

**AN EVALUATION OF THE EFFECTIVENESS OF THE  
INSTITUTIONAL MECHANISM TO MANAGE SUBSTANCE  
ABUSE IN SOUTH AFRICA**

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**Submitted in fulfillment of the requirements for the degree of Masters in Social  
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**COMPULSORY 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.

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## **ACRONYMS / ABBREVIATIONS**

AIDS: Acquired Immune Deficiency Syndrome  
CBO: Community-based Organisation  
CDA: Central Drug Authority  
CSO: Civil Society Organisation  
DSD: Department of Social Development  
DBE: Department of Basic Education  
DJCS: Department of Justice and Correctional Services  
DPPME: Department of Planning Performance Monitoring and Evaluation  
FBO: Faith Based Organisation  
HIV: Human Immuno Deficiency Virus  
HPF: Health Promotion Foundation  
HPDNet: Health Promotion and Development Network  
LDAC: Local Drug Action Committee  
NGO: Non-Government Organisation  
NPO: Non-Profit Organisation  
NPC: National Planning Commission  
NDP: National Development Plan  
NDMP: National Drug Master Plan  
PSAF: Provincial Substance Abuse Forum  
SACENDU: South African Community Network on Drug Use  
SANAB: South African Narcotics Bureau  
SAPS: South African Police Services  
UNODC: United Nations Office on Drug Control  
WHO: World Health Organisation

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## **Abstract**

This mixed method study of the effectiveness of the management of substance abuse in South Africa explored the way policies are formulated and implemented. A governance lens used coordination and public participation as indicators to measure the efficacy of the coordinating substance abuse structures (the Central Drug Authority, Provincial Substance Abuse Forums and Local Drug Action Committees) to implement the National Drug Master Plan 2006-2011. Coordinated governance, which include empowerment and resourcing of structures at the provincial and municipal levels will be helpful to provide necessary resources, expertise and skills to the “whole of society” for the implementation of future strategies. Furthermore, an overwhelming majority of respondents (N=80, 81 per cent) recommended that a central government structure with requisite resources, leadership and capacity can improve coordination of future policy formulation, policy implementation and reporting to parliament. Another recommendation from experts included the establishment of a civil society-driven National Health and Development Promotion Foundation. The quantitative design managed a 70 per cent response rate.

**Key Words and phrases: Coordinated Governance, Coordination, Public Participation, Substance Abuse, Management**

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# CHAPTER 1: GENERAL PERSPECTIVE AND ORIENTATION

## 1.1. INTRODUCTION

The topic for this study has been formulated as “An evaluation of the effectiveness of the institutional mechanism to manage substance abuse in South Africa”. The management of substance abuse policies and strategies in South Africa is of national concern. This includes correlated issues of policy formulation, coordination and implementation. This was highlighted by both the 1<sup>st</sup> Biennial Anti-Substance Abuse Summit (hereafter referred to as the 1<sup>st</sup> Summit) in Johannesburg, in Gauteng, in 2007 and the 2<sup>nd</sup> Biennial Anti-Substance Abuse Summit (hereafter referred to as the 2<sup>nd</sup> Summit), held in Durban, in Kwazulu-Natal, in 2011. These Summits provided stakeholder platforms for engagement between all stakeholders involved in substance abuse policy formulation, coordination and implementation, including the Presidency, Parliament, Government and non-government organisations (DSD, 2011). The outcomes of both summits included resolutions to attend to reducing the supply, demand and related harms caused by alcohol and drug abuse. These resolutions have been slow in being implemented and demand a study to ascertain reasons for this delay. This invariably involves providing an understanding of how policies are formulated and its linkages to coordination and implementation.

The success or failure of the management of substance abuse can be best understood by measuring processes of policy formulation, coordination and implementation. This has been the rationale and direction of this study: to evaluate the effectiveness of the management of substance abuse in South Africa. The resolutions of the two Anti-substance Abuse Summits provide the basis of what essentially was identified as being the problems of the management of substance abuse. The main concern of the 1<sup>st</sup> Summit included that the substance abuse legislative framework was outdated. This drew attention to the need for a review of existing legislation and policies to keep up with

especially illicit drug trends and associated problems. A further concern was that there was a dearth of data which led to challenges and constraints on the inability to share such knowledge based on statistical evidence. These challenges made it difficult for policymakers and government to identify the needs of people and to implement necessary (efficient and effective) programmes. While this was a national problem, it was also highlighted as a global problem (UNODC, 2009). In addition, the 1st Summit identified a concern about the easy transit of drugs into and out of the country due to the country's border paucity (DSD, 2007).

The effects of globalisation was evident in the increased amount of drugs entering and exiting South Africa. After 1994, relatively more drugs were confiscated at border posts. This concern was raised by the police (safety and security) stakeholders at the Summit. The 2<sup>nd</sup> Summit established 34 resolutions which again called for, amongst others, a focus on policy review and a review of policy management. The primary resolutions included inter alia, the review of substance abuse policies and legislation to reduce the demand, supply and related harms caused by especially alcohol and drug abuse on individuals, families and communities. The focus was on how to reduce access to drugs and alcohol, from especially the youth and other vulnerable groups, such as pregnant women. The results of the two Summits thus provide a baseline and map of substance abuse policies that need review but more importantly identifies a need to improve substance abuse policy management, which includes policy formulation, coordination policy implementation. This forms the main tenets for exploration of this thesis. Literature on substance abuse is expansive but at the same time limited to areas other than the management of substance abuse in South Africa.

There is sufficient literature on studies concerning alcohol and drug abuse. Most recent scientific studies have focused on the effects of drugs and alcohol on people's brain (NIDA, 2010). These studies confirm that although people have inherent agency to make choices to use or not use substances like drugs and alcohol, the long term effects of these chemicals on their brains results in dependence or addiction.

Other studies have shown linkages between alcohol and drug use, gang violence, dysfunctional families and risky sexual behaviour (Haefele, 2011; UNODC, 2009; Flisher et al, 2003; Kalichman et al, 2007 ;WHO, 2005). These studies confirm that alcohol and illicit drug use affects individuals as well as their families, peers and communities. Policy review in South Africa and internationally has also received coverage and serve as best practiced models for national and global use (Parry, 2010; Babor, 2003; Babor, 2010; Karlsson, et al, 2013, Anderson, et al, 2009; UNODC, 2009, WHO, 2010). Various studies have looked at strategies to combat substance abuse (WHO, 2008; UNODC, 2011; Parry & Myers, 2011; Corrigan & Matzopoulos, 2013: Parry, 2010; Anderson, 2009; Osterberg, 2012).

However, studies on the management of substance abuse in South Africa are not evidently many. This thesis seeks to fill this research gap as the focus of the research thesis is broadly on the management of substance abuse policies in South Africa. More narrowly, the study focuses on how policies are formulated and implemented in South Africa and what needs to change for improvement of future substance abuse legislation and policies. Management of substance abuse in South Africa is guided by global influences.

The management of substance abuse in South Africa is primarily guided by international and regional protocols and national legislation and policies. Conventions of the United Nations and the African Union provide the framework for drug control – internationally and in Africa, while the World Health Assembly prescribes research-based global policies on alcohol control. The African Union prescribes collaborative efforts between neighbouring and international states to control illicit trade and trafficking in drugs, especially organised crime. National legislation and policies are guided by the Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008) and the National Drug Master Plan (NDMP).

Government established the NDMP in 1999 as a response to the drug and alcohol problem in the country (Drug Advisory Board, 1999:1). The NDMP forms the framework for more detailed policies in all departments and provinces involved in substance abuse (like the Department of Social Development, Department of Health, South African Police Services, and others). The main objectives of the NDMP are to reduce the demand, supply and related harms caused by drug and alcohol abuse. This national strategy serves for five year periods. Cabinet approved the NDMP 1999-2004, the NDMP 2006-2011 and most recently, the NDMP 2013-2017 strategies. The NDMP 2006-2011 will be analysed in this thesis as part of the evaluation of the effectiveness of the management of substance abuse in South Africa.

## **1.2. BACKGROUND TO THE PROBLEM**

In his first opening address to Parliament in 1994, South African President Nelson Mandela specifically singled out alcohol and drug abuse among the social pathologies that needed to be combated, and proclaimed that: “[a]lcohol and other drug abuse is a major cause of crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability, the escalation of chronic diseases such as AIDS and tuberculosis (TB), injury and premature death. Its sphere of influence reaches across social, racial, cultural, language, religious and gender barriers and, directly or indirectly, affects everyone” (DSD, 2006). This has been the premises for advancing policies and legislation to reduce the supply, demand and harms related to substance abuse in post-1994 South Africa.

Global bodies, such as the World Health Organisation (WHO) and the United Nations Office on Drugs and Crime (UNODC) play an important role in developing research and providing technical and financial resources to South Africa and other countries in reducing the demand, supply and harms related to substance abuse. The UNODC’s *2011 Report*

espouses that globally, approximately 210 million people use illicit drugs annually, and about 200 000 of them die from drugs (UNODC, 2011). According to the report, “there continues to be an enormous unmet need for drug use prevention, treatment, care and support, particularly in developing countries” (UNODC, 2011). Furthermore, the Report states that cannabis is by far the most widely used illicit drug type, consumed by between 125 and 203 million people worldwide in 2009. In terms of annual prevalence, cannabis is followed by amphetamine-type stimulants (ATS), mainly methamphetamine (UNODC, 2011). While these statistics may be flawed by non-disclosure, over or under-reporting, they do however reflect a cause for concern among countries, as drug use affects not only individual users, but also their families, friends, co-workers and communities. Children whose parents take drugs are themselves at greater risk of drug use and other risky behaviours.

Drug abuse is increasing in Africa and while the pattern fluctuates, there is a negligible decline in the age of drug users, marking a concern for youth at risk to other social ills and health consequences (Odejide, 2006; Parry *et al*, 2004; SACENDU, 2010). In South Africa, cannabis is the most commonly used illicit drug across provinces, except in the Western Cape Province where treatment demand for methamphetamine (also known as “tik” because of the tik-tik sound the crystals make when heated) has increased substantially (SECUNDA, 2013). There is also cause for concern of new types of drugs and mixtures of drugs (like Nyope and Whoonga, which is a mixture of cannabis, heroin and other chemicals, like rat poison, household detergents and reportedly, also antiretroviral (ARV) tablets. Drug mixtures complicate treatment, as medical personnel are required to treat people for substances not yet researched (Interview with Director of Treatment Centre, 2012). Furthermore, research by the Human Sciences Research Council (HSRC) has found that in South Africa, the age of initiation of substance abuse using alcohol and drugs is 10 to 12 years (HSRC, 2010). This makes it imperative for prevention and treatment programmes to include children in its target (risk) groups. This kind of evidence provides for effective policy-making and programmes generally. This notwithstanding, the management of substance abuse is our focus of exploration.

Policies on social issues, like substance abuse, in South Africa are driven by government and primarily influenced by the majority ruling party, the African National Congress (ANC). At the launch of the “Ke Moja” national anti-substance abuse [prevention] campaign in the Northern Cape Province, on the 14 October 2010, the Deputy Minister of Social Development (currently the Minister of Social Development), Ms. Bathabile Dlamini, stated that the ANC had prioritised substance abuse at the 2007 National Conference (Dlamini, 2010). Furthermore, President Jacob Zuma stated his concern for the high levels of substance abuse in the country and called on everyone (government and non-government stakeholders) to fight the scourge together, at the 2<sup>nd</sup> Biennial Anti-substance abuse Summit in 2011. President Jacob Zuma said the government would be working on creating substance abuse awareness and education programmes for communities around the country. He said Government would also be intensifying policing and law enforcement against drug traffickers. “This is aimed at curbing the problem and at helping to improve treatment for addicts and support provided to affected families,” he said (DSD, 2011; Ramela, 2011).

Leadership is thus evident in championing substance abuse in South Africa. This is generally advantageous for policy making and provision of funds for implementing policies. However, these actions must also be measured with what government spends on substance abuse which can show if they take issues seriously or otherwise. Therefore, government’s spending on resources to combat substance abuse can be considered a measure of how important substance really is. Because substance abuse is a multisectoral problem involving various departments and NGOs, it is difficult to calculate exactly what government spends on reducing the supply, demand and related harms of substance abuse. This should be considered for further study perhaps.

By reviewing the Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008) and the NDMP 2006-2011, this study will highlight good [and bad] governance practices in policy formulation with focus on the strategy to combat substance abuse in South Africa.

The main focus of the study is to use good governance principles and practices to measure the effectiveness of the management of substance abuse in South Africa. These principles include: coordination and participation. International best practiced models, to improve future policies on substance abuse will also be explored. The research focusses on the formulation, coordination and implementation of alcohol and drug policies and programmes. The study of the governance of substance abuse, which can be described as a complex problem, can have a significant impact to future approaches of the various stakeholders working in the sector to provide efficient and effective services to people who need it.

### **1.3. MOTIVATION FOR THE STUDY**

As a parliamentary Researcher for the Select Committee on Social Services, my functions include, amongst others, analyses of legislation and policies of the Departments of Social Development, Home Affairs, Health and the Departments of Human Settlements and Water & Sanitation). My interest in the subject of substance abuse is primarily due to being involved in finalising the Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008) during the parliamentary legislative process – between 2006 and 2008, when I worked as the Parliamentary Liaison Officer of the Deputy Minister of Social Development. Furthermore, I have a personal concern about the extent of the alcohol and drug abuse problem in communities in Cape Town and in South Africa, generally. It seems that the effects of drugs and alcohol on poor communities in particular are never-ending.

Furthermore, the ramifications of drugs and alcohol abuse on families and communities in South Africa are often in the media. Newspapers reported that a mother, from Steenberg, in the Western Cape, strangled her drug-addicted son because of his protracted thieving, verbal and physical abuse against her (Mrs. Pakkies case in 2007 (Prince, 2012)). Another high-profile case in the media spotlight was the violent rape and murder of a young Bredasdorp woman, also in the Western Cape Province, in February

2013 (Anene Booyens case in 2013 (Mafu, 2014). The 17 year old girl was raped and disemboweled after a night of drinking alcohol. These occurrences are not isolated to any one province and communities are seen to raise their concerns with politicians and the president in the media and when government is involved in oversight and public participation events. A mother from Eldorado Park in Gauteng Province wrote a letter to President Zuma in 2013 and pleaded for help to rid the community of the many drug dens in the area. The presidency and other government departments (South African Police Services (SAPS), Department of Social Development (DSD) and the Department of Basic Education (DBE)) visited the area and followed this up with a collaborative effort (together with government departments and the community) which included to arrest people dealing in drugs and assisting people who requested drug treatment.

A community-based organization, called People against Gangsterism and Drugs (PAGAD) was established in Cape Town and in Kwazulu-Natal, in the 1990s, to physically march on drug trafficking dens with the objective of forcing them to close down. This however resulted in violent confrontations between drug dealers and citizens that led to deaths and consequent imprisonment of many members and the leadership of PAGAD. This shows that drug trafficking and drug abuse is something that communities passionately reject and that non-government stakeholders and government departments can play a role in fighting drug abuse in our communities. However, this needs to be done in a coordinated and participative manner, within the confines of law and order. The need for civil society participation and especially ordinary citizens in substance abuse is most relevant in South Africa but this requires synergy with government within a coordinated and public participation framework.

I am of the opinion that there are generally good laws and policies in South Africa. However, implementation of such policies is often challenging. The issue of managing and coordinating substance abuse policies is even more challenging due to the complexity of substance abuse itself and inherent structural governance structures. Alcohol especially, is very complex. While it has devastating effects in terms of health

consequences, traffic accidents and violent crime, it simultaneously has social benefits because some people enjoy drinking socially and it also has economic benefits, such as employment and revenue for countries. The way in which government approaches combating substance abuse including, policing, treatment and care is fundamental to not only reaching narrow, short-term objectives, but also other long term objectives. These include developing social cohesion, creating better family units and reducing crime and violence, especially against women and children. International protocols and best practices can provide guidance for doing this, but government should also invest in local research to be updated to identify people's needs and implementing cost-efficient evidence-based programmes.

Evidence shows that dealing with substance abuse requires dealing with the underlying causes, like poverty and unemployment as well. The problem of government dealing with complex issues, such as substance abuse, reducing poverty, inequality and unemployment (all at once) depends on various stakeholders (government departments, the private sector and non-government organizations) to work together to share resources and to deliver effective and efficient services to people who need it most. It is also important that initiatives include people on the ground. Policy formulation and implementation must include people at the coalface of where the problems exist. This results in people-centred development and includes good governance principles of public participation. The bottom-up approach to policy-making and policy implementation automatically includes people and ensures that they are involved in solutions to their problems.

The political interest from the Executive and the general complexity of policy making and policy implementation in South Africa has thus been my motivation to pursue a study of "an evaluation of the effectiveness of the institutional mechanism to manage substance abuse in South Africa". Furthermore, the premises of the study stems from deliberations at the 2<sup>nd</sup> Biennial Summit in Durban, in 2011, which concluded that the management of

substance abuse in South Africa was not effective. The problem formulation is discussed in the next section.

#### **1.4. PROBLEM FORMULATION**

In this section of the dissertation, the research topic and research questions and research objectives will be discussed.

##### **1.4.1. Research Topic**

The topic for this study has been formulated as “An evaluation of the effectiveness of the institutional mechanism to manage substance abuse in South Africa”.

##### **1.4.2. Research Questions**

The main question to be explored in this study will be: Is the overall management of substance in South Africa effective?

Sub-questions include: Are coordinating structures effective? Are relations between structures positive?

##### **1.4.3. Research Objectives**

The research objectives of the study include the following:

1. to evaluate coordination and public participation in management issues as they relate to policy formulation and policy implementation;
2. to assess coordination and public participation principles in the NDMP 20062011[and the PATSA Act]; and
3. to explore new best practice models that could improve South Africa's substance abuse strategy and feed into future NDMPs.

The study relies on the perceptions of the respondents and thus is phenomenological in nature (Leedy & Ormrod, 2005:139). The study is pragmatic in nature as it seeks to make recommendations for future substance abuse strategies. Though an objective truth is aimed for, it is admitted that truth itself is at best a relative concept, and although objectivity is applied as a standard, it is admittedly influenced by subjective experience and interpretation of both the research respondents and the researcher (Toma, 2000).

The study makes use of a “coordinated governance” theoretical framework which combines good governance principles of public participation as well as public administration principles of coordination to evaluate the effectiveness of the management of substance abuse policies in South Africa.

## **1.5. RESEARCH APPROACH AND METHODOLOGY**

The study follows an empirical research design (cf. Chapter 3). The research is based on qualitative and quantitative data gathered through a survey among stakeholders involved in coordinating structures and people working in the sector at various spheres of government and in various sectors. In-depth interviews, an expert perception survey and national perception survey were used to collect information, using mailed questionnaires and a structured interview schedule. The study population consisted of non-randomly selected sample of provincial drug forum members, experts in the field and members of Local Drug Action Committees from all provinces.

This study used a mixed methods approach which is also referred to as “triangulation” to assess the effectiveness of the institutional mechanism to manage substance abuse in South Africa. Mouton (2006) observes that “the inclusion of multiple sources of data collection in a research project is likely to increase the reliability of the observations”

(Mouton, 2006:156). The composer of the term “triangulation”, Denzin (1978) used it to describe multiple methods of data collection, which include both quantitative and qualitative techniques. The reason for using mixed methods research for this study was because of its ability to produce a balanced outcome or report.

The primary research study comprised a sequential mixed methods research design process which combined qualitative and quantitative methodologies. The qualitative phase included in-depth interviews and an Expert Perception Survey which culminated into a Case Study of the Western Cape. The quantitative phase included a National Perception Survey. These two processes evolved sequentially and represented a mixed method research design. The design was appropriate because comparisons between the two data-sets could be made and inferences could be related to the literature review and discourse and the sector generally.

## **1.6. DEFINING TERMS**

The following terms used throughout the study are defined.

### ***Community Based Services***

Community based services include prevention, early intervention and community-based treatment programmes (treatment, aftercare and re-integration) (DSD, 2006). Evidence is mounting that the most effective prevention strategies are community based (Parry, 2011).

### ***Demand Reduction***

There are generally three types of demand reduction strategies: primary prevention strategies, treatment services for substance users, and harm reduction programmes (DSD, 2006; Babor, 2010).

### ***Drug Master Plan***

A drug master plan is a national strategy that guides the operational plans of all departments and government entities involved in the reduction of the demand for and the supply of drugs in a country (DSD, 2006:4)

### ***Early Intervention***

An early intervention is a therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. Treatment is offered or provided before voluntary admission, and in many cases, before they become aware that their substance use may cause problems. It is directed particularly at individuals who have not developed physical dependency or major psychosocial complications (DSD, 2006).

### ***Evidence-based policy-making***

Policy makers need evidence to inform their decisions so that they can make informed policy choices and improve the implementation of those policies (Davies, 2008:3). Good quality research can help to illustrate the extent of problems and the underlying causes. This is important in deciding where to focus resources and programmes, as well as which interventions are needed to address problems. "Evidence" refers to the body of knowledge that is being drawn on and used to inform policy decisions. Good evidence is technically sound, of good quality and trustworthy, as well as relevant and timely (Segone, 2009:19). Current practices include the innovative use of spatial photographing to provide clear geographical pictures of areas under study.

### ***Harm reduction***

“Harm Reduction” refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of licit and illicit psychoactive drugs without necessarily ending drug consumption (IHRA, 2010). This term is used with reluctance in South Africa because government aspires to a zero-tolerance of substance abuse, as opposed to using one drug to ameliorate harm from another drug, as is the practice internationally (DSD, 2013).

### ***Institutional Mechanism to Prevent and Manage Substance Abuse in South Africa***

The institutional mechanism to prevent and manage substance abuse in South Africa is embodied firstly in the policies and legislation developed by the Executive and passed by Parliament. Secondly, it includes government and non-government stakeholders involved in implementing the policies and providing substance abuse programmes and services in the sector. These programmes and services include: early intervention, treatment, prevention and aftercare. In addition to the human resources to implement policies, there are also financial resources required to implement policies and legislation.

### ***Governance (Coordination and Management) of Substance Abuse***

The governance of substance abuse in South Africa is led by the Inter-Ministerial Committee on Alcohol and Substance Abuse, comprising Executive Ministers of: Social Development and executives / ministers of other departments. The Committee is supported by the coordinating structure of the Central Drug Authority (CDA) who is further supported by Provincial Drug Forums (PSAFs) in all nine provinces and Local Drug Action Committees (LDACs) in all (225) municipalities. Further programme implementation support is provided by government departments, non-government organizations (NGOs), civil society organizations (CSOs, like tertiary institutions), community-based organizations (CBOs), and faith-based organizations (FBOs).

### ***Prevention***

Preventive intervention is intended to stop people from starting to use substances and make those people who are using substances aware of long term consequences. The Department of Education, Department of Health, Department of Social Development and Soul City are the primary actors in raising awareness of and educating people about the dangers of drug abuse (DSD, 2007: 23).

### ***Supply Reduction***

Supply control approaches to drug problems focus on the production, distribution, and sale of illicit psychoactive substances, whereas criminal sanctions deal with the punishment of drug sellers and users (Babor, 2010a).

### ***Substance Abuse***

According to the NDMP 2006-2011, "substance abuse includes the misuse of substances such as nicotine, alcohol, glue, over the counter drugs, prescribed drugs, alcohol concoctions, indigenous plants, solvents, inhalants as well as the use of illicit drugs, such as cannabis, cocaine, heroin and amphetamines"(DSD, 2006:40). Substance abuse is used in this thesis interchangeably with substance misuse. According to Mc Ardie (2008) substance misuse is defined as, "...maladaptive pattern[s] of use leading to clinically important impairment or distress". Substance abuse can manifest "...through failure to fulfill obligations such as work or school as well as persistent use despite persistent/recurrent social or interpersonal problems caused or exacerbated by effects of the substance" (Mc Ardie, 2008:46). In this study, the term substance abuse refers to mainly illicit drugs and licit alcohol use as they are the main substances under review.

## 1.7. CONTEXTUALISATION

The historical and environmental context within which substances are used and abused is very important to provide understanding of why people use and abuse drugs and alcohol. According to the former Minister of Social Development, Ms. Edna Molewa (2010), it is important to understand the dynamics of substance abuse in poor communities and the role that poverty and deprivation plays in driving substance abuse. Poverty and inequality are major factors in contributing to people partaking in substance abuse, even though the overwhelming majority of poor people do not turn to drugs and alcohol to survive (DSD, 2010). It must be acknowledged though that substance abuse prevails in rich and poor communities in South Africa and the central reason for people using substances is based on the individual's own choices even though biological, social and economic drivers prevail that increases the propensity for people to become substance dependent (or addicted).

During the pre-1994 apartheid era, South Africa was isolated and therefore substance use has mainly centred on locally produced (licit and illicit) substances such as alcohol, tobacco and cannabis (Heerden et al., 2009). Post-1994 South Africa became less isolated and began trading with the international community. Global production and increased marketing of illicit drugs resulted in an increase of drug use (opiates and amphetamines) in South Africa (Parry et al., 2009). According to Fakier and Myers (2008:10), supply and demand indicators suggest that the domestic market is expanding, with drug prices decreasing, availability increasing and treatment demand for substance related problems on the rise.

The post-1994 democratic government has focused on transforming government and governance to improve the lives of all people in all spheres of their lives. This transition has been accompanied by a review of policy and legislation and expanding services to

everyone. Furthermore, the transition included an improved service delivery model, based on “Batho Pele” principles (DPSA, 1997). This model emphasises the rights of people to government services and is premised on strengthening partnerships between the public and government in service delivery, thereby ensuring citizen participation.

The management of substance abuse policies and legislation was originally prescribed in the Prevention and Treatment of Drug Dependency Act (Act No. 20 of 1992). This legislation was repealed by the Prevention of and Treatment for Substance Abuse (No. 70 of 2008) (hereafter called the PATSA Act). The overarching legislation focusing on substance abuse is incorporated in relevant principles of the Constitution of the Republic of South Africa (Act No. 108 of 1996). Section 10 and 27(1)(a), provides an overarching mandate to stakeholders within government, parliament and the executive, to implement initiatives to protect the health and dignity of South Africans, who are in need of assistance (Constitution, 1996). This provides the premises for a rights-based approach to health provision and relevant services to South African citizens.

The NDMP 2006-2011 and the PATSA Act are the primary focus of this study as it constitutes South Africa's framework to reduce the supply, demand and related harms of substance abuse. A review of the strategy and the Act will identify stakeholders involved in the governance and policy implementation. The study provides primary data on the relations between stakeholders and perceptions of stakeholders involved at the local municipal governance level, namely members of Local Drug Action Committees (LDACs). Ethical considerations are discussed to establish the framework of the data-collection operations in Chapter 4 of the thesis as well as the ethics of the research in general.

## **1.8. ETHICAL CONSIDERATION**

According to Strydom (2005), ethics can be defined as "...a set of moral principles which is suggested by an individual or group is subsequently widely accepted, and which offers rules and behavioural expectancies about the most correct conduct towards experimental subjects and respondents". Looking at the aforementioned definition it can be said that ethics involve the study of human action in light of good and bad, or right and wrong. When conducting a research study, a number of ethical considerations have to be taken into account. Some of the ethical considerations to take into account include voluntary participation, anonymity and confidentiality and accurate information.

### ***Voluntary Participation***

According to Babbie and Mouton (2011) voluntary participation entails making sure that the respondents volunteer willingly to participate in the study. Strydom (2005) describes this ethical consideration as informed consent. For this to take place, the respondents need to be provided with accurate information pertaining to the study which includes both positive and negative aspects (Strydom, 2005). Moreover, the respondents have to be psychologically competent to give informed consent to take part in the study (Strydom, 2005). In light of the current study, the researcher ensured that the respondents were fully aware of the study and its aim in the introduction on the questionnaire. In terms of being psychologically competent, the questionnaire was meant to be answered by the directors of the targeted organisation. Thus, the researcher assumed that for one to be a director of an organisation he or she has to be psychologically competent.

### ***Anonymity and Confidentiality***

Anonymity refers to "...a situation whereby the researcher cannot identify a given response with the given respondent" (Babbie & Mouton, 2001:523). With confidentiality on the other hand, the researcher may know the identity of the respondent but ensures that the identity is not shared with the public (Strydom, 2005). Anonymity and confidentiality thus protect the

privacy of the respondents. For the purpose of this study, the name of the respondents (in the quantitative study) was not-compulsory, and this ensured that the principle of anonymity was upheld, as the researcher did not know which respondent had given a particular response.

### ***Accurate Information***

This ethical consideration entails making sure that the researcher reveals his/her identity and the purpose of the study to the respondents (Babbie & Mouton, 2001). In this research study, the researcher ensured that the respondents had accurate information. This was done by sending out a cover letter, signed by the Deputy Director General of the Department of Social Development (in charge of Substance Abuse), together with the questionnaire. The cover letter clearly articulated the name of the researcher, as well as the purpose of the study. Besides ethical considerations, as the Researcher, I also needed to consider my own reflexivity which had influence on the study.

## **1.9. REFLEXIVITY**

This concept encompasses the process whereby the researcher reflects on how he or she may influence the study. This may be personal experiences as well as individual perceptions. Payne and Payne (2004:11) define reflexivity as "...the practice of researchers being self-aware of their own beliefs, values and attitudes and their personal effects on the setting they have studied and self-critical about the research methods and how they have been applied".

I was well aware that my passion about the field of substance abuse was a major motivating factor to undertake the research in the first place. Moreover, my experience of being directly involved in finalising the PATSA Act raised my awareness of policy formulation in the South African context. With the points mentioned above in mind, it was

important for me to ensure that my thoughts and feelings on the subject matter did not influence the study. This was mainly applicable to the formulation of the interview schedule and questionnaire. My supervisor was instrumental in ensuring that the questions in the questionnaire were not biased.

## 1.10. OUTLINE OF THE THESIS

Chapter 1 outlines the introduction of the study, the problem statement and hypothesis to be investigated in chapter 2 is the literature review which links the research objectives to the existent literature on coordinated governance and policy formulation and policy implementation within a South African context. The methodology of the project is described in chapter 3 and quantitative and qualitative results reflected in chapter 4. Chapter 5 summarises the results and makes recommendations to improve the management of substance abuse in South Africa. Figure 1 below outlines the full research process.

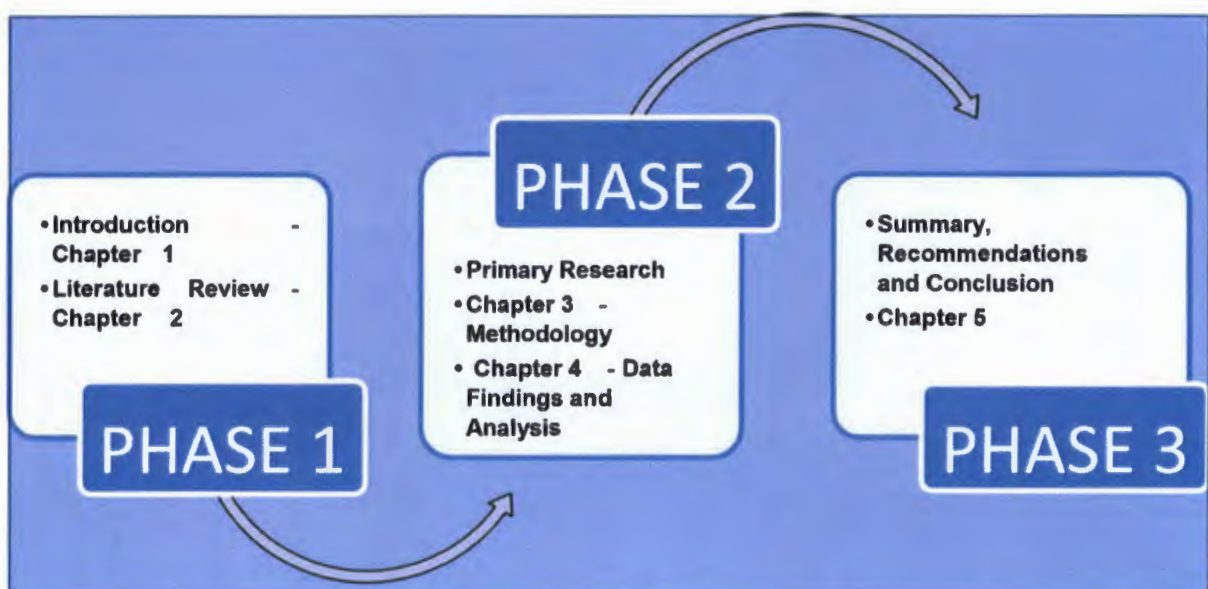


Figure 1.1: Research Outline

## **1.11. CONCLUSION**

The first chapter of this dissertation has introduced the research problem of the institutional mechanism to manage substance abuse in South Africa. This was done by giving the rationale behind the study as well as giving background information of the research topic, research questions research assumptions and theoretical framework. Important terms were defined and ethical considerations as well as reflexivity were discussed. Now that the problem has been introduced and the rationale and objectives of the study discussed, the next chapter will look at the literature review.

