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UNIVERSITY OF CAPE TOWN
DEPARTMENT OF SOCIAL DEVELOPMENT



**AN ANALYSIS OF THE IMPLEMENTATION OF THE OPERATIONAL
ALCOHOL AND DRUG STRATEGY 2007-2010 IN THE MARBLE FLATS
COMMUNITY: A CASE STUDY**

A minor dissertation submitted in partial fulfilment of the requirements for the award of the
Degree of Masters of Social Science in Social Development

By

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The financial assistance of the National Research Foundation (NRF) towards this research is hereby
acknowledged. Opinions expressed and conclusions arrived at, are those of the author and are not
necessarily to be attributed to the NRF.

PLAGIARISM DECLARATION

This work has not been previously submitted in whole or in part for the award of any degree. It is my own work. Each significant contribution to, and quotation in this dissertation, from the work, or works, of other people, has been attributed, and has been cited and referenced.

Signature:

Date:

University of Cape Town

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ABSTRACT

This dissertation focused on two key issues that concern policy implementation in South Africa. Firstly, the researcher analysed the extent to which formal government policy implementation successfully occurs. Secondly, the researcher analysed the implementation of a specific policy, the Operational Alcohol and Drug Strategy 2007-2010 (OADS), through the use of a case study in the Ottery Marble Flats community, in order to illustrate the major issues concerning policy implementation in South Africa.

Fourteen respondents took part in semi-structured interviews that focused on the implementation of the OADS in the Ottery Marble Flats community. A purposive sampling method was adopted and the techniques of snowball sampling were relied on. The main research findings are that governments' responses are not coordinated to ensure that policies are being implemented and the inclusion of the people at grass roots level is largely overlooked when formulating government policies. Moreover, government fails to ensure monitoring and evaluation throughout the life cycle of its policies.

Recommendations were made to National Government and Local Government to improve policy implementation, and recommendations were made to Non-governmental Organisations (NGOs) and researchers. A major recommendation to local government and the NGO sector is greater partnerships and coordinated responses formulating policies to ensure the successful implementation thereof.

ACRONYM LIST

AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
CDA	Central Drug Authority
CRU	Community Residential Units
DSD	Department of Social Development
HIV	Immunodeficiency Virus
MA	Crystal Methamphetamine
NDMP	National Drug Master Plan 2006-2011
NGO	Non-governmental Organisation
NYP	National Youth Policy 2009-2014
OADS	Operational Alcohol and Drug Strategy 2007-2010
OECD	Organisation for Economic Cooperation and Development
PIU	Policy Innovation Unit
SACENDU	Southern African Community Epidemiology Network on Drug Use
SALDRU	Southern Africa Labour and Development Research Unit
SAPS	South Africa Police Service
SAU	Substance Abuse Unit
UNDP	United Nations Development Programmes
WHO	World Health Organisation

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 Introduction

This dissertation focuses on two key issues that concern policy implementation in South Africa. Firstly, the researcher will explore the extent to which formal government policy implementation successfully occurs. Secondly, the researcher will analyse the implementation of a specific policy, the Operational Alcohol and Drug Strategy 2007-2010 (OADS) (refer to Appendix A), through the use of a case study in the Ottery Marble Flats community.

In this chapter, the researcher will establish the rationale of the study and describe the background to the study. Thereafter, the researcher will formulate the problem statement and the research topic. The research questions and its main objectives will be stated. Next, the researcher will clarify the concepts central to this study. In addition the researcher will give a brief outline of the methodology adopted in this research. Finally, an outline of the chapters to follow will be laid out.

1.2 Rationale for the Study

Over the past few decades, policy implementation in South Africa has revealed itself to be relatively ineffective in translating theory into reality. Brynard and De Coning (2006) regards the implementation of policies and programmes to be under-researched and often neglected despite it being one of the most critical pillars on which planning is based. Similarly, Dennis Rondinelli (1993) provides a substantial amount of evidence which suggests that translating plans into action continues to be one of the most difficult tasks facing development administrators in the 21st Century. Despite various attempts to rectify this problem, the gap

between policy formulation and implementation continues to widen. An extensive review of experience over the last two decades in development and policy studies shows that development policies, projects and programmes deviated widely from preconceived plans, despite the detailed and comprehensive requirements it entailed (Rondinelli, 1993).

Government Policies can be seen as powerful tools used to address social and economic problems. In the 1960s and 1970s, policies became the primary means through which governments of developing countries translated their plans into programmes of action (Rondinelli, 1993). According to David Gil (1992), social policies are designed to influence the overall quality of life in society. Hence, there is an urgent need for research to be done in policy formulation and implementation as the literature argues that there is a substantial gap between policy formulation and implementation (see Kallonga, 2010; Makinda, 2005; O'Toole, 2000). This gap often results in exclusion and marginalisation of the most vulnerable groups in society (Kallonga, 2010).

The broad issue of policy implementation will now be addressed by focussing on a specific policy in a specific place - the OADS policy in the Ottery Marble Flats community. The motivation for selecting the OADS policy stems from the reasoning that substance abuse is high on Local Government's agenda and is shown to be intricately connected to academic failure (Hawkins, Catalano & Miller, 1992), crime (City of Cape Town [c], 2009) and risky sexual behaviour (Research Triangle Institute, 2008). For instance, Myers and Parry (2002) note that substance abuse is associated with declining grades and academic difficulties. Furthermore, the implementation of substance abuse policy has been identified as particularly problematic by the Department of Social Development (DSD) (2008). According to the DSD (2008) and the Central Drug Authority (CDA) (2009), the

successful implementation of Substance Abuse Policy is hampered by countless challenges. These challenges include: “lack of resources; difficulty in obtaining accurate and current statistics on the supply and demand of alcohol and illicit drugs in South Africa; an out dated legislative framework; limited opportunities/platforms for sharing information; and the geographical position of South Africa” (CDA, 2009). Hence, the purpose of this study is to support government initiatives that contribute to successful policy implementation.

The above-mentioned are amongst the many challenges of policy formulation and implementation faced by administrators in the 21st century. However, nearly two decades ago, Rondinelli (1993) listed similar constraints to development planning, such as “difficulty in defining goals and objectives precisely, lack of adequate data, inadequate understanding of social and cultural conditions, political influence and pressures and failure to include intended beneficiaries in decision-making” (1993: 105). This analysis is not time-bounded, as we find that policies are still vulnerable to the same challenges and constraints.

This research study attempts to contribute to literature that seeks to close the gap between policy formulation and implementation as well as to promote improved implementation. Through analysing the OADS policy, this study attempts to address the challenges faced in policy formulation and implementation in a specific community. However, this study population serves as a pilot; the research methodology may easily be replicated in other contexts.

The development of the OADS policy stems from the revision of the National Drug Master Plan 2006-2011 (NDMP) which was drafted in accordance to the stipulations of the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992). The NDMP stipulates

that particular government departments are responsible for drawing up operational plans referred to as ‘mini-drug master plans’ in line with the core objectives of the NDMP (Department of Social Development, 2006). Hence, the OADS policy serves as Local Government’s operational plan as mandated by the NDMP. Thus, one can connect the infancy of this policy with substance abuse services in societies such as the Cape Flats, where there seem to be few comprehensive interventions focusing specifically on addressing the impact of substance abuse on individuals, families and the community.

A case study research design is undertaken to analyse the implementation of the OADS. The purpose of this research study is to use the case study to illustrate the major issues concerning policy implementation. The analysis of the implementation of the OADS policy is set in a particular historical and geographical context where the implementation of the OADS as a social policy is relevant to highlight the broader issues facing policy implementation, being confronted in South Africa.

This case study locates itself within a specific geographical context as the entire Cape Flats is beyond the scope of the study. The issue of substance abuse was selected because it is a social problem that severely negatively impacts on the quality of life of this community and this particular community has been neglected in terms of academic research. In addition, there is a high rate of school drop-out and crime; which can partly be accounted for by the increasing abuse of substances (Adolf, 2009; March, 2009). Furthermore, the researcher has engaged with members of the Ottery Marble Flats community and discovered critical issues faced by people living there on a daily basis as a result of substance abuse. Thus, Ottery Marble Flats community is selected as the case study site for the analyses of the implementation of the OADS policy.

Furthermore, Ottery Marble Flats community was selected as the case study site because it is a community that the researcher is familiar with and is of a great concern to the researcher. In addition, substance abuse is slowly gaining acknowledgement as an area needing serious attention. This was highlighted when the previous mayor (now the Premier of the Western Cape), Helen Zille, placed the issue of substance abuse high on Local Governments' agenda for immediate intervention.

The OADS policy focuses both on alcohol and drug-related issues in the City of Cape Town. However, for reasons of specific focus and manageability, this research paper will focus more on the drug related section of the policy and its attention on drug related issues in local communities.

One of the primary contributing factors concerning the topic selection for this study is that the researcher's area of interests lies in policy development, evaluation and implementation. The researcher is particularly interested in effective formulation and implementation of policy to address socio-economic problems faced in South Africa.

Social and public policies are used as tools for intervention in the various socio-economic issues faced by societies. This study aims to contribute to the knowledge base of policy formulation and the analysis of policy implementation. This will be done through analysing the implementation of a social policy.

1.3 Background to the Study

1.3.1 Geographical Context

This research study aims to undertake a case study of the implementation of the OADS as a social policy aimed at addressing substance abuse related issues in the City of Cape Town. The OADS is aimed at “effectively and sustainably managing the substantial and rapidly growing drug and alcohol related challenges facing our society” (City of Cape Town, 2007: 3).

The Marble Flats community was originally called the “Skurwe Fletse” – an area more formally known as Ottery Marble Flats. The ‘Skurwe Fletse’, built in the late 1960s, is better known as the ‘Marble Flats’ after its name change in 2000 by the then Councilor Achmat Brinkhuis (Petersen, 2010). It consists of forty-three four-storeyed blocks and is situated between the borders of Daniel Avenue and Ivan Road in Ottery in Cape Town, South Africa (Pollack, 2010) (refer to Appendix B).

The Marble Flats community in Ottery is a sub-section of the bigger Ottery area. This study only focuses on the Marble Flats community since a study on the general larger Cape Flats community is beyond the scope of this study. To date, there has been no census that focuses on the demographic details of this sub-section of Ottery. However, the Census 2001 provides useful data on the broader Ottery area. The community consists of 14 662 people, of which 48.2 percent are male and 51.7 percent are female. Of this total population only 26.3 percent has grade 12 and 0.5 percent has higher education. Of the economically active people, 6 627 are employed while only 562 are unemployed; however there are 2 843 economically inactive people (City of Cape Town [b], 2009). From these figures, one can deduce that the area is doing well economically and socially, however, it is still in need of economic and social

development that focuses on less developed and marginalised parts of the area such as the Marble Flats.

One such socio-economic problem, namely substance abuse, poses a great threat to marginalised communities such as the Cape Flats. The Cape Flats is a very large geographical area and according to the City of Cape Town (2009), it is defined as the “Metro South East Sector” which lies “north of Table Mountain and now forms a large part of the metropolitan region of Cape Town” (City of Cape Town [a], 2009).

The Marble Flats community experiences a critical concern with substance abuse. Personal communications with the Councillor of Ward 66, Mr George March, a housing official, Mr Basil Peters and the Principle of Lotus Senior Secondary, Mr Adolf confirmed that substance abuse is a serious social concern in the Marble Flats.

According to the Southern African Community Epidemiology Network on Drug Use (SACENDU) (2009), substance abuse is most common to Cape Flats communities, and Crystal Methamphetamine (MA) has been identified as one of the most common substances of abuse, along with alcohol, cannabis and heroin. Together, they comprised 89 percent of all patients admitted for substance abuse between July - December 2008 across 24 Specialist Treatment Centres in the Western Cape (SACENDU, 2009). In particular, there has been a huge increase in the use of MA in Cape Town since 2002 where only 0.3 percent of patients admitted for substance abuse used MA as their primary or secondary substance, to a staggering 46 percent in 2006 (Pluddermann et al [a], 2008). These concerning figures emphasize the intensity and severity of substance abuse in Cape Town and the greater

Western Cape. However, according to the City of Cape Town (2009 [c]), these figures are estimated to be much higher than actual figures have been reported.

Andreas Pluddemann (2009), a prominent scientist and researcher in this field of study writes that that the use of MA is becoming a global issue. Research has shown that this drug has been more powerful than any other drug which hit the market and its rates of increase over the years has been the fastest.

Pluddemann (2009), among others, notes that Cape Town faces the worst MA addiction in the world, “It is a crisis which nobody knows how to deal with completely and effectively” (Kapp, 2008:1). According to Pluddemann (2009), Cape Flats coloured communities are most vulnerable to MA addiction because it is cheap and easy to access. It was initially used by gang members, but was soon used throughout the communities. A common trend described in Pluddemann’s research and many others such as Leggett (2003), SACENDU (2009) and Harker et al (2009), is that MA usage is most common amongst coloured males across the Western Cape.

Most of the research on MA use and addiction is concentrated in the Western Cape. Very limited research has been conducted on specific towns or communities. However, the data and reports suggest that MA use has escalated dramatically in areas of mixed race or rural dwellings due to declining socio-economic conditions (Pludderman, 2009).

1.3.2 Why the Cape Flats?

Vincent Williams describes the Cape Flats as the following:

[T]he Cape Flats consists of a vast number of townships where the majority of coloured and african¹ people live. As is consistent with the composition of the population, most of the townships are coloured townships and only four are home to africans. An interesting phenomenon, which clearly reflects apartheid planning, is that african and coloured townships, in some cases very close to each other, are separated by open strips of land, a highway or a railway line. It is amazing how effective these strips of ‘no mans land’ were, in keeping African and coloured communities separated (William, 2009: 1).

Hence, the Cape Flats serves as a very relevant site for this study as it portrays much of the socio-economic dimensions of substance abuse relevant to the policy being analysed. Samson (2007) states that the Cape Flats has always been portrayed as undesirable. In the past it was known for lacking basic resources and amenities such as telephone lines and police stations, today it is well known for its high levels of crime, gangsterism and drug flow (Samson, 2007). According to Venter (1974: 86), “the Cape Flats is an unpleasant area in which to make a home, it is windswept for much of the year and often partly flooded during the winter months”. Yet, it has become home to close to a million people as a result of the stringent Group Areas Act imposed and enforced by the Apartheid Government.

¹The use of the term ‘African’ is largely debated in contemporary literature. For the purpose of this study, ‘African’ people include all Black South Africans.

These historical facts formed the basis for most of the social problems faced by communities on the Cape Flats. Substance abuse is one such extreme social problem, and to a certain extent, its severity can be accounted for by the historical legacy of apartheid. Even though the use of MA only became dominant in the late 1990s, Coloured communities on the Cape Flats were always vulnerable to these substances as they faced a wide range of socio-economic problems such as social exclusion, poor family support, poverty and unemployment.

1.3.3 Significance of Policy

John Kingdom (1984), in his *Agenda, Alternatives and Public Policies*, notes that a policy community and key policy entrepreneurs with the motivation, political skills and opportunity to invest their own energy and political resources in the shaping of political issues are key in addressing pressing policy issues. Hence, the creation of good policies can be used as a vital tool for eradicating the problem of substance abuse in the Cape Flats. While the OADS is identified as a policy with this goal, this research study aims to identify whether this policy has achieved its objectives, in a particular community as a case study.

It is clear that the need exists for a comprehensive policy to respond to the drug problems in Cape Flats communities. While the OADS serves as such a policy, there are serious questions with regards to its implementation.

1.4 Problem Formulation

The focus of this research study is to analyse the implementation of the OADS policy, using the Marble Flats as a case study. The purpose of the research study is to examine the policy implementation concerning the issue of substance abuse in the Ottery Marble Flats. The main

goal is to analyse if the policy is effectively or ineffectively implemented and explore the challenges encountered.

1.5 The Research Topic

An analysis of the implementation of the Operational Alcohol and Drug Strategy 2007-2010 in the Ottery Marble Flats community: A Case Study.

1.6 Research Questions

The main research questions for this study are:

- Has the OADS policy been implemented at all in the Marble Flats community?
- Which of the objectives identified in the OADS policy have been implemented in the Marble Flats community?
- What challenges and successes have been experienced in the implementation of objectives of the OADS policy in the Marble Flats community?
- What impact has the implementation of the OADS policy had in the Marble Flats community?

1.7 Research Objectives

The main objectives of this research are:

- To explore participants' perceptions of whether the OADS policy has been implemented in the Marble Flats.
- To explore the participants' perceptions of whether the objectives of the OADS policy have been implemented in the Marble Flats community.

- To identify the challenges and successes experienced in the implementation of the OADS policy in the Marble Flats community.
- To obtain participants' perceptions of the impact of the implementation of the OADS policy in the Marble Flats community.

1.8 Concept Clarification

In this section the researcher will clarify the central concepts which are used extensively throughout the study. These are *implementation* with regard to substance abuse policy. This requires the researcher to clarify the concept *policy*. A specific type of policy is of particular importance in this study, namely *social policy*, which requires clarification. Furthermore, the researcher will provide clarification on *Cape Flats* and *Community* as used throughout the study.

1.8.1 Implementation

The argument presented here is premised on the definition of implementation provided by Brynard and de Coning who states that: "implementation will be regarded as the (successful) conversion of mainly physical and financial resources into concrete service delivery outputs in the form of facilities and services, or into the concrete outputs aimed at achieving policy objectives" (2006:183).

Hence, the implementation of the OADS is primarily concerned with navigating a course of action and making sure that it is carried out. The implementation of the OADS includes, amongst others, access to information and access to credible treatment centres. Accordingly, implementation is generally regarded as a physical activity, the actual process of delivering

the policy. The Marble Flats community lacks both of these services, information is limited and access to credible treatment centres is hampered by costly transport.

1.8.2 Policy

In its most general sense, the term *policy* can be described as “a statement of intent” (Cloete, Wissink & de Coning, 2006: 3). In this research paper, the OADS is a policy with the intentions of eradicating substance abuse at a local level. A policy specifies the basic principles to be achieved in order to reach certain goals (Cloete et al, 2006). The ultimate goal of a policy is to pursue the public good by enhancing civil society and social justice (Raadschelders, 1999).

1.8.3 Social Policy

The term social policy is “not a technical term with an exact meaning” (Gil, 1992: 3). It draws from different disciplines, from public policy to economics to social development. A broad definition offered by Ramesh Mishra (1980: X) refers to social policy as the “aims and objectives of social action concerning needs as well as the structural patterns or arrangements through which needs are met”. Furthermore, David Gil (1992: 3) highlights that the core function of social policy is “the reduction of social inequalities through redistribution of claims, and access, to resources, rights, and social opportunities”. The OADS is a social policy which responds to the escalating social concerns associated with substance abuse. The researcher will evaluate the OADS policy as a structural arrangement to address the socio-economic issue of substance abuse in the Ottery Marble Flats.

1.8.4 Cape Flats

According to the geographical definition provided by the City of Cape Town, the Cape Flats is defined as the “Metro South East Sector” (City of Cape Town [a], 2009) or more commonly known as the Cape Metropolitan Area. The Cape Flats encompass deep issues, relationships, cultures and traditions. Chris Ledochowski (2005: 1) refers to the Cape Flats as “a vast stretch of exposed sandy wetlands that lies north of Table Mountain and which now forms a large part of the metropolitan region of Cape Town.

The Ottery Marble Flats community is a very specific geographically located community within the Cape Flats and serves as the site for the Case Study.

1.8.5 Community

The notion of communities emerged as early as the 1900s and was then already complicated to precisely define. John Western (1996: 163) writes of the concept of community as “value laden but also incapable of a definition ... the term appears to be a morass of indefiniteness”. Contrary to Western (1996), Amitai Etzioni (2003) defines community with reasonable precision. Etzioni (2003) defines a community using two characteristics: “first, web of affect-laden relationships among a group of individuals, relationships that often crisscross and reinforce one another, and second, a measure of commitment to a set of shared values, norms, and meanings, and a shared history and identity - in short, to a particular culture” (Etzioni, 2003: 4).

According to World Net (2011: 1), a community can be defined as “a group of people living in a particular local area”. Thus, a community can also be associated to its geographical boundaries.

The Ottery Marble Flats is therefore characterized as a community because of its geographical boundaries and shared values, norms, history and identity.

1.9 Research Methodology and Design

1.9.1 Research Methodology

This study adopts an explorative, qualitative research methodology. This allows the researcher to collect large amounts of data, quickly, but also have depth in the data (Greef, 2002).

1.9.2 Research Design

A case study research design will be used in this study. This study understands a case study as defined by Robert Yin (2009). According to Yin (2009), case study research brings about an understanding of a complex issue or object and can “extend experience or add strength to what is already known”. A case study can also be a group (such as a family), an institution (such as a school) or a community (such as a town) (Gillham, 2000).

Given the understanding that the implementation of programmes differs in different contexts, a case study through the use of semi-structured interviews and field visits was deemed the most appropriate research design to explore the implementation of the OADS in the Marble Flats community.

1.9.3 Sampling Methodology

According to Arkava and Lane, the term research ‘population’ refers to “individuals in the universe who possess specific characteristics which are relevant to a particular study” (Strydom & De Vos, 1998: 191). The population of this study comprises all people from

Local Government, Non-governmental Organisations (NGO) and Parastatal Organisations who are mandated or responsible to implement the OADS policy.

A purposive sampling method was adopted whereby the researcher had to consult the OADS policy thoroughly. From this strategy, the researcher identified who was mandated or responsible for certain tasks in implementation. Where these people were not highlighted explicitly, the researcher contacted relevant city departments as highlighted in the strategy and enquired about certain people working in the area of substance abuse or with the strategy. Furthermore, the researcher relied on the snowball sampling technique to locate more respondents relevant to the study. Finally, a sample size of fourteen respondents was used for the study.

1.9.4 Data Collection Strategy

In-depth individual interviews via a semi-structured interview schedule are the data collection method and instrument for this study. Furthermore, a tape recorder and the researcher's notes served as the data collection tools.

1.9.5 Data Analysis Strategy

All of the interviews were transcribed by listening to each interview and typing it out verbatim. This method follows Tesch's method (1990) of openly coding and sub-coding.

1.10 Reflexivity

The conscious fact that South Africa lacks the ability to deliver quality services is something that the researcher is fully aware of. In addition, the researcher has engaged with many substance abuse victims and has seen the physical and emotional dimensions of their struggle.

This has frustrated the researcher even more with the government for failing to implement their policies. The researcher needs to ensure that this will not affect her objectivity, and that she remains impartial throughout the study.

1.11 Outline of the Chapters to Follow

The study will be structured in the following way:

Chapter One: Introduction to the Study

This chapter outlines the introduction to the study, the rationale for the study, the background to the study, the problem formulation, the research topic, the research questions and objectives. Furthermore, a section on concepts and clarification of key terms such as implementation, policy, social policy, cape flats and community is given. This is followed by a brief description of the research methodology and design.

Chapter Two: Literature Review

Chapter two will present a literature review addressing the findings of other research who have asked similar or related questions. Firstly, it will evaluate policy implementation in South Africa. The second section will look at the substance abuse problem internationally, nationally and locally in the Cape Flats, as well as substance abuse trends in the Cape Flats. The third section will look at how South Africa policy addresses substance abuse. Lastly, the OADS and the issue of implementation will be discussed, with an emphasis on the Cape Flats and its problems of substance abuse.

Chapter Three: Research Methodology and Design

In this chapter, a full description of the research design and methodology, including the sampling framework, the data collection method and the data analysis structure will be provided. Following this will be a section on the ethical considerations and the possible limitations to the study. This chapter sets out the planning that took place to operationalize the study.

Chapter Four: The Presentation and Discussion of Findings

This chapter will present and analyse the research findings based on the data collected on the case study selected. It will be analysed in relation to the research questions and the research objectives.

Chapter Five: Conclusions and Recommendations

This chapter will describe the conclusions reached in the study based on the research objectives. Lastly, recommendations will be made on how policies can be improved for successful implementation, as well as how policies can more effectively be utilised by those mandated with implementation.

CHAPTER TWO: LITERATURE REVIEW

[W]e will work with communities and other key stakeholders to deal with drug peddling and drug abuse which are tearing some communities apart. My visit to a drug rehabilitation centre in Mitchells Plain on Tuesday convinced me that we need more energy in the fight against drug abuse and drug peddling in our communities. I have directed our police force to deal decisively with people who sell drugs to children in Cape Town and other areas. We will also not tolerate tavern owners who sell alcohol to children (Zuma, 2011).

2.1 Introduction

In this chapter, a review of the literature will be presented on the implementation of substance abuse policy in the Cape Flats to the extent that that literature is available. This literature review will be broken down into four sections. Firstly, it will evaluate policy implementation in South Africa. The second section will look at the substance abuse problem internationally, nationally and locally in the Cape Flats, as well as substance abuse trends in the Cape Flats. The third section will look at how South Africa policy addresses substance abuse. Lastly, the Operational Alcohol and Drug Strategy 2007-2010 (OADS) and the issue of implementation will be discussed, with an emphasis on the Cape Flats and its problems of substance abuse.

The purpose of this review is to provide a conceptual framework of the study, informing the research objectives; and situate it in the present ongoing debate with regards policy making and the challenges of policy implementation. Ideological issues, gaps or time-bound natures of previous research are highlighted to further justify the researcher's own.

2.2 The Evaluation of Policy Implementation

2.2.1 Background to Policy Implementation

The field of policy implementation is a rather under-researched (De Coning, 2008) and neglected issue despite it being “one of the most critical pillars on which policy management is based” (Brynard & De Coning, 2006: 180). According to Brynard and De Coning (2006), the method of policy implementation is one of the most neglected areas in political theory and has been given the least attention. Based on research in this context, the successful implementation of policies and the successful delivery of quality services to the public, require a system of inter-governmental relations in which national, provincial and local government and all departments interrelate to work together efficiently (Policy Innovation Unit (PIU), 2001).

