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Final Report on the Implementation Evaluation of the National Drug Master Plan 2013 - 2017

11 May 2016

Southern Hemisphere

SUPPORTING MEANINGFUL CHANGE

This report has been independently prepared by Southern Hemisphere. The Evaluation Steering Committee comprises the Department of Social Development, Department of Planning Monitoring and Evaluation in the Presidency, the Central Drug Authority and other experts identified in the field. The Steering Committee oversaw the operation of the evaluation, commentary and approval of the reports.

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List of Acronyms

APP	Annual Performance Plan
AU	African Union
CAPS	National Curriculum and Assessment Policy Statement
CBO	Community-Based Organisation
CDA	Central Drug Authority
CND	Commission on Narcotic Drugs
CSO	Civil Society Organisation
DBE	Department of Basic Education
DCS	Department of Correctional Services
DHA	Department of Home Affairs
DHET	Department of Higher Education and Training
DIRCO	Department of International Relations and Cooperation
DMP	Drug Master Plan
DOA	Department of Agriculture, Forestry and Fisheries
DOL	Department of Labour
DOH	Department of Health
DOJCD	Department of Justice and Constitutional Development
DOSR	Department of Sport and Recreation
DOT	Department of Transport
DPME	Department of Planning, Monitoring and Evaluation
DSD	Department of Social Development
DTI	Department of Trade and Industry
EPWP	Extended Public Works Programme
EXCO	Executive Committee
FAS	Foetal Alcohol Syndrome
FASD	Foetal Alcohol Spectrum Disorders
FIC	Financial Intelligence Centre
HOD	Head of Department
IDP	Integrated Development Plan/Planning
IMC	Inter-Ministerial Committee on Combating Substance Abuse
INCB	International Narcotics Control Board
ISS	Institute for Security Studies
JCPS	Justice, Crime Prevention and Security (Cluster)
LDAC	Local Drug Action Committee
M&E	Monitoring and Evaluation

MCC	Medicine Control Council
MEC	Member of Executive Council
MRC	Medical Research Council
MTSF	Medium Term Strategic Framework
NDMP	National Drug Master Plan
NGO	Non-Government Organisation
NPA	National Prosecuting Authority
NPO	Non-Profit Organisation
NSP	Needle Syringe Programme
NYDA	National Youth Development Agency
OST	Opiate Substitution Therapy
PHA	Public Health Approach
PSAF	Provincial Substance Abuse Forum
PWID	People Who Inject Drugs
QuASAR	Quick Analysis of Substance Abuse Reports
SA	South Africa
SACENDU	South African Community Epidemiology Network on Drug Use
SANAC	South African National AIDS Council
SANCA	South African National Council on Alcohol and Drug Abuse
SAPS	South African Police Service
TADA	Teenagers against Drug Abuse
TOC	Theory of Change
TOR	Terms of Reference
UNDCP	United Nations Drug Control Programme
UNODC	United Nations Office on Drugs and Crime
UNESC	United Nations Economic and Social Council
WHO	World Health Organisation

Glossary of Terms

"Drug"/"substance"/"dependence-forming substance" and "alcohol and other drugs"	These terms are used interchangeably in this report and include illicit drugs such as alcohol, over-the-counter and prescription medication and the use of illegal and illicit

	substances[1]

[1] Department of Social Development together with Central Drug Authority (2013 – 2017), *National Drug Master Plan*. Pages 9 and 13

1 Introduction

This implementation evaluation of the National Drug Master Plan 2013-2017 (NDMP) was commissioned as part of the National Evaluation System, contracted by the Department of Performance Monitoring and Evaluation (DPME) in partnership with the Department of Social Development (DSD). The purpose of this evaluation was to understand the implementation of the NDMP and to assess the likelihood of the Plan facilitating efficient and effective service delivery across different institutions and programmes to reduce substance abuse.

Forming part of the global community, South Africa (SA) is affected by the problems associated with the abuse of alcohol and other drugs (DSD & CDA, 2013, pg. 9). As signatory to international treaties such as the 1961 UN Single Convention on Narcotic Drugs and the 1972 Protocol (DSD & CDA, 2013, pg. 73), SA is required to do what is necessary to address the negative impacts of substance abuse on individuals and society – what the NDMP refers to as the "scourge of substance abuse". Furthermore, fighting substance abuse is a key aspect of the SA government's promotion of "social cohesion and stable communities" (DSD&CDA, 2013, pg. 9).

According to the NDMP 2013-2017, the South African Revenue Service (SARS) estimated the known cost of illicit drug use in 2005 as about R10,100 million. Further, at the time of drafting the NDMP, international data suggested that the social and economic cost of the abuse of alcohol and other drugs could be estimated at approximately 6.4% of GDP (Gross Domestic Product) or about R136 380 million per year (NDMP 2013-2017, pg. 73)

Regarding consumption trends in SA, the South African Community Epidemiology Network on Drug Use (SACENDU) update of June 2015 shows that poly-substance abuse remains high, with between 17% (Northern Region – Limpopo and Mpumalanga) and 44% (Western Cape) of patients indicating usage of more than one substance of abuse (Dada et al., 2015, pg. 2). A study by Ramlagan et al (2010) on government treatment centres in SA found that the most commonly abused drug by a large margin is alcohol, followed by cannabis and crack/cocaine. Pasche and Myers (2012, p. 338), states that alcohol "remains the substance with the greatest burden of harm". Other types of substances mentioned by respondents as being used in SA are methamphetamines such as tik and Methcathinone (e.g. CAT), and heroin (also in the form of concoctions referred to as, inter alia, 'nyaope', 'sugars' or 'woonga'), although use of these differs depending on the region. The study by Ramlagan et al (2010) highlighted the young age SA children are being exposed and initiated into substance abuse. Children as young as nine were found to be sniffing glue, which though not classified as a drug is harmful and can be a passage to other drugs. Young adolescents between ages of 10 and 12 are being introduced to alcohol, while the onset age for using marijuana was found to be as early as 11 and 12. Teens as young as 14 are beginning to use multiple drugs (alcohol, tobacco and marijuana), and older teens between 16 and 17 are more likely to experiment with harder drugs (cocaine and heroin).

The SA NDMPs are based on the United Nations Office on Drugs and Crime (UNODC) recommendations. The United Nations Drug Control Programme "defines a 'drug master plan' as a single document covering all national concerns regarding drug control. It authoritatively summarises national policies and defines priorities and allocates responsibility for drug control efforts" (DSD & CDA, 2013, pg. 13), with the aim of combating substance abuse.

Two NDMPs precede the NDMP 2013-2017. These are the NDMP 1999-2004 and the NDMP 2006- 2011. The NDMP 2013-2017 states as its ultimate goal a SA "free of substance abuse" (DSD &CDA, 2013, pg. 33). The objectives of the NDMP are set out below:

- Ensure effective coordination of efforts to reduce demand, supply and harm caused by substances of abuse;
- Ensure effective and efficient services for the combating of substance abuse;
- Strengthen mechanisms for implementing cost-effective interventions to empower vulnerable groups;

- Ensure the sharing of current good practices in reducing harm including social ills related to substance abuse;
- Provide a framework for the commissioning of relevant research;
- Provide a framework for monitoring and evaluation (M&E); and
- Promote national, regional and international cooperation to reduce the supply of drugs (DSD& CDA, 2013, pg. 9-10).

To meet these objectives, the NDMP 2013-2017 proposes a balanced approach using an integrated combination of strategies, namely that of demand reduction, supply reduction and harm reduction.

The NDMP 2013-2017 also sets out outcomes which are aligned to the above objectives. They are as follows:

- Reduction of the bio-socio-economic impact of substance abuse and related illnesses on the SA population
- Ability of all people in SA to deal with problems related to substance abuse within communities
- Recreational facilities and diversion programmes that discourage vulnerable populations from becoming substance dependent
- Reduced availability of substance dependence-forming drugs and alcoholic beverages
- Development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders and for funding such diagnosis and treatment
- Harmonisation and enforcement of laws and policies to facilitate effective governance of the alcohol and drug supply chain and
- Creation of job opportunities in the field of combating substance abuse (DSD&CDA, 2013, pg. 36).

1.1 Background to the National Drug Master Plan

Since the late 1980s, the United Nations Drug Control Programme (UNDCP) has prioritised the promotion of national drug master plans. According to the Commission on Narcotic Drugs (CND), the rationale for the promotion of such plans is each country's need "to develop and implement a comprehensive set of responses, coordinated to achieve the maximum impact and relying on the active involvement of all government agencies and numerous bodies and institutions…that play a role in drug control". The plan is described by the Commission as a "tool" for the purpose of:

- Addressing the extent and nature of the drug abuse problem
- Setting out a coordinated approach to its solution; and
- Identifying consistent and comprehensive "national drug control objectives" (UNESC, 1996, pg. 3)

The NDMP 2013-2017 was formulated in response to the promotion of national drug master plans by the UNDCP. The NDMP further states that it was formulated to meet the needs of SA communities (DSD & CDA, 2013, pg. 9). The alignment of countries' approaches in this manner to the strategies of the UNODC and the World Health Organisation (WHO) have been criticised for being based on the assumption of a "global consensus on the nature of the 'drug problem'", when in fact there are varying policy approaches around the world (UNESC, 1996, pg. 14). Furthermore, it is felt that this global approach neglects to address the problems specific to a country (UNESC, 1996, pg. 24).

1.1.1 Main international and national legislation, policies, guidelines, strategies and other documents that informed the NDMP 2013-2017

The NDMP 2013-2017 was informed by both international conventions and national legislation. These are provided below.

International obligations

The South African response fulfils its international obligations as a state party to the following instruments:

- Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol, United Nations;
- Convention on Psychotic Substances of 1971 of the United Nations; and
- United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

Domestic legislation

The Central Drug Authority (CDA) was established under the 1999 amendment to the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992) (the Drug Dependency Act). This act regulated substance abuse treatment facilities and provided for programmes to combat substance abuse (DSD & CDA, 2013, pg. 73). It was repealed and replaced with the Prevention of and Treatment for Substance Abuse Act No. 70 of 2008, which now governs the CDA.

A major function of the CDA is to coordinate the stakeholders to combat substance abuse in South Africa, develop a NDMP to guide the stakeholders in the field of substance abuse and to oversee its implementation. The CDA produced the NDMP 2006-2011, which was the second drug master plan in SA (DSD & CDA, 2011, pg. 13). The CDA was preceded by the Drug Advisory Board, which produced the NDMP 1999-2004, also with reference to the Drug Dependency Act (No 20 of 1992).

The Drug Dependency Act also required that the CDA review the NDMP every five years and amend it if necessary. The changing international policy landscape to a "research-based, comprehensive, multi-sectoral, balanced and integrated approach to countering substance abuse", as well as changes in the SA local context, necessitated new initiatives as well as a review of the NDMP 2006-2011 (DSD & CDA, 2011, pg. 12-16). Hence, the NDMP 2013-2017 was developed. Its legislative base is the Prevention of and Treatment for Substance Abuse Act No. 70 of 2008 (the Substance Abuse Act). The current NDMP 2013-2017 also aligns with the international treaties to which SA is a signatory, as well as resolutions passed by the CND and the requirements of international bodies. The NDMP is also based on UNODC, African Union (AU) and the South African National AIDS Council (SANAC) documents and, of course, on the previous NDMP 2006-2011 (DSD &CDA, 2013, pg. 9, 63, 73).

For background context, outlined below are the purposes of the Substance Abuse Act and other legislation related to substance abuse in SA (it is not an exhaustive list):

- The Substance Abuse Act aims at demand and harm reduction through prevention, early intervention, treatment and reintegration programmes. It also provides for the registration and establishment of treatment centres and halfway houses, and the development of minimum norms and standards to regulate in- and out-patient treatment. It includes guidelines for the treatment of children and youth in treatment centres (DBE, 2013, pg. 15). For coordination and community participation, the Act provides for the establishment of a Provincial Substance Abuse Forum (PSAF) in each province to combat substance abuse in that province, in a manner aligned to the NDMP and to assist the CDA to carry out its provincial functions. Similarly, it provides for the establishment of Local Drug Action Committees (LDAC) in each municipality in order to combat substance abuse in that municipal area in ways that are consistent with the NDMP and to provide local representatives within PSAFs. The Act also outlines the lines of reporting between these structures (Act No. 70 of 2008).
- The Medicines and Related Substances Control Act No. 101 of 1965 (Medicines Control Act) provides for the registration of medicines and other medicinal products to ensure their safety for human and animal consumption. It also provides for the

establishment of a Medicines Control Council, the purpose of which is to control medicines and the scheduling of substances and medical devices (DSD &CDA, 2006, pg. 73).

- The Drugs and Drug Trafficking Act No. 140 of 1992 (the Drug Trafficking Act) prohibits the use, possession of and dealing in drugs and certain acts relating to the manufacture or supply of certain substances. It also provides for reporting obligations on specified information to the police and for the exercise of the powers of entry, search, seizure and detention in specified circumstances (DSD &CDA, 2006, pg. 73).
- The Liquor Act No. 59 of 2003 (the Liquor Act) aims to reduce the socio-economic and other costs of alcohol abuse by setting norms and standards in the liquor industry and for the sale and micro-manufacture of liquor; regulating the manufacture and wholesale distribution of liquor and providing for public participation in the consideration of applications for registration. It also promotes the development of a responsible and sustainable liquor industry (Liquor Act, 2003).

1.1.2 The process of developing the current NDMP (2013-2017)

Besides the legislation and other documents outlined above, the NDMP 2013-2017 was informed by research and consultations. A Rapid Participatory Assessment (RPA) consisting of a household survey and a workshop with representatives of PSAFs and the CDA were conducted. The following was assessed:

- The extent of community awareness of problems, prevention and treatment services, laws related to substances abuse and communities' responsibilities for countering substance abuse
- The nature, extent and impact of substance abuse in communities
- Community views on what government, communities and others should do to combat substance abuse (DSD & CDA, 2011, pg. 28)

This was followed by a series of provincial summits set up by the CDA to discuss the outcome of the RPA and campaign, and identify provincial problems and solutions. These summits were attended by representatives of PSAFs, LDACs, non-governmental organisations (NGOs) and other civil society organisations (CSOs). The second Biennial Anti-Substance Abuse Summit (second Biennial Summit) was thereafter held, among other purposes, to solicit input into new initiatives such as the drafting of the 2013-2017 NDMP (DSD &CDA, 2011, pg. 16-17). There were 670 attendees representing organisations that included: the Justice, Crime Prevention and Security Cluster, Parliament; provincial executives and legislatures; PSAFs; LDACs; organised labour; the House of Traditional Leaders; CSOs; NGOs; faith-based organisations; the UNODC and the WHO (DSD &CDA, 2011, pg. 7). It was reported that that resolutions developed at this summit were then used as a basis of the NDMP and its measurable outcomes. Government departments then did presentations on their activities and needs, and these were also incorporated into the final NDMP. UNODC has also been a key stakeholder involved in the development of previous NDMPs.

1.1.3 Uniqueness of the NDMP 2013-2017

The NDMP 2013-2017 is similar to previous NDMPs in that it includes a focus on prevention programmes and it outlines the role of each government department in collaboratively trying to combat substance abuse (DSD &CDA, 2006, pg. 4, 5, 13).

The current NDMP, however, takes the strategy further and includes three (instead of two) pillars, namely demand, supply and harm reduction (DSD&CDA, 2013, pg. 13). Over and above harm reduction, it has also extended the strategy by adding the following:

- Adopting a bottom-up rather than a top-down approach in that communities are consulted in furthering the combating of substance abuse
- Shifting the focus from supply reduction to primary prevention

- Incorporating M&E processes by formulating outcomes, outputs and targets to be achieved and reported on
- Using research to predict future changes in patterns of substance abuse and to apply evidence-based solutions (DSD &CDA, 2013, pg. 23).

1.1.3.1 Concluding Summary

The NDMP 2013-2017 was informed by local legislation and aligns with international treaties, resolutions and the requirements of international bodies. It is also based on UNODC, AU and SANAC documents and the previous NDMPs. The NDMP 2013-2017 was also informed by consultation with stakeholders at community, provincial and national level. The current NDMP although similar to the NDMP 2006-2011 in certain respects, takes the previous strategy further through the introduction of new points of focus, approaches and mechanisms, specifically a stronger emphasis on harm reduction and community-centred approaches.

1.2 Evaluation purpose and objectives

This implementation evaluation of the NDMP 2013-2017 was commissioned as part of the National Evaluation System, contracted by the DPME in partnership with the DSD.

The evaluation took place between August 2015 and March 2016.

The Terms of Reference (TOR) states that the purpose of this evaluation was to understand whether and how the NDMP 2013-2017 has been implemented and the likelihood of the plan facilitating efficient and effective service delivery for reducing substance abuse (across different institutions and programmes). This evaluation report assesses the relevance and appropriateness of the plan, given the rapidly changing nature and complexity of the substance abuse problem. Additionally, it identifies strengths, challenges and lessons learned from the implementation and makes recommendations to improve the quality of implementation in order to enhance the cumulative impact of the different institutions and programmes on substance abuse.

According to the National Evaluation Policy Framework (NEPF) (DPME, 2011), the main aim of an implementation evaluation is to assess whether an intervention's operational mechanisms support the achievement of the objectives or not, and to understand why. It takes place during the intervention in order to help improve the efficiency and efficacy of operational processes.

The following key evaluation questions are addressed as per the TOR for the evaluation:

- Has the NDMP 2013-2017 provided clear policy statements and direction for aligned operational planning, resource prioritisation and measurement of results across the different sectors?
    - Are the overall goals and objectives of the NDMP recognised and shared across the sector?
    - To what extent has NDMP helped clarify the mandates and roles of relevant stakeholders, and addressed duplications and contradictions in mandates?
    - Is there alignment between the NDMP and other sector plans, including provincial and local level plans?
- Are there adequate resources allocated to support the implementation of the activities in the NDMP?
- To what extent have departments/implementing agencies prioritised activities of the NDMP? What are the barriers to implementation?
- What is the likelihood of the NDMP contributing to enhanced state and agency capabilities to reduce demand, supply and harm related to dependence-forming substances and to improved access to treatment?
- Are governance arrangements (at all three levels) appropriately structured to provide leadership, coordinate NDMP activities and perform oversight?

  - Given the scale of the sector and the scope of interventions, do the DSD and CDA, have the requisite capacity for leadership, implementation, management, and oversight?
  - Have the national and provincial forums functioned to provide coordinating mechanisms for the sector at provincial levels?
  - What are the condition and quality of M&E frameworks and systems in the sector? Does M&E inform operational and management decisions?
- What lessons have been learnt thus far from the implementation of the NMDP? How can implementation be strengthened?

1.3 Methodological approach

1.3.1 Participatory approach

The evaluation team followed a participatory approach in order to build cooperation and buy-in of the participating institutions and other stakeholders involved. This approach also allowed for input into the evaluation framework and questions from those who have expertise and experience in the sector.

The NDMP Evaluation Steering Committee or representatives thereof were involved directly in the inception phase, in formulating the research questions, developing the Theory of Change (TOC), and shaping the recommendations through the validation workshop and by commenting on the draft report.

1.3.2 Systems approach

A systems approach was adopted for the evaluation, as it underpins the premise of the NDMP that enhanced CDA coordination of the role-players identified in the NDMP will help ensure that relevant state agencies and communities have the necessary systems in place to achieve the objectives of the NDMP.

The systemic elements which were evaluated included:

- Legislative framework and policies
- Human resources
- Service delivery
- Planning, monitoring and evaluation
- Communications and awareness
- Coordination and management

These system elements informed the design of the analytical framework for the evaluation, the evaluation instruments and the reporting structure.

1.3.3 Systems approach to assessing coordination

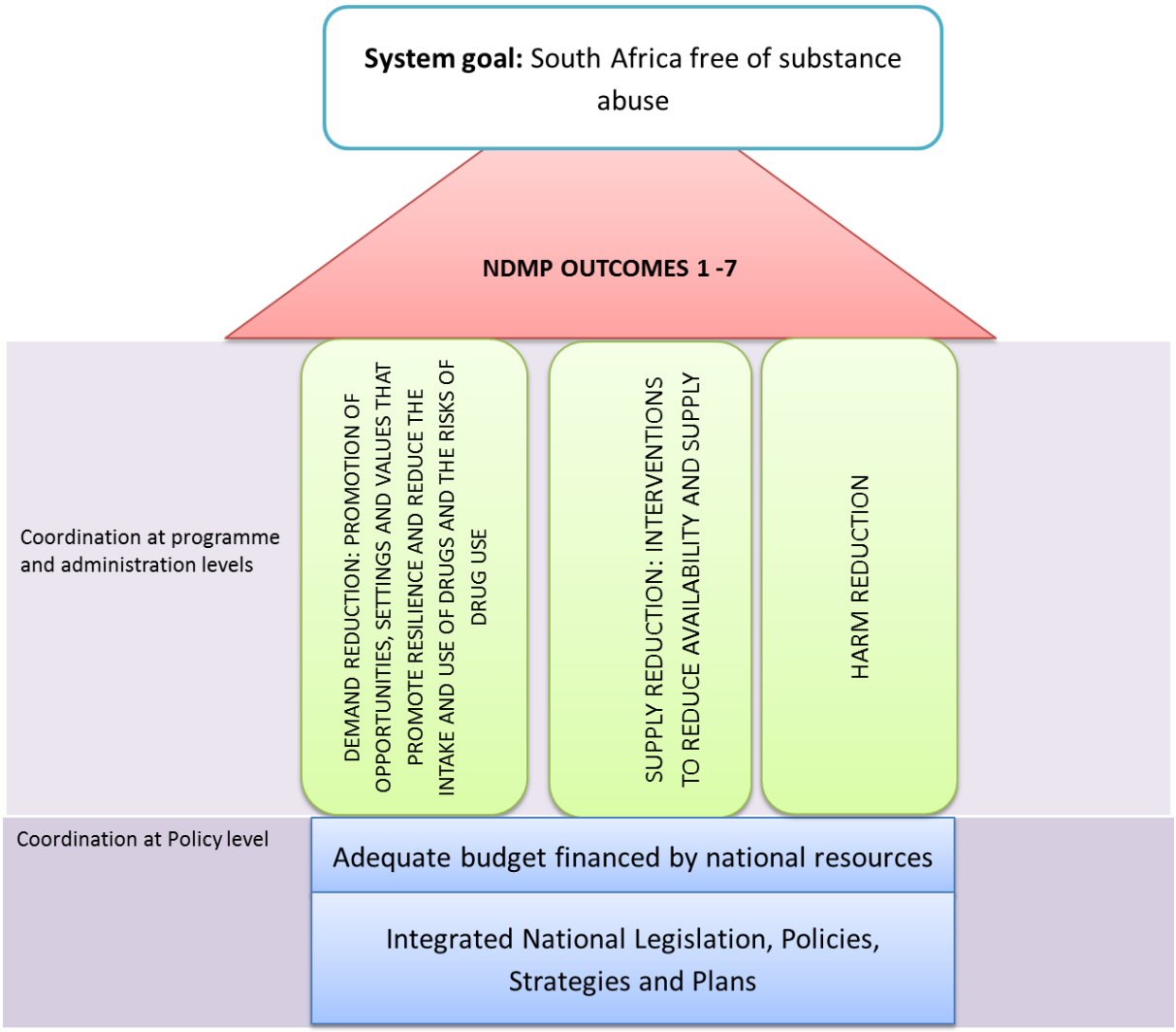
One of the objectives of this evaluation was to determine whether the governance arrangements at all three levels are appropriately structured and established to provide leadership, coordinate NDMP activities and perform oversight. To undertake this analysis, the consultancy team applied their knowledge and experience in the field of social protection coordination. It is based on the understanding that, to be truly effective, coordination of any government intervention needs to take place on the following three different levels to ensure an holistic approach to planning and implementation:

- Policy level
- Institutional or programme level
- Administration level

This framework was used to analyse the extent of coordination that has taken place to tackle the problem of substance abuse and whether the governance/institutional arrangements have been sufficient to support an integrated and holistic response to the social issue. The

concept model below shows how the different elements of the system work separately, but are interlinked and work together to achieve NDMP goal and outcomes.

Figure 1: Concept model of system elements



1.4 Evaluation method and sample

The evaluation used a mixed-methods approach combining literature review, document review, focus groups, semi-structured interviews and two workshops, including a theory of change workshop. The process for the evaluation followed the DPME guidelines for implementation evaluation.

1.4.1 Literature review and the document review

The purpose of the literature review was to define key concepts and to provide a conceptual framework for the evaluation from both national and international literature.

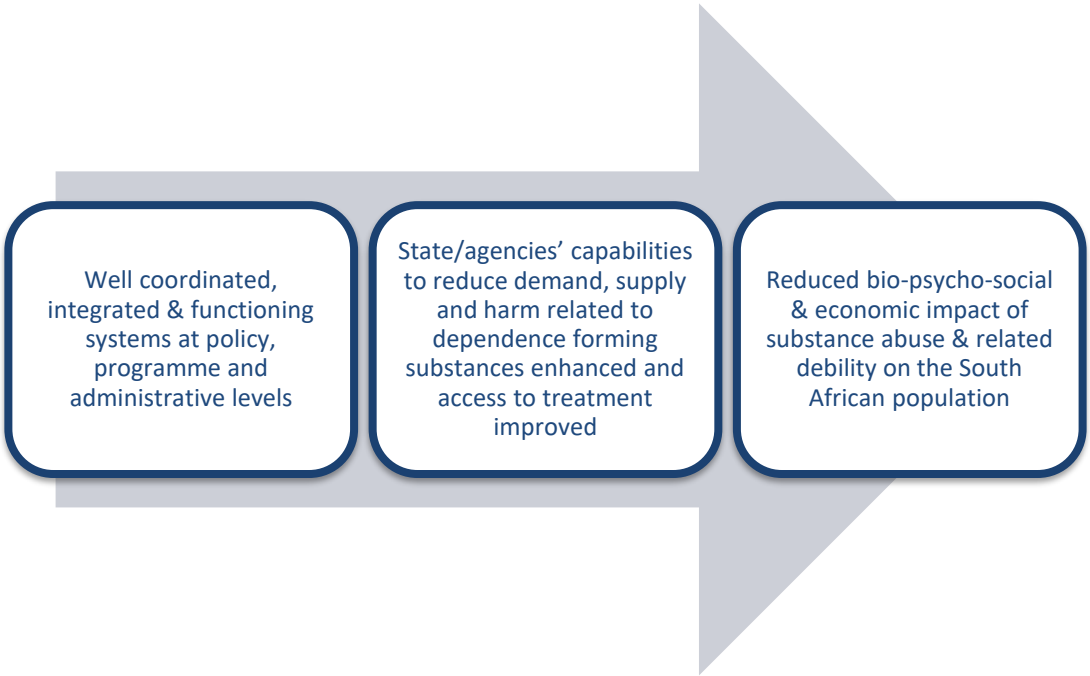
The document review allowed the evaluation team to develop an understanding of the project and its context. It also informed the TOC, helped to develop appropriate evaluation questions and instruments and informed the institutional review. The evaluation team reviewed existing programme plans and M&E records considered relevant and appropriate by the NDMP Evaluation Steering Committee. A full list of all documents reviewed is found in Annexure 1 of this report.

1.4.1.1 Logframe/Theory of Change workshop

A TOC workshop was held with key stakeholders identified by the Steering Committee on the 7th October 2015. Goals, outcomes, outputs, indicators, source of data, means of verification and assumptions for the NDMP 2013-2017 were identified. The workshop applied TOC to review and interrogate the causal chain of the intervention, its mechanisms and the assumptions in place for the intervention. The TOC was informed by the desktop review and a workshop with the Evaluation Steering Group.

The TOC focused on two main levels. The first level of change is in the system elements – with the understanding that unless these function effectively and are well coordinated it is unlikely that the changes at the second level of societal outcomes, or programme and policy level, will be achieved. At the first level the TOC addressed effective coordination of the systems related to the NDMP. At the second level, the TOC addressed the intended outcomes of the integrated strategy for demand reduction, supply reduction and harm reduction. This has been translated into the impact statement for the TOC, which has been translated into outcomes and outputs for the logframe and TOC.

Figure 2 Overview of the TOC for NDMP



In a nutshell, the TOC posits that if the system for addressing the multi-faceted nature of substance abuse is well co-ordinated, integrated and functioning at policy, programme and administrative levels, then the capability of the state and agencies to reduce the demand, supply and harm related to dependence-forming substances will be enhanced and treatment improved. As a result there will be a reduced bio-psycho-social and economic impact of substance abuse, and related debility on the SA population.

This is unpacked in a narrative and pathway of change diagram, provided in Annexure 2.

1.4.1.2 Data collection instruments

The qualitative instruments used were informed by the literature and document reviews, and the inception and TOC workshops. A total of nine semi-structured interview schedules and one focus group discussion schedule were designed. All instruments were reviewed by Southern Hemisphere experts, DPME, the Steering Committee and the peer reviewer, and piloted in the field before finalisation. The following themes were explored with stakeholders including CDA members; CDA Secretariat; LDAC and PSAFs; CSO and government treatment centres; national departments and entities and sector experts:

- Legislation, policies, strategies, plans and guidelines
- Adequate financing and budget
- Evidence-based planning and M&E
- Programmes, services and service delivery mechanisms
- Coordination at policy, programme implementation and administration at national, provincial and local level including international collaborations
- Appropriately skilled workforce
- Lessons learned and recommendations

1.4.1.3 Ethical clearance

Ethical clearance for the evaluation was granted by the Humanities Faculty Research Ethics Committee through delegation to the Sociology Department Research Ethics Committee at the University of Cape Town. A copy of this letter is contained in Annexure 4 of this report.

1.4.1.4 Fieldwork

A training session was held on the 13th of November 2015 in Cape Town where the fieldworkers were trained in the evaluation purpose, design and instruments prior to going into field.

Qualitative fieldwork took place in November 2015 across four provinces with local, provincial and national stakeholders including the CDA; national departments or entities; the Inter-Ministerial Committee on Combating Substance Abuse (IMC) technical task team; sector specialists; PSAF; LDAC; CSOs and treatment centres. The details of the qualitative sample are presented in section 2.5 below. The fieldwork was followed by data capturing and analysis.

A thematic analysis was conducted of the **qualitative data** with the assistance of Nvivo 10 software. Data were coded, collated and analysed to get an overall analysis for each evaluation question in terms of key findings, challenges, lessons learned and recommendations. Inter-coder reliability was achieved by having multiple coders, with the lead evaluators cross-checking the analysis.

1.4.2 Evaluation sample

1.4.2.1 Sample of provinces and structures

The purposive selection of provinces, PSAFs and LDACs was conducted in conjunction with the Steering Committee for the NDMP Implementation Evaluation. The provinces selected were the Western Cape, Northern Cape, KwaZulu-Natal and Gauteng. This selection included two provinces with large metropolitan areas (the Western Cape and Gauteng), the Northern Cape due to its unique demographic and specific problems with alcohol, and KwaZulu-Natal as a province with large rural areas, high degrees of poverty, high use of heroin and a port where drug trafficking takes place. The provinces were narrowed down to four due to budgetary constraints, and the final selection was decided by the Evaluation Steering Committee based on the criteria suggested by the evaluation team drawn from the literature review.

PSAFs and LDACs were selected from a list provided by the provincial DSDs and based on striking a balance of rural and urban functional LDACs. The table below provides the location of the PSAFs and the LDACs visited for fieldwork.

Table 1: Provincial substance abuse forums and local drug action committees visited

PSAF	LDAC
Gauteng	Roodeport
KwaZulu-Natal	Richard's Bay
Western Cape	Swartland

Northern Cape	Pampierstad

1.4.2.2 Sample of interviewees and focus group participants

A total of 123 semi-structured interviews and four focus group discussions were conducted. The table below captures the details of these stakeholders.

On average interviews were between one and half to two hours and focus groups were generally around two hours in duration.

Of the 123 interviews, 26 were conducted telephonically and 97 were face-to-face interviews.

Table 2: Semi-structured interviews and focus group discussions conducted at national, provincial and local level

Stakeholder group	Method	Detail	Actual
CDA members, CDA Secretariat, National departments and National entities	Semi-structured interview (SSI)	CDA Secretariat (3), including director of Substance Abuse in DSD Director level interviewees from the following stakeholder organisations: CDA members (9), National Departments (16) – DSD, DOSR, DHA, DBE, DIRCO, DOJCD, DHET, Treasury, DOL, DTI, DOH, DOT, DCS, DOA, SAPS. National entities (5) NYDA, NPA, FIC, MCC, SANAC.	33
Inter-ministerial Committee on Alcohol and Drug Abuse (Technical Task Team)	SSI	IMC Technical task team members from DOH, DSD, DOSR, DHET, DPME	5
Sector specialists	SSI	Ms Neo Morejele - SA Medical Research Council-Deputy Director-Alcohol, Tobacco & Drug Research Unit Dr Charles Parry - SA Medical Research Council, Ms Alina Bocai - UNODC Dr Simon Howell - Institute of Criminology, University of Cape Town Professor Monique Marks - Academic Leader of the Community Development Programme at the University of KwaZulu-Natal Mr Shaun Shelley - Addictions specialist affiliated with the Addictions Division: Department of Psychiatry and Mental Health, University of Cape Town Dr Nadine Harker Burnhams – SACENDU Mr Lebowa Malawa- SANAC	8
Provincial Substance Abuse Forums (PSAFs)	SSI	Planned 6 SSIs with PSAF members per province, but only managed to get 5 PSAF members in Northern Cape and KwaZulu-Natal. Respondents included a mix of the following representatives across the PSAFs: Chairperson,	22

		Deputy Chairperson, representatives from government departments and CSOs, heads of PSAF portfolio committees.	
Local Drug Action Committees (LDACs)	SSI	Planned 3 SSI with LDAC members in four provinces (1 in each province) but had an additional one in the Western Cape and one in Eldorado Park. Respondents included a mix of the following representatives across the LDACs: Chairperson, Deputy Chairperson, Secretary, municipal representatives, CSO representatives.	14
Local Drug Action Committees (LDACs)	Focus group	1 focus group discussion per LDAC: Gauteng – 18 representatives Northern Cape – 11 representatives Western Cape – 25 representatives KwaZulu-Natal – 13 representatives	4
Civil society organisations (CSOs)	SSI	Stakeholders from the following organisations were interviewed: SANCA; PASCAP Trust; Community Outreach Organisation at Kensington Civic Centre; Helderberg Cares; Cape Town Drug Counselling Centre; Westview Clinic Gauteng; Mighty Wings Life Centre Gauteng; Open Disclosure Foundation; Soul City; Pampierstad Youth Forum; FAMSA; Sinqobile Community Based Organisation; Network Action Group; Sinethemba / Hope Organisation	15
Government treatment centres	SSI	De Novo Public Treatment Centre- Kraaifontein (Western Cape) Kensington Public Treatment Centre (Western Cape) Dr Fabian and Florence Rebeiro Treatment Centre (Gauteng) Swartfontein (Mpumalanga) Madadeni Rehabilitation (KZN) Newlands Park KZN (KZN)	6
Treatment centres run by CSO and private sector	SSI	Centre managers or directors from the following CSO treatment centres: **Western Cape:** Favor SA and CARES, Hout Bay Hasketh King Salvation Army, Muldersvlei Toevlug Treatment Centre, Worcester Cape Town Drug Counselling Centre, Atlantis The Mudita Foundation Out-patient programme, Blue Downs **Eastern Cape:** Family Outreach, Graaf Reniet Sheperd's Field, Port Elizabeth	20

		Gauteng: SANCA Horizon treatment centre, Boksburg The Guardian Project Ministry, Pretoria East The Moon Recovery Centre, Roodepoort **Mpumalanga:** SANCA, Witbank Healing Wings, Ehlanzeni **Free State:** Aurora, Bloemfontein **Northern Cape:** SANCA, Posmasberg Noupoort Christian Care **KwaZulu-Natal:** SANCA, Durban Siyakhula Rehabilitation Centre, Durban **Private treatment centres included:** **North West:** Beethoven Private Centre **Western Cape:** Harmony Treatment Centre	
TOTAL			**123 SSI** **4 FGD**

1.4.3 Limitations of the study

The main challenges and limitations of the evaluation include:

- Some of the stakeholders at national level had very limited insight into functionality of local structures and departments, and departments with no Drug Master Plan (DMP) or just a draft DMP and could give very limited insight into the NDMP or the CDA.
- The 90 minutes allocated for the semi-structured interviews with informants was not sufficient time to cover all the questions listed in the interview schedule. Where interviews could not exceed the 90 minutes, follow-up telephonic interviews were arranged or other respondents from the stakeholder group answered the remaining questions which were not answered in initial interviews.
- Not all documents were provided for the desktop review despite numerous requests from the CDA and directly from stakeholders during fieldwork. For example, the evaluation team only received two of the Provincial DMPs and these are outdated. This has interfered with team's ability to triangulate the qualitative data.
- The input of the Judiciary on substance abuse matters, their take on whether the current approach is achieving the aims of the NDMP 2013 – 2017 and whether the dedicated drug courts are having the necessary impact should have been obtained. This stakeholder group was not identified in the planning or implementation of the study and only emerged in the final feedback session.

2 Findings from the literature review

An extensive literature review was conducted to inform the design of the TOC and the evaluation. The three main focus areas of the literature review were to understand the mandate and history of the NDMP in relation to substance abuse in South Africa; to identify what is meant by the key strategies in the NDMP (specifically demand reduction, harm reduction and supply reduction) and to help develop a framework for building the TOC using

a systems perspective. The main findings are summarised below, and the full literature review can be found in Annexure 7.

2.1 Trends in the abuse of alcohol and other drugs in South Africa

The first section of the literature review attempts to provide a brief snapshot of the alcohol and other drug consumption trends in South Africa. The purpose was to identify any interesting trends that should be noted by the CDA in the implementation of the NDMP going forward. The literature review revealed that the biggest challenge in identifying trends is the dearth of comprehensive, accurate and comparable information on the use and abuse of dependence-forming substances and related issues in South Africa. Even though the need for this research was identified in Chapter 8 of the NDMP, the planned household survey proposed by the CDA has not yet been conducted. Hence, much of the data provided in the NDMP 2013-2017 as baseline data has not been updated, or the data sources are not comparable. The two main data sources are the SACENDU data (a project of the Medical Research Council [MRC] analysing treatment centre admissions) and the Youth Risk Behaviour Survey that was conducted in 2008 and then again in 2013.

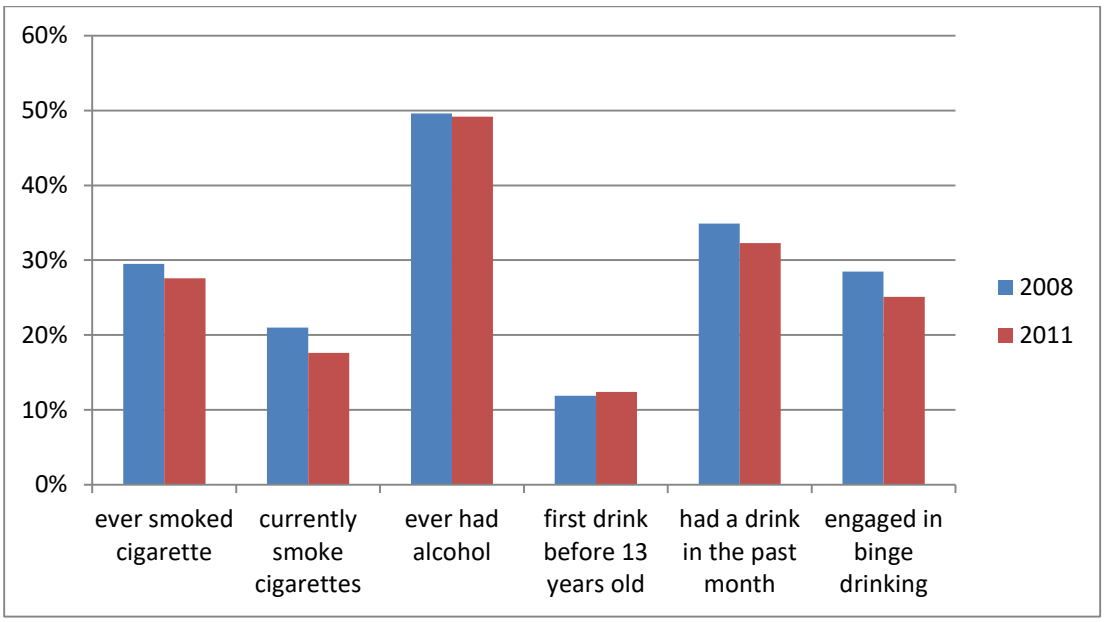
The data reveals that the nature of the problem is similar to what it was when the NDMP 2013-2017 was drawn up, but there are some increases in the use of heroin (particularly in Kwa-Zulu Natal [KZN] and Mpumalanga). Otherwise the SACENDU data shows that alcohol remains the substance mostly driving people to treatment centres. Treatment centre admission data highlights poly-drug use as an issue of concern, which is also recognised in the NDMP 2013-2017. The most recent SACENDU update (June 2015) shows that poly-substance abuse remains high, with between 17% (Northern Region[2]) and 44% (WC) of patients indicating the abuse of more than one substance.

A study by Ramlagan et al (2010) on government treatment centres found that the most commonly abused drug by a large margin is alcohol, followed by cannabis and crack/cocaine. A Health24 article from August 2015 identifies codeine as South Africa's most abused over-the-counter drug and mentions that the country is one of the top 50 codeine selling countries in the world (Health 24, 2015). Pasche and Myers (2012), state that alcohol "remains the substance with the greatest burden of harm" (Pasche and Myers, 2012, p. 338).

The Youth Risk Behaviour Survey reveals moderate decreases in key indicators as the graph below shows. The only increase was that slightly more learners were trying alcohol at an early age (under the age of 13) (Reddy et al, 2010; 2013).

[2] Northern Region consists of Mpumalanga and Limpopo provinces

Figure 3 Percentage of learners engaged in specific behaviours related to tobacco and alcohol



The literature review did reveal that there are key target groups that are not sufficiently identified in the DMP. These are prison populations and sex workers - two populations for which substance abuse is supposedly correlated, and where HIV becomes a concern. Another area where there is a gap in research is the health implications of the drug problem in South Africa; specifically when discussing the link between substance abuse and violence, and HIV infections from needles.

