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UK Khat Prohibition

And the Making of a Harmful Drug

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Abstract

This article delves into the complex dynamics of khat (*Catha edulis*) prohibition in the UK, with a particular focus on a Somali community in north-west London. Despite the Advisory Council on the Misuse of Drugs finding no substantial evidence of khat causing societal or medical harms and recommending public health interventions instead of prohibition, the UK Home Office classified khat as a Class C drug in June 2014. This decision raises critical questions about what constitutes a harmful drug. Based on ethnographic fieldwork conducted during the peak of prohibition discourse in 2013–14, the article explores how notions of harm operate across moral, political, and epistemological registers as people grapple with framing khat's drug status and the effects of its use. It illustrates how prohibition discourse not only amplified perceptions of khat's harmfulness but also sidelined the more nuanced concerns of Somali community members over persistent socioeconomic integration issues, mental health, and social marginalisation. Thus, the harm of khat may not lie in its potency as a psychoactive substance but as an object of prohibition that overshadows interventions to address the adverse conditions associated with its use among certain individuals.

Keywords

Drug policy, Khat, Drug harms, Prohibition, Somali diaspora.

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Introduction

On 24 June 2014, the UK listed khat (*Catha edulis*) as a Class C drug. Early in autumn of the same year, London Metropolitan Police searched local establishments in Somali-populated areas of north-west London on suspicion that khat trade and consumption continued despite prohibition. Prior to June 2014, khat was imported from East Africa as a 'stimulant drug' and was widely available in grocery stores and khat cafés, known as *mafrishes*.[1] Consumed for its mild stimulating and euphoric effects, khat had been a popular recreational activity among diaspora groups such as Somalis, Kenyans, Yemenis, and Ethiopians.

Khat prohibition was introduced despite recommendations from the Advisory Council on the Misuse of Drugs (ACMD) in their report, *Khat: A Review of Its Potential Harms to the Individual and Communities in the UK* (ACMD 2013).[2] This was the second time the ACMD reviewed khat, each time concluding there was insufficient justification for prohibition under the Misuse of Drugs Act 1971 (ACMD 2005; 2013). The Home Secretary initiated this 2013 review to assess potential medical and societal harms caused by khat. Although the ACMD did not find direct causal links to 'medical harms', they observed, 'it is often difficult to disentangle whether khat is the source of community problems or, to some extent, its prevalence and use is symptomatic of the problems for some individuals and groups within the community' (ACMD 2013, 4). Instead of prohibition, the ACMD suggested public health interventions and community engagement in areas where khat consumption was prevalent. Despite these recommendations, the Home Office proceeded with the prohibition, arguing that 'we risk underestimating the actual harms of khat in our communities owing to the limitations of the evidence base available to the ACMD' (Home Office 2013a).

The communities referred to above were Somali people who had predominantly become associated with khat use in the UK. Indeed, the khat prohibition was welcomed and celebrated by a small but vocal group of Somali anti-khat advocates who claimed to represent the needs and concerns of the Somali diaspora. The core group of these activists was composed of several influential Somali community organisations, and led by self-described 'ex-addict' and 'the Lead Anti-khat Campaigner', Abukar Awale (Awale 2013b). Their anti-khat campaign culminated in a demonstration outside Downing Street in 2012 and an endorsement letter to the Home Secretary to support prohibition (BBC 2012b;

[1] *Mafrish,* or sometimes *marfish,* is a khat café frequented exclusively by Somali men. They could, however, be run and owned by women, often as a side-business to a standard café or a shop.

[2] The Advisory Council on the Misuse of Drugs (ACMD) is a statutory advisory public body responsible for comprehensive evidence-based evaluation of psychoactive substance-related harms and for suggesting policies on drug control measures in the UK.

Hiiraan Online 2013). In their own khat report, they called on the government to protect the Somali community from the harms of khat, which, they argued, were overlooked by the ACMD (Community Perspective 2013). For them, the evidence on the harms of khat was clear and they believed prohibition would align with the government's commitment to promote social integration, community cohesion, and the health and wellbeing of disadvantaged members of society (Awale 2013a; BBC 2012a).

Within everyday community discussions—and in contrast to the claims of anti-khat advocates—the issue concerning harmfulness of khat was less clear-cut. A few days before prohibition, I overheard a rhetorical question posed by a Somali man in north-west London where I was conducting my fieldwork: 'Why is khat being banned but not alcohol? Alcohol is a drug, too. What is a drug anyway if khat is a drug here, but not in Somalia?' From his perspective, khat was equivalent to alcohol, and mafrishes were comparable to pubs. Both served recreational purposes and both could be potentially harmful if used irresponsibly. Yet, unlike alcohol, khat did not inspire public health attention or information campaigns addressing its use. Prohibition was therefore a significant turning point, abruptly recasting khat as a harmful drug. So, why and how was khat framed as a harmful drug, affecting the Somali diaspora in particular?

Based on ethnographic fieldwork in a north-west London Somali community during the peak of the khat prohibition discourse, this article explores how conceptions of harm operate across moral, political, and epistemological registers as people grappled with framing khat's drug status and the effects of its use. I suggest that the prohibition discourse amplified the perception of khat's harmfulness in response to its ambiguous potency and anti-khat advocacy. Meanwhile, this amplification further sidelined the concerns of khat consumers and others over persistent socioeconomic integration issues, mental health, and social marginalisation. Consequently, the entire spectrum of khat use, from potentially problematic to benign, was encompassed within a prohibitionist framework that posits drug control as a protective measure for vulnerable individuals. The harm of khat, therefore, may not lie in its potency as a psychoactive substance, but as an object of prohibition that overshadows interventions to address the adverse conditions associated with its use among certain individuals.