The argument presented here is premised on the definition of implementation provided by Brynard and De Coning who states that: “implementation will be regarded as the (successful) conversion of mainly physical and financial resources into concrete service delivery outputs in the form of facilities and services, or into the concrete outputs aimed at achieving policy objectives” (2006:183).

The study of social policy requires one to understand what defines a policy. According to Cloete, Wissink and De Coning (2006), a policy can be understood as “a statement of intent” (2006: 25); it specifies the basic principles to be achieved in order to reach certain goals (Cloete et al, 2006). The broad aim is to change systems, practices and behaviours, or change existing situations in an environment.

Within any nation, before a policy is passed it goes through vigorous scrutiny regarding the issue it aims to address in different sectors. For this process to happen, a need or problem is first identified, which is then advocated for by different stakeholders before it is brought into parliament and passed as a policy to be implemented on the ground. Gil (1992) elaborates that social policy is as an attempt to address social issues that affect a country's socio-economic well-being.

2.2.2 Challenges for Policy Implementation in Post-Apartheid South Africa

Policy implementation in South Africa only really became an issue of concern amongst analysts after the early 1970s (Brynard & De Coning, 2006). Before then, policy analysis was preoccupied with the process of decision making in solving problems (PIU, 2001). The 1980s saw a decline in government's capacity to deliver due to limited funds. This resulted in many state institutions having to be privatised to encourage competition and improve service delivery (PIU, 2001). In the 1990s implementation began to receive overwhelming attention and this continued to improve (PIU, 2001).

In 1994, policy analyses and implementation in South Africa was a top issue on the agenda of most policy analysts (Pretorius, 2003). White papers drawn up between 1995 and 1997 emphasise the biggest challenge in South Africa, which is to translate policy into practice (Brynard & De Coning, 2006) and rectify the inequalities caused by Apartheid. Here, emphasis is placed on transforming policy to strategy in order to attain consequential service delivery (De Coning, 2008).

However, the newly appointed government of the African National Congress (ANC) of 1994 simply did not have the experience, capacities, instruments or resources at its disposal to

rectify the past inequalities brought about by the Apartheid regime. The ANC faced a majority of what was previously referred to as „non-white’ people who looked up to them as the conqueror of the day with the expectation of bringing to them the social, economic and political resources that they were deprived of for decades. The ANC acted in haste with its sole purpose to satisfy the mass of people’s accumulated needs (Bernstein, 1999). As a result, the ANC could be considered as being over-ambitious in setting its policy objectives and not fully taking into account the implications involved in getting these policies implemented. According to Bernstein (1999: 27), “the government set itself far too many change objectives, all of which needed to be tackled simultaneously. Radical interventions took place without a clear plan of attack often at the expense of delivery.”

Thus, the cost of policy implementation was often neglected in setting these over ambitious policy transformations by a very inexperienced and proletarian government in 1994. Should they rather have aimed lower in setting these objectives? Or was it simply a problem of the government lacking the ability to prioritise more important issues over others as it found it being faced with euphoria of possibilities.

The task that faced the political incumbents in 1994 was enormous and to underestimate it in any way would be a mistake. Dr. Ncholo, the first newly appointed Director General of the Department of Public Services and Administration states that:

[P]ublic officials are being faced with multiple challenges of restructuring the public service, while simultaneously trimming it down, extending the reach of the public service to previously under-serviced communities, while adhering to a

commitment of fiscal discipline and simultaneously creating representivity (O'Dowd, 1998: 8).

In addition, the Government of 1994 found itself being faced with an almost empty treasury, international sanctions, numerous economic challenges such as a slow growth rate and its domestic issues of racial discrimination and inequitable practices (Bernstein, 1999). The government had to start from scratch and aside from the immense expectations which confronted them from their own people; their every action was under pressurized scrutiny from international observers.

According to the PIU (2001: 5), "governments are judged by how well they deliver on their promises". South Africa as a whole was faced by the pressurized observations of global financial investors, waiting for a sign of failure that South Africa was not delivering, to pull out investments they were in the first place not confident to make in the country (O'Dowd, 1998). In addition, people want to see tangible results being delivered. This demonstrates accountability and gives people a sense of ownership when they can see actual on-the-ground progress (Schindler and Cheek, 1999; Yaffee and Wondolleck, 1997).

In conjunction, these pressures exerted a strain on government officials and in turn resulted in a system which did not perform too well in the form of policy implementation. Despite the passing of nearly two decades since democracy, policy-makers are still faced with similar constraints and challenges in policy implementation. According to Birkland (2005) policy-makers are faced with two pressing challenges: (1) a clear definition of defining clear concepts and (2) understanding the important components that leads to successful implementation.

2.2.3 The need for the evaluation of Policy Implementation in South Africa

In his book Dennis Rondinelli (1993) acknowledged that even though development planning has become more rigid and detailed, systematic analysis and design of development face problems of complexity and uncertainty. He explores the reasons why projects that were planned and designed by international agencies and governments often deviated from the preconceived plans during implementation. As limits to systematic planning, resulting in deviation from the plans, delays, cost over runs or change of project objectives, he highlights key factors such as costly and ineffective analysis, inconsistency, inappropriate interventions or constraints on managers as key challenges to policy implementation. Despite the passing of nearly two decades, these challenges are still present in formal government policy implementation in South Africa. Hence, Rondinelli's (1993) influence in this area of research is still largely significant.

According to Rondinelli (1993), developing nations are confronted with the insurmountable challenge of translating policy and programmes into action. There are various limits and constraints to achieving policy implementation. Rondinelli (1993) stresses the importance of the inclusion of beneficiaries in policies and programmes to ensure successful implementation.

Rondinelli (1993) assesses that there is a huge gap between rural people and government officials and this results in a major constraint in policy achievement. Similarly, Amartya Sen (1999) argues that individuals matter. Less than a quarter of all United Nations Development Programmes (UNDP) rural development projects included local involvement, but none involved beneficiaries in evaluation, which largely accounted for the problems with implementation (Rondinelli, 1993). These projects failed to include all organisations with the

same aims and objectives, which ensures pooling of information, resources and ideas and could enhance the sustainability and viability of any organisation.

By mobilising people to take an active interest in the development of their community ensures that they are enabled politically and economically at community level, thus the acquisition of first-hand knowledge in the economic activities. Sen (1999: 39) refers to the concept of „social arrangements’ whereby people come together and agree on what their priorities are and how they will access it. At a micro level, individual contribution in the form of a participatory action research, allows people to assess what their own needs are. This ensures transparency and accountability which are important for any democracy. Transparency guarantees play an important role “in preventing corruption, financial irresponsibility and underhand dealings” (Sen, 1999: 40), thus aiding in the promotion of a true democracy.

In addition, middle-income countries such as South Africa face a more hostile environment such as limited exports to Western markets, a decline in the demand for unskilled labour and raw materials, non-sustainable technological developments and more unstable international market. This kind of environment makes it more difficult and less effective for development policies to be implemented (Rondinelli, 1993).

When development planners, government officials or political leaders develop policy or programmes for their own interest and gain, implementation is flawed (Rondinelli, 1993). Thus, corruption can have a negative effect on policy implementation. While this is a very difficult issue to solve, the best approach would be agreement amongst parties, good structural conditions and informed participation.

It is important to note that even the simplest policies may appear to be easily achievable at face-value, but face unexpected challenges during its implementation. This is not to say that effective planning would not play its part in attempting to avert undesired outcomes. Rather, the role of the local person on the street at whom the policy targets should be incorporated into planning and implementation to ensure more desirable results (Rondinelli, 1993).

It has been argued by Rondinelli (1993) that policy implementation is one of the major problems confronting developing nations such as South Africa. There is a global consensus that there is an inability to translate policy to implementation. More so, the method of implementation to ensure its success is one of the most neglected areas in development studies. Hence, critical aspects of planning and administration need to be re-examined.

The inclusion of the person on the street and the importance of monitoring and evaluation throughout the entire lifespan of a policy are stressed (Rondinelli, 1993). The need for accountability, transparency and good governance within government and political parties was highlighted. This will ensure strong institutions and eliminate the possibility of corruption.

According to authors such as Rondinelli (1993), Sen (1999), the PIU (2001) and Brynard and De Coning (2006), policy implementation is an essential, yet neglected step in the policy-making process. While these authors analysed the broad issue of policy implementation, little was provided on the effects of poor policy implementation in a small town or community. Hence, this study attempts to analyse the OADS policy in the Ottery Marble Flats, drawing from the broader theoretical frameworks. The following section will analyse substance abuse nationally, provincially and locally.

2.3 Substance Abuse: The Social Ill and Scourge

Barlow and Durand (2005) refer to a substance as a „chemical compound’ that is ingested by an individual, resulting in the adjustment of the individual’s mood and behavior. Substances are generally thought of in the form of „hard drugs’ such as crystal methamphetamine (MA), cocaine and heroin. However, alcohol, caffeinated beverages and nicotine present in cigarettes also constitutes as substances (Barlow & Durand, 2005).

Similarly, the OADS defines a drug as “all psychoactive substances, illicit or otherwise that change patterns of thought, behaviour and emotions. Drugs, which impact most visibly in the City of Cape Town, include methamphetamine (tik), heroin, methaqualone (mandrax), and cannabis (dagga)” (City of Cape Town, 2007: 10).

In addition, a distinction can be made between substance abuse and substance use. According to Lo (2009) substance abuse can be distinguished from substance use in that substance abuse involves frequent usage and dependency on the substance. Although there is a conceptual difference between use and abuse, initial substance use may lead to abuse. Relevant to this study is the concept of substance abuse which can be defined as the degree to which the use of a particular substance negatively disrupts an individual’s life (Barlow & Durand, 2005).

The inability of a substance abuser to focus in school is an example of substance abuse. Thus, substance abuse can result in the development of substance dependency. Substance dependence is a form of addiction whereby an individual experiences a tolerance towards a particular substance, and therefore requires greater intake of the substance to acquire the desired effects (Barlow & Durand, 2005).

2.3.1 Substance Abuse and the International Arena

Substance/drug abuse is a global issue and is symptomatic of other deeper problems. Substance abuse is linked to unhealthy lifestyles and risky behaviours such as unsafe sex leading to the possible spread of Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS), involvement in gangsterism and crime and peer pressure. Substance abuse is also more common with children who lack adequate support and guidance from their parents or guardians.

Pluddermann et al. (2009), among others, note that the use of MA is becoming a global issue. Research has shown that this drug has been more powerful than any other drug which hit the market and its rates of increase over the years has been the fastest. According to Brian McCormick (2000: 16), “the internet is fuelling addictions” because it is easily accessible and affordable. This allows people to share information concerning using and manufacturing substances (McCormick, 2000), which intensifies the global issue of substance abuse.

2.3.2 Substance Abuse in South Africa, Nationally

Substance abuse has reached epidemic proportions amongst youth, particularly in South Africa (Flisher, et al. 2003). On 10th March 2011, the Entertainment Television (E TV) reported on Social Development Minister Bathabile Dlamini acknowledging that substance abuse constitutes a serious threat to health and development in South Africa (E TV News, 2011). As a result, a National Summit on Substance Abuse was held in Durban between March 15th and 17th, 2011.

Government has prioritised substance abuse in South Africa. The country faces some of the highest statistics, with one third of all crime being related to alcohol or drug misuse (World Health Organisation (WHO), 2011).

The WHO Global Status Report on Alcohol and Health (2011) reports that South Africa is one of the leading countries in alcohol abuse disorder. Women over the age of 15, in particular, are known for binge drinking habits, and often lead to risky sexual behaviours. Myers and Parry (2002) record that South Africans consume well over 5 billion litres of alcohol per year. According to Edna Molewa Spokesperson for the ANCWL:

[S]outh Africa comes from a history where alcohol was used as one of the strategic means to fuel social destruction, especially in the black communities. In many instances, workers, especially in the farm areas were paid nothing but alcohol. Our government has moved decisively to strengthen controls to limit alcohol abuse by ensuring effective means to regulate alcohol sale and distribution. However, the reality is that much still needs to be done, especially in curbing the mushrooming of illegal shebeens and the production of binge drinks that have proven hazardous and toxic (Molewa, 2011).

Similar trends are echoed in Parry and Bennets (in Press) where alcohol misuse is reported among persons in particular occupations such as farming and mining; or amongst residents in disadvantaged or cluttered communities where access to alcohol is relatively easy.

While there is no reliable data base underpinning substance abuse in South Africa, the most recent data categorises substance abuse into three categories, from most extensive use, to

moderate use and less frequently used. Alcohol remains the most commonly abused drug in South Africa, followed by cannabis (dagga) and the cannabis/Methaqualone (mandrax) (white pipe) combination (Parry, 1998). Factors such as age, gender, socio-economic conditions and urbanisation have contributed to the overall prevalence of alcohol and drug misuse (Parry, 1998).

In order to contribute to the research base underpinning substance abuse in South Africa, the gap between substance abuse policy formulation and implementation need to be addressed.

2.3.3 Substance Abuse in the Western Cape, Provincially

Across the Western Cape, rates of substance abuse far exceed those in the rest of the country (Department of Social Development (DSD), 2008). According to the National Drug Master Plan 2006-2011 (NDMP), approximately 42 percent of treated patients in the Western Cape use MA as the primary choice of drug (DSD, 2006: 8). Therefore, almost half of patients which are treated for substance abuse use MA as their primary drug of choice.

Table 1 show the proportion of patients and their preference with regards to primary substance of abuse in the Western Cape for each respective six-month period since 1996 (where 1996a refers to January – June 1996, 1996b to July – December 1996, etc.). This table clearly highlights the staggering figures in the use of MA in the Western Cape as the primary choice of substance.

Table 1: Primary substance of abuse of patients reporting for treatment in the Western Cape over an 11 year period (percent)

PERIOD	Alcohol	Cannabis	Methaqualone (mandrax)	Cocaine	Heroin	Ecstasy	*OTC/PRE	MA	**N
1996a	81	4	9	2	1	0	2		1954
1997a	82	5	7	4	1	<1	2		2103
1997b	78	6	9	4	1	1	1	0.1	2160
1998a	74	5	10	6	2	<1	2	1	2301
1998b	64	9	14	8	2	<1	2	0.1	1361
1999a	56	9	20	8	4	1	2	0.1	1527
1999b	50	15	20	9	3	<1	2	0.1	1550
2000a	48	12	23	8	4	2	4	0.2	1695
2000b	51	13	19	7	5	1	3	0.1	1696
2001a	46	12	21	9	7	2	4	0.1	1571
2001b	46	12	25	6	6	1	2	0.3	1561
2002a	48	14	21	7	7	2	2	0.3	1608
2002b	47	18	17	7	6	1	2	0.8	1549
2003a	43.6	15.2	20.4	7.9	6.5	0.8	2.7	2.3	1724
2003b	39.4	15.4	23.6	8.4	7.1	1.4	2.2	2.3	1659
2004a	38.3	12	16.9	9.7	8.8	0.5	2.4	10.7	2255
2004b	33.7	11	15.5	9.1	8.2	0.5	2	19.3	2308
2005a	34.4	9.7	9.1	8.3	10	0.4	1.6	26.1	2469
2005b	25.1	11,2	5.5	7.6	13.8	0.2	1.1	34.7	2131
2006a	30.2	7.7	3.3	6	13.5	0.1	1.4	37.2	2660
2006b	26.4	10.5	2.9	4.8	10.2	0.1	1.6	42.3	2798
2007a	29.5	10.4	2.7	3.9	10.6	0.2	1.1	40.7	2862

(Harker et al., 2009)

* Over the counter or prescription medication.

** N – refers to the total number of patients treated for substances in that particular time period

- Data is used for this 11 year period as it is the most recent and available data.

The above findings show that there is a dramatic increase in the use of MA across the entire Western Cape since 2003, from 2.3 percent usage in 2003 to 41 percent in 2006. The majority of those treated for MA abuse are under the age of twenty years. Reports by Phudderan et al. (2009) suggest huge increases in the abuse of this drug (DSD, 2008).

Methaqualone (mandrax) was previously the primary drug of choice, but as the figures show, usage in methaqualone, alcohol and cocaine substantially decreased as users were clearly substituting their primary choice of drug use.

A possible explanation for the constant usage of cannabis is that most users do not consider it as an extreme form of substance, and most people smoke cannabis as they would smoke a cigarette. In addition, certain cultures such as the Rastafarians consider it as part of their tradition and culture in the form of herbal or medicinal use. However, in South Africa, the use of cannabis is not legalised (The Presidency, 2009). The figures for heroin has also remained somewhat consistent, this could be because it is the most common drug amongst users that provides them with immense feelings of a come down. While MA is the primary ‚high’ drug, heroin is considered as the primary ‚low’ drug.

2.3.4 Substance Abuse in the Cape Flats, including the Marble Flats, Locally

Cape Town is home to the majority of people classified by the government as ‚Cape Coloureds’ (Scott, 1955) who embody most of the Cape Flats Communities. The Cape Flats, known in Afrikaans as the *‘Kaapse Vlakte’*, is a vast area of land on the east of the Southern Suburbs and north of Table Mountain in the Metropolitan region of Cape Town. It is named the Cape Flats because when viewed from afar, it is essentially a very flat area of land. According to its physical boundaries, the City of Cape Town ([a] 2009) defines it as the

„Metro South East Sector’, however, this definition fails to include a number of important parameters and is thus lacking.

The Cape Flats experiences some of the worst winter floods and very harsh South-Easter winds, thus living conditions are highly undesirable and unsuitable. In the past it was known for lacking basic resources and amenities such as telephone lines and police stations, today it is well known for its high levels of crime, gangsterism and drug flows (Samson, 2007). Venter (1974: 86) describes the Cape Flats as “an unpleasant area in which to make a home as it is windswept for much of the year and often partly flooded during the winter months”. Yet, it has become home to close to a million people as a result of the stringent Group Areas Act imposed and enforced by the Apartheid government. Millions of Coloured people were forcibly restricted and removed from their homes from all over Cape Town, and forced to live together in much cluttered communities.

According to Ndou (2009), Cape Flats communities are faced by common conditions such as poor working class mothers who don’t have the time to spend with their children and in most cases, fathers are unemployed, substance abusers or alcoholics. Thus, substance abuse is more likely to prevail amongst youth in these communities, as it is symptomatic to these social and economic issues.

The structuring of the Cape Flats into blocks is one of the major factors that accounts for these socio-economic problems such as substance abuse. It lays the foundation for gang related activities and gangs typically rely on drugs for these activities as it boosts their confidence levels in conducting illegal activities. This block structuring of the Cape Flats also aids in drugs being easily manufactured, distributed and hidden from police (Ndou, 2009).

Additionally, the poor planning process and lack of resources employed can account for the severe social problems faced by these Cape Flats communities. The Cape Flats was known as a dumping ground for Coloured people during the Apartheid government era. Additionally, the Apartheid government did not follow a coherent planning process (March, 2009). According to Waterston (1982: 8), planning *should be* an “organized, intelligent attempt to select the best alternatives to achieve specific goals”. Thus, there is a great demand to re-plan many of the existing features to aid with the development of these communities, with the long-term goal of eradicating its social problems and addressing the needs of the underprivileged groups in society.

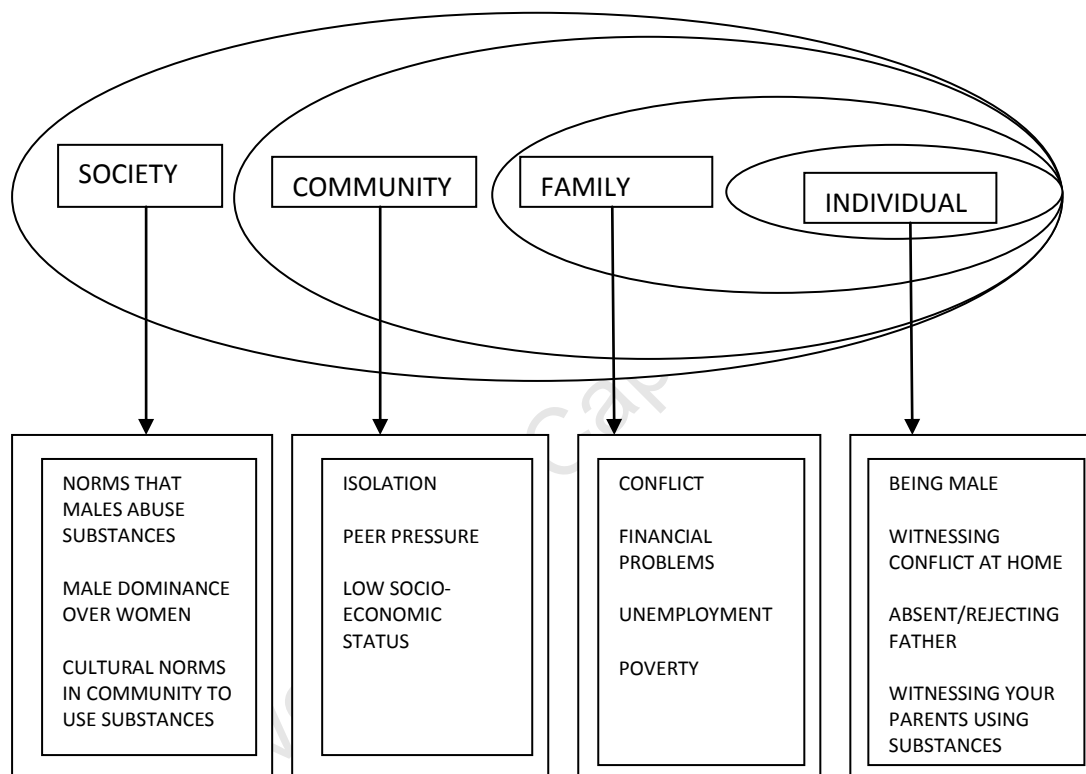
The City of Cape Town launched a R100 million Community Residential Units (CRU) upgrade project to repair and upgrade the Ottery Marble Flats (Petersen, 2010). According to Mr Zaahir Jassiem, the CRU project manager, “the upgrade will not only help build better homes, but also help build a healthier and safer community, which will help the fight against drugs and gangsterism” (Petersen, 2010: 1). This highlights an improvement in the planning process, where social and human needs are taken into account. According to Councillor George March, residents will be fully informed about every stage of the project. This emphasises the inclusion of the beneficiaries, which according to Rondinelli (1993) is significant in successful project implementation.

2.3.5 The application of the Ecological Theoretical Framework

The central theme in this area of research is that researchers are interested in tracing the changing trends of substance abuse in communities at risk to address issues of substance abuse and the broader social problems leading to substance abuse in these communities.

The ecological model is a prevalent theoretical framework used in studying risk factors associated with substance abuse (Bronfenbrenner, 1979). The model organises social influences on the individual in a series of four levels, which consists of society, the community, family and emphasis is placed on the individual.

Figure 1: An Ecological Framework for explaining Substance Abuse:



(Violence Prevention Alliance, 2009)

Society at large has a huge impact on the rate of substance abuse. As identified in the above figure, gender plays a dominant role as well as the perceived norms that a certain community would have on the problem of substance. Thus, people are more inclined to characterise communities such as the Cape Flats as a community high at risk. Another important fact is the family environment. When family members witness or are part of violent conflict,

financial problems, poverty and unemployment, they are more likely to engage with substances as they see it as a scapegoat from the pressure within the household.

According to Arnett (2000) and Johnston, O'Malley, & Bachman (2002), the transition from adolescence to adulthood has been identified as a period of increased prevalence of substance abuse. This is further exasperated as young people are exposed to underprivileged socioeconomic status and high family conflict (Lo, 2009).

2.4 Substance Abuse Trends in the Cape Flats (including the Marble Flats)

2.4.1 Types of Substances

Andreas Pluddemann ([b] 2008), a dominant scientist and researcher in this field of study writes that Cape Town faces the worst MA addiction in the world. This is echoed in Kapp (2008: 1) who says, "it is a crisis which nobody knows how to deal with completely and effectively". This study reveals that Cape Flats Coloured communities are most vulnerable to MA addiction. It was initially used by gang members, but was soon used throughout the communities. A common trend in Pluddemann's (2008) work and many others is that MA is most common amongst Coloured males across the Western Cape.

MA is the most dominant form of substance being abused in Cape Flats' areas across Cape Town. It is better known by the street names as 'tik', 'ice' or 'glass'. This is a highly toxic and dangerous substance, and is powerful and extremely addictive. It is colourless and odourless, which make it easy for users to use behind closed doors, and comes in various forms from a clear white powder to larger crystals (Leggett, 2003; Pluddemann et. al [c], 2008) which are smoked through a pipe. Like powdered methamphetamine, it has long-lasting euphoric effects, but MA tends to be more potent than its powdered counterpart.

Abuse of this drug can have serious and long-lasting effects. MA abuse can cause psychosis for months and years, long term disruption of brain chemistry (Leggett, 2003) even if the abuser is able to stop using the drug.

The research further conveys that heroin is the primary accompaniment to MA. Although heroin has a greater risk of overdose and is harder to treat once users are addicted, users of MA continue to suffer from more severe long term psychological effects (Pluddemann et al [c], 2008; Kapp, 2008; Southern African Community Epidemiology Network on Drug Use (SACENDU), 2009). There is also evidence that alcohol and cannabis are main accompaniments or continue to be used excessively despite the increasing levels of MA (Pluddemann et al [c], 2008).

A study was conducted by the National Institute on Drug Abuse called an *Examination of Tik Use and Sexual Behaviour in Cape Town* in which four hundred and fifty females, aged between thirteen and twenty in poor communities in Cape Town were interviewed. According to this study, the following is a brief summary of MA and related social problems in Cape Town:

- The average age for dropping out of school is 17.
- 88 percent of participants were unemployed.
- 62 percent of participants have used MA (13 percent Black African; 91 percent Coloured).
- Most teens that ever used MA used it every day and reported trading sex for MA.
- MA use is associated across numerous studies with having multiple partners and trading sex for drugs.

(Research Triangle Institute, 2008).

