DECRIMINALISATION OF DRUG USE AND POSSESSION

SUMMARY

- South Africa's current **drug policy framework is fragmented**, with contradictions between legislation that criminalises personal drug use and policy commitments that recognise prevention, treatment, harm reduction and social reintegration as essential components of the national response.
- Criminalisation **contributes to poor health and social outcomes** by reinforcing stigma, limiting access to health and harm reduction services, increasing HIV, hepatitis C and overdose risks, and disproportionately affects vulnerable populations.
- **International evidence and policy guidance** increasingly support decriminalisation of personal drug use and possession as part of a public health and human rights approach, with models from countries including Portugal, the Netherlands, Mexico and Uruguay providing lessons for implementation.
- A **South African approach** should combine legislative reform with expanded harm reduction and treatment services, supported by evidence-based possession thresholds, workforce training, public awareness initiatives and ongoing monitoring.
- This brief **recommends decriminalising personal drug use and possessio**n through amendments to existing legislation and aligning national law and policy with constitutional, public health and human rights principles to improve health outcomes, reduce pressure on the criminal justice system and strengthen social inclusion.

South Africa's fragmented and incoherent legislative and drug policy framework continues to marginalise people who use and inject drugs (PWID), despite their recognition as a vulnerable and key population under the UNDP Global Health Implementation Manual (Key Populations Health Implementation Manual UNDP). This misalignment between law, policy, and public health obligations underscores the urgent need for policy harmonisation and legal reform to enable a rights-based, evidence-informed response. Exponentially across many jurisdictions, key populations face discrimination, human rights violations, and criminalisation that restrict access to health care.

In South Africa, the criminalisation of drug possession and use entrenches stigma, restricts access to services, and undermines constitutional rights to dignity, equality, and health—highlighting the urgent need for legal reform and a public health–based approach. The legislative framework is contradictory: the Drugs and Drug Trafficking Act (1992) treats drug use solely as a criminal justice issue, while the Prevention and Treatment of Substance Abuse Act (2008) recognise the need for a multifaceted approach, including prevention, early intervention, treatment, harm reduction, and reintegration programmes. Over time, National Drug Master Plans have been inconsistent. The 1999 Master Plan was the only framework to explicitly support the decriminalisation of personal drug use; subsequent plans have phased this out, leaving the issue unresolved and the policy landscape fragmented.[1]

Criminalisation of drug use assumes a position that drug use is merely a criminal justice issue when it is encompassing both human rights and health. This punitive framework disproportionately impacts vulnerable populations, particularly people who use drugs, exacerbating public health challenges such as HIV, Hepatitis C, and tuberculosis (TB) soft tissue and serious systematic infections and overdose deaths. It also perpetuates social and economic marginalisation, hindering access to essential healthcare, housing, and employment opportunities while placing people who use drugs at increased risk of human rights violations.

ACKNOWLEDGEMENTS

This policy brief was commissioned by NACOSA with funding from the Global Fund and developed by Students for Sensible Drug Policy International (SSDPI). It was written by Charity Monareng, Executive Director of SSDPI and benefited from the technical contributions of Yolaan Andrews, Kalvanya Padayachee, Vuyokazi Yokwe, Noxolo Mnguni, Anke Houtzamer and Sophie Hobbs from NACOSA.

The authors gratefully acknowledge the contributions of the South Africa National People who use Drugs (SANPUD) and Vusubuntu Decriminalisation Coalition for their review and valuable inputs.

CITATION: NACOSA and SSDPI, July 2026. *Policy Brief: Decriminalisation of drug use and possession for personal purposes in South Africa.*

This policy brief advocates for the decriminalisation of drug use and possession for personal usage and the harmonisation of the South African legislative and policy framework in response to the drug and substance use. A comparative examination of global models in alignment with human rights principles, conventional instruments, regional frameworks, South Africa can adopt a harmonised legislative and policy framework, that is health and human rights-centred approach that reduces harm, stigma, and the burden on the criminal justice system.

Key Terms and Definitions[28]

De facto Decriminalisation
Where the drug-related activity remains a criminal offence, but the law is not enforced in practice.

Legal regulation
Legally regulating drugs establishes formal controls over their production, availability (sale), and use. This includes controls on price, taxation, marketing, quality, and implementing age restrictions. Each drug is regulated based on an assessment of the risks it presents.