Following a brief reflection on my fieldwork, I will consider the concept of harm as it relates to substance use and control. Then I will overview the regulatory and scientific contexts surrounding khat, emphasising its ambiguous harmfulness and status as a drug in the UK. Next, I will introduce the story of Ilwad, a Somali community advisor involved in the khat prohibition discourse, who navigated policy debates and advocated for a balanced public health approach to khat use in the

Somali community.[3] Subsequently, I will analyse how khat was depicted as a harmful substance in a government campaign aiming to legitimise the prohibition through the promissory language of 'drug facts'. Finally, I will consider the identity of *jaadkaholic*[4] and, through Fuaad's story, explore how it opened a critical space to call for meaningful public health interventions.

Fieldwork during the prohibition

My ethnographic fieldwork in a north-west London Somali community (2013–2015), focused on a small area dotted with various Somali diaspora establishments—convenience stores, barbershops, cafeterias, internet cafés, a mosque, remittance offices, and, before khat was prohibited, several mafrishes.

In 2012, I met outreach volunteer Hayaan at a Somali NGO, and he introduced me to a broad spectrum of individuals in the community at a time when khat was a hot topic due to the ACMD review and media exposure from anti-khat advocacy. Sometimes, the khat debate could be quite divisive and my fieldwork required me to acknowledge and accept certain 'ethics of discomfort' (Caduff 2011). As an outsider conducting research in Somali community spaces, I was cognisant of the boundaries established by language, personal background, and historical context. I navigated these complexities as an immigrant from a post-Soviet country myself. My background sometimes served as a bridge with my interlocutors who had also been affected by Cold War geopolitics. Most of the time, however, people would just wonder why a 'Latvian guy' was interested in khat!

The discrepancy between evidence of khat's harmfulness and public perceptions of its risks, underscored the ambiguity surrounding its status as a drug, commodity, and cultural value (Cassanelli 1986). Throughout my research, I remained aware of how my perspectives on khat and drug prohibition more broadly, influenced my approach, striving to maintain neutrality in the divisive debate. Despite avoiding khat chewing to respect opposing views, my impartiality was occasionally perceived as taking a stance, interpreted as agreement with the 'opposite' side. Reflecting on this, I had to acknowledge that I view prohibitionist approaches to drug control as crude and harmful, particularly ones that ignore potential public health interventions that could address the nuances of drug consumption, including khat. Nonetheless, I also acknowledged the validity of views welcoming prohibition, emphasising the importance of understanding everyday concerns about khat and

[3] All names, except for public figures, have been changed.

[4] In colloquial Somali, people have widely adopted *chat* from the Amharic term for khat. In Somali orthography *chat* is written as *jaadka* or *jat*, and 'khat' is written as *qaad, qat* or *qaadka.*

their political implications, about which I have written elsewhere (Ermansons 2022).

Drug harms

The notions of harm and harmfulness figure prominently in ethnographic studies, dating back to classical works on witchcraft. More recently, manifold dimensions of harm underpin what has been aptly termed 'dark anthropology', an analytical perspective preoccupied with neglect, exploitation, marginalisation, and destruction within predominantly neoliberal contexts (Ortner 2016). Various conceptual frameworks developed by anthropologists to theorise human hardship and adversity, such as trauma, social suffering, and structural violence, are grounded in exploration of harm and harmfulness (Farmer 2004; Fassin and Rechtman 2009; Kleinman, Das and Lock 1997). Focusing on drugs, some notable examples include the extensive harms of the war on drugs (Zigon 2018), intergenerational harm of heroin addiction and historical dispossession (Garcia 2010), and everyday violence and precarious care among people at the margins of society (Bourgois and Schonberg 2009). In the context of behavioural addictions, efforts to define and address harm underscore its ambiguous role in the biomedical categorisation of these disorders (Vrecko 2010). Thus, as an ethnographic category, harm encompasses a multitude of forms and configurations, both purposeful and accidental. In its broadest sense, harm can be understood as a reduction in well-being and an increase in suffering, resulting from a harmful presence or absence. Although the concept remains somewhat elusive, it is feasible to differentiate harm as an action, process, or practice—and their respective outcomes—from the inherent or presumed harmfulness of something or someone.

In the realm of drug policy, Babor and colleagues (2010, 47) note that '"harm" is both a subjective and a normative concept that is influenced by social and cultural valuation'. Use-related harms, such as health issues directly resulting from drug consumption, and response-related harms, like stigmatisation or legal consequences from drug use, largely depend on the local context and the specific drug. This includes the exercise of sovereign authority to inflict a certain level of 'acceptable' harm, such as prohibiting a drug and implementing measures to mitigate 'unacceptable' harms. Therefore, any drug policy regime stems from a situated form of moral reasoning that draws on international drug conventions, scientific evidence, and cultural context, as well as political and economic interests, to prescribe how individuals should live and how they should be treated (Monaghan 2011; Room and Lubman 2010; Stevens 2010). Indeed, abstentionist and prohibitionist frameworks have traditionally held that a life of sobriety is inherently free and pleasurable, while a life that involves drug consumption is

plagued by compulsive behaviour and suffering, necessitating deterrence at all costs (O'Malley and Valverde 2009). Conversely, harm reductionist approaches emphasise the psychological, environmental, and pharmacological factors that contribute to the negative effects of drug consumption. They advocate pragmatic strategies to minimise the synergistic and direct harms associated with precarious forms of drug use and punitive responses to it (Marlatt and Witkiewitz 2010; Single 1995).

While 'drug harms' is a cultural construct and an object of description and interpretation that spans both pharmacological and sociological domains (Cohen 2010; Room 2006), it also becomes an arena where power dynamics play out. From a critical perspective, drug policy itself, by distinguishing between acceptable and unacceptable use-related harms, falls within the realm of response-related harms embedded within a larger field of governmentality with its contested perspectives on autonomy, responsibility, and agency. Consequently, the limits of individual agency are expected to align with the boundaries of 'correct' consumption, fitting into 'neoliberal projections of healthy citizenship' (Race 2009, 17). Yet, importantly, 'this formulation of healthy citizenship has very little time for the actual bodies impacted by drugs' (ibid.). The operationalisation of these boundaries via drug policy is an outcome of deliberate process produced by a 'policy constellation', 'a set of social actors (individuals within organisations) who come together in deploying various forms of socially structured power to pursue the institutionalisation in policy of shared moral preferences and material interests' (Stevens and Zampini 2018, 62).

