Social Development

Department:
Social Development
REPUBLIC OF SOUTH AFRICA

C D A

CENTRAL DRUG AUTHORITY (CDA)

ANNUAL REPORT 2012/2013

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ABBREVIATIONS

AA	Alcoholics Anonymous
AIDS	Acquired Immunodeficiency Syndrome
ATS	Amphetamine-type stimulant (e.g. Ecstasy tablets and the local version of crystal methamphetamine known as "tik")
CAD	Christian Action for Dependents
CDA	Central Drug Authority
CND	Commission for Narcotic Drugs
DMP	Drug Master Plan
DPCI	Directorate of Priority Crime Investigation of the SAPS
DSD	Department of Social Development
ECOSOC	Economic and Social Council of the United Nations
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use
INCB	International Narcotics Control Board
LDAC	Local Drug Action Committee
MEC	Member of the Executive Committee
MRC	Medical Research Council
NDMP	National Drug Master Plan
NGO	Non-governmental organisation
NPS	New Psychoactive Substances
OTC	Over-the-counter medication
PDMF	Provincial Drug Master Plan
PSAF	Provincial Substance Abuse Forum

RPA	Rapid participatory assessment
SACENDU	South African Community Epidemiology Network on Drug Use
SANCA	South African National Council on Alcoholism and Drug Dependence
UNISA	University of South Africa
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1. FOREWORD BY THE MINISTER OF SOCIAL DEVELOPMENT

I present the annual report of the Central Drug Authority (CDA) outlining the main programmes and activities that took place during the 2012/2013 financial year. The annual report highlights areas of success and the challenges that the CDA was faced with during 2012/2013 financial year.

Substance and drug abuse still remain a challenge to South African communities. Central to social ills such as violence, crime, domestic violence, sexual offences, spread of HIV/Aids and other diseases, poverty, money laundering, illicit drug trafficking, human trafficking, to mention but few, is substance and drug abuse. The situation requires the involvement and active participation of men and women, children and youth and each and every South African citizen

2012/2013 financial year was one of the busiest years of the CDA. The Prevention of and Treatment for Substance Abuse Act, (Act 70 of 2008) was proclaimed by the President on 30th March 2013. Regulations for Act 70 of 2008 were developed and promulgated. Act 70 of 2008 makes provision for services such as Early Intervention, Prevention, Inpatient and Outpatient, Treatment, Reintegration and Aftercare services. All these services are currently being rolled out throughout the country.

The year was also marked by the coming to an end of the term of office of the second CDA committee. We had to review the operations and functioning of the CDA in accordance with Act 70 of 2008. This led to the appointment of the third CDA. The National Drug Master Plan (NDMP) 2013/20117 was endorsed by Cabinet in September 2013. The NDMP gives emphasis of treatment and prevention. The Anti-Substance Abuse programme for Adults, the Treatment programme Reintegration and Aftercare programmes were developed and implemented.

As we move forward as a collective to combat substance abuse, we need to do so in a comprehensive and coordinated manner. We look forward to the implementation of the new National Drug Master Plan (NDMP) 2013–2017 by all stakeholders. Together and united we can make South Africa a drug-free country.

Ms B.O. Dlamini, MP
MINISTER OF SOCIAL DEVELOPMENT

Date: 17 September 2014

2. EXECUTIVE SUMMARY BY THE CDA CHAIRPERSON

2.1 INTRODUCTION

This report covers the period 1 April 2012 to 31 March 2013. It deals with the activities and achievements of the second Central Drug Authority (CDA). This report further deal with targets achieved through the coordinated efforts of all stakeholders in addressing the scourge of substance abuse in South Africa.

The achievements of the second CDA include, amongst others, the development of the National Drug Master Plan (NDMP) 2013–2017, which is ready for implementation by all relevant stakeholders. The NDMP 2013–2017 advocates a strategy of primary prevention as proposed by the United Nations Office on Drugs and Crime (UNODC). This is a long-term strategy designed to get communities to reject substance abuse. The implementation will entail demand, supply and harm reduction and the achievement of short, medium and long-term targets related to substance abuse. As pointed out in the National Drug Master Plan 2013–2017 (Department of Social Development, 2013), drugs encompass psychoactive or dependence-producing substances such as alcohol, nicotine, over-the-counter and prescription medication as well as illicit drugs such as cannabis, cocaine and heroin. Psychoactive drugs/substances refer to 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).

Another achievement of the second CDA is the development and activation of the support structures in the form of nine Provincial Substance Abuse Forums (PSAFs) and their Local Drug Action Committees (LDACs), which total 238.

