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

11 May 2016

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

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 researches 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 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 patters (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 underpins 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

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 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 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 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

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 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 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.

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.

> *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 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 Department's 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 is 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 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. 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: T**erminological 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.

1 Introduction

This implementation evaluation was commissioned as part of the National Evaluation System of the government of South Africa. Southern Hemisphere was contracted through a bidding process 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 review period starts in 2013, with the beginning of the NDMP 2013-2017.

1.1 Background to the NDMP 2013-2017

As 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". 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). The purpose of the NDMP 2013-2017 is therefore to meet international requirements as well as meet South African communities' specific needs.

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 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 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 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 prevent vulnerable populations from becoming substance dependents
- 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 diagnoses and treatment
- Harmonisation and enforcement of laws and policies to facilitate effective governance of the alcohol and drug supply chain
- Creation of job opportunities in the field of combating substance abuse (DSD&CDA, 2013, pg. 36)

1.2 Evaluation objectives, approach and methodology

1.2.1 Purpose and objectives

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 across different institutions and programmes for reducing substance abuse. The following aspects 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?
- To what extent have departments/implementing agencies prioritised activities of the plan? What are the barriers to implementation?
- Are there adequate resources allocated to support the implementation of the activities in the NDMP?
- What is the likelihood of the plan contributing to enhanced state/agencies' capabilities to reduce demand, supply and harm related to dependence-forming substances and improved access to treatment?
- Are governance arrangements (at all three levels) appropriately structured to provide leadership, coordinate NDMP activities and perform oversight?
- What are the lessons learned in the implementation of the plan? And how can implementation be strengthened?

1.2.2 Methodological approach and Theory of Change

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

A systems approach has been adopted for the evaluation to inform the design of the analytical framework, the data collection instruments and the reporting structure for the evaluation. It also included a systems approach to assessing coordination to determine whether the governance arrangements at the level of policy, institutions and administration are appropriately structured to provide leadership, coordinate NDMP activities and perform oversight.

The TOC was informed by the literature review. The first level of change is in the system elements – with the understanding that unless these function effectively and are well co-ordinated it is unlikely that the changes at the level of societal outcomes, or programme and policy level, will be achieved.

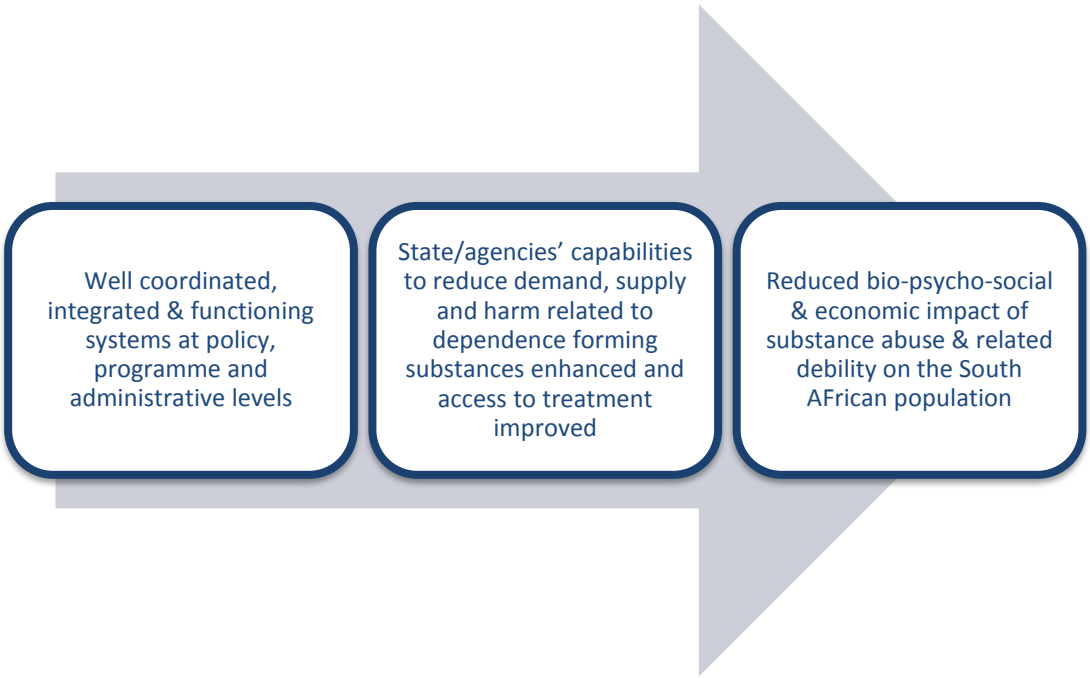
Level one: TOC related to the intended outcomes of the integrated strategy for demand reduction, supply reduction and harm reduction.

