. Edward Schatz refers to the 'state's ability to frame political debate' as 'the cement of soft authoritarian rule…defining the political agenda and channeling political outcomes' (Schatz 2009:203). Lisa Wedeen explores the nature of power produced in domestic contexts through symbolic displays of power and how 'symbols themselves create, sustain and undermine the disciplinary circumstances through which any regime exercises some of its power' (Wedeen 2002:726). As I show in this thesis, the Tanzanian government is able to pursue its anti-human rights agenda through framing and persuasion. The use of the concept of 'symbolic power' or 'the ability to make appear as natural, inevitable, and thus apolitical, that which is a product of historical struggle and human invention' (Loveman 2005:1655), is an important way in which policies and state actions can be considered social constructions aimed at disciplining a portion of the population.

The war on drugs is a fascinating example of how states attempt to exercise power over the practice of drug use, which is notoriously difficult to control, and therefore must rely on framing narratives and how intimidation and fear are used as tools in implementing this war. In creating a crisis narrative, positioning drugs as a threat to development and a cause of moral decay, the government of Tanzania is actively framing political debate and shaping understandings of drug use in the country. While not a 'tradition', Hobsbawm and Ranger's idea of invented tradition is useful here:

> 'Invented tradition' is taken to mean a set of practices, normally governed by overtly or tacitly accepted rules and of a ritual or symbolic nature, which seek to inculcate certain values and norms of behaviour by repetition, which automatically implies continuity with the past (Hobsbawm and Ranger 1983:1).

In chapter 5, I show how the government of John Magufuli is involved in the invention of tradition in many ways, using clear connections with the past to justify policies in the present. I quote Hobsbawm and Ranger here as a way to understand the constructed nature of the war on drugs and how governments frame and attempt to produce beliefs and ideas through the creation of narratives similarly falsely linked to a past. The quote above also helps explain why drug wars are often framed

as a return to some mythic past, which in Tanzania recalls the moral, one-party rule of the country's first president.

In this chapter, as I examine illicit drug use in Tanzania, this approach is a lens to deconstruct the narratives not only of drug use in general, but drug use in Africa. Africa itself is the site of many constructed narratives that, when applied to drug use, combine to support negative images of countries in Africa where drug use is widespread. Understanding the constructed nature of drug use and policy, as outlined above at the domestic and international levels, provides a way in which African agency can be explored. Global policy debates and academic work often depict African countries as themselves victims of external or foreign drug wars which are assumed as being spread by more powerful Western countries. My theoretical framework, however, while acknowledging the influence of the West and the United States in particular in crafting the war on drugs as a dominant approach, relies on works which analyze the contribution of countries considered peripheral in the construction of these discourses. More specifically, I draw upon the works of Stephen Brown, Jonathan Fisher and William Brown who all show how African countries manipulate and shape global politics and do not passively receive dominant policy directives from donor countries.

William Brown and Sophie Harman, in their 2013 edited volume, *African Agency in International Politics,* note that African studies 'has for a long time been dominated by a concern to explain how the continent has been governed, shaped and marginalized by external actors' (Brown and Harman 2013:1). The chapters in this book seek to address 'how African actors exert agency in international negotiations; in peace, conflict and intervention processes; in transnational security issues; as well as reflecting on the implications of African agency for International Relations theory' (Brown and Harman 2013:2). Through the concept of framing narratives, I seek to expand on this literature and provide an example of how an African state, despite constraints, is able to frame an issue effectively and thus create the conditions in which domestic policy can be enacted. As Peter Haas argues:

> how states identify their interests and recognize the latitude of actions deemed appropriate in specific issue-areas of policymaking are functions of the manner in which the problems are understood by the policymakers … control over knowledge and information is an important

> dimension of power and that the diffusion of new ideas and information can lead to new patterns of behavior and prove to be an important determinant of international policy coordination (Haas 1997:74).

The influence of framing in the identification of interests and priorities at the international level emphasizes the ways in which African states, despite their lack of material power, can contribute to international policy debates.

In this thesis, I apply a framework that challenges assumptions of African state marginalization in the international sphere to the war on drugs, an aspect of policy study that has not been explored in this way. The war on drugs in Africa is similarly influenced by these assumptions, as the UNODC's top donors are powerful Western countries, as well as China and Russia and again, it is assumed that 'the power of the purse shapes the range of options presented by international organizations and therefore dictates what is considered acceptable and what is dubbed untenable' (Hollender 2016:23). Few studies explore the issue from African perspectives, or 'the bottom-up', to understand how African countries are not only linked into dominant prohibition approaches, but promote and pursue these approaches themselves.

Jonathan Fisher has shown the ambiguous influence of donor countries in promoting democracy (2013) and how the use of securitization narratives (2014), allowed an authoritarian country, Uganda, to pursue its interests and shape American interests in the region. William Brown (2013) makes the case that aid does not undermine African sovereignty but can influence some policy areas. The work of these scholars is important for this thesis, as my argument is not meant to dismiss the influence of western donor countries, but rather clarify that influence and examine its discursive relationship with domestic governments in Sub-Saharan Africa. Stephen Brown and Rosalind Raddatz make this clear in their work on democracy in Kenya, stating that 'a more complete account of donors' ability to influence domestic policy thus depends on both structure and agency, including the agency of both donor and recipient governments' (Brown and Raddatz 2014:46). Likewise, the desire to stop the flow of illicit drugs may align for both the Tanzanian and American governments, with the threat magnified and utilized by Tanzania to support a domestic policy hostile to people who use drugs.

I also employ the theory of extraversion, coined by Jean-François Bayart, which is a useful contribution in considering the discursive space in which policy is formed internationally and domestically. Bayart argues that the dependence of African countries on Western countries was not passive but rather a strategy of extraversion – where African elites or governments use their subordinate position in global politics to serve their own agenda (Bayart 2000). Taken with the works discussed above, the examination of the war on drugs in Tanzania can be analyzed within a framework inclusive of the agency of African governments and a number of other competing sources of influence, from NGOs to Ministries, in shaping policy.

The influence of African governments is an unexplored area in shaping drug policy, despite the increasing importance of the continent as a trafficking route and a site of increased drug usage. In this thesis I intend to show the influence of Tanzanian in supporting its goals to marginalize drug users, reduce access to services and goes against harm reduction. Furthermore, a simple line of causation between Western countries influencing policy discourses ignores relationship that exists between donors, Western governments, NGOs and African governments in producing new configurations of political power and policy.

2.2 Thinking about drugs in Africa: constructivism, extraversion and agency

Extraversion on drugs

Extraversion, a concept theorized by the influential Africanist Jean-François Bayart (2000), was an important intervention in the study of African politics. Bayart argued in his work that the seeming lack of agency of African countries in the international system and global economy could be seen as a mode of action, rather than simply the dependence argued previously by Marxist dependency scholars (Bayart 2000:248). Through extraversion, Bayart provided 'a way of bypassing the sterile argument between promoters of an international civil society and those critical of the neocolonialist grip of international actors over some African protesters' (Pommerolle 2010:264). The theory of extraversion provides a way of understanding the power inequities of some African states in the international system, while also considering these states as legitimate actors with distinct agendas and motives. Noting the sometimes limited nature of African agency within global systems

is also a way to open up space where interactions can be understood more fully, without simplifying complex relationships and discursive policy formation.

Bayart shows how African political elites, recognizing their limited options in an international sphere, maximize their benefit and manipulate global systems to their advantage. In this sense, 'Africa's contemporary political struggles and wars are not the consequences of a radical rupture – colonization – but are symptomatic of a historical line of continuity, namely, a practice of extraversion. They are not an expression of the marginalization of Africa within the world economy but of older dynamics (or occasionally of very new ones) generated by the manner of its insertion into this world economy' (Bayart 2000:237). While it is disappointing to still have to point out that African actors, like any others, have agency, Bayart's work remains important in bridging the gap between dependency and the more limited options available in African countries, many of which are dependent on official development assistance (ODA), foreign direct investment (FDI), and Western support more generally.

While Bayart utilized this concept to discuss African politics, extraversion is also a useful way to understand how the war on drugs in African countries is applied and to how drug policy is developed. Extraversion considers African societies over the longue durée and, as I mentioned earlier, when applied to drug use, takes into consideration the economic, social and cultural contexts in which drugs exist along with the insertion of African states into a global drug economy. A perspective inclusive of a larger historical and socio-economic scope avoids a war-on-drugs, one-size-fits-all discourse in which drugs proliferate in a void where generic policies, often originating in Western countries, can be implemented. When countries replicate, utilize and reproduce a dominant discourse, this strategy can be considered not as a reflexive obeisance to greater powers, but a viable strategy in itself. The theory of extraversion allows for a more integrated analysis of the war on drugs in which African countries are not passive receptors of a discourse but active interpreters and promoters. Again the inclusion of African states in policy development reflects the challenge Bayart offers of the assumed relationship between African countries and the international system:

> [Extraversion] by-passes a sterile distinction between the internal dimension of African societies and their insertion in the international system…The interaction between Africa and

> the rest of the world cannot be considered as a relationship, since Africa is in no sense extraneous to the world. (Bayart 2000:234).

Rather than view the war on drugs as an outside influence on African states, this statement supports the notion that this war is a part of an international political system in which African states act and influence policy development.

Extraversion has since been used more radically to show how African polities have maintained continuities with their precolonial pasts (Chabal and Daloz 1999), and by other authors (Hibou 1998, Pommerolle 2010) who use the concept to examine African political trajectories in a globalized world. My goal here is not wade into the debate of dependency vs. unique African political trajectories, but rather to take into account both concepts to develop a fuller picture of drug cultures in East Africa and their interaction with Western ideologies of prohibition and control. Illicit drugs, given the energy devoted by the United States and international agencies to ensure they are viewed as a menace, represent a locus for competing discourses. These discourses vary, but are subject to arguments over whether drugs and drug policy should be considered from public health perspectives, cultural and social perspectives, as a method of controlling and pacifying the poor, as instruments of chaos or, as substances to be eradicated. Utilizing extraversion, I argue that African states can be considered a part of the production of the negative, war on drugs discourse that persists in the international system.

The domestic space of African countries is subject to these competing discourses in a unique way as it is inclusive of numerous actors, international and domestic, within one geographic space, collapsing distances between a simple line of external versus domestic political influence. The presence of numerous international actors within the domestic space, however, does not necessarily reduce the ability of African political elites to exert power. As Pommerolle notes, the 'monopoly of international relationships enjoyed by ruling powers' was compromised, with new actors and agents, not subverting extraversion but rather making dependency and this relationship more complex' (Pommerolle 2010:267). In other words, the presence of international actors in areas such as the war on drugs, may complicate the relation of African governments to the international, but it does not always reduce the influence of African powers to steer their own course in creating and enforcing policies. For instance, the policies enacted by the Magufuli government, while still maintaining an

authority and connection to the international sphere, exist among competing actors with interests both aligned and opposed to this policy framework. As I show in later chapters, drug policy in Tanzania is not only subject to a number of actors and narratives, but, is also an area where the government still exerts control, demonstrating a more complex example of dependency and extraversion in policy creation.

The framework of extraversion, along with studies which have shown the utility of African countries shaping and altering policies, provides a fuller picture of how the war on drugs functions as an international discourse and interacts in the domestic sphere. Understanding the constituent parts making up the war on drugs within states also illustrates how this global war is tied to a framework and infrastructure, part of numerous interests and political economies and producing a number of intended and unintended outcomes. Understanding the domestic ability to pursue a war on drugs, even in countries with seemingly little capacity, can also help account for the durability of the war on drugs and its accompanying beliefs. Countries such as Tanzania contribute to the continuation of the war on drugs and help transform how it is implemented and practiced for a number of reasons, despite the obvious failings of these policies. The concept of extraversion is important, but it does not go far enough in acknowledging the influence of African states in shaping global policy. As I explore below, African actors are not only inserted into global policy discourses, but are active in influencing and contributing to understandings of the issues facing their countries and the best ways to address them.

African actors and the creation and reproduction of global policy discourses

Donor engagement with Africa is a subject of comprehensive academic focus, with the major tropes of study viewing official development assistance (ODA) as a way of promoting democratic development or as a continuation of colonialism, with Western donors leveraging their influence to promote a neo-imperialist agenda on the continent. In this section, I look at how these underlying assumptions of Western influence need to be challenged. As noted in the introduction, literature on aid-dependent African states, which are often considered weaker in advancing their agendas in the international sphere, can limit their agency. While several scholars have attempted to show how this influence should be understood with a renewed focus on African government agency, the war on drugs is often considered as emanating from powerful states, with the US as the

most influential state in holding up the war on drugs (Hollender et al. 2016:24). While I do argue in this thesis that the war on drugs was initially propelled by major US support and that, at the international level, there continue to be greater resources given to prohibitionist policies, African states have come to play a role in the enduring war on drugs.

Despite a lack of resources and a weaker position in the international sphere, Tanzania is not being forced to undertake a war on drugs to access resources (including ODA), nor is the state a major priority in the international war on drugs. Tanzania instead is actively pursuing a war on drugs in its own interest, through both policy change and public crackdowns. The ability of the Tanzanian government to do so is an example of an African state, which is in some ways limited in the international sphere by its aid dependence, to move within global policy debates and discursively reproduce and harness these for its own ends.

Agency should be understood in how it interacts and shapes foreign understandings of policy issues in African countries. For example, works by Stephen Brown and Jonathan Fisher have shown that the agency of African governments is undervalued when it comes to shaping policy initiatives often associated with Western governments such as democracy promotion or securitization. As I am using a constructivist approach, I do not view agency solely in terms of material power, but also as the 'ability to willfully determine and pursue one's own priorities, including the ability to reject external ideas' (Grimm 2013:81). In focusing on ideas as well, state agendas and policy change can be considered not just in light of the material impacts of policy change, but the discursive and ideological impacts of pursuing certain policies. In the case of the war on drugs, the material outcomes of reduced health care and human rights are evident, less so is the continuation of epistemologies that marginalize drug users.

Stephen Brown examines how a number of factors, including donor fears and misunderstandings, contributed in part to the success of the Daniel arap Moi regime in Kenya (Brown 2001). This work effectively shows the number of factors involved in promoting, or in this case failing to promote, democratization. The result is that Western 'intervention can perpetuate autocratic rule while simultaneously providing legitimation via multiparty elections' (Brown 2001:736). Brown's work highlights the ambiguous ways in which Western involvement impacts domestic politics, and how Moi's ruling party manipulated Western interest. In this case, Moi was

not only able to utilize foreign aid to his advantage, but also benefited from the legitimacy that the continued support of Western powers lent to the country during elections. Specific political calculations by the Moi regime satisfied donors, and the regime was therefore able to pursue its objective of holding on to power with little external interference (Brown 2001). As I found during fieldwork, Magufuli similarly used donor fears of being ejected from the country to sideline their interests, while using continued foreign involvement in drug treatment as a form of legitimacy, making his drug war appear less punitive.

This over-emphasis on key outcomes in Kenya, namely orderly elections, furthers the idea of extraversion and challenges assumptions that African states are passive recipients of foreign aid. Complex issues are simplified both by western donors and the political leaders that benefit from their interventions. The result of simplifying complex issues is the failure to achieve donor objectives while benefiting the domestic government. As Brown states, by 'looking for quick results and avoiding more uncertain but farther-reaching reforms, donors actually forestalled more fundamental change' (Brown 2001:735). The influx of resources from donors does not only provide material benefits, but also less tangible benefits such as the appearance of legitimacy. As I discuss in later chapters, the material benefits of foreign support for healthcare and drug treatment in Tanzania are just one aspect of the government's strategy. The legitimacy this foreign support offers also allows the government to pursue repressive policies while maintaining the appearance of comprehensive supports for drug users.

This argument is furthered by Stephen Brown and Rosalind Raddatz who note that donors have done little to promote democracy in Kenya in the interest of 'short-term decision' making and 'reluctance to use potential leverage over the Kenyan government' (Brown and Raddatz 2013:43). This lack of ability to exercise influence is understood by the Kenyan government, which effectively manages donor expectations while pursuing goals that do not necessarily align with donor agendas. As with donor reluctance to hold the Moi regime accountable in the 1990s, the continued short-term decisions of donors undermine fundamental change and the advancement of democracy. In Tanzania, the quick and easy narratives of stopping the flow of drugs or treating only HIV, appears a worthy goal but ignores the actual difficulty and complexity of supporting drug users and ensuring long-term adherence to treatment. Further, the simplified goals of donors play into the domestic goals of the Tanzanian government which, like Moi and democracy, are actually opposed to

supporting people who use drugs. Finally, as I note in the next chapter, in other countries trying to reduce drug use, the outcome is a status quo in which drug supply is not actually reduced, users continue to be marginalized and money continues to be spent with no lasting changes to drug supply and demand.

In his work, Jonathan Fisher takes the agency of African governments further, showing how, for example, Ugandan President Yoweri Museveni was able to effectively 'frame' the Lord's Resistance Army 'in a way that has persuaded both Washington officials and many of the analysts, advocates and activists who hope to influence them [Ugandan Government] to ultimately adopt its perspective on the "problem", and on the best "solution"' (Fisher 2014:700). In this case, not only is the Ugandan government able to pursue its own agenda, it is able to garner the support of a donor country and decisively shape that country's understanding and political interest in the region. David Anderson and Jonathan Fisher consider this ability of African governments to shape foreign policy, noting that illiberal states are benefiting from a growing securitization agenda, previously only seen as a priority for Western governments, and using it to bolster their authoritarian power (Anderson and Fisher 2015).

Contrary to the idea that policies are foisted upon African states by pushy donors, Anderson and Fisher argue that 'securitization is not something that the west has done to Africa, but rather a set of policy imperatives that some African governments have actively pursued' (Anderson and Fisher 2015:132). Using the idea of the 'donor support rationale' structure, Fisher argues, 'both donors themselves and African governments, along with other actors, interact with it [the donor support rationale] – and can therefore influence the focus and the nature of it. The securing of agency by these governments in this process might consequently be demonstrated by their successful focusing and refocusing of this rationale around donor support "narratives" more favourable to continued direct assistance' (Fisher 2013:538).

Likewise, in Tanzania, Magufuli's illiberal project demonstrates the ability to pursue his own agenda within frameworks and narratives seemingly produced and prioritized by the West. Drugs as a development threat, a health crisis or a source of corruption are all narratives that the Tanzanian government can actively produce and use as ways to shape foreign understandings of drug use in Tanzania and support Magufuli's desire to reduce services for people who use drugs. In allowing the

continuation of methadone, and highlighting this singular intervention as comprehensive harm reduction, the Tanzanian government is also creating a donor support rationale in a policy area that is not deemed important.

As Fisher argues, the failure of donors to shape policies in Uganda and Museveni's ability to pursue his own agendas despite the asymmetry of power is under-theorized in regard to other policy areas (Fisher 2015). The works examined above show the linkages, and often blurred lines, between what appear to be sovereign policies – in both African and Western countries – and the discursive formation of policies between these governments. If African agency is considered in terms of the confluence of structure and agency, the war on drugs is an example where an African state, through its use of limited agency, frames drug use and justifies policies to produce structures that uphold the war on drugs.

The analysis above considers not only domestic goals in forming policy, but the resulting changes in policy at the international level as well. Combining extraversion with these works supports an argument for the participation and influence of African countries on the international stage in global policy formation and in shaping their own domestic policy agendas despite the seemingly overwhelming influence of Western powers. Extraversion is an important starting point in understanding the inclusion of African actors at the global level, and how agency is utilized within limited structural space. However, it is the works by William Brown, Stephen Brown and Jonathan Fisher, among others, that advance the idea of African agency not just operating within a constrained structural moment. African agency is built on both the framing of policy issues and utilizing constructed frameworks to produce structures and outcomes on the ground. In this thesis, I show how the use of framing constitutes agency, allowing the government of Tanzania to pursue goals antithetical to donors and to foreign agencies supporting drug users. As there are very few areas of consensus as lasting as the war on drugs, this example is a good framework through which to showcase how African countries are integrated, and can uphold, a longstanding set of policies still being promoted at the international level.

Bringing it together: African agency, extraversion and the war on drugs in Tanzania

Together, the literature on African agency and extraversion are a useful way to explore the complexities governing drug policy in Tanzania. The framework is flexible in that it goes beyond domestic/international and government to government, including a number of actors such as NGOs, activists and academics influencing policy outcomes on the ground. As the war on drugs continues to be upheld by some Western governments and the Tanzanian government through various strategies, including aid, security, loans, training programs and political support, there is also a grassroots movement opposing the continuation of this war. Unlike in western countries, where local activism to support drug users is largely a domestic affair, in Tanzania activists opposing the war on drugs also include a number of actors and a network of NGOs, former users, medical professionals and harm reduction advocates that are linked through shared goals. This complex field of actors pursuing better services for people who use drugs has created various policy outcomes, programs and initiatives. As legislation and funding remains weighted towards the war on drugs, however, the supports available for marginalized groups most in need of assistance remain inadequate. As I wrote above, the inclusion of a number of actors does not necessarily overcome the Tanzanian governments' role in policy creation.

The framework of extraversion and the linking of an African government in shaping domestic policies and goals with active donor support has not been applied to the war on drugs in African countries. Just as the Ugandan government successfully framed its solution to the LRA, the Tanzanian government has framed its intervention into drug treatment as an effective solution to development in the midst of widespread repression. As Fisher and Anderson note in regard to their theory on donor funding being used for illiberal state-building, 'other types of African states, including those in which democratic institutions and participatory politics appear to be well entrenched, are adopting some of the same strategies' (Anderson and Fisher 2015:150). Despite directly challenging many donors, in some instances causing funding to be pulled, Magufuli has deftly managed to maintain donor funding while pursuing his own agenda. He is also able to argue for aid independence even as donors continue to support major sectors of the Tanzanian state.

The studies I describe here challenge assumptions of passive African reception of foreign policy discourses and directives. African agency has long been a contested space as dependency

theory and positivist approaches to international relations depicted African countries as weak and non-influential on the international stage, manipulated by dominant actors such as the USA. The works of Bayart, and approaches that look deeper at the underlying dynamics of how African countries interact on the international stage, support a more complicated version of how policy and change occur in these countries. I discuss the war on drugs not only in how it is constructed by actors such as the United States, but also how development organizations, the UN, activists and civil society actors contribute to this structure.

While acknowledging the power imbalance between countries, it is still possible to break down areas such as the war on drugs in terms of how it meets multiple needs at once, including security, development, health and authoritarian narratives. Viewing the war on drugs in one African country may seem a minor area to examine. However, the number of narratives and beliefs ascribed to drug use and how it should be dealt with is one way in which the agency of African governments can be explored, and the under-studied role of African governments in upholding a war on drugs epistemology can be seen.

2.3 Methodology

Introduction

My research is based primarily on a qualitative approach that mainly focused on utilizing interviews, semi-structured discussions and participant observation to provide perspectives from Tanzanians involved in the issue of drug use at various levels, from grassroots activists to long time NGO workers. I was able to gain access to interviews with people who provided great insight into the actual lives of people who use drugs. Prior to fieldwork, I had found that much of the research on heroin in Tanzania focuses on health only, using statistics and medical approaches to show adherence to methadone treatment or track the number of users in the country. In contrast, I found few works that explore how medical interventions such as methadone are perceived and conceptualized by those involved, as well as the larger context in which these interventions are allowed politically. I therefore shaped my methodology around a constructivist approach to address this gap, focusing on qualitative data including interviews, participant observation and secondary sources.

As Lisa Maher and George Dertadian find in qualitative studies on drug use in particular, this approach shows:

> How drug use is shaped by complex sets of factors situated within social contexts, viewing drug users as agents engaged actively in social processes and worlds. Their [qualitative researchers] findings have been used to challenge stereotypes about drug use and drug users, develop a deeper understanding of drug use among hidden, hard-to-research and under-studied populations, and provide the foundations for significant developments in scientific knowledge about the nature of drug use' (Maher and Dertadian 2018:167).

I quote this passage at length to highlight the need for qualitative social research in realms often considered criminological or medical only. A qualitative approach allowed me to see the subjects of drug use, treatment and policy as a constructed in a discursive space that is changing and being driven by a number of actors. Given my theoretical approach, the research design described below is reflective of the changing nature of drug use and drug policy.

Case Selection

I chose Tanzania as a case study for a number of reasons. First, drug use in Tanzania is understudied from a political perspective despite its active policies surrounding drug trafficking and use and the wide array of actors involved. Countries such as Kenya also have similar issues. Kenyan drug policies, however, have evolved to be relatively less controversial than Tanzania's. In a reversal of expectations Kenya, having learned from the Tanzanian approach, pursued harm reduction to a greater extent. Tanzania, which led the way in methadone treatment in the region by opening a clinic in 2011 has, since 2015, seen a reversal in policy with an authoritarian leaning ruler who has declared a war on drugs. The results of this policy change have not been studied. Second, I have previously lived and studied in Tanzania. While this research was primarily based on my interest in harm reduction and the war on drugs, I was also interested in how the change in government was impacting and changing the country. Given my somewhat limited time for fieldwork, knowledge of the country and pre-existing contacts were important in getting started quickly once in the country and maximizing my research time.

I chose Dar es Salaam, the largest urban centre in Tanzania with the highest population of people who use drugs in the country, as my fieldwork site. Dar is also the centre of NGO activity, business and, as a port city, is a prime spot for drug trafficking and availability. While there is heroin use in other cities such as Mwanza and Dodoma, there are fewer services, particularly international NGOs, as most are based in Dar es Salaam. Further, I anticipated travel to these cities would not necessarily have resulted in a high volume of diverse interviews. In Dar, the hotspots are well-known and accessible due to the larger NGO presence. The situation in other urban centres was unlikely to provide a much different perspective on drug use and rural areas would have been difficult to access, as the majority of heroin use is only documented in urban centres.

I received no funding for fieldwork, which limited my ability to spend a lot on travel and spend time outside of an area where I was able to establish connections among NGOs and people involved in this sector. I was able to connect with NGOs in Dar and build connections with a network of sober houses and outreach organizations across the city. I travelled to some locations several times to continue to develop relationships and observed several hotspots. I have chosen to keep these organizations and individuals anonymous. I was in contact, however, and spent time with certain outreach organizations and sober houses more than others, observing outreach and having several discussions. In writing, I will refer to interviewees by the specific neighbourhoods or districts where I undertook the interviews. As seen by the map below, this involved time in specific areas known for drug use such as Temeke and Kigamboni.

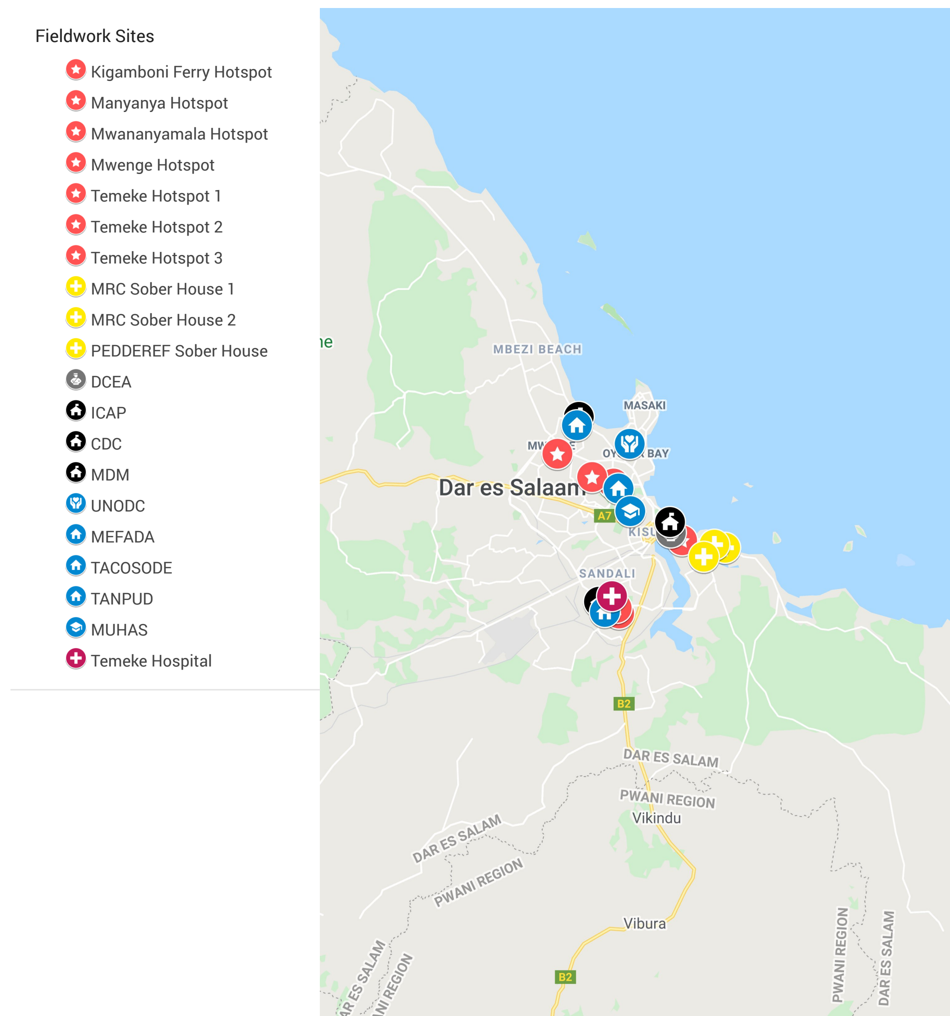

Figure 1. Main Research Sites and Organizations in Dar es Salaam. Image produced by Google Maps.

Data collection

I received ethics approval from the University of Ottawa on December 11, 2017. Despite submitting my application for Tanzanian research approval in early June 2018, I only received approval from the Tanzania Commission for Science and Technology (COSTECH) in September

2018 after repeated attempts to expedite the process. Fellow researchers faced even greater challenges and delays. I undertook fieldwork in Tanzania from August to November 2018. As a result, August 2018 mostly involved preparing, making initial contacts and securing this permit.

I followed the process of receiving approval through COSTECH as directed. However, it should be noted that this organization has become increasingly politicized in recent years. Several researchers I talked to, both foreign and Tanzanian, noted the difficulties in working through COSTECH since Magufuli came to power. For Tanzanian researchers, the compromised research approval process is a concern as Magufuli has worked to align research priorities with his vision for development. At the Muhimbili University of Health and Allied Sciences (MUHAS), researchers told me there are increased reporting requirements and a lack of funding for research outside of the priorities set by the government. Another troubling development was the banning of a Human Rights Watch report critical of the government in 2017. Immediately prior to my arrival, COSTECH issued a letter to Twaweza, an organization that published substantially decreased approval ratings of Magufuli's presidency, notifying the organization that they had violated research guidelines (Amnesty International 2019:26-27). This story is illustrative of the difficulties being faced to produce evidence-based research in the country. It remains important to follow the protocols of the country in which I was doing research, but I found it much more difficult than previous visits.

While I was able to get a permit, I was very concerned about being able to undertake this research for other reasons. Arbitrary detention, deportation and revocation of permits seemed very possible. For these reasons, I was concerned about talking to the government. As my research reflects, the government was not terribly cooperative and the methadone program was a particularly sensitive area. For example, I visited the Mwananyamala methadone clinic five or six times, each time being referred to another individual. Eventually, approval to undertake interviews required the involvement of the head of this hospital who required the approval of Health Minister Ummy Mwalimu directly. As a Western researcher, I feel in no way entitled to access these spaces. However, I found the methadone clinics to be extremely guarded and inaccessible. This experience was an opportunity to reflect on my biases as a researcher, as methadone in my perspective is not contentious whatsoever, while in Tanzania it seemed highly controversial (to those in power, not to people on the drug), or was at least presented as such to me as an outsider. Having learned this, and not wanting to test my luck with the government, I decided to focus on the support system, NGOs

and social workers involved in the methadone program outside of the actual clinics. Eventually I did visit the Health Ministry, where I was again given a number of excuses and referrals that did not lead to any interviews.

While I discuss the nature of Western research in Tanzania below, I experienced a high amount of secrecy and worry from colleagues, friends and some interviewees about my research on drug use and methadone. In general, any criticism I made of the government was greeted with concern by interviewees and friends, a reaction I had not experienced in previous visits. During fieldwork for my Master's thesis in 2013, I travelled to rural areas and openly discussed the ruling party with a number of citizens freely. Admittedly, my perspectives on the party and Magufuli are not positive and critiques or jokes about the government were a part of my daily experiences. On this trip, in public areas or in hotels for example, I sometimes met people interested in my work or what I was doing. I was surprised in these discussions that even relatively benign comments caused concern or anxiety.

The overall effect of this, whether I imagined it or my comments could have led to problems, was a feeling of increased control and possibly being watched. Ultimately, it made the research environment much more difficult. Having travelled to Tanzania several times before, I am skeptical about the ability of the government to assemble a surveillance apparatus or security regime capable of monitoring minor researchers like myself. Even writing now, it seems a bit foolish to have taken the fears of Magufuli seriously during my visit. The abstract fear Magufuli has promoted, however, produced a different environment in the country from the most vulnerable to the most privileged. I kept the restricted environment in mind when talking to people who already experienced targeting or repression from the government as to not make their situations worse.

The system of control Magufuli is trying to implement is erratic, with bursts of repression and highly visible acts of power that resemble authoritarianism, but it did not seem organized during my time there. In Tanzania under Magufuli, fear is manifested through rumour and hearsay, subsequently creating an environment in which civic space is shrinking. During fieldwork, there were several examples of Magufuli asserting control and then walking it back. The effect of this assertion of control created the appearance of a government truly capable of a high level of control in society. At the same, there were also crackdowns and physical manifestations of increased political

control. For example, during my time in Tanzania, the government issued a call to publicly list and attack homosexuals, wealthy individuals were abducted and mysteriously returned and, shortly after my stay, two foreign journalists were briefly detained for apparently having the wrong permits for their work. The combination of Magufuli's culture of fear along with his attempts to formalize and control bureaucracies such as COSTECH created an environment where continual delays made work challenging as people were afraid to talk without express permission from superiors (who then also needed permission).

While my approach to fieldwork was not ethnographic, I do borrow the principles of engaging in observation as a way of viewing reality as continually constructed and reconstructed. I found a distance between the attempted construction of people who use drugs as threats and drugs as difficult to find and the reality on the ground. Magufuli's efforts to construct a reality of power, authority and fear have both real effects but are also not fully apparent in those areas, such as drug use, where he has been so vocal. A fellow Tanzanian researcher asked me to remember the resilience and contestation of the Tanzanian people, noting how he had seen people working to fight Magufuli's more repressive edicts, such as intimidating homosexuals. While I agreed, we also shared our concerns over the authoritarian tools available to Magufuli should he decide to fully reverse the democratic advances that have been made in the country over the past decades. In this study, I reflect on the distance between Magufuli's threats, the policies the government has put in place and the ability of the government to fully implement Magufuli's moralistic vision for society. The Tanzanian government's ability to intimidate cannot be fully realized with the constraints of the Tanzanian state. However, the enacted policies do have impacts, even if not intended. I explore these impacts, both intended and unintended throughout this thesis.

Interviews and Participant Observation

Despite some delays, I was able to speak with most of the non-profit organizations I set out to contact, both local and international, directly involved with the issue of drug use in Dar es Salaam. Interviews included an individual at the local office of the United Nations Office on Drugs and Crime (UNODC), local harm reduction organizations involved in supporting access to treatment and sober houses. I also was able to meet with President's Emergency Fund for AIDS Relief (PEPFAR) funded organizations and some academics from MUHAS. The government was

difficult to access but I was able to interview a senior member of the Drug Control and Enforcement Agency (DCEA). My interview selection process evolved during fieldwork. The lack of access to government officials resulted in me focusing more on grassroots efforts to respond to drug use and treatment. I found a strong willingness from these groups as well as international actors to discuss the issue with me. Despite the apparent controversy surrounding drug use that I mention earlier, anyone involved in the issue outside of Tanzanian government control or policy was relatively accessible. Further, communities of former drug users or activists were very open about their own histories of drug use. These interviews provided great insight into the use of drugs in Tanzania.

Some areas I had not intended to explore also became a larger part of my research, such as visiting hotspots or talking to people at sober houses. Through local NGOs, I was able to participate in outreach and connect with people who had lived experience with drug use. I also undertook outreach with methadone support NGOs and was able to see the differing approaches to supporting drug users that exist, almost all built entirely from the ground-up with little to no government support or with foreign funding from major INGOs. Given the goal of simply helping in any possible, approaches often bled into each other, between abstinence-based sober houses offering harm reduction, and harm reduction organizations focusing on abstinence. I did not anticipate the level of access I would have to these groups and am very grateful I was able to have this experience.

Obtaining consent for interviews was of utmost importance and I decided early on, based on the sensitivity of the issue and the apparent fears around this work, that all interviews would be anonymous. While I did undertake interviews with consent in hot spots, I did not approach anyone actively using or intoxicated. I did witness drug use, and at times had informal conversations with people using drugs, but these are not included as data as consent could not be received. Interviews with people actively using are difficult, as heroin use causes a high that is very obvious and prevents discussion. The rush of euphoria typically lasts some minutes, while the fatigue or 'nodding off' lasts much longer. In sober houses, there is a zero tolerance policy so I trusted the interviewees to be sober and received consent. I was careful with this consent as sometimes former users do relapse. For example, I was able to interview the head of a local advocacy organization who was very open and honest about their struggles with sobriety. Over the following months, it became impossible to connect as they were struggling with painkillers and repeatedly cancelled or missed meetings. I

found, as can be the case in recovery models, a lot of openness among these workers about their past experiences and their drive to support others in either accessing treatment or getting sober. I believe that respecting people who use drugs is important regardless of their success or failure in attaining sobriety a goal which, in itself, is often part of the journey and not a final end.

I told every individual interviewed the nature of my project and gave them a handout with information on who I was and my intentions, with a request for verbal consent to be interviewed. I left handouts, which included my contact information, with the interviewees and was clear that they could withdraw verbal consent at any time. Some organizations, concerned about funding and about criticism of the government, requested that I not use their information. As this is a sensitive area, the main concern of all involved was the potential of the government shuttering their services completely which, as I argue, is a tool Magufuli has used well in pursuing his agenda. One organization, after I explained how I intended to present the government in a critical light, talked with me and provided a tour but asked that their name not be included.

I recorded the majority of interviews and in others took notes. At the DCEA I was asked not to record but, for the most part, interviewees were comfortable with the recording. In some interviews I took notes and recording together to remember key details. Most interviewees spoke English. At sober houses and hot spots, interviewees mainly spoke KiSwahili. The outreach workers I accompanied would occasionally translate when I did not understand. During some participant observation, I did not understand all the conversations occurring and would debrief with the outreach worker afterwards and ask questions for clarification. I translated recorded interviews in KiSwahili.

In hot spots I mainly remained a participant observer, however, I was also able to obtain some interviews with former users at these sites. For example, outside of Mwananyamala methadone clinic, I was able to interview people in the program which requires participants to only use methadone. At the hot spot I was told some people continued to use, but the Mwananyamala site was in the middle of a neighbourhood that was a centre of a lot of everyday activity. These hot spots were often in neighbourhoods that were poor and did not just include people using heroin. For example, Kigamboni ferry hot spot is off the main road among boat repairers and builders, with

some people using drugs among people working and living. These spots are well known but are not clearly demarcated or separate from others often living in poverty.

Other spots were smaller, but most were large, almost social settings with their own nearby shops and places to hang out. Overall I estimate encountering well over 200 people at these spots but only talked to about 20 individuals, as it was difficult to find a willing participant and ensure they were appropriate to be interviewed. For ethical reasons, I preferred to do fewer interviews in these areas and instead engage at sober houses and with people in treatment. I do use my observations for general and wider statements that are anonymous as data to illustrate the experiences of some people in these areas. I also debriefed after visiting the areas with outreach workers which are interviews that I use as data in my study.

In these areas, I was a visible participant observer. As a white man with a notebook it was clear I was an outsider. In some hot spots, people mentioned other 'wazungu' coming to visit, often from international NGOs, to do HIV/AIDS testing or try to support some health care. For this reason, I was not greeted with concern but rather openness. This situation did create some difficulties in clarifying that I was not there to provide supports. I was always introduced by the outreach worker as a student and did not undertake any 'undercover' observation. Some individuals took this opportunity to appeal to me for some kind of support, which is a daily experience walking around Dar es Salaam. The hot spots as mentioned are within neighbourhoods that are considered poorer or lower income than other areas. Outreach workers, similar to social workers anywhere, sometimes acted as friends, sharing cigarettes or providing small sums of cash for bus trips for example. While I ensured that I did not offer compensation for interviews, I sometimes paid for bus trips or meals outside of interviews. This is the nature of fieldwork in a country where very small sums are requested daily, regardless of active fieldwork.

In total I interviewed 68 individuals. While I did not achieve my goal of accessing more elite level interviews, my experience was such that I deemed the value of talking to the government as less important given the culture of fear and the lack of openness in the government. For example the head of the DCEA has spoken at the United Nations outlining harm reduction in Tanzania as far more advanced than it is. The public statements of the government, especially with the control in place currently, made it seem likely to me that government interviews would simply be a rehash of

the talking points in publicly available statements. I utilize these statements in later chapters to contrast with the realities I noted and discussed on the ground.

On the contrary, I had not expected the level of access I was able gain in hotspots, sober houses and among people with greater lived experience of drug use. As is often the case with fieldwork, I found this change in my work unexpected but incredibly rewarding. I owe a great thanks to the former users working with people who use drugs who were glad to take me with them, discuss these issues openly and who genuinely want to support people who are struggling with drug use, repressive policies and poverty. In challenging the war on drugs anywhere in the world, it is these activists who do the work of advancing human rights for people who use drugs.

It will be apparent in this work, and it is often my approach, to looks at things from the bottom up. The cross-section of interviews showed the issue of drug use not from the eyes of policymakers (as mentioned, I gained enough on these perspectives from public statements and documents) but from the eyes of those working within the system to try and advance better outcomes for people who use drugs on the ground. This was true whether the interviewee was from a 'powerful' foreign NGO such as ICAP or from the coalition of sober houses or the Tanzanian Network of People who use drugs (TANPUD), which receives little or no financial support. I focused in discussions less on patterns of use and more on questions regarding the political situation and environment in which people who use drugs experienced the policies as enacted. While many still shared their histories of use which were revealing in their own right, examining how things have changed, progressed, improved and what is needed showed a lot of overlap in experience and aspiration.

Challenges and learning

Having previously undertaken research in Tanzania, I was expecting a similar experience to my time there in 2013. I found new challenges however, perhaps as a result of more thought and reflection on my role as a Caucasian, privileged male Canadian in Tanzania. The inkling of this ethical dilemma began during my first visit to Tanzania in 2008 and has only grown since. During my first visit, as a 22-year-old with little experience, a Member of Parliament visited my fellow volunteers and I to praise our work in the country. While I did not think this strange at the time, in

retrospect I realized this level of access was not normal. As Westerners, my fellow young volunteers and I, were seen at the local NGO I was volunteering with as having legitimate and valued knowledge despite our age and inexperience. I learned later that Westerners in Tanzania are often treated as more intelligent, special or somehow politically powerful even as naïve voluntourists. Upon my return to Canada, I also realized how a little experience abroad also gave me gatekeeper status, as a definitive voice explaining to others what the real Africa is like. During this fieldwork, access to former drug users and visiting hotspots further challenged the ethics of my privileged self, talking to extremely vulnerable people and likely going home to tell exciting or exotic stories of a different and foreign place.

I was in an extremely privileged position and was very aware, especially when visiting hot spots, of my ability to leave the country when I wanted, purchase what I needed and live the way I wanted. My early interest in Tanzania was connected to a naïve young person's desire to 'do something' in response to images of poverty and despair often connected to Sub-Saharan Africa. This depiction, best summed up by Binyavanga Wainana[3], always troubled me. However, I also feel uncomfortable with the 'African Renaissance' narrative. These opposite views construct Africa as either poor 'shit-holes' according to the most powerful man in the world, or thriving and exceptional. The reality, again, is messier than this. It remains a challenge to write about Tanzania in a balanced manner. My goal has been to try to treat Tanzania as complex and diverse, as any other country is.

On self-reflexivity in research, I have struggled to manage my approach to African studies. As a foreign researcher in Tanzania, there is a long history of outsiders coming in to undertake research and pass judgment on politics, policies and practices. I remain circumspect about self-reflexivity in African studies as I find it can become a way to acknowledge difference and power imbalance before simply continuing to purport western beliefs and assumptions. There is a difficulty in fully understanding the Tanzanian context as an outsider. Therefore, I do not believe I offer a full understanding but rather a Western educated perspective on policies undertaken in Tanzania.

[3] 'How to write about Africa', published in 2005, is now a well quoted essay on precisely how not to write about African states. While the essay accurately sums up much of western writing on African countries, the tropes and stereotypes it outlines are still apparent in writing about Africa. I have sometimes written about Tanzania in the ways it should not be written about and have tried to avoid it.

My perspective is also shaped by my past experiences there, my support for harm reduction in Canada and my rather dim view of John Magufuli and the ruling party. I have worked with people who use drugs in a harm reduction focused centre, where I first learned about the potential for harm reduction and the limitations imposed by state policies that target people who use drugs unnecessarily. The aim of my research is to provide evidence to support better interventions for the people I interviewed. In this approach, my study is not meant to be a piece of advocacy work, but I am certainly in favour of harm reduction, better policies for people who use drugs and a better Tanzania for marginalized groups. I consider work in Tanzania to be emotional and my connection to people and places there to be emotional as well.

As an outsider, I was also concerned about my role even being in Tanzania as a researcher, and what my contribution would be. I have several friends in Tanzania, and met many committed people, who will understand the issues much better and could undertake similar work but, due to lack of opportunity, poverty and stigma are not in my position. I cannot claim to not be advancing the continued role of Western academics being gatekeepers to African issues, but I do hope that, being in a privileged position, I can produce some evidence and arguments that will in a small way advance understandings of drug use, stigma and policy. In looking at the larger connections to international factors, policy and histories of the war on drugs, I also hope that this perspective can deepen and contribute to studies of drug use in Tanzania and support opportunities for further research.

2.4 Conclusion

This study, in both my theoretical approach and my methodology, reflects the need to explore existing narratives more deeply, and question common understandings and beliefs about drug use. In the next chapter, I review the literature to explore the construction of the war on drugs, using the approach I outlined in this chapter to interrogate assumptions about drugs. My methodology supports a framework that illustrates the need to move beyond the war on drugs while also showing some of the reasons for its continuation. Utilizing interviews and perspectives from those most involved on the ground fighting against the war on drugs highlighted the hard, and sometimes seemingly impossible, work of contesting stigma within an environment of ongoing marginalization within persistent, repressive frameworks.

Finally, in this chapter I illustrate how the works of Bayart, Brown and Fisher can be applied to the war on drugs in African countries specifically, using the ideas of African agency to explain how Tanzania has pursued its war on drugs. The government of John Magufuli is pursuing a war on drugs with the support of foreign donors, controlling narratives of drug use, treatment and beliefs in the country. The Tanzanian government is taking a more aggressive approach than previous regimes, but the overall linkage of Magufuli undertaking this war on drugs with the support of donors is linked to Tanzanian politics since independence. The country has remained a donor darling despite corruption, poor governance, centralizing tendencies and top down efforts at control. In terms of the international consensus on drugs, Tanzania sits easily within existing narratives of drug use and the policy responses to people who use drugs yet, as I show in the coming chapters, is also actively shaping a response linked to histories of control, moral panics and diversion from the endemic problems facing Tanzanians.

CHAPTER 3

An unwinnable war and an enduring global threat: the war on drugs and Africa

3.1 Introduction

In this chapter, I review the literature on the war on drugs and on drug use in an African context. While there is a growing amount of literature on the war on drugs and its impacts, largely critical, there is less literature on the policies and influences of this war in African countries. This review illustrates the gaps in literature on drug use in Africa, but also establishes an important critique of the war on drugs and its epistemic underpinnings. In this chapter I also define, through an analysis of the literature, what is meant by the international drug control regime, the war on drugs and harm reduction.

The war on drugs is guided by assumptions of the inherent criminality vested in illicit substances. However, there is a critical literature that attempts to deconstruct this global drug regime. Analyzing the literature on the war on drugs and harm reduction, I argue that the construction of the threat of drugs has persisted in shaping drug policy despite its failures. I also show that, while harm reduction is the best policy approach to support the health and wellbeing of people who use drugs, activism has failed to effectively establish an alternative to the war on drugs due to continued beliefs and understandings surrounding drug use, addiction and the place of people who use drugs in society.

I begin by reviewing the war on drugs, how it is deeply ingrained in an international system of control, largely with the United States supporting and upholding it. I also examine literature on harm reduction, an approach to drug use aimed at reversing the damages done by the war on drugs and focused on supporting people who use drugs regardless of their decision to continue to use drugs or to get treatment. Through this review, I show that the war on drugs was initially led by the United States and, over several decades, is now an established epistemology of drug use, in which drug users are criminalized and stigmatized. I also describe how the war on drugs spread internationally to become a hegemonic system of control, providing policies that could be adapted and utilized in a number of countries in support of various agendas.

I then turn to the growing literature on illicit drug use in Sub-Saharan Africa. While the war on drugs and harm reduction have been written about at length over the past several decades, the literature available on drug use in African countries is not as comprehensive as works on drug use in other regions. Much of this existing literature is shaped by old ideas of Africa as corrupt, poor and a site of chaos that may impact the stability of the West. These ideas have focused studies on drugs in Africa on the growing use of East and West African ports as major trafficking points to destinations in Europe and North America and the use of the illicit drug trade to support terrorist networks and fuel corruption, crime and terrorism rather than on the realities of drug use in African countries with less obvious or sensational dynamics of drug use.

Despite the negative literature that exists, in recent years many authors have worked to better understand and conceptualize the war on drugs in Africa and the associated health needs of people impacted by drug use. There is a growing literature on actual drug use in areas where, while the use of certain drugs such as alcohol and marijuana have long histories, injection drug use is a relatively new phenomenon. Scholars like Sheryl McCurdy, Neil Carrier and Gernot Klantschnig have broken ground in actually studying drug use within Sub-Saharan African countries, focusing on the use of drugs in urban areas and the socio-economic context of drug use.