2.2 CENTRAL DRUG AUTHORITY

The previous CDA operated in terms of the Substance Abuse Act (Act 20 of 1992),
The CDA functions as a non-implementing body and is required to:

- Oversee and monitor the implementation of the NDMP;
- Facilitate and encourage the coordination of strategic projects;
- Facilitate the rationalisation of existing resources and monitor their effective use;
- Encourage government departments and private institutions to compile plans to address substance abuse in line with the goals of the NDMP;
- Advise government on policies and programmes in the field of substance abuse and drug trafficking; and
- Organise a biennial summit on substance abuse.

2.3 TRENDS IN SUBSTANCE ABUSE IN SOUTH AFRICA

Alcohol remains the primary substance of abuse in South Africa, followed by tobacco and then cannabis. Available data suggest that substantial proportions of South Africans consume alcohol, and those who do, tend to imbibe comparatively high volumes, especially during weekends.

2.3.1 TARGETS SET FOR 2012/2013

The targets set were as follows:

- Ensure approval of the reviewed NDMP 2013-2017;
- Improve access to substance abuse information, interventions and treatment;
- Reduce demand for and supply of illicit substances of abuse;
- Reduce harm associated with substance abuse (including morbidity and mortality);
- Reduce social ills associated with substance abuse;
- Conduct a national household survey focusing on substance use/abuse;
- Strengthen the capacity of the CDA's support structures with regard to the implementation of the NDMP 2013–2017.

2.4 ACHIEVEMENTS

Progress in the implementation of the NDMP 2006–2011 involved:

- Evaluated the success of the NDMP 2006–2011;
- Developed, consulted on, and submitted a final draft of the NDMP 2013–2017.
- Maintained 9 PSAFs and established 238 LDACs;
- Made contributions to the development of Regulations to Act 70 of 2008
- Monitored the implementation of the resolutions of the 2nd Biennial Anti-Substance Abuse Summit that were conveyed to the implementing agencies (information on progress being included in the CDA Annual Report to Parliament);
- Developed and shared the Resource Directory on substance abuse services with the relevant stakeholders;
- Partnered with the UNODC and the University of South Africa (UNISA) to launch the World Drug Report in 2012; and
- Prepared a Handover Report for the inauguration of the third CDA.
- Limpopo, Mpumalanga, Northern Cape and Free State province were capacitated to implement the anti-substance abuse programme of action.

- The Prevention and Treatment of Substance Abuse Act (No.70 of 2008) came into force, and regulations were promulgated and enforced.
- The treatment model was approved and capacity to enhance its implementation was built in all provinces.
- A social mobilisation strategy was developed and approved.
- Developed a National Strategy for the Prevention and Management of Alcohol and Drug Use amongst Learners in Schools.
- Developed advocacy material for learners, Educators and Parents. (the material outlines what are drugs, what are their consequences, sign and symptoms of abuse and the role that each stakeholder can play to prevent and mitigate its impact.
- Declared Cocoa Tea undesirable in terms of the Medicine and Related Substances Act, 1965.
- Investigated and pronounced on the concoction “Nyaope” drug. Which falls under schedule 7(banned substances)
- Draft Bill on alcohol advertising, sponsorship and promotion.
- A total of 1, 824 865, 821 litres of liquor was confiscated by the SAPS between the period 1st April 2012 and 31st March 2013. This includes 57, 061, 967 litres of home brew beer.
- Managed and administer doping control services that are required in terms of international sport regulations.
- Developed draft detoxification guidelines.

2.5 CHALLENGES

The CDA has to review its structure so as to deliver on its mandate.

2.6 RECOMMENDATIONS

CDA presents the following recommendations:

- The public take note of the achievements of the CDA for the 2012/2013 period.
- The NDMP vision of drug free South Africa be supported by all.
- Concerted efforts and dedication to implement the NDMP be doubled.
- The partnership between the CDA, UNISA and the UNODC, which has created greater awareness of patterns, trends and the impact of substance abuse locally and globally, should be strengthened.

- Efforts towards addressing emerging substance use/abuse patterns in our communities should be sensible. LDACs need to be trained to identify such patterns timely and wherever they occur.

- Finally, resources be made available to address the scourge and realise the NDMP.

Mr M Kalaeamodimo
CHAIRPERSON: CENTRAL DRUG AUTHORITY
Date: 17.09.2014

3. ANNUAL REPORT OF THE CDA 2012/2013

3.1 BACKGROUND TO THE REPORT

This annual report of the CDA covers the period 1 April 2012 to 31 March 2013. It deals with the activities and achievements of the second CDA in that period, the appointment of the third CDA in January 2013 and its inauguration in March of that year.