The use of MA has been the fastest growing drug in Cape Town. There has been a dramatic increase in the demand for drug treatment in the City of Cape Town, which provides evidence of the increasing substance abuse rates.

The usage of MA is most dominant and increasing drastically. What is also common is that users are mixing MA with cocaine to experience ecstasies that are more pleasurable. While MA is considered to provide these elated feelings („uppers’); alcohol, cannabis, methaqualone, and heroin are considered as a sedative to come down („downers’).

Table 2 shows the proportion of patients under twenty in Cape Town who use MA (amongst others) as a primary choice of drug for each respective six-month period since January 2003 (where 2003a refers to January – June 2003, 2003b to July – December 2003, etc.).

Table 2: Primary Substances of Abuse for patients younger than 20 years (percent) – Cape Town Treatment data

Period	Alcohol	Cannabis	Cannabis/ Methaqualone	Cocaine/ Crack	Heroin	Ecstasy	MA	Other	Total
2003a	7.2	45.9	30.7	2.9	4.8	1.9	4	2.9	375
2003b	4.1	41.9	32.5	4.7	7.4	3.6	4.7	1.1	363
2004a	5.1	33.1	23.3	3.7	8.2	0.9	24.9	1.1	571
2004b	2.3	24.4	17.6	2.9	8.6	0.6	42	1.6	619
2005a	2.5	24.5	9.3	1.9	11.5	0.8	48.7	0.9	637
2005b	3.1	22.1	6.7	1.3	12.9	0.4	53	0	674
2006a	1.7	17.4	3.9	0.6	15.3	0	60.2	1	724
2006b	2.9	26	2.6	0.4	7.1	0	58.6	0.1	761
2007a	3.6	24.4	2.4	0.6	9.6	0.1	56.5	0	803

(Harker et al., 2009)

- Data is used for this 5 year period as it is the most recent and available data.

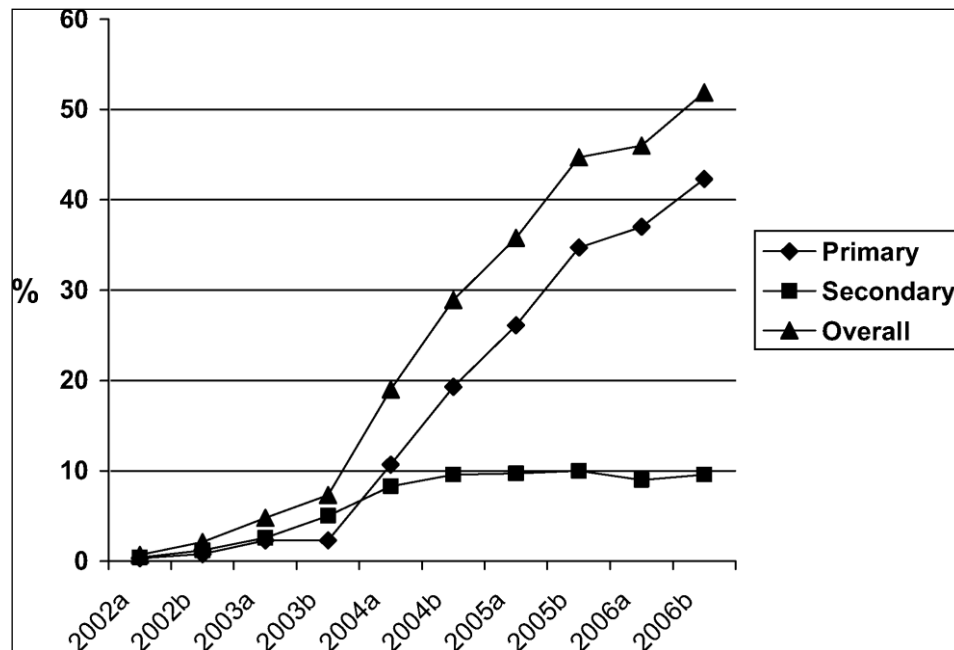
The data above shows the severity of substance abuse with people under twenty. However, it is clear to see that while most of the substances remains steady or only gradually increases or decreases, the use of MA escalates drastically and very suddenly.

By the beginning of 2007, more than half of people who are treated for substances used MA as their primary substance of choice. The figures shockingly multiplied by fourteen since the beginning of 2003 when only 4 percent of treated patients used MA.

This table emphasizes that greater and immediate attention is needed by those people under twenty as they are more likely to engage with substances. This could be the result of a consortium of social and economic problems, such as peer pressure, unemployment, lack of opportunities and social exclusion.

However, stringent intervention for remedial measures need to be explored as the age group of twenty constitutes part of the youth and the youth constitutes the largest portion of the South African population. According to the National Youth Policy 2009-2014 (NYP), a significant component of the South African population is characterised by people under the age of 35. This presents ample opportunity for the youth to contribute towards the growth and development of the country (The Presidency, 2009:1). Noting this, it follows that strategic focus and the development of services fostering the holistic development of these youth (socially, emotionally, and intellectually) is detrimental for societal development.

Figure 2: Proportion of patients with MA as their primary, secondary or overall (primary or secondary) substance of abuse. (Note: 2002a is the period January – June 2002, 2002b is July –December 2002, etc.)



(Pluddermann et al. [b], 2008)

This figure uses data extracted from twenty-seven specialist substance abuse treatment centres across Cape Town between 2002 and 2006 (Pluddermann et al. [b], 2008). (See Pluddermann et al. [b], 2008 for more information of the methodology adopted in data collection).

The above figure isolates MA from other substances, and shows how its usage as the primary or secondary substance of abuse escalated since 2002. There was a significant increase from 0.7 percent in 2002 to a shocking 51.9 percent in 2006. The majority of people use MA as

their primary choice of drug. This figure exemplifies the staggering proportions of people using MA.

2.4.2 Geographic Trends

Most of the research on substance abuse is limited to Western Cape. Few research attempts have been conducted on specific towns or communities. However, the data and reports suggest that MA use has escalated dramatically in areas of mixed race or rural dwellings due to declining socio-economic conditions.

Cape Town faces some of the worst drug related issues across the entire Western Cape. According to the State of Cape Town 2008 (2009) drug related crime is particularly prevalent in the Cape Flats. The increase in drug related crime has been dramatic – “from 241 per 100 000 in 2001/2, to a staggering 830 per 100 000 in 2007/8” (City of Cape Town [c], 2009: 42). These figures exemplify the relationship between substance abuse and social problems such as crime, which contributes to the declining socio-economic situation within the Cape Flats.

[I]n areas such as the Cape Flats, while the related violence will never cease to shock and depress, the criminal economy cannot be perceived as a force that is simply an external threat to society; it is no longer a fringe activity perpetrated by outsiders who can be easily separated from a normal legal society containing good citizens. On the Cape Flats the criminal economy is substantial, its various boundaries blur with other economic and social activities and it involves thousands of people. It is therefore a core dimension of the community (Standing, 2003: 1).

It is also common that the Cape Flats communities tend to be misused by communities that are more affluent. Due to their deprived social and economic circumstances, they are likely targets to be used by established drug merchants to sell and distribute this drug in the Cape Flats, thus, making it easily accessible and available to the people in these communities.

2.4.3. Racial/Ethnic Trends

Even though the use of MA only became dominant in the late 1990s, Coloured people of the Cape Flats were always vulnerable to substances as they faced a wide range of socio-economic problems such as social exclusion, poor family support, poverty and unemployment (William, 2009).

This formed the basis for most of the social problems faced by Cape Flats communities. Substance abuse is one such extreme social problem, and to a certain extent, its severity can be accounted for by the historical legacy of Apartheid (William, 2009).

In a study conducted by Southern Africa Labour and Development Research Unit (SALDRU) for two areas in the Cape Flats, it was revealed that the Cape Flats faces an unemployment rate of approximately 46 percent and 61 percent for those under the age of thirty (Standing, 2003). Of the patients admitted for drug treatment in the Western Cape in 1996, 90 percent of them were Coloured males (DSD, 2008).

The Coloured people of Cape Town are characteristically a group of “people of mixed racial decent” (Morse & Peele, 1974; Adhikari, 2005) from Malaysian Slaves, Hottentots, Bushmen and the early White settlers (Morse & Peele, 1974: 3). The term *Coloured* refers to a “varied social group of highly diverse cultural and geographic origins” (Adhikari, 2005: 2). They

arrived in the Cape in the early 1600s when Jan van Riebeeck established a refreshment station on the Table Bay shores for the Dutch East Indian company. Labourers were soon needed, and Jan van Riebeeck imported slaves, hence the arrival of the Cape Coloureds. Today, approximately 40 percent of the total coloured population resides in the Cape Town area, while two thirds of the three and a half million total population resides in the greater Western Cape (Adhikari, 2005).

The Coloured people are one of the marginalised groups of people in the South African communities and has often been described as „not black or white enough’ (Adhikari, 2009). With limited political powers, they have always been a group of people in search of their true identities.

Table 3 isolates the primary choice of substance in relation to race and province.

Table 3: Primary substance by race and province (percent) (Columns per site add up to 100 percent): July- December

		Alcohol	Cannabis	Methaqualone	Cocaine	Ecstasy	Heroin	MA
Western Cape	Black/African	10	16	8	6	0	1	3
	Coloured	52	74	89	53	50	79	90
	Asian/Indian	1	1	1	2	0	1	<1
	White	38	9	1	39	50	19	7
Kwazulu-Natal	Black/African	50	46	36	5	50	2	0
	Coloured	8	6	7	18	0	1	0
	Asian/Indian	20	38	57	52	50	96	0
	White	22	10	0	25	0	1	0
Eastern Cape	Black/African	38	45	54	5	-	15	0
	Coloured	33	33	32	41	-	29	27
	Asian/Indian	2	3	0	1	-	0	3
	White	28	19	14	53	-	56	70
Gauteng	Black/African	35	6	66	17	20	30	11
	Coloured	6	13	8	16	40	1	22
	Asian/Indian	3	4	2	5	0	3	11
	White	55	19	25	62	40	66	56
Northern Region	Black/African	58	85	50	18	0	60	-
	Coloured	2	2	0	11	0	0	-
	Asian/Indian	0	1	0	3	0	2	-
	White	40	12	50	68	100	38	-
Central Region	Black/African	35	46	50	3	0	0	-
	Coloured	18	36	50	30	0	0	-
	Asian/Indian	1	5	0	3	0	0	-
	White	47	3	0	65	100	100	-

(SACENDU, 2009)

The above table gives a neat comparison of substance abuse across provinces and races. It is clear to see that the Western Cape has the highest rate of MA amongst its Coloured population, sitting at a very high 90 percent, while Kwazulu-Natal is 0 percent; Eastern Cape sits at 27 percent and Gauteng at 22 percent. This gives weight to the argument in this paper that Coloured people in the Western Cape in particular are most vulnerable to using and abusing MA.

A number of factors can be explored to identify why this may hold true. Most importantly, one must not forget the social and economic conditions that Coloured people were forced into during the Apartheid regime. While transition to democracy in 1994 opened a door of equality and new opportunities, most of the Cape Flats Coloured's remained trapped in their social and economic surroundings. Over the years, these inequalities transcended from one Coloured generation to the next and the same ideologies and beliefs were carried down.

Looking across all substances, one can see that it is a common trend for Coloured's in the Western Cape to occupy the highest percentages. Although MA is the highest at a soaring 90 percent, the Coloured population in the Western Cape faces the highest percentages for other primary substances. These include 89 percent for methaqualone, 74 percent for cannabis and 79 percent for heroin which are all more than double compared to the low levels of 32 percent methaqualone, 33 percent cannabis and 27 percent heroin in the Eastern Cape and even lower 7 percent methaqualone, 6 percent cannabis and 1 percent heroin in Kwazulu-Natal.

Thus, it can be inferred that MA is most dominant substance of abuse in the Western Cape and in Coloured communities such as the Cape Flats.

2.4.4 Gender Trends

Although a vast majority of the literature (City of Cape Town [a], 2009; City of Cape Town [b], 2009; City of Cape Town [c], 2009; DSD, 2006; DSD, 2008; Harker et al, 2009; Leggett, 2003) highlights that males, especially Coloured males, are the dominant users of MA, the literature is increasingly suggesting that women and teenage girls are also easily lured into this drug by its “weight loss properties” (Kapp, 2008: 2). There is also a vast body of opinion which suggests that the increasing usage of MA is likely to result in increasing HIV/AIDS rates as more people continue to trade sex for the drug (Pluddemann, et al [c], 2008). It is also highly related to crime, violence and gangsterism (Williams, 2009).

According to the South African Demographic and Health Survey 2003, substance abuse is more prevalent amongst young males who seem to be more pressurised to use substances than young females. Between 2002 and 2007, the use of MA was more dominant with Coloured males (Harker et al, 2009). However, the study takes into account that Coloured males have better access to treatment centres than Black males and females (Harker et al, 2009).

2.5 South African Policy addressing Substance Abuse

Substance abuse is both a national and local concern, but government policies struggle to achieve overall objectives.

Addressing substance abuse is primarily the responsibility of National government; Local Government can be seen as the agent giving effect to the policy stipulated by National Government. The National Drug Master Plan 2006-2011 (NDMP) provides a comprehensive policy and legislative framework for all substance abuse strategies. The plan identifies nine priority areas for intervention, but three have been highlighted to demonstrate how it is the priority of National Government to address and respond to substance abuse in the country.

- Crime – there is a clear link between substance abuse and criminal activity. The main objective of the NDMP is to eradicate trafficking in supplying illegal drugs and ensure strict legislation against perpetrators involved in this area.
- Youth – the youth are given top priority as they form the largest percentage of the Western Cape. Different categories of youth exist and those with more pressing needs are given more attention. Youth most at risk are youth who heads households as they are more susceptible to peer-pressure and are in need of education or vocational training. The NDMP uses drama, music and sport as tools and mechanisms to mobilize the youth.
- Poor and vulnerable groups such as the unemployed, children, street children, orphans, workers, women, people with disabilities and older persons (senior citizens) are given more priority as their social and economic conditions make them more susceptible to substance abuse.

(DSD, 2006)

Furthermore, through the OADS policy by the City of Cape Town, Local Government has a very distinctive role in addressing alcohol and drug abuse. They are responsible for dealing directly with the impacts of substance abuse in the city through a combination of demand and

supply reduction activities (City of Cape Town, 2007). Part of local government's response to combating substance abuse includes the following:

- The social responsibility imperative of local government and its office bearers to affect change in areas of socio-economic concern that has a direct bearing and impact on the stability of the City.
- Community expectations that give rise to local government responses (such as development of localized approaches, for example through participation on Local Drug Action Committees, Community Policing Forums and the provision of supply and demand reduction services)
- Identification of gaps in existing service provision
- Legislative requirements and obligations

(City of Cape Town, 2007).

The use of this substance has reached a critical point and highlights the need for urgent responses from all sectors in society. Both the OADS policy and the NDMP emphasize the concern and priority for addressing substance abuse at both local and national levels.

With the different responsibilities mentioned above and the key priority areas, the government needs to realize that with poorly functioning services (social services and police force), lack of resources (both monetary and human power) and the recession that the world just faced, it will hinder successful achievement of the objectives of local and national government policy. Therefore, instead of planning to achieve all the objectives, the government should first lay a foundation that they can build on and work on the more demanding issues of the policy in combating substance abuse.

The NDMP highlights the necessity of a coordinated response to reduce the supply of and demand for drug dependency and partnerships between all stakeholders at local and provincial level (DSD, 2006). This is a main strategy, which is lacking within Cape Flats communities.

It is common to find established community organisation in Cape Flats communities which seeks to address social problems such as substance abuse. However, while many of these communities have the necessary organisations and initiatives in place, they stray from aligning their goals and objectives to formal government policy.

2.6 The OADS and the issue of Policy Implementation, with an emphasis on the cape Flats and its problem of Substance Abuse

The OADS policy additionally highlights that part of its main goals are to minimise alcohol and drug related harm to vulnerable groups, two of which are the youth and the unemployed. This is also seen as a mechanism for decreasing vulnerability to substance abuse.

The City of Cape Town, through the OADS policy, identifies the following category of people as most vulnerable to substance abuse:

- Youth (14-35)
- People affected and infected by HIV/AIDS and Tuberculosis,
- Women (especially pregnant women),
- People who are unemployed,
- People with physical disabilities and mental illnesses,
- The elderly and people who are homeless

(City of Cape Town, 2007)

Substance abuse in Cape Town (and across the entire Western Cape) has been on a rise and has significant negative health impacts for those who use it. The above criteria of vulnerable groups emphasises its effect on all aspects of society such as morbidity, mortality rates, family welfare, crime, educational attainment, local and economic development and it demotes social inclusion (City of Cape Town, 2007). Since 2000, the use of MA escalated dramatically and is considered as the primary or secondary choice of drug with most users. The City of Cape Town expresses their concern for substance abuse and reducing these negative impacts is their priority.

The Ottery Marble Flats community is a Cape Flats community infiltrated with substances. With predominantly Coloured people residing in the flats, the use of substance abuse is large and growing every day. MA has been identified as the primary substance of abuse in this area. As identified, this deathly drug targets mostly Coloured males under the age of twenty, but generally it targets a wide range of people where age is no factor. Negative and declining socio-economic conditions within the area are part of the symptoms of substance abuse. Of these, lack parental guidance and peer pressure make people more vulnerable to substance abuse, and was identified as the two major social problems leading to drug dependency in the community.

2.7 Conclusion

While policies may appear to be easily achievable, they should be flexible to accommodate for unexpected challenges. It is also important to include the intended beneficiary in the policy from its inception.

In line with this, there should be a greater investment in monitoring and evaluation of the OADS policy. However, monitoring and evaluation should be approached from a people-centred perspective whereby continuous consultation is done with the community to ensure their input. In addition, the policy must be open and flexible to accommodate for change where change may be necessary (Brynard & De Coning, 2006).

The concept of a people centred approach (Korten, 1984) is formulated around the idea of integrating and actively engaging the targeted group of people in the preparation and planning of the policy from its inception. By incorporating a people centred approach into the proposed plan or policy, the rate of successful implementation can be achieved.

The response to substance abuse can be successful if community organisations function with the long-term goal of forging partnerships with other organisations to pool information and resources. It is clear that first and foremost for development to occur, a conglomeration of different stakeholders is necessary. The main factor that increases the likelihood of drug use and dependency is a lack of parental guidance and strong role models. However, one of the major problems in Cape Flats communities is that there is a lack of finances to fund further studies and children are often de-motivated to make any effort. In most cases, they end up being involved with illegal dealings such as gangsterism, crime and drugs.

Four core areas should be addressed in an attempt to combat substance abuse in the Cape Flats:

- Hinder access to drugs
- Treatment of the victim
- Promoting education

- Maintain the moral support of the entire community

Policy implementation is central to achieving all of which has been described above.

CHAPTER THREE: RESEARCH METHODOLOGY AND DESIGN

3.1. Introduction

This chapter focuses on the research design and methodology that has been implemented in this study, including the use of a case study approach. Given the understanding that the implementation of policy differs in different contexts, a case study was deemed the most appropriate research strategy to understand the implementation of the Operational Alcohol and Drug Strategy 2007-2010 (OADS) at a local community level. Furthermore, the ethical considerations that have guided the process of the study will be discussed. Attention will be given to the limitations of the study. This will be followed by a short section of conclusions.

3.2 Research Methodology

An explorative qualitative research methodology has been adopted in this research study. Qualitative data is a good source of rich data within specific contexts, according to Miles and Huberman (1994: 2), ‘qualitative data ... are a source of well grounded, rich descriptions and explanations of processes in identifiable local contexts. A qualitative research design was chosen for this study as it allowed the researcher to discover in-depth information through descriptions and understandings of respondents. It allows the respondents to offer their account of meaning, experience and perceptions (Schurink, 1998).

3.3 Research Design

The research design adopted in this study is a single case study. Until very recently, case studies were considered to be “less than scientific” (Babbie and Mouton, 2007: 280). Given the nature of the dissertation as a mini-dissertation, time and financial constraints prevent the detailed analysis of the OADS policy in more than one Cape Flats community. A qualitative

research methodology formed the basis of the case study which comprised structured interviews with community officials, and stakeholders in the Ottery Marble Flats, who are mandated or responsible to implement the OADS policy.

Recent research showed that case studies can yield valuable scientific information (Babbie and Mouton, 2007). According to Handel in Babbie and Mouton (2007: 280), a “case study is an intensive investigation of a single unit....which involves the examination of multiple variables”. While the ‘single unit’ is often an individual person, it may also be a community, as this research encompasses.

Cresswell in de Vos (2005: 272) offers a more detailed definition of a case study, which regards a case study “as an exploration of in-depth analysis of a ‘bounded system’, or a single or multiple case over a period of time”. By being bounded, it means that “certain features are within the system, within the boundaries of the case, and other features outside” (Stake, 2005: 444). The purpose of a case study is to enhance the reader’s experience of the case in the form of a narrative and situational descriptive (Stake, 2005).

Similarly, Yin (2003: 1) points out that “case studies are the preferred strategy when ‘how’ or ‘why’ questions are being posed, when the investigator has little control over events and when the focus is on a contemporary phenomenon within some real life context”.

The point of departure and the important factor that influenced the selection of the case study was the researcher’s interest in policy formulation and implementation. The researcher’s motivation for adopting a case study approach is that it will allow a strong focus on the implementation of the OADS policy in a specific community, and highlight what is unique in

the community's implementation process. This idea is echoed by Robert Stake (2005: 443) who explains that a case study "draws attention to the question of what specifically learned from a single case".

3.4 Sampling Methodology

3.4.1 Population

The term research 'population', according to Arkava and Lane in Strydom and De Vos (1998: 191), refers to "individuals in the universe who poses specific characteristics" relevant to the study. The population of this study comprises all people from Local Government, Non-governmental Organisations (NGO) and a Parastatal Organisation who are mandated or responsible to implement the OADS policy.

The researcher searched the City of Cape Town's website to find a list of people involved in drafting and implementing the OADS policy. Once these people were identified, the researcher approached the community under study and approached community officials who are mandated by the policy for implementation. This allowed the researcher to ascertain if there is effective coordination between government and communities to ensure successful implementation of the OADS policy.

3.4.2 Sampling Method

This study adopted a purposive sampling method, as the interviewees are the implementers of the OADS policy. Purposive or judgemental sampling "is based on your judgement and the purpose of the study" (Babbie & Mouton, 2007: 166). According to Bickman and Rog (2009: 292), "a purposive sample is typically designed to pick a small number of cases that will yield the most information about the particular phenomenon. Purposive sampling can occur

before or during data collection and it relies heavily on the expert judgement of the researcher”. This study relied heavily on the information from the OADS policy. Hence, a purposive sampling technique is the best suited method for the research study.

The techniques of snowball sampling were also applied during the data collection period as the researcher felt that more respondents were needed to enhance the quality of the study. According to Srydom and De Vos (1998: 200), “snowballing involves approaching a single case who is involved in the phenomenon to be investigated, to gain information on other similar persons. In turn this person is again requested to identify further people who may make up the sample”.

Hence, after each interview, the researcher asked the respondent to identify any people he/she might know that are linked to the OADS policy and could give further input to the study. This method proved to be effective, as the researcher discovered that the OADS policy did not list all the people that were involved in its drafting and implementation. These people were thus identified through snowballing.

3.4.3 Sampling Size

Fourteen participants were interviewed. This consisted of eleven City of Cape Town officials, two researchers in the field of study and one person from the NGO that was contracted by Local Government to draft the OADS policy. No preference was given to age, race or gender. Given that this dissertation is a mini dissertation and that the sample was determined by the people implied in the OADS as the role players for implementation based on their positions, fourteen participants were deemed as appropriate for this study.

3.5 Data Collection Strategy

3.5.1 Data Collection Method

The data collection method chosen for this study was face-to-face interviews using a semi-structured interview schedule. This study has chosen this study based on Greef's (2002: 292) definition, which defines qualitative interviews as "attempts to understand the world from the participant's point of view, to unfold the meanings of people's experiences [and] to uncover their lived world prior to the scientific explanation".

3.5.2 Data Collection Instrument

A semi-structured interview schedule was adopted as the instrument to collect data. The interviews are designed to take between forty-five to sixty minutes. All fourteen participants were asked the same questions, using one interview schedule (refer to Appendix C).

Interviews were done individually and every participant could feel free to express their opinions thus eliminating any discomfort that may be felt in a larger group. The interviews were recorded and transcribed.

According to Robson (1993: 237), when interviews are semi-structured, they generally have a "shopping list of topics and want to get responses to them, but as a matter of tactics they have greater freedom". Similarly, Berg (1998: 61) says that "questions are typically asked of each interviewee in a systematic and consistent order, but the interviewees are allowed freedom to digress, that is, the interviewees are permeated (in fact expected) to probe far beyond the answers to their prepared and standardized questions".

3.5.3 Data Collection Tools

A tape recorder and the researcher's notes were relied upon as the data collection tool.

3.5.4 Data Verification

According to Guba and Lincoln (1985), data verification can be determined according to a set of four criteria. These are: credibility, transferability, dependability, and confirmability (Guba & Lincoln, 1985). The researcher has therefore kept these four key elements in mind while assessing the accuracy and consistency of the study.

In terms of credibility, the respondents were selected according to specific criteria and the identified respondents were the people mandated by the OADS to carry out specific implementation tasks. These respondents were clearly identified in the sample size. Credibility was ensured by prolonged engagement with respondents, persistent observation of interpretations, triangulation (asking different questions, seeking different sources and using different methods), referential adequacy (documents were available relevant to the study), peer debriefing (the researcher's supervisor was involved in the process) and member checks (checking the data and interpretation). In doing so, the overall adequacy of the data is ensured (Babbi & Mouton, 2007).