These works have advanced understandings of drug use in African countries while also highlighting the gaps and need for further, more in depth, studies of drug use in Africa. For instance, there is little data to support an understanding of the size and extent of drug use within African cities. Given the lack of attention to the health and human rights of drug users, works by these authors mainly focus on trying to understand the basic elements of the issue in an attempt to develop programs in these areas. While these authors therefore provide a basis for my study, scholarly works that have worked to develop more in-depth analysis of the politics, economies, and international and domestic dimensions of drug use, particularly in East Africa, remain rare. Further, work on harm reduction in an African context is also uncommon. Harm reduction has been shown to produce improved health outcomes for people who use drugs, whether reducing the spread of HIV/AIDS through provision of clean needles or supplying condoms to avoid the spread of sexually transmitted infections (STIs). For people who inject drugs, especially in marginalized communities, harm reduction can have immediate positive impacts on health, reducing abscesses and disease transmission rates, preventing infections and overdose deaths.

Understanding how drug use is shaped in Tanzania and how the government deals with people who use drugs is a gap in the literature that I address with this thesis. While my project is concerned with illegal drugs in general, my particular focus is on heroin, as the implementation of harm reduction is more relevant to people who inject drugs (PWID) than marijuana and khat users who use drugs in less harmful ways. I end my literature review by looking at the existing scholarly works on injection drug use in Kenya and Tanzania, before concluding with a critical section to highlight the gaps in the literature and show why this project is necessary.

3.2 Conducting war against an abstract threat

The rise of the drug warriors

The development of international cooperation in combatting illicit drugs has reflected, and subsequently been shaped by, cultural and political attitudes around drug use. By global war on drugs, I am referencing the evolution of a United States-led prohibition and punishment approach towards drug users which was formalized at the international level through the United Nations over the course of several decades (Paoli et al. 2012). Bryan Roberts and Yu Chen provide a good overview on this war and its major failures, effectively showing the general moral underpinnings (initially emanating from the United States) and assumptions that promote prohibition, mainly viewing drug users as threatening, criminal and failed elements of society (Roberts and Chen 2013). Works by Barrett (2014) and Wodak (2014) similarly show how the development of a drug control regime was linked to the post-WWII international order, based on the heavily US-influenced Bretton Woods Institutions. The United Nations drafted a succession of drug related protocols in 1961, 1971, and 1988 – all focused on the absolute eradication of drugs and the punishment of drug users (Barrett 2014).

This international consensus on drug control is clearly connected to prohibition and supply side controls. While Collins (2018:113) writes that this international system 'was a reflection of these [cultural] norms, not a determinant,' the system is more of a discursive space, shaped by states but also providing a set of policies that could be utilized and followed in domestic spaces. Using a set of policies aimed at prohibition and punishment often instead serve the purpose of highlighting crime,

and justifying policies to deal with it. The crisis narratives entailed in the war on drugs both create the problem of the drug user and establish a set of punitive policies to deal with them. While the American war on drugs initially appeared as a domestic fight with specific, racialized targets, the assumptions became widespread globally in the 1970s and 1980s. The global consensus on drug prohibition is a result of the deep and longstanding construction of a threat to society and the use of this construction for political purposes.

The term 'war on drugs' was coined by Richard Nixon in 1971, formalizing a post-WWII American agenda of limiting the global supply of illicit substances. As has been the case since its declaration, the war on drugs has had implicit racial and class connotations. In seeking election, Richard Nixon courted the silent majority, a group of older, mainly white voters, who feared crime was rising and the use of a substance as a target allowed a population gaining greater political power, African Americans, to not be targeted without being named explicitly (LoBianco 2016). Ronald Reagan continued the fight in the 1980s, increasing punishments and legal restrictions on possession and further entrenching discrimination in the United States.

At the height of the HIV/AIDS crisis, along with increased criminal penalties for drug possession, Reagan also systematically removed supports for mental health, addiction and social programming (Cummings 2012). When Reagan announced his war on drugs in 1982, 'less than 2 percent of the American public viewed drugs as the most important issue facing the nation' (Alexander 2011:49). Reagan framed the issue, created a crisis and, with the passing of his Anti-Drug Law of 1986, 'effectively criminalized addiction' (Cummings 2012:418). One of the most cited examples of how this law acted discriminatorily was the difference in penalties for possession of crack-cocaine, primarily used by marginalized African Americans, versus the less harsh penalties for cocaine, used more often by wealthier, white people (Cummings 2012). In the early 1980s, 'FBI antidrug spending increased from $8 million to $95 million' and 'DEA [Drug Enforcement Agency] antidrug spending grew from $86 to $1,026 million' (Alexander 2011:49).

While Reagan-era United States is not considered repressive, this approach allowed a President to massively incarcerate African Americans, making drug misuse among racialized populations the target of increased enforcement and harsher punishment (Cummings 2012). Michelle Alexander (2011) compares the American war on drugs to the new Jim Crow, given its

clear similarity to the control and punishment of African Americans following the American Civil War. In the United States in 2006, the war on drugs was a major factor in the rates of incarceration for black men being 1 in 14, compared to 1 in 106 white men (Alexander 2011:98). These remarkable inequities do not include even more onerous challenges faced once out of prison such as stigma, probation and legal costs. As I show in later chapters, the imposition of new policies targeting vulnerable people, crackdowns and framing drugs as a sudden crisis requiring society to come together and fight was also part of Magufuli's war on drugs, showing the resilience of what remains a highly cynical political strategy.

In the literature, while the role of the United States is sometimes disputed, it is clear, at least as this system gained prominence from the 1960s onwards, that the United States played a major role in promoting prohibition. Prohibition and moral panics against illicit drugs existed and played out for political ends in other countries over the 20th century, but it was the war on drugs, initiated by the Nixon Administration for 'short-term domestic political reasons', that left its footprint in many other prohibitionist pushes throughout the globe (Wodak 2004:800). Later efforts to control drugs would follow the same model and have the same effects: criminalizing marginalized groups, stripping the social and cultural context away from drug use, increasing violence and vulnerability among drug users and stigmatizing specific substances and the people that use them. This high cost and ineffective approach was a guidebook for repressive regimes who grasped the political power of this set of policies.

Internationally, the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, encouraged the approach of criminalizing drug use while weakening social and health supports for people who use drugs. This convention was perhaps the clearest distillation of war on drugs policies at the international level, as it encouraged criminalization and punishment, reflecting the growing social anxieties around widespread drug use and the Reagan-era tough-on-crime agenda. Meetings to continue the approach established through UN conventions now take place under the guise of the United Nations Office on Drugs and Crime (UNODC) and are enforced by the International Narcotics Control Board (INCB). Therefore, this drug control regime which I refer to as a global war on drugs (also referred to as the 'Vienna consensus'[4]) in the last

[4] The Vienna consensus refers to the headquarters of the UNODC in Vienna, Austria, where these meetings and conferences supporting a war on drugs have been held (Boister 2016).

century can now be seen as a general international agreement, reaffirming a 'zero-tolerance' approach to drugs practiced by a majority of states across the globe (Boister 2016).

The wide prevalence of these policies is not reflective of their effectiveness. This international consensus, promoting practices such as alternative crop programs, increased legal restriction on drug use and funding for more repressive militaries and police, has failed at achieving even modest goals. Rather than moving closer to the ultimate goal of a drug free world, set out in numerous UN conventions and declarations, drug use and trafficking is as prevalent as ever if not more so. These failures are well documented, as are the negative impacts that have resulted. As Alex Wodak argues, not only has drug prohibition not addressed the problems it was aimed to solve, namely reduction in 'drug production, drug consumption, or drug related harms', it has resulted in unforeseen consequences such as 'a rise in organized crime, corruption, high social and healthcare costs, and the deaths and incarceration of thousands of drug users' (Wodak 2014:191, 193-195).

In many ways, the war on drugs and those it leaves as victims in its wake, are a reflection of modern capitalism and neoliberalism. As Toby Seddon (2010) argues, it is impossible to discuss drug use and control without considering global systems and modern liberalism with its focus on choice and free will. Dominic Corva, in discussing the spread of the war on drugs in the Americas, sees this war as inseparable from neoliberalism and illiberal governance, with the 'economic vulnerability' produced by neoliberalism and the punitive war on drugs creating a prison industrial complex targeting marginalized people (Corva 2008:181). In many ways, the war on drugs can be linked to the economic vulnerabilities of neoliberal capitalism, in which free markets ensure an unrestricted flow of drugs, and a corresponding system of punishment and control that allows for the politicization of drug use and the criminalization of poverty. The epistemic basis of drug use in this system is similar to neoliberal capitalist ideology, where race, stigma, discrimination and systemic poverty are erased as factors in drug use, just as they are erased in why certain segments of society are more prone to poverty and poor health outcomes. The war on drugs paints drug use as a solely individual failure, rather than one linked to numerous socio-economic factors.

The ongoing failures of the policies enforced internationally have resulted in more space for alternative discourses. However, the major UN positions enshrined in 1961, 1971, 1972 and 1988 remain the basis of response to global drug control (UNGASS 2016 Draft Outcome Document). In

understanding the international drug control system, it should be considered 'a complex global governance phenomenon rather than simply as a matter of international relations in which the sovereign nation-state is the basic unit of analysis' (Seddon 2010:116). In this complex international space, most authors (Seddon 2010, Wodak 2014, 2017, Roberts and Chen 2013) agree that prohibition and the moral judgement of drugs users has had a disproportionate influence in shaping drug policy. The most recent gathering, UNGASS 2016, revised prohibitionist language of a society free of drugs to 'a society free of drug abuse', with major prevention and treatment options recognized (UNGASS 2016 Draft Outcome Document). Harm reduction is not mentioned. The main concerns with limiting drug use internationally are overwhelmingly connected to reducing criminality and the spread of HIV/AIDS. It is the latter concern that has attracted the most funding in Sub-Saharan Africa, rather than truly understanding and supporting interventions shaped and requested by people who use drugs themselves.

Some authors (Collins 2018) note the flexibility of the international drug control system, which can provide greater space for alternative approaches to drug use such as harm reduction. However, while it appears that regulation and treatment for people who use drugs is at times favoured over outright prohibition, the focus on limiting drug supply always remains the basis of most policy approaches (Paoli et al. 2012:931). Further, despite instances of regulation being evident over the past century of international drug policy, the 1960s, 1970s and 1980s represented the 'consolidation and expansion of the control regime' with prohibition at its heart (Paoli et al. 2012:932). The ontological proposition of drug policy is almost always treatment and control, rather than just treatment or treatment and human rights. I argue that the result of the medicalization and treatment approach, often touted as a break with efforts to control and discipline drug users, is simply complementary to a system of control and not a radical break with war on drugs policies.

The literature clearly shows that the internationalization of a normative set of policies related to the war on drugs has been successful. Paoli et al. link the expansion of prohibitionist policies, starting in the 1950s and accelerating in the 1970s and 1980s, reflecting the 'cultural biases of the western societies and governments' where the 'tone and provisions of the treaties become increasingly prohibitionist, mainly at the insistence of the United States' (Paoli et al. 2012:931). Roberts and Chen refer to this international regime as path dependent, with 'drug control

agreements creat[ing] a basis for international intervention in a country's internal affairs' (Roberts and Chen 2013:112).

As with the domestic political benefits of executing a war on drugs, the expansion of international control and power into other countries allowed for an extension of US soft power, coinciding with the rise of a powerful global security apparatus (Pembleton 2016:30 – 31). While the United States does not always have a positive relationship with the United Nations, the UN has been a partner in supporting the execution of this soft power throughout the globe. This support comes not only through the chairing and holding of meetings that reiterated the prohibitionist message of conservative American presidents, but through the creation of an office, the UNODC, dedicated to prosecuting the war on drugs in partnership with member states.

The war on drugs has endured as a set of tools that can provide legitimacy and be politically useful. As I argue in later chapters, the government of Tanzania both utilizes the norms set out by the international control regime and co-opts and projects these norms in the drive to consolidate authoritarian control while contributing to discussions at the international level on how to tackle the issue of illicit drugs. Since the failed war on drugs has become more commonly understood, the actors shaping drug policy often project narratives that have little to do with the object itself (eg, Heroin) and much more to do with short term political goals. As Alex Wodak states, 'its [drug prohibition] major success has been as a political strategy' (Wodak 2014:190).

Illicit drugs are depicted as a source of crime, corruption and waste so often that they are an easy political target across wide spectrums of society. People impacted by drugs want the scourge to end and many less impacted by drug use want their families and children to be safe. The connection of drugs to vulnerable populations also allows an appeal to a majority with less understanding of the complex socioeconomic dynamics that produce severe addiction. Ending the war on drugs and reversing these ideas requires much greater resources and attention than most governments are willing to give. Thus, the war on drugs remains in place in various guises throughout the world today.

Drugs in other places: comparative works on the war on drugs

While comparative work on the war on drugs adds somewhat to our understandings of drug use, there are limitations. Studies on Latin America, for example, focus on drug-producing states, where drug use and trade is intimately tied to internal politics, the problems that production has presented and how foreign policy positions towards these countries have been shaped by the war on drugs (Bergman 2010, Labate et al 2016). US interest in Central and South America as a source of illicit drug production and the disastrous implications of the war on drugs in Mexico, Colombia and Honduras, among other countries, have been similarly well documented (Hobson 2014, Labate et al. 2016, Valenzuela 2012).

The harsh and punitive policies driving conflict and violence in Latin America have led many policy researchers to seek alternatives to the status quo (Metaal 2012). Due to the long history of failed drug policy and its ill effects, governments in Latin America and the Global South, as with governments globally, are increasingly using other discourses to justify the war on drugs. Salvador Santino Regilme argues that the Uribe and Duterte regimes, in Colombia and the Philippines respectively, 'deployed the notion of peace as a justificatory discourse for increased state repression, intensified criminalization of the drug problem, and the reluctance of the state in embracing a public health approach to the proliferation of illegal drugs' (Regilme 2020:1). This work highlights how war on drugs narratives adapt under different guises.

The war on drugs promising peace in these countries, contrary to the evidence that ineffective drug policy is driving high levels of state repression and violence, is little different to the idea that eliminating drugs would lead to a better world, free of crime and poverty. As I show in later chapters, Tanzania similarly repackages old war on drugs rhetoric in different guises of moral nationalism and reducing poverty to justify increased control, repression and reduced health and social support for drug users. The war on drugs sets up an impossible and idealistic end to justify an array of policies which, were they undertaken in different contexts, would quickly be seen for what they are, abusing human rights and abdicating the responsibility of the state to support and protect all of its citizens.

The literature on more developed states reflects the longer engagement with drugs such as heroin and cocaine and the much larger public health infrastructure that exists for treating drug users. The scholarly attention devoted to the United States, for example, the epicentre of global drug control and the country with the most interest in combating the drug trade over the past decades, is too extensive to attempt to cover here. While there are similarities between drug wars in countries such as the United States and Tanzania, there is also a need to focus on unique contexts in which these wars take place. In the previous section, I provide an overview of some of this literature in order to illustrate the importance of the United States in the development of the war on drugs. However, the mass incarceration, racial dimensions and continued prevalence of drug use within the United States have received much critical attention, making up a literature of its own (Hinton 2016, Khan 2015, Patten 2017).

In regard to Sub-Saharan Africa, West Africa has been the focus of some scholarly attention, as Nigeria and Ghana have been the focus of increased drug trade, notably in cocaine (Akyeampong 2005, Howell and Atta-Asamoah 2014). As is often the case in the war on drugs, works on West Africa are based more on conjecture – West Africa's so-called cocaine coast has garnered media and academic attention as a possible catastrophe waiting to happen given the disaffected youth and conflict throughout the region (Kaplan 1994, Klantschnig and Carrier 2012). West Africa is also of particular concern as a trafficking route for cocaine from South America due to worries this is being controlled by Islamist terrorists in the Maghreb (Rotberg 2016). These articles highlight the international nature of the drug trade (Akyeampong 2005) and the failure of punitive war on drugs policies (Howell and Atta-Asamoah 2014). Few deal with the less explosive, though just as important, issues of drug use and its spread within these societies.

While there is much more literature on the failures of the war on drugs (Cummings 2012, HRI 2015, Roberts and Chen 2013), these works are representative of the critical literature on the war on drugs in which I situate myself. Using these studies asserts a normative position strongly against the decades-long policy failure that is the war on drugs. This normative position is supported throughout my work; just as war on drugs policies are not neutral and support a position which is both harmful and not fact based, the opposing position supports an evidence-based approach which seeks to explore alternatives to the drug war. The best alternative at the moment, though not perfect, is harm reduction which, as I show below, at worst protects the health of people who use

drugs and, at best, could lead us to a different epistemic understanding of drug use, the human rights of people who use drugs and a way out of the war on drugs.

3.3 Is there another way? Harm reduction and reversing the war on drugs

The rise of harm reduction

While injection drug use did not spread to most Sub-Saharan African countries until the 1990s and 2000s, in Western countries, with longer histories of injection heroin use, harm reduction emerged earlier. As the AIDS crisis unfolded in the 1980s, the rates of infection among people who inject drugs (PWID) rose sharply due to needle sharing. In response to government inaction, a grassroots movement to support the health and wellbeing of people who use drugs spread. In this section I discuss how harm reduction is defined and how it grew out of this grassroots movement. Through analysis of the literature on harm reduction, I highlight both its importance as an alternative to the war on drugs, and also how the war on drugs continues to subvert and slow the meaningful implementation of harm reduction practices.

Harm reduction, inspired by both concern for public health and the scientific evidence that sharing needles dramatically increases the transmission of infectious diseases, was controversial when it emerged in the 1980s. Countries in Europe, however, experimented and successfully implemented some harm reduction programs that were proven to reduce transmission of HIV/AIDS and other diseases such as Hepatitis C. Harm reduction practices such as needle exchanges and education within a public health framework slowly became 'institutionalized across much of northern Europe, Canada and Australia' (Gowan et al. 2012:1252).

Although harm reduction can take on different meanings, the initial goal among harm reduction activists was simply the need to save lives regardless of drug use or misuse. Harm reduction can be complex with competing definitions. For the purpose of this study, the common definition here gives an idea of the general concept: harm reduction is a set of 'policies, strategies and services which aim to assist people who use legal and illegal psychoactive drugs to live safer and healthier lives. Reduction of use is a personal choice, and supported, but is not expected or required' (Canadian Drug Policy Coalition 2016). This definition, however, is sometimes disputed, mainly the

idea that individuals do not need to cease their drug use. As Gowan notes, 'current wisdom on harm reduction with injection drug users may be moving towards abstinence as a desired endpoint' (Gowan et al. 2012:1253). This focus on abstinence, while not an undesirable goal in itself, cannot be understood in the absence of a number of social constructs around what abstinence means and how this can be achieved.

Rates of relapse and continued use are very high among many people who use drugs. However, the belief in a final cure to this disease, and its eradication through abstinence, remain the dominant perspective in formulating drug policies. The use of the harm reduction concept, aimed at supporting the human rights of drug users, is in this way made to be simply another mode of quickly getting people off of drugs and eradicating drug use. As I argue in this thesis, harm reduction can be tied in to a prohibitionist approach which envisions an end to drug misuse as 'the notion of a self-managing drug user inherently problematizes the epistemological basis of the drug war' (Gowan 2012:1257). In other words, even progressive approaches to treating drug use are often still tied to abstinence and prohibition. This epistemic belief in ending drug use has made it difficult for harm reduction to be considered in the absence of the eventual end of addiction and drug use altogether.

The literature on harm reduction reflects its controversial nature, as there is a tension between more fulsome and radical approaches, such as the decriminalization of illicit drugs, and more realistic approaches in a prohibitionist context which focus on the health of people who use drugs. This tension is a result of harm reduction being opposed to common societal assumptions constructed around the use of certain drugs that are lasting and difficult to reverse. Even many progressive actors find it hard to build a case for the legalization and making substances that can be harmful, more available. Further, harm reduction also goes against decades of wisdom that see drug use as a crime and source of ills. Harm reduction advocates do not focus on ending and eliminating drug use and do not pursue abstinence or view drugs as a social evil. In this way, harm reduction can be considered as possibly encouraging drug use or approving of it, a contrast to the moral judgement and stigma of criminalization and abstinence-based approaches.

Due to these challenges, the harm reduction activism of drug users or former users and volunteers, which was often explicitly anti-establishment and political, did not receive official recognition from governments early on. While the literature reflects the aspirations of a more radical

approach to deconstructing drug use, early harm reduction efforts were largely volunteer-based and only received state support begrudgingly. In Canada, harm reduction programs existed for decades before the government officially endorsed even basic harm reduction measures.

Even as harm reduction is shown to be effective in reducing mortality, overdoses and preventable disease, promoting it remains difficult today. In order to overcome conservative concerns, harm reduction advocates often focus on the less controversial aspects of this approach. For example, harm reduction has often been promoted as a purely public health intervention, keeping people who use drugs alive and ensuring risks to the general public are reduced. This perspective also highlights the cost efficiency of preventing HIV as compared to treating it. Despite the well evidenced basis for these facts, which are not necessarily controversial – after all it is a proven way to save public money and provide health care to citizens – governments have often continued to oppose harm reduction and support abstinence based approaches. This lack of acceptance reveals a deep attachment to prohibition, abstinence and individualism inherent in the war on drugs approach.

Given the opposition to harm reduction even in its most basic form, it is not surprising that the eventual implementation of harm reduction in many contexts was not a radical transformation, but rather a response to moral panic and crisis. The reactionary implementation of harm reduction is apparent in the rise of harm reduction in the 1980s during the AIDS crisis, and the current response to the rise of fentanyl in many Western countries and the associated rise in overdose deaths. A constant throughout these crises is that people use drugs and will continue to do so, even if some risks are associated with it. This logic underlies harm reduction approaches where this reality is accepted.

Simplifying drug use and harm reduction to a medical model allows governments with little interest in the human rights of people who use drugs a way in which they can show support for drug uses while not addressing any of the underlying issues. In this model which, as I show in the next chapter describes Tanzania well, 'poor and working class drug users are treated elsewhere as zombies only curable through forced treatment' (Gowan 2012:1258). The motive is not to improve their health and wellbeing but to get them off drugs as quickly as possible so they do not impact the larger society.

The need for immediate interventions to save lives is often in conflict with the longer-term, meaningful reforms required to achieve the goals of harm reduction have resulted in grassroots campaigns with radical goals eventually achieving minor victories. These minor advances in supporting people who use drugs exist within existing paradigms of prohibition. The major assumptions of the war on drugs persist, emphasizing individual power to get clean through the 12-step program or through sticking to treatment. These programs may work for some people, but the underlying assumption of individual responsibility belies the 'political economic and cultural forces, rather than pharmacology' that shape drug epidemics (Bourgois 2003:31). Considering the larger contexts surrounding heroin use does not dismiss the addictive nature of psychoactive substances, but rather acknowledge what the war on drugs has erased, its socio-economic and cultural context.

Harm reduction is favoured by anthropologists but has carried less weight in advancing a progressive drug policy. As pointed out in *Drugs in Africa,* while scientific approaches have 'had the desirable effect of undermining deeply held and remarkably resistant racial arguments regarding the appeal and effects of drugs, it has unfortunately also marginalized understandings of the importance of context – social, historical, cultural, economic – in shaping the patterns of drug use and abuse' (Ambler, Carrier and Klantschnig 2014:5). The science behind psychoactive substances has advanced knowledge of addiction greatly. However, the findings can easily be co-opted and subordinated to support the ineffective policies of the past. Further, scientific interventions, while evidence based, are still subject to political and social realities that are often messier and more challenging to address.

Harm reduction is not necessarily meant to solve all of the issues associated with illicit drug use. The need for reform, however, recognizes the different contexts in which people use drugs. As I show in chapters six and seven, expressing harm reduction as a medical treatment and curative for heroin addiction results in a one-size fits all approach. In Tanzania, this means methadone treatment is the only choice for heroin users, despite different patterns of use, different backgrounds and different reactions to treatment. It is a victory to provide at least this level of service to people with drug use issues. However, in the longer term, understanding the human rights and contexts of use could help support interventions beyond methadone treatment that support meaningful and better lives. Instead of working towards this expanded view, most countries cling to the notion of ending

addiction and drug use as the only way forward, continuing the ineffective and inhumane policies that surround their limited harm reduction interventions.

The larger picture and international war on drugs policy

There is a relatively extensive literature aimed at understanding the political economy of drugs, either through examining specific drugs and their role in the global economy (Humberto and Libby 2011) or through more historical general perspectives on how the current system of drug control has come about (Buxton 2006). *The World Heroin Market* by Paoli et al (2009) focuses on several country case studies to examine the global heroin trade, but this work is mainly focused on supply, how heroin enters the market and how it then interacts with a global policy regime focused on control. Alex Stevens (2011) focuses on health policy in the US and the UK, developing a critique around their approach to drugs as criminal instead of a larger health problem; he also argues for more social approaches to these issues.

These works all agree on the need for some sort of reform in the dominant approach to drugs, which is overwhelmingly focused on prohibition. The United States looms large in these works as the ideological force behind this dominant narrative, shaping the norms and policies enacted in the late 20th century. For my own work, this point is important. However, in regard to African countries, the mechanics of how the United States has dominated approaches to drug use and trade, and how these countries have adapted and shaped a global policy framework are understudied.

Historical studies such as Paoli et al. (2009) and Julia Buxton (2006) offer some insight into how the United States has asserted this dominant narrative through international agencies and institutions, diplomacy and funding. Buxton's approach in particular describes how, over the past century, the United States has consistently taken a dominant role, acting internationally to promote its intense commitment to prohibition (Buxton 2006:2). With heroin specifically, Paoli et al. argue that 'the current drug control system was developed primarily by western policy makers informed by western values, cultural practices, and interests' (Paoli et al. 2009: 249). Again, this shows how the historical framing of drugs as criminal substances that need to be eradicated is interlinked with Western, and primarily American beliefs, as mentioned above. These works, however, do not

account for the evolving attitudes that have emerged to counteract this narrative and work this ideology in the past decade. They also focus only on the US and some drug producing states, so there is also very little about how other states understand, manipulate and adapt this dominant American discourse on the war on drugs for their own purposes; how it interacts discursively with distinct and varied drug cultures around the world.

Addressing this gap in Africa in particular, works such as Neil Carrier (2005, 2006) and David Anderson et al. (2007, 2009) have shown the cultural importance of khat for example in East Africa. These works highlight how a drug consumed for centuries in countries around the Gulf of Aden has clashed with the prohibitionist motives of Western countries. The most influential proponent of drug ethnographies, however, is Merrill Singer (2008, 2008b, 2012). Singer shows how deeply drugs are connected to culture and society, and how drug use and drug control regimes disproportionately impact the poor (Singer 2008). Ethnographies of drug use, and the historical studies examining the development and spread of the ontological assumptions associated with the war on drugs help us better understand the complexity of drug use and control in countries in the global South on the peripheries of the global war on drugs. Further, these works highlight the need to understand drugs within a larger social, cultural, economic and political context.

Currently, work on the import and use of heroin along the Swahili coast is limited. Quantitative studies measuring the extent of the issue rely on basic information such as drug seizures and evidence from methadone programs. As a result qualitative studies suffer a lack of evidence to support theoretical works. As mentioned above, the positioning of drugs within their unique context is important in the developing world where drugs take on a different kind of threat. Drugs threatening development has become a popular way, among aid workers and politicians, to support supply-side interventions. While never really discussed as such in the West, where stronger institutions exist and drug use persists, the idea of drugs as a major threat to development gives a strong incentive for several actors in favour of continuing the war on drugs to support increased controls on trafficking and programs cracking down on smugglers.

This is not to argue that organized crime and corruption do not present major issues for countries such as Tanzania, simply that portraying drugs themselves as a main issue underlying corruption, poverty and youth disempowerment subverts the main reasons for the persistence of

these problems. Drugs do not cause corruption, poverty or lack of opportunity. Stemming the flow of drugs through the country, which is a major task, will not aid development. The ability of organized crime to be flexible and adapt to changing political and economic climates is proven time and again, as new sources of illicit funding can be found when one source ends.

3.4 Africa and trajectories of drug use

Overview

While I look more in depth at the background and context of drug use in Tanzania in chapter five, here I review the general literature available with a critical lens. Most scholarly works on drug use in Tanzania focus on epidemiology, the rising risks of HIV/AIDS transmission among PWIDs and patterns of drug use. Nearly all of these works call for increased harm reduction policies and, though some describe the limited harm reduction provisions available, few go beyond these limited references to domestic policies to discuss the origins of these policies, the political implications of the war on drugs and the barriers to enhanced care for PWIDs.

Neil Carrier and Gernot Klantschnig (2012, 2014) have attempted to offer more comprehensive studies of drug use and trade in Africa more generally. Their most recent work with Charles Ambler (2014) provides several chapters highlighting growing alcohol use, the cultural properties of khat and includes a chapter by Sheryl McCurdy on heroin use in Tanzania. An important contribution made in the introduction of this book is the call to focus on specific cultures of drug use. These authors not only caution against the dramatic language often used in the war on drugs (Cocaine coast, narco-states), but also argue against pharmacological determinism, which is the idea that users become immediately addicted to substances and follow the same patterns of drug use no matter where they are (Carrier, Ambler and Klantschnig 2014:5). According to this belief, drugs transcend social and political configurations, and the reasons behind their use and how drugs interact with local societies and cultures are seen as unimportant. The drug itself is the agent of misuse and criminality. This understanding is wedded to a war on drugs mentality, constructing the illegal drug as a menace to which youth will become immediately addicted, providing cause for governments to enact stronger measures to combat it (Dimova 2016).

My intention with this study is to oppose these views and look at how a global policy is interpreted and shaped in different cultural and social contexts. John Magufuli's war-on-drugs rhetoric, for example, interacts within a different cultural context, where beliefs and fears of drugs are informed by a different history of drug use and different cultural norms. Drugs 'are soaked in sociality and culture, and understanding fully the effects and appeal of their pharmacology requires also understanding the social and cultural contexts in which they are consumed' (Carrier, Ambler and Klantschnig 2014:5). Understanding the policies and rhetoric surrounding drug use requires a similar context; despite the language and policy choices often being directly borrowed from other countries using a hardline approach to people who use drugs, the pre-existing culture and socio-economic environment in which the war on drugs is being adapted in an East African context must be considered.

This context mirrors some of the larger issues with studying African politics more generally and the constant tension between extraversion and domestic policy. Drug use in Africa is considered both as a foreign problem, something imported from the West, not a part of 'African culture' and as a menace poised to wreak havoc among Africa's youth. Many scholars have critiqued these ideas, pointing out that African youth and cultures, similar to youth and cultures globally, have had long histories with intoxicants, with some groups integrating substances like alcohol or khat into their cultural fabric (Afinnih 2002, Akyeampong 2005, Anderson et al. 2007, Klantschnig and Carrier 2012, 2014).

While longer histories of drug use are important to point out, injection drug use is a relatively new phenomenon in many African states, and the use of drugs in an increasingly globalized world is subject to divergent and complementary international and domestic narratives. Drug use is a novel approach to understanding both global and local responses to policy issues, as drugs in particular are the site of a remarkably globalized discourse surrounding their use and trade, which is, almost always, overwhelmingly negative (Herschinger 2011). Drug use ties together not only global discourses with strong political motives, but also global economies and markets which have grown increasingly complex. Furthermore, there is an emotional and cultural connection that goes beyond the cold, rational works in which drugs are viewed as inherently addictive, evil substances devoid of the cultural and emotional connections inherent in addiction itself (Ambler, Carrier and Klantschnig 2014).

Injection drug use in East Africa

East Africa has not been often considered a major site of drug use and trafficking in comparison to producing countries in South America, or countries such as Mexico, that have garnered greater attention due to the havoc wreaked by American anti-drug policy and anti-trafficking efforts. In the literature, East Africa is seemingly on the periphery of global drug production and trade. While the increasing attention to injection drug use due to the high rates of HIV/AIDS is important, the policy frameworks within these countries are not well documented. Policies developed in East African countries such as Tanzania are not easily comparable to producing regions or more developed countries.

East African states have been largely able to avoid the conflicts associated with drug production in South and Central America. Tanzania does not produce any drugs, other than marijuana in some quantities, and khat – a stimulant milder than coffee that is strangely illegal in both the United States, Canada and, most recently, Britain. However, major trafficking routes have been diverted to less obvious routes through East Africa, where domestic use of heroin has increased throughout the 1990s and 2000s. According to the 2017 UNODC report on global drug use, 'heroin use in Africa appears to have increased more than in other regions' (UNODC 2017:23). Despite this growth in heroin use in East Africa, the region still has not received as much attention beyond concerns over limiting traffic and addressing the high rates of HIV/AIDS among people using heroin.

Sheryl McCurdy and Susan Beckerleg, however, have brought attention to this growing drug use. McCurdy, who has done the most extensive research on PWIDs in Dar es Salaam, wrote in 2007 that the need for harm reduction services was dire (McCurdy 2007). Her work highlighted both the public avowals to fight drugs among high-ranking Tanzanian politicians and the larger implications of drug use, its relation to poverty, and its connection to risky behaviours, from sex work to needle sharing. Susan Beckerleg (1995) also brought attention to rising heroin use in Kenya as early as the 1990s. Many works on heroin use are still limited and their scope often aligns with funding opportunities and accessible field research. The result is 'emerging' studies that are

beginning to grasp the realities of addiction in an East African context yet remain limited (Carrier, Ambler and Klantschnig 2014).

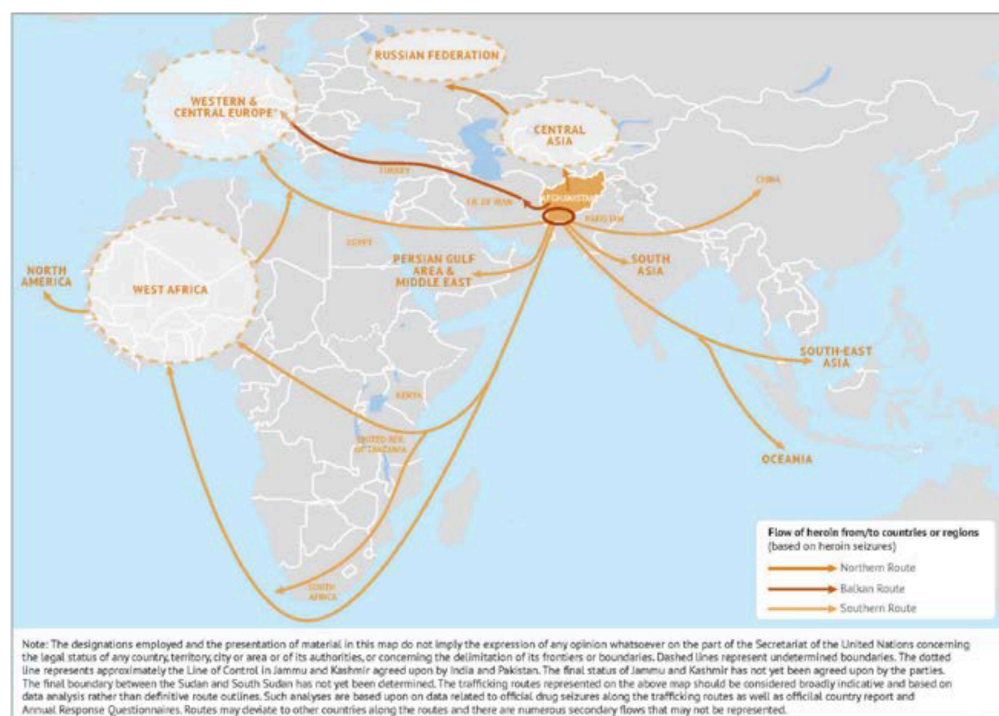

Figure 2. The Afghan Opiate Trade and Africa: a baseline assessment 2016, UNODC Research Paper.

While the works of Susan Beckerleg and Sheryl McCurdy have focused on large urban centres with marginalized populations such as Dar es Salaam and Mombasa, few studies have focused on drug usage elsewhere in East Africa. One study looks at drug usage in Mwanza, Tanzania, on Lake Victoria for example (Xulin Tan et al. 2015). This study helps highlight the fact that (without mimicking the alarmist language surrounding drug use) that there is more widespread usage than is understood, and drug use is not an insignificant problem in these countries. A full picture of usage, however, is difficult with the lack of in-depth studies on Tanzania specifically, with its unique history, culture and political environment. Although other studies have confirmed drug use to be present in several regions, with pervasive use in Mwanza, the Coastal Region, Dodoma and Tanga (Tiberio et al. 2018), the development of further studies on these regions, and Tanzania more generally, are few.

In this thesis, I look at how, despite increased drug use and rising HIV/AIDS rates, and scholarly consensus being mostly opposed to the war on drugs (Singer 2008, 2012), Tanzania has opted for relatively heavy-handed war on drugs rhetoric, voicing extreme concerns that 'evil' drugs will destroy their youth (Yussuf 2016). In 2017, Tanzanian President John Magufuli has attempted to position himself as the strongman in East Africa – fighting corruption and drugs, summoning MPs, celebrities and bizarrely threatening his own wife in a massive anti-drug sweep (All Africa 2017, The Citizen 2017, Reuters 2017). High-level Tanzanian officials have made fighting illicit drug trafficking a priority (Xinhua news 2016). The new Drug Enforcement Act of 2015 outlines severe penalties for drug possession and use, including five years for drug use in public and people in possession for purpose of trafficking of drugs subject to 30 years in prison (Mbashiru 2015, The Drug Control and Enforcement Act, 2015). The new agency allows for treatment while further criminalizing drug addiction. The Tanzanian war on drugs is a relatively recent development, and there is a gap in literature on the impacts of this policy change, both with Tanzania and in relation to the international drug control regime.

In Kenya, much like Tanzania, President Uhuru Kenyatta has used language focused again on 'saving youth' from a malevolent force – drugs (The Daily Nation 2015). The focus on punishment has come into conflict with policies that are more humane, resulting in an incoherent strategy that acknowledges the need for treatment of addicts while severely punishing them; attempts at harm reduction are thus a challenge (Murage 2016). This dissonance between the desire to help addicts while trying to curb trafficking revealed a gap between stated goals and realities which I explore in this thesis. While the Kenyan government in recent years has relaxed its war on drugs and turned towards harm reduction, Tanzania has opted for a severe system, targeting drug use while leaving some supports in place. Ratliff et al. (2016) have called the implementation of harm reduction in Tanzania a 'complex adaptive system', influenced by multiple stakeholders and beliefs which allowed harm reduction to be implemented to a limited extent. This analysis also proposes that governmental actors need to be included to allow policy initiative such as harm reduction to take hold (Ratliff 2016). However, the space for harm reduction is closing, with access to services for drug users increasingly impacted by other policy areas pushing Tanzania back towards prohibition.

Tanzanian policy, with increasing arrests of high-profile politician and celebrities 'under the guise of reducing drug trafficking and corruption' (Motani 2017) marks a change from the country being applauded for its modest harm reduction programs a decade ago. Again, the need for works examining how this change has impacted drug users and why and how these policies are enacted is lacking. Writing on Kenya, Margarita Dimova is one author that has worked to address this gap in the literature. She finds that Kenyan leaders have used 'crisis narratives' to shore up their own power, and that their own war on drugs 'runs parallel to increasingly unleashed global market forces' (Dimova 2016:238). Dimova further notes that 'a locally led war on drugs thus offers a whole new set of smokescreens and discursive planes through which to manipulate public perception and to bolster donors' confidence' (Dimova 2016). This position allies the government with a global drug war and justifies demands for the funding to carry it out (Ahmed 2015).

What Dimova does not fully account for, and where a further gap emerges in the literature, is that the local drug war in these countries is not just governmental and market-based, but also contends with the interests of numerous actors, non-governmental, inter-governmental and private. There are a number of pressures influencing how policy is shaped and implemented and why harm reduction remains challenging to introduce. Considering societal pressures, in a recent report on harm reduction trials in Kenya, one author notes that 'stigma against users and practices like mob justice, remain strong' (Hyde 2016:17). Barriers to harm reduction include this stigmatization and the heavy criminalization of substances and those who use them (Phelan, Nougier and Bridge 2013:11).

As mentioned, grassroots initiatives supported by international donors and foreign health policy experts with a focus on harm reduction have emerged, but these now seem to have less support from domestic governments (Mbiritu 2015). The war on drugs in Tanzania is developed within a network of interrelated motives and beliefs, with numerous initiatives resulting in a chaotic field subject to a variety of contested initiatives. The government's advocacy of a war on drugs must contend with a number of actors, however, as I argue in this thesis, this does not mean the war is not having major impacts.

It is unclear how these efforts will actually impact drug trafficking – what is clear is that the crackdown serves a performative purpose, reinforcing Magufuli's image as a powerful anti-drug crusader to both domestic and international actors. This also raises the question of whether the

Tanzanian government is operationalizing a war-on-drugs policy framework and using a securitization discourse to access funding, making itself a useful ally in the war on drugs. With thousands of arrests being reported currently in Tanzania (Motani 2017), no research has been done recently on the impacts of Magufuli's crackdown on harm reduction services.

Even as this troubling trend towards authoritarian anti-drug crackdowns is emerging, most of the work on illicit drug policy in East Africa is confined to journals on public health and addiction rather than politics and policy implications. Political works on the construction of the global war on drugs (Herschinger 2011) and the policies of Western countries such as the United States (Patten 2017) do not delve deep enough into how this rhetoric and the accompanying funding impact specific countries in their own context and according to their own political interests. Dimova (2016) is perhaps one of the few scholars currently trying to grasp the implications of the global war on drugs within the context of an East African country, but there is still much more room for further analysis of why these policies are being pursued and how they are impacting local and global discourse.

3.5 Conclusion

The existing literature on the war on drugs provides a good basis to critique the common assumptions that are part of this war and illustrate the many failures of this global consensus. With these failures obvious to most observers, there is a growing literature on the practice of harm reduction and theories and practices that challenge the criminalization of drugs. In this chapter I established what the war on drugs is and why harm reduction is more than just medical practices, but can help overturn the harmful war on drugs measures that have been in place for decades.

I also examined the literature on drug use in Africa, which shows a clear need to add to understandings of how drug use is perceived and addressed in these countries. The political perspective in particular is an important contribution, as the existing literature is more focused on establishing the numbers of drugs users and their health needs. While clinical studies are important, each of these authors themselves call for more work on drug use in East Africa and better understandings of the deeper context and implications of drug policies. In my consideration of harm reduction, I argue that interventions need to go beyond simple medical supports. Similarly, scholarly

works need to examine the larger context, international and domestic, in which drug use exists. My study aims to address this gap and provide a greater perspective on this issue in the hopes of guiding more comprehensive and inclusive programs to support the health and wellbeing of people who use drugs.

The existing literature provides a theoretical basis for how the war on drugs continues and the lasting epistemologies around drug use that it has produced. I argue that these lasting epistemologies have impacted current policies as well as the implementation of harm reduction, contributing to an international structure where the war on drugs is enshrined. While this chapter shows that the war on drugs leads to poor outcomes for people who use drugs and its epistemic roots, I illustrate in the next chapter how the war on drugs persists throughout international structures and with greater resources afforded to its continuation.

Chapter 4

The international war on drugs – regimes of control and mechanisms of enforcement

4.1 Introduction

This chapter explores the international nature of the efforts to both control the flow of drugs and deal with those who use them. I look at how the dynamics of treating addiction while controlling and eliminating drug use have evolved at the international level and are enacted through the United Nations, regional organizations, donors and NGOs. While the literature review focused on the epistemic underpinnings of the war on drugs and harm reduction, this chapter examines the actual structures that uphold and continue this war; how the epistemic power of the drug war is expressed and continues to be put into practice.

I also look further at how East Africa is linked in this international system. Through an international lens, this chapter sets the stage for how Tanzanian drug use is influenced by the international drug control regime and how international actors have developed their own responses and interventions in Tanzanian drug policy. Throughout, the chapter explains the salience of the international drug control regime in shaping a global drug response as well as the role of states and civil society actors responding to this regime and participating in its formation and evolution.

In the first section, I provide an overview of the United Nations system. This system has expanded beyond the resolutions I discuss in the literature review, and is formalized as the United Nations Office on Drugs and Crime (UNODC), an organization epistemically, and in practice, linked to perpetuating a global war on drugs. The UNODC provides statistics on the global drug problem while maintaining a focus on crime and prohibition. I then show how the UN more generally, through meetings focused on the international drug problem, remains committed to prohibition. In recent years, meetings at the UN have shown the complexity of global consensus around drug use, as decades of prohibition have only led to deepening health and social concerns. The current state of prohibition outlines these concerns as well as the absolute failure of the war on drugs to effectively address the human rights of individuals who use drugs. I illustrate how the persistence of this ideology is actively maintained by some actors, while other actors attempting

reform are trapped within these lasting systems of control. Overseeing attempted reform, and remaining symbolically committed to the war on drugs, is the United Nations.

The role of African countries in these systems is complicated, but reflective in some ways of common perceptions of African countries, especially in the case of illicit drugs, as areas of chaos and insecurity. These assumptions support fear-provoking securitization narratives (Gberie 2016). I discuss how ideas around illicit drugs and Africa have prevented a meaningful understanding of drug use in African countries and have driven interventions focused on security and control, rather than development. Alternately, NGOs working in development and in HIV/AIDS have reacted to the rising rates of marginalization and high rates of HIV/AIDS among people who use drugs with attempts to provide medical supports. I examine the impulse to support the health of people who use drugs and show that these responses, while desperately needed, are limited by the legal, economic and social restrictions enacted by domestic governments such as Tanzania.

This chapter argues that the construction of the global war on drugs has not only created a set of policies and dynamics which support the continuation of prohibition, but also reinforces an epistemic framework in which people who use drugs remain subjects of either criminal punishment or basic medical treatment. The discursive connection between narratives of drug use as a threat and the material power and resources that uphold the war on drugs serve to create an enduring and powerful commitment to failed policies.

Seeing the realities and the underlying issues that accompany drug misuse, would lead to a better understanding of what is needed by individuals who use drugs. Better policy interventions, however, have been prevented by reducing the needs of drug users to methadone or forced sobriety, rather than acknowledging deeper causes and more sustainable solutions. Reforms such as harm reduction cannot overturn decades of constructing ideologies and beliefs around drug use. In applying this to Sub-Saharan Africa, I argue that countries such as Tanzania, due to low capacity, low political will or even malicious political motives, have becomes focused on prohibition and curing drug use, rather than recognizing the complex realities underlying drug use in their countries. In African countries, meaningful reform in how illicit drug use is understood and responses to illicit drug use remains subordinate to the continued failed attempts to eradicate drug use.

4.2 The architecture of the international drug control regime

While the literature review explored perceptions of drug use and trafficking, this section describes the international mechanisms in place that actively uphold the war on drugs through meetings, resolutions, official statements and financial support. Large scale, international consensus on policy issues consists of an assemblage of actors, with varying levels of access and power to influence policy. Out of this large array of actors with differing and sometimes complementary motives, it can be difficult to see a coherent consensus emerge. What is clear, and what I show below, is the difference in power between those advocating for the status quo and those advocating for reform.

Despite anti-war on drugs advocates gaining greater access to challenge the war on drugs in recent years, the consensus at the international level remains settled on the prohibitive control of drugs. States with war on drugs agendas are active, while states with real interest in harm reduction are opting out or, in some cases, simply being apathetic allowing the war on drugs to continue. The UN is a site upon which states and civil society actors converge to contest and support war on drugs policy. While contestation exists, the UN still largely reflects the failed policies of the past. I argue that the war on drugs is rooted in both ideological and material power, with greater resources and efforts aimed at continuing it rather than turning towards an alternative set of policies.

The United Nations Office on Drugs and Crime (UNODC)

The mission of the United Nations Office on Drugs and Crime (UNODC) is apparent in the epistemic linkage the name suggests, to 'contribute to the achievement of security and justice for all by making the world safer from drugs, crime and terrorism' (UN Budget 2018/19). Formed in 1997, the UNODC was another iteration of global drug control, continuing the work outlined in the UN conventions and the International Narcotics Control Board (INCB). Over the past several decades, these institutions have maintained relative policy coherence with most countries adhering to prohibitionist policies, often referred to as the Vienna consensus (Boister 2016). As late as 1998 the slogan for the UNODC remained 'a drug free world: we can do it!' (Wodak 2014:191). The year 2008 was set to achieve this goal (Jelsma 2003). Harm reduction is a difficult shift for the global body and drug prohibition remains the main goal of the agency.

In recent years, however, authors have noted that the Vienna consensus may finally be breaking (Collins 2017, Jelsma 2016). In the 2019 World Drug Report, the Executive Director of the UNODC notes, 'successes identified amid the many, formidable problems that countries continue to face in grappling with drug supply and demand highlight that international cooperation works' (UNODC 2019:2). The increased evidence of the failure of decades of cooperation seems impossible to ignore and has indeed been pointed out by several states that are grappling with increased levels of opioid poisoning deaths. Several countries have continued to ignore this evidence, however, and reaching global consensus in tackling drug use has resulted in the production of approaches that appease more conservative countries. This power imbalance reveals not necessarily the greater influence of countries such as Russia and China in advancing repressive policies but rather the apathy of states invested in harm reduction willing to meaningfully back this approach. Further, many of the countries supposedly favouring a less repressive approach still see the value in war on drugs style policies, failing to recognize the contradiction between these policies and their half-hearted implementation of harm reduction.

The result of disagreements at both ends of the spectrum is a growing lack of interest in working collectively. As many conservative actors remain in positions of power, there is a less concerted effort to overhaul a system and rather a number of countries opting to work within a failed system while pursuing their own agendas. As Boister (2016) argues, the current drug control system is more open to flexibility for limited change within the existing consensus rather than meaningful reform. This consensus, however, favours the status quo as it is easier and requires less effort to overturn than a commitment to reform the system. In this context, harm reduction measures are introduced domestically in spite of the UNODC and INCB, not because of their active support (Paoli et al. 2013:933). In Canada, the introduction of harm reduction measures was the result of decades of activism, in spite of the government itself which repeatedly resisted these reforms. Only after decades of advocacy and rising overdoses due to more potent drugs did the government realize the importance and effectiveness of harm reduction interventions such as supervised consumption sites.