Approaches in the NDMP 2013-2017

One of the main mandates of the CDA is to ensure the implementation of an integrated and balanced approach to address substance abuse. The NDMP notes that it is generally accepted that no single approach will sufficiently address this multi-faceted problem. The NDMP posits an integrated strategy for demand reduction, harm reduction and supply reduction. These are underpinned by the social development approach, the public health approach and the law enforcement approach respectively. The literature review explored what these approaches entail.

Social Development

Prior to 1994, South Africa followed a criminal model towards substance abuse and drug-related crime. However, post 1994 saw the adoption of the Reconstruction and Development Programme, which paved the way for a social development response to people's needs and rights. In a South African context, social development is encapsulated in numerous principles found within the current constitution, namely equity, non-discrimination, social justice, transparency and human rights (Ministry for Welfare and Population Development, 1997 p. 16-17).

Geyer (2012, p. 53-59) conducts an analysis of the NDMP 2006-2011, in terms of the social development approach. The analysis is based on the following ten dimensions identified for social welfare in South Africa: capital development; innovation; integrated service delivery strategy; intervention by social services professionals; levels of service delivery; mandate; partnerships/welfare pluralism; principles; rights-based approach; and target groups. A checklist, consisting of the social development indicators, was used to analyse NDMP 2006-2011 content. Geyer concludes that equal focus is not placed on all dimensions; certain factors are stressed while others briefly mentioned. Levels of service delivery and integrated service delivery were the most focused-on dimensions of social development. The rights-

based approach and capital development were given the least attention in the NDMP 2006-2011. Geyer contends that the strengths of the NDMP in terms of social development are in the partnership approach and in targeting vulnerable groups. The limitation of the NDMP 2006-2011 falls under integrated service delivery. This is particularly relevant for harm reduction, where there is a failure to make provision for strategies. Furthermore, although human capital development indicators are well reflected, capital development is not. In terms of levels of service delivery, not enough attention is paid to prevention or reintegration services. Additionally, while specific mention is made of vulnerable groups, directives are not specific with regards to gay, lesbian, bisexual, transgender and intersex people. Unfortunately the updated analysis by Geyer on the NDMP 2013-2017 was due for publication at the time of the evaluation and was not made available to the evaluators. However, it is clear that the new NDMP attempted to address some of the concerns raised by Geyer, particularly in relation to strengthening integrated service delivery. The issues raised by Geyer as challenges were used to guide the analysis in the evaluation.

The Public Health Approach

The Public Health Approach (PHA) looks beyond a biomedical understanding, and instead views "health and harm as also products of the social and policy environment… contemporary public health thus characterises risk and health decision-making as a responsibility of health conscious individuals whilst also emphasising the significance of the social environment in producing harm and in shaping the capacity of individuals and communities to avoid risk" (EMCDDA, 2010:20). As an approach, it explicitly recognises that drug use is complex, variable, and interconnected with broader socio-economic conditions. It views the drug-crime phenomenon as an outflow of three related issues: agents (drugs, crime/violence), hosts (individuals who consume drugs and commit crime/violence) and environments. Importantly, it "lends itself to a comprehensive and integrated understanding of the complex field of drug-crime links, towards an explicit focus on prevention and, thus, an emphasis on monitoring the empirical relevance of prevailing thinking on the subject" (Da Rocha Silva, 2004, p.13). Emmet and Butchart (2000, p.4) argue that "Public Health … provides a preventative counterpoint to the more reactive, deterrence-oriented approach to criminal justice." A benefit of this approach is that it allows agencies concerned with countering drug-related harm (e.g. crime) to link the issue to efforts towards facilitating social development (Da Rocha Silva, 2004). Ultimately, focusing on health is seen to be effective in reducing not only illicit drug use, but the accompanying social harm (Gerra; Clark, 2009). Crime is an example of one such harm. Globally there has been an increase in research supporting the PHP and its effectiveness in "preventing the harms associated with substance use, including HIV prevention" (WHO 2002, p.15). It is important to note that this approach relies on multi-level interventions to change both "risk factors and risk behaviours" (WHO, 2002, p.15).

The Law Enforcement Approach

The law enforcement approach is losing popularity globally. The global trend is towards a public health approach, particularly in relation to drug users. However, the international drug control paradigm is still located in this approach and there are a number of countries where penalties are becoming harsher. Twelve countries are violating international law by maintaining the death penalty for drug related charges. There are also countries with compulsory "drug detention" programmes, often acting as forced labour camps. In these programmes, there is no access to any evidence-based treatment. Punitive policies such as these are associated with elevated risk behaviour and negative health outcomes for people who inject drugs (PWIDs). Furthermore, criminalising drug use and possession can undermine harm reduction efforts as well as create stigma, which prevents health-seeking behaviours (Strathdee et. al, 2014). This approach is also concerned with reducing supply of alcohol and other drugs through legislation and law enforcement. The assumption is that reduced supply will lead to reduced demand.

Human Rights Based Approach

Although not explicitly mentioned as an approach, post-apartheid South Africa is a rights-based state and the human rights approach underpins the social development approach. The human rights approach towards alcohol and substance abusers is positive, similar to the PHP and social development approach (Jurgens et. al, 2010). It emphasizes helping those who abuse alcohol and other substances rather than reducing supply or punishing them. The rights-based approach asserts that the protection of human rights is not only intrinsically important, but a necessary precondition for improving the health of those who use drugs. Rights based approaches have been effective in countries where they have been implemented (Jurgens et. al, 2010). These types of approaches include holding states accountable, developing policies and programmes consistent with human rights, and facilitating compensation for those who have had their right to health violated (Leslie, 2008). Another example is proving legal services to people who use drugs (Jurgens et. al, 2010).

In an attempt to bring the three key stakeholders on board (the law enforcement agencies, the Department of Social Development and the Department of Health), the NDMP contains all these approaches under three pillars of demand, harm and supply reduction, but argues that the three should be integrated. These three strategies are discussed in the section on the likelihood of the NDMP contributing to the state's capabilities of reducing demand, supply and harm related to substance abuse and each is described at the start of the section.

In terms of these three strategies, the literature review explored international best practice. With regard to prevention, the International Standards on Prevention Programmes designed by UNODOC were released in 2014 (UNODC, 2014). These should be used as a guide when designing and evaluating current prevention efforts. They emphasise the need for evidence-based interventions that are targeted to the lifecycle of individuals; and they describe the characteristics of an effective prevention system.

The primary conclusion from the section on harm reduction is that if it is to be truly effective, it needs to be applied uniformly across the system. Decriminalisation of drug users is key to its success. Law enforcement also requires training on harm reduction strategies in order for its implementation to be effective.

The gender dimension of the drug problem also emerges as a key factor, not only in drug use trends, but also in vulnerability assessments for criminalisation.

A public health approach and the recognition of risk and protective factors are key for prevention, harm reduction and supply reduction.

The **main recommendation** from the literature review was for the evaluation to consider whether the NDMP has a consistent policy direction, and whether the three strategies of prevention, supply reduction and harm reduction are complimentary and mutually reinforcing. If this is not the case, then it is unlikely to achieve its intended objectives.

A systems perspective with an emphasis on coordination

The literature review suggests that unless the system elements are correctly functioning the NDMP will not achieve its objectives of contributing to enhanced demand, supply and harm reduction. Hence, the evaluation assessed various system elements to see whether they have or still can be strengthened by the NDMP 2013 – 2017.

One of the main aims of the CDA and the NDMP is to strengthen the system to respond to the challenges associated with the abuse of alcohol and other drugs.

The TOC and instruments were designed to explore each of the system elements that were described above. One of the key mandates of the CDA is to coordinate the initiatives and efforts of all relevant national and provincial departments, the PSAFs and other stakeholders in their implementation of the NDMP 2013-2017. Literature on coordination challenges in government settings was reviewed with a view to identifying the barriers to effective coordination, as well as the strengths and challenges of coordination. When stakeholders share power and accountability without a strict hierarchy, Jones (2012) argues that a central stakeholder is needed. This stakeholder coordinates, convenes, and supports joint work of

the stakeholders. For the NDMP, which gives the various departments specific tasks, coordination is vital in order to integrate the different parts into one whole. The CDA is this stakeholder in the NDMP. Coordination is often hard to define, making it difficult to objectively evaluate the effectiveness of the different coordination approaches (Dietrichson, 2013). Nevertheless, there are definitions that are useful; Bouckaert et al (2010), for example, define coordination as "instruments and mechanisms that aim to enhance the voluntary or forced alignment of tasks and efforts within the public sector. These mechanisms are used in order to create a greater coherence and to reduce redundancy, lacunae and contradictions within policies, implementation or management". The Victoria State Services Authority (2007) identifies the following to be characteristics of coordination: a sharing of information and resources; defined roles; frequent communication; some shared decisions; and some altering of activities in line with the goals of the sector. In order to be effective, coordination requires appropriate institutional arrangement. It is also necessary to have a facilitating environment, which consists of three categories of mechanisms; favourable organisational culture, strong leadership and an appropriate level of resources and incentives (Mansholt Graduate School of Social Sciences, 2008).

One of the strengths of the current NDMP is the integrated nature of its approach. This level of integration, however, requires close coordination between a number of different government departments, who aside from the goals of the NDMP, have their own department-specific goals and limitations, which makes implementing the NDMP a complex process.

The literature review presents a model for analysing coordination at different levels of the state, namely policy, programme, and administrative. Policy level is the highest level of engagement, and includes overall strategic vision, legal frameworks and programme mandates. At programme level, programmes can be designed so that they can be better integrated, coordinated and linked with other programmes and sectors. The administrative level focuses on the "nuts and bolts" of the implementation of the NDMP (Chames, Davies, 2015).

It is this understanding which informed the design of the TOC and the evaluation relating to systems strengthening elements.

3 Evaluation findings

The following section reflects the evaluation findings according to the systemic elements and the Terms of Reference for the evaluation. Most of the indicators identified in the logframe (see Annexure 2) are either sub-headings or integrated in to the findings of the sections.

3.1 Whether the NDMP has provided clear statement and guidance

The TOC behind the NDMP is that the facilitation of coordinated planning should support departments to make sure that their strategies for fulfilling their obligations in relation to the NDMP find expression in their Annual Performance Plans (APPs). Further, planning aligned to the NDMP and mini DMPs should allow departments to avoid duplication and pool resources where necessary.

The following section provides an assessment of the NDMP by the evaluators followed by perspectives of staff and volunteers from the treatment centres and ends with an analysis of whether there have been any legislative changes as a result of the NDMP.

3.1.1 Assessment of the NDMP

Based on a review of the NDMP a number of weaknesses are set out below:

- Although the NDMP attempts to be a plan, it falls short as it does not unpack or explain concepts. The result is that although it does give guidance, it does not provide role players with knowledge on how and what to implement. This is also clear from reports of respondents, set out in the course of this report.

- Furthermore, the M&E plan in the NDMP is too high level and not implementable. The plan has not been followed up with an M&E framework and system. This is supported by a number of respondents, as set out in the body of this report. Also, indicators developed for the successful achievement of outcomes and activities need to be interrogated to determine whether they are practical to apply.
- The plan does not provide direction to role players regarding how to prioritise, apply and align resources so that they are more efficiently used. Respondents also echoed this gap.
- Regarding the NDMP's approaches, past NDMPs are said to have been dominated by prohibitionist and supply reduction approaches (Pienaar & Savic, 2015, pg. 4). The current NDMP instead purports to adopt an integrated and balanced approach to the substance abuse problem by combining demand, supply and harm reduction approaches. However, despite the inclusion of a harm reduction ("harm prevention") approach, it has been criticised for "leaving little place for harm reduction and its acknowledgement that …people continue to drink and take drugs and therefore public health interventions are more effectively directed at minimising (alcohol and other drug) related harm, rather than reducing or preventing use…" (Pienaar & Savic, 2015, pg. 23). This can be seen, for example, in the plan's lumping together of "use" and "abuse" when there is in fact a distinction between the two and an acceptance by the UNODC that many substances are not inherently harmful. Thus the plan is still said by some to still be prohibitionist (Pienaar & Savic, 2015, pg. 19).
- On reading the NDMP, it appears contradictory in that, although its ultimate goal is "a South Africa free of substance abuse" (DSD &CDA, 2013, pg. 33), this is not aligned to the objectives in the NDMP which include the reduction of the demand, supply and harm caused by substances of abuse (DAD &CDA, 2013, pg. 10). It is also not aligned to the functions of the PSAF, which aims to address the problem of substance abuse at provincial level, and that of the LDAC, which aims to combat substance abuse in municipalities (DSD & CDA, 2013, pg. 60). The NDMP's aim is to guide the plans of government departments, PSAFs and LDAC's. Given that the ultimate goal of the NDMP contradicts its objectives and desired impact, it is expected that its potential to foster aligned operational planning is limited in this respect. Furthermore, the NDMP 2013-2017 refers to the goal of the NDMP 2006-2011 which was to "strive towards a drug-free society", and suggests that the CDA is required to fulfil this mission. The result is a confusing message about the policy direction of the NDMP. The demand reduction interventions in the NDMP are informed by the social development approach to problem solving. The NDMP suggests that demand reduction interventions should include one or more of the five accepted methods of this approach. These are: poverty reduction (reducing poverty in identified families and communities); development (developing the competency of individuals, families and communities to deal with drug-related social problems); education and communication (broadening the knowledge base of individuals, families and communities faced with drug-related problems as a prerequisite for empowering them to deal with these problems); social policy application (developing and applying social policy to address the needs of the community in combating drug use and abuse); and advocacy (using the experiences of families and communities to advocate for systematic changes to policies relevant to the drug problems (DSD & CDA, 2013, pg. 29). However, although the NDMP does unpack the other accepted methods, it does not unpack poverty reduction and is vague in this regard.
- The NDMP is not evidence-based (Pienaar & Savic, 2015, pg. 11). The result is that it is criticised for assuming a number of causal links, for which there is no evidence. For example, it assumes that all kinds of dependence-forming substances contribute to the substance abuse problem, whereas this is not necessarily the case (Pienaar & Savic, 2015, pg. 12). It is suggested that a drug prevention system should be based on scientific evidence and support research efforts to contribute to the evidence base. Two dimensions are relevant; one which is choosing interventions and policies on the basis of an accurate understanding of what the situation is; and secondly to

understand the effectiveness and cost effectiveness of delivered interventions and policies. These will have to be strictly evaluated and the results of that evaluation will allow decision-makers to know the impact on outcomes, such as decreasing initiation of drug use and to inform and expanding the base of knowledge related to prevention interventions (UNODC, 2014). The NDMP 2013-2017 reveals that extensive research is required to fill the current gaps in drug-related information in SA. Examples of areas in need of study include the dynamics of drug use among different groups, the costs of substance abuse and the impact of current government policies. It is also necessary to evaluate the effectiveness of community-based interventions and other existing drug abuse services as well as recommendations for policy change, which in turn will impact on planning (DSD & CDA, 2013, pg. 62-63).

- Whilst substance abuse is a problem that affects large numbers of people in society, there are specific target groups that are potentially more vulnerable than others and who may require targeted interventions. The NDMP 2013-2017 makes no mention of substance abuse as it relates to sex workers or prostitution. This seems to be a serious oversight; Parry et al found that there is a very strong correlation between sex work and substance abuse, as sex work is often a way to support a drug addiction and drugs are a way to cope with sex work (Parry et al, 2009). While the Department of Correctional Services (DCS) is identified as a role-player in the CDA, the CDA does not specifically provide any information on the use of drugs in prisons. Muntingh clearly identifies drugs in prison as one of the factors contributing to prison violence. There is, however, very little literature available on the use of drugs in South African prisons (Muntingh 2009).
- Where a convicted person is referred to a treatment centre, the Substance Abuse Act states that they are discharged from the facility from which they were transferred, for example a prison. They can use this to manipulate the system. Similarly, a child referred to a treatment centre from a child and youth care centre does not have to return to the centre after treatment (Act 70, 2008). This needs to be addressed.
- There is conflict between certain laws and the NDMP; between different laws; and between laws and their implementation in practice. They are as follows:
    - Conflict between laws and the NDMP: For example, laws provide that people be arrested and convicted for possession of drug paraphernalia, but this is contrary to harm reduction policies in the NDMP. One expert went so far as to say that the NDMP encompasses harm reduction, and laws should not criminalise drug use. There is also conflict between the NDMP and the Drug Trafficking Act as users and people in possession of drugs are criminalised in the Drug Trafficking Act, while the NDMP advocates for a harm reduction approach.
    - Conflict between laws: Municipalities change by-laws to minimise the alcohol abuse problem. Where you change liquor by-laws, it must be harmonised with changes in other legislation (such as that concerning distribution, consumption and advertising) to have any significant effect. However, the Department of Trade and Industry (DTI) and the Department of Sport and Recreation (DOSR) have not changed such legislation.
- Some respondents highlighted that the policies do not focus sufficiently on the social context underpinning the problem, such as poverty and unemployment.
- The NDMP does not include the threat of spreading HIV through intravenous drug use.
- The NDMP does not provide guidance on the appropriateness of police raids for alcohol and drugs in schools.

It is evident from the above that the NDMP has a number of weaknesses. If they are not addressed they will present an obstacle to the reduction of the substance abuse problem in SA. This was partly supported by staff and volunteers from the treatment centres. Three respondents said that the current plan is sufficient and provides a good basis for reducing substance abuse in SA. Its progressive nature was pointed out and a number of respondents

commended its bottom-up approach of eliciting input from communities. When respondents involved in service delivery were asked whether they were aware of the NDMP, most said that they were aware of it, but they could not confirm that it had contributed to their interventions. This is a poor indication of the NDMP's influence on the sector of service delivery. Those that said that they believed the NDMP had contributed to improvements in the sector (9 out of 35), identified the main contribution of the NDMP as:

- Improving clarity on the role of departments in relation to service delivery;
- Improving regulation and norms and standards in the sector; and
- Contributing towards the prioritisation of strategies to address substance abuse.

Table 3: Knowledge about NDMP and contribution to improved service delivery

Centre	Know about NDMP	Agrees it has contributed to supply, demand and harm reduction	Total Number of centres interviewed
Private	6	2	7
CSO	20	6	22
Government	5	1	6
TOTAL	31	9	35

3.1.2 Legislative and policy alteration as a result of the NDMP 2013-17

A number of new policies and legislative amendments are being developed, and there have also been some legislative changes since 2013. Set out below are the legislative and policy changes that have been finalised, followed by those still in progress. However, it is not clear whether they are all directly as a result of the NDMP or would have been amended or developed anyway, aligned to the NDMP:

- Amendments have been made to schedules 1 and 2 of the Drug Trafficking Act in order to criminalise the possession and use of nyaope (DOJCD, no date). As explained by one respondent, this was necessary as every batch of nyaope is different and therefore it was a challenge to classify it as such. Now any drug used as a concoction to make nyaope is illegal.
- Changes to the Medicines Control Act have been made so that prescriptions for a drug are only valid for six months. If necessary, new prescriptions must be re-issued after six months have lapsed. However, as a result of people moving to different doctors, the Pharmaceutical Society of South Africa is setting up an information technology system to track prescriptions to patients.
- New substance abuse treatment guidelines, called the "Treatment Model for Substance Abuse" DSD. Its aim was to improve the quality of service delivery at treatment centres. Furthermore, the norms and standards for in-treatment centres, previously part of the now repealed Drug Dependency Act, have now been incorporated as part of the Substance Abuse Act.
- In terms of the Liquor Act, the Minister of Trade and Industry has published norms and standards for the liquor industry. The purposes of these norms and standards are the harmonisation between the regulations of the different provinces and national legislation in terms of the Liquor Act; consistent enforcement and application of the liquor laws; and reduced access and availability of liquor (DTI, 2015, pg. 3). In order to align with the norms and standards, the provinces are currently amending their regulations.

- The Employee Health and Wellness Strategic Framework for the Public Service aims to facilitate the implementation of health and wellness of employees in the public service (DPSA, no date, pg. 7). Included as one of the main four strategic objectives for Wellness Management is the development and implementation of "effective workplace prevention programmes and policies for violence, substance abuse" (DPSA, no date, pg. 55). This is the only mention of substance abuse in the strategy and it is not clear whether this inclusion came about as a result of any of the NDMPs. However, it is important to mention it as the activities of a number of government departments in respect to combating substance abuse are focused on internal staff. Although published before 2013, the framework does in any event further the statement within the NDMP 2013-2017 that "government and the private sector must be encouraged…to start implementing comprehensive, ethical and affective workplace substance abuse management programmes as soon as possible" (DSD& CDA, 2006, pg. 61).

Generally, there have been no alterations of regulations at provincial and municipal level. However, interviews reported one change which has been effected, and which is unlikely to be the only change made. The fact that the evaluation was based on a small sample means that it would not pick up changes in all provinces and municipalities. A municipality in KZN has reviewed and addressed its by-laws around nuisance to the public due to the issue of people drinking in public.

There are a number of legislative and policy changes still in progress. The proposed changes at national level are listed below:

- The Substance Abuse Act is in the process of being reviewed by DSD, in consultation with the CDA as they recognise that there are some issues that need to be addressed. Issues being reviewed include[3]:
    - The requirement that municipalities must establish an LDAC and members must be appointed by the mayor, both of which are not being implemented by a number of municipalities;
    - The fact that many stakeholders are not reporting and the Act is not compelling them to;
    - The requirement that treatment centres registered according to the Drug Dependency Act do not have to be re-registered under the Substance Abuse Act.
- A substance abuse policy of the social development sector is currently being developed. Its purpose is to direct and influence the amendments that will address the gaps in the Substance Abuse Act. The contents of the amendments are still being crystallised and thus it is too early to report on this. However, respondents reported that it does not take gender, but does take vulnerable groups, into account.
- The CDA has been instrumental in developing the Control of Marketing of Alcoholic Beverages Bill, which aims to restrict the advertisement of alcoholic beverages and prohibit sponsorship and promotion associated with alcoholic beverages. Due to

[3] As the legislative review is in its early days it was not possible for the evaluation team to obtain a draft bill.

dissent on the Bill, its the economic and social impact is being assessed before it is issued for public comment (Thompson and Pienaar, 2014).

- In response to the Second Biennial Anti-Substance Abuse Summit, the DTI issued a Liquor Policy for public comment, which closed in October/November 2015. The document sets out policy proposals intended to amend the Liquor Act to address the harm related to alcohol abuse, such as placing onus on alcohol manufacturers, suppliers and traders for the harm related to alcohol abuse and increased regulation of where and when alcohol can be sold (for example stipulating that a liquor vendor may not be within 500 metres of a school; increasing the minimum drinking age from 18 to 21) (DTI, 2015, pg. 4-7).
- As a result of the NDMP, the Department of Health (DOH) is currently presiding over changes in regulations for warning labels on alcohol containers to improve their visibility.
- Over the past three financial years, the Department of Agriculture (DOA) has twice reviewed their regulations on the control of liquor products under the Liquor Products Act No. 60 of 1989.
- The National Road Traffic (Amendment) Bill of 2015, which aims to amend aspects of the National Road Traffic Act No. 93 of 1996, including the reduction of the blood alcohol concentration limit in drivers, was published for public comment last year. Currently, comments are being incorporated into the Bill, after which it will proceed to Cabinet for approval.
- The Medical Innovation Bill of 2014, which is currently in parliament, aims to legalise the commercial, industrial, and medical applications of marijuana. However, it is being opposed in parliament with some parties calling for only the medical applications of marijuana to be legalised (Belville, 2015).
- The South African Schools Act is currently under review and the introduction of random testing for doping in sports at schools is being considered.

Although there have not been many proposed changes reported at provincial and local level, limited proposed changes are listed below:

- New or amended by-laws for licensing in terms of the Liquor Act are to be promulgated at provincial level in the Western Cape. It is proposed that when a liquor license is applied for, the community is provided an opportunity to give input as to whether the liquor outlet should be set up in the community or not.
- Certain LDACs could also be involved in influencing local government policy. For example, the KZN LDAC district structure is doing research on how to respond to challenges related to homelessness and crime linked to substance abuse, with a view to preparing policy.

Also considered during the evaluation was whether these actual and proposed changes cater for vulnerable groups in terms of age, gender, sex workers, prisoners, HIV and people living with disabilities. The NDMP itself includes vulnerable groups as a priority for attention and action by National and Provincial departments (DSD &CDA, 2013, pg. 35). There was an interesting comment from a representative of the Northern Cape PSAF that, although the NDMP identifies these groups, they are still marginalised Most respondents were of the view that the actual and proposed changes to legislation and policy do not take vulnerable groups into account. However, the Substance Abuse Act does require the norms and standards issued by the Minister of Social Development to provide for the protection of children in treatment centres and halfway houses, and also promotes the establishment of prevention and early intervention programmes and community-based services targeting children and youth (Act No. 20 of 1992).

Lastly, it is important to point out that, although some of the above changes can be said to be linked to the NDMP, there were a number of instances where respondents explained that changes to legislation and policy affecting substance abuse signalled progress. These changes, although not instigated by the NDMP, were aligned to it. This means that in

deciding on the changes, respondents said the NDMP was used as a guide for direction and to ensure that the changes run parallel with, and not in conflict to, the NDMP.

3.1.3 Extent of the NDMP 2013-2017 NDMP providing clear policy statements and direction for aligned operational planning

An important objective of the NDMP 2013 to 2017 is to guide the operational plans of all government departments and other entities (stakeholders) involved in combating substance abuse. The plan is also to ensure the coordination of stakeholders' plans and activities (DSD & CDA, 2013, pg. 10-11). Coordination of stakeholders is facilitated through structures set up in terms of legislation and these structures are required to align their planning in the following manner: i.) Government departments develop their Departmental Drug Master Plans (DMPs) in line with their core functions and ii.) they are guided by the NDMP. The current government clusters, established so that national government departments can integrate their planning, also assist here (DSD&CDA, 2013, 36-54). These clusters are those used by government in executing its policies and consist of: infrastructure and development; economy and employment; human development; social protection and community development; justice, crime prevention and security; governance and administration and international cooperation and security (DSD&CDA, 2013, pg. 32). The PSAFs are supposed to use the DMPs of national government departments to compile an integrated provincial DMP for each province. The LDAC, in cooperation with the provincial and local government, in turn is supposed to develop its action plans from the PSAF plans, but limited to its particular areas of relevance (DSD&CDA, 2013, pg. 50-60). The evaluation considered whether the NDMP itself provided clear policy statements and direction for aligned operational planning.

3.1.3.1 Overall perception of whether the NDMP provides clear policy statements and directions for operational planning

When asked whether the NDMP provides clear policy statements and direction for aligned operational planning, 29 of the respondents said yes while 11 respondents said no. All national departments and entities said yes, with the exception of three respondents. Five respondents reported that the stratification of objectives into the three tiers of demand, supply and harm reduction means that the activities in each plan are grouped in this manner and strategies are thus aligned. The inclusion of outcomes in the plan was reported by one stakeholder to have directed them to focus on outcomes.

However, a number of weaknesses were reported with the NDMP's ability to provide clear direction for aligned operational planning. Overall, four respondents were of the view the NDMP did not guide stakeholders on how to coordinate and integrate provincial and municipal drug plans. Ten respondents were of the view that the plan does not give direction on implementation, specifically how and what to implement. One respondent attributed this to the high-level and technical language that is difficult to understand. Other weaknesses raised included that the NDMP does not define the roles of the LDAC and municipalities, in contrast to DSD. It also does not clarify the voluntary nature of the LDAC. Two respondents said that reporting to the CDA is not feeding into integrated planning.

Respondents provided the following examples of aligned operational planning:

- Cooperation between the Department of Basic Education (DBE), DSD, South African Police Services (SAPS) and the DOH in implementing the policy for schools regarding testing for drugs, searches and life skills content for drug awareness;
- Collaboration between the SAPS and SARS on the importation of chemicals to be used in the manufacture of drugs;
- The DTI and DOH working together on warning labels on alcohol containers.

Combating driving under the influence of alcohol and other drugs was mentioned as an area where aligned planning could receive more attention. An example of poorly aligned operational planning was in the Western Cape where SAPS is not providing the statistics that can inform the DMP prepared by the Western Cape PSAF.

In order to assess whether the NDMP 2013-2017 has provided clear policy statements and direction for aligned operational planning, the following sub-chapters will assess whether there has been alignment between the NDMP and other sector plans; whether the national departments have prioritised the NDMP activities in their plans; and whether there is sufficient alignment with provincial and local level plans.

3.1.3.2 Extent of alignment between the NDMP and other sector plans

Section 56 (d) in the Prevention of and Treatment for Substance Abuse Act (Act 70, 2008) stipulates that the CDA must encourage government departments and private institutions to compile plans to address substance abuse in line with the goals of the NDMP, while section 56 (e) says that the CDA must ensure that each department of state has its own performance indicators. The NDMP requires that the CDA, the departments and the provinces should facilitate alignment between the NDMP and other sector plans, including provincial and local plans. Alignment should be understood as producing plans in line with the goals of the NDMP. The following assessment examines this in a narrow way; namely whether there is any reference to the NDMP, to substance abuse, or to supply, demand or harm reduction in other sector plans.

The NDMP interfaces with the Medium-Term Strategic Framework (MTSF) by including and aligning the NDMP outcomes with the relevant government outcomes as stipulated in the MTSF 2009-2014 (DSD &CDA, 2013, pg. 38-39). The NDMP makes specific reference to the outcomes of: “a long and healthy life for all South Africans” (Outcome 2); “all people in South Africa being and feeling safe” (Outcome 3) and “suitable human settlements and improved quality of household life” (Outcome 8). This table also includes outcome indicators, baseline and target. However there have been no adjustments to the NDMP to align it with the subsequent MTSF 2014-2019. For example, the new Outcome 13, “a comprehensive, responsive and sustainable social protection system” refers to the social welfare system being reformed to deliver better results for vulnerable groups. Likewise, it should also be noted that the MTSF 2014 -2019 makes no reference to the NDMP or to substance abuse in general.

Although it might be premature to expect that the NDMP 2013-2017 should have influenced sector plans already, there are some examples where intervention on alcohol and other substances has reached a prominent place. For example:

- DSD’s Strategic Plan 2015-2020 is aimed at intensifying prevention and treatment efforts and the implementation of the National Anti-Substance Abuse Programme of Action. A key part of 2015/16 is to provide additional resources to organisations which seek to run educational campaigns about the dangers of substance abuse.
- As reflected in the National Mental Health Policy Framework and Strategic Plan 2013-2020[4], the DOH, during parliamentary debate on the Prevention and Treatment of Substance Abuse Act (2008), committed itself to provide care, treatment and rehabilitation for users that present with co-morbid substance use and mental disorders in designated psychiatric hospitals, rather than referring them to the substance abuse treatment centres run by the DSD. However, despite isolated examples, this commitment has not been honoured according to medical experts in the sector.

[4] The National Mental Health Policy Framework and Strategic Plan, 2013 – 2020 was however most likely developed before the NDMP 2013 - 2017

- The SAPS Minister in the 2013/14 Annual Report recognises the primacy of the Justice, Crime Prevention and Security (JCPS) Cluster in maintaining law and order. In their role in making citizens be and feel safe, this department is committed to combating substance abuse in partnership with communities, which will include the formation of street committees and community safety forums, strengthening the anti-crime awareness campaign and introducing stronger legislation.
- DBE has developed a strategy for the prevention and management of alcohol and drug use among learners in schools (DBE, 2013)
- According to the DOSR's Strategic Plan 2012-2016, there is a clear need to maintain integrity in school sport by putting firm anti-doping measures and education in place[5].

3.1.3.3 The reflection of the NDMP in departmental APPs

The mentioning of the NDMP and substance abuse in APPs is a good indication for whether the national departments have prioritised the NDMP activities in their plans and ultimately for whether the NDMP 2013-2017 has provided clear policy statements and direction for aligned operational planning.

A review of the APPs reveals that some departments include the NDMP in their APP while other departments make no mention of the NDMP or substance abuse or drugs in general. Worth noting is that some of the departments who are not mentioning the NDMP should be highly involved in the fight against substance abuse, such as the DOH.

> *"All departments should have indicators related to substance abuse. Health has detoxification unit and they don't have indicators for that." (PSAF, Western Cape)*

Only five of the departments mention the NDMP or substance abuse, and the DSD is the only department that mentions the NDMP directly in its APP. Nineteen departments or entities make no mention of either. SAPS only mentions drugs and substance abuse and their relationship with crime. SAPS, along with the DBE, mention programmes for staff who have substance abuse issues. The Department of Agriculture, Forestry and Fisheries (DOA) only provides information to their staff on substance abuse. The DOSR mentions activities related to the NDMP, such as the department being represented on the CDA and IMC on substance abuse.

The table below indicates whether the departmental APP made mention of the NDMP 2013-2017, or substance abuse in general.

Table 4: Inclusion of the NDMP 2013-2017 or substance abuse in APPs

Reflected	Year	Not reflected	Year
Department of Basic Education	2013-2014[6]	Department of Arts and Culture	2013-2014

[5] It should be noted that this strategic plan was developed before the NDMP 2013 – 2017.

[6] Mentions the creation of a National School Safety Framework which deals with various issues including alcohol and substance abuse

	2014-215[7]		2014-2015
Department of Agriculture, Forestry & Fisheries	2013-2014[8]	Department of Correctional Services	2013-2014 2014-2015 2015-2016
Department of Social Development	2014-2015[9] 2015-2016	Department of Cooperative Government and Traditional Affairs	2013-2014 2014-2015 2015-2016
Department of Sport and Recreation	2013-2014[10] 2014-2015[11] 2015-2016[12]	Department of Agriculture, Forestry & Fisheries	2015/16-2019/20
South African Police Service	2013-2014[13] 2014-2015[14]	Department of Home Affairs	2013-2014 2014-2015 2015-2016
		Department of Health	2013-2014 2014/15-2016/17
		Department of Labour	2013-2014 2014-2015 2015-2016

[7] Mentions that the department offers its employees substance abuse counselling

[8] Mentions that the department offers its employees information on substance abuse

[9] Includes aspects of NDMP as performance indicators

[10] Mentions the mandate of the South African Institute for Drug-Free Sport

[11] Mentions the department being represented on the CDA and IMC on substance abuse

[12] Mentions the department being represented on the CDA and IMC on substance abuse

[13] Mentions the drugs and substance abuse and the link to crime, but not the NDMP

[14] Mentions programmes for staff who are dependent on substances

	Department of Labour – Compensation Fund	2014-2015 2015-2016
	Department of Trade and Industry	2013/14-2015/16 2015/2018
	Department of Transport	2013-2014 2015-2016
	Department of Higher Education and Training	2013-2014 2014-2015 2015-2016
	Department of International Relations and Cooperation	2014-2015 2015-2016
	Department of Justice and Constitutional Development	2014/2015
	National Treasury	2014-2018 2015-2019
	National Prosecuting Authority	2013-2014
	National Youth Development Agency	2013-2014 2014-2015
	South African Police Service	2015-2016
	South African Revenue Service	2014-2015 2015-2016
	Department of Planning, Monitoring and Evaluation	2014-2015 2015-2016

3.1.3.4 Departmental DMPs

National departments are all required to produce their own departmental DMPs, which are operational plans for dealing with substance abuse issues (DSD&CDA, 2013, pg. 79). These DMPs are to incorporate the three elements of the NDMP 2013-2017: integrated demand, supply, and harm reduction in terms of strategy and interventions (DSD&CDA, 2013, pg. 30) All departments are required to submit their DMPs to the CDA at the start of every financial year, and the CDA then monitors and evaluates the implementation of the plans. However, the completion and submission of the DMPs varies by department, as does the scope of the DMPs written. One CDA official explained:

> *"Different government departments work differently. Some [DMPs are] operational plans. Some [DMPs are] a well-written framework." (CDA- government official)*

A review of the departmental DMPs reveals that only the DSD, Department of Justice and Constitutional Development and National Youth Development Agency (NYDA) have produced final, approved and up-to-date DMPs. The following departments have completed a draft DMP[15]:

- Department of Correctional Services
- Department of Trade and Industry
- Department of International Relations and Cooperation
- Department of Basic Education
- South African Police Service (draft still to be reviewed)
- Department of Health (DMP from 2011/2012-2013/2014)
- South African Revenue Service
- Department of Labour

Of the DMPs received and reviewed by the evaluation team, it was evident that the DMPs by DSD and DOH were good as both have action plans with clear activities to implement. They also provide a time frame[16] for the implementation of the activities. Interviewees also suggest that the quality of DMPs vary by department. When asked which national departments had produced good DMPs, a respondent said:

> *"DSD, Health, Transport, DBE, SAPS (but need to review), NYDA, Correctional services all have while DIRCO, DOJCD and DOL have not." (CDA government official)*

Departments highlighted as having weak DMPs include Department of International Relations and Cooperation (DIRCO), Department of Justice and Constitutional Development (DOJCD), and the Department of Labour (DOL).

The capacity building that has been undertaken was emphasised as a success factor. The reporting tool used by the CDA was further mentioned as a positive factor. There were also departmental success factors that were highlighted, such as the task team established by the Department of Transport (DOT). The task team consists of representatives from various units and stakeholders. Additionally, as mentioned by a CDA member, once a department grasps the NDMP and links it with government outcomes and current needs in communities, it is successful. Other factors that facilitate the prioritisation of the DMPs are strong political leadership in these departments, and an understanding of its importance. Strong representatives on the CDA also act as an enabling factor in terms of the quality of the DMP.

There are general challenges facing all departments, including the CDA, as well as department-specific challenges. A challenge raised by the DBE is that although its strategy is complete, it is only partially implemented and there is uncertainty over whether it includes the correct outcomes. The DBE has requested UNICEF to provide a consultant to assist with this. As the body overseeing the DMPs, the CDA also faces specific challenges, such as a

[15] The Southern Hemisphere evaluation team has received the following: Department of Industry Strategy to combat alcohol abuse (no date), Draft DMP for the Department of Higher Education (no date), Department of Social Development 2015/2016, Department of Health 2011/12-2013/14, and Department of Basic Education National Strategy for the Prevention and Management of Alcohol and Drug Use Amongst Learners in Schools (2013)

[16] For DSD the time frame was quarterly, and for DoH, it is divided into short and term and medium term

small budget and inadequate number of staff, which could be related to the fact that certain respondents felt that the CDA was not providing the necessary monitoring and feedback. It also lacks the capacity to enforce deadlines for DMPs and as there are no consequences for not submitting a plan, certain departments do not prioritise its development or review, which helps to explain the reason for the different states of DMP development of the different departments.

A necessary factor for successful DMPs is buy-in from all stakeholders as well as political will; however, according to many of the respondents, a lack of political will hinders the completion of a DMP. Interviewees also suggest that departments are not integrating their DMPs and furthermore, that collaborating can be an additional challenge.

> *"The departments think and function in silos." (CDA expert)*

Additionally, in cases where the DMPs have been completed, the challenge is to implement it:

> *"The biggest challenge is [it] provides a framework…provinces then decide what to prioritise. [It] doesn't mean things put there will be prioritised or got to by provinces because it doesn't come with additional funding." (CDA, government official)*

There are also general challenges with staff turnover once they have been capacitated, which affects both the development and revision of the DMPs. The long approval process by the Director-General also affects whether they are developed in time, which suggests that the DMP is not a priority for the Director-General.

3.1.3.5 Whether the goal and objectives of the NDMP are recognised and shared across the sector

The NDMP 2013-2017 recognises that the multiple dimensions of substance abuse are much more numerous and more complex than what one department can solve alone. The NDMP lists 21 departments, the PSAFs, LDACs and civil society as being pivotal in the fight against drugs (DSD&CDA, 2013 p. 54-60). Although not mentioned in the plan, some of these departments are core to the implementation of the NDMP and it is critical that they share the same vision - this includes SAPS, DOH and DSD.

A coordinated response to the problem of substance abuse starts by making sure that all stakeholders understand the goal and work towards this shared or commonly recognised goal and set of objectives or outcomes.

Respondents were asked the extent to which the overall goals and objectives of the NDMP are shared and recognised across the sector. The majority of CDA members from national departments indicated that the NDMP goals and objectives had been shared with them by the CDA Secretariat. The data did not reveal whether they feel these have been shared more broadly across the sector; however it was mentioned that a broad consultative process was used for the drafting of the NDMP 2013-2017, which has enabled relevance and consensus on the goals and objectives across the sector.

The respondents from the participating departments indicated that the NDMP goals and objectives have informed the CDA members' departmental five-year strategic plans and APPs. However, as addressed above in sections 3.1.3.3 and 3.1.3.4 only two departments (DSD and NYDA) have produced finalised and approved departmental DMPs, and only five departments have mentioned the NDMP 2013-2017 or substance abuse in general in their APPs. Of note is that the DOH, a critical department in the implementation of the NDMP, has not included the NDMP in its APPs. This raises concerns that the goals and objectives of the NDMP are not being adequately recognised by *all* core departments.

Furthermore, a number of departments and most of the IMC members indicated that the NDMP goals and objectives are not sufficiently understood or recognised across the sector. It was mentioned that many people in the broad substance abuse sector have not even heard of the NDMP and CDA. Furthermore, those who have actively engaged with the plan lack a uniform understanding of the three pillars of the plan (demand, supply and harm reduction) and thus the objectives may be interpreted differently.

It was frequently mentioned that, although the DMP goals and objectives have been shared at national and provincial level, it is not equally recognised by all departments as an important issue, as the following stakeholder explains:

> *"If you look at the plan, it is supposed to permeate all planning in government, especially departments. Yes, individual departments factor the plan into their own, but those departments who don't have the primary mandate around drugs would put the issue at the periphery." (CDA National department).*

The challenge highlighted here is that substance abuse is still viewed as an issue for which certain departments have the primary mandate to intervene.

3.1.3.6 Whether the NDMP has contributed to clarifying the mandates and roles of the relevant stakeholders

The NDMP 2013-2017 sets out the contribution and role of various government departments at national and provincial level in addressing substance abuse. It does this by specifying the roles and mandates of the CDA, and chapter seven of the plan describes the institutional roles and responsibilities of the infrastructure supporting the CDA, including national departments, PSAFs, LDACs and civil society.