There will always be problems in assessing the transferability of a qualitative study, because a qualitative researcher is not primarily interested in generalizations (Babbie & Mouton, 2007). However, the researcher has clearly laid out theoretical framework of the study as well as how data was collected and analysed according to this framework. This can be transferred to another case study or with other respondents (Babbi & Mouton, 2007).

According to Guba and Lincoln (1985), the demonstration of credibility is sufficient to establish the existence of dependability, since there can be no credibility without dependability (Babbie & Mouton, 2007).

The last issue of confirmability is linked to whether or not the findings are the product of the research focus and not on the biases of the researcher (Babbie & Mouton, 2007). The onus is placed on the data and not on the researcher since the data is interrogated as to whether or not it is trustworthy or whether the findings is similar to, or different from, other related studies.

3.5.5 Pilot Study

The semi-structured interview schedule was pretested in order to ascertain the clarity and logical order of questions. Therefore, a community active member of the ward councillor was interviewed to test flow of the interview schedule. This deemed effective and no problems were encountered.

3.5.6 Data Analysis Strategy

All of the interviews were transcribed through a process that involved listening to each interview and typing it out verbatim. This analysis follows Tesch's (1990) method of openly coding and sub-coding. Tesch's (1990) method requires the reading the transcripts several times while taking notes and identifying similar categories. This process highlights themes, categories and sub-categories which fall in line with the main research questions and objectives. This information is then compared and analysed with existing literature in the field.

3.6 Ethical Considerations

De Vos (2005) highlights the significance of ethical considerations concerning the proper conduct towards experimental subjects. These guidelines serve as regulatory principles for the researcher to evaluate his/her own conduct. Increasing knowledge is a central principle of research, but care must be taken as not to harm human beings at its expense.

According to Stake (2005: 459), “case study research shares an intense interest in personal views and circumstance, and those whose lives and expressions are portrayed risk exposure and embarrassment”. It is therefore important that ethical standards are maintained. This was ensured by offering confidentiality to interviewees and complying with their requirements. If the interviewees wished to remain anonymous, the researcher ensured it. The following ethical considerations were highlighted in De Vos (2005) and Babbie and Mouton (2007) which most relate to this study:

3.6.1 Consent

Each respondent was approached with a research concession letter. In this letter, the researcher provided adequate information about the objectives of the research (refer to Appendix D). This was made available to each respondent before interview dates and times were finalised. At the beginning of each interview, each respondent was informed about anonymity and they were permitted to withdraw from the research at any time, if they felt uncomfortable with the process. Lastly, the use of a tape recorder was negotiated (refer to Appendix B, section one)

All respondents participated voluntarily and the researcher came across no obstruction during any interview process.

3.6.2 Confidentiality

The respondents were informed of their anonymity before the interview took place. Thus, the study does not refer to respondents by their real names so that expressions cannot be traced back to a specific person. Alphabetical letters, from A to N were used in place of respondents names. City Departments were also not specifically referred to, rather they were clustered under a common theme, e.g. community safety comprised of three different City Departments working towards the enhancement of safety in communities.

3.6.3 Competency

The researcher took precaution so as not to harm participants in any way and to formulate and clearly convey information unambiguously. Thus, all issues and information that came out of the data was dealt with sensitively. The researcher assured each respondent that their organisation would receive copies of the final research report.

3.7 Limitations to the Study

The following limitations are applicable to this study:

3.7.1 Limitations of the Research Methodology

According to Babbie and Mouton (2007), a limitation of qualitative research is that respondents are not open to exact explanation, prediction or control. Qualitative research depends on the honesty of respondents and this could influence the reliability of findings. The fourteen respondents might not have been willing to express all their opinions or to share everything with the researcher, particularly those respondents who work for the City and who are mandated to implement the objectives.

3.7.2 Limitations of the Research Design

Case study research design often limits the researcher's ability to provide comparison (Strydom & De Vos, 1998). The basic strategy of a single case study is to "thoroughly describe a single unit during a specific period of time" (Strydom and De Vos, 1998:125) and does not allow for contrast with similar cases.

3.7.3 Limitations of the Sampling Methodology

A limitation of purposive sampling, as adopted in this study, is that it is entirely based on the judgement of the researcher (Strydom & De Vos, 1998) which could become subjective and influence the reliability of the findings.

3.7.4 Limitations of the Data Collection Strategy

Interviews involve personal interactions and thus cooperation is a prerogative (Greef, 2002). The respondents might not have been willing to share everything or the researcher might not have asked the correct questions to evoke the desired response. The researcher is also aware that a limitation of using tape recorder does not allow the researcher to capture expressions which could be useful in analysing the data.

3.7.5 Limitations of the Data Analysis Strategy

A limitation of analysing qualitative data is that a high level of interpretation is involved. Due to the subjective nature of the research, multiple meanings could be derived (Strydom & De Vos, 1998). There is also the possibility that the researcher can overlook or minimise categories and sub-categories that should be given more attention.

3.7.6 Limitations of the Researcher

The time frame of conducting interviews took three months contrary to what the researcher expected. Some respondents took up to seven weeks to confirm a date and time for the interview. The researcher discovered that respondents were unsure about the nature of the interviews and may have felt that their work is being questioned. This delay in data collection posed a huge time constraint to completing the dissertation.

As a researcher who is passionate about addressing the gap between policy formulation and implementation, and using this as a tool to addressing the socio-economic conditions faced by Cape Flats' communities, it was difficult to maintain complete objectivity. The construction of the research questions could lead to bias as the researcher noticed that at times she may have asked leading questions differently to obtain the information she was seeking.

3.8 Conclusion

This chapter discussed the research design, including the use of a case study research methodology used in this research. A description of the sampling strategy, data collection and data analysis that guided the process of the study was provided. Ethical considerations and limitations relevant to this study were discussed.

The following chapter presents and discusses the findings from the case study, which responds to the four research objectives.

CHAPTER FOUR: THE PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents a discussion of findings of the fourteen in-depth interviews conducted with the respondents of the study. It begins with a presentation of the profiles of the respondents, which is graphically represented in Table 4. A framework for discussion and analysis is presented in Table 5, which is followed by a discussion of the findings. The major themes are linked to the study objectives and the sub-themes are listed as categories. Further themes emerging from these categories are listed as sub-categories. Each category and sub-category identified is linked and supported with verbatim quotations from the respondents. Direct quotes taken from the transcriptions will be used to illustrate the respondents' perceptions and experiences. Further analysis in relation to categories and sub-categories are discussed within the framework of relevant literature and research already done in the field.

4.2 Context: Operational Alcohol and Drug Strategy 2007-2010

The format for the interview schedule was derived from the five main objectives as stated in the Operational Alcohol and Drug Strategy 2007-2010 (OADS). These five objectives are as follows:

1. Reduce [Alcohol or Drug] AOD-related crime and anti-social behaviour, and minimise AOD-related accidents and injuries.
2. Improve access to a range of evidence based treatment and prevention interventions to minimise AOD-related harm among the citizens of Cape Town, particularly vulnerable people, such as youth, people affected and infected by [Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome] HIV/AIDS and [Tuberculosis] TB, women (especially pregnant women), people who are unemployed, people with physical disabilities and mental illnesses, the elderly and people who are homeless.
3. Improve access to information on AOD-related harms for the city community, and how they can respond to these harms.
4. Improve reporting on local interventions and their effectiveness.
5. Cooperate with other spheres of government for enhanced responses to AOD-related impacts on people and places.

Source: Operational Alcohol and Drug Strategy 2007-2010, page 14.

In line with the above objectives, the researcher sought to determine the extent to which persons or organisations mandated by, or engaged with the strategy implemented the objectives.

4.3 Profile of Respondents

This research gathered information from fourteen respondents coming from different backgrounds, ranging from Local Government Departments, Non-governmental Organisations (NGO) and a Parastatal Organisation. Each respondent represented and spoke

on behalf of the organisations in terms of their mandate or responsibility, or the organisation's mandate or responsibility to implement the OADS or part thereof in the Ottery Marble Flats community. Hence, respondents were identified with regards to their mandate as identified in the OADS.

Table 4: Profile of Respondents

PARTICIPANTS	GENDER	ORGANISATION	POSITION	INTERVIEW DATE
Respondent A	Female	Local Government: Municipal	Active member of the Ward Councillor	16/09/2010
Respondent B	Female	Local Government: Municipal	Social Services Assistant	16/09/2010
Respondent C	Male	Local Government: SAPS	Captain	21/09/2010
Respondent D	Male	Local Government: Community Safety	Chief	11/10/2010
Respondent E	Male	Local Government: Health	Executive Director	5/11/2010
Respondent F	Female	Local Government: Health	Coordinator	5/11/2010
Respondent G	Female	Local Government: Soc Dev	Professional Officer	12/11/2010
Respondent H	Female	NGO	Executive Director	18/11/2010
Respondent I	Female	Local Government: Soc Dev	Professional Officer	22/11/2010
Respondent J	Female	Local Government: G & I	Functional Operations Manager	22/11/2010
Respondent K	Female	Parastal: MRC	Researcher	25/11/2010
Respondent L	Male	Local Government: Community Safety	Head	25/11/2010
Respondent M	Female	Parastal: MRC	Scientist	2/12/2010
Respondent N	Male	Local Government: Community Safety	Strategy Manager	6/12/2010

4.4 Analysis of Findings

** Please note that respondents are quoted verbatim and grammatical errors are not corrected*

This section presents a discussion of the findings of the study. Tesch's (1990) approach was used for writing up a framework of analysis, which will serve as a format or guide for writing up the data presentation and analysis in a logical and systematic manner. This is presented in Table 5 below.

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Table 5: Framework of Analysis

RESEARCH OBJECTIVES	RESEARCH QUESTIONS	THEMES	CATEGORIES	SUB-CATEGORIES
<i>Introduction</i>		<i>Theme 1</i> Respondents understanding of substance abuse	<ul style="list-style-type: none"> Types of substance abuse Social Ills associated with substance abuse Impact on youth 	
<i>Objective 1</i> To explore participants' perceptions of whether the OADS has been implemented in the Marble Flats.	Has the OADS been implemented at all in the Marble Flats community?	<i>Theme 2</i> Implementation of OADS in the Marble Flats community	<ul style="list-style-type: none"> Familiarity with the OADS When and how respondents were informed about the OADS 	
<i>Objective 2</i> To explore the participants perceptions of whether the objectives of the OADS have been implemented in the Marble Flats community	Which of the objectives identified in the OADS have been implemented in the Marble Flats community?	<i>Theme 3</i> Objectives implemented in the OADS	<ul style="list-style-type: none"> Awareness of objectives 	
			<ul style="list-style-type: none"> Mandated/Responsible to implement objectives 	<ul style="list-style-type: none"> Highlighted objectives
			<ul style="list-style-type: none"> Objectives operationalised/implemented Objectives not operationalised/implemented 	<ul style="list-style-type: none"> Form Outcome Factors that played a role in non-implementation
<i>Objective 3</i> To identify the challenges and successes experienced in the implementation of the OADS in the Marble Flats community	What challenges and successes have been experienced in the implementation of objectives of the OADS in the Marble Flats community?	<i>Theme 4</i> Challenges and successes in implementing the OADS	<ul style="list-style-type: none"> In the implementation of the policy In the policy itself 	
<i>Objective 4</i> To obtain participants' perceptions of the impact of the implementation of the OADS in the Marble Flats community	What impact has the implementation of the OADS had in the Marble Flats community?	<i>Theme 5</i> Impact of the OADS	<ul style="list-style-type: none"> Benefit Non-benefits 	
<i>Recommendations</i>		<i>Theme 6</i> Respondents recommendations regarding the OADS	<ul style="list-style-type: none"> Policy Implementation Substance Abuse 	

4.4.1. Respondents' understanding of Substance Abuse (Theme 1)

This section will look at three main categories that emerged with regards to the respondents' understanding of substance abuse. These categories are 'types of substance abuse', the 'social ills associated with substance abuse' and 'impact on youth'. The purpose of this theme is not to fulfil the requirements of a specific research objective, but to provide context for all four research objectives.

4.4.1.1 Types of substance abuse (Category 1.1)

Respondents associated their understanding of substance abuse in the Marble Flats community with one particular substance. More than half (eight respondents) indicated the introduction of Crystal Methamphetamine (MA), commonly known as 'tik', to the Marble Flats community largely contributes to the intensity of substance abuse. Most respondents related the fact the MA usage is increasing rapidly because it is easily accessible and inexpensive. The understanding of the problem of substance abuse is particularly related to MA abuse and it is related to the fact that the Marble Flats is a very poor community.

"It's immense and out of control. It's been growing for the last couple of years at a terrible rate, especially since the introduction of Methamphetamines to the Cape Flats community. That is obviously driven by the fact that tik is inexpensive and easily accessible" (Respondent N).

"The younger generation is hooked onto methamphetamine in the form of tik because it's cheap and it hits hard" (Respondent D).

This echoes a report by Pludderman et al [b] (2008) which graphically illustrates the staggering rise in MA since 2002 across the Western Cape.

Six out of fourteen respondents indicated that the misuse of alcohol also largely contributes to the growing problem of substance abuse in the Ottery Marble Flats community. These respondents highlighted that parents are often abusers of alcohol which makes the situation volatile for children to abuse substances and parents are not good role models.

“Most of the parents are single mothers, they either get a grant and some of them are heavy drinkers, they are completely addicted to alcohol and their children just do what they want to do, they start using drugs” (Respondent C).

“When I say substance abuse, I include alcohol, and maybe alcohol is the biggest problem. I think more people abuse alcohol compared to dagga and tik” (Respondent G).

Of the six respondents that highlighted the misuse of alcohol, four of them also highlighted that the abuse of alcohol was misunderstood. It is often viewed as an acceptable until it causes violence or children are neglected. Respondent M illustrates this point.

“Alcohol is a forgotten drug and the use thereof is so normalized. It’s not even seen as a problem by community members, its only seen as a problem when alcohol use becomes violent or when children are being abused or neglected, then people will start speaking up about it.”

An additional two substances was also highlighted significantly during interviews, which respondents emphasised as their understanding of substance abuse that largely impacted the Ottery Marble Flats community. These are cannabis (dagga) and methaqualone (mandrax), and are said to be frequently used amongst the older generation of the community.

“We find that the older generation is stuck on their dagga and mandrax. They still stick to that. The younger generation is hooked onto methamphetamine in the form of tik because it’s cheap and it hits

hard. And now we are going with this unga [heroin] which is upper and downer mixture together”

(Respondent D).

These findings are parallel to the wider literature, which says that alcohol is the most common abused drug in South Africa, followed by cannabis and methaqualone (Parry, 1998). This is further emphasised in Pluddemann et al [c] (2008) which shows that alcohol and cannabis are main accompaniments or continue to be used excessively despite the increasing levels of MA.

4.4.1.2 The social ills associated with substance abuse (Category 1.2)

All of the respondents agree that substance abuse in Cape Flats communities is very rife and it stems from the broader social ills faced by the communities. Ten of the fourteen respondents expressed their views concerning the social ills faced by the Marble Flats community. Negative and declining socio-economic conditions within the area are cause for substance abuse. Of these, lack of parental guidance, unemployment, poverty and socio-political historical factors makes the community more susceptible to substance abuse and was identified as the four major social problems leading to drug dependency in the community.

“Really, the issue of substance abuse is obviously a symptom of many of the social problems that are in the community. If one has to look at substance abuse, then one has to look at what are the issues and needs that need to be addressed in the community” (Respondent E).

Obviously, unemployment is a big thing, the communities on the Cape Flats are quite densely populated, its low socio-economic communities, but I also think that we inherited some of this as a result of apartheid and the group system” (Respondent F).

These findings correspond with the literature which states that substance abuse is a global issue and is symptomatic of other deeper problems (Pluddemann et al. [a] 2008). Substance abuse is

linked to unhealthy lifestyles and risky behaviours such as unsafe sex leading to HIV/AIDS, involvement in gangsterism and crime and peer pressure. It is also more common with children who lack adequate support and guidance from their parents or guardians. Substance abuse does not just affect the user, but the entire society.

Furthermore, William (2009) refers to the historical legacy of Apartheid which formed the basis for most of the social problems faced by Cape Flats communities. As a result, Coloured people of the Cape Flats were always vulnerable to these substances as they faced a wide range of socio-economic problems such as social exclusion, poor family support, poverty and unemployment.

4.4.1.3 Impact on Youth (Category 1.3)

Seven respondents reported that their understanding of substance abuse concerned youth as the most vulnerable group at risk to substances in the Marble Flats community. These respondents emphasised that the biggest problem associated with this was that the youth do not have role models. In today's society, it is common to find that most icons, singers or actors are in and out of rehabilitation centres and battling with addiction problems. Closer to home, gangsters are role models. In addition, drugs complement the fast and dangerous lifestyles such as clubbing and speeding.

“If you look at substance abuse, you can basically look at the youth, most of them. Our youth...well if you look at their role models, most of their role models use drugs...if you look at the singers, if you look at some of the sports celebrities and other role models, drugs are involved somewhere”

(Respondent C).

These findings correlate with the National Youth Policy 2009-2014 (NYP) which emphasises that a large portion of South Africa is made up of youth aged fourteen to thirty-five. However, South Africa lacks adequate support structures that facilitate youth development. As a result, youth are more vulnerable to social ills such as substance abuse, gangsterism and crime (The Presidency, 2009).

What makes the situation more volatile for youth is that most of them come from dysfunctional families with poor parenting. They are faced with challenges where parents are addicted to substances and the home environment is completely unstable (Lo, 2009).

“The parents also get involved, you find that parents and children do drugs together and out of that hectic things happen” (Respondent L).

Six respondents referred to poor parenting as the catalyst behind the addiction problems faced by youth in the community. If parents are not using substances with their children, then they are in denial about the addiction problems in their home. They tend to cover up for their problems or totally ignore it. This was echoed by Respondent A when she said:

“Uhm, parents...what I found is that parents are...uhm I don't know if they are shy, but if they do come out it's one or two parents, but I think most parents are shy for what is happening in their households.”

This was reiterated by Respondent C:

“Firstly, if you look at one of the problems would be parents that are addicted to alcohol, especially mothers. What type of society do we have at the end? And the problem is that there's no father figure, or let me rather say that there is a father figure but the father figure doesn't play a prominent role in

the life of the child. He's not a good role model firstly, you can't use him as a mentor because what does gangsters teach children?"

In essence, they highlight that youth in the Ottery Marble Flats community are faced with insurmountable challenges around substance abuse. This is highlighted in the City of Cape Town's (2007) OADS policy where youth are identified as the most vulnerable group to substance abuse.

4.4.2. Implementation of the OADS in the Marble Flats community (Theme 2)

Note: the following theme fulfils the requirements of the first research objective: "To explore participants' perceptions of whether the OADS policy has been implemented in the Marble Flats."

The second theme will explore two categories identified, firstly if respondents are familiar with the OADS and secondly, when and how they were first informed about it.

4.4.2.1 Familiarity with the OADS (Category 2.1)

Twelve out of fourteen respondents indicated that they are familiar with the OADS. Of these twelve of respondents, one respondent indicated that she was not directly familiar with the OADS, but with the National Drug Master Plan 2008-2011 (NDMP) from which the OADS stems.

According to the literature, policy implementation requires active participation from organisations that are mandated or responsible to implement the objectives of the policy

(Performance and Innovation Unit (PIU), 2001). Hence, problems often arise when the necessary people are not informed about a particular policy or the policy does not roll out adequately.

Six respondents highlighted that meetings in the area of the policy implementation and substance abuse were not consistent regarding the roll out of the OADS. Once the policy was launched, the euphoria soon died. However, nine respondents indicated that a revised edition of the OADS is underway.

Two respondents indicated that they were not familiar with the OADS. Respondent B even acknowledged that the researcher was the first person to present the OADS to her.

“No one from government comes to us and presents on these issues. You know, you are the first person to show me this policy.”

According to the PIU (2001: 47), bureaucrats have an important “role in ensuring the performance of a policy”. It will also give them an opportunity to express their goals and desires, which could contribute to the success of the policy. However, a common characteristic of beauracritic system is delays in communication, which often lead to delays in policy implementation.

4.4.2.2 When and how respondents were first informed about the OADS (Category 2.2)

Of the eight-six respondents (twelve out of fourteen) that are aware of the OADS, four were informed through a government facilitated meeting held to deliver the strategy. Four of the respondents were involved in putting the strategy together, by either being consulted for input into the strategy or being part of the team that drafted the strategy. Two respondents informed

me that they discovered the strategy informally through their formal work within their organisations.

“You now I was never actually informed about the strategy. It’s just something that I heard about in the passages” (Respondent K).

Lastly, two of the respondents indicated that their department was not formally consulted in the drafting of the strategy and their awareness of the policy only came about when the policy was launched. The following quote from Respondent G illustrates this:

“It came to Social Development once it was already completed. Our department was never consulted in the drafting of it. The first time we came to hear about it was when it was launched. So we didn’t have any input in it. And even in the strategy, there isn’t a lot that speaks to the role of social development.”

Respondent A, Respondent C and Respondent G both expressed that their departments had the capacity to largely contribute to the strategy, but there was minimal or no consultation from their directorate in the drafting of the strategy. They were merely informed about the strategy upon its launch.

This concurs with the NDMP which highlights the importance of a coordinated response to reduce the supply of and demand for drug dependency and partnerships between all stakeholders at local and provincial level (Department of Social development, 2006). If all stakeholders are not involved and strong partnerships are not forged, the implementation of policy will be hindered.

4.4.3 Objectives implemented in the OADS (Theme 3)

Note: the following fulfils the requirements of the second research objective: “To explore the participants’ perceptions of whether the objectives of the OADS policy have been implemented in the Marble Flats community.”

In the third theme, four categories were identified to determine which of the objectives were implemented in the Ottery Marble Flats community. These are ‘awareness of objectives’, ‘mandated or responsible to implement objectives’, ‘objectives operationalised or implemented’ and ‘objectives not operationalised or implemented’. In these four categories, three sub-categories emerged. In the second category, sub-category ‘highlighted objectives’ was identified. In the third category, sub-categories ‘form’ and ‘outcomes’ were identified, and in the fourth category, sub-category ‘factors that played a role in non-implementation’ were identified.

4.4.3.1 Awareness of objectives (Category 3.1)

The twelve respondents that indicated that they were familiar with the OADS also indicated that they were aware of the five objectives of the strategy. Of these respondents, two indicated that they were not aware of the contents of the objectives, but they were aware of the broader objectives from which it stems from the NDMP. Respondent C indicated that the objectives of the OADS were encapsulated in the annual plan of his organisation.

“What happened with this strategy is that the broad theme is encapsulated in the annual police plan so didn’t need to know this plan verbatim. We knew that we are giving input to these objectives and hence we were covered in some of the objectives. If you take this plan, we are already in line with objectives of this strategy.”

4.4.3.2 Mandated or responsible to implement objectives (Category 3.2)

Of the twelve respondents that indicated that they were aware of the objectives of the OADS, two of these respondents indicated that their mandate has changed as they are no longer involved in the area of substance abuse or other projects have taken precedence over the OADS. Thus, they no longer are responsible for implementing the objectives. Two of these respondents who are researchers in the field of substance abuse indicated that they perform a contributing role to the area of substance abuse and the implementation of the OADS. Therefore, they are not directly mandated to implement objectives, rather they are responsible to contribute to research that will aid in implementation of the objectives. Finally, another two respondents in this category indicated that they perform a monitoring role; hence they are also not directly mandated to implement the objectives but ensure that those who are mandated are performing their roles.

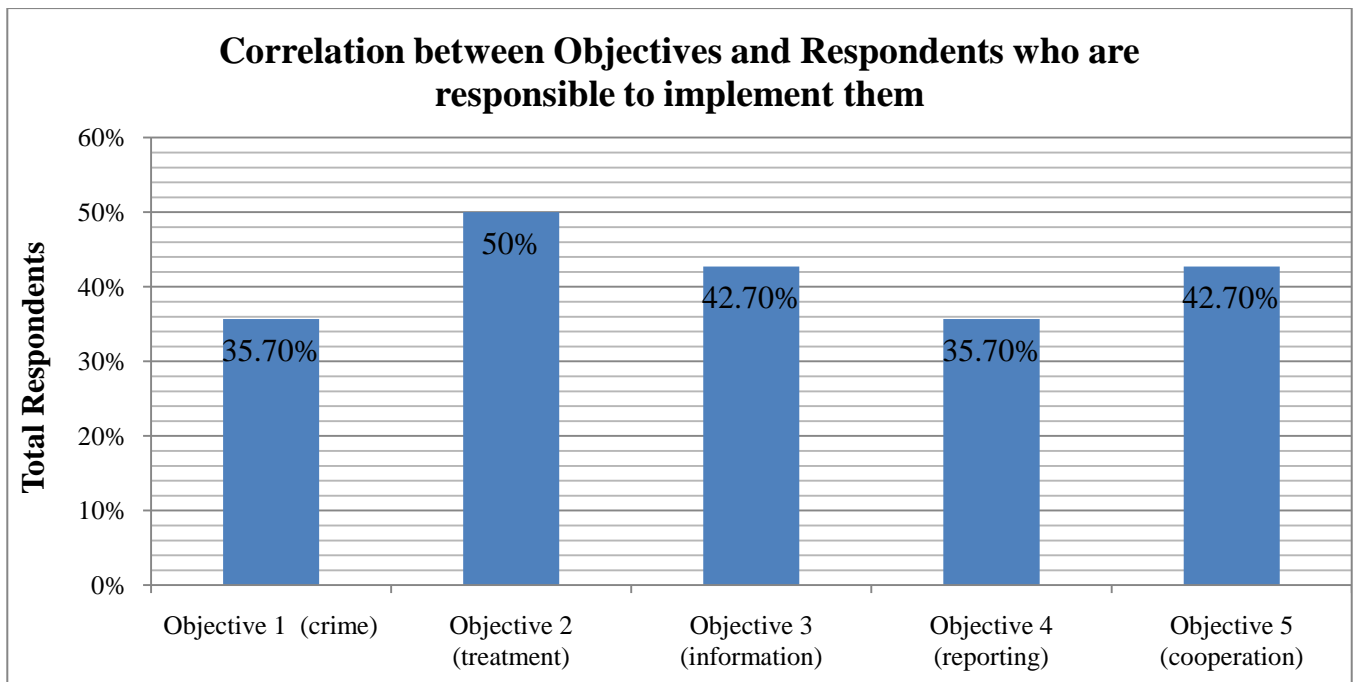
During four interviews, respondents had to re-read the objectives of the OADS and be reminded of what their mandate was before answering the questions.