Drawing on critical medical anthropology, Gezon stresses, '*Khat (or any other drug, for that matter), in itself is neither good nor bad*. Rather, criteria can be established for evaluating its effects on a population in particular contexts' (Gezon 2012, 29; emphasis original). This perspective resonates with me, particularly for its acknowledgment that drug effects depend on the specific circumstances framed within 'political, economic, cultural, and social frameworks' (ibid.). In this article, I focus on how the harmfulness of khat is assessed within a given context. Employing Gezon's terminology, my interest lies in examining how a population influences the drug, specifically, how its effects are identified and judged as either harmful or benign. In the context of khat prohibition, I aim to illustrate the intricate interaction between the 'medico-penal constellation' (Stevens and Zampini 2018) and the notion of 'healthy citizenship' (Race 2009), demonstrating the complexity of these dynamics.

Ambiguous harms of khat

In the 1960s, Canadian medical historian and psychiatrist Edward Margetts wrote: 'Whether or not addiction to [khat] exists is not clearly stated in the literature, because no one really knows. It depends on semantics, what one understands by the word "addiction" [. . .] So far as the general population is concerned, *Catha edulis* as a drug probably does not do much harm' (Margetts 1967, 361; emphasis original). Half a century later, in 2011, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) stated: 'The dependence potential of [khat] remains poorly understood, and although overall dependence appears relatively mild in comparison with some other psychoactive substances, some users do exhibit compulsive patterns of consumption similar to those seen in stimulant addicts' (Odenwald, Klein, and Warfa 2011). These statements confirm a lasting ambiguity both about the potential of khat to cause harm and the definition of 'khat addiction'. Yet, both articles agree khat is a 'drug'.[5]

Khat, which contains the psychoactive compounds cathine and cathinone, belongs to the amphetamine class. It stimulates the release of serotonin, dopamine, and noradrenaline in the central nervous system (Graziani, Milella, and Nencini 2008). It is consumed in various contexts, including recreational, work, study, healing, and religious practices (Beckerleg 2010a; Carrier 2007). Consumption of khat leads to increased alertness, heightened empathy, reduced appetite, and elevated heart rate, and it facilitates socialising with a sense of camaraderie and enthusiasm. Mild withdrawal symptoms such as dysphoria, drowsiness, and irritability can occur (Graziani, Milella, and Nencini 2008). In contrast to synthesised amphetamines, the potency of khat is considerably lower due to its plant form and the fact it is chewed.

The League of Nations and its Advisory Committee on Illicit Drug Traffic discussed khat in 1935, but no further action was taken. However, a shift in tone occurred in 1956 after the establishment of the United Nations, when its Commission on Narcotic Drugs (UNODC) published a report following a comprehensive review of khat. Although the report did not explicitly call for scheduling, it concluded: 'The observations, however superficial, that have been made show that khat may produce a definite intellectual and moral deterioration and that its social consequences may be serious' (UNODC 1956). Further evidence was deemed necessary, leading to the commissioning of a study on khat by the World Health

[5] This section focuses on the contemporary khat prohibition discourse in the UK. However, this discourse is grounded in racialised history of attempts to control khat and local people in former British East Africa and post-colonial politics in the region. Previous prohibitions in history—during British colonial rule in Kenya and in British Somaliland, and later by the Siad Barre regime in the 1980s Somalia, and in the USA in the 1990s, to name a few—reveal distinctively politicised and moralised landscapes of khat consumption and control measures (Anderson et al. 2007; Anderson and Carrier 2009; Hansen 2010).

Organization (WHO). The results were eventually published in 1964 (Halbach 1972) and concluded that ‘problems connected with khat and amphetamines should be considered in the same light because of the similarity of their medical effects’ (UNODC 1964). Soon after, the 1971 UN Convention listed the active alkaloids in khat, cathinone and cathine, under Schedules I and III, respectively. The control of khat in plant form was left to individual countries. However, the association of khat with more potent psychoactive substance has led to its designation as a ‘natural amphetamine’ (Kalix 1988; 1996). This has contributed to exaggerated claims about its causal role in social problems, health issues, and even mortality (Corkery et al. 2011a; 2011b; Critchlow and Seifert 1987; Kassim, Croucher, and al’Absi 2013).

Throughout history khat control reflects the complex interplay of morals, politics, and science, leading historian Lee Cassanelli (1986) to characterise khat as a ‘quasilegal commodity’, capturing its fluctuating status between a harmful drug, cash crop, and innocuous substance. Today, khat has been prohibited in most Global North countries, but black-market activities and khat consumption persist within diaspora communities (Nabben and Korf 2017; Swain 2017). In producing countries where it remains legal, studies reveal tensions between local khat economies supporting the livelihoods of many, and global drug policies framing khat as an obstacle to economic development (Beckerleg 2010b; Carrier 2007; Gezon 2012; Hansen 2010). Susan Beckerleg aptly captures this ambiguity: ‘Controversy bedevils the substance, with one camp arguing that use of khat has serious ill effects on the health, sanity, and social well-being of consumers and their families [. . .] A second camp denies that khat does any significant harm’ (2010a, 1). In the UK context, this controversy becomes more evident because the perception of khat as a stimulant has become deeply intertwined with the changing dynamics of its Somali diaspora.

‘Khat problem’ in the UK Somali diaspora

Before the late 1980s, the consumption of khat among UK Somalis was largely a domestic practice and ‘symbolic of a cultural revival among the communities from the Red Sea region, who were then taking renewed pride in their culture of origin’ (Anderson et al. 2007, 151). However, the outbreak of the Somali Civil War in 1989 ushered in profound changes to the patterns of khat use. As Somali refugee settlement grew during the 1990s, khat imports increased to cater to the burgeoning diaspora in the UK and beyond (Anderson et al. 2007, 153). In contrast to earlier patterns, Somali male refugees started frequenting mafrishes, to bond, reminisce, and offer mutual support in the face of displacement (Klein and Beckerleg 2007). Yet, as Axel Klein (2007) observed, there were no established customs to prevent excessive consumption (see Carrier, this issue, on ‘taming *handas*’) exacerbated by forced migration.