Ultimately, the fractured consensus means there is no concerted international effort to move forward with harm reduction, and there is no country acting as a champion outside of their domestic

sphere. In countries around the world, prohibition remains the epistemic assumption of policy with advocates of a different approach carving out a small niche at the bottom that does not overturn this policy framework, but rather fights to fit within it. At the same time, despite this fracturing and the increased distance between hardline approaches and the movement to save lives through harm reduction, the need for global cooperation is still seen as important in reaching the unreasonable goal of global drug prohibition. As Barrett writes, 'advocating for a move towards policy based on the aims of the UN naively presumes genuine government support for those aims, when in fact other political agendas are more likely the drivers of current drug control efforts' (Barrett 2010:143). As the idea of a drug free world has persisted for decades, the current drug control regime serves the purposes of those resistant to meaningful reform.

This overall consensus has not meant there has not been any progress towards more humane policies. For example, acceding to pressure to respond to the health and well-being needs of drug users, the budget of the UNODC for 2018/19 reflected an increase of 140.5% for a balanced approach to drug use, $265 million to support the health of this population through prevention, treatment and HIV/AIDS prevention (UNODC 2019). However, at the same time, the UNODC provides $210.9 million for countering transnational organized crime through training and support of anti-trafficking activities, $45 million to counter corruption, $69.1 million to strengthen justice an legislation governing drug trafficking, $28.8 million for terrorism prevention and $672.4 million for alternative livelihoods programmes in six drug producing nations (UNODC 2019). Taken together, these funds are four times the amount of funding put towards treatment and prevention. Further, of the treatment and prevention funding, harm reduction is an even smaller portion.

While increases in treatment and prevention funding are positive, it is confusing how the strengthening of criminal justice, punitive measures and anti-trafficking efforts are not considered as directly opposed to supporting drug users. These measures criminalize drug use, result in increased police harassment and limit drug supplies, increasing the likelihood of riskier use and overdose and limiting access to services. The epistemic linkage to prohibition style approaches is so strong that legal discrimination is not seen as antithetical to providing treatment and harm reduction services, but rather a complement to a full suite of policies for drug users. What is certain is the lack of engagement with people who use drugs themselves in shaping these ideas.

The evidence for such interventions producing positive outcomes is highly tenuous. Another example is alternative livelihood/crop production initiatives which have been massive failures, with Afghanistan producing more opium in 2018 since production was first recorded and Colombia continuing to produce large amounts of cocaine, despite the peace deal put in place (UNODC 2019). Contradictory policy-making is magnified in the case of Tanzania where the strengthening of strong criminal justice interventions, the regulation of drugs and the harsh penalties for users seriously limit the potential positive impacts of any treatment programs.

As I discuss in greater depth below, UNODC involvement in Sub-Saharan Africa is focused on the threat of drugs to stability in the region, and to development. At the same time, however, a 2016 UNODC report admits that 'the links between insecurity and the drug trade in Africa remain largely unknown' and 'the extent of drug related corruption within government structures in Africa is difficult to assess' (UNODC 2016:9). These admissions reflect the lack of evidence to support the focus on corruption and insecurity. This lack of evidence has not changed the focus of the organization on targeting these areas. The budget of the UNODC for 2018-19 included 27.4% devoted to countering transnational organized crime, 34.4% for a balanced approach to countering the world drug problem and support for countering corruption, terrorism prevention and policy support (UNODC Budget 2018-19). The majority of this funding was for global programming and Latin America, with Africa and the Middle East receiving 15.2% of this funding specifically (UNODC Budget 2018-19).

The UNODC is stuck in an old paradigm, counter to the health and protection of vulnerable populations. While it may appear that the old war on drugs is no longer relevant, the continuation of policies associated with it provides a context and framework that can be easily utilized and revitalized in domestic contexts. The war on drugs is being revisited and seeing support from populist authoritarian leaders around the globe, who see a benefit in continuing this war for their own purposes. The way the international paradigm of drug control unfolds in the domestic environment of Tanzania mirrors this broken consensus. The government is able to pursue harsh and punitive policies against vulnerable populations while touting limited methadone and anti-HIV programs that exist in a very restricted space. Again, there is no evidence that the disproportionate amount of funding going towards counter-terrorism, anti-trafficking and justice globally have had

significant effects. As I show below in examining a recent major meeting between UN member states to discuss drug control, these policies are not likely to change anytime soon.

The United Nations General Assembly Special Session on Drugs (UNGASS)

In 2016, the UN General Assembly Special Session on Drugs (UNGASS) took place, with high hopes that this international gathering would be an opportunity for large scale reform of a broken system. Ultimately, the outcome document of the 2016 UNGASS was a disappointment for many hoping for more substantial change. The document illustrates the grand undertaking of changing a very long held set of international norms. As noted by a participant in the proceedings, the outcome document 'reaffirms the unrealistic goal of a society free of drug abuse' and 'does not explicitly mention harm reduction despite this being agreed UN General Assembly language' (IDPC 2016:3). Indeed, the outcome document only reaffirms past resolutions, reiterating all of the misguided policies they proposed, highlighting the individual nature of drug misuse, raising concerns over criminal and 'safety problems' that arise from drug use and doubling down on the determination to 'eliminate the world drug problem' (UN Res S-30/1:2016).

The global make-up of the UNGASS conference showed divisions, with countries such as Norway voicing more progressive ideas and other countries remaining staunch in some extremely conservative perspectives. One example of the divide between conservative and progressive approaches was the push for evidence based harm reduction by New Zealand while 'Indonesia called the death penalty an "important component" of the country's drug control policy' (IDPC 2016:5). Russia lobbied to have harm reduction left out of the outcome document completely, and insisted on the 'inclusion of language that deferred to national legislation – a carveout that appears 18 times in the document – effectively giving member states the room to ignore what the document actually suggests' (Oakford 2016).

The outcome document re-asserted the need for 'increased international cooperation [which] demands an integrated, multidisciplinary, mutually reinforcing, balanced, scientific evidence-based and comprehensive approach' (UN Res S-30/1 2016:2/21). The document then underscores previous conventions and leaves out harm reduction, the leading science based approach (Oakford 2016). As a compromise among states, the opposition to harm reduction and re-assertion of a

prohibitionist approach led by countries such as Russia and China ensures old assumptions of drug misuse are kept alive even as some states attempt to pull back from these harsh approaches.

Collins argues that it was in fact the NGOs and civil society reformers who sabotaged meaningful reform in the process due to their 'highly myopic view of political reality, an absence of understanding of what "reform" actually meant and the active sustenance of a selective group-think' (Collins 2016:89). Collins' view does not reflect the implementation of harm reduction over the past several decades. In the past, it has always been civil society, pushing for radical and more extreme measures to address the health and human rights of people who use drugs who have advanced dialogue, even though it often means settling for less aggressive reforms. As I discussed in the previous chapter, with a lack of political will and genuine interest from more powerful actors, these organizations are forced to dilute their political aims and achieve change slowly and partially, resulting in the piecemeal advancements we have seen in the past decades. Collins blaming harm reduction advocates is disappointing when compared to the slowness of governmental actors to implement their suggestions. The real issue is the lack of recognition of the needs and human rights of people who use drugs worldwide, and the lack of commitment of countries to make the health and safety of this population a priority.

As mentioned in the previous chapter, the continued epistemic dismissal of people who use drugs as deserving of rights and services underlies this situation. The frustration with the UNGASS outcome document was not the fault of high expectations among reformers but rather the reemergence of hard liners and the lack of commitment among more sympathetic governments to get fully behind harm reduction. The most progressive members of the meeting were frustrated and, rather than continue fighting for a difficult consensus, simply stated their desire to pursue their own position. This was summed up by the Prime Minister of New Zealand, Jacinda Arden: 'we have a number of challenges that are quite specific to New Zealand and particular drugs that are present, but also on taking a health approach. We want to do what works and so we're using a strong evidence base to do that' (Nichols and Mason 2018). This statement, while understandable, does not bode well for a consensus on a more progressive approach forming.

UNGASS, Africa and outcomes: further challenging consensus

While the African Union (AU) does not actively align with the strongly prohibitionist approaches of some countries, the role of Africa in shaping these documents is itself riven with disagreement among member states. The African Group contribution to the UNGASS outcome document reflected a compromise between more hardline countries such as Egypt and countries more open to harm reduction such as Kenya and South Africa. The contribution of the AU is important to highlight as, while 'the global hierarchies of political and economic power that were established under imperialism and colonialism, and in which Africa was subordinated, did not cease with political independence', the AU is increasingly using its role to 'exert influence' and 'using common negotiating positions, in order to produce negotiation outcomes that benefit weak African countries' (Zondi 2013:19 – 20). The AU documents being developed prior to UNGASS mentioned harm reduction, stating the effective approach to drug policy combines 'supply reduction, demand reduction, harm reduction and international cooperation' (African Union Common African Position 2016:4). The outcome document focused instead on hopes for a drug free world (IDPC 2016:5).

Further, Rogers Siyanga, head of the Drug Control and Enforcement Authority of Tanzania made remarks highlighting Tanzania's focus on harm reduction (Siyanga 2016). His comments centre around health, 'Tanzania's harm reduction strategy aims in reducing social and health risks associated with drug use through a set of interventions such as needle and syringe exchange, HIV counseling and testing, anti-retroviral therapy, opioid substitution therapy, prevention and treatment of sexually transmitted infections, condom programmes, vaccination against viral hepatitis and treatment of tuberculosis' (Siyanga 2016). While promising, Siyanga's statement highlights simply the extension of regular health supports to people who use drugs, not necessarily showing any legal, social or further interventions that would support people who use drugs. As I show in following chapters, the statement also presents gaps between international rhetoric, domestic policies and the realities on the ground.

Ultimately, the Africa Group outcome document to UNGASS erased all references to harm reduction, re-asserting the three previous UN international drug conventions and re-stating previous AU positions. The document further states 'governments are encouraged to enhance close collaboration between their law enforcement authorities and their national HIV/AIDS authorities so

as to ensure that the challenge of HIV/AIDS among injecting people who use drugs us properly addressed in accordance with national law' (African Union Common African Position 2016:4). As with Russia, the importance of national law is emphasized, allowing countries to voice their commitment to combatting HIV/AIDS, while maintaining regressive laws that seriously impact populations most at risk, such as PWID. As a final contribution, the document notes that 'misguided policies such as the legalization and decriminalization of certain drugs will hinder the ongoing efforts to combat the illicit production, trafficking and abuse of drugs and also the balanced approach which Member States have committed to in the global fight against the world drug problem' (African Union Common African Position 2016:4). This reworking of a more progressive approach that is almost directly opposed to even moderately progressive policy was the input of several African countries to UNGASS 2016.

The UNGASS outcome document, due to the interventions of hard liners such as Russia and contributions such as the African Union document outlined above, does not mention harm reduction and remains focused on treatment only as a means to end the threat of drugs. The document highlights a continued fracturing in the global consensus on the approach to drug use. As was evident at UNGASS, the UNODC continues to portray drugs as a criminal threat, conflating the harms caused by drugs with drugs themselves rather than the policies governing their use and trade.

At another recent gathering of the UN general assembly, in follow-up to UNGASS 2016, US President Donald Trump again asserted the threat of drugs to development and stability, with no mention of development, only treatment in order to support recovery (Global Call to Action on Drug Control 2018). Trump, through a mixture of coercion and persuasion, attained 130 signatories on a document affirming the failed approaches of the war on drugs (Nichols and Mason 2018). This strange intervention is generally reflective of Trump's scattered international drug policy, but also a performance, recalling the more active days of US hegemony in the global drug war. While the United States continues to uphold fears of the drug threat, the inflammatory language of the war on drugs has become increasingly critiqued, especially in the midst of the opioid crisis and other failures their policies have wrought. Drug warriors now, with the exception of some loud populists, seem to prefer to prosecute their drug wars quietly.

Ultimately, Trump's intervention on behalf of the US was not significant, but is rather indicative of Trump's larger policy of removing the United States from major foreign policy debates. The chaos of Trump's foreign policy, often resulting in their absence from previously held leadership positions, plays into the hands of leaders such as Russian President Vladimir Putin, and John Magufuli in Tanzania, who seek to influence debates in ways that allow them to pursue their own goals. Member states during UNGASS and in subsequent meetings have continued to show a lack of meaningful support for reform. Civil society actors and harm reduction organizations, sometimes made up of people who use drugs themselves remain a strong voice pushing the debate forward. Hard line leaders and governments have been able to continue to uphold prohibition even as their countries face higher and higher levels of drug related harms.

4.3 The current state of prohibition and the results of an unwinnable war

The cost of pursuing a drug free world

Despite efforts towards prohibition over past decades, there has been little change in the production and trade of illicit drugs such as heroin. On the contrary, riskier uses such as injection drug use have spread. Drug use and availability are more prevalent than ever. In 2011, the UNODC estimated between 149 and 271 million people between 15 and 64 years old had used an illicit drug at least once (Degenhardt 2012:56). Global opioid users were estimated to number approximately 12 and 21 million and, in 2007, the number of people who inject drugs was estimated to be between 11 and 21 million people (Degenhardt 2012: 56 – 57). In 2017, UNODC reported the range of people who have used drugs at least once in the previous year to be between 201 to 341 million (UNODC 2019). Of this sample, 53.4 million people used opioids (UNODC 2019). Overall, UNODC estimates that global drug use has increased by 30% since 2009 (UNODC 2019).

These numbers continue to be difficult to estimate, but they have risen. The 2019 drug report I am citing utilized more in-depth studies in Nigeria and India, where data has been difficult to access, to show that the numbers of opioid users and people with drug use disorders is much higher than previously estimated (UNODC 2019). The problem seems to be growing, yet harm reduction language continues to be limited, and is not mentioned at all in this report. While

references to health and treatment are many, this is only in regard to dealing with the spread of diseases such as HIV and hepatitis C.

Further, even though the war on drugs approach has apparently been slowing, higher use now also includes use of harsher drugs such as fentanyl and rising opium and cocaine use in countries with previously lower levels. The emergence of more potent drugs and their prevalence reflect a global market in which more potent formulas are more profitable. Small amounts of fentanyl are easier to mail or smuggle and produce much more profit than larger quantities of heroin. The increase in the use of more potent drugs is directly linked to the illegality of their more common predecessors.

The use and misuse of illicit drugs has grown, and the use of more harmful drugs and riskier methods of use has firmly spread over the past several decades of international cooperation to end the illicit drug trade. This trade, estimated to be valued at $400 billion in 2005 (Roberts and Chen 2013:107), was estimated to be worth $426 to $652 billion in 2017, one third of all estimated transnational crime (Global Financial Integrity 2017). Global cocaine production increased 25% in 2017, mainly driven by Colombia despite a peace deal now in place with the FARC (UNODC 2019:7). In 2018, the third largest amount of opium was produced since UNODC began monitoring production in 1990, and would have been higher had there not been a drought in Afghanistan, which produced 82% of the world's opium supply (UNODC World Drug Report 2019:13).

Efforts to limit the market and supply have clearly failed but it is also important to note the greater impacts that have accompanied supply side efforts as compared to providing treatment or supports for people who use drugs. The criminalization of drug use results in drug users engaging in riskier use, pursuing more dangerous activities to pay for illegal and expensive drugs, discourages them from seeking access to treatment and exposes them to violence and infectious disease (Degenhardt 2012:65). Further, drug wars disproportionately impact already marginalized portions of society, targeting populations 'unequally by race, gender, class, and region' (Roberts and Chen 2013:106). As prohibitionist policies often adopt a one-size fits all approach, the results are similar despite differing cultural and social contexts, impacting vulnerable minorities the most.

Lasting narratives of drug use and control

As is clear throughout this chapter, working to reverse the global drug war has proven difficult, despite the evidence of its failures being relatively well known. Drug use is inextricably linked to ideologies and beliefs which create an epistemology of addiction, crisis and control. At its most basic level, decades of working to eliminate drug use has constructed the addict as at fault for policy failures. The war on drugs paints addicts 'as an isolated agent who perversely acts against his own self-interest' and removes the social context, placing drug users firmly in the neoliberal order where personal responsibility is paramount (Acker 2010:72).

This personal weakness supports the case for criminalizing drug addiction, but also underlies scientific models which consider addiction a disease impacting specific individuals. As Acker argues, the advancement of research in neuroscience and the reward centres of the brain to advance the disease model of addiction has furthered understanding of drug dependency, but is still linked to prohibitionist stances, promoting a model that does not answer questions of social context and systemic inequalities (Acker 2010). As I discussed in the previous chapter, new forms of understanding addiction have supported progress towards more humane treatment, but have not meaningfully challenged the constructed notion of addiction.

Over the past century, many concerned members of society have genuinely seen drug use as a source of social ills (Paoli et al. 2012). Given the correlation of drug misuse and mental illness, poverty and social alienation, drugs serve as an easy target on which to lay blame for the complex systemic and social inequities underlying addiction (Roberts and Chen 2013). Despite the awareness of the harms and social disintegration caused not by drugs but by discriminatory drug policy, war-on-drugs rhetoric has proven politically useful to some populist leaders. In its strong messaging and large educational component, it has created societal support for continuation of these policies – only now that overdose deaths related to opioids have reached epidemic levels has the larger public become more concerned.

The tension between the realities of drug use and addiction, which have become even more present in the West with the influx of powerful synthetic opioids, and the political usefulness of narratives associated with drug control result in a diverse range of outcomes internationally and

domestically. A recent example can be illustrated in Canada, where Stephen Harper's Conservative government strongly opposed harm reduction and evidence-based policy for almost a decade, even as potent opioids and addiction rose among marginalized and middle-class citizens alike. In 2014-15, as the leading opposition party advocated legalization of marijuana, Harper injected over $7 million into an anti-drug advertising campaign which, while consistent with his ideology, could also be seen as a tactic to appeal to his demographic base (Cheadle 2015). Harper's campaign served immediate political interests, but also rehashed unscientific and dubious fears that marijuana is a highly addictive substance and legalization would endanger children (Macqueen 2015).

Framing drug policy not as a healthcare issue but as a criminal one has a strong influence even in Western countries which have been unable to effectively enforce drug prohibition for decades. Dominic Corva goes as far as to call this 'the penalization of poverty', stating 'poverty is criminalized, de facto, but it would be more accurate to say that narco-delinquency tends to produce excluded populations, and the spaces they inhabit, as criminal' (Corva 2008:191).

Some conservative politicians in the West have now grudgingly accepted that more support for treatment is necessary, particularly as synthetic opioids and painkillers impact society at all levels. Increased public pressure to address the crisis may have seemed a perfect moment to implement comprehensive harm reduction measures. Populists wishing to utilize the war on drugs face the challenge of maintaining the image of a tough drug warrior while also responding to real concerns over rising opioid poisoning deaths. The solution has often been maintaining legal restrictions while supporting treatment options that are focused on curing the addict and getting people permanently off of drugs. In Russia, a country with high rates of HIV/AIDS and a strong commitment to the war on drugs, there are no needle exchange programs and no methadone treatment. Their approach is simply to force opioid users into social and educational treatment, managing withdrawals with naloxone (Glenza 2016).

Canadian conservative leaders recently, under pressure to respond to the opioid crisis, have also opted to focus on treatment and getting people permanently off drugs (Kaufman 2019). Discussions of decriminalization or meaningful reform are not on the table. As I discuss in the following chapters, Tanzania's focus is also less about supporting the underlying challenges facing

drug users and is more focused on solving the problem permanently, regardless of what is needed by people who use drugs themselves.

These ideas reflect decades of focus on a drug-free world and the seemingly permanent linkage of drug use to a social problem that needs to be eradicated. While the urge and necessity to stop using drugs is important and treatment and supports should be available for this purpose, the realities of many users' environments and support systems lead to relapse. The effectiveness of prohibition and its associated norms is such that the dichotomies instilled by this narrative remain a powerful thread in most discussions of drug use and misuse. The options that have accompanied the war on drugs mainly focus on individual responsibility, whether this is a 12 step program, or a medical treatment.

Bruce Alexander, working to challenge dominant approaches, used rats to illustrate the greater social and emotional aspects of drug dependency. His experiments, which would be famously dubbed 'rat park', showed that rats increased their opioid usage in isolation and, when surrounded by plentiful food, companionship and better conditions, ceased using opioids. Alexander has long tried to illustrate that addiction is not an individual problem but is social, 'a way that large numbers of people adapt to the breakdown of psychologically sustaining culture under the global influence of free-market society' (Alexander 2012:1475). Addiction narratives are rooted in discourse on drug use yet there is little attention given to the broader causes of drug use being embedded in deeper social and economic issues. Despite evidence of drug use impacting vulnerable people to a greater extent, unlinking understandings of addiction from individual responsibility remains a challenge.

4.4 Drug use in Africa: narratives of control, development and chaos

Histories of drug use

In this section I highlight the narratives that have driven interventions on a larger scale in some African countries. The narratives that inform how Africa is depicted in the context of drug trafficking are predictably shaped by long-held assumptions and misunderstandings of the continent itself, a diverse and complex number of countries with unique histories of drug use and trade. As

with other topics on Africa, narratives are impacted by the otherization of African countries and a lack of consideration for unique cultures and economies. In the first section, I provide a general overview of drugs in Africa before focusing on three main narratives in which African countries have interacted in the context of global drug prohibition: drugs as a security threat, drugs as impacting development and drugs as a health crisis.

In the 2014 book *Drugs in Africa,* Charles Ambler, Neil Carrier and Gernot Klantschnig note how little attention has been paid to Africa in terms of global trafficking and, when attention is paid, coverage often depicts 'a continent defenceless in the face of international narcotics trafficking…embellished with lurid tales of violence and corruption' (2014:1). As discussed above, African countries have also been subjected to the global war on drugs, including dramatic statements such as the one above that ignores the complexity, history and cultures of drug use in Africa. While it is true that several countries in Africa have seen an increase in drug trafficking and the integration of harder drugs into existing networks, it is unfortunate that dated tropes continue to be used in describing drugs in Africa.

The influx of heroin in East Africa accompanied the liberalization and capitalist expansion of the 1980s. This trade, however, should not be seen as new but rather a re-integration as 'age-old practices persist or are transformed and linked to new ones, as African producers, traders, and consumers engage in an increasingly complicated global drug market' (Ambler, Carrier and Klantschnig 2014:2). This complexity is more useful than considering Tanzania and African countries in the Sahel, where trade has increased, as blank slates integrated into a globalized market. On the Swahili coast, injection drug use is new, but shipments are often transported by dhow along centuries old trade routes. In Mali, trade is integrated into old trade routes as well (Gberie 2016).

The disruptions in older practices of drug use and the imposition of new and alarmist ideas about the dangers to development have resulted in a one-size-fits-all approach to drug misuse and trafficking in many cases. The fears of western Africa's 'cocaine coast' destroying a generation of youth, the use of drugs to fuel Islamist terrorism in the Sahel and the fears of injection drug users spreading HIV/AIDS in East Africa have animated most of the literature on drug use in Africa. While I reviewed some of the literature that goes against these assumptions, the works of Sheryl McCurdy, Neil Carrier and Gernot Klantschnig are in the minority. The resultant lack of literature

on people who use drugs is a major gap and has left these populations open to top-down interventions designed by foreign donors or unsympathetic governments.

Narratives of securitization and support for the drug war in Africa

In 2010, a United States congressional report noted that 'U.S. policy responses to the rise in drug trafficking through Africa remain in the formative stages' (Wyler and Cook 2010:33). Despite this lack of coherent direction, initial concerns were clear: 'how to develop a strategy and find the resources to both stem the rising flow of drug trafficking through Africa – particularly West Africa – in the short term, through such means as effective interdiction operations, and simultaneously address the underlying, long-term law enforcement capacity weaknesses that make the Region vulnerable to drug trafficking' (Wyler and Cook 2010:33).

Militarily, most African countries are a lower priority than other regions involved in drug trafficking. That said, by 2012, United States Africa Command (USAFRICOM) was providing approximately $20 million in aid to various partner nations in Africa for counter-narcotics activities (Turse 2018). USAFRICOM leads the United States' counter-narcotics efforts on the continent among other support such as anti-terrorism. This support, unlike support given by USAID which usually tries to consider human rights or development implications, includes key partners such as Uganda and Ethiopia, repressive regimes aiding in the fight against terrorism in the Horn of Africa (USAFRICOM 2018).

From 2014 to 2016, USAFRICOM and United States Central Command (USCENTCOM) provided $496 million to support counter-narcotics activities (US Department of Defense 2017). US military assistance for training and capacity has risen the highest among other regions in Sub-Saharan Africa, with Tanzania and Senegal seeing the highest rise in US trainees (Security Assistantce Monitor 2017). In 2013, the United States provided $50 million to 'combat transnational organized crime, and particularly drug trafficking, through the West Africa Coast Initiative' (Gberie 2014:4). This initiative, among others in the region, reflect the fears of the drug trade in west Africa, which also prompted the Economic Community of West African States (ECOWAS) to not only ratify all the UN treaties and conventions (which as I highlighted earlier are prohibitionist), but to 'meet the requirements of these Conventions and the Protocols' (Gberie 2014:4). Given the focus of Western

countries on drugs flowing into their own borders, West Africa has received a lot of attention as a hub for cocaine passing through to Europe and the United States.

Again, despite some fears being founded – for instance, Al Qaeda in the Maghreb does use drug revenue to fund some activities – these policies and this funding has shown little in terms of results. Remarkably, a review of USAFRICOM and USCENTCOM spending from 2014 to 2016 revealed major flaws with data collection, monitoring of efforts and coordination to the extent that neither agency could 'determine whether their CN [counter-narcotics] programs effectively used the $496 million …in fiscal years 2014 through 2016 to counter illicit trafficking' (US Department of Defense 2017:11). This admission highlights not only how bad policies are pursued, but how they are not even effectively implemented at great cost. It is a statement that also shows how the fractured consensus of global prohibition, while maybe deteriorating in terms of rhetoric, is still supported by high levels of funding.

The costs of propping up this war in one region seem high. United States counter-narcotics activities in the western hemisphere from 2010 to 2015, however, dwarf this, valued at over $5 billion (United States Government Accountability Office 2017:10). While East Africa is not necessarily a priority region, the high amounts of funding show that even a non-priority region is able to access funds for security purposes. Further, as I show below, funding for development has become linked into securitization narratives and is another way to fund the war on drugs.

Drugs and development, the continuation of supply side control

The policies outlined above are driven by fear of the chaos and destruction drugs supposedly cause, and by Western countries' self-interest in reducing drug availability in their own countries. These fears and the associated policies of prohibition, previously depicted in self-interested terms have now become increasingly cloaked in win-win language for third world countries and the West. Effectively, the punitive language of the war on drugs has transformed into more compassionate language aimed at caring for the developing world and hoping to support development, which illicit drugs prevent. Deborah Alimi tracks the rise of this narrative over the past decade, noting that policy divergence and the desire to improve drug policy has opened up space for the diffusion of this agenda (Alimi 2019). The idea of drugs impacting development needs to be unpacked, however,

as it again tends to ignore the histories and complexities of drug use and trade in Africa. While the mantra of drugs being bad for development is assumed, it decontextualizes the ways in which illicit drugs can have complex interactions within the socio-cultural, economic and political environments in specific countries.

War on drugs discourses are connected to drugs and development through the narrative that tackling drug use is somehow a way of fostering development. The narrative offers little analysis of how development is actually impacted and obscures how combatting drug users is often just another way of bolstering government repressive capacity and security. As Klantschnig, Dimova and Cross argue in their introduction to the special edition on drugs in Africa, 'it is perceptions of security, rather than real concerns with development, that still drive drug policy elaboration and implementation in Africa' (Klantschnig, Dimova and Cross 2016:171). While drug use is often repeatedly mentioned as a threat to security and development, there is no evidence of how or why development is impacted by drugs. Instead of considering the actual impacts of drugs in society, let alone the connection to development, many major states and organizations are highly supportive of this agenda.

As Dimova's work has shown, drugs can have a real impact on society but supply reduction and increased enforcement initiatives often impact 'street-level dealers, who often come from marginalized backgrounds' (Klantschnig, Dimova and Cross 2016:171). Further, those who are severely marginalized and who already face major pressures in finding drugs face dangerous withdrawal, switch use to higher risk substances or engage in riskier behavior such as needle sharing. From interviews with those who work with PWIDs in Dar es Salaam, the only real impacts are felt among the most marginalized population involved in using drugs.

Fears of drug trafficking in East Africa impacting development were illustrated clearly in a USAID publication entirely focused on the development response to drug trafficking in Africa published in 2013. This document, aimed at guiding development responses framed drug trafficking as a threat to democracy and development, with the 'failure to address this threat' posing the risk of 'undermining the U.S Agency for International Development (USAID)'s investments and thwarting U.S. Government objectives on the continent' (USAID 2013: 1). The focus of the US Government in building accountable governance to counteract this major threat has had the opposite effect:

building up the repressive state apparatus in many countries to combat drugs and supporting the power of authoritarian states. The USAID report reads more like instructions for an enforcement agency, with a focus on 'bolstering political will, fostering accountable governance and developing counter-narcotics capacity' (USAID 2013:25).

The linkage between drugs and development shows a passing focus on human rights and instead a much greater interest in using aid dollars for security efforts. More recently, a high level US bureaucrat reiterated this grave picture stating, 'if we do not act decisively…drugs and illicit enterprise will corrode the rule of law and the gains of globalization' (US State Dept. 2017:8). The connection between a globalized war on drugs which has inflated the price of illicit drugs and forced traffickers to develop new routes for trafficking is not remarked upon.

Similarly, Penny Mordaunt, the Minister of Foreign Development for the United Kingdom, following suit with the mingling of drugs and development position of USAID, made high profile visits to Tanzania. Mordaunt was in Tanzania in support of a 1.3 million pound programme to support Tanzanian and Kenyan authorities investigate organized crime with the support of the British Royal Marines (Elgot 2018). Mordaunt suggested this initiative would prove that funding has the effect of helping developing countries, where development is compromised by drugs, but also support an end to organized crime in the UK (Rweyemamu 2018). Mordaunt's suggestion promotes the assumption, again without evidence, that increased security in the Indian Ocean somehow reduces traffic to the UK and supports stability in Tanzania. Claiming to have stopped millions of pounds of heroin being trafficked through the Indian Ocean, Mordaunt noted the double-win, 'combating organized crime and improving security is good for developing nations and directly contributes towards the security and safety of the UK' (Elgot 2018). Mordaunt here echoes USAID policy, raising the spectre of drugs as a threat to development.

While seemingly an admirable goal, helping a developing country through supply side interventions, visits like Mordaunt's are simply a continuation of the war on drugs. A common assumption contained in this 'drugs threatening development' narrative is the idea that corruption is due to illicit drug trafficking. The removal of drugs from the equation, however, would not solve issues of corruption. As the most recent World Drug Report (2017) states, 'fewer groups are exclusively dedicated to drug trafficking, while more are operating in other illicit sectors' (UNODC

2017:9). In countries such as Tanzania, there is an array of opportunities for organized crime, both licit and illicit. Drugs can be, at different times, a viable way to support other illicit activities, and crackdowns seem to have little impact on the major players involved. At worst, slight disruptions and the need to wait out increased efforts to crackdown result in adaptation by criminal groups and elites.

Underlying the claims of championing development, there seems to be little interest in examining how drug use actually impacts Tanzanians. Common phrases attacking corruption or poverty writ large do not actually help people impacted by drug use and instead betray a highly cynical self-interest aimed at reducing supply in the West under the guise of development work. Importantly, in this context, aid dollars become an extension of enforcement in the pursuit of an intervention that will definitely fail. As Carrier and Klantschnig (2016:185) argue, 'current drug policy itself has the capacity to ruin livelihoods and impede development, sometimes more so than the drugs themselves…in most African states, drug-supply control has clearly been prioritized and it is mainly petty cannabis traders, farmers and users who 'meet justice' as they are easy targets for law enforcement officers.' In 2017 in Tanzania, khat farmers were indeed targeted by the Drug Control and Enforcement Agency (Motani 2017).

The *Tanzanian Daily News* noted, 'narcotic drugs, which include khat, are a health hazard and indeed, a threat to life' (*Tanzanian Daily News* 2016). This bizarre claim is not based in any evidence. Khat is a mild stimulant with a long history of use in East Africa, and it is very unclear how a raid on its production would aid development. The example of the Tanzanian government touting its successes builds its own legitimacy and also raises questions, which I explore later, as to where the narrative of drugs impacting development originates. After all, using Tanzania's limited resources to target poor khat farmers would seem questionable outside of the realm of aiding development.

As I will discuss in the next chapter, the targeting of vulnerable and poor people was absolutely evidenced in my research with opioid users in Dar es Salaam. Sheryl McCurdy (2014:147), in writing about Tanzanian heroin users also notes, 'most poor drug users want to escape the pain of poverty and also access education and income-earning activities that will help them change their life circumstances.' Development aid that goes towards supply reduction does not help address these needs, nor does the encouragement of governments to support supply side interventions.

The Sustainable Development Goals (SDGs) also include illicit drugs as a threat to development and 'embrace human well-being from a combination of economic development, social inclusion, accountable governance and environmental sustainability' (Alimi 2019:40). Despite these high hopes and the idea that SDGs will address the root causes of illicit drug trafficking, it is unclear how current efforts actually do so. As shown above, and discussed in the section below, efforts to deal with drug use remain trapped in the dichotomy between public health intervention and supply reduction. This unhelpful dichotomy does little to address the root causes of drug use and continues the lack of recognition for people who use drugs as deserving of dignity and human rights.

NGOs, donors and public health crisis

Alongside security concerns, the overriding issue of HIV/AIDS rates among injection drug users has driven a large portion of the public health response in Sub-Saharan Africa (SSA). As I discuss in the next chapter, in many countries like Tanzania with high rates of HIV/AIDS, and with significant foreign investment in their health budget, donors have supported interventions aimed at reducing HIV transmission among key vulnerable populations (KVP). The largely foreign funded interventions from organizations such as the President's Emergency Plan to Fight HIV/AIDS (PEPFAR) and the Global Fund are significant and, despite the challenges remaining, are remarkable responses to a major public health crisis. PEPFAR alone has spent more than '$70 billion on programmes globally to combat HIV and AIDS, tuberculosis, malaria and other opportunistic infections since 2003' (AVERT 2019).

This important work is driven by the disproportionate burden of HIV in SSA, where 12% of the global population makes up 71% of infections (Kharsany and Karim 2016:35). Despite a focus on treatment and its now greater accessibility, many individuals still do not know their status, prevention is a challenge and, with gender inequality, young women are still disproportionately impacted. While major investments have been made, heterosexual sex remains the dominant mode of HIV transmission, impacting potentially large numbers of people and leaving little focus for marginalized groups who may be considered deserving of their status (Kharsany and Karim 2016).

The need to focus on HIV/AIDS, a true public health crisis that does not receive the extent of funding needed, can have adverse effect on funding for more comprehensive harm reduction approaches which remain chronically underfunded. UNAIDS has estimated that $26.2 billion is required in 2020 for global HIV response, however donor funding has been declining (AVERT 2019). In 2017, funding climbed to $20.61 billion, however over half of this was made up of domestic funding rather than funding from donors (AVERT 2019). It should be noted that this domestic funding is largely representative of higher income countries such as South Africa, while in East Africa, more than 80% of HIV response remains foreign funded (AVERT 2019). The larger trends in donor funding for HIV/AIDS can have significant repercussions for people who use drugs, as this is often the only source of funding available. While there is a need for greater investment in HIV/AIDS generally, this is declining and countries such as Tanzania, with lower rates of successful program implementation, are unable to make up donor funding reduction. As I show in the next chapter, Tanzania is dependent on foreign funding for its HIV/AIDS response and is therefore deeply impacted by cuts.

UNAIDS has estimated that $2.3 billion annually is required for HIV prevention among PWID (Cook et al. 2015:2). In 2015, only 7% of this funding, or $160 million, was provided (Cook et al. 2015:2). As harm reduction funding is usually only a subset of HIV/AIDS prevention, these funds are often only for drug injection and does not meet the needs of PWID beyond treatment. With the high rates of HIV among PWID, this discrepancy shows that $160 million is not enough. What is even more difficult is the cost-effectiveness of harm reduction comparatively. Intervening early, treating and preventing HIV saves massive costs in the long-term, especially in developing countries with struggling health systems. Unfortunately, money is instead put towards supply-side interventions which are considered supportive of development or towards downstream services such as Anti-Retroviral Therapy (ART).

I am focusing on HIV/AIDS response as this funding globally is primarily what is available to support people who inject drugs in SSA. This is one of three groups who make up KVP, along with female sex workers and homosexuals, where the overriding concern has been implementing basic harm reduction supports to prevent and treat HIV/AIDS. It is estimated that 40 – 50% of new infections are among these groups while global HIV prevention funding specifically allocated to these groups is only 2% of the global total (AVERT 2019). This statistic is important to remember

in SSA, as KVP make up tens of thousands of the most vulnerable individuals in these societies, legally, economically and socially. There is domestic funding available in some larger economies. However, as mentioned earlier, this is not possible in countries such as Tanzania which are unable to meet the basic health needs of the general population. AVERT estimates that '$137 million is spent annually on global human rights response to HIV, accounting for just 0.13% of all HIV spending in low and middle income countries' (AVERT 2019). For KVP, including homosexuals and PWID, obstacles are faced in legal and social discrimination while funding to address their needs is inadequate. The focus on simply addressing the medical needs of individuals with HIV/AIDS leaves out the larger context in which some of these highly marginalized people live.

The response to reduce HIV/AIDS among these groups reflects the crisis on the ground, recalling the emergency type response in the early days of HIV to simply prevent the spread before anything else. This is understandable, as I discuss in later chapters, and it is difficult to criticize this focus given the magnitude and size of this issue. However, the single minded focus on health has not considered non-medical interventions as an important part of the overall response. For instance, homosexuality is reduced to the medical term 'men who have sex with men', defined as encompassing 'a large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with any particular community or social group' (World Health Organization 2016).

This definition, while serving a medical purpose, does not acknowledge homosexuality as an identity with the rights that accompany it. In countries hostile to homosexuality, a lack of recognition does not further the health and wellbeing of this group. Ignoring the human rights of homosexuals may allow limited services for this population to be allowed in hostile countries, however, it should be questioned to what extent services are successful in the midst of greater repression and abuse.

In general, the use of the term KVP, while initially meant to allow epidemiologists to study infection among this population regardless of sexual or gender identity, collapses real persecuted populations such as homosexuals into a vector for disease. Similarly PWID are considered less as individuals requiring social, economic and mental supports than as a population requiring a simple

medical intervention. With little funding available for these groups in general, framing extra activities beyond providing methadone for example and getting these groups on treatment can be difficult. However, the reality on the ground is much more complex for poor, vulnerable groups with unstable living conditions committing illegal acts, maintaining anti-retroviral treatment is a major challenge. ART requires a high level of consistency. Leaving out the larger context in which people access treatment is a major gap in ensuring positive outcomes for KVP. As summed up by Katherine McLean:

> An investment in the health of IDUs [injection drug users] – and drug users at large – is not incompatible with a broader concern for social justice, the macro-level determinants of drug use and addiction, and the larger context of risk. Where the language of biological citizenship may be expedient within a nation that retains a strictly pathological view of drug use, needle exchange and harm reduction proponents at large should be wary of the ways in which it contributes to the devaluation of users' social and political existence (McLean 2011:78).

Addressing these challenges would require significant investment and, ultimately, economic and social development more generally. In this context, the limited interventions are still highly needed. It is clear there is a basic understanding of addiction, in which personal responsibility despite incredible obstacles, is seen as a reasonable way of managing growing heroin use. The model of getting people on methadone, however, curing them of their addiction and then maintaining ART while they return to society is not only unrealistic, it allows drug warriors to create a semblance of harm reduction while upholding extremely repressive laws.

As with harm reduction practices in other countries, people who use drugs have to settle for limited supports that do not address the root causes of stigma (which are often stoked by governments themselves) and addiction is constructed as a disease to be cured. The persistence of the ideology of addiction without context and as a personal failing goes beyond Africa. The implementation of treatment and rehabilitation, while maintaining a high level of commitment in funding and resources to eliminating drug use, is still dominant. The continuation of supply-side efforts along with harm reduction may seem innocuous but in many countries with limited resources, this prevents meaningful and realistic interventions on behalf of people who use drugs.

4.5 Conclusion

In keeping with Bayart's point that African countries should not be considered outside of global dynamics but as a constituent part, I used the international drug control regime as an example of how African countries are a part of a global consensus on drug policy. The inclusion of African actors is not only apparent in domestic policy but at the UN and international meetings focused on dealing with issues of drug use and trafficking. African leaders are influenced and themselves advocate different policy positions in the discursive space of international policy making. They can take performative positions as tough on drugs, as compassionate human rights advocates or as deeply concerned about working together on development and ending the scourge of drug use.

As with any country in the West, despite unequal resources, African countries pursue their interests, which sometimes align with a tough, war on drugs ideology. While many countries that make up this global consensus have come to realize its failures, many of the policies attached to the war on drugs continue in practice. This chapter illustrated how the epistemic underpinnings of the war on drugs continue to be the basis for drug policy, despite rhetoric to the contrary. In this climate, countries have pursued war on drugs policies, but must also balance the continuation of this war with the appearance of caring for people who use drugs. As I argue in this chapter, the inability to abandon failed policies while implementing minor harm reduction programming is not meaningful reform but simply the persistence of old norms and values.

In the section on Africa, I divided the narratives that have emerged about drug use in Africa into three broad tropes: securitization and fear, drugs impacting development and drugs as a public health crisis. While these categories may simplify a complex situation, in regard to Tanzania, they are narratives that have driven international donors' and NGOs' response towards people who use drugs in the country. As I argue in later chapters, these narratives are an effective array upon which the government of Tanzania can pursue its own policies and drive an agenda while maintaining donor confidence. Concerns over a public health crisis among people who use drugs and have HIV/AIDS do reflect the reality of high rates in the country and need to be addressed. In the context of Magufuli's Tanzania, however, these interventions do not consider the needs or lives of people who use drugs.

In the next chapter, I explore Magufuli's authoritarianism in the context of the longer political history of Tanzania as a one-party state with authoritarian tendencies. The politics of Tanzania serve as a background into which Magufuli has come to power and reversed supports for people who use drugs. I also describe the ongoing donor dependence of Tanzania to argue, in later chapters, that in pursuing its own agenda towards people who use drugs, Tanzania has contributed to a misunderstanding of harm reduction, in this case, by passing off methadone treatment ending in abstinence as harm reduction. This mentality, simplifying harm reduction to a basic medical treatment ultimately aimed at abstinence, has larger ramifications as it is the dominant approach to people who use drugs globally and fits into emerging narratives that combine supposed care for people who use drugs with marginalization and repression.

CHAPTER 5

Tanzania since independence: authoritarianism, aid dependence and the bulldozer

'In Tanzania, we had our problems, but at least we knew where we were going"[5]

5.1 Introduction

In this chapter I provide an overview of the dynamics of Tanzanian history since independence, with a focus on the governance of the country, its aid dependence and the rise in authoritarianism under President John Magufuli. As mentioned in the introduction, there are unique trajectories of drug control, use and understandings vary in different contexts. The nature of the response to increased heroin trafficking and use in Tanzania reflects the country's history, its aid dependence, its high rates of HIV/AIDS and its dominant-party political system.

I first provide a brief overview of Tanzanian history with a focus on the aid dependence of the country and the ability of one party to effectively maintain relationships with donors despite corruption and mismanagement, and remain in power since independence. I then discuss how Magufuli has in some ways changed this path through his more overt style of populist politics while also continuing to manage relationships with donors as previous governments have. Magufuli, in this way, represents continuity with the past as he works to erode democracy and centralize power around himself and his party.

In this chapter, my focus is on illustrating the aid dependence of the Tanzanian ruling party since independence and the ability of the elites to manipulate donors and pursue an agenda focused on the centralization of power. These centralizing and authoritarian tendencies have been present throughout Tanzanian politics since independence, setting the stage for Magufuli's populist authoritarian policies and his ability to increase his control of the Tanzanian state. I also show how this authoritarianism is based on exclusion, misogyny and the targeting of marginalized groups such as people who use drugs. This chapter establishes the main themes – aid dependence, centralized

[5] Individual interview 14, October 2018, Mikocheni

power, manipulation of donor funds and exclusionary nationalism – that have shaped Magufuli's approach to people who use drugs and the policies of his government.

5.2 The one-party state, donors and international influence in Tanzania

Independence and the Party of the Revolution

Mainland Tanzania gained independence in 1961 as Tanganyika, a former colony of Germany, before being incorporated into the British Empire following World War I. In 1964, Tanganyika merged with Zanzibar to become Tanzania. The country emerged out of colonialism under the leadership of Julius Nyerere and his party, the Tanganyikan African National Union (TANU). Nyerere was educated in Fabian socialist ideals at the University of Edinburgh and, after independence, he began to enact his vision of African socialism through a number of policies, most well-known perhaps is Ujamaa, meaning familyhood.

Following the Arusha Declaration in 1967, Ujamaa became official policy and Tanzanians were forcibly resettled in villages throughout the country. This process accelerated in the 1970s and, by 1976, 95% of Tanzanians lived in Ujamaa villages (Jennings 2002:511). Ujamaa is often credited with improving basic social programs and instilling a nationalist unity that has kept Tanzania relatively stable compared to its neighbours. The forced nature of the program of Ujamaa, however, was also repressive and authoritarian. As Leander Schneider writes, Ujamaa combined 'Nyerere's and other politicians' paternalistic view of the peasantry and their belief that they knew best; a framing of postcolonial politics as an ongoing struggle against neo-colonial enemies' (Schnieder 2014:319). Economically, it was inefficient and left the country in an economic crisis that was so severe in the 1980s, Nyerere chose to step down and make space for the country to turn towards market liberalization (Kelsall 2002:56). Despite Nyerere retiring, Ujamaa left an imprint on Tanzanian politics and, as Dan Paget (2020) suggests, the unfinished nature of Nyerere's post-colonial project of liberation has now been taken up by Magufuli to justify his own state-led, top-down authoritarian project.

The CCM (Chama cha Mapinduzi or the Party of the Revolution), has ruled over Tanzania since independence. The party officially emerged in 1977 when the two dominant parties in

Tanzania, the Afro-Shirazi Party (ASP) in Zanzibar and TANU joined to form a single party. The CCM, with its ties to Nyerere and memories of the national unity he represented, has been in power ever since, with Nyerere himself closely tied to the party until his death in 1999. Nyerere's successor, Ali Hassan Mwinyi (1985 – 1995), aggressively courted foreign direct investment and opened the formerly socialist country to structural adjustment programs aimed at saving the economy through rapid privatization. While economic growth did slowly improve, the privatization of government-owned industries fostered growing economic gaps in the country and erased some of the benefits of a socialist economy such as improved education and better healthcare. The transition to a free market economy coincided with an opening of the political system as well. In 1991, Nyerere encouraged Tanzania to allow opposition parties to participate and engage in the first multiparty elections in 1995.

This opening up did not necessarily improve the lives of Tanzanians. Under Mwinyi, business contracts were awarded in less than transparent circumstances and the rapid transition from a socialist economy to a more liberal one was more beneficial to CCM elites than Tanzanian citizens. As Sheryl McCurdy and Pamela Kaduri have pointed out, this period marked the beginning of the involvement of Tanzanian elites and organized crime in the trafficking of drugs such as heroin (McCurdy and Kaduri 2016:313). The transition period over the 1990s set the stage for the corruption and economic mismanagement that has plagued Tanzania since.

The election of Benjamin Mkapa (1995 – 2005) did little to change this trajectory as he even more aggressively pursued foreign investment and economic liberalization. Again, this period was characterized by widespread corruption as elites benefited from the new economic environment (Warioba Report 1996). By the time Jakaya Kikwete (2005 – 2015) was elected, Tanzania had been marred by corruption scandals and remained highly aid dependent. During Kikwete's rule, the country's Human Development Index (HDI) increased slowly but the country is still low on the scale and is one of the poorest countries in the world. Further, corruption continued to be a defining characteristic of CCM rule, implicating high level officials and politicians in the party on numerous occasions. Elections are held every five years, and are considered by most international observers to be free and fair. However, the CCM remains dominant and has comfortably won every election despites its failures to bring development to the country and end corruption.

Aid Dependence, corruption and dominance

The CCM won the first multiparty elections in 1995 and, though many Tanzanians maintain a deep loyalty to the party, its victories depend on patronage and intimidation. In a country that has had only one party in power since independence, the reach of the CCM into all aspects of Tanzanian life and the resource inequality between opposition parties and the ruling party, ensure its continued dominance. In this context, authoritarian tendencies have been a part of Tanzanian politics even under the benevolent rule of Nyerere. Most CCM politicians and leaders, however, have been content to allow opposition parties to operate relatively freely. Allowing opposition is perhaps easier as these parties have never been particularly threatening. In the 2005 elections, President Jakaya Kikwete won 80.3% of the vote and the CCM took 264 of 307 seats in the national assembly (Kelsall 2007). In 2010 these numbers were reduced, with Kikwete receiving only 63% of the vote. However, no effective opposition challenge materialized (O'Gorman 2012:318). By 2015, an opposition coalition formed and managed to garner a greater share of the vote, but the CCM still won by a comfortable margin, with 58% of the vote (Paget 2017:153).

The CCM is deeply embedded in Tanzanian society, particularly in rural areas. Its popularity at the rural level can be summed up by a survey of farmers whose main reasons for CCM support were: 'they performed well during one-party rule, they are the only strong party, they have maintained peace, they identify with farmers and they brought us independence' (O'Gorman 2012:320). As Catherine Boone argues, post-colonial states are not 'suspended above' rural societies but rather 'constituted through fusions of state power with the societally-based forms of power, some of which are embedded in peasant modes of production' (Boone 1998:25).

The CCM integrated itself early on into these modes through Ujamaa and one party rule and remains strongly linked to many levels of Tanzanian society. As Tim Kelsall notes, 'the sheer size of the party, its penetration of society, the administration, and the economy, means that the CCM exerts a massive gravitational pull on the political system, drawing in Tanzanians of all races, religions, regions, ethnicities and classes' (Kelsall 2007:529). As observers of Tanzanian politics have noted, it can be difficult to find where the Tanzanian state begins and the CCM ends.