National level respondents were asked whether the NDMP has contributed to clarifying roles and mandates of departments and other stakeholders. The respondents gave mixed responses. The majority of interviewees (17 out of 24) responded positively to this question with many adding that this clarity has provided guidance for defining departmental priorities and plans. One respondent said:

> *"Yes it has, each department's roles are clearly outlined…once you know what your mandate is as a department and the role you play it helps you to align yourself when you design your own objectives – you know what is expected." (National Department)*

On the other hand, some respondents (six) stated that the department roles and mandates captured in the plan are either too vague or not adequately defined. For example, one respondent said that the plan indicates *what* the department must do, but not *how* they must do it.

A review of the NDMP (DSD&CDA, 2013, pg. 54-60) confirms these findings above. In its description of roles and responsibilities for 21 departments and entities, these are broadly defined for most departments, with some containing a detailed description of strategies being implemented to address substance abuse. However, for at least four of the departments listed, their mandated roles and responsibilities in relation to substance abuse are very broad and not adequately defined.

Some CDA members explained that this was deliberate as they were trying not to be too prescriptive on how departments should be run and it allowed each department to design their own plans based on their own departmental mandates. It is worth noting that the role of National Treasury is not mentioned in this chapter of the plan even though it is identified as a member of the CDA in the Substance Abuse Act (Act 70 of 2008).

At provincial level, the data does not clearly reveal the extent to which respondents feel the NDMP has contributed to clarifying roles and mandates. However, at local level the majority

of LDAC members interviewed (11 out of 14) indicated that the role of the LDAC is clear and is sufficiently defined in the NDMP.

3.1.3.7 Extent of the NDMP contributing to addressing duplications in mandates

The CDA Secretariat has attempted to address duplications in mandates by encouraging and coordinating stakeholders to work together; highlighting linkages between programmes; and using the "cluster concept" by requesting departments to produce their DMPs in clusters. As stated in the NDMP, the planning and implementation of specific NDMP outcomes requires various role players to integrate their planning and implementation via clusters of national and provincial departments, emulating clusters used by government[17]. However, this approach has not always been successful as some cluster departments have found it difficult to link their activities and outputs because of the different ways in which they measure success.

Although the NDMP has contributed towards clarifying the mandates and roles of different departments, the majority of respondents indicated that this had not contributed significantly towards addressing duplications in the implementation of services. Numerous examples of duplication were provided by national level respondents such as the work being done by NYDA and DSD targeting youth and substance abuse; or the multitude of education programmes and awareness raising activities being undertaken by DOH, DBE and DSD with little collaboration between stakeholders. As one respondent stated: *"everyone does virtually the same thing – there is still no coordination".*

At local level respondents from the CSO sector and government treatment centres confirmed that substance abuse programmes and services are being duplicated. However, as respondents pointed out, services are insufficient to address the scale of the problem in the first place, and therefore duplication is not necessarily a problem. This is reflected in the quote below:

> *"As there are insufficient services, duplication here is a good thing. People need to be doing the same thing but should coordinate with each other." (CSO treatment centre, Gauteng)*

As this quote suggests, it is not a duplication of services if they are reaching different people. Furthermore, the focus should rather be on promoting integration of services and ensuring sufficient geographical spread of a range of substance abuse services to improve access for all.

3.1.3.8 Extent of provinces producing DMPs and alignment

This sub-section provides an assessment of whether provinces have produced provincial DMPs and whether there are other provincial alignments in order to ascertain ultimately whether the NDMP 2013-2017 has provided clear policy statements and direction for aligned operational planning.

The NDMP stipulates that each province through the PSAF should develop a DMP and it should be reviewed annually (DSD&CDA, 2013, pg. 36). National Government departments have departmental DMPs that require them to monitor and evaluate DMP implementation by their provincial equivalents (where applicable). In turn, PSAFs monitor and evaluate the

[17] Government clusters include: economic sectors and employment; human development; social protection and community development; justice, crime prevention and security; and international coordination and security.

implementation of DMPs by LDACs. Each province has an operational plan derived from the provincial DMP that details how it addresses substance-related issues in the province. The respondents indicated that all provinces have developed a DMP (sometimes called a plan or strategy) through their PSAF structures.[18] It appears that it is often the provincial DSD that takes the lead in producing the DMPs with the involvement of other provincial departments, CSOs and experts. The DMPs from Limpopo, Western Cape and Gauteng provinces are in the process of being reviewed.

The provinces are faced with the following challenges when developing, implementing and reporting on their provincial DMPs: Firstly, most provincial DMPs are in a draft form and have not received the final approval. Secondly, despite training from the CDA, there is often poor understanding on how to develop the DMP. This is exacerbated by the poor functioning of some PSAFs, which hampers the production of the DMPs. Furthermore, some members lack a clear mandate and buy-in from the heads of departments in the provinces. Also, with PSAF members leaving and new members coming on board it requires additional training from the CDA on how to develop DMPs, which is not always forthcoming. It was raised as a gap that the NDMP has not been translated in to simple steps for implementation. Finally it was mentioned a few times that it is unclear where the budget for the implementation of the activities as outlined in the DMPs comes from.

Respondents indicated that Western Cape and Limpopo have produced good DMPs as they had understood well how to produce them and they had good support:

> *"The ability of the people who write it and the support they get are key. In Western Cape it had the support of the Premier, while in Limpopo they used a consultant who knew how to produce it." (CDA expert)*

The support and political will of the Premier seems to be an enabling factor:

> *"Some departments don't want to be under DSD. Some provinces are elevating it to the Office of the Premier", (DSD official).*

Furthermore, the training and the receipt of the template for developing the DMP has been an enabling factor for the Western Cape PSAF:

> *"We are currently updating out DMP. It is more simplified the new one. The old one is like a thesis but now we have got a template is simpler." (PSAF)*

At provincial level there were further examples of alignment: In the Western Cape Provincial Strategic Plan 2014-2017, reducing the impact of alcohol abuse on the population has become a game changer (Western Cape Government, 2014, pg. 32). "Game changers centre on very particular problems and opportunities that need new and innovative solutions. They are bold, focused initiatives to bring about transformative change that citizens can see and feel." (ibid, pg. 8)

> *"The province has stepped up its plan with regards to alcohol use and an 'inter-sectoral' alcohol game changer project has been launched with outcomes placed on the Premier's dashboard to monitor." (PSAF)*

Gauteng Province has a Provincial Integrated Anti-Substance Abuse Prevention and Treatment Strategy, while the Northern Cape has developed and implemented an Integrated

[18] The evaluation team was only able to source provincial DMPs from Kwa-Zulu-Natal and Northern Cape and none of them were up to date.

Substance Abuse Prevention Strategy, 2012-2017. This was however developed before the NDMP 2013-2017.

Each of the experts on board of the CDA has been allocated a PSAF, which they supervise. It appears that where the CDA Secretariat or experts are training the departments, PSAFs and LDACs, there is more understanding of the NDMP and buy-in. However it was raised a number of times by respondents from the PSAFs that it is not necessarily directly due to the NDMP that provinces or municipalities are addressing substance abuse issues in their plans:

> *"The NDMP is too vague, so the province has interpreted it and they have put it in to different sections, so the provincial blue print speaks to different sections of substance abuse. At local level they have also done the same but not because of the NDMP." (PSAF)*

Respondents from the Gauteng, Northern Cape and Western Cape PSAFs confirm that networking, workshops and information sharing sessions have been undertaken to share the goals and objectives of the NDMP and get buy-in and support from provincial and local level stakeholders.

In contrast the KwaZulu-Natal PSAF members all indicate that there is no recognition and sharing of the NDMP and provincial DMP across the sector, but this is largely a result of the poor functionality of the PSAF which is discussed in more detail in section 5.3.2 of this report.

3.1.3.9 LDACs producing a local action plan and alignment

The NDMP stipulates that the PSAF and CDA train the LDACs in how to produce a local action plan. All 238 municipalities are meant to have a LDAC and they are meant to develop an action plan. There is no specification in the NDMP as to what the local action plan should contain – only that it should be aligned to the three pillars. However, they are guided by the national template.

The extent of whether LDACs have developed local action plans seems to be dependent on which province they are in and how far CDA and the PSAFs have reached in terms of training and supporting the LDAC. The LDACs in Gauteng and KZN said that they have developed local action plans while the LDACs in the Northern Cape do not have local action plans. In the Western Cape only 8 out of 30 LDACs are functional (although the PSAF is busy resuscitating them) and only the City of Cape Town has developed a local strategy. In Swartland in the Western Cape they are in the process of completing their action plan and described the process as follows:

> *"We did a needs assessment and a situation analysis working with different government departments and other stakeholders, gathering all information and checking what the problems are and who is most in risk in terms of age, gender, socio-economic status and drug-related crimes. We involved all stakeholders, such as government, community NGOs. We also did community service assessments checking drug trends, rehab centre availability and social worker availability." (LDAC)*

Despite the quote above, the interests of the community are only represented through the representation of CSOs and officials on the LDAC. For example, in Richards Bay the ward committee members were left out of the planning process.

> *"All stakeholders got together in a meeting. NGOs and government worked together on the document. Unfortunately, the ward committees were left out and this means that local community perspectives were left out." (LDAC)*

In general the local action plans are informed by the action plan in the NDMP, the provincial DMP and community needs as indicated in the TOC. However, in Richards Bay the local action plan was guided by the action plan in the NDMP and community needs, though not by the provincial DMP as the latter was not shared with the LDAC.

In terms of alignment at local level, the City of Cape Town has developed an Alcohol and Other Drug Strategy 2014-2017 (City of Cape Town, 2014) where the focus is on four pillars, namely prevention, intervention, coordination and suppression. It is however noticeable that

it is not based on the NDMP's three pillars of supply, demand and harm reduction. A review of the Northern Cape regional and local operational plans indicate that they are aligned to the provincial DMP.

3.1.3.10 Whether the local action plans, DMPs and NDMP guided implementation

The NDMP provides a broad guideline for implementation which is not prescriptive. This enables the implementers to identify what they want or need to focus on. The local action plans seem to have limited alignment with the Integrated Development Plans (IDPs). For example, in eThekwini in KZN the Safer Cities Plan deals with social crime including substance abuse; it did take the IDP in to consideration, while the local action plan does not seem to have done so. It was a general comment by respondents that local action plans, DMPs and the NDMP have not guided implementation for two reasons: firstly, the NDMP does not indicate how it should be implemented in the communities; and secondly, lack of funding or lack of clarity of who should fund the implementation constrains implementation. One Western Cape PSAF member summed it up:

> *"It does provide guidelines on what policies should be in place. What it does not make provision for is the budget/resources. Training is required for inter-sectoral collaboration which only appears to be there at forum meetings, while for in-between meetings each department and NGO continues with business as usual. The only difference is the Drakenstein project where concerted effort is made to collaborate and make it more sustainable at local level, (PSAF).*

3.1.4 Extent of the 2013-2017 NDMP providing clear policy statements and direction for resource allocation

In the NDMP 2013 – 2017 it is stipulated that "the NDMP provides the means for harnessing existing resources to achieve the key NDMP outcomes" (DSD&CDA, 2013, pg. 36). "Each national department must produce a five-year strategic plan that is aligned with that of government as contained in the Government Programme of Action". "Based on the strategic plan (the NDMP and the DMPs), the CDA and the national and provincial departments prepare their budgets (including the input aspect), called Estimates of Expenditure or Medium-Term Expenditure Framework. These are submitted for approval to the national and provincial departments (in the case of the CDA, to the DSD) and Treasury, and eventually to Parliament" (DSD&CDA, 2013, pg. 51).

The CDA receives funding from DSD to carry out its coordinating and M&E mandates. With regards to government departments, the NDMP allocates no additional funds to carry out activities to combat substance abuse and states that departments are required to incorporate this as part of their "normal planning and budgeting" (DSD&CDA, 2013, pg. 36). The funding for PSAF activities must be provided by the provincial DSD in that province. The LDAC is required to use monies provided by the municipality in which they operate for purposes of their activities (DSD &CDA, 2013, pg. 60).

It was reported that as the NDMP is a guideline, and as the national departments were to develop programmes and strategies following that guideline, it was left to these departments to cost the programmes and strategies. The NDMP was intended to coordinate the more efficient use of funding through the various line departments. As the NDMP did not introduce new activities and programmes, additional funding was not needed.

There were very few positive statements on the NDMP's handling of the financing of activities. The lack of additional financial allocations to departments was criticised by numerous respondents as leading to a lack of commitment to and prioritisation of activities related to the NDMP. It was reported that one cannot expect departments to implement and integrate their services if there is no allocated budget for activities in terms of the NDMP. This contradicted the expectation in the NDMP that departments would accept their role in addressing substance abuse and allocate resources accordingly. Further criticisms of the NDMP's direction on resources were as follows:

- The NDMP was said by two respondents to lack guidance for departments on how to apply their resources.
- A few respondents from the treatment centres and a municipality said that the NDMP leaves out the important area of resourcing facilities, for example, recreational facilities and also does not resource harm reduction.

Overall, although the NDMP (through the CDA) was meant to coordinate more efficient use of funding through various line departments, many criticised the requirement that departments incorporate the NDMP activities in their own budgets. Departments seem not to have enough resources to achieve what is expected in terms of the NDMP and expect that these would be funded through their participation in the NDMP. Respondents also felt that the NDMP lacked guidance on how to apply for, prioritise, as well as align resources.

If departments do not have enough financial resources to achieve what is expected of them in accordance with the NDMP, then without additional financial resources it is unlikely that its objectives will be achieved.

3.1.5 Extent of the NDMP 2013-2017 providing clear policy statements and direction for measurement of results

The NDMP itself sets out outcomes, indicators and baseline data as well as the departments responsible for those outcomes (DSD&CDA, 2013, pg. 37-45). DMPs of departments and PSAFs are then aligned to the NDMP and these contain outcomes, outputs, indicators and targets honed to those in the NDMP. The NDMP requires that the DMPs of departments and PSAFs be submitted to the CDA and used by the CDA as a basis for M&E (DSD&CDA, 2013, pg. 54). In addition, departments and PSAFs are required to submit standardised reports on the achievement of outcomes and outputs quarterly and annually to the CDA. It is intended that the CDA uses these reports to monitor and evaluate the implementation of the NDMP and reports results annually to the Minister of Social Development and Parliament (DSD&CDA, 2013, pg. 14). In turn, PSAFs monitor and evaluate the implementation of the local action plans by the LDACs (DSD&CDA, 2013, pg. 54). Besides that the NDMP does not provide any M&E framework or system.

A few respondents said that by inclusion of outcomes and indicators, the NDMP does provide direction for measurement, but that it is hard to apply in practice. Other respondents provided more detail.

- Two said that the outcomes were not worded in the plain language necessary for stakeholders to utilise them and six said the outcomes were too broad and high-level. This is likely to have been the reason for two additional respondents' views that the outcomes are not clear. Although the NDMP allows people at grassroots level to give input on problems on the ground, three respondents raised the specific concern that this group and those not used to planning would not understand the outcomes and would not find the plan user-friendly.
- A significant number of respondents (7) reported that there was nothing practical in the NDMP to guide people on how to measure results.

Although the NDMP was said to provide direction for measurement through the inclusion of outcomes and indicators, the basis of many of the comments was that it is difficult to apply in practice. The M&E Plan in the NDMP is too high level and not implementable. The NDMP has furthermore not been followed up with an M&E framework and system.

3.1.5.1 Concluding summary

The evaluation considers the extent to which the NDMP has provided clear policy direction and guidance. The evaluators have included in this analysis whether the policy direction has been translated into strategies and plans at a national and provincial level and whether there is agreement and alignment between these.

In general, the NDMP is recognised for providing guidance on the general policy direction on substance abuse in South Africa. The policy direction of the NDMP can be found in the three

pillars of harm reduction, demand reduction and supply reduction, and one of the main criticisms of the NDMP and Act No. 70 of 2008 is that there is policy confusion around harm reduction. The NDMP is criticised for being short on details around implementation, and this is where supporting structures responsible for implementing the NDMP and achieving its objectives have become stuck. The document in fact is more of a guiding framework than a plan per se, and hence the use of the term "plan" becomes confusing. A key challenge is that the NDMP assumes that policy and direction set at a national level, by national departments, will filter down to the provinces. However, in reality, each provincial department can define its own strategies and produce its own legislation. Hence, a key lesson learned is that the integration of NDMP goals and objectives into national departmental planning frameworks does not necessarily guarantee that they will filter down into provincial level department plans. This is therefore a false assumption in the TOC.

It is evident that, since 2013, there are a number of legislative and policy changes that have been effected and are in the pipeline. Although some of these may not directly be linked to the plan, it has provided impetus in the sector. In order to ensure that their implementation is effective, these changes and proposed changes are welcome in furthering the overall purpose of the NDMP. There are, however, a few proposed changes that are taking an extensive amount of time like the Control of Marketing of Alcoholic Beverages Bill and the Liquor Policy, which needs to be fast-tracked.

Although the majority of respondents were of the view that the objectives of the NDMP are shared and that the NDMP provides clear policy statements and direction for aligned operational planning, in reality it has not been sufficiency reflected in sector plans or APPs. Only three departments/entities have finally approved departmental DMPs and five departments have the plan reflected in their APPs. Although the NDMP is aligned with the MTSF 2009-2014, it was not revised when the MTSF 2014-2019 was adopted and should be aligned with Outcome 13 on social protection. Likewise the NDMP has not informed the MTSF 2014-2019. There are only a few examples where the NDMP is aligned with departmental sector plans and this was not necessarily due to the NDMP, but more due to the existing mandates of the departments. This indicates that the alignment could have been achieved without the existence of the NDMP.

The main barrier to proper buy-in to the NDMP's goals and objectives is that some departments do not view substance abuse as their primary mandate.

The NDMP has contributed to clarifying the roles and mandates, particularly of the national CDA members (departments) and the LDACs. However, it has made a limited contribution towards reducing duplication of services with many examples of duplication provided in the substance abuse sector. On the other hand it could be argued that, in the context of limited access to services at local level, duplication is not necessarily a bad thing. Thus the work of the CDA should be focused more on improving integration and access to services in all areas rather than emphasising the need to reduce duplication.

All provinces have produced a DMP, however none of them are up to date and finalised. A concern is the lack of clarity as to who will fund the implementation of the provincial DMPs and the local action plans. Three out of the four LDACs visited in the evaluation are functional and it was reported that countrywide only a few of the LDACs are operational and functional. Hence there are only a few local action plans produced. It also appears that the local action plans are often not aligned to the IDPs. In conclusion, the inter-sectoral nature of the NDMP makes its implementation a complex process. However, there is to some extent alignment between the NDMP and other sector plans, but further alignment with the IDPs is needed.

In terms of policy direction for resource allocation, the NDMP is clear that it does not allocate any additional funds to carry out activities to combat substance abuse and states that departments are required to incorporate this as part of their normal planning and budgeting. However, there is a lot of confusion around where resources should come from to implement substance abuse related strategies and plans as envisaged in the NDMP. Departments seem not to have enough resources to achieve what is expected of them according to the

NDMP and expect that these would be funded through their participation in the NDMP. However, the NDMP expects that departments will accept their role in addressing substance abuse and allocate resources accordingly. Also the NDMP does not clearly stipulate which departments are expected to contribute. This leaves a resource gap in the sector and is hindering implementation.

Lastly, there is no M&E framework, and the M&E Plan in the NDMP is too high level, abstract and not easily implementable at lower levels in the system.

3.2 Adequacy of resources for the NDMP

This section examines systemic elements in an assessment of the adequacy of the financial and human resources to support the implementation of activities in the NDMP.

3.2.1 Adequacy of financial resources

This section provides an analysis of whether the financial resources allocated have been adequate to support the implementation of activities in the NDMP. It starts by looking at the sources and procedure of budget allocations for substance abuse for the various stakeholders mentioned in the NDMP. It specifically analyses the DSD substance abuse budgets before it provides an analysis of whether the financial resources have been sufficient.

3.2.1.1 Mandates

The NDMP 2013-2017 stipulates that it "provides the means for harnessing existing resources to achieve the key NDMP outcomes" (DSD & CDA, 2013, pg. 36). It further states that "each national department must produce a five-year strategic plan that is aligned with that of government, as contained in the Government Programme of Action" (DSD & CDA, 2013, pg. 36), and that "based on the strategic plan (the NDMP and the DMPs), the CDA and the national and provincial departments prepare their budgets (including the input aspect), called 'Estimates of Expenditure' or 'Medium-Term Expenditure Framework'. These are submitted for approval to the national and provincial departments (in the case of the CDA to the DSD) and Treasury, and eventually to Parliament" (DSD&CDA, 2013, pg. 51). However, the NDMP does not clearly stipulate which departments are expected to contribute financially.

The funding for PSAF activities must be provided by the provincial DSD in that province. The LDAC is required to use monies provided by the municipality in which they operate for purposes of their activities (DSD&CDA, 2013, pg. 60).

In the Prevention of and Treatment for Substance Abuse Act, section 56 (c) stipulates that the CDA must facilitate the rationalisation of existing resources and monitor their effective use. In section 57(4) it says that "adequate and sustained funding must be provided by the provincial department responsible for social development"; in section 60 (8) it further says that "the municipality in which a LDAC is situated must, from the moneys appropriated by the municipality for that purpose, provide financial support to the LDAC".

3.2.1.2 Location of substance abuse funding within national departments and entities

This section focuses on the location of substance abuse funding within each of the national departments, and the purpose for which it is used. Where available, it presents estimates of the amount allocated to substance abuse for each department. It also presents responses to the question as to whether the NDMP had resulted in any changes in allocations. The following section deals specifically with DSD's substance abuse budgets.

National Treasury allocates funding to national departments, including the national DSD. National Treasury is, however, not directly responsible for allocations to provincial departments or local governments. DSD is the main funder of substance abuse-related activities in that provincial DSD budgets include a substance abuse sub-programme.

Substance abuse is thus clearly "visible" in the DSD budgets. Provincial DSD substance abuse allocations, as for provincial budgets as a whole, are primarily funded through equitable share funding. The equitable share funding is channelled by National Treasury to the provincial treasuries, which then channel funding to departments which, in turn, allocate funding to programmes and sub-programmes.

Substance abuse sub-programmes of provincial DSDs are used, amongst others, to transfer funding to non-profit organisations (NPOs) that delivery services. National DSD also has a substance abuse sub-programme. Some of the allocation for this sub-programme is used to fund the CDA, but some funds are also used for transfers to national NPOs such as Soul City.

The National DSD budget funds activities such as Ke Moja, the national helpline, and the establishment of government-owned treatment centres in the provinces. As discussed further below, there is currently a conditional grant for the establishment of treatment centres in provinces. Provincial treasuries fund the operation of treatment centres. National DSD reported that they generally had a deficit. A DSD official noted that while a conditional grant had been provided to ensure that there was at least one government treatment centre in each province, they had assumed that the provinces would contribute the necessary operating costs. In one province, while construction of the centre had been completed and 56 staff hired, the centre was not yet operating as they did not yet have the necessary certification. Beyond the treatment centres, national DSD needed more funds to be able to register out-patient and other programmes. With the available funds, national DSD's main activity has been to conduct four major campaigns at an average cost of R500 000 per campaign. DSD also used radio and TV once a year for indirect outreach, but without additional budget the approach remained "*just wide and we hope somebody will be reached*." If more funds were available, the department would like to use community media, such as having branding on taxi and buses (National government).

The DTI reported that it had about R2 million available for substance abuse. These funds were located within the budget for education and awareness of the National Liquor Authority, which was a sub-programme within the Consumer and Corporate Regulations Division of the DTI. It was mentioned that staff drew on the DTI marketing division's budget to assist with outreach. To date the NDMP had not resulted in any changes in budget allocations or expenditure. However, going forward, the draft policy specifies that the liquor industry will be required to contribute to a fund for NDMP-related initiatives for which stakeholders can submit applications. DTI plans to reposition the National Liquor Authority as a trading entity which will enable it to apply for funding.

The National Prosecuting Agency (NPA) could not provide an estimate of the budget allocated for substance abuse as this would fall within the general budget for prosecutions, and the agency does not keep separate statistics on drug-related cases. The NPA's budget falls within the broader budget of the DOJCD.

Although the DOJCD has allocated an amount of R750 000 for a relevant though as yet unspecified project reflected in the APP for 2015/16, it was not possible to estimate the overall amount allocated for substance abuse by the DOJCD.

For DIRCO the introduction of the NDMP had not resulted in any changes in budget allocations for expenditure. Their relevant expenditure related to attending meetings. A department official said that the limited funds available prevented them from attending all relevant meetings of bodies such as the United Nations, African Union and Southern African Development Community (SADC).

Similarly, the SAPS cannot separate out the budget or expenditure related to substance abuse as such cases are covered by the budget for its general functions. SAPS has five budget programmes – Administration, Visible Policing, Detective Service, Protection and Security Service, and Crime Intelligence. Much of SAPS' work related to drugs would fall within the Visible Policing programme. Salaries are the main cost driver, responsible for 70% of the budget, as delivery of policing services requires personnel to do the work. The amount

spent on substance abuse would depend on the number of hours spent on incidents of crime related to drugs and alcohol. It was noted that while some incidents related directly to substance abuse, a large proportion of other crimes, including murder, were related indirectly to substance abuse because they were performed under the influence of alcohol or other substances. Detailed analysis of the many thousands of dockets could produce an estimate, but would require major work. It was mentioned that it was doubtful whether the NDMP had influenced the budget, as substance abuse was previously already part of the core business of SAPS.

The National Youth Development Agency (NYDA), which is funded by the Presidency, said that substance abuse was one of their key performance areas. A total of approximately R2 million was allocated for the key performance area of health and wellbeing for the country as a whole, and substance abuse was only one of the issues covered in this area.

A Department of Sport and Recreation (DOSR) official reported that they are responsible for the provision of sports facilities and diversion programmes, however did not mention their responsibility for ensuring that competitive sports are drug-free. The related activities fall within Programme 2 of their budget and APP, while infrastructure is located in Programme 5. For 2015/16, Programme 2 received about 40% of the total departmental budget of approximately R630 million. It was noted that national, provincial and local government all have responsibilities in relation to sport. Within local government, each municipality is meant to allocate 15% of every infrastructure grant for sports infrastructure. Most of the DOSR activities cannot be categorised as specifically or primarily related to substance abuse. DOSR does, however, have a national laboratory that is internationally accredited to perform doping tests, and does so both for South Africa and the SADC more generally. The department allocates approximately R20 million to the South African Institute for Drug-free Sports (SAIDS). This is supplemented by R7 million from the National Lottery.

For the DBE the NDMP was considered an “unfunded programme”. It was estimated that out of the total R1 million[19] allocated in the relevant area, R300 0000 or R400 000 was allocated to NDMP-related activities. The allocation was small as the full amount was for seven different programmes. Locating substance abuse within the curriculum did not, in fact, require major finances. However, the main activities would be in the provincial sphere and “if there is no allocation at provincial level, there’s no implementation”.

It was raised that for the Department of Correctional Services (DCS) that they were funded “to keep prisoners in prison” and would need additional budget to deal with “additional issues”, especially given that the budget for their core responsibility was insufficient.

In the national DOH, substance abuse and mental health constitute a directorate within the Non-Communicable Diseases sub-programme. The sub-programme’s budget (R28,3 million in 2015/16 according to Estimates of National Expenditure) makes provision for a Deputy Director and Assistant Director. The allocation for substance and abuse was estimated to amount to about R2 million annually. Expenditures related to substance abuse obviously extend beyond this in that some illnesses and conditions are related to substance abuse. However, at provincial level there was no money specifically allocated to substance abuse.

[19] The Estimates of National Expenditure record an amount of more than R1 billion for Curriculum Enhancement and Quality.

It was noted that unlike the two vertical programmes of HIV/AIDS/TB and Infrastructure, it is difficult, if not impossible; to estimate how much is spent on an integrated (non-vertical) programme such as substance abuse. One respondent said that it helped to have a national plan to which departments could commit and allocate the necessary human and other resources.

In the DOA, the insufficient and shrinking budget meant that they were unable to monitor trade to check if there were any illicit products, and were only able to service clients within driving distance of their office. There were four regional offices, in Gauteng, KwaZulu-Natal, Western Cape and Eastern Cape, which between them were meant to cover all nine provinces. Given such limited resources, DOA did not initiate raids but instead supported others, such as SAPS, when they organised raids. If the DOA did plan activities, they would fall under Programme 3. But raids and similar activities would not be budgeted for separately and it would be difficult, if not impossible, to separate out NDMP-related activities.

It was not possible to estimate the allocation to substance abuse related activities in the national DOT. The Department has an employee health and wellness programme that addresses substance abuse, but did not mention any substance abuse-related activities beyond those run by its own personnel.

Similarly the Department of Home Affairs' (DHA) main current responsibilities in terms of the Act No. 70 of 2008 are related to the employee wellness programme for its 10 000 employees. Activities include ongoing education, screening of employees, referral and transport to rehabilitation centres, and aftercare. Although it was raised by a respondent from the DHA that they currently overspent on the approximately R150 000 allocated to NDMP-related activities, it was not possible to ascertain the amount allocated for all substance abuse activities.

For the Compensation Unit within the DOL, the NDMP-related activities are also centred on employee wellness. It was reported that as from the 2016/17 financial year they would have a separate budget for employee wellness, rather than this being part of the general human resources budget. There was no specific budget for NDMP-related activities.

3.2.1.3 DSD's substance abuse budget analysis

Size of provincial substance abuse budgets

The structure of the provincial DSD budgets is largely standardised in terms of the programmes and sub-programmes that comprise the budgets. All provinces have a sub-programme for substance abuse prevention and rehabilitation within the restorative justice programme. Tables 5 to 7 detail the budgets for the period 2011/12 to 2017/18 as recorded in the 2015 budget books for each of the nine provinces for the department as a whole, the relevant programme, and the relevant sub-programme respectively. For the first three years the tables show the audited outcomes. For 2014/15, which had not ended when the budgets were tabled in the legislatures, the tables show the original voted allocation ("main"), the adjusted allocation at the time of the mid-year vote ("adjusted"), and the prediction as to actual expenditure at the time the 2015/16 budget was drawn up ("revised"). The 2015/16 figure is the amount that was voted in 2015, while the 2016/17 and 2017/18 are predictions as to what will be allocated in the two "outer years" of the Medium-Term Expenditure Framework (MTEF). To simplify the presentation, some of the tables that follow show only the adjusted amount for 2014/15.

Overall, the tables show a total amount of R18.4 billion allocated across the nine provinces for DSD. R2.5 billion of this is allocated to the Restorative Justice Programme, of which R0.6 billion is allocated for the prevention of substance abuse.

Table 5: Provincial Department of Social Development (R000)

	Outcome	Outcome	Outcome	Main	Adjusted	Revised	MTEF	MTEF	MTEF
	2011/12	2012/13	2013/14	2014/15	2014/15	2014/15	2015/16	2016/17	2017/18
EC	1678948	1739533	1928811	2158958	2156718	2151485	2230784	2347283	2464472
FS	803679	867136	962711	973054	973554	973054	1019233	1084007	1106268
GT	2351044	2524880	2899683	3524662	3524662	3421446	3975875	4170464	4378987
KZ	1934257	1985386	2329906	2497952	2489760	2489760	2630481	2767560	2905938
LM	1162397	1191502	1315050	1468887	1468887	1468887	1537756	1627183	1706213
MP	927196	918116	1132962	1232065	1220309	1220309	1367074	1411137	1480305
NC	522687	531722	604415	651206	660623	654192	709856	739084	759301
NW	883010	922172	1048717	1241360	1241360	1254141	1343637	1396770	1481710
WC	1317002	1402227	1580143	1755933	1757668	1757668	1899985	2002673	2102807
RSA	11580221	12082674	13802398	15504077	15493541	15390942	16714681	17546161	18386000

Table 6: Restorative Justice Programme (R000)

	Outcome	Outcome	Outcome	Main	Adjusted	Revised	MTEF	MTEF	MTEF
	2011/12	2012/13	2013/14	2014/15	2014/15	2014/15	2015/16	2016/17	2017/18
EC	86217	92214	237467	267075	338708	337071	354317	374218	392909
FS	65814	78595	89094	114740	116845	116425	108310	138867	114836
GT	237629	280142	303098	371180	371180	362517	420461	452817	475458
KZN	170067	182233	202074	288131	282457	282457	301173	311062	326615
LIM	34994	35377	57811	187892	187892	187892	198718	216674	227508
MPU	43521	49659	118657	82152	87394	87394	169058	179193	187823
NC	121234	108593	116892	120696	124440	126610	149909	152834	141980
NW	109634	131132	206266	182951	182951	195102	285200	268644	286564
WC	207312	224905	248299	279809	287420	287420	308393	326471	343420
RSA	1076422	1182850	1579658	1894626	1979287	1982888	2295539	2420780	2497112

Table 7: Prevention of substance abuse (R000)

	Outcome	Outcome	Outcome	Main	Adjusted	Revised	MTEF	MTEF	MTEF
	2011/12	2012/13	2013/14	2014/15	2014/15	2014/15	2015/16	2016/17	2017/18
EC	8174	8057	8210	21671	25590	25508	50514	51549	54516
FS	16344	21379	26379	26838	41210	40511	37841	57799	29714
GT	73372	82192	92164	102927	102927	100914	126129	143056	150209
KZN	43437	40351	38391	47261	47261	47261	73639	78692	82627
LIM	1461	1270	5330	9208	9208	9208	7800	13191	13851
MPU	20626	20876	26037	24873	31543	31365	31388	33219	35481
NC	7534	5596	20218	10474	10474	10474	44211	41455	24698
NW	15379	22896	38649	49193	49193	59626	93103	74290	77729
WC	67274	78519	84879	86585	88775	88775	95684	101318	106571
RSA	253601	281136	340257	379030	406181	413642	560309	594569	575395

The numbers in the tables above are difficult to interpret, as one would expect funding allocations to differ across provinces on account of the differences in population size, among other factors. In this regard Table 8 is helpful because gives some indication of the relative importance attached to substance abuse by showing what percentage the allocation for substance abuse constitutes of the total DSD budget in each province. For 2015/16 the North West, Northern Cape and Western Cape provinces allocated the largest shares for substance abuse, allocating 7%, 6% and 5% of the total DSD budget respectively. Over the full period, the Western Cape had the highest allocation for substance abuse as a proportion of total DSD budget with figures of 5% or more for all years. The high percentages for North West and Northern Cape are not sustained across the full period and, as discussed below, at least in part reflect conditional grants allocated for the construction of substance abuse treatment centres. The Eastern Cape and Limpopo are consistently low spenders on substance abuse in relative terms. This could to some extent be justified by the fact that both of these provinces contain large areas that were previously homelands and according to unpublished data from the Human Sciences Research Council's 2012 HIV and AIDS survey, at least for alcohol, substance use and abuse tends to be lower in these areas. Conversely, the Western Cape and Northern Cape have particularly high levels of substance abuse amongst the population.

Table 8: Substance abuse as a percentage of total provincial DSD budget

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
EC	0%	0%	0%	1%	2%	2%	2%
FS	2%	2%	3%	4%	4%	5%	3%
GT	3%	3%	3%	3%	3%	3%	3%
KZN	2%	2%	2%	2%	3%	3%	3%
LIM	0%	0%	0%	1%	1%	1%	1%
MPU	2%	2%	2%	3%	2%	2%	2%
NC	1%	1%	3%	2%	6%	6%	3%
NW	2%	2%	4%	4%	7%	5%	5%
WC	5%	6%	5%	5%	5%	5%	5%
All provinces combined	2%	2%	2%	3%	3%	3%	3%

The table above does not tell the whole story, as a small percentage of a relatively generous provincial DSD budget may be more favourable than a larger percentage of a less generous provincial DSD budget. Figure 4 provides an alternative measure, by calculating the amount allocated for the substance abuse sub-programme per capita of the total population of each province. The calculation uses Statistics South Africa's mid-year population estimates for 2015. The estimates are made excluding the conditional grant portion of the substance abuse sub-programme allocation, to avoid skewing by these non-repeating amounts. The figure shows North West, Northern Cape and Western Cape having the highest allocations, with allocations of more than R15 per person (for the year). Limpopo allocates only just over R1 per person each year.

Figure 4: Annual per capita expenditure on substance abuse sub-programme by province, 2015/16 (Rands)

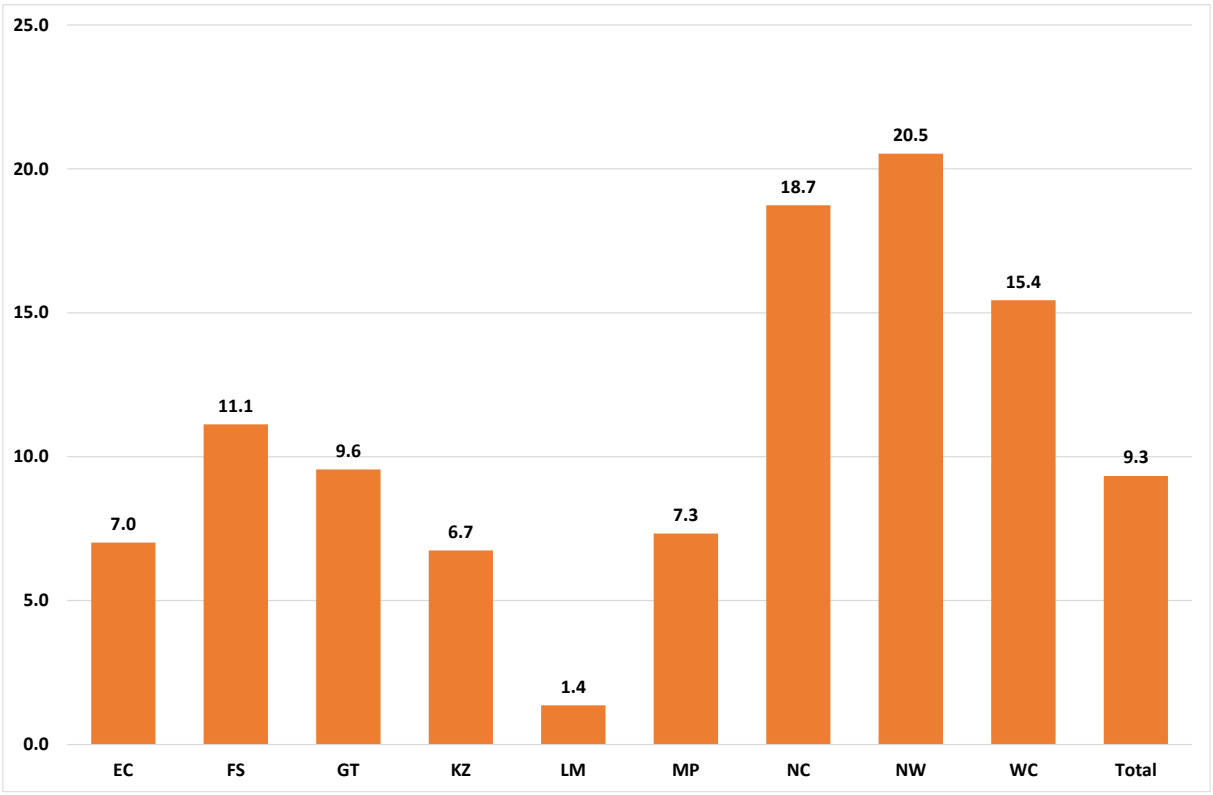


Table 9 shows the annual real increase in the sub-programme allocations excluding the conditional grant. The real increases are calculated by adjusting the allocations for inflation using the consumer price index (CPI) as reported by Statistics South Africa for the years 2012 to 2014, and the CPI for 2015, 2016 and 2017 predicted in the National Treasury's Medium-Term Budget Policy Statement. The three-year average is the real increase for the MTEF period, while the six-year average is for the full period 2011/12 to 2017/18. The table shows all provinces recording a real increase over the full period, and all but Free State and Mpumalanga doing so for the MTEF period. For some provinces, particularly the Eastern Cape, Northern Cape and North West, the increases are substantial. These three provinces all receive the substance abuse conditional grant. The Free State's small real increase for the full period is disappointing given that this province also benefits from the conditional grant. While the overall increases are necessary, the erratic expenditure within all of the provinces is unusual when compared with other sub-programmes. In some cases it might reflect temporary increases to allow for the construction of centres and other one-off costs.

Table 9: Percentage real increase in substance abuse allocations excluding treatment centre conditional grant

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	3-year average	6-year average

EC	-7%	-4%	45%	264%	1%	0%	54%	30%
FS	24%	17%	40%	-25%	-14%	0%	-14%	4%
GT	6%	6%	5%	16%	7%	0%	7%	7%
KZN	-12%	-10%	16%	47%	1%	0%	14%	5%
LIM	-18%	297%	63%	-20%	60%	0%	8%	38%
MPU	-4%	18%	14%	-6%	0%	1%	-2%	4%
NC	-30%	242%	-60%	148%	0%	0%	35%	15%
NW	41%	60%	-9%	93%	-8%	-1%	21%	24%
WC	11%	2%	-1%	2%	0%	0%	1%	2%
RSA	5%	14%	4%	28%	1%	0%	9%	8%

Government-run substance abuse treatment centres

As noted above, some provinces without government substance abuse treatment centres have received conditional grants for this purpose. The grants were first allocated in the 2014/15 budget and extend to 2015/16 for all four provinces, while two provinces extend to 2016/17. The amounts are shown in Table10 below.

Table 10: Conditional grants for substance abuse treatment centres

	2014/15	2015/16	2016/17
EC	13000	2000	
FS	2000	6500	29500
NC	2000	22000	18000
NW	12000	17000	

In the Eastern Cape's 2015 'Estimates of Provincial Revenue and Expenditure' it is reported that the grant was reduced for 2015/16 as a result of completion of the centre in Nelson Mandela Bay metro. Reprioritisation of funds to allow for the operation of the new centre has resulted in a reduction in transfers to other entities, but this reduction does not seem to have affected the substance abuse sub-programme.

The Free State's 'Estimates of Provincial Revenue and Expenditure' reports that it has identified a site for the new centre on the premises of the Botshabelo State Hospital in Mangaung Metro. During 2014/15, the province did not proceed beyond the planning phase. This province was collaborating with Northern Cape, whose basic design it planned to utilise. The North West province notes that construction of the centre in Dr Ruth Segomotsi Mompati will be completed in 2015/16.

