



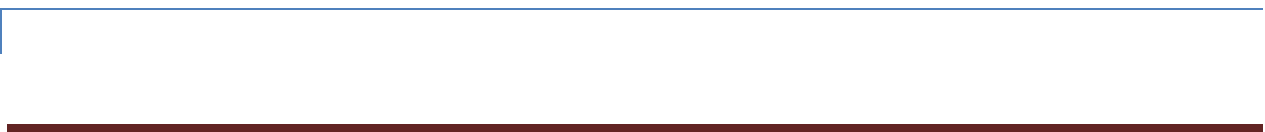
social development

Department:
Social Development
REPUBLIC OF SOUTH AFRICA



NATIONAL DRUG MASTER PLAN

2013 – 2017



FOREWORD BY THE MINISTER OF SOCIAL DEVELOPMENT

The impact of alcohol and substance abuse continues to ravage families, communities and society. The youth of South Africa are particularly hard hit due to increases in the harmful use of alcohol and the use and abuse of illicit drugs.

The use of alcohol and illicit drugs impact negatively on the users, their families and communities. Alcohol and drugs damage the health of users and are linked to rises in non-communicable diseases including HIV and AIDS, cancer, heart disease and psychological disorders. Users are also exposed to violent crime, either as perpetrators or victims and are also at risk of long-term unemployment due to school dropout and foetal alcohol syndrome, being in conflict with law and loss of employment. The social costs for users are exacerbated due to being ostracised from families and their communities. In acute cases users are at risk of premature deaths due ill health, people involved in accidents as well as innocent drivers, violent crime and suicide.

The harmful use of alcohol and drugs exposes non-users to injury and death due to people driving under the influence of alcohol and drugs and through being victims of violent crime. Socially, the families of addicts are placed under significant financial pressures due to the costs associated with theft from the family, legal fees for users and the high costs of treatment. The emotional and psychological impacts on families and the high levels of crime and other social ills have left many communities under siege by the scale of alcohol and drug abuse.

The revised National Drug Master Plan 2013 – 2017 and the work done by the Inter-Ministerial Committee on Alcohol and Substance Abuse seek to address these challenges. The Inter-Ministerial Committee has worked on policies, laws and strategies that seek to reduce the supply and demand for alcohol and illicit drugs. Extensive work is also being done to improve treatment for addicts and other harm reduction modalities. The National Drug Master Plan complements the work of the Inter-Ministerial Committee on Alcohol and Drug Abuse by guiding and monitoring the actions of the government departments to reduce the demand for and supply of drugs and the harm associated with their use and abuse.

The Government further displayed its commitment through the leadership of the President when intervening in the challenges faced by the community of Eldorado Park. A special intervention plan was developed in line with the pillars prescribed in the National Drug Master Plan 2013-2017.

The interventions in Eldorado Park are going to help us implement the consolidated programme throughout the country.

The plan is intended to help realise the vision of a society free of substance abuse so that more attention can be focused on raising the quality of life of the poor and vulnerable and of developing the people to achieve their true potential. In comparison with the National Drug Master Plan 2006 – 2011, the revised plan focuses more on the delivery of evidence based strategies that are designed to meet the defined needs of communities. It also strengthens prevention which is the most important leg of this programme.

MS BATHABILE DLAMINI, MP
MINISTER OF SOCIAL DEVELOPMENT

EXECUTIVE SUMMARY

The National Drug Master Plan (NDMP) 2013 – 2017 of South Africa was formulated by the Central Drug Authority in terms of the Prevention and Treatment of Drug Dependency Act (20 of 1992), as amended, as well as the Prevention of and Treatment for Substance Abuse Act (70 of 2008), as amended, and approved by Parliament to meet the requirements of the international bodies concerned and at the same time the specific needs of South African communities, which sometimes differ from those of other countries.

At the 2nd Biennial Anti-Substance Abuse Summit in Durban, President Jacob Zuma pledged his support and the support of Parliament and national and provincial authorities to combating substance abuse in South Africa.

The NDMP sets out the contribution and role of various government departments at national and provincial level in fighting the scourge of substance abuse. It also recognises the need for a significant contribution to be made by other stakeholders in the country.

In reviewing the NDMP 2006 – 2011, the CDA identified several challenges and impediments that need to be addressed and incorporated with the NDMP 2013 – 2017.

It is generally accepted that a single approach such as criminalising or decriminalising substances or abusers will not solve the problem. Instead, a number of strategies should be applied in an integrated way. The commonly recognised strategies applied in the NDMP 2013 – 2017 are: demand reduction, supply reduction and a localised version of harm reduction. The key specific outcomes derived from a review of the NDMP 2006 – 2011 are described in the NDMP 2013 – 2017 in terms of the basic concepts of monitoring and evaluation (Public Service Commission of South Africa, 2008). These outcomes are listed below.

1. Reduction of the bio-psycho-social and economic impact of substance abuse and related illnesses on the South African population
2. Ability of all people in South Africa to deal with problems related to substance abuse within communities
3. Recreational facilities and diversion programmes that prevent vulnerable populations from becoming substance abusers/dependents
4. Reduced availability of dependence-forming substances/drugs, including alcoholic beverages

5. Development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders and for funding such diagnosis and treatment
6. Harmonisation and enforcement of laws and policies to facilitate effective governance of the supply chain with regard to alcohol and other drugs
7. Creation of job opportunities in the field of combating substance abuse

In a national rapid participatory assessment (RPA), community respondents indicated that alcohol and cannabis were the two main substances of abuse. Their opinion is supported by data gathered from other sources such as the findings of the South African Community Epidemiology Network on Drug Use (SACENDU) (Dada, Plüddemann, Parry, Bhana, Vawda, Perreira, Nel, Mncwabe, Pelser & Weimann, 2012).

The predominant strategy for dealing with the drug problem had for years been that of supply reduction. However, the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO) recently advocated a shift to primary prevention, i.e. a strategy based on the need to prevent the risk of substance abuse/dependence.

The review of the NDMP 2006 – 2011 made it clear that the new NDMP would have to be changed in the following key respects:

Devising solutions from the bottom up rather than from the top down;

Shifting from a national to a community approach to devising strategy (from one size fits all to a community-specific solution);

Shifting from supply reduction to primary prevention in an integrated strategy;

Developing and applying evidence-based solutions wherever possible;

Introducing a monitoring and evaluation (M&E) approach to the formulation of the results to be achieved, i.e. impact, outcomes, outputs and targets;

Aligning the NDMP and national and provincial department drug master plans with an M&E approach;

Applying research and development to meet the predicted needs and future changes in the field of substance abuse;

Reporting in terms of M&E needs instead of activities carried out; and

Extending the reporting base beyond the CDA and its supporting infrastructure by including non-CDA sources and linked databases.

In analysing the substance abuse challenges facing South Africa, the CDA identified a country free of substance abuse as the ultimate goal. The delegates at the 2nd Biennial Anti-Substance Abuse Summit adopted this goal as the vision for NDMP 2013 – 2017. This vision was also endorsed by all the high-level political figures attending the summit.

The mission of the CDA, or that which it must do in order to achieve the vision, is to direct, guide, co-ordinate, monitor and evaluate the initiatives and efforts of all relevant government departments at a national and provincial level, the provincial substance abuse forums (PSAFs) and other stakeholders in their implementation of the NDMP 2013 – 2017 and its goal of a country free of substance abuse.

The NDMP provides the means for harnessing existing resources to achieve the key outcomes of the NDMP. The NDMP requires national and provincial government departments to plan for and deal with substance abuse problems as part of their normal planning and budgeting. Their drug master plans (DMPs) must be submitted to the CDA at the beginning of each financial year. The CDA must monitor and evaluate the implementation of these plans continuously as described in the CDA's mission.

Designated members of the CDA must attend the monthly and quarterly meetings of the PSAFs to carry out the monitoring and evaluation as required, and also the meetings of the local drug action committees (LDACs) if necessary.

Monitoring is to be based on the requirements of a standardised reporting tool, the quick analysis of substance abuse reports (QuASARs). These reports are to be submitted by the last day of June, September, December and March of each year.

Designated members of the PSAFs must attend the quarterly general meetings of the CDA and submit their reports for discussion at those meetings. Departmental representatives on the CDA must also attend these meetings and submit their departmental reports based on the QuASAR for discussion at those meetings.

In terms of legislation, the CDA must submit an annual report to the Minister of Social Development for onward transmission to Parliament by the end of September each year. The report is based on the CDA's monitoring and evaluation by means of departmental and provincial reports or research conducted by or on behalf of the CDA; other matters of relevance should also be included in the annual report.

The CDA also reports verbally and in writing to the Minister of Social Development after each general meeting and on such other occasions as the need demands, in order to

carry out the mandate of advising on matters affecting substance abuse in South Africa.

The success of the new NDMP depends on the continued support of the government and the people, the provision of the necessary resources and, in particular, the ability of the CDA and its supporting infrastructure (national and provincial government departments, PSAFs, LDACs and community structures) to deliver the outcomes, outputs and activities needed to meet the needs of the people.

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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
AOL	Alcohol and other drugs
ATS	Amphetamine-type stimulant (e.g. Ecstasy tablets and the local version of crystal methamphetamine known as "tik")
AU	African Union
CBO	Community-based organisation
CCF	Crime Combating Forum
CDA	Central Drug Authority
CDC	Centers for Disease Control and Prevention
CIA	Central Intelligence Agency
CND	Commission for Narcotic Drugs
CSTL	Care and Support for Teaching and Learning
DEA	Drug Enforcement Administration
DIRCO	Department of International Relations and Co-operation
DLO	Defence Logistics Organisation
DMP	Drug Master Plan
DOH	Department of Health
DPCI	Directorate of Priority Crime Investigation of the SAPS
DSD	Department of Social Development
DTI	Department of Trade and Industry
FBI	Federal Bureau of Investigation
FBO	Faith-based organisation
FIC	Financial Intelligence Centre

GDP	Gross domestic product
HIV	Human immunodeficiency virus
IDU	Injecting drug use
IMC	Inter-Ministerial Committee
ITAC	International Trade Administration Commission
JCPS	Justice Crime Prevention and Security
JOINT	Joint Operation and Intelligence
LDAC	Local Drug Action Committee
M&E	Monitoring and evaluation
MCC	Medicines Control Council
MEC	Member of the Executive Committee
MINMEC	Ministers and Members of Executive Council
MTEF	Medium-Term Expenditure Framework
NDMP	National Drug Master Plan
NGO	Non-governmental organisation
NLA	National Liquor Authority
NLPC	National Liquor Policy Council
NYDA	National Youth Development Agency
OTC	Over-the-counter medication
PESTEL	Political, economic, social, technological, environmental and legislative scan
PSAF	Provincial Substance Abuse Forum
PSC	Public Service Commission
QuASAR	Quick Analysis of Substance Abuse Report

RPA	Rapid participatory assessment
RTMC	Road Traffic Management Corporation
SACENDU	South African Community Epidemiology Network on Drug Use
SADC	Southern African Development Community
SAIDS	South African Institute for Drug-Free Sport
SANCA	South African National Council on Alcoholism and Drug Dependence
SAPS	South African Police Service
SARPPCO	South African Regional Police Chiefs Co-operation Organisation
SARS	South African Revenue Service
SUD	Substance abuse disorder
TB	Tuberculosis
UNDCP	United Nations Drug Control Programme
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

GLOSSARY

Abuse: Persistent or periodic excessive drug use inconsistent with or unrelated to acceptable medical practice. (See also “drug” and “drug or substance of abuse”.)

Chemical precursor: A substance frequently used in the illicit manufacturing of narcotic drugs or psychotropic substances as defined in Article 12 of the 1988 UN Convention against Illicit Drugs and Psychotropic Substances mentioned in Table I and Table II annexed to the Convention.

Community-based treatment: Community-based treatment refers to programmes or initiatives that arise out of the needs of a particular community (through a needs assessment) and programme that identify and utilise existing infrastructure to provide for these needs. (See also “treatment”.)

Demand reduction: A general term used to describe policies or programmes directed at reducing the consumer demand for psychoactive drugs. It is applied primarily, but not exclusively, to illicit drugs and focuses on education, treatment and rehabilitation strategies, as opposed to law enforcement strategies that aim to bar the production and distribution of drugs. (See also “drug” and “psychoactive substances or drugs”.)

Dependence: A person is dependent on a substance when it becomes very difficult or even impossible for him/her to refrain from taking the substance without help, after having taken it regularly for a period of time. The dependence may be physical or psychological or both. (See also “drug or substance of abuse”.)

Designer drug: A novel chemical substance with psychoactive properties, synthesised specifically to be sold on the illicit market and to circumvent regulations on controlled substances. These regulations now commonly cover novel and possible analogues of existing psychoactive substances. (See also “psychoactive substances or drugs”.)

Drug: A term of varied usage. In medicine, it refers to any substance with the potential to prevent or cure disease or enhance physical or mental well-being, and in pharmacology to any chemical agent that alters the biochemical or physiological processes of tissues or organisms. In common usage, the term refers to psychoactive or dependence-producing substances and often, more specifically, to those that are illicit. (See also “dependence”, “drug or substance of abuse”, “illicit drug” and “psychoactive substances or drugs”.)

Drug control: The regulation, by a system of laws and agencies, of the production, distribution, sale and use of specific psychoactive drugs (controlled substances) locally, nationally or internationally; alternatively, as an equivalent to drug policy in the context

of psychoactive drugs, the aggregate of policies designed to affect the supply of and/or the demand for such drugs, locally or nationally, including education, treatment, control and other programmes and policies. (See also “drug”, “drug or substance of abuse” and “psychoactive substances or drugs”).)

Drug master plan: A single document, adopted by government, outlining all national concerns regarding drug control.

Drug or substance of abuse: Encompasses psychoactive or dependence-producing drugs such as alcohol, nicotine, over-the-counter and prescription medication as well as illicit drugs such as cannabis, cocaine and heroin. (See also “dependence”, “drug”, “illicit drug” and “psychoactive substances or drugs”).)

Drug testing: The analysis of body fluids (such as blood, urine or saliva), hair or other tissue for the presence of one or more psychoactive substances. (See also “psychoactive substances or drugs”).)

Early intervention: A therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. Treatment is offered or provided 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. (See also “dependence”, “drug or substance of abuse” and “treatment”).)

Harm reduction: The development of policies and programmes that focus directly on reducing the social, economic and health-related harm resulting from the use of alcohol and other drugs.

Illicit drug: A psychoactive substance, the production, sale or use of which is prohibited. (See also “drug or substance of abuse” and “psychoactive substances or drugs”).)

Licit drug: A drug that is legally available by medical prescription in the jurisdiction in question or, sometimes, a drug legally available without medical prescription. (See also “drug or substance of abuse”).)

Money laundering: Engaging directly or indirectly in a transaction that involves money or property obtained through crime, or receiving, processing, conceiving, disguising, transforming, converting, disposing of, removing from and bringing into any territory, money or property obtained through crime.

Prevention: A pro-active process that empowers individuals and systems to meet the challenges of life's events and transitions by creating and reinforcing conditions that promote healthy behaviour and lifestyles. It generally requires three levels of action: primary prevention (altering the individual and the environment so as to reduce the initial risk of substance use/abuse); secondary prevention (early identification of persons who are at risk of substance abuse and intervening to arrest progress); and tertiary prevention (treatment of the person who has developed substance/drug dependence).

Psychoactive substances or drugs: Substances that “when taken into a living organism, may modify its perception, mood, cognition, behaviour or motor function” (United Nations International Drug Control Programme, 1997).

Street children: The term refers to market children (who work in the streets and markets of cities selling or begging, and live with their families) and homeless children (who work, live and sleep in the streets, often lacking any contact with their families).

Substance abuse: The misuse and abuse of legal or licit substances such as nicotine, alcohol, over-the-counter and prescription medication, alcohol concoctions, indigenous plants, solvents and inhalants, as well as the use of illegal or illicit substances. (See also “abuse”, “illicit drug”, “licit drug” and “drug or substance of abuse”.)

Supply reduction: Policies or programmes aiming to stop the production and distribution of drugs, particularly law enforcement strategies for reducing the supply of illicit drugs. (See also “drug”, “drug control” and “illicit drug”.)

Treatment: A process aimed at promoting the quality of life of the drug dependant and his/her system (husband/wife, family members and other significant persons in his/her life) with the help of a multi-professional team. (See also “dependence”.)

CHAPTER 1: BACKGROUND TO THE CENTRAL DRUG AUTHORITY AND THE NATIONAL DRUG MASTER PLAN

INTRODUCTION

As part of the global community, South Africa is entangled in the world drug problem. The term "world drug problem" or "drug problem" relates primarily to the global demand for illicit drugs. However, in South Africa the concept is expanded to the demand for all types of dependence-forming substances (i.e. alcohol and other substances such as various types of prescription and over-the-counter medication or illicit substances/drugs such as cannabis, cocaine and heroin), and is referred to as the "substance abuse problem".

As other countries across the world, South Africa is required to take the steps necessary to combat the drug problem, applying policies and practices agreed by the world community and acceptable to South Africa as an individual country. These policies and practices are formulated in response to the relevant United Nations conventions and the conventions of other relevant international bodies.

The National Drug Master Plan (NDMP) 2013 – 2017 of South Africa was formulated by the Central Drug Authority (CDA) in terms of the Prevention and Treatment of Drug Dependence Act (20 of 1992), as amended, as well as the Prevention of and Treatment for Substance Abuse Act (70 of 2008), as amended, and approved by Parliament to meet the requirements of the international bodies concerned, and at the same time to meet the specific needs of the South African communities, which sometimes differ from the needs of other countries.

PRESIDENTIAL MESSAGE OF SUPPORT

At the opening of the 2nd Biennial Anti-Substance Abuse Summit in Durban on 15 March 2011, President Jacob Zuma stressed the dire consequences of substance abuse in South African communities, with special emphasis on the effects of alcohol and cannabis.

He stated that the South African government is concerned with promoting social cohesion and stable communities. The fight against substance abuse is the key aspect of that programme. He emphasised that the abuse of substances such as alcohol and other drugs as well as drug trafficking would receive renewed and more energetic attention from government, and that collaborative efforts were required to reduce the

scourge of substance abuse.

He also urged the delegates (who included representatives of urban and rural communities) to develop a series of resolutions to combat these effects and listed a number of suggestions for dealing with the problem of substance abuse. In closing he pledged his support and the support of Parliament and the national and provincial departments in combating substance abuse in South Africa.

COMMUNITY NEEDS AND THE DRUG PROBLEM

In the months before the 2nd Biennial Anti-Substance Abuse Summit, a national rapid participatory assessment (RPA) and a door-to-door anti-substance abuse awareness campaign were carried out (Department of Social Development, 2012). To facilitate wide community input, a series of provincial summits (facilitated by the CDA) followed the RPA and door-to-door anti-substance abuse awareness campaign. Participants at the provincial summits (1) discussed the outcome of the RPA and campaign, (2) identified common issues of concern, (3) recommended ways of addressing these issues, and (4) formulated a set of potential resolutions that were eventually debated and finalised at the 2nd Biennial Anti-Substance Abuse Summit. Representatives of the CDA, PSAFs, LDACs as well as relevant non-governmental organisations (NGOs) and other civil society agencies attended the provincial summits.

The RPA used a variety of data sources to explore the communities' needs regarding the substance abuse problem. A special attempt was made to establish from community members what the government and others should do to prevent substance abuse. (Chapter 3 elaborates on the methodological characteristics of the RPA and notes its key results.)

DEALING WITH THE DRUG PROBLEM: THE CDA AND THE NATIONAL DRUG MASTER PLAN

The CDA is the body authorised in terms of the Prevention and Treatment of Drug Dependency Act (20 of 1992), as amended, as well as the Prevention of and Treatment for Substance Abuse Act (70 of 2008), as amended, to develop a National Drug Master Plan (NDMP) and to direct, guide and oversee its implementation, as well as to monitor and evaluate the success of the NDMP and to make such amendments to the plan as

are necessary for success.

The NDMP is designed to bring together government departments and other stakeholders in the field of substance abuse to combat the use and abuse of and dependence on dependence-forming substances and related problems. It sets out the contribution and role of various government departments at national and provincial level in fighting the scourge of substance abuse. It also recognises the need for a significant contribution to be made by other stakeholders in the country.

The success of the NDMP depends on the efforts of each stakeholder in crafting national and provincial department drug master plans (DMPs) in response to the problems defined in the NDMP.

The overall objective of the NDMP is to:

- ensure coordination of efforts to reduce the demand, supply and harm caused by substances of abuse;
- ensure effective and efficient services for the combating substances of abuse through the elimination of drug trafficking and related crimes;
- 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 - substance abuse;
- provide a framework for the commissioning of relevant research;
- provide a framework for Monitoring and Evaluation; and
- promote national, regional and international cooperation to reduce the supply of drugs and other substances of abuse.

The concerted effort of all stakeholders will make the implementation of the plan a success, and contribute towards the achievement of a South Africa free of Substance Abuse.

CHAPTER 2: THE CDA AND THE NATIONAL DRUG MASTER PLAN

ROLE AND MANDATE OF THE CENTRAL DRUG AUTHORITY

The CDA is a statutory body established and functioning in terms of the Prevention and Treatment of Drug Dependency Act (20 of 1992), as amended, as well as the Prevention of and Treatment for Substance Abuse Act (70 of 2008), as amended, and serves for a period of five years in the following capacity:

Giving effect to the NDMP;

Advising the Minister of Social Development, who is the chairperson of the Inter-Ministerial Committee on Substance Abuse, on any matter associated with such abuse, and

Reviewing the NDMP after five years.

The NDMP of 2006 – 2011 was the blueprint for combating substance abuse in South Africa during that period. Its mission was to "strive towards a drug-free society". The CDA was established to give effect to the NDMP.

In pursuing this mandate the CDA was required to:

Direct, guide and oversee the implementation of the NDMP;

Monitor and evaluate the success of the NDMP;

Make such amendments to the NDMP as are necessary for success;

Review the NDMP every five years; and

Produce a new NDMP for the period 2013 – 2017.

The CDA's mandate requires that it:

Co-ordinates the efforts of all departments (at national and provincial level) to combat substance abuse;

Facilitates the integration of the work of the different stakeholders (including the national and provincial departments concerned); and

Reports to Parliament on the outcomes of the NDMP about the outputs achieved by the CDA's institutional support framework (i.e. the national and provincial departments, PSAFs and LDACs), as well as striving to achieve a society free of

substance abuse.

MEMBERSHIP OF THE CDA

Members of the CDA serve for five years. The body consists of 13 experts on substance abuse appointed by the private sector, and representatives of 18 national departments and three other national government entities (34 members in total). The meetings of the whole body (general meetings) are held quarterly, and those of the Executive Committee are held monthly.

The stakeholders are the following:

Department of Arts and Culture

Department of Correctional Services

Department of Basic Education

Department of Higher Education and Training

Department of International Relations and Co-operation

Department of Health

Medicines Control Council

Department of Home Affairs

Department of Justice and Constitutional Development

Department of Labour

Department of Agriculture

National Treasury

Department of Cooperation and Traditional Affairs (Provincial and Local Govt)

National prosecuting Authority

Department of Sport and Recreation

National Youth Development Agency

Department of Social Development

South African Police Service
South African Revenue Service
Department of Trade and Industry
Department of Transport

The 12 experts are drawn from:

Non-governmental organisations (NGOs)
Research councils and universities
Teachers' trade unions
Community-based organisations
Faith-based organisations
Alcohol treatment centres
Addiction Counsellors' Association

Representatives of the provincial substance abuse forums serve ex officio.

ROLES OF MEMBERS OF THE CDA

In addition to executing the CDA's mandate as a team, members are required to serve the CDA in a variety of roles as described below.

The expert members are expected to apply their expertise in the field of substance abuse collectively and individually to develop and apply an integrated strategy (entailing demand, supply and harm reduction) as well as policies, protocols and practices relating to the prevention, treatment, aftercare and re-integration with society of persons affected by substance abuse/dependence. They are also expected to participate in the clusters of the national and provincial entities involved in the development of national and provincial department DMPs and in the execution of the CDA's mandate. Furthermore, they liaise between the CDA and the various provincial organisations, especially the PSAFs, and therefore attend the meetings of the PSAFs.

National and provincial department representatives are expected to lead the development of their respective drug master plans collectively and individually and together with the 13 experts apply their particular expertise to the functioning of their departments to the interpretation of the NDMP. In addition to participating in the clusters of national and provincial entities involved in the execution of the CDA's mandate, they have to guide and co-ordinate their activities so as to achieve that mandate.

ROLE OF THE SECRETARIAT OF THE CDA

The CDA is supported by a Secretariat who ensures that the day-to-day work of the CDA is carried out in line with the outcomes required by the NDMP. It also provides such administrative support as is required by the CDA and its supporting institutional framework.

DEVELOPING THE NATIONAL DRUG MASTER PLAN 2013 – 2017

REVIEW OF THE NATIONAL DRUG MASTER PLAN 2006 – 2011

The CDA's mandate is to formulate a "new" five-year NDMP for the period 2013 – 2017 (i.e. review the NDMP 2006 – 2011, analyse achievements and determine those aspects that require further attention). It is also required to incorporate aspects of relevant international policy with the new NDMP as well as address aspects of substance use, abuse and dependence of a specifically South African nature.