This report details the targets achieved through the coordinated efforts of all stakeholders in addressing the scourge of substance abuse in South Africa. It summarises the reports received from representatives of government and consolidates inputs from departments. It outlines the strategy for meeting the challenges posed by the use and abuse of and dependence on alcohol and other psychoactive substances in South Africa, and for honouring international commitments to the combating of substance abuse.

3.2 PURPOSE OF THE REPORT

The purpose of this report is to highlight:

- The role, membership and functions of the CDA;
- Links between the CDA and national and international organisations engaged in combating substance abuse;
- The extent of the substance abuse problem worldwide and in South Africa;
- The targets set by the CDA for combating substance abuse for the year under review; and
- The progress registered and targets achieved by the CDA and its support structures during the 2012/2013 financial year. In short, it attempts to paint a picture of how South African stakeholders – mandated by the Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008) and the previous Substance Abuse Act (Act 20 of 1992) – have combated substance abuse.

3.3 CDA MEMBERSHIP

CDA members comprise 13 appointed members from the private sector (experts in the field of substance abuse) and representatives of 21 national departments and entities. Prior to appointment, members from the private sector underwent a nomination and selection process. Representatives from government departments were nominated by their respective ministers and appointed by the minister of Social Development.

3.4. ROLES OF CDA MEMBERS

Members of the CDA are expected to apply their expertise in the field of substance abuse to the development and application of the integrated strategy for demand, supply and harm reduction. In addition, they are required to assist in the development and implementation of policies, protocols and practices relating to the process of prevention, treatment, aftercare and reintegration into society of those affected by substance dependence. The CDA, as the primary body that advises the Minister of Social Development and Parliament on substance abuse, must oversee and monitor the implementation of the NDMP. The mandate, role and composition of the CDA are described in the Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008).

CDA members are required to serve the CDA as follows:

- To facilitate the establishment of the Provincial Substance Abuse Forums (PSAFs) through the members of executive councils (MECs) in all provinces and to establish of Local Drug Action Committees (LDACs) in all municipal districts in the country through the mayors in those municipal districts.

- The expert members collectively and individually are expected to apply their expertise in the field of substance abuse to the development and application of the integrated demand, supply and harm reduction strategy that is described in the NDMP 2013–2017, and to the development and implementation of policies, protocols and practices relating to the process of prevention, treatment, aftercare and reintegration into society of those affected by substance dependence.

- The expert members are also expected to participate in the clusters of sectors involved in the development of national and provincial drug master plans (DMPs) and in the execution of the CDA's mandate.

- These expert members of the CDA liaise between the CDA and the PSAFs and attend their meetings. They are expected to guide and advise such forums in their field of expertise and in the interpretation and implementation of the NDMP and the provincial DMPs.

3.5 ROLE OF THE CDA SECRETARIAT

The CDA is supported by a secretariat that has to ensure that the day-to-day work of the CDA is carried out in line with the outcomes specified in the NDMP. It also provides administrative support to the CDA and its support structure or institutional framework.

4. CDA LINK WITH NATIONAL AND INTERNATIONAL ORGANISATIONS

4.1 NATIONAL ORGANISATIONS

4.1.1 DEPARTMENTAL REPRESENTATION

By virtue of their representation in the CDA, government departments are an integral part of the CDA structure. This enables the departmental representatives to oversee and guide the development and implementation of the respective national and provincial DMPs.

4.1.2 PROVINCIAL REPRESENTATION

Conceptually and in its membership, a PSAF consists of representatives of provincial government departments that correspond with the national government departments that are represented on the CDA, key non-government organisations functioning in a province and other stakeholders represented by the expert members of the CDA. This enables a PSAF not only to oversee and guide the development and implementation of the provincial DMP concerned but also to provide a link to the LDACs and their communities.

4.1.3 KEY NATIONAL SUBSTANCE ABUSE-RELATED ORGANISATIONS AND SYSTEMS

Through the representatives mentioned above, the CDA has links to and is able to tap the expertise and some of the resources of the following national organisations dealing with substance abuse and related matters:

- SA National Council on Drugs and Alcoholism (SANCA), a national organisation representing a number of treatment and rehabilitation centres;
- SA Community Epidemiology Network on Drug Use (SACENDU), a national sentinel surveillance system, compiling and disseminating data on substance use and abuse provided by a number of treatment and rehabilitation centres in the country;
- Medical Research Council (MRC) and in particular the Alcohol and Drug Abuse Research Unit of the MRC, a national research organisation/unit focusing on substance abuse-related matters;
- Alcoholics Anonymous (AA), an international support and aftercare group for recovering alcohol dependents, and its related Narcotics Anonymous and other subsidiaries; and
- Christian Action for Dependents (CAD), an aftercare and support group for recovering substance dependents, and similar organisations.