By the mid-2000s, the connection between the UK's khat market and the Somali diaspora had been firmly established (Klein 2008). Media portrayals intensified these concerns, depicting Somalis as particularly susceptible to khat's adverse effects (BBC 2005; 2008; Jha 2004). Although many in the diaspora appeared to consume khat without issues, growing worries emerged about the link between excessive khat use and negative post-migration factors (Anderson and Carrier 2011; Warfa et al. 2007). Somali refugees in the UK grappled with fractured families, economic hardships, dependency on welfare, and challenges in housing, employment, and healthcare (Cole and Robinson 2003; Harris 2004; Pollard et al. 2019). In this context, Warfa and colleagues (2007, 316) noted that 'widespread *khat* usage would also be expected to drain individual and family income and therefore exacerbate poverty levels and social problems.' Moreover, traumatic experiences raised concerns about potential links between khat consumption and mental health problems (Bhui and Warfa 2010).

These concerns lead to the 2005 ACMD review. The ACMD found no direct causal link between khat and societal or health-related harms. However, it noted that 'poor housing, poor education, social isolation, and poor health are common characteristics of those that use Khat' (2005, 28). The 2013 review reaffirmed these factors and emphasised that khat likely exacerbated pre-existing issues, among those who 'have been subject to adverse historical events in their own home countries, particularly civil war and long-term human rights abuses in Somalia' (31). It also highlighted the need for 'more formal capturing of epidemiological data about khat use among those accessing NHS services for help with drug misuse and related problems' (86). The Home Office interpreted this recommendation as indicating 'an absence of robust evidence', using it to justify khat prohibition as a measure to protect 'vulnerable members of our communities' and to 'protect the public from the potential harms associated with this drug' (Home Office 2013a; 2013b; Delegated Legislation Committee 2014). The Home Office's approach to khat prohibition was based on the assumption of its inherent potential to cause harm. Despite the ACMD consistently highlighting social determinants, their perspective was overshadowed by concerns about hidden risks associated with khat itself. This led to khat being treated as inherently harmful to everyone.

The most vocal opposition to khat emerged from the Somali diaspora itself.[6] Concerns revolved around the effects of khat on 'broken families', 'absent fathers', and fears of a 'lost generation' (Community Perspective 2013). Khat was held responsible for undermining post-civil war social, economic, and political restoration both at home and in the diaspora (Ermansons 2022; Hansen 2013). It also emerged as a gendered issue, with many women supporting and advocating

[6] Similar Somali diaspora anti-khat sentiments have been documented in the Netherlands where khat was banned in 2013 (Klein, Jelsma, and Metaal 2012).

for its ban. They saw mafrishes as symbols of failed social integration and a threat to family welfare (Klein and Beckerleg 2007). This opposition is also mirrored in economic concerns in places like Somaliland, where the financial burden of khat is seen as contributing to underdevelopment and household poverty (Hansen 2013), suggesting a broader economic and moral rationale behind women's leadership in the prohibition movement. Somali anti-khat activists distilled these anxieties into a political cause, framing khat as an active agent of harm.

Some experts likened this to moral panic (Anderson and Carrier 2006; Odenwald, Klein, and Warfa 2010). For instance, Warfa et al. (2007, 315) remarked: ‘The reification of the harmfulness of khat use can perhaps be better understood as a case of “moral panic”, in which the behaviour of a group, often a minority or sub-culture, is exaggerated or falsely projected as dangerous’. While the media contributed to this perception, the locus of the moral panic seemed largely within the diaspora itself, with anti-khat campaigners perpetuating stereotypes about khat (Awale 2013a; BBC 2012b). An activist report to the Home Secretary notably said: ‘The word Khat means “capture” within the Somali language, which refers to how it takes control over your life in a negative manner’ (Community Perspective 2013, 5). While this is not accurate (khat does not mean ‘capture’ in Somali), the statement explicitly ascribed agency to khat, implying its overpowering negative effects.

In response, the Home Office focused on ‘societal harms’, the most ambiguous domain (Anderson and Carrier 2006; Manghi et al. 2009). The absence of conclusive evidence of causality was taken as hidden evidence similar to that for fake drugs (Hornberger and Hodges 2023). Ironically, as I will show in the following sections, this assumption appeared to foreclose meaningful engagement. Describing khat as a harmful drug, whether accurate or not, portrayed the Somali community as both victims needing protection from the substance and contributors to their own marginalisation.

Ilwad: Turning points

In September 2014, at a workshop on war trauma in London, I met Ilwad, a Somali psychotherapist who arrived in the UK in the mid-1990s. When we discussed khat, Ilwad recalled being invited to consult the UK Parliament during the review in 2005 (ACMD 2005). Throughout our conversation she emphasised that not all Somalis who chewed khat experienced problems, and she stressed the same in Parliament: ‘As a psychotherapist, I went there from a neutral position because khat to Somalis is what alcohol is to Europeans’. Like many, she compared khat and alcohol in cultural terms, from which she derived public health implications. Her primary concern was the lack of adequate consideration of potential risks of

khat akin to those around alcohol. Ilwad thought that admission of commensurability would introduce public health interventions without radical steps such as prohibition. Her frustration with the lack of public health attention and provision of care to those who she saw as struggling with khat addiction increased over time:

> Back home, khat was a form of socialising, but I was aware as a psychotherapist that when Somalis came here with a trauma or whatever background, the consumption turned into something else. There was a lot of psychosis, mental illness associated with khat. So, I spoke to the Parliament, and I said, look, I am in the neutral position, but I think as much as there are addiction clinics and all of that, there should be khat addiction clinics somehow for the khat consumers. But no one paid any attention.