One benefit attributed to one-party rule is that, compared to its East African neighbours, Tanzania has experienced little in the way of ethnic or religious conflict and has avoided large-scale electoral violence and divisionism. Despite the peaceful decades following independence, structural adjustment and the transition to multiparty democracy in the 1990s, Tanzania has not seen the scale of development that could be expected in a country rich in natural resources. GDP increased following structural adjustment, and has continued to rise yearly over the past decade. However, development for many has continued to arrive slowly for Tanzania's over 60 million people, the majority of whom live in poverty.

The government's inability to leverage stability and access to resources such as gold for development has not been due to a lack of donor interest or support either. Tanzania has long been considered a donor darling and was often seen as a source of optimism among the donor community throughout its history (Tripp 2012, Jennings 2002). Early on, even in the midst of Cold War politics, the authenticity of Nyerere's mission was attractive to Western liberals. Ujamaa as a policy, despite its clear ideological bent and questionable economic benefit attracted Western support, as 'NGOs and activist groups, intellectuals, academics, development workers and members of the British public, all came to regard Tanzania as the great hope for the developing world' (Jennings 2002:529). What was remarkable about this support, as Michael Jennings argues, is that, in supporting Ujamaa, a top-down, government-initiated process, groups like Oxfam 'became part of a process that withdrew power and representation from the grassroots' (Jennings 2002:530).

As I discuss below, the roots of Tanzania's close relationship with development partners is based on the CCM's powerful ability to assuage donor concerns over a lack of development, while determining donor priorities and involvement in the country. Despite decades of failed development, Tim Kelsall, writing in 2010, notes that this positivity remains and 'there is considerable optimism about the country's prospects' (Kelsall 2010:56).

According to OECD data, Tanzania has been a major aid recipient since independence, in 2016 fourth among Sub-Saharan African countries. From 1990 to 2010, it was one of the largest recipients of multilateral and bilateral aid in Africa, second only to Ethiopia (Tripp 2012:1). The relative neutrality of the country and lack of conflict have drawn donors including the Nordic countries, Canada and the United States. Following democratization, the stability of the country and

its willingness to take on structural adjustment policies ensured its continued status as an attractive aid recipient (Tripp 2012). As shown in Figure 3, the government has increasingly prioritized independence, reducing its overall aid budget and increasing aid towards projects rather than as part of central government general budget support (GBS). However, this has not necessarily meant the government is not still highly reliant on aid through project funding and in the health sector which, as shown below, has fluctuated but remained . Further, it does not mean that donor dollars previously provided, particularly in the health sector, are being replaced with this reduction.

Financial Year	Foreign Aid (USD 2015 billions)	% of central government expense	Foreign Aid as % of Health Budget
2009	3.008	70.05	unavailable
2010	2.844	70.09	37
2011	2.233	49.01	32
2012	2.629	50.78	28
2013	2.188	50.68	38
2014	2.444	32.99	26
2015	2.600	36.69	26
2016	2.349	34.83	18
2017	2.585	30.84	26

Figure 3: Foreign aid to Tanzania, as per cent of general and health budgets. World Bank Data: Aid to Tanzania, Economic and Social Research Foundation 2016). Percentage of health budget in Health Policy Plus Policy Brief (2019).

Foreign aid is particularly important to the health sector and plays a key role in Tanzania's efforts to combat HIV/AIDS. NGOs operating in the health sector make up a large part of Tanzania's health system generally. As Michael Jennings notes, 'in many African countries, the state (colonial and post-colonial) could only expand its services across large parts of their country through co-opting voluntary services, making them, in effect, a part of the national system' (Jennings 2015:2). Despite stating its desire at various points to develop a national health system, Tanzania is subject to the 'colonization by private, albeit not-for-profit, actors across swathes of the public service sector, including and perhaps especially health. Schools, clinics, hospitals etc. have been pushed into the hand of NGOs, the state increasingly bypassed in both its funding and regulatory role' (Jennings

2015:5). In Tanzania the colonization of the public health sector is evident, although this has not meant the government's ability to influence this sector is bypassed.

In the health sector in Tanzania a major focus of donors, particularly the United States, is on HIV/AIDS prevention and treatment, reflecting the stubbornly high rates of HIV, estimated at 1.6 million in 2019 (AVERT 2019). The relationship with donors in this sector is indicative of the issue Jennings raises, as in Tanzania 'the vast majority of spending on HIV and AIDS is financed by development partners – over 98 percent between 2011/12 and 2013/14' (Wuyts, Mushi and Kida 2017:26). A more recent report estimated this number at 90% (Global HIV Prevention Coalition 2018:8). While the high dependence on foreign funds for HIV response is considered a risk, especially for a government which espouses compassion for people living with the virus, the government does not seem to share this priority. Health funding in the budget decreased in 2018/19 by 8%, from 10% of the total budget to 8.9% (Sikkika 2019).

Health funding went down from 11.3% of the budget in 2015/16, and was 2,222 billion TSh, significantly underfunding the sector and not reflecting population growth and increased need (Sikkika 2019). The result is per capita funding of 37,951 ($16 US) per person in Tanzania, a huge gap in funding that continues to go unaddressed (Sikkika 2019). These figures show a government keen to allow donors to prop up the health sector, especially HIV/AIDS response. Rather than following through on calls for donor independence, in these areas, the government is not preparing to fund the sector at all. Yet, as I explore below, the policies significantly impacting vulnerable populations are being shaped by the Tanzanian government, despite its donor dependence.

Donors have largely led the drive to tackle HIV/AIDS and significant investments have helped to lower infection rates from 12 to 5 percent over the past two decades (Sieff 2016). The President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund, the Gates Foundation and UNAIDS are all significant contributors to reducing HIV/AIDS transmission and providing treatment in Tanzania. The Global Fund has invested $1.9 billion in Tanzania between 2002 and 2018, and Tanzania makes up 6% of the total 2017 – 2019 Global Fund allocation (Global Fund Audit Tanzania 2018:9). Tanzania's foreign aid, has addressed some of the issues challenging Tanzanian development, notably reducing HIV/AIDS prevalence. The country, however, remains

low on the human development index, 154 out of 189 countries, with 68.3% of the population living in poverty (HDI Report 2018).

Lack of development, corruption and the influence of the donors

The CCM has weathered several major scandals which, despite their prominence, did not impact electoral results. In 1996, Joseph Warioba issued an infamous report that linked corruption to almost all sectors of governance and showed that the introduction of free market principles to the economy in the 1980s caused a rise in corrupt practices (Warioba 1997). In another study focused on local government associations, the author concluded that corruption impacted 'every aspect/sector of the social fabric' (Ngware 2005:9). In 2008, an internal audit revealed 60 million pounds in improper payments from the Central Bank to local companies (Commonwealth Secretariat 2010:19). One high profile CCM politician brought down in these scandals, Attorney General Andrew Chenge, resigned after taking a $1 million bribe from BAE, a British aerospace company (Norad Report 2011:13).

Given the high number of corruption scandals, the implication of many politicians and the unlikelihood of prosecution, corruption has not been effectively addressed. Warioba's report named 70 people involved in grand-scale corruption during Benjamin Mkapa's rule and not one was ever convicted (Kelsall 2010:70). Later scandals were even larger and implicated several high level officials, including former Prime Minister Edward Lowassa. Lowassa chose an unknown energy company, Richmond, to provide power in Tanzania. The government spent over $100,000 USD per day despite the company failing to deliver any services (Norad Report 2011:13). While Lowassa was forced to step down as Prime Minister in 2008, he later ran for leadership of the CCM, lost, and then joined the opposition in the 2015 election. The CCM won this election and Lowassa has since rejoined the party, showing how accusations and proof of corruption do not end in disgrace but are simply a stage in many successful CCM careers.

Prior to the 2015 elections, the Escrow scandal implicated a number of Cabinet Ministers, the Attorney General and the President (Tanzania Governance Review 2014). The opposition discovered that CCM officials were siphoning off massive amounts of public funding for personal use. The scandal showed the ability of CCM politicians to act with impunity. Andrew Chenge, was

not prosecuted following his misdeeds in 2008, and was able to regain a position with the CCM after stepping down. In the Escrow scandal, Chenge, along with Minister Anna Tibaijuka, improperly attained $1 million each (Tanzania Governance Review 2014:11).

These highly publicized incidents are discussed among citizens, who are engaged politically and discuss the scandals. For many Tanzanians, however, while these scandals are larger in scale, corruption is simply a part of daily life. 'Kitu Kidogo' or 'a little something' is still joked about often, and citizens expect to pay small bribes to police or other public officials. As I discuss in the next chapter, many groups of drug users mentioned paying off police when caught or said that they are sometimes held by police until their family or friends can pay a bribe[6]. It is also important to remember this context when considering the blame for corruption being placed at the feet of drug users during the 2016/17 crackdowns.

Tim Kelsall effectively sums up the situation, which has changed little since 2010: 'people struggle for access to corruptly acquired resources; other people struggle to put information about these struggles into the public domain with a view to righting wrongs; and, finally, politicians, some of whom are corrupt themselves, struggle to use the discourse of corruption as a stick with which to beat their equally corrupt opponents' (Kelsall 2010:71).

All of this 'fisadi', or corruption/graft, has had a major impact on development. As I discuss in this chapter, while illicit drugs are often targeted as inimical to development, this focus sees drugs as the causal variable. Corruption however, with or without an illicit drug market, persists in Tanzanian society regardless of the inputs. The current Tanzanian government has conflated much criminal activity, such as poaching and drug trafficking, as causes of corruption rather than the ability of CCM officials to avoid any actual consequences to their actions. Further, international influence has had minimal impact in improving governance. As Aili Mari Tripp found in her study on the impacts of aid in Tanzania, 'donors have implicitly supported a system that seeks executive expansion (albeit not as extensive as some other countries), centralized government control with the decentralization of resources that would give localities real power, and corruption taken to extreme levels' (Tripp 2012:22).

[6] Interviews, October – November 2018

I have described these examples of corruption and aid dependence in order to show that, even with a power imbalance in the donor-recipient relationship, Tanzania has been able to control priorities in largely donor funded sectors, a telling example of extraversion. While Tanzania appears to be an amenable aid recipient, with goals aligned to those of their many donors, foreign aid has contributed to a system in which multiple agendas are pursued while the CCM uses and controls aid as it sees fit. As Furukawa argues, 'Tanzania is a country with significant ability to manage aid and the receipt of development aid resources, despite being considered a passive donor-driven recipient' (Furukawa 2016:282). This system 'allows it to be more proactive in obtaining resources, while pursuing the development it desires' (Furukawa 2016:282).

The results of this system, as I show below, has troubling implications for sectors that are almost entirely donor driven. For example, injection drug users, and people who use drugs more generally, largely only have access to a small portion of HIV/AIDS funding, most of which, is still aimed at supporting the general population. No other large scale government funding, or programming specifically to address addictions is available. Further, the government sets priorities in which key vulnerable populations are not important and organizes funding accordingly. As I discuss in the next section, President John Magufuli, with his strong desire to end aid dependence and his advancement of Tanzanian nationalism, has worked to further distance himself from donors' goals while maintaining their actual support and pursuing his agenda.

5.3 Morality, authoritarianism and control – enter President John Magufuli

The Rise of Magufuli

John Magufuli, the former Minister of Infrastructure under President Kikwete, was a relatively unexpected candidate for the leadership of the CCM. Prior to the 2015 election campaign he rose to prominence in the CCM leadership contest. His main adversary, former PM Lowassa, a longtime CCM member with popular support, had since returned to the party and was expected to win the CCM leadership. Magufuli, however, was a contrast to Lowassa, with a clean record and upstanding reputation. He surprised the country by being selected to lead the CCM and, despite opposition gains, won the general elections of 2015, preserving CCM dominance. (Paget 2017)

John Magufuli, unlike other CCM members, emerged as a champion of ending the culture of corruption in Tanzania, a welcome change following the Escrow scandal and the failures of Jakaya Kikwete to reign in abuses of power. Foreign and domestic observers alike applauded Magufuli's initial focus on cleaning up the bureaucracy, combatting corruption and improving the lives of Tanzanians. Magufuli followed through on this promise, immediately cracking down on high levels corruption in the public service, visiting bureaucrats unannounced and sacking several high ranking public officials. This turn in a country long mired by corruption earned Magufuli the hashtag #whatwouldmagufulido and some observers drew favourable comparisons between him and Julius Nyerere (Mkony 2016). The disruptive change was taken seriously by many, as one interviewee noted, 'there was a sense of fear, nobody is sure of anyone anymore. This was a time when you know Magufulication is happening, he is firing everyone, nobody is sure and they [government employees] were scared'[7].

The initial excitement over Magufuli's activism and war on corruption quickly began to sour however. According to Dan Paget, 'since early 2016, it has become apparent that Magufuli is not just waging war on corruption – he is also declaring war on democracy' (Paget 2017:2). While his policies initially seemed to be positive ways to deal with endemic problems in the Tanzanian political system, Magufuli's approach has since come to look familiar to previous CCM leaders. As Tripp (2012) noted, the centralizing tendencies of the CCM have been a longstanding theme in Tanzanian politics, preventing the growth of a strong opposition and healthier democracy.

Magufuli's policies not only reinforce the centralized control of the CCM, but also his own executive power. He has worked to ensure his increased oversight over several key sectors, and over ministries and departments. As I discuss below in regard to drug policy, by ensuring reports are directed to the CCM, controlling Ministers, and his willingness to silence critics, Magufuli is the most active President in pursuing centralization since Nyerere. His focus on increased CCM control is ostensibly in order to reign in corruption through increased oversight but also forces all priorities and government work to align with him. Michaela Collord (2019) notes how this approach is reminiscent of past state-led economic policies.

[7] Interview 14, October 2018, Mikocheni

Magufuli's approach has drawn both admiration and derision, with liberal publications such as *The Economist* (2018) heralding his anti-liberal and anti-foreign investment policies as profoundly dangerous. In March 2018, it noted that 'Mr. Magufuli is fast transforming Tanzania from a flawed democracy into one of Africa's more brutal dictatorships' (*The Economist* 2018). Other scholars such as Goran Hyden have compared this approach to Ethiopia and Rwanda, countries pursuing a developmental state model focused on development rather than democracy (Hyden 2017). As Michaela Collord points out, Magufuli has stepped into a false dichotomy of state versus market, heavily favouring the state and intervening in a number of aspects of the economy (Collord 2019).

Magufuli initially gained support from Tanzanians in his calls to end aid dependence and in his desire to pursue a more state-led approach. *The Economist* and organizations such as the International Monetary Fund (IMF) reacted predictably, lamenting the turn away from market-based principles implemented after Nyerere. As Collord states (2019), these arguments seem to paint a picture in which market or statist economies can only exist independently, rather than as a mixed strategy. In Tanzania, neither a purely state-led approach or a strong market-based approach has worked, yet Magufuli has staked himself as a Nyerere like leader who will return power to the state or, more accurately, to the CCM.

Unfortunately, the developmental state model is often accompanied by a reduction in press and democratic freedoms. The loss of some rights of expression are considered a trade-off in this model, worthwhile in the short term as long as economic development increases. Whereas Rwanda received donor aid and invested in lucrative industries such as information technology and tourism, Magufuli's erratic policies have had mixed results[8]. For example, Magufuli charged Barrick Gold subsidiary Acacia Mining plc. with a $190 billion tax bill, which eventually resulted in a payout of $300 million (*Financial Post* 2017). While this can be considered a success in advancing Magufuli's goal of increased state presence in the economy and improved economic outcomes, his pledges to end tax evasion and corruption to increase investor confidence are not leading to similar success (Norbrook 2019).

[8] see Golooba-Mutebi and Kelsall 2012

Ending corruption, and enforcing taxes and regulations in an informal sector that has functioned without much interference for decades, present a major challenge. The imposition of regulations can have the effect of shuttering businesses unable to function in a formal setting, or pay taxes that are suddenly imposed and enforced with regularity. Further, with the loss of numerous public sector jobs, and the money spent by these employees in the informal sector, circulation of currency has slowed. Tackling corruption will also be a long process and, in the interim, poor and vulnerable members of this informal economy are still subject to police and authorities that continue to exercise power unfairly. Once optimistic investors have been scared away by new regulations and foreign direct investment (FDI) has fallen 18% since 2014 (*Washington Post* 2018). In pursuing these policies, Magufuli has created a narrative that presents Tanzania as the victim of greedy multinationals, which is certainly true to an extent, but obfuscates how his own party has benefited at the expense of the rural poor since liberalizing the economy in the 1980s.

In alignment with the blame he assigns to foreign interests, Magufuli has also worked towards ending aid dependence. His statements on ending foreign support have often been clearly connected to his desire to pursue his own agenda. For example, Magufuli called for an end to aid dependence immediately following donor condemnation the unfair elections in Zanzibar in 2015. Again, when donors disapproved of his attacks on gay men in 2018, Magufuli called for an end to foreign influence in Tanzania.

Magufuli's motivation for ending aid dependence reflects a desire for increased control. In 2016, he called for Tanzanians to 'work hard and end the country's dependence on donor money as a United States government agency confirmed its cancellation of a $472 million aid package due to Zanzibar's disputed election' (Shekighenda 2016). While the motive is self-interested, it does recall the spirit of the Arusha Declaration of 1967 in which Nyerere called for African socialism independent of Western interference. This call for independence is in interesting contrast to the historical, and continued, aid dependence of the country (Anyimadu 2016:5). Following the condemnation by Western donors for abuses against gay men in 2018, Magufuli also bristled and stated his preference for aid from China, who are less vocal about his human rights abuses.

As depicted in Figure 3, aid dependence as general budget support has fallen over the past decade. Yet, as the Tanzanian government pursues different priorities, sectors such as HIV/AIDS

response are not priorities and falling donor support there is not being replaced. Despite Magufuli's performative protests, the country continues to rely on aid in many areas of the economy, continuing its successful use of this income to support the dominant party in the face of continued poverty which decades of aid has done little to change.

In projecting the image of an independent, strong state, Magufuli has tried to present himself as similar to, and a suitable successor of, Julius Nyerere. Many Tanzanians still revere Nyerere as the father of the Nation and he casts a long shadow on politics. Further, Nyerere's calls for familyhood and kujitegemea (self-reliance) also continue to be an important theme in Tanzanian politics (Hunter 2008), which Magufuli seems intent to uphold. Disputes over who 'owns' Nyerere's legacy have persisted since his death in 1999, with both opposition parties trying to show how the CCM is no longer Nyerere's party, and the CCM working to maintain their link to him as their founder (Becker 2013, Fouere 2014). The CCM has often won this battle, giving it an important advantage in rural politics where nostalgia for socialist rule and the incorruptible Nyerere remain strong (O'Gorman 2012).

Magufuli has explicitly patterned himself on the Father of the Nation, more so than past leaders, drawing a straight line to a past that conveniently ignores the hardships it wrought. Dan Paget (2020) describes this comparison as 'restorationist developmental nationalism', a post-colonial project started by Nyerere which has yet to be completed and which, just as it did under Nyerere himself, justifies top-down state control and authoritarianism. In emphasizing and repeating discourses utilized during one party rule, the CCM under Magufuli has 'embraced the claim that the nation has strayed from its developmental trajectory and promised to restore it' (Paget 2020:1251). Magufuli, as is often said of American President Donald Trump, is not a cause of authoritarianism and moral nationalism, but a symptom of post-colonial Tanzanian politics which, though cloaked in the benevolence of Nyerere's socialist mission, is actually based in repression and authoritarianism.

As mentioned in the theoretical framework, the 'invented traditions' of the Magufuli regime are helpful in justifying harmful policies which borrow the vernacular of Tanzanian nationalism and Nyerere's socialism. According to Hobsbawm and Ranger, the practice of inventing traditions is not to restore the past but utilize the language of tradition 'to construct invented traditions of a novel type for quite novel purposes' (Hobsbawm and Ranger 1983:6). Thus, while moral nationalism is not

new, the purpose it is being used for and the intensity of discrimination against vulnerable populations, is.

Through policies evoking the Arusha Declaration, a focus on self-reliance and the creation of an image that is traditional and devout, Magufuli is identifying with Nyerere. In other ways however, he has moved far beyond Nyerere's brand of politics, working to increase state control throughout the country. For example, his crack down on regulations regarding foreign businesses and NGOs have not been focused on increasing efficiency. Rather, his goal is the increased control over the activities of NGOs. Interviewees regularly remarked on how calls for accountability have increased, with more reporting requirements in line with top down mechanisms of policy control. As Anyimadu notes, 'the selection of more permanent secretaries [in Cabinet] than in previous governments suggests a desire to hold direct authority over the technocratic aspects of policy implementation (Anyimadu 2016:8). Magufuli has tried to sell his interference in this sector as a way to reduce corruption. However, he has increased obstacles for NGOs even when they already face greater oversight and are forced to align with top-down goals set by his government.

Magufuli has also tried to reduce his government's expenditures, recalling Nyerere's humble lifestyle. Magufuli's modest brag of not attending the UN General Assembly is meant to be a sign of his unwillingness to squander public funds on expensive foreign trips. However, his lack of foreign travel also plays a useful role as Magufuli does not have to face an international community that has grown increasingly concerned with his authoritarian tendencies. Magufuli was not as well-known as many CCM politicians when he assumed power, and he controls what stories are told about his private life and how they are presented. One example of a story from his largely hidden personal life is a pandering piece on how he had no suit to wear to his wedding (Shiundu 2018). Other stories highlight his strong family values and religious beliefs or the humble origins of his family.

Magufuli, unlike past leaders of the CCM who have been entrenched in party power and do not tend to highlight their individual power, seems to be positioning himself as an individual amongst the party. A commitment to the CCM in the face of a growing opposition threat has long been the focus of leaders. Magufuli, however, has replaced it with a cult of personality. He is the first leader of the CCM to hint at serving longer than 10 years. While presidents in Tanzania are often

pictured in offices and hold a revered position, Magufuli is advancing this further by ensuring it is known he is the decision maker and power holder.

Questionable tactics and increasing control

Magufuli's focus on economic nationalism, discipline and state-led economic growth is accompanied with the same authoritarian tendencies that characterize other so called developmental states. Magufuli has publicly cracked down on members of his own party, the opposition and even popular public personalities such as the pop singer Diamond Platnumz (*The Standard* 2017). Members of the opposition have been harassed, arrested under questionable charges or simply restricted in movement. Zitto Kabwe, a member of the opposition in Parliament, has been imprisoned multiple times and is now banned from travelling outside the country (Wako 2019). Wealthy members of Tanzanian society have been targeted with charges of drug trafficking or improper conduct (Sixpence 2017), or have mysteriously disappeared. During my fieldwork in 2018, Mohammed Dewji, one of Tanzania's richest men was abducted for 10 days and then returned. There was no investigation or arrest of any responsible party.

In a telling example of the move toward state control, Magufuli outlawed any statistics not published or vetted by the government, making the government the sole source of statistics in the country. When the government reported positive GDP figures, they were questioned by Zitto Kabwe who was promptly detained by police (Sandefur 2018). Twaweza, a non-profit organization that conducted polling studies, published a report in 2018 showing a major downturn in the approval ratings of the President, from 80% to 41%. The government revoked the organization's research permit and accused it of not having appropriate clearance from COSTECH. The head of the organization had his passport revoked pending investigation (Elias 2018).

Magufuli is working to become the sole power and arbitrator of knowledge in the country through the production of his own truths and the repression of other opinions. In March 2019, Magufuli banned *The Citizen* for one week for violation of 'an obscure regulation regarding reporting on the Central Bank' (Chambers 2019). This paper is the leading English language news source in the country, serving as my main source in many cases given the lack of other independent English publications. It is certainly not known for controversy. In 2019, Amnesty International and other

observers of press freedoms in Tanzania such as Journalists Without Borders raised concerns over the imprisonment of journalist Erick Kabendera, who is also having his citizenship investigated (Maclean 2019).

Magufuli is clear on his belief in traditional values and conservatism, as evidenced by many questionable public comments including statements criticizing young women who are pregnant, supporting legislation banning them from schools, noting they may encourage other young girls to engage in premarital sex (Githaiga 2017). Magufuli also stated that 'outsiders who promote birth control are giving bad advice, and that people who use contraceptives are lazy' (*The Guardian* 2018). He then banned family planning advertisements, announcing 'women should stop using contraceptives because Tanzania needed more people' (*BBC News* 2018). In 2019, Magufuli urged women to 'set their ovaries free', a bizarre idea to boost the economy through increasing the population, many of whom remain poor and unemployed (Ng'wanakilala 2019).

Magufuli has also maintained an extremely conservative stance towards gay men since gaining power. I discuss crackdowns specific to gay men with HIV/AIDS below. However, his willingness to attack homosexuals so publicly is unprecedented. As several NGOs noted, gay civil society leaders have either fled or stopped advocacy activities[9]. In November 2018, Magufuli's close political ally, Paul Makonda, declared that homosexuals needed to be rooted out of Tanzanian society and encouraged the sharing of information on individuals engaged in these activities (Kirby 2018). While this declaration was only an escalation of Magufuli's preoccupation with gay men as many advocates had left the country already, it is a definite intensification in a country known for a more peaceful and tolerant approach.

Previously, while gay men were certainly not accepted in society at large, they were not actively hunted. The main difference between Magufuli and his predecessor is not a change in legislation but rather a more active stance in applying repressive laws criminalizing homosexuality and drug use. Ironically, despite Magufuli's invocation of African values, many of these laws originated during the colonial era and are simply being brought back to prominence by Magufuli for his own purposes, again recalling the invention of tradition (Akumu 2018).

[9] Individual interviews 4, 6, 10 and 11, August – September 2018

As mentioned above, Magufuli has been willing to take on foreign donors in his calls to end aid. Following the Escrow scandal, donors initially halted aid, holding back $558 million in general budget assistance though not for long (Makoye 2014). The World Bank more recently withheld $300 million over concerns with Magufuli's policy towards women and girls (*CNN* 2018). In both cases however, through negotiation the government was able to reach an agreement for the aid without reversing its position. These are just two examples that illustrate the limitations of donors seriously challenging Magufuli's course, as cutting aid impacts the poorest and most vulnerable (*The Daily Nation* 2018).

While all of the actions above show a government committed to restricting political, civic and moral space, the actual ability of the Tanzanian state to express its will across society remains in question. From my own fieldwork, Magufuli's ability to dictate policy and the ability of the Tanzanian government to make policy a reality on the ground was surprising. In my previous experience, Tanzania was a state with weak power at the ground level yet, the statements of the CCM leadership translated into vulnerable groups being increasingly targeted and facing increased repression. Further, the words of other members of the CCM, including Paul Makonda, Health Minister Ummy Mwalimu and Prime Minister Kassim Majaliwa, all reflected the harsh tone of John Magufuli, revealing a surprising level of cooperation among CCM elites. This cooperation is all the more notable given the reversal in tone in the statements of Minister Mwalimu, who previously did not attack harm reduction.

Despite Magufuli's ability to influence the top level of Tanzanian government, the Tanzanian state is still considered relatively weak by most scholars (Bélair 2018, Kelsall 2005). State authority in sub-Saharan Africa has attracted much scholarship, with notable contributions from James Scott (1998), Jeffrey Herbst (2000) and Jean Francois Bayart (2000). Scott uses Ujamaa as a classic example of how top-down state projects inevitably fail in their attempts to make society legible (Scott 1998). The war on drugs should fit this description, as it is always a top-down project that does not consider realities on the ground and is impossible to fully enact. Further, the Tanzanian state is 'infrastructurally weak', or a state with a low level of power projected through society, unable to fully project its power throughout society (Bélair 2018).

The supposed inability of the Tanzanian state to pursue a top-down agenda may help explain why the current government is so focused on vulnerable populations. To date, the government's targeting of vulnerable individuals is enabled by their presence in Dar es Salaam, where the coercive power of the state is strongest and is also enabled by the relative lack of support and regard for groups such as drug users, who have been constructed as morally deserving of harsh treatment.

Joanny Bélair (2018), in her work on land investments in Tanzania, analyses conceptions of state power to illustrate the flexibility and agency of local actors to exploit the central states' low infrastructural power and lack of local knowledge and to their own ends. While this may be the case in rural Tanzania, my purpose is not to delve into the much larger project of understanding Tanzanian state power. Given where I conducted fieldwork, Dar es Salaam is a site of focused state control where the expression of state power can be more realized than in the countryside. even though rural areas may still have flexibility to resist central control.

Further, as this chapter illustrates, the project of the Magufuli regime represents continuities with Tanzanian politics but also evidence of a new and concerted push towards authoritarianism. The current Tanzanian government uses a mix of discourse, policy change and performance to bolster its authority. As depicted above, while the Tanzanian state is far from a fully realized authoritarian government, the tactics of sporadic enforcement, fear-based rhetoric and performative crackdowns have real impacts on the ground. Lisa Wedeen (1998) argues that while symbolic power is not a simple practice, the fact that citizens who may not believe in the messages and policies crafted by the government does not mean they do not play a role in enforcing these policies. In pursuing authoritarianism as Magufuli does, 'people are degraded not because of the content of the norms [produced by authoritarianism] but because, although no one believes in them, everyone enforces them…ideology is insidious because it allows people to hide their reasons for obedience from themselves' (Wedeen 1998:513). As I show in later chapters, the mutually constitutive power of rhetoric and policy change together create an environment of repression.

The CCM has always been able to exercise a high degree of flexibility while maintaining huge levels of foreign support as is evidenced by its ability to control elections and commit human rights abuses. As I discuss in depth later, Tanzania receives significant funding in the health sector and this has had a major impact in reversing preventable disease and HIV/AIDS prevalence. However, the

government maintains relationships with donors while continuing to impose major restrictions by groups in great need of assistance, such as key vulnerable populations. As long as aid can be subordinated to the goals of the ruling party to maintain power and absolute control over the direction of the country, the Magufuli government will continue to pursue an authoritarian agenda while not prioritizing those in society who need the most help.

These developments represent a troubling move towards authoritarian consolidation with popular appeals to morality and individual responsibility. While rhetoric opposing corruption, drug use and sexual immorality may be seen as a positive step to ordinary Tanzanians, the enforcement of these policies are tied to Magufuli's attempts to distract the public from his drive to centralize power. His rhetoric has had two immediate impacts: ensuring those working with vulnerable groups are aligned to the central government, not their clients (not to improve effectiveness of programming but rather to ensure these groups do not encourage homosexuality or contravene any laws) and, to make the lives and situation of vulnerable people in poverty including PWID, gay men and women and girls, much worse. In the next chapter I explore the rise of injection drug use in Tanzania, the government's response and the limited services available to drug users prior to Magufuli's election.

5.4 Conclusion

The CCM is deeply ingrained in the Tanzanian state and many of the legacies of the one-party era remain. In this chapter, I outlined this background and these themes to show the context in which the government of Tanzania has pursued policies addressing illicit drug trafficking and use. The aid dependence of the Tanzanian state, particularly in the health sector and in HIV/AIDS response, has left this sector vulnerable and exposed to changes in funding and priorities. Further, the current authoritarian government is able to pursue its own priorities in regards to illicit drugs while foreign funding supports the majority of programming available to drug users, making the sector vulnerable to policy change.

The setting for John Magufuli's authoritarian project is connected to historical trends in Tanzania since independence. While fondly remembered, Julius Nyerere presided over a one-party state with centralized control. After stepping down, despite moving towards multi-party politics, the

CCM maintained a firm grip on political power in Tanzania. Magufuli has not reinvented Tanzanian politics but has returned towards one-party control, utilizing the existing political and legislative power established by his predecessors to implement authoritarian policies. In 2015, Magufuli presided over the slimmest victory in the CCM's history, which still was a sizeable win. In November 2019, however, the CCM gained 99% of the vote in local elections. Opposition parties boycotted the elections, intimidated candidates or encouraged defections. Tanzania is not witnessing the establishment of a one-party state, but is rather seeing the realization of a trend in Tanzanian politics that had seemed to be losing salience in a time of increased openness, tolerance and development.

While Tanzanian politics is complex, Magufuli's regime represents some of the underlying elements of Tanzanian politics that have hobbled the state since independence: authoritarianism, aid dependence and discriminatory nationalism. In this context, Magufuli is not an aberration even though his moral politics may be more extreme than previous leaders. Drug users, gay men, girls and women and other groups deemed immoral are trapped in an authoritarian project deeply rooted in the history of the Tanzanian state, where these groups have often been seen as not belonging. In the next chapter, I turn to drug use and trafficking in the context of the Tanzanian state to show how the realization of authority under the current government is experienced by people who use drugs and work in the sector.

CHAPTER 6

Maskini, Maskani na Matatizo (poverty, hot spots and problems): using drugs in Dar es Salaam

'Many people using drugs in Tanzania, their families are very poor and the stigma for the people that are using drugs is very high because they don't know anything about addiction. They think that life, you choose it. The people in the government don't know anything about addiction. We are going everywhere but they don't know how to help. This program, and the people that help me, [are the] addicts. We stop using and start to help [one] another. There is no professor here, only addicts'[10].

6.1 Introduction

In the past three decades, the quantity of heroin being trafficked through East Africa has steadily increased as it is transported to major markets in Europe and North America. In Tanzania, the beginning of a larger-scale heroin trade began in the mid-1980s, coinciding with the disruption to social and economic life brought by the transition to a multiparty democracy and the liberalization of the economy. The increase in heroin availability during this time led to local use around trafficking routes, mainly in coastal towns along the Swahili coast including Dar es Salaam. Heroin use continued to rise in the later 1990s and, by the 2000s, injection drug use was highly prevalent and spreading in Dar es Salaam and Zanzibar.

The heroin being trafficked through Tanzania was, and still is, mainly destined for European countries and the United States, drawing the attention of these powers and the UNODC to improve anti-trafficking measures in the region. However, despite some increased efforts at reducing this supply, heroin has continued to be readily available in Tanzania and is relatively cheap, especially compared to prices in Western countries. Further, the efforts to control opium production in Afghanistan, the main source for global opium production, have had the opposite effect of reducing supply. Alternative crop incentives and military intervention only resulted in more opium from Afghanistan being produced than ever before.

[10] Individual interview 17, October 2018, Kigamboni

With a large supply to export, the Indian Ocean route continues to be utilized by drug traffickers, bringing large amounts of heroin to Tanzanian shores. As with attempts to shut down trafficking across the globe, increased enforcement has only led to temporary disruptions in trafficking or to the creation of new routes, including one now in place through Pakistan and Iran to the Indian Ocean (Rweyemamu 2018). The heroin trade shows no signs of slowing. The UNODC reported that opium production in Afghanistan reached 10,500 tonnes in 2017, the highest amount recorded since 2000 (*The Economist* 2018). The UNODC measure of drug seizures reported in Tanzania was 14 kilograms in 2004, the highest seizure of heroin between 1990 and 2005 (UNODC 2018). In 2010 the seizure of heroin was 190 kg and in 2014, total seizures reached 400 kg (UNODC 2018).

As heroin use increased in Tanzania, so too did activism and concern for the rights and health of people who use drugs. Tanzania opened Sub-Saharan Africa's first methadone and needle exchange programs in 2011. The urgency of these programs was highlighted by the high rates of HIV/AIDS and other infectious diseases among PWID. Throughout the 2000s, increased political willingness to pursue harm reduction interventions grew as concerns arose around the potential for the spread of HIV to the general population (Ratliff et al. 2016). The methadone program has drawn academic interest, however, much of this scholarly work is focused on the health and medical aspects of the program. Few have delved into the larger context of drug use in Tanzania. During my fieldwork, I was able to discuss with former users and NGO workers their experiences with drug use on the ground, and I found their perspectives on programs available and the challenges they faced had not been explored to a great extent. It appeared those most impacted by drug use and policies had less involvement in shaping programs and having their needs addressed.

In this chapter, my aim is to describe these perspectives and explore the gaps in Tanzanian drug policy and programs available to people who use drugs. I begin with an overview of services available to people who use drugs and how treatment and a response to heroin use was led by local activists accessing foreign funding, most of which was intended to reduce rates of HIV/AIDs in the country. I then look at the experiences of people who use drugs in Tanzania and observations gained from hot spots where individuals gather to use drugs. My focus here is to show the challenges this population faces and how a lack of political will to provide adequate supports

resulted in increased vulnerabilities. I examine these vulnerabilities and experiences of people who use drugs to illustrate the setting in which John Magufuli's crackdown and policy revisions took place. In Tanzania, heroin use occurs within the context of high levels of poverty and low employment, meaning it is often risky and can have major adverse impacts for those who fall into patterns of misuse. As I illustrate below, heroin use in Tanzania can cause a number of challenges for people who use the drug, with most of the adverse effects caused not by the drug itself, but by poorly thought out policies and a general lack of support. With this context, the full negative impacts of what appear to be minor policy changes and a temporary crackdown, can be seen as highly impactful on a population already facing many obstacles. As I show in the following chapters, these impacts exacerbated police harassment and violence, eliminated tenuous and limited services and made drug use risker.

One of the biggest challenges drug users would face, as described in this chapter, is the narrowing of services to only methadone provision. As noted in the literature review, the focus on methadone in treating heroin use can result in a lack of attention to the larger socio-economic context of drug use, reducing treatment to a medical cure. Using evidence from interviews, I argue that this approach has important limitations and that there is a need for greater social supports to improve this program. While more fully discussed in the next chapter, under John Magufuli, methadone is the only real option for people who use heroin, as sober houses are not funded and there are no other addiction treatments available. In my fieldwork, most interviewees found methadone a limited service prior to Magufuli and it is clear that the government is currently not working to improve the program. Methadone is a harm reduction method. However, in John Magfuli's Tanzania, the program reflects his focus on individual responsibility and abstinence, rather than larger socio-economic factors and harm reduction. In this chapter, I provide an overview of heroin use in Tanzania with this critical lens to fully illustrate the limitations of drug policy and the need for far greater supports for people who use drugs in Tanzania.

6.2 The realities of heroin use in Tanzania

Background

With injection drug use rising in East Africa, and the high rates of HIV/AIDS in these countries, NGOs and donors involved in HIV prevention began to work with PWID to prevent transmission. Pioneering work by Sheryl McCurdy and Susan Beckerleg revealed extreme levels of HIV infection among PWID in the early 2000s. In 2005, a study in Kenya among a group of injectors showed a 52.5% rate of HIV infection (Beckerleg et al. 2005:1). Early studies in Tanzania showed high rates among users as well (McCurdy 2006). Activists, mainly people who use drugs, also worked to advocate for their rights and lobby for a response to the steady rise in HIV/AIDS from the government.

In a 2011 report, a clearer picture of the extent of HIV infection emerged. The estimated number of PWID in Tanzania was estimated to be 25,000 – 50,000 in 2011, with an overall HIV prevalence of 42% as compared to 5.1% among the general population (Nieburg 2011). In 2014, a National AIDS Control Programme (NACP) estimate put the number of PWID at 30,000, with 35% living with HIV (AVERT 2016). These rates rise among women who inject drugs. In 2009, female injection drug users were found to have rates estimated at 62% and, in another study in 2011, at 71% (Balaji et al. 2017:2094). Higher risk behaviours such as sex work and the practice of flashblood, which involves re-injecting blood from another user right after they have injected heroin, highly increase risks of infection among women (McCurdy 2009).

HIV/AIDS rates are estimates and an accurate number is very difficult to confirm. However, key and vulnerable populations are known to have much higher rates than the general population. Among people who inject drugs this rate is now estimated at 36% (Global HIV prevention 2017:3). For other key and vulnerable populations, the rates are estimated at 26% among female sex workers and 25% for homosexuals (Global HIV prevention 2017:3).

A majority of individuals in Tanzania, from my interviews, preferred to smoke heroin and claimed that most of those they used with also smoked. Smoking heroin is cheaper and easier to facilitate in the streets. While it may appear dangerous to some users, injection use persists as the

same amount of heroin injected, rather than smoked, enters the blood stream quicker, providing a more powerful high. In a 2015 study of 480 people who use drugs in Mwanza, 13.5% of respondents injected (AVERT 2018). A 2018 study showed that, in 436 interviews, 'most primary key informants reported smoking "cocktail" described as a combination of ground-up cannabis, tobacco and heroin (Tiberio et al. 2018:23). However, PWID, as the most at risk population, attracted far more attention at first from international donors and NGOs concerned with high rates of HIV/AIDS. The first methadone clinic in Tanzania was opened at Muhimbili National Hospital in 2011 and was open to injection heroin users only (Saleem et al. 2015:60). When the program began, it had to operate with limited funding, and focused on the highest risk individuals for testing and treatment. This has since changed, and the program is now open to those smoking or inhaling heroin, thus expanding enrolment in the methadone program considerably.

The methadone program was, and continues to be, entirely funded by foreign donors such as PEPFAR (Ng'wanakilala 2013:89). The clinic was the result of years of growing concerns and local advocacy. The Tanzanian Network for People Who Use Drugs (TANPUD), was an early instance of a network of users hoping to spread education and understanding (Jensen 2016). In 2011, TANPUD was formed to advocate for the rights of people who use drugs and promote harm reduction. In discussions with one of the original members they described how, given the difficulties faced by people who use drugs in everyday life, organizing was a challenge at first[11]. Syringes were (and remain) illegal, drug use was criminalized and life for many people who use drugs was a constant series of obstacles and problems[12]. This member told me about the difficulties of forming an organization among people who use drugs without external support, and noted that the group was not a popular choice for funding. Other organizations that were bigger, but did not have as comprehensive an understanding of harm reduction, were better able to organize themselves to access foreign funding[13]. As I discuss in the next chapter, fledgling activist organizations have remained an important part of advocacy and have even been invited to consult with the government. The election of Magufuli, however, has had a severe impact on the advocacy work of these groups.

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[11] Individual interview 4, August 2018, Mikocheni
[12] Individual interview 4, August 2018, Mikocheni
[13] Individual interview 4, August 2018, Mikocheni

Other organizations formed and became more active in 2011 to support outreach and safer drug use. Some organizations, such as Methadone Families Advocating Against Drug Use (MEFADA) formed with direct connections to the methadone program, working to connect people who use drugs to the program. The French NGO Médecins du Monde (MDM) began a needle exchange program in Temeke district (McCurdy and Kaduri 2016:315). These interventions, the result of advocacy and education, slowly gained the support of the government. The results of these interventions also proved effective in reaching some people who use drugs and connecting them to needed supports. As these supports grew, however, it also became clear that much more support was needed. Between 2011 and 2016, an estimated 1000 clients were enrolled in the methadone program (Saleem et al. 2016:60). However, this was a small amount in comparison to the many who required supports. New methadone clinics in Mwananyamala and Temeke neighbourhood have helped increase access and the expansion beyond syringe users has increased numbers enrolled in the program. While the methadone program grew, accompanying wrap around supports and outreach worked with limited funds to keep up.

The major focus of methadone treatment is to ensure that PWID can access Anti-Retroviral Treatment (ART) should they be HIV positive while ending risky drug use practices. Given the high rates of HIV among this population, the implementation of these services was of major importance even if it did not address the root causes of addiction. When the program began, the aim was not only getting individuals on treatment but also simply testing individuals to get a better understanding of the scale of the problem. The rate of HIV diagnosis, with those diagnosed aware of their status, is lower in Tanzania compared to its neighbours, at 78% (AVERT 2019). Of this 78% that have received their diagnosis, around 92% are receiving treatment. The rate of treatment for KVP, however, is not known (AVERT 2019). These challenges underline the importance of testing, informing patients and supporting their access to treatment. The improved numbers in Tanzania also reflect the overwhelming focus on achieving the 90-90-90 target, which focuses on ensuring 90% of people know their status, are receiving treatment and are viral suppressed by 2020. While this focus is important, it is not always suited to including KVP.

In terms of reducing HIV/AIDS prevalence and facilitating access to treatment for PWID, the methadone program was a major step towards enhanced health services for people who use drugs. Many proponents of the program, however, including local NGOs and academics, anticipated

that the program would develop and grow beyond a simple medical intervention. As noted by Ratliff et al, 'in Tanzania, methadone is a substance designed only to reduce HIV transmission: it is one component of this harm reduction strategy along with comprehensive health services, individual and family counseling and occupational training. It is not intended to treat addiction and foster recovery as in other settings or systems' (Ratliff et al. 2016:12). This position reveals the limitations and issues that have persisted with the provision of methadone in Tanzania. It is not intended to treat addiction or other issues surrounding drug use. However, it has become the sole service available to people who use drugs. In only allowing methadone in the country and not providing other services for recovery, the government has basically reduced the treatment of drug use to methadone programming.

During fieldwork in 2018, it was clear that methadone was being provided with little support beyond the daily dosage. Stigma remains a barrier to access particularly among women, who make up a much smaller portion of those accessing treatment. Individuals enrolled in the program are required 'to commit to a treatment plan, which includes abstinence from alcohol and illicit drug use' (Ng'wanakilala 2013:90). While this rule is to be expected, in the everyday context of Tanzanian life, and in the absence of social and economic supports, sticking to this program can be challenging. Methadone patients are required to present themselves respectably when they appear for their dose every day, regardless of their circumstances.

Pointing out the limitations of the methadone program is not necessarily a critique of the program itself, but rather a critique of the practice of implementing one aspect of a more comprehensive and needed health and human rights intervention. The medicalization of addiction through the provision of one program in the absence of other supports has major impacts on people who use drugs. Most importantly, people who use drugs have little option in accessing other services such as mental health supports, outreach, counselling and supportive treatment centres, all of which are not funded with the limited dollars present in the sector.

The focus on methadone allows donors to maintain their goal of reducing HIV transmission, even as people who use drugs continue to require more comprehensive supports. The continuation of the program also can be trumpeted by the government as promotion of its 'harm reduction' approach, which apparently consists of providing methadone to 'solve' the problem of addiction.

The concern that 'isolated epidemics never remain concentrated among drug users' but reach the general population (Bruce et al. 2014:24), drives this intervention, not the human rights and right to health of PWID. In other words, 'dispensing methadone is acceptable harm reduction activity because it also corresponds to the values of prohibitionists in reducing the demand for heroin' (Ratliff et al. 2016:13).

It is exactly this framing of harm reduction that has given the government of Tanzania space to pursue a war on drugs while supposedly retaining harm reduction supports. Framing methadone as comprehensive harm reduction challenges and changes fundamental understandings of what harm reduction actually is, and simplifies to one intervention that is intended to promote abstinence. As I witnessed in Dar es Salaam, the work at the methadone clinics is important. Pioneering doctors such as Jessie Mbwambo have worked to save lives for over a decade through the methadone program. However, advocacy for greater social and economic supports will be needed to meaningfully address the greater supports that many of the people I talked to requested.

Framing harm reduction as a strictly medical practice contributes to altering its meaning, and making its implementation a seemingly straightforward medical intervention. Recommendations in 2016 for improving methadone treatment were only focused on HIV prevention and highlights 'the importance of higher doses of methadone to maximize HIV treatment benefits for PWID' (Lambdin et al. 2016:47). Calls for greater supports often have not gone beyond a focus on how to get individuals in the program and retain them, rather than considering other important needs that address the everyday realities of people who use drugs. Comprehensive harm reduction involves basic healthcare, such as treating lesions, outreach, mental health and social supports and, most importantly, should be based on the principle of meeting the needs of drug users and not promoting abstinence.

The danger of this single minded focus, as pointed out by Caroline Acker in regard to syringe exchange, is that interventions are 'stripped of the symbolic charge surrounding illicit drug use, syringe exchange is simply good, old-fashioned infectious disease control: a pathogen has been identified; its life cycle has been studied, and how it is transmitted from one body to another understood; and syringe exchange interrupts that transmission by providing drug users with sterile injecting equipment' (Acker as quoted in Gowan et al. 2012:1252 – 1253). Similarly, with

methadone, a population of individuals with various challenges, histories and experiences are considered a vector for disease control, without any meaningful interventions aimed at increasing chances for recovery and improved health outcomes. Methadone, in available studies, is written about in Tanzania as a public health intervention to reduce HIV/AIDS and appears to be the only treatment that interests Magufuli. Ultimately it should only be considered as one aspect of comprehensive treatment and aftercare. As noted by McCurdy, 'socioeconomic and educational investment are the key to responding to the triple threat of the crack, heroin and HIV/AIDS epidemics. In other words, to effectively respond to this epidemic we must address its socioeconomic determinants' (McCurdy and Kaduri 2016:317). During my time in Tanzania, this sentiment was echoed by every drug user and activist I talked to, many of whom are accessing methadone despite poverty, lack of opportunity and stigma.

Despite the major focus on reducing HIV/AIDS, even in reaching this goal several barriers persist, including lack of support at point of contact, limited social supports and stigmatization (Saleem et al. 2016:63). The stigmatization and barriers are particularly prevalent among women who use drugs who are estimated to make up 33% of PWID but only make up 8% of methadone clients (Balaji et al 2017:2094). Women face a huge number of obstacles in accessing services, often facing intimate partner violence, sex work, stigma and having no or little income (Balaji et al. 2017). The difficulty of addressing drug use through methadone at public health institutions, with less focus on individual patterns of use, is evidenced by those who choose not to attend, who continue to use while attending treatment or who end up going to sober houses where they can receive more social and mental health supports. The drive, for example, of the Global Fund to enroll 400,000 people in ART (Waititu 2018) is important but changes little for the most vulnerable who face stigma, obstacles to treatment, low prospects of employment and lead very difficult lives. The result, as shown in a more recent estimate, is that only an estimated one in five injection heroin users are accessing treatment and methadone (AVERT 2019).

In 2015, the methadone program needed expansion and support, but found in Magufuli a very reticent sponsor. While addressing systemic poverty and discrimination in one of the poorest countries in the world is a major task, the idea of curing people who use drugs of their illness through a purely pharmacological intervention sets people who use drugs up for failure. In 2015, Tanzania was committed to the expansion of services as organizations diverted money towards

people who use drugs. Harm reduction drop-in centres that provided services such as syringes, peer support and a safe space to spend time for users who still face societal stigma were available to people who use drugs.

