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**Substance Abuse and Rural Realities:
Experiences and Perceptions of service
Providers in Northern KwaZulu Natal, South
Africa**

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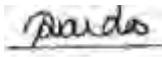
**Substance Abuse and Rural Realities: Experiences and Perceptions of Service
Providers in Northern KwaZulu Natal, South Africa.**

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ABSTRACT

Introduction: Substance abuse is recognized as a worldwide problem and in South Africa contributes to significant morbidity and mortality. However, there appears to be concerns in the service delivery especially in rural areas. This is partly due to the minimal South African research that has overlooked the impact of indigenous substances which have affected many, notably those in rural areas and disadvantaged communities. Therefore a qualitative phenomenological study with substance abuse service providers in UMkhanyakude Rural District of KwaZulu Natal, South Africa was conducted. **Methods:** Focus groups and interviews were conducted with various stakeholders, namely Mental Health Care Teams within hospitals, managers at a District Health Level, social workers and managers from Department of Social Development and fieldworkers and manager of the NGO-Ophondweni Youth Development Initiative in UMkhanyakude District. **Results:** The findings of the study suggests that service providers experience challenges in service delivery in rural areas of South Africa. These include, culture (amarula festival and ancestral worship) that exacerbates the use of substances, high rate of unemployment and poverty such that people resort to home brewed substances for sustainable living, lack of resources within the respective work places (NGOs and governmental departments) of service providers (staff shortage and equipment/vehicles). The lack of resources is also exacerbated by the geographical isolation of rural areas, consequently, the treatment or rehabilitation is weak and disjointed among stakeholders. Furthermore poor monitoring and evaluation of services coupled with lack of research in rural areas was noted. Strengths included prevention programmes, good inter-sectoral collaboration including strong support from civil societies. **Conclusion:** The collective perceptions and experiences of rural substance abuse service providers were challenging in rendering the service in rural areas. However, there were strengths or enablers noted. Evidently, the South African acts and policies has overlooked rural areas and a lack of resources exacerbates the situation. It is recommended that protocol and service standard for Substance Abuse Occupational Therapy services for after care and community based rehabilitation should be developed for easier monitoring and evaluation for quality improvement rehabilitation services

Keywords: substance abuse, service providers, rural, service delivery, community occupational therapy

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ABBREVIATIONS

- SANCA: The South African National Council on Alcoholism and Drug Dependence
- DSD: Department of Social Development
- DOH: Department of Health
- CDA: Central Drug Authority
- NDMP: National Drug Master Plan of South Africa
- UKZN: University of KwaZulu Natal
- KZN: KwaZulu Natal
- NGO: Non-governmental Organization
- OT: Occupational Therapy
- SADC: Southern African Development Community
- FBO: Faith Based Organization

OPERATIONAL DEFINITIONS

- **Substance abuse:** also known as drug abuse, means the sustained or sporadic excessive use of substances and includes any use of illicit substances and the unlawful use of substances (No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, 2008)
- **Substance abuse service provider:** an employed person or a professional who provides services (prevention, promotion, rehabilitation and remedial) in relation substance abuse.
- **Mental health team:** Refers to a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide psycho-social, mental health care, treatment and rehabilitation services (No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, 2008)
- **Fieldworkers:** people or professionals who are working in a ground or first level of substance abuse services especially being in touch with people abusing substances.
- **Fieldwork Substance Abuse Service Provider:** an employed person or a professional who provides services (prevention, promotion, rehabilitation and remedial) in relation substance abuse at a fieldwork/ground level
- **Management Substance Abuse Service Provider:** an employed person or a professional who provides services (prevention, promotion, rehabilitation and remedial) in relation substance abuse at a management or supervisory level

- **Substance Abuse Service Providers Team:** A team of Substance Abuse Service Providers.
- **Substance abuse stakeholders:** Any government department or private or any structure that has a role in substance abuse services. This include civil society.
- **Shebeen:** A Shebeen is an unlicensed outlet for the sale of alcoholic beverages ranging from traditional African sorghum beer, to wines, liquors and other home distilled brews (Maiden, 2001).