In addressing these aspects, the CDA:

- Held a workshop in September 2010 to review progress regarding the NDMP 2006 – 2011;

- Attended various local and international conferences and analysed their implications for the South African situation;

- Analysed the reports emanating from the CDA's infrastructure, including those of departments represented in the CDA and the provincial substance abuse forums;

- Conducted a desktop review of the problem of substance abuse in South Africa;

- Carried out a national rapid participatory assessment (RPA) of the problem of substance abuse as well as a door-to-door anti-substance abuse awareness

campaign; and

Held the 2nd Biennial Anti-Substance Abuse Summit, from which arose 34 resolutions representing community needs in combating substance abuse (Department of Social Development, 2012).

KEY CHALLENGES ARISING FROM THE REVIEW OF THE NDMP 2006 – 2011

From its review of the NDMP 2006 – 2011, the CDA identified several challenges and impediments that need to be addressed in the NDMP 2013 – 2017. These include, but are not limited to, the following:

Re-align the NDMP strategy to meet the legal and other implications of the changing patterns of the use and abuse of alcohol and other dependence-forming substances in South African communities as well as the latter's expressed needs in this regard as identified in the 34 resolutions of the 2nd Biennial Anti-Substance Abuse Summit;

Re-align the NDMP strategy with the changing strategies of the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO);

Re-align the research and development of the CDA to enable it to become proactive in its efforts to identify and combat the changing threats posed by substance abuse in South Africa and in neighbouring territories, especially those related to the main substances of abuse, i.e. alcohol and cannabis;

Reposition the CDA in accordance with the recommendations of the final report on the review of the CDA so as to enable it to strive more effectively towards the achievement of the outcomes of the NDMP and to finance its efforts accordingly;

Develop the capacity and ability of the CDA support structure so as to ensure the compilation and implementation of the national and provincial department DMPs, using the principle of clusters as applied in Parliament;

Implement the revised legislation on substance abuse (Act 70 of 2008) and its accompanying regulations;

Provide and implement solutions to the problems of funding the CDA support structure, especially relating to the PSAFs, LDACs and NGOs, the related protocols and the Public Finance Management Act (1 of 1999);

Create, through capacity building, research and development, and through marketing and communication, effective partnerships between the CDA and Southern African and other countries, and national and global organisations in striving to achieve the outcomes of the NDMP;

Develop the National Database on Substance Abuse so as to ease monitoring and evaluation regarding the combating of substance abuse in South Africa; and

Develop the capacity and ability of the CDA support structure so as to ensure the submission of reports in a format that will enable the accurate assessment of the outcomes and outputs of the NDMP and enhance the use of the National Database on Substance Abuse and the accompanying clearing house.

OUTLINE OF THE NATIONAL DRUG MASTER PLAN 2013 – 2017

DEFINITION OF "DRUG MASTER PLAN" AND "DRUG"

The United Nations Drug Control Programme (UNDCP) defines a "drug master plan" as a single document covering all national concerns regarding drug control. It summarises national policies authoritatively, defines priorities and allocates responsibility for drug control efforts. In essence, a drug master plan is a national strategy that guides the operational plans of all government departments and other entities involved in the reduction of demand for, supply of and harm associated with the use and abuse of, and dependence on, dependence-forming substances.

For purposes of the NDMP the term "drug" refers to illicit drugs as defined in the Drugs and Drug Trafficking Act, 1992 (140 of 1992), commonly abused licit medicines both prescribed and non-prescribed, alcohol and tobacco, inhalants/volatile solvents and other as yet undefined dependence-forming substances. For convenience the terms "drug", "substance" (of abuse), "dependence-forming substance" and "alcohol and other drugs" (AOD) are considered interchangeable in the NDMP.

INTEGRATED AND BALANCED APPROACH TO THE SUBSTANCE ABUSE PROBLEM IN THE NDMP 2013 – 2017

In the field of substance abuse it is generally accepted that no single approach such as criminalising or decriminalising substances or abusers would solve the problem of substance abuse. Instead a balanced approach that uses an integrated combination of strategies is advocated. The following strategies are recognised by the NDMP 2013 –

2017:

Demand reduction, or reducing the need for substances through prevention that includes educating potential users, making the use of substances culturally undesirable (such as was done with tobacco) and imposing restrictions on the use of substances (for example by increasing the age at which alcohol may be used legally);

Supply reduction, or reducing the quantity of the substance available on the market by, for example, destroying cannabis (dagga) crops in the field; and

Harm reduction, or 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 re-integration of substance abusers/dependents with society.

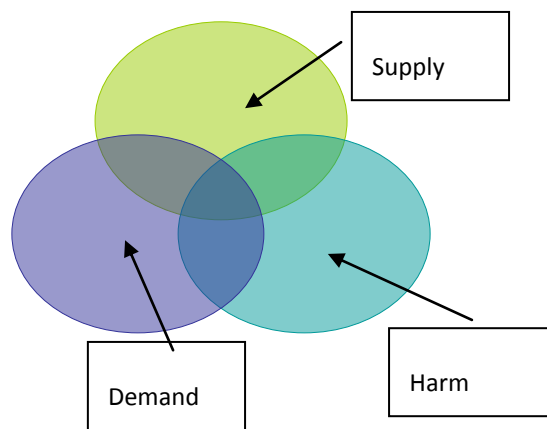


Figure 1: Illustration of the recommended balanced integration of three strategic ways of combating substance abuse

APPLICATION OF THE INTEGRATED STRATEGY TO THE NATIONAL DRUG MASTER PLAN 2013 – 2017

Firstly, in applying the integrated strategy to the NDMP 2013 – 2017, the impact and key specific outcomes derived from the review of the NDMP 2006 – 2011 were described in terms of basic monitoring and evaluation concepts (Public Service Commission of South Africa, 2008). These outcomes are listed below.

1. Reduction of the bio-psycho-social and economic impact of substance abuse and related illnesses on the South African population
2. Ability of all people in South Africa to deal with problems related to substance abuse within communities
3. Recreational facilities and diversion programmes that prevent vulnerable populations from becoming substance abusers/dependents
4. Reduced availability of dependence-forming substances/drugs, including alcoholic beverages
5. Development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders, and for funding such diagnosis and treatment
6. Harmonisation and enforcement of laws and policies to facilitate effective governance of the supply chain with regard to alcohol and other drugs
7. Creation of job opportunities in the field of combating substance abuse

Secondly, continuing in the format required by the logic of the monitoring and evaluation process, the key outcomes were translated into specific NDMP as well as national and provincial DMP outcomes, outputs, activities and targets, and responsibility was allocated for their achievement.

Thirdly, in terms of the roles and responsibilities of CDA members) the relevant national and provincial government departments in their various clusters were required to translate these outputs and activities into their respective DMPs for achievement by their respective entities and clusters. The DMPs should incorporate the elements of the integrated demand, supply and harm reduction strategy and the interventions associated with these elements as noted earlier.

Fourthly, the PSAFs and LDACs and other stakeholders are required to apply the DMPs

of the national and provincial departments so as to achieve the desired impact, the specified outcomes and outputs, and the CDA mandate.

Fifthly, for the duration of implementation, standardised reports on progress with the achievement of the targeted outcomes and outputs in the DMPs are generated and submitted to the CDA and to the respective national and provincial authorities.

Sixthly, and concurrently with the application of the DMPs, the CDA executes a planned cycle of monitoring, evaluation, adjustment and reporting in order to ensure the achievement of the desired impact, outcomes and outputs, with the CDA providing annual reports to the Minister of Social Development and Parliament.

This process is illustrated in the figure below.

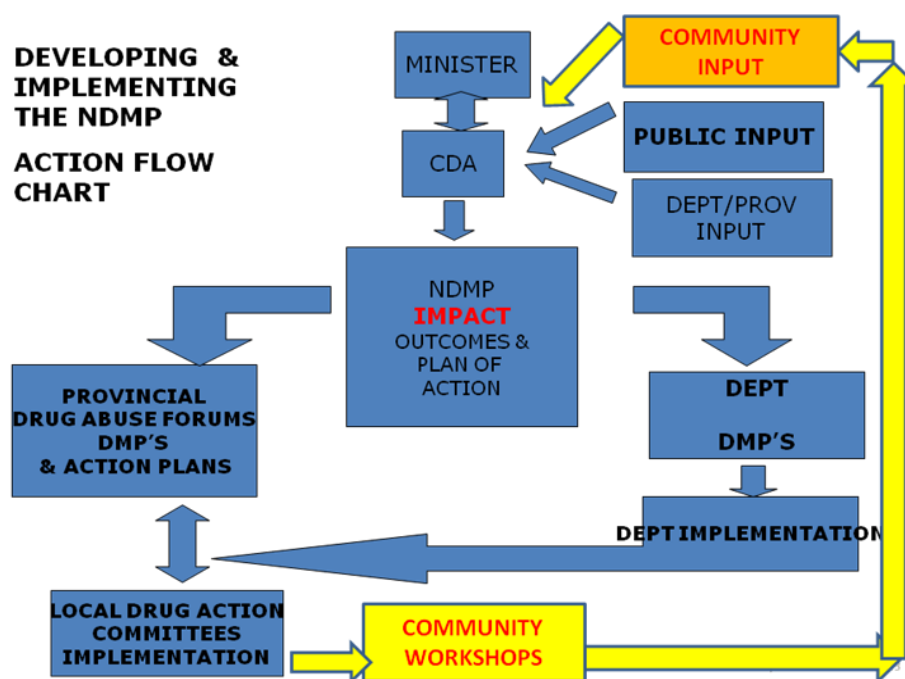


Figure 2: Application of the NDMP 2013 – 2017

CHAPTER 3: COMMUNITY NEEDS AND THE DRUG PROBLEM

DETERMINING COMMUNITY NEEDS

As indicated in previous chapters, a national rapid participatory assessment (RPA) was conducted in an effort to determine communities' needs regarding the substance abuse problems confronting them (Department of Social Development, 2012). The RPA was designed along the lines of what the World Health Organization (2002) describes as a “rapid assessment and response” (RAR) study, and what social science researchers such as De Vos, Strydom, Fouché and Delport (2005) regard as participant action research. Procedurally, the RPA consisted of a household survey, a desktop review of relevant data, and an in-depth discussion of the issues concerned during a workshop attended by representatives of the PSAFs and the CDA.

The target population of the RPA survey was household residents in the age category 10 years and older in South Africa.

The population surveyed in the RPA can be profiled as follows:

About 65% were female and 35% were male respondents.

Most of the respondents were aged between 16 and 65, and less than 5% were under the age of 16 years.

The respondents were mainly from the African (49%) and Coloured (34%) population groups, with the remaining 17% being of other population groups.

Of the respondents, 42% were from urban areas, 20% from peri-urban areas, 33% from rural areas and 5% from semi-rural areas.

Altogether 63% of the respondents were unemployed, 10% were self-employed and 45% earned an income of less than R1 000 per month.

EXTENT OF THE DRUG PROBLEM IN SOUTH AFRICA: ALCOHOL USE AND ABUSE

MEASURES OF EXTENT

In South Africa the extent of the alcohol problem and that of the illicit drug problem are measured in a similar way. In fact, five indicators and their trends over time are used to measure the extent and success of combating the alcohol problem:

Alcohol use as a means of quantifying the total number of people engaged in the activity, the types of alcohol used and patterns of use;

Alcohol production described in terms of where alcohol is manufactured. This can be used to determine the potential supply of particular types of alcohol, primarily "recorded alcohol", i.e. alcohol produced legitimately in a registered production facility, and "unrecorded alcohol", which includes "concoctions" (which contain unacceptable ingredients) and "home brews" (which contain acceptable ingredients), both of which are made at illegitimate production facilities;

Alcohol prices as an indication of the economic impact of alcohol use;

Alcohol seizures, which provide data on underlying changes in unrecorded alcohol use patterns; and

Treatment demand, which gives some insight into the magnitude of the alcohol problem by measuring both the number of people asking for treatment and those receiving treatment for dependence-related symptoms, as an indicator of impact on social support systems.

It is also important to note that data that give in financial terms the social and economic impact of alcohol abuse are a direct indicator of the economic cost of such abuse to society (Business and Economic Research Ltd., 2009; World Health Organization, 2006; Single, Collins, Easton, Harwood, Lapsley, Kopp & Wilson, 2003).

ALCOHOL USE

Available data suggest that substantial proportions of South Africans consume alcohol, and those who do, tend to imbibe comparatively high volumes, especially during weekends. For example:

In the 2003 South African demographic and health survey (Department of Health,

Medical Research Council & OrcMacro, 2007), 33% (49% among males and 22% among females) in the overall sample (persons 15 years and older) admitted that they used alcohol at some time in their life; 26% (39% males and 16% females) that they used it in the 12 months before the survey; and 18% (30% males and 10% females) that they did so in the week before the survey. In the more recent 2008 South African national HIV prevalence, HIV incidence, behaviour and communications survey (Peltzer, Davids & Njuho, 2011), 28% admitted using alcohol in the month before the survey (42% among males and 17% among females).

In terms of volume of recorded alcohol consumption, and as noted in the *Global Status Report on Alcohol 2004* (World Health Organization, 2004a), South Africa ranked 47th out of 189 countries in 2003, with an adult (persons 15 years and older) per capita consumption of 7, 81 in litres of pure alcohol. When added to the estimated (World Health Organization, 2004a) volume of unrecorded consumption (an annual adult per capita consumption of 2, 2 in litres of pure alcohol for the years after 1995), the total rises to 10 litres. The 2011 *Global Status Report on Alcohol and Health* (World Health Organization, 2011), furthermore, estimates the average annual adult per capita alcohol consumption (in litres of pure alcohol) in the period 2003 – 2005 in South Africa as 7,0 for recorded alcohol, 2,5 for unrecorded alcohol and 9,5 in total. The latter figure is higher than the corresponding figure (6, 2) for Africa (World Health Organization, 2011).

In the 2003 South African demographic and health survey (Department of Health, Medical Research Council & OrcMacro, 2007), fair proportions of drinkers (15 years and older) reported “hazardous/harmful” amounts of alcohol consumption, namely

12, 7% among past 12 months' drinkers (those who admitted that they used alcohol in the 12 months before the survey) (12, 3% among males and 13, 5% among females); and

5,6% among past week drinkers (those who admitted that they used alcohol in the week before the survey) (7, 1% among males and 2, 2% among females).

The mentioned survey also established that the consumption of “hazardous/harmful” amounts of alcohol occurred on weekends rather than weekdays (Department of Health et al., 2007). (To calculate “hazardous” and “harmful” levels of alcohol consumption, the researchers (Department of Health et al., 2007:271) used the survey’s “data on the [respondents] average number of drinks consumed per day and drinking frequency over the past 12 months as well as past week. ‘harmful levels’ [constituted] four drinks to less than six drinks a day for men and two drinks to less than four drinks per day for women [and] ‘hazardous levels’ six or more drinks per day for men and four or more

drinks per day for women”.)

The 2011 *Global Status Report on Alcohol and Health* (World Health Organization, 2011a:100), furthermore, estimates that substantial proportions of adult (≥ 15 years old) drinkers in South Africa were “heavy episodic drinkers” in 2003 – 48,1% among male drinkers and 41,2% among female drinkers. (“Heavy episodic drinking” equalled an intake of “at least 60 grams or more of pure alcohol on at least one occasion weekly” (World Health Organization, 2011a:100).)

In the 2008 South African national HIV prevalence, HIV incidence, behaviour and communications survey (Peltzer et al., 2011) fair proportions in the overall sample admitted past month binge drinking (10%) (i.e. imbibed 5 or more “drinks” on the same occasion on at least one day in the month before the survey) and past 12 months’ hazardous/harmful drinking (9%) (scored 8 or higher on the 10-item Alcohol Disorder Identification Test (AUDIT)). Among past month drinkers a substantial proportion (32%) registered a hazardous/harmful drinking pattern. Binge drinking and hazardous/harmful consumption were male rather than female phenomena, and manifested in urban rather than rural areas.

Few studies have been done on the consumption of alcohol among young people. However, available data suggest that substantial proportions consume alcohol. For example, the 2002 and 2008 South African youth risk behaviour surveys among learners in Grades 8 to 11 recorded the following data (Reddy, Panday, Swart, Jinabhai, Amosun, James, Monyeki, Stevens, Morejele, Kambaran, Omardien & Van den Borne, 2003; Reddy, James, Sewpaul, Koopman, Funani, Sifunda, Josie, Masuka, Kambaran & Omardien, 2010):

49% (56% among males and 44% among females) in the 2002 survey, and 50% (54% among males and 45% among females) in the 2008 survey admitted that they had 1 or more “drinks” of alcohol at some time in their life;

32% (39% among males and 26% among females) in the 2002 survey, and 35% (41% among males and 30% among females) admitted that they had a “drink” of alcohol on 1 or more days in the month before the respective surveys; and

23% (29% among males and 18% among females) in the 2002 survey and 29% (34% among males and 24% among females) in the 2008 survey admitted past month “binge” drinking (i.e. imbibed 5 “drinks” or more within a few hours on 1 or more days in the month before the respective surveys).

There are also indications that beer tends to be the most commonly drunk alcoholic

beverage in South Africa, followed by sorghum or African traditional beer, wine, brandy, other spirits, alcoholic fruit beverages, whisky, fortified wine and sparkling wine. However, available data sources suggest that drinking patterns are changing with less lager and more cider being drunk.

ALCOHOL PRODUCTION, CONSUMPTION AND PRICES

While recorded alcoholic drinks continued to see a steady growth in total value of production, growth in volume stagnated in 2009 in the world (Euromonitor International, 2010). This was attributed to the economic crisis that forced consumers everywhere to curb their expenditure on non-essential items.

The high value growth was attributed to increased unit prices as a result of manufacturers trying to recoup the increased manufacturing and distribution costs.

Specialist retailers continued to be accountable for by far the most alcoholic drink sales. However, while these outlets used to be companies that operated in this market, several leading supermarkets have introduced their own brands and are setting up their own specialist liquor outlets.

There is furthermore a growing tendency in South Africa to sell alcohol from outlets without the necessary licences, which complicates the control or regulation of such sales, including sales to underage purchasers.

TREATMENT DEMAND FOR ALCOHOL ABUSE

Data on admissions to substance abuse related treatment centres between 2008 and 2010 suggest that alcohol tends to be the leading substance of abuse throughout the country, except in the Western Cape and Mpumalanga/Limpopo (the two provinces are combined in SACENDU) (Dada et al., 2012). Between 29,8% (Western Cape) and 70% (Free State, Northern Cape and North West) of patients in treatment were primarily admitted for alcohol abuse in the period 2008 – 2010 (Dada et al., 2012).

Admissions to treatment centres of people younger than 20 years for primarily alcohol abuse varied between 3,3% (Western Cape) and 26,8% (KwaZulu-Natal) in the period 2008 – 2010 (Dada et al., 2012).

SOCIAL AND ECONOMIC COST OF ALCOHOL ABUSE

A conservative estimate of the economic cost to South Africa of alcohol abuse based on research conducted in other countries is 1% to 2% of gross domestic product (GDP) per

annum. Recent research in New Zealand suggests that the social and economic cost is nearer to 4, 95% or approximately R104,8 billion on average per year (Business and Economic Research Ltd., 2009).

It is important to bear in mind that the emotional, social and financial costs arising from alcohol abuse affect not only the drinkers themselves, but also other members of their (immediate) families.

LINK BETWEEN ALCOHOL AND HIV/TB IN AFRICA

In 2008 an estimated 1, 9 million people living in sub-Saharan Africa became newly infected with HIV, bringing the number of people in this region living with HIV to 22,4 million (Parry, 25 January 2010).

There was an estimated 9, 3 million new TB cases worldwide in 2007, with some 460 000 cases in South Africa (Donald, 2009).

At a conference in Cape Town in July 2008, 25 international experts from 8 countries concluded that:

Associations between alcohol consumption and worse disease outcomes (death and re-infection) for both HIV/AIDS and TB are strong and consistent;

There are well-explained pathways to describe these associations; and

Dose-response relationships clearly indicate that more problematic alcohol consumption and abuse are linked to worse courses in the progression of these diseases (Parry, 25 January 2010).

EXTENT OF THE DRUG PROBLEM IN SOUTH AFRICA: ILLICIT DRUGS, AND PRESCRIPTION AND OVER-THE-COUNTER MEDICATION

MEASURES OF EXTENT

The *World Drug Reports* of 2006, 2008 and 2009 (United Nations Office on Drugs and Crime, 2009) use the following five indicators and their trends over time to measure success in combating the drug problem and especially illicit drug use:

Drug use as a means of defining the total number of persons engaged in the activity and the types of drugs used;

Drug production described in terms of where the product is cultivated as a natural

product and where it is produced (e.g. in a factory or laboratory) so as to determine the potential supply of drugs;

Drug prices as an indication of the economic impact of drug use;

Drug seizures, which provide data on underlying changes in drug trafficking patterns; and

Treatment demand, which gives some insight into the magnitude of the drug problem by measuring both the number of people asking for treatment and those receiving treatment for dependence-related symptoms, so as to determine the impact on social support systems.

As in the case of alcohol abuse, data that give in financial terms the social and economic impact of illicit drug use are a direct indicator of the economic cost of such use to society (Business and Economic Research Ltd., 2009; Single et al., 2003).

CATEGORIES OF SUBSTANCES OF ABUSE

For ease of reference and simplicity, substances or drugs of abuse are divided into three categories (Snyder, 1986; Van Niekerk, 1998):

Depressants, or more correctly called "central nervous system depressants", are the most commonly used and abused drugs in society. They slow down the action of the central nervous system, which controls the functioning of the user's body, ostensibly making the user calmer and more controlled. Also called "downers", they include: alcohol, inhalants (such as glue and lacquer thinners), analgesics or painkillers, tranquillisers, hypnotics and sleeping pills, and narcotics (such as opium, morphine, heroin, codeine and pethidine).

Stimulants, or more correctly called "central nervous system stimulants", speed up the way the body and the mind work. Physically they create an immediate and intense "high" of short duration, an overpowering feeling of well-being, mental clarity and great energy. Also called "uppers", they include: tobacco, appetite suppressants, Ephedrine (found in decongestants and asthma medication), cocaine and crack cocaine, and amphetamines or amphetamine-type substances (ATS), the most common of which is known as Ecstasy.

Hallucinogens, which cause the individual to see, hear and smell things that are not really there. The best known is cannabis (also known as dagga or marijuana), but one of the strongest hallucinogens available is Lysergic Acid Diethylamide or

LSD.

POLY-DRUG USE

Although drugs are categorised by type, users often use more than one type at a time. Such multiple-drug or poly-drug use is meant to enhance the effect of the specific drugs on the individual or, in certain cases, to disguise or conceal the use of a specific drug or drugs.

In addition, it is common for drugs, especially combinations of drugs, to be given local or street names. In South Africa the street names and the combinations differ from province to province and region to region and change from time to time.

Data on admissions to substance abuse related treatment centres suggest that poly-drug use is quite common in the country. For example, SACENDU showed that between 30% (Eastern Cape) and 50% (Gauteng) of patients who reported for treatment in the period January to June 2011 indicated more than one substance of abuse (Dada et al., 2011).

TYPES OF SUBSTANCES OF ABUSE IN USE

The four types of substances or drugs on which the UNODC reports are:

Cannabis (dagga), which is usually smoked separately or in combination with other drugs;

Opiates or derivatives of the opium poppy, normally smoked but it may be injected in refined form, with heroin being the dominant opiate in South Africa;

Cocaine, which is inhaled or "snorted" in powder form;

Amphetamine-type stimulants (ATS), such as Ecstasy tablets and the local version of crystal methamphetamine known as "tik", and usually smoked in some special holder; and

Over-the-counter (OTC) and prescription medication, which is purchased over the counter from a pharmacy or stockist of such medication or obtained with a prescription of a medical practitioner.

DATA ON THE SOUTH AFRICAN DRUG PROBLEM, FOCUSING ON ILLICIT DRUGS AS WELL AS OVER-THE-COUNTER AND PRESCRIPTION MEDICATION

As in the case of alcohol use, accurate, comprehensive and up-to-date data on the nature, extent and consequences of the use of drugs other than alcohol in South Africa are not available. No comprehensive national population study on these issues has been done over the past more or less two decades. Indeed, the paucity of data on especially the use of illicit drugs and the non-medical use of over-the-counter and prescription medication complicates the identification of patterns of use and in particular trends over time in this regard.

The CDA commissioned a national household survey of the problem that had to be completed in 2010. Unfortunately, for reasons beyond the control of the CDA, this survey has not been done as yet.

However, data on admissions to substance abuse related treatment centres in South Africa suggest that the use and abuse of drugs other than alcohol is (fairly) common. For example, the respective proportions of people who were admitted to treatment centres in the period 2008 – 2010 cited the following drugs as their primary substances of abuse (Dada et al., 2012):

Cannabis: Between 11,2% (Western Cape) and 50,2% (Mpumalanga/Limpopo) of patients reported this drug as their primary drug of abuse.

Cocaine: Between 1,9% (Western Cape) and 20,1% (Eastern Cape) of patients reported this drug as their primary drug of abuse.