Decriminalisation
The removal of criminal penalties for certain activities related to drug use — usually possession of lesser amounts for personal use, but sometimes minor supply or cultivation offences. In some legal systems, criminal penalties are replaced by civil sanctions (such as small fines), while in other systems no penalties are applied.

De jure Decriminalisation
Where criminal penalties are removed from the legal framework.

Background

South Africa faces a critical public health and human rights challenge: the country's drug laws and policies remain fragmented, punitive and inconsistent, leaving people who use drugs highly marginalised. While legislation such as the Drugs and Drug Trafficking Act (1992) criminalises personal drug use, other frameworks, including the Prevention and Treatment of Substance Abuse Act (2008), recognise the need for prevention, treatment, and harm reduction—creating a contradictory and incoherent policy landscape. This misalignment not only undermines access to essential health services but also perpetuates stigma, social exclusion, and human rights violations.

THE PROBLEM AND CURRENT BARRIERS TO DECRIMINALISATION

South Africa has acknowledged in regional and international reporting that people who use and inject drugs (PWID) constitute a vulnerable population requiring health-centred, harm-reduction, and social protection interventions[2]. International instruments similarly call on Member States to align domestic legislation and policy frameworks with a public health–oriented approach[3].

However, this position is inconsistent with domestic legislation, notably section 4 of the Drugs and Drug Trafficking Act 140 of 1992, which criminalises drug use and possession and reinforces a punitive enforcement approach.[4]Despite this, the 1999 National Drug Master Plan only considered limited decriminalisation for minor offences, and subsequent National Drug Master Plans have not advanced this approach. As a result, drug policy continues to prioritise arrests, prosecution, and criminal justice responses over public health, harm reduction, and social support for PWID.[5]

PWID increasingly use injectable substances, including heroin, methaqualone, cocaine, and synthetic opioids, heightening risks of HIV, hepatitis, overdose, and social marginalisation[6]. South Africa's punitive approach has entrenched a cycle of harm, overburdened the criminal justice system, and sustained an illicit market valued at approximately US$3.5 billion[7], with an estimated 400,000 using heroin, 350,000 cocaine, and 290,000 methamphetamine.

Structural drivers such as poverty, inequality, and barriers to treatment access exacerbate the crisis.[8] PWID face disproportionately high health risks amid underfunded harm-reduction services, highlighting a misalignment between international commitments and domestic law and policy.

Key barriers for PWID are grouped into three domains: health and service gaps, criminal justice challenges, and social and gender-based vulnerabilities:

HEALTH DISPARITIES AND UNDER-FUNDED SERVICES

In South Africa approximately 82,000 people who inject drugs (PWID) experience significant health disparities, including high HIV and Hepatitis C (HCV) infection rates.[9] These disparities are exacerbated by underfunded harm-reduction services: needle and syringe programmes (NSPs) reach only 25% of PWID, and less than 1% of people with opioid dependence receive opioid agonist therapy (OAT). Global funding shortfalls have further disrupted these services, limiting access to NSPs and OAT, undermining trust with PWID, and increasing their risk of HIV, HCV, and overdoses.[10]

OVERBURDENED CRIMINAL JUSTICE SYSTEM

South Africa's punitive drug laws strain the justice system, diverting resources from serious crime and disproportionately affecting marginalised communities.[11] Each year, an estimated 200,000 arrests occur, mostly for minor possession[12], contributing to overcrowded prisons, an overburdened judiciary, and cycles of repeated incarceration that fail to address the root causes of substance use. Black men are particularly affected, with criminal records limiting employment, social reintegration, and access to essential services.

Correctional centres provide inadequate opioid agonist therapy (OAT), HIV prevention, and mental health support, while fear of arrest, harassment, and stigma discourages PWID from seeking care and disrupts access to harm-reduction services. This criminal justice-led approach reinforces social exclusion and perpetuates poor health and social outcomes.