## **CHAPTER 2: COORDINATED GOVERNANCE TO MANAGE SUBSTANCE ABUSE: A LITERATURE REVIEW**

### **2.1. INTRODUCTION**

“All that is necessary for evil to succeed is for good men [and women] to do nothing”  
Edmund Burke (1729-1797).

The above quotation translates into: if you want the world to change, do something about it! The connotation of this quote is very relevant to substance abuse as the problem is faced by everyone. People are invariably either directly or indirectly affected by drug or alcohol abuse because the effects of addiction and dependence extends to rich and poor, male or female, all races and all countries. This therefore calls for a “whole of society” approach to policy formulation and policy implementation. The whole of society here refers to government, the private sector, civil society organisations (CSOs) and parliamentary institutions. CSOs include: non-profit organisations (NPOs) (also referred to as non-

government organisations (NGOs)), community-based organisations (CBOs), faith-based organisations (FBOs) and tertiary (research) institutions. This provides a pretext for the study which has focus on the management of substance abuse in South Africa with special focus on how policies are formulated and implemented.

This chapter focuses on the literature review of the study. The literature review provides a conceptual overview of current research of substance abuse. Furthermore, it forms the foundation of this thesis, which aims to add to the body of existing substance abuse knowledge. The chapter starts with a background of substance abuse policy management. This includes policy formulation and policy implementation. It then discusses “coordinated governance” as the theoretical framework of the study, which includes defining good governance (as the measurement lens) and principles of good governance (as measurement indicators). This is followed by a discussion on the legislative framework and a review of substance abuse policies. The PATSA Act and the NDMP 2006-2011 will be analysed against principles of good governance (coordination, and public participation). Lastly, the chapter discusses international best practice and concludes with a comment of the chapter.

## **2.2. BACKGROUND**

Historically, the control and management of alcohol and illicit drugs, which includes the production, sale, access and use of alcohol and drugs, was achieved at various levels, through legislation and policies. After a century of alcohol policy experimentation, including prohibition laws, current alcohol policies are based on scientific and medical research (Babor, 2003; Babor, 2010a; WHO, 2010a). Between 1914 and 1921, legislation prohibiting the manufacture and sale of all or some forms of alcohol beverages were adopted in the United States of America (USA), Canada, Iceland, Finland and Russia. Problems related to alcohol abuse in the 1970s, encouraged an interest in alcohol policy research as a public health strategy (Babor, 2003). The WHO sponsored the publication of *Alcohol control policies in public health perspective* (Bruun, Edwards & Lumio, 1975),

also referred to as the “purple book”. This book stimulated debate among academics and policy makers alike. The book’s main argument included that: the more alcohol consumed in a society, the greater the incidence of problems experienced by that society.

Consequently, the accepted ideal has been to develop policies to reduce the availability and access to alcohol – so as to reduce alcohol problems in societies. The WHO again sponsored global alcohol policy research in the 1990s, emanating in the study by Edwards et al. (1994) called “Alcohol policy and the public good”. This research concluded that effective public health measures do exist to serve the public good by reducing the widespread costs and harms related to alcohol use [and abuse] (Babor et al., 2003).

The follow-up WHO-sponsored study by Babor et al. (2003) named, “*Alcohol: no ordinary commodity-research and public policy*” again reviewed international alcohol policies and concluded that alcohol has multiple (socio-economic and other) functions in society. This includes, being a drug, used for social (pleasure and intoxication) purposes, as well as for economic purposes (of making economic profits for corporates, creating employment, and extracting revenue for governments) (Babor et al., 2003:17). The research acknowledges the complexity of substance abuse and highlights effective and efficient means of dealing with issues towards reaching the objective of reducing the demand, supply and related harms caused by (alcohol) substance abuse. International research on drugs is described in the next section.

International reporting and policy directives on illicit drugs have especially been propelled by the United Nations Office on Drugs and Crime (UNODC). Since 1998, the UNODC has reported on trends in the evolution of global illicit drug markets, in the form of the “*Global Illicit Drug Trends*”. From 2004, the UNODC incorporated the “*World Drug Report*” with the “*Global Illicit Drug Trends*” to provide a comprehensive report (*World Drug Report*) on the international drug problem.

In 2009, the *World Drug Report* showed that global markets for cocaine, opiates and cannabis were constant or in decline, while the production of synthetic drugs (which can be manufactured anywhere) was increasing in developing countries. The Report also emphasised the impact of drug-related crime and recommended countries implement stronger measures to fight drug related crime and that more resources be used for drug prevention and treatment. Recommendations to improve drug control include: universal access to treatment, international agreements against organised crime, and greater efficiency in law enforcement (UNODC, 2009). Again, the discourse calls for sound management principles to combat substance abuse as well as integrated and collaborative efforts among neighbouring states to fight drug related crimes, including human trafficking, money laundering and corruption among officials.

Evidence from studies in the United Kingdom (UK), include that drug policy does not influence either the number of drug users or the share of users who are dependent. There are numerous other cultural and social factors that appear to be more important with regard to people's propensity to use substances. It is notable that two European countries that are often used as contrasting examples of tough or liberal drug policies, Sweden and the Netherlands, both have lower rates of overall and problematic drug use than the UK (Reuter & Stevens, 2007). International studies of substance abuse policies highlight broader issues around the actual problem of people abusing drugs and alcohol. The complexities of alcohol and drug abuse have directed focus to the underlying social and economic problems which needs simultaneous attention. This has an impact on policy formulating and policy implementation. In essence, it has linkages to what type of initiatives and programmes are relevant to reduce the related harm caused by substance abuse. This notwithstanding, unintended consequences of substance abuse policies also prevail, and discussed next.

### ***Unintended Consequences of Policies and Legislation***

While there are some positive effects of legislation, alcohol and drug policies have also been prone to unintended consequences (Babor, 2010). Legislation linked to the prohibition of alcohol in the United States of America (USA) in the 1920s resulted in unintended consequences of illicit alcohol smuggling (“bootlegging”) which meant the emergence of an alcohol “black-market” characterised by illicit unregulated sales of alcohol. In the instance of illicit drugs, the unintended consequences of policies and legislation were similar to alcohol, but much worse. A large drug underworld, linked to all sorts of crime, including organised crime, gang violence, human trafficking, firearm trafficking (and in the instance of South Africa, abalone smuggling and illicit cigarette trafficking), rapidly proliferated on a global, regional and national scale. Organised crime has especially proliferated in Southern Africa (Hübschle, 2010). This has complicated law and policy-making and the control of illicit drugs in particular.

### ***The “War on Drugs”***

The issue of whether to continue with the “war on drugs” is now an international dilemma in question. International and national researchers have conceded that too much money has been spent on controlling the supply of drugs and propose more resources be spent on prevention and treatment for substance abusers (Van Niekerk, 2011; UNODC, 2011; Babor et al., 2010a; Parry, 2002; Parry & Myers, 2011; SAMJ, 2012; Fellingham, 2012;

Fellingham et al., 2012). On the other hand, proponents against ending the “war on drugs” argue for stricter control measures to thwart the vestiges (of health and other impacts) of drug abuse on families and societies (DEA, 2010; Doctors for Life, 2009). The policy debate on drugs also extends further, towards decriminalisation of some drugs for medical and economic purposes. A derivative of cannabis (THC) is used to retard the manifestation of some cancers and Hemp, also a derivative of cannabis, can be used for manufacturing clothing.

Inkatha Freedom Front (IFP) Member of Parliament in the National Assembly, Dr Mario Oriani-Ambrosini tabled a private member's bill, namely, the "Medical Innovation Bill" in an attempt to legalise use of cannabinoids for medical purposes, in Parliament, on 20 February 2014. According to Dr Ambrosini, "the bill seeks to remove the problems created by the law, creating a space in which doctors can follow the dictates of their professional experience in cases where there is nothing else better to be given." It further aimed to legalise treatments that would otherwise not be allowed – and will shield doctors from liability (Davies, 2014). This bill was again tabled in the new fifth parliament, after the passing of Dr Ambrosini, and will provide robust debate to test whether South Africa is ready to conform to international discourse and policy-making, to decriminalise cannabis for medical purposes.

It is argued that "prohibition is a constitutional limitation, but does not necessarily achieve its purpose in the least repressive or most effective way" (Fellingham, 2012). Van Niekerk (2011: 1) in a journal paper entitled 'Is it time to decriminalize drugs?' makes the point that drug use is at worst a vice, it shouldn't be considered as a crime, and to punish those who use or abuse drugs, is criminal in itself. This is the ethical issue at stake in the question of the decriminalization debate. Is it ethically acceptable for the state to treat those who use drugs as criminals? (Fellingham, 2012).

Furthermore, Parry & Myers (2011) questions why alcohol and tobacco, which is much more harmful than cannabis, is legal, while cannabis is not. These researchers as well as international bodies call for global states, including South Africa, to shift towards decriminalising personal drug use and adopting a rights-based public health approach to drug policy focused on preventing and reducing the harms associated with drug use (Global Commission, 2011).

### ***Evidence-based Research***

Research-based evidence on substance use/abuse in South Africa, since the 1990s, present the following information which provides a national and regional context of the problem:

A broad range of substances are being used in South Africa, including: alcohol, cannabis, heroin, crystal methamphetamine (tik), glue, tobacco, cocaine and methaqualone (also known as mandrax) (Reddy, et al., 2003; HSRC, 2010, CDA, 2011). While some patterns of drug use are unique to South Africa (for example the mix of cannabis and methaqualone known as the “white pipe”) a range of substances that are available on the international market, are being used (DSD, 2007). These include cocaine and crack cocaine, heroin and a range of club drugs (Reddy, et al., 2003).

Moreover, the use of new drug mixes has become common in various parts of the country and of major concern. These drug mixtures include Nyaope, used mainly in Gauteng and in Kwazulu-Natal (a.k.a. Whoonga). This drug includes ingredients of heroin, cannabis and other ingredients like: rat poison, milk powder, bicarbonate of soda, pool cleaner and anti-retrovirals (ARVs) (Health 24, 2014). This drug is more addictive and more devastating to the health and well-being of the user, as well as those around him/her (family and society in general). Furthermore, the ARVs which are meant for people affected by HIV and AIDS are now being targeted for theft by users and drug dealers (TV programme). The drug meant to save lives is now causing addictions and societal problems.

There is national and international concern about the link between drug trafficking and organised crime as an indirect consequence of globalisation. Organised crime include criminal activities such as large-scaled theft of motor vehicles, smuggling of people for use in prostitution, gun trafficking, and money laundering. Organised crime poses a significant threat against the economic and political stability of a nation (UNODC, 2009). Several international initiatives have been undertaken to control organised crime. In 1998

the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic substances was adopted to criminalise cross border laundering of money derived from drug trafficking and to enable extradition processes between signatory states. In Sub-Saharan Africa, the South African Regional Chiefs Cooperation Organisation (SARPCCO) and the Inter-State Defense Security Conference (ISDSC), Interpol and the Regional Intelligence Liaison Office (RILO), has been established to look at international co-operation and organised crime. South Africa promulgated the Prevention of Organised Crime Act (POCA), 1998 (Act No. 121 of 1998) in 1999. The purpose of the POCA Act is to deny criminals of the proceeds of their criminal activity and to prevent them from deriving benefit from such proceeds. While this act may or may not have reduced organised crime in some areas, it has resulted in millions of Rands of property and assets being confiscated from criminals and placed into state coffers (Majuzi, 2010).

The issue of border control, to restrict inter-country drug trafficking, was highlighted at the 1<sup>st</sup> Biennial Anti-Substance Abuse Summit, in Johannesburg, in 2007. The Department of Home Affairs currently leads the process of establishing a Border Control Management System together with other stakeholders, such as SAPS, Department of Defense and the National Treasury (Radebe, 2014).

Substance abuse has negative health and social consequences on individuals, families and communities (WHO, 2010b; UNODC, 2011). Research studies show that alcohol and drugs has a direct cause and effect on crime, poverty, reduced productivity, unemployment, dysfunctional families, political instability, the escalation of chronic diseases such as HIV and AIDS, tuberculosis (TB), hepatitis, injury and death (Parry et al, 2009; Parry & Myers, 2011, Seggie, 2012, WHO, 2010; UNODC, 2011; DSD, 2006:6). Ben Haefele (2011a) suggests that substance abuse in areas like Mitchell's Plain, in the Western Cape province, is related to gang activity, unemployment, poverty, disrupted families and broken homes. While we cannot generalize this situation to all communities, the incidence of substance abuse is prevalent especially amongst the youth in all provinces as shown by data collected at treatment centres across the country (SACENDU, 2011; Ramsoomar & Morojele, 2012). This in itself deems substance abuse to be a

national problem which needs attention and holistic solutions. Initiatives and programmes should however be research-based to ensure effectiveness and efficiency (WHO, 2004; UNODC, 2011).

Alcohol is the most common primary substance of abuse in most areas across the country and no doubt still causes the biggest burden of harm in terms of 'secondary risks', including injury, premature non-natural deaths, fetal alcohol syndrome, and as a potential catalyst for sexual risk behaviour and hence HIV transmission (SACENDU, 2010; MRC, 2008; Parry et al., 2011; Corrigan & Matzopoulos, 2013). There is evidence and related concerns of the incidence and consequence of substance abuse on/among women. The incidence of Foetal Alcohol Syndrome (FAS) among pregnant women has been found to be very high in Western and Northern Cape provinces (Viljoen et al., 2005). In fact, these areas show the highest incidence of Foetal Alcohol Syndrome (FAS), in the world (WHO, 2010). FAS includes a spectrum of physical, neurological and behavioural problems in children exposed to alcohol before birth (while their mothers were pregnant with them) (Viljoen et al., 2005; May, 2005; MRC, 2008).

Furthermore, a study conducted at the University of California Los Angeles (UCLA) in 2010, on the effects of Methamphetamine on unborn babies found that the drug is even more damaging to the foetus than alcohol as seen in Foetal Alcohol Syndrome (FAS) (Sowell et al., 2010; Haefele, 2011b). Some states in the United States of America (USA) have attempted to criminalize prenatal drug use or treat it as grounds for terminating parental rights, while others have placed a priority on making drug treatment more readily available to pregnant women (Dailard & Nash, 2000).

Gender gaps are closing particularly for the white and so-called "coloured" population groups. More females are abusing alcohol and illicit drugs, although they are not reporting for treatment at centres (HSRC, 2010). This makes it difficult to monitor the trend within and between gender groups. This notwithstanding, pregnant women should be special

targets for interventions of substance abuse treatment and prevention programmes because of the effects of alcohol on themselves and their unborn babies (HSRC, 2007).

Regular drinking of high volumes of alcohol, binge drinking, has been linked to long term chronic alcohol-related diseases such as cirrhosis of the liver (Parry et al., 2009). Binge drinking has been linked to acute alcohol related consequences such as homicide and road traffic accidents. Risky drinking or binge drinking is more concentrated in the north and north-west of South Africa, with Mpumalanga showing the highest concentration (Pludderman et al., 2009). While an average of 7.5 per cent of the population aged between 25 and 54 indulges in risky drinking during weekdays, this rises to an alarming 31.5 per cent on weekends.

The prevalence of risky drinking is greater among middle age drinkers in rural areas who are the least educated and is higher in females than for males (HSRC, 2007). It is also very high among the youth (particularly males) with more than a quarter of youth indulging in it in many communities (DSD, 2006).

International guidelines for estimating the costs of substance abuse define such economic costs as including the social costs of treatment, prevention, research, law enforcement, lost productivity and quality of life compared to a situation in which there was no abuse (WHO, 2010; Babor et al., 2010). Social costs are those costs incurred by persons other than the person who engages in alcohol abuse. These externalities are borne by society at large (Budlender, 2009). Estimates of the social and economic costs of alcohol abuse are hampered by the lack of consistent and reliable data (DSD, 2006; DSD, 2007).

### ***Financial Costs of Alcohol and Drugs***

National Treasury estimate that national government allocated more than R10 billion and provincial governments allocated almost R7 billion in 2009/10 to deal with the direct

consequences of alcohol abuse, reduce the extent of alcohol abuse, and address its negative social impact (National Treasury, 2014; Budlender, 2009). After the revenue gained through excise duties on alcoholic beverages, VAT collected on alcohol sales and provincial liquor licenses, net alcohol-related expenditure of about R890 million remained to be funded through general tax revenue and borne by the taxpaying public at large (National Treasury, 2014:6).

### ***The Economic Benefits of Alcohol***

On the flip-side of economic costs, there are at the same time economic benefits of the alcohol industry. The liquor industry provides employment and income to thousands of workers and makes a substantial contribution to export earnings and government tax revenue in South Africa. Total sales volumes of alcoholic beverages in South Africa for the 2008/09 financial year amounted to 3.3 billion litres at an estimated value of R57.5 billion (Punt, 2010). South Africa is a net exporter of alcoholic beverages, largely due to wine exports. Total wine, beer, spirits and other fermented beverage exports amounted to R7.068 billion in 2009, while imports were estimated at R3.356 billion (Econex, 2010). The estimated total economy wide contribution of the alcoholic beverages sector is R73.3 billion in terms of value added, R34.7 billion towards total government tax revenue and 522 553 jobs are supported throughout the economy (Punt, 2010). Econex estimates the total economy-wide contribution of the liquor industry to employment opportunities at 548 000, similar to that of Punt at 522 553 (Econex, 2010; Punt, 2010). This represents 4.5 per cent of total employment in South Africa, with 37.1 per cent of these jobs in the wholesale, retail, catering and accommodation sectors.

Total labour remuneration directly related to the liquor manufacturing industry amounted to R9.9 billion in 2009. (National Treasury, 2014:56). The income generated from alcohol becomes a factor when considering the related harms caused by alcohol abuse on individuals, families, communities and the country in general. Policy-makers need to consider the extent of these pros and cons when formulating policies.

## ***Illicit Trade***

The World Health Organisation (2010) estimates that unrecorded alcohol consumption constitutes approximately 27 per cent of the total worldwide alcohol market. Unrecorded alcohol consumption represents both illicit trade as well as home-brewing of alcoholic beverages. The prevalence of unrecorded alcohol consumption is proportionately higher in poor countries and also tends to be higher in countries with strict anti-alcohol policies, including higher alcohol taxes. Unrecorded alcohol consumption in Africa is estimated at 36 per cent of the total alcohol market and the corresponding percentage for South Africa is estimated at a conservative 20 per cent due to relatively strong domestic enforcement policies (National Treasury, 2014). Given the serious health effects of consuming illicit and home-brewed alcohol, unrecorded alcohol consumers contribute significantly to the negative social externalities of alcohol abuse. Another problem area concerning alcohol use is regulating of the unregulated. About 80 per cent of alcohol consumption occurs in about 35,000 licensed taverns and 180,000 unlicensed shebeens / taverns across South Africa.

It is argued that the regulatory framework is sufficiently enforced in the formal sector but that its impact does not reach the vast majority of liquor outlets in the informal liquor trade (National Treasury, 2014). Furthermore, the 1<sup>st</sup> Biennial Anti-Substance Abuse Summit pronounced that: “The complexity of the drug and alcohol abuse problem in the country [in general] demands a coordinated and highly integrated approach if the goal of creating a “drug free society” is to be achieved” (DSD, 2007).

## ***Treatment and Care***

Demand-side treatment and care for people who abuse substances are mainly done by the Department of Health (DOH) and Department of Social Development (DSD) while

prevention and supply-side initiatives is the task of various other departments. Supply side programmes are the function of the South African Police Services (SAPS) and the Department of Justice and Correctional Services. Furthermore, some demand side functions (like prevention programmes, retail licensing and opening and closing regulations) are implemented by provinces and municipalities (Department of Basic Education, Provincial Department of Trade and Industry, and local municipalities). This incoherence plays itself out in various forms of challenges to manage policies generally and discussed in later chapters.

The discourse on substance abuse thus shows that in the main, controlling access to substances is important but not the panacea. Furthermore the complexity of the phenomenon of substance abuse (addiction and dependence) requires understanding and ongoing research to manage it most effectively and efficiently. Substance abuse affects people's social and economic environment and therefore requires government to consider the immediate vulnerabilities of the person as well as the underlying causes and effects on families, communities and the country generally. Policy makers should therefore consider the cultural and economic context of why people abuse drugs and alcohol and seek holistic solutions to target the groups most affected. The following section deals with the theoretical framework of the study.

## **2.3. THEORETICAL FRAMEWORK**

### ***The Governance Lens***

The effective management of policies and implementation of programmes related to substance abuse was the topic of discussions at both the 1<sup>st</sup> and 2<sup>nd</sup> Biennial Anti-substance Abuse Summits. The resolutions which emanated from the Summits (see Appendix G for a list of all the resolutions) included consensus of the need for a

comprehensive review of the Prevention of Substance Abuse Act, as well as a review of the NDMP 2006-2011. This provided impetus for this study: to “evaluate the effectiveness of the management of substance abuse in South Africa”. This section deals with “coordinated governance” as the theoretical framework of the study.

In this study, the effectiveness of the institutional mechanism to manage substance abuse in South Africa is measured through a “good governance lens”. The “good governance lens” includes a mix of principles of “good governance” and “public administration” which are inherent of policy formulation, policy coordination and policy implementation. The theoretical framework of good governance as a lens to guide the study was thought to be the most pragmatic for purposes of providing a picture of how substance abuse policies are formulated, coordinated and implemented in South Africa.

The aim of the study is to test the hypothesis: that the institutional mechanism to manage substance abuse in South Africa is not effective. The study’s objectives include: explaining how substance abuse is managed in South Africa. For this purpose, I explored how policies are formulated, coordinated and implemented. Moreover, I investigated whether the management of substance abuse included good governance principles. I selected good governance principles of coordination and participation as measuring indicators for the study. My contention was that provided that the institutional mechanism to manage substance abuse contained these good governance principles, it was not effective. The journey of this study therefore starts with an exploration of literature on substance abuse management (policy formulation, coordination and implementation)

In this chapter, substance abuse policies are assessed by investigating issues of coordination and citizen participation. The following chapter (3) includes primary research which is a mixed methods study to investigate people’s perceptions (experts, practitioners and committee members of Local Drug Action Committees) of substance abuse management in South Africa. Chapter 4 provides a space for discussion of the findings of the primary research process. The final chapter (5) combines all the data to: summarise

the findings; answer the hypothesis; provide recommendations; and conclude the study. The next section defines the terms governance, government and good governance as it forms the theoretical framework of this thesis.

### ***Governance Defined***

While governance may mean different things to many people, it can be defined as: “The sum of the many ways individuals and institutions, public and private, manage their common affairs” (Commission on Global Governance, u.d.). Governance is also defined as comprising the legislative framework, laws, policies and practices that prescribe and enable government to produce and deliver goods and services (Lyn et al, 2000:3; Fuhr, 2000:64; UNDP, 2006). Government is defined by Kettl (2002:xi) as the structure and function of public institutions; and governance as the way government gets its job done.

A broader definition of governance, used in this thesis, includes that governance is the product of interactions, in which government and other non-government institutions, including: public bodies, private sector and civil society, participate, aiming at solving societal problems or creating societal opportunities (Kooiman, 2003:182; Stren and Polèse, 2000; Kedogo, et al., 2010). The interplay between stakeholders involved in public policy formulation and public policy implementation can therefore tell us what kind of governance is at work and if this is effective or sustainable.

Governance is closely related to public administration and coordination which together tell us how the job gets done (policy implementation) in the public sector. Public administration theory, according to Pedersen et al. (2010): “is built around descriptive and prescriptive questions concerning the coordination of governance activities relevant for the implementation of public policy” (Pedersen, et al., 2010:378). This statement converges the themes and thinking of this thesis, which broadly asks: “are substance abuse policies in South Africa being managed effectively?” Moreover, I am specifically exploring if substance abuse policies (including the NDMP 2006-2011 and the PATSA

act) are effectively coordinated? This means that a governance and public administration lens is a suitable “fit for purpose and use” tool as the theoretical framework of the study.

### ***Types of Governance***

There are various types of governance models that have evolved within the public governance arena which needs more description and definition. The three “ideal types” of governance that have played a role in western administrations since the 1950s are hierarchical, market and network governance (Kaufman et al., 1986; Thompson, 2003; Schout & Jordan, 2005 – cited in Meuleman, 2008). According to Thompson (2003) hierarchies, networks and markets can be used as coordination mechanisms and as governance structures as well (Thompson, 2003:37). Governance research has produced various positions but remain within the framework of state (as bureaucracy or hierarchy), market (as in private sector) and civil society networks.

The Traditional public administration approach was dominant for much of the twentieth century, emphasised hierarchy, rules and procedures. Max Weber’s bureaucratic ideal type became the prototype of hierarchical governance (Schmidt, 2008:111). The New Public Management (NPM) emerged in the 1970s: incorporated both the managerial style and involvement of the private sector in delivering public services. It was prominent in the 1980s and became less so in the 1990s due to governance challenges (Schmidt, 2008:111). Smith and Keynes were leaders of this reform movement which identified “the invisible hand” as an active agent in coordination within an economic governance paradigm. The network governance approach emerged in the 1980s and became prominent in the 1990s (Provan & Milward, 1995, Sorenson & Torfing, 2005; Koliba, Meek and Zia, 2010). Partnership with civil society, co-innovation and civic leadership became the chosen paradigm and drivers of change. This paradigm developed from a need to deliver publicly-funded services at the local level and to integrate and coordinate service providers.

Sorenson and Torfing (2005:195) describe “governance networks” as: “a relatively stable horizontal articulation of interdependent, but operationally autonomous actors, who interact through negotiations that involve bargaining, deliberations and intense power struggles”. The advantages of network coordination in the public sector include: enhanced learning, more efficient use of resources, increased capacity to plan for and address complex problems, greater competitiveness, and better services for clients and customers (Provan and Kenis, 2007).

Gumede (2008) espouses that NPM was the favoured approach in South Africa's public administration sector. This study will argue that the cluster approach of cabinet and the executive has advanced a stronger central government with weakened actors (stakeholders) at the extreme lowest level (municipality) and that partnerships (between government and non-government stakeholders) need better coordination and public participation.

### ***Towards Coordinated Governance***

Schmidt (2008) purports that the three paradigms (hierarchies, markets and networks) build on one another (rather than the one replacing the other over time) but also compete with each other. This complexity may require a good public sector manager to be a bureaucrat, a manager and a leader at the same time (Schmidt, 2008:116). This essentially explains the current public management (administration) paradigm in a multisectoral context.

Davis and Rhodes (2005:25) and Fleming and Rhodes (2005:203) imply that future governance styles include a mix of the three systems of markets, hierarchies and networks (cited in Meuleman, 2008:67). This mixing gives rise to meta-governance, which is defined by Meuleman (2008) as “...a means by which to produce some degree of coordinated governance, by designing and managing sound combinations of hierarchical,

market and network governance, to achieve the best possible outcomes. [Furthermore] public managers are considered as 'meta-governors'" (Meuleman, 2008:68). A review of the theoretical literature on meta-governance emphasise various characteristics, including: management by objectives, incentives steering, top-down and remote (at a distance) policy implementation, and participation in self-governance (Sorenson & Torfing, 2007; Pedersen et al., 2010).

The contestation between meta-governance discourse involves NPM reform advocates on the one side, who call for hands-off and low-level vertical coordination, the alternative paradigm, governance networks, propagate a combination of hands-on and hands-off forms of meta-governance. Horizontal and vertical coordination therefore become intrinsic but of less analytical salience to a broader "coordinated governance" involving multisectoral stakeholder involvement (Pedersen et al., 2010). Governance theory therefore provides important insights and a conceptual framework to "coordinated governance" within a context of multi-sectoral and intersectoral (public and private) stakeholder participation, which have resonance with substance abuse in South Africa as well as globally.

In the South African context, more extensive establishment of Inter-Ministerial Committees (IMCs) resembles a meta-governance government structure. Within a multisectoral environment, a meta-governance structure requires good coordination at lower government levels and hence the concept of coordinated governance is most appropriate.

In addition, the notion of including the "whole of society" (private sector, NGOs, NPOs, CBOs, CSOs and citizens generally) in policy formulation and policy implementation further indicate the appropriateness of coordinated governance. Governance and good governance are two sides of the same coin and used interchangeably in this study. However, it is necessary to clarify the term "good governance" and describe its utility in the context of this thesis.

## **Good Governance**

Good governance is described by Bang and Esmark (2009) as a new managerial paradigm of self-governing (of civil society) under strategic supervision (of public authorities), seen in diverse areas as employment policy, crime prevention, educational policy and health policy. "Good governance" was first used by the World Bank, in the 1990s, to denote countries who complied with various prescripts for funding programmes. The concept of good governance emerged mainly because practices of "bad governance", characterised by corruption, unaccountable governments and lack of respect for human rights, had become increasingly concerning and the need to intervene in such cases had become urgent (CGG, u.d.).

Good governance is characterised by the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP, 2008) and United Development Programme (UNDP, 2006) to comprise of eight major characteristics. These include: it is participatory; consensus orientated; accountable; transparent; responsive; effective and efficient; equitable and inclusive and follows the rule of law. It ensures corruption is restricted, the views of minorities are recognised, and the voices of the most vulnerable in society are heard in decision-making (UNESCAP, 2008). The European Union (White Paper) proposes five principles that underpin good governance. These include: openness, participation, accountability, effectiveness and coherence (European Union, undated). The terms "governance" and "good governance" is context-specific. In most instances, it is impossible to fully implement all principles at the same time (UNESCAP, 2008).

In Section 195 of the South African constitution (Constitution, 1996) there are nine governance principles which influences good governance and effective public administration in the public sector. The principles with a specific focus on good governance include: to promote and maintain high ethics; to utilize resources efficiently,

economically and effectively; to provide services impartially, fairly, equitably and without bias; and to provide for people's needs and encourage them to participate in policy-making. Furthermore, sound administration principles include public administration being: development-orientated; accountable; inherent of good human resource management which include career development; and broadly representative of all people in South Africa. For purposes of this thesis I selected the following good governance indicators: coordination and public participation. These principles of good governance are intrinsically linked to policy formulation, coordination and implementation and will be further explained to highlight the linkages between these concepts.

### ***Policy Formulation and Policy Implementation***

As a starting point of this discussion on policy formulation and policy implementation, it is necessary to define the terms public policy, policy formulation, and policy implementation.

#### ***Public Policy***

According to Roux (2002), "public policy refers to a proposed course of action of government, or guidelines to follow to reach goals and objectives, and is continuously subject to the effects of environmental change and influence. Furthermore, policies should constantly be adapted to match the impact of environmental variables and influencing factors, such as technological developments, international trends, the effects of globalisation, research, public needs and personal views of public officials and political role players (Roux, 2002). The process of policy formulation (discussed in detail next) is therefore inherent of political, social and economic issues and considerations.

#### ***Policy Formulation***

The formulation of national legislation (laws) and policies is the function of the President and members of the Cabinet (Ministers) (Section 85 (2) of the Constitution, 1996). At a provincial level, legislation and policies are vested in the Premier of the province and the members of the Executive Council (MECs) (Section 125 (1) and (2) of the Constitution, 1996). In accordance with Section 151 of the Constitution (1996), the executive and legislative authority for municipal level laws are vested in the municipal council. The Mayor of the municipality serves as the executive authority (Fox and Bayat, 2006:17). Policies and legislation is in the main produced by the national sphere of government, approved by parliament, and implemented by provincial departments and municipalities (Gumede, 2008; Fox and Bayat, 2006).

### ***Policy Implementation***

Implementation literally means carrying out, accomplishing, fulfilling, producing or completing a given task. The founding fathers of implementation, Pressman and Wildavsky (1973) (cited in Paudel, 2009) define implementation in terms of a relationship to policy as laid down in official documents. According to them, policy implementation may be viewed as a process of interaction between the setting of goals and actions geared to achieve them (Pressman and Wildavsky, 1984: xxi-xxiii – cited in Paudel, 2009). This generally means that policy implementation encompasses those actions by public and private individuals or groups that are directed at the achievement of objectives set forth in policy decisions. However, issues of policy implementation become complicated because of governments three sphered structure and related powers and mandates. Some government functional areas have concurrent national, provincial and municipal legislative competence. Each sphere of government has autonomy and power to spend budgets in relation to the needs of their constituencies (Gumede, 2008; Levy, 2001; DPLG, 2007).

