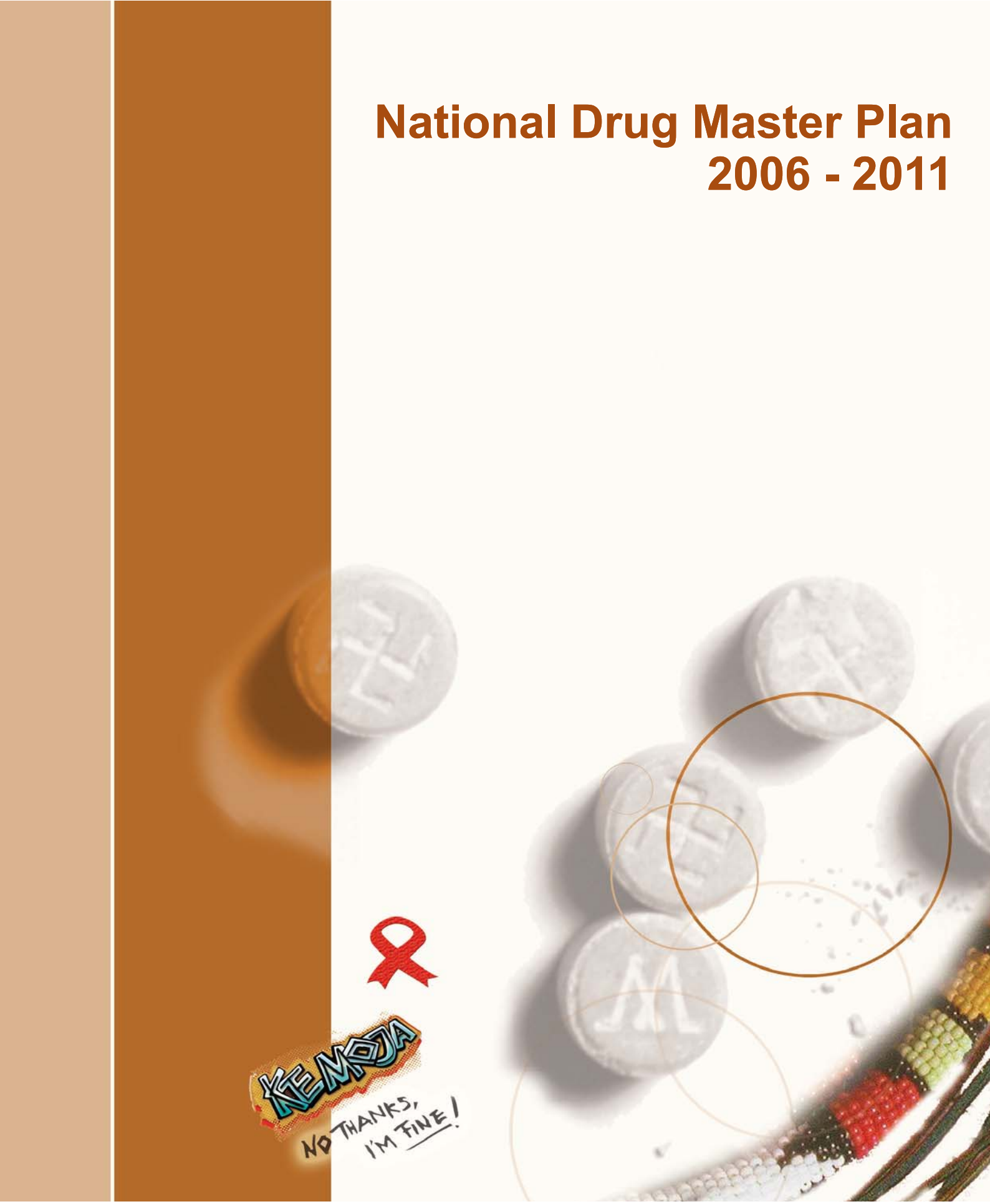
National Drug Master Plan 2006 - 2011

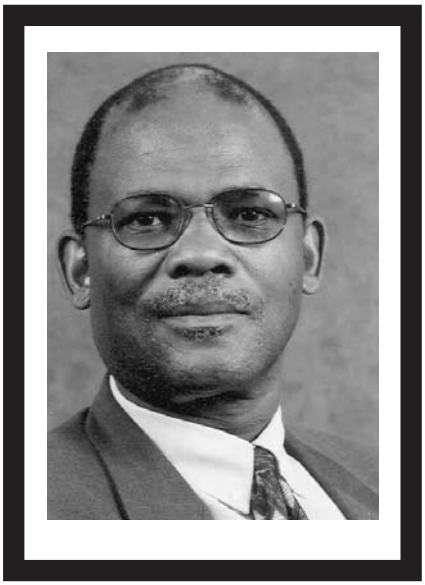


social development

Department:
Social Development
REPUBLIC OF SOUTH AFRICA

CDA

FOREWORD BY THE MINISTER



The scourge of substance abuse continues to ravage our communities, families and, particularly, our youth; the more so, as it goes hand in hand with poverty, crime, reduced productivity, unemployment, dysfunctional family life, escalation of chronic diseases and premature death. South Africa should address the problem of substance abuse in partnership with other African countries.

Substance abuse does not respect economic class, race, colour, gender or the professional status of an individual. This is cause for great concern, given the fight to restore Africa to its rightful place in the world.

The operationalisation of the New Partnership for Africa's Development (NEPAD) will therefore be a key factor in resolving the substance abuse problems of South Africa and the rest of the continent. A further key factor will be the ability to implement a coordinated, multipronged plan that takes cognisance of legal, health and socioeconomic issues and is supported by all spheres of government and all sectors of society.

The revised National Drug Master Plan 2006-2011 is South Africa's answer to this challenge. It has been designed to serve as the basis for holistic and cost-effective strategies to reduce the supply and consumption of drugs and limit the harm they cause.

Ultimately, the plan is intended to help realise the vision of a drug-free society where drug services will no longer be required and where attention can be focused exclusively on improving the quality of life of the poor and vulnerable. In comparison with the first National Drug Master Plan, the focus in the revised plan is more on the delivery of interventions based on best practices. The revised plan also supports the government's commitment to intensify delivery during its third term in office.

DR ZST SKWEYIYA
MINISTER OF SOCIAL DEVELOPMENT

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CHAPTER 1
INTRODUCTION

1.1 BACKGROUND

The National Drug Master Plan (NDMP) was drafted in accordance with the stipulations of the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992). It reflects the country's responses to the substance abuse problem as set out by UN Conventions and other international bodies. The administrative unit of the Act is the Central Drug Authority (CDA) whose secretariat is located in the Department of Social Development. The NDMP enables cooperation between government departments and stakeholders in the field of drug prevention.

The NDMP outlines the role that each department should play in fighting the scourge of drug abuse. It also acknowledges the significant contribution in this regard of various departments and agencies in the country.

The success of the NDMP depends on the extent to which CDA participants succeed in crafting sector-based responses to the drug problem. The CDA then has to draw these responses into a single master plan for South Africa.

In his opening address to parliament in 1994, the former South African President, Mr Nelson Mandela, singled out alcohol and drug abuse as social pathologies requiring urgent attention. Substance abuse is a major contributor to crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability, the escalation of chronic diseases such as acquired immunodeficiency syndrome (AIDS) and tuberculosis (TB), injury and premature death.

It reaches across social, racial, cultural, language, religious and gender boundaries and affects everyone directly or indirectly. Even tobacco use has been shown to exacerbate poverty and reduce productivity and, together with alcohol, is also recognised as a gateway to the use of other drugs.

Alcohol abuse is a factor in nearly half of the motor accidents in South Africa every year, resulting in the loss of some 7 000 lives and a cost to the country of nearly R20 billion. Drug use also has a negative effect on transport safety as many (up to a third) long-distance drivers admit to using drugs (mainly alcohol and cannabis) to relax and stay awake.

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 departments and government entities involved in the reduction of the demand for and the supply of drugs in a country.

For the purposes of the National Drug Master Plan, the term **"**drugs**"** refers to illicit drugs as defined in the Drugs and Drug-Trafficking Act (No. 140 of 1992) and to the commonly abused licit medicines. Although not specifically included in the definition, alcohol, tobacco and volatile solvents are also recognised as major contributors to health and social problems in South Africa.

In South Africa, levels of substance abuse continue to rise with the age of first experimentation with drugs dropping to ten years. However, South Africa is not alone in its campaign against drugs the rapid globalisation of the drug trade over the past decade has meant that no country is immune from the threat. The drug trade transcends national borders, and South Africa continues to serve as a transit route for the drug trade and has also become a major consumer of drugs.

Sections 10 to 12(1) of Chapter 2 of the Constitution of the Republic of South Africa (No. 108 of 1996) grant citizens the right to have their dignity respected and protected, and the right to life, freedom and security. To realise these rights, the South African government is committed to reducing the supply of illegal drugs and the demand for such drugs through a wide range of measures and programmes.

The Prevention and Treatment of Drug Dependency Act (No. 20 of 1992) provides for the establishment of the Central Drug Authority (CDA). The administration of the Act is entrusted to the Department of Social Development, which is the lead department in the fight against substance abuse and also provides the secretariat for the CDA. A major function of the CDA is to develop the National Drug Master Plan as a national strategy for managing the demand for and supply of drugs in the country and for facilitating an integrated approach to service delivery and the coordination of programmes on the management of the drug problem in all spheres of government and civil society.

A concerted effort is required from the government and the different sectors of society to make South Africa a drug-free country. This goal can be achieved through collaboration between all levels of government and other key stakeholders such as healthcare professionals, traditional healers, traditional institutions, religious organisations, schools, parents, sports groups, the media and the private sector.

The South African National Drug Master Plan 2006-2011 sets out the country's national policies and priorities in the quest to build a drug-free society and to fight substance abuse. The plan deals with the intensification of the anti-drug campaign, national and provincial departments' inclusion of measures to counter substance abuse in their programmes, and budgeting for these interventions. It also calls for community participation through the establishment and support of provincial forums and local drug action committees.

1.2 SUBSTANCES OF ABUSE

In order to understand drug use, one should ask, **"**What is a drug?**"** In the case of pharmaceutical preparations as well as naturally occurring substances, a drug is a substance that is used with the intention of bringing about change in some existing process or state be it psychological, physiological or biomedical. The intended modification can be directed towards changes in medical, behavioural or perceptual states and for either therapeutic or non-medical purposes. Substances not usually considered as drugs may function as drugs under certain circumstances, for example foods, beverages, solvents and aerosols.

The above definition indicates that a variety of substances from a wide range of sources can be considered drugs, and they can be divided broadly as follows according to source.

Naturally occurring substances: Certain plants and animal tissue have psychoactive effects; in some cases, the crude material is used as a drug preparation while in other cases the psychotic substances are extracted and purified. Examples of naturally occurring substances are cannabis (dagga), tobacco and khat.

Semi-synthetic drugs: Chemical manipulations of psychoactive substances that have been extracted from natural materials may result in drugs with different properties. Examples are cocaine, alcohol and heroin.

Synthetic drugs: These involve psychoactive agents neither found in nature nor derived from natural psychoactive agents. They are created entirely by the laboratory manipulation of two or more relatively simple chemicals, which are themselves usually psychoactively inert. Examples are methylenedioxymethamphetamine (MDMA) (ecstasy), methaqualone (mandrax), methamphetamine and methcathinone.