SOCIAL AND GENDER-BASED VULNERABILITIES

PWID face intersecting social vulnerabilities that limit access to care. Stigma, discrimination, and fear of criminal penalties discourage with health care services[13]. Women who inject drugs experience heightened risks of gender-based violence, exploitation, and marginalisation, yet gender-sensitive harm-reduction and treatment services remain scarce[14]. Many women balance drug-related risks with unpaid care responsibilities, which worsen when family structures break down[15]. Women are also the fastest-growing prison population for non-violent drug offences, often disproportionately affected by harsh drug laws. Limited economic opportunities, low political status, and systemic barriers further entrench vulnerability[16]. Criminalisation and stigma reinforce poor health outcomes, social exclusion, and barriers to reintegration for women PWID[17].

> *"Decriminalisation is another crucial step towards a more humane and effective drug policy – accompanied by support for social reintegration. We need to start treating the person, not punishing the drug use disorder."*
>
> Volker Türk, UN High Commissioner for Human Rights

Key International and South African Endorsements for Decriminalisation of Drug Use and Possession

YEAR	ORGANISATION	KEY STATEMENT / POLICY SHIFT
2015	UNAIDS	Called for decriminalisation of drug use among young people to support HIV prevention, treatment, and care. UNAIDS 2015
2014	WHO	Advocated for decriminalisation in the context of HIV prevention and care for key populations. WHO 2014
2016	UN Women & UNDP	Supported decriminalisation in the 2016 UNGASS process, highlighting gender-sensitive and development-focused approaches. UN Women 2014, UNDP 2015
2016	Global Commission on Drug Policy	Advocated decriminalisation to reduce harm, enhance public health, and minimise criminalisation of users. GCDP 2016
2018	UN Chief of Board (31 Agencies)	Adopted a common position endorsing decriminalisation of personal use and possession. UN-CEB 2018
2020	Office of the High Commissioner for Human Rights	Called for decriminalisation of personal use, possession, cultivation, and decriminalisation of minors.
2020	Global Fund to Fight AIDS, TB and Malaria	Recommended decriminalisation to support effective health responses, reduce prison populations, and improve law enforcement efficiency.
2023	South African National AIDS Council (SANAC)	National Strategic Plan (2023-2028) advocates decriminalisation of personal drug use and possession, emphasising evidence-based approaches.

DE FACTO AND DE JURE DECRIMINALISATION IN THE SOUTH AFRICAN CONTEXT

While the terms de facto and de jure decriminalisation both refer to reducing or removing criminal penalties for drug use and possession, they differ in their impact, legal basis, enforcement and longevity.

ASPECT	DE FACTO DECRIMINALISATION	DE JURE DECRIMINALISATION
Definition	Drug use/possession remains criminal, but enforcement is minimal.	Law formally removes criminal penalties for personal use/possession.
Key Effects	Immediate relief, fewer prosecutions.	Legal certainty, aligns law with public health, protects rights, reduces stigma.
Authority	Prosecutorial directives, police/judicial discretion.	Legislative amendments, court rulings, policy frameworks.
Mechanism	Prosecutors deprioritise minor cases; police limit arrests; judges give minimal penalties.	Enforcement follows legal change; compliance mandatory.
Duration & Reliability	Short- to medium-term; reversible.	Long-term, systemic, stable reform.
Implementation in South Africa	Directives to deprioritise minor cases, SAPS guidelines, pilot/diversion programmes, treatment-based judicial precedents.	Amend Drugs and Drug Trafficking Act, constitutional challenges, threshold regulations, stakeholder consultation including PWUD and healthcare providers.

De facto decriminalisation, such as non-enforcement of drug laws, can provide immediate relief at the individual level and is faster to implement. However, it does not address systemic criminal justice approaches or the stigma attached to drug use and can be reversed by administrative decisions. De jure decriminalisation fundamentally reforms the legal framework, enabling systemic change and health- and human rights–centred approaches. The two approaches can complement each other: de facto measures may serve as an interim step while pursuing de jure reforms, allowing South Africa to reduce harm and stigma in the short term while ensuring long-term stability, accountability, and consistent rights-based policy implementation.

REVIEW OF GLOBAL DECRIMINALISATION MODELS AND RELEVANCE[18]

Despite decriminalisation for personal use and possession, most jurisdictions maintain strict criminal sanctions for manufacturing, cultivation and distribution[19]. Several countries have adopted decriminalisation models that prioritise health and human rights over punitive approaches. These models offer valuable lessons for South Africa, where the urgent need for reform is clear but also considers the thresholds to guide regulation.