The implementation discourse developed from a longstanding concern to explain the “gap” between initial policy formulation and policy output (Hill and Hupe, 2002:197). The mainstream implementation literature originated from Pressman and Wildavsky's

influential book *Implementation* (1973) (cited in Paudel, 2009). The implementation literature featured primarily around the debate and arguments about whether ‘top-down’ or ‘bottom-up’ views of implementation were more appropriate. This debate was driven mainly by concerns about accountability. The top-down preoccupation with eliminating the “gap” between policy formulation and output contrasted with the bottom-up view that accountability was a product of the inevitable participation of other role-players in policy making and policy implementation. These other role-players include non-government organisations, civil society and the private sector. Contemporary implementation theorists however acknowledge that implementation varies within different institutional contexts and that there is no one “best way” of implementation (Hill & Hupe, 2002:198; Paudel, 2009:51). There is consensus among theorists that developing countries differ to western countries in the way they are able to implement policies because of debilitating factors in developing countries, such as unpredictable social and economic settings.

### ***Converging Coordinated Governance, Policy Formulation and Policy Implementation***

Cameron (2009) argues that South Africa’s governance and public administration transformed after 1994 but only partly followed the NPM approach. While new structures of governance included public managers being granted more responsibility and powers by ministers, not much decentralization of powers are really evident. South Africa has evidently been more influenced by the joined-up government approach, building a stronger central government and a developmental state. This is seen in the cluster approach of Cabinet and the establishment of inter-ministerial committees which lead processes of policy formulation and policy implementation within South Africa’s public administration and governance sector. Leftwich (2006:63) defines the developmental state as “a state whose politics have concentrated sufficient determination, power, autonomy, capacity and legitimacy at the centre to shape, pursue and encourage the achievement of explicit developmental objectives, whether by establishing, promoting, and protecting the conditions of economic growth, or a varying combination of both”. The developmental state is thus intended to simultaneously promote economic growth and

social objectives such as substance abuse, which facilitate state intervention in the market.

### ***Joined-up Government***

Joined-up government (JUG) refers to a strategy which seeks to co-ordinate the development and implementation of complex social policies across government departments and agencies, in a comprehensive, integrated way. Bogdanor (2008) purports that JUG has been a systematic approach for greater effectiveness in the public service, and involves stakeholders which include government, private bodies and nongovernment organisations (NGOs). JUG implies shared responsibility between civil servants from different departments, local municipalities and the NGO sector. This includes an integration of resources and cultures towards combating social issues. JUG became prominent in [British] governance in the 1990s, with the realisation of the cultural nature of social problems and an understanding that human motivation was a more complex matter, to that realized by NPM (Bogdanor, 2005; 2006).

The reason for the renewed focus on coordinating government departments and sectors apparently emerged due to old practices of governments historically working in “vertical silos”. Departments had exclusive focus on their specialist field and defending their institutional turf – to expand the influence of their own organisation - referred to as departmentalism (Hood, 2008:22).

The intent of joined-up government was to harness resources of several organisations simultaneously to produce better or more cost-effective results and address especially the “wicked problems”, which include inter alia: drug and alcohol abuse, child care and poverty (ibid.). This departmentalism (the opposite of joined-up government) has long been cited as a bureaucratic failing. In fact, it was the weaknesses of departmentalism in British governance that gave rise to the joined-up government approach as an alternative. Departments were evidently dumping their problems onto other departments. For

example, schools would dump unruly children onto the streets, where they would become a problem for the police, while prisons dump ex-prisoners into the community without adequate job preparation or housing, so that they become a burden for social security. In the end, more energy and resources were expended on protecting turfs, than to serve the public (Mulgan, 2008:177). JUG became prominent in British governance to address cross-cutting tasks which require better coordination and integration of new structures and powers (ibid).

To achieve the objectives of JUG, of more efficient and effective service delivery, Mulgan (2008) suggest governments do the following: Using a project-based approach to initiatives; Policy-making done in a cross-cutting way with close involvement of practitioners [people working in the particular sector]; Budgets to be linked to outcomes and allocated across departments and agencies; Services to be linked to people's needs; and Partnerships created across tiers of government [non-government organisations and communities] (Mulgan, 2008:186). Mulgan (2008:187) argues that to achieve successful JUG, requires proper coordination of the various stakeholders and role-players. Currently there is no formula for this.

What is perhaps most relevant is that the silo approach to the current way of doing things in government will firstly need to be changed. There is a need to enforce a paradigm shift in government towards multi-sectoral models of governance. This should include different government departments working together with NGOs, FBOs, CBOs, and CSOs across national, provincial and local levels. As purported by Mulgan (2008) the various government departments' budgets needs to be synchronized to outcomes and people's needs considered for most efficacy and sustainability.

### ***Policy Reform in South Africa***

South Africa has since 1996 embarked on policy reform to correct underdevelopment and apartheid laws that segregated and marginalized the majority black population prior to 1994. This reform formed part of a greater project of reconstruction and development of the citizens of South Africa. Whereas the majority of black people were segregated from social and economic opportunities by apartheid policies, the transformation of policies and legislation became inherent of the Constitution of the Republic of South Africa (1996).

Policy formulation in South Africa includes the involvement of citizens, as a constitutional right and is therefore people-centred. Governance is also integrated as it includes nongovernment stakeholders such as NGOs, CSOs, FBOs, CBOs and communities in general in the policy formulation process also. Good governance principles and “people centredness” are enshrined in Section 152 of the Constitution and further propelled in the *White Paper on the Transformation of the Public Service (1997)*, also called the Batho Pele (a Sotho word, meaning “people first”) *White Paper* (Gumede, 2008). Network governance is therefore inherent in South Africa’s policy formulation and policy implementation processes.

With regard to the successful and sustainable implementation of policies, coordination and citizen participation features prominent. Mubangizi, Nhlabathi and Namara (2013) examined network governance in two case studies – in South Africa (the KwaNaloga Games) and in Uganda (the Nutritional and Early Childhood Development Project [NECDP]). The comparison of the two public sector programmes is done through the lens of Network Governance and Intergovernmental Governmental (IGR) practices. Both states are similarly structured and governed along decentralized lines of governance. In South Africa’s case, governance structures include national, provincial and local government and in the case of Uganda, the decentralized government include district, municipal and sub-country delineation. These case studies represent a microcosm of the challenges of implementing public programmes within an environment which is complex. The Network governance model is identified in these case studies because both the programmes involve multi-sectoral stakeholders from government and non-government

sectors. Within the general context of both countries, service delivery failure can be attributed to problems of coordination, corruption, historical backlogs and institutional complexity.

The resultant civil unrest, related to bad service delivery, in both countries marks the premise for the study but what is most important is the way in which both programmes are able to provide lessons on how especially coordination (in the form of IGR) and public participation (in network governance) help to mitigate negative factors in policy/programme implementation. The study argues that the strength of network governance provides the impetus to address complex issues in decentralized administrations.

The traditional horizontal “administrative silos” (relating to the various government departments involved in policy implementation) are further divided into vertical layers of national, provincial and local government in the case of South Africa, and central, district and sub-country in Uganda. Therefore, both vertical silos and horizontal layers are active in policy implementation processes in these countries. The authors claim that in South Africa, many services which require functional intergovernmental relations with input from all spheres (like water, housing [and sanitation]) have suffered because of a lack of coordination and sharing of key resources (p781). Furthermore, coordination between various stakeholders is an important tool for bringing together different expertise, experience and perspectives (Hetting and Vedung, 2012:30; cited in this case study). This also emphasizes the importance of public participation and its close relation to coordination. While the study emphasizes the complexity of institutional structure (and the importance of IGR), it also acknowledges complexity of dealing with cross-cutting problems that require cross-sectoral interventions or network governance. Moreover, the case studies help to contextualize and conceptualize important principles of good governance (coordination and participation) within a broad theoretical framework of governance and an even broader context of “coordinated governance”.

There are thus sufficient constitutional and theoretical frameworks which give citizens rights and responsibilities within the policy-formulation process. Governance structures (spheres) and government departments are also guided by policies and the Constitution (1996) on how to work together during the implementation process (the IGR Framework Act). The question then arises as to what are the constraints and challenges to implementation and the management of substance abuse in South Africa? and How can this be improved? These questions form part of the primary research conducted in the next chapter of the thesis. The following section discusses coordinated governance which includes coordination as an intrinsic part of good governance and public administration.

### ***Coordinated Governance***

In its most basic form, coordination is defined as the act of working together harmoniously or smoothly (Hoosain et al.). Coordination facilitates social interactions among multiple actors working towards a common goal. Inter-organizational coordination is defined as managing capability of inter-organizational collaborations and relationships, which can be in many forms including inter-organizational teams, partnerships, alliances, and networks (Kapucu, 2005). Intra-organizational coordination, on the other hand, is the mutual influence of working processes of two or more actors who work within the same organization in order to attain a certain objective (Van Eijck and de Vreede, 1995). Within a network governance model, the coordination of policies and programmes involves the effective collaboration of pooling of resources of the various stakeholders. While the various stakeholders involved in substance abuse come from different sectors (government, non-government and private sector) successful outcomes will depend on good coordination and relations generally.

The differences in coordination between the three governance types are described by Pedersen et al., 2010:378). The traditional (hierarchy) model relies on vertical (top-down) coordination (state rule). The main traditional instruments of public governance are power, money and law. Governments make and define rules. Implementation of policies is done

by an administration organized as a bureaucracy. This model excludes involvement by politicians or non-government stakeholders. The Markets sphere is coordinated and guided by the “invisible hand”. This is the world of what used to be hierarchy, namely public governance, and is now being reorganized to increase efficiency. In the network sphere, coordination is based on negotiation.

### ***Cooperative Governance***

Coordination within the South African government is premised on the integrated and cooperative governance model. The Constitution (1996) established three spheres of government: namely, national, provincial and local government. These spheres are distinctive, interrelated and interdependent and bound to cooperate with one another on matters of common interest. The spheres are distinctive as it is a democratically elected government in its own right, accountable to its electorate for its actions and has powers to determine a budget and a plan and decide what services to supply, in response to the electorate. The spheres are interrelated to the extent that they should: “co-operate with one another in mutual trust and good faith” for the greater good of the country as a whole.

The functions of the national sphere primarily include formulating policies and regulations, whereas provinces and municipalities are responsible for implementing policies and programmes and service provision. Intergovernmental relations (IGR) are complex to operationalize within the public sector, mainly because of diverse worldviews between the three spheres and the additional political power play amongst stakeholders, especially politicians.

Furthermore, the interplay between vertical spheres as well as different departments (horizontal linkages) make coordination more complex. Central to IGR is the efficient and effective use of resources for purposes of sustainable human development through collaboration and public participation (Patel and Powell, 2008).

## ***Public Participation***

This thesis emphasizes the importance of the local sphere of government as the sphere where actual groundwork is done with people in communities, learners at schools and with individuals in households. The study explores coordination structures and public participation at the national, provincial and local levels of government. Apartheid history, prior to 1994, was inherent of segregation, underdevelopment and marginalization. The majority black population in South Africa was denied and deprived the right to vote and to participate in governance (in policy-formulation and implementation). The democratically elected government in 1994 proceeded to transform all apartheid laws and policies and established a Constitution (1996) that set out guidelines to include citizen participation in policy-formulation. Masango (2002) describes public participation to be a process which includes citizens, workers, communities and society who deliberately take part in a goal orientated activity. Citizen or public participation in governance can reduce poverty and social injustice by strengthening citizen rights and voice, influencing policymaking (Taylor & Fransman, 2004:1). Moreover, citizen participation is one of the most effective ways to improve accountability and governance (Ackerman, 2004:448).

Maphunye (2005) highlights the importance of public participation for good governance and development which has the following outcomes: public participation legitimizes government decisions and actions; improves quality of decisions made and citizen compliance with policies; reminds policy-makers to make space for public opinion in their decisions; and enhances people-centred democracy.

The South African Constitution creates a requirement that government engage with citizens when making the decisions that affect their lives. The constitutional requirements for public access and participation are dealt with in detail in chapter 5. Broadly, they provide citizens the right to participate in the legislative and policy-making processes that

goes beyond the right to vote in elections. Not only must citizens be given the opportunity to speak on issues that affect them; there is also an onus on the legislatures and the executive to take their views seriously. The legislative framework of public participation in policy making and implementation is captured in the following legislation and policies: Section 152 of South Africa's Constitution (1996) mandates the local government sphere to provide services to communities in a sustainable manner.

The White Paper on Local Government (Notice No. 423 of 1998) as well as Section 19 of The Municipal Structures Act, 1998 (Act 117 of 1998) encourages municipal councilors to promote and annually review the involvement of citizens and community groups in the design and delivery of municipal programmes. The Municipal Systems Act, 2000 (Act 32 of 2000) [Section 5] "requires municipalities to regularly disclose information regarding the affairs of the municipality to the public". Therefore, participation is a right in itself. Eyben (2003) takes this point further, to purport that participation in governance is an entry point to realizing all rights generally.

According to Masongo (2002) "public participation conveys information about public needs and demands from the public to policy makers and implementers, and vice versa". Public participation thus involves two kinds of processes. In the one process, government (policy-makers) collects information from members of the public (individuals or groups of people) to develop policies. In the second instance, people receive information from government about services and relevant government programmes. This two-way engagement between government and citizens implies that public participation contributes to policy making as well as policy implementation.

However, the quality or genuineness of public participation is also a consideration. Experiences of co-optation and betrayal are highlighted by studies (Sisk et al., 2001:163; Buccus & Hicks, 2008:528). Manor (2004:9) correlates the consequences of "superficial or cosmetic processes" of public participation to citizens' feelings of betrayal or being conned. The issue raised here highlights the fact that government decision-making and

implementation processes should ideally include citizens from the onset of planning through to implementation because they are best placed to identify their own needs and should preferably be part of finding and implementing solutions. These are tenets of a bottom-up governance approach and characterizes initiatives which are more sustainable and effective.

Experience has shown that when policies are formulated without consultation (top-down) and imposed on communities, problems tend to arise. In these circumstances, communities could reject the policies when it reaches the implementation stage (Masongo, 2002). This could also be the case if people are not informed timeously about impending services government intend to provide – they could reject it on the basis that they were not informed. Furthermore, a “blanket approach” to citizen engagement with government does not encourage citizens to exercise their civic rights of participation. This therefore means that government needs innovation and creativity to sustain active engagement with communities and civil society organizations (Van Donk, 2010).

“Effective participation” is, as the World Bank (1996) defines it, a process through which people influence and share control over development initiatives. In other words “effective” refers to instances when people’s participation makes a difference within the decision-making processes or policy outcomes of government (Cole & Caputo 1984 – cited by Waheduzzaman, 2010). More empowerment of people means more accountable, transparent and predictable government, and this is what makes people’s participation with local development programmes more effective (Brett 2003, Cooper, Bryer & Meek 2006).

However, just empowering local people is not enough to achieve good governance. Governing agencies, that is, officials that are working in local governing institutions, also need to include people in the decision making process (Lawson & Gleeson 2005; Sobol 2008). As good governance means creating a bridge between government and the

governed (Barten *et al* 2002), both government officials and local people need to uphold the values of people's participation.

On the one hand, a sound and robust participatory system and complementary laws are required to build the capacity of local governing agencies. On the other hand, strong civil society groups and high social capital is required to empower local people. Effective networks between governing bodies and people thus depend on the fulfillment of some normative elements in the society, such as power-balance, equity, empowerment and social capital (Waheduzzaman, 2010). Public participation therefore not only improves democracy and includes people-centred development, but also improves broader national imperatives and objectives, such as social cohesion, as set out in the National Development Plan (National Planning Commission, 2012). Public participation is central to how this study evaluates the institutional mechanism to manage substance abuse in South Africa. The legislative framework of the thesis is discussed next.

#### **2.4. LEGISLATIVE FRAMEWORK**

The legislative framework of substance abuse is guided by the Constitution of the Republic of South Africa (Act No. 108 of 1996) as well as international agreements and protocols of the United Nations (UN), World Health Organisation (WHO), the African Union (AU) and Southern African Development Community (SADC). These international and regional agreements provide the framework for establishing policies and legislation within all participating countries. However, countries are at liberty to implement policies and strategies as they feel fit and within their budget constraints. Invariably, countries develop and implement policies due to their perception of drugs and alcohol as well as in relation or as a reaction to related harms caused by substance abuse.

Sections 10 to 12(1) of Chapter 2 of the Constitution grant South African citizens the right to have their dignity respected and protected, and the right to life, freedom and security.

To realise these rights, Government is committed to reducing the supply of illegal drugs and the demand for such drugs through a wide range of measures and programmes. The principles of the Constitution of the Republic of South Africa (Act 108 of 1996), Section 10 and 27(1)(a), provides an overarching mandate to stakeholders within government, parliament and the executive, to implement initiatives to protect the health and dignity of South Africans, who are in need of assistance (Constitution, 1996). This provides the framework and premises for a human rights-based approach to provide substance abuse treatment services to people in South Africa to people who need it most. The developmental stance of government to providing services to people in need of it also plays a role in upholding people's rights to health and other services to combat substance abuse.

#### **2.4.1. INTERNATIONAL PROTOCOLS AND INSTRUMENTS**

From an international perspective, South Africa is signatory to various resolutions on alcohol, agreed to at the World Health Assemblies. The World Health Assembly Resolution of 2005 called upon the World Health Organisation (WHO) to collaborate with member states to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption (WHO, 2005). This was followed by the World Health Assembly Resolution, 2008, which called on the WHO to prepare a "global strategy to reduce harmful use of alcohol" based on best practices (WHO, 2008). The Global Strategy to Reduce Harmful Use of Alcohol was produced by the WHO in 2010. This strategy promotes effective evidence-based policies to reduce the harm caused by alcohol abuse. These policies will be discussed as part of best-practiced policies in the last section of this chapter. South Africa is a signatory to the following inter alia international agreements on drugs (Drug Advisory Board, 1999):

Under article 38 of the Single Convention on Narcotic Drugs (1961) as amended by the 1972 Protocol 12 and under article 20 of the Convention on Psychotropic Substances of

1971, parties to these conventions are required to take all practicable measures for the prevention of abuse of narcotic drugs or psychotropic substances and "for the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved".

Article 14 of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988) states that parties 'shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic'.

In 1996, the Southern African Development Community (SADC) concluded a Protocol on Combating Illicit Drug Trafficking, stating its commitment to 'the establishment of a regional institutional framework for co-operation in combating illicit drug supply, demand and corruption in member states, through legislative and social policies'. In terms of this protocol, which South Africa has ratified, member states are required to participate in a 'joint concerted effort' to 'eradicate illicit drug production and trafficking' through 'the implementation of coordinated, comprehensive and integrated drug control and prevention programmes that address both supply and demand' (Drug Advisory Board, 1999). In the next section, substance abuse policies are discussed. The Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008) and the NDMP 2006-2011 will be discussed with regard to the selected good governance principles of coordination and public participation.

## **2.5. SUBSTANCE ABUSE POLICIES**

Drug policies differ among nations in both appearance and substance. Some countries treat drugs mostly as a problem for law enforcement and primarily suppress trafficking.

Other countries focus their efforts on prevention, education, treatment and on reducing the adverse effects of drug use. For example, Mexico has experienced a huge rise in the number of killings related to drug trafficking and its drug problem is often defined in terms of violent deaths (UNODC, 2009). This variation across countries reflects differences in attitudes toward drug use itself, individual rights, the role of government and the different ways in which drugs affect countries (Babor, 2010). At the 2nd Biennial Anti-Substance Abuse Summit, in Durban, in 2011, it was highlighted that South Africa does not have a national drug policy that provides guidelines and standards to comprehensively deal with the problem of illicit drugs. This notwithstanding, the NDMP 2006-2011 provides a framework of who the stakeholders are who coordinate and implement initiatives and programmes.

### ***Alcohol Policy Review***

Professor Charles Parry, of the Medical Research Council (MRC), reviewed effective policies to reduce the harm caused by alcohol abuse in South Africa, between 1994 and 2009 (Parry, 2010). The review provides an understanding of the policy formulation process in South Africa, and identifies challenges for successful policy implementation. The review covered alcohol policies across different government departments and defined the roles of different stakeholders. The four policies highlighted include: alcohol advertising (spearheaded by the Department of Health); regulation of retail alcohol sales (provincial Departments of Economic Affairs – sometimes called by other names); alcohol taxation (National Treasury); and controls on alcohol packaging (Department of Agriculture). This study shows how South Africa's alcohol policies are impacted by political, social and economic issues, as well as competing interests, values and ideologies (Parry, 2010). It also highlights challenges of policy-implementation, due to management and coordination problems. Moreover, the review highlights issues relating also to good governance principles and related challenges of government's three tiered structure.

## ***Coordination and Alignment of Legislation Regulating the Alcohol Industry***

The alcohol industry is regulated by various sections of legislation. These are: (i) the Liquor Products Act, No.60 of 1989 which regulates the type of alcoholic beverages that may be produced and imported to ensure consumer protection, (ii) the National Liquor Act, No.59 of 2003 that regulates who may manufacture and distribute liquor, (iii) Provincial Liquor Acts that regulates the retail sale of liquor (also) and (iv) the Customs and Excise Act, No.91 of 1964, which classifies alcoholic beverages for excise duty purposes. The Customs and Excise Act broadly follows the harmonised system of trade classification as determined by the World Customs Organisation (National Treasury, 2014:80). There are therefore a myriad of alcohol policies which are formulated both at the national and provincial levels which require implementation and oversight by provincial and local spheres. Discussions at the 2nd Anti-Substance Abuse Summit in Durban, in 2011, highlighted incoherence and weak coordination of alcohol policies in South Africa. This is a major focus of this thesis which will explore coordination of substance abuse policies in terms of formulation and implementation.

South Africa's predisposition of transforming pre-1994 policies and legislation and developmental approach to improve people's lives provides the rationale for upholding good governance principles enshrined in the Constitution (1996). This is no different when it comes to substance abuse. A review of relevant substance abuse legislation follows, for purposes of defining context and identifying good governance principles. We start with a review of the Prevention and Treatment of Substance Act (No. 70 of 2008), which is followed by an analysis of the National Drug Master Plan. This features as the central focus of analysis for this thesis.

### ***The Prevention and Treatment of Substance Abuse Act (No. 70 of 2008)***

The former Minister of Social Development, Dr Zola Sweyiya, finalised the Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008) (hereinafter referred to as the

“PATSA Act”), in 2008. The PATSA Act was promulgated by President Kgalema Motlanthe on the 19 April 2009 (Government Gazette, 2009). This legislation repealed the Prevention and Treatment of Drug Dependency Act (Act No 20 of 1992) – hereafter referred to as the “repealed Act”.

The rationale for the PATSA Act include: “To provide for a comprehensive national response for the combating of substance abuse; to provide for mechanisms aimed at demand and harm reduction in relation to substance abuse through prevention, early intervention, treatment and re-integration programmes; to provide for the registration and establishment of treatment centres and half-way houses; to provide for the committal of persons to and from treatment centres and for their treatment, rehabilitation and skills development in such treatment centres; to provide for the establishment of the Central Drug Authority; and to provide for matters connected therewith” (The Presidency, 2009).

There are various reasons, cited by the Department of Social Development (DSD) (2007) for revising the repealed Act. These include that the repealed Act was outdated, as the substance abuse terrain had changed considerably, since 1992 and, as such, the repealed Act was not optimally responsive to current challenges (DSD, 2007). Research showed that the demand for treatment had increased substantially, especially by younger people (SACENDU, 2007; HSRC, 2007). There was a greater demand for outpatient treatment facilities as opposed to former institutional-type centres. According to the DSD, the PATSA Act made provision for efficient and effective use of resources to combat substance abuse. This Act also encouraged community-based programmes which meant citizens were to participate in dealing with the substance abuse problem in communities; especially with regard to reintegrating users into society and encouraging a prevention approach (DSD, 2006). The issue of coordination of the PATSA Act is prescribed in the National Drug Master Plan (NDMP). The NDMP provides the framework for coordination of policies and stakeholders involved in combating substance abuse in South Africa. This is explained in the following section.

## ***The National Drug Master Plan***

In terms of the United Nations Drug Control Programme (UNDCP), a drug master plan is a strategic document which seeks to guide government in terms of its national response to drug control over a 5-year period. In 1997, the Minister of Welfare (now referred to as Social Development) requested the Drug Advisory Board to draft a National Drug Master Plan (NDMP) for South Africa. South Africa's first NDMP (1999-2004) was completed in 1999. There has since been a Cabinet approved NDMP 2006-2011 and more recently, the NDMP 2013-2017.

The NDMP enables cooperation between Government departments and stakeholders in the field of substance abuse and drug prevention. However, as discussed by delegates at the 2nd Biennial Anti-Substance Abuse Summit, non-government organizations play a significant role in delivering substance abuse services but lack financial resources and relevant capacity and training (DSD, 2011). Notwithstanding these constraints to implement initiatives and programmes, the NDMP outlines the role of coordinating structures and government departments in fighting the scourge of drug abuse (DSD, 2006:4). While the NDMP 2006-2011 provides the framework for cooperation between sectors and stakeholders it is not explicit about resources needed for work at grassroots levels. The next section will discuss the NDMP 2006-2011 in terms of good governance and public administration principles. These include coordination and participation.

### **2.6. COORDINATION STRUCTURES**

The NDMP 2006-2011 established coordinating structures to ensure the implementation of the strategy. These structures include the Central Drug Authority (CDA) at the national level, Provincial Drug Forums in all nine provinces, and Local Drug Action Committees (LDACs) in all 238 municipalities. The duties of these structures are outlined in the

Prevention of and Treatment for Substance Abuse, 2008 (No. 70 of 2008). These are now described.

### ***The Central Drug Authority (CDA)***

The primary function of the CDA is to oversee and monitor the implementation of the National Drug Master Plan. This includes facilitating and encouraging the coordination of strategic projects and encouraging government departments and private institutions to compile plans (Mini-Drug Master Plans) to address substance abuse in line with the goals of the National Drug Master Plan. Furthermore, the CDA is required to ensure the establishment and maintenance of information systems which will support the implementation, evaluation and ongoing development of the National Drug Master Plan. The CDA must submit an annual report, to the Minister of Social Development and to parliament. Moreover, the CDA must advise Government on policies and programmes in the field of substance abuse and drug trafficking (DSD, 2007).

### ***Provincial Substance Abuse Forums (PSAFs)***

The PSAFs' function is primarily to assist Local Drug Action Committees, established in terms of section 60 of the Prevention of and Treatment for Substance Abuse Act, in the performance of their functions. Furthermore, they must compile and submit an integrated Mini Drug Master Plan for the province for which it has been established. This report must be submitted not later than the last day of June annually, to the CDA for the purposes of the Annual Report of the CDA. In addition the PSAF should assist the Central Drug Authority in carrying out its functions at a provincial level (DSD, 2007).

### ***Local Drug Action Committees (LDACs)***

Local Drug Action Committees were established through the NDMP 2006-2011 - at the municipal level, to provide support to locally-based substance abuse initiatives. The relationship between LDACs and municipalities and provincial departments is thus very important as the objectives of the LDACs should be part of the municipality's Integrated Development Plan (IDP) and support to the LDAC should be forthcoming from the municipality and provincial departments. These functions are espoused in Section 154 (1) of the Constitution (1996). The primary research process (in chapter four) will explore relations between stakeholders involved in substance abuse in the various provinces.

LDACs must ensure that effect is given to the National Drug Master Plan in the relevant municipality. It must compile an action plan to combat substance abuse in the relevant municipality in cooperation with provincial and local governments. Furthermore, they must ensure that its action plan is in line with the priorities and the objectives of the integrated Mini Drug Master Plan and that it is aligned with the strategies of government departments. LDACs annually provide a report to the relevant Provincial Substance Abuse Forum concerning actions, progress, challenges and other related events and provide information as required by the CDA (DSD, 2006).

## **2.7. BEST PRACTICE SUBSTANCE ABUSE POLICIES**

Alcohol and drug policies can be divided into interventions to control the supply, demand and to reduce the harms caused by drugs and alcohol. International responses to drugs and alcohol problems typically include a mix of these three approaches. Scientific research should be central to guide the selection and implementation of demand, supply, and harm reduction programmes and initiatives. There is scientific evidence that shows the effectiveness of supply, demand and harm reduction initiatives. These are further discussed.

## ***Supply Reduction***

Supply reduction (control) approaches to drug problems focus on the production, distribution and sale of illicit psychoactive substances, whereas criminal sanctions deal with the punishment of drug sellers and users. Policies include mainly policing and criminalizing illicit drug users. Supply-control interventions absorb the bulk of drug control spending in most nations. However, the evidence supporting the effectiveness of these interventions is weak. In general, the existing evaluations fail to demonstrate effects on either the supply or the price of drugs in the marketplace (MacCoun and Reuter, 2001). However, street-level enforcement can help to control the harms associated with drug markets, encouraging dependent users to make contact with service providers. This requires the police services (SAPS) to be trained to refer abusers to relevant service providers for help.

Some countries have explored reducing or eliminating criminal penalties for possession of small amounts of drugs for personal use, particularly for cannabis. Most decriminalization programmes involve the substitution of civil penalties for criminal penalties for possession offences, while retaining formal prohibition of what are considered more harmful substances. Evaluation of such changes in countries like the Netherlands, the Czech Republic and Portugal suggests that decriminalization makes little difference to prevalence of cannabis use (MacCoun & Reuter, 2001; Zabransky et al., 2001; Hughes and Stevens, 2007). The evidence indicates that removing or reducing criminal penalties on possession does not lead to substantial increases in use (Babor et al., 2010; Reuter & Stevens, 2007; Fellingham, 2012; Parry & Myers, 2011).

## ***Demand Reduction Strategies***

The global strategy to reduce the harmful use of alcohol, endorsed by the 63rd World Health Assembly in May 2010, recognized close links between the harmful use of alcohol

and socio-economic development. The strategy builds on several WHO global and regional strategic initiatives, including the action plan for the global strategy for the prevention and control of non-communicable diseases which was endorsed by the World Health Assembly in 2008 (WHO, 2010a). Global studies on feasibility, effectiveness and cost-effectiveness of different policy options and interventions aimed at reducing the harmful use of alcohol indicate the following (WHO, 2010b):

Alcohol-education programmes on harmful use of alcohol have not made real impact. To be more effective, education about alcohol needs to go beyond providing information about the risks of harmful use of alcohol to promoting the availability of effective interventions and mobilizing public opinion and support for effective alcohol policies. This means that people should have access to information of where services are found, as well as having access to the services itself.

Media advocacy is an important component of community action programmes, which has been shown to change young people's drinking behaviour and on alcohol-related harm such as traffic accidents and violence. Again, the issue of access to information is important for people to be aware of the consequences of driving when intoxicated from alcohol. This is also relevant for drugs.

Evidence demonstrates the importance of a legal framework for reducing the physical availability of alcohol including restrictions on both the sale and serving of alcohol. Having a licensing system for the sale of alcohol allows for the opportunity for control, since infringement of laws can be met by revocation of the license. Implementation of laws that set a minimum age for the purchase of alcohol show clear reductions in drinking-driving casualties and other alcohol-related harm. An increased density of alcohol outlets is associated with increased levels of alcohol consumption among young people, increased levels of assault, and other harm such as homicide, child abuse and neglect, self-inflicted injury, and road traffic injuries. Moreover, reducing the hours or days of sale of alcoholic beverages leads to fewer alcohol-related problems, including homicides and assaults.

These laws however require implementation and monitoring for sustainable impact on individuals and societies (Babor, et al., 2010).

### ***Harm Reduction Strategies***

Harm reduction approach can be supported by stronger promotion of products with a lower alcohol concentration, together with mandated health warnings on alcohol-product containers. Although such warnings do not lead to changes in drinking behaviour, they do impact on intentions to change drinking patterns and remind consumers about the risks associated with alcohol consumption. In an international context, harm reduction in drug abuse includes the use of pharmacotherapy and used widely in France and some other states. However, in South Africa, the use of pharmacotherapy is not so widely implemented because of the objective of “complete abstinence” proposed by the NDMP 2006-2011 (DSD, 2006; CDA, 2008; CDA, 2011). Therefore, harm reduction is conceptually limited in both the NDMP 2006-2011 as well as the NDMP 2013-2017.