According to the Gauteng 'Estimates of Provincial Revenue and Expenditure', the province has not benefited from this conditional grant as it already has government-owned substance abuse treatment centres. However, it is mentioned in the budget that there are plans to construct an additional centre in each year of the MTEF. This is noted under the administration programme, suggesting that the substance abuse sub-programme does not include all relevant expenditure for this province.

KwaZulu-Natal also has not benefited from this conditional grant. The 'Estimates of Provincial Revenue and Expenditure' for the province reports that the over-expenditure in 2013/14 was partly attributable to attempts to address the poor condition of its Newlands Park substance abuse centre, among other facilities.

The 'Estimates of Provincial Revenue and Expenditure' for Mpumalanga reports that the province generates some revenue from patient fees charged at the government-owned substance abuse treatment and rehabilitation centre. This is not discussed further and fees are not mentioned by any of the other provinces.

Transfers to NPOs

For all provincial DSDs combined, between 36.6% and 38.0% of the total budget has been allocated for transfers to NPOs over the period 2011/12 to 2017/18. The figure for 2015/16 is 37.1%. These percentages indicate the extent to which DSD is dependent on NPOs for service delivery. Within the restorative justice programme, the percentage allocated to NPOs is lower than for DSD as a whole, falling from 30.8% in 2011/12 to 26.4% in 2015/16, and then predicted to increase slightly to 26.7%.

Unfortunately, provinces are not required to show in their Estimates of Expenditure publications the amount allocated for NPOs within each sub-programme. Seven provinces do, however, provide such information. Some of them provide further disaggregation of the NPO transfers. The Western Cape does not publish this information, but the Western Cape Provincial DSD provided information relating to transfers in 2015/16 for the purposes of this evaluation. The available information is shown in Table 11. In all provinces for which there is disaggregated information, welfare organisations receive more than half of the NPO allocation. In KwaZulu-Natal, in particular, the budget goes predominantly to non-governmental welfare organisations which provide other services, rather than to treatment centres. The department describes the 20 NPOs that it funds as providing "in-patient, out-patient, halfway house, prevention, and community-based services." The Eastern Cape reports funding five NPOs for drug rehabilitation and reintegration programmes, as well as 25 Teenagers Against Drug Abuse (TADA) projects spanning eight districts.

Table 11: NPO transfers within substance abuse (R000)

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Welfare organisations	*4723*	*4242*	*4585*	*4035*	*3707*	*3911*	*4107*
Priority projects	*3122*	*3476*	*3309*	*2980*	*5303*	*5505*	*5874*
EC total	**7845**	**7718**	**7894**	**7015**	**9010**	**9416**	**9981**
Out-patient clinics	*1274*	*385*	*985*	*1040*	*1040*	*1040*	*1040*
Social service organisations (prevention)	*2422*	*2707*	*5215*	*4530*	*4530*	*4530*	*4530*
Training programmes	*283*	*928*	*291*	*318*			
Residential treatment centres	*626*	*690*	*470*	*640*	*449*	*449*	*449*
Expanded Public Works Programme (EPWP) IG (income generation)		*2637*	*2032*				
FS total	**4606**	**7347**	**8994**	**6528**	**6019**	**6019**	**6019**
GP total	**39612**	**44657**	**55187**	**60193**	**67502**	**71080**	**74634**
Out-patiens clinics	*505*		*861*	*575*	*582*	*613*	*644*
Treatment centres	*1950*		*1076*	*3343*	*3384*	*3563*	*3741*
Welfare organisations	*9726*	*12305*	*10727*	*15886*	*16427*	*17298*	*18163*
KZN total	**12181**	**12305**	**12664**	**19804**	**20393**	**21474**	**22548**
MP total	**7824**	**6944**	**9734**	**10841**	**11000**	**11583**	**12162**
NC total	**1394**	**1423**	**3963**	**1434**	**1482**	**1556**	**1634**
NW total	**5994**	**5972**	**6924**	**11181**	**13294**	**10026**	**11253**
In-patient treatment (Funded beds)					*14981*		
Community-based treatment					*20788*		
Prevention / awareness					*2719*		
Early intervention					*8095*		
Aftercare					*4570*		

Universities (4 specialist courses)					*5407*		
WC total					**56600**		

Mpumalanga lists individual NPO transfers. The list of NPOs funded shows five transfers in each year to different branches of the South African National Council on Alcoholism and Drug Dependence (SANCA) alongside transfers to the Healing Wings Youth Centre. The allocations for Healing Wings show substantial fluctuation from year to year.

Table 12 shows NPO transfers as a percentage of the sub-programme budget for the seven provinces. In Eastern Cape almost all the funds are allocated to NPOs for the first three years. The fall-off in the later years reflects the inclusion of the conditional grant for construction of a treatment centre. The conditional grant also helps explain the sharp decrease in the percentages for the Northern Cape and North West provinces. In Gauteng, half or more of the budget is allocated to NPOs, although the percentage has tended to decrease over the period.

Table 12: NPO transfers as a percentage of substance abuse

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
EC	96%	96%	96%	27%	18%	18%	18%
FS	28%	34%	34%	16%	16%	10%	20%
GT	54%	54%	60%	58%	54%	50%	50%
KZN	28%	30%	33%	42%	28%	27%	27%
MP	38%	33%	37%	34%	35%	35%	34%
NC	19%	25%	20%	0%	3%	4%	7%
NW	39%	26%	18%	0%	14%	13%	14%
WC					58%		

The Western Cape reports that it plans to replace outsourced substance abuse centres with in-house services, in part at least because of “infrastructure constraints” of the outsourced centres. This decision is mirrored in increased allocations for compensation of employees (government salaries).

Gauteng and KwaZulu-Natal note efforts to register existing private and NPO treatment centres.

Provincial service delivery indicators

Provinces are not obliged to report service delivery indicators in their budget books, although these are required in APPs. However, while the estimates of expenditure are all easily downloadable from the National Treasury website, the APPs are not all available online.

Although it is not required, several of the provinces report some service delivery indicators. Some do so only for the three years of the MTEF, which disallows assessment of whether service delivery is increasing. Some include delivery for 2014/15. The number of indicators reported differs across provinces.

Table 13 shows that the Eastern Cape reports on only one indicator. The narrative does not explain why the target for 2015/16 is lower than delivery for 2014/15. Even by 2017/18 the province will not have reached the 2014/15 level.

Table 13: Eastern Cape service delivery indicators

	2014/15	2015/16	2016/17	2017/18
Users who accessed in-patient treatment services at funded centres	255	227	238	250

Gauteng reports the largest number of indicators. None of the indicators show a decrease over time, and almost all show a steady increase. The table shows clearly the extent to which the reach of funded NPOs exceeds that of government facilities for prevention, out-patient and in-patient services.

Table 14: Gauteng service delivery indicators

	2015/16	2016/17	2017/18
Beneficiaries reached through substance abuse prevention programmes managed by government	41771	44110	46580
Beneficiaries reached through prevention programmes by funded NPOs	316218	333926	352626
Out-patient treatment centres managed by funded NPOs	35	37	39
Service users access out-patient centres managed by funded NPOs	17324	18294	19319
Private in-patient treatment centres funded by government	9	10	10
Service users accessing private in-patients centres managed by funded NPOs	1241	1312	1385
Public in-patient treatment centres	1	1	1
Service users accessing public in-patient treatment centres	1360	1436	1517
Service users who completed in-patient treatment at funded centres	259	274	289
Children reached through Ke Moja drug prevention programme	156130	164873	174106
Youth (19-35) reached through Ke Moja drug prevention programme	58837	62132	65611
Persons who received treatment participating in aftercare programme	9056	9563	10099
Anti-Substance Abuse Halfway Houses established	1	1	1
Community-based services	45	48	50
Service users who accessed community-based services	8800	9293	9813
Beneficiaries counselled through mobile counselling service buses	280	296	312
Local drug action committees established in poorest wards/hot spots	45	48	50

Table 15, for KwaZulu-Natal, shows lower targets for 2015/16 than delivery in 2014/15 for two of the four indicators, both of which relate to prevention programmes. For in-patient services, the target for 2015/16 is almost double the delivery for 2014/15. In time it will be seen whether this is realistic.

Table 15: KwaZulu-Natal service delivery indicators

	2014/15	2015/16	2016/17	2017/18
Children under 18 reached through prevention programmes	31394	26740	28077	29481
People 19+ reached through prevention programmes	19052	18092	18997	19947
Users who access in-patient services of funded treatment centres	615	1117	1173	1232
Users who accesses out-patient treatment services	823	967	1015	1066

Table 16 records the three indicators reported by Limpopo. The numbers increase quite sharply for two of the indicators over the MTEF period. The narrative in the Limpopo Estimates of Expenditure notes an increase in 2014/15 of people aged 19 years and above reached through prevention programmes from 99 312 to 160 000. This is not shown in the table. For 2015/16 it records a target of 165 000 children to be reached; more than is recorded in the table.

Table 16: Limpopo service delivery indicators

	2015/16	2016/17	2017/18
Children under 18 reached through prevention programmes	125000	130000	135000
Service users who access in-patient treatment at funded centres	150	220	220
Service users who accessed out-patient treatment services	500	600	700

Mpumalanga provides narrative on service delivery in its estimates of expenditure but not tables. The narrative regarding delivery for 2014/15 contains contradictory numbers, as summarised below:

- 63 of 69 users of public and funded private in-patient treatment centres
- 210 users accessing public in-patient treatment service (contradicts number above)
- 68 users accessing funded private in-patient treatment service (again a contradiction)
- 4 693 or 7 182 children aged 4-18 years reached by Ke Moja
- 3 014, 11 230 or 2 738 youth aged 19-35 years reached by Ke Moja
- 110 users accessing out-patient treatment services
- 336 users reached through social work services

For 2015/16, the planned targets are:

- 220 users of public in-patient treatment service
- 73 users of funded private in-patient treatment services
- 40 000 children reached through Ke Moja
- 22 000 youth reached through Ke Moja
- 2000 service users of out-patient treatment services
- 900 users of social work services
- 150 users of aftercare services

It is difficult to assess how realistic these targets are because of the contradictions in the numbers reported for 2014/15. However, the two targets for Ke Moja seem unrealistic when compared with all the relevant service delivery numbers reported for 2014/15.

Table 17, for Northern Cape, shows substantial increases between 2015/16 and 2016/17 for three of the four indicators. Again, time will tell whether this is realistic. For two of the three indicators there is no further increase between 2016/17 and 2017/18

Table 17: Northern Cape service delivery indicators

	2015/16	2016/17	2017/18
Service users who accessed treatment services at funded centres	151	169	169
Persons receiving community-based services – NPO & government	820	940	959
New clients receiving aftercare services	127	169	169
Prevention programmes implemented	308	308	308

Table 18 for North West, shows a substantial increase in the numbers reached by public in-patient services between 2015/16 and 2016/17. This is expected given the new treatment centre constructed with the conditional grant. Unlike most other provinces, North West records far more people aged 19+ than children to be reached by prevention programmes. In other provinces the number of children usually far exceeds the number of older people reached.

Table 18: North West service delivery indicators

	2015/16	2016/17	2017/18
Service users who have accessed public in-patient centres	216	396	396
Prevention programmes implemented for children	1	1	1
Children 18- reached through prevention programmes	128500	141350	155485
Preventions programmes implemented for youth	1	1	1
People 19+ reached through prevention programmes	233171	256488	282136

Western Cape Provincial DSD provided information for 2015/16. The NPOs funded include universities and the Medical Research Council.

Table 19: Western Cape service delivery indicators

Targets	**Number of NPOs funded**	**Target**
In-patient treatment (Funded beds)	5	695
Community-based treatment	11 NPOs at 20 sites	3514

Prevention / Awareness	3 programmes (Foetal Alcohol Syndrome)	1920
Early intervention	21 NPOs at 28 sites	3950
Aftercare	13 NPOs at 16 sites	2100
Universities (4 specialist courses)	4	67
Research (Medical Research Council)	1 research project	

Substance abuse in the national Department of Social Development budget

Substance abuse is one of 12 sub-programmes within the welfare services policy development and implementation support programme of the national DSD. The welfare services programme, in turn, is one of six programmes within NDSD's budget. In 2015/16 substance abuse was allocated R62.6 million of the R662.4 million allocated to welfare services and the R138 169 million allocated to national DSD as a whole.

One component of the money allocated for substance abuse is for the Central Drug Authority (CDA), and the main objective of the sub-programme is ongoing monitoring of the NDMP. The National Treasury official reported that the CDA allocation for 2015/16 stood at about R6 million. As seen in Table 20, there is also an allocation in respect of transfers for national NPOs. DSD's Annual Report for 2014/15 shows R1,2 million going to the SANCA for 2014/15. It is not clear which other NPOs are funded by this sub-programme.

Table 20 shows substantial fluctuation in the total allocated for substance abuse over the period. In particular, the amounts for 2014/15, 2015/16 and 2016/17 are much larger than for other years because of the inclusion of the conditional grant for substance abuse treatment centres. This money is intended to be transferred to the provinces (as seen in the provincial budgets discussed above) and thus represents double counting if the provincial and national allocations for substance abuse are added together. In 2017/18, when the conditional grant comes to an end, substance abuse will account for 2,4% of the welfare services programme budget and 0.01% of the total national DSD budget. (The very small percentage here is largely explained by the fact that DSD includes the allocation for social grants.)

Table 20: Substance abuse in the national Social Development budget (Rm)

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Substance abuse, of which	14.9	12.9	29.5	62.7	62.6	63.2	16.4
Of which conditional grant				29.0	47.5	47.5	
- NPO transfers	1.7	3.2	2.6	2.8	2.9	3.0	2.9
Substance abuse excluding grant	14.9	12.9	29.5	33.7	15.1	15.7	16.4
Of which national NPO transfer	1.7	3.2	2.6	2.8	2.9	3.0	2.9

3.2.1.4 Budget allocation and sources for the CDA, PSAFs, LDACs and treatment centres

Central Drug Authority

The CDA produces annual business plans that they submit to DSD for inclusion in its bids to National Treasury. However, because the CDA did not have a separate budget, the allocations were not ring-fenced and the resources were instead used for other programmes. The CDA's dependence on DSD meant that it had to "*wait for our handout*" and were not able to implement their business plan. However, on the recommendation of the Auditor-General a separate budget for the CDA was established. The budget was based on the plan submitted by the CDA.

It was raised by CDA members that the fact that the chair is a DSD official resulted in difficulties in differentiating the needs of the CDA from those of the department. The CDA has requested a costing of the NDMP, but this has been turned down by the DSD, as the Prevention of and Treatment for Substance Abuse Act had been costed[20]; all respondents indicated that this costing has not been used.

Provincial Substance Abuse Forums

National Treasury does not fund provincial departments. Instead, allocations are made to Provincial Treasuries. The latter, in turn, allocate funds to provincial departments.

Provinces are meant to allocate money for the NDMP, but not all of them have done so. It was unclear how much each province allocated except what has been allocated from the provincial DSDs (see section 4.3.1.3).

PSAF interviewees across provinces were clear that there was generally no budget for the PSAF itself. Further, it was generally only DSDs among the provincial departments that had a dedicated budget for substance abuse. Beyond DSDs, departments were said to be required to mainstream substance abuse into their existing programmes. For example, substance abuse education could be incorporated into a sports day event.

Several interviewees noted that the PSAF itself did not require a big budget, as it was not an implementation body. Instead it served as a forum for sharing information.

Local Drug Action Committees

Municipalities are meant to provide funds for the LDACs, but the majority of respondents indicated that except for two LDACs (Welkom and Kroonstad) this did not happen. One of the reasons given was that the mayors did not see it as a priority. It should, however, be noted that there are pockets of initiatives where the mayors have funded substance abuse initiatives (e.g. the Mayor of Tshwane had committed R15 million to fight drug abuse and had funded a summit).

Across provinces, the lack of funding from municipalities was borne out by most LDACs. The common pattern was that different "stakeholders" were expected to fund their own activities using their own budgets. The main categories of expenditure were related to events. These typically included refreshments and transport, often only for the officials involved. There were examples where some municipalities were said to provide free venues for events or access to municipal cars. For example, in Swartland it was said that while the LDAC was an unfunded mandate, the Municipal Development Fund and West Coast district provided some funding; between R10 000 and R15 000 in the case of the district. While there were no funds

[20] The evaluation team was unable to obtain the costing of the Act.

for running and management of the LDAC, existing resources were used effectively and the amount provided by the Municipal Development Fund and the West Coast district enabled the LDAC "to do everything they wanted to do". For example, if community representatives needed transport for meetings and road shows, police and municipal cars were used.

Most LDAC interviewees were not aware of a budget for substance abuse at municipal level. Cape Town was an exception, in that there was a budget of R4.5 million for this area. In Cape Town, the substance abuse area did not have a line item for the LDAC, but the LDAC was sometimes able to access funds on an ad hoc basis for particular activities. Other City departments meanwhile funded relevant activities. For example City Health funded "*matrix*" clinics while Safety and Security funded a Drug Unit. One of the Cape Town officials noted that the budget in the City was "tight", but that many other municipalities had no funding at all, and therefore no relevant services and facilities.

An official from KwaZulu-Natal said that while community-based organisations, municipalities and other stakeholders might allocate funds, this would only be within their own key performance areas. However, there were no funds for "targeted interventions" developed by the LDAC.

eThekwini's LDAC reported that it used budgets for communication and for vulnerable groups for LDAC activities, and also fundraised from business; for example, from local bakeries for rolls, and from Coca Cola for drinks when there were events.

Richards Bay's LDAC seemed less successful in managing without a dedicated budget. They said that they had planned a holiday programme for children to prevent, or replace, the usual big end-of-year "concert", known locally in isiZulu as *kulahlwa amapeni* ('throwing pens away'), where drugs and alcohol are usually available. However, the LDAC was unable to implement the programme because there were no funds.

It appears that Gauteng Province might be the only province that funds the LDACs. In Gauteng, LDACs are required to submit business plans which had initially been funded at R50 000 per region. The local plans were consolidated into regional plans, which were further consolidated into a provincial implementation plan. The funds provided by the province were supplemented by departmental budgets (for example, the DOH might fund an awareness campaign), while the municipality was expected to provide the venue and refreshments for meetings.

LDAC interviewees in Roodepoort described different ways in which they had sourced funds. These included submitting proposals or annual action plans, with budgets, to private donors as well as to DSD. The main source of funding appeared to be provincial DSD. In some, perhaps all, cases the submission is done through the regional LDAC committee. One respondent said that approximately R200 000 had been made available, which was divided among the LDACs in the area. Funds were spent, among other items, on awareness campaigns; door-to-door visits; road shows; camps and school talks, with refreshments as the main expenditure item.

National DSD officials and CDA experts mentioned that after the planned audit of the LDACs, CDA hoped to motivate to Treasury that the LDACs be given resources through the provincial DSDs. This had reportedly happened in the past, but the money was not ring-fenced. The LDACs were also hamstrung in that they could not open bank accounts as they were not registered as NPOs.

Treatment centres

Interviews were conducted with 26 treatment centres and substance abuse service organisations in different provinces. Some of the centres were NPOs, some were private for-profit bodies, and a few were government-run.

Many, but not all, of the NPOs said that they receiving funding from DSD. They have furthermore secured additional funding through funders like the National Lottery, Community Chest, trusts and corporate social investment (CSI). Some of the NPOs also charge fees from their clients, while others are able to get payment through medical aids. Others run

fundraising activities like golf days and other corporate events or income generating activities.

Some of the challenges raised by the NPO treatment centres funded by DSD included that DSD only wanted to fund a four-month treatment programme, but not a prevention programme; serious delays in payments from DSD; the subsidy had also increased by only 1.2% on the 2014/15 amount and not the CPI-regulated index; and the subsidy was far too low.

Some of the private centres supplemented revenue from fees through fundraising. Two mentioned using golf days for this purpose. Several noted that the fees were often paid by medical aids. One specified that 80% of its payments came from medical aid, leaving only 20% to be paid by their private clients.

The six government treatment centres are all fully funded by government and had patients referred by public hospitals and social workers.

4.3.1.1 *Sufficiency of budget allocation*

As expected, for the most part interviewees from national departments, CDA, PSAFs, LDACs and treatment centres said that budget allocations were insufficient. Both explicit and implicit observations about insufficiency of budgets are recorded in previous sub-sections of this discussion on financial resources.

One of the main challenges is that neither the CDA nor the DSD can engage the Treasury around the NDMP activities. The DSD only engages the Treasury about treatment centres and facilities, which fall within their particular mandate, but not around the NDMP more broadly. It was, however, noted that DSD could not, in fact, ask that the NDMP as a whole be budgeted for as each department had to engage the relevant sector experts in Treasury in respect of their particular budget.

It was raised by a respondent from the National Treasury that the budget process was not tailored to deal with integrated plans because while departments and other agencies might plan together, budgeting was done agency by agency. It would thus be relatively easy for departments like DSD, which had a key role in the NDMP, to engage on funding for their mandates. They would need to do so by putting together a proposal, which Treasury would assess and which would then go through a lengthy formal budget process involving several committees before being submitted to Cabinet.

It would be more difficult for departments with smaller mandates to access funding as they were unlikely to put the NDMP-related activity “on top of their list” when making proposals to Treasury. For example, DOH would prioritise funding of National Health Insurance over the NDMP.

The National Treasury has a section responsible for inter-sectoral support, which includes programmes like the Expanded Public Works Programme (EPWP) and Early Childhood Development (ECD). For this type of inter-sectoral issue, a department would need to show how their activities contributed to the desired outcomes and follow up with other departments to ensure that they submitted appropriate plans. In such cases, Treasury would not recommend funding of the activities unless it was clear that all the key activities were in place for implementation. It was furthermore raised that substance abuse activities might be “integrated” but not “interlinked”, in that one department’s activities did not depend on the activities of another. This meant that Treasury could recommend funding of treatment centres without doing so for other activities in the plan. It was furthermore noted that the Auditor-General focused its audit on individual departments rather than cross-departmental plans, which consequently would not highlight missing elements.

Another challenge in respect of DSD’s role in the NDMP is related to data. DSD could not, for example, provide Treasury with information on how many people were receiving services in respect of substance abuse, let alone the number who might need services. Treasury itself undertook research and analysis to try to fill this gap, but the absence of information would affect how all proposals in respect of the NDMP were received. An official from the National

Treasury said that it had been relatively easy to get approval for funding of government-owned treatment centres, as centres and patients were easy to "count". A conditional grant was provided for four such centres in the 2014 MTEF process, as discussed elsewhere in this report. The challenge now was the funding of operational costs, which would need to be provided for in provincial budgets.

One expert suggested that the majority of resources were being spent in the wrong areas, such as policing, in-patient rehabilitation and Ke Moja. In respect of the latter, the expert said there was no evidence showing that the programme worked, while there was evidence saying it "does more harm than good". The expert observed that there would never be enough funding, but felt that "money is there but spent in the wrong areas".

One government official said that allocations from both government and non-government sources were not sufficient. The many individuals without medical aid are reliant on government centres, where there are long waiting lists, with the situation described as "dire". Many communities had no facilities at all, whether government or non-government. Furthermore, the standard of services varied greatly and was not well regulated. "Reorientation" of substance abuse as a health problem had, however, assisted in prioritising the issue.

Unsurprisingly, many NPOs and other treatment centres said that funding was inadequate. Some NPOs referred to the number of people they turned away as an indication of the need for services. NPOs also emphasised the unaffordability of private services, as well as the concentration of private services in urban areas. Virtually all noted that their funding was insufficient. They reported that the government subsidy accounted for between 25% and 80% of their expenditure. Several noted that they would be able to do far more if the subsidy was increased.

4.3.1.2 *Percentage of the costing of the Act provided in terms of budget allocation*

A costing was done of substance abuse services alongside several other DSD service areas (social crime prevention, children, older persons, victim empowerment). The costing was funded by the UNODC and finalised in 2012. The exercise was not intended to provide an estimate of the cost of providing services to all in need, as it did not include estimates of the number in need of services; instead, these costing models allow for an estimate of the cost of providing particular services, such as in-patient treatment, to a given number of users. Because government does not have estimates of the numbers in need of the various services, it is not possible to calculate the percentage of the costing provided by budget allocations even for DSD, which is the only government agency with an explicit budget allocation for substance abuse.

In the absence of information on a costing, it is not possible to estimate the percentage of the costing allocated. Even if the costing were available, a percentage calculation would be difficult because, as seen above, budgets for substance abuse are not separate in most agencies.

4.3.1.3 *Extent of CDA influencing and facilitating the rationalisation of existing resources*

Interviewees were asked how the CDA and/or NDMP influenced the allocation of budgets. Most responses indicated that the CDA did not have much, if any, influence over budget allocations by other agencies. Most of the national departments gave a clear "no" in response to this question. This is despite the acknowledgement of some of the departments that the CDA has guided where money should be spent by defining outcomes and targets for departments.

Responses generally suggested that if the power to influence lay anywhere, it was within DSD. There were a few references to DSD's success in taking forward a bid for national funding which resulted in the conditional grants for treatment centres in provinces without any public treatment centres.

Some of the CDA members said that the CDA was able to influence, but the influence was limited. The first route for influence was in the IMC, through CDA members who were part of the IMC task team. The second route for influence was the Portfolio Committee for Social Development, where the CDA chairperson made presentations. However, the CDA had not received feedback on whether this was being done.

Many interviewees bemoaned the fact that CDA was dependent on DSD for funding. Some suggested that the CDA be given the status of a public entity so as to give it greater control over its budget. Public entities are however generally funded through departmental budgets. For example, the National Development Agency (NDA) and South African Social Security Agency (SASSA) are financed through transfers from national DSD.

Some of those who proposed that the CDA be independent and be given a larger independent budget might have seen it as an implementing body, rather than one responsible for oversight and coordination. One expert noted: “I would be frustrated if I were with the CDA and a lot of emphasis is placed on them as an implementing agency.” Currently the cost drivers or standing items in the budget are for meetings of the agency, payment of board members and travel and accommodation for non-governmental members, consultation and printing. All these expenses relate to oversight-type activities rather than implementation.

At national level, there were few, if any, indications that the CDA or NDMP had resulted in rationalisation of resources. Instead, one interviewee complained that the various agencies did not “synergise” activities, suggesting that in particular the different agencies should capitalise on each other’s campaigns so as to achieve better outreach.

There were some suggestions that the PSAFs (rather than the CDA) had resulted in a rationalisation of resources. This had reportedly happened through sharing of information so that different agencies did not duplicate activities. In Gauteng, for example, DSD and Department of Education collaborated on camps for learners rather than each doing this activity separately.

Several PSAF interviewees, particularly in the Western Cape, said that the existence of the PSAF had enhanced efficiency and avoided duplication of resources. The DOH was named more than once as collaborating with other departments, such as DSD and DOA. A local government representative said that they had shared information on intervention centres with the Department of Education which was now able to make referrals when contacted by schools.

In Gauteng, the DSD PSAF representative felt that the PSAF had facilitated a more efficient use of resources with regards to LDACs in the communities. However, in the Northern Cape a PSAF representative felt that duplication of services persisted, especially in respect of prevention. For example, the representative said that duplication of door-to-door campaigns “confuses the community”. Further, SAPS did not collaborate with other departments when doing raids. The duplication was exacerbated by different people attending meetings on behalf of departments, and by representatives failing to give feedback to their colleagues.

4.3.1.4 *Concluding summary*

With the exception of the DSD none of the national or provincial departments have a separate budget for substance abuse and as a consequence they are unable to provide a figure for their NDMP-related activities. Furthermore, to date the NDMP 2013 – 2017 has not resulted in any change in budget allocations in the departments with the exception of DSD.

A total of around R0.6 billion is allocated by DSD for prevention of substance abuse in the nine provinces. All provinces recorded a real increase in budget for substance abuse and all but Free State and Mpumalanga doing so for the MTEF period. Some of the provinces, namely those without government substance abuse treatment centres, have received conditional grants for this purpose.

Although provincial DSDs transfer more than one third of their budget to NPOs, it is not clear from their budget books the amount allocated for NPOs within each sub-programme (i.e. substance abuse).

At national DSD, the allocation to substance abuse for 2014/15, 2015/16 and 2016/17 are much larger than for other years because of the inclusion of the conditional grant for substance abuse treatment centres. In 2017/18, when the conditional grant will have come to an end, substance abuse will account for 2.4% of the welfare services programme budget and 0.01% of the total NDSD budget.

Until recently, the CDA did not have a separate budget. For the PSAF itself there is no budget. The provincial DSD has a dedicated budget for substance abuse as the only provincial department. Municipalities are meant to provide funds for the LDACs, but this did not happen as the mayors did not see it as a priority. The different stakeholders on the LDACs are therefore forced to fund their own activities using their own budget. It appears however that the Gauteng Province provides funds for the LDACs. The treatment centres run by NPOs which receive DSD funding raised that the amount is not covering expenses, and that they have to fundraise elsewhere to support their activities.

The budget for substance abuse is inadequate to provide the services and activities as envisaged in the NDMP. This evaluation found that the budget process was not tailored to deal with integrated plans because while departments and other agencies might plan together, budgeting was done agency by agency as the NDMP is not considered an inter-sectoral programme by the National Treasury.

Respondents indicated clearly that neither the CDA nor the NDMP has been unable to influence the allocation of budgets by other agencies; nor resulted in rationalisation of resources as stipulated in the Prevention of and Treatment for Substance Abuse Act, section 56. However, it appears that rationalisation of resources has happened at PSAF level.

3.2.2 Human resources[21]

All systems rely on sufficient numbers of appropriately skilled or qualified people to run them. Without this, it cannot be assumed that the systems will function. Hence, the NDMP includes an attempt to ensure that the relevant role players allocate sufficient human resources to address the problem.

Through integrated planning and reporting, the CDA should be in a position to identify strategies for supporting training and development that can strengthen the impact of the NDMP.

At the level of coordination, the CDA is expected to provide capacity building and conduct selection and induction of CDA and PSAF members (TOC, 2015, pg. 12).

[21] Details on the functionality of the CDA and level of participation by government departments on the CDA are discussed in detail in section 3.3.1 of the report.

3.2.2.1 Extent of capacity building of members of the CDA, PSAF and LDAC to fulfil their function

According to the NDMP, the primary role of the CDA is to develop the NDMP and to direct, guide and oversee its implementation, as well as monitor and evaluate its success and to make necessary amendments to the plan (DSD &CDA, 2013, pg. 9).

The members of the CDA are not implementers themselves, but are required as members to play a capacity building role in the following ways: facilitating the establishment of the PSAFs and LDACs; liaising between the CDA and PSAFs; as well as attending meetings and guiding and advising such forums regarding the interpretation and implementation of the NDMP and DMPs (DSD &CDA, 2014, pg. 6).

In line with this, the CDA (Secretariat) Action Plan contained in the NDMP 2013-2017 reflects the following broad capacity building activities for each financial year:

- Conduct induction and develop capacity of CDA members
- Select PSAF and LDAC members and do induction and build their capacity
- Increase membership and capacity of PSAFs and LDACs in all provinces to optimum level

However, the plan does not speak specifically of the type of capacity building required to achieve these. (for example workshops, conferences etc.).

The section below assesses the extent to which members of the CDA, PSAF and LDAC have been exposed to capacity building to fulfil their functions.

Whilst the 2013/2014 CDA Annual Report makes no reference to the capacity building activities of the members of the CDA, the 2014/2015 Annual Report mentions a capacity building workshop with fourteen national departments as a key achievement, together with assistance being provided to the DOJCD, DOT and SAPS to develop their departmental DMPs (DSD &CDA, 2015, pg. 32).

Interviewees from the CDA secretariat indicated that, whilst there has been no specific, targeted training for CDA members, capacity and knowledge is built by sending them to conferences and new members receive orientation materials. Interviewees from national government departments gave mixed responses when asked about the extent of capacity building for members of the CDA to fulfil their function as members. Of the 14 interviewees who responded to this question, six indicated that CDA members had received one to two days of capacity building on the NDMP, reporting templates and the TOC; five were unsure; and three indicated that members had not received any training thus far.

With regards to the extent of capacity building of members of PSAFs to fulfil their function, both Annual Reports make reference to assessment and training of the provincial support structures of the NDMP. In the 2013/2014 reporting period, an assessment of the training needs of the provincial support structures was made; meetings were held with the CDA supporting structures (PSAFs) and training was undertaken (DSD &CDA, 2015, pg. 30).

The 2014/2015 Annual Report indicates that provincial forums received capacity building, whereby stakeholders in nine provinces were trained in implementing the prescriptions and regulations of the Substance Abuse Act 70 of 2008, and on the components and implementation of the NDMP (DSD &CDA, 2015, pg. 35). However, the reports give little detail about the length and content of the training, or the purpose of the capacity building.

More detail was provided in the interviews with members of the CDA Secretariat who confirm that they have conducted two-day training sessions with each of the PSAFs (and some of the LDACs). The training was undertaken by CDA members and experts, and the content included the broad topics: of the NDMP; how to develop a provincial DMP; and community mobilisation. There is no standardised training manual developed on any of these topics but a PowerPoint presentation is used by CDA members and experts which specifies the outcomes for the workshop as to:

- Describe the vision, mission and strategic principles of the NDMP

- Explain the integrated strategy of the NDMP 2013-2017
- Define and identify the priority areas of the NDMP and those of own organisation
- Describe the key outcomes, outputs, and measures of achievement of the NDMP
- Describe the provincial/departmental DMP format, purpose and scope
- Using the strategic planning model develop a DMP that meets specified criteria
- Describe the monitoring and evaluation model

PSAF interviewees from the Northern Cape, Western Cape and Gauteng report having received capacity building on the NDMP whilst those from KwaZulu-Natal report that they have not received any thus far.

Capacity building of the LDACs rests with the PSAFs, which are required to assist LDACs, according to Section 60 of the Substance Abuse Act (70 of 2008) in the performance of their functions.

The CDA annual reports provide evidence that capacity building activities have been undertaken at LDAC level in order to assist these groups to fulfil their function. However, it appears that this training was undertaken in an ad hoc manner and to varying degrees across provinces.

The generalised nature of the CDA annual reports makes it difficult to determine who undertook the training, who was targeted, and the content and duration of the training. The PSAF annual reports (where available) provided some more detail on capacity building activities in general. The data from both sources is captured in the table below.

Table 21 Summary of training activities of PSAFs and LDACs to fulfill their functions[22]

Province	Content	Trainer	Target group	Number of participants	Date
KwaZulu-Natal	Consultation on Substance Abuse Policy	National Department of Social Development	Officialsand stakeholders	34	7th to the 8th of November 2013
	Training on the Prevention of and Prevention for Substance Abuse Act 70 of 2008.	National Department of Social Development	Officials and stakeholders	32	8th to the 10th of October 2013
	Training on the NDMP	National Department of Social	Officials and stakeholders	68	19th and 20th of September

[22] Data for the table was obtained from CDA Annual Reports (2013/2014 and 2014/2015) and PSAF reports (where available).

		Development			2013
	Provincial review of the Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008)	*No data*	Officials and stakeholders	30	4th of April 2014
	Provided inputs and attended a national review of Act 70 of 2008	*No data*	*No data*	*No data*	22nd and 23rd of April 2014
	Training on the Prevention of and Prevention for Substance Abuse Act 70 of 2008.	*No data*	Government officials and stakeholders	40	8th to the 10th of September 2014
Northern Cape	Integrated substance abuse strategy	*No data*	Stakeholders serving on the Provincial Substance Abuse Forum	*No data*	May 2013
	Training on strategy	*No data*	Local drug Action Committees: Britstown, Noupoort, Phillipstown	*No data*	2013/2014
Free State	NDMP	*No data*	LDAC members	133	2013/2014
	LDAC capacitating programme	*No data*	LDAC members	66 (3 sessions)	2014/2015
Gauteng	Substance abuse Act	*No data*	Service providers and community members	125	2014/2015
	NDMP	*No data*	Service providers and community members	318	2014/2015

	Share info, best practices, reporting	*No data*	LDAC members – 3 representatives from each LDAC	*No data*	2014/2015 (Quarterly basis)
Mpumalanga	NDMP and Substance Abuse Act	*No data*	No data	*No data*	2013/2014 (Two trainings)
	Provincial Drug Master Plan	*No data*	No data	*No data*	2014/2015 (Two trainings)
Limpopo	Substance Abuse Policy	*No data*	Government officials and stakeholders	50	2014/2015
	NDMP	*No data*	Stakeholders	47	2013/2014
North West	Guidance	*No data*	LDACs	*No data*	2013/2014

There was no data available on the capacity building activities of PSAFs and LDACs in the reports for Western Cape and Eastern Cape.

The interviews reveal that PSAFs are at different stages of implementing capacity building for LDAC members. The Northern Cape PSAF interviewees indicated that capacity building on substance abuse has been limited thus far but has been included in DSD's 2016 annual plan, and this will assist with funding allocations for this year. The Gauteng PSAF has partnered with the University of Johannesburg to work on a training programme on substance abuse. The Western Cape PSAF indicated that they have been assisting the LDACs and that they will develop training plans and manuals. They will then roll out the training once the MEC has appointed members and legislated the PSAF, and once a provincial DMP has been developed. KwaZulu-Natal PSAF reports that no training of LDACs have been undertaken thus far.

All six of the LDACs[23] included in this evaluation confirm that they have received training either by the CDA or by provincial DSD. However, some respondents indicated that it was more of a once-off information sharing session on the background to the NDMP, rather than training on their function per se.

Besides this, four of the six LDACs indicated that they have received additional training and workshops focused on improving their technical competency around substance abuse related issues, such as identification of substances and dealing with cases of substance

[23] Eldorado Park, City of Cape Town, Richard's Bay, Swartland, Pampierstad, Roodepoort

abuse, for example through referrals. Other topics mentioned include counselling skills; focus group training; and gender-based violence.

This training is being undertaken by a range of stakeholders at local level including SAPS, chairpersons of the PSAF, treatment centres and faith-based organisations. In one case the training was funded by the local municipality (Swartland, Northern Cape).

3.2.2.2 Strengths, challenges and gaps in capacity building of members of the CDA, PSAF and LDAC to fulfil their function

One identified strength is that capacity building has been implemented with national departments and PSAFs on the development of departmental and provincial DMPs. This has enabled them to fulfil their function of developing these plans as laid out in Section 56 (d) and Section 58 (d) of the Substance Abuse Act (2008). As a result, the PSAFs have developed or are in the process of finalising their provincial DMPs. However, not all departmental plans have been developed, despite receiving training[24].

Interviewees frequently mentioned among their challenges that the training for PSAFs and LDACs has been insufficient and once-off in nature, and therefore does not fully prepare them to fulfil all their functions as laid out in Sections 58 and 60 of the Substance Abuse Act (2008). For example, they need to develop skills beyond planning and have capacity building on how to implement or operationalise the provincial and local plans.

The main reasons cited for insufficient capacity building are that the CDA secretariat does not have the human and financial resources to develop and roll out a comprehensive capacity building strategy for all structures; that there has been limited funding allocation for training on substance abuse by provincial departments (DSD); and that specialists in this sector are often expensive to contract for capacity building.

A further barrier to ensuring adequate capacity of members of PSAFs and LDACs is that new recruits have missed the initial once-off training and now lack the basic knowledge about their role and function:

> *"Once-off training on the plan is problematic as people leave and then new people do not get in-service training on the NDMP." (LDAC member, KwaZulu-Natal)*

Some interviewees also indicated that people on the local level struggle to understand the NDMP document.

> *"The CDA needs to simplify the NDMP for people on the ground.". (LDAC member, Gauteng)*

Without this basic knowledge, it is difficult for LDAC members to understand how their work on the ground is contributing to the "big picture" of reducing substance abuse. The lack of a user-friendly, standardised training manual or guideline document is therefore a barrier to future capacity building for PSAF and LDAC members.

3.2.2.3 Government stakeholders' capacity to implement programmes and services

According to the NDMP TOC, the CDA should be in a position to identify gaps in human resources capacity through integrated planning and reporting.

[24] Details on which departments have produced Departmental DMPs is contained in section 4.2.1.1 of this report.

There are no statistics on the exact numbers of social workers in government and CSOs who are providing substance abuse services and programmes. The overwhelming majority of respondents (31 out of 36) from CSOs, CSO treatment centres and government treatment centres stated that the human resources to provide services in the substance abuse sector are inadequate to deal with the scale of the problem in the country. The most frequently mentioned barrier is inadequate funding to afford "specialist salaries".

> *"One of the barriers is that NGOs cannot afford to pay market related salaries. This makes it difficult to get skilled people to come work for NGOs. In rural areas it is difficult to find a registered nurse who is working with substance abuse." (CSO treatment centre, Western Cape)*

As the above quote suggests, substance abuse specialists are a scarce resource in particularly rural areas. It was also noted that government social workers are often "spread too thin" as they have to supervise social auxiliary workers and provide services for a range of clients.

> *"The biggest problem is DSD – it is so short-staffed that social workers share programmes – substance abuse, disability, aged. They focus on so many problems in the community that drug abuse is not prioritised." (Government treatment centre, Mpumalanga)*

However, one of the 36 respondents provided an interesting perspective stating that the problem does not lie with inadequacy of human resources, but rather with the limited sharing of resources and poor networking.

> *"I don't think we are short of human resources, if we use them widely…people work in silos and there is no sharing or networking or 'working smart'…we can piggy back addiction with ARV (anti-retroviral) clinics and TB clinics as they are doing a lot of the (substance abuse related) work already." (CSO, Gauteng)*

In terms of skills level, it was mentioned frequently by interviewees at treatment centres that substance abuse is a specialised skill and that "not just any social worker can provide substance abuse treatment". Despite this, it is mostly social workers who work in drug treatment centres, many of whom have not received specialist training.

It was mentioned frequently by respondents from treatment centres that the registration requirements of treatment centres stipulates that staff must be qualified to treat people with addictions. This is reflected in the Substance Abuse Act (2008) sections three and four respectively, which state the following:

- No person may be involved in the treatment, rehabilitation and skills development of people abusing substances or affected by substance abuse unless such person has completed an accredited training.
- The accreditation contemplated in subsection (3) must be provided in terms of the South African Qualification Authority Act, 1995 (Act No. 58 of 1995)

According to a key expert there are hardly, if any, people studying for a Master of Philosophy (Addiction Psychiatry). There are very few doctors being trained to work in the field of addiction. This is a problem in relation to the burden of disease that addiction presents.