CHAPTER ONE

INTRODUCTION

1.1 Introduction and Background

The definition of substance abuse in a non-medical context which includes both substance abuse and substance dependence and any other substance related disorder. According to the Substance Abuse Act of 2008, substance abuse, also known as drug abuse, means the sustained or sporadic excessive use of substances and includes any use of illicit substances and the unlawful use of substances (Substance Abuse Act, 2008). In the revised chapter of the Diagnostic and Statistical Manual of Mental Disorders (DSM), version IV (DSM-IV) of 2013, the categories of substance abuse and substance dependence was combined into a single disorder measured on a continuum from mild to moderate (American Psychiatric Association, 2013); this meant that each disorder was noted and addressed individually e.g. alcohol use disorder, stimulant use disorder etc. however they all fall within the overall umbrella of substance use disorders.

According to the DSM-5, **substance use disorders** involve substance abuse and substance dependence disorders. Substance abuse is defined as the continual use of a substance/s or a maladaptive pattern of recurrent use of a substance/s that extends for a duration of one month or more over a period of 12 months, with continual use of the substance despite social, occupational, psychological, and physical or safety problems caused or exacerbated by the substances (DSM-5, 2013). According to the DSM-5, **substance dependence** is defined as a maladaptive pattern of substance use over a 12-month period characterized by the use of the substance/s in larger amounts for longer periods than intended, persistent desire or unsuccessful attempts

to quit substance use, where much time/activity is directed towards the substance/s use, and failing to fulfil or giving up of important social, occupational, or recreational activities. Furthermore it is characterized by tolerance and withdrawal symptoms (physiological response/symptoms are relieved by taking substance) and there is a continual use despite knowledge of adverse consequences such as failure to fulfil role obligation and health/physical risks. . In the context of this study, the term “substance abuse” is used as an umbrella term for substance abuse and substance dependence for better understanding by the study participants as some of the participants were not medical/health practitioners, neither from a medical or health background for instance, participants that were included from the non-governmental sector.

1.2 Setting the Context for this Study

According to United Nations Office on Drugs and Crime (UNODC, 2012), there is a global burden of drug/substance use which accounts for 0.9 per cent of all disability-adjusted life years lost at the global level, or 10 per cent of all life years lost as a result of the consumption of psychoactive substances (drugs, alcohol and tobacco). This indicates substance abuse as a problem for developed, under-developed and developing countries. However, there may be variations due to access to different substances. For instance, in Africa as a continent with developing and underdeveloped countries, some substances are inaccessible. As a result, some substances are used more frequently, for example, cannabis is commonly used in Africa, and with opioids, contributes considerably to the demand in Africa (UNODC, 2012). This is partly due to the fact that cannabis is easily accessible as some individuals are able to produce this in their gardens or back yards.

According to Central Drug Authority (CDA) in 2009, 15% of South Africa's population has a drug/substance abuse problem. According to the South African Community Epidemiology Network on Drug Use (SACENDU) update of February 2014-phase 34, alcohol remains the primary substance in South Africa with exception of Western Cape and Northern Region provinces. Cannabis is still the most used illicit drug used mainly by youth followed by heroin which is used in other forms where it is mixed with other substances (cannabis) for instance Whooga/Nyaope, however heroin use remain stable in KwaZulu Natal (SACENDU 2014, P.5). According to Parry (2005), the substance abuse services offered in South Africa remains inadequate, poorly distributed geographically and poorly coordinated between health and social welfare sectors. Disjointed service results in an uncoordinated service which is likely to yield minimal benefit to the service users as opposed to un-fragmented, inter-sectoral and interdisciplinary efforts or approach to service delivery.

In addition, South Africa has not yet developed regional or national monitoring systems for substance abuse services (Myers, Harker, Burnhams, and Fakier, 2010). This indicates the great need for a monitoring and evaluation system to be in place. Nevertheless, South Africa has been working on improving substance abuse services and has subsequently revised the Prevention and Treatment of Substance Abuse Act 70 of 2008 and the National Drug Master Plan of 2006-2011 has now been revised to the National Drug Master Plan 2012-2016. This resulted in the formation of the Central Drug Authority (CDA) which is responsible for substance abuse services. Furthermore, this gave birth to the formation of Provincial and District Drug Forums and Local Drug Action Committees, which are aiming at integrating substance abuse services thus ensuring a collaborative effort of all sectors, both governmental and non-governmental. In addition to these measures in progress, the province of KwaZulu

Natal (KZN) Government through the Office of the Premier has the Operation Sukuma Sakhe, previously known as Flagship Program which enforces the inter-sectoral/departmental collaborative effort in service delivery. This aims to eradicate disjointed service delivery which has minimal impact and misuse of resources.