At this time, scholars highlighted the critical importance of building on this programming, noting 'further initiatives must address law enforcement abuse as well as the stigma and discrimination faced by PWID' (Lambdin et al. 2015). The continued support for people who use drugs seemed possible, even though this idea appeared to be more of an afterthought in the largely clinical literature focused on reducing HIV transmission among injection drug users. Further, the MDM needle exchange program was set to expand through Dar es Salaam from its base in Temeke district. Outside harm reduction organizations such as Mainline looked into operations in Dar es Salaam and even undertook preliminary studies on establishing harm reduction supports in the country.

Tanzania was on a positive trajectory to increase harm reduction supports. As I show in the next sections, the beginnings of the methadone program were promising and appeared to be a basis on which to build a more comprehensive approach to support people who use drugs. Experiences with drug use, available services and methadone treatment in reality show some of the limitations of Tanzania's approach to people who use drugs. Service providers and scholars saw that methadone was not a holistic solution but part of a greater human rights based approach towards drug use. Prior to Magufuli, advocacy in this direction was well underway, and the government was listening.

Patterns of use and the experience of people who use drugs

While it was not my intent to describe the personal stories of people who use drugs in Tanzania, many of the people I interviewed discussed their histories with me. I use these histories to illuminate how experiences are shaped discursively in the context of wider policies and social environments. I also use these interviews to provide a brief glimpse of some of the realities of drug use I would not have been otherwise able to discover, such as the cost of drugs and the ideas and beliefs of those who use them. During my interviews, I asked questions that related everyday experiences to the larger political context and interactions with the government. In most cases, government policies were inadequate or directly opposed to improving the lives of people who use

drugs. I found this to be the case with existing programs available and in terms of the stigma, police harassment and the large gap in health services available to people who use drugs. In this section, I show the connections between drug use and the social and economic context in which it takes place.

In several interviews, people noted that the first drug they used was bangi (cannabis), which is cheap and widely available in Tanzania. The transition to harder drugs was the result of a number of factors, from social connections to a lack of understanding of what certain drugs were or their effects. In some cases, individuals noted their desire to simply get a better high after using other drugs such as marijuana. One man at a sober house began using drugs by dealing heroin across the Indian Ocean to Kenya and Comoros from Zanzibar and Dar es Salaam[14]. Since he transported drugs by swallowing them, he would sniff heroin to reduce the possibility of a bowel movement, and eventually began sniffing regularly regardless of his trafficking duties. Soon he became what he described as a mteja (client or junkie) and his employer lost trust in his ability to continue his work[15]. In another case, a woman had dropped out of school and was using bangi for some years before trying heroin, as she believed it was just a different kind of cannabis[16]. Another former drug user at the sober house also started with cannabis before feeling the need for something stronger. Since the people she spent time with had access to heroin, social connections increased this desire for something stronger, 'there was peer pressure and people would use heroin around so I started using it too, I was 15 years old' [17].

This study is not focused on paths to heroin use, but I highlight these examples to show some of the ways in which use can begin and some of the commonalities to beginning drug use that were confirmed in other interviews. For instance, beginning in trafficking is rare and trying drugs was more benign than depicted in war on drugs narratives of disaffected youth targeted by criminals. The effects of the drug war, however, which limit access to education on drugs and do not limit supply, result in easy access to cannabis, and a lack of knowledge around drug use and to social and economic supports.

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[14] Individual interview 39, October 2018, Kigamboni
[15] Individual interview 39, October 2018, Kigamboni
[16] Individual interview 28, October 2018, Kigamboni
[17] Individual interview 26, October 2018, Kigamboni

Some interviewees noted that they were around other people who use drugs and transitioned over several years to higher doses of heroin. While this may sound like a confirmation of the 'gateway drug' idea that marijuana leads to heavier drug use, this is not the case. I only talked to those who became heroin dependent, not the huge majority of others who tried and abstained from marijuana or heroin, nor those who continued to only use marijuana, a very common drug in Tanzania. There is no one factor identified as the reason people told me they began using drugs. Paths to use vary, however, drug war narratives often erase the very human factors behind drug dependency and do not consider the many who do not become dependent on drugs. Poverty, lack of opportunity and boredom impacted people's decisions to use, while other factors were the same as anywhere, curiosity, trauma, peer pressure or a desire to have fun. From my limited experiences in Tanzania, the higher levels of poverty and unemployment did not seem to have the impacts predicted, where people with limited hope of a better future resort to heavy drug use. Drug use was just as common as any other country, albeit in a different context.

As with the spread of crack cocaine in the United States in the 1980s, Tanzania's drug use does appear differently, as it is impacted by poverty. The smoking of a cocktail, which as mentioned is a mix of cannabis, heroin and tobacco, appeared to be the most common form of use among interviewees and in hot spots as it is cheaper and easier to do in a vulnerable setting, often among homeless individuals. Injection use was avoided by some because of the known risk and the ability to continue to have needs met by smoking. The transition to injection use, illustrated more fully in a 2015 study by Margarita Dimova, depended on a number of factors. In discussing the transition from smoking heroin to injecting in Kenya, Dimova et al. note how 'agency is produced and enacted within these structural pressures through the creation of a logic of economic constraint that shapes how transitions are understood and managed' (Dimova et al. 2015:7). This statement points to multiple levels of reasoning, from social networks to economic constraint that shape transitions from cannabis to heroin, and from smoking heroin to injecting heroin.

In interviews with both outreach workers and former users themselves, the most common reason for the transition to injection use I found was based on economic calculation. The economic choice behind the switch points to the influence of a structural component over behavioural. However, agency is present in the need to increase use as tolerance rises. Dimova et al (2015) rightly point to the multilayered reasons for a transition, but economic pressure and rising prices can

motivate a switch. As one interviewee noted, they could hustle all day and get enough to smoke a few times. However, rising dependence and higher costs mean that you could also just inject providing a more direct high (to the bloodstream) for less money[18]. Inland, where costs are higher, a hit of heroin could be from 5,000 to 7,000 Tsh (US$ 2 – 3). A person with high tolerance could smoke easily 30,000 Tsh worth in a day ($12) but if they are injecting they can have a more powerful effect for the same cost[19].

Using drugs in Tanzania is shaped by high levels of poverty and individuals often have to resort to desperate means to maintain their use which also grows as tolerance increases. The income and poverty levels in Tanzania put the costs of drug use in sharp relief. In 2015, the World Bank estimated the number of Tanzanians below the poverty line to be at 28.2% using a figure of 36,482 Tsh ($15.84) per adult per month (World Bank Poverty Assessment 2015). This poverty line is now at 26.4% according to state sanctioned statistics (Masare 2019). In contrast, the cost of drugs and the average use for many heroin users easily outstrips average incomes. One man at a sober house noted that for one day he could spend 50,000 Tsh ($22), 'because I am using crack cocaine which is 5,000 Tsh ($2.20) for one hit, heroin is 2,000 or 3,000 Tsh ($0.85 or $1.30) so if I want to get high I need to have 10,000 Tsh ($4.40) in the morning. I need this to avoid withdrawal, and if I don't have it I have to maybe beg the pushers[20]. Another former injection heroin user who now worked in outreach told me he often stole as he was spending upwards of 40,000 Tsh/day ($17), and some days could even spend 100,000 Tsh ($43)[21].

These sums are extremely high in Tanzania and many individuals resort to differing means to support this. At one hot spot I saw men disassembling electronics to extract any valuable parts, likely for a small return[22]. In others, men prepared to begin a day of hustling in Tanzania's informal economy, and spend the day doing small odd jobs to avoid withdrawal. Several interviewees told me that when they were using, thoughts of treatment or getting clean were far from their mind as the need to avoid withdrawal and get money to survive the day was paramount. A main goal for people

[18] Individual interview 26, October 2018, Kigamboni
[19] Individual interview 5, October 2018, Kigamboni
[20] Individual interview 5, October 2018, Kigamboni
[21] Inividual interview 44, October 2018, Kinondoni
[22] Mwenge Hotspot participant observation, October 2018

who use heroin is to avoid withdrawal, or dopesickness (rusto), which means ensuring adequate supply in the morning to stave off sickness and then hustling to make money for the next hit.

In general the costs of heroin in Dar es Salaam were reported as around 2 – 3,000 Tsh ($0.85 – $1.30) per dose which, depending on tolerance could mean spending well over what most Tanzanians make in a month in one day. These costs are just for the heroin and do not include other basic needs meaning a major objective for people who use drugs is simply scraping enough together for the day and repeating the cycle the next day. Many people at hot spots have to weigh the options of getting enough money together to stave off withdrawal against the burden of attending some treatment. In cases of medical need, filariasis[23], malaria and other easily treatable diseases are common, but medical services also cost money in Tanzania and are weighed against the need to save for another dose of drugs.

For women, getting money for drugs can often lead to prostitution. Almost every former female heroin user I talked to discussed informal sex work as a means to make money. In focusing on abstinence and not reaching people who use drugs in ways that combat stigma and are more accepting, this challenge will remain. The stigma and challenges facing women reflect the realities of how drug use impacts populations differently, and how interventions cannot be a homogenized service for everyone that does not recognize this fact. Foreign donors may prioritize women and girls in other sectors, but not women who use drugs. As a former heroin user told me,

> You are going to do outreach you see women without money, many are prostitutes with STIs. I was a sex worker when I used drugs, I needed the money. That is normal for the addict. The money can go, but me I do it. It is dangerous. We have a house for women I stay with them there, we have many we take them in the past we had a house women only. And then some women come here[24].

[23] Lymphatic Filiarias 'is a parasitic disease caused by microscopic, thread-like worms. The adult worms only live in the human lymph system. The lymph system maintains the body's fluid balance and fights infections. Lymphatic filariasis is spread from person to person by mosquitoes. People with the disease can suffer from lymphedema and elephantiasis and in men, swelling of the scrotum, called hydrocele. Lymphatic filariasis is a leading cause of permanent disability worldwide. Communities frequently shun and reject women and men disfigured by the disease. Affected people frequently are unable to work because of their disability, and this harms their families and their communities' (Centers for Disease Contol and Prevention 2020).

[24] Individual interview 17, October 2018, Kigamboni

The overlap between women who use heroin and female sex workers is not known, but the much higher rates of HIV among women who use drugs illustrates the greater risk factors they undertake to pursue the habit. While male injection drug users have an estimated HIV prevalence of 28%, females have an estimated rate of 62% (Tan et al. 2015:2). As one interviewee noted, it is 'very hard here to get drugs, very expensive. You have to go sell yourself. Sometimes you use a condom, sometimes it is very risky you know. [It is] very risky to get HIV. Some men offer you a lot of money to not use a condom'[25]. Women who use drugs in Tanzania and sex workers are highly stigmatized and have lower rates of participation in all programs.

Using in Hot Spots ('Maskani')

I witnessed and discussed most of these issues in hot spots around Dar es Salaam. In Dar es Salaam, 'maskani' or hot spots emerged as sites where people who use heroin spend their time, using together, supporting each other, hustling and buying drugs. While not all people who use drugs spend time in these places, maskani are areas where drugs can be purchased and are sometimes used, creating makeshift communities in poorer neighbourhoods. I visited six hot spots that were well known, in Kigamboni, Mwenge, Mwananyamala (outside the methadone clinic), Temeke, Kinondoni and Manyanya. These sites ranged from highly social areas with dozens of people, to small groups using together in various spots around the neighbourhood. I visited some areas more than once, and accompanied outreach workers from methadone support organizations, sober houses and with one international NGO.

The first hot spot I visited was in Kigamboni, an area in Dar es Salaam reachable by ferry or across the new Nyerere toll bridge. Kigamboni is a poor area and is known for higher levels of drug use. The hot spot was among boat builders and repairers, with some individuals using and others who had just smoked or injected nodding off. There were over 100 people in the spot, beginning their day and, for some, staving off dopesickness with their first hit. Notably, this was one spot where I noticed a man dealing, with a large wad of money.[26] While I discuss this in the next chapter, I found it quite remarkable that this man was able to have such a large amount of money visible

[25] Individual interview 46, October 2018, Mwananyamala
[26] Kigamboni ferry hotspot observation, October 2018

while also being very transparent about his actions. In conversation with the outreach worker I was with afterwards, the dealer is apparently able to pay off police if needed.[27]

Beyond this individual dealing drugs, visitors to offer support were uncommon. The outreach worker I was with discussed the lack of supports available in the spot, a sentiment shared among those living and spending time in Kigamboni. The outreach worker pointed out several individuals who required medical attention for infections and parasites. The focus on HIV is important, however, there are a number of other less serious illnesses that are very common in Tanzania, from malaria to water-borne pathogens. As many of these people were homeless or using and they were not able to take proper precautions against these issues. Nutrition seemed non-existent, a much lower priority for many of those who are focused on getting through the day and buying heroin. The maskani showed both the complexity of supporting a highly vulnerable population and the impacts of changes in policy which can reduce outreach or raise the cost of drugs, upsetting the tenuous daily balance many of these individuals face.

In Dar es Salaam, the informal economy in poorer neighbourhoods is evident, with street vendors and small businesses in place among more formal shops. I had not realized in previous visits how drug use in some poorer neighbourhoods was common, and how little separation there was between individuals actively using and others just living and working in these areas. The lack of separation is not meant to dismiss the stigma that certainly persists but rather highlights the realities of poverty and life in these neighbourhoods. Drug use appeared to be a part of the social environment in these areas which are known as places where people use. As I was visiting after Magufuli's crackdown on these people, I was told that there was much less use in public now. However, it appeared out in the open and is illustrative of how a war on drugs attempts to create and reinforce a social division that, in reality, may not be as clear cut.

I went to these hot spots as a participant observer both with workers from sober houses and with organizations meant to support a transition to methadone treatment. I also went on one outreach trip with the needle exchange program in Temeke, which was more harm reduction focused and included cleaning up needles at hot spot locations. Many outreach workers were former

[27] Kigamboni ferry hotspot observation, October 2018

users themselves and had different experiences, as the methadone outreach teams had all used methadone to get clean and were hopeful about supporting others through this process. The sober house outreach workers were less keen on methadone, as it did not work for them, but did not focus on abstinence either in their outreach. The goal of the methadone outreach teams was to encourage people to start treatment. The outreach worker used experience, rhetoric and a mixture of cajoling and enthusiasm to encourage individuals there to come with him and get clean[28]. At one hotspot, the small group of men we visited all said they would like to quit drugs but the prospect of interrupting their ability to find money for their next fix and the fear of withdrawal was difficult to get past.

One local NGO director told me, 'everyone wants to quit of course, my experience is that 90% of people I talk to want to quit'[29]. Similarly, while many interviewees who continued to use in hotspots told me or outreach workers they aspired to quit and wanted to be in sober houses, they obviously did not have the means to do so. As I outlined above, the prospects of going through the processes required to begin methadone treatment would be difficult for most. The aspiration of quitting versus the realities of doing so, are an issue for people who use drugs in general, not just in Tanzania. However, the supports in Tanzania are far from adequate even though a more effective model of harm reduction and outreach could have been developed by now.

The methadone program in Tanzanian and harm reduction

Methadone is the main focus of Tanzania's drug treatment response, and this intervention is mainly in place in order to reduce HIV/AIDS prevalence. Since its inception in 2011, the program has grown to support several thousand clients, with outreach organizations also supporting people who use drugs to access services (see figures 4 – 6). MEFADA, one of the main organizations doing outreach work, has reportedly supported 1,154 clients since opening in 2014[30]. Outreach work involves getting beneficiaries connected to supports and easing their access to methadone treatment[31]. Ensuring beneficiaries are successful in graduating from the initial outreach sessions and remain committed to getting their methadone treatment daily, can involve a lot of work. This process also relies on a real desire on the part of the drug user to participate. Once the week of

[28] Mwenge Hot Spot observation II, October 2018
[29] Individual interview 24, November 2018, Temeke
[30] Individual interview 2, October 2018, Kindondoni
[31] At most local organizations, the name given to people who use drugs is beneficiaries.

preparation is complete, further supports are not as available as when beneficiaries begin the program. There are many more clients than can be adequately served by outreach organizations which have to continue finding people to get them on treatment and then doing follow-up work should they relapse.

The process of doing outreach to encourage people who use drugs to attend treatment makes sense on paper as a harm reduction intervention. Beneficiaries are supposed to enter counselling to prepare for methadone, reducing their likelihood of quitting the program and receiving education to help them on their journey. The reality of this process can be messy and challenging. During my first outreach trip with the methadone support outreach organization, I watched as the outreach worker I was with spent over an hour discussing the benefits of methadone treatment with a group of young men using heroin. Encouraging these men to interrupt their day and begin treatment did not appear very convincing[32].

The outreach worker ultimately convinced three beneficiaries to return to the NGO office with us to begin the process of starting treatment. This process begins with counselling and registration. However, as several of these beneficiaries had just used that morning, they nodded off or outright slept during the counselling session. When we caught up with them the following week, they were back where we found them in the hotspot. They related how, since it had been too late to get to the methadone clinic on the day they received counselling, they had to return the following day and were then forced to wait several hours. They complained that this took time away from their limited window to make money and avoid withdrawal[33]. The process was not easy and I was surprised at how tenuous it was. Any hiccup or difficulty and the individuals would evaporate, as their desire to attend treatment in this context seemed to be low.

During another outreach trip to the same hot spot in Mwenge, the outreach worker was able to complete the process as intended. Again it appeared a major challenge to support the beneficiaries through the initial process of attending counselling. After an hour of discussion, some of the group did decide to enter into the treatment process and go to the initial counselling session with the outreach organization. With little funding, the outreach organization has no vehicle so we paid for

[32] Mwenge Hot Spot observation, October 2018
[33] Mwenge Hot Spot observation, October 2018

the men to get on to a bus. We had to change buses to reach the NGO offices, again paying bus fare. While the cost of the bus is not high (from a Western perspective), getting people who have used heroin recently to undertake a long bus journey is a physical challenge. As with the previous outreach trip, the group was registered and received their first counselling session. Again, it was unclear how effective the counselling was, as some of the men nodded off or appeared to struggle to pay attention. The process so far had already taken several hours and it was a hot afternoon and the beneficiaries had little energy. After the counselling session, we took another bus to the methadone clinic for registration in the program. With registration completed they left to go about their usual day[34].

The methadone program receives the majority of harm reduction funding, reducing funding available for other supports. The organization I accompanied to do outreach received its funding from the Global Fund. However, it was clear the majority of funding went to the provision of methadone itself. The organization had a humble office building and outreach workers were volunteers. The importance of this work, including counselling and education essential to supporting beneficiaries through the methadone process, was not reflected in their funding. I was surprised to see how hard it could be to get people to access treatment. Deciding to start treatment is already difficult enough without the obstacles. In Temeke, I found the needle exchange program to be less focused on getting people to methadone, and more on establishing connections and practicing harm reduction. However, the more expansive services offered were due to the fact that this organization had different, more substantial funding and was able to offer other services at its office, such as a drop-in, basic medical services and some counselling. While this program also supports people in accessing methadone, it is not necessarily the goal.

Unfortunately, as mentioned earlier, the harm reduction services in Temeke have not been scaled up and, at the time of my fieldwork, were limited to one neighbourhood. The focus on methadone is far less client-centred and harm reduction based. Rather than receiving greater social and economic supports, personal responsibility is of great importance. Maintaining methadone requires dressing responsibly every morning, paying your own way on transit to attend treatment and ensuring you are on time every day, potentially for years. During the outreach I observed, breaking

[34] Mwenge Hot Spot observation II, October 2018

the focus on 'hustling' to get the next fix and avoid withdrawal seemed a major deterrent in encouraging individuals at hotspots to attend treatment.[35]. Individual responsibility is paramount as there is little incentive to begin the counselling and methadone treatment unless one really wants to get off drugs. Many individuals want support in some way and sober houses seem the aspiration, less because of their approach but more because people using drugs know there will be some security, food and support. These are also places where former drug users are present and offer an understanding of addiction. Methadone treatment does not offer greater support or understanding, and therefore the first days in treatment can be difficult.

The issue of continued use during this time is common. One man at the sober house noted that, 'when you use heroin you can feel it, you can't feel the methadone so at the same time I was using cocaine because you can feel the high. So most of us who are taking methadone, we are also taking cocaine. One day I skipped (methadone dose) so I was banned for one week and I found myself using again'[36]. This statement does not mean methadone does not eventually work or that all people who enter methadone continue using other drugs. As an individual on methadone for two years told me, 'at the beginning I was using methadone and drugs, then later I realized this was not good so I stopped drugs and use only methadone. The methadone is helping me'[37]. Two people I talked to had been on methadone for over 4 years, and one of these women stopped and has been on methadone again for eight months[38].

One man at a hotspot in Kinondoni told an outreach worker he was on methadone but had continued with other drugs. He had developed a dependency to methadone but also complained that going every day cost him money and time he could not afford[39]. Several people I encountered at hotspots told outreach workers they had tried methadone and it had not worked or claimed to be continuing methadone but were visibly intoxicated. Methadone of course works for some people, as can be seen in figures 4 – 6 below. The lack of support for greater harm reduction intervention reveals an evolution towards one method of treatment, with the intention of stopping and eradicating drug use which, for many, may not be possible.

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[35] Mwenge hotspot observation, October 2018
[36] Individual interview 5, October 2018, Kigamboni
[37] Individual interview 45, October 2018, Mwananyamala
[38] Participant observation and interviews 45-49, October 2018, Mwananyamala
[39] Participant observation, October 2018, Mwenge

A major area where I discussed methadone and use was outside of the Mwananyamala hospital, one of the sites in Dar es Salaam, along with Muhimbili and Temeke, where methadone is offered. The neighbourhood is known for being poor and outreach is regularly undertaken as the area just outside the clinic is where people gather after having taken their methadone dose. In the morning the area was busy, with at least 100 people gathered, talking and visiting. Several people I talked to discussed how, as methadone is their daily routine, they spend time here after taking their dose in this place, with their friends.

The community aspect of hotspots is a feature I have not seen considered in the literature, or more generally in works on homelessness, vulnerability and drug use. In the absence of meaningful counselling, psychological or social supports from the methadone clinic, former drug users in the program gather to support each other. As a key factor in both gaining and maintaining sobriety, social support is a remarkably under-theorized aspect of recovery. Most of the literature on methadone in Tanzania does not mention it at all. As I discuss later, drop-in centres closed by Magufuli's government were one area where both former and current drug users could gather to support each other. With the closure of these centres, the area outside Mwananyamala seemed to be one site that emerged in their place.

When I asked one woman who had taken her methadone dose a couple of hours before why she was still spending time outside Mwananyamala hospital, she said 'where can we go? When we are finished drinking methadone we come here, we talk to each other…when we go home, what are we supposed to do at home? You sit with your friends, you talk, change your minds, give a little bit of advice. Some people are still using, some people they don't use'[40]. The need for social support and lack of meaningful work mean people prefer to stay, even if they are around drug use. The alternative of being at home, facing the challenges of being bored and not being able to go to work are potentially worse risk factors for relapse. As another woman at this spot told me, 'when I'm home I'm bored, the whole time I'm at home I have nothing to do and then I started to use. I still come here, I stay for a while and then I go to my house…these people they're my friends, they are friendlier. That's why we are here'[41].

[40] Individual interview 46, October 2018, Mwananyamala
[41] Individual interview 47, October 2018, Mwananyamala

With the lack of employment, every interviewee that day noted their preference to stay at the clinic and visit. The burden of attending every day showed a real commitment among some interviewees wanting to get clean. While return bus fare is only 1,500 Tsh ($0.65), for individuals without real employment (like many other Tanzanians most work in the informal sector), this is a cost that adds up. The cost of transport is exacerbated for women who have children to care for. Travelling by dala dala, as the buses in Dar es Salaam are called, often involves waiting for the bus to fill before departure. There are no strict schedules and dala dalas are not always quick which takes up time during the day – and for methadone users this is every day – that could be spent working. However, everyone still wants employment and some are able to fit methadone treatment into their schedule before work. In interviewing people who use drugs themselves, everyone requested better services, financial support and work. The main issue confronting people who use drugs in Dar es Salaam, whether they have completed time at a sober house or are in methadone programs for years is social and economic support.

It is difficult to criticize the methadone clinics, as they do important work and methadone can be a path to sobriety or a healthier life for some people who use drugs. The table below shows attendance records in 2016 for the methadone clinics. The numbers are high, but also show some of the continuing challenges with the program, as a number of people stop treatment and a very low number of women access treatment.

In this section, I showed the difficulties of using methadone as a single intervention for people who use drugs. The issue is not the clinics themselves, nor the service providers who work in them, but rather the lack of harm reduction supports around these clinics and a lack of work to address the economic and social barriers to access. These barriers could be addressed in part by scaling up the needle exchange programs, providing more counselling and undertaking small interventions such as the provision of basic medical services that could alleviate pressure on individuals attending treatment. In Temeke, the goal of the outreach organization is to provide options, as methadone is not for everyone[42]. Unfortunately the government has chosen a one-size-fits-all approach which exists with little support beyond foreign donors. In the next section I discuss

[42] Individual interview 18, November 2018, Temeke

another grassroots option being offered. In the absence of government supports, sober houses offer an alternative to methadone. However, with little official support or capacity, this intervention has its limitations as well.

Figure 4. Attendance in Mwananyamala Methadone Clinic, 2016

	Males	**Females**	**Totals**
Total enrolled	1,167	203	1,370
Continued treatment	849	143	992
Stopped treatment	225	35	260
HIV positive	152	76	228
Tuberculosis	58	26	84

Figure 5. Attendance at Muhimbili Methadone Clinic, 2016

	Males	**Females**	**Totals**
Total enrolled	1,201	77	1,278
Continued treatment	849	59	943
Stopped treatment	183	18	201
HIV positive	241	28	269
Tuberculosis	82	16	98

Figure 6. Attendance at Temeke Methadone Clinic, 2016

	Males	**Females**	**Totals**
Total enrolled	857	48	905
Continued treatment	589	29	618
Stopped treatment	188	17	205
HIV positive	152	18	160
Tuberculosis	37	9	46

Source for figures 4 – 6: Jamhuri ya muungawo wa Tanzania Ofisi ya Waziri Mkuu, mamlaka ya kudhibiti na kupambana na dawa za kulevya, 'Taarifa ya hali ya dawa za kulevya ya mwaka 2016.' (United Republic of

Tanzania Office of the Prime Minister, Drug Control and Enforcement Agency 'Report on the state of drugs in 2016'). Tables translated by author.

Sober Houses, 12 steps and approaches to help people who use drugs

Through connections built with local NGOs, I heard about a former heroin user who spearheaded the sober house movement in Dar es Salaam. Learning about the movement was unexpected as there have been no academic studies that I was able to find on sober houses other than a planned future study from Volda University. Sober houses started in Zanzibar and are a mix of 12 step approaches borrowed from the United States, harm reduction and a grassroots effort to provide some supports for people with drug use issues. They have become more common in recent years, led largely by former heroin users or others with substance misuse issues. I met with some of the sober house volunteers and staff and was able to observe their program. This program, while abstinence based, included outreach that seemed to be based on harm reduction principles, with the recognition that most people were unable to attend a sober house and in the interim require understanding and help. Many of these houses have formed networks that are mutually supportive and are founded in the hope of reaching people who use drugs, helping them better understand their addiction and make improvements in their lives.

The first sober houses in Tanzania opened in 2009, founded by a man named Suleiman Mauly, with supporters from the United States (Warner and Boswell 2015). The first sober house in Zanzibar was called Detroit Sober house, owing to its roots in American 12 step programs. One man I talked to currently at a sober house, started his recovery there in 2009 as 'detroit sober house, that was the first place of the sober houses'[43]. Since this time, the model spread into Dar es Salaam and some other towns in Tanzania. A proposed project from Volda University numbered sober houses at seven in Zanzibar and three in Dar es Salaam (Volda University 2019). During my time I visited three houses in Kigamboni, a lower income area of Dar known for drug use, but also heard of another site south of Dar and one that had opened in Dodoma. There seemed to be a growing movement as the supports are in high demand and exist in the absence of any other social supports

[43] Individual interview 39, October 2018, Kigamboni

or meaningful approaches that address addiction beyond a medical model. Sober houses offer people who use drugs some tools to understand drug addiction.

The development of sober houses is a novel process in Tanzania, where heroin users are more often treated as criminals or medical clients. As I noted previously, mental health supports are weak and are far from enough to support people who use drugs that require these interventions[44]. The lack of training within mental health education also presents a major obstacle. In fact, the woman I talked to who organized the sober houses in Dar had done so because of her experience with mental health:

> A long time, I used for 12 years and before the 12 steps I was in mental hospital. In 2003 I was in mental hospital, that time there is no sober house, no other treatment here. I go to mental hospital, they treat me like I am mentally ill. They tell me I have substance abuse and then next time bipolar or mania. In 2006 I went there three times. They treated me with mental illness but I'm not. They don't talk with us or treat drug use[45].

While this experience may be unusual, it does depict the lack of understanding in medical training at that time of substance misuse. No other interviewees received any mental health interventions. At the methadone clinic, I talked with a social worker at Temeke, one of three who sees between 15 – 25 clients per day[46]. This number is out of close to 1,000 beneficiaries enrolled there. In our discussion, the social worker outlined how they support planning treatment, connecting with family to discuss the needs of the client and intervening in the case of relapse[47]. The health-centred approach for injection drug use and drug dependency more generally does not receive much attention in official health policy, despite the growing methadone program. While mental health care is often an important component of treatment for drug use, mental health services in Tanzania are inadequate, with over 80% of mental health work being done by traditional and faith healers (Tanzania National Health Policy 2017:9).

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[44] Individual interview 12, October 2018, Muhimbili University
[45] Individual interview 17, October 2018, Kigamboni
[46] Individual interviews 21,22, October 2018, Temeke
[47] Individual interviews 21,22, October 2018, Temeke

In this context, where drug use is not talked about or understood well, these houses offer a spot away from use with a community of people who have shared experiences. Many interviewees noted their desire to attend a program at these houses where there is an understanding of their experience. 12 step programs are based on abstinence and a higher power, but they also offer peer support, something that is lacking in Dar es Salaam. As with the supportive communities of former users around methadone clinics, sober houses are a reaction to a lack of other social supports available.

While not the focus of my study, I found that sober houses really are the only other option available in Tanzania for people who use drugs, or for any people with substance misuse issues. I also found the community that had developed in these houses to be an important network in continuing involvement and encouraging mutually supportive relationships, as sober house volunteers often follow up with beneficiaries even though many return to drug use. Sober houses have people who found sobriety and swear by the process as the only way to move forward. There are also high rates of relapse as is the case with many drug addiction programs. The 12 step program, though abstinence based shares a unique perspective with harm reduction, in recognizing the challenge of overcoming addiction and expecting and forgiving relapse, which is a part of the recovery process. In the context of the limited options available for people who use drugs, at sober houses there is at least an attempt understand addiction itself, forgive and break down the stigma around drug use. In the absence of government supports, sober house volunteers play multiple roles role including outreach, support and advocacy.

All of these roles and work are done without any government support or any foreign or donor funding. In discussion with one sober house director, he described how random sources of funding sometimes became available when private individuals took interest and offered short term funding for periods of three to six months[48]. With no sustainable sources of funding, attendees at the clinics are required to pay for their stay, depending on the sober house this can range from Tsh 300,000/month to Tsh 500,000/month ($130 - $220 per month). These costs are extremely high for the average Tanzanian, let alone vulnerable people who use drugs. There are few ways to pay these costs for the majority of people who use drugs, unless they are able to rely on family or friends to

[48] Individual interview 19, October 2018, Kigamboni

pay their way. Many interviewees lacked these connections. The staff at sober houses try to support as many people as possible even when they cannot pay. In one sober house with room for 10 clients, only two were paying the full costs, six were paying half and two were not paying at all[49]

The efforts of sober houses to include individuals who cannot pay, and likely could not repay their stay after attaining sobriety, is due to the high demand and an understanding that most people truly cannot afford to stay at a sober house. Many people want to attend but can only do so through sponsorship by friends or family. The model is similar to the United States, where treatment is offered through numerous private clinics, often based on intensive counselling, trauma based care and a 12 step program to abstinence. This, now multibillion dollar industry in the United States, has been a cornerstone of drug treatment for decades in the West, despite the mixed evidence on their effectiveness. While the 12 step approach may provide meaningful change for those who attend, in the West, as in Tanzania, relapse is still common. Treatment and sobriety are difficult, and require continued support. In Tanzania remaining sober after leaving the sober house is remarkably difficult. In one sober house, rates of relapse were estimated at 30 – 40 %, which is quite low. However, this number is based on relapsing and leaving during treatment, not on experiences afterwards where clients can face even greater challenges.

Interestingly, the overlap between harm reduction, abstinence and methadone in sober houses is based less on hard ideological lines and more on the need to simply do something. The motives guiding actives, in contrast to the Tanzanian government, are based less on ideology and more on lived experience. As with grassroots organizations across Dar es Salaam, the need to get involved and work towards some level of supports is a genuine desire among former drug users who recall the difficulties drug users face. I found sober house staff also undertook outreach that was not focused on preaching abstinence but rather seeing what individual needs are, visiting and sometimes providing a little support. The outreach I witnessed was not highly organized but was appreciated in the hot spots, even in the absence of material support.

In contrast to methadone, which is foreign funded with outreach workers able to directly encourage people who use drugs to start treatment, outreach from sober houses is not based on

[49] Individual interview 19, October 2018, Kigamboni

encouraging people to attend. There is less pressure and more openness, and the shared understanding, based on the volunteers' own experiences, that sometimes understanding and hope is all they can offer. The flexibility required in working with a variety of individuals, with unique histories is reflected in this outreach, rather than the one-size-fits-all, top-down approaches favoured by war on drugs ideologues who tend to view this population as homogenous.

6.3 Conclusion

Over the past three decades, heroin use has greatly increased in Tanzania and efforts to slow the traffic or influx of drugs into the country continue to fail. The literature on heroin use in Tanzania has tended to focus on HIV/AIDS. However, the greater context in which use takes place can help guide interventions and better meet the needs of people who use drugs. In this chapter, I showed some of the complexities surrounding drug use in Tanzania and describe individual experiences that could guide the implementation of better services for people who use drugs. In outlining the experiences above, my goal is to show the unique trajectories and lives of people accessing services, which better illustrates the efficacy and weaknesses of existing programs in place in the unique context of Tanzania.

I found some common threads throughout these stories, as the combination of poverty, lack of opportunity and the expense of drug use produce vulnerabilities that are not being addressed by current programming. People who use drugs are at increased risk of contracting HIV/AIDS, a number of preventable and treatable diseases, face random police harassment and are criminalized, which I describe more in the next chapter. All interviewees needed much greater support, whether it is accessing and maintaining methadone or getting some basic, inexpensive medical treatments. From the perspective of people who use drugs, the common refrain was a desire for greater opportunity.

In this chapter I show that existing services, including methadone and sober houses, are not enough to support people who use drugs to build my argument in this thesis that harm reduction is being simplified and imposed upon people who use drugs. Existing supports are underfunded or not funded at all, resulting in people who use drugs organizing ad hoc communities of support that require much greater support. I also highlight the experiences of drug users to show how their

experiences should be the basis of interventions which, as is more fully argued in the next chapter, are purposely excluded by the government of Tanzania. The voices and concerns of drug users are not included in shaping the policies that affect them, a fact that is common in many countries despite the strong, evidence based voices of activists and former users.

While the next chapter explores the top down policies that have worsened the situation for people who use drugs, this chapter illustrates the tenuous and limited supports that were available prior to the election of John Magufuli and how cracks in services could be exploited to create the illusion of greater services for people who use drugs. In chapter 8, in showing how the government sidelined donors and changed policies without their involvement, local activists, reliant on external partnerships for funding, had their voices curtailed as the Tanzanian government cracked down with little opposition from any foreign agencies.

My interviews and observations belie the war on drugs focus on individual failure and responsibility. The lack of opportunity, economic development and widespread corruption in the country place people defined as criminal by the state in precarious positions. Despite the lack of government support, people who use drugs have organized themselves and are continually advocating for greater support, even in the face of an increasingly repressive government. Methadone treatment, sober houses, informal and formal networks are only in place due to the activism of people who use drugs themselves. However, it is the government that takes credit for available supports, while not addressing the underlying concerns and much greater needs among this population.

The election of John Magufuli in 2015 should be understood with this context in mind. Magufuli represents the continuities in Tanzanian politics, but he has also had a much greater desire to impose his values on people who use drugs and he is more active in doing so than any previous leader. The services available for people who use drugs prior to him were far from perfect. However, the Tanzanian government since 2016 has only introduced fear, along with unhelpful policies, that are not improving life for people who use drugs. In the next chapter, I explore how this happened.

Chapter 7

Performance and reality: the war on drugs in Tanzania

'Because this guy knows how to perform, he makes people to have this fear, he does this purposely to make people afraid of doing anything so he can do what he wants to do'[50]

7.1 Introduction

Early in his tenure as president, while still enjoying a reputation for being tough on corruption and 'cleaning up' Tanzania, John Magufuli began cracking down on vulnerable populations. In 2016, the Tanzanian government targeted female sex workers and gay men. At the same time, the government initiated a review of policies towards these populations and their access to life-saving Anti-retroviral treatment (ART) and harm reduction supports. In 2016 and 2017, Magufuli then very publicly declared and a war on drugs and drug use in the country. Within months, following the arrest of many low-level drug users and accusations against several higher profile targets, including members of opposition political parties, the government announced its success in tackling the issue of drug use in Tanzania (Kamagi 2018).

The official stories told by the government and the impacts of this crackdown on the ground, however, were quite different. While pursuing a war on drugs was clearly performative and fit well with Magufuli's greater drive to 'clean-up' Tanzania, the crackdown was not successful in eliminating drug use and made life for people who use drugs worse. Despite the lack of success in fully eliminating drugs, the high level of cooperation between the Ministry of Health, the Drug Control and Enforcement Agency, District Commissioner Paul Makonda and the police resulted in drug users being targeted on multiple levels, legally, socially and in accessing health services.

Referring to the Kenyan government's pursuit of its own war on drugs, Margarita Dimova argues that 'Kenyan political leaders perform the war on drugs in order to shore up their image…a locally led war on drugs thus offers a whole new set of smokescreens and discursive planes through which to manipulate public perceptions and to bolster donors' confidence' (Dimova 2016:238).

[50] Individual interview 39, October 2018, Kigamboni

Dimova's argument about the performative aspects of the war on drugs and its use as a way to produce an image and shape perception is important. However, from my fieldwork, I found Magufuli's performance had not only created a sense of fear and anxiety but that this strong rhetoric was mirrored in government policy, with high-level ministers aligning to his vision and many levels of government working together to enact new, harsher policies that broke with previous ones.

In this chapter I show that, while a war on drugs makes sense for Magufuli's particular brand of moral populism, the government of Tanzania intended to implement real policy change in dealing with people who use drugs. As outlined in chapter 5, the CCM has a long history of aid dependency, leaving responsibility for the delivery of services to vulnerable Tanzanians almost exclusively in the hands of foreign donors. The KVP population relies on foreign funding for the limited services they receive which leaves a precarious sector exposed to risks should there be any changes to funding levels. In spite of the difficult situation fostered by the Tanzanian government, local NGOs have worked hard to advocate for better services. However, these local NGOs have also faced new challenges, as the Tanzanian government has avoided real consultation and pays little attention to the grassroots work being done to address the gaps in service caused by decades of aid dependency and government inattention.

While determining the internal dynamics of the Tanzanian government is difficult, during my fieldwork, the Tanzanian government was no longer prioritizing harm reduction as it has in the past. I also expected to see some of the limitations of the Tanzanian state, and that its ability to determine drug policy and implement it would be reflective of its limitations and relative lack of involvement in the sector. Instead, it was apparent in the seeming alignment of many ministers, such as Health Minister Ummy Mwalimu, to ending drug use and curtailing harm reduction, that the government of Tanzania was serious about dealing with drug users. The continuation of donor support despite the actions and statements of Magufuli, often directly opposed to the goals of these donors, challenged my assumptions about the drug war in Tanzania being influenced by the West. What I saw instead, and what this chapter illustrates, is the extent to which the Tanzanian government controlled the process of changing policy towards drug users and cracked down with little interference from the well-funded foreign agencies working in the sector, and Western donors to Tanzania.

This chapter answers my second research question: what are the impacts of Magufuli's war on drugs for people who work with drug users and drug users themselves? Using evidence from my fieldwork, I show how the worsened situation is directly linked to the policies of the Tanzanian government. Building on evidence from the previous chapter, which illustrated how precarious and limited services were for drug users prior to 2016, in this chapter I argue that the government of Tanzania made life worse for drug users by disrupting local and international partnerships, cracking down and stigmatizing people who use drugs.

In this chapter I also seek to gather evidence to answer my first research question of how drug policy is being determined in Tanzania. As I mentioned previously, my expectation of donor influence curtailing the excesses of the drug war and challenging policy changes, was proven untrue by the situation on the ground. In this chapter, I look at the experiences of those working with people who use drugs to show the extent to which the Tanzania government achieved its goals of punishing drug users and making longer-term policy changes reducing their access to needed services. In chapter 8, I will combine this evidence with the experiences of foreign agencies to argue that the Tanzanian government used appeasement, narrative framing and intimidation to bring control to an established development sector focused on helping drug users and sideline this sector to achieve their goals.

In Tanzania, where police already have accountability and corruption problems, government policy that increases enforcement of drug offences is a license to harass people who use drugs while being paid off by drug dealers. The crackdown on drug use is a visible manifestation of the war on drugs, however, the government also targeted people who use drugs by dismantling progressive health policy and harm reduction supports, effectively reducing access to services and weakening the already limited services available. While I look at international NGOs more in the next chapter, I aim to demonstrate here that international influence is minimal and the war on drugs in Tanzania has proceeded without much interference.

This chapter is organized into four sections. I begin by looking at the public crackdown, how it was implemented, what it achieved and what it looked like from the ground for people who use drugs. I then examine the policy changes being implemented at the same time, showing how the Tanzanian government was not only cracking down on drug use but working to create an

environment with reduced access to services for vulnerable people. I argue that while the crackdown was performative, the government changed drug policy in a way that punished people who use drugs. I show how this intent to change policy manifested through the services available to drug users and in the lives of this population and conclude by arguing that the Tanzanian government is both shaping policies around drug use and controlling the narratives of how to deal with people who use drugs.

7.2 The Crackdown

Magufuli's war on drugs

While many of Magufuli's authoritarian tendencies have garnered more attention, in particular tightening restrictions on opposition and the press, his war on drugs can be seen as yet another avenue he is pursuing to consolidate power. Similar to authoritarian leaders elsewhere, Magufuli's attempts to establish greater control in Tanzania have included increased policing and control over vulnerable populations. The use of a war on drugs narrative is a tool to increase oversight of NGOs working with people who use drugs and people who use drugs themselves. This disciplinary power is an attempt to reorder society according to the priorities of the Tanzanian government and reduce space for opposition to drug policies.

The ability to pursue this goal requires the cooperation and support of a number of levels of government, none of which have opposed the repressive drive of John Magufuli to attack vulnerable people. The war on drugs, as a project of the Tanzanian state, also reveals the overall efforts of Magufuli to bring various sectors of the Tanzanian government under his control. As I show in this chapter, while Magufuli is far from able to exert authoritarian control, the cooperation of the government with a directive from him to target vulnerable populations is a major factor in disrupting the lives of already vulnerable drug users.

The level to which the Tanzanian government has successfully been able to set priorities for people who use drugs can be seen in both levels of access to harm reduction services and the experiences of people who use drugs. While Magufuli's drug war entails a highly rhetorical

performance, the war on drugs sets impossible goals and the Tanzanian state is in reality limited in its capacity to truly eliminate drug use.

People who use drugs represent an easy population to target, especially when stigmatized as part of the endemic corruption that has saddled Tanzania over the past decades. The manufactured linkage of drug use and corruption provides Magufuli a useful tool to depict his war on drugs as taking down the big fish, the corrupt drug trafficking elites perceived to be involved in the drug trade and the corruption that is, more generally, slowing Tanzanian development. Due to this idea of tackling high level corruption, I found in interviews that some NGOs initially welcomed the crackdown on drug use and even some individuals using drugs at the time saw the crackdown as a positive step in addressing the corruption in the country[51]. Some interviewees saw the government as actively involved in the drug trade and supported Magufuli's pledge to take down corrupt elites.

In February 2017, Magufuli undertook a number of policies to enact a war on drugs, enlisting the Dar es Salaam Regional Commissioner, Paul Makonda, along with the armed forces to root out the 'social cancer' of drug use (*Famagusta Gazette* 2017). Magufuli made clear that 'no one is too prominent to be arrested even if they are politicians, security officers, cabinet ministers or the child of a prominent person…even if my wife, Janeth, is involved she should be arrested' (Shaban 2017). Magufuli also launched crackdowns on sex workers and gay men who continue to be targeted periodically. The appearance of control, while also causing chaos and confusion among targets of a crackdown, is a useful tool in asserting and establishing a position of power. Dimova (2016) similarly explores how crisis narratives around drug use in Kenya were utilized by the government during elections to create a similar effect. Similarly, Magufuli engineered 'a crisis', as drug use and gay men were present previously, using powerful rhetoric to raise these issues to prominence and give them the appearance of major social problems. In doing so, Magufuli began the work of shaping narratives around drug use in the country, echoing war on drugs ideology.

The Government of Tanzania, at the same time, took action to change policy that, in many ways, reflected Magufuli's harsh rhetoric. Policy change included the implementation of the Drug Control and Enforcement Act in 2016, replacing the Drugs and Prevention of Illicit Traffic in Drugs

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[51] Individual interview 19, October 2018, Kigamboni

Act and empowering an agency, the Drug Control and Enforcement Agency (DCEA), to prosecute and enforce it (*Xinhua News* 2017). The DCEA order includes provisions allowing for harsher penalties for people in possession of drugs or involved in drug trafficking. The punishment for anyone caught trafficking or producing drugs can be life imprisonment, and anyone caught with drugs may face a sentence of up to five years or be fined 500,000 to 1 million Tanzanian shillings ($217 - $435), depending on the type of drug (DCEA 2017). Further, the onus is put on any individual caught with small quantities of drugs to prove they are not for sale or distribution (DCEA 2017) which can be a difficult task that is subject to interpretation by law enforcement. Syringes and other drug paraphernalia are illegal, as is the act of using drugs itself.

In contrast to the basic tenets of harm reduction, making the act of using drugs illegal severely impacts access to care. As Michelle Alexander writes in regard to the United States, people who use drugs are 'legally barred from employment, housing, and welfare benefits – and saddled with thousands of dollars of debt – these people were shamed and condemned for failing to hold together their families…Historians will likely wonder how we could describe the new caste system as a system of crime control, when it is difficult to imagine a system better designed to create – rather than prevent – crime' (Alexander 2011:171). The system is not as formalized in Tanzania but still produces a similar effect, creating stigma and hardship for people who use drugs. While the American penal system is much more effective at finding and incarcerating drug users, the quote above is revealing in how criminality goes beyond simple interactions with police on occasion. Drug users are known to police, face temporary detainment or harassment and are subject to even further stigma due to their interactions with criminal justice in Tanzania. Perhaps the greatest issue, in a country with widespread unemployment, is the ability to find and access work once marked as a drug user.

One aspect of the Act that appears to support people who use drugs is a new provision that allows users to avoid up to three years in jail or a fine by going to government recognized treatment. Some interviewees thought this to be a positive development. The realities of enforcing the act are already unrealistic as police do not have the time or capacity to arrest every single drug user. Seen from the perspective of people who use drugs, however, being forced to attend treatment can be equally unrealistic. As one director of a harm reduction organization told me when asked if this provision was a positive, 'no, because methadone is not for everyone. Now police have to enforce

more. It doesn't work anyway because even if they are caught and have to go on methadone, we have to prepare them and we try to give them options'[52]. Rather than engaging with drug users to the extent of ensuring their commitment to treatment, police in Tanzania do what they always have done, harass and temporarily detain drug users.

Treatment is of course better than imprisonment, but the focus remains not on the individual and their needs, but on enforcing a single option for people who use drugs, which is required rather than chosen. Further, treatment still ignores the myriad of challenges faced by drug users and, as I mentioned in describing the crackdown, it is unclear to what extent the police have really followed through in supporting treatment. Most people I interviewed or people who use drugs at hotspots were not given the option of treatment but rather, as always, were simply harassed or temporarily detained.

The creation of the DCEA and the government's stated commitment to ending drug use for the betterment of Tanzanians helped foster the appearance of an activist leader and citizens were called upon to come together and contribute to support the war on drugs. A *Tanzania Daily News* editorial reported in September 2018 'we should join forces in the anti-drug war' (*Tanzanian Daily News* 2018). In Mwanza, northern Tanzania, Prime Minister Kassim Majaliwa warned that 10,000 people needed rehabilitation and requested 'Tanzanians to work closely with the Drug Control and Enforcement Authority (DCEA) to thwart the network of narcotic trade' (*Xinhua News* 2018). The *Tanzania Daily News*, a paper often supportive of government initiatives, pitched this battle in epic terms: 'perpetrators of the illicit drug trade are virtually human satans. For their machinations are hugely costly to the human race, through wrecking the health of may {sic} potentially resourceful individuals who would otherwise contribute immensely to the social welfare enhancement and economic development of particular countries' (*Tanzanian Daily News* 2018).

The calls for Tanzanian citizens to support a national drug war is a novel way of framing drugs and the people that use them as a social problem to be removed. Despite a largely pro-government media, many activists and NGO workers challenged the narrative of the drug war. In some interviews, I was told that Magufuli's crackdown was a cynical attempt to increase his own

[52] Individual interview 24, October 2018, Temeke

control over NGO work. Some individuals even noted that the war on drugs may be a way for the corrupt Tanzanian government to gain greater control over the drug trade itself. Dimova found a similar discourse in Kenya, as people view the government as 'both complicit in transnational crime and the most effective antidote to it' (Dimova 2016:232). While Magufuli appeared genuine in his desire to end drug use, the idea of the government itself trying to displace major drug dealers and earn money from the illicit drug trade is plausible. Such a theory is impossible to confirm, but few, if any members of the CCM were implicated in the war on drugs, despite their long time hold on power and access to capital.