Some respondents mentioned that the Universities of Stellenbosch, Western Cape and Cape Town provide courses on substance abuse. These are at postgraduate level; besides these, there are currently no other accredited courses on substance abuse.

The lack of diverse courses that cater for different needs and that build capacity at different levels is therefore a significant barrier to ensuring there are sufficiently skilled people working in the sector and implementing good quality programmes and services.

The Colombo Plan was mentioned by two national level interviewees as a good example of internationally recognised training. The aims and objectives of the Colombo Plan are: to promote technical cooperation and sharing of technology among member states, and to review relevant information. It also aims to facilitate the transfer and sharing of development experiences among member countries, especially those in the Southern Hemisphere. There

are four permanent programmes carried out by the Colombo Plan. These are the Drug Advisory Programme; the Programme for Public Administration and Environment; the Programme for Private Sector development and Long Term Scholarships Programme.

According to the 2014/2015 CDA Annual Report, the CDA has supported the Colombo Plan initiatives, programmes and training sessions within South Africa. It was also noted that, when accredited by the South African Qualifications Authority (SAQA), the various programmes should be valuable tools in the CDA's efforts to strengthen its support structures (PSAFs and LDACs) (DSD &CDA, 2015, pg. 18).

Only two of the interviewees provided further detail on the progress in developing these programmes, indicating that the CDA is currently discussing collaboration with UNODC regarding the Colombo Plan, around issues of capacity building. They further indicated that DSD has appointed a service provider to develop a plan, presumably based on the Colombo Plan. A key objective of the CDA Business Plan (2014/2015) is to adapt the Colombo Plan to the South African context; the related activities include developing a TOR for accreditation[25] of Colombo Plan substance abuse programmes (DSD &CDA, 2014, pg. 8).

To address the current gap in accredited training, most of the CSOs and treatment centres have developed their own materials and training programmes on substance abuse to up-skill staff. Some centres report that DSD occasionally makes use of these training programmes.

Building the capacity of government stakeholders to implement programmes and services to address substance abuse is a key component of the NDMP 2013-2017. Professional education and training on substance abuse and related illnesses is identified as a priority area for addressing substance abuse problems in the NDMP 2013-2017 (DSD &CDA, 2013, pg. 35). Despite this, the Annual Reports reveal that capacity building undertaken by government departments is limited and conducted on an ad hoc basis. In the 2013/2014 reporting period only two departments reported on capacity building interventions:

- DSD capacitated 457 stakeholders in nine provinces to implement Act 70 of 2008 and its regulations;[26] and 90 service providers in the Eastern Cape, Gauteng and Free State to implement a social mobilisation strategy.
- DTI undertook capacity building sessions, targeted at National Liquor Authority registrants and SAPS members to enhance understanding of the Liquor Act 59 of 2003.

Similarly, in the national departmental reports, two departments report on capacity building activities in the 2014/2015 Annual Report:

- DSD trained stakeholders in nine provinces on implementing the prescriptions and regulations of the Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008), as well as on the components and implementation of the NDMP;
- DCS trained140 employees on countering substance abuse amongst offenders and employees; and trained health care operational managers on medicine management.

[25] The report does not state which body, SAQA or SETA, has been approached for accreditation.

[26] The report does not provide details on which section of the Substance Abuse Act are covered in this capacity building.

Reporting by the PSAFs reveals that numerous training interventions have taken place across the provinces on a range of topics. The trainings target multiple stakeholders including government officials. However, as mentioned previously, there is little detail in the CDA Annual Reports and PSAF reports on the content, duration or target groups for this training. This gives the impression that these training interventions have been implemented in an ad hoc and uncoordinated manner.

3.2.2.4 Concluding summary

According to the Substance Abuse Act (2008), Sections 56, 58 and 60, the CDA is responsible for supporting national government departments and PSAFs to fulfil their functions, and in turn PSAFs are required to support LDACs to fulfil their functions.

The findings from this section reveal that capacity building of CDA and PSAF members has taken place to support the development of departmental DMPs and provincial DMPs. Furthermore, some LDACs have received training on the NDMP and additional technical training on substance abuse. With limited details in the reports, it is difficult to assess the full extent of the training, however, the overall impression is that capacity building has generally been once-off and has not been sufficient for LDACs to fulfil their functions as specified in the Act. There are also no standardised training materials or guideline documents. The main barriers cited are the CDA's lack of resources, both human and financial, and the limited allocation of budgets for training from provincial departments.

Some aspects of substance abuse are highly specialised, particularly in relation to treatment; as such the ability of government officials to implement substance abuse programmes and services remains limited. Academic institutions do not offer undergraduate courses (neither degrees nor short courses) in substance abuse. There are courses at postgraduate level at some universities and most of the staff working at treatment centres and CSOs develop their specialist skills through in-service training. There is an absence of accredited courses on substance abuse targeting personnel working at different levels of the system. The findings reveal that the workforce in this sector is stretched and inadequate both in terms of numbers and skills, although it could be argued that there are cases where the current resources are not being used efficiently.

Respondents identified a range of topics which should be included in the capacity building of the CDA, PSAFs and LDACs. These fit into two broad categories; those related to the functioning of the CDA, PSAF and LDACs and those related to technical issues of substance abuse. These are captured in the table below according to each structure and should be considered for inclusion in the development of a capacity building programme or strategy.

Table 22: Capacity building needs of the CDA, PSAFs and LDACs

Structure	Capacity building required to improve functionality	Technical capacity building required on substance abuse
CDA	• Programme management • Issues of governance of the CDA • M&E • Participatory workshop methodologies to ensure adequate feedback from provincial and local structures • How to coordinate	• Substance abuse – including up to date information on substance abuse

PSAF	• Programme management • Planning and accountability (M&E) • NDMP • Prevention and treatment of Substance Abuse Act (2008) • Roles and responsibilities of PSAF members including those of each department and LDAC members • Integration of services and programmes including stakeholder management.	
LDAC	• Programme management – particularly around prevention programmes • M&E • NDMP • Legislation including: Mental Health Act, Prevention and treatment of Substance Abuse Act (2008), Liquor Regulations Act • How to establish an LDAC; roles and responsibilities; TOR – some suggested targeted training of the chairperson, Secretary and Co-Secretary to ensure role clarification • How to work together and promote coordination and integration of services • Community mobilisation and how to get community buy-in • Practical tools to use for communication such as WhatsApp groups	• Substance abuse - identifying drugs, effects of drugs, symptoms of drug abuse, FAS. • Understanding of the complexity of the problems being dealt with. • Impact of substance abuse on the individual and communities. • Role of SAPS in dealing with substance abuse at local level

3.3 Governance arrangements in the sector

3.3.1 Leadership, implementation management and oversight capacity by CDA and DSD

The CDA is a statutory body established in terms of the Prevention of and Treatment for Substance Abuse Act. According to Section 56 in the Prevention of and Treatment for Substance Abuse Act (Act 70, 2008) and the NDMP (DSD &CDA, 2013, pg. 54) the function of the CDA is to:

- Direct, guide and oversee the implementation of the NDMP;
- Monitor and evaluate the success of the NDMP;
- Make such amendments to the NDMP as are necessary for success;
- Review the NDMP every five years; and
- Produce a new NDMP for the period 2013 – 2017.

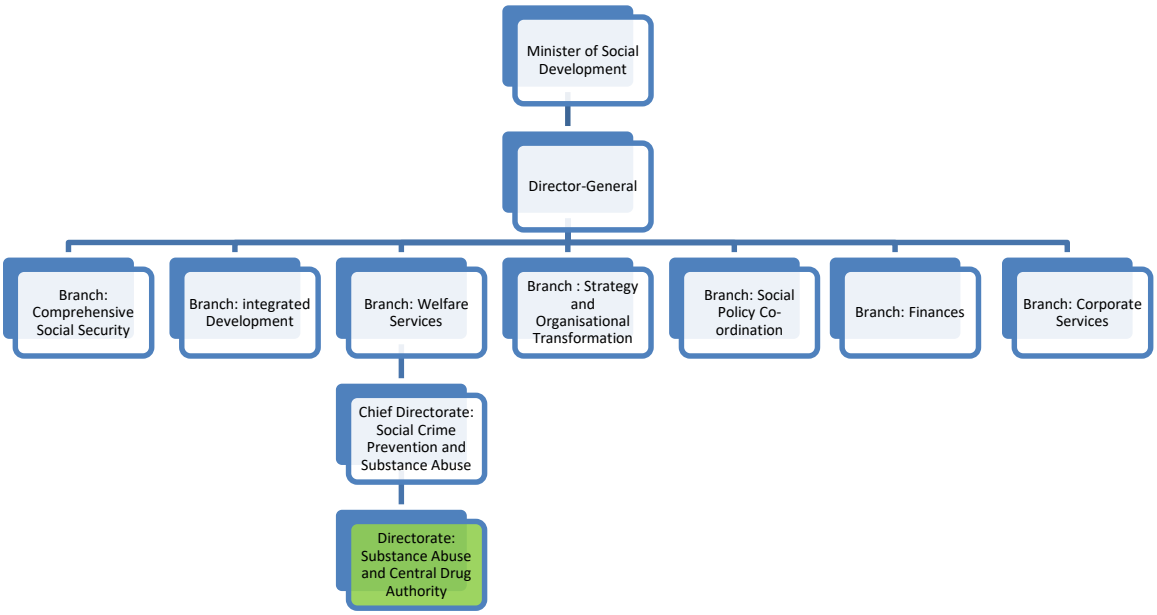
The CDA's mandate requires that it:

- Co-ordinates the efforts of all departments (at national and provincial level) to combat substance abuse;
- Facilitates the integration of the work of the different stakeholders (including the national and provincial departments concerned); and
- Reports to Parliament on the outcomes of the NDMP about the outputs achieved by the CDA's institutional support framework (i.e. the national and provincial departments, PSAFs and LDACs), as well as striving to achieve a society free of substance abuse.

The following sections assess the leadership, implementation management and oversight capacity by the CDA and DSD.

3.3.1.1 *The location of CDA in the DSD*

Figure 5: Location of Central Drug Authority within DSD organisational structure



The CDA is hosted in the DSD's Substance Abuse Directorate. The rationale for hosting CDA in the DSD is linked to various factors: Firstly, DSD was considered the custodian of the Act. Secondly, the hosting was linked to South Africa choosing to move away from a law enforcement approach to a social approach in addressing substance abuse. However, some experts have argued that it should adopt a health approach similar to the approach taken by some of the other countries.

> *"It is seen as a psycho-social issue and was in the beginning. Now it has been defined as a health/medical disease of the brain which makes it a bio-psycho-social issue." (CDA expert)*

The challenges of the DSD hosting the CDA are that CDA is perceived as a sub-directorate of the DSD. This is exacerbated by the current chairperson of the CDA being the director of

the Substance Abuse Directorate in the DSD, hence playing the role of the "referee" and the "player" at the same time. Therefore the CDA is not perceived as having a separate and independent identity (from DSD) by other government departments.

> *"The challenge is that DSD is reporting to CDA and then on the other hand the CDA has to report to the DSD. How do you referee yourself and monitor yourself? Other departments do not want to give full cooperation as they don't want to be monitored by another department." (CDA government official).*

The CDA is constrained by having to receive approval by the DSD before it can, for example, undertake research or attend conferences. This has limited the ability of the CDA to play a leadership role in the sector, both in knowledge development and policy direction.

There is furthermore insufficient political will or buy-in from the other departments to report to the CDA. Effectively other departments (through their Directors-General) are being asked to report to a director from another department. The quote below is illustrative of this difficulty:

> *"The challenge is that because the CDA and the NDMP falls under another minister, other government departments see it as DSD's problem which they must deal with and with their own budget." (CDA expert).*

For the CDA to fulfil its mandate, its autonomy and authority should be strengthened[27].

3.3.1.2 Functionality of the CDA

In order to assess the leadership, implementation management and oversight capacity of the CDA, the compliance with its mandate and its functionality needs to be assessed. In accordance with the Act, the CDA developed the rules governing quorum, procedure at meetings and, generally, conduct of functions of the CDA, drafted in terms of the Prevention of and Treatment for Substance Abuse Act 2008 (CDA, no date) (hereafter referred to as "the Rules"). These rules have been gazetted.

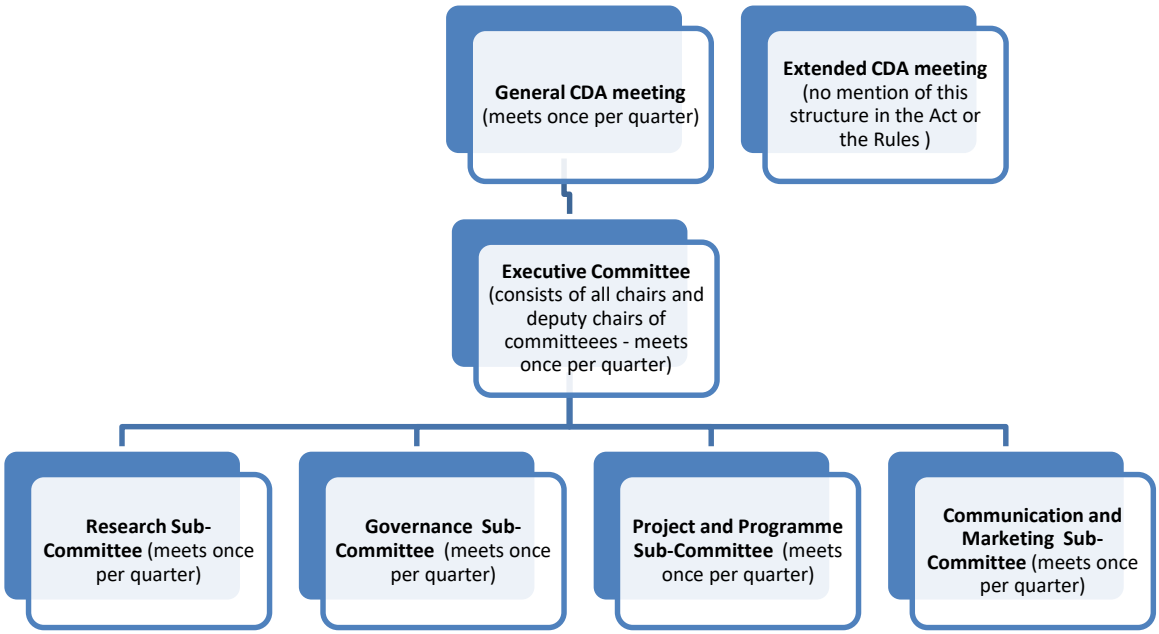
As can be seen in Figure 6 below, the CDA consists of the following structures, which are regulated by the Act and the Rules:

- General CDA meetings, consisting of the departments and experts listed below. According to the Rules it is meant to meet quarterly.
- Executive Committee (EXCO) meetings (consisting of the chair and deputy chair of the sub-committees, as well as the chair and deputy chair of the CDA and the CDA secretariat. According to the Rules it is meant to meet once every quarter. According to the Act the EXCO may, subject to the directions of the CDA, exercise all the powers and perform all the duties of the CDA between meetings of the CDA,
- Extended CDA meetings, consisting of the CDA and the 2 PSAF members per province. This structure is not mentioned in the Act or the Rules.
- The four sub-committees, namely Research; Governance; Communication; and Marketing and Project and Programme. The CDA Chairperson appoints the

[27] This is aligned with the findings and recommendations of Deloitte (2010) which reviewed the function and scope of work of the CDA and its secretariat. It furthermore provided benchmarking with other entities like the Centre for Public Service Innovation, the National Development Agency and the South African National AIDS Council and suggested that CDA should be a separate 'government component'.

Chairpersons and Deputy Chairpersons of the Sub-Committees and these Sub-Committees can co-opt persons on an ad hoc basis who are not members of the CDA. According to the Rules they are meant to meet once per quarter.

Figure 6: CDA committees and sub-committees



In terms of representation, the following departments and entities are represented on the CDA general committee (core departments are highlighted in bold):

- Department of Arts and Culture
- **Department of Basic Education**
- Medicines Control Council
- Department of Correctional Services
- **Department of Health**
- Department of Higher Education and Training
- Department of Home Affairs
- Department of International Relations and Cooperation
- **Department of Justice and Constitutional Development**
- Department of Labour
- **South African Police Service**
- South African Revenue Service
- **Department of Social Development**
- **Department of Sport and Recreation**
- Department of Trade and Industry
- Department of Transport
- National Youth Development Agency

Furthermore, 15 expert representatives from the CSO sector and academia are also involved.

Despite the establishment of the CDA several years ago, the following departments and entities still need to appoint representatives:

- Department of Cooperative Governance and Traditional Affairs
- National Prosecution Authority (discussions have started on getting them on board)
- Department of Agriculture, Forestry and Fishery

- National Treasury

Section 53 of the Prevention of and Treatment for Substance Abuse Act stipulates that the representatives should be at least the rank of director. Although the representatives are mostly officials of such rank, there are some departments who send more junior officials who do not have the mandate to make decisions.

> *"No they are not always at Director level. Someone may be appointed as a director, but don't have the time or expertise and send lower rank." (CDA Expert).*

One of the respondents questioned whether representatives should be at director level:

> *"I know of a Director who has been identified but is resistant as she finds it waste of time. The agendas don't necessarily speak to what the departments are working on. I think the issue of needing director level and not a nominated person is a problem. The departments don't want their directors sitting at these meetings unless showing deliverables." (National Department Official).*

Although the above quote illustrates that the directors are balancing different demands on their time it is important that representatives at director level and above attend the CDA meetings as they are authorised to make strategic decisions. The quote also raises the issue of the value people ascribe to the meeting or perceived usefulness and effectiveness of the meetings. It is important for directors to be able to see the value of attending a meeting.

A number of respondents pointed out that for those departments that are committed, the representatives are usually the same and they attend regularly. However, some departments send different representatives and they attend irregularly[28].

> *"The shortcoming is that the person assigned to attend CDA meetings does not stay in the position for the entire period and there is a change in representatives. We cannot dictate to them but it impacts on us because we have to start over again with new representatives", (CDA expert)*

The departments and entities that were considered to be "committed" were DHET, DOH, DSD, SAPS, DOCS, DOJCD, NYDA (and DTI to some extent).

Section 53 (9) of the Prevention of and Treatment for Substance Abuse Act stipulates that the CDA should meet at least twice a year (the first year at least three times), while the subsequent Rules stipulates that it should meet once every quarter (see section 6.1 (b) (iii)). Until 2015, the CDA met four times a year, however in 2015 they only met twice. The Executive Committee also meets four times a year according to the Rules section 6.1 (a) (ii). The CDA Chairperson appoints the Chairpersons and Vice Chairpersons of the committees to be part of the EXCO. One interviewee noted that the Research Sub-Committee of the CDA did not meet in 2015.

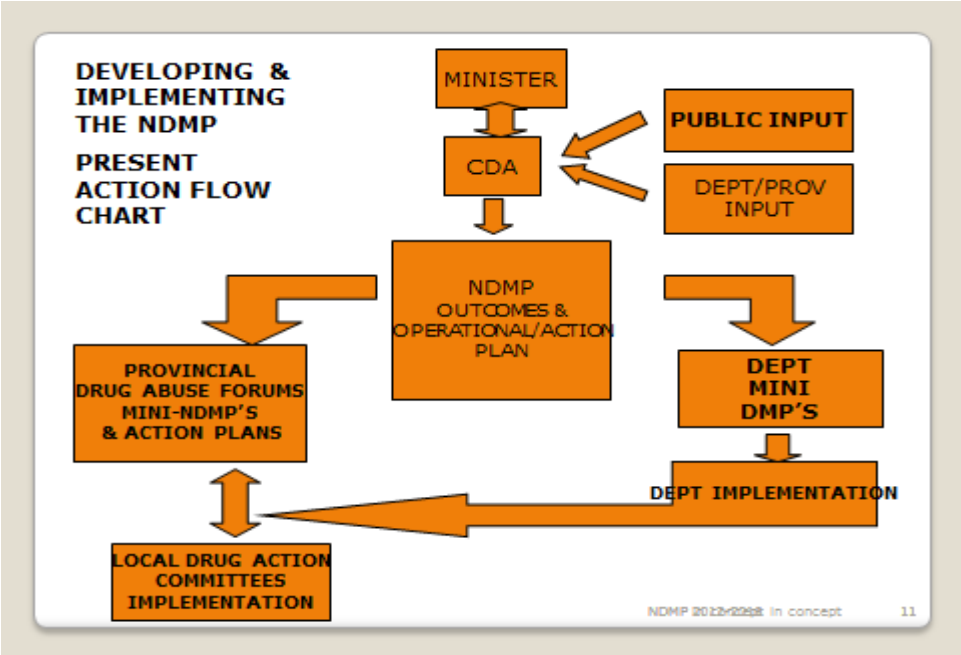
Clause 5(j) in the Rules says that "the draft minutes of the meetings of the CDA shall be available within seven working days before the next meeting." However it was raised by CDA members that since the minutes are distributed just seven days before the next meeting, they have limited time to act on the action points. It was furthermore raised as a problem that the CDA members do not receive the minutes of the EXCO meetings. The Rules of the CDA only

[28] It should be noted that this could also be ascribed to the high turn-over of staff in government departments.

stipulate that the EXCO shall report regularly on its activities, decisions and deliberations to the CDA general committee. It does not state that the minutes should be shared with the CDA General Committee. However, it appears that that this reporting has not happened satisfactorily.

The following section reflects on the institutional structures for the implementation of the NDMP.

Figure 7: Institutional Structures of NDMP 2013-2017 Implementation



The NDMP 2013-2017 outlines the roles and responsibilities of the departments and entities of the CDA, the PSAF and the LDACs (DSD& CDA, 2013, pg. 54-61). This is followed up in the training provided by the CDA secretariat and experts to the departments, PSAFs and LDACs. The majority of the respondents from the departments and the entities found that the roles and responsibilities were clear in the NDMP 2013-2017, but that they struggled to know exactly how to implement the NDMP. Despite the introduction of a "cluster concept", whereby national department representatives on the CDA act in concert with one another similar to the "clusters" used by government in the overall management of its programmes, the departments are still reportedly working in silos. It was furthermore felt that the role of each of the CSOs should also be clarified.

The Governance Sub-Committee has developed the rules for how the CDA should govern itself. Furthermore, the Programme and Project Sub-Committee has developed a TOR for how they govern themselves. The evaluation team was unable to access the TORs for the other three sub-committees. On numerous occasions interviewees noted that there are no protocols to guide coordination of services and programmes besides what it outlined in the Act and the NDMP.

It can be argued that to have a large committee of 32 members (15 experts and 17 government officials) to direct, guide and oversee the implementation of the NDMP is not efficient particularly when decisions need to be taken. Likewise it was raised that the committee could benefit from having sub-committees focused on each of the three pillars of supply, demand and harm reduction and lead by experts in those fields.

Despite these challenges, the following strengths were mentioned by respondents:

- The CDA is driven by resourceful drug experts (7 respondents);
- It has an international and national legal mandate (4 respondents); and
- The existence of the NDMP guides alignment to other sector plans (4 respondents).

- As one respondent stated, the primary strengths are "the expertise on board and [that] they have international legal mandate; they got a budget and a secretariat". (Government official)

Other strengths mentioned by interviewees included:

- That it has provided leadership despite limited resources;
- The bottom up approach launched in the NDMP 2013-2017; and
- The reality and the potential of having government officials, experts and NGOs interacting with one another and knowing more about what the others are doing.

3.3.1.3 The CDA secretariat

Section 55 (1) in the Prevention of and Treatment for Substance Abuse Act stipulates that the "Work incidental to the performance of the functions of the Central Drug Authority must, subject to the control and directions of the Central Drug Authority, be performed by a secretariat consisting of the Director: Secretariat of the Central Drug Authority and such other administrative and support staff as may be required for the performance of its functions by the Central Drug Authority'. According to sub-section 2, the staff must be appointed by the Minister of the DSD. Although the staff are appointed by the minister they are subject to the control and directions of the CDA.

The CDA Secretariat is hosted in the DSD Substance Abuse Directorate. It consists of two professional staff members and is supervised by the Director of the Substance Abuse Directorate who is also the Chairperson of the CDA. The Secretariat facilitates the implementation of the NDMP 2013-2017, for example through training and capacity building of CDA support structures in nine provinces; organisation and reporting on CDA meetings; organising and processing reports such as CDA annual reports as well as reports on events such as the completed treatment symposium and roundtable on cannabis; as well as ensuring the submission and processing of support structures' reports.

When the respondents were asked whether the CDA directorate was providing sufficient support to the CDA, almost all of them said "no" because in their view the two people that provide support for the CDA are not enough, and they are often deployed by the Minister of Social Development to other tasks. Furthermore, the CDA is considered not to have dedicated permanent executive leadership to the implementation of the NDMP and the various decisions by the CDA. The location of the CDA and its secretariat within the DSD restricts their mandate and they do not have the authority to enforce reporting compliance in the departments. It was furthermore raised that they need to have a proper filing system (hard copy and electronic) in the secretariat as CDA members often struggle to access documents.

3.3.1.4 *CDA and the IMC (Inter-Ministerial Committee on Combating Substance Abuse)*

Emanating from the second Biennial Anti-Substance Abuse Summit in Durban and the 34 resolutions adopted by the delegates, the IMC was formed in 2011. This was also on the initiative of the CDA so as to strengthen the departments' commitment to anti-substance abuse initiatives. The IMC swiftly produced a programme of action to address all the resolutions and developed indicators and yearly targets and responsible role-players. The objectives of the programme of action are (Anti-Substance Abuse Programme of Action, 2011-2016):

- To develop policy, review and align liquor legislation;
- To educate and create awareness on substance abuse;
- To promote equal access to resources across South Africa;
- To respond to policies and legislation regarding drugs and organised crimes; and
- To review institutional mechanisms to prevent and manage alcohol and drug use in the country.

The IMC consists of ministers from the relevant departments. An inter-departmental technical team has been established of officials from the same departments at the rank of Chief Directors, and chaired by the Chief Director of Social Crime Prevention and Substance Abuse in the DSD. Prior to each IMC meeting the technical task team meets.

There are examples of cooperation between the IMC and the CDA. The CDA chairperson is invited to the Technical Team meetings and sometimes leads the meetings when the Chief Director cannot attend. The Deputy Chairperson of the CDA has occasionally attended but only when he has been invited by the Minister of Social Development. The same departments are represented on the two structures[29]. The various departments and the CDA report to the IMC, and the IMC reports to the CDA. The IMC and its technical team have their own challenges with meetings being postponed or cancelled, partly because they are not scheduled in advance and because these are high-level personnel with many other responsibilities. However, it was raised that the Anti-Substance Abuse Programme of Action has more political clout than the NDMP; it is specific and implementable and the IMC is able to monitor its implementation.

Half of the respondents said that there is good cooperation between the CDA and the IMC while the other half said that they do not think so. Some respondents said there is a bit of competition between the two structures. Also, as some of the same people are on the IMC technical team and the CDA, the two secretariats that are in the same department are competing for their attendance. One of the CDA members summed it up:

> *"One of the most important developments was the appointment of the IMC by the Minister and this was based on suggestion from the CDA due to the lack of commitment of departments. Unfortunately it became an 'us and them' situation, but at least the DSD Minister is talking to different departments and ministers as opposed to us talking to different members of other departments." (CDA)*

It is problematic that there are two structures addressing similar goals and it appears that they are duplicative; hence it is not an effective or efficient use of public resources in a sector constrained of resources. The sense of competition between the two structures could be explained by the absence of role clarification between IMC and CDA. The IMC has more political clout as it consists of cabinet ministers. As the two structures are pursuing the same goals and are complementing each other the two structures need to be adequately differentiated and roles and responsibilities clarified. It will also be important to formalise their interaction.

3.3.1.5 *International cooperation*

The CDA participates in activities of a number of international organisations and structures like the African Union, the BRICS Formal Anti-Drug Committee, the UNODC and most notably the Commission on Narcotic Drugs (CND). The CND is a UN Commission, which meets annually and reviews reports by member states. The respondents agreed that the cooperation was useful, to ascertain whether South Africa's legislation is aligned to international treaties. However, one of the respondents said that the government officials attending sometimes are unable to translate information from conferences into action and to report back to the CDA.

[29] The CSOs are omitted from IMC.

3.3.1.6 CDA's reporting and advisory roles

In terms of legislation, the CDA must submit an annual report to the Minister of Social Development who in turn submits it to Parliament by the end of September each year. Findings from interviews indicate that CDA did not submit their reports to Parliament in time. The main challenge they encounter is delays in receiving reports from departments which delays reporting to Parliament. They have also been unable to meet with the Minister of Social Development because she has not made herself available. However, they do report to the portfolio committee and IMC on a quarterly or six monthly basis.

According to the CDA Annual Report (2007- 2008) the CDA has to submit reports to UNODC on the global illicit drug problem. CDA respondents said that this has not taken place as they are not authorised to submit reports to UNODC as this is done by DSD.

3.3.1.7 Concluding summary

The CDA is legally mandated and is driven by resourceful drug experts. The institutional structures have been set up for the various committees and the CDA is on the whole operating in a functional way. The CDA secretariat is supporting the CDA, but due to an inadequate number of staff members, competing responsibilities and lack of dedicated executive leadership, this support is insufficient. The CDA has no protocols to guide coordination of services and programmes. Despite the introduction of the "cluster concept" the departments are still working in isolation. The location of the CDA in the DSD is a challenge that urgently needs to be addressed. CDA is left with no authority particularly when it comes to ensure compliance with reporting requirements. There is cooperation with the IMC, but due to the lack of role clarification between the two structures the cooperation is not working in an optimal manner. Based on the above assessment, the evaluation concludes that the CDA has not been provided with sufficient resources and authority to provide the necessary leadership, implementation management and oversight capacity to successfully facilitate the implementation of the NDMP.

3.3.2 Coordination mechanisms at provincial level

The Prevention of and Treatment for Substance Abuse Act (70 of 2008) provides for the establishment of a substance abuse forum (PSAF) for each of the nine provinces. PSAFs are appointed by MECs from the ranks of stakeholders in education, community action, legislation, law enforcement, policymaking, research and treatment, the business community and any other body interested in addressing substance abuse.

Adequate and sustained funding for PSAFs must be provided by the provincial department responsible for social development (DSD &CDA, 2013, pg. 60).

3.3.2.1 Support provided to Provincial Substance Abuse Forums (PSAF)

One of the roles of the CDA is to support the establishment of the PSAFs and liaise between the CDA and PSAFs by attending their meetings and guiding the PSAFs in the interpretation and implementation of the NDMP and DMPs (DSD &CDA, 2013, pg. 6). There are no details in the Substance Abuse Act (70 of 2008) or the NDMP on what the CDA is expected to do in relation to the establishment of the PSAFs.

Two interviewees from the CDA secretariat and the chairperson indicated that they support the PSAFs mainly through capacity building and intervening on issues raised at meetings and in their programmes. Furthermore, PSAF representatives from each province attend CDA meetings at national level and representatives from CDA attend PSAF meetings, although it is unclear from these interviewees whether this occurs for all provinces. This is an attempt to facilitate vertical communication and alignment of planning between both structures.

There were mixed responses from the eight national department members and entities when they were asked what support the CDA provides member departments to PSAFs. Their responses are summarised as follows:

- Two of the eight respondents stated that they support PSAFs by monitoring them;
- One respondent stated that they support the PSAFs by ensuring that there is a departmental representative on each of the nine structures:

  "SAPS has a representative on all of them - Police implementation is happening according to what they are meant to report on at provincial level. We are not adequately represented in all local drug action committees but we are trying to deal with this and get up to speed." (National department, CDA)

- One respondent noted that they intervene at provincial Premier level to ensure that the Premier endorses the structure which facilitates establishment of PSAFs:

  "As the CDA (members) we also intervene at a premier level of the Provinces to facilitate the establishment the PSAF. It is important that the Premier endorses the structure. We do intervene occasionally. It is difficult at this level - you are at mercy of the Province." (National department, CDA)

- Four indicated that their departments are not substantially involved in initiating and supporting these structures with one stating that this is the responsibility of the CDA secretariat.

These responses highlight firstly, that CDA national department members are supporting PSAFs in different ways and thus they may not be clear about what type of support they are meant to provide for the establishment and maintenance of the PSAFs; and secondly, that support from national departments remains limited.

A total of fifteen members across the four PSAFs included in this evaluation were asked what support the CDA and DSD has provided for the establishment and maintenance of PSAFs. Once again, the responses were varied across provinces:

- The **Gauteng PSAF** has been in existence since 2000 and the CDA reportedly did not provide support for its establishment. A CDA board member attends meetings and supports the PSAF where necessary with facilitation of workshops, training, development of the DMP and monitoring.
- A provincial representative from the **Western Cape PSAF** attends the CDA meetings at national level. All of the interviewees report very little or no support being provided by the CDA.
- A provincial representative from the **Northern Cape PSAF** regularly attends CDA meetings at national level and the CDA visits the province annually to explain the reporting format and presentations on latest research and statistics on supply of drugs in the province.
- The **KwaZulu-Natal PSAF** receives no support from the CDA except for a presentation on the NDMP 2013-2017. There was one meeting held in Pretoria which the MEC from DSD did attend but did not provide feedback to the PSAF members.

In summary, these findings reveal that, firstly, three out of four PSAF members are attending national meetings regularly and this helps to maintain the linkages between these two structures; and secondly that a CDA representative is only attending one of the four PSAFs (Gauteng), to provide regular support for maintenance of the structure. However, for the other three PSAFs this kind of support from the CDA remains limited or non-existent.

3.3.2.2 Role of the Premier's Office in the PSAFs

As specified by The Presidency (2008), the buy-in and support from the Premiers' Office is crucial for any programme or service as they play a pivotal role in providing strategic leadership and coordination in provincial policy formulation and review; planning and

overseeing service delivery planning; and implementation in support of provincial and national priorities and plans.

The CDA has visited all Premier's Offices in the past in order to get political buy-in for addressing the problem of substance abuse, and plans to do this again. This is reflected in the CDA Business Plan (2014/205) under the objective "to create political, social and public awareness of the Central Drug Authority by CDA presenting to provincial Premiers" (DSD &CDA, 2014, pg. 9). Overall respondents indicated that, where there is good buy-in and support from the Premier's Office, the PSAF is generally more likely to be functional.

Interviews reveal that support from the Premiers' offices varies across provinces. At national level, CDA members noted that premiers of Western Cape, Gauteng and Limpopo are supportive of PSAF. However, provincial respondents had different views from those expressed by national CDA.

It was indicated that the Northern Cape and Gauteng Premier's Offices are not involved in the PSAF. Although, it seems that the Gauteng PSAF has good support from the MEC for DSD, and this facilitates good support from DSD from all levels across the province.

For KwaZulu-Natal, the current Premier is the chair of the PSAF but has not chaired any of the meetings[30]. Whilst the previous Premier supported the fight against substance abuse and was passionate about the issue, the current Premier's support is reportedly lacking. To address this, the PSAF chairperson has made several to visit the office but these have been unsuccessful.

Finally, in the Western Cape the Chair of the PSAF was sitting in the Office of the Premier for the past two years, but has recently been moved into DSD under the social welfare and special programmes unit on substance abuse. The PSAF chairperson is the director for this unit, which also houses the Secretariat. Although the move to a unit dedicated to substance abuse within DSD is positive, there has been a noticeable change to the level of commitment of PSAF members since the office of the Premier has been less involved. This confirms the finding that support from the Premier's Office has a critical effect on the functionality of the PSAF.

3.3.2.3 Extent to which PSAFs are operational and functional

According to Section 57 of the Substance Abuse Act (2008), PSAF membership should consist of the following representatives who are appointed by the MEC:

(a) Relevant provincial departments;

(b) Community action groups;

(c) Law enforcement agencies;

(d) Research institutions;

(e) Treatment institutions;

(f) NGOs;

[30] There are not minutes of PSAF meetings to validate this finding from the interviews.

(g) The business community; and

(h) Any other structure considered relevant by the MEC.

Section 58 of the Act states that the functions of the PSAF are as follows:

a) Strengthen member organisations to carry out functions related directly or indirectly to addressing the problem of substance abuse;
b) Encourage networking and the effective flow of information between members of the Forum in question;
c) Assist Local Drug Action Committees established in terms of section 60 in the performance of their functions;
d) Compile and submit an integrated Mini Drug Master Plan for the province for which it has been established;
e) Submit a report and inputs, not later than the last day of June annually, to the Central Drug Authority for the purposes of the annual report of the Central Drug Authority; and
f) Assist the Central Drug Authority in carrying out its functions at a provincial level.

The Act does not specify the frequency of meetings required by PSAFs.

The CDA Annual Reports (2013/14 and 2014/15) state that all provinces have established and maintained PSAFs. However, the interviews reveal that the extent to which these structures are operational and functional varies across provinces and is influenced by a number of factors including regularity of meetings, membership and attendance. These are discussed in more detail below.

A key strength is that all except the KwaZulu-Natal PSAF[31] hold regular meetings and the frequency differs from monthly to bi-annually. The evaluation team was able to review a total of nine annual reports from eight provinces. These reports were either from the 2013/2014 or the 2014/2015 reporting period. This review revealed the following regarding frequency of meetings:

- The Northern Cape held monthly meetings in 2013/2014 and held two meetings in 2014/2015;
- Gauteng held monthly meetings in 2014/2015;
- KwaZulu Natal has held one meeting in 2013 and one in 2014;
- Free State held three quarterly meetings in 2013/2014;
- The Eastern Cape does not report on frequency of meetings in the 2013/2014 report;
- Mpumalanga held three executive meetings, one annual general meeting and two management meetings in 2013/2014;
- North West held quarterly meetings in 2013/2014;
- Western Cape held quarterly meetings in 2013/2014.

[31] The KwaZulu-Natal PSAF has only met twice since its establishment in 2013 and the last meeting was held in February 2014.

A further strength is that all structures report that they keep meeting minutes and record decisions. The evaluation team was only able to review minutes from Gauteng (September and October 2015) and from Western Cape (June, August, October 2015) to triangulate this finding. It was mentioned frequently that it is difficult to keep everyone accountable as DSD does not have authority over other departments and thus cannot enforce decisions taken.

With regards to membership of the PSAFs, the data received from the four PSAFs is captured in Annexure 6 of this report and provides a snapshot of membership for these structures. In summary, it was found that, although membership is fairly representative across the structures, none of the PSAFs have full membership of all the required representatives. The main gaps are the lack of business community and research institution representatives (except the Western Cape PSAF which has a representative from the MRC). Overall there is good representation from NGOs and law enforcement agencies although the Gauteng PSAF indicated that SAPS do not attend the meetings.

Whilst DSD, DOH, DBE and SAPS are represented on all structures, a challenge highlighted is the lack of full representation of *all* relevant government departments. The reason cited is that substance abuse is perceived as DSD's responsibility and not prioritised by other government departments.

This also affects meeting attendance by departmental representatives, which is irregular, and there is inconsistency in individuals who attend. Furthermore, representatives are often not at the right level in government to make decisions, as the following quote reveals:

> *"Another gap is that some departments send junior people to attend to cannot make decisions then and there." (PSAF member, Western Cape)*

Some external factors influencing poor attendance and general functionality of PSAFs include: the lack of a substance abuse focal person in departments; competing priorities for government officials; limited involvement of the MECs and lack of leadership; lack of a constitution; and lack of accountability for non-attendance.

Output 2 of the TOC is: "Provision of effective coordination of multiple sectors and levels with adequate and skilled human resources". This can only be achieved if PSAFs play their role of ensuring that joint planning takes place.

Interviewees with PSAF members reveal that joint planning is taking place in Gauteng, the Western Cape and the Northern Cape. The Gauteng PSAF requests provincial departments to forward their annual implementation plans, which are then consolidated into a provincial DMP for submission to the CDA; departments then present their annual plans during the PSAF meetings. The structure also has sub-committees to facilitate planning, for example marketing and awareness-raising, but this is reportedly not working optimally. The Western Cape PSAF requests each department to develop and submit a DMP and discusses them in their bi-monthly meetings. The Northern Cape PSAF follows a similar process but has difficulty in obtaining plans from each department.

These plans and quarterly reports are submitted to the CDA, which then inform the development of the CDA Annual Reports. According to national level respondents, attempts are made to address the challenges and recommendations made by provinces; and some departments will include them in their national priorities and interventions. However, the extent to which the PSAF is informing national policies and strategies remains unclear.

There is no implementation role envisaged for PSAFs in the Prevention of and Treatment for Substance Abuse Act, 2008, but they are supposed to support their members to implement substance abuse programmes and services. According to the TOC, if output 2 has been achieved, this will ultimately lead to improved coordination of service delivery and integration of services.

Individual departments recognise that having a strategy developed by the PSAF at least assists them to know what is expected of them, and then they mostly attend PSAF meetings to report on their activities. However, for the most part, PSAFs do not have programmes specifically for substance abuse. The Western Cape PSAF is developing a joint programme

of action with the DBE regarding a schools-based intervention, where each department will commit resources for a common action.

The tables contained in Annexure 5 summarise activities and achievements on demand, supply and harm reduction for the two reporting periods extracted from the provincial reports submitted by the PSAFs.

The majority of respondents from the functional PSAFs in Gauteng, Western Cape and Northern Cape report that the PSAF does provide a platform for improved coordination of services to some extent. It also facilitates improved relationships, and opportunities to share information and best practices amongst stakeholders. This is reflected in the following quote:

> *"The partnerships and coordination of services has been the greatest strength – to have DSD and DOH sitting together has improved the relationship – now they even have education on board in the liaising committee. The working relationship has strengthened … to get the wheel moving forward." (PSAF member, Western Cape)*

The table below provides a framework for understanding coordination as part of a continuum of relationships that require gradually increasing levels of trust and the sharing of resources, risks and rewards (State Government of Victoria, 2007).