## **2.8. CONCLUSION**

The following points can be made from the literature review. This forms the basis of the whole study:

The management of substance abuse in South Africa is steeped in political, moral, economic and social stresses. This has resonance on substance abuse policy-making and policy implementation. There is a consistent struggle between moral, health and other social issues related to substance abuse policy-making, on the one hand, and the economic benefit of alcohol advertising and jobs created in the sector, on the other.

The management of substance abuse, which includes policy formulating, policy coordinating and policy implementation, requires good governance principles of coordination and public participation for effectiveness and sustainability. This is linked to the constitutional imperative of a democratic and developmental South Africa. A coordinated governance approach to formulate and implement policies ensures integration and pooling of resources of government departments with other nongovernment organisations and the private sector. This approach includes the “whole of society”, especially ordinary citizens and communities as well the latter.

The PATSA Act and the NDMP 2006-2011 forms a challenging framework for policy coordination and implementation and needs to be updated with international trends and research-based practices. The NDMP and the Prevention of and Treatment for Substance Abuse Act (No.70 of 2008) (hereafter called the PATSA Act) form the legislative framework of substance abuse in South Africa, although various other policies and legislation at national and provincial levels exist which aim to reduce the demand, supply and related harms caused by substance abuse, especially drugs and alcohol.

International protocols and instruments guide the NDMP and helps to provide evidence-based or best practice models of implementing substance abuse policies and programmes. However, the NDMP 2013-2017, like its predecessor (NDMP 2006-2011), does not provide realistic and standard solutions with regard to who provides the necessary resources for programme implementation. For example, the NDMP 2006-2011 and the PATSA Act proposes that municipalities establish Local Drug Action Committees (LDACs) and that municipalities provide resources for them to support the implementation of the NDMP. Due to the manner in which municipalities raise their own revenue (through inter alia: costs for water, electricity, taxes and rental income), it seems that this provision can be regarded as an unfunded mandate from the national government sphere. This notwithstanding, community-based programmes (like prevention and after-care programmes) involves participation from communities and invariably requires funds for travelling, operational equipment and communication costs.

There is a need to review all substance abuse policies in South Africa to ensure that prevention and treatment services reach those most at risk and people who need it most - to be restored into their families and communities.

South Africa lacks a coherent alcohol policy as well as a comprehensive drug policy. Linked to this, current coordinating structures (the CDA, PSAFs and LDACs) lack necessary resources to assist government departments to reduce the supply, demand and related harms caused by especially drug and alcohol abuse and addictions.

Furthermore a more bottom-up approach to identify needs in households and communities should be considered. This involves including citizens and families in processes of engagement to identify community needs and challenges.

Substance abuse policies require a coordinated management system. A single approach such as criminalizing or decriminalizing substances or abusers will not solve the problem. Instead, a mix of demand reduction, supply reduction and initiatives to reduce the harmful effects of drugs and alcohol abuse (harm reduction) on individuals, families and communities. All government, non-government and private sector stakeholders should be represented on a task team to monitor and evaluate programmes for purposes of ensuring that good governance principles, such as coordination, access and transparency and participation is upheld throughout policy formulation and implementation.

The Joined up government (JUG) approach espoused by Mulgan (2008) seems appropriate for the South Africa context because it encourages a “whole of society” approach to deal with cross-cutting issues related to substance abuse. Moreover, JUG emphasizes that people from the various departments and sectors should combine resources and to plan budgets and implement initiatives together – rather than in silos. A central structure to manage substance abuse (policy formulation and policy

implementation) in South Africa should be considered, as proposed by Parry (2010). This structure should have autonomy to formulate drug and alcohol policies with access to financial and human resources to implement policies.

## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.1. INTRODUCTION**

The process of research, or the research methodology, constitutes the formulation of a problem, from which questions emanate as well as the methods used to gain the information needed to answer them (Fox & Bayat, 2007). The research methodology therefore connects the researcher to particular approaches and tools of data collection and the analysis thereof. The research methodology and design ensures that the research is designed and planned according to scientific parameters. The process of research, or the research methodology, constitutes the formulation of a problem, from which questions emanate as well as the methods used to gain the information needed to answer them (Fox & Bayat, 2007). The research methodology therefore connects the researcher to particular tools of data collection and the analysis thereof for purposes of answering the research question/s.

This section provides the rationale for the research method and explains the appropriateness of the design. Furthermore, the process of how the design will attain the study goals will be explained.

## **3.2. RESEARCH DESIGN**

To distinguish between research design and research methodology Babbie & Mouton (2001:74) uses the example of building a house. Ideas about the house become a design created by an architect which is then constructed by the builder. The design is thus the plan and the methodology is the process of answering the research question. The research design can be more broadly defined as the operations used to test a specific hypothesis under given conditions (Bless, Higson-Smith & Kagee, 2007) or to answer the research question/s (Babbie & Mouton(2001). Various types of research methods are used by researchers. In social science, it is salient to choose the most appropriate research method best suited to the method of data collection and analysis. Invariably, the researcher designs his/her research project around the research method that he/she selected (Creswell, 2003). This can depend on various factors including the researcher's skills, resources and time limitations. The various types of research can be divided into three broad categories, namely quantitative, qualitative and mixed methods research. These methods co-exist in the research field and have distinct characteristics which are now discussed.

### **3.2.1. QUANTITATIVE RESEARCH**

Quantitative research concerns things that can be counted and commonly use statistics to process and explain data and to summarise findings. Generally, quantitative research is concerned with systematic measurement, statistical analysis and methods of experimentation (Fox & Bayat, 2007; Cresswell, 2003; Delport, 2011). Quantitative research relies on a positivist approach to science, used in the natural science field of study, such as botany, zoology, physics and chemistry. Positivists believe in laws, which they contend can explain and predict the occurrence of (controlled) phenomenon. During the process of explaining a phenomenon, researchers aim to establish a causal relationship between the variables under study. Causal laws are linked to deductive theory (Hussey, 1997:52).

Maree and Pietersen (2007:149) classify quantitative research designs into two groups, namely experimental and non-experimental designs. Non-experimental designs are mostly used in descriptive studies, such as surveys. The most widely used quantitative research methods include: experimental - when researchers need to show that method A produces better results than method B); observation - used when researchers want to systematically record occurrences or the patterns of behaviour of subjects, or to communicate with them in a particular way; and survey research - for large-scaled research, where a sample of a given population is drawn, to collect particular information, through questionnaires, telephone surveys, e-mail and Internet surveys, and personal interview surveys (Fox & Bayat, 2007:79).

### **3.2.2. QUALITATIVE RESEARCH**

There are various decisions qualitative researchers need to consider when undertaking qualitative research. These include research questions, the design, data collection and data analysis. Furthermore, the researcher has to consider how this process will be undertaken. This involves thinking of the principles and logic that will be used to substantiate related claims and analysis. In-between the process of planning what and how the research will be executed, researchers must consider issues of quality and rigour. Lastly, a post-study process, which includes a reflexive account of how the research process unfolded should be reported in the final analysis and interpretation of the study (Fouche, Delpont and De Vos, 2011:323-324).

Qualitative research methods are designed to scientifically explain events, people and matters associated with them. Unlike quantitative data, which are numerical, qualitative data may include words, images or recorded sounds (English et al., 2006:313). Qualitative studies use qualitative methods of collecting data, for example, participation observation, semi-structured interviewing and documents. Qualitative research is the most commonly

used approach in the social sciences and includes: case study, biography, ethnography, grounded theory and phenomenology.

### **3.2.3. MIXED METHODS RESEARCH**

Mixed methods research has experienced a dynamic growth, with some authors, like Creswell (2003) and Tashakkori & Teddlie (2003) advocating that mixed methods should be considered as a separate research design in its own right, alongside quantitative and qualitative designs (Cresswell, 2006:16). Creswell (2006) defines mixed methods research as follows: "Mixed methods research is a research design with philosophical assumptions as well as methods of enquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases in the research process. As a method, it focuses on collecting, analysing, and mixing both qualitative and quantitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approaches alone" (Cresswell, 2006:5).

An effective approach to Mixed Method Research is to involve community-based stakeholders. A community-based participatory approach is an example of a multiphase design. This advanced mixed methods approach involves community participants in many quantitative and qualitative phases of research to bring about change (Mertens, 2009).

Using a mixed methods study has several advantages which include that it compares quantitative and qualitative data. Mixed methods are especially useful in understanding contradictions between quantitative results and qualitative findings. Mixed methods give a voice to study participants and ensure that study findings are grounded in participants' experiences. It also provides methodological flexibility. Mixed methods have great

flexibility and are adaptable to many study designs, such as observational studies and survey studies.

The research design includes the research approach as well as the methodology. The methodology comprises the data collection instruments, sampling and data analysis processes. The research design is discussed by firstly elaborating on the research approach and then discussing the study's methodology.

### **3.3. THE RESEARCH APPROACH**

This study explores stakeholders' perceptions of substance abuse issues and results in a report with recommendations. Therefore, the study is premised on two paradigms, namely the interpretive worldview (which focuses on the subjective views of people) and pragmatism (which focuses on the results of the research). Paradigms or worldviews, here referred, are holistic systems of interrelated practice and thinking and include: positivist, interpretive and constructionist paradigms. These paradigms are used in quantitative or qualitative research designs. The positivist approach seeks to describe laws and mechanisms that operate in social life, while the interpretive paradigm aims to explain the subjective meanings and reasons that lie behind social action. Researchers use the constructionist paradigm to show how versions of the social environment are produced in discourse, and to demonstrate how these constructions of reality make certain actions possible. Positivism may suit those who seek objective facts, whilst interpretive research may suit those who consider the meanings people attach to objective facts. Social constructivism may suit those who wonder how the social world actually gets constructed.

Tashakkon & Teddlie (2003) espouse that a fourth paradigm, pragmatism, encompasses both quantitative and qualitative paradigms, and is the most appropriate philosophical foundation for mixed methods research (cited in Cresswell, 2006:15). Pragmatism "focuses on the consequences of research, on the primary importance of the question

asked rather than the methods, and on the use of multiple methods of data collection to inform the problems under study” (Cresswell, 2011:415). This study epitomizes a pragmatic study because it seeks to answer the research question by using multiple methods of collecting and analysing data and information.

### **3.3.1. METHODOLOGY**

My empirical study included a mixed method research design which incorporated various tools and instruments to collect and analyze the data. The reason for selecting this design was that it provided flexibility to explore both qualitative (in-depth) and quantitative (statistical) data of how stakeholders in the sector (from multiple spheres of government and areas of interest) perceived the management of substance abuse in South Africa.

The study intended to confirm or dispute the outcome of deliberations between multisectoral stakeholders at the 2<sup>nd</sup> Biennial Summit – which inter alia concurred that alcohol policies were incoherent and the general management of substance abuse was not effective to combat substance abuse (DSD, 2011). My research question was primarily based on inferences of the 2<sup>nd</sup> Biennial Summit – that the institutional mechanism to manage substance abuse in South Africa was not effective. I furthermore extended the study to explore international best practices to guide more improved policies and practices (including coordinating structures).

The methodology includes a systematic three-phased process. The study commenced with a qualitative research design in phase 1 which included two in-depth interviews and a Delphi expert perception survey. A quantitative research design followed, which comprised of a national perception survey of LDACs from across the nine provinces. The diagram below (Figure 3.1) displays the process of the study or the studies’ methodology.



Figure 3.1: Methodology of the Study

The mixed method research design was deemed a good fit for purposes of the research as the study was a multiphase design including sequential qualitative and quantitative processes. The study was pragmatic and transformative, involving stakeholders from various spheres within the substance abuse sector (as part of the “community”) to bring about policy improvement (Mertens, 2009). The qualitative research phase included key respondents from various sectors including government (health and social development departments), non-government, research and private sector (treatment centre). The quantitative design included key respondents from local drug action committees (LDACs) from across the nine provinces in the country. I used the mixed method design because of the flexibility of providing a platform for stakeholder’s voices through both qualitative and quantitative design. The difference though, is that more rich and comprehensive data can be collected through the qualitative process, as compared to the quantitative design.

I therefore had the advantage of pursuing more in-depth information in the qualitative process. Mixed methods design has the advantage of strengthening the rigour and enriches the analysis and findings of policy evaluations (Cresswell et al, 2011). This is so

because both design methods are used to entrench the findings of the study. The weakness of the one design is counterbalanced by the strength of the other. Another reason why I used a mixed methods design was to compare the qualitative and quantitative data to see if there are differences between my qualitative findings and quantitative results.

The data collected from the qualitative process served to answer broad questions of how substance abuse is managed in South Africa as well as the relations between stakeholders. I specifically wanted to explore who were the stakeholders involved in policy formulation and policy implementation and the relationships between them. Because of constraints of resources to travel to all provinces to explore this question, I opted to focus on issues related to the Western Cape Province. The purpose was to explore how substance abuse was managed in one province in South Africa. The focus was on the stakeholders involved and how they relate to each other – in the Western Cape Province.

I chose to use the implementation evaluation approach to explore how policies are formulated and implemented in the Western Cape Province. Implementation evaluation (also known as formative or process evaluations) is recommended for use in either new or revised interventions, as a means to understand the specific components of the programme [or strategy] being delivered (Cresswell, 2003). Other evaluation research methods include outcome or impact studies which are designed to assess a programme's efficacy. This was not the objective of the case study design. Moreover, I also had a special interest in the relationships between the coordinating structures which included the CDA, PSAFs and the LDACs and other stakeholders, like the municipality, provincial government departments, national departments and the non-government sector (NGOs, CSOs, CBOs and FBOs). The implementation evaluation method was therefore most appropriate for the study. The expert panel survey served both purposes of providing data for the Western Cape as well as providing a broader national perspective of the effectiveness of the management of substance abuse in South Africa.

### **3.3.2. ETHICAL APPROVAL AND SAMPLE ASSISTANCE**

My research journey with regard to ethical approval post the tertiary institutional phase started with consent to embark on the quantitative research design study through formal processes with the national Department of Social Development (DSD). Substance abuse was coordinated at the provincial level through Substance Abuse Directors in DSD or the Premier's Office, in the case of the Western Cape (at the time of interviews – in 2012). I received written consent from the Deputy Director General (Ms. Maria Mabetoa) managing the welfare services branch (see Appendix A: Letter Written Consent). This letter was attached to the correspondence to all Heads of Provincial Department of Social Development and Provincial Substance Abuse Directors for consent and assistance to select a sample for the study (see Appendix B: Letter Provincial Assistance). Consent to participate in the study by respondents was appended to the questionnaire to committee members of LDACs (see Appendix C: Delphi Expert Survey Questionnaire and Appendix D: National Perception Survey Questionnaire).

### **3.3.3. THE QUALITATIVE DESIGN**

The qualitative research design (in phase 1) explores, describes and analyses the implementation of the NDMP 2006-2011 in the Western Cape Province as a case study. It identifies various stakeholders involved in substance abuse programmes in the province, describing their roles. Furthermore, the case study discusses the relations between coordinating structures (the CDA, the Forum and LDACs). The qualitative research design also explores broader challenges of substance abuse policy formulation and implementation in South Africa. Principles of good governance (coordination and participation) are used as measuring indicators to assess the "effectiveness" of the management (policy formulation and policy implementation) of Substance Abuse in South Africa. The effectiveness of relationships between stakeholders were measured using indicators of: being supportive (with information, financial and other resources),

accessible (with information, financial and other resources) and having good communication lines between stakeholders – which relates to transparency and accountability). The qualitative research design also solicited opinions from respondents of how to improve future NDMPs in South Africa.

### ***The Case Study of the Western Cape***

The Case Study of the Western Cape was in the form of an implementation evaluation (also referred to as a process or formative evaluation) to describe how the NDMP 2006-2011 was implemented in the Western Cape Province. According to Rossi et al. (2004:170-179) and Fouche et al. (2011:452), an implementation evaluation is useful to ascertain how well a programme is operating. The qualitative design included collecting data through two in-depth interviews with Key Informants and a Delphi Perception Survey of six experts involved in the substance abuse sector. The descriptive Case Study of the Western Cape Province was aligned to Yin (2003) and Mark (1996) who purports that this type of study focuses on one particular case for purposes of description.

The objectives of the Case Study of the Western Cape Province included to: describe, analyze and interpret substance abuse policy formulation and policy implementation in the context of one province in South Africa. The intention was not to generalize to other provinces in the country, even though the National Drug Master Plan 2006-2011 forms the framework for all national, provincial and municipal level policy formulation and implementation processes. The method used in collecting and analyzing data was qualitative and the approach followed the form or structure of a process evaluation. In-depth interviews with two key informants and a Delphi expert perception survey was the instruments used to solicit data for the case study. The process evaluation approach was appropriate because I wanted to identify who was involved in policy formulation and implementation. Furthermore I also wanted to analyze the processes (of policy formulation and implementation) under the guise or lens of good governance principles, including: coordination and public participation. According to Patton (2002:159-160), a focus on

process involves looking at how something happens rather than, or in addition to, examining outputs of outcomes. The results and findings of the case study is discussed in chapter 4. Figure 3.2 below, displays the case study process. The next section describes the instruments used to collect the qualitative data.

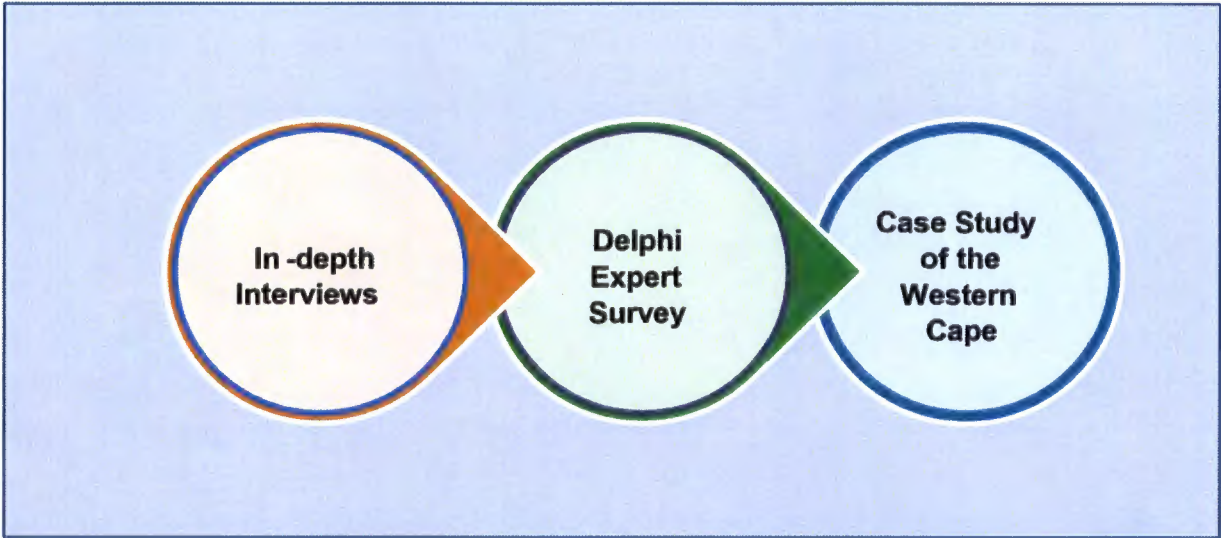


Figure 3 1: Qualitative Research Methodology

**Data Collection Instruments**

Data for the Case Study of the Western Cape was collected through two in-depth interviews as well as a Delphi Expert Perception Survey (with six Key Informants). The instruments for collecting data for the case study is further explained. Table 3.1 illustrates data collection instruments for the in-depth interviews and the Delphi Expert Survey.

Table 3 1:Data Collection Instrument	
In-depth Interviews	Delphi Expert Survey

<p>Interview schedules for the two in-depth interviews comprised of open-ended questions which included the following questions:</p>	<p>The data collection instrument for the Expert Perception Survey involved an open-ended questionnaire (see Appendix C: Expert Survey Questionnaire).</p>
<p>Interview 1: Explain the type of structures you have in place in terms of supply, demand and harm reduction to combat substance abuse in the Western Cape. Who is involved in substance abuse in the Western Cape? What programmes are being implemented and by whom? (See Appendix Interview Schedule 1).</p>	<p>Questions focused on perceptions of respondents with regard to: Challenges and strengths of CDA, PSAFs and LDACs?</p> <p>To what extent are structures effective?</p> <p>What are gaps in substance abuse policies in SA?</p>
<p>Interview 2: What is your perception of the relations between the CDA, the Western Cape Alcohol and Drug Forum and other stakeholders? How are the municipal structures working now in relation to how it use to work [in the past – prior to the current local government]? (see Appendix C: Interview Schedules).</p>	<p>How can South Africa best improve to combat substance abuse, as regards the substance abuse national strategy (NDMP)? and How can the management of substance abuse be improved?</p>

I used an electronic Dictaphone to record the in-depth interviews and these were transcribed, ready for analyses. Both respondents consented verbally to the use of the Dictaphone to record the interviews. The information was incorporated into a Case Study of the Western Cape to describe the role of stakeholders involved in the various substance

abuse programmes in the province (see Appendix E: Case Study of the Western Cape Province).

A multi-contact system was used to communicate with respondents, as prescribed by Mouton (2007). This included: email, telephone and mobile phone sms to communicate with key respondents of the perception survey. Various measures were taken to improve the response rate of key informants. This included reminders and follow-up emails, sms and telephone calls.

### ***Sampling for the Qualitative Study***

<b>Table 3 2: Sampling for Qualitative Study</b>	
<b>In-depth Interviews</b>	<b>Delphi Expert Survey</b>
The sample of the In-depth interviews was selected non-randomly or purposively. The Key Informants included two people involved with the Western Cape Provincial Substance Abuse Forum. These respondents were purposively chosen because of their in-depth	A group of six “experts” in the substance abuse field were chosen through the Delphi method. These respondents were purposively sampled from national, provincial and local government levels as well as respondents from government and non-government organisations. The respondents had in-depth / rich knowledge of the substance abuse sector. They included researchers, government officials, a Director of a treatment centre and a respondent formerly from the liquor industry. Two of the respondents were former CDA members. These experts therefore represented an eclectic panel of sector

<p>knowledge of the substance abuse sector in the Western Cape Province.</p>	<p>experience from the national, provincial and local levels as well as government and non-government organisations. The panel of experts was selected based on the Delphi approach although in this case I did not seek to find consensus among the experts, but rather their rich knowledge and perceptions on issues of policy formulation and implementation. The origins of the Delphi approach emanated in the Cold War in the 1950s when the Rand Corporation, funded by the US Air Force, was trying to find a way to establish reliable consensus of opinion among a group of experts about how Soviet military planners might target the US industrial system in an attack and how many atomic bombs would be needed to have a specified level of impact on US military capability. This was the original "Project Delphi" (Linstone &amp; Turoff, 1975).</p>
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### **Data Analysis**

The qualitative data analysis process followed Miles and Huberman's (1994), Punch (2009) and Bazely's (2012) approach of analysing qualitative data, which include data reduction, data display and conclusion drawing and verification. The data analysed in the qualitative design included textual data, as opposed to the numeric data used in the quantitative design. Data reduction refers to the process of selecting, focusing, simplifying, abstracting, and transforming the data that appear in written-up field notes or transcriptions (summarising, coding - structured code lists/start-list of codes, and memoing). Punch (2009: 174) notes that "the objective of data reduction is to reduce the data without significant loss of information". Data display is an organized, compressed assembly of information that permits conclusion drawing and action (matrices, graphs). It

is important to mention that data reduction, data display and conclusion drawing and verification are “interwoven and concurrent throughout the data analysis” (Punch, 2009: 175).

Using NVivo (Version 2.0), a computer-assisted qualitative data analysis software package, this study used Miles and Huberman’s (1994) approach to analyse the in-depth interviews and findings from the qualitative expert survey. The approach involves using data reduction, data display, conclusion drawing and verification to work through data (Miles and Huberman, 1994). Miles and Huberman (1994: 51) emphasise the need to outline questions prior to data analysis.

Bazeley (2012) refers to Miles and Huberman’s (1994) start-list of codes, as a possible “coding trap” if the researcher does not remain open to the data speaking for itself. I was therefore cognisant of this and was open to finding nuanced information through this process. The main themes I used as my start-list codes or tree nodes were: Policy coordination and Policy implementation and added a further tree node of “Relationships between stakeholders”. The initial child nodes (which formed sub-themes), included: stakeholders (involved in formulating and implementing policies and programmes), programmes (to combat substance abuse) and resources (financial and human, required to implement policies and programmes).

For purposes of the final analysis of the study I focused only on policy formulation, policy implementation and relationships which I thought sufficed to draw inferences to the main question, which was: Is the institutional mechanism to manage substance abuse in South Africa effective? The primary tree nodes analysed therefore ultimately comprised: policy formulation, policy implementation and relationships. The in-depth interviews and the expert survey was the first phase of the qualitative instrument and the data was instrumental in my decision to also develop a Case Study of the Western Cape Province which then became part two of the qualitative instrument. In part two, I used an implementation or process evaluation approach that focused on how policies were

implemented in the Western Cape Province. The child nodes in this instance, included the main national government programmes of supply reduction, demand reduction and harms reduction. These child nodes were substance abuse programmes and initiatives linked to various stakeholders (government departments and non-government organizations). Good governance principals of effective coordination and participation were used as measurement instruments of the child nodes and in addition, relationships between stakeholders were measured as positive or negative.

### ***Trustworthiness of Data***

The 'trustworthiness' of qualitative data can be determined according to a set of criteria (Shenton, 2004; Guba and Lincoln, 1985). The four criteria are: credibility, transferability, dependability and confirmability. Thus in assessing the soundness of the study the research has kept these four key constructs in mind.

In terms of credibility (an alternative to internal validity) the Key Informants and Experts in the qualitative study were selected according to specifically stated criteria and the identified respondents were people involved in the substance abuse sector with specialist knowledge and experience. These respondents were clearly identified in the research sample. The research topic (problem) was best answered by these respondents and the nature of the qualitative data collected allowed for a deeper understanding of the problem. The study had clear boundaries so as to further add rigour to the study.

In relation to the credibility (an alternative to internal validity)) of the study it will always present some problems in a qualitative study but to counter this, the researcher has clearly laid out the theoretical framework of the study as well as how data was collected and analysed according to this framework. Thus it could be transferred to another setting.

Regarding the issue of 'dependability' (an alternative to reliability) changing conditions in the qualitative approach is taken as a 'given' since the social world is constantly being constructed.

Lincoln and Guba (1985) suggest that confirmability (an alternative to 'objectivity') is linked to whether or not the findings can be confirmed by another. 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, whether the findings is similar to or different from other related studies .

#### **3.3.4. THE QUANTITATIVE DESIGN**

The quantitative design comprised of a national perception survey which is discussed in this section. The discussion includes elaboration on the data collection instrument, sampling method, data analysis, reliability and validity.

##### ***National Perception Survey***

The quantitative research design, which was phase 2 of the methodology, comprised of a national perception survey of a sample of members of Local Drug Action Committees (LDACs) from across the nine provinces in South Africa. Respondents were asked questions as regards their opinions of the effectiveness of the institutional mechanism to manage substance abuse in South Africa. This was done through a structured survey questionnaire and divided into themes concerning: coordination structures, policies and stakeholder involvement (participation). The data collection instrument used in the study is discussed.

##### **Data Collection Instrument**

The survey questionnaire used in the quantitative research design was structured with quantitative questions (5-scale Likert-type questions; and yes and no questions) (see Appendix National Perception Survey Questionnaire). According to Babbie and Mouton (2001), questionnaires are most directly linked to surveys. The advantages of using a questionnaire include the fact that the sample gets the same questions and therefore, the findings can be generalized. However, a disadvantage is that the researcher would not be able to probe or clarify the respondents' answers (Strydom, 2005).

The questionnaire used in the qualitative design was structured and close-ended with themes including: structures for managing substance abuse, policies and legislation, resources for prevention and managing substance abuse and programmes to reduce substance abuse. I pilot-tested the questionnaire with four colleagues (researchers) and four people working in the administration section. This was done to eliminate any form of ambiguity, repetition or grammar errors in the instrument.

The self-answered questionnaire was emailed and posted to Chairpersons and Secretaries of the LDACs who distributed it to all members of the LDACs selected in the sample. I telephoned the Chairpersons or Secretaries to explain the process of completing the questionnaire and the return thereof to myself. This established a direct communication line between the LDAC Chairpersons and Secretaries and myself (as the researcher). The Chairpersons and Secretaries of LDACs played the role of "Facilitator", to receive, distribute (to respondents) and finally return the questionnaires to me.

The disadvantage of using a facilitator in this process was that I had no contact with respondents. The exception was the Cape Town LDAC, whose meeting I attended and briefly engaged with committee members (respondents) to complete the questionnaire. Survey administration, to properly record respondent's information and responses (or non-response) was kept in a journal for purposes of the study.

## Sampling

In the instance of the quantitative national perception survey, I used a stratified nonrandom sampling method. In non-random sampling the chances of selecting a particular individual are not known because the researcher is not aware of the population size or the members of the population (Salkind, 2000:87; Gravetter & Forzano, 2003:118). Various types of non-random sampling include: purposive, snowball and key informant sampling. Purposive sampling is based on the judgement of the researcher, in that the sample is composed of elements that contain all the characteristics of the population that serve the purpose of the study best (Monette, Sullivan & De Jong, 2005:148).

I purposively chose to interview members of LDACs because I thought this group to be in close contact with “grassroot” community-based organizations. I therefore used the purposive sampling method of selecting my sample. I used the database of LDACs received from the secretariat of the CDA. The criteria used to select the sample from the total population included that the LDAC had to be operational for the previous 12 months at least. LDACs that had regular monthly meetings in the last 12 months were described as functional and the rest was deemed not functional and excluded from the study.

From the database received from the CDA, I calculated that 116 LDACs were deemed functional across all nine provinces. I purposively selected two LDACs per province (18). However, the Western Cape Province only had one functional LDAC (because they made the previously established 44 community-based LDACs obsolete). Of the 18 LDACS selected one LDAC was to be selected from an urban area and the other from a nonurban (rural or peri-urban) area of each province. This sample represented 15 per cent of the population.

According to Strydom (2011:223), we can only generalize the findings of a study when we can assume that what we observed in the sample of subjects would also be observed in any other group of subjects from the population. Some researchers choose to draw a ten

per cent sample to represent the general population as a rule of thumb (Strydom, 2011:227). My sample was reduced to 15 per cent because of the Western Cape Province having only one functional LDAC at the time of the study (in 2012). This sample can thus be deemed a reasonable sample to represent the population of LDACs that were functional.

My sample excluded LDACs which were deemed non-functional and those committees in the process of being established. In the Western Cape Province only one LDAC was functional and the rest was in the process of being established. I was therefore unable to get more than one LDAC for this province. There was one LDAC that self-selected out of the study from the Eastern Cape Province, due to not having held meetings for the previous 12 months. This committee was replaced by an alternative LDAC, from the same province, with the requisite criteria which circumvented any possibility of creating bias in the sample.

### **Data Analysis**

The data analysis plan for the quantitative research design started with setting analysis objectives. This included deciding between using descriptive data analysis or inferential statistics. Because my focus was not on hypothesis testing, descriptive data analysis became the favoured technique to be used in the study. The quantitative or numeric data was statistically analyzed using the 2009 version of STATA statistical software package. Graphs and charts depict and describe the data in the next chapter of the thesis, as espoused by Salkind (2006).

The analysis involved: descriptive analysis and reliability testing. The descriptive procedure in STATA produces means and standard deviations for variables. Likert scale questions are appropriate to show means - since the number that is coded can give us a feel for which direction the average answer is. The standard deviation is also important as it give us an indication of the average distance from the mean. A low standard deviation

would mean that most observations cluster around the mean. A high standard deviation would mean that there was a lot of variation in the answers. A standard deviation of 0 is obtained when all responses to a question are the same.

Responses to a single Likert item are normally treated as ordinal data, because, especially when using only five levels, one cannot assume that respondents perceive the difference between adjacent levels as halfway. When treated as ordinal data, Likert responses can be analyzed using non-parametric tests, such as the Mann-Whitney test, the Wilcoxon signed-rank test, and the Kruskal-Wallis test. Data from Likert scales are sometimes reduced to the nominal level by combining all agree and disagree responses into two categories of "accept" and "reject". The Cochran Q, or McNemar-Test are common statistical procedures used after the change. In this study, the most frequent response (mode) was calculated for each theme. The applicable variables (themes) were then assessed by categories of variables: Province, Geography (urban or rural) and Municipality using Kruskal-Wallis tests.