Heroin: Between 0,3% (Central Region: Free State, Northern Cape, North West) and 29,5% (KwaZulu-Natal) of patients cited heroin as their primary drug of abuse. (The comparatively high proportion of heroin abusers in KwaZulu-Natal could be the result of the use of "sugars" or nyaope (a low-quality heroin and cocaine mixture) by young Indian males in the south of Durban (Dada et al., 2011). It is also important to note that although heroin is mostly smoked, SACENDU data (Dada et al., 2011) suggest that injection of this drug is not uncommon. For example, and with regard to the period January to June 2011, respectively 6%, 16% and 11% of those patients who were in treatment centres in the Western Cape, Gauteng and in the Mpumalanga-Limpopo region for primarily heroin use reported that they injected this drug (Dada et al., 2011).)

ATS: Between 0,1% (KwaZulu-Natal) and 40,6% (Western Cape) of patients reported tik as their primary drug of abuse. Tik was also the most commonly reported primary drug of abuse among patients admitted to treatment centres in the Western Cape.

OTC and prescription medication: Between 0, 1% (Western Cape) and 12,3% (Eastern Cape) of patients reported OTC/prescription medication as their primary drug of abuse.

As in the case of alcohol use, there is a paucity of national data on the nature and extent of the use of drugs other than alcohol among young people. However, the 2002 and 2008 South African youth risk behaviour surveys among learners in Grades 8 to 11 (Reddy et al., 2003, 2010) recorded the following data:

13% admitted lifetime use (used the substance at some time in their life) of cannabis in 2002 as well as in 2008;

6% admitted lifetime use of mandrax in 2002 and 7% in 2008; similar proportions admitted the use of cocaine;

12% admitted lifetime heroin use in 2002 and 6% in 2008;

7% admitted lifetime use of crystal methamphetamine (tik) in 2008; and

16% admitted lifetime use of over-the-counter/prescription medication in 2002 and 12% in 2008.

(It is also important to note that inhalant/solvent use among especially young people continues to be a problem in the country, although available data suggest that the proportions that report such use are comparatively low (Dada et al., 2011; Reddy et al., 2003, 2010). For example, in the 2002 and 2008 South African youth risk behaviour surveys among learners in Grades 8 to 11 (Reddy et al., 2003, 2010), 11% admitted lifetime use of inhalants in 2002 and 12% in 2008.)

SOCIODEMOGRAPHIC AND REGIONAL VARIATION IN DRUG USE/ABUSE

Data on admissions to substance abuse related treatment centres (e.g. Dada et al., 2012) and reviews of the nature and extent of drug use/abuse (e.g. Peltzer, Ramlagan, Johnson & Phaswana-Mafuya, 2010; Da Rocha Silva, 2004; Parry, 2000) have consistently shown that such use/abuse not only tends to vary over time but also across regions and sociodemographic sectors. For example, drug use/abuse is generally a male rather than female phenomenon and occurs in urban rather than rural areas. The non-medical use of over-the-counter and prescription medication, however, tends to be a female rather than male phenomenon.

DRUG CULTIVATION AND PRODUCTION

Worldwide, and in developing countries in particular, there is a paucity of comprehensive and reliable data on the cultivation and production of illicit drugs. The 2009 *World Drug Report* (United Nations Office on Drugs and Crime, 2009:9), for example, notes that illicit drug “markets are clandestine, and tracking changes requires the use of a variety of estimation techniques. Data are sparse, particularly in the developing world, and the level of uncertainty in many matters is high.”

However, based on (1) information provided by the Directorate of Priority Crime Investigation (DPCI) of the South African Police Service (SAPS), (2) data published in the *World Drug Report 2009* (United Nations Office on Drugs and Crime, 2009) and (3) the UNODC’s global assessment of ATS (United Nations Office on Drugs and Crime, 2008), the following can be said about the cultivation and production of illicit drugs in South Africa:

Cannabis: Cannabis is one of two drugs produced in South Africa. Altogether 22% of the world's harvest of cannabis comes from Africa, where it is produced in almost every country. The largest producer is South Africa with about 2 500 metric tons of the total of 8 900 metric tons produced, i.e. 28% of the African production and 7% of the world production. Despite large-scale domestic cultivation of herbal cannabis, the latest vogue is hydroponic cannabis. Several hydroponic cannabis production facilities have been dismantled in the last couple of years.

ATS: Methamphetamine can be made by using a variety of licit precursor chemicals and simple processes. Manufacturing takes place in mega and super laboratories, but more commonly in small kitchen laboratories. This convenience of manufacturing makes ATS the most widespread illicit drug but also the most difficult to determine the total amount produced. The detection of ATS laboratories is also becoming more difficult, as they are run in hard-to-detect spots. During the last estimate there were 35 such laboratories still functioning. The number of such laboratories that were dismantled increased by 55% between 2005 and 2006, with 17 such laboratories reported dismantled in that time and another 15 in 2007/8. It is also important to bear in mind that South Africa is one of the world's largest importers of licit ephedrine and pseudoephedrine, two of the precursor chemicals used to manufacture methamphetamine.

The role of the internet in providing recipes/formulas to manufacture illicit drugs and information on sites offering illicit drugs and precursor chemicals for sale must be addressed in prevention and law enforcement programmes. Unscrupulous drug

traffickers are recruiting their mules/couriers on social networking sites.

PRECURSOR CONTROL

Precursor control is aimed at controlling the manufacture and supply of chemicals used in industry and the production of pharmaceuticals and illicit drugs. Three statutes govern precursor control in South Africa:

Article 12 of the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances;

Section 3 of the Drugs and Drug Trafficking Act (140 of 1992); and

Section 6 of the International Trade Administration Act (71 of 2002), which regulates the import and export of precursor chemicals.

TREATMENT DEMAND

In addition to the earlier outline of the proportions of persons admitted to treatment centres for the abuse of various drugs (other than alcohol) in the period 2008 to 2010, it should be noted that the total number of persons treated for drugs other than alcohol in this period in various provinces were (Dada et al., 2012):

17 820 in the Western Cape;

7 459 in KwaZulu-Natal;

4 601 in the Eastern Cape;

16 962 in Gauteng;

4 288 in the Northern Region (Mpumalanga and Limpopo); and

3 527 in the Central Region (Free State, North West and Northern Cape)

SOCIAL AND ECONOMIC COSTS OF DRUG USE

Figures provided by the SA Revenue Service (SARS) indicate that the known direct cost of illicit drug use in 2005 was roughly R101 000 million.

Based on international data, the social and economic cost of illicit drug and alcohol

abuse can be estimated at approximately 6, 4% of GDP or about R136 380 million per year.

As in the case of alcohol abuse, it is important to bear in mind that the emotional, social and financial costs arising from the abuse of drugs other than alcohol affect not only the abusers themselves, but also other members of their (immediate) families.

LINK BETWEEN DRUG USE AND HIV/AIDS

The prevalence of injecting drug use (IDU) varies considerably around the world, both between and within countries. An estimated 15,9 million people worldwide are injecting drugs and up to 3 million of them are infected with HIV (noted in 2010 by the regional office for Southern Africa of the United Nations Office on Drugs and Crime).

Until recently IDU was thought to be a problem in Asia, America and Europe only, but the data indicate that it is increasing in Africa.

Although South Africa has one of the highest levels of HIV and AIDS infection in the world, the extent of IDU and its relationship to the epidemic have not been researched adequately.

The CDA in collaboration with the UNODC is preparing to determine the extent of the link between HIV and IDU in South Africa.

COMMUNITY NEEDS AND PRIORITIES IN DEALING WITH THE DRUG PROBLEM

As pointed out in previous chapters, the CDA did an RPA of the needs of communities in South Africa with regard to substance abuse. The key findings of the survey component of the RPA are noted below.

Regarding the respondents' level of awareness/knowledge of the substance abuse problem and related issues, the results were as follows:

58% of the respondents indicated that they were aware of the problem;

65% reported that they had a substance user/abuser in their home; and

40% were aware of the support services available to substance users and

abusers.

The respondents were also in more or less agreement that the drugs mostly used in their communities were alcohol and cannabis.

In the opinion of the surveyed community members, and in line with a public health understanding of substance abuse (World Health Organization, 2004b), a combination of environmental and individual oriented factors need to be dealt with in order to combat substance abuse. These factors are, in order of priority:

Better parenting or the development and application of parenting skills and competencies that will enable community members to deal with substance abuse;

Recreation or providing facilities and opportunities for especially the youth so as to occupy the time and resources that might otherwise be devoted to substance abuse;

Tavern closure or a plea, related to the availability of alcohol and drugs, to remove this source of dependence-forming substances;

Law enforcement or the application of policies, laws, protocols and practices designed to reduce the threat of substance abuse;

Spiritual care or the provision of facilities and opportunities for spiritual or religious observance;

Availability or reducing the availability of dependence-forming substances such as alcohol and cannabis;

Knowledge or knowledge of the process of identifying and dealing with the problems of prevention, treatment, aftercare and re-integration with the community of those affected by substance abuse;

Rehabilitation or provision of access to and application of detoxification, rehabilitation, aftercare and re-integration with society for those suffering from substance abuse/dependence;

Influence or the ability to persuade community members to become involved in the process of dealing with substance abuse;

Healthy mind or the ability to resist the temptation to abuse substances, coupled

with the concept of bipolar problems;

Employment or lack thereof; and

Poverty or the lack of adequate means of support.

In an attempt to identify the key strategies and interventions needed to satisfy community needs and priorities, these needs can be grouped into common categories and the results compared to the three elements of the earlier mentioned integrated strategy, i.e. demand reduction, supply reduction and harm reduction. The results are shown in the figure below.

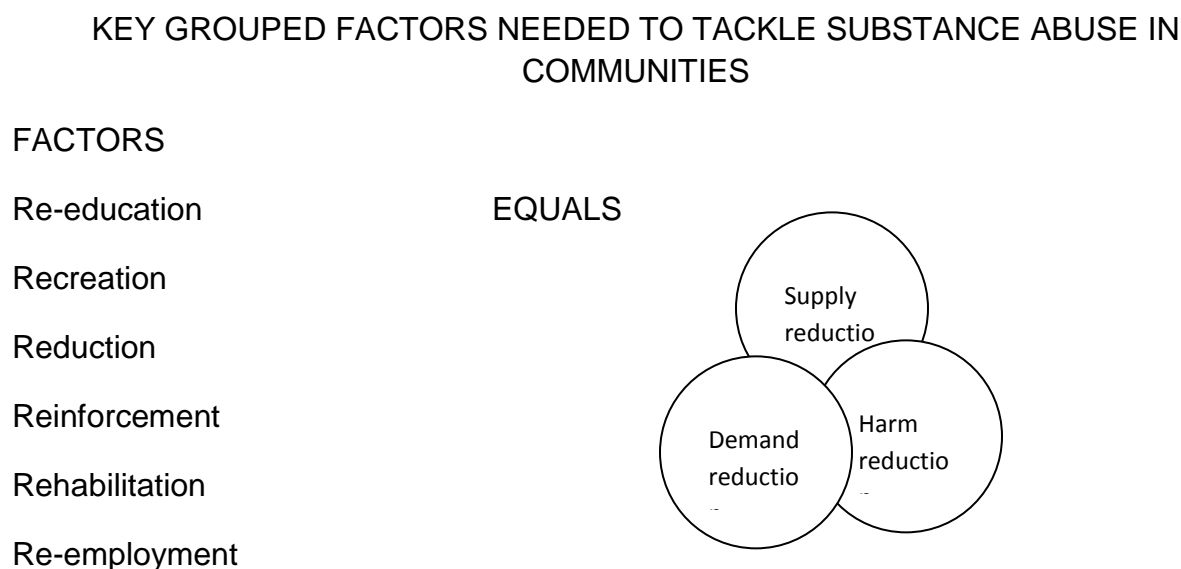


Figure 3: Common categories linked to the integrated strategy

The six common categories are the following:

Re-education towards better parenting, spiritual care, knowledge, influence and a healthy mind

Recreation

Reduction or tavern closure


Re-enforcement or law enforcement to reduce availability

Rehabilitation

Re-employment or increased employment and reduced poverty

Further analysis shows that the six common categories can be grouped into the three elements of the integrated strategy. Re-education and recreation form part of demand reduction; reduction and re-enforcement form part of supply reduction, and rehabilitation and re-employment form part of harm reduction as interpreted in South Africa.

It is thus clear that community needs can be dealt with by the application of the interventions applied in each of the three strategic elements, on condition that they are dealt with in terms of the priorities expressed by the community.



CHAPTER 4: STRATEGIC APPROACHES TO DEALING WITH THE DRUG PROBLEM

EVALUATION OF THE IMPLEMENTATION OF THE NATIONAL DRUG MASTER PLAN 2006 – 2011

The CDA, together with provincial representatives, reviewed the NDMP 2006 – 2011 in September 2010. Several factors emerged that pointed to a need to adapt the NDMP strategy in order to meet the challenges of a changing world drug strategy and associated aspects.

CHANGING WORLD DRUG STRATEGY

For years, the predominant strategy for dealing with the drug problem had been that of supply reduction. However, the UNODC and the WHO recently started advocating its replacement with the strategy of primary prevention, i.e. preventing the onset of substance abuse/dependence and focusing on the general public as well as those at risk of developing substance abuse/dependence (e.g. World Health Organization, 2004b). This shift is linked to the following factors:

- The globalisation of drug use and illicit drug trafficking;

- The trend in certain countries to decriminalise and legalise illicit drugs;

- Changing patterns of use among the user population, including the growth in poly-drug use and in the non-medical use of prescription and over-the-counter medication;

- The development of cheaper, more accessible drugs;

- The recognition of alternative approaches to dealing with potential substance abuse/dependence, highlighted by developments in research on the subject; and

- A growing awareness of the need for localised approaches to the drug problem, i.e. solutions specifically applicable to countries and regions where these approaches are applied or implemented.

CHANGES IN PERCEPTIONS IN SOUTH AFRICA

Over the period of currency of the NDMP 2006 – 2011, similar changes in perceptions were occurring in South Africa. These included:

Substance abuse is often a primary underlying contributor to or cause of bio-psycho-social debility;

Culture and the acceptance of substance use and abuse are linked to each other;

Low quality of life is linked to substance abuse;

Changes in the patterns of substance use and abuse imply a culture change over a long period of time (a generation change cycle);

The NDMP strategy has to be adjusted to address local substance use and abuse tendencies, usage patterns and cultures;

Community-based and community-driven approaches are important in the fight against the substance use and abuse problem; and

Community needs are being met by the achievement of predetermined targets.

DEMAND FOR MEASURABLE ACHIEVEMENT

During the lifecycle of the NDMP 2006 – 2011 it emerged that although the business plan derived from it had been formulated in terms of results to be achieved (impact, outcomes and outputs), the interventions were applied in terms of activities (things to do instead of measurable objectives to be reached). Hence achievement could not be measured.

When the government began to insist on measurable achievements in 2008, the demand for measurement of achievements and the application of standardised monitoring and evaluation increased. However, the NDMP 2006 – 2011 did not provide for this.

IMPLEMENTATION OF THE NDMP

The achievement of NDMP outcomes, outputs and targets requires relevant national and provincial government departments, PSAFs and LDACs to implement the integrated strategy of demand reduction, supply reduction and harm reduction as

stipulated in the NDMP. Ideally, all these elements of the strategy should be described in the national and provincial department DMPs, with each focusing on the mandate of the organisation concerned and the specific problems identified in its area of responsibility. However, the implementation of this process in accordance with departmental mandates created two key weaknesses:

Departments and provinces concentrate on their respective mandates, without necessarily consulting other relevant departments, and produce DMPs that do not necessarily link with those of other departments – the so-called silo effect.

National and provincial department representatives in the CDA and the supporting infrastructure do not always have the necessary expertise in the field of substance abuse to develop effective DMPs.

A third problem was that many of the organisations that form the CDA supporting infrastructure do not submit duly authorised DMPs. This is attributed to the relatively low rank of certain national and provincial department representatives, the resultant relatively low priority given to the drug problem and the inability of the CDA to enforce the application of the process.

IMPACT OF THE CDA STRUCTURE ON THE NDMP 2006 – 2011

During the tenure of the NDMP 2006 – 2011 it became abundantly clear that the CDA structure, the limits placed on its functioning as an authority as envisaged in Act 20 of 1992 as amended, as well as its lack of financial independence severely hampered the achievement of the vision and mission of the NDMP.

A separate report on the findings of an independent study on this aspect was provided by the firm Deloitte and Touché. The recommendations have not been implemented yet.

CHANGES NEEDED IN THE NDMP 2013 – 2017 APPROACH TO THE SUBSTANCE ABUSE PROBLEM

The NDMP 2006 – 2011 review pointed to key changes that had to be made to the new NDMP. These included:

Devising solutions from the bottom up rather than from the top down;

Shifting from a national to a community approach to devising strategy (from one size fits all to a community-specific solution);

Shifting from supply reduction to primary prevention, using a more

comprehensive and integrated overall intervention strategy;

Developing and applying evidence-based solutions wherever possible;

Introducing a monitoring and evaluation (M&E) approach to the formulation of the results to be achieved, i.e. impact, outcomes, outputs and targets;

Aligning the NDMP and national and provincial department drug master plans with an M&E approach;

Applying research and development to meet the predicted needs and future changes in the field of substance abuse;

Reporting in terms of M&E needs instead of activities carried out; and

Extending the reporting base beyond the CDA and its supporting infrastructure to include non-CDA sources and linked databases.

PUBLIC POLICY OPTIONS AND STRATEGIC INTERVENTIONS IN ALCOHOL ABUSE

During the implementation of the NDMP 2006 – 2011 it became apparent that various policies had been applied in dealing with substance abuse, especially regarding the alcohol problem and, to a lesser extent, the abuse of illicit substances.

It also became clear that in certain projects such as placing warning labels on liquor bottles and prevention programmes such as Ke Moja, little or no attempt had been made to measure success. The omission of output measurement in relation to the money spent and the effort put into such projects and programmes not only deny the public and substance users knowledge of their value but can, and in many cases do, lead to fruitless expenditure and effort.

EFFECTIVENESS OF PUBLIC POLICIES ON ALCOHOL

The effects of some 42 public policies that have been used to control alcohol consumption in some parts of the world have been assessed by Babor, Caetano, Casswell, Edwards, Giesbrecht, Graham, Grube, Hill, Holder, Homel, Livingston,

Österberg, Rehm, Room and Rossow (2010a). Some of these policies are similar to those proposed during the 2nd Biennial Anti-Substance Abuse Summit, the contents of which are incorporated with the NDMP 2013 – 2017.

Before the proposed policies can be included in national and provincial department DMPs and plans of action, their effectiveness needs to be considered. In this respect it is useful to take cognisance of Babor et al.'s (2010a) analysis of the effectiveness of various alcohol-related strategies/interventions as noted in the table below.

In reading the descriptions in the table it should be noted that:

The effectiveness of a strategy or intervention is indicated by *, ** or ***, with three asterisks being the highest.

Breadth of research support is indicated in the same way.

As for cross-national testing, 0 means the results have been tested in one country, and *** means the results have been tested in many countries.

Strategy or intervention	Effectiveness	Breadth of research support	Cross-national testing	Comments
Pricing and taxation				How people's consumption is affected
Alcohol taxes	***	***	***	Evaluated on people's consumption
Tax on alcopops or youth-oriented beverages	*	*	*	Evidence that higher prices reduce consumption
Regulating physical availability				Effect on people's consumption
Ban on sales	***	***	***	Effectively reduces consumption but encourages black market
Ban on drinking in public places	?	*	*	Affects young or marginalised high-risk drinkers

Minimum legal age	***	***	**	Effective in reducing traffic accidents but needs enforcement
Restricting hours and days of sale	**	**	***	Effective where hours reduce availability and where late-night violence prevails
Restricting density of outlets	**	***	**	Evidence for both reduction of consumption and problems
Strategy or intervention	Effectiveness	Breadth of research support	Cross-national testing	Comments
Modifying the drinking environment				Staff training, legal liability
Server liability	**	**	*	Effects stronger where liability is publicised
Drinking and driving counter measures				Effect on traffic accidents
Sobriety check points	**	***	***	Typically short-term effects
Random breath testing	***	**	**	Consistent enforcement needed
Lowered BAC limits	***	***	***	The lower the BAC level, the more effective the policy
Admin licence suspension	**	**	**	Effectiveness increased by swift punishment
Low BAC for young drivers (zero tolerance)	***	**	**	Clear evidence of effectiveness for those below legal alcohol purchase age
Restrictions on marketing				Effects of advertising and promotion

Legal restrictions on marketing	*/**	***	**	Evidence of small per capita reduction
Education and persuasion				Effect on onset and drinking problems
Education and persuasion in classrooms	0	***	**	May increase knowledge and change attitudes but no long-term effect on drinking
Mass media campaigns, including drinking and driving campaigns	0	***	**	No evidence of impact of messages on a reduction in drinking
Warning labels and signs	0	*	0	Raise public awareness but do not change drinking behaviour
Treatment and early intervention				Evaluation of period of abstinence
Mandatory treatment of drinking and driving offenders	*	**	0	Punitive and coercive approaches have time-limited effect
Medical and social detoxification	***	**	**	Safe and effective for treating withdrawal symptoms
Pharmaceutical therapies	*	**	**	Consistent evidence of moderate improvement

Table 1: Effectiveness of alcohol policy options

EFFECTIVE ALCOHOL POLICY OPTIONS

Based on the results of the mentioned assessment, illustrated in the table above, the strong policies are those that relate to:

Restrictions on affordability;

Availability;

Accessibility; and

Drinking and driving deterrence measures (Babor et al., 2010a:242).

Of all the policy options, alcohol taxation is rated as one of the strongest and is supported by extensive and convincing research findings. Evidence is also strong for the restriction of physical availability (e.g. reducing the number and density of outlets such as taverns and stores supplying liquor) and limits on hours and days of purchase. Availability theory indicates that consumption increases with increased ease of access to alcohol.

In addition to alcohol taxation and restricting availability, most drinking and driving countermeasures are highly effective if constantly enforced.

PUBLIC POLICY OPTIONS AND STRATEGIC INTERVENTIONS WITH REGARD TO ILLICIT DRUGS AS WELL AS OVER-THE-COUNTER AND PRESCRIPTION MEDICATION

Designing and implementing policies to combat the abuse of drugs other than alcohol is less straightforward than designing and implementing those for alcohol. Furthermore, problems related to drugs other than alcohol, as in the case of alcohol, are unfortunately assumed to have come to stay (Babor, Caulkins, Edwards, Fischer, Foxcroft, Humphreys, Obot, Rehm, Reuter, Room, Rossow & Strang, 2010 b) in some form, no matter what policies are put into practice. (For convenience the term “drug” is used in the following paragraphs in this section as an overarching term for illicit drugs as well as over-the-counter and prescription medication.) Drug problems are inter alia social problems that need to be solved again and again as society changes and as the value system of that society changes.

Drug policy can minimise the damage caused by drugs and influence the type of problem that continues to exist, but it cannot free society completely from drugs (ibid: 252).

As with alcohol policy, various policy options have been tested and evaluated. A selection of policy interventions and conclusions reached about them are presented in the table below.

Intervention	Effectiveness	Research support and cross-national testing	Comments
School, family and community programmes			Target: non-users, casual users, parents and general public
Family/parenting	Some effect in reducing onset	USA only	Some positive findings
Environmental/classroom	Some evidence supporting Good Behaviour Game	Few studies in USA	Some evidence of reduced lifetime drug abuse up to 50%
Social or life skills	Limited evaluation beyond immediate and short-term effect	USA only	Positive results for cannabis and other drugs
Information/knowledge only	None	A few USA school-based studies	Effect sizes small or negligible
Drug testing in schools	No evidence	No research available	Programmes could have negative effects on trust levels
Services to change behaviour			Target: drug users
Methadone maintenance	Good evidence for reduced drug use	Numerous studies in high-income countries	Dosing level and populations treated important
Strategy or intervention	Effectiveness	Breadth of research support	Cross-national testing
Buprenorphine maintenance	Good evidence for reduced drug use	Numerous studies in high-income countries	May reduce overall drug-related mortality

Heroin substitution	Recent limited evidence for effectiveness	Demonstration programmes evaluated in some countries	Potential positive results
Opiate antagonists, e.g. Naltrexone	Some evidence	Few studies outside USA	No evidence of medications' effectiveness
Needle exchange programmes	May reduce HIV-related infections	Most research done in USA, Canada, UK and Australia	May prevent HIV-related infections; no evidence of Hepatitis C reduction
Psycho-social treatment	Good evidence for reducing drug use, problems and criminal activity	Numerous studies in many countries	Often combined with other treatment modalities
Peer self-help/support organisations	Good evidence for reducing drug use, problems, crime and infections	Evidence available from several countries	A very cost-effective way to manage chronic drug users
Naloxone distribution	Minimal good equality evidence	Few studies	May have limited applicability
Brief interventions	Good evidence for reducing drug use	Variety of countries	Evidence available for a variety of substances
Strategy or intervention	Effectiveness	Breadth of research support	Cross-national testing
Supply control interventions			Target: producers or illicit market users
Alternative development	No known correlation with drug use	Qualitative info available	May be counter-productive

Crop eradication	Sometimes noticeable but short-term effect	Qualitative evaluation in Latin American countries	Often results in shift in production area
Precursor chemical control	Good evidence for temporary disruption in drug market	Several studies	Low implementation cost but high enforcement cost
Imprisonment	Some evidence of diminishing returns	Few investigations	High prison management costs
Criminalisation and decriminalisation			Target: drug users, especially cannabis users
Shifting between criminalisation and other penalties	Modest or no effect on cannabis users	Several studies	Some benefits to criminal justice system
Changing the level of criminal penalties	Moderate or no effect on cannabis users	Contested literature studies	Some benefits to criminal justice system
Switching between diversion and legalisation	Circumstantial evidence of effect of Dutch system	No controlled research	Contested results
Regulatory interventions			Target: medically inadvisable use or changing prescribing behaviour of doctors or selling by pharmacologists
Restrict over-the-counter sales	Conflicting results	Mostly USA	Some evidence on pain killers
Prescription requirements	Support for some effect	Only one study on psychoactive substances	Varying effects on sales

Prescription restrictions, registers and monitoring	Reduced prescription of targeted drugs	Many studies	Harmful substitution may result
Intervention	Effectiveness	Research support and cross-national testing	Comments
Control of opiate substitution therapy	Some reduction of overdosing	Several countries	Some evidence for reduced diversion

Table 2: Effectiveness of drug policy options: illicit drugs and over-the-counter/prescription medication

EFFECTIVE DRUG POLICY OPTIONS

Science is unable to forecast confidently the precise effects of many drug policies, i.e. there is no known policy or set of policies that are conclusively effective. However, there is some consensus about the following conclusions on drug policy options (Babor et al., 2010b) that can be used to guide policymakers:

No single effective drug policy: The drug problem differs within or across societies, and no single policy will solve "the drug problem".

