

Alcohol and other drug use



High levels of abuse of alcohol and other drugs (AODs) by certain groups in South Africa are documented as well as an indication of the resulting health and social burden incurred. A critique of the most prominent policy initiatives promoted by various government departments at a national level to address AOD abuse indicates that there have been activities on several fronts. Activities undertaken by the Department of Health specifically have included strategic planning exercises, departmental restructuring, support for research in key areas, the establishment of a committee to look into advertising, and support for certain prevention initiatives. Gains have, however, been less than hoped for at national and particularly at provincial levels. Various recommendations are presented for taking things forward. In the short term priority should be given to addressing AOD treatment and rehabilitation, instituting work place interventions, forbidding or restricting alcohol advertising, and implementing specific harm reduction strategies. In the medium term attention should be given to increasing community support for substance abusers, and education of persons at risk as well as the general public. Other recommendations include the need for the Department of Health to work with other departments, for example, in increasing excise taxes on alcohol, in establishing a national substance abuse clearing house, and in lobbying the Department of Finance to provide the funds needed to implement the National Drug Master Plan.

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Introduction

Following the first democratic elections in South Africa optimism was expressed in the government's willingness to tackle all forms of substance abuse.¹ In this chapter we review progress made since 1994 in addressing alcohol and other drug (AOD) use. The focus will mainly be on policy developments and their implementation by the health sector.

The nature and extent of alcohol and other drug use and associated consequences

Based on the findings of the Department of Health's South African Demographic and Health Survey (SADHS) conducted in 1998 by the Medical Research Council (MRC) and Macro International Inc., just under half of men (45%) and one-fifth of women (17%) 15 years and older report that they currently consume alcohol (Table 1). For both sexes, the rate is 28%, which translates to 8.3 million South Africans 15 years or older. Rates of current drinking differ substantially by population group and gender, with the highest levels reported by White males (71%), followed by White females (51%), and Coloured males (45%). The lowest rates were reported by African and Asian females (12% and 9% respectively). For both men and women higher rates of current drinking were recorded in urban areas. For both men and women, persons with either low or high levels of education are more likely to drink than those with moderate education (Standards 4 - 9). For males the highest current drinking levels were reported in the Free State and Gauteng (50% or more) and the lowest levels were reported in the Northern Province (28%). For females, the lowest levels were also recorded in the Northern Province (9%), with the highest levels being in the Free State, Western Cape and Northern Cape (23%-25%). For both men and women the highest levels of current alcohol use were recorded among persons in the 35-44 and 45-54 year age groups, and the lowest levels in the 15-24 year group. Given the method used (a few questions in an omnibus survey) the reported levels of drinking are likely to underestimate actual levels.

Table 1: Percentage of males and females (≥15 years) reporting current use of alcohol, and percentage of current drinkers engaging in risky drinking