Table 23: Continuum of relationships

Networking	Coordinating	Cooperating	Collaborating
Exchange of information for mutual benefit	Exchange of information for mutual benefit	Exchanging information	Exchange information
Informal relationship	Alter activities	Alter activities	Share resources
Minimal time and trust	Formal relationship	Sharing resources to achieve a common purpose	Enhance capacity of another to achieve common purpose
No sharing of resources	Requires moderate time and trust	Formal relationships	Formal relationship
	Minimal sharing of resources	Substantial time and trust required	Extensive time and trust required
		Share resources	Share risks, responsibilities and rewards
		Some sharing of risks and rewards	

Using this framework for analysis, the PSAFs are operating somewhere between the level of networking and coordinating in that there is minimal sharing of resources but an exchange of information for mutual benefit, and more formal relationships have been established.

The majority of national level respondents indicated that the establishment of PSAFs has contributed to reduced fragmentation and duplication of services at provincial level because all stakeholders are contributing towards developing one DMP and then coordinating through

a centralised provincial structure. On the other hand, PSAF respondents were cautiously optimistic when asked the same question with members from Gauteng, Northern Cape and Western Cape indicating that fragmentation and duplication of services have been reduced "to some extent" through joint planning.

In most provinces it is the DSD that is driving implementation of the NDMP or provincial strategies. People are able to refer to what individual departments are doing, but not to what the PSAF's are doing to support implementation. The following comment is illustrative:

> *"We have portfolios in the PSAF but most are not operating. The PSAF is not really driving the implementation of strategy." (PSAF member)*

Overall, there is still much room for improvement as proper integration and coordination of services and programmes can only occur if the challenges with PSAF functionality, as discussed above, are addressed. The efforts of the Western Cape PSAF, which are summarised in the text box below, provide a good example of how this structure has attempted to improve its functionality.

Efforts made by the Western Cape PSAF to improve its functionality

In order to improve high-level buy-in and accountability, a request has been made for the Premier to nominate PSAF representatives.

To facilitate support and buy-in from provincial departments the PSAF chairperson, who is at Director level in DSD, and the Secretary have reviewed all departmental APPs. When it was found that none of them have indicators related to substance abuse, the chairperson held meetings with each department, asked them what they are willing to commit to, and encouraged them to develop their own DMP, advocating for them to have the substance abuse indicators in their APPs. This process has already resulted in the Department of Local Government committing to support LDACs even though it is not currently in their APP as an indicator.

PSAF bi-monthly meetings are held regularly and minutes and attendance registers are kept. This is facilitated by the secretary, who is active in setting up and coordinating meetings, writing minutes and facilitating information sharing amongst members.

In an attempt to improve attendance of representatives and hold government departments accountable, a TOR has been developed which specifies roles and responsibilities of the members and will be signed by each departmental representative. Nominated representatives are required to be at director level to enable decision-making.

Support has also been provided for the establishment of the LDACs together with local government. Visits are made to each LDAC informing them of the NDMP, the Substance Abuse Act and the purpose of an LDAC. Follow-up support is provided where required. Substance Abuse Coordinators drive the process at local level. Two LDACs have been established per month in 2015 and there are currently eight functional and seven non-functional LDACs, for which a refresher course is being rolled out.

Although evidence of improved PSAF functionality is still required, four out of the seven sector experts indicated that the Western Cape is the province which is dealing most effectively with substance abuse. The PSAF has overseen the development of a Substance Abuse Service Directory and there is also some evidence of improved coordination of service delivery. Some examples include DSD and DBE jointly funding NGOs to render adolescent programmes to children who have tested positive in schools, and having them attend afterschool programmes; DBE complaining about a drug den next to a school in the PSAF meeting and the metro police clamping down on them; the provision of a resource list to the Liquor Authority to facilitate outreach; and joint substance abuse mapping exercises undertaken by DSD and DOH.

3.3.2.4 Concluding summary

The CDA secretariat and experts have supported the PSAFs mainly through capacity building, information sharing sessions and intervening on issues raised at meetings.

However, support from the CDA national department members remains limited and most are unclear on the extent of support they are meant to provide for the establishment and maintenance of these structures.

Attempts to facilitate vertical alignment between the CDA and PSAFs has been undertaken through provincial representatives attending national CDA meetings and a CDA representative sitting on the PSAF to provide expert guidance and support. However, the findings reveal that this does not necessarily take place for all nine PSAFs and support is variable across provinces – three out of the four PSAFs included in the evaluation report that CDA support has ranged from limited to non-existent. With only two officials, the CDA secretariat currently does not have the resources and capacity to provide this regular support.

Support from the provincial Premier's Offices is crucial for ensuring high-level buy-in and strategic direction for addressing substance abuse in the province. However, none of the PSAFs report full support and buy-in from the Premier's Office and, where there has been strong support in the past, this has declined over time. The CDA recognises this and visits to each Premier's Office have been done in the past. It is included as an activity in the CDA Business Plan 2014/2015.

The level of operation of the four PSAFs was found to be variable, with KwaZulu-Natal PSAF being virtually non-operational. The other three structures (Gauteng, Northern Cape and Western Cape) are operating reasonably well in that regular meetings are held; membership is fairly well aligned to section 57 of the Substance Abuse Act (2008); and minutes and reports are being produced. Despite this, the PSAFs face numerous challenges with the irregular and inconsistent attendance at meetings being the most critical challenge. Some of the main contributors are that substance abuse is seen as a DSD issue and it is not prioritised by other departments; that it is not included in provincial APPs for each department; and the lack of provincial leadership on the issue.

The evaluation has found that joint planning has been facilitated by the three functional PSAFs (Gauteng, Western Cape and Northern Cape) and this has made some contribution to reduced duplication and fragmentation of services. These structures have reportedly provided a platform for improved networking and coordination of service delivery. The Western Cape has made some good progress in terms of improving PSAF functionality and the benefits of this are already becoming evident. The KwaZulu-Natal PSAF is virtually non-functional and thus its coordination of the substance abuse sector in this province is limited.

Based on these findings, the evaluation concludes that when PSAFs are functional they can coordinate the sector at provincial level. However, even functional PSAFs continue to face a number of challenges with their functionality, which should be addressed before they can reach the full potential of coordinating and integrating substance abuse implementation in the provinces.

3.3.3 Coordination at local level

3.3.3.1 Support provided for the establishment and maintenance of the Local Drug Action Committees (LDACs)

The Substance Abuse Act (70 of 2008) stipulates that a municipality must establish a Local Drug Action Committee (LDAC) to represent the municipality and to give effect to the Mini Drug Master Plan. The municipality in which the LDAC is situated must provide financial support to the LDAC.

The LDAC should consist of interested persons and stakeholders who are involved in organisations dealing with the combating of substance abuse in the municipality in question. Members of LDAC are meant to be appointed by the Mayor of the Municipality and they must consist of the following officials:

- Officials from government departments represented at local level;

- A member of the South African Police Service (SAPS) nominated by the local police station commissioner;
- A correctional official nominated by the area Commissioner of Correctional Services;
- A representative from an educational institution in the area nominated by the mayor of the relevant local municipality;
- A representative from prevention, treatment, and aftercare services within the municipality nominated by the mayor of the relevant Municipality;
- A representative from the local health authority nominated by the municipality mayor;
- A representative of the local business sector nominated by the municipality mayor;
- A legal professional from the local community nominated by the Regional head of the Department of Justice and Constitutional Development; and
- Representative from the local traditional authority.

LDACs must designate a member of the committee as chairperson. It must be linked to the PSAF established for the relevant province and must represent substance abuse forums at local government level.

The TOC states that each LDAC is supposed to produce an action plan in line with the priorities and the objectives of the integrated Mini Drug Master Plan, which is also aligned with the strategies of government departments. It is supposed to coordinate programmes and services of local stakeholders, conduct community mobilisation and support evidence collection and local evidence-based planning. The strategies of the various departments and LDACs should reflect the continuum of care, namely prevention, early-intervention, reintegration and after care.

According to the NDMP 2013-2017 local government should take the lead in the establishment and functioning of the LDAC by providing a secretariat for the LDAC, which liaises with the PSAF (DSD & CDA, 2013).

In three out of four provinces covered in this evaluation DSD has provided secretariat support to LDACs and also supports with coordinating the activities of LDACs. Local government could not do this fully across all provinces due to lack of funding and personnel. As one respondent stated:

> *"There is no funding to establish LDACs and I also do not have personnel support in my unit to work on this. The only support I receive is from PSAF. They go with me to do different presentations in different municipalities." (Department of Local Government)*

The support of PSAFs in the establishment of LDACs is evident in three out of four provinces covered in this evaluation. They train LDACs on the Substance Abuse Act (70 of 2008), the NDMP as well as the provincial drug strategy. During these presentations they also clarify roles and what is expected from LDACs. In Western Cape, the PSAF provides further support by providing refresher trainings to LDAC members and they also invite them to their quarterly meetings to discuss their reports and challenges. Not all PSAFs play this supporting role; in KwaZulu-Natal the LDAC members mentioned that they do not know who the members of PSAF are and they have never had any interaction with them as the following quote reflects:

> *"We are doing what we think is right but we have no guidance. It is like the blind leading the blind. Maybe we are off track but we hope that we are doing well." (LDAC Member)*

3.3.3.2 The role of the mayor's office in the LDACs

There are mixed responses about the role of the mayor's office in supporting LDACs. Some respondents mentioned that their municipal mayors are involved in LDACs, but others said they are not involved. The evaluation revealed the following:

- Respondents from Western Cape said that mayors from Swartland, Drakenstein and the City of Cape Town are supportive of LDACs, but there are challenges in other municipalities where mayors are not supporting the establishment of LDACs. They are hoping this will be dealt with in 2016.

- In the Northern Cape all respondents from LDACs and PSAFs interviewed said that mayors are not involved in the LDACs.
- In KwaZulu-Natal the mayor of eThekwini Municipality signed off a budget to be used for LDAC activities. Three out of four respondents from Richards Bay (Umhlathuze Municipality) mentioned that the mayor's office supports them with the venue and sometimes refreshments.
- In Gauteng five out of six LDAC representatives interviewed said that the mayors' offices are not involved in LDACs. When they invite them to meetings they do not attend and they also do not send apologies.

Those who said that they are supported by the mayors' offices indicated that they receive funding to ensure effective functioning and support for coordination of LDACs activities. The most notable challenge is that some municipalities see this as an unfunded mandate and that they have no funding to support LDACs. This results in the frequent rotation of people in LDACs.

It was mentioned by one respondent in the Western Cape that, where ward councillors attend meetings regularly, they assist to ensure that plans are executed. Only one out of the four LDACs (Western Cape) included in this study indicated that ward councillors attend meetings on a regular basis. The LDAC in KwaZulu-Natal indicated that it reports to ward councillors at community meetings.[32]

In areas where the mayor's office is not involved, DSD has taken a lead role to support LDACs. As one person said:

> *"Municipalities are not playing their role. They should be appointing LDAC through the mayors but this is not happening. The absence of this structure leaves a huge gap in implementing the NDMP, so DSD has taken over and set up LDACs and ward level committees." (PSAF Member)*

3.3.3.3 Extent of functionality of the LDACs and their ability to provide a platform for effective coordination of service delivery, joint planning thereof and reduce fragmentation and duplication

The NDMP 2013-2017 stipulates that each municipality is required to establish a LDAC. The total number of LDACs to be established at the time the NDMP 2013-2017 was developed was 238. The CDA Annual Report (2013/2014) shows that 165 LDACs were established and functional[33], and the CDA Annual Report (2014/2015) shows that the number of existing LDACs had increased to 187 (excluding Western Cape and Limpopo provinces which were not reported on). The accurate number of functional LDACs is not known but the CDA will conduct an audit in 2016 to determine the functionality of the LDACs and how often they meet. The table below shows the number of functional LDACs by province as per the CDA Annual Report 2014/2015:

Table 24: LDACs per province[34]

[32] The regularity of these meetings was not clear in the data.

[33] There is a lack of definition of 'functional LDAC', CDA reports reflects them as functional and non-functional

[34] Non-functioning LDACs not reported on

Province	LDACs functioning	LDACs being set up
Eastern Cape	24	Not reported
Free State	8	1
Gauteng	44	Not reported
Kwazulu-Natal	67	Not reported
Limpopo	Not reported	Not reported
Mpumalanga	18	Not reported
North West	19	Not reported
Northern Cape	7	Not reported
Western Cape	Not reported	Not reported

According to section 61 of the Prevention of and Treatment for Substance Abuse Act (70 of 2008), the functions of the LDAC are to:

- Ensure that effect is given to the National Drug Master Plan in the relevant municipality;
- Compile an action plan to combat substance abuse in the relevant municipality in cooperation with provincial and local governments;
- 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;
- Implement its action plans;
- Annually provide a report to the relevant provincial substance abuse forum concerning actions, progress, problems and other related events in its area; and
- Provide such information as may from time to time be required by the central drug authority.

Three out of four LDACs included in this evaluation have developed action plans that are in line with the local municipality plans. They developed their action plans based on community campaigns. After these campaigns they meet and plan jointly.

Respondents across all four LDACs[35] indicated that their LDAC is functional. They meet regularly (either monthly or quarterly) and they report to the PSAFs. The most frequently mentioned challenges they face are a lack of services to which referrals can be made, and the poor coordination of services. The non-participation of departments in LDACs contributes to poor coordination and integration of services.

Participants in three out of the four LDAC focus groups and the majority of LDAC interviewees (six out of seven) agreed that for those LDACs which are functional, they do provide a platform to plan jointly, coordinate services and prevent duplication and fragmentation of services. They are closer to the communities and know what is happening;

[35] It should be noted that these LDACs were chosen by the provincial DSDs (with the exception of the KZN) and the evaluation team selected based on a balance of rural and urban LDACs and ensuring that the LDAC was functional. In KZN the LDAC was selected based on recommendations by the provincial DSD, functionality and availability of LDAC members.

this gives them an opportunity to respond quickly to the issues of substance abuse. Furthermore, because they know who is doing what and where, it is easier to make referrals for those who are in need of services. As one person said:

> *"LDACs are ward-based so they know what is going on in their communities. LDACs have office bearers who sit in an area meeting where ward-based LDACs give reports on their programmes. At the area LDAC meeting we engage department stakeholders where programmes are discussed and it becomes clear what is happening where and by whom. We also sit back and check the successful interventions or programmes implemented in local areas and take them to other areas." (LDAC member)*

In areas where there is duplication of services, LDACs create a platform to engage with stakeholders and services to see how well they can work together and share resources.

Although joint planning is being undertaken, the problem lies with integrated implementation because government departments still implement programmes and services in silos. LDACs do not have an M&E plan in place, which makes it difficult to measure outputs and outcomes.

3.3.3.4 Role of LDAC in implementation

The evaluation included SWOT (strengths, weaknesses, opportunities and threats) workshops with four LDACs and the results show varied effectiveness of LDACs.

The activities described by the LDACs are predominantly awareness campaigns, as well as the existing activities implemented by the municipalities or CSOs. The DSD in Gauteng is providing limited funding to the LDACs to support their functioning.

Cameos of two LDACs included in this evaluation are provided below. These describe the types of activities conducted by LDACs, role-players and challenges that they face. LDACs do not have their own programmes of action, as programmes and activities are implemented by their members, however many do implement awareness campaigns and as shown in the first case below, may address specific hot spots in communities such as "lolly lounges".

LDAC 1

Wide network of stakeholders:

LDAC1 has a wide contact network in the local community. On top of organisations within the sectors of law enforcement, educations and social affairs, it also includes other stakeholders such as traditional healers, CBOs and local businesses including the Liquor Trading Association. Forging such relationships has been central to both strengthening the work of the LDAC as well as providing them a more visible and trusted profile in the community.

Actions of the LDAC

The LDAC has a strong awareness of youth initiatives, which focus on prevention, help to young addicts and youth and children as an aspect of assistance to families.

Apart from the urgent task of closing down lolly lounges, the LDAC is also involved in aftercare facilities and youth activities such as sports and edutainment programmes in order to promote a healthy lifestyle for children and youth. The LDAC also makes referrals for treatment or counselling.

The LDAC also provides information on drug crimes to the authorities, and expects that these receive swift attention and are acted upon, otherwise people become discouraged.

This LDAC has furthermore identified assistance to families, such as counselling for parents of drug abusers and classes in good parenting skills, as a focus area where they would like to be able to offer more support.

Relationships with government and authorities

The LDAC seems to have good relationships with the City of Johannesburg Department of Social Development, which provides two social workers who offer assistance to the LDAC.

Challenges

In this context there were two main challenges.

First of all, the lack of sufficient rehabilitation facilities means that although there is a system in place for referral, many substance abusers or addicts and their families do not receive the necessary help.

Secondly, there is no proper monitoring of the use of resources by NGOs that are funded by government to help communities with programmes against substance abuse.

LDAC 2

Activities

This LDAC is involved in a wide range of activities which include prevention, awareness and skills development programmes for youth, families, local businesses and ex-offenders. Its range of partners and stakeholders in the community are impressively diverse, including DHA, SAPS, COGTA, Water Affairs, DSD, DBE, DOH, DOJCD, the Traffic Department; Municipality; and NGOs such as Youth Centre; Agang; Albino Association, Gentlemen's Club (an organisation for ex-offenders in community) and local business from the liquor trade.

This LDAC has also started working on strategic work and drafted a Mini Drug Master Plan.

It is run very professionally with quarterly meetings, timeous invites, an attendance register and minutes of meeting.

Challenges

One of its challenges has been internal mistrust and poor understanding of roles and responsibilities. Political interference may have been a factor in creating this situation. Also externally the LDAC feels the need to "brand" itself to overcome mistrust and misunderstanding from the community, which is mainly rooted in the stigma that surrounds addiction.

Another major challenge is the limited budget of the LDAC. There is a R 20 000 budget which is funded by the DSD for running costs such as catering and transport for the coordinator, but there is for instance no budget for telephone costs despite an active profile on social media, and communication remains a challenge.

There is no budget for major events and the LDAC has no influence over potential funding. However, it does have access to a social worker and three implementers.

Another key role of the LDAC is to support cooperation between government and CSOs. There are some positive examples of cooperation. The community matrix model should in theory facilitate cooperation because services are offered by both civil society and state service providers. The City of Cape Town is conducting a pilot based on this model. There is also cooperation on the level of research, advocacy and policy work which is positive for the sector. The main government role players consistently mentioned as active by LDACs and CSOs are DSD, DOH, SAPS, DBE, Community Safety, DOSR, local government social development departments, DOJCD and DTI.

However, there are also some problems with cooperation. Firstly, CSOs are seen as service providers to the state, not partners. This means that lessons from the CSO sector and other opportunities for collaboration and innovation may be missed. Secondly, there are still many CSOs who feel marginalised and are not informed about sector-wide activities, and have never heard of LDACs. This varies from province to province because in some provinces DSD specifically links the CSOs it funds to LDACs (for example in Gauteng).

3.3.3.5 Concluding summary

Most interviewees agree that LDACs which are functional do provide a platform to plan jointly, coordinate services and prevent duplication and fragmentation. However, the biggest challenge facing their functionality is the poor participation of municipal departments. The main reason for this is that they do not see the problem of substance abuse as a municipal priority.

According to the Substance Abuse Act (70 of 2008) the municipality in which the LDAC is situated must provide financial support to the LDAC. However, a challenge is that some municipalities see this as an unfunded mandate and that they have no funding to support

LDACs. The result is that LDACs do not have funding to implement their action plans. For this reason there is a high dropout rate of LDAC members, which has led to the poor sustainability of LDACs and limited implementation of action plans.

3.3.4 Monitoring and evaluation

3.3.4.1 Condition, quality and use

The NDMP 2013-2017 is the first drug master plan to contain an M&E plan with indicators and targets. It was raised by an expert that the aim of the M&E plan was to be more focused on results than activities.

No other M&E system has been put in place. The evaluation found that the CDA monitors implementation through departmental and provincial quarterly and annual reports, and by attending provincial forums. It was mentioned by one of the expert members of the CDA that there is a problem interfacing with departments' M&E systems. This is because some departments do not include substance abuse indicators in their M&E systems.

The Quick Analysis of Substance Abuse Reports (QuASAR) tool was developed and accepted by the Executive Committee and then by the CDA in May 2010. The purpose of developing the QuASAR tool was to guide the reporting process at provincial, departmental and entity level and to assist the CDA in compiling of the CDA Annual Reports. However, the QuASAR reporting tool was considered too complicated and the CDA stopped using it and developed a simplified table. This table requires the departments and provinces to report on outputs, indicators, baseline, targets, activities and achievements. Most departments and provinces have been trained in the use of this table and they are using it for reporting. Each provincial department sends reports to the PSAF to submit to the national department and each MEC has to sign the report before it is sent to CDA. It was raised several times by the respondents that the departments and provinces report too late. This is partly due to the fact that national departmental Directors-General have to sign off the reports before submission to CDA. As a result of the late receipt of reports, the CDA has been late in finalising the annual report and submitting it to parliament. This is partly because of lack of authority of the CDA to compel reporting by other ministries, but also the need for internal departmental approval of reports by Directors-General before they are submitted to the CDA.

A simple data management system was set up but there was no funding to implement it.

Although the community survey informed the development of the NDMP, some of the research activities envisaged in the NDMP have not been implemented or commissioned. These research activities were as follows:

- The implementation of a comprehensive national population survey on drug use;
- The economic costs of substance abuse for the country;
- The extent to which drug use interacts with broad socio-economic conditions such as poverty;
- The dynamics of drug use (especially the use of alcohol and cannabis) among different groups in different parts of the country;
- The relevance of current international and local policies regarding cannabis use, including measures such as legislation and/or decriminalisation;
- The relationship between substance use and abuse, and national issues (HIV and AIDS, TB, crime, youth development and poverty);
- The impact of substance abuse on current government policies (for example regarding drug-affected driving and walking);
- Determining the identity and functions of CSOs affected by and involved in combating substance abuse;
- A baseline study on the percentage reduction of the bio-psycho-social and economic impact of substance abuse on South Africa's public service by province, region and district;
- A predictive analysis of substance abuse patterns and trends in South Africa and implications for policy.

A baseline study was also anticipated, but due to the lack of funding it was not approved by the DSD. One respondent stated:

> *"It is important to note that a lack of, amongst other things, funding prevented the implementation of the 2013-2017 NDMP's research project priorities as specified in Chapter 8 of the plan, namely the implementation of a comprehensive national population survey on drug use, a user-friendly national clearing house and database, and a methodologically refined project on the economic cost of substance abuse in South Africa. The lack of implementation of these research priorities inhibited firstly the implementation of evidence-informed interventions on the part of the CDA's support structures, and secondly an overall assessment of the impact of completed interventions, and thirdly a better understanding of, and thus response to, issues particularly mentioned in the NDMP 2013-2017 as needing to be addressed." (CDA Expert).*

The following research related to the NDMP was carried out:

- A review of the CDA structure of 2010 was conducted by Deloitte and Touche in 2011, but recommendations of this review are still under embargo by the Minister of DSD.

Other research that has been undertaken by or for various departments include:

- A study by DNA Economix on the Socio-Economic Effects of Substance Abuse in South Africa for DTI in July 2013;
- A study by NYDA on substance abuse among youth in South Africa in December 2013.

Other departments and entities also mentioned that they had undertaken evaluations of their programmes such as the "I have a Drug Problem Campaign" by City of Cape Town. The most notable is the Ke Moja project which has been evaluated twice, first in 2009 and 2012. The 2012 evaluation found that the programme had a positive impact in the community at large, and that the families and the communities where the target groups lived are more aware of the negative impacts of drug use and abuse. This evaluation also revealed that there is a need to improve the materials and manuals use to ensure that they are relevant[36]. The third evaluation of the Ke Moja project is currently underway.

Most of the data on drug use and abuse is available from SACENDU. It is an alcohol and other drug sentinel surveillance system that monitors trends in alcohol and drug use and associated consequences on a six-monthly basis by collecting data from treatment centres in nine provinces in South Africa[37]. The SACENDU data was said to be the first source of information, but it does not look at general population prevalence.

> *"We've got so little data. We rely heavily on SACENDU data which is great for what it is but doesn't look at general population prevalence. We are stuck at a 10% figure which was one study. In some communities we have a much higher rate, so we need prevalence data. In South Africa we have this thing where we must look at South African data so we should look at epidemiology. Also we should look at the percentage of harmless versus harmful use. We*

[36] Ke Moja Evaluation Final Report February 2012.

[37] UPDATE JUNE 2015 Monitoring Alcohol, Tobacco And Other Drug abuse Trends In South Africa (July – December 2014)

> *also need to get rid of the term substance abuse - it's meaningless. At what point does it start? Also people think anyone who is using is abusing." (Expert)*
>
> *"I think we need more information on the burden of harm and we have some elements of that- we have the SACENDU treatment data that gives us information about treatment access but we do not have coverage data on how many people may need treatment but don't get it. We need to understand treatment coverage – who is not getting access to treatment? We also need better information on the burden – what are negative outcomes associated with alcohol and drug use?" (Expert)*

Respondents from the DOSR, DBE, DSD, DOA, SAPS, DTI and NYDA indicated that they have indicators on substance abuse. However, this is not reflected in their APPs. Only the Department of Social Development has substance abuse indicators in its annual performance plans. The departments and provinces that have developed DMPs have included relevant indicators.

With regards to treatment centres run privately, some collect statistics for their own purposes, but they do not seem to be analysed or shared. Those treatment centres receiving grants from DSD report on a monthly, quarterly and six-monthly basis to DSD with the help of a template. Most of the respondents said they provide statistics to SACENDU and the MRC on intake, patient profiles, and treatment on either a monthly or quarterly basis. The report to SACENDU includes the patients' gender, race, age, where they come from, type of admission (whether it is voluntary or not), literacy level, language, employment status, level of education, person who referred them, how frequent a person is using, whether they are using one or multiple drugs, when they started using drugs, the type of treatment and primary source of funding for treatment.

3.3.4.2 Extent of M&E data and research being used to inform the development of policy, programmes and services related to NDMP

Some interviewees from DSD, DBE, DOH, NYDA, and City of Cape Town mentioned that they are using M&E and research data to inform their DMP. They also use it to feed into their policies and strategies; to decide which programmes to implement; to check their programme effectiveness and impact; and to decide if they should continue, halt or make amendments to their programmes. For example, DOH mentioned that they used the research on HIV/AIDS to quantify the populations injecting drugs and where they exist. They are currently setting up interventions for the selected sites. DBE has commissioned the School Violence Study, which touches on issues of alcohol and drug use in schools. They used the findings of this study to inform their Schools Strategy.

Other respondents mentioned that they are not using M&E data as they felt that it is not of good quality, not scientifically based and not written in the way that the NDMP requires.

3.3.4.3 Extent of CDA monitoring the core departments represented in the CDA

The NDMP 2013-2017 states that the CDA is meant to monitor the core departments represented in the CDA and their respective DMPs in terms of the NDMP. Findings from interviews indicate that the regular monitoring of departments was not done. The departments send quarterly reports on their activities but nothing else is done to monitor them. Others also mentioned that M&E support from the CDA is limited and there has been

no training on how to comply with the monitoring requirements of the NDMP. Responding to this, members of CDA mentioned that they have not done much in this regard as there are no funds available to carry out this task. The DMP does not clarify if the CDA has to use DSD's M&E unit or its own capacity to monitor.

3.3.4.4 Extent of the CDA monitoring the PSAFs

The NDMP 2013-2017 states that designated members of CDA are meant to attend the monthly and quarterly meetings of the PSAFs in each province to carry out the monitoring and evaluation as required, and also attend meetings of the LDACs if necessary[38]. Findings from interviews indicate that PSAFs report to the CDA on a quarterly basis, and representatives of PSAF are invited to attend at least two extended CDA meetings per year where they can present their reports and their challenges. The CDA expert members and the CDA secretariat are meant to attend all PSAF quarterly meetings. The evaluation findings indicate that they do go to some, but due to the shortage of personnel they fail to attend all of them. A CDA expert said that they are delegated to attend PSAFs meetings; he attends 10 out of 12 monthly meetings but he does not get feedback from others.

The CDA has attended some LDAC meetings in Gauteng but findings from other provinces indicate that there has not been any visit from the CDA member to LDACs. One person said:

> *"Only by invitations – and then I go but [there are] so many of them so can only attend a small fraction. I spoke in English and LDAC members did not. Do they report and how often, and in what form? They are meant to report quarterly to PSAF and some do and others don't – less than half in Gauteng do – but [they] report on activities!" (CDA Expert).*

Not all departments report on the NDMP. Respondents from two national departments, which were interviewed, said that they are not reporting as yet, and they do not have indicators to report on. The lack of reporting has made it difficult to assess which districts are mostly affected and in need of substance abuse interventions.

Respondents from the CDA highlighted that they get seven reports from national departments and all reports from the provinces. The most notable challenge mentioned by members of PSAFs is that they struggle to get reports from other departments in the provinces. This is because some departments send reports to their respective provincial offices and not to the PSAF, and others do not send anything at all because they do not understand their role in the DMP.

LDACs which are functional submit reports to PSAFs on a regular basis, but some LDAC members in KwaZulu-Natal mentioned that they submit reports to DSD or district forums because they have never met with PSAF members.

Some LDACs do not submit reports at all because they do not have indicators to report on. They only send minutes of their meetings to PSAFs when they report to the CDA.

3.3.4.5 Concluding summary

In assessing the condition and quality of M&E frameworks and systems in the sector, the evaluation team found that the NDMP 2013-2017 has an M&E plan which includes indicators and targets. Data collected from interviewees indicates that there has been a problem with interfacing with departments' M&E plans. The CDA developed the QuASAR reporting tool,

[38] National Drug Master Plan 2013- 2017

but it failed because it was too complicated. However, a simplified reporting template is now used and it seems to be working.

Several research studies envisaged in the NDMP have not been commissioned, mostly because of a lack of funds. A few departments commissioned their own research studies and evaluated their programmes and used that data to inform their programmes. SACENDU appears to be the main source of data on substance abuse, but it does not provide data on the prevalence of substance abuse.

The CDA tried to fulfil its role of monitoring core departments represented in the CDA as well as PSAFs, but they could not reach their target due to lack of resources to fulfil this role. Departments and provinces reported on the NDMP to the CDA as required by the Substance Abuse Act (70 of 2008), but the challenge was that reports were often delayed which resulted in the delay of the CDA reports to parliament.

The findings above have highlighted the numerous challenges with M&E at all three levels of the governance arrangements.

The evaluation concludes that the assumptions in the TOC on evidence informing programme and policy planning are not holding, as the various research projects proposed have not been implemented and the evidence gathered by LDACs and PSAFs has not informed policies, perhaps as reporting is considered as an accountability exercise more than as a means to inform policies. The lack of an M&E system has also contributed to these challenges. Until these challenges are addressed the use of M&E to inform the operational and management decisions will remain ad hoc and limited.

3.4 Likelihood of NDMP contributing to enhanced state/agencies' capabilities to reduce demand, supply and harm related to dependence-forming substances and improved access to treatment

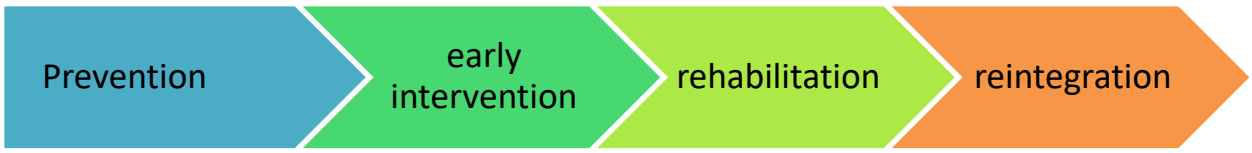
This section provides an overview of what is happening with regard to the demand, supply and harm reduction programmes and services in order to assess whether the plan is contributing to effective service delivery. As described in the TOC, the effective and efficient implementation of programmes and services relies on the optimal functioning of the system elements. As can be seen from the above analysis, there are substantial challenges in each of these areas.

One the main mandates of the CDA is to ensure the implementation of an integrated and balanced approach to address the substance abuse problem. The NDMP notes that it is generally accepted that no single approach will address this multi-faceted problem. Essentially, the message in the current NDMP is that South Africa has been slowly shifting away from a law enforcement approach to a more integrated strategy; the NDMP reflects this and posits an integrated strategy for demand reduction, harm reduction, and supply reduction. These are underpinned by the social development approach, the public health approach and the law enforcement approach respectively. These approaches are unpacked briefly in the literature review.

The evaluation explored the extent to which demand, supply and harm reduction have been supported by the NDMP, and this is the focus of the sections below. The continuum of care is used as a basis for analysis, starting with demand reduction (which is made up of prevention

and early intervention), and then harm reduction (which comprises rehabilitation and treatment, and then after care and reintegration). The first section deals with demand reduction. The question of whether integration has been achieved along the continuum of care and between role-players is also considered.

Figure 8 Continuum of care and levels of intervention[39]



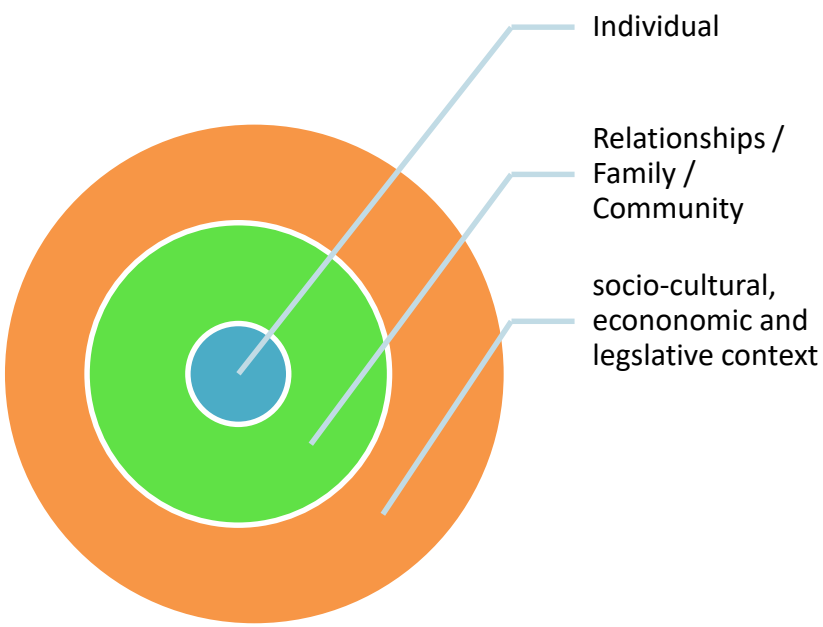
3.4.1 Demand reduction

The demand reduction strategy of the NDMP 2013-2017 "… is aimed at preventing the onset of substance abuse and/or dependence, and eliminating or reducing the effect of conditions conducive to the use of dependence-forming substances" (NDMP, 2013-2017). The NDMP suggests that demand reduction interventions should include one or more of the following five accepted methods of this approach:

- Poverty reduction: Poverty reduction which is aimed at reducing poverty in identified families and communities
- Development: Developing the competency of individuals, families and communities to deal with drug-related social problems. This is a key consideration of the nested system, which informs the Social Welfare approach of DSD
- The nested system or ecological systems approach recognises that people do not exist in isolation; they are part of families and communities, which in turn are part of broader society. Hence, interventions aimed at changing individual behaviour (for example that of the substance abuser or seller) must consider the interplay between the different levels of the system.

Figure 9 Nested system / ecological system

[39] Adapted from the Guidelines for Prevention and Early Intervention Programmes in South Africa (PEIP) 2012, Department of Social Development, Government of South Africa



- Education and communication: Education and communication which is designed to broaden the knowledge base of individuals, families and communities faced with drug-related problems as a prerequisite for empowering them to deal with these problems.
- Social policy application: Social policy application, which aimed at the development and application of social policy to address the needs of the community in combating drug use and abuse. This includes evidence-based programmes to inform policy, applying existing policy to interventions and monitoring and evaluating the effect of social development interventions when dealing with drug-related problems.
- Advocacy: Advocacy by using the experience of families and communities to ensure systematic changes to policies relevant to the drug problems (NDMP 2013- 2017, 2013).

The evaluation findings suggest that the majority of prevention programmes are in the area of development, education and communication, and advocacy. The community-based model for substance abuse services (DSD) and its location within the framework for developmental social welfare fits into the development approach. Services are targeted towards individuals, families and communities. However, the emphasis is still very much on the individual, and although there are policies and strategies to build stronger support systems around individuals, there are still not enough family strengthening or parenting programmes that would strengthen prevention efforts, although this seems to be an increasing focus in the social welfare sector. Programmes like *Isibindi,* which are family strengthening programmes, are being rolled out by DSD. Lastly, the LDACs are an attempt to increase community competence to prevent the onset of substance abuse but these have their own challenges as described earlier in the report. There are also challenges with the municipalities and police enforcing by-laws, which weaken community level responses to substance abuse.

3.4.1.1 Prevention

Prevention can be defined in the three stages primary prevention, secondary prevention and tertiary prevention (see box below). Respondents were asked to identify the prevention programmes that they offered. The tally below represents the different kinds of programmes implemented by different implementing agencies. It is clear that most programmes mentioned are in primary prevention (57 out of 84) and that most of these are awareness raising, information provision and education (34), followed by sports and recreation programmes (10). There could be two possible reasons for this. Firstly, prevention may not

be well understood in the sector, and most people understand it as being primary prevention. Secondly, it was suggested by one respondent that running awareness programmes is less expensive and requires less specialised skills than running secondary or tertiary programmes. It makes sense that screening, testing and assessment is coupled with counselling as the main secondary prevention programmes.

Table 25 Prevention programmes by type

Type of programmes	Total
PRIMARY PREVENTION	
Awareness raising and information provision, education	34
Sports and recreation	10
Skills development	1
Youth empowerment programmes (e.g. life skills) / peer education	7
Community development	0
Employee wellness programmes	5
Sub total	**57**
SECONDARY PREVENTION	
Screenings, drug testing and assessment	10
Help lines	3
Counselling and support groups (e.g. parent support groups)	8
Road blocks	1
Sub-total	**23**
Tertiary prevention (Qalakabusha)	1
Relapse management	3
Sub-total	**4**
TOTAL	**84**

Figure 10 Defining prevention

Primary prevention	Enables households to avoid problems or dysfunction. It is directed a households, vulnerable groups and communities who do not currently manifest problems.
Secondary prevention	Aimed at the identification of problems and early intervention into the lives of individuals, families and groups who are at risks of developing social problems before the situation becomes critical.
Tertiary prevention	Aimed at individuals and families with critical problems or dysfunction. The focus is on intervention, healing, rehabilitation and the prevention of further problems or possible placement in care. Services include developmental and therapeutic programmes to ensure that those who have been identified as being at risk are assisted before they require statutory services, more intensive intervention or placement in care settings.

Source: Guidelines for prevention and early intervention programmes, DSD, 2012 p. 14.

Most prevention efforts take the form of information and education programmes. The prevention programmes tend to be offered by NGOs or CBOs in communities (mainly funded by DSD) or in schools; at workplaces through employee wellness programmes, and by the private sector as part of corporate social responsibility initiatives (such as private treatment centres, beverage companies or medical aid schemes). Some treatment centres have community outreach prevention programmes, but this is not the norm in all provinces. In some provinces (such as Gauteng) both DBE and DSD fund prevention work of organisations that also provide out-patient programmes. However in KZN some organisations indicate that DSD does not fund prevention programmes of treatment centres.

An analysis of the data reveals that the DSD is the department that is most active in prevention work, followed by the DBE, DHET, NYDA, DOSR, SAIDS and DHA. This is well

reflected in the summary tables from the CDA annual reports on the activities of the key departments in the provinces that are provided in Annexure 5.

The data from these reports shows that there is clearly a wide variety of prevention programmes and methods targeting various age groups, from as young as five. Most of the prevention programmes implemented by CBOs and DSD are aimed at reducing the demand for substances among youth by empowering them to make informed choices and resist peer pressure. The intention is to create abstinence. The prevention programme of DSD is Ke Moja, which has been running since 2003. The UNODC and the Government of South Africa, with the DSD as a lead, adopted Ke Moja as a national drug awareness and prevention programme that aims to mobilise against drug abuse. There are a number of NGOs in the evaluation sample who are funded by DSD to implement Ke Moja. It includes a theoretical component on drug awareness and a practical component for a healthy lifestyle.

> The focus of Ke Moja 1 is on substance abuse and the aim is to empower participants from the age of 10-18 years of age around the issue of substance abuse and its harmful effects through workshops. The goal is also for participants attending the workshops to positively impact on other learners, peers, their families and friends.
>
> The focus of Ke Moja 2 is on healthy lifestyles and physical activity, and is the practical component that supports the theory provided in Ke Moja 1 (soft skills). The aim is to educate young people on healthy lifestyles in order to develop their wellbeing and help them to become healthy and effective contributors to South African society. (Chames et al, 2009)

There are a few other programmes being supported by DSD such as TADA, as highlighted in the section on budgets. DSD has provided funding to Soul City to develop and test a social mobilisation initiative. Soul City developed a Drink Wisely campaign in townships and found the community supportive, but they were unable to sustain the campaign as they had no funding for it. Besides International Drug Awareness Day and the Ke Moja prevention project, there is little evidence of a coordinated approach towards raising drug awareness across the key government departments. Role players do address substance abuse issues in the “16 Days of Activism” campaign and at times during “Child Protection Week”.

Even though prevention programmes seem to be the main focus of demand reduction strategies of the organisations in the sample, the NDMP itself states that school, family and community prevention programmes have a modest impact, and there is little consensus about their general effectiveness (DSD, 2013). The UNODC is supporting the implementation of prevention programmes and released the International Standards on Drug Use Prevention, which says that programmes of prevention and education, based on personal and social skills and social influence (such as Ke Moja), have proven to be effective for prevention. Evidence is primarily from developed countries.

Respondents generally have a positive view that Ke Moja provides a packaged programme with a curriculum and materials that organisations can pick up and implement. A number of respondents argue that Ke Moja is not evidence-based. However, a 2012 evaluation of Ke Moja found that beneficiaries of Ke Moja had significantly better knowledge about drugs and their negative effects compared to non-beneficiaries. The caveat, however, was that the levels of knowledge were generally low amongst both groups in all provinces. Further, measuring knowledge of drugs does not necessarily translate into abstinence or harm reducing behaviours. Hence, there is no evidence of whether Ke Mojo is having an effect on behaviour change and hence demand reduction. The 2012 evaluation made a number of suggestions for improving Ke Moja, including updating the materials and extending it to other age groups (Chiroro et al, 2012).