Notable global decriminalisation models

COUNTRY	LEGAL MODEL	IMPLEMENTATION	THRESHOLDS	RELEVANCE TO SOUTH AFRICA
Mexico	De jure (2009)	Voluntary referral for minor possession; mandatory after 3rd; cannabis cultivation via Supreme Court; arrests persist	Heroin 50mg Cannabis 5g Cocaine 0.5g MDMA 40mg/ 200mg Opium 2g	Guides personal-use thresholds; shows legislative challenges; treatment-based, voluntary harm reduction approach
Netherlands	De facto (1976)	Non-enforcement for personal possession; cannabis tolerated; separates hard/soft markets; low HIV/overdose impact	Cannabis 5g / 5 plants Other drugs 0.5g	Demonstrates non-enforcement reduces over-policing; cannabis tolerance informs soft drug policy; market separation reduces health harms
Paraguay	De jure (1988)	No sanctions within thresholds; medical assessment guides treatment; high pre-trial detention; limited prison health services	Cannabis 10g Cocaine 2g Heroin 2g	Thresholds guide personal-use definitions; medical involvement improves treatment; highlights voluntary vs compulsory care; emphasizes alternatives to incarceration
Portugal	De jure (2011)	Dissuasion Commissions suspend proceedings; voluntary referral to treatment, harm reduction, social services; focus on trafficking; HIV/TB/overdose prevention	Cannabis (herbal) 25g Resin 5g THC 5g Heroin 1g Cocaine 2g MDMA 1g	Voluntary treatment reduces HIV/ HCV risk; eases court/prison burden; aligns justice with public health; thresholds guide police discretion
Uruguay	De jure	No sanctions for personal use; judges determine intent; enforcement inconsistent; impacts health/HIV outcomes	No fixed thresholds – judge decides	Judicial discretion avoids unnecessary criminalisation; highlights need to align law and policing to protect health

Photo by Cathrin Schultz

Implications of global models

PUBLIC HEALTH IMPROVEMENT

Decriminalisation has the potential to significantly improve public health by increasing access to harm reduction services. By removing legal barriers and shifting the perception of drug use from a criminal issue to a public health matter, decriminalisation could foster an environment where PWUD can access judgment-free, evidence-based healthcare services. The benefits of decriminalisation have been noted in many jurisdictions including Portugal[20], Mexico, and Netherlands.[21]

With fewer resources spent on policing and incarceration, governments can reallocate funding toward holistic public health and social interventions, ensuring that PWUD receive the necessary support to address health concerns, housing insecurity, unemployment, and other social determinants of health.

CRIMINAL JUSTICE REFORM

Decriminalising drug possession in South Africa, whether through de facto measures (informal non-enforcement) or de jure reforms (formal legal changes removing criminal penalties), offers a chance to reallocate law enforcement resources to serious crimes, reduce prison overcrowding, and improve public health[22]. Pre-arrest diversion[23] under de facto approaches can lower recidivism and improve treatment access, but reliance on police discretion risks inconsistency. De jure reforms standardise enforcement, reduce the Department of Correctional Services' costs (currently R500 per inmate daily), and help address 48% overcrowding in 2023/24[24], supporting social reintegration and breaking cycles of criminalisation and marginalisation.

By removing these legal obstacles, decriminalisation could enhance individuals' ability to enter and contribute to the formal economy, increasing tax revenue and reducing dependency on social assistance programmes. Bryan et al also highlights that in the UK 24% to 36% of people incarcerated for cannabis possession and supply would be in productive employment, thus resulting in an estimated loss of 10.2m GBP to the economy.[25] In jurisdictions that have implemented decriminalisation, studies suggest increased workforce participation and improved economic outcomes for people previously affected by punitive drug laws.[26] Similarly, South Africa, by adopting a health- and rights-based approach, can remove barriers to employment, housing, and financial inclusion, enhancing workforce participation, increasing tax revenue, and reducing reliance on social assistance.