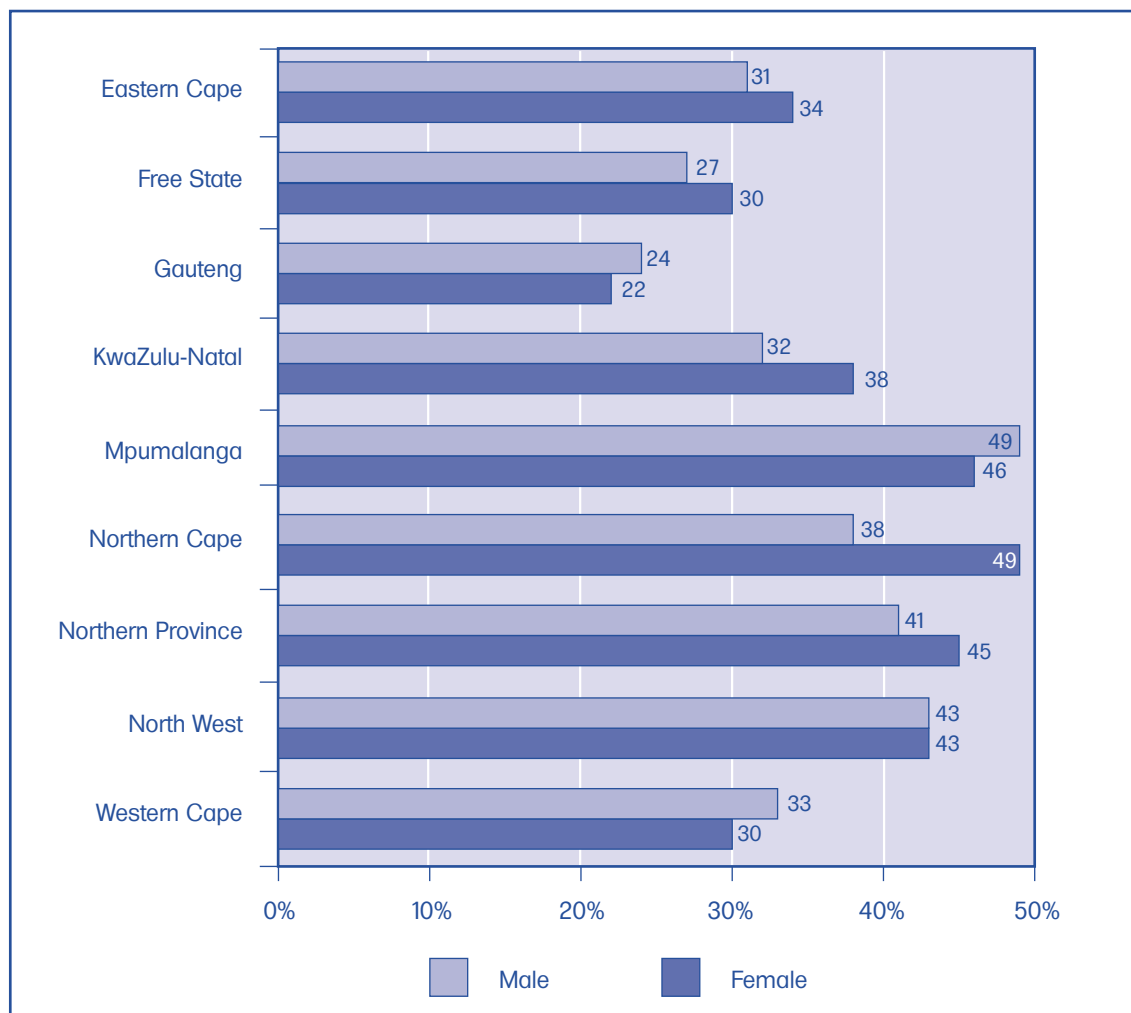
Background characteristics	Total sample (5 574 males and 7 962 females)		Current drinkers (2 478 males and 1 321 females)			
	Drink now (Current drinking)		Risky drinking - weekdays ^a		Risky drinking - weekends ^a	
	Males	Females	Males	Females	Males	Females
Age						
15-24	23.5	8.5	3.1	1.2	29.3	30.1
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
Northern Province	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: Department of Health's 1998 South African Demographic & Health Survey

a Defined for males as drinking ≥5 drinks per day, and for females as drinking ≥3 drinks per day

Risky drinking was defined as drinking five or more standard drinks per day for men and three or more drinks per day for women. While communal drinking is often also risky, respondents who reported communal drinking were not classified as 'risky drinkers'. Rates of risky drinking for males and females were very similar and were roughly 4-5 times greater at weekends than on weekdays, with one-third of current drinkers drinking at risky levels over weekends. For both males and females, risky drinking at weekends appears to be highest among persons in the middle categories for age (35-44 years for males and 45-54 years for females), among persons residing in non-urban areas, with a low level of education (Sub A to Standard 5), and Coloureds and Africans. This data should not, however, be interpreted to mean that there is a simple relationship between race and level of risky drinking. Instead it is likely that factors such as poverty and lack of access to recreational and other resources are intervening variables which need to be taken into account. While an analysis of such factors has not been undertaken on this part of the SADHS dataset, analysis of data on use of drugs and crime did indeed show that race, monthly income and patterns of drug use were highly correlated (see below).

Weekend risky drinking by males appears to be highest in Mpumalanga, whereas for females the highest levels appear to be in the Northern Cape (Figure 1). The provincial differences may partly reflect inequities in terms of the distribution of treatment and rehabilitation services as well as prevention/health promotion activities. According to the Department of Welfare's 1997 Resource directory on services and facilities for the prevention and treatment of substance abuse² there are no detoxification facilities or inpatient treatment centres listed in the Northern Cape. In Mpumalanga one detoxification facility and two inpatient facilities are listed. Seven percent of pregnant women (13/190) acknowledged current drinking.