Ilwad's observation that 'no one paid any attention' highlights the dual threshold of epidemiological scope and cultural sensitivity at the intersections of drug policy and marginalisation. The ACMD report she consulted on stated: 'Use of the substance is very limited to specific communities within the UK, and has not, nor does it appear likely to, spread to the wider community. However, that is not to say that the use of Khat is without detrimental effects and its use should be discouraged' (ACMD 2005). To many Somalis, including Ilwad, such a conclusion meant their wellbeing was deemed of little importance. 'Khat addiction clinics' could have offered therapeutic interventions to address a harmful pattern of consumption in the diaspora. With a careful reference to 'association' rather than 'causality', Ilwad tried to engage with the epidemiological epistemological framework of policy debate on khat. She was familiar with peer-reviewed articles on khat that suggested association with some harms but, without established causation, it was impossible to elevate her concerns beyond what evidence-based discourse classed as anecdotal evidence.

Philosopher Gilles Deleuze asks: 'How do we account for a "turning point" in drugs, how do we determine at what moment this turning point occurs?' (Deleuze 2007, 153). For Deleuze, there is a turning point between 'vital' and 'deadly experimentation' in drug use when 'control is lost and the system of abject dependence begins [. . .] If there is a precise point, that is where therapy should intervene' (153–4). 'Vital experimentation' involves changes in perception of the world and generation of new connections through drug use. However, when such a turning point occurs, consumption of a drug distorts reality, reducing behaviours to destruction and disconnection. Ilwad described such a turning point for Somalis, particularly men. 'I can see the damage khat is doing to the Somali community and it has done a lot to my own personal family. My cousin is schizophrenic because of all the problems he was hearing from home [i.e., the civil war], and then using khat and not sleeping'. Yet both the 'close' personal and 'neutral' professional

positions of Ilwad run up against the disconnect between evidence-based discourse and decision-making in public health concerns of ethnic and racial minorities.

Scientific evidence usually seeks to determine harmful properties intrinsic to drugs themselves (Milhet, Bergeron, and Hunt 2013; Sessa and Nutt 2015). What counts as evidence depends on the form and meaning of information, and policymakers tend to prioritise technical and quantitative data over other forms of knowledge (Epstein, Farina, and Heidt 2014; Pearce, Wesselink, and Colebatch 2014). Yet, drug policy is not only derived from the material and epidemiological properties of substances, but it is also an outcome of political and moral deliberations within policy constellations (Stevens 2024; Liverani, Hawkins, and Parkhurst 2013; Monaghan 2011). This was the only opening offering anti-khat advocates the opportunity to argue for reframing khat as a harmful drug.

Comparisons of khat to alcohol foregrounded cultural and epidemiological commensurability that should have led to therapeutic equity, i.e., recognition that khat had a ‘turning point’ just like alcohol, where therapy should intervene. But there appeared little interest and sensitivity toward determination of such turning points beyond usual platitudes about ‘vulnerable members of society’ who needed protection from the drug. The MP Diane Johnson said during a House of Commons debate on khat prohibition in March 2014 that ‘the use of khat is part of a cycle that is extremely damaging and that leads to a range of social problems and to social exclusion’ (Johnson 2014). So does alcohol, as Ilwad and others noted. This root incommensurability points to the way categorisation of substances differentiate between ‘alcohol, drugs and tobacco’, reflecting deeply embedded historical, moral, and cultural assumptions about psychoactive substances in public and academic discourses. Many agree alcohol is a drug and is much more harmful than some internationally and nationally controlled substances (Nutt, King, and Phillips 2010; Robbins et al. 2007). The division between alcohol and drugs is indicative of powerful tropes of differentiation between licit and illicit drugs that take shape in political and public perceptions about substance harmfulness and character of their users (see also Room 2006). Any new substance under consideration already falls within the category of ‘drugs’. This might not align with scientific evidence yet often appears politically justified and morally right.

Time played a crucial role in the evolution of drug policy regarding khat. It took nine years and an ACMD review in 2013 before any significant policy changes were implemented. The lack of response to Ilwad’s cautionary advice highlights a missed opportunity to consider evidence-based approaches over prohibition. Throughout this period, the ACMD consistently recommended public health interventions, yet the government’s inclination towards a prohibitionist stance left

little room for nuanced perspectives on khat, categorising it as either entirely harmful or benign. The real issue lies not just in missed opportunities for a more balanced approach, but also in the shift of responsibility for health and wellbeing away from broader social determinants to focus narrowly on the drug itself. Approaches like this often 'fetishize and exaggerate the inherent, dangerous potency of particular substances, to create "problems" where none exist and fail to deal with real problems elsewhere' (Hugh-Jones 2007, 47).

Ilwad's frustration grew and, despite having reservations about a straightforward account of khat as harmful, she started to agree with the anti-khat activists. By the 2013 ACMD review, when the anti-khat advocacy was at its height, Ilwad was leaning towards prohibition but sceptical about its prospects. She recalled part of a conversation with a leading anti-khat advocate seeking her support: 'It's not emotion that is going to make the Home Office to ban khat, it's facts and we don't have those facts.' Ilwad was concerned about lack of a nuanced understanding of historical circumstances and turning points. For many Somalis who had fled the civil war, time and circumstance were consumption risk factors.

Although Somali calls for an intervention appeared to be formally answered, the substance of this response had become a measure of how much the government was genuinely interested in what people like Ilwad had to say (see also Kujog 2001; Patel 2008). When prohibition was announced, many did not believe it would happen. For the government, it was a legislative step to classify khat as a Class C drug, bringing its policy in line with other Western countries. For the Somali community members I spoke with, the issue was more about moral responsibility and welfare of their community.