A respondent in Gauteng indicated that in 2016 there would be funding from DSD for community development and substance abuse education.

The DBE also plays an active role in the implementation of the NDMP, at least at a national level. They have ensured that prevention is also a part of the life orientation and life skills curriculum for learners (particularly in National Curriculum and Assessment Policy Statement (CAPS) Grade 6, 7 and 8). The DBE also has a national strategy for the prevention and management of alcohol and drug use among learners in schools, and has written guidelines for drug testing in schools as an early intervention activity. The challenge for DBE is that there is little buy-in at a provincial level for this national strategy, primarily as it is viewed as an unfunded mandate by provincial departments of education. The DBE also supports an awareness campaign around keeping schools alcohol and drug-free. It has further printed and distributed advocacy and awareness materials to learners, educators and parents. Other stakeholders also support prevention activities, such as the SAIDS "I play fair" education programme, which promotes anti-doping outreach activities, and DOT 'Arrive Alive' campaign in conjunction with tertiary institutions.

One of the key strategies to reduce demand is to control access through supply reduction, which will be discussed under the corresponding section. Advocacy is another of the main prevention areas. Of the 21 interviews with CSOs, four organisations said that they engaged in direct advocacy, while eight said that they undertook research or participated in research projects (such as by SACENDU) and in policy processes. Three of these organisations engaged in both research and policy work and direct advocacy. A further 11 said that they did no advocacy at all.

> *"We work with as many organisations as we can – MRC, UCT – to look at policies that exist. We support good policies with research so they can be passed and implemented. We had forums and have done community-based advocacy work; for example we supported a group in the Northern Cape where they mapped alcohol outlets and what they do with the alcohol. We produced booklets where people told stories about alcohol in the Northern Cape and distributed it to stakeholders."* (CSO representative).

3.4.1.2 Early intervention

Early intervention refers to "a therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. Treatment is offered or provided before patients present voluntarily 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 dependence or major psycho-social complications related to substance use" (CDA draft annual report, 2014-2015). Prevention and early intervention activities are often conducted together because people with problems may come forward for assistance during prevention programmes. Early intervention can also fall into the category of secondary prevention.

High-risk groups for early intervention include children of addicts, a child who has a friend who is an addict, street kids and children who are experimenting with drugs.

It is difficult to gauge the quantitative extent of these services from the data available, and there is no consistency in reporting on these services in the CDA annual reports. They are also not differentiated in the DSD service delivery indicators (see section: **Error! Reference source not found.**).

From the interviews conducted, there are a range of early intervention services and programmes being offered in South Africa. Early intervention starts with identification, and problem behaviours are usually identified through reporting (by self or family member), screening or drug testing (at school or at work). Problems are identified by family members or friends, through employers and referred to employee wellness programmes for counselling (including motivational counselling), testing and referral. The DBE policy for drug testing states that it is located within a restorative justice framework, with the aim of keeping the learner in school. Drug testing is only allowed on the basis of reasonable suspicion, although the data suggests that random drug testing is conducted, though most often in sport.

Support groups for users and their families are also offered as part of early intervention programmes by a number of organisations, but the extent of these is unknown. A number or organisations, including SANCA, use individual treatment plans as a methodology.

Parents, teachers, and learners are taught to identify the signs of substance abuse and to recognise problematic behaviours that indicate the beginning stages of addiction, so that they can intervene as early as possible in the person's using behaviour. Social workers render counselling to the affected people and their families and then make appropriate referrals to organisations such as SANCA. It is important that early intervention initiatives provide a holistic assessment of the risk factors; for instance a learner struggling with drug use may also have learning difficulties that need to be addressed.

The DOH plays a key role in early intervention through the screening practices contained in Primary Care 101[40] (page 83 deals specifically with substance abuse[41]). If this primary level of screening was being implemented effectively in primary health care centres, then cases could be picked up earlier and referred to out-patient treatment, in which case expensive in-patient detoxification and treatment could be avoided.

One respondent from the CDA suggested that there is increasing traction within the DOH for screening and early detection and management for substance abuse. At a policy level there is work being done on reviewing the clinical package, which then allows services to follow.

3.4.1.3 Gaps in demand reduction

Programmes are not well targeted or designed

Generally, the main criticism about prevention programmes is that they are generally ad hoc, sporadic and not evidence based. There is also a need for more culturally appropriate and age-specific programmes. One national official commented that they need professionals to help with developing communications:

> *"… we are just social workers. We need experts for messages for prevention. We should do less and do it good than do a hundred things and mess it up. There is too much trial and error." (National respondent).*

Some respondents were also critical that brochures designed in 2003 are still being handed out, and said that information should be updated and modernised.

Not enough programmes addressing risk and protective factors

Programmes that focus on general risk and protective factors, with a particular emphasis on strengthening family coping mechanisms (including parenting programmes), and providing recreational activities for youth are identified as important but lacking by a number of stakeholders in the sample.

There is generally very little focus on poverty reduction in the NDMP and poor linkage with existing poverty alleviation strategies. As one key informant commented:

[40] Primary Care 101 is a symptom-based integrated clinical management guideline for the management of common symptoms and chronic conditions in adults. The guidelines are intended for use by all health care practitioners working at the primary care level in South Africa, according to the document's forward.

[41] To review this document visithttps://www.idealclinic.org.za/docs/guidelines/PC%20101%20Guideline%20v2_%202013%2014.pdf

> *"The total approach needs to include a comprehensive social development intervention that not only deals with prevention, treatment and reintegration but addresses the social and economic issues that predispose young people and adults to substance abuse." (PSAF)*

One example that stands out is the City of Cape Town, which has been linking people who have been participating in rehabilitation programmes to the EPWP.

Stigma

Stigma is still a barrier to drug education programmes and treatment. Some churches and funders, for example, will not participate in substance abuse issues because of the negative association.

Advertising

The intention to reduce advertising for alcoholic beverages has not been fulfilled. The proposed law to control alcohol-related advertising and sponsorships, the Control of Marketing and Beverages Bill, was discussed by Cabinet in 2013. From a Sunday Times article of 29 December 2015 it appears that the Minister of Health, Dr Aaron Motsoaledi is extremely frustrated with the slow process of the bill and is calling on civil society to support his bid to get it passed through Cabinet. There is clearly resistance from other sectors including the industry itself and DOSR (who want advertising for sport).

The biggest challenge in demand reduction perhaps is the lack of integration between prevention and early intervention. Some of the challenges with early intervention are highlighted below.

Lack of programmes, services and funding for early intervention

The general consensus amongst respondents is that there is more funding available for awareness raising and less for early intervention services. While the campaign days and awareness raising around substance abuse problems are important in that they help to mobilise organisations and communities, they need to be backed up with services to help those who seek assistance as a result of the awareness raising activities. This is often lacking.

> *"The problem is the NDMP focuses on prevention through awareness, now I raise the awareness. Demand for facilities increases but now how do I implement the awareness? We must start looking at how many facilities we need, so many psychologists and psychiatrists and counsellors. Correct, you must create the awareness. But once you have created the awareness, that's where it drops you." (Local government)*

Limited referral systems

A key problem raised by respondents is that referral mechanisms are lacking and there are not sufficient services to assist those presenting with problems.

Policy conflict – punitive versus restorative or harm reduction

Raids and random drug testing in schools

Despite the National Policy on drug testing based on reasonable suspicion, there are schools that still practice random drug testing and respond punitively instead of in a restorative manner that allows the child to stay in school. Although the guidelines may have been distributed to schools, they are not being consistently implemented. The National Strategy for the Prevention and Management of Alcohol and Drugs used amongst learners in schools does not speak about police raids and does include SAPS as a key role-player, so raids on schools may be against government policy. They certainly seem to go against the ethos of the National Strategy of the Prevention and Management of Alcohol and Drugs in schools.

Criminalisation of users

One of the key obstacles to early intervention as an approach is the criminalisation of users. Currently users caught with drugs are dealt with through the criminal justice system. Putting users or addicts in jail is counter-productive and is not likely to contribute to the goal of a substance abuse-free South Africa because the DCS does not have treatment, detox or rehabilitation or reintegration services for addicts. Users end up in prison where they are likely to get further entrenched into drug use and suffer further psycho-social damage. Further, not all of those arrested for using illegal substances are addicts or presenting social problems; besides that they are breaking the law for possessing illegal drugs.

> *"About 70% of prison populations are actually there because of drugs. Rather send them to rehab….addicts are not bad people, they are sick people who do bad things." (Private sector)*

> "They also get involved in crimes because children are going to jail for drug use. We must include a people-centred approach – prison is for correction, people must stop judging them [*the users]." (LDAC member)*

> *"We're spending 30% on the problem, but 70% on the effects of the problem. R87 million is being contributed by Provincial Government to substance abuse. Four times that amount is given to correctional services. There prisons are overcrowded. Many substance users are not hardened criminals so diversion at court level needs to be addressed. Does the judiciary understand substance abuse [enough to] provide effective sentencing? I sat in courts and was shocked by a judge's comments to a user and how the user is treated. For example, the judge gave user sentence of five years and drug dealer R5 000 bail, so there is a lack of capacity in the understanding of substance abuse." (CSO treatment centre)*

The racial dimension of the criminalisation of the use of illegal substances is increasingly discussed in international literature. This means that black (and poor) people are more likely to be arrested for drug-related crimes than white people. A recent study in South Africa confirmed that there is racial and socio-economic discrimination in policing regarding the use and possession of drugs, that results in the criminalization of certain segments of South African society over others. (Pouthier 2015)

Within the current system that criminalises possession and use of drugs, diversion programmes is minimal. One way to address this is the decriminalisation of possession of certain drugs, especially cannabis. This would be consistent with the CDA statement on cannabis.

Another concern worth mentioning, raised by one respondent, is linked to the corruption of police and lawyers, who reportedly prefer not to tell users about diversion programmes because they extort money from them to help them stay out of jail.

Prosecuting users for possession also means that forensic labs become backlogged as it takes the same amount of time to test a small dose of, for example, five grams as it does to test 500 grams. Hence, it reduces the effectiveness of the criminal justice system to deal with big time dealers, as evidence takes longer to produce.

3.4.1.4 Concluding comments on demand reduction:

The strategy of demand reduction including prevention and early intervention is predominantly focused on prevention and awareness raising activities, and in essence attempts to address the symptoms of social problems rather than the causes (such as joblessness, idleness, risk-taking behaviour and mental health issues). Nevertheless, helping people to make healthy and responsible choices is not a bad thing. However, there are not enough early intervention services, screening and referral systems to assist those who present with early signs of problems related to substance abuse. The effectiveness of prevention programmes that promote abstinence is still disputed in the NDMP, yet it is also a key strategy of the DSD (particularly through Ke Moja) and is supported by the UNODC. Whereas there are attempts to reduce harm through early intervention (for example to keep learners in school or to prevent the onset of dependence), the punitive approach and the criminalisation of users and the associated stigma prevents people from coming forward and seeking assistance, or worse, these factors result in them being exposed to further harm

when they end up in prison. This contradiction is an indication that the objectives of demand reduction may not be achieved.

In conclusion, in terms of demand reduction, the NDMP has not contributed sufficiently to improving responses to reduce demand for dependence-forming substances largely because of the lack of an evidence base for prevention programmes and because of concern around the criminalisation of users. The data on trends related to the abuse of dependence forming substances is insufficient to say conclusively whether there has been a reduction in demand, but the indications from the literature review is that there has not been a reduction in demand (see appendix 7); in fact, there is evidence that the use of heroin is on the increase.

The other key aspect of the integration of services, particularly for prevention and early intervention in terms of demand reduction and harm reduction remains a challenge and has not been sufficiently achieved.

The following section explores the extent of services related to harm reduction.

3.4.2 Harm reduction

The NDMP views harm reduction as, "limiting or ameliorating the damage caused to individuals or communities who have already succumbed to the temptation of substance abuse. This can be achieved, for example, by treatment, aftercare and reintegration of substance abusers and dependents with society" (DSD, 2013, p. 31). The NDMP highlights that it has adopted the term 'harm reduction' due to the use of the term by the UNODC, although in South Africa it is more closely aligned to 'harm prevention' given that the term 'harm reduction' practices appear to condone drug use (DSD, 2013, p. 31). The NDMP notes that the term and its meaning are still under discussion South Africa, and that this period of the NDMP should be used to clarify a South African position in this regard. As an approach it has numerous proponents and opponents. Some argue that it enables increased substance use or "sends the wrong message" (Lee et al., 2011). However, its advocates maintain that harm reduction provides an important public health alternative to the disease and moral models of substance abuse (Lee et al., 2011). It is important that this is resolved as it has implications for policy implementation.

The main departments who have been involved in harm reduction activities are the DOH, DSD, and the Medical Control Council. The primary harm reduction strategies are rehabilitation or treatment, and aftercare and reintegration.

3.4.2.1 Rehabilitation / treatment

Most of the effort for harm reduction is focused on rehabilitation and treatment.

From the interviews we see that for treatment centres, private, public, and non-profit, the NDMP 2013-2017 has not strongly informed the substance abuse activities that have been implemented. Although it has provided guidance in some instances (such as norms, standards and guidelines), it has often been unable to provide clear indications for implementation. Additionally, when respondents felt that there was sufficient guidance for implementation, there were a large number of challenges at the point of implementation; these included a lack of budget, human resources and coordination.

The main treatment options in South Africa follow a therapeutic model, however the medical model is also followed. Rehabilitation options include in-patient and out-patient, a range of therapies, medical substitution (such as opiate substitution therapies) and detoxification services. There are a number of important guidelines regarding rehabilitation, which were produced by the DSD or the IMC, but unfortunately most of these documents are not dated and therefore it is difficult to determine if they were produced before or after the current NDMP. These guidelines include:

- A manual for minimum norms and standards for in-patient treatment centres (in accordance with the Prevention and Treatment of Drug Dependency Act (No.20 of 1992) produced by the DSD and CDA, with the support of UNODC. A model for

treatment of substance dependent youth in residential facilities by the DSD is based on the above document.
- A Community-Based Model for Substance Abuse by the DSD
- A guideline on treatment of co-morbidity of substance abuse and mental disorder/illness, which is current being produced by the IMC on substance abuse.
- A detoxification guideline as captured in the previous master plan, which is currently being produced by the IMC.

There is thus evidence of progress towards increased standardisation and regulation to facilitate quality services. There is also evidence of attempts to increase access through the building of government treatment centres in each province and funding to CSOs.

There is little evidence though to confirm that these approaches are working. There are three main modes of rehabilitation: in-patient treatment; out-patient treatment and community-based responses (which usually work on an out-patient model; in South Africa the matrix model is included in the guidelines for community-based responses). The majority of respondents support a multi-disciplinary and multi-modal approach as per the NDMP 2013-2017; especially since it is part of the norms and standards for treatment.

One challenge is that unregistered centres may not work with the norms and standards, and another is that the ratios of social workers to clients may be too high (one social worker to 20 clients) to render effective multi-modal services.

Multi-modal methods require multi-disciplinary teams. Most organisations mention that they have a mix of counsellors, social workers, occupational therapists, psychologists and medical doctors (where detoxification is involved). Psychiatrists and clinical psychologists are also sometimes mentioned but their services are said to be very expensive. Some centres also have spiritual healers, nurses, dieticians and art, drama or music therapists.

A community-based model is essentially an out-patient model, linked to a substance abuse organisation (out-patient centre). The Community-Based Model (which is really more of a framework document used by DSD) advocates for the use of the Matrix Model for community intervention, but a concern is that this has not yet been evaluated for its suitability in the South African context. This is a lower cost model because it does not require in-patient facilities. Many of the organisations in our sample that offer out-patient services use the Matrix Model.

The community-based out-patient model requires well developed referral networks and case management because it relies on the motivation of the individual and on the availability of related services (such as peer support groups; for example Alcoholics Anonymous.). The City of Cape Town is an example of a local government that has adopted this model. They currently support six out-patient clinics using the matrix model of treatment.

Detoxification

According to Primary 101 (DOH, 2013/2014) only alcoholics and heroin addicts really need in-patient detoxification services. Detoxification services are predominantly provided by the DOH, and most rehabilitation NGOs will refer clients to DOH for detoxification before admission. Stikland hospital, for example, has an Opioid Detox Unit with ten beds treated by a multi-disciplinary team. There were also concerns raised by respondents over the number of patients able to access beds for detoxification.

Drug use and HIV - services for people who inject drugs

Strategies that could be employed to reduce harm to users are not being implemented because of the lack of consensus about, and poor understanding of, harm reduction in South Africa. Even though legislation and policy supports the use of needle-syringe programmes (NSP) and Opioid Substitution Therapy (OST), these programmes are rarely implemented by provincial health departments, and there are few examples of NSPs in the CSO sector. The prevailing attitude towards drug use in South Africa is still essentially conservative promoting

abstinence. This is where the policy confusion around harm reduction results in confused policy implementation. One respondent from the IMC warned that failure to "gear up" for substance abuse and HIV programmes in the context of nyaope use is very risky for the spread of HIV amongst drug users because nyaope (which is inhaled) is laying the foundation for injecting heroin. The DSD Substance Abuse Directorate says that they have no strategy for addressing HIV as part of their programme, however it is part of the Ke Moja materials as a risk factor.

Coverage of treatment centres

A national audit of all treatment centres (both registered and unregistered) in the country is currently being conducted, with an updated list expected in March 2016. However, a review of the most current available data on treatment centres provided by DSD for the evaluation (2013 – see table below) indicates that there were a total of 122 treatment centres in the country; almost half of which were in Gauteng; the Western Cape and KwaZulu-Natal have the second and third highest numbers of treatment centres. Of the 122 across the country there are 59 out-patient centres, 41 in-patent centres and 17 centres that offer both in and out-patient services and five state owned facilities. However, there appears to be only two halfway houses in the country, which is not sufficient.

Table 26 Treatment facilities. Source: DSD lists (2013)

Province	In-patient	Out-patient	In-patient & out-patient	Halfway House	Unspecified	Total
Eastern Cape	7	3	2	0	0	12
Free State	0	2	1	0	0	3
Gauteng	16	30	5	1	1	53
Kwazulu-Natal	4	7	2	1	2	16
Limpopo	0	1	0	0	0	1
Mpumalanga	5	4	0	0	0	9
North West	4	2	2	0	0	8
Northern Cape	1	1	0	0	0	2
Western Cape	4	9	5	0	0	18
TOTAL	**41**	**59**	**17**	**2**	**3**	**122**

Most of the treatment centres (78 out of 122) receive some government funding and the vast majority are operating as NGOs. The Northern Cape, however, has no funded treatment centres; only a private centre and an NGO.

This report does not provide total bed capacity because these figures are not currently available.

Treatment centre admission data from SACENDU for the second half of 2014 shows that close to 10 000 people were treated either as in-patient or out-patient. It can be assumed that beds tend to be fully occupied, considering the waiting times for treatment, which can be

up to 5 months in some areas. SACENDU covers about 66% of the treatment centres spread unevenly across the nine provinces. This data does not tell us how many people who want treatment are not accessing it.

Table 27: Substance abuse at treatment centres in the second half of 2014

	WC	KZN	EC	GT	NR1[42]	CR2[43]
Total number	3444	929	663	3172	1134	655
Alcohol (%)	22	36	35	20	18	39
Cannabis (%)	23	40	21	36	42	31
Mandrax (%)	5	5	7	2	<1	5
Cocaine (%)	2	6	5	4	2	2
Heroin (%)	13	5	1	14	26	6
Meth. (%)	35	<1	16	3	1	4

Source: SACENDU, 2015

In terms of coverage, many of the organisations are required to service areas larger than they can manage, resulting in inequitable access. For example, the Dr Fabien and Florence Ribeiro Treatment Centre in Gauteng covers Gauteng, and the other four provinces that do not have state-run treatment centres. “Our 2013-2014 APP target per year was 1320, but in the last financial year we had over 2860 service users [more than double the target].” (Government official)

Table 28: State-run in-patient treatment centres by province

Province	Government treatment centre	No government treatment centre
Eastern Cape	X	
Free State		x
Gauteng	X	
Kwazulu-Natal	X	
Limpopo		x
North West		x
Northern Cape		x
Mpumalanga	X	
Western Cape	X	

[42] Northern region: Mpumalanga and Limpopo

[43] Central Region: Free State, North West, Northern Cape

Four provinces do not have state-run centres, and all have conditional grants to establish them. The provinces that currently have government treatment centres are Gauteng, Western Cape, KwaZulu-Natal, Mpumalanga, and Eastern Cape, where a new centre was recently opened. Gauteng also plans to construct an additional treatment centre in each year of the MTEF. A centre is currently under construction in the North West Province. The centre in Limpopo was completed in June 2015, but it has not yet opened for patients. Free State and Northern Cape planned to collaborate to build a treatment centre in Mangaung Metro, but during 2014/15 the province did not proceed beyond the planning phase.

Coverage of the rural areas and hard to reach areas is a problem. One organisation is supposed to cover the whole of Nkandla for example, but can only afford to reach 4 out of 14 wards. Some treatment centres extend their coverage by offering out-patient stations. West View Clinic in Roodepoort, for example, has six satellite out-patient stations subsidised by DSD which includes Bekersdal, Dooroonkop, Kagiso, Manziville, Motlakeng and Toekomsrust.

Success rate of treatment

The success rate of treatment proved to be a difficult indicator because the definition of success varies widely. For example, for one organisation success is measured in terms of abstinence and relapse rate, but for another using a medical management model for severe cases, avoidance of death is a success. Success rates also differ for different drugs; heroin is more difficult to address than cannabis, for example. This makes it difficult to measure a success rate over time per centre as the patient profile and drug use patterns change.

Most of the respondents agree that aftercare and reintegration services are a key to lasting recovery management. One respondent elaborated:

> *"It's easy to say 100% because in the centre they're clean and after they leave they're clean but we maintain contact with them for 6 months after. We found our heroin success rate was 7.5% and tik was 12%. But overall last quarter was 72% and whole year was 62% across everyone and everything - that's why we have family group sessions. We have these sessions even after they've left. But unfortunately some families come and some don't and sometimes they're also a big problem." (CSO respondent)*

Another respondent made a similar point about aftercare and reintegration into society from a very different perspective:

> *"They are sent to the treatment centre, about 70% relapse because we don't have a halfway house. We train them but sometimes there is no communication between the social worker and the treatment centre and us. They don't tell us to check on them or help with reintegration." (CSO respondent).*

A number of respondents argued that it is important to recognise that there is no cure for addiction; that it is a chronic and relapsing disease. From this perspective success would be considered if people who relapse seek support and show responsible behaviour. This, however, is very difficult to measure.

For learners, a sign of success is their performance at school, and school attendance.

3.4.2.2 Aftercare and reintegration

The NDSD has developed a reintegration and aftercare model recognising that treatment and care does not end with the release from treatment centres, and that most treatment centres in South Africa do not have the capacity to provide these services. The document provides a model for halfway houses and other reintegration and care services to follow to promote ongoing abstinence while people reintegrate with their families and communities. The data above Table 26 shows that in 2013 there were only two registered halfway houses in South Africa.

The norms and standards for in-patient treatment centres requires that prior to release, the centre ensures adequate referral and linking of the patients to their original referral social workers, local community services or self-help groups.

The guidelines for aftercare and reintegration do not specify duration and dosage, and there is no reference to the evidence used to support the development of the model.

There are a number of models used by CSOs and private treatment centres such as the recovery management model (used by Mighty Wings), and the SMART programme (self-management and recovery training) of FavorSA-CARES.

Most centres start with family integration during treatment, but this depends on the family's ability to travel to the centre. Where the Matrix Model is offered as an in-community model there is no need for reintegration, but aftercare is a part of the model. Some CSO centres maintain contact and monitor users for between two weeks and two years.

School reintegration is very important for learners to ensure that they are able to complete their education.

Aftercare and reintegration has been identified as one area which is significantly lacking in services by many respondents from all sectors.

> *"It would be nice to have more aftercare, it would be great if we could have secondary facilities in the major centres because then we can integrate the services that are way beyond our funding. It is not practical to shuttle people around when they start their reintegration process." (CSO respondent).*

A number of respondents mentioned two particular services that were closed down or refused registration. Both were from reputable organisations, one of them being the SANCA halfway house in the Northern Cape, which closed down presumably because of lack of funding. This raises questions around why functional services are being closed when there is a desperate need for them.

Challenges in relation to harm reduction

Accreditation: Registration of treatment centres is generally perceived as necessary because it compels providers to follow norms and standards; however the red tape and delays surrounding procedures for registration inhibit progress in the sector. A number of respondents complained about unregistered services (both in-patient and out-patient) that are not following regulations and are not monitored by the state for good practice. A number of respondents from treatment centres noted an increase in unregistered treatment centres or programmes.

Availability: There are not enough treatment centres and waiting periods of up to 6 months are reported in some provinces (such as KZN). A sector expert explained: "Most people who need treatment do not have medical aid and have to go to a government or NGO treatment centre and there are long waiting lists. The situation is dire." (Sector expert). Respondents indicate that people can wait for between two weeks and six months to receive treatment.

The medical model: Key experts raised concerns about the availability of the medical model for treatment programmes in South Africa. The concerns raised were that DSD does not have the clinical expertise to offer treatment in terms of the medical model, and the DOH has not found the budget to do so. As a result there are insufficient treatment services using a harm reduction approach.

Detoxification: According to one respondent the more stringent regulations around detoxification programmes have resulted in fewer detox services being offered by in-patient facilities, and they are now offered mainly through referral to the DOH putting additional strain on government services. *"There are no primary detoxification centres apart from government ones in the Eastern Cape." (CSO representative)*

The evaluation has not been able to establish exactly how many hospitals provide opioid substitution therapy (for example using buprenorphine, morphine), but the evaluation did

establish that there is one in the Western Cape. As one expert commented: "This is a well-known and important treatment of opioid addiction, part of harm reduction. There are however vanishingly few hospitals at which out-patients receive these treatments." (Email correspondence, CDA expert)

Skills: According to an expert, the lack of skills and specialisation of health professionals at all levels (primary level, secondary and tertiary), in particular the specialist skills needed for psychological treatment, is a major challenge facing the sector. At primary care, there are extremely few trained personnel that are able to provide either 1) evidence-based psychotherapy, or 2) evidence-based pharmacotherapy for substance use disorders. At secondary care level, although again people are admitted with methamphetamine-psychosis or other kinds of dual diagnosis in general psychiatric units, there are very few trained personnel that provide either of the above interventions. At tertiary care level, in the Western Cape, there is one facility that provides in-patient detox for alcohol and opioid dependence. This is staffed by a senior registrar in addiction psychiatry. The expert suggests that to the best of their knowledge this is the only such post in the country.

> *"So we train all sorts of doctors, but despite our particular burden of disease, not doctors with a specialisation in addictions." (Email correspondence – CDA expert)*

Access for people who are on diversion or who are committed: Many centres will only take people on voluntary admission (especially private treatment centres), and hence there are not enough spaces for people who are sent by order of the state. The DSD in the Northern Cape for example does not have a rehab centre and buys beds from the private sector, but private treatment centres only take voluntary admissions.

Affordability: In-patient treatment is expensive, as is the medical model. This is due to the cost of living, as well as meeting the norms and standards (what one respondent termed 'formalities and legalities"). The specialists such as psychologists and psychiatrists are very expensive, and there are not enough in the government hospitals.

There are serious ethical issues around medical aids only paying for 21 days of in-patient rehabilitation whereas evidence suggests this is insufficient; there are industry standards for duration of treatment depending on the substance of abuse and whether this is a first entry or a relapse. Some medical aids refuse to pay for rehabilitation programmes at all.

Information sharing: A number of CBOs complain about a lack of information sharing, that they are not aware of what is happening outside of their centres. Even though the SACENDU[44] network provides excellent information sharing services, it does not reach everyone.

Family therapy: Family therapy has been identified as a gap in treatment programmes by a few respondents. This becomes particularly difficult when patients have to be in treatment centres far away from home because of a lack of services in their home towns. Yet treating individuals with their families is critical for their rehabilitation since many of the underlying problems are linked to family issues, especially for children and youth.

[44] SACENDU is a programme of the Medical Research Council (MRC) which gathers; analyses and reports on data based on treatment centre admissions, and also invite people to share information at its quarterly feedback sessions. They also have a website with up to date information.

Referral networks: The National Strategy for the Prevention and Management of Alcohol and Drug testing in schools (DBE, 2013) tasks the school principals and school-based support teams with establishing or strengthening existing referral systems, but this was raised as a weakness by a key informant:

> *"At a national level we had to call social development to get a contact person within a province to facilitate access for a learner to be seen at a treatment centre. The parents feel they are let down by the system as their immediate need is not sufficiently addressed. You are pushed from pillar to post without getting the necessary support. Many times it is a parent that cannot afford to come back and keep dealing with it." (National)*

Even though the guidelines for in-patient centres require that adequate referral and linking arrangements take place, a number of respondents from the treatment sector indicate that the referral relationships between treatment and aftercare or reintegration services are not strong, and that there are not enough aftercare programmes.

Access for children, women and girls: There are insufficient services for children. Most treatment centres are for people over 15 or over 18, and while child and youth care centres can be accredited to provide treatment, most are not. Some provinces, such as the Northern Cape, have no in-patient facilities for children and the children have to go to other provinces, interfering with their school work and family relationships. The lack of out-patient facilities for children is also problematic as they are admitted to facilities unnecessarily and this affects their schooling and increases avoidance because of the associated stigma of being an in-patient in rehab. Children are being sent to child and youth care centres, but these are not well equipped to deal with substance abuse issues. One respondent said the Cape Youth Rehabilitation Centre, which was doing very well, was closed by the Western Cape Provincial Government. They elaborated: "They were doing very good work with children and dumped these children in children's homes – they are just falling into a hole right now." According to another respondent the system is failing younger children in need of treatment.

> *"The age of drug users is getting younger, children as young as nine years have already started experimenting with drugs. The facilities don't accept children younger than 15 years and this is a gap. Somehow the system is failing the children as they cannot get treatment." (LDAC)*

Access for pregnant women is another issue because of the specialised care needed to avoid potential side effects on the baby from detoxification.

A number of respondents mentioned that rehabilitation centres only provide services for men, but we were not able to confirm this through the lists provided by DSD. However, as an example, the new detoxification unit at Baragwaneth hospital which can admit 40 people, and serves the whole of Gauteng, only admits men over the age of 25. Another respondent from a CSO working in the substance abuse sector states:

> *"It is very frustrating that we cannot admit females. DSD said that they must have another building for females. The current buildings need serious renovations - where can we get the funds for new buildings?" (CSO treatment centre)*

Respondents suggest that out-patient facilities are better for women because they do not have to be separated from their children and can keep on working; however there are not enough of these services throughout the country. It is acknowledged that if men played more of a role in child rearing and child care, it would also be a problem for them; but they generally do not.

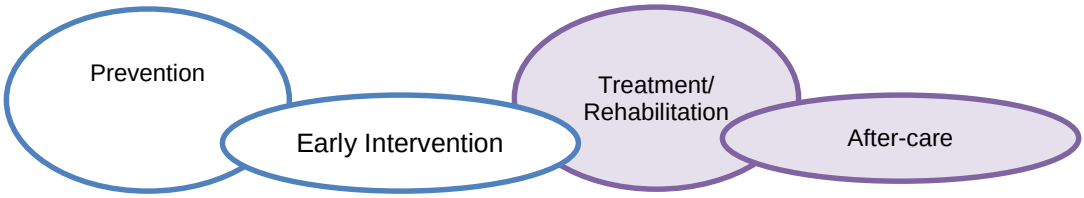
Access for people with disabilities: Most of the in-patient facilities in the sample were not able to assist people with physical disabilities or people in wheelchairs.

Gang turf: Access is also a problem if a centre is built on the turf of a particular gang; it prevents access for members from other gangs.

Lack of integration with aftercare: It was frequently emphasised that the success of rehabilitation and treatment often rests on the take up of aftercare and reintegration services.

The results show that in terms of the continuum of care is there are fewer services for early intervention and for after care. However, for prevention to be effective, early intervention services must be available and accessible, and the same applies to treatment and after-care.

Figure 11 Services along the continium of care



3.4.2.3 Conclusion – harm reduction (treatment / rehabilitation and after care/ reintegration)

In sum, there is clearly a need for more substantial evidence based on what works for rehabilitation programmes, including types of treatment options, dosage and duration of treatment. While the minimum norms and standards for in-patient care have created an awareness of good process, there are concerns around whether the model itself is good process, and whether there are sufficient skills to implement the programmes. A key concern raised by respondents from all sectors is with the integration of treatment and aftercare services, which is essential for effectiveness. Clearly, while there are increased efforts towards harm reduction, systemic elements such as a lack of budget, insufficient human resources, lack of clear policy direction and poor coordination are hampering effective implementation. The ongoing commitment by key role players (including those in the DOH, DSD and SAPS) to a punitive approach to drug users influences where they choose to put their resources and who they are prepared to work with.

The NDMP has not yet been effective in creating conditions for different agencies to collaborate and concertedly reduce harm of substances. There are promising signs, such as the mention of rehabilitation in the norms and standards for treatment, but this does not go nearly far enough.

3.4.3 Supply reduction

The supply reduction strategy of the NDMP includes key interventions to control the supply of alcohol and other drugs including raw drugs and precursor materials. This entails control over distribution and access, production, manufacture, sale, distribution and trafficking of drugs and precursor materials and manufacturing facilities. It also includes seizure and destruction of both the inputs and outputs of drug production. The supply reduction strategy includes legal action against people who do any of the above.

The main role players in supply reduction are the SAPS, SARS, DTI and the Medicine Control Council.

The TOC behind supply reduction is that reducing supply will reduce access to alcohol and other drugs, which will in turn lead to reduced demand. In this regard, the regulation of legal liquor sales and the control of illegal alcohol sales is a key concern.

In terms of supply reduction, most of the respondents feel that the NDMP 2013-2017 has made no contribution to reducing the supply of drugs in the country, or controlling the sale and distribution of alcohol. In fact, many feel the situation has worsened. No respondents spoke about the abuse of registered drugs (such as codeine), although the Medical Research Council is currently supporting a study on codeine dependency.

Regulation the liquor trade (legal and illegal): There are a number of concerns here. Firstly, the failure of provinces to adopt updated legislation on the supply of alcohol. According to the Sunday Times (29 December 2015) six out of nine provinces still apply the

Liquor Act of 1989, even though a new Liquor Act was promulgated in 2003. This implies a failure of provincial governments to buy in to more recent attempts to control the supply of liquor. Secondly, there is insufficient enforcement of by-laws where they are in place. A number of respondents lamented the lack of enforcement of by-laws:

> *"There is no effective control of selling, there are no inspectors to check when taverns open and close and whether they adhere to the age limit of children using alcohol." (PSAF).*

The third is the over-abundance of liquor outlets in small towns and locations, which a number of respondents raised as a concern.

The CDA annual reports contain figures for inspection, closure of illegal liquor outlets and confiscation of alcohol in a number of provinces. It is difficult to tell from the absolute numbers provided in the reports whether they are close to the real scale of the problem. It is difficult to know whether things are getting better or worse (see Annexure 5).

Furthermore, what is not said in the reports but is mentioned by respondents, is that the illegal traders pay an 'admission of guilt' fine and then open doors again the following day. Clearly law enforcement is neither consistent nor harsh enough.

Drug dealing: Supply reduction is part of the core business of SAPS. SAPS report an increase of 3% in seizures over the last three years (SSI-National). SAPS comes under a lot of criticism from respondents for their strategies of dealing with drug dealers. Some respondents say that they tend to focus on the smaller dealers or runners (some attempt to push up their arrest rates), whereas their focus should be on the main illegal drug distributers.

> *"Stop with petty criminal arrests but focus on the high level people, it is such a waste of resources because you are reacting symptomatically without dealing with the diseases [systemic issue]. Instead of arresting people, find out where it is coming from and going after the main suppliers, we need to figure out how the drug economy works." (Expert)*

Corruption: Corruption between the police and the drug dealers is mentioned a number of times by respondents, and it was also identified as a concern in the literature review. Goga (2014) argues that the high level of corruption in the police is one of the biggest barriers to solving the drug problem in the Western Cape.

Forensics: Forensic processes take one to two years to test drugs found on dealers. This affects the speed of finalisation of cases and incarceration of drug dealers because within this period they get bail and simply come out of jail after being arrested, to once more sell drugs. Arresting users for possession also contributes to this congestion.

Community involvement: At a lunchtime event at the University of Cape Town, Simon Howe from Centre for Criminology identified local community action as a key strategy in supply reduction. For example, if dealers move into a park, then the community need to start using that park, having braais, picnics and so on. The intention is to reclaim the space from the dealers.

Courts: The police are frustrated because dealers who are arrested multiple times pay 'admission of guilt' fines and are released by the courts to continue dealing. *"The criminal justice system is not an effective deterrent – we do not really deter them from trading." (National department, CDA).*

Production: Cannabis is still the main illegal drug produced in Africa (International Narcotics Control Board (INCB) report 2014). Based on recent large scale seizures of methaqualone (Mandrax) and its precursors (N-acetylanthranilic acid) in South Africa and Mozambique, the INCB suggests that the drug is being manufactured for local consumption in Southern Africa, predominantly in South Africa.

Even though the NDMP says that there is little evidence that crop destruction leads to supply reduction, it still remains a strategy of the SAPS. There are concerns about collateral damage from spraying cannabis with glyphosate – both for the environment and for the health and economic wellbeing of the villagers who are affected.

> *"Cannabis eradication campaigns in Lesotho, Swaziland and South Africa have been highly controversial and unsuccessful. The Agent Orange-type chemicals employed by the South African Police Service have led to the toxification of arable land and ground water. Subsistence farmers have moved their plantations to inaccessible land in the mountains. A divergence of legal and social morality is clearly discernible where local communities regard the cultivation of cannabis as necessary to survival thereby depriving the police of legitimacy and support from civil, political and social structures." (Hübschle, 2011)*

Trafficking: Regional cooperation is a key consideration in the control of the supply of drugs. A 2010 study by the Institute for Security Studies (ISS) (Hübschle, 2010) highlights this to be a problem due to a number of factors such as corruption, lack of cooperation between border officials from different countries, language barriers between officials from different countries and conflicts between the police and the customs authorities.

The majority of the trade in illegal and legal substances is controlled by organised international crime syndicates. However, the ones that are most likely to be caught are the couriers. Typically couriers are women, especially those from low-income backgrounds, who continue to be vulnerable to recruitment as drug couriers and are most susceptible to arrest. There is thus a gender dimension to the control paradigm in the war on drugs (INCB Report, 2014)

Southern Africa continues to be a main transit route for heroin and cocaine mainly due to the sophisticated transport infrastructure (INCB Report, 2014). It seems that maritime transport is overtaking air courier as the preferred means of smuggling heroin in East Africa. Heroin is mainly trafficked along the East Coast, which could suggest why we are seeing the increased use of heroin in the border and coastal towns in Limpopo, Mpumalanga and KwaZulu-Natal. In Southern Africa heroin is increasingly trafficked by means of international mail and parcel services.

The INCB report suggests that the expansion of the Durban port is being tested by trackers as possible entry points for drugs into Southern Africa. The report also states that Southern African criminal groups are increasingly also engaged in the online sale of cannabis.

Alcohol and cigarettes are also frequently smuggled to avoid tax regimes, and this has been an increasingly contentious issue in South Africa. Recent claims implicate British American Tobacco, a private investigation firm, and State Security Agency officials in cigarette smuggling (Eye Witness News, April 2015).

The last detailed report on smuggling routes in Africa was produced in 2010 by the Institute for Security Studies (Hübschle, 2010).

Hübschle also suggests that the role of the formal sector in substance abuse is vastly under-researched; for example issues regarding money laundering, and involvement with criminal syndicates as front businesses.

Drug control paradigms: South African supply reduction strategy is still firmly located within the predominant drug control paradigm over the last 50 years, which has been the war on drugs. This paradigm is set by the UN Single Convention on Narcotic Drugs of 1961. The Global Commission on Drug Policy released a report on the failings of the war on drugs and its detrimental effects for individuals and societies globally. The Global Commission on Drug Policy has attempted to bring to an international level an informed, science-based discussion about humane and effective ways to reduce the harm caused by drugs to people and societies (Hübschle, 2011).

In the 2013/14 CDA Annual Report, DIRCO raises that this issue was discussed at the 57th Commission on Narcotic Drugs (CND57) in March 2014. DIRCO notes that there is an increasing call for a review of the international drug control policy. This call emanates largely from Latin America and some European countries, which has been given impetus by the legalisation of cannabis for recreational use in some states of the USA. South Africa's position was to defend the centrality of the current international drug control system and called for its full implementation. DIRCO reports that the 2016 session of the CND will hold a

special session on a high-level political dialogue to exchange views about new approaches and alternative evidence-based policy options to address the world drug problem.

There are a number of priorities suggested by respondents for moving forward. There are short-term focuses, such as diversion programmes. However, it has been suggested by think tanks such as the Institute for Security Studies (Hübschle, 2011) that there needs to be serious consideration and redirection of the policing of operational strategies and protocols, as well as decriminalisation and de-penalisation of drug use. Mandatory sentencing should also be addressed. An expert in the sample suggested that under current conditions, legalisation in South Africa would not be feasible in the short term because he doubted whether the country would be able to regulate it sufficiently. However he did suggest, that drug use should be decriminalised and that all the focus of police efforts should be on understanding and attempting to control the drug trade. This would also free the court system up to deal with the dealers, relieve congestion in the correctional facilities and address use within a social and health paradigm.

> *"Drug use is a function of deeper systemic issues. Until we can deal with them we need to work at creating alternatives. The police hate policing drugs – it is such a waste of resources for them. But, I would not argue for legalisation but for decriminalisation. Legalisation and criminalisation are poles on a long spectrum. We are at the hard end but simply going the other way won't do what it is meant to do – those driving legalisation go all the way. To legalise, means to regulate and the cost to government is so expensive… " (Expert)*

On the other hand, the CDA position on cannabis suggests that a differentiated approach based on evidence should be adopted for different substances and target groups (for example, a strategy for children under 18 should be different to that for adults). The position on the legalisation of cannabis is that "there is relatively little evidence that supply reduction via criminalisation is effective in reducing cannabis abuse, but there are insufficient data to indicate that legalisation of cannabis will not be harmful." (CDA, 2015)

3.4.3.1 Conclusion – supply reduction

Although there are clearly a lot of activities around supply reduction that are reported in the CDA annual reports (such as confiscations of alcohol closures and fining illegal liquor outlets), they do not seem to be making a dent in the supply of alcohol or illegal drugs. The regulation of medicines through the pharmaceutical system does not emerge as a concern, and we are not able to conclude anything about this. The evaluation identified a number of indicators to explore in the literature review regarding trafficking, but there does not seem to be recent research on the supply of illegal drugs; the most recent article found was written in 2010 (Hübschle, 2010). We cannot confirm the TOC assumption that supply reduction will lead to demand reduction, because there are no statistics that correlate supply to demand, and because there does not yet seem to be a reduction in either supply or demand.