Figure1: % of weekend risky drinking (current drinkers) – 1998 SADHS

No recent, national statistics are available on drug use in South Africa, nor is information available on national trends in alcohol and drug use. The most up-to-date information available is from the South African Community Epidemiology Network on Drug Use (SACENDU) Project, an AOD sentinel surveillance system operational in Cape Town, Durban, Port Elizabeth (PE) and Gauteng (Johannesburg/Pretoria). Mpumalanga was added in 2000. The system, initiated by the MRC and the University of Durban-Westville in 1996 monitors trends in AOD use and associated consequences on a six-monthly basis using multi-source information. According to the SACENDU Phase 7 (July 1996 to December 1999) findings, alcohol is still the dominant substance of abuse across sites and dominates admissions to specialist substance abuse treatment facilities, with between 50% (Cape Town) and 65% (Durban) of all patients admitted for treatment having alcohol as their primary substance of abuse.⁵ Since 1996 the proportion of alcohol-related treatment admissions has shown a steady decline in Cape Town and Gauteng relative to other substances. Although treatment demand does not equate with prevalence and is dependent on factors such as admissions policies, the SACENDU data supports the view that drug use is increasing in South Africa and that there is a move towards a greater variety of drugs of abuse.

Treatment demand for cannabis increased in three of the four sites, whereas for Mandrax (methaqualone and antihistamine) alone or in combination ('white-pipes'), treatment demand

was stable or declined. Between 50% (Gauteng) and 78% (PE) of patients attending specialist treatment centres had cannabis and/or Mandrax as their primary drug of abuse. Treatment demand for heroin has remained fairly stable. Heroin use is mostly concentrated in Cape Town and Gauteng where 7% and 8% respectively of patients in specialist treatment centres have heroin as their primary drug of abuse. The abuse of over-the-counter and prescription medicines (mainly benzodiazepines and pain killers) continues to be an issue across sites especially in PE. However, demand for treatment where these substances are the primary drug of abuse was either stable or showed a slight decrease across the sites. Treatment demand for cocaine powder/crack cocaine has increased in Durban (26% of patients have cocaine or crack as their primary drug of abuse), but remains stable in the other sites (ranging from 3% in PE to 28% in Gauteng). Overall, the level of drug use as well as the range of drugs used is higher in Cape Town and Gauteng compared with PE and Durban. Poly-substance abuse is also common, especially alcohol in combination with most other drugs, cannabis and Mandrax, cocaine and heroin, and Ecstasy, LSD and Speed.³

The statistics presented above, however, do not give a complete picture of substance use among young people. More localised research⁴ found that 36% of male and 19% of female grade 11 (Standard 9) students in state-funded schools in Cape Town in 1997 reported binge drinking during the two weeks prior to the study. This was 4% to 7% higher than in a similar study conducted in 1990. Four percent of female students reported ever having used cannabis compared to 16% for males, almost doubling between 1990 and 1997. Club drugs appear to be entrenched in youth culture, particularly middle to upper class Whites. A 1998/99 RaveSafe study among 228 young people attending rave parties in Durban and Johannesburg reported lifetime prevalence rates ('use ever') of 77% for Ecstasy, 70% for LSD and 60% for poppers (amyl nitrate).⁵ With regard to children of younger ages, Visser and Moleko⁶ found that 14% of 460 grade 6 and 7 learners from an historically disadvantaged area in Pretoria indicated that in the 14 days preceding the study they drank alcohol to get drunk. Nine percent had used over-the-counter-medicines, 4% had smoked cannabis and 3% had sniffed solvents in the preceding 30 days. Solvent use is reportedly much higher among street children.⁷

Currently, in developing countries alcohol-related problems commonly result in trauma, violence, organ system damage, various cancers, unsafe sexual practices, injuries to the brain of the developing foetus and general poor nutritional status of families with a heavy drinking parent/parents. Many of these problems are associated with intoxication episodes.⁸ Research on the health consequences of AODs in South Africa has focused mostly on alcohol, and on fatal and non-fatal injuries and foetal alcohol syndrome (FAS). A study of alcohol-related mortality in 10 mortuaries spread throughout five of South Africa's nine provinces was conducted in 1999 as part of the National Non-Natural Mortality Surveillance System. Data are currently available on 4 484 autopsies, 37% of the 12 269 autopsies registered in the 10 mortuaries.⁹ Over 50% of cases were found to have positive blood alcohol concentration (BAC) levels, with 29% of cases having BAC levels at or over 0.08g/100ml. Almost 50% of cases involving death due to homicide and traffic collisions had BACs of 0.08g/100ml. Just over one quarter of deaths resulting from suicide or other 'accidents' had blood alcohol levels of 0.08g/100ml.