Generally, substances that are abused in South Africa can be divided into three categories according to level of use:

- Extensively used substances
- Moderately used substances
- Infrequently used substances

In the first category, the most common substances are alcohol and tobacco followed by cannabis and the cannabis-mandrax combination (white pipe). Mandrax (methaqualone) is rarely used on its own. The widespread abuse of over-the-counter and prescription medicines (e.g. pain relievers, tranquillisers (including benzodiazepines), cough mixtures (containing codeine) slimming tablets and solvents (especially glue)) is also cause for concern. The unregulated use of home-brewed alcohol requires monitoring as poisonous additives form part of the ingredients of many types of home-brewed substances.

In the second category are crack cocaine, cocaine (powder), heroin, speed, LSD (lysergic acid diethylamide), hashish, methamphetamine and ecstasy. Crack cocaine may be placed in the first category in future, as may methamphetamine as its use has increased rapidly since 2003, especially in the Western Cape.

In the third category are substances such as opium, Rohypnol (flunitrazipam), ketamine, Wellconal and methcathinone (khat).

Many substance users are polysubstance users (i.e. they use various drugs in combination with alcohol as well as other combinations such as cocaine and heroin). In terms of pharmacological properties, the substances most abused in South Africa are depressants (e.g. alcohol, white pipe, mandrax, benzodiazepines) followed by hallucinogens (e.g. cannabis, LSD, speed and ecstasy).

1.3 SITUATION ANALYSIS: THE DRUG PROBLEM IN SOUTH AFRICA

1.3.1 Trends in substance dependency

Accurate, up-to-date statistical data on the use and abuse of alcohol and illicit drugs in South Africa are difficult to obtain, but valuable deductions can be made from recent research, departmental reports and information from international sources. The following are the most commonly used drugs in South Africa.

Alcohol: Alcohol remains the primary drug of abuse in South Africa. Indications are that between 7,5% and 31,5% of South Africans have an alcohol problem or are at risk of having such a problem. A drinker at risk is someone whose health is likely to be affected by drinking or who is or is likely to become an alcoholic. Risk drinking during weekdays involves on average 7,5% of the population and is more prevalent at weekends (**"**binge drinking**"**) with an average of 31,5% of those aged between 25 and 54 at greatest risk. A binge drinker can be expected to drink nine tots of spirits, a bottle or more of wine or more than two litres of beer a day.

Alcohol abuse of this nature costs the country in the region of R10 billion each year. Average per capita consumption of alcohol is approximately 20 litres a year, making it one of the highest consumption rates in the world.

Cannabis herb: The unique properties of the cannabis plant (**"**dagga**"**) have led to its diffuse and widespread cultivation. Total global production of dagga is estimated at 40 000 metric tons with South Africa producing 3 000 tons. Half of the production is used by the local user population of approximately 5 500 persons who spend roughly R3 560 million annually on cannabis at R0,65/gram. Cannabis remains the most consumed substance of abuse after alcohol.

South Africa is a significant producer of cannabis, and, although most of it is consumed locally, significant amounts are shipped abroad.

Cannabis resin: South Africa's estimated user population of cannabis resin at 825 000 is far greater than the number using the herb. Some 123 metric tons are used annually with a retail value of R3 926 million at a cost per gram of R32,50. Cannabis, used alone or in combination with other drugs, is the second most common drug of choice. Cannabis is exported to the United Kingdom and Ireland, Europe, the Far East, the United States of America and Namibia. Export methods include air and sea freight, road transport, and post and personal carriage by passengers known as **"**mules**"**.

Cocaine: South Africa's user population of about 265 000 use 4,6 metric tons annually with a street value of R1 430 million. Cocaine sells on the street at over R300 a gram. The drug enters the country from South America primarily through the OR Tambo International Airport with air freight and couriers the preferred form of transport. Some cocaine is transhipped from South Africa to the United Kingdom and Australia directly by air passengers and crew or via Asian countries.

Ecstasy: The main sources of ecstasy are East and South-East Asia, North America and, to a lesser extent, the Netherlands, Poland and Belgium. Production in South Africa is a relatively recent phenomenon totalling just over 900 kilograms a year. Total annual world production exceeds 422 metric tons and comprises some 322 tons of amphetamines and 90 tons of ecstasy. Approximately two tons of amphetamines entered South Africa in 2005 and were used by 1,2 million people who paid R143 million for the drugs at roughly R72 a gram. About 108 000 consumers of ecstasy paid R610 million for just more than a ton of the drug. A new trend is the movement of consumption from traditionally white urban areas to black communities, schools and universities.

1.3.2 Other illegal substances of abuse

On the basis of information from the South African Community Epidemiology Network on Drug Use (SACENDU), which measures trends for admission to treatment centres as a yardstick for drug use, the following picture emerged.

- Treatment for **mandrax (methaqualone)** dependence declined in Cape Town, Port Elizabeth and Gauteng province but increased by 8% in Durban.
- **"White pipe" (mixture of cannabis and methaqualone or mandrax)** use decreased in all the SACENDU sites according to the July-December 2005 report. For example, Cape Town remained at 6% while Gauteng province and Durban decreased from 6% to 3%.
- **Heroin** has become the primary drug of abuse for between 9% and 11% of patients in Gauteng, Cape Town and Mpumalanga province.
- **"Tik" (methamphetamine)** is the primary drug of choice for a large number of patients (approximately 42%) in the Cape Town area whileCAT(methcathinone) is increasingly being used in the Gauteng province area. Metamphetamine use and the use of the broader category of amphetamine-type stimulants (ATS) is spreading across the globe faster than the use of any other illegal substance.
- **"Nyaope" (a mixture of dagga and heroin)** is being used increasingly in the Tshwane metropolitan area.
- **"Over-the-counter" or prescription medications** have become the primary drug of choice of between 2% and 6% of all patients admitted for treatment at treatment centres. These substances are the secondary choice of 7% to 8% of patients in Cape Town and Gauteng and include benzodiazepines, analgesics, Codeine, sleeping pills, Ritalin and Xanor.

1.3.3 Precursor chemicals and clandestine laboratories

- Chemical precursors used in the manufacture of illicit drugs should be subjected to strict control measures. For example, methamphetamine is easily produced using over-the-counter cold medicines, pseudoephedrine, red phosphorous and iodine.

1.3 HEALTH AND SOCIOECONOMIC CONSEQUENCES

The health and socioeconomic consequences of substance use, abuse and dependency, particularly the abuse of alcohol and trafficking in drugs, undermine democracy and good governance and have a negative impact on the environment.

With regard to tobacco, the National Council on Smoking estimates that about 25 000 smoking-related deaths occur annually in South Africa and that 2,5 million workdays are lost due to absenteeism arising from tobacco-related illnesses. Tobacco smoke affects smokers as well as non-smokers; hence the legislation prohibiting smoking in the workplace.

The overall prevalence of alcohol abuse could be as high as 30% in certain groups and as low as about 5% in others and is linked to age, gender, socioeconomic status and degree of urbanisation. Binge drinking among the youth, especially males, is high (more than 25% in many communities). High levels of alcohol abuse are reported among persons in certain occupations (e.g. farming and mining) and in disadvantaged communities where ease of access to alcohol is a contributing factor (Parry & Bennets, in press). Home-made concoctions can also be more lethal than conventional substances.

The table below shows the current use of alcohol compared to risky current use in South Africa.

Table 1: Percentage of males and females reporting current use of alcohol and percentage of current drinkers engaging in risky drinking

Background characteristics	Total sample (5 574 males and 7 962 females)		Current drinkers (2 478 males and 1 321 females)			
	Drink now (current drinking)		Risky drinking – weekdays[a]		Risky drinking – weekends[a]	
Age	Males	Females	Males	Females	Males	Females
15-24	23,5	8,5	3,1	1,2	29,3	30,1
25-34	51,8	15,6	8,4	9,1	37,2	33,4
35-44	61,1	21,0	7,5	7,4	39,0	32,4
45-54	60,1	23,5	8,1	14,0	31,7	35,3
55-64	54,2	20,4	7,6	12,5	27,2	31,8
? 65	45,8	20,3	6,6	7,0	21,0	30,2
Residence						
Urban	46,7	19,2	6,4	7,1	30,0	29,5
Non-urban	41,4	13,2	8,3	12,9	38,0	39,3
Province						
Eastern Cape	47,5	16,2	6,5	9,8	31,4	33,6
Free State	56,2	24,5	5,6	5,6	27,3	30,0
Gauteng	49,7	20,6	6,1	4,7	24,0	22,1
KwaZulu-Natal	39,8	11,5	8,5	14,2	31,7	37,8
Mpumalanga	45,9	14,2	5,8	8,6	49,4	46,4
Northern Cape	48,5	23,1	6,2	7,7	38,1	48,7
Limpopo	28,3	8,6	11,1	18,1	41,1	45,2
North West	46,6	17,0	9,1	14,9	42,9	43,0
Western Cape	43,6	24,2	6,1	5,4	33,4	30,2
Education						
No education	54,6	22,9	6,9	14,6	36,0	38,6
Sub A-Std 3	50,7	16,3	12,1	11,3	40,3	44,6
Std 4-Std 5	42,0	13,2	10,5	9,5	42,9	44,9
Std 6-Std 9	39,6	12,7	4,7	7,6	30,4	32,5
Std 10	46,7	18,5	6,9	5,9	24,4	18,3
Higher	57,8	33,4	2,0	1,9	24,0	12,6
Population group						
African	41,5	12,3	7,7	13,3	35,7	42,1
Afr. urban	43,6	12,8	6,6	11,3	32,5	40,7
Afr. non-urban	38,8	11,8	9,2	15,3	40,2	43,5
Coloured	44,8	23,2	9,3	4,3	39,2	34,2
White	71,4	50,5	3,4	2,7	18,7	14,0
Indian	37,4	9,0	1,5	0,0	6,1	0,0
Total	44,7	16,9	7	8,8	32,8	32,4

Source: South African Demographic and Health Survey, Department of Health, 1998

The previous table reveals the following: At the time of the survey, rates of risky drinking on weekdays were similar for men (7%) and women (9%). Rates were approximately 4-5 times greater at weekends than on weekdays with a third of current drinkers drinking at risky levels over weekends. Risky drinking at weekends was apparently highest among persons in the middle categories for age (35-44 years for males and 45-54 years for females), persons residing in non-urban areas, persons with less education (Sub A-Standard 5), and coloureds and Africans. The rates of risky drinking for females in this study were higher. Targeted intervention is required especially for the middle age categories where the people are still sexually active and productive.

Judging by the age categories, it seems that while there is a higher percentage of male drinkers than female drinkers in all age groups, risky drinking during weekends is higher among females in the age cohorts 25-34, 45-54 and 55-64. The reason could be that more males than females are employed. Risky drinking is highest among males in the 25-34 age cohort with more females as risky drinkers in the other age categories.

In terms of the education variable, the findings indicate that risky drinking increases the lower the education level for males as well as females.

Concerning the province variable, risky drinking is higher for males in Mpumalanga that women in the same province. As regards the provincial rate of drinking, more women in Mpumalanga, Limpopo and the Northern Cape indulge in risky drinking than in the other provinces.

Regarding the population group variable, risky drinking is increasing among Africans and coloureds and is significantly higher for Africans in non-urban settings.