This has been translated into the impact statement for the TOC.

Level two: TOC for effective coordination of the systems related to the National Drug Master Plan.

This has been translated into outcomes and outputs for the logframe and TOC.

Figure 1 Overview of 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 state's and agencies' capabilities to reduce the demand, supply and harm related to dependence-forming substances will be enhanced and treatment improved. As a result of this there will be reduced bio-psycho-social and economic impact of substance abuse and related debility on the South African population.

This is unpacked into a narrative and pathway of change diagram that is attached to this report as Annexure 2.

1.2.3 Method and sample

The evaluation used a mixed-method approach combining a literature review, a document review, focus groups, semi-structured interviews and workshops. The process for the evaluation followed the DPME guidelines for implementation evaluation. Following ethical clearance by the Humanities Faculty Research Ethics Committee through delegation to the Sociology Department Research Ethics Committee at the University of Cape Town, data was collected at national, provincial and local level in the Gauteng, Western Cape, Kwazulu-Natal and Northern Cape. The provinces were narrowed down to four due to budgetary constraints, and the final selection of provinces was decided by the Evaluation Steering Committee based on the criteria suggested by the evaluation team drawn from the literature review. A total of 123 semi-structured interviews and four focus groups took place with a pre-defined set of government and non-government stakeholders. There was an extensive review of programme documents and relevant literature. A thematic analysis was conducted of the qualitative data with the assistance of Nvivo 10 software.

2 Findings from the literature review

The full literature review is provided as an annexure to the main report.

2.1 Trends

The literature review sought to identify trends in drug use in South Africa. Besides data from the South African Community Epidemiology Network on Drug Use (SACENDU) and the

Youth Risk Behaviour Survey there is little 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 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 patters (Reddy, 2013). Otherwise alcohol remains the substance mostly driving people to treatment centres and that has the greatest burden of harm (Pasche and Myers, 2012, p. 338). The literature review did reveal that there are high risk groups that are not sufficiently identified in the NDMP; specifically prison populations and sex workers - two areas in which substance abuse is prevalent, and where HIV becomes a concern. Another area where there is a gap in research is determining the burden of harm (both health and social) that is related to alcohol and substance abuse in South Africa, specifically when discussing the link between substance abuse and violence, and HIV infections from needles.

2.2 Approaches to substance abuse

There are main four approaches that underpin countries' approaches to addressing substance abuse. These are the social development approach, the public health approach, the law enforcement approach and the human rights approach. Internationally there is growing interest and support for a public health and rights-based approaches. However unless the law enforcement approach is aligned to these they are not likely to be effective because users are criminalised and stigmatised, reducing the likelihood of them seeking and accessing services. The spread of HIV among people who inject drugs is a growing concern in South Africa and globally.

2.3 Developments in prevention and harm reduction

In terms of prevention, the International Standards on Drug Use Prevention designed by UNODOC were released in 2014. This should be used as a guide when evaluating current prevention efforts. It emphasises the need for evidence-based interventions that are targeted to the lifecycle of individuals, and describes the characteristics of an effective prevention system.