The Tanzanian government targeted high profile individuals with less obvious links to international drug trafficking. In 2017, the government accused the main opposition leader of CHADEMA, Freeman Mbowe, of involvement in a drug trafficking ring (Musiyo 2017). The charges were dropped but Mbowe has faced numerous charges since then, including prison time for illegal protesting, part of the CCM's focus on eliminating political opposition. The government never produced any evidence of his involvement in drug trafficking. The CCM also accused Yusuf Manji, CEO of Quality Group Limited and Chairman of YANGA FC, of heroin use among other charges (Sixpence 2017). These are just a few of 65 high profile individuals, including celebrities and a pastor, that the government accused of involvement in drug trafficking or possession, none of whom were subsequently found guilty (Musiyo 2017).

While high-profile accusations made the news, a major push to nab low-level drug traffickers and drug users was also underway. Prime Minister Majaliwa claimed 11,303 suspects were arrested between July 2016 and January 2017, with 9,174 suspects found guilty and 238 found not guilty (*The Citizen* 2017). By the time of my fieldwork, the Prime Minister declared the war on drugs a triumph, estimating a 90% success rate, a strange statement possibly referring to drug supply (Kamagi 2018). The *Tanzanian Daily News,* without any supporting evidence, repeated these claims as facts*,* 'it [the government] has scored high marks in the anti-drug war. This is borne out emphatically by the 90 percent reduction rate of illicit drugs trade in the market and illicit trafficking' (*Tanzanian Daily News* 2018). Apparently, Magufuli had done what other countries with greater resources and capacity could not and successfully ended the war on drugs.

While there was some evidence during my fieldwork 2018 of disruption to the drug supply, the trade and use of heroin appeared to be largely back in place. The crackdown in 2016-2017 did impact drug supply, causing large scale traffickers to adapt by lying low or temporarily continuing operations remotely from another region or country. Lower-level dealers faced increased scrutiny and potential arrest if caught. Ultimately, however, the supply limitations did little other than force people who use drugs into more desperate circumstances. From interviews undertaken with people involved in working with drug users or who were themselves using at the time, it seemed more likely that long term impacts on drug supply would be minimal, while the short term impacts on marginalized people who use drugs were much greater. NGOs noticed some clients resorting to use of other drugs, going further to find drugs and participating in riskier behaviours such as needle-sharing, flashblood or using other, more dangerous, substances. When the trade did return to pre-crackdown levels prices remained slightly higher and the disruption left lasting fears of arrest and discrimination.

A recent report described the political economy of the drug trade in Tanzania as 'a disrupted criminal market' due to the impact of reforms undertaken by President Magufuli (Haysom, Gastrow and Shaw 2018:3). This report highlighted how Magufuli has not ended the illicit drug flow but rather transformed it (Haysom, Gastrow and Shaw 2018), a reality borne out by my fieldwork. At MEFADA, an organization supporting drug users' access to methadone treatment, one employee noted an increase in users seeking treatment as drugs became more difficult to access due to fears of being caught using or selling drugs. As mentioned, the DCEA contains a provision for the 'identification, treatment, education, after care, rehabilitation and social integration of drug addicts' (DCEA 2017). While this appears to be a humane policy, there is little effort put toward rehabilitation, education, after care or social integration.

Forcing people into treatment is antithetical to a harm reduction approach. Further, forcing treatment as the alternative is not a meaningful reform as, out of fear and the need to continue using, many individuals opt to avoid treatment through bribes, continue using while on methadone or commit to treatment and return to use. One thing is certain, Magufuli's interventions in the drug war 'has created a feeling of huge insecurity for anyone who has been involved, or could be accused of being involved in the drug trade or corruption' (Haysom, Gastrow and Shaw 2018:6). Interestingly, it was not the first time a war on drugs was declared in Tanzania. In 2006-2007, the

government regularly touted the war against drug use and police sporadically cracked down on people publicly using drugs (McCurdy et al. 2007). In that case, people who use drugs and drug traffickers similarly adapted, hid and waited for the efforts to cease in order to continue their activities. The difference now is that, while drug use will undoubtedly continue, Magufuli has actively tried to disrupt the only sector providing supports to people who use drugs.

In the next section I look at how the Tanzanian government has contributed to disrupting the supports available to drug users. The actions described above show how the war on drugs became a site for a demonstration and performance of the President's power in tackling a seemingly ever-present social issue. While this performative aspect is important, I also showed the policy changes undertaken to make the war on drugs a reality for people who use drugs, in empowering the DCEA to actually implement the directives of the President. The policy changes reveal that the Tanzanian war on drugs is not just performative. As I expand on below, Magufuli is committed to concrete actions and policies that have serious repercussions for people who use drugs.

7.3 Behind the crackdown: shifting policy and marginalization

The KVP revision and policy change

As mentioned in the previous chapter, a focus for foreign donors aiming to prevent and treat HIV/AIDS in Tanzania is reaching Key and Vulnerable Populations (KVP). It is through the funding provided by these donors that much of the harm reduction available in the country, including methadone treatment, is possible. Prior to the election of Magufuli, the sector was relatively free to determine the supports needed to reach and provides services to KVP, including harm reduction services such as needle exchange and provision of lubricants. Magufuli's war on drugs involved a reevaluation of available harm reduction supports and a review of the delivery of programs to KVP in the country.

In the previous section, I looked at Magufuli's public and performative acts, as well as the increased enforcement and legal restrictions on drug use. In this section, I aim to illustrate how the more visible actions of enforcement and incarceration were only one aspect of the Tanzanian government's war on drug users. In 2016, Magufuli's government was also disrupting the aid sector,

putting program delivery on hold as the new government worked to adjust laws governing KVP and HIV/AIDS transmission. While incarceration, lower supply of drugs and police harassment can be temporary, changes to aid and support for KVP have longer lasting impacts. During a period of almost six months in 2016, several NGOs, both local and international, described being unable to meaningfully engage with KVP and offer services and many are still dealing with the impacts of the Tanzanian government turning its back on harm reduction.

The review of supports to KVP was one of the first major actions by the Tanzanian government and it was immediately apparent that this review was not intended to bolster harm reduction services. The result of the review was a disappointment for more harm reduction oriented groups focused on KVP, but it did seem to be an improvement for HIV/AIDS interventions more generally. The government loosened previously restrictive policies supporting HIV/AIDS interventions, allowing the work of major NGOs such as JHPIEGO and ICAP to reach more people and provide better treatment, aligning with the 90-90-90 goals of UNAIDS. Major concerns impacting all Tanzanians, such as the fact that many Tanzanians with HIV/AIDS do not know their status, drove the government to increase flexibility and capacity in testing.

However, the review also included some notable reverses towards services available for KVP. While funding for HIV/AIDS is limited, the expansion of testing and treatment for all Tanzanians did not need to include any cuts for KVP. Funding was not the issue, as the review was clearly ideologically driven. Health Minister Ummy Mwalimu, describing the findings of the review, found that 'despite the good intention of the Government and its HIV and AIDS partners to start provision of HIV and AIDS services at community level…some implementing partners were promoting homosexuality, contrary to the laws of the land' and reports had 'provided detailed evidence of existence of homosexuality promotional activities' (United Republic of Tanzania 2017).

The findings of the review came after the government's active involvement in intimidating homosexuals and threatening organizations that worked with them in 2016. Some local NGOs reported being subject to raids if they did not get rid of lubricants[53]. The other KVP populations did not fare much better. PWID, already facing increased harassment and intimidation due to Magufuli's

[53] Individual interview 24, November 2018, Temeke

drug war, now saw their options for treatment and support narrowed. The government shuttered harm reduction centres, where drug abuse was supposedly rampant, and a fear of reprisals led PWID with HIV or other infectious diseases to not seek treatment. The government did allow the Médecins du Monde (MDM) needle exchange to continue. However, they also restricted its expansion to other areas of Dar es Salaam. During outreach in 2018, MDM was still unable to provide needed and effective services beyond Temeke and limited its outreach services to other hotspots. NGOs had to adapt to these laws, submit reports and not act contrary to the penal code. Minister Mwalimu's statement also directed health care providers to provide service free of discrimination. It is unclear, however, how unbiased service can be achieved given the discriminatory stance of the government.

The revision of KVP policy reduced evidence-based practice and went against advice given to the government by local advocates to reduce HIV/AIDS among KVP. Many grassroots activists and service providers advocated for evidence based interventions, such as 'promoting and providing condoms for MSM and FSW [Female Sex Workers], promoting the use of water-based lubricants for MSM, screening and treating STIs, harm-reduction techniques for IDUs (e.g., needle syringe exchange programs), and HIV counseling, testing, and early treatment initiation' (Mpondo, Gunda and Kilonzo 2017:4). The need for these services is evidenced by the fact that, while HIV/AIDS rates went from 5.1% in 2011 to 4.6% in 2018, rates among KVP remain stubbornly high as these populations are subjected to politically motivated policy directives that severely hinder their access to healthcare. The government has ignored the recommendations above and has instead focused on a limited and partial approach.

The tension between supporting KVP from a healthcare lens, while also making their existence illegal, illustrates the state of harm reduction in the country and, as I show in the next chapter, is an issue facing many states across the globe. With PWID, the need for interventions (not harm reduction necessarily, but to limit HIV transmission) is clear. However, the possession of any quantity of drugs or any drug use equipment is illegal, raising major questions as to how services can effectively be delivered to these people who are in constant violation of the law. While the government presented the KVP revision process as inclusive consultation in order to improve harm reduction services, the perspective of those involved in this process told a different story.

A view of the process from the ground

As mentioned above, the election of Magufuli was not necessarily seen in opposition to improving the health and wellbeing of people who use drugs. Among many service providers, there were hopes that his tough approach would clean up a number of sectors, tighten up the practices of local and international NGOs and ensure funding reached the areas it needed to. Corruption was considered an issue that impacted all sectors, including local NGOs. Improved oversight, better tracking of outcomes and a realignment of available funding towards efficient and high performing NGOS indeed could have been a step forward in improving services to KVP.

Magufuli's initial statements and involvement in the sector reflected a move towards these improvements. As one local NGO found, once Magufuli was in power, bureaucrats were on notice, and were worried about keeping their jobs. Magufuli did arrive on the scene like a bulldozer, affecting wide cuts of public service employees and cracking down on unnecessary spending. The random spot checks made by Magufuli in certain departments made civil servants nervous and therefore responsive. As a director at one NGO I visited noted, 'there was a time when Magufuli is firing everyone, nobody is sure. During this time we were conducting a survey and we had the best cooperation [with the government] because they were scared'[54]. In this case, a process that previously faced delay or lack of response was now easier to undertake. This example, however, was one among many other instances where I heard of government obfuscation and confusion as a unruly bureaucracy, long used to getting its own way, was reformed to try and follow myriads of new processes, or at least appear to be following Magufuli's dictates.

The crackdown and the KVP revision process outweighed any of the potential benefits from a temporarily more responsive bureaucracy. A major problem was fear, in both the public service and among politicians, of engaging in issues that are not priorities for the current government or on sensitive topics such as methadone. One foreign harm reduction organization, hoping to begin operating in Tanzania, found it difficult to connect with anyone interested in supporting their entry into the country to provide very needed services. This organization did find some support from the Health Ministry, but this support dissipated during the KVP revision process[55]. When I talked to the

[54] Individual interview 14, October 2018, Mikocheni
[55] Individual interview 1, September 2018, Conducted remotely

director of this organization, she noted how the government seemed disorganized, and believed that the lack of engagement seemed to be less a tactic of disengagement, but rather an uncertainty and sensitivity as to what the government could support. The difficulty in operating in Tanzania during this time was echoed by other NGOs already working in the country, unsure about what guidelines would emerge, how new policies would impact them and whether they would be able to continue their work.

While some NGOs were asked to participate in the KVP revision process, the development of the new policy guidelines was ultimately a top-down process. In several interviews, participants in the process told me that the discussions were a one-sided exercise in dictating terms rather than engaging in meaningful consultation. The head of a local drug users support organization noted that the process was very much driven by a focus on HIV/AIDS treatment only, not broader services. Local NGOs, willing to focus only on HIV/AIDS prevention and treatment were eligible for more funding, while the government considered those organizations in favour of greater harm reduction efforts outside of the focus of the KVP revisions[56]. The head of a sober house network who was also involved in the process emphatically told me:

> I was part of this process, we talk so many times, even now we talk, but we just see them [government officials] and they don't know anything, they don't know what we do. I worked with the government on guidelines about the MSM [men who have sex with men] and other KVP but after this government comes, and the election of this president, they say they don't want to give them support. I am the addict, others were there, and there were a lot of discussions the government was trying not to accept. But we try our best, that's why these [guidelines] are not strong, but if you are not there, there are more problems[57].

The revision of guidelines impacted local organizations greatly, as many are small with little or no funding. For larger NGOs with greater ability to access funding from partners such as the Global Fund, concerns over working with MSM required a need to choose language carefully. The director of one NGO noted that there is less flexibility than under Kikwete, and HIV/AIDS is a more useful

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[56] Individual interview 4, September 2018, Mikocheni
[57] Individual interview 17, October 2018, Kigamboni

narrative to access funding, from both donors and the government[58]. Harm reduction is part of the goals for agencies such as the Global Fund but, in this case, framing work as medical and HIV/AIDS focused was a result of intimidation by the Tanzanian government, not the desire of these agencies.

Some organizations accepted this new reality, indeed there was no other choice, as the government dismissed the rights based approach being advocated by grassroots organizations in favour of focusing only on HIV interventions. This restriction of services coincided with the active harassment and arrests of people who use drugs. A human rights-based approach was not possible and, despite some advocacy, it was clear that the government would only allow for methadone treatment to continue[59]. The work of outreach organizations supporting people who use drugs also continues. However, the focus on getting people on methadone is more pronounced, reducing the services being offered at hot spots. Even larger organizations involved, funded through PEPFAR or the CDC, had less of a say, as one CDC employee told me that it was clear some things would not continue such as giving lubricants to men who have sex with men[60]. An epidemiologist I spoke to at Muhimbili University summed up the whole process of intervening in the provision of services to KVP frankly: 'the KVP revision process was absolutely politically driven with too many discussions around behavioural isssues'[61].

The political sensitivity around the issue of drug use, in a country like any other where many people have friends and family impacted by illicit drugs, appears manufactured. The renewal of conservative stigmas around drug use is part of a larger process Magufuli is pursuing to align organizations with his personal vision for the country. Magufuli's government has refocused issues around vulnerable people such as young women, gay men and drug users, sometimes under the guise of morality and other times simply revealing his deep resentment of these groups, the most vulnerable in Tanzanian society. During my time in Tanzania, most people involved in supporting drug users, or even those who knew people who used drugs, did not seem to fully share the sensitivities and issues surrounding methadone. It appeared that any sensitivities or concerns

[58] Individual interview 10, August 2018, Mikocheni
[59] Individual interview 2, October 2018, Kinondoni
[60] Individual interview 13, September 2018, Dar es Salaam city centre
[61] Individual interview 15, October 2018, Muhimbili

emanated from the government, as if providing supports to drug users is taboo and needs to be shrouded in secrecy.

The reverberations of Magufuli's opinions have echoed down the channels of power in his government. While some interviewees felt that politicians formerly supportive of harm reduction changed their opinions to appease Magufuli, it was unclear to what extent ministries actually did oppose Magufuli's directives. For example, the Minister of Health's KVP guideline statement encourages the streamlining and centralizing of service provision through health centres only, and introduces stringent reporting and registration requirements for all NGOs in the sector (Tanzanian Ministry of Health Statement on KVP 2017). Further, the document 'urges' regional officials to 'closely supervise activities undertaken by NGOs working to fight HIV and AIDS in their respective areas' so they 'adhere to their geographical scope' (Tanzanian Ministry of Health Statement on KVP 2017). Finally, as illustrated above, policies and directives are in place and being followed by many levels of government. The separation between an independent civil service working to support evidence-based approaches and an ideologically driven government does not appear to be prominent.

Increasing oversight in the NGO sector may not be a bad thing, however, under Magufuli, it appears to be motivated less by concern for a well-functioning NGO sector and more for control. A legal and human rights focused NGO described how previous relationships with top-level bureaucrats, who had worked in these sectors for years and were often experts, were disrupted as Magufuli removed long-time bureaucrats with experience and appointed unknown candidates with questionable expertise[62]. The removal of experienced civil servants helps to explain the change in direction from support by those who understood the issues, to a political project enacted by government allies.

As mentioned above, even international NGOs with greater resources experienced disruptions. In aligning with the Ministry of Health, NGOS must 'ensure that they do not act contrary to the National laws, including the Penal Code' (Tanzanian Ministry of Health Statement on KVP 2017). NGOs faced a difficult situation. The politically driven process of targeting

[62] Individual interview 14, October 2018, Mikocheni

vulnerable people in Tanzania is an example of the major tensions between legal and moral strictures and the provision of harm reduction services. When practiced as a medical treatment without consideration of the larger restrictions being put in place, harm reduction cannot fully address the needs of people who use drugs. Some NGOs I talked to saw some basic harm reduction support as better than nothing, even if their work was compromised in some ways. As the director of one organization noted,

> That's why you see we have very weak KVP guidelines. At the NGO level, we fear we would be tracked down because we had supplies of lubricants. We don't have them, they are illegal now so we had to pack them. It did affect the community we served. MSM used to come, they would come to the office, the drop in centres. You cannot get them anymore. They are gone now you can't see them. We are living with them but you can't see them.[63]

This director also discussed how the fears induced by the government led to riskier practices such as flashblood, sharing syringes and using other substances in secret. As the latest harm reduction report on Africa states, 'in Tanzania, NSP provision remains poor and high risk behaviour such as needle sharing and the practice of flashblood have been reported, with an estimated 15.6% of people who inject drugs practicing flashblood and 14.2% sharing a needle with another at last injection' (Harm Reduction International 2018:165).

The services available for drug users reflect Magufuli's antipathy towards drug use and his misunderstanding of the realities of addiction, which seem to be shared by the government generally. The personal failures represented by people who use drugs are the opposite of Magufuli's story, which emphasizes hard work and moral rectitude, dismissing the benefits or privileges he has experienced along the way. Drug use is simply not a good fit within his moral universe or his vision for Tanzania. While some interviewees remained confident that he would not disrupt the methadone program, many often admitted he was successful in limiting greater supports beyond this one program. Among Tanzanians living and working in poor neighbourhoods with drug use present, there is certainly stigma that persists. The Tanzanian government, however, is actively stoking this

[63] Individual interview 23, 24, November 2018, Temeke

stigma against drug users through its inflammatory rhetoric and policy, rather than working to combat it.

Similar to authoritarian governments across the globe, blame for the rise in stigma against vulnerable populations is denied even as the leader of the country, and his ministers, regularly invoke stigmatizing language. There is a discursive relationship between people actively disapproving of those who use drugs, and the government producing and perpetuating this disapproval. From my fieldwork, I noted that the scourge of drug use amplified by the Tanzanian government did not seem to be filtering down to the neighbourhood level, where community bonds and relationships exist. While this observation is based on limited experience, it does raise questions for future studies on how the government's war on drugs has succeeded in shaping public opinion.

In framing the issue as a moral one, Magufuli has gone against the previous government's approach. One interviewee related how supportive former President Jakaya Kikwete was, albeit with limited resources. This interviewee told me that Kikwete had personal experience with friends of his having problems with drug misuse and therefore understood the issue better[64]. As mentioned previously, Kikwete originally did not understand the drug problem in the country but grew to see harm reduction as a solution. While certainly not a zealous advocate, according to the NGOs I interviewed, Kikwete listened and was open. A better understanding of drug use requires empathy and the ability to understand unique individual experiences with drug use. The war on drugs and the conservative narratives being used by the Tanzanian government frame drug use as a moral problem where people who use drugs are not seen as individuals with different stories and histories of drug use. One individual, who had been in and out of sober houses for 10 years and on methadone, summed up his thoughts on Magufuli as, 'he [Magufuli] talks a lot about drugs, but people they know, people they are still doing drugs. He hates drug addicts, drug dealers he hates them. You get caught it is 30 years but its full of drugs in Tanzania, any kind of drug'[65].

A good example of the Tanzanian government successfully reframing the issue as a moral one was the shuttering of harm reduction centres. I had not seen any mention of them in the literature. However, they operated quietly and were described to me as drop in centres where KVP

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[64] Individual interview 12, October 2018, Muhimbili
[65] Individual interview 39, October 2018, Kigamboni

could go and access services, and also simply have a safe space to spend some time. The revised KVP guidelines officially closed these drop-in centres stating, 'the use of drop in centres for provision of health and HIV services to KVPs will not be allowed. When necessary, outreach services through the use of service providers from nearby health facilities will be used' (Tanzanian Ministry of Health Statement on KVP 2017). Again, this centralization allows only the government to be in charge of these services and only organizations with a narrow focus on HIV prevention to be involved, hence the overwhelming focus on methadone.

I received mixed messages about these centres as official voices from larger NGOs and the government did not see their benefit, while almost every grassroots organization did. One interviewee at the CDC told me that the centres were closed because they were being abused by beneficiaries and, while admitting their closure meant these people had nowhere to go, they were being used by homosexuals to have sex and by drug users to use drugs[66]. Local NGOs involved in these had different opinions and spoke of their benefits as harm reduction centres:

> The drop in centres were very important for beneficiaries. They were harm reduction centres. They have information, supplies…no they are not using drugs. It's a lie. In rare cases if you don't include the beneficiaries themselves in the management of the centres, but if they are included no one is abusing the drop in[67].

Even an official at the UNODC, which has a small presence in Tanzania, discussed how drop in centres were places where people could go and feel safe and access services, but the change in political environment made them untenable[68].

The contradictory accounts were difficult to reconcile. However, it is possible that, in the absence of other safe spaces, people may have used drugs or felt comfortable enough to attend these centres intoxicated. Not turning away people who are intoxicated and not requiring their abstinence to access services is common harm reduction practice. Further, having safe spaces where individuals can access services regardless of their sobriety is important in overcoming stigma and being able to

[66] Individual interview 13, September 2018, Dar es Salaam City Centre
[67] Individual interview 24, November 2018, Kigamboni
[68] Individual interview 25, November 2018, Msasani

connect and establish relationships with individuals. Providing services only to sober people is similar to only providing poverty alleviation only to those who are no longer poor. In any case, the government gave no evidence of the supposedly rampant abuse of these centres. Their closure is an example of how moral ideology can override evidence based practices and create narratives of people who use drugs as out of control, moral failures undeserving of services and justify a shift towards punishment and abstinence.

The government of Tanzania clearly focused its' interventions on reducing and limiting the types of services available to people who use drugs. As I outlined in the previous chapter, services available prior to the crackdown were not comprehensive enough. The reversal of greater, more comprehensive progress while maintaining methadone has helped to obfuscate how little the government is doing to support people who use drugs. The approach of implementing a single harm reduction practice, without comprehensive supports does not effectively improve the wellbeing of people who use drugs. Actively implementing harmful policies, while maintaining a single practice such as methadone, is even worse for people who use drugs. Foreign donors remain involved and, in some cases, NGOs explicitly asked me not to use their interviews for fear of being unable to continue operations in the country. While this policy process was underway, drugs continued to come into the country and people continued to use them. I outline below how the government has not only shied away from official support but actively worked to make daily life for people who use drugs more difficult and discuss the outcomes of the reduction in services impacted the activists and workers in the sector.

7.4 Finding a way to cope: supply, survival and resilience in Dar

Impacts of the crackdown

The fear of being caught during the initial crackdown was very real. As one sober house volunteer who had been using drugs at the time stated, 'there was a change because the government just dealt more with people selling drugs and people bringing drugs in the country and this Regional Commissioner Makonda named all people selling drugs publicly'[69]. One organization found that

[69] Individual interview 5, October 2018, Kigamboni

major drug traffickers left but were just waiting to come back, and the decrease in supply was temporary but resulted in people who use drugs turning to more dangerous use, other substances or, more positively, to methadone[70]. This reduction in supply was commented on by most interviewees. Supply reduction, however, as is the case with any attempts at prohibiting substances was temporary and not total. The increased pressure and reduction in supply drove up costs, a typical result of the war on drugs approach.

One individual at a sober house for marijuana addiction, noted that the price of cannabis went up from approximately 800 to 2000 Tsh ($0.35 – 0.85) for one joint[71]. However, he always had access to drugs even when the crackdown was at its most intense. Referring to a boast by the Prime Minister that the war against drug trafficking was 90% effective (Kamagi 2018), he noted 'we were laughing you know, how come everywhere there are still drugs? So the major kingpins were caught but the drugs are still there? 90%, I don't know how they base these statistics[72]. One possible response could be that the government has outlawed other sources of statistics and is free to produce statistics however they want, even in areas impossible to measure.

Another individual noticed a difference, as the low level dealer he worked for quit due to pressure and increased police presence[73]. As this individual was using at the time, the result for him was simply more time spent searching for drugs, 'we went to Kindondoni, people who were bringing the drugs found it harder. The price went up from 2,000 Tsh ($0.85) to 3,000 Tsh ($1.30) and even up to 5,000 Tsh ($2.20). But now they have come back down'[74]. The rise in price and the temporary reduction in supply does not signal a success in the drug war. People who use drugs are simply forced into greater hardship, needing to seek out different areas to find drugs and undertaking riskier behavior to avoid dopesickness. In the case of the individual quoted above, Kigamboni is a ferry ride and a bus ride away from Kinondoni, adding to the difficulties already faced in finding and paying for heroin.

[70] Individual interview 1, August 2018, Mikocheni
[71] Individual interview 27, October 2018 Kigamboni
[72] Individual interview 27, October 2018 Kigamboni
[73] Individual interview 30, October 2018, Kigamboni
[74] Individual interview 30, October 2018, Kigamboni

In several interviews, as I mentioned previously, people who use drugs and work in the sector were not opposed to the crackdown netting higher level drug traffickers. These higher level traffickers are seen as contributing to corruption in the country and profiting off of addiction. However, in Tanzania as there was little evidence the crackdown netted any 'big fish'. One notable drug baron, nicknamed Shkuba, ran a major trafficking ring and was arrested and extradited to the United States (Kapama 2017). He was arrested in South Africa in 2014, prior to Magufuli's war. Otherwise, many interviewees commented on the lack of effectiveness of the crackdown in either eliminating drug supply or really capturing those really high level traffickers. The bragging of the government, including the high levels of incarceration and their successes in stopping supply, did little to net any major traffickers. The only high-profile people implicated all seemed to be opposition politicians and high-profile businessmen.

The result of failing to tackle the higher level traffickers meant the continuation of the drug trade which, after 2016/17, had returned to previous levels. Prices remained slightly higher than before Magufuli had come to power, but whether this was due to a crackdown or simply a rise in price was unclear. When I was in Tanzania, it appeared that the old norms of drug use and trade in the hotspots had returned. When asked the reason for this return to normalcy, many interviewees saw this as a failure to meaningfully tackle the politicians and businessmen acting with impunity[75]. In the current political climate, investigating this would be an impossible prospect. The outcomes of the government of Tanzania's failed drug war are not unique, as the war on drugs has failed globally. The government, instead of taking of responsibility, however, has framed the project in a way that makes them appear successful. The successes the government highlights are not truly addressing drug use in the country but rather increasing the vulnerability of people who use drugs and targeting the wrong high-level politicians and elites who are usually opponents of the CCM.

Police were also at the forefront of enforcing Magufuli's war on drugs. However, after the initial arrests and crackdowns, it also appeared the old cycles of bribery, temporary detention and the informal understandings between police and users had returned. Magufuli, in attempting to tackle corruption, has not addressed the underlying issues such as police pay. Corruption persists and does not seem to be changing. As I observed, drug dealers were visible and not concerned seemingly with

[75] Individual interview 4, August 2018, Mikocheni

hiding their actions. As one outreach worker and former heroin user told me, 'laws should help us. I was already hurting from the drugs, so why do they [government] punish me too? Police go to maskani [hot spots] they bother them [people who use drugs] they try to get some money then they leave. They are not scared. He sell drugs, pays police so sometimes I say that police are dealers too[76].' Police, as before, add an element of chaos to hotspots, appearing and retreating randomly. Given the lack of consistency, it is no surprise that interactions with police are shaped by individual police officers who may have relationships with NGOs or be more supportive of not repeatedly arresting the same people.

The experience of stigma and violence in hot spots persists. Almost everyone I talked to said the police come, 'they disturb us. They catch us. They don't take us to jail but the post [a local station], they keep us sometime and then let us out'[77]. This common experience for low-level users is getting temporarily detained until you can pay a bribe or, if you can't, simply being detained to make a point. At the sober house, one man told me,

> when police come we all run. Anytime they catch you, you get hit. I have been caught 4 or 5 times. You stay at the police for some days and then first thing you go to sleep. Sometimes, if they catch you, maybe they might have seen evidence like the syringe, they can't hold you they can take it from you, they just keep you at the post for some time, but not to court.[78]

One interviewee who had worked in the methadone program offered the metaphor of low level drug users as moto drivers or bajaj (small, three-wheel taxis) drivers who don't get pulled over because they can't pay much[79]. Unfortunately, by this principle, higher level pushers are 'pulled over' but simply pay off the police. This example reveals the complexity of the Tanzanian government presenting itself as tough on drugs, when its ability to effectively control these situations is limited. Even inconsistent police actions can have impacts on people who use drugs, however. One man had been arrested three times, the second time he had been detained for almost two weeks with no access to methadone or naloxone, undergoing an extreme withdrawal[80].

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[76] Individual interview 44, October 2018, Kinondoni
[77] Individual interview 47, October 2018, Mwananyamala
[78] Individual interview 26, October 2018, Kigamboni
[79] Individual interview 15, October 2018, Muhimbili
[80] Individual interview 30, Kigamboni, October 2018

The word that came across most often in interviews was '-sumbua' (to disturb, annoy) or 'wanatusumbua' (they disturb/annoy us). This word reflects a shared experience, as people seemed to be less worried about serious criminal repercussions and more about the disturbance that unexpected and sporadic incursions into hot spots would entail. These incursions could lead to serious withdrawal or simply interrupt time that could be spent using drugs and getting together money. At no point did it appear the police were working with the wellbeing of citizens in mind. The current government seems to be content having 'performed' its crackdown, with a return to the more sporadic and occasional use of police to keep people who use drugs aware of their status as immoral and deserving of punishment.

It should be noted that the Tanzanian police do have a reputation for rushwa [taking corruption]. For many of those I interviewed, bribery is so common that it is simply another aspect of life. Many drivers ensure they have proper amounts of cash so if they are threatened with a ticket they can strike a deal with officers. It is the most vulnerable, however, that are more often targets of harassment and subjects of surveillance and control. As Transparency International reports, 'corruption and impunity are deemed to be pervasive in the Tanzanian police force …a factor contributing to high incidents of bribery among the police force is their low salaries – they are paid an average salary of less than US$40 a month. In fact, bribes in the force are so common that there are directives for tourists on how to deal with officers demanding payments' (Transparency International 2019). The lack of trust in police and institutions is a result of decades of corruption. In many interviews, there was so little faith the government could achieve its goals that other motives were given for why they would attempt a crackdown. Many interviewees even insinuated the government was in fact benefiting from the rise in drug prices.

A more plausible benefit than directly involving itself in the drug trade, was perhaps the appearance of the government as able to extend its power into all reaches of Tanzanian society. As I noted in my own experience during this trip to Tanzania, the appearance of control sometimes felt real and overwhelming. In a country with a weak judiciary, corrupt police and a government actively targeting people who use drugs, it didn't matter that the government was not actually capable of catching all of them. It was enough that the government cared enough to ensure they were at least sporadically targeted, and more of a target than in the past. The impacts for people who use drugs

were entirely negative. A former drug user who now runs a grassroots advocacy organization stated this clearly: 'many people, those most vulnerable, were scared and resorted to riskier use and sharing needles [syringes are still illegal in Tanzania], outreach became difficult and many people were being sent to prison. This impacted the small dealers and people on drugs the most, this was done to make politicians look good while many suffered'[81].

On the other hand, the government also worked to appear to be compassionate to people who use drugs who were accepting of treatment and could achieve redemption and reintegration into society. While boasting of prevention efforts, methadone outreach and even posing for photo ops at sober houses, the government does not fund any support for the sector. Participating enough to appear involved and engaged makes the level of support seem greater that it actually is. In reality, much greater support is needed, and government intransigence is the major obstacle to increased foreign funding and involvement. While there are issues with low funding for harm reduction and lower donor interest than in other areas, a lot more could be done and is available were the government to choose this approach and get behind it.

Harm reduction supports persisted in spite of John Magufuli not because of him, but could grow much further without his interventions. The framing tactics of the Tanzanian government – that it is providing comprehensive services that it is not and that it is 'cleansing' Tanzania of drug use, even as supply and police harassment remain the same – are effective tools in fooling outsiders and ensuring little media or international attention is devoted to the reality As I expand on in the next chapter, these narratives rather than being challenged or shaped by foreign actors, would be followed by them.

As a result, supports in hotspots have dried up with nothing put in place to replace them. During my visit to Kigamboni ferry hotspot, a volunteer related how outreach workers used to come but have stopped in the current environment. While there was mention of services starting again, specifically under a local organization slated to spearhead needle exchange and harm reduction in the city, progress was slow and, in the meantime, nothing was available[82]. During this same visit the outreach worker I was with showed me an x-ray and explained how the people using in this area had

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[81] Individual interview 2, August 2018, Mikocheni
[82] Individual interview 32 and participant observation, October 2018, Kigamboni ferry

pooled money to contribute to this as it cost 10,000 Tsh ($4.30) as the individual who needed it did not have enough money[83]. Apparently, some medical services were previously funded through outreach, or at least individuals were given some support in accessing medical services and health care.

At the Kigamboni ferry hotspot there were many health concerns that were now not being supported, such as diarrhea, malaria and parasites. Despite the funding restraints globally in harm reduction, in contrast to the large amounts of funding being put towards perpetuating the war on drugs, a small amount of funding could go a long way in helping people who use drugs. However, people who use drugs remain a low priority, exposing the real and lasting mentality the Tanzanian government, and governments across the globe, have towards drug use.

Failing people who use drugs: rhetoric and reality

While the Tanzanian government receives the majority of funding for methadone and drug treatment programs from foreign donors, control over this funding is still largely influenced by the government. As Magufuli's priority is state-led development, less funding is available for social programs and projects must increasingly align with the country's priorities, which appear to be largely focused on infrastructure. Magufuli has positioned himself as a state-led project leader, focusing on development at all costs, similar to the models being pursued in Ethiopia and Rwanda. State-led development projects as modelled in these countries does not usually focus on marginalized groups. As one sober house director told me, there are no funds because of other priorities and the DCEA is stretched too thinly[84]. The result is a haphazard network of sober houses undertaking work that is possibly beyond their scope and capabilities.

With a complete lack of supports for people who use drugs other than methadone, sober houses are combining outreach with harm reduction and mental health interventions. One man I spoke to was found on the street with severe problems in his legs from injecting with old syringes and brought to a sober house by an outreach worker. The director of this sober house told me that their sober house, which receives no financial support from the government, paid his full medical

[83] Individual interview 32 and participant observation, October 2018, Kigamboni ferry
[84] Individual interview 19, October 2018, Kigamboni

costs, over 1,000,000 Tsh ($434)[85]. The sober house covered all costs for the medical treatment of its beneficiaries without financial aid, whether this was 20,000 Tsh ($8.50) for malaria medication or 72,000 Tsh ($31) for antibiotics[86]. These costs are far above what an unfunded sober house is able to pay.

Again, I was reminded that the issues faced by poor and vulnerable Tanzanians, regardless of drug use, are already multi-faceted without HIV/AIDS. Malaria is common, as are parasites. In one hotspot, the outreach worker told me that a number of individuals had filariasis and had not been treated. While these are often curable diseases, and treatment does not cost that much by Western standards, accessing medical treatment and paying the costs of medicines are significant for people living in poverty. For people who use drugs, tuberculosis and hepatitis are also major risks and, for those who are HIV positive, the threat of opportunistic infection is high. The government has offered no solutions or support for these individuals, leaving volunteers to scrape together meager supports when they can.

As I mentioned, mental health support and learning about addiction within the mental health curriculum in Tanzania is low. Similar to physical ailments, the lack of mental health services sometimes leaves places like sober houses in charge of clientele with complex mental health issues as well. One man who had attended sober houses in Zanzibar and in Dar stated, 'there is a difference between a crazy person and a drug user…there are some limitations to some people affected totally'[87]. It was unclear how widespread the inclusion of mentally ill people in sober houses was. With a lack of understanding of the true extent in which mental health issues are prevalent among drug users, it is likely volunteers at sober houses will face challenges with certain clients. There is nowhere else for people to go.

While the lack of outreach and mental health supports made sense given the government's abstinence focus, I was surprised to see very little being done in terms of prevention. Prevention, mainly educating youth around the dangers of drug use is often a cornerstone of the war on drugs, and is complimentary to abstinence based-approaches. During the Reagan era in the United States,

[85] Individual interview 17, October 2018, Kigamboni
[86] Individual interview 17, October 2018, Kigamboni
[87] Individual interview 39, October 2018, Kigamboni

the 'Just Say No' campaign was a major policy pillar. In Tanzania, however, the government was not even doing basic education. Several interviewees told me that children are not taught the difference between major drugs and end up using drugs that they may think are marijuana or different forms of it.

During one of my visits to a sober house in Kigamboni, the director was organizing an outreach trip to a local school near which drug use occurred. The government included prevention in its planning, which would include education on drug use to youth. The session, however, was organized through the sober house as little government programming had actually been put in place. The sober house was actively doing this work in the absence of a concerted government effort to reach out. This important work was noted by the teacher:

> It is really sad because there are a lot of people out there and we really expected the government would do more. I think we need someone who knows these things and can talk to the whole school, 500 students and 60 workers. Students were interested and it was new knowledge. I have a different perspective now. Most people see them [people who use drugs] as outcasts, I didn't know there are a lot of factors[88].

The efforts to provide some preventive education are being undertaken without official support. The prohibitionist stance of the government would seemingly be in great support of prevention efforts, but no funding was available.

Ultimately, prevention is a low priority for the government, as are supports for people who use drugs and efforts to meaningfully addressing the challenges they face. Despite the lack of government involvement in supporting the sector, however, NGOs are required to align with the government's goals and report in great detail on their activities. This issue of reporting came up in several interviews, as the reporting requirements have increased to the point that it appears that the government wants greater control over all sectors in the country. As one interviewee noted, 'now we must provide, in addition to our annual report and audited financial reports, further information on

[88] Individual interview 18, October 2018, Kigamboni

where funds are coming from and the contracts we have signed. NGOs also need to explain how much their projects align to country priorities.'[89]

Sober houses also have strict reporting requirements to the government, even though there is no financial support. In discussion at the DCEA I was told that increased control over sober houses was meant to increase accountability and support the implementation of best practice as these sites. So far this increased oversight has only increased the reporting burden on volunteers and the minimal staff at these sites, however, and the government still is not committed to any supports despite identifying the need for more training, mental health education and funding at sober houses.

Methadone and harm reduction: persistence and change

With the crackdown, the methadone program, out of political design, has emerged as the dominant and often only option for people who use drugs to access treatment. The program presents a compromise, as it is a harm reduction initiative focused almost solely on healthcare rather than supporting a full suite of services. Drug replacement therapy is scientifically proven to support people who use opiates to live more productive lives and act as a measure to treat and prevent HIV. However, methadone alone is not a cure for a disease, but rather a replacement therapy meant to support people who use drugs should they choose to get clean.

I was repeatedly told in interviews that the government would not interfere in the provision of health services, including methadone. Other harm reduction supports such as needle exchange or mental health services that would increase adherence to methadone treatment are apparently not considered health services. As Tim Rhodes points out, methadone is a subject invested with 'recovery potential' which is 'an assemblage of relations; of connections between various social, affective and material forces which flow between, and thus make up, both the objects of methadone and recovery' (Rhodes 2018:72). In other words, methadone cannot be separated from its practice and it is often connected to narratives of recovery. The treatment itself, while sometimes seen as a purely medical intervention, is invested with a number of connections making it not just a simple intervention, but part of an assemblage of relations between the substance itself, the drug user and

[89] Individual interview 14, October 2018, Mikocheni

the social context in which it is offered. Methadone is a site for narratives that can both support a government, such as Tanzania, to pursue discriminatory practices against drug use while also touting itself as a champion of harm reduction. Depicting methadone as medical is itself ascribing a narrative to the treatment. In divesting methadone of its intended position within an array of resources and supports for people use drugs, the potential for the treatment doing what it is intended to do, drug replacement, is replaced by what it is not intended to do, offer a medical cure for addiction.

Among the people I talked to who were now sober, I found a full array of perspectives on, and experiences with, methadone. These perspectives and experiences were coloured by my selection process but do reveal some interesting aspects of lived experience with this program. I talked to people who had been on methadone, recovered and now did outreach work to support others; some still on methadone while using drugs; others on methadone living their lives; and some at sober houses who considered methadone as another form of dependency who wanted to be completely clean. These narratives are not about the efficacy of a certain treatment, but rather show the complexity of drug use and dependency. Recovery is possible, but the lived experiences listed above were often shared at some point by people who use drugs. The narrative of a linear path to sobriety, getting on methadone and being cured, was not an experience shared by any of the people I talked to. The reality of 'getting clean' can often involve being on and off methadone and in and out of treatment numerous times. As I mentioned above, the purpose of methadone is drug replacement along with other supports that can help a drug user choose sobriety when they are ready, not as a one-time cure. The main thread underlying these experiences are the universals of job loss, alienation, impoverishment (or exacerbating existing poverty) and stigma, none of which are meant be, or are in reality, addressed by methadone.

Methadone is successful for some but even those in the program for an extended period still face challenges. One woman, on methadone for two years, described her current experience:

> No, the only support we are getting really is methadone. For other medical services, me or my baby, we have to pay. It is very hard, I don't have a job. My baby dad he helps, but he doesn't have a job. He has a small business which is not enough. We have to pay for a room every month, 30,000 Tsh ($13) every month, you pay every 6 months. My husband doesn't

> make enough for us to eat. Pay for a room, support baby when she is sick, you know all that. I am happy because I have beat drugs and it is good I am happy with that[90].

Methadone is not aimed to fix every aspect of a person's life and it is certainly not a way to address deep rooted socio-economic inequality. However, the lack of supports beyond giving people a daily dose is a weakness in the program. Many interviewees had aspirations and goals in their lives which are out of reach, from starting support organizations to operating cooperatives[91]. Even outreach workers I talked to who supported methadone saw the gaps in existing services:

> It is still easy to get drugs still. He [Magufuli] makes it up. Many can still use up until now. Many use now, he is doing nothing. There are still problems. At the methadone we need other services, they have problems there, other sicknesses. They use methadone but they are not busy. They have to go methadone and then they need to be busy and have jobs. Harm reduction is really centred around HIV, but drug users have bigger problems. HIV is full support, drug users are supported through HIV but drug users don't get their own program. It's not enough, we need full support. Government doesn't want this. Little NGOs like us try to raise up our voice and our government its slow. They help so little[92].

The government's approach to drug use in Tanzania is not client-centred. The needs of people who use drugs are not a priority, rather encouraging abstinence without the appropriate support is the focus. As one outreach worker, who had quit drugs with methadone, told me, 'counselling helped me more. They [beneficiaries] can't meet their goals, but if they come here they win. They think most about finding money, not future. They drink methadone but they can't eat, they can't help themselves. If you miss the education you lose'[93]. In focusing on the agency of the person using drugs, the government accepts none of the blame for individuals who are not successful in the methadone program, even though they face numerous systemic obstacles to success.

The head of a larger harm reduction organization pointed out, 'there are not options. It is very hard when you see beneficiaries cannot go to sober houses. They want something easy for them

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[90] Individual interview 46, October 2018, Mwananyamala
[91] Individual interviews 45 – 49, October 2018, Mwananyamala
[92] Individual interview 44, October 2018, Kinondoni
[93] Individual interview 44, October 2018, Kinondoni

in daily life, methadone is free and legal. The motivation is to stop the drug use, that is the major motivation…we had to work on methadone sites because it wasn't well envisioned. It wasn't client centred. For example, you could be punished for being late, even being late'[94]. This statement revealed some of the early challenges with methadone that the program that advocates are working to address. The expectations on the beneficiaries are high, and the onus, despite their low income, was on them to appear respectable and be on time for their daily dose of methadone. I am not arguing that people who use drugs are not capable of punctuality or respectability. However, the reality of daily life in Tanzania does make the methadone program appear less client focused than it could be.

At Kigamboni ferry hotspot, the outreach worker I was with discussed the challenges of supporting clients in accessing methadone. We talked to one man who described how outreach workers come and test for HIV and, once finding someone is HIV positive they are told to start methadone[95]. Again, this depicts getting on methadone as a simple course involving just deciding to stop using heroin and get on methadone. The reality is difficult, however, and some at the hotspot either chose not to leave or kept using methadone and then returning to the hotspot to use more heroin, a dangerous mix[96]. The push to support methadone, driven by the idea of abstinence and curing individuals of their addiction has realigned priorities along a war on drugs epistemology in which greater supports can encourage increased drug use.

The drop in centres, outreach and provision of harm reduction materials in hot spots and prevention have been essentially replaced by methadone. While programs can exist concurrently, the limited resources available mean a diversion in one direction reduces the availability of resources in other areas. Outreach organizations are aware of the issues, as they are usually comprised of former drug users with a genuine desire to improve people's lives but limited in their mandate. Outreach workers have no resources and are not able to provide any services at the hotspot, driving them to encourage people in the hotspots to come with them. This approach is markedly different than the needle exchange, where basic medical services can be offered and syringes are cleaned up.

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[94] Individual interview 24, November 2018, Temeke
[95] Individual interview 30 and participant observation, October 2018, Kigamboni ferry
[96] Individual interview 30 and participant observation, October 2018, Kigamboni ferry

The needle exchange program in Temeke, once seen as ready to expand, may still do so in coming years. However, expansion could have occurred much sooner and saved many more lives. Further, the revision of legal restrictions could also have reduced the sharing of syringes. One local advocate noted how hard this still can be, as police enlist pharmacies to keep an eye out should someone return often to purchase a syringe (which many already can't afford)[97]. As one former injection drug user at a sober house told me, 'when you are around a lot of syringe it is easy, sometimes it gets late and shops are closed so you go and try to find a syringe you used before but it is not there. Then you share. Even at the pharmacies there are difficulties'[98]. It should be noted here that this individual had only come to the sober house due to outreach workers noticing the swelling and abscesses in his legs, caused by using old or dirty needles.

The needle exchange program offers more services than methadone, as people with minor injuries can be treated before they become serious. Methadone is part of a continuum of services, the intent of which is meant to be focused on the improved health, dignity and wellbeing of people who use drugs. A needle exchange is often considered a first step in this continuum. Testing can also take place at the outreach stage and support the development of a community network. This network can improve relationships and follow-up with individuals. The relationships built between Médecins du Monde (MDM) and local partners is significant. More than this, the work helps to reduce stigma and break down barriers. As several people told outreach workers at hotspots, Temeke hospital was the most comfortable site to access methadone due to their relationship with MDM.

The provision of harm reduction has reduced the barriers in Temeke hospital, such as stigma and a lack of understanding of addiction, and facilitated positive interactions where people who use drugs feel safer and more supported regardless of their failure or success in the program. The expansion of this model to other hotspots would only increase similar outcomes in other neighbourhoods. Further, the needle clean-up was appreciated by residents of Temeke and also reduces risks and stigma. The holistic model of harm reduction is clearly a positive step in helping those who use drugs, however, it is contrary to the stigma and ill will Magufuli and his government are cultivating. The grassroots work of harm reduction activists could achieve so much more in

[97] Individual interview 4, September 2018, Mikocheni
[98] Individual interview 26, October 2018, Kigamboni

terms of improved health and wellbeing of people who use drugs, if it were to receive official support.

7.5 Conclusion

The war on drugs in Tanzania has produced a variety of outcomes and is a combination of performance, rhetoric, policy change and controlling narratives. In examining the multiple sites in which this war on drugs is taking place, it is possible to see the impacts as part of a coherent whole. In short, Tanzania's war on drugs has meant a removal of supports from people who use drugs and further marginalization. The crackdown impacted individuals across Dar, who were forced into hiding, saw drug prices rise and struggled to find their usual supply. The war on drugs was connected to Magufuli's overall push to 'clean up' Tanzanian society according to moralistic and conservative norms. This connection cemented the belief that drugs, and by extension, people who use drugs, need to be cleaned up as they are part of a corrupt and immoral Tanzania.

While the Tanzanian government boasted its successes in fighting the war against drugs, the real impacts of this war were mainly felt by already vulnerable Tanzanians. As with his other crackdowns on sex workers and gay men, Magufuli does not have a state apparatus capable of effectively combatting drug use. No state is able to do this effectively. The government of Tanzania does have capacity to disrupt the lives of people who use drugs, however, and to manipulate and control access to the sector for foreign and local NGOs. A war on drugs, even in a state with greater coercive capacity, surveillance reach and resources is a huge task. It always fails. The war on drugs, as conducted in a low-income country, with its own histories of drug use and its own political priorities, is no different. There is a lack of consistency in how it is applied, when arrests are made, when bribes are taken and when, in essence, the rules are applied. This lack of consistency has not greatly altered drug supply or demand, but it has made people afraid and aware that they are targets.

In this chapter I argued not only that the visible crackdown hurt people who use drugs but that, at the same time, a one-sided, top-down policy change was foisted upon the only sector through which people who use drugs receive support. While the Minister of Health and the DCEA gave voice to equitable health care and comprehensive harm reduction services, in reality these departments are involved in removing the rights to health of people who use drugs and enforcing

legal restrictions. Seeing the war on drugs as a cynical political ploy is only part of the picture. The creation of real stigma and the authentic beliefs underlying the motives of those who pursue the war on drugs need to be considered as well.

The war on drugs is a discursive space, where performance and belief meet and mutually support each other. It is in this space that the Tanzanian government worked to create narratives, which I explore more in this next chapter, that there are comprehensive supports for people who use drugs and that drugs can be eliminated through a tough approach. As I showed in this chapter, neither is the case, but the framing of drug policy along abstinence and prohibitionist lines would be useful in intimidating and appeasing foreign agencies involved in the sector.