South Africa is in many ways an ideal arena for the drug trade. Well-developed international air links combined with the country's geographical position on major trafficking routes between East Asia and the Middle East, the Americas and Europe, a well-developed transportation infrastructure, modern international telecommunication and banking systems and long, porous borders make South Africa a natural target for drug traffickers. The overflow of drugs shipped through South Africa is also finding its way onto the local market. The problem is exacerbated by desperate and unemployed South Africans falling prey to the promises of syndicates that easy money can be made by acting as drug couriers.

South Africa is not alone in the campaign against drugs. The rapid globalisation of the drug trade over the past decade has meant that virtually no country is immune from the threat. Because a growing number of countries are developing stringent long-term strategies to deal with the problem, drug trafficking is likely to be channelled to countries and regions lacking such strategies.

1.5 POLICY AND LEGISLATION

The control of illicit drugs in South Africa is dealt with through legislation:

The Medicines and Related Substances Control Act (No. 101 of 1965). This Act provides for the registration of medicines and other medicinal products to ensure their safety for human and animal use and for the establishment of a Medicines Control Council for the control of medicines and the scheduling of substances and medical devices. The Act also promotes transparency in the pricing of medicines.

The Drugs and Drug Trafficking Act (No. 140 of 1992). This Act provides for the prohibition of the use or possession, or the dealing in, of 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.

The Prevention of Organised Crime Act (No. 121 of 1998). This Act provides for the recovery of the proceeds of crime (irrespective of the source) and for the combating of money laundering.

The Prevention and Treatment of Drug Dependency Act (No. 20 of 1992). This Act 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.

The Road Traffic Amendment Act (No. 21 of 1998). This Act makes provision for the mandatory testing of vehicle drivers for drugs. The legally acceptable blood alcohol level has been reduced from 80 mg to 50 mg of alcohol per 100 ml of blood.

The Tobacco Products Control Amendment Act (No. 12 of 1999). This Act provides for the control of tobacco products, the prohibition of smoking in public places, of advertisements of tobacco products and of the sponsoring of events by the tobacco industry.

Other relevant Acts

- Child Care Act (No. 74 of 1983)
- Domestic Violence Act (No.116 of 1998)
- Health Act (No. 63 of 1977)
- Liquor Act (No. 53 of 1989)
- Medicine and Related Substance Control Act (No. 59 of 2002)
- Mental Health Care Act (No.17 of 2002)
- Occupational Health and Safety Act (No. 85 of 1993)
- Pharmacy Act (No. 53 of 1974)
- Promotion of Equality and Prevention of Unfair Discrimination Act (No. 52 of 2002)
- Road Transportation Act (No. 74 of 1977)
- Road Traffic Act (No. 93 of 1996)
- Sexual Offences Act (No. 23 of 1957)
- South African Constitution Act (No. 108 of 1996)
- South African Schools Act (No. 84 of 1996)
- Extradition Act (No. 67 of 1962)
- Witness Protection Programme Act (No. 112 of 1990)
- Extradition Act (No. 77 of 1996)
- Financial Intelligence Centre Act (No. 38 of 2001)
- International Co-operation in Criminal Matters Act (No. 75 of 1996)
- Institute for Drug-Free Sport Act (No. 14 of 1997)

Bills:

- Child Justice Bill, 2003
- Criminal Law (Sexual Offences and Related Matters) Amendment Bill, 2006

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 a signatory to the African Union and the Southern African Development Community (SADC) Drug Control Protocol. South Africa is also a signatory to the United Nations Convention on Transnational Organised Crime.

The South African drug enforcement agencies cooperate and collaborate with similar agencies in the United Kingdom and the United States, notably the Defence Logistics Organisation (DLO), the Drug Enforcement Administration (DEA), the Central Intelligence Agency (CIA) and the Federal Bureau of Investigation (FBI).

Regionally, these agencies cooperate and collaborate with similar agencies in SADC countries, specifically the South African Regional Police Chiefs Co-operation Organisation (SARPCCO). Nationally, the South African Police Service (SAPS) is involved in the following committees to combat drug trafficking: Joint Operation and Intelligence Committee (JOINTS), Provincial Joint Operational and Intelligence Committee (provincial JOINTS), Provincial Crime Combating Forum (PCCF), Station Crime Combating Forum (SCCF).

Several treatment centres are currently operational in the country, and mandatory norms and standards for inpatients have been finalised and approved. This will assist in facilitating a uniform procedure for registration and management at such centres.

CHAPTER 2
FRAMEWORK FOR ACTION

2.1 VISION

The vision of the National Drug Master Plan (NDMP) is a drug-free society.

2.2 MISSION

The mission of the NDMP is to implement holistic and cost-effective strategies to reduce the supply and consumption of drugs and to limit the harm associated with substance use, abuse and dependency in South Africa. To accomplish this mission, measures have been introduced to

- reduce the demand for alcohol, tobacco and other drugs;
- reduce the social health and economic costs associated with substance abuse in South African society;
- reduce substance abuse-related mortality and morbidity;
- improve access to substance abuse information and effective interventions including treatment;
- reduce the supply of illicit substances (and licit but unregulated alcohol and tobacco).

2.3 GOALS

Goals of the NDMP

- To ensure the coordination of efforts to reduce the supply of and demand for drugs/substances of abuse;
- To strengthen efforts aimed at the elimination of drug trafficking and related crimes;
- To strengthen the legal and institutional framework for combating the illicit supply and abuse of substances;
- To promote the integration of substance abuse issues into the mainstream of socioeconomic development programmes;
- To ensure appropriate intervention strategies through awareness raising, education, prevention, early intervention and treatment programmes;
- To promote family and community-based intervention approaches in order to facilitate the social reintegration of abusers;
- To promote partnerships and the participation of all stakeholders at local and provincial level in the fight against illicit substances and abuse;
- To promote regional, national and international cooperation in the management of The illicit supply of drugs and substances of abuse.

2.4 NATIONAL PRIORITY AREAS

The NDMP provides the means by which existing resources can be harnessed. It accordingly provides for national and provincial departments to take full account of substance abuse issues in their activities and budgets through the implementation of their mini-drug master plans (MDMPs). MDMPs are the operational plans of departments that have to be submitted to the CDA at the beginning of each financial year. The CDA continuously monitors the implementation of these plans and facilitates coordination and service integration.

At the end of the financial year, departmental reports on the implementation of the operational plans have to be submitted to the CDA. These reports inform the CDA's annual report to parliament.

To achieve its aims, the NDMP has identified nine priority areas:

- Crime
- Youth
- Other vulnerable groups (such as children on and off the streets, workers, women, people with disabilities, the elderly, unemployed persons and persons affected by HIV/AIDS, road users especially drivers and pedestrians)
- Community health
- Research and information dissemination
- International involvement
- Communication (cross-cutting area)
- Capacity building
- Occupational groups at risk

2.4.1 Crime

Substance abuse issues are encountered at every level of the criminal justice system from the international trade in drugs and the use of the proceeds of that trade for corrupt ends to driving under the influence of alcohol or drugs. Most substance-related crimes, however, are the culmination of a variety of factors (personal, situational, cultural and economic), and the precise relationship between substance abuse and crime is therefore hard to determine. The South African Arrestee Drug Abuse Monitoring (SA-ADAM) project nevertheless demonstrated a strong link between these two factors.

Drug-related crime, which is committed on both the supply and demand side, falls into the following three main categories.

- Crime due to the psychopharmacological effects of drugs ingested by the perpetrator, for example alcohol, certain stimulants and hallucinogens.
- Crime due to the need to pay for the perpetrator's expensive drug habit.
- Crime as a by-product of involvement in drugs and/or drug trafficking, for example violent territorial disputes between rival drug gangs and violent confrontations between frustrated communities, the police and drug dealers and syndicates.

Objectives for the crime priority area

- To ensure effective law enforcement against those involved in trafficking in and supplying illegal drugs and in the illegal supply of legal drugs and alcohol;
- To reduce drug-related crimes, including domestic crimes;
- To reduce the level of drug use in prisons;
- To reduce the level of substance abuse among road users;
- To establish diversion programmes and build capacity in the courts for dealing with drug-related offences;
- To ensure proactive policing to prevent the manufacture and supply of, trafficking in and use of illegal drugs and the illegal use of alcohol;
- To ensure law enforcement and compliance with the laws regulating the manufacture, supply and use of drugs.

2.4.2 Youth

The children of South Africa have been accorded priority attention since the advent of the new democracy. On 16 June 1995, South Africa accordingly ratified the Convention on the Rights of the Child and the declaration emanating from the World Summit for Children in December 1993 and, in so doing, committed itself to the principle of the "First Call for Children" in all areas.

Specific treatment services have to be provided for young people because of their different needs. For example, young people occupy a dependent position in the family and society; they are more influenced by peers and popular culture; they often need education or vocational training; and they are more likely to use drugs.

For the purpose of sharing available resources, the programmes/facilities of different departments should be integrated such as the after-care programmes in schools and multipurpose centres for unemployed youth. Although coordinating structures for the youth exist, their effectiveness in relation to substance abuse has to be improved.

Information on substance abuse should be accessible to the parents of learners, and mechanisms for disseminating information should be identified and streamlined. Parents should take responsibility for monitoring and countering substance use among their children. Children are not born drug abusers, and consequently parents should teach their children appropriate values long before peer pressure and other influences intervene.

Major gaps still exist in intervention programmes for the youth, especially in rural areas. A special effort is required to establish proper youth programmes and to ensure that they are accessible to all young people in South Africa.

Objectives for the youth priority area

- To motivate the youth to refrain from abusing substances through ongoing and integrated prevention programmes, including the use of drama, music and sport;
- To apply restorative justice in countering the drug-crime problem;
- To enforce the law rigorously in respect of the sale of alcohol, tobacco and other drugs to the youth;
- To ensure that schools offer effective drug education programmes, giving learners the facts, warning them of the risks and helping them to develop an anti-drug attitude;
- To promote a healthy lifestyle through awareness programmes;
- To develop effective national and local public education strategies focusing particularly on young people;
- To ensure that young people have access to life skills and other programmes that promote a healthy lifestyle;
- To empower the youth to take charge of their destiny, for example through training young people as peer educators

2.4.3 Poor and vulnerable groups

The use and abuse of substances such as alcohol, tobacco, solvents and illicit drugs places an enormous health and socioeconomic burden on South African society. Numerous studies have highlighted the link between substance use/abuse and various health and other social problems:

- Intentional and non-intentional injuries and premature death
- Risky sexual behaviour
- Infectious diseases such as TB, HIV and AIDS, and Hepatitis B, C and G
- Other health problems (e.g. cancer and foetal alcohol syndrome)
- Crime (particularly crimes of violence, property crimes and crimes associated with the supply of or trafficking in substances)
- Absenteeism and school failure
- Loss of productivity and other negative economic effects

The above socioeconomic consequences are most prevalent among people who can least afford them such as the unemployed, children, street children, orphans, workers, women, people with disabilities and older persons (senior citizens).

Objectives for the vulnerable groups priority area

- To ensure that all government departments take responsibility for preventing and combating substance abuse and for offering effective information, education and communication (IEC) programmes to facilitate informed decision making by vulnerable groups;
- To increase awareness among community members of issues related to substance use and abuse among vulnerable groups;
- To ensure that vulnerable groups who abuse or become dependent on substances have increased access to a range of advice, counselling, treatment, rehabilitation and after-care services;
- To empower all vulnerable people so that they know their rights under the South African Constitution and can access support and/or avoid future victimisation.
- To introduce programmes for the constructive use of leisure time and alternatives to substance use.