### **Reliability**

The two types of reliability criteria that determine the quality of a research study are (a) the reliability of the study and (b) the reliability of the research instrument. Reliability is the extent to which other researchers could arrive at the same or similar results if they conducted the same study with the same participants or subjects using the exact same procedures.

As proposed by Neuman and Kreuger (2003:179-180) and Salkind (2006:108) the following procedures can increase the reliability of measures: Increase the number of observations; Be clear and unambiguous; Do pilot studies prior to the study; standardise instructions; Keep the instrument simple; standardise the conditions under which the test is taken; and Increase the level of precision of measurement (Delport & Roestenburg, 2011:177). In reference to these proposals, I pilot tested the quantitative questionnaire

with four researchers and four administrative assistants in my departments at work. This was done to improve the instrument with regard to clarity and to reduce any unambiguity.

The questionnaire was structured and standardised with specific instructions. I also attached a list of terms with definitions to the questionnaire to ensure that terms are understood uniformly. I tried to improve the response rate of the questionnaires sent to the sample, through constant communication with chairpersons and secretaries. The response from LDACs was 12 out of the 17 sampled. This therefore gave me a response rate of 71 per cent.

In reference to reliability of the research instruments, reliability is the degree to which the instruments consistently measure what the instrument is designed to measure. Reliability is measured numerically. For example, a coefficient over 0.60 (Cronbach's alpha) would indicate an acceptable reliability. A standard error of measurement is another way to express reliability. Cronbach's alpha in the high 0.90s might indicate multicollinearity (the questions on an instrument are measuring exactly the same thing and not different dimensions of the same variable). The study uses Cronbach's alpha to measure the reliability of the quantitative questionnaire in chapter 4.

## **Validity**

Validity refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration. Content validity refers to how much a measure covers the range of meanings included within a concept (Babbie & Mouton, 2001:123). The measure of effectiveness of the management of substance abuse in South Africa in this study comprises indicators that include: good governance principles of coordination and public participation. These concepts do not fully cover the meaning of effective management, but it does provide some degree or an indicator of what effective management should comprise of. Furthermore, content validity is concerned with the representativeness or sampling adequacy of the content (topic or items) of the instrument (Delpont & Roestenburg, 2011:173).

### **3.4. CONCLUSION**

This chapter discussed the methodology of the primary research study. This includes a sequential process using both qualitative and quantitative research methods to collect and analyze data for purposes of evaluating the effectiveness of the management of substance abuse in South Africa. The qualitative research design (in the first phase of the process) provides rich data of the stakeholders involved in substance abuse policy formulating and policy implementation in the Western Cape and in South Africa generally. Moreover, the relationships between stakeholders are explored in the first phase. The quantitative research design, in the second phase of the research process was included in the study for purposes of comparing and triangulating data collected in the qualitative process. The primary evaluative questions of the study focused on the effectiveness of the coordinating structures' (CDA, PSAFs and LDACs), involvement of communities in policy formulation and policy implementation, and recommendations for future policies.

Measurement indicators used to assess the effectiveness of the management of substance abuse included coordination and public participation. The third and final phase of the research design, in chapter 5, includes the summary, recommendations and concluding part. The triangulation of using various research designs to answer the research questions was deemed most appropriate for the objectives of the study.

The populations and samples of the qualitative design (phase 1 of the methodology) included two key informants were purposively selected for in-depth interviews because of their involvement in the provincial substance abuse structure in the Western Cape Province. The key informants of the Delphi Expert Survey were also purposively selected because of their knowledge of the sector and experience of working in the sector at various levels and in different government departments.

Samples for the quantitative research design (phase 2 of the methodology) were drawn purposively or non-randomly from LDACs across the nine provinces in South Africa. The population of LDACs as per the CDA database comprises of 225. However, only 116 LDACs were functional (meaning they had regular monthly meetings for the 12 months prior to the study (in 2012)). The population in terms of the study therefore comprised of 116 LDACs. A sample of 17 LDACs represented the sample of the population. The intention was to get a two LDACs per province (which would have amounted to a sample of 18=N LDACS or 16 per cent). However, the Western Cape Province only had one functional LDAC (because they made the previously established 44 community-based LDACs redundant). This sample (17=N) represented a 15 per cent of the total population of functional LDACs. The 15 per cent sample was deemed a reasonable sample of the total population of functional LDACs as according to Strydom (2011:227).

I received written consent from the Deputy Director General (Ms. Maria Mabetoa) managing the welfare services branch. This letter was attached to the correspondence to all Heads of Provincial Department of Social Development and Provincial Substance Abuse Directors for consent and assistance to select a sample for the study (two LDACs per province). Consent to participate in the study by respondents was appended to the questionnaire to committee members of LDACs. Furthermore, confidentiality was also entrenched within the questionnaire and interview schedule (verbally). Respondents were assured that the information shared with myself would not be attached to themselves and their names were not a compulsory provision in the questionnaire.

For purposes of reliability, I pilot-tested the quantitative questionnaire with colleagues at work to ensure that the questionnaire was legible and easily understood. I attached a list of definitions of substance abuse terms to the questionnaire to make sure that respondents had the same understanding of the terms. Follow-up telephone calls, sms and emails were sent to chairpersons and secretaries to request return of completed questionnaires. Reliability testing, using the STATA (2009 version) statistical software

was done for the numeric data in the quantitative research design. The Cronbach's Alpha technique was used for this purpose. In this study, the most frequent response (mode) was calculated for each theme. The applicable variables (themes) were then assessed by categories of selected variables: Province, Geography (urban or rural) and Municipality using Kruskal-Wallis tests.

With regard to validity, the concepts of coordination and public participation were deemed to be intrinsic to good management. These concepts are used to measure the effectiveness of policy formulation and policy implementation in substance abuse in South Africa.

The qualitative data analysis process followed Miles and Huberman's (1994), Bazely (2012) and Denzin and Lincoln (2005) approach of analyzing qualitative data, which include data reduction, data display and conclusion drawing and verification. Using NVivo (Version 2.0), a computer-assisted qualitative data analysis software package, I followed Miles and Huberman's (1994) approach to analyze the in-depth interviews and findings from the qualitative expert survey. Miles and Huberman (1994: 51) emphasise the need to outline questions prior to data analysis. The main themes I used as my start-list codes or tree nodes were: Policy coordination and Policy implementation. Good governance principals of effective coordination and public participation were used as measurement instruments of the child nodes and in addition, relationships between stakeholders were measured as positive or negative.

The quantitative data collected was cleaned, coded and analyzed using the 2009 version of the STATA software package to develop tables, graphs and pie charts to illustrate and display the data collected. The next chapter consists of the presentation and discussion of findings.

## CHAPTER 4: DATA ANALYSIS & DISCUSSION

### 4.1. INTRODUCTION

In this chapter, the collected data will be analyzed and in some instances visual supplementation will be provided through the aid of tables and graphs. The findings will be presented in two parts, namely the Qualitative Instrument (Case Study and Expert Survey) and the Quantitative Instrument (National Perception Survey). Profiles of respondents for both instruments are provided at the outset. The procedures of the data analysis of both the qualitative and quantitative designs are described and the research findings are then discussed. The research findings will be presented and discussed under the main theme of governance [policy formulation and policy implementation] and related sub-themes of coordination and participation. The research's reliability, validity and other analysis forms the end part of the chapter which concludes with an overview of the limitations of the study and processes. The population profile of the studies' respondents follows.

### 4.2. POPULATION PROFILE

The following table shows the population profile of the Key Informants (KI) involved in the qualitative in-depth interviews. Key informants were purposively selected based on their prior or current involvement in the Western Cape Provincial Drug Forum.

<b>Table 4 1: Population Profile of Qualitative In-depth Interview Respondents</b>		
<b>Respondent</b>	<b>Organisation</b>	<b>Province</b>
KI#1	Premier's Office	Western Cape

KI#2	NGO Sector	Western Cape
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Both Key Informants interviewed through in-depth interviews were from the Western Cape. One of the Key informants was currently working in the sector and the other was a former Western Cape PSAF member. These respondents provided rich information and perspectives of policy formulation and policy implementation in the Western Cape Province. The next table shows the population profile of respondents who participated in the qualitative expert panel survey.

<b>Table 4 2: Population Profile of Qualitative Expert Perception Survey</b>			
<b>Respondents</b>			
Respondent	Gender	Organisation	Nat/Prov/Local
ES: 1	Male	Medical Research Council (MRC)	National
ES: 2	Male	Private Treatment Centre	National
ES: 3	Male	Department of Social Development	National
ES: 4	Female	Department of Health	Municipal (Cape Metro)
ES: 5	Female	Department of Health	Provincial (Western Cape)
ES: 6	Female	NGO [Formerly Alcohol Industry Director]	Provincial/National

The six respondents who participated in the Expert Survey included government officials from national, provincial and local government, therefore providing perspectives from all three spheres of government. Respondents were from the Department of Social Development, Health, Medical Research Council, NGO and private sector. This means

that perspectives from all sectors (government, non-government, research and private sector) were represented in this study. Furthermore, one respondent was from the Western Cape Health Department and one respondent was from the Cape Town Metropolitan Health Department, which provided in-depth information of the Western Cape Province for the purposes of a Case Study.

There were 50 per cent male and 50 per cent female respondents which provided equal gender representation in the sample. The population profile of respondents who participated in the qualitative design (In-depth interviews and the Expert Survey) were thus an eclectic mix of officials and people working in the substance abuse sector from national, provincial and municipal spheres of government and had representation from the two main departments involved in substance abuse, namely Health and Social Development. Moreover, sectors represented included government, non-government and the private sector.

Most respondents were from the Western Cape Province. These included both Key Informants (100 per cent of the population sample) from the In-depth Interviews and two (one third of the sample) of the Expert Survey respondents. This selection of respondents was purposively sampled to provide information-rich data of the Western Cape Province as a Case Study example – of how policies are formulated and implemented in one of the nine provinces in South Africa.

#### **4.3. SAMPLING FOR THE QUANTITATIVE RESEARCH DESIGN**

I purposively selected two LDACs per province (18). However, the Western Cape Province only had one functional LDAC (because they made the previously established 44 community-based LDACs obsolete). Of the 17 LDACS selected as the sample one LDAC was to be selected from an urban area and the other from a non-urban (rural or peri-urban) area of each province. This sample represented 15 per cent of the population.

The sample was stratified from Local Drug Action Committees (LDACs) across the nine provinces in South Africa (Western Cape, Eastern Cape, Northern Cape, Free State, Gauteng, Limpopo, North West, Mpumalanga, and Kwazulu-Natal). Samples were stratified firstly across all nine provinces and then between urban, peri-urban or rural geographic areas across the country as well as according to various municipalities (metro, district and local). This I did to get an inclusive (representative) sample from urban and non-urban settings and from the various municipalities.

The response rate from the 17 LDACs who were the selected sample representing the population of all functional LDACs in South Africa equaled 12 in total. This calculates to a response rate of 71 per cent. I received completed questionnaires from a total of 99 respondents. The next section shows the sample population (by population, geographic area and municipalities) displayed by tables and graphs.

### ***Sample Population by Provinces***

As depicted in Table 4.3 and Figure 4.1 below, there were a total of 99 respondents involved in the quantitative perception survey. Most of the respondents (N=22 or 22.22 per cent) were located in the North West Province and from the Free State Province (N=15 or 15.15 per cent). Respondents were from two LDACs in each of these provinces. There were 13 respondents from the Eastern Cape Province (13.13 per cent), 11 respondents from two LDACs in Mpumalanga (11.11 per cent), 10 respondents from the Western Cape Province (10.01 per cent) and 8 respondents from Limpopo (8.08 per cent).

There were 7 respondents from both Gauteng and Northern Cape Province respectively (7.07 per cent), and the lowest number of respondents were from Kwazulu-Natal (N=6 or 6.06 per cent). The provincial distribution of respondents is significant because low representivity in the study is in contrast to high incidence of substance abuse. For instance Gauteng, the Western and Northern Cape and Kwazulu-Natal provinces have very high

incidence of drug and alcohol abuse (SACENDU, 2010) but these provinces are under-represented in the study. The high representivity in the study of smaller provinces, like the North West and Free State provinces could skew the results and findings of the study to a narrower view of the effectiveness of the institutional mechanisms to manage substance abuse in South Africa.

<b>Table 4 3:Sample Population by Provinces</b>		
Province	Frequency	Percent
Eastern Cape	13	13.13
Free State	15	15.15
Gauteng	7	7.07
Kwazulu-Natal	6	6.06
Limpopo	8	8.08
Mpumalanga	11	11.11
North West	22	22.22
Northern Cape	7	7.07
Western Cape	10	10.1
Total	99	100

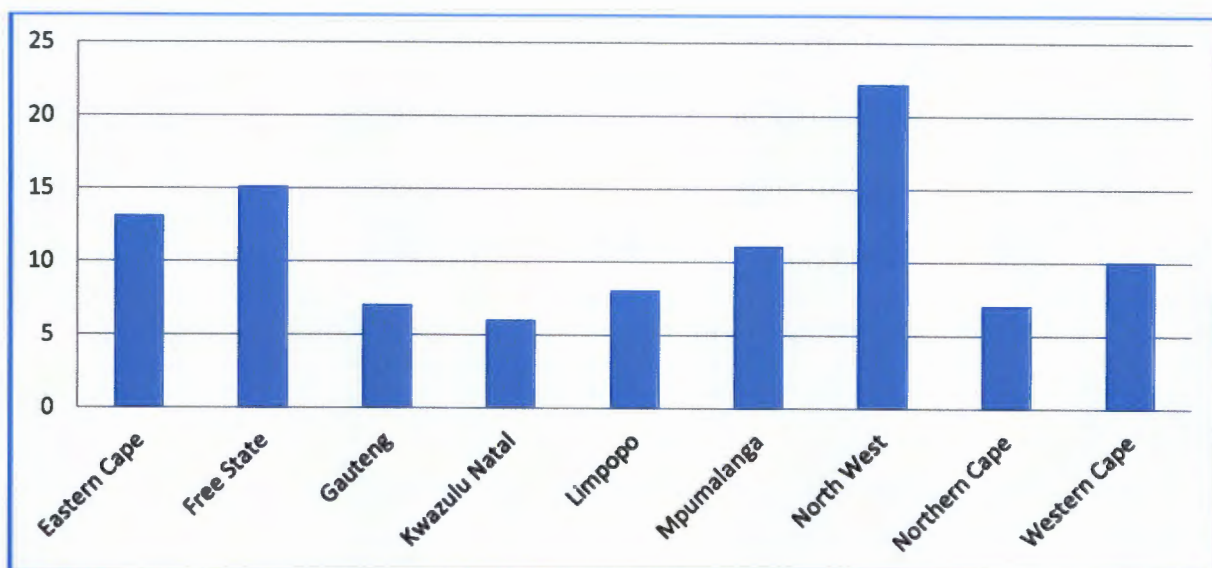


Figure 4.1: Provincial representation of Respondents

Table 4.4 and Figure 4. 2 show that the majority of respondents (N=71) (71.72 per cent) were from an urban area. There were 16 respondents (amounting to 16.16 per cent of the sample) from a rural area. Only 12 respondents (12.12 per cent) were from a peri-urban area. The spread of respondents amongst the various geographical areas therefore shows a bias towards the urban area. This means that perceptions shown in the study will be biased towards an urban perspective of the institutional mechanism to manage substance abuse in South Africa.

Geographic Location	Frequency	Percent
Peri-urban	12	12.12
Rural	16	16.16
Urban	71	71.72
<b>Total</b>	<b>99</b>	<b>100</b>

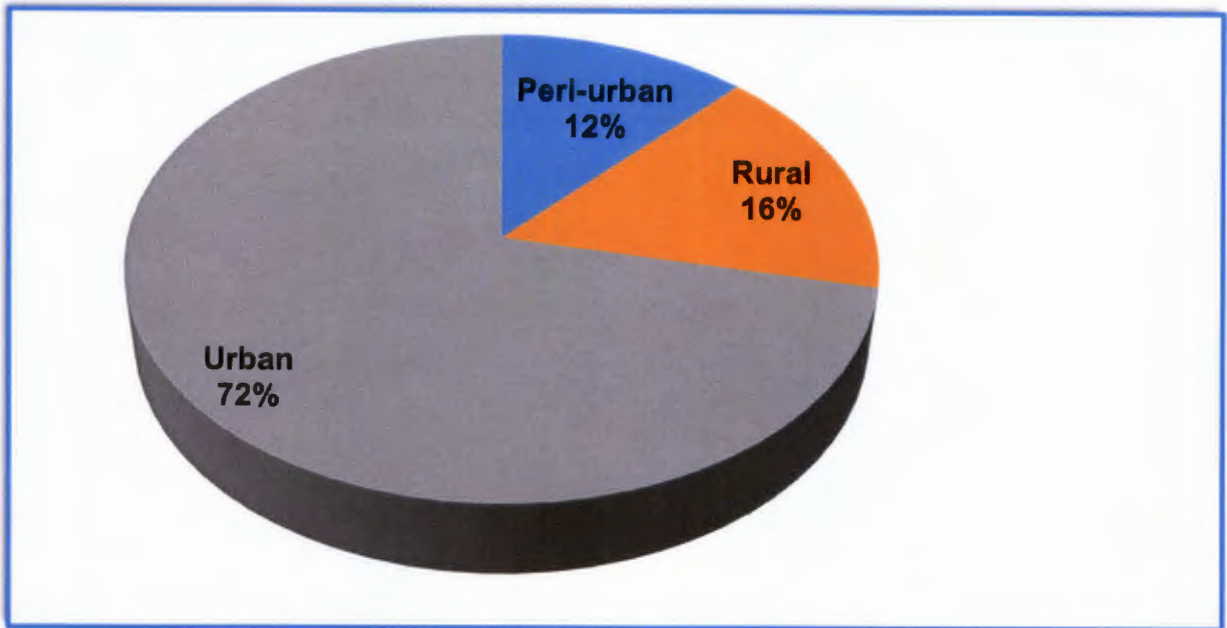


Figure 4.2. Geographical Location of Respondents

### Municipal Representation of Respondents

Table 4.5 and Figure 4.3 below, show that there was an imbalance of respondents from the various municipalities. A large majority of respondents (76 per cent) were from local municipalities, while 22 per cent were from metro municipalities and only 2 per cent respondents were from the district municipality. Perspectives with regard to the effectiveness of policy formulation and implementation will therefore have a bias of local municipality respondents. The following section discusses the findings of the study starting with the qualitative design and then the quantitative design.

Table 4 5: Respondents from Municipalities		
Municipality	Freq.	Percent
Local	75	75.76

Metro	22	22.22
District	2	2.02
<b>Total</b>	<b>99</b>	<b>100</b>

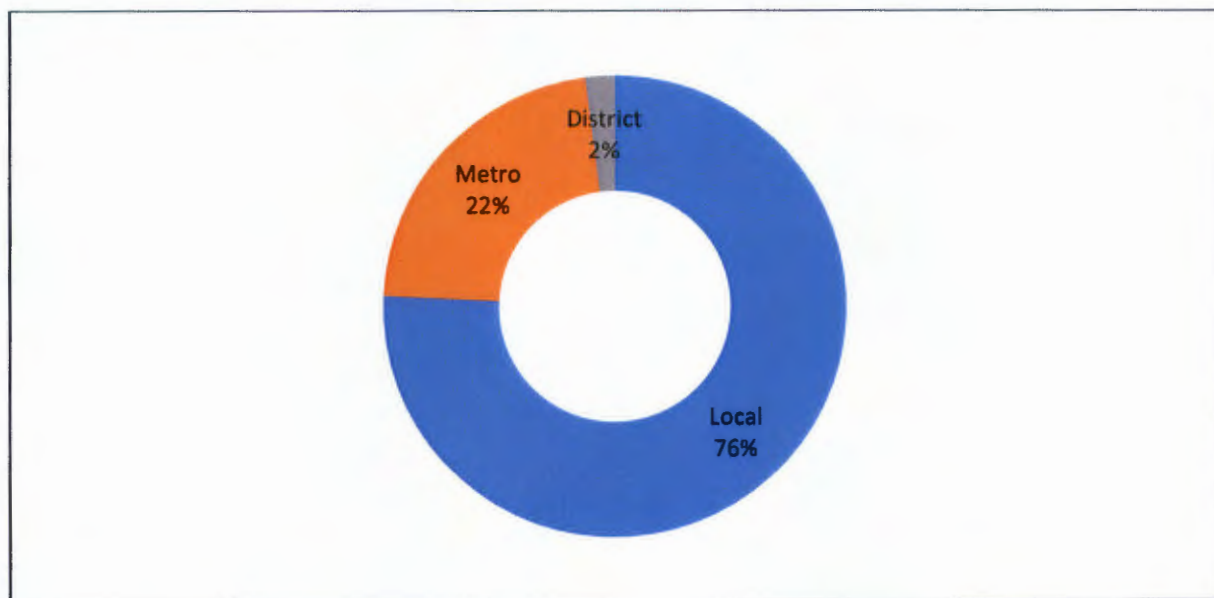


Figure 4 3: Respondents from Municipalities

#### 4.4. RESULTS AND FINDINGS OF THE STUDY

Next, the results and key findings of the mixed methods study is represented and discussed. Firstly, the data collection procedure is explained, followed by an analysis of the findings. The qualitative and quantitative designs are dealt with sequentially and this data becomes embedded in the final analysis in the next and final chapter (c.f. chapter 5).

##### 4.4.1 THE QUALITATIVE DESIGN

The qualitative design comprised of two in-depth interviews and an expert panel survey of six key informants. The data collection procedure is explained after which the data analysis is described and discussed.

#### 4.4.1.1. Qualitative Data Collection Procedure

<b>Table 4 6: Questions explored through In-depth Interview and the Expert Panel Survey</b>	
<b>Perceptions of Policy Formulation &amp; Policy Implementation</b>	
<b>Main Questions</b>	<b>Sub-questions</b>
Is the management of substance abuse effective with regard to coordination and participation?	Are the CDA, PSAFs and LDACs effective? 1. Effective Coordination 2. Effective Participation
How can the management (coordination and participation) of substance abuse be improved?	What are gaps in substance abuse policies in SA? What are international best practice?

The data collected from the two In-depth Interviews were recorded and transcribed, ready for analysis. The data collected from the qualitative process served to answer broad questions of how substance abuse is managed in the Western Cape. Furthermore, the case study of the Western Cape highlighted issues of relations between stakeholders also. I had a special interest in the relationships between the coordinating structures which included the CDA, PSAFs and the LDACs and other stakeholders, like the municipality, provincial government departments, national departments and the nongovernment sector (NGOs, CSOs, CBOs and FBOs).

The outcomes of the qualitative phase of the study include: (1) Expert's perceptions of the effectiveness of coordinating structures and (2) a Case Study of the Western Cape Province (see Appendix E: Case Study of the Western Cape Province) which provide perceptions of how policies are formulated and implemented in that province; and (3) how processes can be improved for future NDMPs.

#### **4.4.1.2. Qualitative Data Analysis Process**

This section will describe the procedure of the data analysis process and then discuss the findings. My study used a start list of codes derived from preconceived key themes. I started by framing key themes according to the Central Research Question (CRQ) and sub-research questions which asked: (1) is the institutional mechanism to prevent and manage substance abuse in SA effective? And (2) how can the institutional mechanism to prevent and manage substance abuse in SA be improved? From these two questions it became apparent that I needed to focus on the processes of how the formulation and implementation of substance abuse policies work. Secondly, it highlighted the need to examine key informant's responses in light of governance processes and principles. I chose good governance as a lens for my study because policy formulation and policy implementation encompasses public sector governance and public sector administration – which is my field of interest. Good governance principles of coordination and public participation were used as evaluative indicators in the study.

I used a journal to note similarities and differences between responses and how they could be categorised amongst the tree nodes (main themes) and child nodes (subthemes) in NVivo (version 02) - which follows the work of Bazeley (2012: 1). Miles and Huberman (1994: 51) emphasise the need to outline questions prior to data analysis. Bazeley (2012) refers to Miles and Huberman's (1994) start-list of codes, as a possible "coding trap" if the researcher does not remain open to the data speaking for itself. I was therefore cognisant of this and was open to finding nuanced information through this process.

The main themes I used as my start-list codes or tree nodes were: Policy coordination and Policy implementation, which formed the overarching “management” theme (or tree). The initial sub-themes (child nodes) which were the focus of the study included: coordinating structures (involved in formulating and implementing policies and programmes), programmes (to combat substance abuse) and resources (financial and human, required to implement policies and programmes).

For purposes of the final analysis of the study I focused only on the coordinating structures. Following the literature review, which provided the secondary data and basis for the study, I selected coordination and public participation as measuring indicators to assess “effective management” or coordinated governance. Nodes developed from the data, including: Weak power and resources (which I defined as “ineffective coordination”). Starting with the CDA, the child nodes constructed with relation to “ineffective coordination” included: weak power and resources, which included sub-nodes of weak leadership; lack of capacity and resources; and lack of clear roles and commitment. These same child nodes were used to measure the PSAFs and the LDACs in the qualitative design. The child nodes constructed with relation to “effective Participation” included: community involvement.

In-depth interviews provided rich data on broad issues of coordination, policy formulation and policy implementation. With regard to policy implementation: The relationship between stakeholders and structures involved in substance abuse prevention and management in the Western Cape identifies challenges to this system. Child nodes which listed these challenges include: duplication; lack of control and central coordination; lack of authority and support for the Central Drug Authority; lack of monitoring and evaluation and performance assessments.

#### **4.4.1.3. Qualitative Research Findings**

I investigated whether respondents thought that substance abuse coordinating structures were effective in what they were meant to do, which is to fight substance abuse (in providing support to other structures) in the national, provincial and municipal spheres in South Africa. I proceeded to create the child nodes: "Role of CDA" and "Ineffective" to cater for "bits of data" which spoke to non-effectiveness of the structure in fulfilling its role and mandate. I used good governance principles of coordination and participation as indicators to measure effectiveness. However, I was actually measuring ineffectiveness of the coordinating structures, due to the data I received. I therefore developed a dual instrument of "effective coordination" and "effective participation" and sorted the textual data for all coordinating structures. I repeated the same process of measuring effectiveness / ineffectiveness for the CDA, PSAF and LDACs. The following sub-section discusses the findings of the research.

#### **4.4.1.3.1. Perceptions of the Effectiveness of Coordination Structures**

The following section discusses the research findings with regard to the effectiveness of the coordination structures involved in policy formulation and policy implementation. Respondent's views on the effectiveness of coordinating structures (CDA, PSAFS and LDACs) were measured, using indicators of coordination and public participation as a lens to assess the efficacy of the coordinating structures.

The majority of respondents from both the expert survey and in-depth interviews acknowledged that the key role of the CDA is to coordinate stakeholders and structures to implement the NDMP 2006-2011. The NDMP 2006-2011 also included a monitoring and evaluation role for the coordinating structures (DSD, 2006). All the respondents interviewed in the Delphi Expert Survey expressed notions that the CDA was without authority and not effective to carry out its mandate, to coordinate the implementation of the NDMP 2006-2011. Furthermore, responses from the majority of respondents confirmed the CDA, PSAFs and LDACs all exhibit characteristics of weak leadership; lack

of capacity and resources; and lack of clear roles and commitment. In addition community involvement, especially by ordinary citizens, was exempt from Western Cape structures.

The study shows that before 2009, the Department of Social Development (DSD) established LDACs in all local municipalities, comprising community-based organisations. A total of 44 LDACs existed in 2009 until these committees were informed by the city and the province that they were redundant. What follows after 2009, is a top-down approach of the City's LDAC being represented only by government departments and inviting NGOs to present programmes – at PSAF and LDACs meetings. The evaluation of the management of substance abuse in the Western Cape Province with regard to indicators of coordination and public participation principles thus produces a negative result. This is due to the lack of requisite capacity, resources, leadership and public participation in all coordination structures (CDA, PSAF and LDAC).

It can be argued that the Western Cape Province does have effective coordination because of functional provincial and municipal level plans to reduce substance abuse (the province's "Blue Print" strategy and the City of Cape Town's municipal alcohol and drug policy). However, excluding citizens from being involved in resourced structures to support the implementation of the NDMP 2013-2017 presents challenges for the province in the long term. These notions not only concurred with the opinions of stakeholders at the 2<sup>nd</sup> Biennial Summit, but the Delphi Expert Survey also added insight to the national leadership problems and the lack of effective secretariat support and resource constraints. The study shows that the CDA is not effective to carry out its mandate, to coordinate the implementation of the NDMP. This is reflected in responses from the majority of respondents confirming that the CDA inhibits characteristics of weak leadership; lack of capacity and resources; and lack of clear roles and commitment.

#### **4.4.1.3.2. Perceptions on How to Improve Future NDMPs**

South Africa should consider the following recommendations to improve the management of Substance abuse:

Because the CDA is unable to fulfill its mandate of coordinating the implementation of the NDMP because of various reasons, including lack of resources and support, government must consider either a full-scale improvement plan to resource and capacitate the CDA with requisite staff and training, or consider the recommendation of an alternative central structure with more power and resources. A central structure (as an agency or within the Presidency) is required to oversee the management of substance abuse in South Africa. Part of the mandate of the central structure should include to coordinate government, nongovernment and the private sector to formulate and implement policies. The structure should consist of a monitoring and evaluation element that is able to design standard indicators linked to reducing the demand, supply and related harms caused by substance abuse. The structure must be able to collaborate with regional and international stakeholders to reduce drug trafficking and curb related organized crime.

The responsibility of the CDA to provide timeous reports to parliament has been ineffective to date. This has been regularly stated by parliamentary committees (Portfolio Committee on Social Development and the Select Committee on Social Services). The result of this is that it retards the ability of parliament to do oversight of the CDA as an agency of the DSD. While the CDA depends on provinces and departments to submit their reports to the agency a structured intergovernmental relations (IGR) system is needed. This structure must be linked to current Minister and Members of the Executive Council (MINMEC) structures and the structure that includes the municipality and provinces, like South Africa Local Government Association (SALGA).

Government should consider establishing a National Health Promotion Foundation (which is separate from the proposed "central structure" to manage substance abuse in the country) to provide research and resource support to coordinating structures and community-based programmes. A consortium of civil society organization stakeholders

from research and advocacy groups, called the Health Promotion and Development Network (HPDNet) has proposed to cabinet (the IMC on Substance) to establish a “Health Promotion and Development Foundation (HPSAF)” in 2013 (Perez, 2013). This proposed Foundation will be an independent structure financed through (1 to 2 per cent) taxes on alcohol and tobacco and comprise of experts in the sector. It is a non-government structure (civil society owned and managed) that will work with government to help to provide research and information to the public and provide resources to LDACs and community-based organisations.

The Foundation, as the name implies, will have focus on substance abuse as well as other health and social development issues, like teenage pregnancies and sexually transmitted diseases (STDs) which is linked to substance abuse. International best practice models of a Health Promotion Foundation (HPF) is evident in 16 countries and states in the world. Examples include VicHealth in Australia and ThaiHealth in Thailand. These HPFs are funded by 2 per cent taxes from alcohol and tobacco and serve to provide research support to government, for evidence-based policy-making, and are involved in various initiatives, like inter alia reducing road traffic accidents (Verins, 2013). Advocacy and informing people of the dangers and harms related to substance abuse are key programmes managed by the HPFs.

This kind of foundation or structure is much needed in South Africa to assist the implementation of the NDMP 2013-2017 and the PATSA act as well as other health and social development initiatives to ensure a healthy society. The primary gain of such a structure is that it ensures a “whole of society” approach and therefore ensure that initiatives involves public participation and that coordination is not hampered by government hierarchy or “red tape” that normally retards development in the country. The needs of society can be identified by citizens who themselves are involved, making initiatives more effective, efficient and sustainable.

The role of the CDA should be questioned because overseeing policy formulation and policy implementation should be part of their mandate. The national director of substance abuse at DSD was elected the CDA Chairperson, in 2014. In addition, the secretariat of the CDA is also positioned in the national DSD. This structure gives impetus to the negative way other government departments and provincial structures involved in substance abuse perceive DSD and the CDA, thereby neglecting to provide timeous reports for the CDA annual reports to parliament. By the end of August 2014, the CDA's 2011/12 Annual Report, which was due 30 September 2013, was still not tabled. The report for 2012/13 will be due by the 30 September 2014. The recommendation for a new central structure, located perhaps in the Presidency, will therefore be a most efficient and effective option to combat substance abuse in South Africa in future.