> *With fewer resources spent on policing and incarceration, governments can reallocate funding toward holistic public health and social interventions.*

LESSONS FOR DECRIMINALISATION IN SOUTH AFRICAN

Decriminalisation in South Africa must be tailored to local realities, where high inequality, unemployment, and overburdened health, social, and justice systems limit the impact of drug policy, meaning legal reform alone cannot improve outcomes for people who use drugs. Effective decriminalisation requires both legal reform and investment in harm reduction, ensuring services such as opioid agonist therapy (OAT), needle and syringe programs (NSPs), and overdose prevention are accessible, affordable, and integrated across health and justice systems. It must also confront the country's moralistic and punitive views of drug use, rooted in colonial-era laws and conservative attitudes, by embedding community-informed strategies, culturally relevant education campaigns, and peer-led initiatives to reduce stigma, support public health, and ensure policies align with lived realities.

South Africa's adoption of the golden standard South Africa's Decriminalisation approach must incorporate the 6 key elements of the golden standard of decriminalisation as recommended by the International Drug Policy Consortium.

Decriminalisation gold standard

ELEMENT	SUMMARY
Removal of Sanctions	Eliminate all criminal, civil, and administrative penalties for drug use, possession, acquisition, cultivation, and related equipment for personal use.
Voluntary Access to Health Services	Ensure people who use drugs can access treatment, harm reduction, and social services voluntarily, without punitive conditions.
Meaningful Involvement of PWUD	People who use drugs should actively participate in policy development and implementation, considering diverse needs (race, gender, socio-economic status, etc.).
Expungement and Reparations	Remove all past convictions related to drug use and provide reparations to those affected by criminalisation.
Training and Awareness	Equip public authorities with comprehensive training to implement decriminalisation effectively while respecting human rights and public health.
Redirection of Resources	Shift funds from criminal justice enforcement to health and rights-based services, including treatment, harm reduction, housing, education, and employment support, ensuring access is voluntary and not conditional on compliance or abstinence.

Recommendations

- **Legislative reform**: Amend Section 4(b) of the Drugs and Drug Trafficking Act (Act 140 of 1992) to decriminalise personal drug use and possession, ensuring individuals found with small quantities are not arrested or incarcerated but diverted to appropriate health and social services.
- **Health service integration**: Expand and institutionalise harm reduction and treatment services nationwide—ensuring they are youth-friendly, culturally sensitive, and accessible to communities most affected by drug use—including needle and syringe programmes, opioid agonist therapy, naloxone distribution, and mental health support. These services must also be integrated across the criminal justice continuum, from policing to correctional settings.
- **Evidence-based threshold guidelines:** Develop scientifically grounded thresholds that clearly distinguish personal use from trafficking, based on consumption patterns, tolerance, purchasing practices, and drug market realities, aligned with international best practice and informed by consultation with people who use drugs, to guide law enforcement, prosecutors, and courts.
- **Training for the security cluster:** Provide comprehensive human rights and harm reduction training for police, judicial officers, and law enforcement personnel to promote dignity, prioritise public health, and ensure individuals are not penalised for seeking assistance.
- **Training for healthcare workers:** Implement dedicated human rights and drug use training to ensure respectful, non-discriminatory, and welcoming health services.
- **Public awareness and narrative change:** Launch national campaigns to reduce stigma, frame drug dependence as a health issue rather than a criminal matter and build support for harm reduction approaches.
- **Oversight and monitoring:** Establish a national task force to oversee implementation, ensure adequate resourcing and access to services, and monitor impacts on incarceration rates, public health outcomes, and broader social indicators.

Conclusion

South Africa's drug policy remains rooted in a punitive "War on Drugs" framework that has failed to deter use or address the structural drivers of substance dependence. Instead, criminalisation has reinforced stigma, deepened marginalisation, and placed sustained pressure on the criminal justice system.

A transition to a health-, human rights-, and harm reduction–centred approach is urgently required. De jure decriminalisation—the formal removal of criminal penalties for personal drug use and possession—offers a necessary legal foundation for this shift[27]. By redirecting resources from enforcement to evidence-based health and social services, it can reduce drug-related harm, improve access to treatment, and ease the burden on courts and correctional facilities.

Decriminalisation is a critical component of a more effective national response. It creates an enabling environment in which people who use drugs can seek support without fear, advancing a more inclusive and sustainable drug policy framework for South Africa.

Watch a video about the impact of harm reduction programming:

Endnotes

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