2.4.4 Health

This priority area is the core competency of the Department of Health. Special areas of concern are the high rate of substance abuse among people of childbearing age. Other national issues are teenage pregnancy, foetal alcohol syndrome (FAS), multidrug resistance (MDR) and sexually transmitted infections (STIs), including HIV and AIDS. Local research has shown a clear link between substance abuse and fatal and non-fatal trauma, particularly trauma resulting from motor vehicle accidents and interpersonal violence. However, the impact of substance use and abuse goes well beyond the issues covered here. It also affects school performance, family life, productivity, and safety and security.

Primary prevention and treatment programmes should also include harm reduction, which implies efforts to reduce and prevent the harmful effects of the use of alcohol and other drugs.

According to the International Council on Alcohol and Addictions (ICAA) (1994), this goal can be pursued using different strategies, including those focused on drug-free living.

International best practices indicate that detoxification services are essential as part of the treatment of substance-dependent persons. Detoxification should be provided in private and public health settings and immediately followed by inpatient and outpatient rehabilitation programmes.

The government has to develop strategies to prevent psychological or physical damage to individuals who abuse alcohol and drugs. Alcohol-related harm reduction refers specifically to the reduction of violence, road accidents, unemployment, abuse of children and women, and the spread of STDs as a result of unsafe sex where alcohol is used. Reducing harm thus includes information dissemination about the effects of drugs on the human body and brain, about the risks involved in intravenous drug use and about alternatives to such risky behaviour.

Objectives for the health priority area

- To minimise risks in communities of the harm associated with substance use, including the spread of communicable diseases, injuries and premature death;
- To improve access to information, treatment, counselling, rehabilitation and after-care services for individual substance users;
- To ensure that individuals and significant others have access to best practice in treatment and support services;
- To acknowledge the link between HIV and AIDS and substance use and to devise intersectoral programmes to deal with the problem;
- To ensure that persons suffering from mental illness and substance abuse morbidity (dual diagnosis) receive appropriate and accredited treatment.

2.4.5 Research and dissemination of information

Rational policy making about drugs, whether at the international, national or community level, requires detailed knowledge of the profile of the problems of users of particular substances. The profile will vary from place to place, as well as over time, and calls for a programme of epidemiological monitoring of the patterns of harm and of use. Research in South Africa has generally addressed commercial/prescription substances and has overlooked the impact of indigenous substances, which have affected far more people, notably those in rural and previously disadvantaged communities. Research on indigenous substances and their users has now become imperative.

Ongoing monitoring is required not only to establish the extent of the need for services and prevention programmes but also to identify ways in which particular kinds of drug-related harm can be reduced and to determine trends, patterns and types of drugs used by different communities. This should be complemented by the evaluation of existing services and recommendations for policy change where necessary. In order to optimise the use of such a body of research knowledge, a national clearinghouse and database should be established.

Extensive research is needed to fill the gaps in information on the prevalence of drug use among different groups in different parts of the country, on the economic costs of substance abuse to the country, on the relationship between substance abuse and national issues (HIV and AIDS, TB, crime, youth development and poverty), on effective community-based intervention approaches on and the impact of current policies.

Objectives for the research and dissemination of information priority area

- To conduct ongoing research on trends in substance abuse, particularly in under- serviced or previously disadvantaged areas so that appropriate intervention strategies can be developed;
- To establish and maintain an accessible substance abuse information system that will support the implementation, evaluation and ongoing development of the National Drug Master Plan;
- To coordinate the collection and dissemination of local and international information on substance abuse intervention;
- To promote research on and the design of effective indigenous substance abuse treatment programmes;
- To implement, monitor and evaluate indigenous substance abuse treatment programmes.

Ultimately, an integrated research agenda for South Africa must be agreed upon and prioritised by all role players.

2.4.6 International liaison

South Africa helps combat the global substance abuse problem, notably illicit trafficking in drugs, and also participates in global decision making on solving the drug problem. International forums such as the United Nations Commission on Narcotic Drugs, the United Nations Specialised Agencies, Interpol, the World Customs Organisation, the Southern African Regional Police Chiefs Cooperation Organisation and a number of foreign government agencies play a key role in this regard. South Africa also encourages bilateral cooperation in fighting the drug problem and has entered into four police-to-police cooperation agreements in the area of drugs specifically.

In 1998, the 20th Special Session of the United Nations adopted action plans on judicial cooperation, the eradication of money laundering and illicit drug production, the disruption of trafficking in drugs and the promotion of alternative development. An action plan was also adopted for the implementation of a declaration on drug demand reduction. South Africa pledged its support for these action plans in 1998 and again in 2003 during a high-level ministerial meeting of the United Nations Commission on Narcotic Drugs. The action plans are to be implemented by 2008.

The government places a high priority on the fulfilment of its obligations under international drug control instruments and is a state party to the following conventions.

Single Convention on Narcotic Drugs, 1961
Convention on Psychotropic Substances, 1971
United Nations Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances, 1988

The Eleventh United Nations Congress on Crime Prevention and Criminal Justice was held in Bangkok, Thailand, during April 2005 and ended on 25 April 2005 with the adoption of the Bangkok Declaration in which member states reaffirmed their commitment to improve international cooperation and practical mechanisms in respect of, inter alia, combating trafficking in illicit drugs.

The African Round Table on Crime and Drugs was held in Abuja, Nigeria, from 5-6 September 2005 under the auspices of the United Nations Office on Drugs and Crime (UNODC) and the African Union (AU).

The purpose of the round table was to examine a draft five-year (2006-2011) programme of action addressing the issues of drugs and crime as impediments to economic growth and sustainable development in Africa. The round table concluded with the endorsement of a final programme of action (the Abuja Draft).

The Abuja Draft is a strategic and operationally oriented plan for the African continent, outlining the necessary actions to be undertaken with respect to the clusters identified. As far as the NDMP is concerned, Cluster III, Cluster IV and Cluster V of the Abuja Draft are of specific importance. Cluster III deals with, inter alia, illicit trafficking in drugs, Cluster IV with drug abuse and HIV and AIDS, and Cluster V with the ratification and implementation of conventions on drugs.

Representatives of the SAPS, Foreign Affairs, NICOC, Financial Intelligence Centre, Social Development, Correctional Services, Public Service and Administration, the National Prosecuting Authority and the South African High Commission in Abuja attended the round table. After returning to South Africa, the SAPS recommended in a follow-up memorandum to the Minister for Safety and Security the introduction of the Abuja Draft to the JCPS Cluster and the Joint Operational and Intelligence Structures (JOINTS) in order to initiate the political process of approval and implementation of the draft.

South Africa's legislation provides the necessary support for the implementation of international drug control conventions. South Africa will also continue to participate in strategies to combat the drug problem regionally by implementing the Drug Protocol of the Southern African Development Community and the action plans of the African Union.

Objectives for the international liaison priority area

- To monitor developments in the international environment regarding drug abuse and illicit drug trafficking;
- To communicate the government's policy on multilateral and bilateral issues related to substance use, abuse, trading and trafficking;
- To advise the government on policy options, mechanisms and avenues for achieving objectives;
- To assist departments in navigating complex international dynamics;
- To advise the government on entering into international agreements;
- To facilitate the achievement of international benchmarks on the prevention and treatment of substance abuse.

2.4.7 Communication

The Government Communication and Information Systems (GCIS) collaborates with the CDA and relevant government departments in developing effective communication strategies on substance abuse-related matters in the country. For the National Drug Master Plan to be effective, the public should be well informed on substance abuse, its impact and the need to maintain healthy lifestyles. In addition, anti-abuse agencies should know their role in achieving the goals of the NDMP and have access to information on substance abuse to design effective intervention strategies.

Communication should take into account South Africa's eleven official languages, other cultural and socioeconomic differences, and disabilities such as visual impairment and illiteracy. The current NDMP recognises that many previous drug awareness efforts failed to reach their target audiences because of their inappropriate, viewer-insensitive presentations.

Objectives for the communication priority area

- To ensure that all educational material and other information disseminated to the public is factually correct;
- To ensure that information reaches the public in all languages and in an appropriate mode of communication, for instance pictorial presentations for illiterate persons and braille for blind persons;
- To ensure that facilities for information dissemination are accessible to everyone;
- To engage all stakeholders in the implementation of the NDMP and ensure their accountability;
- To obtain ongoing feedback from all stakeholders to ensure early identification of and action on challenges to implementation.

2.4.8 Capacity building

A pressing need exists for the training of doctors, nurses, social workers and psychologists on substance abuse and other addictions. Doctors and other healthcare workers, particularly primary healthcare nurses, should recognise the part played by substance abuse in their patients' problems and be able to deal with these problems in a non-judgemental way.

Professionals from other sectors, such as the police, personnel officers, the clergy, lawyers, Correctional Services officials, prosecutors and teachers, also require training. This should include training in recognising abuse and dependence and knowledge of places where affected persons can be referred for treatment and rehabilitation. The NDMP proposes the inclusion of such training in as wide a range of curricula as possible.

Because current training on substance abuse is unsatisfactory, the NDMP proposes the establishment of a professional licensing or qualifications board to devise standards for skills training in the various aspects of addiction management (appropriate referrals, coordination and integration of services) and to ensure that these standards are accredited. Standards should also be set for the professionalism of teaching staff, the setting of clear objectives, the teaching of motivational skills, the development of relationships of trust and the systematic assessment of these standards.

Finally, trainers require the right materials; extensive practical experience in the drug abuse field; knowledge of logistics, resources and funding, and adequate communication skills.

Objectives for the capacity-building priority area

- To ensure that good practice models are adhered to in the management of substance abuse;
- To provide for a national accreditation system and to monitor and evaluate organisations working in the substance abuse environment;
- To provide all social service, health and legal practitioners with information on drugs, basic counselling skills and appropriate referral systems;
- To establish a training programme that builds the capacity of law enforcement officers to enforce South Africa's drug laws. The training programme should include basic information on drug detection techniques, peer counselling and specialised fields of drug control.

2.4.9 Occupational groups at risk

Addiction to drugs affects people from diverse cultural, ethnic and socioeconomic backgrounds. Specific occupational groups that seem to be especially at risk include artists, musicians, medical personnel, farm workers and transport industry workers, especially long-distance truck drivers. Further research is required to determine the extent of drug addition among these groups and to plan intervention strategies that take their needs into account. Artists and musicians, in particular, require urgent support.

Objectives for the occupational groups at risk priority area

- To ensure that occupational groups that are vulnerable and that abuse or become dependent on substances have increased access to a range of advice, counselling, treatment, rehabilitation and after-care services;
- To create awareness among the occupational groups at risk of issues related to substance use and abuse;
- To encourage rehabilitated persons to educate new entrants into these occupations and civilians on predisposing factors to and the dangers of substance abuse and how to withstand pressure to take drugs and where to obtain treatment.

CHAPTER 3
STRATEGIC INTERVENTIONS

Substance abuse destroys lives and communities, undermines sustainable human development and leads to crime. Drugs affect everyone in all societies. In an endeavour to combat and prevent substance abuse, the National Drug Master Plan attempts to guide service delivery in terms of appropriate interventions.

