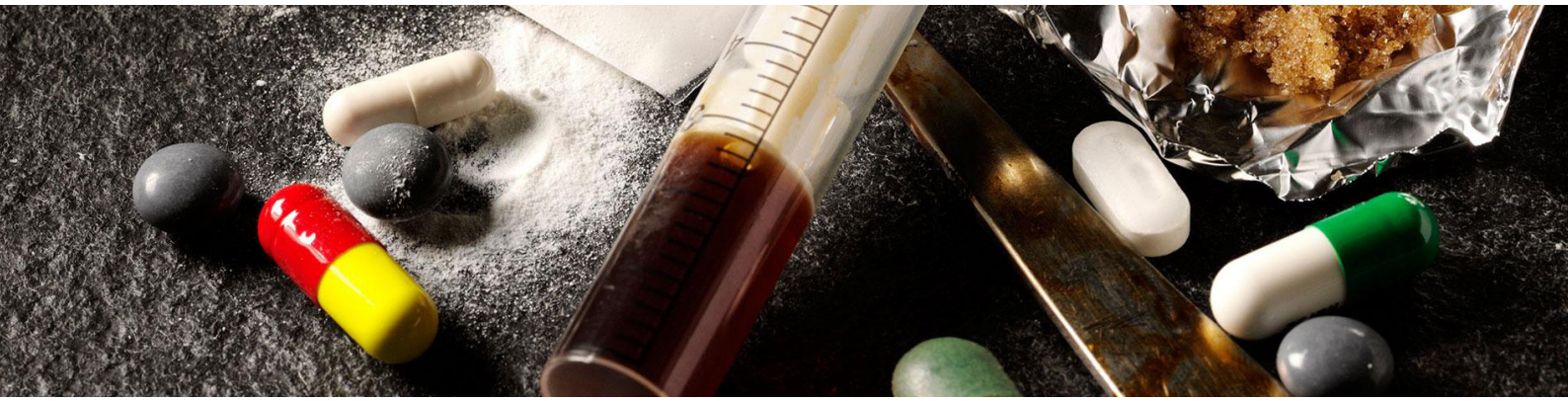
# Implementation Evaluation of the National Drug Master Plan

planning, monitoring & evaluation

Department:
Planning, Monitoring & Evaluation
REPUBLIC OF SOUTH AFRICA

2030 NDP



# Policy summary

This implementation evaluation of the National Drug Master Plan (NDMP) was commissioned as part of the National Evaluation System by the Department of Planning, Monitoring and Evaluation (DPME) in partnership with the Department of Social Development (DSD). The evaluation took place between August 2015 and January 2016. The period under review starts in 2013, with the beginning of the NDMP 2013-2017.

As with many other countries, South Africa is affected by the problems associated with the abuse of alcohol and other drugs. The purpose of the NDMP 2013-2017 is therefore to provide policy direction and coordinate efforts to respond to substance abuse in South Africa. The NDMP 2013-2017 states as its ultimate goal a South Africa "free of substance abuse". To meet these objectives, the Plan proposes a balanced approach using an integrated combination of strategies, namely that of demand reduction, supply reduction and harm reduction. The NDMP also sets out outcomes which are aligned to its objectives.

**Policy findings**

- The NDMP covers the three pillars of harm reduction, demand reduction and supply reduction. However there is policy confusion around harm reduction, with law enforcement criminalising users and addicts and thereby working against the public health approach of restorative justice.

- The NDMP is not effectively directing implementation. Partly this is because the NDMP does not provide implementation details and it is assumed that policy and direction set at a national level will filter down to the provinces, however each provincial department defines its own strategies and produces its own legislation. Secondly, the NDMP has also not sufficiently been translated in sector plans or Annual Performance Plans (APPs). This could explain the challenge that departments face in funding activities in the NDMP. The evaluation found much confusion around where resources should come from to implement the ambitious substance abuse-related strategies and plans. The NDMP is not aligned to the most recent Medium-Term Strategic Framework (MTSF) and only three departments and entities have up

to date Drug Master Plans (DMPs). All provinces have a DMP but none are finalised and there is lack of clarity as to funding of provincial DMPs and the local action plans. As a result there is insufficient funding of the activities.

- The Monitoring and Evaluation (M&E) Plan in the NDMP is too high level and not implementable. There is no information about the real size and scope of the substance abuse problem in South Africa because the household survey and other aspects of research have not yet been conducted, hence the Central Drug Authority (CDA) has been unable to propose evidence-based policies.