Drug policies have unintended consequences: Many policies that affect drug problems are not considered drug policy, and many specific drug policies have large (and sometimes unintended) effects outside the drug domain.

Crop destruction does not reduce supply: Efforts by wealthy countries to curtail cultivation of drug-producing plants in poor countries have not reduced aggregate drug supply or use in downstream markets, and probably never will.

Increased punishment yields little benefit: Once a drug is made illegal, there is a point beyond which increases in enforcement and incarceration yield little added benefit.

Evidence-based services reduce drug-related problems: Substantial investments in evidence-based services for opiate-dependent individuals usually reduce drug-related problems.

Prevention programmes have a modest impact: School, family and community

prevention programmes have a collectively modest impact, the value of which is appraised differently by different stakeholders.

False assumptions mislead policymakers: The drug policy debate is dominated in many countries by the following assumptions that can mislead policymakers about the range of legitimate options and their expected impacts:

Law enforcement and health services/social development approaches are separate and exclusive approaches. Correction: Each makes significant contributions to the other's allegedly exclusive mission, and both are viable and supportive approaches.

The services that target drug use (prevention, treatment, aftercare and re-integration with society) and those that target the damage or harm caused by drug use are distinct. Correction: Where "harm reduction" services are offered, some users become abstainers, and where only abstinence-oriented services are supported, some service users attain non-abstinence outcomes that reduce harm.

"Good drugs" (those legally available or prescribed) can be clearly distinguished from "bad drugs" (those that are neither). Correction: This is a simplistic distinction, as can be seen from the effects of tobacco and cannabis on health and the increasing non-medical use of prescription and over-the-counter medication.

A compromise must be reached between investing in services for heavy drug users (detoxification, treatment and aftercare) and services for the rest of society. Correction: This is an overstatement. For example, treatment centres for substance abuse may benefit not only their own service users but also prevent HIV infections among other people because of stopping the spread of the disease at one of its sources.

Unintended and perverse consequences of drug policy are prevalent.

The legal pharmaceutical system affects the range of policies available: The legal pharmaceutical system can affect the shape of a country's drug problem and its range of available policy options.

Guidance from scientific research is limited: There is virtually no scientific research to guide the improvement of supply control and law enforcement efforts.

EVIDENCE-BASED POLICIES AND PRACTICES

Although most scientific research has policy implications it was not until the 1970s that scientific investigators began to evaluate systematically specific prevention, treatment and enforcement policies in the field of illicit psychoactive substances/drugs (Babor et al., 2010b:8). The scientific studies carried out to evaluate the latter policies since then can be grouped into three broad types of evaluations:

Natural experiments or studies of variations in environmental forces and their effects on changes in drug use or consequences within a particular population;

Efficacy studies or evaluations of interventions with appropriate comparison groups to account for natural changes over time; and

Effectiveness research, or the study of the effectiveness of a particular intervention in natural settings.

In addition to these general types of evaluations, researchers have also investigated the effects of policies through various historical, economic, sociological and ethnographic analyses (ibid.). Given the extent of research on the drug problem, evidence-based (or evidence-informed) approaches to the development of drug policy can and should be the primary basis on which policies are selected and applied.

However, other processes can, do and should also affect the choice of policies applied in any particular case. In addition to evidence-based policies, it is also necessary to consider concurrently democratic processes, religious or spiritual values, cultural norms and social traditions before selecting a particular policy or policies.

DEMAND REDUCTION STRATEGY

As noted in Chapter 2, demand reduction is one of the recognised strategies commonly used in combating the substance abuse/drug problem and is also applied in the NDMP 2013 – 2017. The more specific manner in which it is viewed and applied in the NDMP 2013 – 2017 is discussed in the following paragraphs.

DEMAND REDUCTION OUTCOMES

The demand reduction strategy is aimed at preventing the onset of substance abuse/dependence, and eliminating or reducing the effect of conditions conducive to the use of dependence-forming substances. The actions that are used to implement the demand reduction policy are such that changes may only produce permanent results if applied over a long period of time.

In applying the interventions their effectiveness as indicated in the previous section on alcohol and drug policies, and on evidence-based policy should be taken into account.

DEMAND REDUCTION INTERVENTIONS

Demand reduction interventions require the application of one or more of the five accepted methods contained in the social development approach to social problem solving (Patel, 2006; Van Rooyen, 2003). These methods, their purpose and examples of their application are the following:

Poverty reduction: Aimed at reducing poverty in identified families and communities. Interventions could include:

Providing social relief and social assistance to reduce the need for drug-related crime, violence and employment;

Creating jobs to ensure legal, sustainable employment; and

Running income generation projects with the same purpose.

Development: Aimed at developing the competency of individuals, families and communities to deal with drug-related social problems. Interventions could include:

Running prevention programmes encompassing outreach and awareness;

Providing and encouraging role-modelling of individuals who encourage

resistance to drug use (e.g. the Ambassadors Programme of the Ké Moja campaign);

Presenting peer and lay counselling on the prevention, identification and treatment of drug-related problems;

Applying self-help techniques to avoid or to deal with drug-related social problems;

Creating community and youth services to counter the effects of drug-related problems;

Creating family and community networks to provide support to individuals and families with drug-related problems; and

Providing early intervention to enable those at risk to stay within the family or community.

Education and communication: Designed to broaden the knowledge base of individuals, families and communities faced with drug-related problems as a prerequisite for empowering them to deal with these problems. Interventions could include:

Running prevention programmes aimed at specific communities and groups within communities;

Creating and staffing advice offices or links to the national database, national clearing house and call centre helpline;

Presenting educational programmes on the prevention of drug problems such as the Ke Moja drug advice programme, the various programmes presented by the SA Police Service (SAPS) and the life skills programme presented by the national Department of Basic Education and provincial educational authorities; and

Using community theatre and storytelling to combat drug use and abuse.

Social policy application: Development and application of social policy to address the needs of the community in combating drug use and abuse. Interventions could include:

Using action research to develop and apply new ways of dealing with the drug

problem;

Applying existing policy on early intervention in and prevention and treatment of drug problems and societal re-integration of drug users and dependents;

Developing policy to deal with aspects such as prevention and aftercare using, for example, the models of prevention and aftercare developed by the national Department of Social Development;

Monitoring and evaluating the effectiveness of social development interventions when dealing with drug-related problems.

Advocacy: Using the experiences of families and communities to ensure systematic changes to policies relevant to the drug problem. Interventions could include:

Increasing the knowledge base of communities to enable them to make meaningful contributions to drug-related policy and practice;

Organising campaigns against the location of facilities that could negatively affect the battle against drugs, for example the placing and licensing of taverns close to schools and the identification of drug dealers and corrupt public officials;

Changing communication patterns to limit the exposure of susceptible persons to advertisements and programmes that exhort the use of dependence-forming substances.

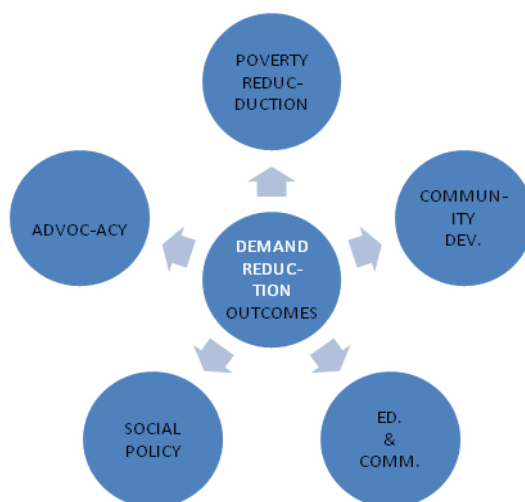


Figure 4: Demand reduction interventions

MEASURES OF SUCCESS OR ACHIEVEMENT IN DEMAND REDUCTION

Success in demand reduction is measured by the success achieved in reducing the demand for and therefore the consumption of illicit drugs, licit and illicit alcohol and selected other drugs, with emphasis on the particular individuals, groups and areas targeted by the programmes developed to implement the primary interventions. Demand reduction data are required to quantify:

Trends in consumption of specified drugs;

Resistance of defined population groups to starting to take specified drugs;

Trends in the growth and success of community interventions to counter drug use;

Trends in the effectiveness of social policies developed to combat drug use; and

Trends in the effectiveness of the application of social policy to combat drug use.

Note that the number and spread of the **activities** or interventions used are not a measure of the success of the interventions. For example, reaching 5 000 pupils in 250 schools is not a measure of the success of an intervention or programme aimed at increasing the resistance of pupils to experiment with drugs. Rather, the success of the programme should be measured by the number of pupils in a given population who do not take drugs, compared to a population who had not experienced the programme.

SUPPLY REDUCTION STRATEGY

SUPPLY REDUCTION INTERVENTIONS

As pointed out in Chapter 2, supply reduction is one of the strategies applied in the NDMP 2013– 2017. Supply reduction interventions entail reducing the supply of drugs (e.g. illicit drugs and alcohol) by inter alia:

Controlling the distribution of and access to raw drugs and precursor materials;

Controlling the production, manufacture, sale, distribution and trafficking of drugs, precursor materials and manufacturing facilities;

Seizing and destroying precursor materials, raw materials and products, refined drugs, production, manufacturing and distribution facilities, and resources;

Taking legal action on the use, abuse, production, manufacture, marketing, distribution and trafficking of precursor materials, raw materials and products, refined drugs, manufacturing and distribution and facilities, and resources.

SUPPLY REDUCTION OUTCOMES

Supply reduction outcomes include the following:

Improved control over distribution of and access to raw drugs and precursor materials;

Improved control over production, manufacture, sale, distribution and trafficking of drugs, precursor materials and manufacturing facilities;

Increased seizure and destruction of precursor materials, raw materials and products, refined drugs, production, manufacturing and distribution facilities, and resources;

Reduced drug-related crime, especially with respect to the use (e.g. driving under the influence; use in prohibited areas such as prisons, schools, etc.), abuse, and production, manufacture and distribution (dealers, factories, etc.); and

Increased successful prosecutions for offences relating to use, abuse, etc. in contravention of existing legislation.



Figure 5: Supply reduction outcomes

MEASURES OF SUCCESS OR ACHIEVEMENT IN SUPPLY REDUCTION

Achieving the required results calls for measures of success, achievement or "impact" against which the CDA can assess performance using data such as those listed below. In order to produce visible outcomes and successes in the short term (essential for acceptance and long-term viability), supply reduction should measure the effects or impact of:

Trends in the world drug market and the South African market for specified illicit drugs, licit and illicit alcohol and selected other drugs;

Production and sources of specified illicit drugs, licit and illicit alcohol and selected other drugs in the same markets;

Seizures of specified illicit drugs, licit and illicit alcohol, selected other drugs, precursor materials and production or manufacturing facilities in the same markets;

Prices of the specified illicit drugs, licit and illicit alcohol, selected other drugs and precursor materials in the same markets;

Purity data on the specified illicit drugs, licit and illicit alcohol and selected other drugs in the same markets;

Consumption of the specified illicit drugs, licit and illicit alcohol and selected other drugs in the same markets, with emphasis on the South African market per province and region;

Trafficking in the specified illicit drugs and selected other drugs, with emphasis on the South African market per province and region;

Control of the distribution and sale of and access to the specified illicit drugs, licit and illicit alcohol, selected other drugs and precursor materials, with emphasis on the South African market per province and region;

Legal action taken to curb production, consumption and distribution of the specified illicit drugs, licit and illicit alcohol, selected other drugs and precursor materials, with emphasis on the South African market per province and region.

HARM REDUCTION STRATEGY

HARM REDUCTION VERSUS HARM PREVENTION

It has been suggested in South Africa that the term "harm reduction" should be replaced by the term "harm prevention" or a similar term. Although this has not been debated publicly, it has been debated at CDA meetings. The debate is based on the view that harm reduction practices appear to condone drug use and that in medical terms the action taken should be seen to be preventative.

In the light of the UNODC discussion in this regard, and the use by the UNODC of the term "harm reduction", the CDA has decided to use this term in the interim.

The term and its meaning are, however, still under discussion, and unravelling the issues concerned will form part of the activities of the CDA in the 2013 – 2017 term of office.

HARM REDUCTION INTERVENTIONS

As pointed out in Chapter 2, and as the term implies, harm reduction focuses on limiting or ameliorating the damage caused to individuals or communities who have already succumbed to the temptation of substances. This can be achieved, for example, by treatment, aftercare and re-integration of substance dependents with society.

Indeed, some harm will accrue to users of drugs and to their families and friends, the so-called "co-dependents", and to society at large despite efforts to reduce the supply of and demand for drugs.

In addition, primary prevention and treatment programmes also entail harm reduction, as they reduce and prevent the harmful effects of the use of alcohol and other drugs.

Guided by the Inter-Ministerial Committee on combating Substance Abuse and together with the Department of Social Development, the CDA will develop national policy on the implementation of harm reduction interventions in its 2013 – 2017 term of office.

THE CLUSTER CONCEPT

In the legislation governing the formation and functioning of the CDA, it is assumed that by appointing representatives of certain key departments, and by their serving together with the 13 experts appointed in terms of that same legislation, the outcomes, outputs and activities of those members will result in the co-ordination of the achievements of the whole. In practice, however, co-ordination does not occur. This lack of co-ordination is attributed to reporting by national department representatives to the CDA as well as to the heads of their departments. It has resulted in the following failings:

National and provincial department DMPs not being completed and approved in accordance with the timetable;

National and provincial department DMPs not being integrated with each other, and reflecting the parochial opinion of a single entity; and

With the CDA structure reflecting this silo mentality, a series of actions occur that reinforce the "national department first" or the "provincial department first" to the detriment of the achievement of the NDMP outcomes.

At the initiative of the CDA, an Inter-Ministerial Committee (IMC) was formed to

overcome this problem if possible. However, to some extent the problem still exists. In order to overcome it, the CDA has adopted the "cluster concept" by which national department representatives on the CDA act in concert with one another in a manner and grouping similar to that of the "clusters" used by government in the overall management of its programmes.

The seven technical clusters concerned are:

Infrastructure and Development

Economy and Employment

Human Development

Social Protection and Community Development

Justice, Crime Prevention and Security

Governance and Administration

International Co-operation and Security

THE COMMUNITY NEEDS CONCEPT

As indicated in the section "Evidence-based interventions", policies for dealing with substance abuse are usually based on scientific evidence of their effectiveness. These evidence-based policies are usually tempered with the needs of the community.

To identify community needs, and as part of a process of reviewing the NDMP 2006 – 2011 (see Chapter 2), the CDA carried out an RPA and held provincial summits as well as the 2nd Biennial Anti-Substance Abuse Summit, from which arose 34 resolutions representing community needs in combating substance abuse.

These needs were then combined into a series of outcomes to be achieved during the term of the NDMP 2013 – 2017 and linked to the 12 outcomes selected by government for priority attention by national and provincial departments.

CHAPTER 5: THE NATIONAL DRUG MASTER PLAN 2013 – 2017

THE SOUTH AFRICAN VISION OF A COUNTRY FREE OF SUBSTANCE ABUSE

The CDA is the body authorised in terms of Act 20 of 1992, as amended, and Act 70 of 2008, as amended, to develop an NDMP and to direct, guide, co-ordinate and oversee its implementation as well as to monitor and evaluate the achievements of the NDMP and to make such amendments to the plan as are necessary for success.

In analysing the substance abuse challenges facing South Africa, the CDA identified a country free of substance abuse as the ultimate goal. The delegates at the 2nd Biennial Anti-Substance Abuse Summit adopted this goal as the vision for NDMP 2013 – 2017. This vision was also endorsed by all the high-level political figures attending the summit.

THE MISSION OF THE CDA

The mission of the CDA, or that which it must do in order to achieve the vision of a South Africa free of substance abuse, is to direct, guide, co-ordinate, monitor and evaluate the initiatives and efforts of all relevant national and provincial departments, the PSAFs and other stakeholders in their implementation of the NDMP 2013 – 2017.

This means that the CDA must:

- Lead the development of holistic and cost-effective strategies to predict the effects of substance abuse problems in South Africa;

- Direct and co-ordinate the implementation of holistic and cost-effective strategies to combat the substance abuse problems in South Africa;

- Monitor and evaluate the implementation of holistic and cost-effective strategies to combat the substance abuse problems, as implemented by the supporting infrastructure of the CDA and other stakeholders;

- Lead the amendment or adjustment of the holistic and cost-effective strategies as evaluated, so as to combat the identified substance abuse problems more effectively; and

- Report progress in dealing with the substance abuse problems to the appropriate

authorities and stakeholders.

THE PLAN OF ACTION AND OUTCOMES APPROACH

As part of Cabinet's planning and decision-making, a new planning cycle has been introduced. This is based on the *Basic Concepts of Monitoring and Evaluation* guide produced by the Public Service Commission in February 2008 (Public Service Commission, 2008). The process requires that all planning take into account the logic model that requires planners to apply an analytical method to break down a programme into logical components to facilitate its evaluation. This model includes the promotion of good monitoring and evaluation practices by government as guided by the Presidency and the Department of Performance Monitoring and Evaluation.

To quote the author above (ibid: 43):

"The logic model helps to clarify the objectives of any project, programme or policy. It aids in the identification of the expected causal links – the "programme logic" – in the following results chain: inputs, process, outputs (including coverage or "reach" across beneficiary groups), outcomes and impact."

The aspects of the programme logic are the following:

Inputs: All the resources that contribute to production and delivery of outputs. Inputs are what we use for doing the work. They include finances, personnel, equipment and buildings.

Activities: The processes or actions that use a range of inputs to produce the desired outputs and ultimately outcomes. In essence, activities describe what we do.

Objectives: The measurable descriptions of the aim or purpose of an activity.

Outputs: The final products or goods and services produced for delivery. Outputs may be defined as what we produce or deliver.

Outcomes: The medium-term results for specific beneficiaries, which results are a logical consequence of achieving specific outputs. Outcomes should relate clearly to an institution's strategic goals and objectives as set out in its plans. Outcomes are what we wish to achieve.

Impact: The results of achieving specific outcomes, such as becoming a country

free of substance abuse.

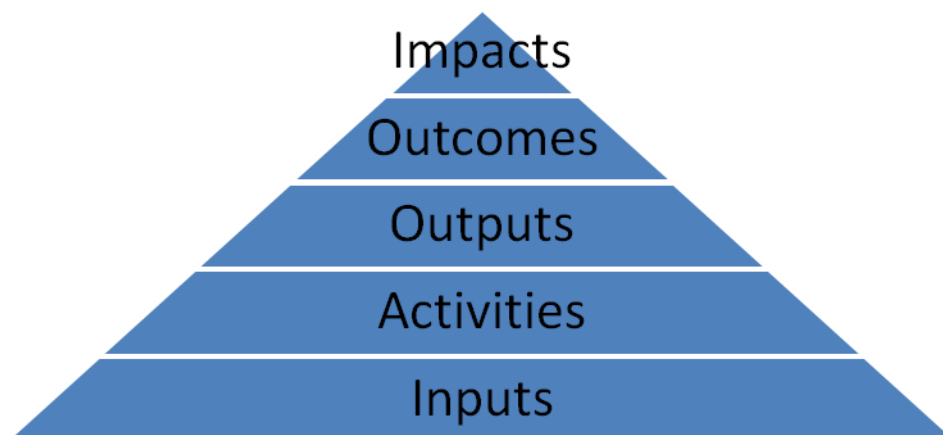


Figure 6: The components of the logic model

THE DESIRED IMPACT OF THE NDMP 2013 – 2017

The desired impact of the NDMP 2013 – 2017 is a South Africa free of substance abuse. This entails the following:

South Africans who have the knowledge, skills and attitudes needed to combat the substance abuse problems;

South Africans who have a value system in terms of which they reject out of hand the use dependence-forming substances;

A strategic approach to substance abuse that involves prevention, treatment, aftercare and re-integration with society as a means of enabling the population to deal with the problem;

A strategic approach that involves the balanced integration of demand reduction, supply reduction and harm reduction; and

A measured level of substance abuse in the country that is less than that of generally accepted international norms, and tends to decrease annually until the country is free of substance abuse.

IMPACT RELATED TO COMMUNITY NEEDS AND RESOLUTIONS

Altogether 34 resolutions arose from the 2nd Biennial Anti-Substance Abuse Summit. These resolutions were compared with the 12 needs expressed by community members in the RPA discussed earlier, and the resolutions and the needs together were linked to the three elements of the integrated strategy (demand, supply and harm reduction). The results of these comparisons appear in the table below and indicate the impact and outcomes required of the NDMP in this respect.

Resolution	Content	Community need	Strategic element
1	Laws and policies on alcohol	Re-enforcement	Demand reduction
2	Structure and mandate of CDA	Re-enforcement	Integration
3	Reducing accessibility of alcohol	Reduction	Supply reduction
4	Reduction of alcohol sales	Reduction	Supply reduction
5	Reduction of liquor outlets	Reduction	Supply reduction
6	Control of home brews and concoctions	Reduction	Supply reduction
7	Raising duties and taxes on alcohol products	Reduction	Supply reduction
8	Health and safety requirements on premises selling liquor	Reduction	Supply reduction
9	Alcohol containers	Reduction	Supply reduction
10	Increasing criminal liability	Re-enforcement	Supply reduction
11	Mandatory contribution by industry	Reduction	Harm reduction
12	Information campaigns	Re-education	Demand reduction

13	Equal access to resources	Recreation	Demand reduction/harm reduction
14	Stemming of drug problem	Re-enforcement	Demand reduction
15	Effective deterrent for offenders	Re-enforcement	Demand reduction
16	Trafficking in persons	Re-enforcement	Demand reduction/supply reduction
17	Smuggling by migrants	Re-enforcement	Demand/supply reduction
18	Drug trafficking legislation	Re-enforcement	Demand/supply reduction
19	Seizure of proceeds of crime	Re-enforcement	Supply reduction
20	Role definitions of SAPS, SARS, NPA and Dept. of Justice	Re-enforcement	Demand/supply reduction
21	Advertising alcohol, etc.	Reduction	Demand reduction
22	Banning sponsorships	Reduction	Demand reduction
23	Continuum of care	Reduction	Demand/harm reduction
24	Prevention programmes	Reduction	Demand reduction
25	Strengthening of aftercare services	Reduction	Harm reduction
26	Cross-disciplinary prevention	Re-education	Demand reduction
27	Public advocacy	Re-education	Demand reduction/harm reduction

28	Integrated diagnosis, treatment and funding of co-occurring disorders	Rehabilitation	Harm reduction
29	SA definition of harm reduction	Re-education	Harm reduction
30	Provision of rehabilitation and aftercare	Rehabilitation	Harm reduction
31	Reduction of legal alcohol driving limit	Reduction	Demand reduction
32	Zero alcohol for novice drivers	Reduction	Demand/harm reduction
33	Prevention and countering of substance abuse in public service	Reduction/re-education	Demand/harm reduction
34	Alcohol-free public service functions	Re-education/reduction	Demand/harm reduction

Table 3: Resolutions linked to the integrated strategy

PRIORITY AREAS AND APPROACHES

The substance abuse problems identified in the NDMP reflect the following priorities for attention and action by national and provincial departments and should be incorporated with and appear in their respective DMPs.

Target populations

The youth

Vulnerable groups, including women and children

Families in all their manifestations (including child-headed families)

Communities

Key populations as defined by UNODC policy

Occupational groups at risk

Priority areas

Crime and violence related to substance abuse

Substance use, abuse and dependence problems related to national and provincial department mandates

Providing target populations with access to prevention, treatment and aftercare, and re-integrating them with society

Legislation, policies and protocols across the spectrum of alcohol and drug supply

Monitoring and evaluation

Community development

Futures research and predictions in the alcohol and drug field

Research and information dissemination

Professional education and training on substance abuse and related illnesses (capacity building)

International policy issues and networking

Strategic approaches

Integrated approach (demand, supply and harm reduction)

Working in defined organisational clusters in order to integrate the implementation of strategies

Delivering measurable outcomes at the level of local communities, regions and provinces and at national level

Delivering measurable outcomes in the short, medium and long term as required by the NDMP

GOVERNMENT OUTCOMES VIS-À-VIS SPECIFIC NDMP OUTCOMES

The 12 outcomes of government as expressed in the Programme of Action are:

Quality basic education

A long and healthy life for all South Africans

All people in South Africa being and feeling safe

Decent employment through inclusive economic growth

Skilled and capable workforce to support an inclusive growth path

An efficient, competitive and responsive economic structure

Vibrant, equitable, sustainable rural communities contributing towards food security for all

Sustainable human settlements and improved quality of household life

Responsive, accountable, effective and efficient local government

Protection and enhancement of our environmental assets and natural resources

Creation of a better South Africa, a better Africa and a better world

An efficient, effective and development-oriented public service and an empowered, fair and inclusive citizenship

From the above government outcomes, the following are considered relevant to the NDMP 2013 – 2017:

A long and healthy life for all South Africans;

All people in South Africa being and feeling safe; and

Suitable human settlements and improved quality of household life.