3.1 SUBSTANCE ABUSE SITUATION

Local research has revealed many reasons for the abuse of drugs in South Africa. These reasons include factors such as unemployment, low self-esteem, educational failure, boredom, and physical, psychological and/or family problems. However, even where the causes relate more to experimentation, enjoyment or a shift from alcohol or tobacco, the expectation that the use of substances will make things better is ostensibly the greatest attraction. Interventions have to take this into consideration.

The NDMP aims to reduce substance abuse and its harmful consequences. In order to address the drug problem effectively, actions that reduce the availability of drugs (control and law enforcement) should be equally balanced with actions that reduce the demand for drugs (prevention, treatment and rehabilitation).

3.2 INTERVENTIONS IN GENERAL

An intervention is a way of helping an individual, group or community to understand that an existing or potential problem requires attention and then assisting them to deal with the problem. Intervention aims at helping people to take greater control of factors that impact on their well-being. It boils down to actions geared to reduce the likelihood of undesirable conditions taking into account individual, environmental and societal factors that contribute to the development of problems.

Service providers, acting on the guidance of policy makers, are called upon to introduce and direct interventions. The most appropriate and preferred intervention is prevention. Preventive approaches attempt to modify or remove the causes of alcohol and other drug (AOD) problems, and examples of such approaches include stiffer penalties for AOD crimes and changing the environment that supports AOD use.

Preventive programmes can be divided into primary, secondary and tertiary programmes, which are defined as follows:

Primary prevention attempts to curb the supply and to prevent the new use of illicit drugs. This type of programme is known as **"**preventing initiation**"**. The focus is mainly on the individual, groups such as families or society at large. In addition to other actions, primary prevention works towards the protection and upliftment of all people and communities by promoting well-being and encouraging and supporting people to take pro-health decisions.

Secondary prevention is aimed at persons who display the early stages of problem behaviour associated with the use of AODs. Secondary prevention attempts to avert the ensuing negative consequences by persuading such persons to cease their AOD use through counselling or treatment. This type of programme is often referred to as **"**early intervention**"**.

Tertiary prevention strives to end compulsive use of AODs and to ameliorate their negative effects through treatment and rehabilitation. This type of programme is most often referred to as **"**treatment**"** but also includes rehabilitation and relapse prevention. Long-term studies on chronic drug-dependent patients indicate that community surveillance, combined with medical treatment and social rehabilitation, can provide a positive outcome.

3.3 SPECIFICS OF INTERVENTIONS

The following interventions are crucial in addressing the substance abuse problem.

- Reduction in the supply of drugs
- Prevention of drug abuse (including education and raising awareness)
- Community-based substance abuse prevention
- Early intervention
- Drug treatment (including rehabilitation and risk reduction)
- Research

3.3.1 Reduction in the supply of drugs (law enforcement)

Although it is the primary function of the SAPS to reduce the volume of illegal drugs through effective policing strategies, other departments such as the Department of Justice, SARS and Home Affairs also play a key role through effective prosecution/sentencing and by facilitating rehabilitation.

Drug prevention organisations need to coordinate efforts with the postal services and SARS to control/screen parcels for illegal medicines or drugs. The Department of Health and the Medicine Control Council should also investigate companies' use of the internet to distribute medicines illegally.

Communities should actively support the maintenance of safety and security within their environments by reporting illegal activities to the police and following up on the results of their initiatives. They should work together with the police and involve themselves in social development community forums. A zero tolerance attitude towards drugs should be inculcated in communities.

3.3.2 Prevention of drug abuse (including education and awareness)

Preventive intervention is intended to help parents, educators, community leaders and any other role players in the field of substance abuse to plan for delivering services at community level. The Departments of Education, Health and Social Development are the primary actors in raising awareness of and educating people about the dangers of drug abuse.

Such awareness should result in people working together with these departments to reduce the use and abuse of licit drugs (alcohol, tobacco and over-the-counter drugs) and illicit drugs (hard drugs).

The NDMP takes cognisance of the views of international agencies such as the World Health Organization and the United Nations Office for Drug Control and Crime Prevention. It takes into account the recent critical reviews of the drug-related preventive efforts of the World Health Organization and the approach and strategies called for in the South African government's 1997 White Paper for Social Welfare.

The NDMP views prevention as various interventions that

- focus in an integrated and balanced way on the individual and the environment (community/group);
- focus on individuals as subjects who can contribute positively to preventive action;
- have strong support in the (wider) community within which preventive action occurs;
- involve target groups in prevention planning and implementation;
- combine demand reduction (e.g. through programmes that enhance life skills and reduce socioeconomic inequalities) and supply reduction (e.g. Through control/law enforcement and poverty alleviation) in a balanced, multilevel manner;
- are evidence/research based and thus based on the dynamics of the applicable context at a particular point in time;
- are implemented at one or more of the following three levels: at the primary level, where prevention is directed at reducing the initial individual and environmental risks of drug-related harm (e.g. crime); at the secondary level, which involves early detection of risk proneness with regard to the development of drug-related harm; and at the tertiary level (usually called "treatment") where the focus is on arresting the intensification and perpetuation of drug-related harm.

In short, the above conception of prevention is part of a social development approach to countering social problems. It also points to the need for a multilevel, multisystem intervention in social service delivery without ignoring therapy approaches and without assigning "blame".

3.3.3 Risk factors and protective factors in drug abuse prevention

Prevention programmes should enhance protective factors and counter or reduce risk factors. Protective factors are those associated with reducing the potential for drug use. Risk factors are those that make drug use more likely.

Protective factors

- Strong, positive family bonds
- Parental monitoring of children's activities and their peers
- Clear rules of conduct that are consistently enforced within the family
- Involvement of parents in the lives of their children
- Success in school performance and strong bonds with institutions such as schools and religious organisations
- Adoption of conventional norms regarding drug use

Risk factors

- Chaotic home environments, particularly where parents abuse substances or suffer from mental illnesses
- Ineffective parenting, especially of children with difficult temperaments or conduct disorders, and lack of parent-child attachments and nurturing
- Failure in school performance
- Poor social coping skills
- Liaisons with peers who display deviant behaviour

- Perceptions of approval of drug-using behaviour in family, work, school, peer and Community environments

3.3.4 Community-based substance abuse prevention

Compelling reasons exist as to why community-based prevention of substance abuse should be a major focus for all practitioners in the field of substance abuse. The combined effects of tobacco, alcohol and other drugs take a greater toll on the health and well-being of South Africans than any other single preventable health problem. Of particular importance is the fact that drug use among the youth has been rising and the age of onset has dropped to ten years (SACENDU, 2004; Rocha Silva, 1998).

The major emphasis of community-based prevention should therefore be on the youth and "gateway" substances such as tobacco, alcohol and dagga. However, as substance abuse disorders occur across the lifespan of an individual, preventive interventions should be targeted at individuals at risk in all age groups and at groups and communities at risk. Such intervention should take into consideration the unique developmental issues of each age group and the risk factors and protective factors that influence the health behaviour of individuals and communities.

Evidence is mounting that the most effective prevention strategies are community based (Burgoyne, 1991). Moreover, the underlying premise of Healthy People 2010 is that the health of the individual is almost inseparable from the health of the broader community, the society and the entire nation. Practitioners should accordingly join with community stakeholders to provide science-based preventive interventions (Marcus, 2000).

Comprehensive community-based prevention programmes should focus on the demand and supply aspects of substance use. Community empowerment is often the key to success in education on and treatment of drug abuse. The community members should therefore be encouraged to take some control over decisions that directly affect them. Especially where social control is largely absent, this approach can be crucial to the success of demand as well as supply reduction strategies. Strengthening the cohesiveness of communities should consequently be a key objective.

3.3.5 Early intervention

Early intervention refers to preventing the onset of any substance abuse. Effective programmes in this respect take into account the complex interplay of environmental, cognitive, physical, psychological, social, spiritual and health factors. Since the 1990s, the mental health intervention spectrum has been informed by early intervention measures in that it categorises interventions as universal (delivered to the general population), selective (targeted at populations at risk) and dedicated (aimed at high-risk individuals who may have minimal but detectable signs or symptoms of the disorder identified) (Gordon, 1983; Mrazek & Haggerty, 1994).

School programmes conducted by teachers or peers are examples of universal prevention strategies. Individual and group counselling and support groups for youths with academic, family or peer problems are classified as selective prevention. Dedicated prevention strategies focus on youths involved in gangs, truancy and criminal activity or who have behaviour disorders.

3.3.6 Drug treatment (including rehabilitation and risk reduction)

The Departments of Health and Social Development need to collaborate in rehabilitating drug-dependent persons. The main task of both these departments is to provide appropriate services to such persons while maintaining a high standard of care. They have to monitor the registration and management of health and social development facilities with the Department of Social Development taking the lead in this regard and the Department of Health taking responsibility for the medical component of the treatment programme, including the provision of detoxification facilities and resources.

The criminal justice system should adopt a restorative justice approach in respect of drug-induced offences through the passing of sentences aimed at restoring offenders as full and productive citizens. This would require collaboration between the Departments of Health, Social Development and Justice, and NGOs and treatment centres, to compel offenders to accept treatment and to reintegrate them into the mainstream of society.

Drug courts should be set up by the Department of Justice in collaboration with the Department of Social Development. These courts should focus on drug-related crime and work together with regular courts.

3.3.7 Drug abuse by drivers

The Department of Transport in consultation with other law enforcement departments should ensure that enforcement is increased so that every person involved in an accident is tested for alcohol and other substances of abuse. After alcohol and drug-related accidents, drivers should be obliged to attend special driving courses, and be retested, in order also to cause inconvenience and expense to the driver.

The Department of Transport should consider mandatory testing of drivers in all accidents involving alcohol and substance abuse. All these interventions should be well documented in terms of their effectiveness so that best practices can be identified and used as benchmarks for service delivery.

CHAPTER 4
INSTITUTIONAL FRAMEWORK

Given the seriousness of the drug problem, an institution is required to coordinate and direct drug counteraction across South Africa on both the demand and the supply side. Action to combat illicit trade in and the use of substances requires broad participation by all spheres of government, organisations, the business sector and civil society. This should be complemented by action to broaden regional cooperation between governments in reducing the cultivation, production, trafficking and distribution of drugs. Such an institution exists in the form of the Central Drug Authority (CDA).

4.1 CENTRAL DRUG AUTHORITY

The CDA is a statutory body in terms of the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992).

4.1.1 Composition of the CDA Board

The Prevention and Treatment of Drug Dependency Act was amended in 1999 to establish the CDA. The institution requires a high-profile head and its members should include representatives of the following institutions.

- Department of Arts and Culture
- Department of Correctional Services
- Department of Education
- Financial Intelligence Centre (FIC)
- Department of Foreign Affairs
- Department of Health and the Medicines Control Council
- Department of Home Affairs
- Department of Justice and Constitutional Development
- Department of Labour
- National Youth Commission
- Secretariat for Safety and Security
- Department of Social Development
- South African Police Service (SAPS)
- South African Revenue Service (SARS)
- Department of Trade and Industry (DTI)
- Department of Transport (DoT)
- Research councils and universities
- Representatives of civil society
- Non-governmental and faith-based organisations
- Business Against Crime
- Community-based organisations
- Treatment centres (inpatient and outpatient)
- Accredited addiction counsellors
- Secretariat for Safety and Security
- National Youth Commission
- Financial Intelligence Centre
- Representatives of the provincial substance abuse forums

Currently, there are no provincial representatives on the CDA, which creates a disjuncture in feedback on and monitoring of work at provincial level. Provincial social development officials should do the secretariat work for the provincial forums, and an interdepartmental forum that includes all national departments should be set up to share information on best practices in terms of strategy and programmes.