The current management of substance abuse must be revised and changed to be more effective, efficient and sustainable. Presently, the Inter-Ministerial Committee (IMC) on Substance Abuse, led by the Minister of Social Development, manages the sector, as a meta-governance structure. Meuleman (2008) describes meta-governance as governance inherent of overlapping hierarchy, market and network governance personality. Meta-governance exhibits a strong central structure which provides governance of governance. The IMC structure resembles meta-governance as it comprises executives from all government departments involved in substance abuse, such as social development, health, basic education, sport and recreation, transport, labour, and agriculture. All policies and legislation is under review by the IMC as per resolutions of the 2<sup>nd</sup> Biennial Anti-substance Summit in Durban, in March 2011.

However, to date, information has not filtered to any level further than cabinet and the executive level. Government officials from departments are also not informed of progress of other departments, which means that all substance abuse policies and programmes are dealt with in a "silo" or singular approach. Parliament is also constrained to do

oversight of substance abuse as a unitary issue because various departments formulate and implement policies relevant to their interest only and not in an integrated manner.

For meta-governance to be successful, it requires coordinated governance; which implies more powers granted to lower governance levels (provincial and municipal) with requisite human and financial resources. This approach also requires involvement of the “whole of society” in policy formulation and policy implementation. Citizens in South Africa who are not by the financial means to acquire health and other services, have basic rights enshrined by the Constitution of South Africa (1996) to receive adequate services (s27) and to be involved in policy making and policy implementation (s.152; s.194).

Furthermore, citizens who are involved in policy formulating and policy implementation are best able to identify their needs and give input to how they want to receive services. This is part of good governance practices that promote bottom-up planning and policy design. Moreover, government has responsibility to treat citizens in a dignified manner through principles of Batho Pele (DPSA, 1997). Intra-government planning (between government departments) and budgeting is needed for substance abuse to be successful. This includes provision of financial resources and training to non-government organisations (NGOs), community-based organisations (CBOs), as well civil society organisations (CSOs) to provide research and sector-specific expertise to the sector generally. Coordinated governance requires coordination to include all involved stakeholders and the “whole of society” in substance abuse as well as related issues in society (attending to poverty, unemployment and inequality, amongst others).

Although the NDMP may in its current form be relevant, it needs to be revised to include the community's needs in a South African context. The country is dealing with major constraints for development, including high unemployment, poverty and inequality. These issues must be addressed in unison with the substance abuse problem. The harms linked to substance abuse, especially alcohol and tobacco, like HIV and AIDS, TB and other

non-communicable diseases (liver cirrhosis and cancer) is a major concern for the Department of Health Minister and should concern everyone (Minister Motsoaledi, 2014). Therefore a “whole of society” approach to deal with substance abuse is the best option concurred by all respondents in the study (both qualitative and quantitative research designs). Community involvement and financial assistance to the NGO sector is crucially needed. In addition, ongoing training for all stakeholders in the sector is required, which can be linked as possible functions of the proposed HPSAF for South Africa.

#### **4.4.2. THE QUANTITATIVE DESIGN**

##### **4.4.2.1. Data Collection Procedure**

5-Likert scale statements were used to assess the LDAC Committee member's perceptions pertaining to policy formulation and policy implementation especially with regard to coordination and participation. I used the database of all LDACs (received from the CDA Secretariat). Samples were stratified firstly across all nine provinces – where I chose two LDACs per province. The criteria for sample selection included: Two LDACs per province that were functional for the last year (12 months); The two samples should include LDACs from a rural urban or peri-urban area; In addition, LDACs should be representative of various municipalities (metro, district and local). This I did to get a representative sample from the population of LDACs across the country. I requested the provincial Substance Abuse Coordinator from all provinces to assist me with the process of identifying LDACs with the stated criteria. I then contacted the relevant LDAC chairperson to assist with the process of distributing the questionnaire to each LDAC member and then to return all completed questionnaires to me.

I developed a self-answered questionnaire which was emailed or posted to the Chairpersons and Secretaries of the LDACs. Besides instructions on the questionnaire, I also telephoned the Chairpersons or Secretaries to explain the process of completing the questionnaire and its return - to myself. This established a direct communication line

between the LDAC Chairpersons and Secretaries and myself (as the researcher). This was deemed very important because the Chairpersons or Secretaries played the role of “Facilitator”, to receive, explain, distribute (to respondents), collect and finally, to return the questionnaires to myself.

The questions to LDAC members who participated in the national perception survey related to narrow themes identified through the qualitative research phase. These questions included the following: To establish if substance abuse is coordinated effectively - Are the structures (CDA, PSAFs and LDACs) perceived to be effective?

#### **4.4.2.2. Data Analysis Process**

The numerical data was statistically analyzed using the 2009 version of STATA statistical software package (STATA, 2009). Graphs and charts depict and describe the data. The analysis involved: descriptive analysis and reliability testing. Inferential analysis (the other type of quantitative analysis) was deemed not of use and purposes to/of the study. The descriptive procedure in STATA produced means and standard deviations for the variables in the study. These variable were predetermined and included coordination structures, policies (and legislation), resources and programmes. For purposes of the analytical study, linked to my questions, I opted to analyze the “coordination structures” and “policies” themes (questions 1 to 10) only. These themes represented one part of the variables used in the analysis. I used the Krukas-Wallus technique to describe associations between the “theme variables” and other variables relevant to my analysis. These variables included: provinces, geographical areas and municipalities. I wanted to assess the reliability and association between theme variables and provinces, geographical areas and municipalities.

Likert scale questions were appropriate to show means - since the number that is coded can give us a feel for which direction the average answer is. The standard deviation is

also important as it give us an indication of the average distance from the mean. A low standard deviation would mean that most observations cluster around the mean. A high standard deviation would mean that there was a lot of variation in the answers. A standard deviation of 0 is obtained when all responses to a question are the same.

#### **4.4.2.3. Results of Data Analysis**

The quantitative data analysis process sought to assess the opinions and perceptions of respondents from members of LDACs across all nine provinces. The majority of respondents surveyed in the national perception survey were of the opinion that all coordinating structures, including the CDA, PSAFs and LDACs, were effective in the way they were carrying out their mandate of supporting the implementation of the NDMP 20062011. This section shows the results of the survey and presents the results in graphic form. Furthermore, reliability testing will be done to ascertain whether the instrument (questionnaire) measured what it was supposed to (the reliability of the instrument).

##### ***Perceptions of the Effectiveness of Coordination Structures***

Most respondents in the national perception survey 54 per cent (N=53) were of the opinion that the CDA has effectively coordinated all stakeholders to reduce / combat substance abuse in South Africa. Only 26 per cent (N=26) of the sample thought that the CDA was ineffective.

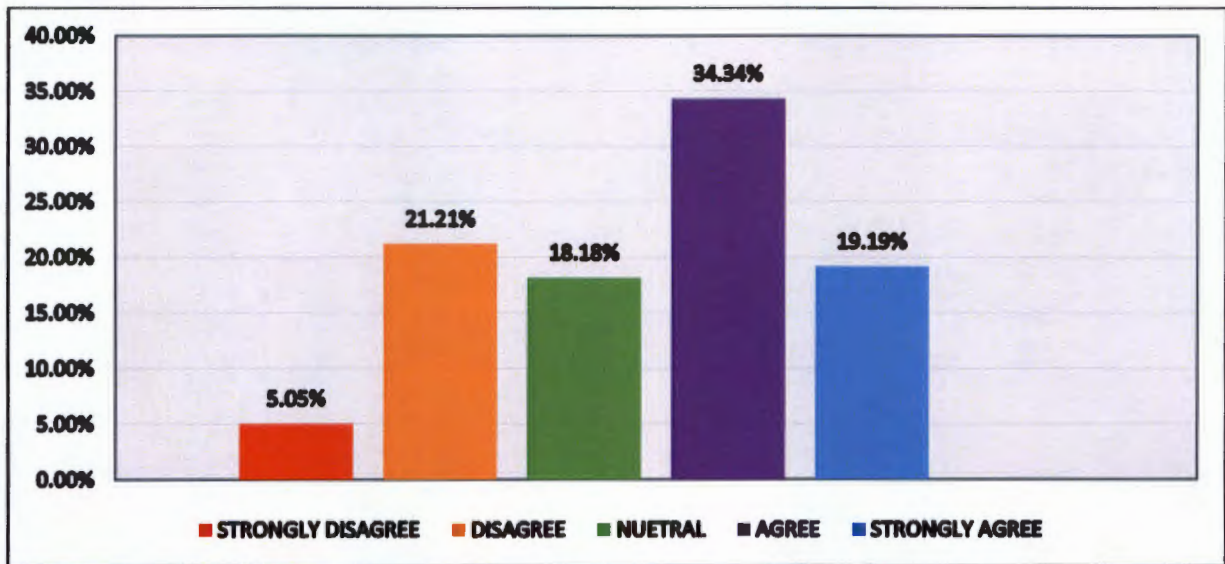


Figure 4.4: Perceptions of the effectiveness of the CDA

The majority of the sample 90 per cent was of the opinion that the PSAF in their respective province were effective, while only 3 per cent did not think so.

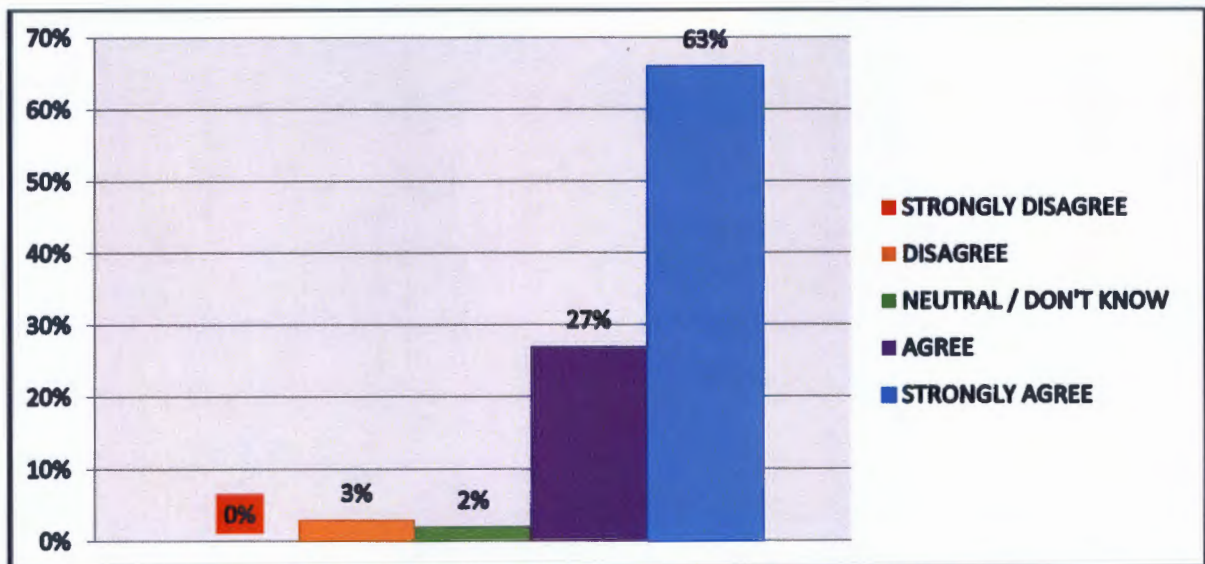


Figure 4.5: Perception of the effectiveness of the PDFs

A large proportion of the sampled population (70 per cent, N=71) thought that their respective LDACs were effective. A minority (12 per cent, N=12) did not think so.

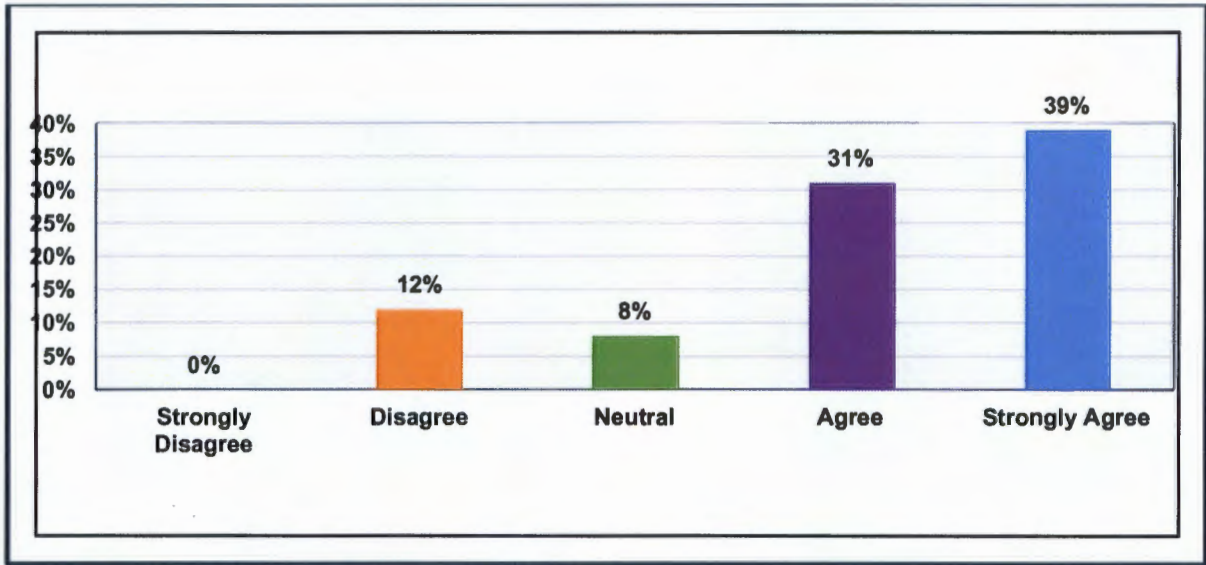


Figure 4.6: Perceptions of the effectiveness of LDACs

The majority of respondents (63 per cent) in the national perception survey agreed that all the structures (CDA, PSAFs and LDACs) work effectively together to combat substance abuse in South Africa. Only 25 per cent (N=25) disagreed.

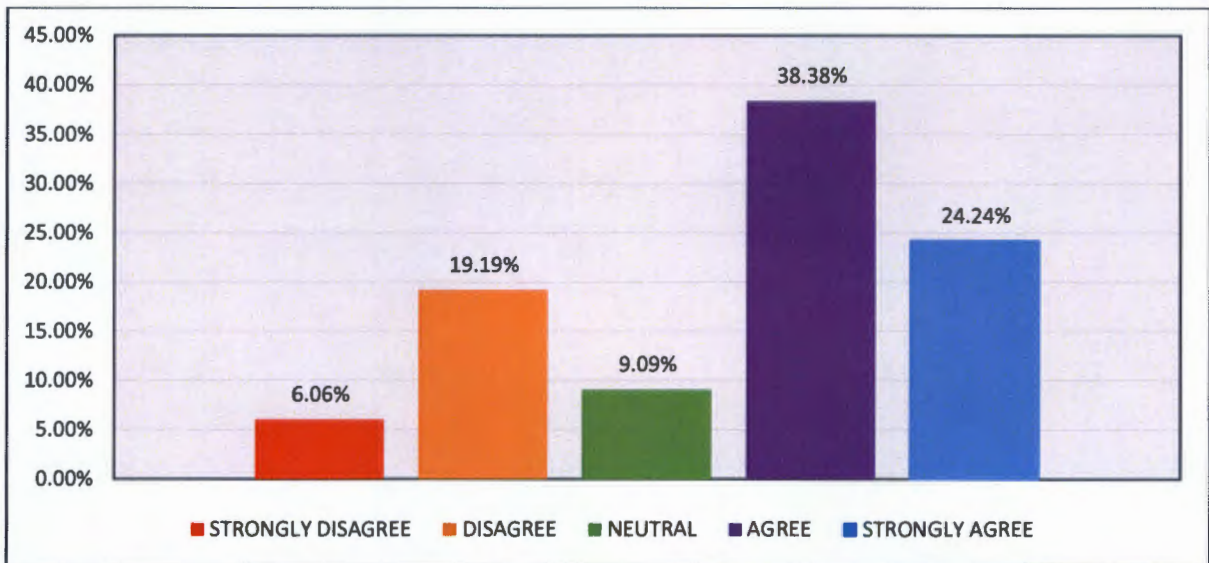


Figure 4.7: Perceptions of structures working effectively together

As many as 81 per cent (N=80) of respondents interviewed agreed that substance abuse should be coordinated by a central agency with sufficient resources and executive powers. Only 10 per cent (N=10) of respondents disagreed with this suggestion.

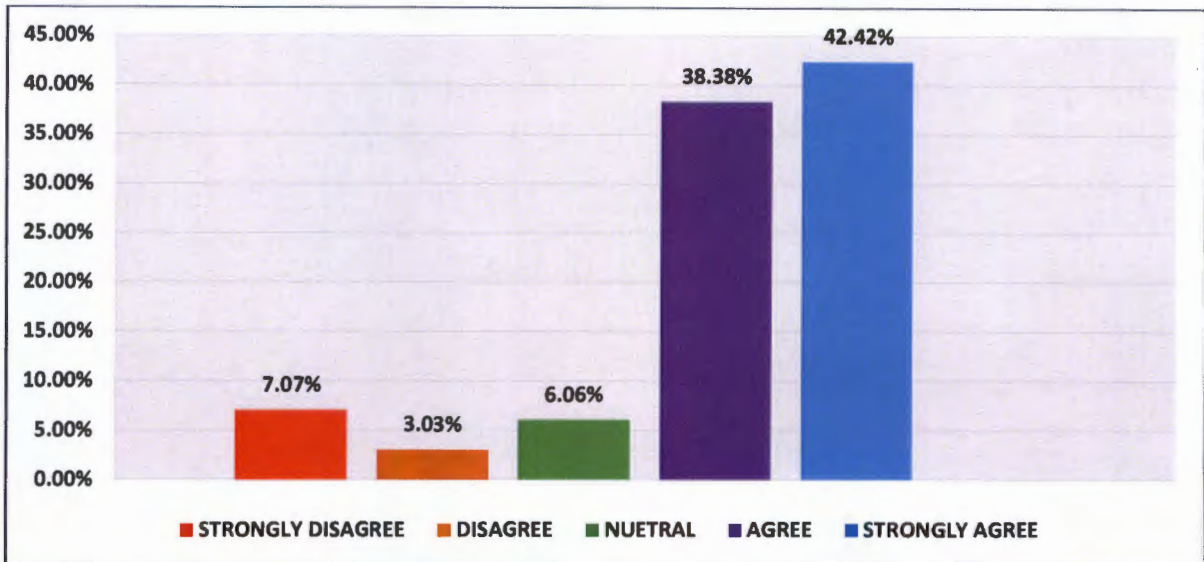


Figure 4 8: Perceptions of whether substance abuse should be coordinated by a Central Agency with sufficient resources and executive powers

#### 4.4.2.4. Reliability Analysis of Likert Scale Questions

Table 4.7: Reliability Analysis of Questions 1 – 10			
Items	Average inter-item covariance:	Number of items in the scale:	Scale-reliability coefficient: (Cronbach's Alpha)
Q1-Q5	0.5222107	5	0.7695
Q6-Q10	0.2759786	5	0.6728

The study used a 5-Likert Scale commonly used in survey research. It is often used to measure respondents' perceptions or attitudes by asking the extent to which they agree or disagree with a particular question or statement. The scale used in this study was a typical 5-

scale including: "strongly agree, agree, not sure/undecided, disagree, and strongly disagree. Most frequent response (mode) calculated for each subject, for each of the themes (coordination structures and participation) and for the 10 Likert items as a whole. These 5 variables were then assessed by categories of variables: Province, Geographical area (rural/urban/per-urban) and Municipality (metro, district and local), using Kruskal-Wallis tests. Note: in cases with multiple modes, the lower value was selected.

**Variable/ Theme: Effectiveness of coordination structures [Q1 – Q5]**

***Categories by Province***

<b>Table 4.8: Questions 1-5 by Categories of Province</b>				
Province	N	Median	25th Percentile	75th Percentile
Eastern Cape	13	2	2	4
Free State	15	5	4	5
Gauteng	7	4	3	5
Kwazulu-Natal	6	3.5	2	5
Limpopo	8	4	2.5	4
Mpumalanga	11	4	4	5
North West	22	4	4	4
Northern Cape	7	3	2	4
Western Cape	10	3.5	2	4
Total	99	4	3	5

Chi-squared = 23.758 with 8 d.f., p = 0.0025

Significant test result, thus, average “most frequent response” to questions 1 to 5 differs by categories of province.

**Categories of Geographical Areas**

<b>Table 4.9: Mode of Questions 1-5 by categories of geographical areas</b>				
Geographical area	N	Median	25th Percentile	75th Percentile
Peri-urban	12	4	4	4.5
Rural	16	5	5	5
Urban	71	4	2	4
Total	99	4	3	5

Chi-squared = 19.519 with 2 d.f., p = 0.0001 Significant test result, thus, average “most frequent response” to questions 1 to 5 differs by categories of geographical area.

**Categories of Municipalities**

<b>Table 4. 10: Questions 1-5 by categories of municipality</b>				
Municipality	N	Median	25th Percentile	75th Percentile
Local	75	4	3	5

Metro	22	3	2	4
sub-district	2	5	5	5
Total	99	4	3	5

chi-squared = 12.865 with 2 d.f., p = 0.0016

Significant test result, thus, average “most frequent response” to questions 1 to 5 differs by categories of municipality.

#### 4.5. LIMITATIONS OF THE STUDY

This research highlights policies and legislative issues related mainly to illicit drugs and alcohol. However, there are a myriad of other substances, like tobacco, over-the-counter drugs, and inhalants which also form part of substances of abuse. The other limitation is that PSAFs were not part of the study, therefore denying this structure a “voice” of their role and challenges in the substance abuse sector. Objectivity is paramount when conducting research. Babbie and Mouton (1998) emphasize that the researcher should be more familiar with the limitations of the study than anyone else and this plays a part in being objective. A research study focusing on PSAFs is therefore an identified gap for future studies.

#### ***Data Collection Instrument***

The questionnaires and interview schedules were thoroughly checked and piloted. However the way in which the qualitative instrument was administered could possibly have been improved if each interview was conducted face to face or telephonically. These methods were however out of the financial bounds constricting this study. Because a third

person was entrusted to facilitate the completion of the quantitative questionnaire by respondents, I missed out on engaging directly with respondents and observing them. I did not receive any negative feedback as to respondents understanding the questions. This notwithstanding, the chairperson or secretary of LDACs contributed tremendously to this study. There were however some chairpersons who promised to return the questionnaires but this did not happen even after numerous telephone calls, email and sms messages.

### ***Sampling***

The ideal of making use of the whole population is impossible. Therefore, the stratified sample selection process used was deemed suitable for the quantitative paradigm. However, a limitation regarding the sampling method could be the fact that the criteria set, excluded organisations that were in the process of development. The list of LDACs (received from the CDA secretariat) in the country is also questionable. At least one LDAC chosen by the Provincial Coordinator turned out to be non-operational, after being selected in the sample – by the provincial coordinator. This sample was replaced and deemed suitable because it conformed to the criteria set. The Western Cape only had one LDAC in operation at the time of the study.

### ***Self / Reflexivity***

My research experience involved mainly the qualitative paradigm. Therefore the quantitative research process was a learning curve. I attended data analysis workshops and engaged with statistics specialists at UCT to learn more about quantitative data analysis processes. Overall, the use of the two research designs did offset the weaknesses of each other to produce a robust outcome.

## 4.6. CONCLUSION

This chapter discussed the findings of the study. This includes the qualitative research design findings and the quantitative research design findings. The mixed design findings are discussed and then the limitations of the study explained. The qualitative findings included perceptions of effectiveness of coordination; effectiveness of public participation; and perceptions of improving the implementation of the NDMP. These are further summarized.

I scored the LDACs as being “not effective” according to responses from the Expert Survey and in-depth interviews. This was based on a majority consensus that LDACs do not have the necessary financial resources to operate functionally and their effect on other structures or organisations to meaningfully contribute to activities in communities are therefore constrained. These responses concurred with discussions at the 2<sup>nd</sup> Biennial Summit that described LDACs as being “insufficiently capacitated with human and financial resources” (DSD, 2011).

The two in-depth respondents paint a “picture” of the establishment and coordination of LDACs in the Western Cape Province before and after 2009. Prior to 2009, LDACS were established and coordinated by the provincial DSD in all municipalities and numbered 44 in total. After 2009, all operating LDACs ceased to exist and funding assistance was withdrawn by the DSD. Coordination of substance abuse in the province became the function of the Manager in the Premier’s Office. The Cape Town Metro established the CTADAC in 2009 in accordance with the Prevention of and Treatment for Substance Abuse Act, 2008 (No. 70 of 2008). The plan was to further establish sub-committee LDACs in the rest of the provinces’ existent health districts, which numbered eight in total at the time of the study – which was mid-2011. This changed to six health districts by the Western Cape Health Department at the end of 2011.

The Western Cape's District Health Councils Act (2010) came into effect on 24 August 2011. This provided for the establishment of six district health councils across the province to ensure the coordination of all health services with their respective municipalities. All six district health councils (Cape Town Metropolitan, West Coast, Cape Winelands, Overberg, Eden and Central Karoo) were established at the end of 2011. The function of the substance abuse manager was also deferred back to the DSD after the manager in the premier's office took the post of provincial head of DSD, in 2012/13.

Based on responses received in the in-depth interviews and the expert survey, there appears to be poor definition of roles and functions of stakeholders, including those of coordinating structures as well as government departments and non-government organisations involved in policy formulation and policy implementation. The CDA's mandate to coordinate government departments to submit reports on time and other functions, is surely not a mandate to coerce. If people are not following the coordination initiatives of the CDA it says they are not doing the coordination well. This is not a military organization, where coordination takes the form of direct orders. It is governance by consent. If the CDA is failing to get consent, coercive powers are not necessarily the best next step, particularly when government is so ungenerous in its funding support. It could make things worse. A better move is to equip the CDA with more expertise through training or seconded staff (from the various departments) with requisite skills. The ineffectiveness of coordination by the CDA seems a very serious systemic problem right the way through the PSAFs and LDACs as well. Everyone (in the expert group) agrees that coordination at all levels is not working.

Based on the lack of citizen or NGO representivity in the CTLDAC and the Western Cape Alcohol and Drug Forum, I assessed both these structures as being ineffective with regards to coordination and participation. Furthermore, the lack of involvement by the CDA in the province generally also makes them ineffective.

The Case Study of the Western Cape Province provides evidence of how policies are interpreted and changed without regard for community involvement. In fact, the involvement of citizens in LDACs before 2009 changed with a change in political power. The community-based structures, representing LDACs, were dissolved in all municipalities and replaced by a metro LDAC structure. This structure, as well as the province's substance abuse forum comprised solely of government department representatives. Citizen participation in substance abuse was thus an evident gap found by the study. Substance Abuse was steered from the office of the Premier from 2009 and then reverts to the Department of Social Development, in 2012, when the manager in the Premier's office becomes the head of department in the DSD.

Because the CDA is unable to fulfill its mandate of coordinating the implementation of the NDMP because of various reasons, including lack of resources and support, government must consider either a full-scale improvement plan to resource and capacitate the CDA with requisite staff and training, or consider the recommendation made by respondents on the Delphi Expert Survey, of an alternative central structure with more power and resources. This central structure (as an agency or within the Presidency) is required to oversee the management of substance abuse in South Africa. The majority of the National Perception Survey respondents (80 per cent

Part of the mandate of the central structure should include to coordinate government, nongovernment and the private sector to formulate and implement policies. The structure should consist of a monitoring and evaluation element that is able to design standard indicators linked to reducing the demand, supply and related harms caused by substance abuse. The structure must be able to collaborate with regional and international stakeholders to reduce drug trafficking and curb related organized crime.

The current management of substance abuse must be revised and changed to be more effective, efficient and sustainable. Presently, the Inter-Ministerial Committee (IMC) on

Substance Abuse, led by the Minister of Social Development, manages the sector, as a meta-governance structure.

The responsibility of the CDA to provide timeous reports to parliament has been unsuccessful so far. This retards the ability of parliament to do oversight of the CDA as an agency of the DSD. While the CDA depends on provinces and departments to submit their reports to the agency a structured intergovernmental relations (IGR) system is needed. This structure must be linked to current Minister and Members of the Executive Council (MINMEC) structures and the structure that includes the municipality and provinces, like South Africa Local Government Association (SALGA).

Government should consider establishing a National Health Promotion Foundation to provide research and resource support to coordinating structures and community-based programmes. A consortium of civil society organization stakeholders from research and advocacy groups, called the Health Promotion and Development Network (HPDNet) has proposed to cabinet (the IMC on Substance) to establish the Health Promotion and Development Foundation (HPSAF). This Foundation will be an independent structure financed through taxes on alcohol and tobacco and comprise of experts in the sector. It is a non-government structure that will work with government to help to provide research and information to the public and provide resources to LDACs and community-based organisations. The Foundation, as the name implies, will have focus on substance abuse as well as other health and social development issues, like teenage pregnancies and sexually transmitted diseases (STDs) which is linked to substance abuse.

The CDA should be reviewed as a suitable structure to perform its mandate to coordinate the implementation of future NDMPs. Decisions of whether this structure can effectively serve the purposes and needs of the country and to perform broader regional and international collaborations has to be questioned against the current perceptions that this organization is powerless and in need of capacity and resources. Also the direct link to

the DSD does not make the agency independent. The DSD Director is the CDA Chairperson and the Secretariat of the CDA is housed in the DSD.

Although the NDMP may in its current form be relevant, it needs to be revised to include the community's needs in a South African context. The country is dealing with major constraints for development, including high unemployment, poverty and inequality. These issues must be addressed in unison with substance abuse problems. The harms linked to substance abuse, especially alcohol and tobacco, like HIV and AIDS, TB and other non-communicable diseases (liver cirrhosis and cancer) is a major concern for the Department of Health Minister and should concern everyone (Minister Motsoaledi, 2014). Therefore a "whole of society" approach to deal with substance abuse is the best option for sustainability and optimum impact. This was concurred by all respondents in the study (both qualitative and quantitative research designs). Community involvement and financial assistance to the NGO sector is crucially needed. In addition, ongoing training for all stakeholders in the sector is required, which can be linked as possible functions of the proposed HPSAF for South Africa.

The quantitative data analysis process sought to assess the opinions and perceptions of respondents from members of LDACs across all nine provinces. The majority of respondents surveyed in the national perception survey were of the opinion that all coordinating structures, including the CDA, PSAFs and LDACs, were effective in the way they were carrying out their mandate of supporting the implementation of the NDMP 2006/2011. A total of 54 per cent (N=53) thought that the CDA was effective and 63 per cent (N=62) agreed that the PSAF in their respective province was effective. A vast majority (71 per cent, N=70) of respondent in the national survey thought that their particular LDAC was effective in what they are mandated to do, which is to support the implementation of the NDMP at the municipal level. Furthermore, most respondents (63 per cent) thought that all structures were working well together. A total of 81 per cent (N=80) of the respondents interviewed in the national perception survey agreed that the management of substance required a central structure. This concurs with the

recommendation made by the Delphi experts of a central structure within government. Besides this issue, the quantitative design actually found the opposite results to the qualitative design.

For purposes of reliability, I pilot-tested the quantitative questionnaire with colleagues at work to ensure that the questionnaire was easily understood. I attached a list of definitions of substance abuse terms to the questionnaire to make sure that respondents had the same understanding of the terms. Follow-up telephone calls, sms and emails were sent to chairpersons and secretaries to request return of completed questionnaires.

Reliability testing, using the STATA (2009 version) statistical software was done for the numeric data in the quantitative research design. The Cronbach's Alpha technique was used for this purpose. In this study, the most frequent response (mode) was calculated for each theme. The applicable variables (themes) were then assessed by categories of variables: Province, Geography (urban or rural) and Municipality using Kruskal-Wallis tests. All tests of the bivariate data showed significant test results, which meant that the instrument used measured what was actually assessed. Therefore, one has to look elsewhere for reasons why the two data sets differed. With regard to content validity, the concepts of coordination and public participation were deemed be intrinsic to good management. These concepts are used to measure the effectiveness of policy formulation and policy implementation in substance abuse in South Africa.

## **CHAPTER 5: SUMMARY, RECOMMENDATIONS & CONCLUSION**

### **5.1. INTRODUCTION**

This chapter provides a summary, makes recommendations and concludes the study.

### **5.2. SUMMARY**

The management of substance abuse in South Africa, which for the purposes of this study include policy formulation and policy implementation, is not effective. This is based on the literature review in chapter 2 and findings of the mixed methods study which combined qualitative and quantitative research designs and instruments of data collection and data analysis, in chapter 4.