The key NDMP outcomes aligned to the government outcomes are listed below, and include those derived from a review of the NDMP 2006 – 2011, the resolutions of the 2nd Biennial Anti-Substance Abuse Summit and relevant international resolutions.

1. Reduction of the bio-socio-economic impact of substance abuse and related illnesses on the South African population
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2. Ability of all people in South Africa to deal with problems related to substance abuse within communities
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3. Recreational facilities and diversion programmes that prevent vulnerable populations from becoming substance dependents
4. Reduced availability of substance dependence-forming drugs and alcoholic beverages
5. Development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders and for funding such diagnosis and treatment
6. Harmonisation and enforcement of laws and policies to facilitate effective governance of the alcohol and drug supply chain
7. Creation of job opportunities in the field of combating substance abuse

Table 4: Key outcomes of the NDMP 2013 – 2017

The NDMP provides the means for harnessing existing resources to achieve the key NDMP outcomes. The NDMP requires national and provincial government departments to plan for and deal with substance abuse problems as part of their normal planning and budgeting. These operational plans are captured in the national and provincial department DMPs that must be submitted to the CDA at the beginning of each financial year. The CDA must continuously monitor and evaluate the implementation of these plans as described in the CDA's mission.

At quarterly intervals and at the end of each financial year, national and provincial departments must submit reports to the CDA on the outcomes they achieved. These reports are incorporated with the CDA's annual report to Parliament.

SPECIFIC NDMP OUTCOMES AND DEPARTMENTAL CLUSTERS

Specific NDMP outcomes have been derived from the key substance abuse outcomes and priority areas. These are to be achieved by the CDA and its supporting infrastructure (national and provincial government departments together with the PSAFs, LDACs and other stakeholders).

Implicit in the interpretation of, planning for and implementation of the specific NDMP outcomes is the need for the various role players to integrate their planning and implementation in terms of effective clusters of national and provincial departments, emulating the clusters used by government in executing its policies. For example, the

departments can be clustered in terms of:

Economic sectors and employment:

Department of Trade and Industry

Department of Labour

Financial Intelligence Centre

Department of Transport

Business and industrial representatives

South African Revenue Service

Human development:

Department of Arts and Culture

Departments of Basic and Higher Education

Department of Health

Medicines Control Council

National Youth Development Agency

Department of Sport and Recreation

Research institutes and universities

Civil society

Non-governmental organisations

Treatment centres

Accredited addiction counsellors

Provincial substance abuse forums

Social protection and community development:

Department of Social Development

Department of Home Affairs

Justice, crime prevention and security:

Department of Justice and Constitutional Development

Department of Correctional Services

South African Revenue Service

South African Police Service

Department of Social Development

Department of Home Affairs

International co-ordination and security:

Department of International Relations and Co-operation

Department of Justice and Constitutional Development

South African Police Service

South African Revenue Service

Department of Home Affairs

NDMP-SPECIFIC OUTCOMES AND NATIONAL AND PROVINCIAL DEPARTMENT OUTPUTS

The table below contains the outcomes of the NDMP, showing the link between them and those of the government, together with indicators of achievement, baseline data (including the resolutions of the aforementioned summit), suggested targets and functional areas, i.e. those departments and other stakeholders who would be expected to achieve them.

Government outcomes	NDMP outcomes	Outcome indicators	Baseline	Target by 2017	Areas
A long and healthy life for all South Africans	1. Reduction of bio-psycho-social and economic impact of substance abuse and related debility on the South African population	Percentage reduction of the bio-socio-economic impact of substance abuse on the South African population	CDA Annual Report Research report on drug situation in South Africa	10% reduction	National and provincial departments represented on the CDA
All people in South Africa being and feeling safe	2. All people in South Africa being able to deal with problems related to substance abuse within communities	Percentage increase in members of communities able to apply parenting skills, knowledge of substance abuse and life skills to influence a reduction in problems resulting from substance abuse	2 nd Biennial Summit Report (Re-education category) Resolutions 12, 24, 26, 27, 29, 33, 34	10% increase in relevant knowledge and skills 10% reduction in problems resulting from substance abuse	National and provincial departments, PSAFs and LDACs, NGOs and communities
Sustainable human settlement and improved quality of household life	3. Recreational facilities and diversion programmes preventing vulnerable populations from becoming substance dependents	Number of vulnerable people frequenting outlets for dependence-forming substances	Reports (CDA and supporting infrastructure) Resolution 13	10% reduction in vulnerable populations becoming substance dependent	National and provincial departments, PSAFs, LDACs, NGOs and communities, particularly Sport and

					Recreation
Sustainable human settlement and improved quality of household life	4. Reduction of the availability of alcoholic beverages and other dependence-forming substances	Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; the frequency of use and consumption by defined populations (e.g. under-aged persons, drivers, public servants, etc.)	Reports of DTI, SAPS, SARS, Dept of Justice Resolutions 3, 4, 5, 6, 7, 8, 9, 11, 21, 22, 31, 32	10% reduction in availability/consumption of alcoholic beverages	National and provincial departments, PSAFs, LDACs, NGOs and communities
Sustainable human settlement and improved quality of household life	5. Development and implementation of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis, treatment and funding of substance dependence and co-occurring disorders	Percentage of prevention, treatment and aftercare policies, practices and protocols that apply an integrated approach to substance dependence treatment	SACENDU and Ministry of Health data Resolutions 23, 25, 28, 30	10% increase in the application of and integrated approach to substance abuse dependence treatment	DSD, DOH and registered treatment centres
All people in South Africa being and feeling safe	6. Harmonisation and enforcement of laws and policies that facilitate effective governance of the alcohol and drug supply chain	Regulatory framework applicable across all provinces and municipalities in accordance with summit resolutions	Available legislation and enforcement as agreed upon by IMC and CDA Resolutions 1, 2, 10, 14, 15,	75% of legislation harmonised and enforced	SAPS, SARS, Dept. of Justice, DTI, DSD

			16, 17, 18, 19, 20		
Sustainable human settlement and improved household life	7. Creation of job opportunities in the field of combating substance abuse	Percentage increase in persons employed in the substance abuse field	Employment data from the report provided by the Department of Labour's door-to-door report	10% increase in jobs created	Department of Labour

Table 5: NDMP outcomes and national/provincial government departments' outputs

NATIONAL AND PROVINCIAL DEPARTMENT DRUG MASTER PLANS

The above table shows that the specific NDMP outcomes each contain a number of resolutions. As they are grouped, these resolutions become the specific outputs that form the nucleus of their respective national and provincial department DMPs.

It is essential that national and provincial departments jointly include in their DMPs those groups of outcomes that fall within their mandate. Hence certain national and provincial departments will be required to achieve those groups of outcomes and resulting outputs jointly, as indicated in Table 6 below.

SPECIFIC NDMP OUTCOME 1: REDUCED BIO-PSYCHO-SOCIAL AND ECONOMIC IMPACT OF SUBSTANCE ABUSE AND RELATED DEBILITY ON THE SOUTH AFRICAN POPULATION

Activity	Indicator	Baseline	Target	Functional area
Implementation of the resolutions of the 2 nd Biennial Anti-Substance Abuse Summit	Percentage reduction in the bio-socio-economic impact of substance abuse on the South African population by province, region and district	<p>National and provincial department quarterly and annual reports</p> <p>Research report on the nature, extent and impact of substance abuse in South Africa</p>	Not less than 10% per province, region and district	All national and provincial departments

SPECIFIC NDMP OUTCOME 2: ALL PEOPLE IN PROVINCES, REGIONS AND DISTRICTS ABLE TO DEAL WITH PROBLEMS RELATED TO SUBSTANCE ABUSE IN COMMUNITIES

Activity	Indicator	Baseline	Target	Functional area
<p>Resolution 12: Intensified campaigns to educate people about substance abuse</p> <p>Educational campaigns to inform and educate people, in particular young people, about the dangers of alcohol and drug abuse</p>	<p>Resolution 12: Awareness campaigns: number of people reached, results of random testing of dealing with problems of substance abuse</p>	<p>Quarterly and annual reports of national and provincial departments</p> <p>Research report on the nature, extent and impact of substance abuse in South Africa</p>	<p>Not less than 10% per province, region and district</p>	<p>All national and provincial departments</p>
<p>Resolution 24: Comprehensive prevention programmes</p> <p>Implementation of universal and targeted programmes, such as those covering life skills, Ke Moja and similar programmes</p> <p>Refer also to Appendix 2 for more</p>	<p>Awareness campaigns: number of people reached, results of random testing of dealing with problems of substance abuse</p>	<p>Research report on the nature, extent and impact of substance abuse in South Africa</p> <p>Report required on the impact of Ke</p>	<p>Not less than 10% reduction</p>	<p>All national and provincial departments</p>

information relating to specific programmes.		Moja		
Resolution 26: Multiple approaches to prevention across different disciplines, e.g. youth development programmes, sport and skills development	Awareness campaigns: number of people reached, results of random testing of dealing with problems of substance abuse	Research report on the nature, extent and impact of substance abuse in South Africa	Not less than 10% reduction	All national and provincial departments
Resolution 27: Public advocacy and messaging, e.g. advertising, T-shirt distribution, roadshows, entertainment programmes	Awareness campaigns: number of people reached; results of random testing of dealing with problems of substance abuse	Research report on the nature, extent and impact of substance abuse in South Africa	Acceptance of definition by the CDA and Cabinet by April 2013	CDA
Resolution 29: Definition of and protocols for harm reduction, e.g. research on alternative approaches to harm reduction; consultation with policymakers, communities and stakeholders in the field of substance abuse regarding an acceptable definition	Definition of "harm reduction" accepted by CDA and Cabinet	CDA Annual Report and minutes	At least 75% reduction	All national and provincial departments

<p>Resolution 33: Adopting a policy to prevent and address substance abuse in the public service, e.g. development of policies, legislation, protocols and practices regarding substance abuse, training and development to change public service culture</p>	<p>Percentage reduction of the bio-psycho-social and economic impact of substance abuse on South Africa's public service by province, region and district</p>	<p>Baseline study to be commissioned</p>	<p>At least 75% reduction</p>	<p>All national and provincial departments</p>
<p>Resolution 34: Setting an example to the public by ensuring that all public service functions are alcohol free, e.g. development of policies, legislation, protocols and practices regarding substance abuse, training and development to change public service culture</p>	<p>Percentage reduction in the bio-psycho-social and economic impact of substance abuse on South Africa's public service by province, region and district</p>	<p>Baseline study to be commissioned</p>	<p>At least 75% of functions free of alcohol</p>	<p>All national and provincial departments</p>

SPECIFIC NDMP OUTCOME 3: RECREATIONAL FACILITIES AND DIVERSION PROGRAMMES IN NATIONAL AND PROVINCIAL DEPARTMENTS PREVENTING VULNERABLE POPULATIONS FROM BECOMING SUBSTANCE DEPENDENTS

Activity	Indicator	Baseline	Target	Functional area
Resolution 13: Ensure equal access to resources, especially for civil society and organisations in rural areas, e.g. recreational facilities, sport facilities, diversion programmes, intellectual development programmes, skills development	<p>Number of vulnerable people frequenting outlets for dependence-forming substances</p> <p>Number of facilities created and percentage use by vulnerable populations</p>	<p>Reports (CDA and supporting infrastructure)</p> <p>Resolution 13</p>	10% reduction in vulnerable populations becoming substance dependent	National and provincial departments, PSAFs, LDACs, NGOs and communities, particularly Sport and Recreation South Africa

SPECIFIC NDMP OUTCOME 4: AVAILABILITY OF ALCOHOLIC BEVERAGES AND OTHER DEPENDENCE-FORMING SUBSTANCES REDUCED BY NATIONAL AND PROVINCIAL DEPARTMENTS

Activity	Indicator	Baseline	Target	Functional area
Resolution 3: Reducing accessibility of alcohol through raising the legal age for purchasing and public consumption of alcohol from the age of 18 to the age of 21, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally; developmental programmes relating to changes; assessing effects of changes	Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use and consumption by defined populations (e.g. under-aged persons, drivers, public servants)	Reports of the DTI, SAPS, SARS, Dept. of Justice Resolutions 3, 4, 5, 6, 7, 8, 9, 11, 21, 22, 31, 32	10% reduction in availability of alcoholic beverages and other dependence-forming substances	National and provincial departments, PSAFs, LDACs, NGOs and communities
Resolution 4: Imposing restrictions on the times and days of the week that alcohol can be sold legally, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally; developmental programmes relating to changes; assessing effects of changes	Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use and consumption by	Reports of the DTI, SAPS, SARS, Dept. of Justice Resolutions 3, 4, 5, 6, 7, 8, 9, 11, 21, 22, 31, 32	10% reduction in availability of alcoholic beverages and other dependence-	National and provincial departments, PSAFs, LDACs, NGOs and communities

<p>Resolution 5: Implementing laws and regulations that will reduce the number of liquor outlets including shebeens, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally; developmental programmes relating to changes; assessing effects of changes</p> <p>Resolution 6: Regulating and controlling home brews and concoctions informed by research that also focuses on traditional use in rural areas, e.g. through changing policy,</p>	<p>defined populations (e.g. under-aged persons, drivers, public servants)</p> <p>Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use and consumption by defined populations (e.g. under-aged persons, drivers, public servants)</p> <p>Reduction in the number of sources of alcoholic beverages and other dependence-</p>	<p>Reports of the DTI, SAPS, SARS, Dept. of Justice</p> <p>Resolutions 3, 4, 5, 6, 7, 8, 9, 11, 21, 22, 31, 32</p> <p>Reports of the DTI, SAPS, SARS, Dept. of Justice</p> <p>Resolutions 3, 4, 5, 6,</p>	<p>forming substances</p> <p>10% reduction in availability of alcoholic beverages and other dependence-forming substances</p> <p>10% reduction in availability of</p>	<p>National and provincial departments, PSAFs, LDACs, NGOs and communities</p> <p>National and provincial departments, PSAFs,</p>
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legislation, protocols and practice in a harmonised manner nationally; developmental programmes relating to changes; assessing effects of changes	forming substances; frequency of use and consumption by defined populations (e.g. under-aged persons, drivers, public servants)	7, 8, 9, 11, 21, 22, 31, 32	alcoholic beverages and other dependence-forming substances	LDACs, NGOs and communities
Resolution 7: Raising duties and taxes on alcohol products to deter the purchasing of alcohol, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally; running developmental programmes relating to changes; assessing effects of changes; implementing sliding-scale tariffs commensurate with alcoholic content	Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use and consumption by defined populations (e.g. under-aged persons, drivers, public servants)	<p>Reports of the DTI, SAPS, SARS, Dept. of Justice</p> <p>Resolutions 3, 4, 5, 6, 7, 8, 9, 11, 21, 22, 31, 32</p> <p>Reports of the DTI,</p>	10% reduction in availability of alcoholic beverages and other dependence-forming substances	National and provincial departments, PSAFs, LDACs, NGOs and communities

<p>Resolution 8: Imposing health and safety requirements on premises where liquor will be consumed, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally; running developmental programmes relating to changes; assessing effects of changes; avoiding overcrowding; providing adequate lighting, food and water and taking into account access to public transport and toilet facilities</p>	<p>Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use and consumption by defined populations (e.g. under-aged persons, drivers, public servants)</p>	<p>SAPS, SARS, Dept. of Justice</p> <p>Resolutions 3, 4, 5, 6, 7, 8, 9, 11, 21, 22, 31, 32</p>	<p>10% reduction in availability of alcoholic beverages and other dependence-forming substances</p>	<p>National and provincial departments, PSAFs, LDACs, NGOs and communities</p>
<p>Resolution 9: Prescribing measures for alcohol containers, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally; running developmental programmes relating to changes; assessing effects of changes; form of containers; warning labels; percentage of alcohol content</p>	<p>Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use and consumption by defined populations (e.g. under-aged persons, drivers, public servants)</p>	<p>Reports of the DTI, SAPS, SARS, Dept. of Justice</p> <p>Resolutions 3, 4, 5, 6, 7, 8, 9, 11, 21, 22, 31, 32</p>	<p>10% reduction in availability of alcoholic beverages and other dependence-forming substances</p>	<p>National and provincial departments, PSAFs, LDACs, NGOs and communities</p>

<p>Resolution 11: Imposing a mandatory contribution by the liquor industry (and pharmaceutical and related industries producing dependence-forming substances) to a fund that will be dedicated to work to prevent and treat abuse of alcohol and other substances of abuse, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally; running developmental programmes relating to changes; assessing effects of changes</p>	<p>Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use and consumption by defined populations (e.g. under-aged persons, drivers, public servants)</p>	<p>Reports of the DTI, SAPS, SARS, Dept. of Justice</p> <p>Resolutions 3, 4, 5, 6, 7, 8, 9, 11, 21, 22, 31, 32</p>	<p>10% reduction in availability of alcoholic beverages and other dependence-forming substances</p>	<p>National and provincial departments, PSAFs, LDACs, NGOs and communities</p>
<p>Resolution 21: Immediately implementing current laws and regulations that permit restrictions on the time, locality and content of advertising related to alcohol and other dependence-forming substances, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally;</p>	<p>Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use and consumption by</p>	<p>Reports of the DTI, SAPS, SARS, Dept. of Justice</p> <p>Resolutions 3, 4, 5, 6, 7, 8, 9, 11, 21, 22, 31, 32</p>	<p>10% reduction in availability of alcoholic beverages</p>	<p>National and provincial departments, PSAFs, LDACs, NGOs and</p>

running developmental programmes relating to changes; assessing effects of changes; banning the advertising of such products in the public and private media; not portraying such products as being associated with sport and social and economic status	defined populations (e.g. under-aged persons, drivers, public servants)		and other dependence-forming substances	communities
Resolution 22: Banning all sponsorship of sport, recreation, arts, cultural and related events by the alcohol industry, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally; running developmental programmes relating to changes; assessing effects of changes	Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use and consumption by defined populations (e.g. under-aged persons, drivers, public servants)	Reports of the DTI, SAPS, SARS, Dept. of Justice Resolutions 3, 4, 5, 6, 7, 8, 9, 11, 21, 22, 31, 32	10% reduction in availability of alcoholic beverages and other dependence-forming substances	National and provincial departments, PSAFs, LDACs, NGOs and communities
Resolution 31: Reducing the current legal alcohol limit for drivers, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally; running developmental programmes relating to	Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use	Reports of the DTI, SAPS, SARS, Dept. of Justice, Dept. of Transport/Road Traffic Management Corporation	10% reduction in availability of alcoholic beverages	National and provincial departments, PSAFs, LDACs, NGOs and

changes; assessing effects of changes	and consumption by defined populations (e.g. under-aged persons, drivers, public servants)		and other dependence-forming substances	communities
Resolution 32: Disallowing novice drivers (0-3 years after obtaining a driver's licence) from consuming any alcohol before driving, e.g. through changing policy, legislation, protocols and practice in a harmonised manner nationally; running developmental programmes relating to changes; assessing effects of changes	Reduction in the number of sources of alcoholic beverages and other dependence-forming substances; frequency of use and consumption by defined populations (e.g. under-aged persons, drivers, public servants)	Reports of the DTI, SAPS, SARS, Dept. of Justice, Dept. of Transport/Road Traffic Management Corporation	10% reduction in availability of alcoholic beverages and other dependence-forming substances	National and provincial departments, PSAFs, LDACs, NGOs and communities

SPECIFIC NDMP OUTCOME 5: DEVELOPMENT AND IMPLEMENTATION OF MULTI-DISCIPLINARY AND MULTI-MODAL PROTOCOLS AND PRACTICES FOR INTEGRATED DIAGNOSIS, TREATMENT AND FUNDING OF SUBSTANCE ABUSE/DEPENDENCE AND CO-OCCURRING DISORDERS OCCURRING IN EACH PROVINCE

Activity	Indicator	Baseline	Target	Functional area
Resolution 23: Implementing a continuum of care and public health approach	Percentage of prevention, treatment and aftercare policies, practices and protocols applying an integrated approach to substance dependence treatment	SACENDU and Ministry of Health data Resolutions 23, 25, 28, 30	10% increase in the application of an integrated approach to substance dependence	Relevant national and provincial departments
Resolution 24: Implementing comprehensive prevention programmes including universal and targeted programmes, e.g. life skills, Ke Moja, peer education and similar programmes	Percentage of prevention, treatment and aftercare policies, practices and protocols applying an integrated approach to substance dependence	SACENDU and Ministry of Health data Resolutions 23, 25, 28, 30	10% increase in the number of facilities, and the application of an integrated approach to substance dependence treatment	DSD, DOH and registered treatment centres

	treatment			
Resolution 25: Strengthening aftercare services, e.g. providing for prevention, early detection, treatment and aftercare services; integrating requisite changes through policy, legislation, protocols and practices, with emphasis on children, young people and learners	Increase in the percentage of aftercare facilities, and facilities applying policies, practices, protocols and an integrated approach to substance dependence treatment	SACENDU and Ministry of Health data	10% increase in the number of facilities, and the application of an integrated approach to substance dependence treatment	DSD, DOH and registered treatment centres
Resolution 28: Developing and implementing multi-disciplinary and multi-modal protocols and practices for integrated diagnosis, treatment and funding of co-occurring disorders for adults, youths and children, e.g. providing for prevention, early detection, treatment and aftercare services, and integrating requisite changes through policy, legislation, protocols and practices	Increase in the percentage of multi-disciplinary and multi-modal protocols and practices for integrated diagnosis, treatment and funding of co-occurring disorders for adults, youths	SACENDU and Ministry of Health data Resolutions 23, 25, 28, 30	10% increase in the number of facilities, and the application of an integrated, multi-modal approach to substance abuse dependence treatment	DSD, DOH and registered treatment centres

	and children in place and applied in treatment facilities			
Resolution 30: Increasing the provision of rehabilitation and aftercare, e.g. through providing for prevention, early detection, treatment and aftercare services, and integration of requisite changes through policy, legislation, protocols and practices, with special provision for access by all communities	Increase in the percentage of aftercare facilities, and facilities applying policies, practices, protocols and an integrated approach to substance dependence treatment, and an increase in the treatment offered to and accepted by patients, and the success rate of treatment and aftercare	SACENDU and Ministry of Health data Resolutions 23, 25, 28, 30	10% increase in the number of facilities, and the application of an integrated, multi-modal approach to substance abuse dependence treatment, and number of successful patients	DSD, DOH and registered treatment centres

SPECIFIC NDMP OUTCOME 6: HARMONISATION AND ENFORCEMENT OF LAWS AND POLICIES TO FACILITATE EFFECTIVE GOVERNANCE OF THE ALCOHOL AND DRUG SUPPLY CHAIN PER NATIONAL AND PROVINCIAL DEPARTMENT

Activity	Indicator	Baseline	Target	Functional area
Resolution 1: Harmonise laws and policies to facilitate effective governance of the supply chain for alcohol and other dependence-forming substances with respect to production, sales, distribution, marketing, consumption and taxation; national applicability of regulation guided by principles and proposals accepted in the prevention, treatment, rehabilitation and aftercare domain, and integration with society	A national regulatory framework that is applicable across provinces and municipalities in accordance with summit resolutions	Available legislation and enforcement as agreed upon by the Inter-Ministerial Committee and CDA Resolutions 1, 2, 10, 14, 15, 16, 17, 18, 19, 20	75% of legislation harmonised and enforced	SAPS, SARS, Dept. of Justice, DTI, DSD
Resolution 2: Review the CDA structure and mandate to allow for proper co-ordination and oversight by the CDA as an independent body, e.g. through harmonising laws and policies to facilitate effective governance across the spectrum of government and non-government organisations involved in combating substance abuse; revision of the mandate and structure of the CDA to enable the CDA to give effect to the NDMP; provision of adequate funding to	Revised CDA structure and mandate in place and functioning to the satisfaction of the Minister of Social Development	CDA Annual Report 2009/10 and Deloitte and Touché review of the CDA structure of 2010	100% of approved structure in place and staffed to the satisfaction of the Minister of Social Development	Minister of Social Development

meet the requirements of the CDA and NDMP				
Resolution 10: Increase the criminal and administrative liability of individuals and institutions that sell alcohol and other dependence-forming substances, e.g. through harmonising laws and policies to facilitate effective governance across the supply chain for alcohol and other dependence-forming substances, with special reference to under-age users, intoxicated patrons, vehicle operators and vulnerable persons	<p>A national regulatory framework that is applicable across provinces and municipalities in accordance with summit resolutions</p> <p>Number of individuals held legally liable for transgression of the law</p> <p>Percentage drop in transgressions per year</p>	Social crime prevention report (including prescripts of Parliament)	100% of regulatory framework in place	SAPS, SARS, Dept. of Justice, DTI, DSD
Resolution 14: Set up a cross-departmental operational unit in conjunction with the CDA to implement measures to stem the drug problem, e.g. through implementing the CDA cluster structure; analyse drug problems; ensure implementation of harmonised policies, legislation, protocols and practices developed in terms of Resolution 1; revise CDA Gazette	Revised CDA structure (incorporating a cross-departmental operating unit) and mandate in place and functioning to	CDA Annual Report 2009/10 and Deloitte and Touché review of the CDA structure of 2010	CDA Annual Report 2009/10 and Deloitte and Touché review of the CDA structure of 2010	Minister of Social Development