- The location of the CDA as a sub-directorate within the DSD is a challenge as it hampers the CDA's ability to provide the necessary leadership, implementation management and oversight capacity to successfully facilitate the implementation of the NDMP.

**Policy Recommendations**

**R1: Strengthen the autonomy and authority of the CDA.** There is a need to strengthen the autonomy, independence and authority of the CDA.

**R2: Review of the NDMP.** There is a need for a comprehensive review of the NDMP to ensure consistency in policy approach to substance abuse.

**R3: Provide sufficient funding for the CDA.** There is a need to provide sufficient funding to the CDA to commission research and thereby to propose evidence-based policies.

# Executive summary

## 1. Introduction

This implementation evaluation of the National Drug Master Plan (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 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. The objective of the evaluation was to assess systems elements, namely: policy clarity and guidance, adequacy of financial and human resources, governance arrangement including monitoring and evaluation and service delivery.

The evaluation took place between August 2015 and February 2016. The review period started in 2013, with the beginning of the NDMP 2013-2017. The evaluation entailed a mixed-method approach combining literature review, document review, four focus groups, 123 semi-structured interviews and four workshops. The process for the evaluation followed the DPME guidelines for implementation evaluation. Following ethical clearance, data was collected at national, provincial and local level in the Gauteng, Western Cape, Kwazulu-Natal and Northern Cape provinces. There was an extensive review of programme documents and relevant literature which together with the Theory of Change (TOC) informed the evaluation.

As in many other countries, South Africa 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), South Africa 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". The NDMP 2013-2017 states as its ultimate goal a South Africa "free of substance abuse" (DSD &CDA, 2013, pg. 33). The objectives of the Plan 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)

## 2. Findings from the literature review

The literature review sought to identify trends in drug use in South Africa. 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 KwaZulu-Natal and Mpumalanga). Youth behaviour has not changed significantly, although there are minor drops in use patterns (Reddy, 2013). The literature review did reveal that there are key target groups that are not sufficiently identified in the NDMP.

The literature review then explored the approaches to substance abuse that underpin the three main strategies. It revealed that internationally there is growing interest and support for a public health and rights-based approach, but that unless the law enforcement approach is aligned to these they are not likely to be effective because users are criminalised and stigmatised.

Following this, the literature review looked at developments in prevention, harm and supply reduction. In terms of prevention, the most valuable document found was the International Standards on Drug Use Prevention designed by UNODC (2014), which should be used as a guide when evaluating current prevention efforts. 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.

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. The literature review provides a model for analysing coordination at different levels in the system, which was applied in the design of the evaluation and the analysis of data.

## 3. Evaluation Findings

### *3.1 Whether the NDMP has provided clear statement and guidance*

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. One of the main criticisms of the NDMP and the Prevention and Treatment of Substance Abuse Act No 70 of 2008 is that there is policy confusion around harm reduction. The NDMP is criticised for being short on detail around implementation, and this is where supporting structures responsible for implementing the NDMP and achieving its objectives have become stuck. The document is in fact more of a guiding framework than a plan , 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 hence a false assumption in the Theory of Change.

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.

Although many respondents were of the view that the objectives of the NDMP were 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. Likewise, the NDMP has not been reviewed to be aligned with the MTSF 2014-2019 nor has it informed the MTSF 2014-2019. The NDMP has contributed to clarifying the roles and mandates of particularly the national CDA members (departments) and the Local Drug Action Committees (LDACs). However, it has made a limited contribution towards reducing duplication of services with many examples being provided of duplication of services in the substance abuse sector.

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. Few LDACs from the four provinces visited in the evaluation are functional and hence there are few local action plans. It also appears that the local action plans are often not inclusive of the IDPs.

In terms of policy direction for resource allocation, the Plan 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 the ambitious substance abuse-related strategies and plans as envisaged in the outcomes of the NDMP. Also the Plan does not clearly stipulate which departments are expected to contribute. This is leaving a resource gap in the sector and is hindering implementation.

Lastly, there is no M&E framework or M&E system, and the M&E Plan in the NDMP is too high level and not implementable.

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 a number of weaknesses that if not addressed, will present an obstacle to the reduction of the substance abuse problem in South Africa

### *3.2 Adequacy of resources for the NDMP*

The findings on the section on 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, to date the NDMP 2013-2017 has not resulted in any change in budget allocations in the departments with the exception of the DSD. The budget for substance abuse is inadequate. It was raised 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 able to influence the allocation of budgets by other agencies, or resulted in the rationalisation of resources; however it appeared that rationalisation of resources has happened at Provincial Substance Abuse Forum (PSAF) level. The findings from the section on adequate human resources reveal that capacity building of members of the CDA and PSAFs has taken place to support the development of departmental DMPs and provincial DMPs. However, training of LDAC members has been limited due to a number of challenges.