Promise of a harmful drug

In December 2013, the local council asked a drug outreach NGO to distribute informative leaflets about the 'khat ban' in my fieldwork area. The leaflet outlined the changing legal status of khat and legal implications for consumers and traders (Fig. 1). It also noted help was available for heavy users of khat, directing people to the confidential support phone line. Two women distributing leaflets shared their apprehension with me about how they would be received, anticipating a lukewarm response from the Somali community. However, they were surprised by the positive reception and the community's willingness to assist in distributing leaflets. This outreach effort commenced well before prohibition. Initially leaflets did not specify a prohibition date. This was added following the vote in March 2014.[7]

[7] Given the coalition government in the UK at the time, theoretically the law might not have passed, with one coalition party, the Liberal Democrats, being against the prohibition, and the other, the Conservatives, unambiguously supporting it. Opposition party Labour was undecided.

In May 2014, the GOV.UK website published a downloadable 'fact sheet' in English, Amharic, Arabic and Somali (Figs. 2 and 3). The sheet made it to Somali cafés (it was even plastered on the walls), and people carried them around, pulling them out to discuss what all this meant. Although khat was still legal, the fact sheet depicted it as a harmful drug to be handled with white gloves, rather like criminal evidence. The rationale behind the prohibition, it stated, was to help protect 'local communities' from khat:

> Khat contains natural ingredients which are already controlled drugs both in the UK and internationally because they are harmful. *To help protect local communities from the potential health and social harms associated with khat* and to ensure that the UK does not become a hub for international khat smuggling, it will become illegal to produce, possess, supply and import or export khat without a Home Office licence (Home Office 2014; my emphasis).

Many Somali establishments displayed a considerable level of support for khat control, and this support especially stood out among consumers inspired by the promise that prohibition meant a change for the better.

Many khat consumers invested a great deal of hope in prohibition and compared how khat control made life better elsewhere. One man told me: 'I am chewing for years, I lose time, and have problems with health, mentally, family. Where [khat] is banned, Somalis are doing better.' There were other similar accounts: 'With [khat] you don't have time to move forward. This country takes long to do something about it.' And another proclaimed: 'Last time I chewed, yesterday. Now I put a lock on and threw the key into the sea.' He was full of determination to find employment or start his own business. Such references to lost time were prevalent indicating the anticipatory momentum of the prohibition. Their inspiration was also mixed with the distribution of responsibility between themselves and the government for the harmfulness of khat.

The prohibition was touted by anti-khat advocates as a solution to issues like family breakdown and unemployment among men frequenting mafrishes, who spend their limited welfare on khat. One of the primary motivations behind the anti-khat campaign was addressing the issue of 'absent fathers', with prohibition seen as a way to mend the gendered rifts fuelling community concerns over khat's harms. Women, who constituted many of the campaign's advocates, highlighted the risk of a 'lost generation', cautioning that an increasing number of young Somalis were using khat because they saw their father's chewing (Community Perspective 2013). Despite these concerns, there was no evidence to suggest a rise in khat use among second-generation Somalis (ACMD 2013). What these worries

seemed to underscore was the gendered dynamics of khat consumption in some families, where limited income was spent on khat, and time was spent away from home by the father as the patriarchal figurehead in Somali households.

However, too much weight was put on khat alone. In an ethnography on Somali British women, Liberatore notes: ‘Resonating with public discourses of moral crises and the dangers of “female-headed households”, these tropes [i.e., broken families; absent fathers] have tended to simplify the situation and assign the notion of ‘absent men’ too much explanatory power’ (2017, 89). Liberatore demonstrates that Somali households often experience fluidity in their composition and support networks, affecting daily life's ease or difficulty. My fieldwork observations aligned, showing that both women and men encountered significant challenges in employment, recognition of their education and underemployment, language proficiency, and untreated health issues—but found less exposure in anti-khat discourse.

While promotion of khat’s harmful potency by leaflet was anchored in anti-khat discourse, the narratives emerging from within the community sought to both highlight the drug’s inherent risks and address broader societal issues. For many khat-consumers, prohibition was a moment of regeneration. Their sense of wasted time was not just retrospective, it also revealed anticipation that the status of harms implied by the label of ‘facts’ on the leaflets would elevate khat to a substance worthy of therapeutic attention. The prohibition was supposed to be the beginning of change. However, such expectations appeared to extend way beyond that which policy makers had in mind. This discrepancy came to the fore in the identity of a *jaadkaholic*.

Figure 1: Leaflet announcing the khat prohibition (no-date version), with the same text in Somali on the reverse. Source: GOV.UK.

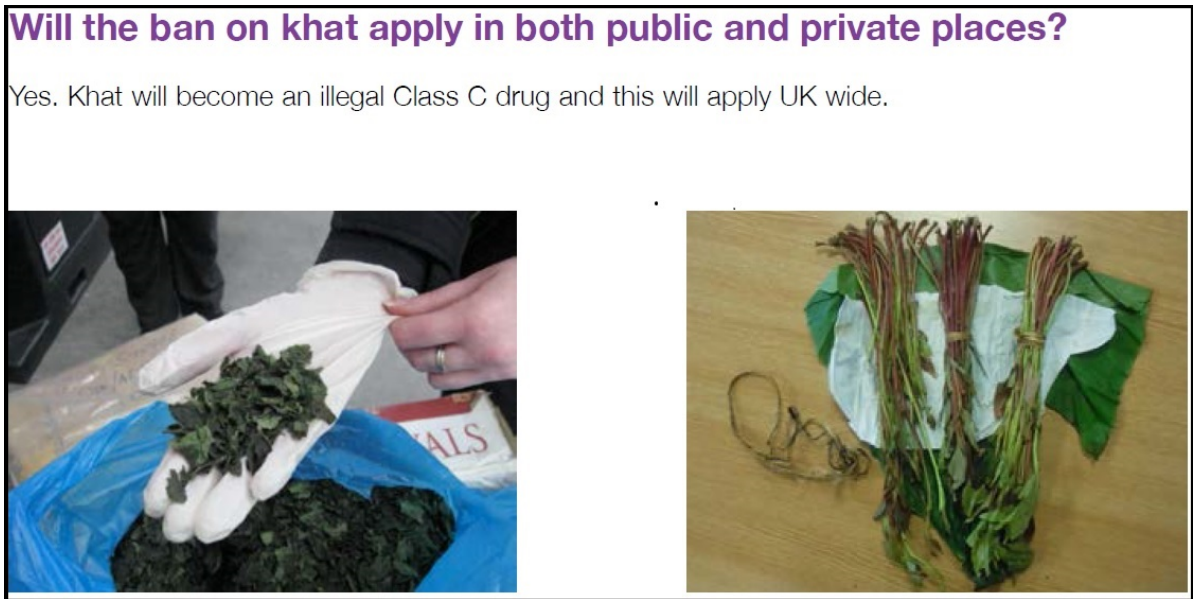

Figure 2: Fragment of the 'Khat fact sheet for England and Wales' depicting khat as a harmful drug. Source: GOV.UK.