Regulation 30 accordingly	the satisfaction of the Minister of Social Development			
Resolution 15: Ensure that the criminal justice system becomes an effective deterrent for offenders, e.g. through harmonising laws and policies to facilitate the creation of effective deterrence measures such as harsher punishment and asset seizure	A national regulatory framework that is applicable across provinces and municipalities in accordance with summit resolutions	Available legislation and enforcement as agreed upon by the Inter-Ministerial Committee and CDA	10% increase in successful prosecutions; 10% drop in transgressions	SAPS, SARS, Dept. of Justice, DTI and DSD
Resolution 16: Speed up finalisation and implementation of legislation on trafficking in persons, e.g. through harmonising laws, policies, protocols and practices to facilitate the creation of effective deterrents to human trafficking, such as harsher punishment and asset seizure	A national regulatory framework that is applicable across provinces and municipalities in accordance with summit resolutions	Resolutions 1, 2, 10, 14, 15, 16, 17, 18, 19, 20	100% of legislation in place and functioning to the satisfaction of the Inter-Ministerial Committee; 10% increase in prosecutions; 10% drop in	SAPS, SARS, Dept. of Justice, DTI, DSD

			transgressions	
Resolution 17: Assess the threat and the need to apply harsher punishment and asset seizure for smuggling by migrants as well as the need for adjusting legislative responses, e.g. harmonising laws, policies, protocols and practices to facilitate the creation of effective deterrents to migrant smuggling	A national regulatory framework that is applicable across provinces and municipalities in accordance with summit resolutions	Resolutions 1, 2, 10, 14, 15, 16, 17, 18, 19, 20	100% of legislation in place and functioning to the satisfaction of the Inter-Ministerial Committee; 10% increase in prosecutions; 10% drop in transgressions	SAPS, SARS, Dept. of Justice, DTI, DSD
Resolution 18: Consider extra-territorial jurisdiction to allow for effective interdiction of drug smuggling, e.g. through harmonising laws, policies, protocols and practices extra-territorially to facilitate the creation of effective deterrents to drug smuggling, such as harsher punishment and asset seizure, e.g. increased international co-operation and an integrated, multi-disciplinary, mutually reinforcing and balanced approach in demand and supply reduction strategies, including trafficking in illicit drugs and psychotropic substances, drug	A national regulatory framework that is applicable across provinces and municipalities in accordance with summit resolutions	Resolutions 1, 2, 10, 14, 15, 16, 17, 18, 19, 20	75% of legislation harmonised and enforced	SAPS, SARS, Dept. of Justice, DTI, DSD, DIRCO and Home Affairs

<p>abuse, prevention or diversion of precursors and availability of controlled substances for medical and scientific purposes</p> <p>Exchange information and provide legal assistance mutually</p> <p>Enhance the provision of technical assistance and capacity building aimed at improving efficiency of the AU Action Plan, regional and national plans, programmes and strategies in defined areas</p>				
<p>Resolution 19: Allow for obtaining a preservation order in terms of the Prevention of Organised Crime Act (121 of 1998), e.g. harmonising laws, policies, protocols and practices in this respect to facilitate the creation of effective deterrents, with special reference to the Act and the temporary seizure of the proceeds of crime</p>	<p>A national regulatory framework that is applicable across provinces and municipalities in accordance with summit resolutions</p>	<p>Resolutions 1, 2, 10, 14, 15, 16, 17, 18, 19, 20</p>	<p>75% of legislation harmonised and enforced</p>	<p>SAPS, SARS, Dept. of Justice, DTI, DSD</p>
<p>Resolution 20: Review the International Co-operation in Criminal Matters Act (75 of 1996) so as to define the respective roles of the South African Police Service, National Prosecuting Authority and Department of</p>	<p>A national regulatory framework that is applicable across provinces and</p>	<p>Resolutions 1, 2, 10, 14, 15, 16, 17, 18, 19, 20</p>	<p>75% of legislation harmonised and enforced</p>	<p>SAPS, SARS, Dept. of Justice, DTI, DSD</p>

Justice and Constitutional Development; engage in effective co-operation and practical action in addressing the world drug problem on the basis of common and shared responsibility for: • Increasing international co-operation and following an integrated, multi-disciplinary, mutually reinforcing and balanced approach in demand and supply reduction strategies; • Strengthening mechanisms for co- operation and co-ordination; and • Developing methods to facilitate the exchange of experiences and good practice.	municipalities in accordance with summit resolutions			
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SPECIFIC NDMP OUTCOME 7: CREATE JOB OPPORTUNITIES IN THE FIELD OF COMBATING SUBSTANCE ABUSE IN NATIONAL AND PROVINCIAL DEPARTMENTS

Activity	Indicator	Baseline	Target	Functional area
Analyse job opportunities emerging from the implementation of the CDA, specific outputs and activities of national and provincial departments in terms of potential job creation and employment, e.g. staff required to deal with prevention, treatment, aftercare and rehabilitation, and enforcement of harmonised legislation	Percentage increase in persons employed in the substance abuse field	Employment data from the Department of Labour's door-to-door report	10% increase in jobs created	Department of Labour

Table 6: Groups of outcomes and resulting outputs

National and provincial department DMPs are derived from the NDMP using the outcomes, outputs and activities described in Tables 5 and 6. The activities described for national and provincial departments are turned into objectives and inserted in the appropriate places in the format of a master plan described on the CDA web page.

DMPs and the NDMP are set out in terms of activities, indicators, baseline, targets and responsibilities. Before activation, the DMPs must be approved by the appropriate head of department at national or provincial level and by the MEC concerned.

The action plans of LDACs are derived from the action plans of the relevant PSAFs (with provincial government department inputs) and expressed in terms of an action plan containing the same information as the DMPs, but limited to that which the LDACs are able to handle individually.

CHAPTER 6: MONITORING, EVALUATION AND REPORTING

MONITORING AND EVALUATION PERSPECTIVES

The CDA's monitoring and evaluation of the NDMP and the national and provincial department DMPs are based on the PSC monitoring and evaluation guidelines (Public Service Commission, 2008).

For the sake of convenience, certain key concepts of monitoring and evaluation are repeated here.

In the national sphere of government each department must produce a five-year strategic plan that is aligned with that of government as contained in the Government Programme of Action. The NDMP is a five-year strategic plan whose impact, outcomes and outputs are aligned to the 12 outcomes of government.

National and provincial departments need to align their DMPs not only with the NDMP but also with the plans of action of national and provincial departments and sectors.

Based on the strategic plan (the NDMP and the DMPs), the CDA and the national and provincial departments prepare their budgets (including the input aspect),

called "Estimates of Expenditure" or "Medium-Term Expenditure Framework". These are submitted for approval to the national and provincial departments (in the case of the CDA to the Department of Social Development) and Treasury, and eventually to Parliament.

Based on the NDMP and the DMPs, annual performance plans are developed for the CDA and the national and provincial departments. The NDMP, the DMPs and the annual performance plans (the latter being normally included in the NDMP and the DMPs) contain statements of impact, outcomes, indicators and targets. Once these plans are implemented, monitoring commences and progress is measured against the outcomes, outputs, etc., which progress is reported to the CDA monthly, quarterly and annually, using a version of QuASAR (quick analysis of substance abuse report).

The process culminates in an annual report and a cumulative five-yearly evaluation of and report on the NDMP and the DMPs, which feed into the planning cycles for each year and for the year following the five-year cycle of the NDMP 2013 – 2017.

In terms of the NDMP, four aspects require monitoring and evaluation:

- Programme performance

- Organisational performance

- Financial performance

- Community needs (PSC, 2008)

PROGRAMME PERFORMANCE

Programme performance is monitored by means of pre-set performance indicators contained in the NDMP. This calls for the routine collection of data on the performance indicators, and reporting the analysis of these data as prescribed to indicate the success of the programmes, their impact and the method (service delivery model) that is used.

ORGANISATIONAL PERFORMANCE

Reviews of organisational performance cover the structures (e.g. CDA, PSAFs and LDACs), their systems and management, and operational processes. Reports deal with organisational structures, organisational performance reviews, management

audits, organisational development or capacity building, and so on.

FINANCIAL PERFORMANCE

Monitoring is executed on the basis of monthly and annual financial statements. Questions such as the following must be answered: Was the money spent as appropriated? Were assets protected? Has the organisation adhered to sound financial controls?

In the case of the CDA, these questions need to be asked through the accounting officer. In the case of national and provincial departments, this is done through their respective accounting officers, with the CDA reporting the execution of the procedure in its annual report to Parliament.

COMMUNITY NEEDS ASSESSMENT

Since the NDMP is based, among others, on the needs of communities, it is essential that the degree of satisfaction with need fulfilment be assessed. In essence this requires that the CDA and the Department of Social Development conduct a rapid participative assessment or use some other form of evaluation to determine the degree of success of the interventions applied to fulfil the identified needs of the community.

THE QUICK ANALYSIS OF SUBSTANCE ABUSE REPORT (QUASAR)

QuASAR stands for "quick analysis of substance abuse report", but also calls up the vision of a real "quasar", a massive and remote (celestial) object that emits exceptionally large amounts of energy, contains large black holes and represents a stage of evolution (of a galaxy). The link rests on the fact that the QuASAR questionnaire is designed to evaluate the results of the massive amounts of energy being emitted by departments, PSAFs and other entities in combating substance abuse and to identify black holes or gaps in their quarterly and annual reports so as to assist in the evolution of the CDA's supporting structure. As this also leads to the standardisation of the format and content of the reports, it eases CDA reporting to Parliament. However, the questionnaire does not replace the detailed research and analysis schedule of the CDA's Research and Development Committee.

The QuASAR, whose format is reviewed annually, is designed around the outcomes, outputs and activities of the NDMP and the objectives of the activities. It

requires quarterly and annual reporting to the CDA on the measurable results of these processes.

A copy of the QuASAR tool version 1.2 appears on the CDA website (www.cda@socdev.gov.org).

APPROVAL, MONITORING AND EVALUATION OF THE NDMP

After compilation of the NDMP by a CDA task team and approval by the CDA, it is submitted to the Minister of Social Development for processing and eventual approval by Cabinet. The national and provincial department DMPs follow a similar process: approval of the DMPs by the respective ministers and provincial premiers.

In monitoring the implementation of the NDMP, the CDA has to:

- Carry out monthly and quarterly evaluations on site of the reports submitted by national and provincial departments using the QuASAR tool;

- Inform the Minister of Social Development (verbally and in writing) of progress with implementation;

- Advise the Inter-Ministerial Committee on Substance Abuse (verbally and in writing) and attend its discussions quarterly or otherwise when so required;

- Report quarterly and annually to the Minister of Social Development using the same tool and the required annual report;

- Report to the Portfolio Committee on Social Services as and when requested, and submit copies of the quarterly and annual reports to the Minister of Social Development; and

- Report to Cabinet annually and as required, in addition to submitting an annual report as provided for in Act 70 of 2008.

MONITORING STRUCTURES

The monitoring structures at national level are:

Cabinet and cabinet committees: Cabinet is responsible for approving and implementing legislation. The portfolio committees of the core departments stipulated in Act 70 of 2008 make recommendations to Cabinet and also monitor these departments.

National Council of Provinces: This structure represents provincial interests and is responsible for monitoring the relevant national departments and their effectiveness in addressing the prevention and combating of substance abuse in terms of the NDMP.

National Assembly: The National Assembly is the lower house of the Parliament of South Africa, located in Cape Town in the Western Cape. Government departments and their entities are monitored by the National Assembly in terms of the achievement of their mandates.

Inter-Ministerial Committee on Combating Substance Abuse (IMC): This entity was formally established by the President and is chaired by the Minister of Social Development to co-ordinate the roles of selected ministers whose portfolios include dealing with substance abuse.

Ministers and Members of Executive Council (MINMEC): This council of the Minister of Social Development and Members of the Executive Committees of provincial Departments of Social Development monitors and evaluates progress with the implementation of the NDMP. Other councils may also monitor the role of departments in the implementation of the NDMP.

Director-General: The Director-General of the Department of Social Development is the accounting officer of the national Department of Social Development and provides the finances necessary for the achievement of the outcomes of the NDMP and the administration of the CDA, and monitors such expenditure.

Central Drug Authority: The CDA is responsible for oversight of the activities of national and provincial departments as set out in the NDMP and the respective DMPs. This entails directing, co-ordinating, monitoring and evaluating these activities. The CDA also advises the Minister of Social Development and through that Minister other relevant ministers on matters affecting the combating of substance abuse.

The Portfolio Committee on Social Development and the Select Committee on Social Services of Parliament oversee the activities of the CDA.

CDA MONITORING OF NATIONAL AND PROVINCIAL DEPARTMENTS

The CDA monitors the core departments represented in the CDA and their respective DMPs in terms of the NDMP, and does the same for the PSAFs. The CDA also receives reports demonstrating the achievement of the outcomes contained in their DMPs.

MONITORING BY NATIONAL DEPARTMENTS AND PROVINCIAL SUBSTANCE ABUSE FORUMS

Government departments have DMPs that require them to monitor and evaluate DMP implementation by their provincial equivalents (where applicable). In turn, PSAFs monitor and evaluate the implementation of DMPs by LDACs. Each province has an operational plan derived from the provincial DMP that details how it addresses substance-related issues in the province.

MONITORING BY LOCAL DRUG ACTION COMMITTEES

Local government has to take a lead in the establishment and functioning of the LDAC by providing a secretariat for the LDAC, which liaises with the PSAF. The LDACs are responsible for combating substance abuse at the local level in terms of the provincial DMPs.

Each municipality has to develop operational plans at local level that detail how the drug problem is to be managed at municipal level. LDACs are composed of the municipal departments concerned, NGOs, CBOs, FBOs and any other local structure concerned.

REPORTING REQUIREMENTS AND TIMESCALES

NDMP AND SUBMISSION OF DRUG MASTER PLANS

The NDMP 2013 – 2017 is operational from 1 April 2013 until 31 March 2017.

Departments, entities and provinces were required to produce their approved DMPs covering the same period by July 2013, using the cluster concept in doing so. The format of the DMP is standardised and an example appears in the appendices to this NDMP.

MONITORING AND EVALUATION TIMESCALES

Designated members of the CDA attend the monthly and quarterly meetings of the PSAFs in each province to carry out the monitoring and evaluation as required, and also attend meetings of the LDACs if necessary.

Monitoring is based on QuASAR requirements. Reports are to be submitted by the last day of June, September, December and March each year.

Designated members of the PSAFs attend the quarterly general meetings of the CDA and submit their reports for discussion at those meetings.

Similarly, national department representatives on the CDA attend the quarterly general meetings of the CDA and submit their departmental reports based on the QuASAR for discussion at those meetings.

CDA'S REPORT TO THE MINISTER OF SOCIAL DEVELOPMENT AND PARLIAMENT

In terms of legislation, the CDA must submit an annual report to the Minister of Social Development for onward transmission to Parliament by the end of September each year. The report is based on the monitoring and evaluation conducted by the CDA, on the reports submitted by national and provincial departments, on the research conducted by or on behalf of the CDA and on other matters of relevance.

In addition the CDA reports verbally and in writing to the Minister of Social Development after each general meeting and on such other occasions as required, in order to carry out the mandate of advising on matters affecting substance abuse in South Africa.

CHAPTER 7: INSTITUTIONAL ROLES AND RESPONSIBILITIES

INFRASTRUCTURE SUPPORTING THE CDA

Given the extent of the drug problem, an institution, organisation or combination of organisations is required to plan, organise, direct, co-ordinate and control the struggle against the drug problem across South Africa in terms of the integrated strategy of demand, supply and harm reduction.

Action to combat trade in, and use and abuse of dependence-forming substances involves broad activities in all spheres of government, and in organisations in the business sector and civil society. This must be complemented by action to broaden regional co-operation between governments to apply similar concepts across the Southern African region. Such an institution exists in the form of the Central Drug Authority (CDA) and its supporting infrastructure.

In pursuing its mandate the CDA is required to:

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

The CDA's mandate requires that it:

- Co-ordinate the efforts of all departments (at national and provincial level) to combat substance abuse;
- Facilitate the integration of the work of all the stakeholders (national, provincial and local); and
- Report to Parliament on achievements related to the NDMP outcomes and the outputs of the CDA supporting framework (i.e. national and provincial departments, PSAFs and LDACs) in achieving the CDA mission.

The CDA's supporting infrastructure is shown in the figure below.

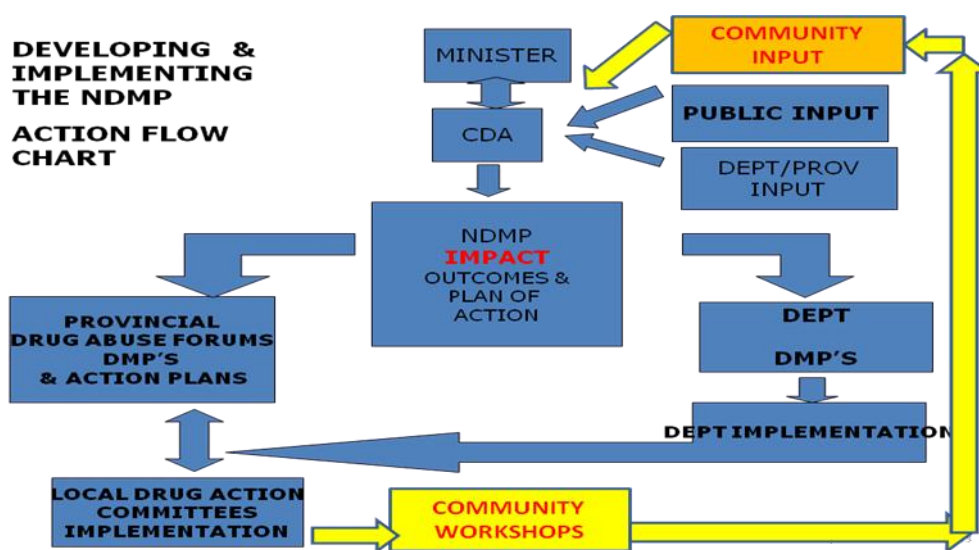


Figure 7: CDA supporting infrastructure

NATIONAL DEPARTMENT SUBSTANCE ABUSE STRUCTURES

In terms of the Prevention of and Treatment for Substance Abuse Act (70 of 2008), as amended, and in accordance with the NDMP, particular national government departments form part of the CDA and are charged with drawing up departmental DMPs in line with their core functions so as to carry out those aspects of the NDMP that fall within their mandate, which aspects are also compiled using the cluster concept. The DMPs are submitted to the CDA for approval and then used as a basis for monitoring and evaluating progress with the achievement of outcomes, outputs and the objectives derived from the activities contained in the DMPs, and for reporting to the CDA on their progress. The reports submitted to the CDA are compiled quarterly for use in the CDA's annual reports to Cabinet on the management of the drug problem across South Africa, as well as for maintaining a national database on combating substance abuse.

Particular departments have been identified as pivotal in the fight against drugs. Below is a brief discussion of these departments and their functions in respect of dealing with the drug problem.

ARTS AND CULTURE

This department is responsible for supporting occupational groups at risk, such as artists, musicians and others. It is required to draw up a strategy on preventing and combating substance abuse among these groups, with particular emphasis on the risks associated with the environment within which they operate. It also has a particularly important role to play in using the arts to provide alternative development among the youth and learners, as part of the prevention of substance use and abuse.

CORRECTIONAL SERVICES

This department provides corporate services to facilitate compliance with the drug policy in the workplace.

In terms of offenders it engages in security strategies that contribute to the prevention of drugs entering the correctional centres, reducing demand by means of educational programmes and implementing harm reduction strategies and rehabilitation programmes for those offenders suffering from substance abuse, in line with Department of Health protocols. The Department of Correctional Services forms partnerships with external stakeholders in civil society as well as with other government departments in fighting substance abuse. Embedded in this approach is the Department's objective to correct the offending behaviour of sentenced persons and to promote corrections as a societal responsibility.

BASIC EDUCATION

This department identifies the provision of quality education as a top priority of government. The achievement of this vision is articulated through the Action Plan to 2014 and the larger long-term vision called Schooling 2025. The use and abuse of alcohol and other drugs are identified as a key barrier to teaching and learning and are addressed primarily through Goal 25 of the Action Plan, namely: "Use the school as a location to promote access amongst children to the full range of public health and poverty reduction interventions."

The Department administers the South African Schools Act (84 of 1996). It has an extensive policy framework that governs the approach towards drug use and abuse in schools. In 2002, the then Department of Education developed a Drug Abuse Policy Framework (2002) as well as National Guidelines for the Management and Prevention of Drug Use and Abuse in all Public Schools and

Further Education and Training Institutions in response to a need to improve the capacity of educational institutions to prevent and manage drug abuse. The Policy Framework has the twin goal of preventing drug use/abuse and intervening early in the lives of learners experimenting with drugs, using a restorative justice approach.

The prevention aspects of the policy are largely implemented through the Life Orientation Learning Area of the school curriculum, specifically the life skills programme. This has been strengthened more recently through the introduction of the Curriculum Assessment and Policy Statement. The programme promotes behaviour change by providing learners with relevant knowledge on the use and abuse of drugs, changes attitudes towards drug use, enhances self-esteem, and teaches learners decision-making skills as well as skills to resist peer pressure. These aspects of the programme are also supported by peer education strategies that aim to change social norms about high-risk behaviours. Support material including an educator manual has been developed to assist educators, officials and school communities in developing and implementing an integrated approach to drug abuse prevention and education.

In response to growing concern about increasing levels of drug use within the school setting and its contribution towards crime and violence in schools, guidelines were developed for random search and seizure as well as drug-testing procedures in schools (Government Gazette No 31417, 19 September 2008). The guidelines are aimed at safeguarding learners' right to education, which can be optimised in an environment free of drugs. Training on drug testing and random search and seizure procedures has been rolled out to the provinces in 2008, 2009 and 2010. The Department of Basic Education has also signed an Implementation Protocol (2011) with the South African Police Service for the prevention of crime and violence in all schools. This partnership has resulted in schools being linked to local police stations. The partnership includes conducting joint drug abuse awareness campaigns together with community stakeholders.

The Department of Basic Education is currently finalising a National Strategy on Prevention and Management of Substance Use for Learners in Public Schools in order to bring coherence to its work on drug use/abuse. The strategy is aligned to the Department's educational outcomes and the NDMP. It is located within a broad framework called the Care and Support for Teaching and Learning (CSTL) Programme. This is a Southern African Development Community initiative whose goal is to realise the education rights of all children, including the most vulnerable, through schools becoming inclusive centres of learning, care and support. Alcohol and other drug use as a key barrier to learning is located within Health Promotion,

one of the nine priority areas of the CSTL Programme.

NATIONAL TREASURY

The National Treasury is responsible for combating substance abuse in South Africa. It will work with the Financial Intelligence Centre (FIC) to provide any drug-related and crime-related information it receives from banks and other institutions to the relevant law enforcement authorities, intelligence agencies and SARS, who in turn pass this information to the CDA as part of their reporting procedure.

INTERNATIONAL RELATIONS AND CO-OPERATION

This department has the following responsibilities:

- To enter into bi-lateral and multi-lateral agreements with other countries and international agencies for the effective management of substance abuse;

- To ensure South Africa's compliance with its international obligations as a State Party to the following instruments:

 - Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol;

 - Convention on Psychotic Substances of 1971; and

 - United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988;

- To ensure South Africa's adherence to the general rules of international law with respect to combating substance abuse;

- To promote enhanced regional and international co-operation in the combating of substance abuse, illicit trafficking in drugs and transnational organised crime; and

- To advise all the national stakeholders on South Africa's international obligation with respect to international instruments for fighting drugs.

HEALTH

This department is responsible for the reduction of drug demand and harm caused by psychoactive drugs, including alcohol and tobacco, through the development of

legislation and policy guidelines for early identification and treatment. It collaborates with the Departments of Basic Education, Higher Education and Training, and Social Development in respect of national awareness and also supports treatment centres through advising on detoxification programmes, the appointment and support of medical personnel, capacity building and supervision.

The database of this department provides important bio-psycho-social data to the CDA.

HIGHER EDUCATION AND TRAINING

This department is responsible for combating alcohol and other drugs (substances of abuse) at a tertiary level. Its DMP and policies should guide prevention efforts at tertiary institutions.

HOME AFFAIRS

This department is responsible for determining and safeguarding the identity and status of citizens and regulating immigration to ensure security, promote development and fulfil our international obligations. The Department also reports on the movement of persons into and out of South Africa through various ports of entry. It is also responsible for the detection, detention and deportation of illegal foreigners, some of whom are involved in criminal activities including drug abuse.

The Department's deportation facility is used as a holding centre for deportees. Hence it deals with drug abuse by deportees. Its small medical facility on site needs to be managed according to set standards and risk management measures. Its database is linked to that of the CDA.