Respondents furthermore highlighted which objectives they are specifically involved in implementing. This will be discussed in the sub-category below.

4.4.3.2.1 Highlighted Objectives

An analysis of the correlation between the five objectives of the OADS and the respondents who are mandated or responsible to implement them will be presented in the graph 2 below.

Figure 3



Seven respondents were mandated or responsible to implement objective two, while five respondents were mandated or responsible to implement objective one. This sub-category related the respondent's individual mandate to specific objectives. Therefore, this should not be interpreted as a lack of implementation on respondents' behalf, rather that there are certain respondents who are only involved in specific objectives depending on their job descriptions. For example, those respondents from a community safety or police background indicated that they were only responsible for implementing objective one. It is important to note that previous findings were not divided by mandate.

4.4.3.3. Objectives operationalised or implemented in the Marble Flats (Category 3.3)

When respondents were asked: "Which of the objectives have to date been operationalised or implemented in the Marble Flats community?" a common trend in answers was identified.

Respondents indicated that all five objectives were implemented but not to the degree that it should have been implemented.

“I think with under each objective there are certain achievements. There are a few achievements under one, for example more road blocks, there’s been alcohol testing and enforcing the blue flag beaches..”
(Respondent F).

This was reiterated by Respondent L who said:

“All of them, but not to the extent that it was hoped to be implemented.”

Two respondents said they are not aware of any of the objectives being implemented in the Marble Flats community, while one respondent said none of the objectives, he felt, were implemented. Respondents expressed a general view that not enough was being done by the City to ensure the successful implementation of the strategy in the Marble Flats community.

4.4.3.3.1 Form

Varying and interesting responses were obtained when respondents were asked what form the implementation of the objectives had taken. The three respondents whose organisations fell under community safety spoke about objective one being implemented through the establishment of the Substance Abuse Unit (SAU). Furthermore, the same three respondents indicated that objective one is part of their organisations main operational focus and is monitored as part of their main objectives. Respondent D from Metropolitan Police informed the researcher that the objectives of the OADS are captured within their units Operational Strategy as substance abuse is an issue high on Metropolitan Police and the South African Police Service’s (SAPS) agenda.

Respondents from City Health, Governance and Interface and Social Development referred to the establishment of Matrix Treatment Centres as the main form for achieving objective two. Three Treatment Centres are currently established and running successfully and there is preparation in place to establish a fourth one.

“Within, the Cape Flats community, we’ve opened three clinics thus far, and that was done under Councillor Grant Haskin, the first one was in Mitchells Plain, then we went to Table View and then Delft South was the third one” (Respondent J).

“I think the biggest achievement was to set up the matrix clinics and three were launched so far, a fourth one that’s a satellite and a fifth one is in plan” (Respondent F).

While none of these treatment centres are located in the Ottery Marble Flats community, City Health informed the researcher that the policy of these treatment Centres are not to turn patients away based on their geographical locations.

“Also, the treatment services is not a fixed catchment area, obviously it becomes a little costly to get yourself there and back if you do not live in the area, but there’s no reason why you can’t access the Matrix Clinics if you do not live in the area” (Respondent N).

Four respondents also spoke about the establishment of the 0800 Helpline which is a twenty-four hour toll free line, as a form of improved access to information, which speaks to objective three. City Health also launched an informational pamphlet, but the success thereof is not as large compared to the toll free line. Operators seated at this toll free centre are not trained councillors, but their mandate is to provide credible information that will refer people to the nearest treatment centre for help.

“Also with regards to access to information, we launched the 0800 help line number which is situated in the 107 Emergency Centre at 24 Wale Street and is guaranteed operational 24/7. You can phone the line any time and operators will assist you” (Respondent G).

The recent establishment of the Cape Town Alcohol and Drug Action Committee is a form of cooperating between different stakeholders and different spheres of government. This committee seeks to bring all the role players together to enhance responses to AOD-related impact. Hence, it responds to objective four and five.

4.4.3.3.2 Outcomes

Overall, the response was that the OADS had positive outcomes for the Cape Flats and the Ottery Marble Flats in particular. However, respondents expressed a similar view that more can be done with regards to implementation. However, the researcher was informed that substance abuse is a new programme on the City’s agenda, following the previous Mayor Helen Zille’s urgency in dealing with the issue.

From the respondents coming from the component of community safety and police, the output was positive. These respondents felt that the number of arrests in the area of drugs and drug trafficking is a clear indication of the outputs achieved in implementation. While this may be misinterpreted, Respondent N indicated that the media can portray information as if it is a negative aspect. Without the direct action from police to track down and arrest drug users and drug peddlers, these statistics would not be available and the media fails to mention this. Thus, that high statistics of drug arrests indicates a positive outcome as it involved police action.

“If you look at the recent release of crime statistics for the Western Cape specifically, it’s all over the newspapers the terrible thing of drug usage increasing, but what they do not report is the fact that the recording of drug related crime is specifically related to police action” (Respondent N).

Random alcohol and drug testing as well as the establishment of blue flag beaches was emphasised as some of the outcomes.

“There are a few achievements under one, for example more road blocks, there’s been alcohol testing and enforcing the blue flag beaches – no alcohol on beaches etc.” (Respondent F).

In addition, respondents from a community safety background similarly felt that the strategy has created a positive response from communities in the form of stronger community-police relationship and a change in community perception regarding alcohol and drugs. Previously, the police battled to gain trust from the Marble Flats community as more trust was placed in gangs and drug dealers who managed to assure the community of their protection. Slowly, there was a change in this trend where community members started to detest drug dealers and sought help for family members using drugs. This resulted in trust and confidence in the police. Respondent D said that after a while, community members would point out places where drug dealers were hiding drugs during police raids:

“I think the social conscious attached to drugs is starting to change in the Marble Flats. We’ve seen it, slowly but surely the community is not accepting it anymore. They don’t want the drugs there. They don’t want to be seen as a culture of drug dealers and drug users. I’m thinking of this specific operation we were at and we couldn’t find the drugs and we were on our way out, a member of the community who was standing and watching said, “kyk onder die ys kas”. Now that shows a change in the community perception, so they are leading us in the right way.”

This was restated by respondent C who said:

“One of the positive outcomes that I can mention is that there is a very strong community police relationship. The police itself have a strong stance with the community regarding drugs and alcohol and we actually don’t have community interference when police conduct raids.”

Lastly, respondents in the community safety and police component emphasized the establishment of the SAU that ensures specialised focus on drugs and drug trafficking as a positive outcome.

Following the establishment of Matrix Treatment Centres, respondents indicated that a positive outcome was access to free credible services. People had access to treatment that was evidence-based. Respondent K, a researcher whose input was contributory, emphasized a positive outcome that the goals and objectives of the OADS policy are more in line with evidence-based prevention, thus making it more achievable and realistic. In addition, two respondents felt that this was even more positive because of the location of the Matrix Treatment Centres, which are located at the health facilities within the respective communities. Thus, people who use the clinics facilities automatically get screened for substance abuse problems and get referred. This referral works two ways. People who seek services from the Treatment Centres automatically get referred if councillors pick up on medical conditions.

“From a health perspective, we divided the metro into eight sub-health districts and we’ve now tried to place a matrix clinic in four of those and then in terms of making free service available to the community. It’s placed in the health facility which makes it accessible and people know about the health facilities in the community” (Respondent F).

“Well I think it was access, number one, if I look at the 0800 number, then I would say that gives them a range of information. Not only the City’s clinics and bearing in mind that the City’s clinics are free, it’s a matrix model. So they have access to free alcohol and drug treatment services as well as access to other service providers that offers alcohol and drug treatment, be it inpatient or outpatient, be it free, be it therapeutic” (Respondent J).

What can be deduced from the above outcomes of the OADS is the people want to see tangible results. If people see more raids, more police patrols, more arrests and more treatment centres being established, it shows them that the City is working towards service delivery.

“Now we try to maintain a balance because sometimes, it’s not what is done that counts, it’s what is seen to be done that counts. People don’t want to hear statistics; they want to see us making the arrests that are what counts” (Respondent D).

This is echoed in Yaffee and Wondolleck’s (1997) work which notes that people's participation becomes more meaningful when they can see actual on-the-ground progress such as completion of a project, improvement in site quality, or the provision of a new public service. According to Schindler and Cheek (1999), efforts that result in tangible outcomes demonstrate accountability and build ownership among those involved.

Blahna and Yonts-Shepard (1989) note that an essential principle in any public process is that intended beneficiaries should be able to see tangible evidence and that their comments or suggestions are actually incorporated into decision making. When people are able to trace the steps used in coming to a decision, understanding improves and they are more likely to support the outcome.

Nothing speaks louder to people than seeing their efforts turn into action. Ostrom (1990) acknowledged that achieving positive outcomes in the multifaceted environment requires considerable trial and error among participants, but their input in the policy process is extremely valuable in achieving successful implementation.

This is similar to what is expressed in Rondinelli's (1993) work which shows that too little knowledge about local conditions and needs are incorporated in policies as well as insight from intended beneficiaries. The participation of beneficiaries is the primary factor affecting the sustainability of projects or policies; therefore, arrangements should be flexible to accommodate changing circumstances and needs.

4.4.3.4 Objectives not operationalised or implemented in the Marble Flats community (Category 3.4)

Seven respondents indicated that it cannot be chronologically listed as to which objectives have been implemented and which have not, rather that there are attempts at implementing all five objectives and these are all still in process of implementation.

“I think that there have been attempts at all of the objectives; we are now at a stage where we are going to review the strategy so the strategy will be reviewed” (Respondent F).

“I can't say that it has not yet been implemented but that some of the objectives are still in the process or in the teething stage” (Respondent C).

The two respondents working in the Marble Flats community indicated that they felt none of the objectives have been implemented, especially objective one as alcohol and drug related crime had increased considerably in the area. They expressed negative concerns, contrary to

respondents from a community safety and police component, and indicated that when they would phone police with information on drug dens, the drug dealers would somehow become aware of the tip off and get rid of all drugs.

“I experience that we don’t have the cooperation from the police. What happens is you call in and the next minute the merchants would know that the police are coming” (Respondent A).

Eight respondents expressed their views that objective three – improve access to information – has seriously failed in implementation. Respondents indicated that sufficient information with regards to alcohol and drugs has not been given to communities as it should be.

“The second one is, not that it has not been implemented, but it hasn’t been done properly yet is the whole thing about access to information, producing material around substance abuse because a lot of the existing material is not good enough” (Respondent E).

“I think at sometimes there’s a problem with getting information out, we need to update our website, we need to maybe get out more information to the community” (Respondent F).

“I think number three in terms of improving access to information, that maybe a slower process that the prevention intervention, because we recognised that something needs to be done with the website. We kind of slowed down in terms of that so that’s definitely something that we need to be working on” (Respondent J).

There was a common response from all respondents indicating that the OADS policy was still in the process of implementation and more work can be done to achieve full implementation. This involved a review of the strategy, which two respondents discussed in detail. This review is in

process and respondents felt that positive outcomes for implementation are expected with the reviewed draft.

4.4.3.4.1 Factors that played a role in non-implementation

Eleven respondents accounted non-implementation to the fact that the OADS policy is a new task on local government's agenda and it is still 'finding its feet'. Furthermore, two respondents made reference to lack of coordinated government structures and that there was no cohesion in rolling out the strategy.

"Because it's something new, bearing in mind. Although we have this operational plan, it's still a draft and we are hoping to put it into an actual strategy next year" (Respondent J).

"You now I think it's something quite simple such as fragmentation in government. I think Local Government departments are not gelling sufficiently enough. I suppose it could be related to manpower and other type of resources, but I don't think there's been sufficient talking on this particular issue" (Respondent K).

The two respondents, who indicated that none of the objectives have been implemented in the Marble Flats community, similarly expressed that access to rehabilitation centres was limited for people in the Marble Flats community. The closest free rehabilitation centre was in Mitchells Plain and people from the community struggle with high public transport costs. In addition, closer rehabilitation centres are too expensive. Respondent B noted:

"There's no help, like we are trying to get these youngsters to drug rehabilitation centres, but if we phone an institution it's almost R33000 for just one month. Now where do our poor people get that money?"

These findings correlates to Birkland (2005), who says that it is important to have a comprehensive understanding of all the components involved in policy implementation to ensure its success. Policy makers failed to take into account that access to the Matrix Model Clinics may be a challenge to many people if they relied on public transportation. Furthermore, policy-makers failed to consider the cost of private rehabilitation centres, as people from the Marble Flats community simply cannot afford those fees.

With regards to the eight respondents who indicated that objective three was not implemented, the same respondents also highlighted that the City has a lot of work to do to produce credible material that gives information to people. The correct mediums are not being utilised to get the right information out. Respondent G expressed his concerns in the medium employed in getting information out to the public, such as scare tactics and this does not have the desired impact on the public.

“A lot of people still don’t have a clear understanding of what we should be telling people, so people are still shown pictures of dying drug addicts and that does not get the proper information out there.”

“I think number three in terms of improving access to information, that maybe a slower process that the prevention intervention, because we recognised that something needs to be done with the website. We kind of slowed down in terms of that so that’s definitely something that we need to be working on” (Respondent F)

“Access to information could be broad or specific, it could be linked to prevention that there is a little access, but I think it’s not enough. I also think they don’t use the proper mediums to get this information out there. There’s a lot of bodies that you can work with you’ve got your street committees and all of that and I think it hasn’t filtered down to where it needs to be” (Respondent K)

In summary, the majority of respondents pointed out that the five objectives of the OADS policy have been partially implemented in the Marble Flats community. Nine respondents made reference to the infancy of this strategy as a Local Government intervention, but they also acknowledged that certain measures can be adopted to speed up the process of implementation. Generally, respondents acknowledged that the City most certainly made tremendous achievements in each of the five areas, given the infancy of the strategy on Local Governments agenda.

Similar findings can be drawn from the literature on policy implementation in the larger South African context (PIU, 2001; Brynard & de Coning, 2006). Policy implementation only started receiving attention in 1994 and as a result of its infancy, the newly democratic government found itself setting over-ambitious goals which resulted in challenges and constraints to policy implementation.

4.4.4 Challenges and successes in implementing the OADS (Theme 4)

Note: the following fulfils the requirements of the third research objective: “To identify the challenges and successes experienced in the implementation of the OADS policy in the Marble Flats community.”

In this section, the researcher will explore two emerging categories, namely ‘challenges and successes in the implementation of the policy’ and secondly, ‘challenges and successes in the policy’ itself.

4.4.4.1 Challenges and successes in the implementation of the policy (Category 4.1)

The majority of respondents indicated that there is a lack of resources in South Africa to implement policies. These included human and financial resources. Respondents, once again, referred to the infancy of the area of substance abuse in Local Government, which in itself posed many challenges. City officials did not have the necessary knowledge and training in the area of substance abuse. In addition, it was indicated that people are not necessarily open to learning new methods. According to Respondent G:

“Also, resources play a huge role. We don’t have the knowledge and training background to really address these problems. I mean when I started I had no idea, I was just told to do this. I had not done any course in substance abuse, I have a social work background, but when I did social work, we never did a module on substance abuse so I came in with what I thought I knew, and I needed to go and do some courses on my own. And a lot of people are not open to learning.”

These findings tend to parallel literature which shows that developing countries lack expertise and resources, such as information and data, required for rationalistic planning of policies and programmes (Rondinelli, 1993). The problem was that the government worked according to a top-down classical method of implementation, such as rationalistic planning and management, without first considering the resource base required for the policy to thrive. Policy was first planned and then the resources for implementation were identified.

The greatest challenge for the implementation of the OADS was found within the policy itself, where there have been failures in the institutions in planning, monitoring and evaluation. Monitoring and evaluation is a crucial step in ensuring successful implementation. According to Respondent A, who works in the Marble Flats community, there have never been follow-ups or feedback from government with regards to the drug problem faced in the community.

“But there’s no feedback. No one has ever come to us from local government or whatever sphere of government and asked us what do you do about this policy, how are you implementing this policy....nothing like that, and that is one of the main factors because at the end of the day things are being written down, they say they are concerned about this and that in the area but they don’t come back into the areas.”

The OADS policy refers to the establishment of a Strategy Review Committee to ensure that objectives are implemented and outcomes are delivered. This Strategy Review Committee was to serve as a monitoring and evaluation body and was to meet annually over the period 2007-2010 (City of Cape Town, 2007). This was not realised. Rondinelli (1993) notes that when monitoring and evaluation is ignored, projects end up being measured by their inputs rather than the quantity and quality of their outputs.

Other interesting challenges were referred to during interviews. Respondent F made reference to the amount of City personnel, which is a challenge in its own especially when work is delegated to different people and departments. The same respondent referred to the slow process through which policies go in order to be implemented, as a result of a beauracritic structure.

“I think all the things that I mentioned in terms with working with people and processes, which is a challenge on its own. It’s a big organisation, it consists of about 22 000 people. But here things take longer, it’s a longer process, because it’s a bureaucratic structure and in terms of different departments and different priorities.”

Eight respondents felt that the most challenging aspect of the policy was getting the buy-in from all departments. There was a similar opinion that fragmentation in government caused huge delays in policy implementation. There was an urgency to get all the right people talking about the same topic.

“I think one of the challenges to this particular policy would be to get the buy-in from different departments” (Respondent K).

Half of the respondents also referred to fragmentation within government where there was a lack of consensus amongst different departments on what priorities are. It was also highlighted that officials mandated to implement the objectives in the OADS policy experienced obstruction from people within the same department.

“You know I think it’s something quite simple such as fragmentation in government. I think local government departments are not gelling sufficiently enough. I suppose it could be related to manpower and other type of resources, but I don’t think there’s been sufficient talking on this particular issue” (Respondent J).

According to the literature, the inclusion of all organisations with the same aims and objectives ensures pooling of information and resources which could enhance the sustainability and viability of any organisation (Rondinelli, 1993).

Furthermore, the successful delivery of quality services to the public, require a system of intergovernmental relations in which all three spheres of government and all departments interrelate to work together efficiently (PIU, 2001).

Lastly, Respondent M and Respondent I indicated that government failed to build a strong relationship with the NGO sector, who have a better understanding of local needs. This is contrary to what is stipulated in the OADS policy, which emphasises partnerships with all sectors in order to deliver appropriate and effective services (City of Cape Town, 2007).

“Also, better partnership with NGO’s should be looked at. Initially there was a lot of tension with other treatment services in the communities as they partly felt threatened” (Respondent M).

“There’s still a lot of work out there, and I think the only way we can combat this problem is by working closely with NGO’s because they know the communities much better than the government. We need to bring them on board and run the programmes in partnership with NGO’s” (Respondent I).

A major challenge was staffing, getting the right competent staff to work. This is a fairly new field in substance abuse and a new competency for the City. It is also a highly political and emotionally volatile topic, thus it may require more sensitivity in terms of how it was approached.

4.4.4.2 Challenges and successes in the policy (Category 4.2)

Four respondents indicated that the OADS was a legible policy, that it was well researched and very progressive. The researcher notes that all four of these respondents came from Local Government; hence their opinions could be biased. These respondents were either working directly with the strategy or gave input into the strategy.

“No I think it’s a very progressive document. I think there was a lot of work that went into it, it was properly researched, so I don’t see any problems with the policy itself” (Respondent F).

Three respondents indicated that they were not in a position to comment on any challenges or successes in the policy itself. Respondent L pointed out that the policy needs a stronger driver as it is not filtering down to the people. For example, Respondent I was not even familiar with the document, but her job description is directly linked to the Marble Flats community.

“I think the policy is kind of well written, it’s clear, but I believe it needs a stronger driver some way or the other” (Respondent L).

Respondent E similarly expressed problems arising as a result of the strategy not being communicated properly through the organisation. He further noted that there was always a poor attendance at workshops and meetings when attempts are being made to filter the policy through the organisation.

“Look I don’t think there have been any challenges to the policy itself, but I do think maybe it hasn’t been communicated properly through the organization. For example, we organise workshops with the councillors to get them to come and listen to the policy, and we get a very poor turnout of people actually coming” (Respondent E).

4.4.5 Impact of the OADS (Theme 5)

Note: the following fulfils the requirements of the fourth research objective: “To obtain participants’ perceptions of the impact of the implementation of the OADS policy in the Marble Flats community.”

Two categories emerged in this theme, namely ‘benefits of the OADS’ and ‘non-benefits of the OADS’.

4.4.5.1 Benefits of the OADS (Category 5.1)

Six respondents indicated ‘yes’ in terms of the Marble Flats benefitting from the OADS. Part of the motive for this response was:

- (a) Four Matrix Treatment Centres had been established.
- (b) People had access to free credible services through the Matrix Treatment Centres.

- (c) The establishment of a dedicated Substance Abuse Unit through Metropolitan Police.
- (d) Huge Public acceptance of SAPS and Metropolitan Police.
- (e) Release of drug related statistics which indicates police action.
- (f) The establishment of the Cape Town Alcohol and Drug Action Committee which brings different role-players together

Only three respondents expressed their views that the OADS policy has partially benefitted the Marble Flats community. These respondents similarly expressed that more work could still be done. They acknowledged that attempts had been made and there were some positive outcomes, but the impact was not large enough.

“Is it measurable? I mean the City has three clinics and we have a 16 week programme, but how many people can we put through it in one year? Is that enough? With the problem that we are facing, surely that can’t be enough” (Respondent J).

This was echoed by respondent G who said:

“I won’t say it benefitted tremendously. If you gave me a scale of one to five, five being they’ve really benefitted and one being they haven’t benefitted, I would probably give it a two.”

4.4.5.2 Non-benefits of the OADS (Category 5.2)

Three respondents were completely pessimistic and indicated that the Marble Flats did not benefit at all as a result of the OADS. Respondent A expresses these views in saying:

“No. I wouldn’t say so. Where’s the nearest rehab? Do you know if I phone for a rehab, they say it costs a couple of thousand rands and these people don’t even have a breads money. So how are they benefitting? And that’s why the problems are continuing.”

4.4.6 Respondents recommendations regarding the OADS (Theme 6)

This final theme will explore three categories with regards to the respondents’ recommendations. These categories are recommendations that could improve the OADS as a policy, recommendations that could improve the implementation of the OADS and finally, recommendations that could improve the problem of substance abuse. The purpose of the final theme is not to fulfil the requirements of a specific research objective, but to it to add concluding remarks drawn from all respondents based on recommendations to improve the OADS.

4.4.6.1 Recommendations that could improve the OADS as a policy (Category 6.1)

Almost all of the (twelve) respondents in this category specified that the City failed to establish a Strategy Review Committee as indicated in the OADS. Hence, there are no clear lines of accountability. Respondent F says:

“I think maybe something that we haven’t done is not set up a review committee. It wasn’t put into place, and if we had a Strategy Review Committee, there could be accountability because there are three departments that are basically responsible for the implementation of the strategy, it would be Health, Social Development and Safety and Security.”

Nine of respondents indicated that a review of the policy is in process and the revised strategy will be sure to take cognises the new substance abuse act as well as changing trends in substance abuse. According to the literature, policies need to be flexible to accommodate for change

(Brynard & De Coning, 2006). Most respondents indicated that the policy needed stronger cohesion from different stakeholders, which should be the focal point of the revised draft.

4.4.6.2 Recommendations that could improve the implementation of the OADS (Category 6.2)

Ten respondents highlighted that the OADS lacked the necessary tools for monitoring and evaluation. Other recommendations pertained to having a clearer understanding of the dynamics involved in substance abuse and clearer guidelines in the strategy. All of the respondents from Local Government departments similarly expressed views that there was lack of coordination within the City. There were no regular workshops or meetings on the OADS which brought together all the role players. Respondent J emphasised that it was important to get all the Executive Directors on board and to find it in their budgets to invest more money into substance abuse:

“Getting all our executive directors to look at it and find within their budgets to put more money into this will contribute to better implementation.”

Respondents A and B, who work in the Marble Flats community recommended that more resources should be made available to implement the objectives of the OADS. They indicated that support was minimal from government.

“Yes I would say resources are the main problem. We don’t just deal with one specific incident in the area. If I want to call a drug workshop now, I would need resources such as pamphlets and it’s always a struggle, and also people need to be educated, really really educated, but we don’t have the resources” (Respondent A).

“The reason here is that we don’t get help from government, there’s no funding and whenever we phone a government department they cannot help us, but whenever they are on TV they make big promises but there’s never anything. Even the police we phone them and they just make a turn and then they go again. What I find is that nothing gets done by government, nothing” (Respondent B).

4.4.6.3 Recommendations that could help ameliorate the problem of substance abuse

(Category 6.3)

Twelve respondents recommended that stronger educational initiatives are needed in the area of substance abuse. It was emphasised that more investment needed to be put into educating the young. All of the respondents emphasised that prevention is better than treatment, but prevention should be focussed at different age groups within the Cape Flats and target their specific needs.

“And not telling a five year old ‘don’t do drugs’, that’s not a message, it makes people inquisitive so we need to get the right messaging out. It must be aimed at that child’s age where that child is at. So you need to look at all your age groups and have different interventions for them” (Respondent J).

In addition, there was an urgency to develop prevention initiatives that are sustainable which targets young children, which does not specifically give substance abuse information, but looking at enhancing their quality of life. There is a need to try and find out what the risk factor in each community is and provide them with protective factors to ensure that they are not at risk at a later age for substance abuse related disorders.