Figure 3: Display on café door. 'Khat fact sheet for England and Wales' in English and Somali, and the prohibition leaflet (with added date). Source: author.

Jaadkaholics

The Somali terms for 'heavy users of khat' imply the often-noted adverse effects of khat on their social and moral relations with others. 'Always in mafrish' (*mafrishka kama baxo*) are those who spend most of their time chewing, do not go to the mosque, and sleep overnight in the mafrishes. 'Khat-eater' (*qaadkuu cunaa*) means the opposite of eating 'good food'—an attribute of a good life—and therefore means not taking care of oneself or others and leading an unhealthy life. 'Khat-lover' (*qaadkuu jecelyahay*) is someone who values khat more than their children and spouse, and neglects responsibilities of others.

Among these terms, jaadkaholic stands out as a neologism and a portmanteau composed of alcoholic and Somali *jaadka* (khat) and, like other terms, carries strong moral implications. A jaadkaholic is someone with no control over the amount and frequency of their khat use, and this absence of control, entwined with the loss of moral personhood and agency, is seen to either manifest as 'madness' or as perceived anti-social and unbecoming behaviour. One interlocutor summarised: 'Permanent problems, temporary solution. They lose kids, money, time. In the evening, they chew and make plans for the future, but when they wake up, the problem is still there.' Jaadkaholics were being deceived by their momentary sense of wellbeing, by the brief effects of *mirqaan* (khat high), which

reduced their daily life to mere chewing and sustenance. ‘Although, they might think [khat] is helping . . . in reality [khat] can never help. If a person chews half a day, he becomes jaadkaholic.’ The term carried significant moral weight because they were also known to owe money and solicit others to purchase khat for them, as well as skip Friday prayers and sleep in mafrishes.

Evoking Western biomedical frames of reference, the term ‘jaadkaholic’ reinforces perceived commensurability between alcohol and khat. Alcohol is *haram,* and its consumption is stigmatised, particularly if it manifests in public and inebriated state. Within Islamic law, Somali interpretation of khat use is debated and there are currently three main positions on khat—*halal* (permitted), *makruh* (discouraged or detested) and *haram* (forbidden)—which are found across khat-using Muslim populations, including Somalis (Douglas and Hersi 2010). However, extensive khat consumption was disapproved of and stigmatised. Although jaadkaholics were usually held responsible for their own problems, many of my interlocutors acknowledged there were few therapeutic options available, no equivalent of Alcoholics Anonymous and no support from GPs who, they said, do not know anything about khat:

> If the government does something, like bans [khat], it needs to put some system in place to deal with it. But there is nothing. Alcoholics have AA, but there is no such thing for khat users.

The above thoughts, echoing Ilwad’s reflections, outline the harm of khat largely as a consequence of sustained neglect by public health and therapeutic services. Anthropological studies of medicalisation have emphasised emergent cultural and political agencies of people who engage with institutions, suggesting the concept reveals more than rearticulations of social and political ills as issues of health and medicine. As Behrouzan notes, people respond to a ‘sanitized language of biomedicine’ in a way that strengthens their political agency (Behrouzan 2016; see also Béhague 2009; Rose 2007). Similar arguments are made in the literature on therapeutic and biological citizenship (Nguyen 2008; Petryna 2002). In this context, the term ‘jaadkaholic’ highlights the stigma and debate within the Somali diaspora about the harms of khat, paralleling concerns with alcoholism but emerging from the absence of equivalent support systems and political commitment.

Here, the story of Fuaad, a self-identified jaadkaholic*,* becomes illustrative of the personal struggles with what many understood to be khat addiction embedded within the absence of support and marginalised status. Fuaad described himself as a jaadkaholic*.* He recalled using khat from an early age. Like others, he spoke frequently about losing time and his livelihood: ‘[Khat] is a drug. For me it’s a drug. I chew for 28 years. I started when I was 11–12 years old, back in Somalia. I would like to stop’. He continued:

> When you chew, you're nervous, and tired, you think people talk behind your back. You cannot get enough sleep. Because you're nervous, you lose job, lose family—this is what happened to me. I lost my dignity. I'm homeless, begging people.

When he said this, a younger man passing by intervened: 'Ban the khat, ruins community, ruins lives!' Fuaad nodded in agreement and added: 'There's a place for alcoholic people, not for jaadkoholic. Jaadkoholic, it's drug-addicted. I have to admit, I'm drug-addicted.' Reinforced by the exclamation of a passer-by, Fuaad's reiteration of the harms of his khat consumption does sounded like a mantra—these grievances were repeated by many.

Patterns running through such accounts about harm—loss of employment and income, undermined health, social and family life—were imbued with expectations that prohibition would not only recognise khat as a harmful drug but would also enable transformation into a worthy member of his community and participation in society as a 'healthy citizen':

> When it will be banned, maybe I will look for work, study. Now I just come here and chew. [Khat] undermined my morals and my life economically, too. I don't have work, don't have benefits. Friends support me, give food, cigarettes, [khat]. I have been homeless for last two years. If I stop chewing, first I would find work.