This section provides a summary of the objectives of the study as set out in chapter 1. This includes a discussion on coordination and public participation in management issues; an assessment of coordination and public participation principles in implementing the NDMP 2006-2011 and the PATSA Act; as well as new best practice models that could improve South Africa's substance abuse strategy and feed into future NDMPs. Furthermore, this section will summarise the empirical research design process as well as findings of the mixed methods study. Recommendations are outlined and finally the study concludes by condensing the conclusions of previous chapters.

#### ***Summary of the Objectives of the Study***

- 1. Evaluate coordination and public participation in management - as they relate to policy formulation and policy implementation***

The management of substance abuse in South Africa is steeped in political, moral, economic and social stresses. This has resonance to substance abuse policy-making and policy implementation. There is a consistent struggle between moral, health and other social issues related to substance abuse policy-making, on the one hand, and the economic benefit of alcohol advertising and jobs created in the sector, on the other (Babor et al, 2010).

The management of substance abuse, which includes policy formulating, policy coordinating and policy implementation, requires good governance principles of coordination and public participation for effectiveness and sustainability. This is linked to the constitutional imperative of a democratic and developmental South Africa. A coordinated governance approach to formulate and implement policies ensures integration and pooling of resources of government departments with other non-government organisations and the private sector. This approach includes the “whole of society”, especially ordinary citizens and communities in processes of policy formulation and policy implementation. Studies of substance abuse policies in South Africa, by Professor Charles Parry confirm that including civil society (researchers and communities) in developing policies results in effective outcomes (Parry, 2011).

Policies on alcohol and drugs are fraught with many complexities that are inherent in historical, cultural, social and economic dimensions. Access and availability of alcohol and illicit drugs have historically been controlled and regulated by policies. The World Health Organisation (WHO) and other institutions, like the USA-based National Institute on Drug Abuse (NIDA) and the United Nations Office on Drugs and Crime (UNODC) has contributed immensely to the research done on alcohol and drug abuse, which has resonance to the international substance abuse legislative and policy framework.

Due to the complexity of substance abuse, it requires more than good governance principles to reduce the supply, demand and related harms caused by substance abuse. The cooperation of all stakeholders is required to deal with substance abuse as well as

the underlying problems: of poverty, inequality and unemployment (Loffler, 2009). This notwithstanding, good governance principles are in particular important with regard to public participation and access to information and services, which can enhance and sustain government interventions.

## **2. *Assess coordination and public participation principles in implementing the NDMP 2006-2011 and the PATSA Act (70 OF 2008)***

The PATSA Act and the NDMP 2006-2011 forms a challenging framework for policy coordination and implementation but needs to be updated with international trends and research-based practices. The NDMP and the Prevention of and Treatment for Substance Abuse Act (No.70 of 2008) (hereafter called the PATSA Act) form the legislative framework of substance abuse in South Africa, although various other policies and legislation at national and provincial levels exist which aim to reduce the demand, supply and related harms caused by substance abuse, especially drugs and alcohol. Substance abuse includes the misuse of various addictive-forming substances, like: licit (over-the-counter) drugs, illicit drugs (cannabis, cocaine, heroin and other synthetic substances), glue, tobacco and alcohol (DSD, 2007).

International protocols and instruments guide the NDMP and helps to provide evidence-based or best practice models of implementing substance abuse policies and programmes. However, the NDMP 2013-2017, like its predecessor (NDMP 2006-2011), does not provide realistic and standard solutions with regard to who provides the necessary resources for programme coordination and implementation. For example, the NDMP 2006-2011 and the PATSA Act proposes that municipalities establish Local Drug Action Committees (LDACs) and that municipalities provide resources for them to support the implementation of the NDMP. Due to the manner in which municipalities raise their own revenue, it seems that this provision can be regarded as an “unfunded mandate” (a instruction without requisite funding) from the national government sphere. This notwithstanding, community-based programmes (like prevention and after-care

programmes) involves participation from communities and invariably requires funds for travelling, operational equipment and communication costs

There is a need to review all substance abuse policies in South Africa to ensure that prevention and treatment services reach those most at risk and people who need it most - to be restored into their families and communities. South Africa lacks a coherent alcohol policy as well as a comprehensive drug policy. Linked to this, current coordinating structures (the CDA, PSAFs and LDACs) lack necessary resources to assist government departments to reduce the supply, demand and related harms caused by especially drug and alcohol abuse and addictions. Furthermore a more bottom-up approach to identify needs in households and communities should be considered. This involves including citizens and families in processes of engagement to identify community needs and challenges – as well finding solutions to problems. This has links to coordinated governance, embracing networks and ensuring efficient and effective systems to coordinate and manage integrated and cooperative governance.

Substance abuse policies require a coordinated management system. A single approach such as criminalizing or decriminalizing substances or abusers will not solve the problem. Instead, a mix of demand reduction, supply reduction and initiatives to reduce the harmful effects of drugs and alcohol abuse (harm reduction) on individuals, families and communities. All government, non-government and private sector stakeholders should be represented on a task team to monitor and evaluate programmes for purposes of ensuring that good governance principles, such as coordination, access and transparency and participation is upheld throughout policy formulation and implementation.

The overall objective of the nascent NDMP 2013-2017 is to “create a country free of substance abuse” (CDA, 2013:6). Furthermore, the NDMP 2013-2017 has a “developmental” approach to reducing substance abuse and is linked to international best practices as well as South Africa’s long term National Development Plan (NDP) 2030. Policies like the NDMP are premised to transform past policies and ensure redress and

equity – for the most vulnerable in society to access services. This is reflected in the strategy as it links substance abuse to broader socio-economic issues, like poverty, crime, HIV and AIDS, mental illness and teenage pregnancy. The involvement of communities in substance abuse, as a “bottom up” approach to combating the problem, is one of the features of the strategy also.

### ***3. Explore new best practice models that could improve South Africa’s substance abuse strategy and feed into future NDMPs***

Because the CDA is unable to fulfill its mandate of coordinating the implementation of the NDMP, because of various reasons including lack of resources and support, government must consider either a full-scale improvement plan to resource and capacitate the CDA with requisite staff and training, or consider the recommendation of an alternative central structure with more power and resources. A central structure (as an agency or within the Presidency) is required to oversee the management of substance abuse in South Africa. Part of the mandate of the central structure should include to coordinate government, non-government and the private sector to formulate and implement policies. The structure should consist of a monitoring and evaluation element that is able to design standard indicators linked to reducing the demand, supply and related harms caused by substance abuse. The structure must be able to collaborate with regional and international stakeholders to reduce drug trafficking and curb related organized crime. The qualitative empirical study highlights the weaknesses of the CDA, PSAFs and LDACs to implement their mandate – to coordinate and manage substance abuse in South Africa.

Government should consider establishing a National Health Promotion Foundation (which is separate from the proposed “central structure” to manage substance abuse in the country) to provide research and resource support to coordinating structures and community-based programmes. A consortium of civil society organization stakeholders from research and advocacy groups, called the Health Promotion and Development Network (HPDNet) has proposed to cabinet (the IMC on Substance) to establish a “Health

Promotion and Development Foundation (HPSAF)" in 2013 (Perez, 2013).

This proposed Foundation will be an independent structure financed through (1 to 2 per cent) taxes on alcohol and tobacco and comprise of experts in the sector. It is a non-government structure (civil society owned and managed) that will work with government to help to provide research and information to the public and provide resources to LDACs and community-based organisations. The Foundation, as the name implies, will have focus on substance abuse as well as other health and social development issues, like teenage pregnancies and sexually transmitted diseases (STDs) which is linked to substance abuse. International best practice models of a Health Promotion Foundation (HPF) is evident in 16 countries and states in the world. Examples include VicHealth in Australia and ThaiHealth in Thailand. These HPFs are funded by 2 per cent taxes from alcohol and tobacco and serve to provide research support to government, for evidence-based policy-making, and are involved in various initiatives, like inter alia reducing road traffic accidents (Perez, 2013; Verins, 2013). Because the fund uses state resources, oversight by Government and Parliament is factored into the governance structures, while maintaining a "whole of society" approach to representation and implementation guidelines.

Advocacy and informing people of the dangers and harms related to substance abuse are key programmes managed by the HPFs. This kind of foundation or structure is much needed in South Africa to assist the implementation of the NDMP 2013-2017 and the PATSA act as well as other health and social development initiatives to ensure a healthy society. The primary gain of such a structure is that it ensures a "whole of society" approach and therefore ensures that initiatives involves public participation and that coordination is not hampered by government hierarchy or "red tape" that normally retards development in the country. The needs of society can be identified by citizens who themselves are involved, making initiatives more effective, efficient and sustainable. This is in line with the objectives of South Africa's broad programme of action, the National

Development Plan – Vision 2030, which recommends citizen participation to achieve broad-based social cohesion and generally, a healthy lifestyle for all citizens (NPC, 2012).

Early detection and brief interventions are effective methods for the prevention of alcohol related health problems and the opportunity to provide such services across the primary health care system is within reach (Anderson *et al.*, 2009; Parry, 2009; Parry & Dewing, 2006). Screening of youth at schools and the establishment of a toll free number where people can access help (e.g. counselling and referral) is also recommended. Furthermore, enhancing the availability, accessibility and affordability of effective detoxification, long-term treatment (behavioural and pharmacological therapies) and aftercare facilities in both the private and public sector is necessary (Parry,

The high incidence of underage risky drinking is commonplace in South Africa (Reddy *et al.*, 2003; Parry *et al.*, 2004; SACENDU, 2010, HSRC, 2010, Kalideen, 2014). Therefore, it is recommended that consideration should be given to amending the Liquor Act, 59 of 2003 to increase the minimum legal purchase age from 18 to 21 years (Parry 2005; Anderson *et al.*, 2009; DSD, 2011; Kalideen, 2014). This is just one of the policies under review by the Inter-Ministerial Committee on Substance Abuse. The progress of the review has not been made public since the resolutions were agreed to by stakeholders at the 2<sup>nd</sup> Biennial Anti-Substance Abuse Summit, in Durban, in 2011.

### **Summary of the Study**

In the process of analysis, researchers must come to a place of stepping back from the data to see the bigger picture. This process of seeing the image created by puzzle pieces is termed “abstraction” (Bazeley, 2012; Miles and Huberman, 1994). After comparing and contrasting, Bazeley (2012) also highlights the need to use theory to explain what emerges in the data. Questions to ask are: do the findings support or refute a certain theory? Does a new theory emerge? The themes originally chosen in this study were preconceived (as per Miles and Huberman, 1994). These included management issues

which I reduced to policy formulation and policy implementation. My sub-themes chosen included coordination, policies, resources and programmes. However, after a literature review of substance abuse and to narrow the scope of the study, I opted to use coordination and public participation as leading themes. These I identified in the literature to represent good governance and public administration principles. I also identified coordinated governance, which represents meta-governance (or governance of governance) in a South African context. Issues such as substance abuse, child justice, early childhood development and others are being managed by a cluster approach in cabinet and government. This involves an inter-Ministerial Committee (IMC) leading policy formulation and policy implementation. This meta-governance certainly strengthens central powers but also exposes weakness and lack of coordination in lower levels of government and governance (at the provincial and municipal levels).

The current management of substance abuse must be revised and changed to be more effective, efficient and sustainable. Presently, the Inter-Ministerial Committee (IMC) on Substance Abuse, led by the Minister of Social Development, manages the sector, as a meta-governance structure. Meuleman (2008) describes meta-governance as governance inherent of overlapping hierarchy, market and network governance personality. Meta-governance exhibits a strong central structure which provides governance of governance. The IMC structure resembles meta-governance as it comprises executives from all government departments involved in substance abuse, such as social development, health, basic education, sport and recreation, transport, labour, and agriculture. All policies and legislation is under review by the IMC as per the resolutions of the 2<sup>nd</sup> Biennial Anti-substance Summit in Durban, in March 2011.

However, to date, information has not filtered to any level further than cabinet and the executive level. Government officials from departments are also not informed of progress of other departments, which means that all substance abuse policies and programmes are dealt with in a "silo" or singular approach. Parliament is also constrained to do oversight of substance abuse as a unitary issue because various departments formulate and implement policies relevant to their interest only and not in an integrated manner.

For meta-governance to be successful, it requires coordinated governance; which implies more powers to lower governance levels (provincial and municipal) with requisite human and financial resources. This approach also requires involvement of the “whole of society” in policy formulation and policy implementation. Citizens in South Africa who are not by the financial means to acquire health and other services, have basic rights enshrined by the Constitution of South Africa (1996) to receive adequate services (s27) and to be involved in policy making and policy implementation (s.152; s.194). Furthermore, citizens who are involved in policy formulating and policy implementation are best able to identify their needs and give input to how they want to receive services. This is part of good governance practices that promote bottom-up planning and policy design.

Moreover, government has responsibility to treat citizens in a dignified manner through principles of Batho Pele (DPSA, 1997). Intra-government planning (between government departments) and budgeting is needed for substance abuse to be successful. This includes provision of financial resources and training to non-government organisations (NGOs), community-based organisations (CBOs), as well civil society organisations (CSOs) to provide research and sector-specific expertise to the sector generally. Coordinated governance requires coordination to include all involved stakeholders and the “whole of society” in substance abuse as well as related issues in society (attending to poverty, unemployment and inequality, amongst others).

The role of the CDA is therefore questioned because overseeing policy formulation and policy implementation should be part of their mandate. The national director of substance abuse at DSD was elected the CDA Chairperson, in 2014. In addition, the secretariat of the CDA is also positioned in the national DSD. This structure gives impetus to the negative way other government departments and provincial structures involved in substance abuse perceive DSD and the CDA, thereby neglecting to provide timeous reports for the CDA annual reports to parliament. By the end of August 2014, the CDA's 2011/12 Annual Report, which was due 30 September 2013, was still not tabled. The report for 2012/13 will be due by the 30 September 2014. The recommendation for a new

central structure, located perhaps in the Presidency, will therefore be a most efficient and effective option to combat substance abuse in South Africa in future.

Another recommendation related to the study was for a civil society-led National Health Promotion Foundation (which is separate from the proposed “central structure” to manage substance abuse in the country) to provide research and resource support to coordinating structures and community-based programmes. A consortium of civil society organization stakeholders from research and advocacy groups, called the Health Promotion and Development Network (HPDNet) has proposed to cabinet (the IMC on Substance) to establish a “Health Promotion and Development Foundation (HPSAF)” in 2013. This proposed Foundation will be an independent structure financed through (1 to 2 per cent) taxes on alcohol and tobacco and comprise of experts in the sector. It is a non-government structure (civil society owned and managed) that will work with government to help to provide research and information to the public and provide resources to LDACs and community-based organisations. The Foundation, as the name implies, will have focus on substance abuse as well as other health and social development issues, like teenage pregnancies and sexually transmitted diseases (STDs) which is linked to substance abuse. International best practice models of a Health Promotion Foundation (HPF) is evident in 16 countries and states in the world (Perez et al., 2013).

### **5.3. RECOMMENDATIONS**

In the context of a dynamic and complex environment, management and coordination of policies need review as worldviews and trends change. The question of who manages substance abuse and how policies are managed becomes more complex within an integrated environment because more diverse stakeholders are involved. However, coordinated governance, involving a central agency or structure to oversee substance abuse policy formulation and policy implementation processes is recommended for

sustainability, efficacy and efficiency. A central structure to manage substance abuse within government is therefore recommended within a joined-up government approach.

All stakeholders from the “whole of society”, which include various government departments, non-government organisations and the private sector all have salient roles to play. Social (people-centred) relations as well as intergovernmental relations should be strengthened for such complex (wicked) problems, such as substance abuse to be successfully combated. Furthermore, parliament’s oversight role and the National Council of Provinces’ intergovernmental and public participation function must be entrenched in programmes that enhance coordination and public participation in especially rural areas.

Furthermore, a National Health & Development Promotion Foundation (NHDF) is proposed to be developed and elevated by the Minister of Social Development to support government’s objectives to implement the NDMP (2013-2017) and the PATSA Act. This independent civil society-driven organization should be funded by a 2 per cent tax on alcohol and tobacco. The NHDF can support community-based substance abuse initiatives as well as broader health and social development initiatives. The main tasks of this structure should include research, advocacy, and an ad-hoc resourcing agent for LDACs and community-based projects.

Alcohol and drug abuse policies need consistent review to conform to global and local trends and changes with regard to usage, treatment and discourse. Research and evidence-based policies ensure that countries utilize their resources effectively and efficiently. However in the case of South Africa this task is monumental due to incongruent policies and departments working in silos. For communities to become involved in community-based programmes for prevention and aftercare initiatives will require sufficient government and non-government resources. This study had great emphasis on community participation.

Respondents from the mixed methods research design all concurred with the ideal of including citizens and communities in policy formulation and policy implementation. Moreover community action could among other things include undertaking rapid assessments to identify gaps and priority areas of intervention at the community level, mobilising to prevent the selling of alcohol to and consumption by underage drinkers and making schools alcohol free, mobilising against certain forms of advertising (e.g. billboard advertising) which impacts on underage drinkers, developing and supporting alcohol-free environments, giving input to liquor authorities on trading hours for premises in particular areas as part of license applications, and even monitoring the use and associated consequences of drinking illegally brewed concoctions (Parry, 2010; Rendall-Mkosi, 2010; WHO, 2009a). The following section summarizes the study's conclusions.

#### **5.4. CONCLUSION**

The first chapter of this dissertation introduced the research problem of the institutional mechanism to manage substance abuse in South Africa. This was done by giving the rationale behind the study as well as giving background information of the research topic, research questions research assumptions and theoretical framework. Important terms were defined and ethical considerations as well as reflexivity were discussed. The objectives of the study included to: evaluate coordination and public participation in management issues as they relate to policy formulation and policy implementation; assess coordination and public participation principles in the NDMP 2006-2011[and the PATSA Act]; and explore new best practice models that could improve South Africa's substance abuse strategy and feed into future NDMPs.

The literature review, in chapter two established the basis of the study, making linkages of the literature with theories, policies and substance abuse research. Furthermore, the literature review linked the research objectives, as identified in chapter 1 of the study to the current body of substance abuse knowledge. The literature review helps to understand

substance abuse as multi-faceted and requires a multi-sectoral and integrated approach linking various stakeholders to public policy formulation and policy implementation.

International studies of substance abuse policies highlight broader issues around the actual problem of people abusing drugs and alcohol. The complexities of alcohol and drug abuse have directed focus to the underlying social and economic problems which needs simultaneous attention. This has an impact on policy formulating and policy implementation. In a broad sense, good governance is fundamentally linked to good management and policy-making, which is inherent of effective and efficient interventions and programmes aimed at improving people's lives (World Bank, 2002). These issues have resonance with substance abuse as research shows that alcohol and drugs are inter alia linked to crime and violence, has both a direct and indirect impact on health, and the cost implications on policing, social development and health care provision impose a severe burden on the country's budget (Corrigal et al, 2013; Fellingham, 2012; Haefele, 2010; HSRC, 2007; Parry, 2010).

The Joined up government (JUG) approach espoused by Mulgan (2008) seems appropriate for the South Africa context because it encourages a "whole of society" approach to deal with cross-cutting issues such as substance abuse. Moreover, JUG emphasizes that people from the various departments and sectors should combine resources and to plan budgets and implement initiatives together – rather than in silos.

This study recognizes that the cluster governance approach of cabinet and the executive has advanced a stronger central government with weakened actors (stakeholders) at the extreme lowest level (municipalities). This has inadvertently or unintentionally been the cause for weak leadership and service delivery at the municipal level. One of the ways to improve services at the lowest level generally, is to build new or enhance existing network partnerships (between government, the private sector and non-government stakeholders) with effective coordination and public participation prescripts.

In chapter three, the research design and methodology is discussed. This includes a sequential process using both qualitative and quantitative research methods to collect and analyze data for purposes of evaluating the effectiveness of the management of substance abuse in South Africa. The qualitative research design (in the first phase of the process) provides rich data of the stakeholders involved in substance abuse policy formulating and policy implementation in the Western Cape and in South Africa generally. Moreover, the relationships between stakeholders are explored in the first phase. The quantitative research design, in the second phase of the research process was included in the study for purposes of comparing and triangulating data collected in the qualitative process.

The primary evaluative questions of the study focused on the effectiveness of the coordinating structures' (CDA, PSAFs and LDACs), involvement of communities in policy formulation and policy implementation, and recommendations for future policies. Measurement indicators used to assess the effectiveness of the management of substance abuse included coordination and public participation. The triangulation of using various research designs to answer the research questions was deemed most appropriate for the objectives of the study.

The populations and samples of the qualitative design (phase 1 of the methodology) included two key informants were purposively selected for in-depth interviews because of their involvement in the provincial substance abuse structure in the Western Cape Province. The key informants of the Delphi Expert Survey were also purposively selected because of their knowledge of the sector and experience of working in the sector at various levels and in different government departments.

Samples for the quantitative research design (phase 2 of the methodology) were drawn purposively or non-randomly from LDACs across the nine provinces in South Africa. The population of LDACs as per the CDA database comprises of 225. However, only 116 LDACs were functional (meaning they had regular monthly meetings for the 12 months

prior to the study (in 2012). The population in terms of the study therefore comprised of 116 LDACs. A sample of 17 LDACs represented the sample of the population. The intention was to get a two LDACs per province (which would have amounted to a sample of 18=N LDACS or 16 per cent). However, the Western Cape Province only had one functional LDAC (because they made the previously established 44 community-based LDACs obsolete). This sample (17=N) represented a 15 per cent of the total population of functional LDACs. The 15 per cent sample was deemed as a reasonable sample of the total population of functional LDACs as according to Strydom (2011:227). The response rate from the 17 LDACs who were the selected sample representing the population of all functional LDACs in South Africa equaled 12 in total. This calculates to a response rate of 71 per cent. I received completed questionnaires from a total of 99 respondents. The next section shows the sample population (by population, geographic area and municipalities) displayed by tables and graphs.

I received written consent from the Deputy Director General (Ms Maria Mabetoa) managing the welfare services branch. This letter was attached to the correspondence to all Heads of Provincial Department of Social Development and Provincial Substance Abuse Directors for consent and assistance to select a sample for the study (two LDACs per province). Consent to participate in the study by respondents was appended to the questionnaire to committee members of LDACs. Furthermore, confidentiality was also entrenched within the questionnaire and interview schedule (verbally). Respondents were assured that the information shared with myself would not be attached to themselves and their names were not a compulsory provision in the questionnaire.

The qualitative data analysis (as phase 1 of the methodology) process followed Miles and Huberman's (1994) approach of analyzing qualitative data, which include data reduction, data display and conclusion drawing and verification. Using Nvivo (Version 2.0), a computer-assisted qualitative data analysis software package, I followed Miles and Huberman's (1994) and Bazely's (2012) approach to analyse the in-depth interviews and findings from the qualitative expert survey. Miles and Huberman (1994: 51) emphasize

the need to outline questions prior to data analysis. The main themes I used as my start-list codes or tree nodes were: Policy coordination and Policy implementation and I added a further tree node of "Relationships between stakeholders". The primary tree nodes analyzed comprised of: policy formulation, policy implementation and relationships. Good governance principals of effective coordination and participation were used as measurement instruments of the child nodes and in addition, relationships between stakeholders were measured as positive or negative. I used the 2009 version STATA software package to develop tables, graphs and pie charts to illustrate and display the data collected in chapter 4.

Chapter 4 included a discussion of the findings and graphic displays of collected data. The mixed methods research design included presentations and discussions of empirical data collected with regard to respondent's perceptions of policy formulation and policy implementation. The main sections included: perceptions of effectiveness of coordination; perceptions of the effectiveness of public participation and perceptions of how to improve future NDMPs.

I scored the LDACs as being "not effective" according to responses from the Expert Survey and in-depth interviews. This was based on a majority consensus that LDACs do not have the necessary financial resources to operate functionally and their effect on other structures or organisations to meaningfully contribute to activities in communities are therefore constrained. These responses concurred with discussions at the 2<sup>nd</sup> Biennial Summit that described LDACs as being "insufficiently capacitated with human and financial resources" (DSD, 2011).

The two in-depth respondents paint a "picture" of the establishment and coordination of LDACs in the Western Cape Province before and after 2009. Prior to 2009, LDACS were established and coordinated by the provincial DSD in all municipalities and numbered 44 in total. After 2009, all operating LDACs ceased to exist and funding assistance was

withdrawn by the DSD. Coordination of substance abuse in the province became the function of the Manager in the Premier's Office. The Cape Town Metro established the CTADAC in 2009 in accordance with the Prevention of and Treatment for Substance Abuse Act, 2008 (No. 70 of 2008). The plan was to further establish sub-committee LDACs in the rest of the provinces' existent health districts, which numbered eight in total at the time of the study – which was mid-2011. This changed to six health districts by the Western Cape Health Department at the end of 2011. The Western Cape's District Health Councils Act (2010) came into effect on 24 August 2011. This provided for the establishment of six district health councils across the province to ensure the coordination of all health services with their respective municipalities. All six district health councils (Cape Town Metropolitan, West Coast, Cape Winelands, Overberg, Eden and Central Karoo) were established at the end of 2011. The function of the substance abuse manager was also deferred back to the DSD after the manager in the premier's office took the post of provincial head of DSD, in 2012/13.

Based on responses received in the in-depth interviews and the expert survey, there appears to be poor definition of roles and functions of stakeholders, including those of coordinating structures as well as government departments and non-government organisations involved in policy formulation and policy implementation. The CDA's mandate to coordinate government departments to submit reports on time and other functions, is surely not a mandate to coerce. If people are not following the coordination initiatives of the CDA it says they are not doing the coordination well. This is not a military organization, where coordination takes the form of direct orders. It is governance by consent. If the CDA is failing to get consent, coercive powers are not necessarily the best next step, particularly when government is so ungenerous in its funding support. It could make things worse. A better move is to equip the CDA with more expertise through training or seconded staff (from the various departments) with requisite skills. The ineffectiveness of coordination by the CDA seems a very serious systemic problem right the way through the PSAFs and LDACs as well. Everyone (in the expert group) agrees that coordination at all levels is not working.

Based on the lack of citizen or NGO representivity in the CTLDAC and the Western Cape Alcohol and Drug Forum, I assessed both these structures as being ineffective with regards to coordination and participation. Furthermore, the lack of involvement by the CDA in the province generally also makes them ineffective.

The Case Study of the Western Cape Province provides evidence of how policies are interpreted and changed without regard for community involvement. In fact, the involvement of citizens in LDACs before 2009 changed with a change in political power. The community-based structures, representing LDACs, were dissolved in all municipalities and replaced by a metro LDAC structure. This structure, as well as the province's substance abuse forum comprised solely of government department representatives. Citizen participation in substance abuse was thus an evident gap found by the study. Governance and coordination of substance abuse in the Western Cape Province also changed with the advent of the Democratic Alliance (DA) taking over political power in the province. Substance Abuse was steered from the office of the Premier from 2009 and then reverts to the Department of Social Development, in 2012, when the manager in the Premier's office becomes the head of department in the DSD.

Because the CDA is unable to fulfill its mandate of coordinating the implementation of the NDMP because of various reasons, including lack of resources and support, government must consider either a full-scale upliftment plan to resource and capacitate the CDA with requisite staff and training, or consider the recommendation of an alternative central structure with more power and resources. This central structure (as an agency or within the Presidency) is required to oversee the management of substance abuse in South Africa. Part of the mandate of the central structure should include to coordinate government, non-government and the private sector to formulate and implement policies. The structure should consist of a monitoring and evaluation element that is able to design standard indicators linked to reducing the demand, supply and related harms caused by

substance abuse. The structure must be able to collaborate with regional and international stakeholders to reduce drug trafficking and curb related organized crime.

The responsibility of the CDA to provide timeous reports to parliament has been unsuccessful so far. This retards the ability of parliament to do oversight of the CDA as an agency of the DSD. While the CDA depends on provinces and departments to submit their reports to the agency a structured intergovernmental relations (IGR) system is needed. This structure must be linked to current Minister and Members of the Executive Council (MINMEC) structures and the structure that includes the municipality and provinces, like South Africa Local Government Association (SALGA).

Government should consider establishing a National Health Promotion Foundation to provide research and resource support to coordinating structures and community-based programmes. A consortium of civil society organization stakeholders from research and advocacy groups, called the Health Promotion and Development Network (HPDNet) has proposed to cabinet (the IMC on Substance) to establish the Health Promotion and Development Foundation (HPSAF). This Foundation will be an independent structure financed through taxes on alcohol and tobacco and comprise of experts in the sector. It is a non-government structure that will work with government to help to provide research and information to the public and provide resources to LDACs and community-based organisations. The Foundation, as the name implies, will have focus on substance abuse as well as other health and social development issues, like teenage pregnancies and sexually transmitted diseases (STDs) which is linked to substance abuse.

The CDA to be reviewed as a suitable structure to perform its mandate to coordinate the implementation of the NDMP. Decisions of whether this structure can effectively serve the purposes and needs of the country and to perform broader regional and international collaborations has to be questioned against the current perceptions that this organization is powerless and in need of capacity and resources.

Although the NDMP may in its current form be relevant, it needs to be revised to include the community's needs in a South African context. The country is dealing with major constraints for development, including high unemployment, poverty and inequality. These issues must be addressed in unison with substance abuse problems. The harms linked to substance abuse, especially alcohol and tobacco, like HIV and AIDS, TB and other non-communicable diseases (liver cirrhosis and cancer) is a major concern for the Department of Health Minister and should concern everyone (Minister Motsoaledi, 2014).

Therefore a "whole of society" approach to deal with substance abuse is the best option for sustainability and optimum impact. This was concurred by all respondents in the study (both qualitative and quantitative research designs). Community involvement and financial assistance to the NGO sector is crucially needed. In addition, ongoing training for all stakeholders in the sector is required, which can be linked as possible functions of the proposed HPSAF for South Africa.

However, respondents involved in the quantitative research design perceived the opposite. The majority of respondents in the National Perception Survey concurred that the CDA, PSAFs and LDACs were effective and that they worked well together. The quantitative data analysis process sought to assess the opinions and perceptions of respondents from members of LDACs across all nine provinces. The majority of respondents surveyed in the national perception survey were of the opinion that all coordinating structures, including the CDA, PSAFs and LDACs, were effective in the way they were carrying out their mandate of supporting the implementation of the NDMP 2006/2011. A total of 54 per cent (N=53) thought that the CDA was effective and 63 per cent (N=62) agreed that the PSAF in their respective province was effective. A vast majority (71 per cent, N=70) of respondent in the national survey thought that their particular LDAC was effective in what they are mandated to do, which is to support the implementation of the NDMP at the municipal level. Furthermore, most respondents (63 per cent) thought that all structures were working well together.

This is a conundrum of note. However, reliability tests prove that the responses were significant and the instrument measured what it was supposed to. This leaves me to conclude that respondents were somehow of the view that it was in their interest to be positive about the coordinating structures because they were representatives on the (LDAC and PSAFs) structures. I don't believe people will purposely want to close the door to whatever is in their interests.

Limitations of the study include exclusions from the study sample of the PSAFs. This group also has valuable information of their experiences and challenges with regard to coordination and public participation issues as it relates to policy formulation and policy implementation in their respective provinces. This research highlights policies and legislative issues related mainly to illicit drugs and alcohol. However, there are a myriad of other substances, like tobacco, over-the-counter drugs, and inhalants which also form part of substances of abuse. The other limitation is that PSAFs were not part of the study, therefore denying this structure a "voice" of their role and challenges in the substance abuse sector. A research study focusing on PSAFs is therefore an identified gap for future studies.

The questionnaires and interview schedules were thoroughly checked and piloted. However the way in which the qualitative instrument was administered could possibly have been improved if each interview was conducted face to face or telephonically. These methods were however out of the financial bounds constricting this study. Because a third person was entrusted to facilitate the completion of the quantitative questionnaire by respondents, I missed out on engaging directly with respondents and observing them. I did not receive any negative feedback as to respondents understanding the questions. This notwithstanding, the chairperson or secretary of LDACs contributed tremendously to this study. There were however some chairpersons who promised to return the questionnaires but this did not happen even after numerous telephone calls, email and sms messages.

The ideal of making use of the whole population is impossible. Therefore, the stratified sample selection process used was deemed suitable for the quantitative paradigm. However, a limitation regarding the sampling method could be the fact that the criteria set, excluded organisations that were in the process of development. The list of LDACs (received from the CDA secretariat) in the country is also questionable. At least one LDAC chosen by the Provincial Coordinator turned out to be non-operational, after being selected in the sample – by the provincial coordinator. This sample was replaced and deemed suitable because it conformed to the criteria set. The Western Cape only had one LDAC in operation at the time of the study.