With regard to non-fatal injuries, a study conducted in state hospitals in Cape Town, Durban, Umtata, and PE in 1999 found that 61% of patients admitted to trauma units in these cities were alcohol positive with a mean alcohol level of 0.12g/100 ml. The study showed that 74% of violence cases were alcohol positive, 54% of traffic collisions and 42% of trauma

from other 'accidents'. Across sites nearly 40% of trauma patients were positive for at least one drug (29% cannabis, 11% Mandrax, 5% cocaine, 5% opiates, 0.3% methamphetamine and 0.2% amphetamine).¹⁰ Research undertaken by the MRC on the relationship between BAC in injured drivers and pedestrians clearly demonstrates that the amount of alcohol consumed is proportional to injury severity.¹¹

Little research has been undertaken in South Africa to directly assess the burden experienced by the health care system as a result of AOD use, but one in four general hospital admissions in South Africa are estimated to be directly or indirectly related to alcohol use.¹² Proportions of AOD-related presentations are lower in primary health care (PHC) settings, with one study indicating that 8% of male and 3% of female patients reported experiencing health problems because of alcohol or drug use.¹³ An enormous economic and social burden associated with alcohol use in South Africa occurs as a result of Foetal Alcohol Syndrome (FAS). In 1997, 992 children in their first year of school were screened in the rural community of Wellington outside Cape Town. A very high rate of FAS was found in the sample with age-specific rates for the entire community ranging from 39.2 to 42.9 per 1 000.¹⁴ These rates are 18 to 141 times greater than prevalence estimates for the USA. FAS in South Africa is in large part thought to occur as a result of the 'dop' (or 'tot') system and its legacy.¹⁵

The 'dop' system in South Africa

Under the 'dop' system, farm workers were paid part of their wages in the form of alcohol (typically wine). The practice dates back to colonial times and was aimed at inducing indigenous peoples in the Cape to work for their masters. The practice played an important role in maintaining control over the labour force and it became indispensable to labour and social relations on farms.¹⁵ Alcohol was usually supplied at the end of the working day or at the end of the week in later times.

The 'dop' system is no longer legal, but wine is still made available to workers on many farms – either directly or purchased on credit by employees.¹⁵ The legacy of the dop system continues and it is likely to be a major contributing factor behind alcohol-related problems such as trauma, interpersonal violence, occupational injuries and social disruption, especially in provinces such as the Western and Northern Cape.

Substance abuse not only has a negative impact on the health sector, but also impacts negatively on the family and society in terms of crime and negative effects on economic and social development. In a study of women abused by their spouses in the previous Cape Province, 69% identified alcohol/drug abuse as the main cause of conflict leading to abuse.¹⁶ In terms of the link between drugs and crime, research conducted by the MRC and the Institute for Security Studies in Cape Town, Durban and Johannesburg in February/March 2000 suggests a very strong link between drug use and various crimes with, for example, over 70% of persons arrested for either theft of motor vehicles or housebreaking testing positive for drugs (excluding alcohol). Up to a third of arrestees who indicated that they were under the influence of substances at the time the crime took place stated that they had used substances to assist them in committing the offense.¹⁷ This research also highlights major differences between race groups in terms of levels of drug use and the different kinds of substances of abuse. For example, a much higher proportion of Coloured arrestees (61%) tested positive for drugs as compared to African arrestees (38%). The drug/race interaction

was, however, found to be linked to income. White arrestees (who were most likely to be in the highest income group), for example, were most likely to test positive for drugs like cocaine (29% as compared to 5% for Africans). Patterns of drug use in South Africa are still highly segmented in race terms with Whites in general consuming a far broader range of drugs than other groups. These differences are likely to be due to different marketing practices in different residential suburbs (which are still to a large extent racially segregated) and differences in disposable income.

Less data is available on the impact of substance use on the economy of the country and social development in general, but it is likely to be considerable. In economic terms, based on international experience (Australia, Canada and the USA), the economic costs associated with alcohol and drug use could be in the region of 1.3% and 2.6% of Gross Domestic Product (GDP).¹⁸ Based on the Canadian experience, direct health care costs associated with alcohol and illicit drugs could amount to about 16% of the total economic cost.