In addition to therapeutic interventions, harm reduction requires a public health approach, as well as services such as OST and needle exchange programmes, together with medical and therapeutic interventions for people who are dependent on substances. For harm reduction to be truly effective, it needs to be applied uniformly across the system. Decriminalisation of drug users is key to success in harm reduction. The criminal justice system (including magistrates) also requires training on harm reduction strategies in order for its implementation to be effective, particularly around diversion programmes. A public health approach and the recognition of risk and protective factors are key for prevention, harm reduction and supply reduction. For example, the gender dimension of the drug problem is a key factor in drug use trends, but also in vulnerability assessments for criminalisation.

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 and analysis

3.1 Extent to which the NDMP provides clear policy statements and direction for aligned operational planning, resource prioritisation and measurement of results across the different sectors

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 interviewees indicated that 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 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 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 hence 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 NDMP, 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 need to be fast-tracked.

Although the majority of respondents (29 out of 40) were of the view that the objectives of the NDMP was 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 out of 22 departments and entities have final approved departmental DMPs, and five departments and entities 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. Furthermore, the NDMP did not inform the MTSF 2014-2019. There are only a few examples where the NDMP is aligned with departmental sector plans. Respondents were of the view that 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 evaluation found that the NDMP has contributed to clarifying the roles and mandates of particularly the national CDA members (departments) and the 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. Examples include 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. 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 but 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 reviewed in the evaluation are functional and it was reported that countrywide only a few[1] of the LDACs are operational and functional. Hence only a few local action plans have been produced. For example, 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. It also appears that the local action plans are often not aligned with the Integrated Development Plans (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, 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. Respondents from the departments claimed that they do not to have enough resources to achieve what is expected in terms of 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 financially. This is leaving a resource gap in the sector and is hindering implementation.

Lastly, despite the NDMP 2013-2017's emphasis on M&E, the evaluation found no M&E framework or M&E system for the NDMP. The M&E Plan in the NDMP is too high level, abstract and not implementable.

3.2 Adequacy of resources for the NDMP

3.2.1 Adequacy of financial resources

A total of around R0.6 billion is allocated by DSD for the prevention of substance abuse in the nine provinces. Some of the provinces – those without government substance abuse treatment centres – have received special conditional grants for this purpose.

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.

At national DSD, the allocations 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 national DSD budget.

[1] The exact number of LDACs who are functional is unknown and is pending an audit from CDA/DSD in 2016.

Until recently, the CDA did not have a separate budget. For the PSAF itself there is no budget. Provincial DSDs are the only provincial departments with a dedicated budget for substance abuse. Municipalities are meant to provide funds for the LDACs, but this did not happen. Respondents were of the view that this is because 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 that the Gauteng Province is the only province provides funds for the LDACs.

The budget for substance abuse is inadequate to provide the services and activities as envisaged in the NDMP. This is partly because the assumption in the TOC that 'the departments pay attention to their mandates and making sure that their intervention is reflected in their APPs, so that they can have a sufficient allocated budget' does not hold. Likewise, the LDAC has not been able to raise funding from the municipalities to implement their activities. 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 have been able to influence the allocation of budgets by other agencies. Furthermore, respondents found that neither the CDA nor the NDMP has resulted in the 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 Adequacy of human resources

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 PSAFs are required to support LDACs to fulfil their functions.

The findings 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. With limited details in the reports, it is difficult to assess the full extent of the training; however, interviews with all six of the LDACs[2] included in this evaluation confirmed that they have received training either by the CDA or by provincial DSD. The assessment of CDA capacity building initiatives to PSAFs and LDACs is that it is has been once-off in nature and has not been sufficient for PSAFs and LDACs to fulfil their functions as specified in the Substance Abuse Act (70 of 2008). There are also no standardised training materials or guideline documents. The main barriers cited to capacity building are the CDA's lack of resources, both human and financial, and the limited allocation of budgets for training to provincial DSD 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 degree nor short courses) about substance abuse. There are courses at postgraduate level

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

at some universities, though 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 sensibly utilised.

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.

3.3 Extent of appropriate governance arrangements at all three levels

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

The CDA was 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; and
- Review the NDMP every five years.

The CDA's mandate requires that it:

- Coordinates 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 strive to achieve a society free of substance abuse.