In KZN, alcohol and cannabis use remains high and there has been a steady increase in the outpatient treatment pattern over time, from 2006 it was 65% and 2009 was 82% (SACENDU, 2010). This means, the province is increasingly relying on outpatient treatment programmes. Furthermore the length of waiting lists in KZN remains very long at non-profit and state facilities (Myers and Fakier, 2007). This raises the question of how does the rural community benefit from this type of intervention as all of these centres are situated in cities far from most rural areas. Such a district is that of UMkhanyakude, the site selected for this study. There are currently no state or non-governmental in-patient facilities for substance abuse services in the district. Patients are thus referred to cities for in-patient services which are located approximately 360km or more. Geographic, economic and social isolation is linked to poor health outcomes and difficulties in health service delivery (Rice and Smith 2001). Geographical and social isolation exists in KZN within this district, as already described. This may pose a unique experience to the service users and providers in these rural areas. In addition, this district is described as one of the poorest rural district in South Africa (District Health Barometer, 2009). It is in this context where the researcher explored the experiences and perceptions of service providers in the provision of substance abuse services in order to highlight the situation in a rural areas. Occupational therapists have an advocacy role in community practices, which includes identifying health related issues and providing solutions (Harzberg and Finlayson, 2001). According to Dorne and Kurferst (2008), the profession of Occupational

Therapy (OT) is expanding outside the rehabilitative approach and is becoming more proactive in addressing health needs that arise in community settings, for instance preventative programmes. It was noted in the World Federation of Occupational Therapy (WFOT) Congress, Yokohama, 2014, that most papers indicated a shift from hospital based mental health care to community based services (Sinclair, 2014). Given this strong shift in the profession, it is essential for OT's to identify health related issues and explore the community context to identify enabling and prohibiting factors to inform their OT community service practices. The study findings will therefore be useful to inform occupational therapists practicing in rural areas of South Africa, especially at a community level.

OTs in community settings need to be able to interact with a multidisciplinary team that includes professionals and community members and stakeholders, because working alone is not recommended as a way of solving social ills and health related problems (Miller and Nelson, 2004). In light of the collaborative approach that is required in a community setting for OT practitioners, it is essential to explore the experiences and perceptions of substance abuse service providers, and this includes the relationship among the stakeholders.

In addition to the knowledge gap regarding community based substance abuse (indigenous and homemade substances) service provision, Parry (2005) noted that South African research has been epidemiological based, and has not explored the impact of substance abuse burden. This calls for a change in research focus to avoid redundancy and resource wastage in providing duplicate services, and gain a deeper understanding of what is happening at a ground level, especially in rural areas. This study thus serves to explore the experiences in service delivery to bridge this knowledge gap and inform practice, future service delivery and policies through the

voices of the people on the ground, who are faced with the daily task of providing services in deprived, under-resourced, poor rural communities.

1.3 Problem Statement

As stated, there is an increasing global burden of substance abuse. In light of this increasing burden in South Africa, there has been a drastic increase in the establishment of private treatment services (both licensed and unlicensed) in the post-apartheid era, but these are still not widely accessible to the poorer communities (Parry, 2005). In addition, the South African National Council on Alcoholism and Drug Dependence education and treatment services are limited and there is minimal extension of treatment services to the majority previously underserved, disadvantaged population (Maiden, 2001).

In South Africa, mental health and substance abuse problems constitute a huge burden of disease among disadvantaged communities (Havenaar, Geerlings, Vivian, Collinson, & Robertson, 2008). The district of UMkhanyakude is listed among the disadvantaged, poor and isolated ones in South Africa (District health Barometer, 2009). Most of substance abuse research conducted in South Africa has focused on service users with less or no focus on service providers. Therefore it is valuable to shift the attention to explore how the service providers in this rural district experience and perceive their provision of services. .