Selected key policy initiatives relating to alcohol and drug abuse

Alcohol and drug policy initiatives are not only the domain of the health sector. In fact, to date the bulk of drug policy development and implementation has been undertaken by the Department of Justice.¹⁹ Since 1994 however, the role of the Department of Health in addressing substance abuse issues has been steadily increasing. Below is a chronological listing of some of the most prominent national policy initiatives promoted by the Department of Health since 1994:

- ◆ Report of the Department of Health's Mental Health & Substance Abuse Committee (1995).²⁰ The Committee recommended immediate involvement and full participation of the Department of Health in all aspects of prevention, treatment and rehabilitation of substance abuse. It also recommended the establishment of an intersectoral structure to facilitate co-operation between health and welfare sectors in the substance abuse area and the re-establishment of the Drug Advisory Board.
- ◆ The Department of Health's report 'Towards a national health system' (1995)²¹ detailed the guiding principles for policy formulation in the mental health and substance abuse area. The national Directorate of Mental Health & Substance Abuse is responsible for co-ordinating the restructuring of mental health services that includes the development of standards of care and the integration of mental health services into PHC services. Epidemiological research and the continuous monitoring and evaluation of mental health services is also the responsibility of the Directorate. Specific programmes addressing substance abuse are to be promoted and encouraged. Functions set out for the provincial health authorities include facilitating intersectoral co-ordination, and ensuring the comprehensive integration of mental health and substance abuse services. District health authorities are tasked with planning and providing substance abuse prevention, promotion and rehabilitative services at district and community level, training of health facility staff, and co-ordinating health education programmes in communities.
- ◆ The Department of Welfare's National Drug Master Plan (1999).²² This plan was formulated by a committee on which the Department of Health served. It sets forth a broad strategy for integrating the efforts of various government departments and civil society in addressing substance abuse. The Plan identifies the following as priorities: crime, youth, community health and welfare, research and information dissemination, international involvement, and communication. A Central Drug Authority (CDA)

comprising both governmental appointees and experts from the non-governmental sector was established in 2000. It is expected that during its first year of operation, priority will be given to several activities, including establishing a Secretariat, getting key government departments to set up mini-drug master plans, establishing substance abuse fora in the provinces, initiating a mass communication initiative, and setting up a national substance abuse clearinghouse. Towards the middle of 2001 the CDA will have to report back to Parliament on progress achieved.

◆ Draft Health Sector Strategic Framework: 1999-2004 (1999)²³

The following target areas are listed:

- i Decrease alcohol/drug abuse by 10% by 2004. Activities listed include implementing the National Drug Master Plan and developing decentralised treatment at general hospitals and rehabilitation programmes and campaigns.
- ii Reduce the incidence of FAS by 50%. This is to be achieved through implementing community-based programmes involving education and assistance to 'problem drinkers'.
- iii 50% of all health facilities will have nurses trained in mental health and substance abuse. This is to be realised by integrating mental health and other health activities at all levels.

◆ A Framework for the Development of Substance Abuse Policy Guidelines (2000)²⁴

This draft document set out the Sub-directorate's aims as being:

- i To develop policy guidelines for the prevention and management of substance abuse
- ii To raise awareness of substance abuse within the context of PHC
- iii To educate and train PHC practitioners to fully integrate substance abuse prevention/management within the PHC domain; and
- iv To develop community-based prevention/management models to reinforce positive behaviours that promote healthy lifestyles. The document also spells out specific objectives relating to these aims and some strategies for their achievement.

Policy initiatives of other government departments which have had or which could have an impact on substance abuse include the following:

◆ The Department of Transport's Arrive Alive Campaign

The ARRIVE ALIVE Road Safety Campaign was initiated as a short-term initiative by the Department of Transport in 1997 to reduce the carnage on South Africa's roads. There have been four campaigns to date: October 1997 to January 1998, February 1998 to April 1998, October 1998 to April 1999, and May 1999 to April 2000. The core targets of this initiative are speed and alcohol. ARRIVE ALIVE 1 brought down the number of crashes by 7.7% and fatalities by 9.3% (in real terms saving 279 lives). The cost-benefit ratio was 4:1 based on an investment of R50 million, most of which came from the Road Accident Fund. Comparison studies found a 2%-4% decrease in drinking rates for the months targeted.²⁵ In 2000 the government promulgated legislation passed previously to reduce the amount of alcohol permissible in the blood of ordinary drivers to 0.05 gms/100ml and to 0.02 gms/100 ml for professional drivers. The value of the new policy, however, will depend not only on having new regulations on the statute books, but more importantly on their rigorous enforcement. Increased random breath

testing will be essential, as will rapid, consistent processing of drunk driving cases and the application of appropriate sanctions to offenders.