The CDA currently consists of 15 national departments, two entities and 15 experts from the academia or the CSO sector. The CDA is hosted in the DSD's Substance Abuse Directorate. Two permanent CDA staff provide secretariat support to the authority. In addition the work of the CDA is coordinated through five clusters that mirror the government cluster system. The evaluation found that the CDA is generally operating in a functional way. However its impact is eroded by a number of factors including:

- Location as a directorate in the DSD. The challenges of hosting the CDA as a directorate in the DSD are that the CDA is not perceived as independent but as a sub-directorate of the DSD. This is exacerbated by the current chairperson being the director of the Substance Abuse Directorate in the DSD and hence playing the role of

both the 'referee' and the 'player' at the same time. 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 ensuring compliance with reporting requirements[3].

- Inadequate secretariat support. The strength of the CDA is that it is legally mandated and is driven by resourceful drug experts. The CDA secretariat is supporting the CDA but due to inadequate number of staff members, competing responsibilities and lack of dedicated executive leadership, this support is insufficient.
- Absence of coordination protocols. 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 number of CDA members is too large, particularly when it comes to making decisions. 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.
- Poor cooperation with the Inter-Ministerial Committee on Combating Substance Abuse (IMC): In 2011 Cabinet approved the establishment of an IMC on Substance Abuse with the purpose of combatting alcohol and other substance abuse. The evaluation found that there is cooperation with the IMC on Substance Abuse but due to the lack of role clarification between the two structures the cooperation is not working in an optimally.

As a consequence of all the above, 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 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 departments are unclear on the extent of support they are meant to provide for the establishment and maintenance of these structures. Two of the eight national department 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; one respondent noted that they intervene at provincial Premier level to ensure that the Premier endorses the structure which facilitates establishment of PSAFs; and 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.

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, the

[3] 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'.

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 participating in this evaluation report that CDA support has ranged from limited to non-existent. It was also found that a CDA representative is only attending one of the four PSAFs (Gauteng) included in this study, to provide regular support for maintenance of the structure. 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 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 and, where there has been strong support in the past, such as in KwaZulu-Natal and Western Cape, this has declined over time. The CDA recognises this and has visited each Premier's Office. It is included as an activity in the CDA Business Plan 2014/2015.

The functionality of the four PSAFs was found to be variable with the KwaZulu-Natal PSAF being virtually non-functional. The other three structures (in 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. 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

The Substance Abuse Act (70 of 2008) stipulates that a municipality must establish a Local Drug Action Committee (LDAC) to represent such municipality and to give effect to the Mini Drug Master Plan. Also, 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, and they are meant to be appointed by the mayor of the Municipality.

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 2014/2015 shows that the number of existing LDACs is 187 (excluding Western Cape and Limpopo provinces which were not reported on). The current number of functional LDACs is not known, but the CDA will conduct an audit in 2016 to determine functionality of the LDACs and how often they meet.

DSD provides secretariat support to LDACs, and the PSAF is supporting these structures in three of the four provinces covered in the evaluation. In contrast, local government plays a limited role due to lack of funding and personnel.

There are mixed responses about the role of the mayor's office in supporting LDACs. In Gauteng and Northern Cape, mayors' offices are not involved for the most part; in Western Cape and KwaZulu-Natal mayors are reportedly involved in some LDACs but not in others.

Those who said that they are supported by the mayors' offices indicated that they receive funding to ensure effective functioning and support for the coordination of LDACs activities. 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 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.

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.[4] In areas where the mayor's office is not involved, DSD has taken a lead role to support LDACs.

Three of the four LDACs included in this evaluation have developed action plans and respondents across all four LDACs[5] indicated that their LDAC is functional. They meet regularly (either monthly or quarterly) and they report to the PSAFs.

Findings from interviews indicate three main strengths of functional LDACs. These include: the use of an integrated approach to substance abuse; prioritisation of resources and support from PSAFs, DSD and the district and local municipalities. The most frequently mentioned challenges they face are a lack of services for referrals 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. Although joint planning is being undertaken, the problem lies with integrated implementation because government departments still implement programmes and services in silos. LDACs also do not have an M&E plan in place, which makes it difficult to measure their outputs and outcomes.