My research experience involved mainly the qualitative paradigm. Therefore the quantitative research process was a learning curve. I attended data analysis workshops and engaged with statistics specialists at UCT to learn more about quantitative data analysis processes. Overall, the use of the two research designs did offset the weaknesses of each other to produce a robust outcome.

The findings of this empirical study confirms inherent challenges of the coordinating structures to implement the NDMP, as identified by the 2<sup>nd</sup> Biennial Summit held in Durban, in 2011. Furthermore, the study identifies a lack of effective coordination and public participation principles within processes of policy formulation and policy implementation. Relationships between stakeholders are negative due to a lack of communication and involvement between coordinating structures and between departments.

This study has therefore fulfilled its objectives to provide answers to the main question: is the overall management of substance abuse demand and supply reduction mechanisms in South Africa effective?

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## **LIST OF APPENDICES**

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social development

Department  
Social Development  
REPUBLIC OF SOUTH AFRICA



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Mr Sean Whiting  
5 Third Crescent  
Fish Hoek  
7795  
11 May 2012

**THE STUDY PROJECT TITLED, "AN EVALUATION OF THE EFFECTIVENESS OF THE INSTITUTIONAL MECHANISM TO PREVENT AND MANAGE SUBSTANCE ABUSE IN SOUTH AFRICA"**

The National Department of Social Development requests its stakeholders, such as Provincial Coordinators, Provincial Substance Abuse Forums, Local Drug Action Committees, Central Drug Authority and other relevant stakeholders to duly support this endeavour. Its objectives are to evaluate the effectiveness of the Institutional mechanism which aims to prevent and manage substance abuse in South Africa; and to make recommendations to improve the institutional mechanism aimed at preventing and managing substance abuse in South Africa. Standard Questionnaires will be administered.

This research will become handy, when the National Drug Master Plan 2006 – 2011 is evaluated. This is evident in the increasing number of young people requiring treatment and rehabilitation, high rates of crimes committed under the influence of drugs and alcohol, and risky sexual behaviour to name a few.

The Department is committed to your line of research. We see strong potential to build the knowledge and research base within your field while also benefiting our Department nationwide.

We hope that your research will receive favourable support and we look forward to working with you on this fundamental project.

Yours sincerely,

**DR M MABETOA**  
**DEPUTY DIRECTOR-GENERAL: DEPARTMENT OF SOCIAL DEVELOPMENT**

DATE: 18/05/2012

## **Appendix B: Letter Provincial Assistance**

5 Third Crescent  
Fish Hoek  
Cape Town  
7975  
14 June 2012

The Head of Department  
Department of Social Development  
Mpumalanga

Dear Sir / Madam

### **REQUEST FOR ASSISTANCE WITH A NATIONAL PERCEPTION SURVEY ON LDACS IN SOUTH AFRICA**

I have purposively selected two Local Drug Action Committees (LDACs) from Mpumalanga as part of my sample population for a national perception survey of LDACS in South Africa. I require your assistance with my research project titled: "An Evaluation of the Effectiveness of the Institutional Mechanism to Prevent and Manage Substance Abuse in South Africa".

#### **The assistance entails:**

- To support the research study; and
- To provide the Contact details of the Chairpersons of the following LDACs:
  1. **Dr J. S. Moroka LDAC in the Nkangala District**
  2. **Govan Mbeki LDAC in Gert Sibande District**

This study will provide input to the next National Drug Master Plan which will be finalized in this year (2012) by the Department of Social Development.

I attach a letter of support for the study from the National Department of Social Development.

Yours sincerely

Ss//

Sean Whiting

Tel: 021-4038289

Cell: 084 2291688

Email: [swhiting@parliament.gov.za](mailto:swhiting@parliament.gov.za)

## **Appendix C: Delphi Expert Survey & Interview Schedules**

### **Delphi Qualitative Research Questionnaire**

Thank you for obliging to participate in my research study of "A Review of the National Drug Master Plan (NDMP)" – as part of the requirements to read towards a Masters in Social Development, at the University of Cape Town (UCT), in 2011.

The Method of Research used to collect data in this study is the "Delphi Method", which is a process to collect perceptions held by experts in a specialized field of study, to extract opinions of a particular field or sector. Respondents in this study are purposively selected and comprise of a panel of experts (practitioners) currently or previously working in the

substance abuse field, from various sectors (government, non-government and the private sector. Respondents and their responses are known only to the Researcher, as prescribed by the Delphi Methodology.

My contact details are: 084 2291688 (mobile) and 021 – 403 8289 (wrk). My Research Supervisor at UCT is Dr Leon Hotzhausen with contact number 021- 650 3495.

**Consent to Participate:** You consent to participate in this research study:

**Please sign here:** .....**Date:** .....

**Right to Withdraw:** You have the right to withdraw from the research study at any time.

**Confidentiality:** Your identity will be known to the Researcher only.

**Acknowledgement:** Your time and effort is much appreciated and your input will be acknowledged in the final thesis.

**Respondent:**

Name :  
Organisation :  
Position :  
Email Address:

**Questions:**

Q1A. What are your perceptions (challenges and strengths) of:

: The Central Drug Authority?

: The Provincial Drug Forum (in your province or generally)?

: Local Drug Action Committees?

**Q2. Substance Abuse (Alcohol and illicit Drugs) Policy Issues:**

**Q2 A. What are policy gaps (if any) in the substance abuse sector in South Africa?**

**Q3. Resourcing Issues:**

Q3A. How should combating alcohol and drug abuse be resourced in South Africa? Q3B.

Please name some best practice models of resourcing alcohol and drug abuse programmes.

**Q4. General Question:**

Q4 A. How can South Africa best improve to combat substance abuse, as regards the substance abuse national strategy (NDMP)?

Thank you for your input.

Please return your response by email to:

[swhiting@parliament.gov.za](mailto:swhiting@parliament.gov.za); [swhiting07@gmail.com](mailto:swhiting07@gmail.com)

22 May 2011.

This is much appreciated and your input will be acknowledged in the final thesis. Ss//

Sean Allen Whiting

Cell: 084 2291688

## **Appendix Interview Schedules**

### **Interview Schedule 1 In-depth Interview Respondent:**

**Date:**

Introduction and consent to use the Dictaphone to record the interview.

Q1: What are the type of structures you have in place in terms of supply and demand reduction?

Q2: How do you perceive the Ke Mojo (national substance abuse prevention) programme to be working nationally and provincially? Q3: What is the community's involvement in substance abuse in the Western Cape? Q4: What is the status quo of registered and unregistered centres and what is the province doing about the unregistered?

### **Appendix Interview Schedule 2 In-depth Interview**

**Respondent:**

**Date:**

Introduction: permission to record interview.

Q1: As someone who has worked in the provincial drugs forum, what would your perception be of how things worked in this province [Western Cape] in that structure [PDF] and how do you perceive the current structures working. You could also relate to local municipal level - which I think you have some expertise on having done some work on reviewing it [a review of the local strategy for the City of Cape Town]. Maybe you can relate separately on how the municipal structures are working [now] in relation to how it use to work [in the past – prior to the current local government]. We can start off with provincial structures and separate the municipal structures.

Q2: What is the extent of citizen / community participation in the Western Cape Province?

## Appendix D: National Perception Survey Questionnaire

### A. PERSONAL INFORMATION

\* Optional

\*\* Compulsory

Thank you for obliging to participate in my research study of **"An Evaluation of the Effectiveness of the Institutional Mechanism to Manage Substance Abuse in South Africa"**, which forms part of the requirements to read towards a Masters by Research Degree in Social Development, at the University of Cape Town (UCT), in 2012.

The Method of Research used to collect data in this study is the Mixed Methods approach. This study gathers perceptions and opinions of Local Drug Action Committees with the following objectives:

- To evaluate the effectiveness of the institutional mechanism which aims to manage substance abuse in South Africa; and
- To make recommendations to improve the institutional mechanism aimed at preventing and managing substance abuse in South Africa.

Your LDAC has been purposively selected to participate in my research study and all members of your particular LDAC are requested to complete this Questionnaire on an individual basis. The Questionnaire can be completed and sent via fax (0865199800) or emailed to me at [swhiting@parliament.gov.za](mailto:swhiting@parliament.gov.za). Alternatively, the Questionnaire can be posted to my physical address: 5 Third Crescent, Fish Hoek, 7795. **Please ensure that you sign the consent to participate item below.**

The process will entail you completing **ALL** questions. Please familiarise yourself with the **Defining Concepts** related to substance abuse - **see list attached**.

**Consent to Participate:** You consent to participate in this research study:

Please sign here:.....Date:  
.....

**Right to Withdraw:** You have the right to withdraw from the research study at any time.

**Confidentiality:** Your identity will be known to the Researcher only.

**Acknowledgement:** Your time and effort is much appreciated and your input will be acknowledged in the final thesis.

My contact details are: 084 2291688 (mobile) and 021 – 403 8289 (wrk). My Research Supervisor at UCT is Dr Leon Hotzhausen with contact number 021- 650 3495.

Respondent Name \*

\_\_\_\_\_

Name of LDAC \*\*

\_\_\_\_\_

Area / Town \*\*

\_\_\_\_\_

Email Address \*\*

\_\_\_\_\_

Contact Tel # \*\*

**LDAC INFO:**

Is your LDAC situated in a rural or urban area?

Is your LDAC situated in a local or district municipality?

What Department co-ordinates substance abuse in your province?

What Department co-ordinates substance abuse in your Municipality?

**Questions: Please Mark Answer with an X**

Nr	Question	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
	<b>Theme 1: Structures involved in managing substance abuse.</b>					

## Appendix D: National Perception Survey Questionnaire

### A. PERSONAL INFORMATION

\* Optional

\*\* Compulsory

Thank you for obliging to participate in my research study of **"An Evaluation of the Effectiveness of the Institutional Mechanism to Manage Substance Abuse in South Africa"**, which forms part of the requirements to read towards a Masters by Research Degree in Social Development, at the University of Cape Town (UCT), in 2012.

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**Acknowledgement:** Your time and effort is much appreciated and your input will be acknowledged in the final thesis.

My contact details are: 084 2291688 (mobile) and 021 – 403 8289 (wrk). My Research Supervisor at UCT is Dr Leon Hotzhausen with contact number 021- 650 3495.

Respondent Name \*

\_\_\_\_\_

Name of LDAC \*\*

\_\_\_\_\_

Area / Town \*\*

\_\_\_\_\_

Email Address \*\*

\_\_\_\_\_

Contact Tel # \*\*

**LDAC INFO:**

Is your LDAC situated in a rural or urban area?

Is your LDAC situated in a local or district municipality?

What Department co-ordinates substance abuse in your province?

What Department co-ordinates substance abuse in your Municipality?

**Questions: Please Mark Answer with an X**

Nr	Question	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
	<b>Theme 1: Structures involved in managing substance abuse.</b>					

1	The Central Drug Authority (CDA) has effectively coordinated all stakeholders to reduce/combat substance abuse in South Africa.					
2	The Provincial Forum (PF) has effectively co-ordinated LDAC programmes to combat substance abuse in your province.					
3	Your Local Drug Action Committee has been effective in coordinating local structures to reduce/combat substance abuse in local communities.					
4	The structures (CDA, Provincial Drug Forum and LDAC) work effectively together to combat substance abuse.					
5	Substance abuse should be co-ordinated by a central agency with sufficient resources and executive powers.					
	<b>Theme 2: Policy and Legislation</b>					

6	The existing National Drug Master Plan (NDMP) 20062011 has been an effective national strategy to reduce substance abuse in South Africa.					
7	Your LDAC has been able to successfully implement policies to reduce alcohol and drug abuse in your area?					
8	There is general understanding of policies to combat alcohol and drug abuse in your LDAC.					
9	Substance abuse policies should be the same across national, provincial and local government spheres.					
10	Regulations of the new legislation (Prevention of and Treatment for Substance Abuse, 2008 – No 70 of 2008) should include practical strategies to reduce substance abuse.					

**Defining Concepts (taken from CDA Report 2008)**

**ABUSE:** The persistent or sporadic excessive drug use inconsistent with or unrelated to acceptable medical practice.

**COMMUNITY-BASED TREATMENT:** Community-based treatment refers to programmes or initiatives that arise out of the needs of a particular community (through a needs assessment) and by identifying and utilising existing infrastructure to provide for these needs.

**DEMAND REDUCTION:** A general term used to describe policies or programmes directed at reducing the consumer demand for psychoactive drugs. It is applied primarily to illicit drugs, particularly with reference to education, treatment and rehabilitation strategies, as opposed to law-enforcement strategies that aim to interdict the production and distribution of drugs.

**DRUG:** A term of varied usage. In medicine, it refers to any substance with the potential to prevent or cure disease or enhance physical or mental welfare, and in pharmacology to any chemical agent that alters the biochemical or physiological processes of tissues or organisms. In common usage, the term often refers specifically to psychoactive drugs, and often, even more specifically, to illicit drugs, of which there is non-medical use in addition to medical use.

**DRUG MASTER PLAN:** A Master Plan is a single document, adopted by Government, outlining all national concerns in drug control.

**DRUGS OR SUBSTANCE ABUSE:** Entail drug, alcohol, chemical substances, or psychoactive substances.

**EARLY INTERVENTION:** A therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. Treatment is offered or provided prior to patients presenting of their own volition and in many cases before they become aware that their substance use may cause problems. It is directed particularly at

individuals who have not developed a physical dependency or major psycho-social complications.

**HARM REDUCTION:** A harm-reduction philosophy emphasises the development of policies and programmes that focus directly on reducing the social, economic and health related harm resulting from the use of alcohol or drugs.

**PREVENTION:** Prevention is a proactive process that empowers individuals and systems to meet the challenges of life's events and transitions by creating and reinforcing conditions that promote healthy behaviour and lifestyles. It generally requires three levels of action: Primary prevention (focuses on altering the individual and the environment in such a way as to reduce the initial risk of developing substance abuse), secondary prevention (focuses on early identification of persons who are at risk of developing substance abuse and intervening in such a way as to arrest progress); and tertiary prevention (focuses on treatment of the person who has developed a drug dependency).

**SUBSTANCE ABUSE:** The term substance abuse includes the misuse and abuse of legal substances such as nicotine, alcohol, over-the counter drugs, prescribed drugs, alcohol concoctions, indigenous plants, solvents, inhalants, as well as the use of illicit drugs.

**SUPPLY REDUCTION:** A general term used to refer to policies or programmes aiming to interdict the production and distribution of drugs, particularly law-enforcement strategies for reducing the supply of illicit drugs.

**TREATMENT:** Treatment is a process aimed at promoting the quality of life of the drug dependent and his/her system (husband/wife, family members and other significant important persons in his/her life) with the help of a multi-professional team.

**I Thank you!**

## **Appendix E: Case Study of the Western Cape Province**

### ***Case Study of the Western Cape Province***

Discussions at the 2nd Biennial Summit, comprising all stakeholders involved in the substance abuse sector (The Presidency, Parliament, government departments, private sector and civil society organisations) revealed that all coordinating structures (Central Drug Authority (CDA), Provincial Substance Abuse Forums (PSAFs) and Local Drug Action Committees (LDACs)) were ineffective to provide sufficient support to stakeholders, especially communities, to implement the NDMP 2006-2011. Challenges highlighted for their inefficacy related to constraints to financial and human capacity (DSD, 2011; and researcher notes).

The objectives of the case study of the Western Cape Province included to: describe, analyse and interpret substance abuse policy formulation and policy implementation in the context of one province in South Africa. The intention was not to generalise to other provinces in the country. The aim of the case study was to analyse the processes (of policy formulation and implementation) under the guise or lens of good governance principles, including: coordination and public participation. Moreover, the case study discusses recommendations from experts to improve future strategies and policies, with regard to resolving problems of coordination and constraints of resources.

**Methodology:** The Case Study of the Western Cape was in the form of an implementation evaluation (also referred to as a process or formative evaluation) to describe how the NDMP 2006-2011 was implemented in the Western Cape Province. The qualitative design included collecting data through two in-depth interviews with Key Informants and a Delphi Perception Survey of six experts involved in the substance abuse sector. The empirical study formed part of a broader study of the effectiveness of coordinating structures (CDA, PSAFs and LDACs) with regard to implementing the NDMP 2006-2011 with focus on coordination and public participation in South Africa.

Findings: the majority of respondents from both the expert survey and in-depth interviews acknowledged that the key role of the CDA is to coordinate stakeholders and structures to implement the NDMP 2006-2011. The NDMP 2006-2011 also included a monitoring and evaluation role for the coordinating structures (DSD, 2006). All the respondents interviewed in the Delphi Expert Survey expressed notions that the CDA was without authority and not effective to carry out its mandate, to coordinate the implementation of the NDMP 2006-2011. Furthermore, responses from the majority of respondents confirmed the CDA, PSAFs and LDACs all exhibit characteristics of weak leadership; lack of capacity and resources; and lack of clear roles and commitment.

Furthermore, community involvement, especially by ordinary citizens, was exempt from Western Cape structures. The study shows that before 2009, the Department of Social Development (DSD) established LDACs in all local municipalities, comprising communitybased organisations. A total of 44 LDACs existed in 2009 until these committees were informed by the city and the province that they were redundant. What follows after 2009, is a top-down approach of the City's LDAC being represented only by government departments and inviting NGOs to present programmes – at PSAF and LDACs meetings.

The evaluation of the management of substance abuse in the Western Cape Province with regard to indicators of coordination and public participation principles thus produces a negative result. This is due to the lack of requisite capacity, resources, leadership and public participation in all coordination structures (CDA, PSAF and LDAC). It can be argued that the Western Cape Province does have provincial and municipal level plans to reduce substance abuse (the province's Blue Print and the municipality's plan). However, excluding citizens from being involved in resourced structures to support the implementation of the NDMP 2013-2017 presents challenges for the province in the long term.

Recommendations were made by respondents to locate substance abuse in a central structure or agency in the Presidency (or create a separate department or agency). The structure should have requisite leadership, expertise and adequate funding from national

treasury. This recommendation is most profound and essential in the context of South Africa's needs and future plans, as it relates to resolving coordination problems in crosscutting issues, such as substance abuse.

The current management of substance abuse must be revised and changed to be more effective, efficient and sustainable. Presently, the Inter-Ministerial Committee (IMC) on Substance Abuse, led by the Minister of Social Development, manages the sector, as a meta-governance structure.

Meuleman (2008) describes meta-governance as governance inherent of overlapping hierarchy, market and network governance personality. Meta-governance exhibits a strong central structure which provides governance of governance. The IMC structure resembles meta-governance as it comprises executives from all government departments involved in substance abuse, such as social development, health, basic education, sport and recreation, transport, labour, and agriculture. All policies and legislation is under review by the IMC as per resolutions of the 2<sup>nd</sup> Biennial Anti-substance Summit in Durban, in March 2011.

However, to date, information has not filtered to any level further than cabinet and the executive level. Government officials from departments are also not informed of progress of other departments, which means that all substance abuse policies and programmes are dealt with in a "silo" or singular approach. Parliament is also constrained to do oversight of substance abuse as a unitary issue because various departments formulate and implement policies relevant to their interest only and not in an integrated manner.

For meta-governance to be successful, it requires coordinated governance; which implies more powers to lower governance levels (provincial and municipal) with requisite human and financial resources. This approach also requires involvement of the "whole of society" in policy formulation and policy implementation. Citizens in South Africa who are not by the financial means to acquire health and other services, have basic rights enshrined by the Constitution of South Africa (1996) to receive adequate services (s27) and to be

involved in policy making and policy implementation (s.152; s.194). Furthermore, citizens who are involved in policy formulating and policy implementation are best able to identify their needs and give input to how they want to receive services. This is part of good governance practices that promote bottom-up planning and policy design.

Moreover, government has responsibility to treat citizens in a dignified manner through principles of Batho Pele (DPSA, 1997). Intra-government planning (between government departments) and budgeting is needed for substance abuse to be successful. This includes provision of financial resources and training to non-government organisations (NGOs), community-based organisations (CBOs), as well civil society organisations (CSOs) to provide research and sector-specific expertise to the sector generally. Coordinated governance requires coordination to include all involved stakeholders and the "whole of society" in substance abuse as well as related issues in society (attending to poverty, unemployment and inequality, amongst others).

The role of the CDA is therefore questioned because overseeing policy formulation and policy implementation should be part of their mandate. The national director of substance abuse at DSD was elected the CDA Chairperson, in 2013. In addition, the secretariat of the CDA is also positioned in the national DSD. This structure gives impetus to the negative way other government departments and provincial structures involved in substance abuse perceive DSD and the CDA, thereby neglecting to provide timeous reports for the CDA annual reports to parliament. By the end of August 2014, the CDA's 2011/12 Annual Report, which was due 30 September 2013, was still not tabled. The report for 2012/13 will be due by the 30 September 2014. The recommendation for a new central structure, located perhaps in the Presidency, will therefore be a most efficient, effective and sustainable option to combat substance abuse in South Africa in future.

Another recommendation related to the study was for a civil society-led National Health Promotion Foundation (which is separate from the proposed "central structure" to manage

substance abuse in the country) to provide research and resource support to coordinating structures and community-based programmes. A consortium of civil society organisation stakeholders from research and advocacy groups, called the Health Promotion and Development Network (HPDNet) has proposed to cabinet (the IMC on Substance) to establish a “Health Promotion and Development Foundation (HPSAF)” in 2013. This proposed Foundation will be an independent structure financed through (1 to 2 per cent) taxes on alcohol and tobacco and comprise of experts in the sector. It is a non-government structure (civil society owned and managed) that will work with government to help to provide research and information to the public and provide resources to LDACs and community-based organisations. The Foundation, as the name implies, will have focus on substance abuse as well as other health and social development issues, like teenage pregnancies and sexually transmitted diseases (STDs) which is linked to substance abuse. International best practice models of a Health Promotion Foundation (HPF) is evident in 16 countries and states in the world. These include VicHealth, in Australia and ThaiHealth in Thailand (Perez et al., 2013).

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**Appendix F: Survey Results - Respondent's perceptions of the Delphi Expert Survey.**

<b>Responses of Stakeholders on Effective / Ineffective Coordination</b>	
<b>The CDA</b>	
<p><b>Ineffective Coordination</b> =</p> <p><b>1. Weak Power &amp; Lack of Resources</b></p> <p><b>2. Weak Leadership</b></p>	<p>"...in its current state, the CDA conforms to international UN Narcotics provisions. However, its international and national recognition do not necessarily translate to authority, power and influence in implementation" (ES:3)</p> <p>"IMC on substance abuse is taking over their role" (ES:2)</p> <p>"Lack of strategic direction that makes a meaningful difference" (ES:2)</p> <p>"The CDA, although mandated to direct, coordinate, monitor and evaluate the development and implementation of the NDMP, does not of itself have the authority to do so" (ES:5)</p> <p>"no decision making authority" (ES:)</p> <p>[The CDA is an] "authority without teeth/powers to implement the NDMP" (ES:6)</p> <p>"it does not have a strong secretariat and leadership (ES:1)</p>

<b>3. Weak capacity resources</b>	"It has a Chair who has little experience in drug issues and is often travelling (i.e. weaknesses in leadership)" (ES:1)
	"lack of executive manager/ director to manage the implementation of NDMP" (ES:2)
	"It does not have a strong Secretariat with a proper budget (i.e. inadequate support mechanisms)" (ES:1)
	: "...my experience with the CDAs: they really didn't have the expertise to operationalise their plan and that for me was a big gap" (KI#2)
	"Functioning of the LDAC is challenging in terms of resources, secretariat and overall functioning" (ES:5)
	"The establishment of these structures [LDACs] and the maintenance thereof is challenging" (ES:3)
	"too dependent on Social Development in terms of funding, secretariat and infrastructure" (ES:2)
<b>4. Lack of clear roles and commitment</b>	"...the role and function [of LDACs] is not always clear (ES:1)
	"Not all departments involved are committed to the CDA " (ES:1)
	"...the CDA is not involved in the WC provincial policy or legislation" (KI#2 and ES:4)
	The commitment of members is questionable and they often lose interest" (ES:5).

	"they [the CDA] didn't see it [the PSAF] as a priority issue." (KI#2).
<b>The PSAFs</b>	
<b>Ineffective Coordination of PSAFs = Lack of resources and ineffective stakeholder involvement</b>	"The general sense is that the PSAFs have the same challenges as the CDA [lack of resources, weak secretariat and weak leadership]"
	"Not properly funded" (ES:1)
	"Support from host departments is unequal" (ES:1)
<b>The LDACs</b>	
<b>Ineffective LDACs = Lack of resources and clear roles</b>	"...the role and function [of LDACs] is not always clear (ES:1)
	Functioning of the LDAC is challenging in terms of resources, secretariat and overall functioning (ES:5)
	The commitment of members is questionable and they often lose interest" (ES:5).
	"Functioning of LDAC is challenging in terms of resources, secretariat and overall functioning" (ES:2)
	"The commitment of members is questionable and they often lose interest" (ES:2)
	"The relation and communication between provincial drug forums and the local drug action committees is often problematic" (ES:2)

	<p>“Who should take ownership in terms of taking the lead, convening meetings etc is another challenge”</p> <p>(ES:2)</p>
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**Perceptions of Effectiveness of Stakeholder Participation**

<b>Effectiveness of Participation</b>			
Citizen Participation in Policy Formulation and Policy Implementation	Legend: # In-depth Interviews *Expert Survey	Effective	
		Yes	No
The Role of the CDA			#
The Role of the PSAF			#
The Role of the LDAC			#

**Perceptions of LDAC Coordination: Participation Issues**

The majority of respondents perceived that coordination structures were not effective due to the following responses:

<b>Responses of Stakeholders on Ineffective Participation</b>	
<b>The CDA</b>	
Negative relations = ineffective participation	Until recently the CDA did not enjoy political support. At this stage it still does not enjoy the support of the national Department of Social Development (ES:3)

	<p>"relation between CDA and Department of Social Development is vulnerable" (ES:2)</p>
<b>PSAF</b>	
Representation (commitment and community-based involvement) = effective participation	<p>"lack of representativity i.e. not all the department serving of the CDA are represented at local level"</p> <p>(ES:3)</p>
	<p>"The NGO sector is currently not represented although communication has been directed to the NGO directors' forum to nominate a representative.</p>
	<p>The previous (PSAF) forum comprised experts in the field with strong interests and knowledge, both from the NGO sector and government department representatives and was driven by the Department of Social Development" (ES:4)</p>
	<p>"(It is a necessary structure for intersectoral collaboration) but is not sufficient and is highly dependent on departments placing high level representatives with decision-making powers in the forum" (ES:5)</p>
<b>LDACs</b>	
Community participation and involvement = effective participation	<p>"Since the change in government, the present Western Cape Substance Abuse Forum has been reformed comprising mainly of government department representation (not necessarily experts in the field of substance abuse)" (ES:4)</p>

	<p>“Committees were encouraged to continue in their function without the support of government funding to the committees and a name change was suggested to avoid any confusion” (ES:4)</p>
	<p>“Confusion exists in some communities and communities are feeling abandoned in the process” ES:4</p>

### **Appendix G: Resolutions of the 2<sup>nd</sup> Biennial Substance Abuse Summit**

The resolutions of the 2nd Biennial Anti Substance abuse Summit were based on five commissions, namely; Policy and Legislation, Supply reduction, Demand reduction, Harm reduction and role of civil society which were discussed during the 2nd Biennial Anti Substance Abuse Summit.

1. Harmonization [coordination] of all laws and policies to facilitate effective governance of alcohol, including production, sales, distribution, marketing, consumption and taxation. The regulatory framework must be national and applicable across all provinces and municipalities and should be guided by the principles and proposals agreed to by this summit and the InterMinisterial Committee on Alcohol and Substance Abuse.
2. A review of the structure and mandate of the CDA to allow for proper co-ordination by government structures and oversight by an independent body;
3. Reducing accessibility of alcohol through raising the legal age for the purchasing and public consumption of alcohol from the age of 18 to the age 21.

4. Imposing restrictions on the time and days of the week that alcohol can be legally sold. These restrictions must be uniform, that is, they must be applicable in all provinces.
5. Implementing laws and regulations that will reduce the number of liquor outlets, including shebeens, taverns and liquor stores in specific geographical areas. These laws and regulations should include stricter licensing laws and qualifying criteria and specific zoning laws and regulations that will prescribe the locations of different types of economic activity that can take place in residential areas. The zoning laws should for example, ensure that no liquor outlets are located near schools, libraries and places of worship.
6. Regulation and control of home brews and concoctions informed by research that includes traditional utilization in rural areas.
7. Raising of duties and taxes on alcohol products to deter the purchasing of alcohol. The tariffs should be implemented on a sliding scale commensurate with the alcoholic content.
8. Imposing health and safety requirements for premises where liquor will be consumed including avoiding overcrowding, providing adequate lighting, food and water, and taking into account access to public transport and toilet facilities.
9. Prescribing measures for alcohol containers such as the form of container, warning labels and the percentage alcohol content.
10. Increasing the criminal and administrative liability of individuals and institutions (bars, clubs, taverns, shebeens and restaurants) that sell liquor when they sell alcohol to underage drinkers, intoxicated patrons and patrons whom they know are to operate motor vehicles.
11. Imposing a mandatory contribution by the liquor industry to a fund that will be dedicated to work to prevent and treat alcohol abuse.
12. Intensifying campaigns that seek to inform and educate people, in particular young people, about the dangers of alcohol and drug abuse
13. Ensuring equal access to resources, especially for civil society and organizations from rural areas.
14. Setting up a cross-departmental operational unit in government that will take responsibility for the implementation of measures to stem the drug problem across its entire value chain.

The unit will inter alia analyse drug production and trafficking trends, drug use patterns, develop and enforce policies and laws that will improve investigations, arrests, prosecutions and improve the legal framework with regards to confiscation of assets acquired through the proceeds of crime.

15. Ensuring that the criminal justice system becomes an effective deterrent for offenders through harsher punishment of drug related offences, including the seizure of assets.
16. The speedy finalization and implementation of legislation pertaining to the trafficking in persons.
17. Assessment of the threat relating to the smuggling of migrants and an appropriate legislative response;
18. Consideration of Extraterritorial jurisdiction relating to South African interests for drug trafficking to allow for effective interdiction of shipments (air or sea) of drugs;
19. Allowing for the obtainment of a preservation order in terms of Prevention of Organised Crime Act to permit police officers to seize proceeds of crime temporarily.
20. A review of the International Assistance in Criminal Matters Act to define the respective roles of the South African Police Service, the National Prosecuting Authority and the Department of Justice and Constitutional Development.
21. Immediate implementation of current laws and regulations that permit the restriction of the time, location and content of advertising related to alcohol and in the medium term banning of all advertising of alcoholic products in public and private media, including electronic media. The short term intervention will include measures that will ensure that alcohol will not be marketed at times and locations where young people may be influenced and the content of the advertising should not portray alcohol as a product associated with sport, and social and economic status.
22. Banning all sponsorship by the alcohol industry for sports, recreation, arts and cultural and related events.

23. Implementation of a continuum of care and a public health approach that provides for prevention, early detection, treatment, rehabilitation and after care services.
24. Implementation of comprehensive prevention programmes including both universal and targeted approaches. All young people need life skills and this should be taught in all schools. In addition in high risk areas this should be supplemented by more targeted approaches.
25. Strengthening of after care services for children including for young people (learners).
26. Utilization of multiple approaches to prevention across different disciplines and structures targeting for example families and schools. Programmes like youth development and sport development can be used as channels.
27. Public advocacy and messaging which advocates for a substance abuse free SA.
28. Development and implementation of multi-disciplinary and multi modal protocols and practices for the integrated diagnosis, treatment and funding of co-occurring disorders for both adults and children.
29. Development of an acceptable definition and protocols for Harm Reduction in the South African context.
30. Increasing the provision of rehabilitation and after care and ensuring that all communities have access to these services.
31. Reducing the current legal alcohol limit for drivers to further discourage the consumption of alcohol of people operating motor vehicles.
32. Disallowing novice drivers (0-3 years after obtaining a driving license) from consuming any alcohol before driving. This means that the legally permitted legal alcohol limit for drivers will not be applicable to novice drivers.
33. Adopting policy to prevent and address substance abuse in the public service.
34. Setting an example to the public by ensuring that all public service functions are alcohol free. **Source: Department of Social Development, 2011. Anti-substance Abuse Programme of Action: 2011-2016**