Substance abuse is a highly specialised sector and the ability of government officials to implement substance abuse programmes and services remains limited. The findings show 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 currently no accredited courses on substance abuse except 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 and/or experience.

### *3.3 Extent of appropriate governance arrangements at all three levels*

The evaluation found that the CDA has a clear legal mandate and is driven by engaged drug experts. The institutional structures have been set up for the executive committee and the four sub-committees and the CDA is at large operating in a functional way. The CDA is supported by a secretariat of two permanent staff. This support is insufficient. The location of the CDA in a directorate in the DSD is a challenge as the CDA is not perceived as independent but as a sub-directorate of the DSD. The CDA is left with no authority particularly when it comes to ensuring compliance with reporting requirements. 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 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. Attempts to facilitate vertical alignment between the CDA and PSAFs have been undertaken through provincial representatives attending national CDA meetings, and a CDA representative sitting on the PSAF to provide expert guidance and support. However, this does not necessarily take place for all nine PSAFs and support is variable across provinces. Support from the provincial Premier's Office 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. The CDA recognises this and visits to each Premier's Office have been done in the past.

The functionality of the four PSAFs reviewed in this evaluation was found to be variable, with the KwaZulu-Natal PSAF being virtually non-functional. The other three structures (Gauteng, Northern Cape and Western Cape) are reasonably well functioning 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. Anecdotal evidence reveals that this has contributed to reduced duplication and fragmentation of services. Whilst these structures have reportedly provided a platform for improved networking and coordination of service delivery, proper evidence of this still needs to be found at implementation level.

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. Three of the four LDACs included in this evaluation have developed action plans and respondents across all four LDACs indicated that their LDAC is functional. The majority of LDAC level respondents who participated in this study 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. However, the biggest challenge facing their functionality is the poor participation of departments.

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.

Evidence from research, monitoring and evaluation is supposed to inform programme and policy planning. However, the various research projects proposed in the NDMP have not been implemented and the evidence gathered by LDACs and PSAFs has not informed policies. The lack of an M&E system has also contributed to these challenges.

***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***

The NDMP provides impetus for the various role-players to address substance abuse in their departments and communities. The main thrust of the NDMP around programmes and services is that demand, supply and harm reduction should be well integrated. The analysis finds that they are not well integrated, and services are not sufficiently provided along the continuum of care to facilitate integration. Firstly, the policy approach is at times conflicting (between harm reduction and law enforcement). For example, the criminalisation of users and the associated stigma prevents the uptake of early intervention services and further pushes users into either the criminal justice system or into a deepening pattern of abuse or addiction. Unless these contradictions are ironed out, the NDMP is not likely to achieve its objectives regarding demand and harm reduction. Secondly, looking along the continuum of care, the main programming for demand reduction is on information, education and communication, and awareness raising, and even the NDMP indicates that the efficacy of these prevention programmes is questionable. There are not enough evidence-based programmes targeted specifically to at-risk groups and communities. High-risk groups that need more attention are people who inject drugs, prison populations, and sex workers, specifically in the light of the spread of HIV and AIDS amongst drug users. In terms of harm reduction, there has been insufficient buy-in from the Provincial Departments of Health to finance drug-related medical care, and there are insufficient skills and in-hospital facilities to confirm that harm reduction is being applied. The results show that in terms of the continuum of care 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 aftercare. For integration to work, the Departments need to work together and the PSAF's need to encourage integrated planning and shared resourcing of programmes.

Regarding supply reduction, the focus of activities should be on the major smugglers and distributers of illegal drugs, and on the control of the liquor trade. Key respondents stated that the trading of liquor (legal and illegal) is proliferating, despite the efforts of agencies to regulate and control this.

There is also a gender dimension to the drug paradigm that needs to be considered: women in particular seem to have less access to services, and are the most vulnerable in the drug trade. Black people are more likely to become criminalised as a result of their drug use, indicating that there is a racial dimension as well.