3.4.4 Specific issues regarding women and children, HIV infection and other medical and psycho-social consequences related to substance abuse

The link between substance abuse and violence against women and children is at times dealt with through prevention programmes and in treatment programmes. Only two of the treatment centres in the sample (in-patient and out-patient) specifically mentioned that they dealt with women and child abuse. Abuse is mainly addressed through a therapeutic response. One programme mentioned that they deal with anger management. Considering the well-established link between substance abuse and violence against women and children, and that most people in treatment are men, this is a concern. More effort should be made to address the intersection of substance abuse and violence in general, and against women and children specifically.

The link between sexual abuse and substance abuse is also a concern for the evaluators (such as in "lolly lounges", which are drug dens where women are said to trade sexual favours for drugs). While one LDAC mentioned that they have a strategy for dealing with this phenomenon, it was only mentioned once in the whole study. The Gauteng report in the CDA

Annual Report 2014/5 states that 5960 visits were made to “lolly lounges”. This issue needs to be given more prominence.

The term Foetal Alcohol Spectrum Disorders (FASD) includes the range of permanent conditions that result from alcohol consumption by the pregnant mother, of which Foetal Alcohol Syndrome (FAS) is the most severe condition. Young women in general and high risk women in particular, need to be specific targets for prevention and early intervention programmes around FAS. There is growing evidence in South Africa that FAS or partial FAS is a significant and underestimated, health and social problem in South Africa, with one of the highest prevalence rates in the world (Oliver et al, 2013; MRC, UCT, UP Policy Brief, 2008). This is particularly problematic in the North West, Northern Cape and parts of the Western Cape. Based on the burden of disease estimates, it is estimated that the prevalence of FAS in South Africa could be as high as 14/1000, but FASD can go up to 119/1000 in high risk areas. FAS is not only a health problem, but a social disorder because people with FAS tend to have poor social judgement, “low intelligence” and behavioural problems (including sexual violence and crime) (Policy Brief, MRC, 2008, pg 1). The policy brief suggests that it is possible that people with FASD are disproportionately represented in correctional facilities. FASD mostly occurs in rural areas, and people in need of specialist substance abuse rehabilitation services (in- or out-patient) are unlikely to have access to such services as they are mainly provided in urban areas. (MRC, UCT, UP Policy Brief, 2008). The policy brief recommends key strategies for FASD prevention and support including surveillance and monitoring, screening and brief interventions, awareness raising and education, liquor controls and further research. FAS is mentioned twice in the provincial summaries of the CDA annual reports (2013/4 and 2014/15). From this it appears that FAS programmes have been conducted in the Northern Cape in 2014/2015, where it is reported that 298 sessions on FASD were conducted, reaching 67 parents and 18 260 young people; and that brochures on FAS were printed and distributed in the North West. The PSAF was also planning a FAS awareness campaign. It is clear that this is not sufficient to address the scale of the problem.

The action plans of various entities such as LDACs and Community Safety Departments show that they integrate substance abuse awareness into campaign days of 16 days of no violence against women and children, and into their victim empowerment programmes and Child Protection agendas.

4 Conclusion

Overall, the TOC states that “if there is a well-coordinated, integrated and functioning system at policy, programme and administrative level, then state/agencies’ capabilities to reduce demand, supply and harm related to substance abuse is enhanced and access to treatment is improved. This in turn will lead to a reduction in bio-psycho-social and economic impact of substance abuse and related debility on the SA population”. This evaluation aimed to measure the first part; namely if all the elements of the system are working, as well as the likelihood of the NDMP contributing to state/agencies’ capabilities to reduce demand, supply and harm related to substance abuse and improve access to treatment.

4.1 Policy direction and guidance

Firstly**,** the evaluation considered the extent to which the NDMP has provided clear policy direction and guidance for aligned operational planning, resource prioritisation and measurement of results across different institutions. The policy direction of the NDMP can really be found in the three pillars of harm reduction, demand reduction and supply reduction, and one of the main criticisms of the Prevention of and Treatment for Substance Abuse Act (Act 70, 2008) is that there is policy confusion around harm reduction. The NDMP was criticised for being short on details around implementation, and this is where the PSAFs and LDACs have become stuck.

Alignment in operational planning means producing plans at every level in the system which are in line with the goals and objectives of the NDMP, and more specifically, whether there is

any reference to the NDMP or to substance abuse in APPs and in other sector plans. Although many respondents were of the view that the objectives of the NDMP are shared and that the NDMP provides clear policy statements and direction for aligned operational planning, in reality it has not been sufficiently reflected in sector plans or APPs. Only three departments have departmental DMPs that are finalised and approved; and five departments have the NDMP reflected in their APPs. Although the NDMP is aligned with the MTSF 2009-2014, it was not revised when the MTSF 2014-2019 was adopted and should be aligned with Outcome 13 on social protection.

One of the assumptions in the TOC is that the plans of the national departments will cascade down to provincial level and resource allocation will follow. Despite all provinces having produced DMPs, none of them are up to date and finalised. Few LDACs from the four provinces visited in the evaluation are functional and hence there are only few local action plans in existence. It also appears that the local action plans are often not aligned to the IDPs.

In terms of policy direction for resource allocation, the NDMP is clear that it does not allocate any additional funds to carry out activities to combat substance abuse, and states that departments are required to incorporate this as part of their normal planning and budgeting. However, the NDMP is not clear about which departments are expected to contribute financially and at the same time the outcomes in the NDMP are ambitious. The CDA does not provide adequate guidance to departments regarding sourcing funding for additional activities in the NDMP. This leaves confusion around where resources should come from to implement substance abuse-related strategies and plans as envisaged in the NDMP.

With regards to policy direction for measurement of results, an M&E plan is included in the NDMP and institutional arrangements are described to provide direction for measurement. However, the M&E plan in the NDMP is too high level and not implementable. The M&E plan has furthermore not been followed up with an M&E framework and system.

In conclusion, although the NDMP has provided some policy direction and guidance for aligned operational planning, resource prioritisation and measurement of results across different institutions, it still has the above-mentioned weaknesses that if not addressed, will present an obstacle to the reduction of the substance abuse problem in South Africa.

4.2 Adequacy of financial resources

Secondly**,** the evaluation considered the systemic element of adequate financial resources. According to the TOC the resource allocation should be adequate to support all elements of implementing and coordinating the programme. The TOC furthermore says that coordination will encourage the departments to pay attention to their mandate as per the NDMP, and if they pay attention to their mandates then they will make sure that their intervention is reflected in their APPs. This will result in their programmes related to the NDMP being adequately funded and with sufficient human resources allocated for implementation. The evaluation's findings on whether there are adequate financial resources show that with the exception of the DSD, none of the national or provincial departments have a separate budget for substance abuse and as a consequence they are unable to provide a figure for their NDMP-related activities. Furthermore, with the exception of DSD, the NDMP 2013-2017 has to date not brought about any change in budget allocations in the departments.

A total of around R 0.6 billion is allocated by DSD for prevention of substance abuse in the nine provinces. At national DSD, the allocations to substance abuse for 2014/15, 2015/16 and 2016/17 are much larger than in previous years because of the inclusion of the conditional grant for substance abuse treatment centres.

Until recently, the CDA did not have a separate budget but now they have a ring-fenced budget. For the PSAF itself there is no budget. Provincial DSDs are the only provincial departments with a dedicated budget for substance abuse. The TOC assumes that the LDACs will be able to mobilise resources from the provincial departments and municipalities based on their plans. Municipalities are meant to provide funds for the LDACs, but this did

not happen as the mayors did not see it as a priority. The different stakeholders on the LDACs are therefore forced to fund their own activities using their own budget. It however appears that the Gauteng Province provides funds for the LDACs. The treatment centres run by NPOs who receive DSD funding raised that the amount is not covering the expenses and that they have to fundraise elsewhere to support their activities.

The budget for substance abuse is insufficient. This is partly because the assumption in the TOC about "the departments paying attention to their mandates and making sure that their intervention is reflected in their APPs so that can have a sufficient allocated budget" does not hold. Likewise, the LDACs have not been able to raise funds from the municipalities to implement their activities. Neither the CDA nor the NDMP has been unable to influence the allocation of budgets by other agencies. Furthermore, respondents found that the neither CDA nor the NDMP has resulted in rationalisation of resources as stipulated in the Prevention of and Treatment for Substance Abuse Act Section 56. However it appears that rationalisation of resources has happened at PSAF level.

4.3 Adequacy of human resources

Thirdly**,** the evaluation considered the systemic element of adequate human resources. The findings about whether human resources are adequate reveal that capacity building of members of the CDA and PSAFs has taken place to support the development of departmental DMPs and provincial DMPs. Furthermore, some LDACs have received training on the NDMP and additional technical training on substance abuse. However, the training has been once-off in nature and has not been sufficient for them to fulfil their functions as specified in the Act. There are also no standardised training materials or guideline documents. The main barriers cited by respondents are the CDA's lack of resources, both human and financial, and the limited allocation of budgets for training from provincial departments.

Substance abuse is a highly specialised sector particularly in relation to treatment and the ability of government officials to implement substance abuse programmes, and services remains limited. The findings reveal that the workforce in this sector is stretched and inadequate both in terms of numbers and skills although it could be argued that current resources are not being sensibly utilised. There are courses at postgraduate level at some universities but academic institutions do not offer undergraduate courses (neither degree nor short courses) for substance abuse. There is also an absence of accredited courses on substance abuse targeting personnel working at different levels of the system. Consequently, most of the staff working at treatment centres and CSOs develop their specialist skills through in-service training and experience.

4.4 Coordination at all three levels

Fourthly**,** the evaluation considered the systemic element of adequate coordination at all three levels of government (national, provincial and local levels). The TOC assumes that by appointing representatives of key departments and by serving together with the 15 experts, the outcomes, outputs and activities will be coordinated and achieved. The findings about whether there are appropriate governance arrangements reveal that the CDA is legally mandated and is driven by engaged drug experts. The institutional structures have been set up for the various committees and the CDA is on the whole operating in a functional way. The CDA secretariat is supporting the CDA, but due to insufficient staff, competing responsibilities, and a lack of dedicated executive leadership this support is inadequate. The CDA has no protocols to guide the coordination of services and programmes. Despite the introduction of the "cluster concept" the departments are still working in isolation. The TOC assumes that the DSD is the appropriate department to lead and coordinate the NDMP because it is the main department caring for social ills. This is partly true. However, the location of the CDA in the DSD is a challenge that urgently needs to be addressed. The TOC assumes that the CDA has the necessary authority to compel reporting and other key functions from the departments. However, in reality, CDA is left with no authority particularly

when it comes to ensuring compliance with reporting requirements. There is cooperation with the IMC, but due to the lack of role clarification between the two structures the cooperation is not working optimally. As a consequence of all the above, the evaluation team found that the CDA has not been provided with sufficient resources and authority to provide the necessary leadership, implementation management and oversight capacity to successfully facilitate the implementation of the NDMP.

The CDA secretariat and experts have supported the PSAFs mainly through capacity building, information sharing sessions and intervening on issues raised at meetings. However, support from the CDA national department members remains limited and most are unclear on the extent of support they are meant to provide for the establishment and maintenance of these structures.

Attempts to facilitate vertical alignment between the CDA and PSAFs have been made by provincial representatives attending national CDA meetings, and a CDA representative sitting on the PSAF to provide expert guidance and support. However, the findings reveal that this does not necessarily take place in all nine PSAFs and support is variable across provinces – three out of the four PSAFs included in the evaluation report that CDA support has ranged from limited to non-existent. The CDA secretariat currently does not have the resources and capacity to provide the much needed regular support.

Support from the provincial Premier's Offices is crucial for ensuring high-level buy-in and strategic direction for addressing substance abuse in the provinces. However, none of the PSAFs report full support and buy-in from the Premier's Office and, where there has been strong support in the past in KwaZulu-Natal and Western Cape, this has declined over time. The CDA recognises this and visits to each Premier's Office have been done in the past. It was included as an activity in the CDA Business Plan 2014/2015.

The functionality of the four PSAFs is variable, with KwaZulu-Natal PSAF being virtually non-functional. The other three structures (Gauteng, Northern Cape and Western Cape) are functioning reasonably well in that regular meetings are held; membership is fairly well aligned to Section 57 of the Substance Abuse Act (2008); and minutes and reports are being produced. Despite this, the PSAFs face numerous challenges with irregular and inconsistent attendance at meetings being the most critical challenge. Some of the main contributors to this situation are that substance abuse is seen as a DSD issue and it is not prioritised by other departments; that it is not included in provincial APPs for each department; and the lack of provincial leadership on the issue.

The evaluation has found that joint planning has been facilitated by the three functional PSAFs (Gauteng, Western Cape and Northern Cape) and this has made some contribution to reduced duplication and fragmentation of services. These structures have reportedly provided a platform for improved networking and coordination of service delivery. The Western Cape has made some good progress in terms of improving PSAF functionality and the benefits of this are already becoming evident. The KwaZulu-Natal PSAF is virtually non-functional and thus its coordination of the substance abuse sector in this province is limited.

When functional, the LDACs do provide a platform to plan jointly, coordinate services and prevent duplication and fragmentation of services. However, the biggest challenge facing their functionality is the poor participation of departments. The main reason for this is that they do not see the problem of substance abuse as a priority. The LDACs do not have funding to implement their action plans and for this reason there is a high dropout rate of LDAC members, which has led to the poor sustainability of LDACs and limited implementation of action plans.

4.5 Monitoring, evaluation, reporting and evidence-based planning, programming and policy

Fifthly, the evaluation considered the systemic element of monitoring, evaluation, reporting and evidence-based planning, programming and policy. The TOC assumes that "the LDACs and the PSAFs will gather evidence which will be used to inform policies that are more

effective"; and that "through coordination of reporting, the CDA will be able to get a good overview of the policy recommendations that are needed to enhance the impact of the NDMP". It also assumes that "planning, programme and policy design will be based on evidence from a functioning M&E system" and that "the CDA will make recommendations to Cabinet based on evidence which will improve harmonisation of skills". Finally, the TOC assumes that "Treasury will provide more financial resources if the departments and the CDA have good evidence that they are achieving their objectives".

In assessing the condition and quality of M&E frameworks and systems in the sector, the evaluation team found that the NDMP 2013-2017 has an M&E plan with indicators and targets. Data collected from interviewees indicates that there has been a problem interfacing with departments' M&E plans. The CDA developed the QuASAR reporting tool, but it failed because of its complexity. However, a simplified reporting template seems to be working. The CDA tried to fulfil its role of monitoring core departments represented in the CDA as well as PSAFs, but they could not reach their target. Most departments and all provinces reported on the NDMP to CDA as per the requirement of the Act, but the challenge was that reports were often delayed which resulted in the delay of the CDA reports to Parliament.

Several research studies envisaged in the NDMP have not been commissioned mostly due to lack of funding. A few departments commissioned their own research studies and evaluated their programmes and used that data to inform their programmes. SACENDU appears to be the main source of data on substance abuse, but it does not provide data on the number of people who abuses substance.

The evaluation found that the assumptions in the TOC on evidence informing programme and policy planning are not achieved, as the various research projects have not been implemented and the evidence gathered by LDACs and PSAFs has not informed policies. Perhaps reporting is considered as an accountability exercise more than as a means to inform policies. The lack of an M&E system has also contributed to these challenges. Until these challenges are addressed the use of M&E to inform the operational and management decisions will remain ad hoc and limited.

4.6 Effective project and programme service delivery

Sixthly**,** the evaluation considered the effectiveness of programmes and services in the substance abuse sector project and programme service delivery. The TOC assumes that if all the system's other elements work and are coordinated, then state/agencies' capabilities to reduce demand, supply and harm related to substance abuse will be enhanced and access to treatment improved. The TOC furthermore assumes that "aligned policies mean that departments' intervention strategies will all be working towards the same objective. If policies are harmonised the various government agencies will not be working at cross purposes".

The NDMP provides impetus for the various role-players to address substance abuse in their communities, but programming for demand and harm reduction is mainly provided by DSD, with the support of a DOH, DBE and the Institute for Drug Free Sport. Supply reduction involves the police, NPA, DOJCD and DTI. A review of the activities directed towards beneficiaries indicates various successes based on the CDA reports. In terms of demand reduction, there were numerous activities employed by the provinces mainly in the realm of information, education and communication or awareness raising. However, even the NDMP questions how effective these types of universal prevention programmes are for addressing substance abuse. There are not enough programmes targeted to high-risk groups with good secondary and tertiary prevention programmes (including early intervention). The evidence base for programmes across the continuum of care, particularly in a South African setting, is not strong. Supply reduction also boasts numerous arrests, confiscations, and searches. However, it is questionable whether the supply of alcohol (legal and illegal) and other substances has actually decreased. The harm reduction activities reported on differ by province, for example only Free State, Mpumalanga, and Limpopo mention diversion programmes for young offenders and only four provinces made mention of detoxification. Only the Northern Cape and North West Province reported providing aftercare services.

Nevertheless, many people received treatment for substance abuse and provinces provided funding for treatment centres. In 2014-2015, DSD was also able to secure R150 million from treasury in order to establish four new public treatment centres in provinces that previously did not have them.

From a programmes and service delivery perspective there are a few main concerns.

The first is that efforts are not correctly allocated across the continuum of care. Prevention and rehabilitation receive more funding than early intervention and aftercare. As long as these key aspects of the pipeline are not adequately funded, the effectiveness of the other aspects will be reduced. This is because if awareness is raised as part of prevention exercises, it is likely to result in people who are already experimenting with drugs, or those who are affected by substance abuse seeking assistance. If there is no funding for early intervention then they will not get the support they deserve until it is too late and a certain percentage will end up as addicts in rehabilitation. Then, the relapse rate from rehabilitation is said to be higher when there is inadequate aftercare. Unless this changes, the cycle of dependency is not broken. Another key conclusion is that there is a wide spectrum of programme options available to South Africans and appropriate treatment should be available based on the individual's needs. For example, a chronically relapsing heroin addict could be placed on an Opioid Substitution Programme, whereas a mild user of cannabis can be provided out-patient services. However, there is no underlying planning to ensure that these services are available where and when people need them. The service provision is not relative to demand. In some provinces DOH refuses to implement Opioid Substitution or needle exchange to prevent HIV infection because of ideological concerns about drug use. This defeats the thinking of the NDMP around the harm reduction approach. The criminalisation of users and the associated stigma also prevents the uptake of early intervention and further pushes users into either criminal justice system or into a deepening pattern of addiction. These are examples of where the assumptions in the TOC of working for the same purposes are not achieved. Unless these contradictions are ironed out, the NDMP is not likely achieve its objectives regarding demand and harm reduction.

The norms and standards for in-patient and community-based services provided by DSD are followed and widely adopted by registered facilities. There is a concern that the Matrix Model and other models, including prevention programmes, have been adopted from international experience without sufficient evidence of them working in the South Africa context.

There is evidence that programmes work within the nested system addressing individuals, families and communities.

Regarding supply reduction, the focus of activities should be on the major distributers of illegal drugs, and on the control of the liquor trade. According to SACENDU data, alcohol has been identified as the major contributor to crime, violence and other social problems in South Africa, and together with cannabis is the reason for most treatment centre admissions. Alcohol has a high burden of harm than any other drug. Of great concern is the increase of heroin use and the threat that this poses for the spread of HIV as people eventually move from smoking nyope to mainlining heroin. Heroin addiction is very hard to treat. South Africa, particularly the provinces of Mpumalanga, Limpopo and KZN need to be geared up for this over the next few years.

There is not enough emphasis on the link between HIV, violence against women and children and substance abuse in the programmes and communications.

Although the NDMP says that the three strategies of demand reduction, supply reduction and harm reduction have over-lapping areas and should be implemented in an integrated manner, at the moment there are legislative, ideological, administrative and political constraints which affect their integration. The LDAC as a model for community mobilisation can work, but the bulk of the evidence is that they are not effectively helping to provide integrated programmes at a community level.

In conclusion unless the various challenges are addressed the likelihood of the state/agencies' capabilities to reduce demand, supply and harm related to substance abuse will not be enhanced and access to treatment will remain limited.

5 Lessons learned

- ✓ An integrated and coordinated plan needs to start with shared goals and objectives by all actors who have a stake in its successful implementation.
- ✓ Participatory processes have played an important role for ensuring relevance and building consensus amongst key stakeholders on the goals and objectives of the NDMP.
- ✓ A joint plan does not guarantee automatic buy-in and prioritisation of goals and objectives by national departments. These need to be shared broadly across the sector and national departments need support to integrate them into planning frameworks. Also not enough has been done on the inter-sectoral planning and implementation of the NDMP, particularly when it comes to the use of clusters.
- ✓ The integration of NDMP goals and objectives into national departmental planning frameworks does not necessarily guarantee that they will filter down into provincial level department plans. This is hence a false assumption in the TOC.
- ✓ The process of supporting departments to develop departmental DMPs is just as important as the plan itself to ensure that departments clarify their mandates in relation to substance abuse.
- ✓ The support and political will of the Premier is an enabling factor.
- ✓ The buy-in from the provincial Premier's Office strengthens commitment, support and accountability from relevant provincial departments for the substance abuse agenda.
- ✓ The training and the receipt of the template for developing the DMP has been an enabling factor for national departments and PSAFs.
- ✓ The selection of suitable government CDA representatives is crucial. When the CDA representatives are in authority in those departments, they are often able to link with departmental needs and hence they are able to produce good DMPs. Hence it is important that that the representatives are authorised to make decisions.
- ✓ Attendance of CDA meetings by PSAF representatives and attendance of CDA experts on the PSAFs facilitates good vertical alignment and communication between the two structures.
- ✓ The reports provided by PSAFs to the CDA do not provide a good indication of the true functionality of PSAFs.
- ✓ Activities undertaken by the Western Cape to strengthen its PSAF are an example of good practice and details should be shared and replicated by PSAFs in other provinces.

The following lessons can be learned about strengthening programmes:

- ✓ The policy confusion in the NDMP 2013-2017 around the drug control paradigm (harm reduction versus abstinence; a restorative versus criminal justice approach) is a barrier to integrating the demand, harm and supply reduction pillars. This in turn negatively affects the effectiveness of programmes and services. This is a critical factor inhibiting the attainment of the policy objectives of the current NDMP.
- ✓ Programmes are not well allocated across the continuum of care, with fewer services available for early intervention and aftercare.
- ✓ The problems with the integration of services along the continuum of care also reduce the effective achievement of the intended outcomes of the NDMP. The evaluation shows that the demand reduction pillar is negatively affected because prevention is not well integrated with early intervention services, and there are not enough early

intervention services. Further, the harm reduction pillar is weakened because there is insufficient referral between treatment programmes and after care, and because there are not enough after care services.

- ✓ There are problems with referral systems between service providers that render linkages across the continuum of care weak and affect the success of the Matrix Model, which relies on a strong network of providers at a community level.
- ✓ The evidence base of programmes in the South African context, across all aspects of the continuum of care, is slim.
- ✓ Funding is a constraint for NGOs in being able to provide services to the required quality and geographical coverage.
- ✓ There are massive gaps in provision of demand and treatment services in certain provinces.
- ✓ DSD is the department that drives programmes and services, and is to some extent supported by the DOH, but not sufficiently. DOH feels let down by DOSR and DTI around the question of control of the supply of alcohol.
- ✓ Stigma is an issue that prevents treatment and needs to be addressed.
- ✓ Medication is a critical part of the treatment regime.
- ✓ There is a need for clear, consistent, non-judgemental and realistic messages on substance use targeted to different age groups and demographics. Just like with HIV, all role players need to come on board with one consistent message.
- ✓ Lessons learned from addressing HIV and AIDS should be adopted in this sector. In order to address the problem, appropriate funding has to be provided at the right levels (especially at a community level).
- ✓ Addressing the underlying causes of substance abuse from social development and economic development perspectives is critical. It is necessary to address the risk factors that cause people to begin taking drugs in the first place, while recognising that some people will become addicted and will need medical or therapeutic interventions.
- ✓ The DBE has produced a good National Strategy for the Prevention and Management of Alcohol and Drug use amongst learners in schools, but it is not sufficiently adopted in all provinces.
- ✓ Employee wellness programmes and medical aids play an important part in the sector. There are some barriers to treatment, and particularly aftercare by medical aids that need to be addressed.

6 Recommendations

The recommendations below consider how to improve the National Drug Master Plan and the structures which support it, as per the requirements of an implementation evaluation. If these recommendations are implemented, and the NDMP is found to still be ineffective, then fundamental questions about the suitability of these structures and whether they are fit for purpose in the first place can be questioned. Currently, the evaluators do not have sufficient evidence about the effectiveness of the CDA to make recommendations about whether it should exist. Firstly, there is not enough evidence generated through the CDA monitoring system; secondly there is no information about the real size and scope of the problem in South Africa because the household survey has not yet been conducted; thirdly, the CDA (and the PSAFs and LDACs) have not been sufficiently resourced and so have not been able to prove themselves yet. The recommendations below are made in this light.

R1: The CDA should advocate for **review and harmonisation of legislation** and addressing inconsistencies identified in the evaluation, and advocate for bills and policies that have been in draft form for some time to go through Cabinet. The Minister of DSD needs to lead on this and perhaps engage the IMC if necessary.

R1.1 Review legislation, including the Drug Trafficking Act, so that it does not conflict with the harm reduction approach in the NDMP and other national legislation so that it harmonises with liquor by-laws of municipalities.

R1.2 Amend the Substance Abuse Act to include the need for a Provincial Substance Abuse profile to ensure that an evidence-based approach for planning is used by PSAFs and LDACs. The process must provide an indication of the need for intervention, where services are located, and then identify the gaps.

R1.3 Fast track tabling of The Control of Marketing of Alcoholic Beverages Bill, National Road Traffic Amendment Bill, amendments to the Schools Act (to allow random testing for doping in sports), Substance Abuse Act and the Liquor Act.

R2: There is a need for a **comprehensive review of the NDMP** to be aligned with the MTSF 2014-2019 and to provide much clearer roles and responsibilities for the departments. Specific issues to be covered include:

R2.1 A stronger and clearer policy position on harm reduction. The following must be addressed:

- To extend harm reduction thinking to prevention and response. There is a need for clear, consistent, non-judgemental and realistic messages on substance use targeted to different age groups and demographics. Just like with HIV, all role-players need to come on board with one consistent, yet targeted message that addresses abstinence, delayed onset, safe use, abuse and dependency. Consider decriminalising use for certain drugs. Ensure that the NDMP clearly supports the provision and up-scaling of OST and NSP, particularly in light of the increasing use of heroin (also in the form of concoctions referred to as, inter alia, nyaope, sugars or woonga).
- Amend plan for consistent messaging to *reduce* substance abuse, as opposed to *eliminate* it.
- Change the TOC in line with the findings of this report and the national priorities.
- More specific focus on vulnerable groups and the interaction of HIV/AIDS and substance abuse.

R2.2 The revision must have an implementation plan with a clear M&E framework and plan for indicators at national, provincial and local level including clear guidance on how to prioritise, apply and align or pool resources for their efficient use. The review process should start with generating evidence including a National Household Survey on substance abuse to determine the size and scope of the problem and research on the harm reduction approach in South Africa.

R2.3 The process should also include awareness raising and lobbying of parliamentarians around harm reduction and a high-level political dialogue about South Africa's position of the International Drug Control Paradigm must be held, preferably before the special session of the Commission on Narcotic Drugs in 2016 (this could be driven by the CDA and DIRCO).

R3: Strengthen the autonomy, independence and authority of the CDA.

R3.1 DSD and CDA could consider ways to increase the autonomy, independence and authority of the CDA and the evaluators are proposing the following two options (and the Substance Abuse Act (No 70 of 2008) must be amended accordingly:

- The CDA should be moved outside of DSD and be completely independent like SASSA, NDA and MCC – a streamlined entity that has a slim operational structure and works in a coordinated manner, which is funded directly by treasury and not through another department. As recommended by Deloitte (2010) the CDA could be registered as a 'government component' and hence be a separate institution in the public service.
- The CDA should be an independent entity hosted in the Presidency.

R3.2 A CEO should be appointed to provide dedicated and permanent leadership. A more streamlined structure is needed for the CDA with a core group of Departments whose mandates align most closely to the NDMP (DSD, DBE, DOH, DOJCD, NPA, DTI,

SAPS and DOSR's Institute for Drug Free Sport). Other departments should be part of the broader CDA consultative forum and part of the extended meetings. Only the core departments should be required to have DMPs. Sub-committees lead by experts should be formed according to the three pillars of supply, demand and harm reduction.

R3.3 As the CDA and the IMC are pursuing the same goals and are complementing each other it is recommended that they clarify the roles and responsibilities of each structure and formalise their interaction.

R4: Improve current functioning of the CDA to provide more direct guidance for and monitoring of the implementation of the NDMP by national departments, provinces and local authorities. In order to achieve this, the CDA needs to do the following at a national level:

R4.1 Ensure that each core department has its own DMP which has outputs that speaks to the outcomes of the NDMP and heads of departments should engage with the NDMP to assist in departmental planning. This will assist them to make sure that their outputs talk to the outcomes of the NDMP. The CDA must provide guidance on how departments are supposed to fund their DMPs. Specifically the CDA must send a letter to the HODs of each national and provincial department setting out exactly the departments' role in substance abuse and request that a DMP be developed, attaching the reporting guidelines.

R4.2 In order to facilitate functioning of the PSAFs, the CDA chairperson, CDA members and experts in the CDA should prioritise visits to provincial Premiers' Offices to gain their buy-in and support for PSAFs and assist with holding non-compliant departments accountable. The functionality of the PSAFs needs to be properly monitored so that adequate guidance in the interpretation and implementation of the NDMP and DMP can be provided. The CDA secretariat should support and guide PSAFs in developing a strategy for securing the support from the sector, including the business sector. The problem of poorly functioning PSAFs such as the KwaZulu-Natal PSAF needs to be addressed immediately.

R4.3 The CDA must strengthen its monitoring, evaluation and reporting and provide more support and onsite monitoring visits to departments and PSAFs, using simple assessment checklists or tools to track functionality.

R4.4 Data collected by the CDA support structures needs to be analysed and interpreted more comprehensively, and it should also be shared with everyone who needs it. The reporting should not only be about what departments are doing (activity level) but about what changes are happening as a result of the activities and outputs (outcome and impact level).

R4.5 The CDA needs budget to implement the recommendations contained in this document, and to implement joint programmes and to initiate its own projects such as the research clearing house or to run (or sub-contract) an information portal, or coordinate and support a research agenda. The new structure should allow budget to be directly allocated to the CDA (not through the DSD), and the CDA should be able to raise its own funds. For example, given the enormous profits made by the liquor industry there is a need and obligation for this industry to be substantively more involved in harm reduction efforts (CDA, 2015).

R5: Institutional strengthening of the PSAFs by ensuring appropriate and adequate human, technical and financial resources for the PSAFs. This would also include ensuring continued support by the Premier. It is furthermore recommended that the CDA develop a **standardised TOR and guideline document for PSAFs**. What this should cover is in Annexure 10.

R6: The PSAFs should ensure that programmes are **well allocated across the continuum of care** throughout the province, based on evidence of need, with equity in service provision as a key consideration. This should include ensuring effective distribution of

resources across the continuum of care so that prevention and early intervention are better linked, and that rehabilitation and after care and reintegration are better integrated. This will facilitate availability of services for those who need them the most.

R6.1 A Provincial Substance Abuse profile should be developed to ensure that an evidence-based approach for planning is used by PSAFs and LDACs. In order to support this, the CDA, together with DSD, must develop a process and tool for determining a substance abuse profile for the province and at local level, which could be updated every three years. It must provide an indication of the need for intervention, and where services are located, and then identify the gaps. An example is the provincial profile tool used for the Children's Act monitoring. This must be written into the Substance Abuse Act (No 70 of 2008) as a requirement.

R7: A support programme aimed at strengthening the **capacity of LDACs** should be developed and piloted. The Expanded Partnership Programme implemented by the Western Cape government, Department of Community Safety in order to strengthen Community Policing Forums is an example of the type of model which could be piloted here.[45] As part of this pilot (or as a stand-alone activity) in order to improve the functioning of LDACs it is recommended that the CDA develop a standardised TOR and Guideline document for LDACs. Annexure 10 suggests what this could contain. National and provincial departments should assist to define the roles and responsibilities of the local structures in LDACs and ensure that provision is made in budgets, operational plans and performance management tools for such functions. If all this is done, and the pilots find that the LDACs are not able to achieve positive outcomes, then the suitability of the structures themselves can be questioned.

R8: Develop and implement a **capacity building strategy for CDA, PSAF, LDAC** including the relevant competencies (skills and knowledge) to guide the selection of members for each structure (CDA, PSAF, LDAC)[46] and addressing the specific functions of these structures as laid out in in Section 56 (d) and Section 58 (d) of the Substance Abuse Act (70 of 2008). In order to maximise impact of this strategy the following should be included:

R8.1 Developing standardised training materials and guidelines for each of the structures. The training of master trainers for training of PSAF and LDAC members and the use of a train-the-trainer approach should be considered as a cost-effective way of reaching large numbers of committee members. If implemented, this approach should include a strategy for selecting suitable participants as master trainers and a strong, well-planned mentoring component for master trainers.

R8.2 An operational plan and adequate budget allocation by the CDA to each province to ensure that capacity building of structures will take place on a regular basis rather than being once-off in nature.

R9: The **DOH must play a greater role in providing the human infrastructure and other resources for providing medication as part of treatment regimes**, including intervention services in hospital settings. Improving the skills in the sector is critical as addiction treatment

[45] Clarke S, Mancebo E, Mahomed S, Cartwright J, (2015)," Implementation Evaluation of the Expanded Partnership Programme, Evaluation Report", Western Cape Department of Community Safety

[46] These competencies should include both technical knowledge on substance abuse and other relevant skills such as research and analytical skills, information management, planning and organisational skills.

is a highly specialised field. For the medical model to work more doctors who specialise in medication treatment of addiction and addiction psychiatrists are needed. To further address the gap in specialist skills amongst the workforce, the CDA should continue its efforts to oversee the development of an **accredited training course** on substance abuse for targeting social workers, auxiliary social workers, nurses, lay counsellors and other mental health professionals as defined in the Mental Health Care Act (Act no 18 of 1973). While pursuing the long term goal of getting approval from the College of Medicine to having a specialisation being developed in addiction medicine, the CDA should in the interim also start with developing programmes that can be Continuing Professional Development (CPD) accredited. (Likewise, shorter certificate and diploma courses could be developed). This should draw on work already done by CSOs and treatment centres and on the Colombo Plan, which was mentioned as a good resource for intensive, internationally recognised training and has already been specified in the CDA Business Plan 2014/2015. Once this course is developed, each department should develop a capacity building strategy which targets departmental officials working in the substance abuse sector.

R10. A quick **response strategy** must be urgently developed to **curb the spread of heroin** including increased awareness about the dangers of **nyaope** (woonga) and that it is in fact heroin and what this means, and prepare for an influx of heroin addicts and needle users in Mpumalanga, KZN and Limpopo. These provinces must be prepared to implement needle supply and Opioid Substitution Therapies. This strategy must be informed by research and it needs a high-level driver, for example the CDA or a national department. According to the Western Cape PSAF a similar response was followed in that province when methamphetamine became a problem. The response needs to be linked to harm reduction

R11: Development and implementation of **guidelines and protocols for substance abuse programmes** including for prevention and early intervention programmes, multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders and for funding such diagnosis and treatment. Guidelines for a referral system at local level should be piloted through a few LDACs to see how it can work. The guidelines must include a process and tool for asset and stakeholder mapping, which can be used to build the referral system. These guidelines must take the integration of services in account at all times.

R12: The **evidence base for prevention and treatment programmes** needs to improve. In particular, prevention models that work for different target groups need to be identified and Ke Moja must be evaluated for effectiveness related to behaviour change. The effectiveness of the Matrix Model must be evaluated for efficacy in the South African context, or a local model developed for community-based treatment. The City of Cape Town is implementing this model and it can be a good site for evaluation.

R13: The CDA can play a very important role in facilitating evidence-based effective substance use intervention in South Africa by **initiating and stimulating relevant research and information sharing** on condition that **adequate funding** is **provided** for relevant initiatives. There are three main initiatives needed, namely the setting and coordination of the implementation of a national research agenda, information sharing and communication. These are elaborated on below.

R13.1 The CDA must set and coordinate the implementation of a national research agenda on substance use related issues. This agenda should provide for the initiation and stimulation of primary research as well as for the collation of secondary data. Special attention should be given to the following initiatives: 1. In terms of primary research, the CDA must commission a comprehensive national population household survey on substance use, preferably before drafting of the follow-up to the NDMP 2013-2017. This survey should be regarded as a baseline for related periodic surveys, the value of which is well documented in the NDMP 2013-2017 (page 62 of the NDMP 20130-2017). Regarding substance use related treatment; the CDA should commission a national protocol-effectiveness study (for an example of such a study see https://www.ncjrs.gov/ondcppubs/publications/treat/trmtprot.html). More evaluations of

intervention programmes are also needed to identify evidence-based programmes across the continuum of care. 2. In terms of secondary data, a CDA substance use "clearing house" should be set-up, either by the CDA or a third party. Generally in line with the specifications in the NDMP 2013-2017 (see page 62), the focus of this service should be on collating completed research and other data on the nature, extent and consequences of substance use in South Africa. The CDA clearing house role should include the integration and re-analysis of collated data to identify and predict substance use patterns and underlying causes and consequences, and thus direct required research and intervention based upon underlying causes and not visible symptoms only.

R13.2 The CDA must facilitate improved information sharing and communication around substance use and abuse through the establishment of the mentioned CDA clearing house. The clearing house should thus have an online portal, providing a dynamic space for sharing information on the nature, extent and consequences of substance use as well as on intervention services (including how to register services and ideas for programmes). It should include a communications platform and directories of intervention services for people who need support with regard to substance use. In addition, the portal can host policy briefs, information updates, and a newsletter.

R 13.3 The CDA must develop and implement a communication strategy for the NDMP and produce a user friendly version of the revised NDMP which can communicate the plan to people at all levels.

R14: To avoid misunderstanding, the CDA has to ensure **terminological exactness** in all material it produces and disseminates. Moreover, the reasons behind the preference for particular terms should be articulated. Special care must also be taken to avoid terminology that may be perceived as pejorative**.**

R15: The DBE must make sure that the **National Strategy for the Prevention and Management of Alcohol and Drug use amongst learners in schools is widely known** and that schools are assisted to establish the support systems envisaged in the strategy.

Annexure 1: References

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Annexure 2: Theory of change and logframe

(See separate document)

Annexure 3: Consent form

(See separate document)

Annexure 4: Ethical clearance letter

(See separate document)

Annexure 5: Summary of provincial reports with achievements/ activities

(See separate document)

Annexure 6: Membership of PSAFs per province

(See separate document)

Annexure 7: Literature review

(See separate document)

Annexure 8: Proposal for national clearing house

(See separate document)

Annexure 9: TOR developed by the Western Cape PSAF

(See separate document)

Annexure 10: Recommendations for terms of reference and guidelines for PSAFs and LDACs

Recommendations for terms of reference and guidelines for the PSAFs

A standardised TOR could be structured according to the TOR developed by the Western Cape PSAF (see Annexure 9) and should cover the following:

1. Purpose and objectives of the forum
2. Procedures for meetings and decision making
3. Membership and details of the level of officials as representatives on the PSAF and the roles, responsibilities and expectations of the PSAF representatives. It is suggested that a focal person from each PSAF department sit on the PSAF and who has sufficient level of seniority to influence decision making.
4. Developing DMPs for provincial departments
5. The inclusion of substance abuse in relevant provincial departments' work plans, APPs and KPIs of relevant government officials
6. Monitoring and reporting on substance abuse related outputs and outcomes by each department.
7. Inclusion of the business sector as a key partner and member in tackling substance abuse at provincial level.
8. Funding of LDACs – where it comes from and what it is for
9. Communication, technical support for and capacity building of LDAC members
10. Building relationships and memorandums of understanding (MOUs) with the municipality (mayors) and sign an MOU to encourage their involvement and support in the establishment and running of LDACs.

Guidelines for the provincial implementation of the NDMP should include guidance on:

1. Funding for the activities of PSAFs and LDACs
2. Developing, monitoring and reporting on DMPs (to CDA, Premier / MEC, LDACs)
3. MOUs with local municipalities
4. Capacity building for PSAF and LDACs
5. Stakeholder management (local government, business, government departments) for PSAF and LDAC
6. Integrated planning
7. Communication with the LDACs and CDA

Recommendations for terms of reference and guidelines for LDACs

A standardised terms of reference should be developed to be used by LDACs that covers at least the following:

1. Structure of the LDAC. It is recommended that LDACs should have a strong executive team which includes a dedicated and strong secretariat and chairperson
2. Roles and functions of the LDAC
3. Developing a local action plan
4. Setting up referral relationships between service providers at a local level

5. Financing the coordination, monitoring and reporting responsibilities of the LDACs
6. Capacity building for LDAC members about their role, and that will help them carry out their role (depending on needs at a local level).
7. Stakeholder consultation
8. Communication with the PSAF
9. Data collection (monitoring) and reporting

Guidelines for LDACs must contain guidance on at least the following:

1. Conducting stakeholder consultation and community needs / asset analysis
2. What a local action plan should contain
3. How to align or integrate local action plans are aligned to the IDPs
4. How to set up referral relationships
5. Guidance on how funding should be allocated
6. Ways in which to deal with non-attendance of members
7. Monitoring and reporting