3.3.4 Monitoring and evaluation

The NDMP 2013-2017 is the first drug master plan to contain an M&E plan with indicators and targets; no other M&E system has been put in place. The evaluation found that the CDA

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

[5] 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.

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.

In terms of reporting to the CDA, the following findings were made: seven out of the 18 national departments and four entities submit reports to the CDA; all the PSAFs submit reports; and functional LDACs submit reports to PSAFs on a regular basis.

A key challenge is that departments and provinces report too late and as a result 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 and also the need for internal departmental approval of reports by Directors-General before they are submitted to the CDA.

The CDA has 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.

The following respondents from the national departments indicated that they had indicators on substance abuse: DOH, DBE, DSD, DOSR, DSD, Department of Trade and Industry (DTI) and National Youth Development Agency (NYDA). However, this is not reflected in their annual performance plans. Only the DSD has substance abuse indicators in its annual performance plans. The departments and provinces that have developed DMPs have included relevant indicators.

Although the community survey informed development of the NDMP, some of the research activities envisaged in the NDMP have not been implemented or commissioned. Departments and entities, however, also mentioned that they undertook evaluations of their programmes. SACENDU data was said to be the first source of information but it does not look at general population prevalence. 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.

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 use of a template. Most of the respondents said they provide statistics to SACENDU or the Medical Research Council (MRC) on intake, patient profiles, and treatment on either a monthly or quarterly basis.

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; to feed into their policies and strategies; and to decide if they should continue, halt or make amendments to their programmes. Other respondents mentioned that they are not using M&E data as they felt that it is not of good quality,

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. This is perhaps because 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

3.4.1 Extent of services for demand

The Theory of Change argues that if the system elements are working effectively and are implemented in a coordinated manner at an administrative and policy level, then the operational aspect, namely the programmes and services, should be more effectively implemented. In this section we explore how the three main strategies of the NDMP in terms of service provision are implemented. These are demand reduction, harm reduction and supply reduction.

Prevention

Demand reduction is made up of prevention and early intervention. 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 five accepted methods of this approach, which are:

- Poverty reduction
- Development
- Education and communication
- Social policy application
- Advocacy

The evaluation data suggests that much prevention work is in the area of information, education and communication; out of the 84 activities mentioned, 57 are in primary prevention, and of these 34 are information, education and communication programmes[6].

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 their corporate social responsibility initiatives. Some treatment centres have community outreach prevention programmes. As evident in the CDA's annual reports The DSD is the department that is most active in prevention work, followed by the DBE, the Department of Higher Education and Training (DHET), NYDA, DOSR's South African Industry for Drug Free Sport and Department of Home Affairs (DHA). There is clearly a wide variety of prevention programmes and methods targeting various age groups, from as young as five, and for pregnant women (especially around Foetal Alcohol Spectrum Disorders [FASD]). 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 with the intention of creating abstinence.

[6] These numbers are indicative only as they were not gathered by means of a survey and there may be gaps in the data

Even though primary prevention programmes seem to be the main focus of demand reduction strategies of the organisations in our 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).

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 is also understood as secondary prevention.

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, screening or drug testing. Problems are identified by family members or friends, through employers and referred to employee wellness programmes for 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. Support groups for users and their families are also offered as part of early intervention programmes.

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 the South African National Council on Alcohol and Drug Abuse (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 which need to be addressed.

There are a number of challenges with early intervention, namely:

- A dearth of programmes, services and funding, including in-hospital intervention services that need to be provided by the DOH; and
- Limited referral systems.

Some critical concerns regarding demand reduction are:

Inadequate programmes for prevention

Generally, the main criticism about prevention programmes is that they are ad hoc, sporadic and not evidence-based. There is also a need for more culturally appropriate and age-specific programmes. Some respondents are also critical that brochures designed in 2003 are still being handed out and believe that information should be updated and modernised.

Policy Conflict – Punitive versus Restorative / Harm Reduction

There are also a number of concerns regarding misaligned policy responses as described below:

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.