## 4. Conclusion

This evaluation aims to measure the first part of the Theory of Change, namely, if all the elements of the system are working then 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 has been enhanced. The evaluation found that the elements of the system are not working effectively, as the NDMP has not provided sufficient clarity and guidance. The financial and human resources are inadequate, and the location of the CDA within the DSD is challenging and hampers the CDA's ability to lead, manage and coordinate. Despite this, the LDAC and PSAF structures are providing a good platform for joint planning, where they are functioning. The evaluation found that the assumptions in the TOC on evidence informing programme and policy planning are not holding, as the various proposed pieces of research have not been implemented and the evidence gathered by LDACs and PSAFs have not informed policies. Although the NDMP says that the three strategies of demand reduction, supply reduction and harm reduction have overlapping areas and should be implemented in an integrated manner, at the moment there are legislative, ideological, political and administrative constraints affecting their integration. In conclusion, unless the various challenges are addressed, the likelihood of the NDMP contributing to increased state/agencies' capability to reduce demand, supply and harm related to substance abuse is not likely to be met.

## 5. Recommendations

**R1: Substance abuse-related legislation must be reviewed and harmonised**. It is necessary to close up the legislative and policy gaps and 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 the DSD must lead this process.

**R2: There is a need for a comprehensive review of the NDMP** to ensure alignment with the MTSF 2014-2019, and to take a stronger position on the drug control paradigm. The evaluators observed support from across all stakeholders groups for a stronger and clearer position supporting harm reduction, such as through decriminalising the use of certain drugs, and providing more focus on vulnerable groups and the interaction of HIV/AIDS and substance abuse. Further, a review must provide much clearer roles and responsibilities for the departments and improve the Theory of Change so that contradictions between the intended outcomes and strategies are removed (for example, 'reducing' the harm related to substance abuse, as opposed to 'eliminating' it). It must also have an implementation plan with a clear M&E framework and plan for indicators at national, provincial and local level; ensure outcomes are in plain language usable by those at grass roots level; and provide clear guidance on how to prioritise, apply and align or pool resources for their efficient use.

**R3: Strengthen the autonomy and authority of the CDA.** There is a need to strengthen the autonomy, independence and authority of the CDA. The DSD and CDA could consider either to move the CDA outside of the DSD as an independent structure, or whether it should be an independent entity hosted in the Presidency. The Substance Abuse Act should be amended according to the new structure.

**R4: Improve current functioning of the CDA.** The CDA needs to be able to provide more direct guidance for, and monitoring of, the implementation of the NDMP by departments, provinces and local authorities. Outcome monitoring needs to be improved. The CDA needs strong leadership, budget and skills to implement its activities and plans, or its functioning is not likely to improve. The budget of the CDA should not be dependent on a re-allocation from the DSD.

**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.

**R6:** PSAFs must ensure that services are spread equally along the continuum of care and respond to the need in their provinces, and make sure they reach the most marginalised and vulnerable people.

**R7: Improve current functioning of LDACs.** A support programme aimed at strengthening the capacity of LDACs should be developed, piloted and evaluated. The CDA should develop a standardised TOR and Guideline document for LDACs.

**R8: Improve capacity building for the CDA, PSAFs and LDACs.** The CDA should be enabled to develop and implement a capacity building strategy for the CDA, PSAFs and LDACs.

**R9: The DOH must become more involved in providing the human infrastructure and other resources for a medical model for treating addiction.** Critical gaps in skills related to the medical treatment of addiction need to be identified. A plan must be developed to encourage more people to study in this field, and to oversee the development of an accredited training course on substance abuse for targeting social workers, auxiliary social workers, nurses, lay counsellors and other professionals.

**R10: A quick response strategy to the spread of heroin, linked to harm reduction** must be developed by the CDA including awareness creation about the dangers of nyaope (woonga)**,** and the provision of Opiate Substitution Therapy (OST) and Needle Syringe Programmes (NSP).

**R11: Development of guidelines for substance abuse programmes.** The CDA, DSD, and DOH need to help develop guidelines for substance abuse programmes and services where there are none, depending on their competencies. For example, for multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders, prevention and early intervention programmes, referral systems and so on.

**R12: Improve the evidence base for prevention and treatment programmes.** More evidence is needed on the efficacy of therapeutic models in the South African context, as well as on prevention programmes – Ke Moja in particular needs to be evaluated for its effect on demand reduction behaviour change.

**R13:** Effective evidence-based substance use intervention should be facilitated by the CDA by initiating and stimulating relevant research and information sharing on condition that adequate funding is provided for relevant initiatives.

**R14: Terminological exactness** should be ensured by the CDA 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 Department of Basic Education (DBE) needs to ensure that their National Strategy for the Prevention and Management of Alcohol and Drug Use among Learners in Schools is widely known and that schools are assisted to establish the support systems envisaged in the strategy.

Department of Planning Monitoring & Evaluations
330 Grosvenor Street, Hatfield,
Pretoria
0028
South Africa

Tel: 012 312 0000

www.dpme.gov.za