JUSTICE AND CONSTITUTIONAL DEVELOPMENT

This department assists with reducing the demand for illicit drugs and reducing the supply of such drugs on the street.

In terms of demand reduction the Department, through the criminal justice system, refers offenders that require drug-related treatment to treatment through a variety of mechanisms, such as diverting young and non-violent offenders to treatment programmes instead of letting them go through the court system, stipulating treatment as a condition of suspension of sentence, pre-trial release, or

correctional supervision, and focusing on the expedition of cases. The Department also ensures that the role players in the courts are educated about substance abuse in order to be able to identify offenders that require treatment. Through education and training the Department ensures that the prosecution and the magistracy are trained in the understanding and use of the laws aimed at prosecuting offenders.

As for reducing the supply of drugs, the Department deals with organised crime involving drugs through asset forfeiture of the gains/property that came about as a result of crime as well as through deterrent sentences in the courts.

As part of the integrated justice system, the Department plays a role in the fight against drugs through the Justice Crime Prevention and Security (JCPS) Cluster and the Social Cluster. In the JCPS Cluster, the Department contributes to the formulation of inter-sectoral strategies relating to combating drug-related offences. In the Social Cluster, it contributes to the formulation of inter-sectoral strategies relating to social cohesion and moral regeneration, focusing on drug-related aspects in crime prevention and combating.

LABOUR

This department establishes the conditions of employment and protects the rights of employees in the workplace. It is expected to develop workplace policies on substance abuse and to measure and combat substance abuse in the workplace through the monitoring and evaluation of the implementation of these policies.

MEDICINES CONTROL COUNCIL

The Medicines Control Council (MCC) is a statutory body appointed by the Minister of Health in terms of the Medicines and Related Substances Control Act (101 of 1965) to oversee the regulation of medicines. Its main purpose is to safeguard and protect the public by ensuring that all medicines that are sold and used in South Africa are safe, therapeutically effective and consistently meet acceptable standards of quality.

The MCC applies standards laid down by the Act to govern the manufacture, distribution, sale and marketing of medicines. The prescribing and dispensing of medicines are controlled by establishing schedules for various medicines and substances.

The monitoring and evaluation of the misuse of regulated medicines produce information that is passed to the CDA to combat the abuse of dependence-forming substances.

NATIONAL YOUTH DEVELOPMENT AGENCY

The National Youth Development Agency (NYDA) was established by the National Youth Commission Act (19 of 1996), and is based in the Office of the Deputy President. The NYDA's primary aim is to assist the government to plan a comprehensive youth development policy with reference, inter alia, to substance abuse and related issues. The NYDA focuses on all youth in and outside school.

SOCIAL DEVELOPMENT

This department is the lead department in the action against substance abuse and provides technical and financial support to the CDA and its Secretariat. It is responsible for developing generic policy on substance abuse. Its strategic objectives are the following:

- To develop a comprehensive legal and policy framework for service delivery on substance abuse;

- To develop and transform programmes related to prevention, early intervention and treatment for substance abuse;

- To facilitate capacity building and training of provincial stakeholders;

- To monitor and evaluate the implementation of policies and programmes on substance abuse;

- To develop minimum norms and standards for service delivery in the field of substance abuse; and

- To provide treatment centres at community and tertiary levels in collaboration with the Department of Health.

SOUTH AFRICAN POLICE SERVICES

The objective of policing, in terms of the Constitution of the Republic of South Africa, 1996 is to:

- Prevent, combat and investigate crime;

Maintain public order;

Protect and secure the inhabitants of the Republic and their property; and

Uphold the law.

The SAPS budget includes five key departmental programmes, namely Administration, Visible Policing, Detective Services, Crime Intelligence, and Protection and Security Services. All five programmes provide for drug demand and supply reduction strategies. Some of the priorities, which cut across and impact on the programme structure, are:

Employee assistance services, which provide for pro-active and reactive social work to members and their families;

Visible policing, which ensures visible crime deterrence through pro-active and reactive policing of drug-related crimes, also in the rail environment, and includes support for demand reduction programmes of the social sector;

Crime intelligence, which entails intelligence operations relating to criminal groups involved in drugs, and gathering, collating and analysing related intelligence information, as well as providing intelligence and information on precursor chemical movements nationally and internationally;

Administration and detective services (including the Directorate of Priority Crime Investigation (DPCI, or the Hawks), which provide for co-operation between the SAPS and foreign law enforcement agencies to address drug trafficking;

Protection and security services, which provide for policing and security at ports of entry and on the border to minimise drug trafficking into and out of the country and ensure arrests and seizures at ports of entry; and

Detective services, which investigate and gather evidence on serious and organised crime and address transnational and domestic narcotics trafficking through intelligence-driven operations, such as:

Project-driven operations, e.g. under-cover operations, controlled deliveries, entrapment, surveillance, interception and monitoring; and

Disruption operations, e.g. search and seizure at ports of entry, nightclubs, drug outlets, etc.

The DPCI has declared the countering of drug trafficking as one of its key operational priorities. Focusing on high-level drug trafficking organisations, it takes responsibility for the following in its fight against the scourge:

To prevent, combat and investigate drug trafficking organisations through integrated intelligence-led operations;

To maintain a National Chemical Monitoring Programme to prevent the diversion of precursor chemicals and laboratory equipment used in illicit drug production;

To ensure compliance with the relevant United Nations drug conventions; and

To promote regional and international co-operation through sharing intelligence and conducting joint operations against transnational drug-trafficking organisations.

SAPS also promotes international co-operation and acts as competent authority under the following United Nations conventions:

Convention on the Law of the Sea, 1982;

Single Convention of Narcotic Drugs, 1961;

Convention of Psychotropic Substances, 1971; and

Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, includes provisions for the control of deliveries in terms of (Article 11) as well as precursors (Article 12) in order to control the import and export of precursors and investigate any illicit uses.

SOUTH AFRICAN REVENUE SERVICE

SARS is mandated to control the cross-border movement of goods including prohibited and restricted goods, e.g. narcotics. Currently SARS intercepts drugs, jointly with SAPS at some ports of entry, and independently at others.

SPORT AND RECREATION

The Department of Sport and Recreation is required to develop and implement prevention programmes against substance abuse in 57 sporting disciplines at

regional, national and international level. Hence the South African Institute for Drug-Free Sport (SAIDS) was established in terms of the Drug-Free Sport Act (14 of 1997) to promote participation in sport that is free from the use of prohibited substances or methods intended to enhance performance artificially.

The Act renders doping practices, which are contrary to the principles of fair play and medical ethics, impermissible and provides for matters connected therewith. It also vests the SAIDS with the statutory power to conduct a national drug-testing programme that may subject any sportsperson to drug testing, at short notice or without notice, both in and out of competition. The SAIDS is the only recognised body in the country that may authorise and enforce the national anti-doping policy. It is funded by Sport and Recreation South Africa, and the Minister of Sport and Recreation is its executive authority.

The Act was amended in 2006 to comply with the requirements of the World Anti-Doping Code, and as such it extends and increases the effectiveness and powers of the SAIDS in implementing its mandate.

The SAIDS is recognised globally as a world leader in the fight against drugs in sport and is one of a handful of anti-doping organisations that has been awarded the international benchmark of excellence, namely ISO 9001/2000 certification.

TRADE AND INDUSTRY

For the purpose of the NDMP, this department is responsible for the regulation of the liquor industry. In particular, the Department administers and enforces the Liquor Act (59 of 2003) through the National Liquor Authority (NLA). The regulation of the liquor industry is a concurrent national and provincial legislative competence.

In summary, the Act provides for the establishment of norms and standards, minimum standards, and measures for co-operative governance in the regulation of liquor. It also provides for the establishment of the National Liquor Policy Council (NLPC), composed of all MECs responsible for the administration of liquor matters in each province and chaired by the Minister of Trade and Industry. The objects of the Act are to reduce the socio-economic and other costs associated with alcohol abuse, and to promote the development of a responsible and sustainable liquor industry. It also provides for public participation in liquor licensing.

The Department of Trade and Industry's International Trade Administration Commission (ITAC) is responsible for the issuing of import and export permits for certain controlled precursor chemicals used in the production of illicit drugs.

TRANSPORT

This department co-ordinate the activities of provincial and local authorities related to the implementation of the substance abuse policy through the Road Traffic Management Corporation (RTMC). The areas of activity are the following:

Training of traffic officers (managed by the RTMC), including the recognition of drug users, the prosecution of alcohol-related crimes on the road through alcohol measurement with the aid of alcometers, blood tests carried out by registered nurses or medical doctors, and recognition of behaviour that indicates that a person is under the influence of alcohol or other drugs.

The responsibility for standards for enforcement equipment lies within the Technical Committee for Standards and Procedures. The committee attends to all matters related to alcohol meters and breath analysers, their acceptance as evidentiary equipment and further development. It also attends to the acceptance of equipment related to the identification of illegal drug use.

The new Road Safety Strategy, compiled in consultation with all the provinces, includes plans to increase enforcement, particularly in the form of mini road blocks and multi-disciplinary road blocks. These measures will identify not only drivers under the influence of alcohol or other drugs, but also people carrying drugs on the roads, which are the dominant means of the transportation of drugs.

Legislation and regulation often lead to the introduction of new alcohol and other drug-related measures, e.g. the reduction of blood alcohol from 80 mg to 50 mg alcohol per 100 ml of blood in 2004 in terms of the Road Safety Strategy. Drug-related issues will continuously be taken into account when legislation and regulations are developed.

As part of the Road Safety Campaign, the alcohol limit of 20 mg alcohol per 100 ml of blood for professional drivers in public transport is enforced through road blocks. As part of the campaign a training programme is run that includes a practical test for these drivers and information on the use and abuse of alcohol and other drugs.

AGRICULTURE

This department is responsible for combating substance abuse, with regard to the prevention of drugs in the agricultural field.

COOPERATION AND TRADITIONAL AFFAIRS (PROVINCIAL AND LOCAL GOVERNMENT)

This department is responsible for combating substance abuse at the provincial and local government level.

NATIONAL PROSECUTING AUTHORITY

The Prosecuting Authority is responsible for combating substance through partnership with other law enforcement agencies.

PROVINCIAL SUBSTANCE ABUSE FORUMS

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

Adequate and sustained funding for PSAFs must be provided by the provincial department responsible for social development.

PSAFs must:

Strengthen member organisations to carry out functions related directly or indirectly to addressing the problem of substance abuse;

Encourage networking and the effective flow of information between PSAF members;

Assist LDACs established in terms of section 60 in the performance of their functions;

Compile and submit an integrated Provincial Drug Master Plan for the province concerned;

Submit reports and inputs in accordance with the CDA programme and timescales to the CDA for the purposes of the CDA's quarterly and annual reports; and

Assist the CDA in carrying out its functions at a provincial level.

It is recommended that PSAFs set up an executive committee and assign the following portfolios to particular members:

Demand reduction

Supply reduction

Harm reduction

Research and development

Communication

Monitoring and evaluation

LOCAL DRUG ACTION COMMITTEES

The mayor of each municipality, of which there are at present 238, must establish a Local Drug Action Committee (LDAC) consisting of interested persons and organisations dealing with the combating of substance abuse in the municipality in question as well as appoint these persons using suitable service providers. In cases where there are grounds for doing so, e.g. geographical distribution over

large areas, it may be more feasible to appoint, in addition, District Drug Action Committees to co-ordinate the activities of a number of LDACs. This is done at the discretion of the MEC concerned.

The municipality in which an LDAC is situated must, from the moneys appropriated by the municipality for that purpose, provide financial support to the LDAC.

An LDAC, in turn, must:

- Ensure that effect is given to the NDMP in the relevant municipality;

- Compile an action plan to combat substance abuse in the municipality in co-operation with the provincial and local government;

- Ensure that its action plan is in line with the priorities and objectives of the Integrated Mini Drug Master Plan and that it is aligned with the strategies of government departments;

- Implement its action plans;

- Provide reports to the relevant PSAF concerning actions, progress, problems and other related matters in its area; and

- Provide such information as may be required by the CDA from time to time.

CIVIL SOCIETY

NGOs that deal with substance abuse are represented on the CDA. Among them are the South African National Council on Alcoholism and Drug Dependence (SANCA), faith-based organisations (FBOs) and community-based organisations (CBOs). Most of these organisations are subsidised and monitored by the Department of Social Development. Their work is complemented by research councils/institutions, Business Against Crime, treatment centres and accredited addiction counsellors, all of whom have in-depth knowledge and experience of substance abuse and are therefore able to advise the CDA on strategies and interventions. In addition, there are NGOs that combat substance abuse in the workplace, since substance abuse threatens the performance, growth and profitability of all categories and levels of government, commerce and industry and thus the economy of South Africa at large. Airline pilots, train, bus, taxi, truck and heavy machinery operators, teachers, the police and defence force personnel,

public utility employees and many categories of public servants are all in careers that require them to be drug and alcohol free. Public and private enterprises generally recognise that being alcohol-free helps prevent catastrophes, but the same can probably not be said about drug abuse. Employers and employees need to understand that a drug-free workplace can lead to superior customer service, higher employee morale, increased productivity, reduced staffing costs and even reductions in employee theft. The management of employee substance abuse should be a fundamental component of any organisation's occupational health, safety and environmental risk management. However, South Africa lags behind international best practice. Consequently, government and the private sector must be encouraged by all legal and moral means available to start implementing comprehensive, ethical and effective workplace substance abuse management programmes as soon as possible. They must also recognise civil society as a partner in addressing substance abuse in communities.

CHAPTER 8: RESEARCH AND DEVELOPMENT

RESEARCH AND DISSEMINATION OF INFORMATION

As indicated to some extent in Chapter 4, rational and effective policymaking and service delivery in respect of drugs, whether at the international, national or community level, require

- (1) knowledge of the profiles of the problems of the users of particular drugs and the drugs themselves, as well as
- (2) the ability to predict to some extent the nature of future problems in the field.

As the mentioned profiles tend to vary from place to place, person to person, as well as over time, it is essential to institute a long-term research programme that monitors them.

Such monitoring has to focus on the demand for drugs and, more particularly, on: the types of drugs used as well as the patterns of use and related harm in various communities and sociodemographic groups, and trends over time in this regard. Issues related to the supply of drugs, e.g. their production and distribution, also have to be monitored.

To facilitate monitoring, researchers need to make a special attempt to harmonise data-gathering processes (World Health Organization, 2000). Cognisance should also be taken of the value of periodic, methodologically comparable, national population surveys on drug use. As pointed out by Da Rocha Silva and Malaka (2007), such surveys enable the gathering of comprehensive data on the nature, extent and consequences of drug use as well as variations across place, sociodemographic sectors and time. They also facilitate to some extent analyses of (1) the economic cost of substance abuse, and (2) the extent to which drug use interacts with broad socio-economic conditions such as poverty. In combination with statistical and mathematical techniques of forecasting, the findings of such surveys could be useful to predict future drug-related trends (see for example European Monitoring Centre for Drugs and Addiction, 2001). Most importantly, these surveys enable “the development of a comprehensive and integrated database on drug use and related issues ... [indeed] provide a broad point of reference for interpreting the findings from research in more restricted settings” such as prisons, emergency rooms and drug-related treatment centres (Da Rocha Silva & Malaka, 2007:9-10).

In short, extensive research is required to fill the current gaps in drug-related information in South Africa. Studies are needed on, for example, the dynamics of drug use (especially the use of alcohol and cannabis) among different groups in different parts of the country; the economic costs of substance abuse for the country; the relationship between substance use/abuse and national issues (HIV and AIDS, TB, crime, youth development and poverty); and the impact of current government policies (e.g. regarding drug-affected driving and walking). It is, furthermore, necessary to evaluate the effectiveness of community-based interventions and other existing drug abuse services as well as recommendations for policy change, which in turn will impact on planning. Cognisance should also be taken of the fact that drug-related research in South Africa has mostly addressed commercial/prescription substances and has tended to overlook the impact of the use of indigenous substances and combinations of substances, which generally affect a much larger number of people, notably those in rural and previously disadvantaged communities.

In addition, a user-friendly national clearing house and database must be established. This should facilitate the dissemination and use of research on drug use/abuse and related information.

In all of this, though, the ultimate requirement of the NDMP and the country is research that will contribute to the combating of substance abuse, i.e. research that can be *applied* to solve present and predicted problems in the field of substance abuse. The following section elaborates on the required research.

DEVELOPMENT OF COMPREHENSIVE (BASELINE) DATA ON SUBSTANCE ABUSE IN SOUTH AFRICA

As noted to some extent in earlier sections, there is a dearth of comprehensive, accurate and comparable information on the use and abuse of dependence-forming substances and related issues in South Africa. This makes the monitoring and evaluation of progress with NDMP implementation extremely difficult. In fact, there is a need for research that takes cognisance of the issues mentioned in the previous section, and especially attempts to:

Determine the nature, extent and impact of substance abuse in clearly defined communities/districts in the country as a whole;

Determine the sociodemographic characteristics of those persons who

use/abuse dependence-producing substances;

Gather the required data

- through a national population survey, (1) designed in accordance with international and local methodological guidelines and substantive needs (see for example World Health Organization, 2006, 2000; Da Rocha Silva & Malaka, 2007), and (2) serving as a *national baseline survey* for future methodologically comparable national population surveys; as well as
- from other primary and secondary South African sources (e.g. SACENDU and the South African demographic and health surveys); and

Make a special effort to compare and integrate data gathered from different sources (e.g. through regular comprehensive reviews) in order to increase validity and insight.

POLICIES, LEGISLATION, PROTOCOLS AND PRACTICES REGARDING CANNABIS

It is well known that cannabis (dagga) is the second-most used/abused dependence-forming substance in South Africa. The preparation of a position paper on cannabis commenced in 2004 and the draft paper was presented to a variety of communities and interested parties for consultation in 2010. However, since then the approach to cannabis in a number of countries including South Africa has changed drastically and further research has now become necessary.

In addition, at the 54th session of the Commission for Narcotic Drugs (CND) in Vienna a resolution was passed that requested "the creation of an infrastructure appropriate to address the challenges faced by African countries ... where cannabis is increasingly abused".

In fact, and as suggested earlier, there is a need for an in-depth investigation of (1) the dynamics of cannabis use and related harm in South Africa, as well as (2) the relevance of current international/local policies regarding cannabis use, including measures such as legalisation and/or decriminalisation. The results of this investigation should then be used to develop government policies, legislation, protocols and practices specifically related to cannabis use.

POLICIES, LEGISLATION, PROTOCOLS AND PRACTICES REGARDING DRUG-AFFECTED DRIVING

Prominent among the resolutions generated at the 2nd Biennial Anti-Substance Abuse Summit are those devoted to dealing with the most abused substance in South Africa, namely alcohol. Special attention has been paid to the dangers of driving while under the influence of alcohol, while little attention has been given to driving under the influence of other drugs, especially cannabis.

Therefore, a resolution was passed at the 54th session of the Commission for Narcotic Drugs (CND) in Vienna that requested member nations to develop appropriate responses to drug-affected driving by assessing and monitoring the magnitude of the problem.

This response would entail:

- Collecting data reflecting the prevalence of drug-affected driving in South Africa;

- Developing effective roadside testing or other appropriate methods to assess drug-affected driving;

- Developing, testing and applying appropriate strategies to address the problem through collaboration between academia, the private sector, professional organisations, NGOs, civil society, responsible government organisations, roadside assistance or similar organisations, youth organisations and the media; and

- Proposing policies, legislation and practices to be applied by the government and bodies involved in combating drug-affected driving, as part of the overall strategy for dealing with road safety.

POLICIES, LEGISLATION, PROTOCOLS AND PRACTICES REGARDING THE SOCIO-ECONOMIC COSTS OF SUBSTANCE ABUSE

As pointed out earlier, figures provided by SARS indicate that the known direct cost of illicit drug use in 2005 was roughly R101 000 million. The social and economic costs of illicit drug use and alcohol have been calculated using

international data and approximate to 6, 4% of GDP or about R136 380 million per year.

Appropriate legislative and other responses to such costs are currently hampered by a lack of detailed and methodologically rigorous local investigations of the issues concerned. This lack, as pointed out by Da Rocha Silva and Malaka (2007:9), “is surprising, considering that ... [such investigations] are known to contribute to a more refined understanding and response to drug-related harm ... [Social and economic] cost analysis, namely, typically focuses on six questions: What constitutes drug-related harm? What is the degree of causality between drug use and such harm? What monetary value is to be assigned to various forms of drug-related harm? What portion of the costs associated with drug-related harm can be avoided? What investments need to be made to avoid costs, and where? How well do the investments in cost avoidance perform over time?” It is also important to bear in mind that detailed international *guidelines* for conducting rigorous studies of the social and economic costs of substance abuse exist (see for example World Health Organization, 2006; Single et al., 2003).

ACHIEVING ZERO NEW HIV INFECTIONS AMONG INJECTING AND OTHER DRUG USERS

For the past two years the CDA has been involved in a pilot project with the UNODC to determine the extent of injecting drug use (IDU) and its link to HIV/AIDS among drug users in South Africa in order to set up appropriate protocols and practices to deal with the problem.

The extent of IDU in South Africa and the danger of users spreading HIV are greater than assumed. Hence, dealing with the problem in a way that would result in zero new HIV infections among injecting drug users calls for research to determine the extent of and methods for dealing with the problem.

The research would entail:

- Collecting data reflecting the prevalence of IDU and HIV infections in South Africa;

- Developing, testing and applying appropriate evidence-based strategies to address the problem through collaboration between academia, the private sector, professional organisations, NGOs, civil society, responsible

government organisations, roadside assistance or similar organisations, youth organisations and the media; and

Proposing the policies, legislation, protocols and practices to be applied by the government and bodies involved in combating IDU and HIV infections as part of the overall strategy for dealing with HIV/AIDS.

EFFICIENT MEASURES TO IMPROVE CIVIL SOCIETY'S PARTICIPATION IN THE NDMP AND THE CDA

The implementation of the NDMP 2013 – 2017 requires participation by civil society (NGOs and other such organisations) in the activities of the CDA and its supporting infrastructure (PSAFs and LDACs). Several thousand such organisations are presently involved in the substance abuse field in South Africa, but very few (if any) can be considered to be representative of and able to speak authoritatively for the whole. In addition, the existence of a body that is able to speak authoritatively for the whole at national and international level is doubtful.

In order for the NDMP 2013 – 2017 to be implemented effectively, it is essential that such an authoritative body be formed to support and actively participate in the CDA's activities, in its supporting infrastructure and in similar bodies at Southern African and international level. A study that would facilitate the formation of such a body is therefore required. Such a study would entail:

Determining the identity and functions of civil society organisations affected by and involved in combating substance abuse;

Determining the need for and functions of an authoritative and representative body to implement a series of functions for and on behalf of such organisations at national, regional and international level in the field of substance abuse policy, protocol and practice; and

Facilitating the creation of such a body, its constitution, functions and funding, and advocating for legislation to render its functioning effective, if necessary.

PREDICTIVE ANALYSIS OF SUBSTANCE ABUSE PATTERNS AND TRENDS IN SOUTH AFRICA AND IMPLICATIONS FOR POLICY

It is accepted that when drug policies target specific problems and populations and are informed by sound scientific evidence, they can alter the course of drug use and even drug epidemics (Babor et al., 2010a, 2010b).

In South Africa there is very little concrete, accurate and detailed evidence of the drug problem and its effect on populations, hence the mentioned need for comprehensive research on the subject. If this need is satisfied, it would become possible to identify problems more scientifically and devise appropriate policy responses. However, due to the complexity of the South African scene, as well as the slow pace at which the required research emerges and government policy is developed and solutions delivered, the implementers of such policy are distinctly disadvantaged, i.e. they are usually reactive in their development and application of policy and must continually catch up.

A prime requirement in any business (and the drug trade is said to be the second biggest business in the world) is to be able to predict the future through an analysis of the environment in which the business is expected to function in the medium term. Environmental scanning is considered a normal part of strategic planning and enables policymakers to become pro-active in their functioning and thus, hopefully, changing from catching up to forward-thinking and planning.

As regards the drug problem, the application of the PESTEL-type of environmental scan could be useful in dealing with the problem. This type of scan attempts to predict the strategies necessary to deal with known and predicted changes in the political, economic, social, technological, environmental and legislative spheres. Such an environmental scan or analysis (in combination with an extensive review of data on drug use/abuse) could therefore help predict the potential policy, practice, protocol and legislative implications of the scanned spheres or scenarios for inter alia:

- Drugs in use, drug use patterns and related bio-psycho-social harm;

- Populations/sociodemographic sectors using drugs, the type of drugs that they use, their patterns of drug use as well as the drug-related bio-psycho-social effects that they experience;

- Factors contributing/determining drug use and related harm;

- Prevention, treatment, aftercare and re-integration of (potential) users of drugs as well as drug abusers and dependents; and

- Existing policy, protocols, practices and legislation regarding the combating

of drug abuse in South Africa.

SERVICE QUALITY MEASUREMENT TO IMPROVE SUBSTANCE ABUSE TREATMENT

Current service quality measurement efforts in South Africa are funded by the Centers for Disease Control and Prevention (CDC) in the United States of America and the Western Cape Department of Social Development. These measurements are executed jointly by the CDA and the Medical Research Council.