Given that the researcher had worked in the rural areas of UMkhanyakude District as an Occupational Therapist for four years, there was a sense that the rural elements of this district pose a unique experience to the substance abuse service providers.

This thus resulted in this study in order to gain a greater understanding of these experiences.

1.4 Research Question

The researcher, in this study aimed to answer the following research question

- What are the **experiences** and **perceptions** of the substance abuse service providers working in UMkhanyakude rural district of KZN, South Africa?

1.5 Aim and Objectives of the Study

The aim of the study was to explore the experiences and perceptions of substance abuse service providers in northern KZN in the district of UMkhanyakude, in order to identify potential challenges/barriers and strengths so as to provide information that may inform policies, practices and guidelines for service delivery in rural areas.

Objectives:

To meet this aim of the study, objectives were formulated as follow:

- A. To explore the **experiences and perceptions** of service providers with respect to services offered/provided in the rural district.
- B. To identify **challenges/barriers and strengths** of substance abuse providers in service provision in the rural district.

1.6 Study Outline

This chapter has given a clear context and background of the study and what it aims to achieve.

Chapter 2 Literature Review: will review the literature related to substance abuse globally, locally and in rural areas. It will also explore the role of the OT in providing services to those afflicted by substance abuse. This will provide insight into the study context and what is known and not known about providing services to abusers in rural areas.

Chapter 3 Methodology: outlines the research design, study location, sample population, data collection tools and process, data analysis, trustworthiness of the study, limitations of the study and ethical considerations.

Chapter 4 Results: presents the study findings with respect to objectives, with the information being presented in table and as text.

Chapter 5 Discussion: this chapter interprets the study findings, and is presented with respect to the first three study objectives. In addition, a comparison with studies done elsewhere as a comparison will be presented.

Chapter 6 Conclusion: restates the study problem and answers the study questions. It then outlines the study limitations, provides recommendations and indicates the significance of the findings for OT as a profession and for improving substance abuse services in rural areas in general.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter outlines the context and background of the study from a review of relevant literature. The global and African context of substance abuse is outlined, followed by a closer look at South Africa, zooming in on the province of KwaZulu Natal, more specifically UMkhanyakude District. Additionally, the multidisciplinary or inter-sectoral collaboration and monitoring & evaluation of substance abuse will be reviewed in details within the South African context in particular rural areas. This will profile the substance abuse issues in South Africa, and rural areas in particular, which will provide a broader context of a nature of the daily tasks and experiences of substance abuse service providers in rural areas of South Africa.

2.2. Substance Abuse in the Global and African Context

2.2.1 Globally

According to the World Drug Report of 2014 by the United Nations Office on Drugs and Crime, it is estimated that in 2012, about 243 million people (range: 162 million-324 million) which is 5.2 per cent of the world population aged 15-64, had used an illicit drug. The substance mostly used belong to the cannabis, opioid, cocaine or amphetamine-type stimulant (ATS) groups (UNODC, 2014). In addition, heroin, cocaine and other drugs kill around 0.2 million people each year whereas illicit drugs impede economic and social development and contribute to crime, instability, insecurity and the spread of Human Immune Virus (HIV) and cannabis is the world's most widely used illicit substance (UNODC, 2012). This indicates that substance abuse

is a world phenomenon and poses a burden to the world's economy. More than that substance abuse has a knock on effect to other globally recognised problems such as spread of HIV, disease burden and crime.

2.2.2 Africa

In Africa, there is no reliable and comprehensive information on the drug and substance abuse situation (UNODC, 2014). Nevertheless, the limited data suggest that cannabis use, notably in West and Central Africa (about 12.4 per cent) is probably higher than the global average (3.8 per cent). In addition, the use of other substances remain low in Africa, except the cocaine which remains at the global average (UNODC, 2014). Cannabis is mostly used substance in Africa, with opioids it contribute considerable for treatment demands. This can relate to the state of Africa as a developing country, because certain substances may not be as accessible as in developed countries.