Criminalisation of users

One of the key obstacles to early intervention as an approach is the criminalisation of users as they end up in the criminal justice system, often becoming further entrenched into drug use in prisons or experiencing further psycho-social damage. Within the current system that criminalises possession and use of drugs, diversion programmes should be a key aspect of early intervention. A concern raised by one respondent only, but worth mentioning, is 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.

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 Department of Correctional Services does not have treatment, detoxification, rehabilitation or reintegration services for addicts. Further, not all of those arrested for using illegal substances are addicts or presenting social problems; however they are breaking the law for possessing illegal drugs.

3.4.2 The extent of services for 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/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 is still under discussion in South Africa, and that this period of the NDMP should be used to clarify a South African position in this regard. 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 DOH, DSD, and the Medicines Control Council. The primary harm reduction strategies are rehabilitation or treatment, and aftercare and reintegration.

Rehabilitation / Treatment

Most of the efforts around harm reduction are focused on rehabilitation and treatment. Reviewing the interviews, it is clear that the NDMP 2013-2017 has not strongly informed the substance abuse activities that have been implemented by private, public, and non-profit run treatment centres. 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 there was sufficient guidance for implementation, there were a large number of challenges in implementation, including lack of budget, human resources and coordination.

Thus there is 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 are three main modes of rehabilitation: in-patient treatment, out-patient treatment and 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. Multi-modal methods require multi-disciplinary teams, and the DOH needs to support the supply of human and physical infrastructure for a medical model.

The Community-Based Model of DSD (which is really more of a framework document) advocates for the use of the Matrix Model for community intervention, though a concern is that this has not yet been evaluated for its suitability in the South African context. Out-patient community-based programmes are lower cost because they do not require in-patient facilities. The community-based out-patient model requires strong referral networks and case

management because it relies on the motivation of the individual and on the availability of related services (for example, peer support groups such as Alcoholics Anonymous).

Detoxification

According to Primary 101 (DOH, 2013/2014) only alcoholics and heroin addicts need in-patient detoxification services. These services are predominantly provided by the DOH, and most rehabilitation NGOs will refer clients to DOH for detoxification before admission. There were 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 NSPs and 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.

Coverage of treatment centres

A national audit of all treatment centres (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) indicates that there are a total of 122 treatment centres in the country. Most of the treatment centres (78 out of 122) do receive some government funding and the majority are operating as NGOs.

There are only four provinces that do not have state-run centres, and all have conditional grants to establish them. The provinces which currently have government treatment centres are Gauteng, the Western Cape, KwaZulu-Natal, Mpumalanga, and the Eastern Cape, where a new centre was opened. Coverage of rural areas and hard to reach areas is a problem. Some treatment centres extend their coverage by offering out-patient stations.

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. This makes it difficult to measure a success rate over time per centre, as the patient profile and drug use patterns change.

There is high agreement from respondents that aftercare and reintegration services are a key to lasting recovery management. A number of respondents argue that it is important to recognise that there is no cure for addiction; that it is a chronic and relapsing disease. In this case success would be considered if people who relapse seek support and show responsible behaviour.

Extent of services related to aftercare and reintegration

The National DSD 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.

Aftercare and reintegration has been identified as one area which is significantly lacking in services by many respondents from all sectors. One challenge for the private treatment

centres is that medical aids are not prepared to cover secondary care (except for psychiatric support), and they only fund three weeks of in-patient recovery per year. People tend to wait for January for re-admission if they relapse. It is noted that medical aids only cover a small proportion of the population.