◆ The Department of Finance's excise tax on alcohol products

Another strategy used by the government to control the use of alcohol and indirectly raise revenue to meet some of the social costs associated with alcohol use is that of excise taxes on alcohol products. Currently the excise tax on beer comprises approximately 34% of the retail price of beer, 20% of the retail price of wine, and 28% of the retail price of spirits.²⁶ The government has, however, been criticised for allowing the excise taxes on most alcohol products to lag considerably behind the inflation rate and thereby missing an opportunity to reduce alcohol-related problems while at the same time increasing revenue.²⁷

◆ The provincial Departments of Economic Affairs' policies regarding liquor outlets

In 1999 there was a Constitutional Court ruling that certain aspects of the national Department of Trade & Industry's 1998 Liquor Bill²⁸ were deemed unconstitutional in that they related to provincial powers. In particular, those aspects of the Bill pertaining to liquor outlet regulations were deemed to be a provincial competency. As of the end of 2000 the only province to have drafted a green paper putting forward policy on liquor outlet regulations has been the Western Cape. The Western Cape policy is expected to make getting a liquor license easier in order to draw many of the unlicensed operators into the regulated market while at the same time offering increased community protections. Such protections are likely to include increased access to information, increased opportunities for community input at the license application stage, ongoing monitoring and annual reports to the provincial legislature, a Code of Conduct for liquor retailers, a provincial inspectorate, and a range of provisions aimed at strengthening the State's ability to take action swiftly against offenders.

With regard to other drugs the major impetus has been in the supply reduction area (reducing the supply of drugs into South Africa and the trade in drugs within the country). Most initiatives have been undertaken by the Departments of Justice and Finance.¹⁹

◆ The International Co-operation in Criminal Matters Act of 1996. This Act provides formal procedures to be used in the obtaining and providing of information in the course of a criminal investigation that spans international borders as well as the procedures for the repatriation of the proceeds of crime.

◆ The Proceeds of Crime Act of 1996. This piece of legislation criminalises money laundering in general, and provides procedures for the restraining and confiscation of the proceeds of crime.

◆ The Money Laundering Control Bill of 1997. This Bill makes certain bodies and institutions 'accountable institutions'. Bodies and institutions which receive money on behalf of clients in the normal course of business will be required to identify them and to keep proper records of business transactions with them. Certain transactions which have the potential of being used for money laundering purposes will have to be reported to a central authority. This bill, however, has yet to be enacted.

◆ The Prevention of Organised Crime Act of 1998. This Act makes provision for drastic new powers for police and prosecutors including the forfeiture of criminals' assets on the grounds of 'a balance of probabilities' rather than 'beyond a reasonable doubt'. The focus here is on civil rather than criminal prosecution. The legislation allows the state

to confiscate assets gained through illegal means regardless of whether the suspects are convicted or not. February 2000 saw the first deposit of monies confiscated from alleged drug dealers into the Criminal Assets Recovery Fund. The money is to be used to support law enforcement initiatives. The legislation initially ran into difficulty in the courts and several forfeitures of property belonging to alleged drug lords by the Scorpions' Asset Forfeiture Unit were overturned by the courts, resulting in amendments to the legislation.

In terms of regional co-operation, South Africa is also a signatory to the Protocol on Combating Illicit Drug Trafficking in the Southern African Development Community (SADC) Region. This was ratified by Parliament in July 1998. The Protocol provides a policy framework that allows the SADC region to co-operate to ensure that it does not become a producer, consumer, exporter and distributor of illicit drugs or a conduit for illicit drugs destined for international markets. South Africa is also an active member of the Southern African Regional Police Chiefs Co-operation Organisation (SARPCCO). While the SADC Regional Drug Control Programme²⁹ focuses mainly on drug supply reduction, Article 7 of the SADC Protocol gives special attention to demand reduction by requiring member states to 'develop, implement and evaluate policies and strategies aimed at establishing a comprehensive and integrated demand reduction programme that will include the development of community prevention, public and school education and research activities so as to address the underlying causes of drug abuse'.³⁰

Implementation of policies and general critique of the department of health's strategic plan

At a national level the Department of Health has been active in seeking to implement many of the broad strategies outlined in the first part of the previous section. Activities given priority have included:

- ❖ The restructuring of the Mental Health Directorate to include substance abuse (also at provincial and regional levels)
- ❖ Supporting the re-establishment of the Drug Advisory Board in 1995 and the ongoing functioning of the South African Alliance for the Prevention of Substance Abuse (SAAPSA). One of the intended outcomes of SAAPSA initiatives is the development and evaluation of demonstration projects designed to prevent substance abuse among disadvantaged youth.
- ❖ Epidemiological research on AOD use (via the SACENDU Project, the 1998 SADHS, and the development of a national injury surveillance system), and research into the toxic effects of home-brew alcohol, and alcohol advertising
- ❖ National guidelines to support the integration of substance abuse management into PHC are under development. To date effort has gone into collecting and assessing existing manuals.
- ❖ The development and evaluation of a life skills programme aimed at reducing substance abuse among school going youth in grades 8-12. This programme is designed to be included in HIV/AIDS education initiatives and will be implemented in schools throughout the country.
- ❖ Training PHC workers in all provinces to work with women of childbearing age to reduce the prevalence of FAS. Health promotion material (videos and pamphlets) have

been developed. The main focus of activity to date has been in the Western Cape and Gauteng, but further initiatives are planned for the remaining provinces, starting with the Eastern and Northern Cape.

- ◆ The establishment of a committee in 1998 to look into alcohol advertising restrictions and the need for counter-advertising and warning labels.
- ◆ Holding workshops during 2000 in each of the 9 provinces to refine the Department of Health's Substance Abuse Policy Guidelines

The Department of Health²³ is to be commended for listing specific, measurable targets to be achieved by 2004, although these require substantial refinement and expansion. The Department of Health has, however, failed to forge a link between substance use and priority areas such as TB, teenage pregnancy, and violence against women and children. It is of concern that more than five years after the establishment of a Mental Health and Substance Abuse Directorate, no substance abuse policy guidelines with specific objectives, strategies for implementation and indicators for assessing progress have been finalised. The Alcohol Advertising Committee established by the Directorate in 1998 has been put on hold due to a decision to first tackle tobacco advertising. However, during 2000 the Department awarded a tender to the South African National Council on Alcoholism and Drug Dependence (SANCA) to summarise local and international information on the impact of advertising of alcoholic beverages (including sponsorships of cultural events and electronic and print media). It is expected that the Directorate will resurrect the Alcohol Advertising Committee at the beginning of 2001. The Directorate, has however, been notably silent in responding to the furore around the sponsorship of the Springbok rugby team. This occurred as a result of the Castle Lager logo being branded in large letters on the jerseys of players selected to represent the national team. Concern has been expressed in various quarters to this form of advertising by among others Advocate Frank Kahn (the Chair of the CDA), the MRC, UCT Public Health, SANCA, past Springbok rugby players, and the public. It is expected that the CDA will work together with the Department of Health's Alcohol Advertising Committee to draft legislation in 2001 to end such practices. The main argument against allowing this form of advertising is that it may influence young people to start drinking. It may also increase the number of drinking occasions people have. It may also work against persons who wish to stop or cut down on their drinking and create a positive societal attitude towards alcohol which will make it difficult for persons working towards alcohol policy reform.³¹

Progress has also been limited in other areas deemed as priority by the Directorate, viz. research into unhealthy forms of home-brew alcohol and the development of treatment protocols for staff at PHC and other levels. The Department has also not provided leadership to other key government departments (e.g. Finance and Safety & Security) in ensuring that their policies adequately address substance abuse issues. The Department of Finance has, however, indicated its intention to consider increasing the excise tax on alcohol products and held one meeting in 2000 which was attended by the Health Promotion Directorate of the national Department of Health.

At a provincial and local level the pace has been slower than at national level due to the delay in establishing mental health and substance abuse sub-directorates. Substance abuse services at a provincial level have in many cases deteriorated since 1994. The Western Cape, for example, has seen the closure of an adolescent substance abuse unit at Lenteguur Hospital and the Avalon alcohol treatment facility without any concomitant improvement

in services at a PHC level.

It is only more recently that steps have been taken to formulate and implement a coherent provincial substance abuse policy. For instance in 1999 the Western Cape Department of Health and Social Services prepared a draft strategy to implement the National Drug Master Plan and ran four workshops in different parts of the province to solicit feedback. Both the Western Cape and Gauteng Provinces have prepared protocols for alcohol detoxification at regional hospitals and the former is in the process of drafting a similar protocol for other substances. The Eastern Cape Department of Health has initiated a demonstration project to address the abuse of alcohol and other drug use among PHC clinic attendees.