“I can only speak from my own area of work which is prevention. I do think that not enough is being done in terms of prevention in the Cape Flats. I think what is happening in the Cape Flats is that there are isolated prevention initiatives that are taking place and the idea is that it’s supposed to bring about

change, behavioural change and those kind of once off ad hoc type things do not bring about lasting change or change to any kind of behaviour” (Respondent K).

There was a strong emphasis from nine respondents on family and community involvement to achieve successful implementation. This was reiterated by Respondent C who said:

“I would recommend that the community come together on a regular basis to identify and report. The marble flats is a very small community. If you stand in the middle of the field you can reach everyone. Some people will listen; some will need a little more encouragement to listen. However, I’ve been working in this community for a long time and I know you can take a horse to the water but you cannot force him to drink. However, if you add a little salt under the horses tongue it will make him thirsty and then he will drink himself. So we just need to find out what we can do to coheres people to voluntarily comply with the law instead of just enforcing.”

4.5 Conclusion

In conclusion, the researcher has given an in-depth analysis of the data which responded to the main research questions, which are: discovering whether the OADS has been implemented in the Marble Flats community, identifying which objectives of the OADS have been implemented in the Marble Flats community, highlighting the challenges and successes experience in implementation and assessing the impact made from implementation of the OADS in the Marble Flats community.

The main findings in this chapter are that government departments lack coordination, cohesion and methods of accountability in implementing the objectives of the OADS. As a result, the policy has not filtered down to community workers and members.

The OADS has the potential to impact the problem of substance abuse in the Cape Flats communities. The inclusion of different stakeholders and the NGO sector can positively impact implementation. In addition, consistent consultation and input from researchers in the field is extremely valuable in addressing substance abuse and understanding the dynamics of the addiction.

A reviewed strategy holds many promises for improved implementation and revision in areas where it has been lacking.

The following chapter offers conclusions and recommendations for further research.

University of Cape Town

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This study has highlighted the gap between policy formulation and implementation, which resulted in failures in policy implementation. In using the Operational Alcohol and Drug Strategy 2007-2010 (OADS), this study analysed the implementation of the strategy in a specific community, namely the Ottery Marble Flats community as a case study to identify challenges and/constraints experienced in policy implementation.

Conclusive remarks will be discussed in relation to the four main objectives of the study:

- To explore participants' perceptions of whether the OADS policy has been implemented in the Marble Flats.
- To explore the participants' perceptions of whether the objectives of the OADS policy have been implemented in the Marble Flats community.
- To identify the challenges and successes experienced in the implementation of the OADS policy in the Marble Flats community.
- To obtain participants' perceptions of the impact of the implementation of the OADS policy in the Marble Flats community.

These research objectives were addressed through consulting the relevant literature and through in-depth interviews with fourteen key respondents. Drawing from the main conclusions, the researcher's experience and respondents' comments, recommendations will be made to National Government and Local Government to improve policy implementation,

and recommendations will be made to Non-governmental Organisation's (NGO) and researchers. Finally, recommendations will be made for further research.

5.2 Conclusions

This section will provide a brief outline of the main conclusions in relation to the four objectives and main themes that emerged from the study.

5.2.1 Introduction: Respondents understanding of Substance Abuse

Findings indicated that respondents associated the increasing usage of Crystal Methamphetamine (MA) (Pludderman et al. [b & c] 2008; Harket et al. 2000) with their understanding of the problem of substance abuse in the Ottery Marble Flats community. The increased usage of the drug is also related to its quick effect, accessibility and affordability. Alcohol, cannabis and methaqualone were also amongst the identified substances being abused in the Marble Flats community.

The respondents indicated that substance abuse was symptomatic of the many declining socio-economic conditions faced by the community. Lack of parental guidance, unemployment, poverty and socio-political historical factors were largely highlighted as more pressing social ills in the Marble Flats community.

Findings highlighted the importance of youth as a group in society. This correlates with respondents who emphasised the vulnerability of youth in the Marble Flats, which exposes them to substance abuse. These vulnerabilities included lack of parenting and role models, both within the community and outside.

5.2.2 Objective One: Implementation of OADS in the Marble Flats community

5.2.2.1 Familiarity with the OADS

The majority of respondents indicated that they were familiar with the existence of the OADS policy, but not all were familiar with its contents. Overall, respondents felt that the OADS policy has not filtered down adequately to community structures and local municipalities.

5.2.2.2 When and how respondents were first informed about the OADS

Most of the respondents were informed about the OADS policy through meetings held by government. Respondents also indicated that they were aware of the strategy as they gave input into its drafting, but some respondents indicated that they were informed about the strategy through the course of work.

5.2.3 Objective Two: Objectives implemented in the OADS

5.2.3.1 Awareness of objectives

While most of the respondents were aware of the existence of the OADS policy, they indicated that they were not aware of its objectives and the contents of each objective. This highlights that the OADS policy has not filtered down to all the relevant stakeholders as it should have.

5.2.3.2 Mandated or responsible to implement objectives

A common trend from respondents was that the OADS policy lacked clear guidelines with regards to indicating specific people or organisations that are mandated or responsible to implement the objectives. While some sections were clearly highlighted, it was discovered that certain people's mandate has changed over the years, thus resulting in implementation becoming dormant. Most of the respondents indicated that their role was not clearly described

and their involvement was minimal in implementing the OADS policy. There was a need to create a cohesive response to address the objectives of the OADS policy.

The researcher found that some of the respondents were able to highlight which objectives they are involved in implementing. However, this was not a mandate in the policy per se, rather many of the respondents indicated that their job descriptions cut across the implementation of certain objectives. They would discover that their work would be involved in certain areas similar to the objectives of the OADS policy.

5.2.3.3. Objectives operationalised or implemented in the Marble Flats

The findings suggest that not enough resources were in place to implement all of the objectives in the Marble Flats. While there were attempts at all, according to the respondents, these attempts were not significant enough to really make an impact. There was success in the establishment of a dedicated Substance Abuse Unit and four Matrix Treatment Centres. However, poor implementation was demonstrated as the City was not as successful in developing “credible AOD [alcohol or drug] information and awareness, education and prevention training materials” (City of Cape Town, 2007) as stipulated in the OADS policy. Limited funding was largely attributed as the source of not being able to expand on projects.

5.2.3.4 Objectives not operationalized or implemented in the Marble Flats community

Conclusive findings in this category suggest that respondents who work at community level agree that none of the objectives (crime, treatment, information, reporting and cooperation) were implemented in the Marble Flats community. The literature suggests that people need to see tangible outcomes, which was not the case in the Marble Flats. These conclusions are completely polarised to what local government officials identified. These officials saw equal

and fair attempts at implementing all the objectives, but acknowledge that there are not enough human resources to deliver equally to every single community.

5.2.4 Objective Three: Challenges and successes in implementing the OADS

5.2.4.1 Challenges and successes in the implementation of the policy

Respondents tended to attribute challenges in implementation with limited resources, both human and financial. Other reasons listed were lack of monitoring and evaluation, the delegation of tasks which result in miss-communication, getting the buy-in from all City departments, fragmentation in government and lack of consensus. According to the OADS policy, “the City will monitor and evaluate the effectiveness of City of Cape Town funded, supported and/ driven interventions to reduce the harms associated with AOD use” (City of Cape Town, 2007: 24). Findings show how implementation can be hindered if a plan does not reflect the realistic goals of any country’s capacity and resources.

Despite these challenges, reference was repeatedly made to the fact the substance abuse was a new agenda for Local Government. Given the infancy of the strategy, a fair amount of respondents referred to the success of getting the strategy to where it is and they seemed optimistic about a review of the strategy which is in process.

5.2.4.2 Challenges and successes in the policy

A few respondents indicated that they did not see any challenges with the format of the strategy. They mentioned that the policy was easy to read and clearly spelt out the objectives. However, reference was made to the fact that the policy may lack a strong driver and is not properly communicated through the channels to ensure its implementation, which could pose as a challenge itself.

5.2.5 Objective Four: Impact of the OADS

5.2.5.1 Benefits of the OADS

Despite the unanimous response that the strategy lacked resources to ensure implementation, most respondents did agree that a lot has been achieved in each objective, given the infancy of the strategy. Most respondents pointed out that people had access to free credible services that was evidence based. The 0800 toll free helpline is also regarded as a significant milestone, as people had access to free credible information twenty-four hours a day. Lastly, the establishment of a dedicated Substance Abuse Unit and the Cape Town Alcohol and Drug Action Committee brings together different role players and places the issue of substance abuse high on the agenda.

5.2.5.2 Non-benefits of the OADS

Respondents' overall view was that the OADS policy has benefitted the Marble Flats community. However, both respondents who work at community level in the Ottery Marble Flats community were completely pessimistic. This response holds huge weight as these respondents are most vital in assessing whether the OADS policy is being implemented in the Ottery Marble Flats community.

5.2.6 Conclusions: Respondents recommendations regarding the OADS

Most of the respondents agreed that a review committee was needed to ensure monitoring and evaluation. This is vital in ensuring the success of any policy.

In addition, respondents indicated that regular meetings and workshops should be held to share information and ideas. Some respondents also felt that the area of substance abuse was not clearly understood; hence some of the guidelines may be understood differently by

different people. Thus, there is a need to find a cohesive approach to combating substance abuse in all communities.

From a community level, respondents also highlighted that building stronger families and communities were significant in combating substance abuse. A dysfunctional family can only escalate the problem.

There was a need to develop strategic plans of action which targets different age groups in communities. The focus should be on educating people about substance abuse, thus increasing their individual abilities to identify risks and empower themselves to not be vulnerable to these risks. From these findings, it is clear that prevention is better than treatment. As development professionals, we need to identify the unique needs faced by different age groups in vulnerable communities and focus strategic interventions at them.

It is the opinion of the researcher, based on the interviews conducted, that the City officials are aware of what is needed to be done to address substance abuse, but lack of coordinated efforts between City departments and personnel hinders policy implementation. However, the simplest policies face unexpected challenges. Thus, policies need to be flexible to adapt to changing environments. In addition, government strongly lacks consensus and coordination. All the right people are involved, but there is a lack of coordinated involvement and response.

5.3 Recommendations

Recommendations will be divided into the following categories:

- Recommendations to National Government to improve policy implementation
- Recommendations to Local Government to improve policy implementation

- Recommendations to NGOs
- Recommendations to researchers
- Recommendations for further research

5.3.1 Recommendations to National Government to Improve Policy Implementation

It is recommended that lines of communication were strengthened by policy congruency between Local Government and National Government policies. For this area of policy-making, National Government is the primary driver and it is recommended that they facilitate and coordinate these policies with other spheres of government. For example, the National drug Master Plan 2009-2014 mandates all government departments to draw up mini-drug plans, and this has not rolled out. While it is acknowledged that government departments also have the responsibility to carry out their mandate, National Government also has the responsibility to monitor and evaluate policies to ensure its implementation.

It is recommended that National government ensure greater public participation in communities regarding the content of policies. This will result in increased transparency and accountability of government policies. In line with this, it is recommended that National government guarantee report backs to departments and communities on what has been achieved to date.

5.3.2 Recommendations to Local Government to Improve Policy Implementation

It is recommended that Local Government prepare a feasibility analysis before drafting a policy in order to ensure that goals and objectives are realistic according to available funding. This also includes more investment in monitoring and evaluation to ensure that the policy can adapt easily to changing circumstances. Given the recent financial crises, South Africa is still

volatile in terms of accessing funding and resources, this needs to be taken into consideration when certain goals are set.

While the objectives of the OADS policy are realistic, it fails to stipulate the number of people it plans to target; neither does it state the cost or source of funding for implementing the strategy.

It is recommended that Local Government build partnerships amongst different stakeholders in society and avoid competitive natures. One respondent highlighted that he experienced obstruction from a colleague within the same department with regards to placing substance abuse high on the agenda. Local Government should set up structures to avoid these incidences.

In the review of the OADS policy, it is recommended that Local Government enhance communication channels with all stakeholders in order to coordinate interventions cohesively. The OADS policy stipulates that there will be active partnership in the Western Cape Substance Abuse Forum (which does not exist at this point) and Local drug Action Committees (few communities have this structure in place, the Ottery Marble Flats community does not have it) (City of Cape Town, 2007).

Furthermore, it is recommended that the community members are included in policy making. Local Government must take into consideration that not all people on the Cape Flats have access to the website for comments or to download policies. Thus, these policies (or summaries of them) should be made available at local libraries and schools to make people aware of interventions in place that could assist them. Furthermore, there should be clear

channels of communication between Local Government officials and local ward councillors to inform the people of having the option to make comments or suggestions on new initiatives. This information must be relayed back to Local Government for significant consideration.

Community officials and sub-councillors often feel isolated from the policy-making process and in many cases they are simply not familiar with government's plans or programmes. It is thus recommended that Local Government enhance methods of communication, such as more presentations or workshops, which effectively transfers policies and its contents to the community officials and sub-councillors for implementation to successfully occur. This can be achieved through regular workshops and meeting by authoritative government departments.

Lastly, the newly established Cape Town Alcohol and Drug Action Committee have all the characteristics to serve as a Strategy Review Committee and carry out extensive monitoring and evaluation of the new OADS policy when it is launched. It is recommended that Local Government use this Committee to serve as a Strategy Review Committee in which monitoring and evaluation can take place.

5.3.3 Recommendations to NGOs

It is recommended that NGOs insist on forging stronger relationships with Local and National Government. For example, an NGO was contracted to draft the OADS policy and once it was presented to government, they had no further involvement in monitoring and evaluation. There should not be a disconnection in any process of policy formulation and implementation. Knowledge and information must be shared more readily between both

government and NGOs. The outcomes are less effective when different organisations are implementing different strategies in their own capacity. It cannot be stressed enough those co-ordinated arrangements, which the OADS policy refers to, will result in positive outcomes.

5.3.4 Recommendations to Researchers

The role of researchers is extremely important in putting together a coherent strategy. It is recommended that researcher's give regular input and guide government on interventions that are evidence based.

5.3.5 Recommendations for Further Research

This research has critically analysed and enhanced our understanding of implementing the OADS policy in the Ottery Marble Flats community. The following recommendations highlight areas which could further be researched.

- Research looking at more than one Cape Flats community and comparing findings between the communities. This would be more representative of challenges faced by the Cape Flats with regards to implementing substance abuse policy.
- Further research could look at interviewing people from the community to get a clearer understanding of any impact they experience from governments new agenda in prioritising substance abuse.
- Lastly, it is recommended that any further research should focus on the challenges experienced by youth in the Cape Flats with regards to substance abuse. The National

Youth Policy 2009-2014 and the OADS policy can serve as key policies that would inform this research.

REFERENCE LIST

- Adhikari, M. 2005. *Not White Enough, Not Black Enough: Racial Identity in the South African Community*, Cape Town: Ohio University Press.
- Adhikari, M. 2009. *Burdened by Race: Coloured Identities in Southern Africa*, Cape Town: University of Cape Town Press.
- Arnett, P. J. 2000. Emerging adulthood: a theory of development from the late teens through the twenties. *American Psychologist*, No. 55, pp.469-480.
- Babbie, E. & Mouton, J. 2007. *The Practice of Social Research*, South Africa: Oxford University Press (Pty) Ltd.
- Barlow, D. N. & Durand, M. V. 2005. *Abnormal Psychology: An Integrative Approach*. USA: Thompson & Wadsworth.
- Berg, B. L. 1998. *Qualitative Research Methods for the Social Sciences*. 3rd ed. USA: Allyn and Bacon.
- Bernstein, A. 1999. *Policy- Making in a New Democracy: South Africa's Challenges for the 21st Century*. Johannesburg: Centre for Development and Enterprise.
- Bernstein, M. 1952. The Scope of Public Administration, *The Western Political Quarterly*, Vol. 5, No.1, pp.124-137.
- Birkland, T. A. 2005. *An Introduction to the Policy Process: Theories, Concepts and Models of Public Policy Making*, New York: M. E. Sharpe Inc.
- Blahna, D. J. & Yonts-Shepard, S. 1989. Public involvement in resource planning: toward bridging the gap between policy and implementation. *Society and Natural Resources* Vol. 2, No. 1, pp.209-227.
- Booyesen, S. 2001. Transitions and Trends in Policy Making in Democratic South Africa, *Journal of Public Administration*, Vol. 36, No. 2, pp.125-144.

- Booyesen, S. 2006. Consolidation of Coordination in the Centre: Trends in Public Policy-making in South Africa, *Journal of Public Administration*, Vol. 41, No. 4, pp.731-749.
- Bronfenbrenner, U. 1979. *The ecology of human development: Experiments by nature and design*. Cambridge, Harvard University Press.
- Brynard, P. & De Coning, C. 2006. Policy Implementation. In: Cloete, F., Wissink, H & de Coning, C. eds. *Improving Public Policy*. Pretoria: Van Schaik Publishers, pp.84-112.
- Central Drug Authority, 2009. *About the Central Drug Authority*, [Online] Available at: www.dsd.gov.za [12.11.09].
- City of Cape Town [a], 2009. *A Profile: The Cape Flats*, [Online] Available at: www.capeflats.co.za [10.07.09].
- City of Cape Town [b], 2009. *City of Cape Town Census 2001: Ottery*, [Online] Available at: <http://www.capetown.gov.za/en/stats/2001census/Documents/Ottery.htm> [10.07.09].
- City of Cape Town [c], 2009. *State of Cape Town 2008: Development Issues in Cape Town*, Cape Town: Strategic Development Information and GIS Department.
- City of Cape Town, 2007. *Operational Alcohol and Drug Strategy: 2007-2010*, [Online] Available at: www.capetown.gov.za [24.09.09].
- Cloete, F., Wissink, H. & De Coning, C. 2006. *Improving Public Policy from Theory to Practice*. 2nd ed. Pretoria: Van Schaik Publishers.
- Damon, I. C. C. 2000. *To what extent do prescriptive decision making models comprehend policy-making in the Third World with reference to South African environmental policy-making?* Cape Town: UCT Press.
- De Coning, C. 2008. Editorial, *Africanus*, Vol. 38, No. 2, pp.1-6.
- De Vos, A. S. 2005. *Research at Grass Roots level: For the social sciences and human service professional*. 3rd ed. Paarl: Van Schaik Publishers.

- Deleon, P. 1998. Stages approach to the policy process. In: Sabatier, P. A. ed. *Theories of the Policy Process*. Westview: Boulder Press.
- Denzin, N. K. & Lincoln, L. S. 1994. *Collecting and interpreting qualitative materials*, California: Sage Publications.
- Department of Health, 2004. South African Demographic Health Survey 2003, [Online] Available at: <http://www.doh.gov.za/facts/sadhs2003/part1.pdf> [10.07.09].
- Department of Social Development, 2006. *National Drug Master Plan 2006-2011*, [Online] Available at: www.dsd.gov.za [10.07.09].
- Department of Social Development, 2008. *The State of the Population in the Western Cape Province*, South Africa: HSRC Press.
- Entertainment Television, 2011. *E TV News*, South Africa [11.03.11].
- Etzioni, A. 2003. *Encyclopedia of Community: From the Village to the Virtual World*, Vol. 1, pp.224-228.
- Flisher, A. J., Parry, C. D. H., Evans, J., Muller, M., & Lombard, C. 2003. *Substance Abuse by Adolescent in Cape Town*, [Online] Available at: <http://www.sciencedirect.com/science> [10.03.11].
- Fouche, C. B. 2005. Qualitative Research Design. In: De Vos, A. S., Strydom, H., Fouche, C. B., Delpont, C. S. L. eds. *Research at Grass Roots*. Pretoria: Van Schaik Publishers, pp.240-267.
- Gawkowska, A. 1999. Neutrality, Autonomy and Order: Amitai Etzioni's Communitarian Critique of Liberalism Under Scrutiny, *A Decade of Transformation*, Vol. 8, No. 4, pp.1-34.
- Gil, D. G. 1992. *Unravelling Social Policy: Theory, Analysis, and Political Action Towards Social Equality*, 5th ed. Vermont: Schenkman Books Inc.

- Giliomee, H., Myburgh, J., & Schlemmer, L. 2000. *Dominant Party Rule, Opposition Parties and Minorities in South Africa*, Kenton: Konrad Adenauer Foundation.
- Gillham, B. 2000. *Case Study Research Methods*, Great Britain: TJ International LTD.
- Greef, M. 2009. Information Collection: Interviewing. In: De Vos, A. S., Strydom, H., Fouche, C. B., Delpont, C. S. L. eds. *Research at Grass Roots*. Pretoria: Van Schaik Publishers, pp.145-157.
- Gumede, V. 2008. *Public Policy Making in a post-apartheid South Africa: A Preliminary Perspective*, *Africanus*, Vol. 38, No. 2, pp.1-6.
- Harker, N., Kader, R., Myers, B., Fakier, N., Parry, C., Flisher, A. J., Peltzer, K., Ramlagan, S., & Davids, A., 2009. *Substance Abuse Trends in the Western Cape: A Review of Studies conducted since 2000*, [Online] Available at: www.sahealthinfo.org/admodule/substance.pdf [11.09.09].
- Hawkins, J. D., Catalano, R. F., & Miller, J. Y. 1992. Risk and Protective Factors for alcohol and other drug problems in adolescence and early adulthood: Implications for Substance Abuse, *Psychological Bulletin*, Vol. 1, No. 112, pp.64-105.
- Henry, N. 1975. Paradigms of Public Administration, *Public Administration Review*, Vol. 35, No. 4, pp.378-386.
- Hogwood, B. W. & Gunn, L. A. 1984. *Policy Analyses for the Real World*, Oxford: Oxford University Press.
- John, P. 1998. *Analysing Public Policy*, London: Continuum.
- Johnston, L. D., O'Malley, P. M., & Bachman, J. G. 2002. *Monitoring the future national survey results on drug use, 1975-2001. Volume I: Secondary school students (NIH Publication No. 02-5106)*. Bethesda: National Institute on Drug Abuse.

- Kallonga, E. A. 2010. *Democratic Policy Formulation and Implementation: Encouraging participation through policy dialogue/discussion* [Online] Available at: www.hakikazi.org/.../BRIDGING+POLICY+FORMULATION+GAP.pdf [24.01.11].
- Kapp, C. 2008. *Crystal Meth boom adds to South Africa's Health Challenges*, [Online] Available at: www.lancet.com/journals/lancet/article/PIIS0140.../fulltext [16.10.09].
- Kingdom, J. 1984. *Agendas, Alternatives and Public Policies*, New York: Harper Collins.
- Korten, D. 1984. *People-centered Development: Contributions toward theory and planning frameworks*, West Hartford: Kumarian Press.
- Ledochowski, C. 2005. *Cape Flats Details: Life and culture in the townships of Cape Town*, Pretoria: Unisa Press.
- Leggett, T. 2003. On the Tuk-Tuk Express: Has methamphetamine hit the Cape Flats? *SA Crime Quarterly*, No. 6, South Africa: Institute for Security Studies.
- Lincoln, Y. S. & Guba, E. G. 1985. *Understanding and doing Naturalistic Enquiry*, Beverly Hills: Sage Publications.
- Lo, L. 2009. Familial and Socioeconomic Influences on Substance Abuse: An Ecological Model, *Sentience*, Vol. 2, No. 1, pp.5-10.
- Makinde, T. 2005. Problems of Policy Implementation in Developing Nations: The Nigerian Experience, *Journal of Social Science*, Vol. 2, No. 1, pp.63-69.
- McCormick, B. 2000. *Opposing Viewpoints Addiction, Opposing Viewpoints Series*, United States of America: Greenhaven Press.
- Miles, M. & Huberman, A. 1994. *Qualitative Data Analysis: An Expanded Sourcebook*. California: SAGE Publications.
- Mishra, R. 1980. *Society and Social Policy: Theories and Practices of Welfare*, Hong Kong: MacMillan Education Ltd.

- Molewa, E. 2011. *ANCWL welcomes World Health Organisations Global Status Report on alcohol and health report which shows that alcohol is the major contributor to death and social ill*, [Online] Available at: <http://www.anc.org.za/7681> [14.03.11].
- Morrin, S. & Collin, C. 2000. Substance Abuse Prevention: Moving from Science to Policy, *Addictive Behaviours*, Vol. 25, No. 6, pp.975-983.
- Morris, J. 1976. *Social Control of the Welfare State*, Chicago: University of Chicago Press.
- Morse, S. J. & Peele, S. 1974. "Coloured Power" or "Coloured Bourgeoisie"? Political Attitudes Among South African Coloureds, *The Public Opinion Quarterly*, Vol. 38, No. 3, pp.317-334.
- Myers, B. & Parry, C. 2002. Fact Sheet – Substance Abuse by South Africa Adolescents, [Online] Available at: <http://www.sahealthinfo.org/sahealthinfo.htm> [14.09.10].
- Ndou, C. 2009. Drugs: *Fighting the Evil*, [Online] Available at: www.info.gov.za/vukuzenzele/number1/files/p13drugsb.pdf [14.09.10].
- O' Dowd, M. 1998. *What the Poor need most*, Johannesburg: SAIRR.
- O'Toole, L. J. 1986. Policy Recommendations for Multi-Actor Implementation: An Assessment of the Field, *Journal of Public Policy*, Vol. 6, No. 2, pp.181-210.
- O'Toole, L. J. 2000. Research on policy Implementation: Assessment and Prospects, *Journal of Public Administration Research and Theory*, Vol. 10, No. 2, pp.263-288.
- Organisation for Economic Co-operation and Development, 2000. *Reducing the risk of policy failure: Challenges for regulatory compliances*, [Online] Available at: www.oecd.org/dataoecd/23/37/46466287.pdf [19.01.11].
- Ostrom, E. 1990. *Governing the Common: the evolution of institutions for collective action*. Cambridge: Cambridge University Press.
- Parry, C. D. H. & Bennetts, A. (In press). *Alcohol policy and public health in South Africa*. Cape Town: Oxford University Press.