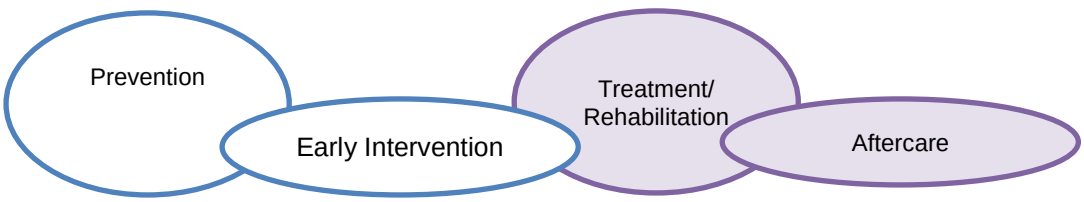
Challenges in relation to rehabilitation and reintegration

There are a number of challenges within the harm reduction sector. These include:

- Accreditation processes for service providers and registration of facilities takes too long and the process needs to be made more user-friendly;
- Availability of services where and when they are needed is a problem;
- The medical model requires human and physical resources and the DOH does not seem to be showing the required commitment to its implementation;
- Detoxification – again, there is not enough evidence that this is being offered in health facilities. There are also problems with the stringent standards that have resulted in fewer providers;
- Access for people who are on diversion or who are committed to treatment programmes is an issue since the private sector (as well as CSOs) tend to prefer to take in voluntary admissions. Hence, there is a need for more state services;
- Affordability is a concern, and experts including psychiatrists and psychologists are expensive. Medical aids also do not cover the required number of days for effective rehabilitation;
- Information sharing across the sector is insufficient and many private and CSO treatment centres remain ill-informed about developments in the sector;
- Family therapy is a key part of substance abuse therapy but is not always possible because of the lack of availability of services; hence people are often in centres far away from family members;
- Referral networks and relationships are not well established and there are no adequate systems for this;
- Access for children, women and girls and people with disabilities is a concern, as well as for older persons;
- Gang turf complicates matters such as where to locate treatment centres; and
- Lack of integration with aftercare reduces the effectiveness of rehabilitation and treatment programmes.

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; the same applies to treatment and aftercare.

Figure 2 Services along the continium of care



3.4.3 The extent of services related to 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. Regulating the liquor trade is a major challenge in the supply reduction sector, and despite the obvious efforts of law enforcement agencies and the DTI (as evidenced in the CDA annual reports), the sale of illegal liquor remains a major challenge. SAPS is criticised by some respondents for over-focusing on arresting small-scale dealers and not going after the main suppliers and supply routes. The use of admission of guilt fines for dealers and illegal liquor traders, a lack of on-going policing, and delays with forensics to finalise cases means that people stay in business.

It is difficult to tell if supply of drugs is actually decreasing as a result of the supply reduction strategy in South Africa; using drug seizure figures does not provide a reliable indicator of this. The International Narcotics Control Board (INCB) 2014 report highlights key trends in Africa as being the rise of amphetamine-type stimulants, as well as heroin – evidenced from both use and seizure patterns. East Africa is a key trade route for heroin heading from Asia for markets in South Africa and West Africa.

Even though the NDMP says that there is little evidence that destroying marijuana crops leads to supply reduction, it still remains a strategy of the SAPS, and there are concerns about collateral damage from spraying of cannabis with glyphosate, both for the environment and for the health and economic wellbeing of the villagers who are affected.

The main challenge with the supply reduction strategy is that it is not aligned with the harm reduction agenda and this causes major problems in the implementation of harm reduction. The supply reduction strategy is still firmly located in the war on drugs paradigm.

The main elements of supply reduction are a) involvement by the criminal justice system, including SAPS, the National Prosecuting Authority (NPA) for prosecution of offenders and the Department of Justice and Constitutional Development (DOJCD) that provides courts and b) regulating the supply of substances and their pre-cursors, including the South African Revenue Services (SARS), the Department of Trade and Industry (DTI) and the Medicines Control Council (MCC).

3.4.4 Specific issues regarding child and women abuse, 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 a minority of the treatment centres (in-patient and out-patient) mentioned specifically that they dealt with women and child abuse. The action plans of various entities such as LDACs and Community Safety Departments show that they integrate substance abuse awareness into campaign days such as 16 days of no violence against women and children, and into their victim empowerment programmes and Child Protection agendas. FASD is a big concern regarding women and children, especially in rural areas and isolated communities.

4 Conclusion and lessons learned

This evaluation aims to measure the first part of the Theory of Change, namely if all the elements of the system is 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.