4.2 INTERNATIONAL ORGANISATIONS

4.2.1 COMMISSION ON NARCOTIC DRUGS

The Commission on Narcotic Drugs (CND) is one of the functional commissions of the Economic and Social Council (ECOSOC) of the United Nations and is the central drug policy-making body in the United Nations. It has important functions under the drug control treaties in force today and can amend the schedules of controlled substances under the Single Convention on Narcotic Drugs and the Conventions on Psychotropic Substances. All the member states of the CND's central drug authorities or similar bodies attend CND sessions to report on and compare the situation in their countries and the lessons learnt during the implementation of the respective national drug master plans.

Mandate and functions of the CND

The CND reviews and analyses the global drug control situation, taking into account the interrelated issues of drug abuse prevention, rehabilitation of drug users and the supply of and trafficking in illicit drugs. It takes action through resolutions and decisions.

Functional commission of the Economic and Social Council

The CND was established by the Economic and Social Council of the United Nations as one of its functional commissions on 16 February 1946 (Resolution 9(I)). The CND assists the Council in supervising the application of international drug control treaties. It also advises the Council on the control of narcotic drugs and psychotropic substances and their precursors.

Normative functions

The CND has important normative functions in terms of international drug control conventions. It is authorised to consider the aims of these conventions and ensure their implementation. As a treaty organ under the Single Convention on Narcotic Drugs, 1961, and the Convention on Psychotropic Substances, 1971, the CND is empowered, on the basis of recommendations by the World Health Organization (WHO), to place narcotic drugs and psychotropic substances under international control. The Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, empowers the CND, upon the recommendation of the International Narcotics Control Board (INCB), to place precursor chemicals frequently used for the manufacture of illicit drugs under international control. The CND is also empowered to remove or modify international control measures for drugs, psychotropic substances and precursors.

Governing body of the UNODC International Drug Control Programme

The mandates of the CND were further expanded in 1991 when it was empowered to approve the budget of the fund of the United Nations International Drug Control Programme, which is administered by the United Nations Office on Drugs and Crime (UNODC), and to finance measures to combat the world drug problem.

Monitoring political commitments on drug control

The CND was also mandated to monitor the outcome of the 1998 Special Session of the General Assembly on countering the world drug problem as well as the renewed commitments enshrined in the 2009 Political Declaration and Plan of Action.

Link between the CDA and the CND

South Africa became a member of the CND in 1995. Hence South Africa is represented on the CND and participates in CND annual meetings. The annual session of the CND gives member countries the opportunity to participate in the formulation of international drug policies that are mandatory for member countries. The CDA participates in CND annual meetings, given that it is a statutory body within the Department of Social Development (DSD) mandated by the Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008) to combat substance abuse in South Africa. It should also be borne in mind that (1) the CDA is required to report annually to the DSD on South Africa's contribution towards the implementation of the various international drug control treaties; and that (2) CDA stakeholders include the national departments, provincial departments and non-government organisations focused on the combating of substance abuse.

4.2.2 UNITED NATIONS OFFICE ON DRUGS AND CRIME

Aims and functions

The United Nations Office on Drugs and Crime (UNODC) was established in 1997. The headquarter of this office is in Vienna, Austria. It has 21 field offices, one of which is in Pretoria, South Africa. The long-term aims of the office are to equip governments to handle issues related to drugs, crime, terrorism and corruption. About 90% of the funding of the office comes from voluntary donations, mainly from governments.

World Drug Report

The World Drug Report is an annual publication that presents a comprehensive assessment of the international drug problem, with detailed information on the illicit drug situation. It provides estimates and information on patterns and trends in the production, trafficking and use of key drugs. The report, based on data and estimates collected or prepared by governments, the UNODC and other international institutions, attempts to identify patterns and trends in the evolution of global illicit markets.

Link between the CDA and the UNODC

The CDA contributes data for inclusion in the World Drug Report, and is presently engaged in a joint project with the Pretoria office of the UNODC to identify the extent of injection drug use (IDU) in selected sites and the link between IDU and HIV/AIDS.