2.2.3 South Africa

South African statistics is disturbingly inconsistent, the burden of substance abuse is not well document. According to World Drug Report of 2014 by the United Nations Office on Drugs and Crime, the expert perception is that there is some increase in the use of heroin and methamphetamine and some decrease in the use of crack cocaine (with use of other drugs being stable). Cannabis remains the leading illicit drug used in South Africa, treatment facilities report almost half of the admissions were mainly related to cannabis use disorders, mostly by young people. South Africa is a substantial producer of cannabis, and, although most of it is consumed locally, significant amounts are distributed abroad (National Drug Master Plan 2013-2017).

This may relate to the porosity of South Africa being a gate for many African countries. In addition, the United Nations (UN), in 2002, ranked South Africa no: Four in the world for drug offence cases per 100000 populations (CDA, 2009).

According South African Community Epidemiology Network on Drug Use (SACENDU) update of June 2010, Alcohol remains the leading substance use by South African followed by cannabis then Heroin and Mandrax. However Mandrax and heroin shows some variations from province to province. Substance abuse contributes to a number of South African challenges or burden, such as high mortality rate, trauma, transport safety and crime. According to Parry (2005), the burden of alcohol related mortality and trauma is extremely high, with just under half of all non-natural deaths in 2002 having blood alcohol concentrations greater than or equal to 0.05 g/100 ml. Almost half of the motor accidents in South Africa every year has alcohol influence, 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 (National Drug Master Plan 2013-2017). These findings indicate that the use of drugs is a worldwide problem however worse in South Africa therefore it is an undisputable fact that South Africa has a lot to do about this social ill. In spite this huge burden it appears that there is minimal or slow progress is improving substance abuse service delivery, notable with the poor recording of this burden. Nevertheless, South Africa has been making progress since the inception of the National Drug Master Plan of 1999 which has been timeously reviewed to date.

2.2.4 The South African National Drug Master Plan (NDMP)

The National Drug Master Plan (NDMP) is defined by United Nation Drug Control Programme as a single document covering all national concerns regarding drug control (UNDCP, 1995, cited by NDMP of 1999). 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. In South Africa, the inception of the NDMP, dates back to the first opening address to Parliament in 1994, South African President Nelson Mandela specifically singled out alcohol and drug abuse among the social pathologies that needed to be combated. He said:

“Alcohol and other drug abuse (hereinafter referred to as substance abuse) is a major cause of crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability, the escalation of chronic diseases such as AIDS and tuberculosis (TB), injury and premature death. Its sphere of influence reaches across social, racial, cultural, language, religious and gender barriers and, directly or indirectly, affects everyone” (National Drug Master Plan 1999).

In addition, the establishment of the NDMP was drafted in accordance with the stipulations of the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992). Furthermore, it is the country’s response to the substance abuse problem as stipulated by UN Conventions and other international bodies (NDMP, 2013-2017).

The NDMP is reviewed every five years. The latest National Drug Master Plan (NDMP) 2013 – 2017 was formulated by the Central Drug Authority (CDA). In 1999, the Prevention and Treatment of Drug Dependence Act (20 of 1992), was amended for establishment of Central Drug Authority. Which is responsible to make provision for the development of programmes and regulates the establishment and management of treatment facilities. In addition, the NDMP of 2013-2017 was influenced by the Substance Abuse Act (70 of 2008), as amended to meet the international bodies concerns, and most importantly meet the specific needs of the South African communities, which sometimes differ from the needs of other countries (NDMP, 2013-2017). The NDMP serves as a guide for national goals/plans and enforces cooperation of all government departments and stakeholders in the area of substance abuse. This translate to formation of Provincial Drug Forum for each province and District Forums as well as the Local Drug Committee for each local municipality. One can note that the NDMP is a vanguard for substance abuse services in South Africa, however the experiences of its agents (substance abuse service providers) is unknown. Therefore the study aims to explore the experiences of these agents in rural areas. It is worth exploring what is happening at a grass root level of rural areas in order to inform the services, polices and mostly importantly the National Drug Master Plan of South Africa.