CHAPTER 9: IMPLEMENTATION OF THE NDMP 2013 – 2017

As indicated earlier, in the course of developing the NMP 2013 – 2017 the CDA explored the dynamics and implications of the drug problem in depth. The CDA, for example, conducted an RPA and consulted a wide range of stakeholders during provincial summits and the 2nd Biennial Anti-Substance Abuse Summit. The results of the RPA and consultations were then integrated with the NDMP 2013 – 2017.

The NDMP's specific outcomes (seven in all) were divided into a series of specific national and provincial department outputs and activities for use in compiling the relevant DMPs to be implemented by the PSAFs and LDACs.

The table below shows the CDA activities to be carried out in five financial years commencing 1 April 2013 and ending 31 March 2017.

CDA Action Plan 2013 – 2017		
Financial year/time frame	Activities/steps	Responsibility
2013 – 2014	Appoint CDA members	Minister of Social Development
	Approve the NDMP 2013 – 2017	Cabinet
	Conduct induction and develop capacity of CDA members	CDA and consultants
	Select PSAF and LDAC members and do induction and build their capacity	CDA and consultants
	Increase membership and capacity of PSAFs and LDACs in all provinces to optimum level	CDA and provincial representatives
	Develop and obtain ministerial approval of the CDA's five-year business plan, including the database, governance, communication and marketing, research and development strategies and projects, capacity building of supporting infrastructure and input requirements	CDA
	Commence implementation of the business plan	CDA committees
	Revise DMP framework of the national and provincial departments and conduct workshops for the development of the relevant DMPs	CDA

	Develop, submit and gain approval for the DMPs of the national and provincial departments concerned	CDA, national and provincial departments, and other entities
	Provide for and obtain resources to implement the NDMP within the current Medium-Term Expenditure Framework (MTEF) period	All national and provincial departments, and other entities
	Select, attend and participate in local, national and international conferences on substance abuse and related matters; analyse the information and include relevant aspects in the business plan	CDA
	Develop monitoring and evaluation schedules for implementing the NDMP and advising the Minister on a regular basis	CDA and supporting infrastructure
	Commence ongoing monitoring and evaluation of progress with NDMP 2013 – 2017 outcomes	CDA and supporting infrastructure
	Report to Parliament on achievement of NDMP outcomes	CDA, national and provincial departments
	Review and adjust the NDMP 2013 – 2017 in the light of the results of monitoring and evaluation, outcomes achieved, research and development findings and international trends	CDA, representatives of national and provincial departments
2014 – 2015	Review and update capacity development of CDA members	CDA and consultants

	Review and update capacity building of PSAF and LDAC members	CDA and consultants
	Review and adjust DMPs 2013 – 2017 of national and provincial departments in the light of the results of monitoring and evaluation	CDA, representatives of national and provincial departments
	Increase membership and capacity of PSAFs and LDACs to optimum level	CDA and provincial representatives
	Obtain approval for continuance of the CDA's five-year business plan, including the database, governance, communication and marketing, research and development strategies and projects, capacity building of supporting infrastructure and input requirements for the current year	CDA
	Continue implementation of business plan	CDA committees
	Revise the DMPs of the national and provincial departments and conduct workshops as necessary for continued DMP implementation	CDA, national and provincial departments
	Provide for and obtain resources to implement the NDMP in the MTEF period	CDA, departments and provinces
	Select, attend and participate in local, national and international conferences on substance abuse and related matters; analyse the information and include relevant aspects in the business plan	CDA

	Continue monitoring and evaluation of progress with the achievement of NDMP 2013 – 2017 outcomes	CDA and supporting infrastructure
	Organise, hold and report on 3 rd Biennial Anti-Substance Abuse Summit	CDA and Department of Social Development
	Report to Parliament on the achievement of NDMP 2013 – 2017 outcomes	CDA and supporting infrastructure
	Review and adjust the NDMP 2013 – 2017 in the light of monitoring and evaluation of outcomes achieved, research and development findings and international trends	CDA
2015 – 2016	Review and update the capacity development of CDA members	CDA and consultants
	Review and update the capacity building of PSAF and LDAC members	CDA and consultants
	Review and adjust the DMPs 2013 – 2017 of national and provincial departments in the light of the results of monitoring and evaluation	CDA, representatives of national and provincial departments
	Increase membership and capacity of PSAFs and LDACs to optimum level	CDA and provincial representatives

	Obtain approval for continuance of the CDA's five-year business plan, including the database, governance, communication and marketing, research and development strategies and projects, capacity building of supporting infrastructure and input requirements for the current year	CDA
	Continue implementation of the business plan	CDA committees
	Revise the DMPs of national and provincial departments and conduct workshops as necessary for continued DMP implementation	CDA, national and provincial departments
	Provide for and obtain resources to implement the NDMP in the MTEF period	CDA, national and provincial departments
	Select, attend and participate in local, national and international conferences on substance abuse and related matters; analyse the information and include relevant aspects in the business plan	CDA
	Continue ongoing monitoring and evaluation of progress with the achievement of NDMP 2013 – 2017 outcomes	CDA and supporting infrastructure
	Report to Parliament on the achievement of NDMP 2013 – 2017 outcomes	CDA

	Review and adjust the NDMP 2013 – 2017 in the light of the results of monitoring and evaluation of outcomes achieved, research and development findings and international trends	CDA
2016 – 2017	Review and update capacity development of CDA members	CDA and consultants
	Review and update capacity building of PSAF and LDAC members	CDA and consultants
	Review and adjust DMPs 2013 – 2017 of national and provincial departments in the light of the results of monitoring and evaluation	CDA, representatives of national and provincial departments
	Increase membership and capacity of PSAFs and LDACs to optimum level	CDA and provincial representatives
	Obtain approval for the continuance of the CDA's five-year business plan, including the database, governance, communication and marketing, research and development strategies and projects, capacity building of supporting infrastructure and input requirements for the current year	CDA
	Continue implementation of the business plan	CDA committees
	Revise the DMPs of national and provincial departments and conduct workshops as necessary for continued DMP implementation	CDA, national and provincial departments

	Provide for and obtain resources to implement the NDMP in the MTEF period	CDA, national and provincial departments
	Organise, hold and report on 3 rd Biennial Anti-Substance Abuse Summit	CDA and Department of Social Development
	Continue monitoring and evaluation of progress with the achievement of NDMP 2013 – 2017 outcomes	CDA and supporting infrastructure
	Report to Parliament on the achievement of NDMP 2013 – 2017 outcomes	CDA
	Review and adjust the NDMP 2013 – 2017 in the light of the results of monitoring and evaluation of outcomes achieved, research and development findings and international trends	CDA
2017 – 2018	Review and update the capacity development of CDA members	CDA
	Review and update the capacity building of PSAF and LDAC members	CDA, national and provincial departments
	Review and adjust the DMPs 2013 – 2017 of national and provincial departments in the light of the results of monitoring and evaluation	CDA, national and provincial departments
	Increase membership and capacity of PSAFs and LDACs to optimum level	CDA and supporting infrastructure

	Obtain approval for the continuance of the CDA's five-year business plan, including the database, governance, communication and marketing, research and development strategies and projects, capacity building of supporting infrastructure and input requirements for the current year	CDA and Department of Social Development
	Revise the DMPs of national and provincial departments and conduct workshops as necessary for continued DMP implementation	CDA and supporting infrastructure
	Provide for and obtain resources to implement the NDMP in the MTEF period	CDA
	Select, attend and participate in local, national and international conferences on substance abuse and related matters; analyse the information and include relevant aspects in the business plan	CDA
	Continue monitoring and evaluation of progress with the achievement of NDMP 2013 – 2017 outcomes	CDA and consultants
	Report to Parliament on the achievement of NDMP 2013 – 2017 outcomes	CDA and consultants
	Review the NDMP 2013 – 2017 in the light of monitoring and evaluation of outcomes achieved, research and development findings and international trends, and commence development of the NDMP 2018 – 2022	CDA, representatives of national and provincial departments

	Commence recruiting and selecting CDA members for 2018 – 2022	Secretariat of the CDA
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Table 7: CDA Action Plan 2013 – 2017

CHAPTER 10: CONCLUSION

The compilation of the National Drug Master Plan for South Africa covering the period 1 April 2013 to 31 March 2017 was somewhat easier than the compilation of its predecessor.

The main difficulty that faces all planners is the availability of information applicable to the problems in question, and the support necessary to implement the plans once they are accepted.

The planners of the NDMP 2013 – 2017 were blessed with the information necessary to develop it, based primarily on the experience of the previous five years, local, national and international support in determining the needs to be satisfied, not the least being those of South African communities, and the burgeoning support of the South African government.

Nevertheless the success of the NDMP depends on the continued support of the government, the provision of the necessary resources **and the ability of the CDA, its supporting infrastructure and civil society to deliver the outcomes, outputs and activities needed to meet the needs of the people.**

An awesome responsibility indeed!

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APPENDIX 1: LEGISLATION RELATING TO SUBSTANCE ABUSE

The control of illicit drugs in South Africa is organised and managed through legislation. The following Acts are of special concern:

Drugs and Drug Trafficking Act (140 of 1992), provides for the prohibition of the use or possession of, or the dealing in, drugs and of certain acts relating to the manufacture or supply of certain substances. It further provides for the obligation to report certain information to the police, and for the exercise of the powers of entry, search, seizure and detention in specified circumstances.

Medicines and Related Substances Control Act (101 of 1965), provides for the registration of medicines and other medicinal products to ensure their safety for human and animal use, the establishment of a Medicines Control Council for the control of medicines and the scheduling of substances and medical devices. It provides transparency in the pricing of medicines.

Mutual Assistance in Criminal Matters Act (86 of 1992)

Prevention and Treatment of Drug Dependency Act (20 of 1992), was amended to establish the Central Drug Authority in 1999. It makes provision for the development of programmes and regulates the establishment and management of treatment facilities.

Prevention of and Treatment for Substance Abuse Act (70 of 2008), will replace Act 20 of 1992 once the regulations are developed and approved.

Prevention of Organised Crime Act (121 of 1998), provides for the recovery of the proceeds of crime (irrespective of their source) as well as money laundering.

Road Traffic Amendment Act (21 of 1998), which makes provision for the mandatory testing of vehicle drivers for drugs, in order to protect the public from the danger of drug abuse. The legally acceptable blood alcohol level has been reduced from 80 mg to 50 mg alcohol per 100 ml of blood.

Tobacco Products Control Amendment Act (12 of 1999), which provides for the control of tobacco products, prohibition of smoking in public places, advertisement of tobacco products as well as sponsoring of events by the tobacco industry.

Other relevant Acts

Child Care Act (74 of 1983)

Constitution of the Republic of South Africa, 1996

Domestic Violence Act (116 of 1998)

Extradition Act (77 of 1996) Financial Intelligence Centre Act (38 of 2001)

Health Act (63 of 1977)

Institute for Drug-Free Sport Act (14 of 1997)

International Co-operation in Criminal Matters Act (75 of 1996)

Liquor Act (53 of 1989)

Medicines and Related Substances Amendment Act (59 of 2002)

Mental Health Care Act (17 of 2002)

Occupational Health and Safety Act (85 of 1993)

Pharmacy Act (53 of 1974)

Promotion of Equality and Prevention of Unfair Discrimination Act (52 of 2002)

Road Traffic Act (93 of 1996)

Road Transportation Act (74 of 1977)

Sexual Offences Act (23 of 1957)

South African Schools Act (84 of 1996)

Witness Protection Programme Act (112 of 1990)

Bills

Child Justice Bill, 2003, passed as the Child Justice Act (75 of 2008)

Criminal Law (Sexual Offences and Related Matters) Amendment Bill, 2006, currently the Criminal Law (Sexual Offences and Related Matters) Amendment Act (32 of 2007)

International conventions

South Africa is a signatory to the 1961 UN Single Convention on Narcotic Drugs, the 1972 Protocol (which amended the Single Convention), the 1971 Convention on Psychotropic Substances and the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The country is also a signatory to both the African Union (AU) and Southern African Development Community (SADC) Drug Control Protocol. In addition, it is a signatory to and ratified the United Nations Convention on Transnational Organised Crime.

The South African drug enforcement agencies co-operate and collaborate with similar agencies in the United Kingdom and the United States, notably the Defence Logistics Organisation (DLO), Drug Enforcement Administration (DEA), Central Intelligence Agency (CIA) and Federal Bureau of Investigation (FBI). Regionally the agencies co-operate and collaborate with similar agencies in SADC countries, specifically the South African Regional Police Chiefs Co-operation Organisation (SARPPCO). Nationally the departments in the Justice Crime Prevention and Security Cluster are involved in committees to combat drug trafficking, such as the Joint Operation and Intelligence committees (JOINTs) and Provincial Joint Operational and Intelligence committees (Provincial JOINTs). (Crime Combating Forum (CCF) structures at provincial cluster and station level are SAPS-specific structures that deal with operational crime combating matters between different SAPS disciplines at these levels.

APPENDIX 2: SPECIFIC ACTIVITIES OF NATIONAL AND PROVINCIAL DEPARTMENT OUTPUTS – COMPREHENSIVE PREVENTION PROGRAMMES ADDRESSING SUBSTANCE USE/ABUSE DISORDERS IN DEFINED POPULATIONS

Specific programmes assist role players to address prevention, identification and treatment of substance abuse disorders (SUDs).

1. They set out how the specific needs of **children and adolescents with SUDs and children of parents with SUDs** should be approached.
 2. **Doctors and multi-professional teams should be trained** to develop critical skills such as early identification, screening, baseline assessment, ongoing assessment of progress, referral (if indicated) and treatment of co-morbid psychiatric disorders.
 3. **A practice parameter for South Africa should be developed** to address the assessment and treatment of children and adolescents with SUDs. Refer to the American Academy of Child and Adolescent Psychiatry practice parameter for the assessment and treatment of children and adolescents with SUDs.
- 3.1 **Practice parameter for children and adolescents with SUDs:**
- (1) Observe an appropriate level of confidentiality during assessment and treatment.
 - (2) Assessment of older children and adolescents requires screening questions about the use of alcohol and other substances.
 - (3) If screening raises concerns about substance use, the clinician should conduct a more formal evaluation to determine the quantity, frequency and consequences of use for each substance used and whether the youth meets criteria for SUDs.
 - (4) Toxicology, through the collection of bodily fluids and specimens, should be a routine part of the formal evaluation and ongoing assessment of substance abuse during and after treatment.
 - (5) Adolescents and children with SUDs should receive specific treatment for their substance use.

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- (6) Adolescents and children with SUDs should be treated in the least restrictive setting that is safe and effective.
 - (7) Family therapy and significant family/parental involvement in treatment should be a major component of treatment of SUDs.
 - (8) Treatment programmes should be developed to minimise treatment drop-out.
 - (9) Medication can be used when indicated for the management of craving or withdrawal or to treat co-morbid psychiatric disorders.
 - (10) Treatment should develop and encourage peer support, especially regarding the non-use of substances.
 - (11) Twelve-step approaches (such as those offered by Alcoholics Anonymous) may be used as basis for treatment. Alcoholics Anonymous and Narcotics Anonymous are an adjunct to professional treatment of SUDs and should be encouraged.
 - (12) Programmes and interventions should attempt to provide comprehensive services in the vocational, recreational, medical, family and legal domain).
 - (13) Adolescents and children with SUDs should receive thorough evaluation for co-morbid psychiatric disorders.
 - (14) Co-morbid psychiatric conditions should be treated appropriately (early identification).
 - (15) Programmes and interventions should provide or arrange for comprehensive post-treatment care.
4. **A protocol needs to be developed explaining the starting point and steps to follow** once the patient has been identified in the community. The contact details of contact persons and other members of the multi-disciplinary team (MDT) should be available in each community clinic, together with information on the referral process.
 5. Clinicians and MDT members should have a **clear understanding of the concepts use, abuse, misuse, dependence and diversion**.
 6. The **patterns of substance use and abuse are different in children and**

adolescents; some illicit substance use could be normative in young people, whereas preoccupation, compulsive use and/or negative consequences of use indicate potential pathology.

7. **Poly-substance abuse in adolescents appears to be the rule** rather than the exception. Therefore adolescents often present with multiple SUD diagnoses.
8. **Patients should be screened for co-morbid psychiatric disorders**, which should be treated concurrently with SUDs.
9. **Risk factors for the development of SUDs in children and adolescents need to be highlighted** when clinicians and MDT members are being trained. Risk factors include individual, peer and family factors, and are common across all substances.
10. Most young people start with **gateway (entry) drugs** that are legal, like tobacco and alcohol; others start with other drugs, like cannabis, and bypass the gateway drugs.
11. **Evidence-based practices for SUDs** include family therapies, cognitive behaviour therapies and motivational interviewing/enhancement.
12. **Aftercare and involvement** in pro-social activities with non-deviant peers are critical following an acute treatment episode.
13. **Empirically based prevention interventions** primarily involve strengthening resilience factors, education and reducing risk factors for the development of SUDs. School-based and community-based prevention methods should be added and followed up by self-reports about past month use of illicit drugs, tobacco and alcohol.
14. **Principles for effective prevention programmes need to be developed and implemented**, bearing in mind international/local guidelines in this respect.
 - 14.1 **Principles for effective prevention programmes:**
 - (1) Enhance protective factors and reduce risk factors.
 - (2) Address all forms of drug abuse, alone or in combination, including the underage usage of legal drugs (alcohol and tobacco); the use of illegal drugs (cannabis and heroin); and inappropriate use of legally obtained

substances (e.g. inhalants), prescription medicines or over-the-counter drugs.

- (3) Address the type of drug abuse in the community, target modifiable risk factors and strengthen protective factors.
- (4) Tailor prevention to address risks specific to population characteristics, such as gender, age and ethnicity, to improve programme effectiveness.
- (5) Family-based prevention programmes should enhance family bonding and relationships and include parenting skills, practice in developing, discussing and enforcing family policies on substance abuse, and training in drug education and information.
- (6) Design prevention to intervene as early as preschool so as to address risk factors for drug abuse such as aggressive behaviour, poor social skills and academic difficulties.
- (7) Prevention for elementary school children should target improving academic and social-emotional learning so as to address risk factors for drug abuse such as early aggression, academic failure and school drop-out.

Education should focus on the following skills:

- Self-control
 - Emotional awareness
 - Communication
 - Social problem-solving
 - Academic support, especially reading
- (8) Prevention for middle or junior high and high school learners should increase academic and social competence through the following:
 - Study habits and academic support
 - Communication

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- Peer relationships
 - Self-efficacy and alertness
 - Drug resistance
 - Reinforcement of antidrug attitudes
 - Strengthening of personal commitments against drug abuse
- (9) Prevention programmes aimed at general populations at key transition points:
- Transition to middle school can produce beneficial effects in high-risk families and children. Hence prevention programmes for the general population should reduce labelling and promote bonding to school and community.
- (10) Community prevention programmes that combine two or more effective programmes, such as a family-based and a school-based programme, can be more effective than a single programme.
- (11) Community prevention programmes reaching populations in multiple settings (schools, clubs, faith-based organisations and the media) are most effective when they present consistent community-wide messages in each setting.
- (12) When communities adapt programmes to match their needs, community norms or cultural requirements, they should retain core elements of the original research-based intervention, which include:
- Structure (how the programme is organised);
 - Content (what the information, skills and strategies of the programme are); and
 - Delivery (how the programme is adapted, implemented and evaluated).
- (13) Prevention programmes should be long term, with repeated interventions (booster programmes) to reinforce original prevention goals.
- (14) Prevention programmes should include teacher training on good

classroom management, such as rewarding appropriate learner behaviour, to foster learners' positive behaviour, achievement, academic motivation and school bonding.

(15) Prevention is most effective when interactive techniques are employed, such as peer discussion groups and parent role-playing, since these allow for active involvement in learning about drug abuse and reinforcing skills.

(16) Research-based prevention programmes can be cost-effective.

15. Management of children and adolescents with parents with substance abuse and psychiatric disorders

- Children who grow up with parents with psychiatric illness are at a higher risk to develop a mental disorder or substance abuse at some point in their life compared to children who have parents with no mental illness or substance abuse.
- Clinicians dealing with these parents need to consider the risk and protective factors present.
- Provide the parents with educational resources and knowledge and help them to promote the health development of their children.

16. Prevention programmes for children of parents with substance abuse disorders

- Building a tool box of coping skills and improving communication between parents and children are important components.
- Programmes need to include information and strategies on how to deal with co-morbidity (SUDs and psychiatric disorders), as these are often present.

APPENDIX 3: NATIONAL ACTION PLAN ON COUNTERING SUBSTANCE ABUSE, UTILISING DEMAND, SUPPLY AND HARM REDUCTION APPROACHES/STRATEGIES

INTRODUCTION

The National Action Plan was set up in consultation with substance abuse stakeholders. The key strategy areas are not mutually exclusive, and the actions and strategies listed below may affect other strategies. Effective policies and strategies to reduce or prevent substance abuse and minimise personal, social and economic harm must aim to bring change. The plan is not prescriptive; it only provides examples to guide the users of the plan.

DEMAND REDUCTION: PROMOTION OF OPPORTUNITIES, SETTINGS AND VALUES THAT PROMOTE RESILIENCE AND REDUCE THE INTAKE AND USE OF DRUGS AND THE RISKS OF DRUG USE

Objective: What is to be achieved	Key action area	Example
Prevent and/or delay the intake of drugs	Programmes targeting the youth	Educational programme including behaviour modification strategies; national drug awareness programme
Promote alternatives to drug use that are acceptable, attractive and meaningful to those most at risk of drug use and those from a disadvantaged background	Effective community education including modalities such as community dialogue, storytelling and sport	Massive social marketing utilising all avenues to disseminate information appropriate to age and culture
Promote community partnership of the family and positive parenting	Primary prevention programmes that target the identified emerging drug problems	Implementation by relevant authorities of a programme that addresses the real drug issues

		Provision of resources for families and parents at risk, such as accessible childcare, parenting support and early intervention programmes
Promote healthy school and community environments that are safe and drug free	<p>Develop school-based policies to ensure that environments are safe and drug free</p> <p>Life orientation that empowers learners with knowledge about the danger of drugs</p>	<p>Skills training and job creation opportunities for young people</p> <p>Joint projects between police and learners</p>

SUPPLY REDUCTION: INTERVENTIONS TO REDUCE AVAILABILITY AND SUPPLY

Objective: What is to be achieved	Key action area	Example
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Prevent and reduce street-level dealing in drugs	Effective control and reduction of the quantity of drugs cultivated and manufactured domestically	<p>Support law enforcement agencies</p> <p>Strengthen institutions to build capacity for addressing drug-related harm</p> <p>Encourage effective border control strategies</p> <p>Uproot the availability of drugs in our society through by-law enforcement agencies that work in partnership with communities and other sectors of government</p>
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Disrupt illicit drug production, manufacturing and distribution networks at all levels and include alcohol concoctions	<p>Disruption and reduction of the movement of substances within and across provinces and through ports of entry</p> <p>More effective interdiction at international ports of entry</p> <p>Review laws that enhance the ability of the police and their partners in the law enforcement fraternity to effectively disrupt syndicates involved in the production, supply and distribution of drugs at local, national and international level</p> <p>Recover the proceeds of criminal activity and redirect to the funding of government programmes</p> <p>Target investigation of those involved in drug trafficking whose activities cause harm to South African communities</p>	<p>Effective technology across all areas of drug law enforcement</p> <p>Best practices to be used by law enforcers</p> <p>Declaring transportation of drugs and precursor chemicals across regions, provinces and the country as a national offence and granting law enforcement agencies the power to search and seize these substances</p> <p>Legislation on the confiscation of assets</p> <p>Disruption of illicit drug market at all levels</p>
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HARM REDUCTION

In September 2011 a workshop was held to start discussion in South Africa of the concept of harm reduction so as to reach agreement on an appropriate definition. The workshop participants agreed that drug-related harm can be categorised as follows:

Direct harm, which arises in the user as a consequence of the effect of the drug on the body. Example: drug overdose.

Indirect harm, which occurs to others as a consequence of the use of a drug. Example: loss of property through crime or being knocked down by an intoxicated driver.

Intrinsic harm, which is attributed to the toxic effects of a drug.

Extrinsic harm, which is attributed to the circumstances of use of the drug but not inherent in the properties of the drug itself. Example: HIV infection from the use of contaminated injection equipment.

Objective: What is to be achieved	Key action area	Example
Reduce harm for individuals who use drugs, their families and the community	Education and information for users to assist them reduce drug-related harm	Implement education and information dissemination projects Implement peer education strategies
	Development of policies and legislation that promote effective harm reduction strategies, or development of a concept paper on the issue	Implement policies and programmes that support harm reduction strategies
	Treatment of people using drugs, including overdose victims	Support proven opioid treatments, including detoxification, and inpatient and outpatient pharmacotherapy Increase attractive and accessible treatment options Encourage treatment programmes for drugs at health facilities
	Involvement of consumer groups in deciding about harm reduction interventions	Involve LDACs and PSAFs in reducing harm caused by substance abuse

Improve community amenities in areas where public drug use, drug-related crimes and disruption occur	Active involvement of affected groups in planning for improved community amenities in locations where drug use is high Minimisation of the negative impact of drug use on the community through co-operation with relevant groups	Improvement of community safety and related amenities Visible policing
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CONCLUSION

The new National Drug Master Plan 2013 – 2017 offers a balanced approach to collaboration on drug control and should help South Africa fight the scourge of substance abuse and set the country firmly on the road to creating a healthy nation.