5. EXTENT OF THE WORLD SUBSTANCE USE PROBLEM

5.1 NEW PSYCHOACTIVE SUBSTANCES

As reported in the World Drug Report of 2013 (United Nations Office on Drugs and Crime, 2013), there has been an increase worldwide in the production and use of new psychoactive substances (NPSs), that is substances that are not under international control but pose a health threat.

Substances regarded as NPSs by the UNODC include:

- Synthetic cathinone and ketamine
- Synthetic cathinones
- Phenethylamines
- Piperazines
- Ketamie
- Plant-based NPSs such as kratom (Mytragyna speciosa) and khat (Catha edulois)

The main health consequences of some of the most widespread NPSs are described below.

- Synthetic cannabinoids: often mixed with various herbal mixtures and sold under various brand names such as Spice and Moon Rocks, producing hallucinatory effects, increased heart rate, slurred speech, severe confusion and shifts in perceptions of reality;
- Phenethylamines: known on the street as Legal E, Nemesis etc, producing a feeling of well-being but can adversely affect thought patterns and heart rates and cause renal toxicity and seizures;

- Khat: when chewed, induces only mild euphoria, excitement and increased talkativeness, but has adverse effects including cardiovascular disorders.

NPS use has been reported in a number of countries in recent years. However, the true extent of its use is largely unknown for lack of systematic studies on its spread.

In Africa, seven countries reported NPS use although only two could specify the specific types of concern. South Africa reported the use of khat and synthetic cannabinoids.

The issue of NPSs and their potential control is scheduled to be reviewed at the high-level meeting of the CND in 2014. South Africa will be represented at the follow-up meetings.

5.2 ILLICIT DRUG USE

Globally the demand for illicit drugs other than NPSs has not been substantially reduced. The implementation of the illicit drug control system, the crime and violence generated by the abuse of illicit drugs and illicit drug trafficking, the NPS and national legislative measures that may result in the violation of human rights also remain a challenge.

The trends in new routes for trafficking of illicit drugs and in the production of such drugs indicate that Africa is increasingly becoming vulnerable to the illicit drug trade within the wider context of organised crime. The lack of accurate information on trends in Africa requires the international community to invest the necessary resources to monitor the drug situation in Africa.

Regarding people who inject (illicit) drugs (injecting drug users (IDUs)) and who live with HIV/AIDS, there have been some improvements. Countries that implemented a comprehensive set of HIV/AIDS interventions were able to achieve a reduction in high-risk behaviours and HIV transmission. The CDA is engaged in a project with the UNODC (Pretoria office) to assess the effect of injecting drug use on HIV in this country.

Illicit drugs and NPSs continue to jeopardise the health and welfare of communities. They pose a clear threat to the stability and security of entire regions and specific countries, and to their economic and social development. Illicit drug dependence is often exacerbated by low levels of economic and social development, illicit drug trafficking, organised crime, and an inability to provide treatment and aftercare for drug/substance abusers.

6. EXTENT OF THE SOUTH AFRICAN SUBSTANCE ABUSE PROBLEM

In preparing this section of the report, the CDA took cognisance of relevant sections in the National Drug Master Plan 2013–2017 (Department of Social Development, 2013). The CDA is also grateful to the Alcohol and Drug Abuse Research Unit of the Medical Research Council (MRC) for its comprehensive reporting on the situation.

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 (1) 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 (2) 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.] … [The researchers assumed that] '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, 2011:100), 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, 2011:100).)

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):

(1) 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;

(2) 32% (39% among males and 26% among females) in the 2002 survey, and 35% (41% among males and 30% among females) in the 2008 survey admitted that they had a “drink” of alcohol on 1 or more days in the month before the respective surveys; and

(3) 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).

Furthermore, 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).

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.

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):

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

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

<u>Heroin</u>
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 (crystal methamphetamine) 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:

(1) 13% admitted lifetime use (used the substance at some time in their life) of cannabis in 2002 as well as in 2008;
(2) 6% admitted lifetime use of mandrax in 2002 and 7% in 2008; similar proportions admitted the use of cocaine;
(3) 12% admitted lifetime heroin use in 2002 and 6% in 2008;
(4) 7% admitted lifetime use of crystal methamphetamine (tik) in 2008; and
(5) 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.

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.

6.1 TREATMENT AND BARRIERS TO TREATMENT

South Africa arguably has the most developed substance abuse treatment system in Africa, yet demand for treatment far exceeds supply. Some provinces do not have affordable state-sponsored treatment facilities, and although some private centres provide high standards of care, these are unaffordable to most substance users/abusers.