4.1.2 Functions of the CDA

The primary function of the CDA is to monitor the implementation of the NDMP. The CDA ensures coordination, facilitates integration of the work of different departments and reports to parliament through the Minister for Social Development. The CDA also liaises with the provincial forums and the local drug action committees.

Functions of the CDA

- Overseeing and monitoring the implementation of the NDMP
- Facilitating the coordination of a limited number of strategic projects
- Facilitating the rationalisation of existing resources and monitoring their effective use
- Encouraging government departments and the private sector to draw up plans to address drug abuse in line with the goals of the NDMP
- Introducing performance indicators whereby the effectiveness and progress of action plans can be monitored and evaluated at all levels
- Facilitating the initiation and promotion of measures, including legislation, to combat the supply of and reduce the demand for drugs
- Reviewing and commenting on psychoactive substance-related policies and programmes developed locally and internationally
- Establishing and maintaining information systems to support the implementation, evaluation and ongoing development of the NDMP
- Submitting an annual report to parliament that describes the national effort in solving the drug problem
- Ensuring the development of effective drug education strategies
- Liaising with the Justice, Crime Prevention and Security Cluster (JCPS) Ministers' Committee where necessary
- Advising the government on policies and programmes on drug abuse and trafficking
- Reviewing the NDMP on a five-yearly basis and introducing changes where necessary
- Organising a biannual summit on substance abuse to enable role players involved in combating substance abuse to share information

ROLE OF THE CDA SECRETARIAT

The core role of the CDA secretariat is to drive the day-to-day work of the CDA ensuring that decisions taken at CDA meetings are carried out, especially with regard to the implementation of the NDMP. The secretariat is located in the Department of Social Development and its role is to provide the CDA with technical and administrative support.

4.2 SPECIFIC INTERVENTIONS BY GOVERNMENT DEPARTMENTS

In terms of the Prevention and Treatment of Drug Dependency Act, as amended, and in accordance with the NDMP, particular national government departments (as shown under 4.1.1) are charged with drawing up operational plans referred to as "mini-drug master plans" (MDMPs) in line with their core functions.

These plans are submitted to the CDA for approval and then used as the basis for annual reports to the CDA on the departments' progress in the fight against crime. These reports help the CDA compile an annual report for the Cabinet on the management of the drug problem across South Africa.

Specific 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 managing the supply of and demand for substances of abuse.

4.2.1 Arts and Culture

The Department of Arts and Culture is responsible for supporting occupational groups at risk such as artists, musicians and others. It has to draw up a strategy for preventing and combating substance abuse among members of these vulnerable groups. It collaborates with other departments in this endeavour.

4.2.2 Correctional Services

The Department of Correctional Services provides corporate services to facilitate compliance with national drug policy in the workplace.

The department helps formulate security strategies aimed at preventing drugs entering correctional centres, reducing demand through educational programmes and implementing harm reduction strategies and rehabilitation programmes for offenders suffering from substance abuse in line with Department of Health protocols. The department has formed partnerships with external stakeholders from civil society as well as with other government departments in its fight against substance abuse. Integral to this approach is the department's desire to correct the offending behaviour of sentenced persons.

4.2.3 Education

As an extension of the National Drug Master Plan, the Department of Education has developed a Policy Framework on the Management of Drug Abuse in all Public Schools and Further Education and Training Institutions. The policy framework encapsulates recommendations made in the National Drug Master Plan and has been distributed to schools throughout South Africa.The policy framework focuses on prevention and early intervention based on a restorative justice approach.

Drug abuse issues form part of the curriculum, specifically within the life orientation learning area. The department has to ensure that life orientation programmes provide learners with relevant knowledge on drug abuse so that they can make appropriate choices when confronted with drugs.Guidelines for the Prevention and Management of Drug Abuse in all Public Schools and Further Education and Training Institutions have been developed and will be distributed to all schools in the country. The guidelines are underpinned by principles enshrined in the Constitution and take into consideration the legal and other requirements pertaining to drug abuse. The guidelines should therefore be used as the basis for developing a drug management strategy for all schools. The training of master trainers in all provinces should precede the implementation of the policy framework and the guidelines.

A reduction in the supply of and demand for drugs can be brought about only through the collaboration of relevant stakeholders such as the Departments of Safety and Security, Social Development, Health, Sport and Recreation, Arts and Culture, and Justice. The programmes of the different departments should facilitate the uninhibited access of children to after-care programmes in schools and of young people to multipurpose centres for unemployed youth.Educational programmes on the abuse of drugs should be made available to all communities.

4.2.4 Financial Intelligence Centre (FIC)

The Financial Intelligence Centre is responsible for passing on to the relevant law enforcement authorities, intelligence agencies and SARS any drug and crime-related information it receives from banks and other institutions. In turn, these authorities and agencies are expected to inform the FIC about enforcement targets and drug distribution typologies in South Africa so that the FIC can do its work effectively.

4.2.5 Foreign Affairs

The Department of Foreign Affairs has the following responsibilities.

- To enter into bilateral and multilateral agreements 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*
- *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 on combating substance abuse;
- To promote enhanced regional and international cooperation in the combating of substance abuse, illicit trafficking in drugs and transnational organised crime;
- To advise all national stakeholders on South Africa's international obligations with respect to international instruments on drugs.

4.2.6 Health

The Department of Health is responsible for reducing drug demand and harm caused by psychoactive drugs, including alcohol and tobacco, through the promulgation of legislation and policy guidelines for early identification and treatment. It collaborates with the Departments of Education and Social Development on national awareness campaigns and also supports treatment centres by advising on detoxification programmes, the appointment and support of medical personnel, capacity building and supervision.

The government has already promulgated far-reaching legislation on tobacco control in the country. The Department of Health recently submitted an amendment bill in parliament aimed at strengthening tobacco control and significantly increasing fines for violation of the Tobacco Control Act. The age restriction on the sale of tobacco has been increased from 16 to 18 years, and the proposed penalties for non-compliance are severe. The fine for the failure of owners of public places or employers to ensure no smoking in a smoke-free area has been increased from R200 to a minimum of R20 000.

The Department of Health has developed a framework for legislation on the control of alcohol. The government needs to fast track the policy and legislative framework on alcohol as alcohol is currently the number one drug of choice in South Africa. Collaboration with the private sector and the alcohol industry is important in developing and implementing such policies.

4.2.7 Home Affairs

The Department of Home Affairs is responsible for determining the status of persons (citizens and foreigners) and for issuing appropriate enabling and/or identification documents to such persons. The department 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 chairs the Border Control Operational Coordinating Committee (BCOCC) and is charged with ensuring that the operations of the various stakeholders (including Port Health, SARS, Agriculture, SAPS, NIA, Defence, DEAT) are coordinated and effective.

The department administers a deportation facility, which also serves as a holding centre for deportees. Like many detention facilities, the deportation facility faces the risk of drug abuse by deportees. The deportation facility also has a small medical facility on site that has to be managed according to set standards and risk management procedures.

4.2.8 Justice and Constitutional Development

The Department of Justice and Constitutional Development helps reduce the demand for illicit drugs and the supply of such drugs on the street.

Regarding demand reduction, the department, through the criminal justice system, diverts young and non-violent offenders who require drug-related treatment to treatment programmes instead of their having to 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 role players in the courts are educated about substance abuse so that they can identify offenders who require treatment. The department sees to it that prosecutors and magistrates receive training on legislation aimed at prosecuting offenders.

Regarding supply reduction, the department deals with organised crime involving drugs through forfeiture of the gains/property (asset forfeiture) ensuing from crime as well as through deterrent sentences in the courts.

The department plays a role in the Justice Crime Prevention and Security (JCPS) Cluster and the Social Cluster in the fight against drugs.

In terms of its involvement with the JCPS Cluster, the department contributes to the formulation of intersectoral strategies for combating drug-related offences.

In terms of its involvement with the Social Cluster, the department contributes to the formulation of intersectoral strategies on social cohesion and moral regeneration focusing, in particular, on drug-related aspects of crime prevention/combating if the cluster identifies this as a priority.

4.2.9 Labour

The Department of Labour establishes the conditions of employment and protects the rights of employees in the workplace. It combats substance abuse in the workplace and draws up workplace policies on substance abuse.

4.2.10 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 (No. 101 of 1965) to oversee the regulation of medicines in South Africa. Its main function is to safeguard the public by ensuring that all medicines sold and used in South Africa are safe, therapeutically effective and consistently meet acceptable standards of quality.

The Medicines Control Council applies standards laid down by the Medicines and Related Substances Control Act (No. 101 of 1965), which governs the manufacture, distribution, sale and marketing of medicines. The prescribing and dispensing of medicines is controlled through the establishment of schedules for various medicines and substances.

4.2.11 National Youth Commission

The National Youth Commission (NYC) was established by the National Youth Commission Act 1996 (Act. No. 19 of 1996) and is located in the Office of the Deputy President. The NYC's primary aim is to assist the government in planning a comprehensive youth development policy with reference, inter alia, to substance abuse and related issues. The NYC focuses on youth in and outside school.

4.2.12 Safety and Security

The Department of Safety and Security includes the South African Police Service (SAPS), the Independent Complaints Directorate (ICD) and the Secretariat for Safety and Security.

The Secretariat for Safety and Security was established in terms of Chapter 2 of the SAPS Act (No. 10 of 1995) and has the following functions.

- To advise the Minister of Safety and Security on the exercise of his or her powers and the performance of his or her duties and functions;
- To perform such functions as the minister may consider necessary or expedient to ensure civilian oversight of the South African Police Service;
- To provide the minister with legal services and advice on constitutional matters.

The ICD was established in terms of Chapter 10 of the SAPS Act (No. 10 of 1995) to investigate complaints of brutality, criminality and misconduct against members of the South African Police Service (SAPS) and the Municipal Police Service (MPS). The ICD operates independently from the SAPS in the investigation of alleged misconduct and criminality by SAPS members. Its mission is to promote appropriate police conduct.

4.2.13 Social Development

The Department of Social Development is the lead department in the campaign against substance abuse, and it provides technical and financial support to the CDA and its secretariat. It is responsible for developing generic policy on substance abuse and has the following strategic objectives.

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

In collaboration with the Department of Health, the department provides treatment centres at community and tertiary levels.

4.2.14 South African Police Service

The objective of policing, in terms of the Constitution Act (No. 108 of 1996), is to

- prevent, combat and investigate crime;
- maintain public order;
- protect and secure the inhabitants of the Republic and their property;
- 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 include drug demand and supply reduction strategies. The following services/functions cut across the programme structure and impact on the functions in the different programmes.

- Employee Assistance Services provides proactive and reactive social work assistance to members and their families;
- Crime Prevention ensures visible crime deterrence through proactive and response policing on drug crimes thus supporting supply reduction programmes;
- Crime Intelligence conducts intelligence operations on criminal groups involved in drugs and gathers, collates and analyses related intelligence information;
- Crime Intelligence provides intelligence on precursor chemical movements nationally and internationally;
- Crime Intelligence provides for international cooperation between South African Police Services (SAPS) and foreign law enforcement agencies in addressing drug trafficking.
- Protection and Security Services provides policing and security at ports of entry and railways thereby minimising drug trafficking into and out of the country; it is responsible for arrests and seizures at ports of entry;
- Detective Services investigates and gathers evidence on serious and organised crime and deals with transnational and domestic narcotics trafficking through intelligence-driven operations:

i. Project operations, for example undercover operations, controlled deliveries, entrapment, surveillance, interception and monitoring;
ii. Disruption operations, for example search and seizure at ports of entry, nightclubs and drug outlets.