It may be impossible to discern the reasons for why people continue the war on drugs, but it is possible to look at the real actions, rhetoric and threats they use to uphold this war which have real world impacts and are not abstract or performative. These impacts are why continued work is needed to interrogate leaders, policy makers and citizens on the reasons for their continued use of bad policy. The contradiction in making claims of equitable health care provision ring hollow when considered in the context of drug policy overall. As I argue in the next chapter, international drug policy continues to disregard this context in creating drug policy, a lasting effect of the conservative war on drugs that removes socio-economic, cultural and historical background from policy making. As states have tried to impose their vision of a drug free world on society, people who use drugs are further marginalized.

In chapter 8, I build on the arguments in this chapter to show how the Tanzanian government's control of the narrative has influenced international work with vulnerable populations and perceptions of drug use in the country. I show the effects of the policy changes pursued by the government on international NGOs which were forced to adapt to the current environment. Chapter 8 combines the evidence in this chapter, with the experience of international NGOs to answer my final research question, how the Tanzanian war on drugs interacts discursively with the global war on drugs. I show how Tanzania is not only shaping narratives around drug use, but is integrated into a global system that is not supportive of the human rights of people who use drugs and is continuing the war on drugs, both in rhetoric and policy.

Chapter 8

Tanzania, the war on drugs and international influence: shaping perspectives and policies

'In Tanzania it is different than places like Kenya, the focus is on reducing use as well as reducing risk. We want to see behavioural change. Harm reduction will reduce use and users. There are challenges. Funding is limited, and there is no support for social, economic activities or income generation. Many return to the same conditions as before and struggle.'[99]

8.1 Introduction

In the previous two chapters, I explored the domestic drug policies of the Tanzanian government and the impacts these policies have on people who use drugs. Tanzania differs from countries that fund and manage their own domestic programs. In a globalized world, the international is domestic and, as I have shown in Tanzania, the implementation of drug policy includes numerous local and foreign actors. In the previous chapter, I argued that Tanzania is shaping policy towards people who use drugs despite any supports being provided to drug users being provided by outside sources. My findings are in contrast to assumptions that 'weak state capabilities' often 'contribute to an inferior position [of African governments] in the international system of states' (Andreasson 2013:143).

This idea, which results in the 'shifting dynamics of international relations' being driven by external agency (Andreasson 2013:143) should mean that Tanzania is unable to pursue its agenda, which goes against the goals of donors to advance human rights and reduce the impacts of HIV/AIDS. In this chapter I expand on my arguments to argue that Tanzania, rather than being influenced by international actors as a weak, aid-dependent state, instead pursued a war on drugs with little interference, using tactic of intimidation and appeasement to exploit a neglected area of policy. In opening up space to explore how this agency is exercised and pursued, I show how the Tanzanian government implemented policies within the space of the international consensus on drug control, where there remains flexibility to adapt this consensus to support the war on drugs. In

[99] Individual interview 2, October 2018, Kinondoni

raising how the government has undertaken its own war on drugs, I question the influence of external actors in the war on drugs in Africa and illustrate the agency of an African government.

The government of Tanzania justified repressive policies by framing drug use as a threat to development and a cause of corruption, while also framing its harm reduction programming (which consists of methadone provided by foreign funding) to appear much more active in prevention and treatment than they actually are. Donors paid little attention to the repressive realities of drug policy in Tanzania and foreign agencies working with drug users were silenced and unable to criticize the government's approach to drug users for fear of harassment, intimidation or even being banned from Tanzania.

While attacks on homosexuals are rightly decried by the international community, little attention is paid to the drug war in part due to the Tanzanian government effectively framing how drug policy and treatment is understood by donors and the international community. The war on drugs in Tanzania can be considered an example of what Fisher (2013) calls 'image management', where the state depicts itself as a more trusted partner in securing donor objectives than it actually is. The Tanzanian government enacted the DCEA, publicly denounced people who use drugs and encouraged police to work to enforce a repressive policy. At the same time, the government revised its policies towards KVP with little meaningful consultation and challenged existing harm reduction services.

While the previous chapter answers the question of how drug policy is being determined and the outcomes for drug users in Tanzania, in this chapter, I analyze how the Tanzanian government sidelined international actors and achieved its war on drugs with little opposition. I show how political hostility from the Tanzanian government and donors prioritizing other areas left people who use drugs without the advocacy and support needed to stop the shift from policies inclusive of harm reduction to policies focused on abstinence and punishment. I continue to describe the framing of narratives I began to outline in the previous chapter, exploring how the Tanzanian government produces narratives of drugs impacting development, causing corruption and causing a major health crisis to justify its targeting of people who use drugs and its attack on evidence-based harm reduction services.

In this chapter I also consider the evolving international consensus around drug use, to situate Tanzania not as a passive recipient of policies and narratives around drugs, but an active participant in these debates. Here I argue that Tanzania is a part of an evolving consensus, supporting policies that may appear compassionate and new that are, in reality, not a real reversal of the repressive and failed policies of the past. I use examples of Tanzania's presence in international debates on drug policy and contrast with my fieldwork, to show the acceptance of repressive and regressive policies at the international level. The international consensus does not prioritize drug users, a fact that Tanzania, and other countries enacting visible and repressive war on drugs policy exploit and maneuver in to achieve their agendas.

This chapter begins with an overview of John Magufuli's already fraught relationship with foreign donors. While Tanzania has long depended on foreign aid to prop up multiple sectors, Magufuli challenges donors directly and leverages aid independence as a political ideal for Tanzania to follow. The response to HIV/AIDS and support available to drug users is almost entirely funded by foreign agencies and Magufuli's threats to foreigners were experienced by these agencies as well. I show how Magufuli sidelined these foreign agencies through threats and harassment to silence opposition to crackdowns on drug users and policy changes reducing access to services provided to drug users by these agencies.

I then discuss the involvement of international NGOs in the KVP revision process and how the revised policies changed the scope of their work. I use the works of Jonathan Fisher and Stephen Brown to highlight the ways in which the Tanzanian government is building narratives and leveraging its position to shape drug policy in the country without losing the existing funds available. Tanzania is putting foreign agencies into a position where their influence on drug policy is considerably weakened, leaving people who use drugs at the mercy of domestic policy. Further, I discuss how Tanzania, still a donor darling, obfuscates the reality of its repression and lack of support for drug users through crafting the narrative of comprehensive harm reduction services being available in the country. The lack of actual investigation or concern for drug users is a reflection of the already weak support available for people who use drugs and their position as a low priority for donors and the international community overall. The collusion of these factors contributes to a lack of real support available to people who use drugs.

I conclude this chapter by reflecting on the current trajectory of the war on drugs and Tanzania's role in it. I argue that Tanzania's seemingly repressive war does not deviate much from international norms and expectations, existing in a context where the quixotic mission to reduce drug supply remains a priority. Internationally, governments are grappling with the challenge of implementing humane policy while continuing to prioritize eliminating drug supply. Practices which are not complementary, such as criminalizing drug use while supporting the human rights of people who use drugs, are packaged as a viable alternative to the war on drugs.

In African countries, this is presented as a series of narratives, which I described in chapter 4, that support continued war on drugs policies that depicts drugs as a threat to security, health and development. It is in this environment that governments, such as Tanzania's, are able to pursue their repressive agenda while contributing to narratives that ensure the war on drugs remains the dominant approach to people who use drugs. The government of Tanzania would be less able to achieve its repressive goals without the continued international consensus that has not meaningfully transformed policy approaches towards people who use drugs.

8.2 Serving drug users: the crackdown and the international

Magufuli and international NGOs, a wary relationship

In December 2019, President John Magufuli expressed his frustration with foreign agents 'sabotaging' Tanzanian progress, stating 'they [foreigners] use NGOs and CSOs (Civil Society Organizations) to push their agendas, pretending they are teaching us democracy and human rights while, in actual fact, they are the ones who are breaking them by creating oppressive systems…through their operations, they interfere with other countries' sovereignty, creating chaos' (Kimboy 2019). Foreigners are a favourite target of Magufuli's, whether in the non-profit sector or as donors. This ire appears less connected to aid independence but rather Magufuli's desire, in the face of challenges to the CCM, for political control. In this section, I show how this desire for control has become a source of frustration and challenge for both international NGOs and the local researchers and NGOs that rely on them for funding.

I found during my fieldwork that the focus on controlling priorities impacted the non-profit sector across domestic and international lines. The 'Magufulication' of civil society is marked by increased oversight over all sectors, more reporting requirements and less certainty over what can be done. One major local NGO employee noted this change with their international partners, stating 'visas are denied, we say there is a shrinking civic space, there is a shrinking humanitarian space, even the UN, the organizations under the UN find it difficult to work'[100]. In interviews at Muhimbili University, the lack of space directly impacted the research being done and what could be explored. As one researcher told me, the 'environment is a bit difficult, there is confusion at the moment on research permits and very little funding'[101]. The lack of support for research has created difficulties for researchers and NGOs wanting to work in areas that do not align with Tanzanian government priorities which are focused on state-led and controlled infrastructure and development projects.

One director of a harm reduction NGO based in Europe described to me the real obstacles faced in trying to begin operations in Tanzania. This organization has an explicit harm reduction focus and, during fieldwork, the need for both their advocacy work and the funding they could provide to better support the needs of people who use drugs was apparent. In order to begin work in Tanzania, this organization undertook a study and needs assessment and planned operations in the country before obstacles and issues with government arose. Instead of interest in accommodating the NGO, the difficulties of applying to work in the country multiplied. The experience of this organization, at the time I talked to them, exemplified the dashed hopes of organizations planning to build upon successes in Tanzania prior to Magufuli. Harm reduction advocates and organizations were now being met with obstacles and difficulties, if not outright refusals[102].

The obstacles faced by this organization were such that work planned to begin in 2016 was only getting underway at the time of this writing, albeit very slowly. In follow-up, I learned expansion of the Needle and Syringe programs beyond Temeke district began in late 2019. In advancing better harm reduction services, the arrival of more funding and an active and supportive organization in Tanzania may finally advance initiatives that should have begun years ago. As with

[100] Individual interview 14, October 2018, Mikocheni
[101] Individual interview 15, October 2018, Muhimbili University
[102] Individual interview 1, September 2018, skype

harm reduction globally, the Tanzanian government is another obstacle to the progress of harm reduction, slowing down the development of the more comprehensive supports that could have been established years ago.

International organizations in the country before Magufuli came to power have also faced obstacles even though, despite interruptions due to policy reviews, they have largely been able to remain in the country. Similarly to local NGOs facing increased reporting requirements and scrutiny, international NGOs have been subject to increased control and oversight over their operations. In chapter 5, I made it clear that Tanzania's status as donor darling is not a result of its success in implementing donor goals or even its amenability to donor priorities. Despite its long standing relationships with foreign donors and NGOs, Tanzania has largely pursued its own agenda.

A departure with Magufuli, however, is that the country was once considered flexible to certain donor driven solutions. The sector of illicit drugs is an example of this. While sometimes drawing the interest of the state, Tanzania under Jakaya Kikwete appeared to have little interest in the sector, allowing the growth of harm reduction services funded by foreign NGOs. The connection of donors and local activists spurred a collaboration that led to the growth of harm reduction services between 2010 and 2015. This relationship is in some ways an example of positive extraversion. Local Tanzanian activists used their lesser position in a limited global harm reduction sector, to leverage support for methadone.

The election of John Magufuli interrupted this fruitful partnership. While Magufuli did not halt the continuing work of advocacy, as was clear from many of the vocal activists I talked to, the freeze on harm reduction in the country slowed the progress underway. Advocacy work persists but Magufuli has created a 'climate of fear' that has made this work more difficult (Jerving 2019). In 2019, Human Rights Watch released a report noting how 'his government has adopted and enforced laws and practices that severely restrict activities, resulting in the arbitrary deregistering or suspension of NGOs – including on accusations of violating Tanzanian "ethics and culture" – and the arrest and harassment of NGO workers' (Jerving 2019).

During fieldwork, I certainly noticed a chilling in this sector, especially among NGOs working with sensitive populations. As one foreign NGO employee stated, 'there continues to be

major gaps [in services for people who use drugs] outside of Dar es Salaam. In Tanzania, there is some support among different politicians but there is a reticence to discussing it, people are nervous about touching these issues'[103]. In sectors where donors are providing the only services to KVP, there appears to be the observation that, were major HIV/AIDS donors to retreat from Tanzania, the government would likely not replace these services. Certainly, in the case of KVP, the Tanzanian government has made it clear they have little interest in offering any support.

My experiences with fieldwork challenged my initial expectations of donor influence in advancing a harm reduction agenda in Tanzania. As I mentioned above, local activists receiving outside funding was the impetus behind establishing harm reduction in Tanzania. That said, with the new government and the imposition of more draconian laws focused on people who use drugs, donor influence faded. Even the UNODC, which has slowly become more open to harm reduction was not an effective advocate in stemming the harsh drug policies of the Tanzanian Government. As with other international organizations, the reticence of the UNODC reflects a lack of will among many countries to implement or advocate for harm reduction measures at the international level. As I discuss below, the retreat of donor influence shows the influence of the Tanzanian government in framing the issue in a way that limits the expansion of harm reduction in the country, an example of extraversion and also the insertion of the Tanzanian government's agenda into a global policy debate. In limiting the conversation to drugs as a threat and a medical problem, the vocal activists who call for human rights and greater socio-economic support for drug users is silenced. Funding is also impacted, as the framing of the debate subsequently frames the priorities of donors who divert funding to reach more accessible goals, such as reducing HIV/AIDS transmission among the general population.

The UNODC representative in Tanzania blamed the lack of funding for people who use drugs squarely on the government, noting how organizations working with KVP face harassment and are in fear of greater government reprisals[104]. International organizations facing complications around regulations and arbitrary restrictions have other priorities to attend to. There is a growing recognition that the Tanzanian government, if it continues its current course in targeting vulnerable

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[103] Individual interview 1, September 2018, conducted remotely
[104] Individual interview 25, November 2018, Msasani

people, will be a bad partner in advancing even basic outcomes such as encouraging HIV/AIDS testing among the general population.

In a sector with fewer actors and high global need for programming, the government's lack of interest and use of intimidation results in a more general lack of donor engagement, especially in working with KVP. The Tanzanian government sets the priorities and threatens harassment or arbitrary bureaucratic obstacles to silence NGOs that may challenge its agenda. As one outreach worker told me, 'The problem is our government, donors are not the problem. They are ready to help. I can't help you if you don't help yourself. Our government doesn't support drug users so how will donors support you? We support but government don't want us to support. But we want it'[105]. Several interviewees told me the same story: money provided for outreach is minimal and needed funds that local organizations had planned on using to expand supports are not available. I explore this more in the next section, however, it is important to note that while KVP have been a particular target of Magufuli's, the larger context of international NGO involvement in Tanzania was subject to challenges as well. The result is the abandonment of people who use drugs and less advocacy for improved services. International NGOs, even with extensive funding, are not successfully challenging this outcome.

Serving people who use drugs, an international perspective

While the twin goals of supporting the health of people who use drugs in Tanzania while also ceasing drug supply remain the drivers of international interventions, interest in expanded needle exchange and improved harm reduction has grown since 2010. In neighbouring Kenya, drug user networks expanded from 2012 onwards, taking the example of Tanzania as a model and groups such as the Kenya AIDS NGO Consortium (KANCO) are continuing to expand the harm reduction supports in the country. The growth of organizations such as KANCO are to such an extent that harm reduction programming in Kenya is now more comprehensive than Tanzania. In Tanzania, foreign support continued to focus on supporting PWID with HIV/AIDS, however, this funding was also being used flexibly to grow outreach programming with the understanding that

[105] Individual interview 44, October 2018, Kinondoni

reaching these populations is difficult and reducing stigma and easing restrictions on access to services is necessary in reaching vulnerable populations.

In this section, I look at policy shifts as experienced by international NGOS working in Tanzania to show how this sector has worked to influence policy and adapt. I illustrate how the Tanzanian government driven process resulted in changes to how services were prioritized and delivered for people who use drugs. I argue that the ability of the Tanzanian government to sideline international influence, despite being established and largely funding supports for drug users, relies both on competing funding priorities, in which drug users are not a high priority, and the control of narratives by the Tanzanian government, appeasing and intimidating foreign agencies. In more concrete terms, for these foreign agencies, the Tanzanian government's intimidation and appeasement, resulted in their inability to influence policy outcomes or curb the excesses of the crackdown. There is a continued inability to challenge the existing frameworks of drug policy in the country and services remain framed within a context of ongoing criminalization and marginalization of people who use drugs.

The linkage of local advocates and activists with major funders such as the Global Fund has been an important avenue in developing methadone and harm reduction programming early on in Tanzania. The scale of funding from the Global Fund outmatches many smaller organizations and, although harm reduction is not the main focus, the Global Fund is advancing harm reduction policy and does include harm reduction in its vision for comprehensive services to reduce HIV/AIDS. A challenge with major funders, as noted by some of the local NGOs I talked to, is that the government controls this funding and funnels it through the DCEA and the Ministry of Health.

As made clear in the previous chapter, since 2015, these government branches have not exactly been friendly to improved harm reduction supports. The opportunities for smaller, less organized groups such as the network of people who use drugs, to link directly with these foreign agencies is limited. There are only a few organizations that operate internationally in support of harm reduction, besides larger NGOs such as Harm Reduction International, which mainly operates in advocacy and research. For people who use drugs in developing countries, besides organizations such as Mainline and Médecins du Monde, there is little focused funding for harm reduction available.

In 2016 the government actively inserted itself into several areas impacting the work on international NGOs. The crackdown, while not directly aimed at foreign donors, stigmatized and targeted the populations they work with, making an already difficult population to reach and provide services even more unreachable. International NGOs could not interfere with this domestic political situation. As it became clear that this was not just a temporary crackdown, international actors were forced to wait and see what their futures in Tanzania would look like.

The Tanzanian government's decision to target KVP and people who use drugs had direct impacts on how organizations could continue outreach and support for vulnerable populations[106]. However a more lasting disruption which donors appeared to be unable to influence was the KVP policy overhaul. Organizations such as Jhpiego and ICAP, with major funding from PEPFAR, awaited the outcome of the revision to the guideline, unsure of the extent to which it would impact their work[107]. Jhpiego, associated with Johns Hopkins University are large contributors to work with KVP. Jhpiego, for instance, received $73 million from 2015 – 2020 to provide HIV tests for gay men and sex workers and was the top USAID partner in 2019 (Sieff 2016). During the crackdown, the NGO faced obstacles in reaching these groups, and was unsure of what its work would look like going forward. Jhpiego was also forced to get rid of all lubricants and submitted to government searches ensuring this was the case.

The size of this NGO and its ability to influence decisions appeared very low considering the funding envelope. The uncertainty of the period during the revisions shook donor confidence in achieving goals for HIV reduction in the country, especially among KVP. Prior to this, gay men already faced numerous obstacles in accessing testing due to stigma and fear. This policy revision further complicated how meaningful engagement and ongoing treatment with HIV positive and already vulnerable Tanzanians could be achieved. To continue operating in the county, even a well-funded organization providing highly needed services in Tanzania was required to play by the rules being set by the Magufuli government.

[106] Individual interviews 4, 6 August 2018 Mikocheni
[107] Individual interviews 7,8 and 9, September 2018, Mikocheni

In interviews with ICAP, the KVP team mentioned a six month suspension to some of their work while the government reviewed KVP guidelines[108]. During this time, while not all services were restricted, the government restricted their work with KVP. While reaching KVP is an important part of the work of ICAP, HIV/AIDS in Tanzania remains a huge issue among the general population and the focus of organizations funded through Centre for Disease Control (CDC) or the Global Fund, facing the prospects of diminished funding, is the general population. The funding available for KVP is a small part of the drive towards the 90-90-90 goals, in which 90% of people are diagnosed, treated and virally suppressed. While hopes to achieve this by 2020 are still in place, a 2017 HIV assessment funded by PEPFAR found only 60.6% of adults aged 15 years and older were aware of their HIV positive status in 2016/17 (Tanzania HIV Impact Survey 2018). In my interview with ICAP, they estimated the number of Tanzanians aware of their status to be 52%[109]. The director told me that the number of people tested is low, therefore the priority is getting the entire population tested, and then getting them on treatment[110].

UNAIDS 2019 data shows that 78% of people with HIV in Tanzania now know their status (AVERT 2019, UNAIDS 2019). The employees I talked to at ICAP in charge of the KVP program did feel they could continue work unimpeded, but also admitted the government imposed restrictions making KVP hard to reach[111]. The understanding among several interviewees was that health funding would not be cut. However, when all other areas impacting the lives of people who use drugs are being targeted, health care is impacted as well. In the context of preventing the spread and increase of HIV/AIDS, reaching and effectively treating key populations will remain a major challenge. INGOs recognized this fact, however, they decided to focus on general population goals in the hope that KVP outreach would improve eventually. The continued inclusion of methadone program assuaged some anxieties even though the limitations of this services were also recognized. The growing difficulties over 2016/17 in getting visas, work permits and being able to work unimpeded, also led to organizations wanting to avoid antagonizing the Tanzanian government.

The focus of major organizations, where KVP are only a subsidiary part of their larger goals, can leave more sensitive subjects behind. Whatever strategy is followed, it will take some time to

[108] Individual interviews 7,8, September 2018, Mikocheni
[109] Individual interviews 7,8, September 2018, Mikocheni
[110] Individual interview 9, September 2018, Mikocheni
[111] Individual interviews 7,8, September 2018, Mikocheni

meaningfully address the considerable task of testing, treating and monitoring all people with HIV in Tanzania. Harm reduction practices beyond methadone, such as distributing lubricants, syringes, expanding outreach and advancing decriminalization are all simple and cost-effective measures to immediately prevent more cases of HIV that will need to be treated in the future. Harm reduction, inclusive of measures deemed by the Tanzanian government as immoral practices are, in fact, healthcare. Yet, this simple truth did not curb the government's highly ideological and abstinence based policies.

The methadone program persists despite the government's attacks on drug users human rights. Magufuli's crackdown, however, may result in the further removal of services to KVP. As I noted above, the success rates for testing and treating HIV in Tanzania do not reflect the sizeable investments, especially as compared to similar countries. No doubt the lack of success is, at least in part, due to the lack of support in reaching KVP. The combination of a new moral code, uncertainty over what kind of work can be done and the lack of political will from the Tanzanian government is challenging some agencies, with limited funding and unlimited need across the globe, to rethink their work in Tanzania.

For instance, PEPFAR has faced cuts due to Donald Trump's overall reduction of foreign aid, with a 11% cut in FY2018, 16% in FY2019 and a proposed 25% cut in 2020 (Rose and Keller 2019). As shown in the chart below this has not necessarily impacted Tanzania, which is a priority country for PEPFAR with strong bilateral ties. Figure 7 illustrates that funding for HIV/AIDS makes up the large proportion of United States assistance to Tanzania, largely provided through PEPFAR which is Tanzania's largest international donor and 'will finance 64% of Tanzania's HIV treatment and care' (AVERT 2020). However, the request for 2020 reflects the disappointment of PEPFAR in achieving its goals in the country and is a 30% reduction over FY2018 (Rose and Keller 2019). The actions of the Magufuli government exploit an area of low priority for donors, and it is much easier to work in reaching KVP in countries more amenable to foreign agencies' priorities. The Tanzanian government is thus not only successfully reducing services in the country with little opposition, in the coming years it may eliminate the remaining services altogether.

	Global Fund ($US)	United States total funding for HIV/AIDS*	United States total funding for Health
2020	138,969,076	266,610,000	335,110,000
2019	174,280,149	464,500,000	537,000,000
2018	95,408,413	470,000,000	513,000,000
2017	241,780,731	393,580,000	496,670,000
2016	219,560,697	393,580,000	494,910,000
2015	155,422,982	372,380,000	475,220,000
2014	182,762,770	330,040,000	431,670,000
2013	231,217,111	344,300,000	440,500,000

*Total Funds represent overall funding from the United States only, including PEPFAR, Global Fund and any other sources. The totals provided for HIV/AIDS funding reflect funding almost entirely through PEPFAR which also provides funds to the Global Fund.

Figure 7. Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR) yearly funding allotments to Tanzania ($US). Source: Global Fund data portal and US foreign assistance dashboard.

At the beginning of 2019, Ambassador Deborah Birx, introducing the 2019 PEPFAR operational plan for Tanzania, wrote:

> Only 61% of persons living with HIV infection (PLHIV) were aware of their serostatus. This result, the lowest in Eastern Africa, is deeply disappointing in light of the cumulative $4.5 billion investment of U.S. tax dollars since 2004. It is also disappointing given that substantial increases in PEPFAR funding over the past 3 years have not yield commensurate achievement… It is noteworthy that the PEPFAR/Tanzania program faces unique structural impediments to its progress. Formal and informal policy developments in Tanzania undermine efforts to diagnose and treatment persons most vulnerable to HIV infection, including arrests of sexual minorities, anti-contraception messaging, and the expulsion of pregnant adolescent girls and young women from school (United States Department of State 2019).

This statement shows how global funding levels specific to this sector already face pressures. Further, the majority of this funding is already aimed at major partners such as ICAP and Jhpiego, which focus on HIV/AIDS in the general population, not KVP. Magufuli's rhetoric and policy is therefore not eliminating aid, simply reducing it for the most vulnerable who are not necessarily the top priority for major donors either. Interestingly, the statement does not include specific mention of drug users, highlighting again their lack of importance even among organizations focused on KVP.

Despite the recognition of the importance of harm reduction, INGOs are not involved in treating drug use which is outside of their mandate. At the CDC, entirely funded by PEPFAR, the lead of the Key and Vulnerable Populations program discussed how the main focus currently is peer outreach in order to undertake HIV and other communicable disease testing and then connect individuals to the methadone program[112]. CDC focuses on injection drug users mainly, and PEPFAR pays for the methadone program entirely. As with the approach to the general population impacted by HIV/AIDS, the focus is understanding the scope of the problem, diagnosing HIV and driving forward the medical based approach that has gained the support of the Tanzanian government and the police[113]. A medical approach to drug use sounds reasonable, however, it also does not fully consider the challenges people who use drugs face, or the nature of addiction itself. In essence, what the government is supporting is a model where a drug user is found, tested, brought to treatment and cured. All of this occurs in a context where people who use drugs are treated as criminals, stigmatized and are almost entirely responsible on their own to access treatment.

Ideally, work towards a better understanding of drug use would lead to a more humane approach to supporting those who use drugs. This is summed up by Smye et al:

> Harm reduction must move beyond a narrow concern with the harms directly related to drugs and drug use practices to address the harms associated with the determinants of drug use and drug and health policy. An intersectional lens elucidates the need for harm reduction approaches that reflect an understanding of and commitment to addressing the historical,

112 Individual interview 13, September 2018, Dar es Salaam City Centre
113 Individual interview 13, September 2018, Dar es Salaam City Centre

socio-cultural and political forces that shape responses to mental illness/ health, addictions, including harm reduction and methadone maintenance treatment (Smye et al. 2011:1).

This is an ideal that has yet to be reached in many states, let alone recognized by the international drug control regime or countries with poor health infrastructure. In this sense, however, Magufuli's work to slow progress is even more dire and can be considered a major reversal of the limited supports previously available.

The crackdown and policies of the Tanzanian government are unfolding in front of international donors and agencies whose ability to reach their goals are impacted by these very policies, and will be even further impacted in the future. The ability of Tanzania to neglect the human rights of KVP while donors continue to provide funding to the Tanzanian government is not just a way of framing support for drug users in a narrow way, but also of the active strategies of obfuscation, obstacle setting and impositions aimed at reducing services for people who use drugs. The lack of real power or concerted effort among larger NGOs, with international backing, to influence this outcome is evident in the government's ability to focus funding only on methadone and silence advocacy for the comprehensive harm reduction programming needed. During my fieldwork, more activist organizations were simply focused on surviving in the country while major funders remained intent on the bigger picture.

I do not intend to criticize the important efforts of these organizations in linking with local activists and advancing harm reduction. Rather, I am simply challenging the categorizations in which people who use drugs fall according to international donors. Other than a select few NGOs trying to advance harm reduction in itself, international development omits people who use drugs as a group deserving of service in their own right. The international focus of NGOs on reducing HIV, along with the repressive domestic approach to drug use, creates an environment in which the needs of people who use drugs are not met. Providing health care to this population is a human right, as stated in the Tanzanian Constitution. Denying services, or creating an environment in which the services exist and do not meet the needs of Tanzanians due to a myriad of political directives, is not harm reduction. Further, the focus on health so narrowly defined comes at the expense of interventions that are just as evidence based, such as needle exchanges and drop-in centres which the government has opposed.

Competing systems of support and control

I was told by one researcher at Muhimbili University that it was the donors that were driving the overwhelming focus on HIV, stating, 'the issue with comprehensive addictions treatment is donors, donors drive the HIV prevention focus to the point it seems to be the only focus of donors'[114]. The idea of donors driving the policy agenda is a common understanding. As noted by Hollender et al., 'at the core of this inequality [in shaping the drug reform agenda] is that the North's domination of deliberations and policymaking in order to tilt the outcome. This is perhaps most evident in reviewing UNODC's donors. The top contributors are overwhelmingly states promoting the prohibition agenda' (Hollender et al. 2016:23).

While these funding inequalities exist, Tanzania is not a passive recipient of a war on drugs agenda. Tanzania is also not a major UNODC donor, yet is still able to promote the prohibition agenda. During my fieldwork, several interviewees told me that funding for greater harm reduction supports was available but the government is not active and open to pursuing these funds. Many local NGOs believed that if the Tanzanian government were an active champion and supporter of tackling HIV for all citizens, regardless of moral virtue, donors would see greater impacts from their investments in HIV/AIDS, a truth seemingly evident in Kenya's progress towards harm reduction in recent years.

The choices of donors are also complex, however, and are reflective of the limitations in funding compared to the need. As I outlined in chapter 4, funding for HIV across Africa is not enough, let alone funding available for people who use drugs. I also made clear the disparity in funding for securitization and war on drugs style policy versus the funding available for the human rights of people who use drugs. Taking these dynamics together presents a more coherent picture of the structural underpinnings of the war on drugs. From the perspective of the global war on drugs, which is still epistemically and structurally dominant, and the low priority of drug users among governments with the resources to advocate for them, the ability of Magufuli to influence policy dynamics despite a lack of resources makes more sense. Using the lens of extraversion, it is clearer

[114] Individual interview 12, October 2018, Muhimbili

how the Tanzanian government has inserted itself into this dynamic, breaking down previously built partnerships between willing local activists and sources of international funding and instead pushing against the advancement of better services for people who use drugs. The Tanzanian government framing drug policy as less repressive and showcasing its methadone program also allows greater agency to achieve a war on drugs agenda with little opposition.

Even the United Nations has been unable to influence any progressive policy towards drug users in Tanzania under Magufuli. A UNODC representative told me that the UN did not have active funding to support harm reduction and instead tried to advocate for the rights of drug users when possible. However, after the election of Magufuli advocacy became difficult and the government's more active role in driving policy was clear:

> The decrease in funding for drugs is due to the political environment. The uncertainty at the moment has scared off some donors. Family planning has collapsed and it is too volatile to risk major programs. With the KVP guideline change more people have gone into hiding. The key is finding a political window, in the meantime all that can be done is supporting existing programs even when inadequate, and wait for opportunities to arise to push for greater advocacy[115].

In the interim, people who use drugs face limitations and the ability to reverse the policies being put in place is difficult.

During my time in Tanzania, people involved with drug users expressed frustrations with the reversal in policy which was definitely shaped by the raising of expectations prior to Magufuli. The situation was summed up to me in conversation with a local NGO:

> The Global Fund, it's not enough. It's very limited otherwise. We appreciate it is the first time the Global Fund is considering funding NSP [needle and syringe programs]. It's the first time. It has never been the case. This was a lot of advocacy and a lot of work done to convince them. We had that filing initially, the previous government, even at the local level,

[115] Individual interview 25, November 2018, Msasani

> was very supportive. For Temeke, they had even wanted their own [NSP] centre. Think about councilors, local leaders of government they are telling you they want to take ownership of that but since the directive is from above they can't speak anymore. So we were on an incline then we went this way and now we are here. Let me tell you, Kenya, I remember they had the first tour in 2013 [of Tanzania's methadone program and harm reduction services]. I was part of this tour, they came to learn, the same from South Africa. They came and learned from us but now when you look at South Africa and Kenya compared to Tanzania? And we talk about this in our working group meetings, we talk about people who come to learn from us but then what has happened with us? That's my question for you.[116]

In this interview, I was told that the change in policy from the Tanzanian government made already reticent donors unwilling to take greater risks in a charged political environment by supporting NSP. As noted in this quote, the chilling effect was among the government itself, with lower level bureaucrats and ministers also afraid to 'take ownership' of politically unpopular programs. While donors do have a focus on the general issue of HIV/AIDS, local activists had come up with flexible and creative ways to use HIV/AIDS funds for harm reduction. The insertion of more active governance and policy from the Tanzanian government disrupted this fragile sector.

The result of the revision process and the priorities of the government are clear. NGOs, while working to advocate for better services, are in a position where the services are needed but limited dollars, a restricted donor presence and policy changes reduce services available to people who use drugs. While the outward appearance, given the continuation of existing programs, is of ongoing support and care, Magufuli has limited space for vulnerable Tanzanians and weakened the ability of well-funded organizations such as PEPFAR to reach those who need it. In this sense, the Tanzanian government's policy changes have contributed more to the long-term marginalization of people who use drugs than the initial crackdown.

The effects of the policy revisions, in combination with the crackdown, had both ideological and practical impacts. In practical terms, foreign agencies involved in harm reduction are

[116] Individual interview 24, November 2018, Temeke

intimidated, fearing harassment or removal from the country or fearing offending the government which could make work harder as employees could face visa denials or temporary detention. The government is also allowing harm reduction to continue under the guise of methadone, meeting their own goals of getting people off drugs and appeasing foreign agencies and donors. In ideological terms, which I explore more below, the government is re-creating the image of drug users as inimical to development, as criminals and agents of corruption. Framing the population in this way justifies the government's policy goals which they have succeeded in implementing despite the impacts these formal and informal measures have on service provision from foreign agencies. These changes went largely unremarked upon by the international community, highlighting the ability of Magufuli's government to maneuver within a neglected area of development and policy, and push through an abstinence based and punitive agenda.

In the next section I show the narrative framing that the Tanzanian government is pursuing in more depth. However, it should be clear that there are material impacts. Magufuli has taken the ability to manipulate donors to a new level, flagrantly abusing human rights, jailing journalists and intimidating the opposition all while maintaining, if not enthusiastic donor support, the continued work of NGOs in the country and general donor funding. The reality of HIV/AIDS advocacy and work in Tanzania is that, without international support, there would be little services left putting international organizations in a tenuous position which further weakened outside support for drug users.

8.3 The international war on drugs: the influence of Tanzania, narrative production and outcomes

The narrative as presented?

While it is difficult to fully illustrate a concerted effort to marginalize people who use drugs among governments and international donors, it is evident in realities on the ground and in the lack of attention paid by foreign agencies and donors, that there is simply a lack of interest in the human rights and lived experiences of people who use drugs. The three narratives surrounding drug use in Tanzania that I outlined in chapter 4, of drugs as harming development, drugs as a criminal threat and cause of corruption and drugs as a disease to be eradicated are all dominant in the county and

being actively promoted by the Tanzanian government, erasing more nuanced understandings of the actual needs of people who use drugs. As I have shown in this thesis, harm reduction and treatment would be much better suited in reducing the burden of infectious disease and poor health outcomes among people who use drugs on already stressed health systems, thus contributing to development over the longer term. Despite strong activism within Tanzania pushing a harm reduction narrative inclusive of the complexities and realities of drug use, this messaging was lost in part due to donor unwillingness to challenge the Tanzanian government and, the fact that Tanzania is shaping and contributing to more facile narratives that are not being interrogated or deconstructed.

As I outlined above, Magufuli's rhetoric re-instills old fears of drug use as linked to corruption and evil, while Tanzanian government policy paints drug users as personally responsible for their addiction in the face of systemic and historic obstacles. In this section, I show that the Tanzanian war on drugs not only frames the issue of drug use in the country, but also contributes to narratives towards people who use drugs that are considered to be produced by Western development policies and political agendas. In creating a crisis to justify a war on drug users, the war on drugs becomes relevant and, once again is used as a way to address the problems war on drugs policies create. I discuss below the control over the narrative more generally before exploring the impacts of Tanzania shaping understandings of drug use in the country through the three narratives I highlighted above.

As I illustrated over the past two chapters, Tanzania's harm reduction programming prior to the election of John Magufuli was inadequate. The decision of the Tanzanian government to reduce its involvement in the sector, reverse progress and enact draconian war on drugs policies has made the situation worse. As is perhaps expected, the official narrative was different than my experiences on the ground. Despite the increased control and move away from harm reduction that I discussed above, the Tanzanian government is working to control the narrative, somehow utilizing both very harsh language against drug users in Tanzania while acknowledging the importance of helping people who use drugs on the international stage. At the level of the DCEA and Ministry of Health, officials often claim that Tanzania continues to be a leader in a strong harm reduction strategy. However, this harm reduction strategy has changed in meaning, from a focus on the needs of people who use drugs to the needs of a government to rid society of the evils of drug use.

Drug use as a health crisis

In 2016 speaking at the Vienna conference on drugs, the head of the DCEA, Rogers Siyanga stated 'Tanzania now provides needles and syringes, opiate substitution therapy and anti-retroviral therapy for people who use drugs. In fact we are providing a comprehensive health package to the people who use drugs' (Siyanga Statement, 59th session of the CND, 2016). He does not mention that needle and syringe exchange is limited to one district or that syringes are in fact illegal in Tanzania. He also doesn't mention that, while he made these remarks, Tanzania was preparing to imprison thousands of people who use drugs and undertake reforms to change the policies designed to help them.

Mr. Siyanga continues, 'we have seen community based outreach programmes and peer education as modalities for delivering specific services to key populations. In existing programmers, outreach workers and peer educators facilitate linkages of key populations to drop-in centres…[Tanzania will] continue to empower civil societies/non-governmental organizations in the fight against the drug problem [and] ensur[e] adequate investment in harm reduction programmes' (Siyanga Statement, 59th session of the CND, 2016). As should be clear based on the previous chapters, the comprehensive health package is not comprehensive at all. Drop-in centres were closed, NGOs have not been empowered but made to fear retribution should they stray from a narrow understanding of harm reduction and the remaining harm reduction services in Tanzania are not adequately funded at all.

This may not be purely the fault of the DCEA, however, it does offer insight into the way in which the Tanzanian government is working to present a picture of their activities externally while changing the narrative within the country. Many interviewees I spoke to were skeptical of the DCEA's power to guide its own agenda. The senior member of the DCEA I spoke to gave me this impression, as his assessment of harm reduction focused much less on abstinence but rather on human rights and the freedom of people who use drugs to continue to use, simply reducing the harms[117]. His conception of harm reduction was much more in sync with progressive views that are definitely not reflected on the ground in Tanzania. In this interview the increased oversight was not

[117] Individual interview 16, October 2018, Dar es Salaam City Centre

about DCEA control but rather ensuring services, such as sober houses, were improved and run properly. From the perspective of this interviewee, the lack of funding for harm reduction was due to lack of donor interest which did not include drug treatment and supply reduction, including a reference to British funding for training and supply reduction[118].

While this may partially be true, due to the shortfalls in funding for harm reduction globally, it does not explain the interest of NGOs such as Mainline and MDM with a clear interest in expanding or offering more comprehensive harm reduction services but being unable to do so because of the political environment. It also does not explain why, given government interest in less controversial options that support abstinence, such as the sober house model or preventative education in schools, there is absolutely no support for either of these strategies. Finally, as I have shown in this thesis, while drug users are certainly a lower priority globally, there is funding that can be exploited and used to at least offer some greater supports, as was the case prior to 2016.

The Tanzanian government has not always made its intentions clear, pursuing contradictory narratives to normalize its war on drugs. While John Magufuli railed against drug use, other members of his government created the appearance of normal, continued support for people who use drugs. In obfuscating the reality of services available to drug users, the government seemed to be trying to present to outsiders, a better picture of what was really available to people who use drugs. In 2018 Health Minister Ummy Mwalimu noted the reduction in HIV/AIDS rates saying, 'without the Global Fund and other global health partners, these achievements [reduction in cases of HIV] could not have been attained…we commit to ensuring continued efforts to scale up and sustain provision of health services that are good quality, equitable, accessible, affordable, sustainable and gender sensitive' (Global Fund 2018). This statement contradicts the reality, in which services are not as equitable or accessible for certain groups and is part of the narrative which does not display the actual motives of the government. When I asked the head of a sober house if the government was doing enough for people who use drugs, he replied:

> No I don't think so, because the two institutions which are dealing with the recovery process is the authority, or the DCEA and the Ministry of Health. Inside these institutions there are

[118] Individual interview 16, October 2018, Dar es Salaam City Centre

> a few technical people for recovery only. The government has put much more effort on drug trafficking, smuggling, production… bur for recovery very little. Still drugs are everywhere.[119]

During my fieldwork, many interviewees questioned the power Magufuli to spread his influence and the independence of certain branches of government to pursue other agendas. The independence of the Ministry of Health was also unclear, as Health Minister Ummy Mwalimu was supportive of methadone but also was involved in actively restricting KVP supports. One NGO director told me, 'I know Mwalimu, her comments on KVP are made under pressure, I don't think this is her belief'[120]. Mwalimu previously made comments supportive of ensuring equitable access to healthcare and is a champion of combatting Tuberculosis, which is more common among people who use drugs, raising questions as to her ability to influence policy. Public statements challenging Magufuli and the CCM's positions are unlikely in the current climate. While bureaucracies operated somewhat independently of the government, the initial Magufulication put public servants on alert, creating an environment of caution and fear. Magufuli created an environment amenable to his conservative agenda, bringing public servants and Ministers in line and removing those who opposed him.

The Minister of Health's statements reflect this environment of fear. Regardless of the Minister's personal beliefs, the impacts of the Government of Tanzania's crackdowns on vulnerable people and policy changes towards KVP have gone against equitable health care under her watch. Human Rights Watch conducted 35 interviews with lesbian, gay, bisexual and transgender people in 2019 and had similar findings. In a letter to Ummy Mwalimu, HRW raised concerns that 'recent laws and policies have prevented key populations from enjoying the right to the highest attainable standard of health, as guaranteed under international law'. The forthcoming report assesses:

> The impact of several policies implemented by the Ministry of Health, Community Development, Gender, Elderly and Children, including the ban on water-based and silica-based lubricants, the prohibition on HIV prevention and outreach led by civil society organizations representing men who have sex with men, and the closure of drop-in centers providing HIV services to key populations. It documents how stigma and discrimination

[119] Individual interview 19, October 2018, Kigamboni
[120] Individual interview 24, November 2018, Temeke

> continue to affect men who have sex with men and trans people in government health facilities, inhibiting access to health services. It also documents a series of police raids on civil society workshops and trainings related to health and rights. (Human Rights Watch 2019).

It should not be surprising, considering the evidence I have outlined in this thesis, that HRW found the Tanzanian government's provision of services to KVP to be a serious concern. While the attention raising by HRW is important, advocacy has not challenged the government in pursuing its agenda or brought about change, at least for people who use drugs.

The Ministry of Health, while attempting to provide some semblance of health services to people who use drugs, such as methadone, is at the same time, severely restricting access to more comprehensive supports. Whether the department has greater capacity to act independently is unclear, the reality and apparent outcomes, however, are that it is following Magufuli's directives closely.

The DCEA is another example of a department making statements not reflected in reality. The ability of the DCEA to influence policy, a relatively new department with a new mandate, is even more questionable. As I was told at the UNODC, 'the DCEA is supportive and learning, but their major issue is funding. There is no government funding and very little capacity for the DCEA to undertake all of the plans – no expertise in data or grant writing for example and a lack of human resources to support this'[121]. The DCEA was primarily created as an enforcement agency, borne out of Magufuli's desire to give greater capacity to the organization to punish drug users and traffickers. While prevention and treatment are included as pillars of the agency, the overall funding is very low, as is their ability to build capacity and better address the needs of people who use drugs[122].

Sober houses have the vocal support of DCEA but no funding, while the Global Fund provides some support for methadone outreach through DCEA. Among interviewees working at different sober houses, the complaint was that the DCEA was focused more on interdiction and

[121] Individual interview 25, November 2018, Msasani
[122] Individual interview 25, November 2018, Msasani

supply control rather than harm reduction or treatment[123]. As the head of a local harm reduction agency told me, 'Yes the support is there. The problem is we do not qualify for accessing grants and funds. The government has funding for DCEA for operations and I am worried they are busy with other priorities[124].'

The government has prioritized a war on drugs at the expense of people who use drugs, yet is working at the international and domestic levels to create the illusion of care and a comprehensive drug policy. Indeed, looking at Global Fund financing for Tanzania, upon which a number of organizations depend, the story does appear different. The government is the largest recipient of Global Fund financing as of 2018 in Tanzania, and therefore controls the direction of this funding which, as noted in previous chapters is largely not for people who use drugs. The disparity between the claims of the government, especially when interacting with donors, shows how the government controls a narrative and somehow segregates harm reduction from the loud, anti-harm reduction rhetoric of the President. It is a narrative that fits into the vision of harm reduction as an intervention somehow compatible with the war on drugs. However, as is increasingly clear from what I observed among people who use drugs and from advocacy organizations, this vision is not compatible.

The narrative that emerges from the Tanzanian government's work to curtail harm reduction is that harm reduction can indeed be compatible with increased stigma, incarceration and harassment of people who use drugs. In my literature review I noted how this narrative is prevalent as part of the current international consensus on drug use, however, Tanzania is a part of propping these ideas up, sanitizing harm reduction to make it a one dimensional piece of an overall war on drugs strategy. The Tanzanian government has changed the narrative of harm reduction into a narrative of abstinence. This change aligns neatly with the war on drugs, which erases the larger context of drug use. The epistemology of the war on drugs presents drug use as a disease to be eradicated, a goal which complements prohibition, forced treatment and abstinence rather than supporting the human rights and needs of people who use drugs.

[123] Individual interviews 17 and 19, October 2018, Kigamboni
[124] Individual interview 24, November 2018, Temeke

As I discussed in my theoretical framework, the framing of narratives by African governments may be just as important as the material aspects of interventions. While Jonathan Fisher (2014) highlights the way in which the Ugandan government framed its conflict with the LRA to pursue its own ends, the Tanzanian government is attempting to remove the human rights aspects of harm reduction activism through framing drug use as a criminal and health issue. In doing so, the Tanzanian government 'shaped the nature and direction of the debate into which such groups [INGOs] have entered' (Fisher 2014:687). Entering into a country in which the debate begins and ends with severe limits for what can actually be discussed curtails meaningful advances in harm reduction policy.

Drug use as a criminal threat

Framing the issue of drugs as a threat is so commonplace that it is easy to forget the actual size and extent of drug related problems prior to the war on drugs. My research on Tanzania showed a growing problem in use, however, there was no sudden and dramatic increase that would precipitate drastic action. As Michelle Alexander writes in reference to the war on drugs in 1980s USA, 'at the time the war on drugs was declared, illegal drug use and abuse was not a pressing concern in most communities' (Alexander 2011:71). The war on drugs was a creation aimed directly at the African American community and which, in the United States, was backed up by policy resulting in mass incarceration and huge growth in funding for police. Tanzania, in embarking on a similar war on drugs, is likewise backing up its efforts to 'create' a crisis, with actual policy which will make the crisis an ongoing reality.

Tanzania and the war on drugs are challenging examples of African agency. While the securitization of development as a policy narrative on the African continent makes up a large body of literature, the war on drugs in Tanzania is far from a priority for both Western donors and scholars. Tanzania is a long-time partner of western countries with few major securitization concerns what would lead to access to security funding at the same level of countries such as Uganda or Ethiopia. In this context, it can be questioned how policy agendas, seemingly passed down from the West are interpreted and implemented in countries that are paid little attention in securitization efforts. The case of Tanzania and the war on drugs also raises shows how policy imperatives currently persist despite a lack of Western interest. Instead, due to this lack of interest,

repressive ideologies such as the war on drugs, and are co-opted and advanced by African countries, able to maneuver in neglected areas of international priority.

Certainly John Magufuli, through his intense rhetoric, has worked to centre the narrative of drug use in his country as a major issue, a criminal threat that must be dealt with. His rhetoric raises an interesting example of how, as Western nations lose interest in actively prosecuting the war on drugs, countries in the global south may be taking up the torch to continue it. While narratives of drugs as a cause of corruption and violence are old, the insertion of the Tanzanian government into the debate upholds a fading idea and frames the issue in the country despite the much greater challenges facing the Tanzanian state. In intimidating and sidelining the few foreign agencies with active harm reduction interests and the larger INGOs with other priorities, the framing goes unchecked and the truth of the realities and challenges faced by drug users in the country are hidden and neglected.

International organizations and activists do continue to oppose Magufuli's rhetoric but are facing challenges, as the government shapes the narrative to support a crisis and organizations follow suit to try and raise the issue at home and abroad. To date, no country, no donor or organization has meaningfully come out to challenge the continuation of the war on drugs by John Magufuli. I would echo here Jonathan Fisher and David Anderson who argue in regard to securitization that, 'each [Ethiopia, Uganda, Rwanda and Chad] has successfully imposed its own priorities onto the security policies of its western allies, often at the expense of other development aims and goals' (Anderson and Fisher 2015:150). In Tanzania, the government is pursuing a war on drugs at the expense of advancing harm reduction for people who use drugs, subsequently impacting access to HIV/AIDS treatment and directly opposing donor priorities and development. The influence of Tanzania in shaping its own agenda is underestimated. The war on drugs has no major detractors willing to take a position that condemns the Tanzanian government, operating instead in restricted environments as best they can while the government continues the war on drugs.

Drug use as a threat to development

A final narrative that is prevalent in Tanzanian drug policy is that drugs impede economic and social development. On the international and domestic levels, people who use drugs are left out

of development efforts where organizations such as USAID see drugs themselves as a threat to development rather than the lack of harm reduction and treatment. Tanzania again contributes to this belief by fostering the idea that the country is indeed under threat from drugs themselves and need interventions that will eliminate drug supply.