7. ACHIEVEMENTS OF THE CDA IN 2012/2013

7.1 TARGETS SET FOR 2012/2013

The targets set were as follows:

- Ensure approval of the reviewed NDMP 2013–2017;
- Improve access to substance abuse information, interventions and treatment;
- Reduce demand for and supply of illicit substances of abuse;
- Reduce harm associated with substance abuse (including morbidity and mortality);
- Reduce social ills associated with substance abuse;
- Conduct a national household survey focusing on substance use/abuse;
- Strengthen the capacity of the CDA's support structures with regard to the implementation of the NDMP 2013–2017.

7.2 SUMMARY OF ACHIEVEMENTS

Given that the second CDA was effectively in office for six months of the reporting year, this part of the report covers that period, i.e. April to September 2012. In that period the CDA in essence:

- Evaluated the success of the NDMP 2006–2011;
- Developed, consulted on, and submitted a final draft of the NDMP 2013–2017.
- Developed and extended the coverage of the PSAFs and LDACs;
- Made acknowledged contributions to the development of Act 70 of 2008 and its accompanying regulations;
- Monitored the implementation of the resolutions of the 2nd Biennial Anti-Substance Abuse Summit that were conveyed to the implementing agencies (information on progress being included in the CDA Annual Report to Parliament);

- Developed and shared the Resource Directory on substance abuse services with the relevant stakeholders;
- Partnered with the UNODC and the University of South Africa (UNISA) to launch the World Drug Report in 2012; and
- Prepared a Handover Report for the inauguration of the third CDA.
- Limpopo, Mpumalanga, Northern Cape and Free State province were capacitated to implement the anti-substance abuse programme of action.
- The Prevention and Treatment of Substance Abuse Act (No.70 of 2008) came into force, and regulations were promulgated and enforced.
- The treatment model was approved and capacity to enhance its implementation was built in all provinces.
- A social mobilisation strategy was developed and approved.
- Developed a National Strategy for the Prevention and Management of Alcohol and Drug Use amongst Learners in Schools.
- Developed advocacy material for learners, Educators and Parents. (the material outlines what are drugs, what are their consequences, sign and symptoms of abuse and the role that each stakeholder can play to prevent and mitigate its impact.
- Declared Cocoa Tea undesirable in terms of the Medicine and Related Substances Act, 1965.
- Investigated and pronounced on the concoction “Nyaope” drug. Which falls under schedule 7(banned substances)
- Draft Bill on alcohol advertising, sponsorship and promotion.
- A total of 1, 824 865, 821 litres of liquor was confiscated by the SAPS between the period 1st April 2012 and 31st March 2013. This includes 57, 061, 967 litres of home brew beer.
- Managed and administer doping control services that are required in terms of international sport regulations.
- Developed draft detoxification guidelines.

7.3 EVALUATION OF THE NATIONAL DRUG MASTER PLAN 2006–2011

REVIEW OF THE NDMP 2006–2011

The CDA is mandated to review NDMP 2006-2011 for the period 2013–2017, based on an analysis of past CDA achievements and an identification of those aspects that require further attention. It is also required to incorporate aspects of relevant international policy within 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 support structures, including those of departments represented in the CDA and the PSAFs;
- 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 second 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

The CDA reviewed the NDMP 2006 -2011, while doing the review the CDA identified several challenges that need to be addressed in the NDMP 2013–2017. These include, but are not limited to, the following:

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

- Re-aligning the NDMP strategy with the changing strategies of the UNODC and the WHO;

- Re-aligning research as well as strengthening research capacity to enable the CDA to become proactive in its efforts to facilitate the combating of substance abuse and related harm in South Africa and, hopefully, in neighbouring territories;

- Repositioning the CDA in accordance with the recommendations of the final report on the review of the CDA (Deloitte & Touche, 2011) so as to be better able to achieve the outcomes of the NDMP and to finance its efforts in this regard;

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

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

- Developing and implementing solutions to the problems of funding the CDA support structures, especially relating to the PSAFs, LDACs and NGOs, the related protocols and the Public Finance Management Act (Act 1 of 1999);

- Developing/strengthening partnerships between the CDA and relevant local, regional and global organisations so as to achieve the outcomes of the NDMP;

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

- Strengthening the capacity and ability of the CDA support structures so as to (1) ensure the submission of reports in a format that will enable the accurate assessment of the outcomes and outputs of the NDMP, and so as to (2) facilitate the development and use of the National Database on Substance Abuse and the accompanying clearing house.