Recommendations

There are several things that the Department of Health needs to do to move the process forward. Further details are provided by Parry and Bennetts.^{11, 32, 33, 34} In particular, policy formulation at both national and provincial levels must be completed as soon as possible. Serious consideration should be given to drawing up an action plan specifically to address alcohol abuse.

In the short term, consideration should be given to:

- ❖ Increasing access to affordable and effective treatment and rehabilitation, including access to detoxification services in public hospitals and brief intervention therapy through PHC services;
- ❖ Instituting work place interventions to address substance abuse, including work place policies, setting up employee education programmes, and treatment referrals;
- ❖ Outlawing the advertising of alcoholic beverages or at a minimum placing restrictions on the types of beverages to be advertised, their location, and times of advertising;
- ❖ Making available a range of interventions including those designed to reduce the impact of injecting drug use, such as needle exchange programmes and oral methadone maintenance for heroin addicts – in a way that does not condone use.

In the medium term:

- ❖ Support should be provided to community structures to address substance abuse-related problems including out-patient programmes for chronic substance abusers;
- ❖ Education should be aimed at high risk groups (e.g. teenagers, pregnant women, and persons in certain occupations) or persons who work with high risk groups (e.g. the police and servers at liquor outlets);
- ❖ Public education programmes aimed at the community at large are required, both active measures (e.g. mass media and social marketing campaigns – including counter-advertising relating to alcohol) and passive measures (e.g. warning labels on alcohol containers).

The Department of Health must work hard to ensure substance abuse issues are on the agenda of other government bodies responsible for national planning and policy. This will include working with:

- ❖ the Department of Finance to increase excise taxes on products such as beer and brandy;
- ❖ the provincial departments of Economic Affairs to implement and enforce strategies for licensing liquor outlets which are sensitive to public health concerns (including

minimum drinking age and restrictions on hours of sale);

- ◆ the Departments of Transport, Safety & Security and Justice to ensure that laws related to driving under the influence of AODs are adequately enforced and offenders swiftly punished;
- ◆ the Department of Correctional Services to ensure improved treatment and rehabilitation of prisoners; and
- ◆ the Department of Education to ensure that schools have adequate policies on managing substance-related incidents and are working towards drug-free environments.

Priority should be given to establishing a national substance abuse clearinghouse to collect, collate and disseminate local and international information useful for informing policy and practice around substance abuse. Support must also be given to substance abuse surveillance and the evaluation of interventions.³⁵ Steps must be taken to facilitate the translation of such policies into action. In particular the Department of Health needs to ensure that there is adequate funding for key policy initiatives, that it has skilled and motivated staff to drive the process at national and provincial levels, and that partnerships with key stakeholders in other departments and civil society are forged.

Conclusion

The time is now ripe for the Department of Health to take a more active role in co-ordinating national efforts to reduce the abuse of substances. Valuable lessons have been learned from formulating and implementing tobacco policy, and the experience gained can profitably be used in the alcohol and drug arena. In a recent speech delivered on her behalf at the 9th International Congress on the Treatment of Addictive Behaviours held in Somerset West in September 2000, the Minister of Health, Dr Manto Tshabalala-Msimang,³⁶ indicated that substance abuse was related to most other national priorities. She urged participants not to focus too much on whether substance abuse is a cause or an effect of various problems but rather to focus their energies on addressing substance abuse. She indicated substance abuse was an intersectoral problem and that there was a need to deal not only with addiction, but also on other issues such as poverty alleviation and job creation.

Phase 1 of policy drafting in the substance abuse area must be brought to completion and the pace of policy implementation must be increased substantially. It is essential that all relevant government departments, including the Department of Finance, give their full support to the CDA (and its Secretariat) as it seeks to implement the National Drug Master Plan. It is encouraging that the Department of Health and other departments are beginning to work more closely with the Department of Social Development in this regard. However, without more tangible financial support from the Department of Finance there will be very real limits on what can be achieved. Civil society is already carrying a substantial burden in terms of providing treatment services for substance abusers and in designing and implementing prevention services. There remains a fair amount of good will to work with the government (nationally and provincially) in addressing substance abuse, but more state resources must be expended to address a problem which could be costing the country about 2% of our GDP – R12 billion per year, or R270.00 for every man, woman and child.³⁷