The SAPS promotes international cooperation and acts as a competent authority under the United Nations (UN) Conventions on the Law of the Sea (FFG) as well as the following UN Conventions:

i. The Single Convention of Narcotics Drugs of 1961
ii. The Convention of Psychotropic Substances of 1971

iii. The Convention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988, including Control Deliveries (Article 11) and Precursor Control (Article 12), which obligates the SAPS to control the import and export of precursors and investigate any illicit uses through the Chemical Monitoring programme, which the SAPS has adopted

4.2.15 South African Revenue Service

SARS is mandated to control the cross-border movement of goods, one of its functions being to prevent the movement of prohibited and restricted goods, for example narcotics. SARS participates in joint SARS/SAPS teams at certain ports of entry to interdict drugs and fulfils this function independently at other ports of entry.

4.2.16 Sport and Recreation

The Department of Sport and Recreation, through the South African Institute for Drug Free Sport (SAIDS), develops and implements prevention programmes against substance abuse from the fifty-seven sporting disciplines at regional, national and international levels.

SAIDS was established in terms of the Drug Free Sport Act (No. 14 of 1997) to promote participation in sport free from the use of prohibited substances or methods aimed at artificially enhancing performance. SAIDS accordingly outlawed doping practices, which are contrary to the principles of fair play and medical ethics, in the interest of the health and well-being of sportspersons.

The Drug Free Sport Act vests 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 competition and out of competition. SAIDS is the only body in the country permitted to authorise and enforce national anti-doping policy. It is funded by Sport and Recreation South Africa and its executive authority is the Minister of Sport and Recreation.

The Act has been amended to comply with the requirements of the World Anti-Doping Code, and SAIDS' Amendment Act (2006) will extend and increase the effectiveness of the institute in implementing its mandate.

The South African Institute for Drug Free Sport is recognised globally as a world leader in the fight against drugs in sport and is one of a handful of national anti-doping organisations that have been awarded the international benchmark of excellence, ISO 9001/2000 Certification, in compliance with the World Anti-Doping Code.

SAIDS' four main focus areas

i. Drug testing for the purpose of detecting and deterring the use of prohibited substances and methods.

ii. Education and awareness programmes for the purpose of preventing and deterring the use of prohibited substances and methods.

iii. Research on sociological issues (knowledge, attitudes towards and use of performance-enhancing drugs among South African sportspeople) for the purpose of planning and implementing effective drug-testing and education programmes.

Iv. International anti-doping alliances and collaboration with similar bodies throughout the world, with the focus on Africa, for the purpose of contributing to the harmonisation and improvement of doping control standards and practices.

In establishing an independent and accountable national anti-doping agency, the government has made a significant commitment to the global fight against banned drugs in sport, and, by virtue of SAIDS' legislative ambit, all national sports federations are obliged to cooperate with the institute.

"Doping**"** is the use of prohibited substances and/or methods that enhance performance or recovery in sport or that lead to enhanced performance in sport. The presence of any prohibited substance in a urine sample constitutes a doping offence, irrespective of how it got there. The use of drugs to enhance athletic performance is against the rules laid down by the governing bodies of most recognised sports worldwide.

Drug-testing programme

SAIDS conducts a comprehensive annual in-competition and out-of-competition drug-testing programme on over 2 500 South African athletes from fifty-four sporting disciplines competing at regional, national and international level. Out-of-competition testing is unannounced and can take place at the athlete's home, place of work, training field or any other venue. SAIDS has 54 accredited part-time doping control officers trained to international standards, based throughout the country, who conduct the testing and 76 trained chaperones who assist them. SAIDS also conducts in-competition and out-of-competition testing services for international sports federations, international anti-doping organisations, including the World Anti-Doping Agency, and organisers of major international events.

4.2.17 Trade and Industry

For the purpose of the NDMP, the Department of Trade and Industry is responsible for the regulation of the liquor industry. In particular, the department administers and enforces the Liquor Act (No. 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 Liquor Act provides for the establishment of norms and standards, minimum standards and criteria for cooperative government in the regulation of liquor in South Africa. The Act also provides for the establishment of the National Liquor Policy Council (NLPC), which consists of the Minister of Trade and Industry, as chairperson, and all MECs responsible for the administration of liquor matters in each province. The objectives of the Act are to reduce the socioeconomic 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 the liquor licensing process.

4.2.18 Transport

The Department of Transport is responsible for ensuring coordination in enforcement activities (actually implemented by provinces and local authorities) through the Road Traffic Management Corporation.

The department is active in several areas concerned with the implementation of national substance abuse policy.

- Training of traffic officers (managed by the Road Traffic Management Coordination RTMC) will from 2007 include a component on the recognition of drug users. Officers are trained to prosecute alcohol-related crimes on the road by three methods: breath tests conducted by means of an alchometer, blood tests carried out by a registered nurse or medical doctor, and recognition of behaviour indicating that the person is under the influence of alcohol or drugs.
- The responsibility for laying down standards for enforcement equipment lies with the Technical Committee for Standards and Procedures. This includes considering all matters concerning alchometers and breathalysers, their acceptance as evidentiary equipment and the latest technical developments in the field. It also includes the approval of equipment for identifying illegal drug usage.
- The new Road Safety Strategy, based on consultation with all the provinces, includes plans to increase enforcement, particularly in the form of mini-roadblocks as well as multidisciplinary roadblocks. Roadblocks can identify drivers driving under the influence of drugs or alcohol and can also lead to the apprehension of people carrying drugs on the roads. Drugs have to be transported from their area of manufacture or importation to the customers, and this is generally done via roads.
- Legislation and regulation often involve the introduction of measures to combat alcohol and substance consumption, for example the reduction of blood alcohol levels from 0,08 to 0,05 in 2004 in terms of the Road Safety Strategy.
- Public transport. The alcohol limit for Professional Driving Permit (PrDP) drivers is 0,02, and this limit is enforced through roadblocks as part of the Road Safety Strategy. Also part of the campaign is a training programme and practical test for PrDP drivers. Lectures on the use and abuse of alcohol and drugs is a component of the training so that all drivers of public transport vehicles can be aware of the dangers of combining alcohol or any illegal drug and driving.

In summary, government departments charged with developing mini-drug master plans (MDMPs) have to commit themselves to providing human, financial and material resources to assist in the implementation of the NDMP. The MDMP should be in line with the particular department's mandate as outlined in the NDMP. Knowledge of substance abuse should be a key performance area of the officials of each government department. MDMPs should also reflect resources allocated per activity in the achievement of specified goals on an annual basis.

4.3 CIVIL SOCIETY

The Department of Social Development has partnerships with various NGOs that deal with substance abuse. The most important of these NGOs is the South African National Council of Drug Abuse and Drug Addiction (SANCA). Faith-based organisations (FBOs) and community-based organisations (CBOs) are other key role players. Most of these organisations are subsidised and monitored by the department. 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 government on strategies and interventions. Civil society organisations that work in the field of substance abuse in the most vulnerable groups and previously under-serviced areas require special training and support.

4.4 PROVINCIAL SUBSTANCE ABUSE FORUMS

Provision has been made for a substance abuse forum for each of the nine provinces in South Africa.

4.4.1 Composition

Provincial substance abuse forums should involve all stakeholders in the fields of education, community action, legislation, law enforcement, policymaking, research and treatment. The business community and any other body interested in tackling substance abuse should also be involved.

Such forums should establish an executive committee and assign the following four portfolios to particular members.

- Treatment and after-care
- Prevention and education
- Community development
- Research and information dissemination

4.4.2 Functions

The main function of the provincial forums is to support member organisations in carrying out their substance abuse programmes and to keep substance abuse issues high on the public/political agenda of the province. These forums should also encourage networking and the effective flow of information between forum members. When necessary, a provincial forum should act as a mouthpiece for member organisations.

Each provincial forum sends a representative to act as ex officio member of the CDA at CDA meetings. Provincial forums also assist local drug action committees in the execution of their tasks.

4.4.3 Funding

The Department of Social Development contributes to the human and material resources of the provincial forums insofar as such resources are available. Although the department also provides technical assistance to these forums, the forums have to develop integrated plans for the management of substances of abuse in their provinces. The plans should reflect the different roles of departments and the resources allocated to their respective activities.

Successful implementation of a national drug control strategy requires adequate, sustained and budgeted funding at all levels from collaborating departments. Spending on demand and supply reduction should be well balanced, and increased collaboration between government, private and voluntary sectors is required as the fragmented response in the past and the consequent duplication of effort has been financially wasteful. Where common goals exist, resources should be shared.

4.5 LOCAL DRUG ACTION COMMITTEES

Local drug action committees (LDACs) are closest to the people as they are part of local government.

4.5.1 Composition

An LDAC is made up of bodies/people from all sectors involved in substance abuse and related problems in a municipality such as justice, police, probation and correctional services, and school, health, social development and community structure officials. Local government drives the LDACs in terms of establishment and functioning. The local government official responsible for the LDAC liaises with the provincial coordinator of the Department of Social Development, and the LDAC co-opts additional members with special skills, commitment or expertise when required. Representation of local and rural traditional authorities is encouraged. LDACs include members of local municipalities geographical boundaries should be flexible for practical purposes. LDACs also elect a chairperson and other office bearers.

Resources required for the LDAC infrastructure are minimal as the existing resources of the representative departments can be accessed. Meetings can be conducted after hours, if necessary, in unused court buildings, Department of Social Development boardrooms and other free venues in municipal areas. The work of LDACs is driven intersectorally by the coordinators of substance abuse action at provincial departments of social development and linked to the work of provincial substance abuse forums.

4.5.2 Functions

Local authorities develop and maintain integrated drug policies in collaboration with all stakeholders in order to prevent drug-related crime and ensure quality of life for residents at the community level. The LDACs ensure that local action is taken in terms of the NDMP in each community. Each LDAC is charged with the following functions.

- Drawing up its own action plan to tackle the drug problem in its area of jurisdiction in collaboration with provincial departments;
- Ensuring that its drug control action plan fits into the local integrated development plan (IDP);
- Ensuring that its action plan is in line with the priorities and objectives of the NDMP and the strategies of government departments;
- Implementing its action plan (mini-drug master plan);
- Reporting regularly to its secretariat on its actions, progress and problems, and on drug-related events in its area;
- Providing any information the CDA may require from time to time through the provincial substance abuse forums;
- Providing, through the provincial substance abuse forums, annual reports to the CDA.

4.5.3 Funding

The particular local government and the departments designated by the Prevention and Treatment of Drug Dependency Act should as far as possible contribute towards the financial, human and material resources of the LDAC.

4.6 COST OF SUBSTANCE ABUSE

The cost of substance abuse is difficult to quantify as it encompasses the public health costs of diseases associated with drug dependence, crime and associated costs, and insurance costs that are borne by individuals and employers. The level of government spending on drug-related issues is also difficult to estimate as expenditure is spread across national, provincial and local government departments, agencies and statutory organisations.