- Parry, D. H. 1998, Substance Abuse in South Africa: Country report focusing on young persons, [Online] Available at:
<http://www.sahealthinfo.org/admodule/countryreport.pdf> [23.02.11].
- Patel, L, 2005. *Social Welfare & Social Development in South Africa*, Southern Africa: Oxford Press.
- Pentz, M. A. 1993. Comparative effects of Community-Based Drug Abuse Prevention. In: Baer, S. J., Marlatt, A., & McMahon, R. J. eds. *Addictive Behaviors Across the Life Span*. USA: Sage Publications Inc, pp.69-87.
- Performance and Innovation Unit, 2001. *Better Policy Delivery and Design: A discussion paper*, UK Cabinet Office.
- Petersen, Z. 2010. Facelift for Ottery's Marble Flats, *Southern Mail Independent Newspaper*, 25 August, p.1.
- Plüddemann [a], A., Flisher, A. J., Mathews, C., Carney, T., & Lombard, C. 2008. Adolescent Methamphetamine use and sexual risk behaviour in secondary school students in Cape Town, South Africa, *Drug & Alcohol Review*, Vol. 27, No. 1, pp.687-692.
- Plüddemann [b], A., Myers, B., & Parry, C. D. H. 2008. Surge in Methamphetamine use in young people in Cape Town, South Africa: Implications for Public Health, *Drug & Alcohol Review*, Vol. 27, No.1, pp.185-189.
- Plüddemann [c], A., Myers, B., & Parry, C. D. H. 2008. *Fact Sheet – Methamphetamine*, [Online] Available at: www.favor.org.za/pdf/tik_facts.pdf [16.10.09].
- Plüddemann, A., Parry, C. D. H., Bhana, A., Dada, S., & Fourie, D. 2009. *Alcohol and Drug Abuse Trends July – December 2008*, [Online] Available at:
www.samhsa.gov/.../Volume.../SubstanceAbuseTrends.aspx [16.10.09].

- Pollack, M. 2010. R100 million upgrade of Marble Flats, Ottery launched, [Online] Available at: www.capetown.gov.za/en/.../R100millionupgdofMrbleFlOttlanch.aspx [25.01.11].
- Pretorius, L. 2003. Six contributions to understanding gaps between Policy and Implementation: An Overview and Comments, *Politia*, Vol. 22, No. 1, pp.6-21.
- Raadschelders, J. C. N. 1999. A Coherent Framework for the study of Public Administration, *Journal of Public Administration Research and Theory*, Vol. 9, No. 2, pp.281-303.
- Research Triangle Institute, 2008. *Drugs, Sex, and Gender-Based Violence: The Intersection of the HIV/AIDS Epidemic with Vulnerable Women in South Africa – Forging a Multilevel Collaborative Response*, [Online] Available at: www.mrc.ac.za/technicalpolicybriefs/Policy%20brief%202008.pdf [11.09.09].
- Robson, C. 1993. *Real World Research: A resource for social scientists and practitioner-researcher's*. Cambridge: Blackwell.
- Rondinelli, D. A. 1993. *Development Projects as Policy Experiments: An Adaptive approach to Policy Administration*, New York: Routledge.
- Roux, N. L. 2002. Public Policy-making and Policy Analysis in South Africa amidst Transformation, Change and Globalization: Views on participants and role players in the policy analytic procedure, *Journal of Public Administration*, Vol. 37, No. 4, pp.418-437.
- SACENDU, 2009. Monitoring Alcohol and Drug Trends in South Africa, SACENDU Research Brief, Vol. 12, No. 1, pp.1-12.
- Samson, S. 2007. *Skinner Stories*, Thesis Collection, University of Cape Town (unpublished).
- Schindler, B. & Cheek, K. A. 1999. *Integrating Citizens in Adaptive Management: A Propositional Analysis*, *Conservation and Ecology*, Vol. 3, No. 1, Art. 9.

- Schurink, E. M. 1998. Deciding to use a Qualitative Research approach. In: De Vos, A. D. ed. *Research at Grass Roots: A Primer for the Caring professional*. Pretoria: Van Schaik Publishers, pp.221-229.
- Scott, P. 1955. Cape Town: A Multi-Racial City, *The Geographical Journal*, Vol. 121, No. 2, pp.149-157.
- Sen, A. 1999. *Development as Freedom*, Oxford: Oxford University Press.
- Sharp, E. B. 1994, *The Dilemma of Drug Policy in the United States*, New York: Harper Collins College Publishers.
- Spieb, C. 2002. *One Party Dominance in Changing Societies: The ANC and INC in Comparative Perspective*, [Online] Available at: <http://www.sai.uni-heidelberg.de/SA/SAPOL/HPSACP.htm> [05.08.10].
- Stake, R. 2005. Qualitative Case Studies. In: Denzin, N. & Lincoln, Y. eds. *The Sage handbook of Qualitative Research*. 3rd ed. USA: Sage Publications, pp. 675-679.
- Standing, A. 2003. *The Social Contradictions of Organised Crime on the Cape Flats*, [Online] Available at: http://www.iss.co.za/index.php?link_id=28&slink_id=572&link_type=12&slink_type=12&tmpl_id=3 [07.07.10].
- Strydom, H. & De Vos, A.S. 1998. Sampling and Sampling Methods. In: De Vos, A. S. ed. *Research at Grass Roots: A Premier for the caring profession*. Pretoria: JL Van Schaik Academic, pp.189-190.
- Tesch, R. 1990. *Qualitative Research: Analysis types and software tools*. New York: Falmer Press.
- The Presidency, 2009. *National Youth Policy 2009-2014*, [Online] Available at http://www.thepresidency.gov.za/docs/policy/national_youth_policy.pdf [20.06.09].
- Titmuss, R. M. 1974. *Social Policy: An introduction*, London: Allen & Unwin.

- Venter, A. 2006. *Government and Politics in the new South Africa*. 3rd ed. Pretoria: Van Schaik Publishers.
- Venter, A. J. 1974. *Coloured: A Profile of two million South Africans*, Cape Town: Human and Rousseau Print.
- Violence Prevention Alliance, 2009. *The Ecological Framework*, [Online] Available at: <http://www.who.int/violenceprevention/approach/ecology/en/index.html> [18.09.09].
- Walker, W. E. 2001. Adaptive policies, policy analysis, and policy-making, *European Journal of Operational Research*, No. 128, pp.282-289.
- Waterston, A. 1982. *Development Planning, Lessons of Experience*, London: The Johns Hopkins University Press.
- Western, J. 1996. *Outcast Cape Town*, California: University of California Press.
- William, V. 2009. *Townships of the Cape Flats*, [Online] Available at: <http://capeflats.org.za/modules/home/townships.php> [25.07.10].
- World Health Organisation, 2011. Global Status Report on Alcohol and Health 2011, [Online] Available at: http://www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf [01.03.11].
- Yaffee, S. L. & Wondolleck, J. 1997. Building bridges across agency boundaries. In: Kohm, K. A. & Franklin, J. F. eds. *Creating a Forestry for the 21st century*. Washington DC: Island Press.
- Yin, R. 2009. *Case Study Research: Design and Methods*, USA: Sage Publications.
- Zuma, 2011. *State of the Nation Address*, [Online] Available at: <http://www.info.gov.za/speech/DynamicAction?pageid=461&sid=16154&tid=27985> [20.02.11].

Personal Communications

Mr Basil Peters, Housing official – Ottery Marble Flats (08 June 2009)

Mr George March, Councillor Ward 66 (08 June 2009)

Mr Adolf – Principle – Lotus Senior Secondary (10 June 2009)

University of Cape Town

APPENDICES

DRAFT
**Operational Alcohol
& Drug Strategy:
2007 - 2010**

City of Cape Town

City of Cape Town

Operational Alcohol & Drug Strategy: 2007 - 2010 (1st Draft)

26 June 2007

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6	Drug and Alcohol Strategy	14
	Objectives:	
1	Reduce drug- and alcohol-related crime and anti-social behaviour, and minimise drug- and alcohol-related accidents and injuries	15
2	Improve access to a range of evidence based treatment and prevention interventions to minimise drug and alcohol related harm among the citizens of Cape Town, particularly vulnerable people, such as youth, people affected and infected by HIV/AIDS, STIs and TB, women (especially pregnant women), people who are unemployed, people with physical disabilities and mental illnesses, the elderly and people who are homeless	19
3	Improve access to information on drug and alcohol related harms for the City community, and how they can respond to these harms	22
4	Improve reporting on local interventions and their effectiveness	24
5	Cooperate with other spheres of government for enhanced responses to alcohol and drug related impacts on people and places	25

Executive Summary

The City of Cape Town presents this draft operational strategy aimed at effectively and sustainably managing the substantial and rapidly growing drug and alcohol-related challenges facing our society. This preventative and curative strategy requires sustainable multi-sectoral, inter-departmental and inter-governmental partnerships.

This is a multi-sectoral strategy in that it acknowledges the role of government, business and community based organisations and establishes and describes a formal partnership between these sectors to the extent that the challenges are addressed. The strategy confirms various roles and functions for each City department and creates a vehicle for cohesivity within one overall strategy where Health is the custodian lead department. Sound, cooperative inter-governmental relationships are key to the success of this strategy. The National Drug Master Plan confirms each spheres roles and responsibilities and it remains the City's stated intention to deliver evidence based prevention and treatment programmes.

In order for them to be effective, the demand and supply reduction components of this strategy must be bolstered by the urgent passing of National legislation defining pseudo-ephedrine as a schedule 5 drug thereby strictly limiting its sale, supply, storage and possession. Pseudo-ephedrine is the precursor chemical used for making methamphetamine (Tik), which, along with alcohol are the number one threats to public safety and community well-being in Cape Town. Similarly, in order not to turn non-violent, and often young users into hardened criminals, legislation providing for the establishment of drug courts, from where drug-related offenders are offered alternative sentencing and diversion options, in the form of evidence based treatment interventions, needs to be urgently enacted. The City urges National Cabinet to expedite and clarify the formulation of the "Prevention of and Treatment for Substance Abuse Bill" in line with grass roots realities in South Africa and international best practice.

The results of alcohol and drug use, leading to risky sexual behaviour and increased HIV/AIDS, TB, Hepatitis B (HBV) and Hepatitis C (HCV) risk and infection; as well as leading to criminality and violent behaviour, are well established facts that are easily identifiable within our communities. This strategy aims to reduce these and all other harms to the individuals and to society as a whole.

1 Introduction:

The use and misuse of drugs and alcohol have significant negative impacts on public health in terms of increased morbidity and mortality; family welfare; crime and community safety; educational attainment; local economic development and social inclusion. Reducing the impacts of these harms is a key priority for the City of Cape Town.

To strategically address the impacts of alcohol and other drug (AOD) use in the public domain, the City of Cape Town has prepared a Draft Alcohol and Drug Strategy (2007 - 2010). The Strategy outlines the unique role of local government in responding to these impacts, and how we can work with our key partners to improve safety for city residents, businesses and visitors, as well as the health of people who use AODs and those around them.

The aim of this strategy

The key aim of this initiative is to reduce the burden of AOD use on the City of Cape Town and its residents, businesses and visitors through the provision of targeted supply and demand reduction interventions.

This strategy will define the role of the City and will direct AOD-related programmes and policies in the City of Cape Town, as well as ensure that these correspond with and contribute to Provincial and National policies and plans.

Why do we need an alcohol and drug strategy?

Historically within the City of Cape Town there has been little interaction between Health, Law Enforcement and Welfare; departments have worked in silos, thus causing fragmentation and often duplication of services.

This document highlights the contributions of each department and outlines ways in which, through inter- departmental and inter-sectoral collaboration, a cohesive operational plan can be implemented.

While good plans are a necessary component of an effective response to AOD-related problems, on their own they are not sufficient to bring about desired change. Implementation of plans is complex and does not always follow a logical and linear path.¹ For implementation to occur, it is essential to include mechanisms that will ensure the proper translation of the plans into action. These mechanisms include setting change priorities, developing action strategies to achieve change policies, and allocating appropriate resources to each change priority. In addition, implementation also requires the motivation of individual actors as well as organizational support.²

A strategy of this nature and importance needs to adhere to certain key principles and be driven in an accountable and transparent manner. To ensure accountability and transparency, annual reporting with regard to progress will be made to the officials and citizens of Cape Town.

Key principles

- 1 Systematic, multifaceted responses are required. Singular stand-alone responses do not generally solve complex AOD-related issues. The City will work with a range of stakeholders, including other spheres of government, service providers and AOD users and those affected by their use.
- 2 The burden of AOD problems is shared by the whole community, as is the responsibility for tackling this burden. Integrated responses are required that complement provincial and national programmes and established health, social welfare, and other regulatory structures and improve reporting to the citizens, target communities, service providers and various government spheres.
- 3 An emphasis will be placed on evidence-based interventions.
- 4 The principle of social inclusiveness is reflected through a commitment to reducing the impact of AOD use on our most vulnerable populations - previously disadvantaged communities, young people, people affected by HIV/AIDS, people who are homeless, women, elderly people, people who are mentally ill and physically disabled.
- 5 A long-term commitment to funding and resource allocation is essential to tackle AOD-related harms.
- 6 Demand reduction is a key principle (i.e. activities targeting the prevention of new AOD use/misuse, and treatment of existing AOD problems).
- 7 Multi-pronged approach: there are always opportunities to intervene in AOD-related problems, and we must engage simultaneously at many stages in the cycle including prevention, early intervention, treatment and reintegration.

2 Background

2.1 Role of Local Government

Local government has a very specific and unique role in addressing AOD-related problems and is ideally located to respond directly to these problems through both demand- and supply-reduction activities.

Local government responses to AOD issues are generated by a number of factors including:

- The social responsibility imperative of local government and its office bearers to affect change in areas of socio-economic concern that has a direct bearing and impact on the stability of the City.
- Community expectations that give rise to local government responses (such as development of localised approaches to AOD issues, for example through participation on Local Drug Action Committees,³ Community Policing Forums and the provision of supply- and demand-reduction services)
- Identification of gaps in existing service provision
- Legislative requirements and obligations

2.2 Legislative and Policy context

Local Government's obligations to address AOD issues are defined in the **National Drug Master Plan** as well as in various pieces of local government legislation. These areas of legislation are discussed briefly below.

National Drug Master Plan

The **National Drug Master Plan**⁴ (NDMP) provides policy and legislative framework for all AOD strategies; it summarises national policies, defines priorities and apportions responsibilities for alcohol and other drug (AOD) control efforts.

Crucial strategies put forward by the NDMP to facilitate its implementation, include the development and execution of mini-masterplans for key government departments, as well as provincial and local mini-masterplans. This local strategy is in part, a response to the NDMP.

Western Cape Liquor Bill (2005)

The Western Cape Liquor Bill seeks to meet a number of objectives, one of which is to reduce the social cost (harms) of alcohol use to the people of the Western Cape; other objectives include making it possible for *bona fide* unlicensed traders in historically disadvantaged communities to legitimise their businesses without encountering unnecessary barriers, and to provide sufficient incentive for them to do so, as well as allowing communities to participate with the City of Cape Town in determining outlets, their hours of trade, and the nature and extent of their activities.

Within the broad objectives of the Bill some of the specific issues addressed are liquor licensing procedures, training of license holders and persons serving alcohol, the sale of liquor in residential areas and ensuring that the licensees restrict noise and do not sell to minors or intoxicated persons.

There is a key role envisaged for municipalities in the Bill, with regard to (i) land use planning issues (as determined by the planning authorities), (ii) having the best available options for informing communities of local developments in the liquor trade, and (iii) providing for processes and structures that allow communities to participate at all levels.

Local Government: legislation and policy

Several **Local Government Acts** require Council to take responsibility for managing public land, and gives them the power to issue and enforce orders that aim to prevent activities (such as AOD use and trade) that place members of the public at risk.

3 Alcohol in the City - a brief overview

3.1 Definition:

Alcohol is a legal regulated drug and licensed premises are custodians of its legal and responsible supply.

3.2 Location of use and related impacts

On any day in Cape Town residents, workers and visitors consume alcohol in regulated, semi-regulated and unregulated environments.

Regulated environment

Licensed Premises

Within the City there are many licensed premises where alcohol is consumed in a regulated environment. Many licensed premises have late-night trading licenses and are located within distinct entertainment precincts. Concentration of licensed premises with extended trading hours provide greater opportunities for alcohol to be consumed, and can result in more people becoming intoxicated. Increased numbers of intoxicated people in public spaces can have a negative impact on the health and safety of consumers and others. The **Western Cape Liquor Bill (2005)** addresses this issue in detail.

Large Public Events

Large events are regularly held in the City, where alcohol consumption is part of the celebrations. Many large national and international sporting and cultural events are held in the City including high profile soccer matches and cricket and rugby tests; the Two Oceans Marathon, the Argus Pick 'n Pay Cycle Tour, the Cape Town Jazz Festival as well as Minstrels Carnivals. These and many more events attract large numbers of local, national and international visitors.

Some areas during large-scale events are licensed and are regulated or semi-regulated environments. The impacts of alcohol during large events relate to:

- Waste management.
- Accidents and injuries.
- Potential anti-social and criminal behaviour.

Use of alcohol in public spaces

The consumption of alcohol in the public domain is a problem affecting many cities nationally and internationally, and Cape Town is no exception. Public intoxication can take many forms including recreational drinking in public spaces and patrons leaving licensed premises already intoxicated.

Unregulated environments

It is estimated that in the City of Cape Town there are approximately 7375 unlicensed premises (shebeens/taverns) where alcohol is consumed.⁵ Other estimates are as high as 20,000. The **Western Cape Liquor Bill (2005)** addresses this issue in detail

3.3 Alcohol-related crime and safety

Alcohol-related crimes (including the crime of drinking and driving) are not only committed by individuals who are high-risk drinkers and regularly drink to excess, but are also committed by individuals who occasionally drink at risky levels.⁶ There is a growing body of research that links alcohol to violent crime, and in particular family violence and sexual violence. For example, a fifth of South African offenders arrested for rape reported that they were under the influence of alcohol at the time of the crime.⁷

AOD use is consistently reported as one of the most common factors affecting the safety of communities and neighbourhoods.

3.4 Alcohol related health and family problems

According to the World Health Organisation (WHO), the hazardous and harmful use of alcohol has now become one of the most important risks to health.⁸

Roughly one in four adult males and one in ten adult females in South Africa experience symptoms of alcohol problems, and almost one in four high school students report binge-drinking in the past month; that is, drinking five or more drinks on one or more days.⁹ Studies have also shown that more than one in three patients seen at trauma units in Cape Town in 2001 had alcohol levels above the legal limit for driving, and more than one in two non-natural deaths in Cape Town in 2002 had alcohol levels greater than 0.05g/100ml.

Almost 1 in 5 HIV patients at selected HIV clinics met criteria for current alcohol abuse or dependence. Patients with alcohol use disorders were more likely to have symptomatic HIV infection.¹⁰

Family

Alcohol use disorders contribute to general family dysfunction, and children of parents with alcohol problems or who have several family members with alcohol problems are at greater risk for developing alcohol problems themselves, often start to drink alcohol at a younger age, and progress towards problems more quickly than children who have no close relatives with alcohol problems.¹¹

While continuing patterns of drinking threaten family subsistence, events that take place when a family member is intoxicated can also have lasting consequences on the well being of their families. These events may include acts of alcohol related violence against women and children. These acts may have severe psychological consequences for the victim.¹²

Economic Costs and overall burden

The estimated economic cost of alcohol-related problems to the Western Cape is likely to exceed R1 billion per year due to lost productivity, absenteeism, motor vehicle collisions and illnesses. Overall, it is estimated that alcohol contributes 7% to the burden of disease (from death and disability) in South Africa, 40% of the total alcohol related burden occurring in the area of homicide and violence, and 15% each to road traffic accidents and Alcohol Use Disorders (AUD).¹³

4 Drugs in the City - a brief overview

4.1 Definition:

Drugs include all psychoactive substances, illicit or otherwise that change patterns of thought, behaviour and emotions. Drugs, which impact most visibly in the City of Cape Town, include methamphetamine (tik), heroin, mandrax (methaqualone), and cannabis (dagga).

4.2 Location of use and related impacts

Public Domain

Consumption and selling of drugs in the public domain is the most visible form of drug related activity. Drug consumption may lead to waste such as discarded smoking pipes and used syringes/needles from injection drug use. Public intoxication by drug-affected individuals is also prevalent and is a concern, particularly with methamphetamine where users sometimes become violent. In Cape Town in 2001 over half of the persons seen at two trauma units (Groote Schuur and GF Jooste Hospitals) tested positive for at least one drug.¹⁴

Private Premises

Drug consumption regularly occurs in residential and commercial premises throughout the City, and although less visible than in other settings, the impacts include:

- Waste generation that may have occupational health and safety implications,
- Risks to the safety of neighbours and broader community due to drug use (crime, theft and gang activity).

Licensed Premises

The consumption of illicit drugs in licensed premises occurs in many of the City's entertainment areas, and may also occur in conjunction with alcohol consumption.

The drugs most commonly used in these settings include amphetamines and methamphetamine (tik, speed), cocaine, Ecstasy, GHB, cannabis (dagga) and prescription drugs. Impacts include:

- Potential for the involvement of organised crime in distributing drugs.
- Potential for overdoses to be fatal, as staff at these premises are poorly trained in how to respond to drug overdoses and drug related anti social behaviour.
- Potential for drug-related injuries due to intoxication.

Clandestine Laboratories

Clandestine laboratories refer to places where illegal drugs are manufactured, often called 'home labs' because they are operated from ordinary residences. There are a range of potential impacts from clandestine laboratories:

- Public health and safety may be adversely affected because the manufacturing process involves toxic and/or explosive chemicals and waste, for example the production of 1 gram of methamphetamine produces 6-7 grams of toxic waste.¹⁵

4.3 Drug related Crime and Safety

There are many harms associated with drug use. This section relates to those directly encountered by the City.

Changing Use Patterns

There have been substantial changes in drug use patterns, in the past mandrax and dagga were the most prevalent drugs of abuse; however in Cape Town we now see a dramatic increase in the use of methamphetamines (Tik, meth) and heroin.

In 2003, 2.3% of people using treatment services in Cape Town had methamphetamine (tik) as their primary drug of abuse, in 2006 this had increased to 42% and over half of these people were under 20 years of age. Research in 2004 estimated that there are between 12000 and 18000 heroin users in Cape Town.

One in 3 males and one in 5 females in Grade 11 in Cape Town engaged in binge drinking over the past two weeks (1997), and 80% of adolescent drinkers have been drunk at least once (2002). Learners in the Western Cape (Grades 8 to 11) exceed the national average in several areas of substance-related risk behaviour (2002): past month alcohol use, past month binge drinking, proportion in initiating drinking prior to age 13, past month dagga use, and ever use of club drugs (males only).¹⁶

Availability, strength and type of drugs used is constantly shifting, and these changing patterns can have unexpected impacts. For example in the past most heroin users in Cape Town reported smoking the drug, but recently 11% of people presenting for treatment reported injecting drug use.¹⁷ Other factors such as enforcement and planning-related activities can also have displacement effects on localised drug activity. Responses to drug use impacts need to be flexible to accommodate these shifts.

Drugs and crime

Involvement in crime compounds the harms caused by illicit drug use. Almost 6 out of every 10 arrestees in Cape Town in 2000 tested positive for an illegal drug, with levels being particularly high for crimes such as housebreaking (66%). Arrestees who tested positive for drugs were significantly more likely to have had a prior arrest than drug negative arrestees.¹⁸

4.4 Health and Treatment services

Of the 761 patients under 20 years of age admitted to substance abuse treatment centres in greater Cape Town in the second half of 2006, 72% had methamphetamine as a primary or secondary substance of abuse.¹⁹

A study of access to treatment among historically disadvantaged communities in the Cape Town Metropole found that barriers to treatment rather than need for services determines whether persons utilise substance abuse treatment services.

Apart from the limited availability of services, these barriers include awareness of treatment services, affordability barriers (such as low income and competing financial priorities), and geographical access barriers such as travelling time to treatment; further barriers to treatment are public perceptions and the stigma attached to entering treatment services as well as possible victimization by authorities.

5 Drug and Alcohol Impacts in Vulnerable Population Groups

Local and international research as well as the national drug master plan indicates that there are several vulnerable populations that are particularly affected by alcohol and other drug abuse.^{20,21} Such vulnerable population groups include:

- People infected and affected by sexually transmitted infections (including HIV/AIDS), and TB.
- Youth
- Pregnant women
- People who are homeless including street children
- Sex workers

6 Drug and Alcohol Strategy

Aim: To reduce the negative impacts of alcohol and illicit drug use in the City of Cape Town

Objectives:

- 1 Reduce AOD-related crime and anti-social behaviour, and minimise AOD-related accidents and injuries.
- 2 Improve access to a range of evidence based treatment and prevention interventions to minimise AOD-related harm among the citizens of Cape Town, particularly vulnerable people, such as youth, people affected and infected by HIV/AIDS and TB, women (especially pregnant women), people who are unemployed, people with physical disabilities and mental illnesses, the elderly and people who are homeless.
- 3 Improve access to information on AOD-related harms for the City community, and how they can respond to these harms.
- 4 Improve reporting on local interventions and their effectiveness.
- 5 Cooperate with other spheres of government for enhanced responses to AOD-related impacts on people and places.

Objective 1:

Reduce AOD-related crime and anti-social behaviour, and minimise AOD-related accidents and injuries by providing:

- Well coordinated regulation and enforcement to address public alcohol sale and use, and the manufacture, sale and use of illicit drugs.
- Public education and other preventive initiatives in order to change community values, attitudes and norms around consumption of alcohol (particularly drunkenness) and drugs like dagga and misuse of over-the-counter and prescription medications.

There is a significant relationship between AOD use and crime. It is mostly the responsibility of national law enforcement agencies (such as SAPS) to respond to these crimes. Local government however, does have a role to play; for example via the Metropolitan Police.