There is a willingness from foreign governments, specifically the United States, to invest in the militarization and the repressive apparatus of African states to pursue certain agendas, especially anti-terrorism and anti-trafficking efforts. While Tanzania is not as high a priority compared to supports for anti-terrorism in Kenya and Uganda for example, there still are efforts to support anti-trafficking. I did not focus on securitization in this thesis, but I did find continued references to the perceived support of anti-trafficking efforts in East Africa. The DCEA was largely thought of, by local activists and NGOS, to be an agency focused on anti-trafficking efforts entirely. However, when I talked with the DCEA, the reasons for this focus seemed to be due to foreign interests.

The United Kingdom, for example, has contributed to supply reduction efforts in an attempt to both reduce supply of heroin reaching the UK and to support development in Tanzania (Elgot 2018). The head of the Tanzanian drug control agency highlighted collaboration with the UK National Crime Agency as a positive, claiming it is reducing the inflow of heroin into the country (Rweyemamu 2018). The senior official I interviewed at the DCEA, however, claimed that the British government did not want to fund treatment in Tanzania – since maybe 85% of drugs are destined for transit the focus is heavily supply focused. The official told me that the British government only cared about limiting transit to Britain[125]. This claim belies other narratives, depicting the Tanzanian government as helpless in the face of foreign donors wanting prohibition and anti-trafficking efforts only.

The reality is more complex. As I discussed in chapter 4, international prohibition efforts and funding from the United States for security and anti-trafficking supports remain far above the harm reduction supports available. Tanzania, however, is not a high priority country for these efforts. It is unlikely therefore that Magufuli has pursued a war on drugs to attract funding for securitization. Shaping a crisis narrative in Tanzania abroad is unrealistic, even though he has tried to

[125] Individual interview 16, October 2018, Dar es Salaam City Centre

cultivate this narrative domestically. Instead, the Tanzanian government is able to shape ideas of drugs impacting development and causing corruption, an acceptable idea to an international community that seems to share this understanding.

With the existing funding available, mainly in the HIV/AIDS sector, the Tanzanian government has instead focused on pursuing its own agenda while allowing funding to continue to prop up a sector it prefers to neglect. In actively discriminating against and targeting KVP, there is limited recognition from outside donors of how these policies impact access to treatment and supports. At the international level, Tanzania continues to present the drug issue as business as usual publicly, taking an issue not terribly important to foreign donors and framing it in a way in which their minimal efforts are progressive. Methadone, needle distribution in Temeke and sober houses exist in spite of the government but the government takes credit and obfuscates how it is limiting supports.

Scholars who have studied the influence of African governments in western policy debates have often focused on higher level priorities for donors such as democratization or securitization. These dual interests have been particularly important in Uganda, where Yoweri Museveni was able to curtail donors' influence on democratization (Fisher 2013) and shape donor perspectives on the LRA (2014) and in Kenya, where again democratization failed in the 1990s due to short-term donor interests among other factors (Brown 2001). Some of these influences are at play in Tanzania, albeit on a much smaller scale and in relation to a much less salient policy issue as I explore below. Despite its less prominent place in donor priority and development, in this thesis I show that the war on drugs presents another example of African influence in shaping narratives and policy.

The narrative of drugs as a health issue is able to survive the continuation of war on drugs policies and donors are still able to ostensibly provide services, even in the midst of hostile political and legal environments. While this narrative appears as a benevolent concession in the context of the war on drugs, a more insidious continuation of prohibitionist policies is the idea of drugs threatening development. In chapter 4 I disputed the idea of drugs impacting development, and in the previous chapters I have attempted to show numerous examples of how poor drug policy could be considered as actually hindering development and diverting resources away from needed areas.

Hollender et al. (2016) rightfully position the threat of drugs to development firmly as an issue of drug policy causing challenges to development, not drugs themselves.

The evidence of Tanzanian policies and larger development for the country will likely take time to fully account for the results. There is little evidence currently, however, that the Tanzanian government's policies towards drug users are aiding development, even as they raise the spectre of drug use impacting development in the country. This narrative falsely places vulnerable Tanzanians as the focus of why development is failing, rather than continued poor policy choices by the government. Under the guise of drugs impacting development, old war on drugs practices such as securitization and repression continue allowing countries such as Tanzania to continue removing supports from drug users and targeting poor people, all in the name of development.

Donors, influence and the role of Tanzania in framing drug use

In my review of the international dynamics contributing to drug policy in Tanzania, I highlighted three broad areas in which these interventions could be considered; drugs as a threat to development, drugs as agents of crime and drugs as a health issue (vector for disease). While all three of these narratives may be considered an imposition of western policies and epistemologies on Tanzania, it is the government of Tanzania that has actively contributed to shaping drug use in their country into these categories, all of which erase the human rights of people who use drugs. Capturing the framework of harm reduction as progressive and user focused has been a long time goal of activists in the country but achieving the recognition of this idea is a tall task when faced with government opposition and a lack of funding and support. Further, many activists are themselves targets of government crackdowns, removing them from involvement in debates or discussions about the direction of Tanzanian drug policy.

The crackdown, policy changes and rhetoric surrounding drug use in Tanzania are all complementary tools in shaping narratives and ideas that justify harsh drug policy in Tanzania. As Jonathan Fisher notes, 'donor and African governments change, and are changed by, these structures [of donor/dependency relationships] through interacting with them; they are not – or do not have to be – directed, regulated and determined by donors alone' (Fisher 2013:541). Utilizing Bayart's assertion that African actors are indeed involved in international policy debates and

structures, these actors exercising agency through framing and information management, is an important part of contributing to global policy structures. In the case of Tanzania, the use of domestic tools to create crisis narratives, intimidate local and international organizations and the appeasement of donors at the international stage are important examples of agency being utilized to pursue a specific agenda. As illustrated above, policies most important to Tanzania, which is not a major hub for securitization funding, relate to the idea of drugs causing the corruption and lack of development in the country. Tanzania also promotes the idea of drug use as a disease to be eradicated to support its anti-harm reduction agenda and build up abstinence-based approaches to drug use.

Tanzania pursuing its own agenda raises questions as to why donors, upon which Tanzania depends, and foreign agencies that are established and fund service provision to KVP, do not have greater influence. In his study on democratization in Uganda, Jonathan Fisher identified three factors limiting donor influence: competing foreign policy priorities, the internal politics of the donor community and beliefs that 'they do not possess sufficient influence over a particular regime' (Fisher 2013:485). These are salient factors in major policy debates, however, the war on drugs in Tanzania remains peripheral to a majority of donors. Major donor countries present in Tanzania, including Norway and Canada, have no programming that includes people who use drugs in their development focus. The war on drugs is an important example of a policy area that is often not discussed in scholarly literature. Yet, drug policy is being actively influenced despite structural limitations by an African actor utilizing narrative construction to shape understandings of drug use and secure a path towards an authoritarian, anti-human rights approach to drug users.

As I mentioned previously, the smaller international harm reduction agencies in the country focused more on survival and providing the services allowed rather than irritating the Tanzanian government. Larger funding bodies, such as the Global Fund, are effectively funneled through government agencies and again diverted away from a human rights based approach. Tanzania, is therefore able to limit donor influence through leveraging competing donor priorities and engaging in an area overlooked by donors. Any donors or organizations that might pay attention to drug use in Tanzania are either appeased by the semblance of treatment for people who use drugs, or intimidated in expressing criticism of repressive drug policy.

The war on drugs appears simply not important enough for major donors to take on. While there are examples of governments conflating the war on drugs with development, in comparison to the major challenges facing sub-Saharan African countries such as democracy, HIV/AIDS and ongoing poverty, drug use is not as pressing of an issue. In comparison to Fisher's three factors, the Tanzanian government's ability to sideline donors and foreign agencies in pursuit of its war on drugs appears to be due to differing foreign policy priorities and a lack of political will to challenge the human rights abuses being committed by the Magufuli regime. Increased calls for aid independence from Magufuli and a lack of clear policy coherence around the issue of drug policy also create a difficult environment to undertake work with drug users, which also allows space for the Tanzanian government to pursue its own agenda.

When applying the theory of extraversion, and further to the arguments of Stephen Brown and Jonathan Fisher, the war on drugs can be transformed into a policy agenda that is not 'something the West has done to Africa, but rather a set of policy imperatives that some African governments have actively pursued' (Anderson and Fisher 2015:132). In this case, Tanzania actively pursues a war on drugs that directly impacts a population being served by major international organizations, showing the limited influence of donors over domestic policy and the power of an African government to frame the issue to outsiders. As Peter Haas writes, 'members of transnational epistemic communities can influence state interests either by directly identifying them for decision makers or by illuminating the salient dimensions of an issue from which the decision makers may then deduce their interests' (Haas 1997:75). The government promotes abstinence on one hand and repression on the other, subverting the interests of donors with the stated goals of promoting human rights, increasing access to needed services and supporting KVP.

In my theoretical framework, I noted works which highlight how African governments insert themselves in global systems and politics and the agency of these governments in potentially defining an issue in a way that is, intentionally or not, supported by donors. The Tanzanian government is a part of global debates on how to move forward and work with drug users, often presenting itself, as an increasing number of countries are now doing, as a champion of harm reduction and in reality doing almost nothing to support people who use drugs in the ways they need. The repression and lack of supports I witnessed were evident in observation and commented on by everyone I talked to.

While I cannot argue that Tanzania is influencing how drugs are dealt with in other countries, the Tanzanian case is an important example of how drug use, and ideas of how it should be dealt with, are framed in an African context and the impacts this framing has on how services are provided in the country by external actors. In this sense, Tanzania is producing narratives that can be applied to African countries, which are also developing and are sources of trafficked heroin. The strategies pursued by Magufuli are accepted and given legitimacy by the lack of international attention or concern for people who use drugs. The ideology Magufuli is promoting results in the same outcomes as anywhere that practices the war drugs – worse health outcomes, greater marginalization of drug users and longer term socio-economic impacts and costs.

Epistemically, the revitalization of the war on drugs and its accompanying narratives on the African continent, ensure its continuation. Agency and structure are mutually constitutive, and the use of framing as a mechanism of agency by the Tanzanian government thus influences the structure, domestically and internationally, of the war on drugs. The war on drugs continues at the international level in a similar way to Tanzania, though in a less concerted and obvious way, with milder language hiding continued repression, stigmatization of drug users and a general lack of support or advocacy, especially for drug users in countries that continue to marginalize and attack them.

The end goals remain the same internationally and in Tanzania, eliminating drug use. New policies that would undo the epistemic assumptions of the war on drugs, such as simply seeing drug users as deserving of services and basic rights, would support a different way forward. However, in reflecting international norms and responses to drug use, Tanzania is actively shaping and ensuring the war on drugs continues. None of the assumptions that are driving the Tanzanian war on drugs are being challenged, putting harm reduction and treatment in the service of abstinence and prohibition, rather than in the service of promoting human rights, recognizing drug use as neither a disease nor a crime, and removing constructed narratives applied to vulnerable populations to serve short term political ends.

8.4 Conclusion – Moving away from the war on drugs?

Over the past several years, an opioid epidemic which has outstripped the mortality rate at the height of the HIV/AIDS crisis has accelerated in many Western countries. Still, countries such as the United States and Canada, with stronger health care infrastructure and longer experiences with the failed war on drugs than states in Africa, have not actually reversed many of the policies that have caused these high overdose and death rates. Many Western countries are implementing half measures too late, while continuing to ignore the legal and socio-economic contexts fuelling drug use and overdose.

In this sense, Magufuli is not terribly different than Western leaders as he works to ensure that the war on drugs remains intact. Magufuli inherited a growing harm reduction infrastructure but slowed progress and implemented policies opposed to the needs of people who use drugs. As the number of right-wing conservative leaders favouring the traditional approach to drug use gain traction in the United States, Tanzania, the Philippines and elsewhere, a resurgence in poor policy choices will undoubtedly follow. International consensus and policy frameworks do not exist in a vacuum, but are discursively shaped by domestic governments with political agendas and values opposed to people who use drugs. Every time drugs are depicted as evil and threatening in the service of political gain, an old narrative is re-awakened and strengthened, renewing the war on drugs at the international level.

In the Tanzanian government's approach to harm reduction, the epistemic roots of the war on drugs are apparent. The war on drugs and its associated policies of prohibition, punishment and the targeting of vulnerable individuals is not designed to recognize different cultures, histories and lives. It is not designed to recognize individuals, other than to assign them full blame for their addiction. Under the cover of individual responsibility, governments reduce available services, condemn people who use drugs and leave them to fend for themselves. This uncaring understanding of drug use remains at the epistemological root of drug policy, including harm reduction interventions which are, at best, not extensive enough to meet the needs of drug users and, at worst, simply new ways to enforce abstinence. Despite decades of activism by former drug users and those who work with them, many of these interventions remain trapped within the ontological belief that

and those who use drugs are failures, criminals and corrupters. This ontology underlies the international consensus which is being actively upheld by the government of Tanzania.

My work in Tanzania confirmed, from my perspective, the ongoing lack of recognition for the rights of people who use drugs. The epistemic underpinning of the war on drugs needs to be interrogated to realize the limitations of current policy measures. The war on drugs in Tanzania is a strong example of how an African state, dependent on aid and with few resources, is able to find space to maneuver and create its own repressive agenda within an international system that continues to de-prioritize issues of drug use. This outcome, and what I observed on the ground, is even more surprising considering that support for HIV/AIDS and for drug users are entirely foreign funded by agencies that should be strongly opposed to Magufuli's agenda to reach their goals.

Drug policy is being discursively shaped by activists, governments and NGOs spanning borders. However, as drug users remain a low priority, the example of Tanzania shows how a government, with limited resources, can take an active role in this discursive space and have a major influence in limiting services for people who use drugs. Using strategies of intimidation, appeasement and narrative framing, obscuring the reality of drug use in Tanzania, foreign agencies are effectively limited in their advocacy, forced to remain silent and forced to follow the narrow directives of the Tanzanian government. Countries such as Tanzania should be seen as part of the ongoing development of the war on drugs in its current iteration, in which abstinence and prohibition continue to be normalized as effective ways to deal with people who use drugs. This study, while perhaps the first exploring the experiences of drug users in Tanzania, is another example of a long line of scholarly works that challenge the continued international system of drug control. This is a system that clearly does not work, yet remains relevant and accepted. As long as an approach that actively targets people who use drugs while providing limited supports is a viable and unchallenged policy option, decades of failed policy for people who use drugs will not be reversed.

As I noted at the outset, the war on drugs has material and epistemic roots. The Tanzanian government changed policy governing KVP services, re-instilled laws and efforts to crackdown on drug users and achieved little in its drug war other than further marginalizing people who use drugs. It is important to consider the epistemic linkages of these actions, and the international consensus on the war on drugs. As Fisher notes when examining the nature of agency in weak states, context is

important (Fisher 2013:112). As I argued in this chapter, in the context of high domestic political will and an international environment in which drug users are not a priority, the Tanzanian government has publicly continued a war on drugs, advancing its own agenda at the expense of drug users in the country.

The inability of even larger foreign funded organizations to counter the Tanzanian government's drive to deter services to KVP reflects the comparative power and agency of a country with few resources to steer its policy agenda and create narratives that have salience among donors and international forums. A confluence of favourable factors, including a general lack of interest among the international development community of supporting drug users, has helped create an environment in which a weak state can do so. The war on drugs in Tanzania is a nexus of competing interests that reflects the current bias in favour of a war on drugs status quo.

The Magufuli government has used and advanced narratives, successfully framing the issues of drug use in the country as being meaningfully addressed by methadone, while doing little to advance better services for people who use drugs and imposing greater restrictions on their lives. With the fractured international consensus, the continuation of the war on drugs and the minimal harm reduction efforts being made globally, Tanzania can pursue its war on drugs domestically. In doing so, the government of Tanzania, works within and promotes an international consensus that continues to uphold the war on drugs and misinterpret what harm reduction actually means. The recognition of the human rights and dignity of people who use drugs is not present in Tanzanian and, until drug users come to be seen as deserving of support, is not present in international norms and practices.

In the literature on drugs in Africa, both academic and non-academic, the narratives I found to be most common were that drugs were a threat to development, as fuelling corruption and violence or agents of disease and poverty. I found the Tanzanian government actively working to support these understandings through policy and rhetoric rather than advancing a model of drug use and treatment that considers the human rights of drug users and the underlying socio-economic obstacles they face every day. Drug users in these narratives are secondary if mentioned at all. In pursuing a war on drugs, the Tanzanian government is upholding the structure and inherent beliefs that have governed the war on drugs for decades.

Chapter 9 – Conclusion: Just say no

Enforcement must be coupled with a rational approach to the reclamation of the drug user himself. The laws of supply and demand function in the illegal drug business as in any other. We are taking steps under the Comprehensive Drug Act to deal with the supply side of the equation and I am recommending additional steps to be taken now. But we must also deal with demand. We must rehabilitate the drug user if we are to eliminate drug abuse and all the antisocial activities that flow from drug abuse (Nixon 1971).

9.1 Introduction

In 2009, I began my first formal job as a support worker at a harm reduction organization in downtown Edmonton. During the short time I worked there, I came face to face with the results of failed drug policy and began to understand how vulnerability and poverty are produced by governments that unnecessarily stigmatize and punish a segment of the population. The people I worked with required care, support and understanding, but instead faced a cycle of incarceration, police harassment, hospitalization and homelessness. The implications of bad drug policy, as I have illustrated throughout this thesis, is the continued marginalization of drug users and the continued waste of needed resources in pursuit of an impossible goal. Governments that implement policies and crackdowns that reflect war on drugs ideology, create and re-create an epistemology in which drug users are not deserving of services and continue to be targets for legal and socio-economic discrimination.

Working at this organization, I also began to learn more about harm reduction which remains a way out of the dynamics of discriminating against people who use drugs. However, as I noted in this thesis, harm reduction must be implemented with the intention of undoing ideological biases towards abstinence and prohibition, not confirming approaches which still include forced treatment and harsh punishment. Over 10 years later, the need for a radical change in the war on drugs is well established, yet governments continue to resist implementing harm reduction policies that move beyond a war on drugs paradigm, stuck within old practices and beliefs that prevent drug users' from accessing the services they need.

This thesis is the culmination of my interest in harm reduction and in Tanzanian politics and history. I watched the 2015 Tanzanian presidential election with interest, as a relative political outsider within the ruling party pulled off a surprise victory. I also watched the initial excitement over this outsider, President John Magufuli, turn to concern as the Tanzanian government used increasingly worrying tactics to supposedly fight corruption. The showy ways in which the government cracked down on vulnerable populations or 'corrupt' civil servants began to look less like a path to development and more like a path to political consolidation and control.

As the international mood towards Magufuli soured, his repressive actions against journalists and women were publicized and gained international attention. The war on drugs, however, which received modest, mostly celebratory domestic media attention in 2017, did not appear to gain any real international notoriety. When I first heard of Magufuli's rhetoric towards drug users, I knew there must be more to understand than the limited coverage in media and academic literature. Only a few news articles covered the beginning of the Tanzanian government's war on drugs and fewer still reported on its outcomes or continuation over subsequent years. Scholarly analysis focused mainly on the methadone program, but offered little context other than the operation of the program itself. Given the crackdown and policy changes being so recent, I was unable to find any academic works that situated the program in the context of Magufuli's policy shifts and crackdown.

In order to address a gap in the academic literature, and to better understand the realities of drug use in Tanzania, I sought to better understand drug policy and the outcomes of the policy changes from the perspective of drug users themselves, and the people who work with them. I had the opportunity to spend time doing outreach, conduct interviews at sober houses, observe harm reduction programs and see many of the diverse and creative ways in which activists tried to help each other and themselves. I was also able to see how the Magufuli government made policy changes and undertook specific actions to undo the progress that had been made prior to Magufuli's election and how the government continues to work against the interests of activists and people who use drugs.

This thesis brings together the many disparate threads that underlie the evolution of the drug war in Tanzania. In order to provide the deeper context behind the war on drugs in Tanzania, I analysed in depth where this war came from, how it is understood, the ways in which it is

implemented internationally and domestically, and how it unfolded in the unique context of Tanzania under the Magufuli regime.

This conclusion summarizes my findings and brings together Tanzanian politics and the global war on drugs to show the importance of understanding the epistemic and material roots governing drug policy, as well as the context in which it is implemented. First, I review the key findings of my thesis, before summarizing the contributions it makes to understandings of the war on drugs, drug use in Tanzania and the international consensus on drug policy. I close by looking at broader implications for future research and reflecting on the importance of changing war on drugs ideology and policy to benefit people who use drugs.

9.2 The war on drugs, harm reduction and Tanzania – key findings

At the outset of this thesis, I described a puzzling change in policy, from the Tanzanian government being relatively uninterested in drug policy, allowing harm reduction supports to take shape with foreign involvement and funding, to a government greatly interested in every aspect of drug users' lives, from treatment and punishment, to drug users' access to basic needs. The government not only implemented policies targeting drug users, it cracked down on all key vulnerable populations, directly challenging local and international NGOs working with these groups and reducing their ability to reach them and provide needed services.

In literature on African politics and international relations, the assumption persists of 'developing states as weak, system ineffectual states that can never, acting alone or in small groups, make a significant impact on the system' (Beswick 2013:159). I expected, therefore, that a poorer state such as Tanzania would be unable to overturn and challenge the growing international presence working to support KVP in Tanzania.

Yet, as this thesis shows, the government of Tanzania did implement a war on drugs and did change policy that would directly reduce the ability of foreign agencies to do their work and achieve their goals. In order to explain how the government of Tanzanian was able to do so, I posed the question: How did the Tanzanian government implement a war on drugs that went against the goals

of a number of powerful foreign actors funding services for drug users and who, prior to 2015, were advancing harm reduction for drug users in Tanzania in cooperation with local activists?

Building on this question, and in order to provide further evidence of the impacts of Tanzania's drug war, I also wanted to find out the outcomes on the ground for drug users in Tanzania. As mentioned above, while studies have looked at patients on methadone, few studies fully elaborate on the context of drug use in Tanzania. This thesis provides evidence of how drug policy in Tanzania led to increased police harassment, higher drug prices, fear of punishment, economic vulnerability, riskier drug use and reduced access to services.

Finally, during my time studying the history, wider implications and narratives that accompany war on drugs practices across the globe, I began to think about what role, if any, African countries have in broader dialogues about drug use and policy at the international level. Again, this is an under-theorized area, where I found states in Sub-Saharan Africa to be peripheral, if not completely disregarded in the formation of drug policy and perceptions, even in their own domestic spheres. This thesis provides evidence for the formation of narratives and policies at the domestic level by an African government that shapes understandings of drug use and policy among foreign agencies and donors. Below are the key findings for each of my research questions.

Intimidation and Appeasement – mechanisms of agency

Over the course of 2016 and 2017, the government of Tanzania made a concerted effort to change drug policy and crackdown on drug users, with the intention of eliminating drug use and reducing access to services for people who use drugs. While these goals were contrary to the harm reduction approaches that local activists worked to implement over the previous years, which were funded and supported by foreign agencies such as the Global Fund, I argue that the government used strategies of intimidation, appeasement and the exploitation of a neglected policy area to achieve its war on drugs agenda. In an area of policy that is a low priority for international agencies and donors, Tanzania used intimidation and appeasement to maneuver, effectively limiting supports for people who use drugs and attacking them openly without any opposition.

During the crackdown on drug users and the policy revisions, the government of Tanzania did not meaningfully engage foreign agencies, which were left instead on the outside of policy processes, unable to contribute to what turned out to be repressive and ideological policies, targeting the people they serve. At this time, many foreign actors working with drug users feared being ejected from the country if they challenged the government. The individuals that I talked to felt that they needed to remain silent to avoid their work being shut down completely or to avoid their employees or colleagues being targeted by the government, either through facing bureaucratic delays that prevent work from being done, or through increased scrutiny and possible harassment. This fear is perhaps surprising among larger foreign agencies, as the government relies on these organizations to lead and largely fund the domestic response to HIV/AIDS and, without their support, Tanzania would see a major reversal in its fight against the virus.

However, despite the fact that it was unlikely foreign agencies would be completely removed from the country, threats to individual employees, especially local workers, were real. News of the Tanzanian government targeting organizations working with gay men, carrying out deportations and erecting bureaucratic hurdles convinced organizations to follow the Tanzanian government's agenda. Jhpiego for instance, a major international HIV/AIDS organization, stopped distributing lubricants and complied with the abstinence-based government approach despite evidence of lubricants reducing the transmission of HIV/AIDS among men who have sex with men.

While the government targeted this sector in 2016/17, many organizations told me during my fieldwork in 2018 about the difficulties they still faced working in the country, from getting proper permits and visas to being able to do their jobs without constant scrutiny and excessive reporting requirements. For many organizations, the threat of being ejected from the country also remained, significantly curtailing their ability to express disagreement with the Tanzanian government or take actions that depart from the government's abstinence based policies. Facing an established development community whose goal was reaching vulnerable populations to reduce high rates of HIV/AIDS, the Tanzanian government deftly used tactics of intimidation and harassment, without attracting international attention, to silence any potential critics.

As local NGOs are much more vulnerable to government restrictions and repressive action than international ones, the cascading effect on the sector was chilling, disrupting what had been,

until that point, a fruitful partnership between well-funded foreign organizations and local NGOs and activists. The sector supporting drug users had weaknesses prior to Magufuli, including the need for more funding and the difficulties of organizing among a vulnerable population, that the Tanzanian government exploited to further silence more progressive activists with funding further reduced and organizing made even more difficult due to stigma and police intimidation.

The government also used another tactic, framing a narrative around the existing methadone treatment to appease any donors or foreign agencies that might have been alarmed by the crackdown. Methadone treatment was not targeted, but left alone and touted as an extensive and comprehensive harm reduction intervention. In 2016, at the Vienna Conference on drugs, the head of the Drug Control and Enforcement Agency of Tanzania, Rogers Siyanga, boasted about Tanzania's drug programming, highlighting drop-in centres, comprehensive health packages and harm reduction programming for drug users in the country. While these barely existed at that time, within a year they all disappeared.

As mentioned above, drug users are a low priority for donors and many states across the globe. As such, there is no actual investigation of services available in countries such as Tanzania, with methadone being accepted as a good first step and pumped up narratives of comprehensive support being accepted without question by the international community. The result is the contradictory state of drug policy in Tanzania, but also in other states around the globe and reflected in the international consensus – limited treatment in the midst of stigma, repression and punishment.

In Tanzania methadone treatment remained, and the government left the program in place as a demonstration of its compassionate approach to drug users, as if a dose of an opioid substitute once daily could indeed take the place of the counselling, peer support and comprehensive health services. No major donors protested and foreign agencies in the sector, most of which are focused not just on drug users, but HIV/AIDS reduction generally, shifted their focus away from comprehensive harm reduction for people who use drugs, trusting that treatment remained in place.

In this thesis I argue that the government of Tanzania used the tactics of intimidation, appeasement and exploiting a neglected policy areas, to frame narratives for donors and instill fear in

the local and international NGO community. Foreign agencies changed their focus to the more general population, reducing supports for KVP and did not challenge the government's crackdown or policy changes. International donors did not notice the extent and severity of the drug war in Tanzania and were silent as drug users faced increased repression and stigma.

Outcomes on the ground – making life worse for people who use drugs

In chapter 7, I described the situation drug users faced in 2016/17. I argued that people who use drugs, already facing numerous obstacles in accessing services and treatment, had police take a greater interest in 'chasing them', were forced into hiding, were the target of renewed stigma directed against them and had the already limited supports available to them further reduced. While I was sceptical about the power of the Tanzanian state's capacity to fully implement policies given its lack of resources and involvement in the sector, it did implement new drug policies that empowered the police, limited foreign support and narrowed the scope of drug treatment.

While it may be obvious that cracking down on drug use is not good for people who use drugs, this finding is important. The outcomes for drug users which I listed above, empirically deepen the puzzle behind my first research question as the Tanzanian government's strategy had such obvious and apparent negative outcomes for drug users that were hard to not notice by foreign agencies working in the sector. Despite these agencies witnessing the reduction in supports for people who use drugs, hearing that clients were resorting to riskier drug use and seeing clients get arrested and harassed by police, they were unable to challenge the government or prevent these outcomes.

The government's actions went against the goals of local activists and foreign agencies and the lasting changes these actions had on the lives of drug users in the country were still obvious to me in 2018. In hotspots and at local NGO offices, people who use drugs all told me how outreach dried up since the crackdown, how they were forced to go further and pay more for drugs, and how the police bothered them. The Tanzanian government revived anti-drug stigma to justify its policies and used the strategies that I described in my first research question to break up the collaborative effort between foreign agencies and local activists to support people who use drugs.

In this thesis, I also note that what the government of Tanzania considers treatment is more akin to enforced abstinence and the eradication of drug use. In this way, Tanzanian drug policy, seen as a whole – from legal, social and health-based perspectives – is simply a continuation of the war on drugs given legitimacy by the false narrative of treatment and support. Magufuli made life for drug users worse and, even should better services be put in place today, hindering the implementation of better services over the past several years has significantly delayed the development of the comprehensive supports that drug users need.

International perspectives and war on drugs narratives – the role of Tanzania

In the early chapters of this thesis, I described the material and epistemic aspects of the war on drugs, with a specific focus on drug war narratives often applied to African countries. In answer to my third research question, I argue that the Tanzanian government produced the narratives of drugs hindering development and causing corruption, justifying policies focused on eradicating drugs and drug use through abstinence and punishment. I also argue that donors such as the United Kingdom accepted these narratives and supported them in the name of development and that foreign agencies working in HIV/AIDS in Tanzania were forced into a situation where they had to follow the dictates of the Tanzanian government.

The result of framing narratives in this way is that foreign agencies focused less on supporting drug users, instead following an agenda that does not meet drug users' needs, or meet their own goals in reaching vulnerable populations. Donors did not notice or prioritize the abuse of drug users' human rights at all, accepting the provision of methadone as evidence of support for drug users, continuing to provide general budget support and specific funding to limit drug supply in the country. Tanzania is contributing to an international consensus in which the war on drugs is justified as long as basic treatment is provided.

In this thesis, I explored the discursive relationship between development discourses, the domestic discourse of John Magufuli and the implementation of drug policy. As noted in answering my previous research questions, the Tanzanian government used a strategy of producing narratives to appease donors and justify its repressive policies. In doing so, I showed how the Tanzanian government shaped the way in which outsiders perceive drug policy and how this policy reflects a

war on drugs ideology where drugs are painted as an obstacle to development, justifying repressive policies to eliminate drug use.

While the narrative of 'drugs hindering development' is found in policy literature from USAID and is also an accepted assumption in academic literature on drugs in Africa, the narrative during my time in Tanzania emanated from the government itself, not from overzealous donors trying to push their own agenda. Tanzania attracted some foreign support, as I noted earlier from countries such as the UK, to support supply-side measures aimed at targeting traffickers. The Tanzanian government also, in government representatives' speeches and in official policy documents, implied that drug users are corrupt and a threat to the goal of development and a united Tanzania.

In chapter 7, I described how the government employed these narratives to demonize drug users and obfuscate its own role in corruption and political mismanagement. Using the idea of drug users as a scapegoat for a lack of economic development and poor governance, the Tanzanian government effectively framed drug use as a crisis to be addressed through policy change and through the aggressive enforcement of harsh laws and penalties.

The use of this narrative, as I noted in my theoretical framework, does not ascribe undue influence to Tanzania in shaping ideas around drug use. However, it does open up space to show how the Tanzania government employs war on drugs narratives in a domestic environment to justify repressive policies. Utilizing this narrative, and repeating it in policy and rhetoric, the Tanzanian government is reproducing and recreating war on drugs ideology at the domestic level. While western countries, with greater resources and interest in limiting drug supply, are often considered the drivers of the war on drugs in literature and at the international level, this thesis shows how Tanzania is discursively upholding a war on drugs ideology as well. Tanzania's war on drugs is an example of African agency in shaping perspectives and policies in the relatively neglected area of global drug policy.

While the United States, in the past, aggressively promoted the war on drugs, especially in Latin America, it is now harder to justify such a harsh approach given its well documented failures. In countries considered peripheral in academic literature in setting a war on drugs agenda such as

Tanzania, despite their lack of resources and power at the international level, the government there is in fact actively promoting policies and rhetoric directly upholding the repression of drug users. Tanzania is discursively producing and manipulating a war on drugs ideology at the domestic level, promoting ideas of drug users as criminals, requiring abstinence and increasing political control over a vulnerable population. While the Magufuli regime is doing this in the service of domestic political goals, the involvement of foreign actors in the sector and the countries' aid dependence necessitated strategies to influence perceptions and policies to limit any external challenges to the anti-drug agenda.

While the crackdown was damaging to drug users' access to services, perhaps more damaging to the long-term goal of advancing progressive policies for drug users is the Tanzanian government, at home and abroad, promoting its strong harm reduction program, presenting the idea that drug use can be solved during a crackdown and without comprehensive supports. As governments use rhetoric and policy that reflect the war on drugs ideology, the use of this ideology by governments such as Tanzania's, results in the ideology changing and adapting. In this thesis, I show how the government of Tanzania's war on drugs appears more humane in allowing treatment, yet offers no real legal, social, economic or political changes to the repression governing all other of drug users' lives.

Tanzanian government officials pose for pictures and take credit for other efforts aimed at supporting people who use drugs such as sober houses, actively creating the illusion that comprehensive services are available for drug users. The framing of drug treatment and support is apparently acceptable to the international community, for whom drug users remain a very low priority. Countries such as Tanzania exploit this lack of interest to punish a vulnerable population and create understandings of drug use that foreign agencies must follow and that foreign donors do not notice. Drug users continue to be a population to be punished and controlled, rather than supported due to this lack of systemic change. Yet, this outcome is acceptable to an international community, which does not speak out against repressive drug policies abroad, instead continuing to legitimize and provide support to regimes that attack drug users.

9.3 Contributions and wider implications

As I established at the beginning of this thesis, context is important. This thesis describes the complexities of Tanzanian history, the history of the war on drugs and the international organizations and structures that uphold it, to reveal the various different policies, motives, ideologies and beliefs converging on drug users in Tanzania. The war on drugs did not emerge by accident, but was the result of the concentrated efforts of domestic governments aiming to discipline their citizens, international organizations with real concerns about ending crime and safeguarding public health, and cynical authoritarian leaders trying to obfuscate their own actions through constructed crises. The way in which Tanzania is pursuing a drug war did not emerge by accident either, but reflects the historical and political threads of aid dependence, moral nationalism and centralized power present in the post-independence Tanzanian state. My goal in this thesis, and my hope for future studies, is to better understand how governments construct drug policy and how this policy reflects historical, social, political and economic factors.

In writing a study inclusive of this larger context, I found that deconstructing narratives and discovering the realities behind the war on drugs in Tanzania required interviewing the population that has the greatest stake in drug policy, yet who are not often included in studies on drug policy. Taking into account the perspectives of drug users and activists working with them is a primary contribution of this thesis. In this thesis, I applied their perspectives to the historical and political trajectory of the war on drugs in Tanzania and used their lived realities to challenge state-produced narratives, expose the limitations of drug treatment in Tanzania and describe the experience of being constantly targeted by a hostile government.

The contribution of those with lived experiences put top-down interventions such as Magufuli's war on drugs in its actual context as a method of centralizing control and repressing a vulnerable population. Revealing this context, and using the perspectives of drug users and activists also supports a new epistemology in which drug use is not evil and social and health services are not a privilege but a right. As I illustrated in chapter 3 and 4, the ongoing epistemic and material resources upholding the global drug war continue to sideline these voices, both in scholarly work and in policy creation.

Using perspectives from the ground provides evidence of how relatively small changes in drug policy can increase vulnerability and poor health outcomes for people who use drugs. It also provides the evidence needed to challenge assumptions and beliefs around drugs in Africa. This thesis shows the fallacy of drugs hindering development or being easily dealt with through narrow treatment options. The drug users and activists I saw in Tanzania pose no threat to development whatsoever and, even were drug users a threat to development, there is no possible way to prevent drugs from coming into the country. Continuing to support the idea of drugs hindering development legitimizes policies aimed at eliminating drug use which is a waste of resources and a way to perpetuate the negative beliefs and ideology associated with the global war on drugs.

The war on drugs is a set of policies, beliefs and practices that, as I have illustrated in this thesis, have real world implications and repercussions for people who use drugs. I have shown how the war on drugs in Tanzania is an actual set of policies and actions producing a reality in which drug users are targeted by the state and are unable to access services. The Tanzanian war on drugs resulted in increased police activity, higher prices for drugs, riskier drug use, huge penalties for anyone involved and a sharp reduction in access to basic healthcare, treatment or peer support. These outcomes are directly related to the policy shift of the Magufuli government and the specific interventions undertaken to increase police activity and empower an enforcement agency to attack people who use drugs.

While Tanzania has not directed much resources to its war on drugs, a contribution of this thesis is also showing the waste of war on drugs policies and the potential that a small amount of resources, directed in the right way, could have in supporting a neglected population. The wasted resources used to stop drugs from entering the country could be put towards other development efforts, such as cooperatives for recovering drug users for example. Money used to increase policing or making spaces to detain people who use drugs could similarly be allocated to drop-in centres for peer support and counseling, efforts that would go a much longer way in supporting recovery. Development cannot be achieved through marginalizing and othering a segment of the population. In exploring the faulty trope of drugs hindering development, this thesis offers a starting point for future studies that provide evidence of how this narrative harms rather than helps people who use drugs.

In this thesis, I show that people who use drugs are not criminals or one-dimensional characters with nefarious goals, but rather people who genuinely want to live full and normal lives, work hard and contribute to their communities. The power of war on drugs ideology, in creating a separation of the drug-using population from the rest of society remains strong enough that it is still necessary to say that drug users, in fact, have the same goals as anyone else and are not driven by criminality or insanity. The fact that many drug users still do contribute to their communities, despite harassment, stigma or having to maintain daily methadone treatment, is a testament to their commitment and effort, not to the government's supposed comprehensive support. Future studies can build on this work, looking at drug use from the bottom up, rather than through the lens of governmental or clinical, institutional narratives. Doing so supports a better understanding of the actual, lived realities of drug users, rather than the constructed, false narratives often applied to them and offers a way to understand how policy can be improved.

Another contribution of this thesis is disrupting the beliefs and ideologies governments prosecuting the war on drugs in their own countries produce. As I noted in chapter 3, decades of harm reduction activism challenged these beliefs, and the slow response of governments to offer a modicum of treatment, does appear to be changing drug policy towards less punitive and more compassionate strategies to deal with drug users. However, in many cases, such as Tanzania's, new drug policies and narratives are simply newly crafted ways in which government can pursue the war on drugs. Juxtaposing the difficulties faced by people who use drugs with narratives such as drugs hindering development, reveals evidence to the contrary – it is drug policy that hurts development efforts, subverting needed resources that could be used for treatment and taking the focus away from actual development issues, such as corruption.

This study also builds an understanding of how war on drugs policies are shaped by the unique social, economic and political history of specific countries. War on drugs policy often ignores context and is transferred across states with the same intentions of cutting off supply, punishing drug users and promoting abstinence. The importance of context can be illustrated using the example of the United States. Without learning about Jim Crow and segregation in that country, the war on drugs there may appear as a misguided conservative attempt to combat drug use. This narrative is indeed how right-wing politicians justify targeting people who use drugs. Taken within the context of the history of racism in the United States, and seeing the impacts of mass

incarceration, however, reveals a much different picture, showing the war on drugs as a set of policies reflective of a longer history of controlling and disciplining young black men.

Similarly in Tanzania, understanding aid dependence, corruption and moral nationalism, situates the government's war on drugs there as discursively reflecting and shaping narratives of drug use in the country. Discourses of moral nationalism which, since Ujamaa, have centred on Tanzanians coming together to work for the good and independence of the nation, and are used by the Magufuli government to define morality and belonging. In this vision of Tanzanian society, drug users are positioned as morally-compromised outsiders, both ideologically and in reality. Magufuli is working to create a Tanzania that reflects patriarchy, abstinence and misogyny, all justified in his drive for state-led development. In reality, the Tanzanian state-led development project reduces basic human rights for many citizens, and hinders the achievement of developmental goals such as reducing HIV/AIDS among vulnerable populations.

This thesis is the first work on the drug war in Tanzania that takes into account this larger picture. Most studies, while important in advancing knowledge of particular programs or interventions, analyse methadone and drug use in isolation, rather than accounting for the larger socio-economic, historical and political context in which programming and drug use takes place. This work can be applied to other African countries where drug use and drug policy are an issue of concern, such as South Africa or Kenya. Kenya is similar to Tanzanian in the trafficking and use of heroin from Afghanistan, yet is a richer country than Tanzanian, also with strong activism and more permissive drug policy. Comparing the trajectory of that country, as harm reduction grew and bonds between local activists and foreign funding were strengthened rather than weakened would be an interesting way to demonstrate agency and political power in African states.

South Africa faces a host of other drug issues, such as methamphetamine use, and again has more resources to devote to drug users than Tanzania. Case studies or comparative studies tracking the trajectory of drug policy in these states, could provide interesting context on the domestic factors within African countries that shape drug policy and influence perceptions on drugs among donors and foreign agencies.

Future studies on drug policy in Africa that do not focus only on the present and internal domestic politics, can take into account historical dimensions as well as the international actors that exist and attempt to exert influence within African countries. In Tanzania, health infrastructure and social programs are largely provided by foreign agencies with financing from donors and other international organizations such as the Global Fund and PEPFAR. The same situation is the case in several African countries, and developing states in other regions. Positioning the politics and strategies of an African country within larger international policy dynamics assumed to be driven by Western or more powerful countries, allows an examination of how African governments exercise agency and maneuver to achieve their agendas, even with limited resources and limited political influence.

Further, this thesis can provide some guidance for future studies on western countries and drug policy at the international level. While states such as Canada do not have a large international presence in the provision of drug services within the country, it is a country that interacts at the international level and is involved in shaping the international consensus on drugs policy. It is just as important in Canada to know the history and context in which drug policy is implemented. As mentioned above, drug epidemics do not emerge among certain populations by accident but are reflective of systems of control, systemic inequalities and state discipline over time.

Drug war policies are a foil for the greater issues such as racism and poverty, disproportionately punishing vulnerable populations. It is no accident that in the United States this is African Americans or that in Canada it is Indigenous people. Future studies could reveal a similar pattern to that I found in this thesis, by asking how drug policy is implemented in Western countries, interrogating the purposes of drug policies and examining the outcomes. Studying drug policy, harm reduction programs, treatment options, legal frameworks and historical trends together, rather than in isolation, will further deconstruct the war on drugs and continue to show war on drugs policies not just as ineffective and cruel, but a completely misguided program of political control.

Finally, it is also important to question harm reduction initiatives themselves with a critical lens. Much of the scholarly and policy understandings of drug use are epistemically linked to abstinence and the war on drugs. This thesis provides theoretical support to the work of scholars

such as Caroline Acker who argue that the epistemic assumptions of the war on drugs still shape drug policies, both at the domestic and international level. While harm reduction advocates have sought to reverse the war on drugs, the dominance of war on drugs ideology has only allowed minor advances for harm reduction. As I illustrated in this thesis, an intervention claimed to be harm reduction actually goes against many basic harm reduction principles such as allowing drug users to choose treatment when they are ready and not promoting abstinence. Future studies can build on the findings in this thesis to continue and advance the idea of harm reduction as it is meant to be, an inclusive and non-judgemental path out of the war on drugs.

9.4 Looking Forward

In this thesis, I showed how the Tanzanian government took a more active role in drug policy over the course of 2016/17 by committing to a drug war and undertaking specific policy changes. I also showed the mechanisms it used to ensure it met its goals and evade donor pressure. These mechanisms included intimidation and appeasement to make foreign agencies unsure of their ability to remain in the country, let alone continue their work. Some agencies, focused on HIV/AIDS prevention in general were satisfied as long as methadone programming stayed in place, even as the government stigmatized drug users and stripped them of their basic rights to not be detained without reason and to access health services. Police unnecessarily harassed or imprisoned drug users who were then often funneled into a treatment option that often did not meet their needs.

In literature on the securitization of development, authors such as Jonathan Fisher show how funding goes to bolstering national militaries and training programs, fulfilling the agenda of African governments that are intent on bolstering their power and authority. Similarly, in Tanzania, foreign resources that support drug users are subordinated into a state-led agenda that omits them completely and are used instead to fulfill the Tanzanian government's goals which bolster state power and control. The Tanzanian government uses the support it receives as it sees fit, a vision that certainly does not involve providing harm reduction supports to drug users. Foreign agencies are forced to act within a narrow scope of action with their ability to reach vulnerable populations undermined by the health and legal policies the Magufuli government introduced.

Using this case study also allowed an exploration of the discursive nature of the war on drugs, how policies and rhetoric continue to be used in pursuit of the idea of eliminating drugs. In exploring narratives, I found the Tanzanian government to be an active producer of narratives and policy, not a passive recipient. The result for drug users is abandonment by the international community, facing policies and actions aimed at eliminating their presence in society and not at providing much of the actual support they need.

The government of Tanzania's war on drugs is not founded on evidence or science, but on ideology. I have shown the strength and persistence of this ideology throughout this thesis, as well as the structures that uphold it. This thesis also debunks some of the myths created by the ongoing war against drug users, positioning drug users and those that work with them at the forefront and as the voices that should guide policy.

The broader implications of my arguments are that, simply put, the perspectives of drug users are extremely important and closer academic attention should be paid to African governments in shaping domestic and global drug policy. Another important, overall goal of this thesis is to show that drug policy needs systemic and radical change. Rather than seeing treatment included as part of a wider approach to drug policy that remains entrenched in social, economic and legal repression, war on drugs policy needs to be abandoned and governments that persist in upholding war on drugs policies need to face repercussions, or at least the same condemnation they would receive if they attacked any other segment of their population. As I have argued in this thesis, the actions of governments like Magufuli's contribute to the continuation of the war on drugs. While treatment is allowed, it is still in the service of the old goals of prohibition and abstinence with the effect of hurting those who need support the most.

Drugs are not the problem; they have been crafted as such by powerful actors such as the government of the United States, the UNODC and, as I have shown in this thesis, the government of Tanzania. Every time a government constructs drugs as an agent of crisis, corruption and violence, the people who use them face unjust policies that reduce their access to services and the rights of being free from state violence and arbitrary detention. The war on drugs is a system of oppression. Similar to other systems of oppression that governments adapt and frame for political

gain, the war on drugs is being constantly redesigned by states and international institutions in the service of an impossible goal.

In its current iteration, drug policies in most countries across the globe appear more humane than in the past. However, the purpose remains the same for governments such as Tanzania's: forcing vulnerable people to bear the blame for much more complex socio-economic and societal failings, such as corruption or a lack of development. Future studies need to continue to challenge these policies, question why and how they are implemented and advocate for a future where drug policy is inclusive of the needs, beliefs and aspirations of people who use drugs.

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Interviews

Interview 1 – Mainline Tanzania
Location and Date – Interviewed remotely, September 2018

Interview 2 – MEFADA
Location and Date – MEFADA Office, Kinondoni, October 2018

Interview 3 – LEAHN
Location and Date – Interviewed remotely, August 2018

Interview 4 – Tanzanian Network of People who Use Drugs (TANPUD)
Location and Date – Mikocheni, September 2018

Interview 5 – Kigamboni Sober House
Location and Date – Kigamboni Sober House, Kigamboni, October 2018

Interview 6 – TACOSODE
Location and Date – Mikocheni, August 2018

Interview 7,8,9 – ICAP
Location and Date – ICAP Office, Mikocheni, September 2018

Interview 10,11 – TACOSODE
Location and Date – TACOSODE Office, Mikocheni, August 2018

Interview 12 – MUHAS
Location and Date – MUHAS Office, October 2018

Interview 13 – Centre for Disease Control (CDC)
Location and Date – CDC Office, Dar es Salaam, September 2018

Interview 14 – Legal and Human Rights Centre (LHRC)
Location and Date – LHRC Office, Mikocheni, October 2018

Interview 15 – Muhimbili University
Location and Date – MUHAS Office, Muhimbili Campus, October 2018

Interview 16 – Drug Control and Enforcement Agency (DCEA)
Location and Date – DCEA Office, Dar es Salaam, October 2018

Interview 17 – Kigamboni Sober House
Location and Date – Kigamboni Sober House, Kigamboni, October 2018

Interview 18 – MRC Kigamboni Sober House
Location and Date – MRC Kigamboni Sober House, Kigamboni, October 2018

Interview 19 – MRC Kigamboni Sober House
Location and Date – MRC Kigamboni Sober House, Kigamboni, October 2018

Interview 20 – Medecins du Monde
Location and Date – MDM Office, Temeke, October 2018

Interview 21 – Temeke Methadone Clinic
Location and Date – Temeke Hospital, October 2018

Interview 22 – Temeke Methadone Clinic
Location and Date – Temeke Hospital, October 2018

Interview 23, 24 – MUKIKUTE
Location and Date – MUKIKUTE Office, Temeke, October 2018

Interview 25 – UNODC Tanzania Office
Location and Date – UN Office, UN headquarters, Msasani, November 2018

Hot spots

Interview 26 - 29, PEDDEREF Sober House, October 2018

Interview 31 – 33 and Participant Observation, Kigamboni Ferry Hotspot, October 2018

Interview 34 – 38 and Participant Observation MRC Kigamboni Sober House, October 2018

Interview 39 – 43 and Participant Observation, MRC Kigamboni Sober House, October 2018

Interview 44, MEFADA Office, October 2018

Interview 45 – 49 and Particiapnt Observation, Mwananyamala Hotspot, October 2018

Interview 50, 51 Manyanya Hotspot, Kinondoni, October 2018

Interview 52 – 54 Mwenge Hotspot, October 2018

Interview 55 – 56 MEFADA Office, November 2018

Interviews 57 – 61 and Participant Observation, Mwenge Hotspot, November 2018

Interviews 62 – 67 and Participant Observation, Temeke Hotspot, November 2018

Interview 68 – Mainline Tanzania
Remotely interviewed from Edmonton, November 2019

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