7.4 DEVELOPMENT OF THE NATIONAL DRUG MASTER PLAN 2013–2017

In applying these findings to the development of the "new" NDMP, the procedure followed was one of:

- Preparation of a first and subsequent drafts of the proposed NDMP 2013–2017;
- Consultation with PSAFs, communities and other stakeholders through the holding of a series of two-day workshops in each province and the subsequent amendment of the proposed NDMP;
- Submission of the revised draft to the CDA for formal comment and subsequent amendment; and
- Formal submission of the final draft to the Minister of Social Development and hence to Cabinet for formal approval.

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 (see Figure 1) 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 substances 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 and dependents with society.

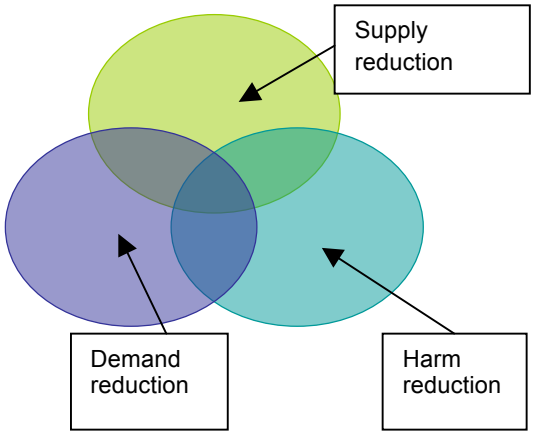

Figure 1: Recommended balanced integration of three strategic ways of combating substance abuse

7.5 APPLICATION OF THE INTEGRATED STRATEGY TO THE DEVELOPMENT OF THE NDMP 2013–2017

In examining the seven key specific outcomes of the NDMP 2013–2017 listed below, it should be noted that they have been derived from the applicable 12 government outcomes that form part of the general framework (Public Service Commission, 2008) within which planning occurs in government, and from the review of the NDMP 2006–2011. A special attempt was also made to ensure that what is done by the CDA and its support structures runs concurrent with the normal work of departments and provinces. Furthermore, the outputs derived from the NDMP outcomes incorporate the 34 resolutions passed at the second Biennial Anti-Substance Abuse Summit in March 2011 as well as the results of the RPA carried out in the same year.

Therefore, and more specifically, in applying the integrated strategy to the NDMP 2013–2017, the following points need to be noted:

Firstly, the seven key specific outcomes were described in terms of the South African government's basic monitoring and evaluation concepts (Public Service Commission of South Africa, 2008). These outcomes are as follows:

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 (Public Service Commission, 2008), the key outcomes were translated into *specific* NDMP and provincial DMP

outcomes, outputs, activities and targets, and responsibility was allocated for their achievement.

Thirdly, and more particularly, the relevant national and provincial government *departments* in their various clusters are required to translate, in concrete terms, the abovementioned outcomes, outputs, activities and targets 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, in effect, the implementation of the NDMP.

Fifthly, for the duration of implementation, standardised *reports* on progress with the achievement of the targeted outcomes and outputs in the DMPs are to be 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 Figure 2 below.

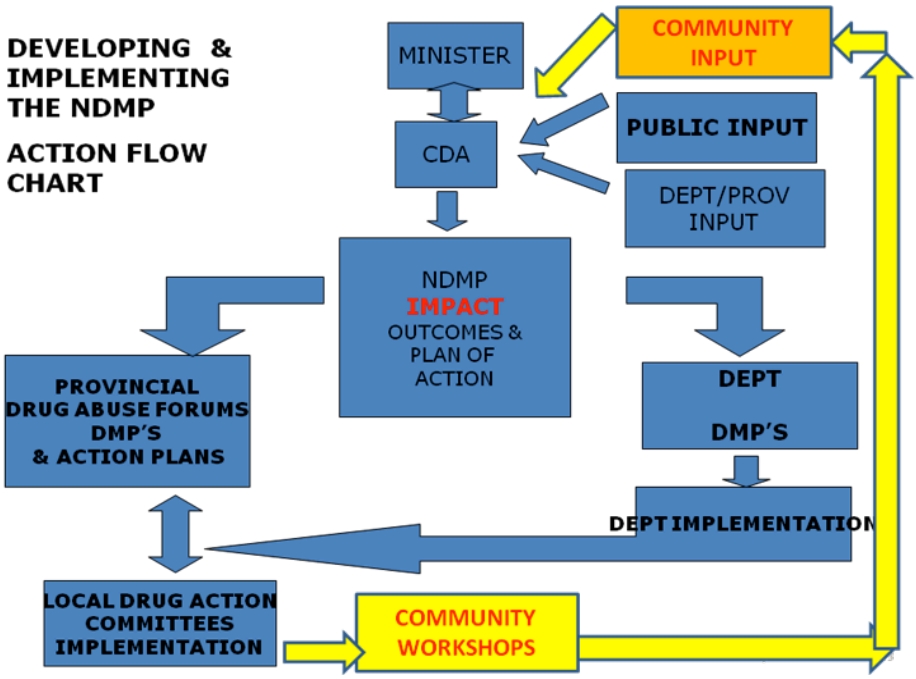

Figure 2: Development of the NDMP 2013–2017

The NDMP 2013–2017 was formally approved in June 2013, after the end of the term of the second CDA.