Indeed, it was 'here' in the discursive space of khat prohibition that Fuaad became painfully aware of his predicament: 'In Somalia whole community chews. Here not all chew, those who chew become worthless.' His account bears similarities with shame, self-blame and guilt found in moral injury resulting from events or experiences that have transgressed deeply held values (Griffin et al. 2019). However, there was no identifiable event or experience with khat as a causal agent at its core. It was possible to model khat addiction on the biomedical category of alcoholism, but the harm was configured by circumstance, being a refugee, fleeing Somalia, and consuming from an early age. The moral script for being a jaadkaholic was organised around problems of social marginalisation, intra-community stigma, and individual responsibility.

Self-identification as a jaadkaholic was a precursor to membership in a society where addressing harm would offer a pathway not only to improved health but to moral therapeutics. Fuaad explained his predicament but did not attempt to absolve himself. Instead, he appeared to conform to a moral judgement that his extensive khat use entailed, and in doing so, showed his readiness to change:

> I want [khat] to be stopped. I support those who stop it, in the UK, Somalia, any other country. Make it like all other drugs. Prohibition will make me do

> something. Successful Somalis don't chew, they don't smoke. Us who chew, we have been missing opportunities in life. Alcoholic or jaadkoholic, it is similar. It's illness, yes, but worse than alcoholic—there's no help, there is no psychiatry of khat.

Although his account may appear self-pathologising, the category of jaadkaholic seemed to resist medicalisation that would render harms of khat as a problem of psychopharmacology and individualising 'substance use disorder'. Perhaps, epidemiological frameworks focusing on causality were misled by the assumption that scrutinising standard variables like withdrawal, tolerance, and dependence, would clarify the nature of khat addiction within the community. Perhaps even, the underlying logic of jaadkaholic was organised around the de-medicalised spatial and temporal circumstances of people like Fuaad. Jaadkaholic—distinctively normative in its orientation—expressed a condition of 'vulnerable members of our communities' that prohibition was meant to protect, if only the politics at the centre of making of a harmful drug would actually strive to benefit them.

Conclusion

In this article, I have traced how a drug, initially deemed not harmful from an evidence-based viewpoint, became categorised as a controlled substance. The discourse surrounding the prohibition of khat centred on negotiations of drug harms, creating an anticipation among many of my interlocutors that classifying khat as a controlled substance would herald positive changes for their lives and the broader community. However, this period also saw missed opportunities to address the potentially problematic patterns of khat consumption. I demonstrated that understanding the perceived harm of khat for certain users necessitated an examination of their specific social and biographical contexts, alongside the material and historical entanglements of their khat use. My interlocutors, who foregrounded the concept of khat addiction and those who took on the identity of jaadkaholics, sought not just therapeutic interventions but called out the political and moral responsibility of the government to 'protect vulnerable members' of Somali communities. Yet, the absence of evidence regarding khat's causal role in medical and societal harms translated into a lack of public health focus, paradoxically because prohibition, as a political act, was predicated on inflating khat's role as a harmful agent.

Reflecting on the government's perceptions of their community, my interlocutors pinpointed a critical issue in contemporary drug control politics: the disconnection between policy and its practical application. As Decorte (2011, 37) highlights: 'The expert tries to grasp what it means to use a substance, instead of trying to understand a whole lifestyle'. Throughout the consultations on khat, many overlapping turning points were missed, escalating khat into a harmful category.

Not every turning point must necessarily prefigure a prohibition. The notion of harm, present in various registers and timeframes, shifts the substance ‘in itself’ between being an innocuous entity and a harmful drug. The prohibition itself, as a bureaucratic and legal event, possibly becomes a significant turning point as a marker of non-response-related harm. In other words, the act of prohibition can serve as a pivotal moment, symbolising harm that arises not directly from the drug use but from the regulatory response to it, by failing to address the underlying issues or needs of the community.

Concerns have also been raised about the effects of khat prohibition and criminalisation on an already marginalised community. The prohibition arguably marginalised not so much the khat users, despite the real risk of criminalisation, but the broader community itself by relegating the responsibility for ‘healthy citizenship’ to the already vulnerable Somali diaspora while ostensibly aiming to protect them. It is challenging not to view khat prohibition as both a regulatory measure and a symbolic act further distancing mainstream UK society from engaging with a marginalised group and their issues.

What would approaching drug harms as an analytical or theoretical concept reveal about the nature of drug consumption and control? Whether explicitly or implicitly, harm and harmfulness are often taken as self-evident, empirical categories. The challenge lies in locating harm when consumption patterns of purportedly more potent drugs can remain safe, as seen in the literature on drug pleasures and functional use, while substances deemed safe can produce harms (Hart 2022; Kiepek et al. 2019; Lende et al. 2007).

Harm can be viewed as an arrangement of boundaries that traverse ambiguities of bodies, language, objects, and environments, thereby momentarily transforming them into tangible indicators of risk and suffering. This perspective calls for reconsideration of the traditional separation between the pharmacological and sociological domains where drug-related harms are understood, providing a stage for drugs politics to play out. Drugs, khat included, embody ambiguity, attesting to their affinity with the notion of *pharmakon*, always fluctuating between ‘remedy’ and ‘poison’ (Montagne 1996). The question presents itself to be about time and place of the boundary between remedy and poison—cutting through biochemistry and pharmacology, markets and paraphernalia, the history and ecology of places of consumption, bodies, and environments—as an ongoing point of contention at the heart of ambiguity that will always surround drugs.

Most of my interlocutors claimed responsible khat use, yet almost everyone knew someone who was ‘using too much’. The prohibition recast khat as a Class C ‘controlled drug’ and a bustling urban environment with Somali establishments, shops and cafés and a few mafrishes experienced a major change in its local

economy and lifestyle. Mafrishes closed, small businesses lost income streams. The price of khat rose by 900% in a few weeks, from £3 per bundle to £25–£30, and people who continued to consume complained that now they needed much more money to do so. One khat consumer summed it up: ‘It was not a drug then, now khat has become a drug.’

Authorship statement

I am the sole author of this article.

Ethics statement

The data for this article were collected for the author’s doctoral dissertation project, which was approved by the King’s College London Research Ethics Committee (CREC Ref: GSSHM/13/14-8).

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