To reduce AOD-related crime, the City will do the following:

1.1 Community Policing:

High visibility patrolling together with the Community Policing Forums (CPFs), SAPS, neighbourhood watches and other partners.

CCTV monitoring and quick responses to incidents in the Metropolitan area.

Continue to impose and enforce alcohol free zones such as parks and beaches.

Ensuring appropriate police presence at large concerts or social events to prevent alcohol-related injuries and accidents and minimise driving under the influence of alcohol and other drugs.

1.2 Metro Police Specialised Unit:

The City will re-establish the specialised Narcotics Unit within the Metropolitan Police.

This unit will coordinate the overall, zero tolerance drug and alcohol policing strategy of the Metro Police, including coordinating evictions of drug dealers from government-owned housing units.

1.3 Random alcohol and drug testing

This will include:

Increasing random alcohol breath testing at all drinking establishments and potential high-risk sites, such as Cape Town International Airport, sports clubs and venues where sporting events take place, and the CBD.

Introducing random alcohol and drug testing for certain occupations where the lives of the public can be endangered (e.g. bus, train, taxi, and truck drivers; Metro Police and emergency personnel).

Impose regular roadblocks for random breath and urine tests for AOD across the City, especially in, and bordering on, high consumption areas. This will also include search and seizure procedures.

1.4 Advocate for new legislation regarding pseudo-ephedrine

The precursor chemical used in the manufacture of methamphetamine type stimulants is either pseudo-ephedrine or ephedrine, both largely unregulated substances used in many patent, over the counter (OTC) and prescription medications. In order to assist in the regulation of this chemical, the City will

Advocate with National Government to urgently introduce legislation limiting and controlling storage (possession) and purchasing quantities.

1.5 Clandestine drug laboratories.

The manufacture of drugs such as methamphetamine and methcathinone produces toxic waste, and can cause health problems for people who have been exposed to these chemicals. In order to minimize the harms to individuals and the environment and to counter the potential risks of these laboratories, the city will:

Develop and distribute information regarding clandestine laboratories.

Develop and distribute health and safety protocols for investigating suspected clandestine laboratories and dismantling existing laboratories.

Provide training for all personnel potentially in contact with labs on how to minimise exposure to toxic waste.

1.6 Participation in Liquor Licensing Accords

Licensing Accords are voluntary agreements between police, councils, licensed venues and other community stakeholders aimed at reducing alcohol related harm associated with licensed premises. Licensing Accords are key as they complement

licensing enforcement, and offer licensees the opportunity to learn new legislative requirements and ways to improve compliance.

- Participate in Liquor Licensing Accords (Metro Police, SAPS Liquor Officers and local municipal inspectors to ensure adherence to regulations).
 - Support the development of accords and have inputs into aims, objectives and strategies, through the provision of incident books, education campaigns for licensed venues and attendance at relevant Accord meetings.
 - Investigate opportunities for unlicensed premises to engage with local licensing accords.
 - Convene an annual meeting of all Accord nominated representatives (chairpersons) to strategise responses to alcohol related crime and antisocial behaviour.

1.7 Enhanced regulation and compliance in licensed premises

This will be facilitated by:

- Supporting new licensees to comply with liquor regulations.
- Support, where possible, the work of the Designated Liquor Officers in requiring that applications for renewal of licenses are subject to demonstrated compliance with regulations through inspections to ensure standards are met.

1.8 Reducing Impacts from Licensed Premises

To address the impacts from licensed premises the City will prioritise the following issues:

- Restricting outlet density and proliferation, and addressing problems associated with the location of outlets (too near to schools, in residential areas, etc.).
- Developing general accords between local government and SAPS, liquor outlets and communities to determine in advance how they will cooperate.
- Ensuring compliance with liquor regulations (and other health and safety issues) in licensed premises.
- Dealing with noise and other forms of pollution around on- and off-consumption liquor outlets.
- Using Environmental Health Practitioners (EHPs) to ensure that liquor outlets comply with all relevant municipal by-laws.

1.8 Participation in the Western Cape Substance Abuse Forum and Local Drug Action Committees

Local Drug Action Committees and the Western Cape Substance Abuse Forum are structures set up by the Provincial Department of Social Development in order to give action to the National Drug Master Plan. The City of Cape Town will ensure that designated officials participate in both structures.

1.9 Capacity Development

The City will develop capacity within Metropolitan Police to have one Substance Abuse Prevention Professional to coordinate all prevention activities and Prevention Professionals/facilitators within each of the Health Districts.

1.10 Education and Training

In consultation with the WC Liquor Board, activities will include:

- Developing and implementing training programmes for liquor sellers and servers on how to implement the new provincial legislation.
- Developing and piloting substance abuse awareness, education and testing programmes for the Metropolitan Police and Emergency Services Personnel.

Objective 2

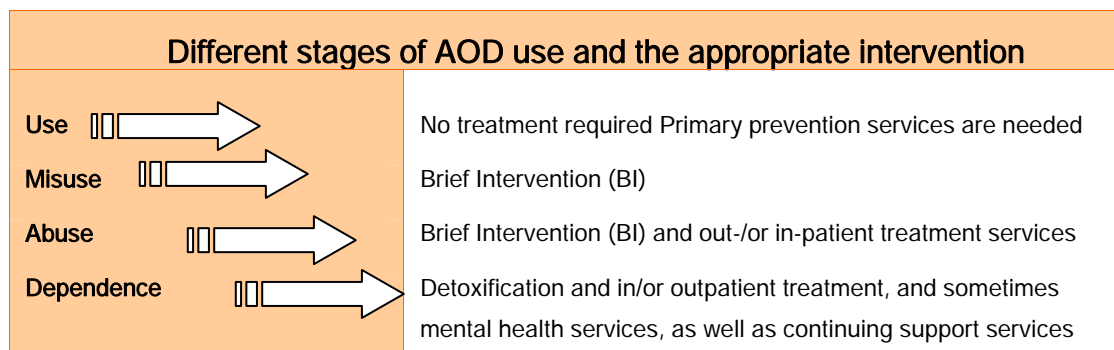
Improve access to a range of evidence based treatment and prevention interventions to minimise AOD related harm among the citizens of Cape Town, particularly vulnerable people, such as youth, people affected by HIV/AIDS and TB, women (especially pregnant women), people who are unemployed, people with physical disabilities and mental illnesses, the elderly and people who are homeless, by

- Developing capacity within the City of Cape Town for the provision of a range of services including screening for AOD use disorders, Brief Interventions (BI) for these disorders, and increase access to outpatient treatment services.
- Addressing inequities in service delivery, including the dispersion, coverage, reach and quality of prevention and treatment services for AOD problems.

AOD problems occur along a continuum that ranges in severity - people don't suddenly 'catch' drug and alcohol dependence as they would 'flu. There are often many opportunities for early intervention but people rarely get the help they need until they are in some form of crisis, and then almost always treated as if they have an acute illness.

Very often, the patient is sent somewhere for a brief period of time and released as if cured, with little or no continuing medical or social services support or monitoring to assist in the early stages of recovery and to avoid relapse. This is problematic as detoxification and formal treatment are only the beginning of the recovery process.

The optimum intervention would be to identify a person (especially a young person) in the early stage, i.e. misuse, where cost effective Brief Interventions can be administered.



Screening, Brief Interventions and dedicated outpatient treatment programmes can all be facilitated within the primary health care and social services systems, as well as through specialised service providers.

It should be acknowledged that workers in the field are currently under-capacitated and require skills development in techniques such as screening and assessment and motivational interviewing (MI), all of which form part of Brief Interventions (BI).

Please see definition in Glossary

Nonetheless, primary healthcare systems, in particular the community health centres and clinics; doctors and nurses as well as social workers are ideal settings for providing accessible and non-stigmatising opportunities for screening and brief interventions.

The City will:

- Ensure that all City of Cape Town funded, supported and/or driven interventions adhere to evidence based practices.
- Provide primary care settings as cost effective and affordable, accessible and non-stigmatising resources for AOD problem identification and early interventions.

Capacity Development

2.1 Various activities will be supported:

- Ensure appropriate skills development and review primary and continuing training of health and social development workers in assessment, diagnosis and management of patients with AOD problems.
- Ensure there is one clinical substance abuse specialist per Health District.
- Ensure that treatment interventions for AOD problems include assessment for HIV/AIDS, Hepatitis B and C, STIs, Tuberculosis and other infectious diseases as well as pregnancy among female substance users.
- Ensure that treatment interventions for HIV/AIDS, Hepatitis B and C, STIs, Tuberculosis and other infectious diseases include assessment for AOD problems.

Treatment

2.2 With regard to treatment,

- Pilot testing evidence based treatment interventions that will increase the reach of services:
 - 4 subsidised Matrix Model outpatient treatment programmes
 - These sites will be located in under-served communities that are most affected by substance abuse
 - Training in Screening and Brief Interventions for City Health staff.
 - This will include monitoring the extent to which this training is implemented and its impact on clinical practice.
 - Developing, implementing and testing a Medical Assistance Programme for Metro Police and Emergency Services Personnel who experience AOD problems.
- Develop monitoring tools and systems for City of Cape Town funded, supported and/or driven treatment and aftercare initiatives.
- Provide medications used to treat persons needing detoxification.
- Provide access to primary mental health services for all clients receiving outpatient substance abuse treatment services provided by the City
- Address barriers to access to specialist substance abuse treatment such as transport and related costs by providing transport vouchers and through considering the use of mobile outpatient clinics, where feasible as outlined in a recent report on access to treatment services in the Metropole.²²

The City will work with the vulnerable and at risk groups of people as listed.

Objective 3

Improve access to information on AOD-related harms for the City community, and how they can respond to these harms, by:

- Initiating public education and other preventive initiatives in order to change community values, attitudes and norms around consumption of AOD.
- Developing credible AOD information with consistent and innovative messaging for use in all City initiatives.
- Developing capacity within the City of Cape Town for the provision of a range of education and prevention services.
- Providing access to information on evidence-based education and prevention practices.

Access to credible AOD information increases understanding of the complexity of AOD problems and the nature of AOD use disorders, and how to respond at an individual, family, religious institution and community level. Currently access to reliable information regarding AOD problems and available resources is difficult; there is no dedicated helpline and various service providers give information on an ad hoc basis. The quality and accuracy of this information often varies and is rarely comprehensive.

3.1 The City of Cape Town will:

- Develop credible AOD information and awareness, education, and prevention training materials with consistent and innovative messaging for use in all City initiatives.
- Ensure that the information provided is culturally appropriate and easily accessible to the citizens of Cape Town via relevant links to the City's website and through libraries, City health facilities and other municipal outlets.
- Develop online information resources for residents on how to respond to noise, and other complaints about licensed and non-licensed premises as well as how to respond to suspected clandestine laboratories and "drug houses".

3.2 Capacity Development

- Develop capacity within the City of Cape Town for the provision of a range of education and prevention services:
 - The City Department of Health is the lead department within the City for all substance abuse related issues, and will coordinate all education, prevention and treatment services
 - A designated official within the City Department of Health must represent the City on the Provincial Substance Abuse Forum and coordinate all AOD Prevention programmes in consultation with the AOD Coordinator for the Metropolitan Police.
 - The City's Department of Health should ensure that there is a dedicated substance abuse professional in each Health District. This person must coordinate and implement prevention and education initiatives and represent the City on Local Drug Action Committees (LDACs).
 - A designated official within Metro Police must represent the City on the Provincial Substance Abuse Forum and coordinate all AOD Prevention programmes in consultation with the AOD Coordinator at the City Department of Health
 - The Metropolitan Police should ensure that there is a dedicated substance abuse professional in each of the 8 Health Districts. These persons will coordinate and implement prevention and education initiatives for the metro police and will represent the City on LDACs, as well as assist in the development and ongoing functioning of Licensing Accords.
 - A designated official within the Department: Economic and Social Development and Tourism to represent the City on the Provincial Substance Abuse Forum.
 - A designated official within the City's Emergency Services to coordinate all AOD Prevention programmes in consultation with the AOD Coordinator at the City Department of Health
 - Telephone operators on the City helpline will be trained to manage AOD related calls and given access to supervision and ongoing support.

Objective 4

Improve reporting on local interventions and their effectiveness

The importance of monitoring and evaluation of interventions in any of the forgoing strategic action areas cannot be over-emphasised. Research, monitoring and evaluation ensures that decision-making is knowledge-based, and allows for regular reporting to policymakers and stakeholders in the relevant sectors, as well as to the broader community.

4.1 The City will:

- Monitor and evaluate the effectiveness of City of Cape Town funded, supported and/or driven interventions to reduce the harms associated with AOD use.
- Monitor and evaluate the effectiveness of all City of Cape Town funded, supported and/or driven training programmes.
- Develop monitoring tools and systems for City of Cape Town funded, supported and/or driven prevention and education initiatives.
- Develop monitoring tools and systems for City of Cape Town funded, supported and/or driven treatment and aftercare initiatives.
- Ensure that future funding is based on results of these monitoring and evaluation activities.

4.2 The AOD Strategy will be implemented over a three-year period. To ensure that the Strategy is meeting key objectives and delivering outcomes the City will:

- Establish a Strategy Review Committee that will meet annually. The Committee will review the outcomes of the Strategy actions for each year. It will be comprised of The Mayoral Special Projects Office, Executive Directors responsible for Health, Community Development, Metropolitan Police, Emergency Services, City of Cape Town Substance Abuse Coordinators, SAPS, Western Cape Provincial Substance Abuse Forum Chairperson, and researchers with expertise in the substance abuse field, and chaired by the Mayoral Committee Member appointed to lead the Mayoral Special Project
- Report to relevant Council structures on the outcomes of the Strategy.

Objective 5

5.1 Cooperate with other spheres of government and civil society for enhanced responses to AOD related problems by:

- Actively participating in The Western Cape Substance Abuse Forum and Local Drug Action Committees.
 - Developing a database of all AOD services within the City of Cape Town
 - Partner with NPOs, CBOs and FBOs in order to deliver appropriate and effective services to the citizens of Cape Town.
 - Advocate at national level for a qualification framework and a professional body for people working in AOD treatment and prevention services.
 - Advocating for medical aid funds to pay for evidence based outpatient treatment.
-








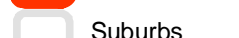
University of Cape Town

References

- ¹ Rycroft-Malone J, Harvey G, Seers K, Kitson A, McCormack B, & Tichen A, (2004). An exploration of the factors that influence the implementation of evidence into practice, *Journal of Clinical Nursing* **13**: 913–924.
- ² Michie S, Hendy J, Smith J, & Adshead F (2004). Evidence into practice: a theory based study of achieving national health targets in primary care, *Journal of Evaluation in Clinical Practice* **10**: 447–456.
- ³ Department of Social Development (2007). National Drug Master Plan (2006-2011). Pretoria: Department of Social Development.
- ⁴ Department of Social Development (2007). National Drug Master Plan (2006-2011). Pretoria: Department of Social Development.
- ⁵ SAPS (Capt Hofstander) Tel 021 935 5113
- ⁶ Parry CDH, Dewing S: *A Public Health Approach to Addressing Alcohol-related Crime in South Africa*: African Journal of Drug and Alcohol Studies, 5 (1), 2006, 41-56
- ⁷ World Health Organisation (2005) *Alcohol and Interpersonal Violence*. International Policy Briefing. Draft Document. Geneva
- ⁸ World Health Organisation (2002). World Health report 2002. Geneva: WHO.
- ⁹ Parry CDH. (2005). *South Africa: alcohol today*. Addiction 100: 426-429.
- ¹⁰ Parry CDH. (2005). *South Africa: alcohol today*. Addiction 100: 426-429.
- ¹¹ NIAAA, NIH. *Alcohol Alerts No 67: Underage Drinking* January 2006
- ¹² WHO Working Group. *Report of et al. WHO working Group on Lifestyles and Behaviour Change*. Copenhagen: WHO 1999
- ¹³ Parry CDH, Dewing S. *A Public Health Approach to addressing Alcohol Related Crime* African Journal of Drug and Alcohol Studies, Vol 5 (2) 2006
- ¹⁴ Parry, C.D.H, Pluddemann, A., Donson, H., Sukhai, A., Marais, S., Lombard, C. (2005). Cannabis and other drug use among trauma patients in South African cities, 1999-2001. *South African Medical Journal*, **95**, 429-432.
- ¹⁵ www.methamphetamine.org
- ¹⁶ Reddy SP, Panday S, Swart D, Jinabhai CC, Amosun SL, James S, Monyeki KD, Stevens G, Morojele N, Kambaran NS, Omardien RG, Van den Borne HW (2003). *Umthenthe Uhlaba Usamila – The South African Youth Risk Behaviour Survey 2002*. Cape Town, Medical Research Council.
- ¹⁷ Plüddemann, A., Parry, C.D.H., Cerff, P., Bhana, A., Harker, N., Potgieter, H., Gerber, W., & Johnson, C. (2006). Monitoring Alcohol and Drug Abuse Trends in South Africa (July 1996 – December 2006). *SACENDU Research Brief*, **9** (1), 1-12.
- ¹⁸ Parry, C.D.H., Pluddemann, A., Louw, A., Leggett, T. (2004). The 3-Metros study of drugs and crime in South Africa: Findings and policy implications. *American Journal of Drug & Alcohol Abuse*, **30**(1), 1-19.
- ¹⁹ Pluddemann, A., Myers, B., & Parry, C..H. (2007). Fact sheet – methamphetamine. <http://www.sahealthinfo.org/admodule/methamphetamine.pdf>
- ²⁰ Department of Social Development (2007). National Drug Master Plan (2006-2011). Pretoria: Department of Social Development.
- ²¹ Parry, C.D.H., Carney, T., Petersen, P., & Dewing, S. (2007). Drug use and sexual HIV risk patterns among non-injecting and injecting drug users in Cape Town, Pretoria and Durban, South Africa. Parow: Medical Research Council.
- ²² Myers, B. Louw J, Fakier N (2007) Access to substance abuse treatment in the Cape Town metropole. Technical report. Parow: Medical Research Council of South Africa.

Ottery Marble Flats (Demarcated Areas)

Legend

-  Sewer Pipe
-  Stormwater Pipe
-  Water Pipe
-  Railway
-  Streets
-  Marble Flats
-  Painted Flats
-  Suburbs

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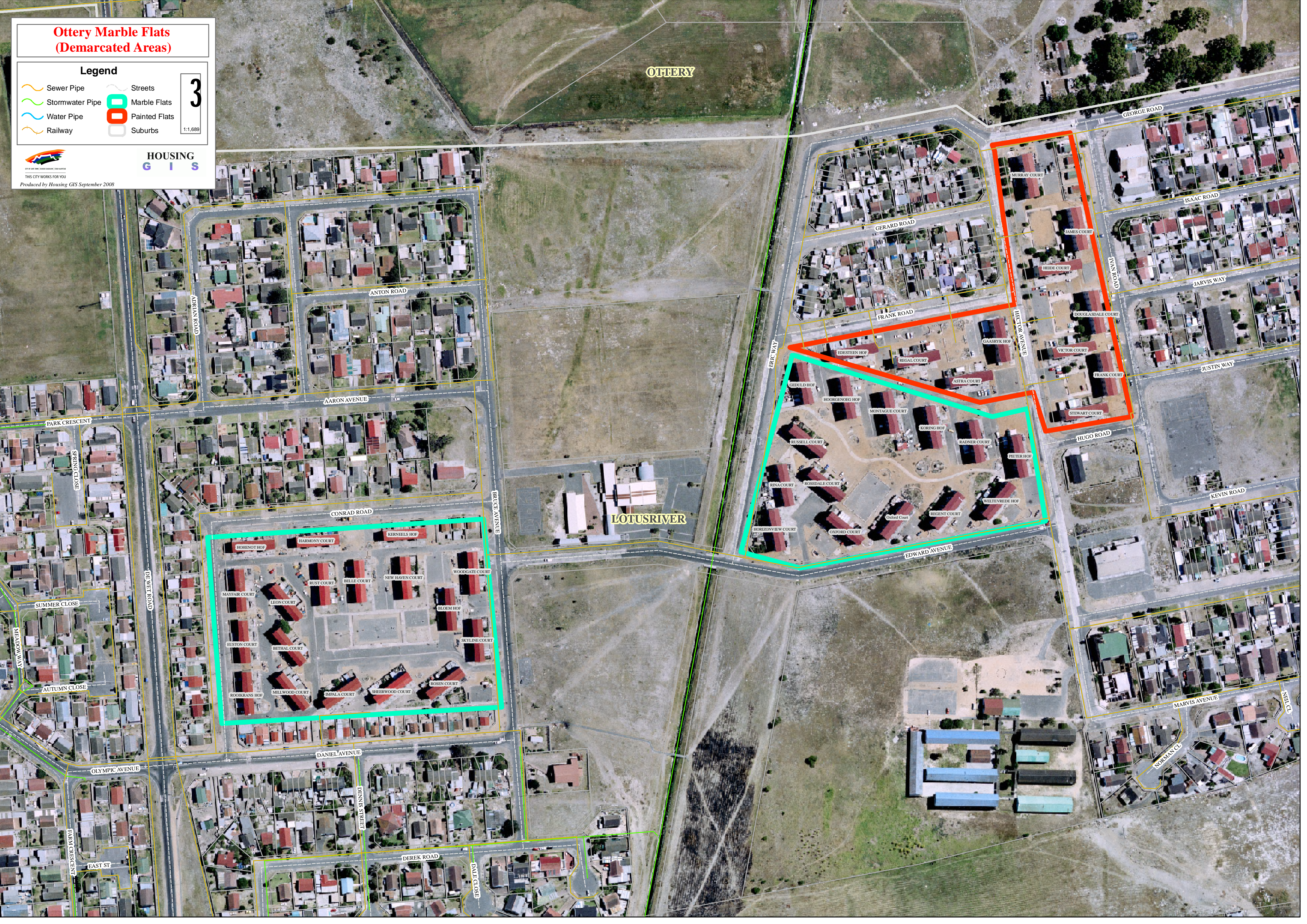


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APPENDIX A

OPERATIONAL ALCOHOL AND DRUG STRATEGY 2007-2010

APPENDIX B

MAP OF THE AREA

APPENDIX C

INTERVIEW SCHEDULE

Researcher: Sharna Johardien

Section one: Introduction

- Introduce self
- Explain the purpose of the research
- Assure the interviewee about ethics and confidentiality
- Encourage interviewees to answer as honestly and openly as possible
- Inform interviewee of the right to terminate the interview at any stage
- Inform interviewee that a copy of the research paper will be made available to the organization or interviewee.
- Negotiate the use of a tape recorder

Section two: The interviewee

- Please tell me a bit about yourself?
- What department and organization do you work for?
- What does that job description entail?
- How long have you worked at this organization?

Section three: Substance abuse in the Marble Flats

- What is your understanding of the problem of substance abuse in the Marble Flats community?

Section four: Implementation of the OADS in the Marble Flats community

- Are you familiar with the Operational Alcohol and Drug Strategy 2007-2010?
- If so, when and how were you first informed about it?

Section five: Objectives identified in the OADS

1. Reduce AOD-related crime and anti-social behaviour, and minimise AOD-related accidents and injuries.
2. Improve access to a range of evidence based treatment and prevention interventions to minimise AOD-related harm among the citizens of Cape Town, particularly vulnerable people, such as youth, people affected and infected by HIV/AIDS and TB, women (especially pregnant women), people who are unemployed, people with physical disabilities and mental illnesses, the elderly and people who are homeless.
3. Improve access to information on AOD-related harms for the City community, and how they can respond to these harms.
4. Improve reporting on local interventions and their effectiveness.
5. Cooperate with other spheres of government for enhanced responses to AOD-related impacts on people and places.

- Are you aware of the objectives of the OADS?
- In your position, are you mandated or responsible to implement any of the objectives of the OADS in the Marble Flats community?
- If so, which of the objectives are you mandated or responsible for implementing in the Marble Flats community?
- Which of the objectives have to date been operationalized and implemented in the Marble Flats community with regards to substance abuse?
- What form has the implementation of those objectives taken?
- What have the outcomes of the implementation of these objectives been for the Marble Flats and the problem of substance abuse?
- Which of the objectives set out in the OADS have not yet been implemented in the Marble Flats community?
- What factors have played a role in the non-implementation of those objectives in the Marble Flats community?

Section six: Challenges and successes

- What have the significant challenges been in the implementation of those objectives to address the problem of substance abuse in the Marble Flats?
- Have there been specific challenges in the policy itself to implementing those objectives in the Marble Flats community?

Section seven: Impact of the implementation of the OADS

- Has the Marble Flats community benefited to date as a result of this policy and its objectives?

Section seven: Conclusion

- Based on your experience with the OADS and participating in the implementation of its objectives, what recommendations would you make that could:
 - Improve the policy itself
 - Improve its implementation
 - Improve addressing the challenge of substance abuse in the Marble Flats community

APPENDIX D

RESEARCH CONCESSION LETTER

To whom it may concern

RE: Master's Thesis

My name is Sharna Johardien and I am a Master's student at the University of Cape Town. I am currently compiling me Master's dissertation and my research is concerned with the implementation of the Operational Alcohol and Drug Strategy 2007-2010. The topic of my dissertation is: An Analysis of the implementation of the Operational Alcohol and Drug Strategy 2007-2010 in the Ottery Marble Flats Community: A Case Study.

After consulting and engaging with this strategy, it has come to my understanding that the City of Cape Town's (name of the department or organization) has a role to play in the implementation of the strategy. I will be focusing on the five objectives as set out in the strategy and the questions are structured around your involvement in the implementation thereof.

It will be sincerely appreciated if you will agree to partake in this research. Each organization/department and respondent will be assured of anonymity. This research is extremely valuable and will contribute to the gap between policy formulation and implementation through the use of a case study in a particular community. As such, your contribution and knowledge will be highly appreciated.

Please be advised that you do have the right to not participate in the research and that there would be no negative consequences should you choose not to participate. The interview can also be stopped at any point during the process.

Yours Faithfully

SharnaJohardien