7.6 DEVELOPMENT OF THE SUPPORT STRUCTURES OF THE CDA

In terms of Act 70 of 2008 (Prevention of and Treatment for Substance Abuse Act), the CDA is required to ensure that there exists support structures consisting of one PSAF for each province and an LDAC for each municipality.

At the end of the second CDA's term of office, this objective had been achieved, i.e. there were 9 PSAFs and 238 LDACs. However, the following should be noted:

- Members of the CDA are delegated to attend the meetings of PSAFs and to assist them wherever possible.

- The membership of these substructures (PSAFs and LDACs) does not meet the requirement proposed by the CDA, i.e. to be a mirror image of the CDA at provincial level.

- Attendance at meetings varies with representation of different bodies changing from time to time.

- Achievement by these bodies tends to reflect the expertise and field of interest and ability of the majority of the members of these bodies and not always that required by the NDMP 2013–2017.

- Members of the relevant bodies (PSAFs and LDACs), particularly at local level, are not remunerated for their involvement in and specific contributions to these bodies.

8. MONITORING AND EVALUATION OF THE NDMP

In the year under review the CDA introduced the concepts of outcomes-based monitoring and evaluation during the process of consultation on and modification of the draft NDMP 2013–3017. The NDMP itself was designed to use the outcomes model as a basis for monitoring and evaluation. In the ensuing national and provincial DMPs, the format of the tables used in the plan to specify goals, outcomes, outputs and activities requires the description of activities to be executed by the CDA, national departments and relevant provincial sectors, together with objectively verifiable indicators (of achievement), baseline measurements, targets and target dates.

The CDA, through its representatives on the PSAFs, commenced with the monitoring and evaluation of the achievements of the relevant support structures, using the Quick Analysis of Substance Abuse Report (QuASAR) and the formal annual reports of national departments and related provincial sectors. However, the QuASAR was found not to be entirely suitable for monitoring and evaluation and has been discarded. A new standardised reporting format has been devised and is, at the time of writing, being piloted.

Once accepted, the revised reporting format will be used as a tool for assessing (1) the achievement of targets set by national and provincial departments/sectors in their respective DMPs, and (2) the success of the NDMP.

9. PREPARATION OF A HANDOVER REPORT FOR THE THIRD CDA

As part of its preparations for the end of its term of office, the second CDA prepared a Handover Report to be used in the induction of the third CDA. The contents of that report appear in the addenda to this report.

10. ACHIEVEMENTS RELATING TO THE IMPLEMENTATION OF THE NDMP 2016–2011

10.1 INTRODUCTION

By way of introduction, the following should be borne in mind:

- The CDA is not an implementing organisation but one that guides, directs, coordinates, monitors and evaluates the activities of support structures consisting of PSAFs, LDACs and represented departmental substance abuse sectors.

- The CDA is dependent on the support structures for the preparation and implementation of and reporting on provincial and national departmental DMPs.

- Although all the relevant provincial sectors submitted annual reports, a number of national departments represented in the CDA did not. The reports were also largely phrased in terms of the *activities* carried out by the relevant agencies instead of also in terms of the achievements emanating from the activities.

The national government departments and agencies that submitted annual reports are:

Department of Arts and Culture
Department of Basic Education
Department of Correctional Services
Medicine Control Council
Department of Health
Department of International Relations and Cooperation
Department of Social Development
South African Police Service
South African Revenue Service
Sport and Recreation (South African Institute for Drug-Free Sport)
National Youth Development Agency
Department of Trade and Industry

The following two sections *summarise* – in tabulated format and in terms of the NDMP's key intervention strategies – the *main* issues noted in the annual reports submitted in writing or presented verbally (at a CDA meeting on 29 and 30 May 2013) by the relevant national and provincial departments/sectors to the CDA. (The full reports received are attached as addenda to this report.) Readers are also reminded that the NDMP's three main intervention strategies (demand, supply and harm reduction) are closely interrelated, i.e. the one affects the other.