4.1 Policy direction and guidance

The evaluation firstly considers 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 main criticism 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. Also, although the majority of the 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. Only two national departments and one entity have final approved departmental DMPs and five departments have the plan reflected in their APPs. Likewise, despite all provinces having produced a DMP, 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. 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.

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 NDMP has furthermore not been followed up with an M&E framework and system.

4.2 Adequacy of financial resources

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 DSD.

A total of around R0.6 billion is allocated by DSD for prevention of substance abuse in the nine provinces. At national DSD, the allocations for 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.

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. 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 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. In conclusion, the budget for substance abuse is inadequate. This is partly because the assumption in the TOC around '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 and the LDACs have not been able to raise funding from the municipalities to implement their activities. Neither the CDA nor the NDMP has been able to influence the allocation of budgets by other agencies.

4.3 Adequacy of human resources

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. 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 enough 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 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; the ability of government officials to implement substance abuse programmes and services as such 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) about 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

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 generally 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. Also the CDA does not have the necessary authority to compel reporting and other key functions from the departments. 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. 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 undertaken 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 Premier's Office 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

The NDMP 2013-2017 has an M&E plan with indicators and targets. The CDA developed the Quick Analysis of Substance Abuse Reports (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 the 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. The evaluation found that the assumptions in the TOC on evidence informing programme and policy planning are not holding, as the various research projects 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. 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

The NDMP provides impetus for the various role-players to address substance abuse in their communities. 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. However it is questionable how effective these are for preventing substance abuse. In terms of early intervention, there was not much reported by the provinces. Attempts at supply reduction also saw numerous arrests, confiscations, and searches. However, not all provinces reported on this aspect of the NDMP 2013-2017. In 2014-2015, The Eastern Cape and Western Cape did not report on these activities to the CDA. In 2013-2014, the North West province similarly did not provide this information. The harm reduction activities reported on differ by province, for example only Free State, Mpumalanga, and Limpopo mention 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.

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 pipeline are not adequately funded, the effectiveness of the other aspects will be reduced. This is because if awareness is raised as part of a prevention exercise, it inevitably results in people seeking assistance who are already experimenting with drugs, or are affected by substance abuse. If there is no funding for early intervention then they will not get the support they require 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 cannot be 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 OST, 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 OST 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 the 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. However, 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.

Regarding supply reduction, the focus of activities should be on the major distributers of illegal drugs, and on the control of the liquor trade. 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 according to SACENDU data. The CDA recognises that even though cannabis use has significant health consequences, it is safer than alcohol and many other substances; policy regarding cannabis should reflect this key point (CDA position on cannabis, 2014/15). 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 needs to be geared up for this over the next few years, particularly the provinces of Mpumalanga, Limpopo and KZN.

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 and political constraints affecting 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 is not enhanced and access to treatment is limited.

5 Recommendations

The recommendations below consider how to improve the NDMP 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; and thirdly, the CDA (and the PSAFs and LDACs) has 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 a **review and harmonisation of legislation**, addressing the 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 Social Development 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 and 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 increasing use of heroin (also in the form of concoctions referred to as, inter alia, nyaope, sugars or woonga).
- Amend the 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, MCC – a streamlined entity that has a slim operational structure and works in a coordinated manner, and is funded directly be treasury 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 (such as DSD, DBE, DOH, DOJCD, NPA, DTI, SAPS, 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. 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 department's 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 that in KwaZulu-Natal, 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 aftercare 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** 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.[7] 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. 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.

[7] Clarke S, Mancebo E, Mahomed S, Cartwright J, (2015)," Implementation Evaluation of the Expanded Partnership Programme, Evaluation Report", Western Cape Department of Community Safety

R8: Develop and implement a **capacity building strategy for CDA, PSAF, LDAC** including the relevant competencies (skills and knowledge) to guide selection of members for each structure (CDA, PSAF, LDAC)[8] 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 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), 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 OST. This strategy must be informed by research and it needs a high level driver such as the CDA or a national department. The Western Cape had MINMAC drive a similar response when methamphetamine became a problem. The response needs to be linked to harm reduction.

[8] 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.

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 could thus 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 preciseness** 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.