CHAPTER 5
MONITORING AND EVALUATION

Ongoing monitoring and evaluation are required to measure progress and achievements in respect of set objectives and the implementation of the NDMP by all stakeholders. More specifically, monitoring and evaluation focus on the following:

- The extent of coordination in dealing with the supply of and demand for substances;
- The extent to which substance abuse issues have been effectively incorporated into the socioeconomic programmes of all stakeholders;
- The extent and effect of service integration at local, provincial and national level;
- The effectiveness of national, regional and international collaboration in combating drug trafficking and enforcing law and order;
- The extent to which individuals, groups (including families) and communities have access to all interventions necessary to address problems associated with substance abuse;
- The extent and impact of information, education and communication as a means of preventing substance abuse;
- The extent of research into the supply of and demand for drugs and the impact of drug abuse on society.

More critically, monitoring also entails the identification of problem areas and the changes needed to ensure effectiveness and efficiency in dealing with the problems. This could lead to proposals for the review of current policies and legislation. The lead department, Social Development, facilitates the development of systems that will enhance the capacity for monitoring and evaluation.

The CDA is mandated by parliament to coordinate substance abuse services and to report to parliament annually on how the substance abuse problem can be managed in a way that will contribute towards making South Africa a drug-free country. The CDA therefore needs to be informed about any initiatives or programmes aimed at dealing with drug issues. On the basis of reports from key government departments, provincial substance abuse forums and local drug action committees, the CDA can monitor and evaluate the drug situation.

Finally, the CDA facilitates quality services to combat and prevent substance abuse. The services are mainstreamed and integrated where necessary, and legislation is reviewed accordingly. The performance of the CDA Board is measured according to the quality and quantity of the completed work.

5.1 MONITORING AND EVALUATION AT NATIONAL LEVEL

Role players at this level

- **Cabinet and cabinet committees:** The Cabinet is responsible for approving and implementing legislation. The portfolio committees of the core departments stipulated in the Act make recommendations to the 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.

- **National Assembly:** The National Assembly is the lower house of the Parliament of South Africa, located in Cape Town, Western Cape Province. The government departments and their entities are monitored by the National Assembly, especially in terms of their mandates.
- **MINMEC (Ministers and Members of Executive Councils):** The Ministers Council of the Department of Social Development monitors progress in the functioning of the CDA. Other councils may monitor the role of their departments in the implementation of the NDMP.
- **Director-General:** The Director-General of the Department of Social Development monitors the CDA and, where necessary, follows up problems with relevant departments to ensure delivery in terms of the NDMP and the achievement of its goals.
- **Central Drug Authority:** The CDA is responsible for the coordination of national and provincial departments in respect of substance abuse. The CDA monitors national departments to ensure delivery of services to prevent and combat substance abuse on the basis of mini-drug master plans and reports. It formulates strategic plans annually to demonstrate how it intends achieving its goals. In turn, the Minister of Social Development monitors the functioning of the CDA, approves the submissions on the activities of the CDA and draws up the CDA's budget. The Portfolio Committee of the Department of Social Development is also responsible for monitoring the CDA's performance. Other parliamentary committees may from time to time call on the CDA to report on its activities.
- ***The Cabinet***. The CDA submits an annual report to the Cabinet indicating how the drug problem is being prevented and combated by the responsible departments.
- ***The National Council of Provinces (NCOP)***. The CDA is monitored by the NCOP insofar as the CDA impacts on provincial interests.

5.2 MONITORING OF GOVERNMENT DEPARTMENTS BY THE CDA

The core departments are charged by the NDMP to submit their mini-drug master plans and reports to the CDA and to show how substance abuse is being prevented and combated. The departments may also be requested to report regularly on progress with the implementation of their mini-drug master plans.

5.3 MONITORING BY PROVINCIAL SUBSTANCE ABUSE FORUMS

The provincial forums are responsible for the implementation of the NDMP. Each province is required to have an operational plan detailing how it deals with substance-related issues. A provincial forum consists of representatives of core departments involved in the substance abuse field. Each province also has a provincial substance abuse coordinator appointed by the Department of Social Development to set up a secretariat for the provincial forum (Addendum 1) and collaborate with the CDA secretariat to ensure that the forum functions appropriately. The coordinator, who is monitored by the provincial department, submits two reports annually outlining progress in the implementation of the provincial mini-drug master plan. All provincial role players are accountable to the provincial department of social development.

5.4 MONITORING BY LOCAL DRUG ACTION COMMITTEES

Local government takes the lead in the establishment and functioning of the Local Drug Action Committee (LDAC) by providing a secretariat for the LDAC, which liaises with the provincial forum (Addendum 1). LDACs are responsible for preventing substance abuse at the local level in line with NDMP objectives.

Each municipal area develops operational plans at local level that detail how the drug problem is being managed at municipal level.

LDACs are composed of departments operational in the municipal area, NGOs, CBOs, FBOs and any other individual structure, such as community policing forums, concerned with the problem of substance abuse. LDACs liaise with the provincial coordinator and are represented in the provincial forums. The plans and reports of the LDACs are sent to the coordinator who, in turn, includes information on LDAC activities in the provincial reports.

5.5 IMPLEMENTATION OF THE NATIONAL DRUG MASTER PLAN

As indicated earlier, different government departments and provincial forums develop mini-drug master plans that cover a period of five years and are submitted to the CDA. The timeline for submission of these plans is 1 April each year. The mini-drug master plans serve as a basis for the development of an integrated plan for the country for which the CDA is responsible. The CDA ensures that the responsible government departments provide the necessary human and material resources to ensure implementation. (The CDA may request the Cabinet to intervene in cases where government departments do not comply with the requirements set out in the NDMP.)

The Central Drug Authority implements the NDMP in the following way.

Year	Activities	Responsibility
One – 2006/07	Appointment of CDA members	Minister of Social Development
	Approval of the NDMP 2006-2011	Cabinet
	Development of the five-year business plan for the CDA	CDA
	Development of the mini-drug master plan framework and conducting of workshops	CDA
	Development and submission of mini-drug master plans	National government departments, entities and provincial departments.
	Provision of resources to implement the NDMP within the current medium term expenditure framework period	All government departments, entities and provinces
	Development of performance measures for the implementation of the NDMP	CDA
	Reporting to parliament	CDA and government departments
Two – 2007/08	Development of communication strategy	GCIS with CDA and all government departments
•	Maintenance and strengthening of existing provincial substance abuse forums	CDA secretariat and provinces
•	Completion of the setting up of local drug action committees in all the provinces	CDA secretariat and provinces

Year	Activities	Responsibility
•	Development of an integrated mini-drug master plan aligned to the government's strategic plan for the country to promote integration and coordination based on the submitted mini-drug master plans by relevant government departments and stakeholders	CDA
•	Monitoring and facilitation of the implementation of the NDMP and reporting to parliament	CDA, provinces and government departments
•	Implementation of the communication strategy	GCIS, CDA, entities, provinces and government departments
•	Organisation of biannual summit to share best practice models	CDA, entities, provinces, government departments, civil society and NGOs
Three • 2008/09	Maintenance and strengthening of the implementation of the mini-drug master plans	CDA, entities, provinces and government departments
•	Ongoing implementation and monitoring of the communication strategy	GCIS, CDA, entities, provinces and government departments
•	Monitoring of the implementation of the mini-drug master plan and reporting to parliament	CDA, entities, provinces and government departments
Four • 2009/10 •	Ongoing implementation of the NDMP through the mini-drug master plans	CDA, entities, provinces and government departments
•	Organisation of biannual summit to share best practice models	CDA, entities, provinces, government departments, civil society and NGOs
•	Ongoing implementation and monitoring of the communication strategy	GCIS, CDA, entities, provinces and government departments
•	Conducting of impact assessment of the implementation of the National Drug Master Plan	CDA
•	Monitoring and evaluation of the implementation of the NDMP and reporting to parliament	CDA and departments
•	Review of the National Drug Master Plan	CDA
•	Commencement of the process for appointing CDA members for the next five years	Department of Social Development and CDA secretariat
•	Commencement of the review process of the National Drug Master Plan for the next five years	CDA

Year	Activities	Responsibility
Five 2010/11	• Ongoing implementation and monitoring of the National Drug Master Plan and reporting to parliament	CDA, entities, provinces and government departments
•	Drawing of final conclusions on the successes, failures and overall effectiveness of the 2006-2011 NDMP	CDA, entities, provinces and government departments
•	• Commencement of the approval process for the next five-year NDMP document	Department of Social Development and CDA secretariat
•	• Appointment of CDA members for the next five years	Minister of Social Development

CHAPTER 6
CONCLUSION

Establishing a National Drug Master Plan should not be seen as the end of a process but rather the beginning. The challenge of translating the plan into a tangible reality can be met by harnessing the resources and political commitment needed to implement the plan. The ultimate aim is to improve the quality of life of all South Africans.

Solving South Africa's socioeconomic problems is an awesome task. In the long term, however, the failure to address substance abuse adequately could jeopardise the attainment of real reconstruction and development in South Africa.

While the need does exist for a house for every family, schoolbooks for every pupil, a hospital bed for every patient and a monthly pension for the aged, it should not be forgotten that drug abuse blights individual lives, undermines families and damages whole communities. Substance abuse is a unique social evil that requires special attention.

All departments designated in the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992) should report to one another and share information in order to improve service delivery aimed at creating a drug-free society. The prevention and combating of substance abuse is the responsibility of every department designated by the Act.

No single department can achieve its goals without the support and involvement of other departments and stakeholders. Against this background, mini-drug master plans should necessarily be linked to the term of office of the CDA.

GLOSSARY

Abuse: Persistent or periodic excessive drug use inconsistent with or unrelated to acceptable medical practice.

Chemical precursors: Substances 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 from the needs of a particular community (established through a needs assessment) and that identify and utilise existing infrastructure to meet these needs.

Demand reduction: A general term used to describe policies or programmes directed at reducing the consumer demand for psychoactive drugs. It is applied primarily to illicit drugs, particularly with reference to education, treatment and rehabilitation strategies as opposed to law enforcement strategies aimed at preventing the production and distribution of drugs.

Dependence: A person is dependent on a drug or alcohol when it becomes difficult or even impossible for him or her to refrain from taking the drug/alcohol without help after having taken it regularly for a period of time. The dependence may be physical or psychological or both.

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.

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 welfare 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 drugs and often, more specifically, to illicit 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 illicit drugs, locally or nationally, including education, treatment, control and other programmes and policies.

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

Drugs or substances of abuse: This term encompasses drugs, alcohol, chemical or psychoactive substances.

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.

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 prior to patients presenting of their own volition 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 dependency or major psychosocial complications.

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

Illicit drug: A psychoactive substance, the production, sale or use of which is prohibited.

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.

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: Prevention is a proactive 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 (focuses on altering the individual and the environment in such a way as to reduce the initial risk of substance abuse); secondary prevention (focuses on early identification of persons who are at risk of substance abuse and intervening in such a way as to arrest progress); and tertiary prevention (focuses on treatment of the person who has developed a drug dependency).

Streetchildren: The term often used to describe 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 on the street, often lacking any contact with their families).

Substance abuse: The term refers to the misuse and abuse of legal substances such as nicotine, alcohol, over-the-counter drugs, prescribed drugs, alcohol concoctions, indigenous plants, solvents and inhalants, as well as the use of illicit drugs.

Supply reduction: A general term that refers to policies or programmes aimed stopping the production and distribution of drugs, particularly law enforcement strategies for reducing the supply of illicit drugs.

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

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