2.3 Substance Abuse in KwaZulu Natal

Alcohol and Cannabis use remains high in KwaZulu Natal and there has been a steady increase of outpatient treatment pattern over time, from 2006 it was 65% and 2009 was 82% (SACENDU, 2010). This means, the province is increasingly relying on outpatient treatment program. Furthermore, the length of waiting lists in KZN remains very long at non-profit and state facilities (Myers and Fakier, 2007). This raises a

question of how does the rural community benefit from this type of intervention as all of these facilities are situated in cities far from certain rural areas. For instance the rural areas of UMkhanyakude are serviced by SANCA at Nongoma (Zululand District) with a satellite office situated at Jozini, which is an outpatient program and is far from other areas.

2.4 Substance Abuse at UMkhanyakude District

The study was conducted at UMkhanyakude District Municipality, which is one of the 11 districts of KwaZulu Natal province of South Africa, located in the northeast corner (refer to 3.3 and annexure 1). The district is geographically marginalized and social isolated. Geographical and social isolation exist in KZN as one would note that for UMkhanyakude District nearest inpatient facility is either Newcastle or Durban Centres, both of these cities are more than 350 kilometers away from this Rural District. This may pose a challenge to the service users and providers in terms of access by this rural community.

There is a dearth of literature about the state of substance abuse at a district level in particular, UMkhanyakude District. However, anecdotal evidence from an unpublished survey on substance abuse incidence done in the two local municipalities (Ingwavuma and UMhlabuyalinga) of UMkhanyakude District by Ophondweni Youth Development Initiative in 2009 among youth, indicated the following. The leading drug used was alcohol estimated at 38% at UMhlabuyalingana (UM) and 37% at Ingwavuma (IN) followed by tobacco which was 37% at UM and 35% in IN, traditional Beer 35% in UM and 36% in 36% and dagga/cannabis 33% in UM and 30% in IN. The use of cocaine was not reported whilst glue was recorded at a very small percentage, 2% in both

areas (Ophondweni Youth Development Initiative, 2009, P.7). This may relate to the rural and poverty state of this district. It is classified as the second poorest district, ranking number 51 out of 52 districts in South Africa, according to the district health barometer of 2009. Therefore a number of well-known drugs may not be accessible in this district such as cocaine, due to financial constraints. Therefore traditional beers and cannabis is the mostly used substance.

The substance abuse services at UMkhanyakude District are provided by four major stakeholders, namely, Department of Health (DOH) (via five district hospitals), Ophondweni Youth Development Initiative (one NGO), Department of Social Development (seven facilities), and SANCA (one satellite office at Jozini). Occupational therapists are part of the mental health care team in each hospital within DOH. The service providers' experiences from these stakeholders are explored to inform service provision and policy development.

2.5. Substance abuse in rural areas

Determinants of health include a number of factors such as the area of residence, level of education, access to basic needs (Murry, Heflinger, Suiter, and Brody, 2011). The health service delivery at UMkhanyakude district is affected by the lack of basic infrastructure and poverty (Zondi, 2004). The district of UMkhanyakude, is rated the second poorest districts in South Africa, ranking 51 among 52 districts according to District Health Barometer (2009). The socio-economic quintile of UMkhanyakude district is regarded most deprived according to District Health Barometer Deprivation index (2007) meaning it contains people with the lowest socio-economic status and are the most deprived (worst off). The study conducted in this rural district, highlight

how service providers working in this district perceive and experience such influences/determinants especially the low socioeconomic status; lack of resources and the marginalization of this district which likely to result to health disparities and poor service delivery.

According to the NDMP (2012-2016), research in South Africa has mostly addressed commercial/prescription substances and has overlooked the impact of indigenous substance and combination of substances, which have affected a much larger number of people, notably those in rural and previously disadvantaged communities. With this oversight by South African research it is clear that there is lot that is not known about rural areas of South Africa. No study has been conducted in South Africa that looks at the experiences of substance abuse service providers in rural areas. In addition, as these areas are under-researched, there are no official strategies/policies/legislature that are tailor made to deal with rural area's unique realities. All policies are formulated to guide both urban and rural simultaneously with no provision for the unique realities of rural areas of South Africa.

These include, the Substance Abuse Act number of 70 of 2008 and the Prevention and Treatment of Drug Dependence Act number 20 of 1992 and the National Drug Master Plan of 2013 to 2017 which provides a generic guideline to substance abuse issues of South Africa. Therefore, the service providers working in such areas might be facing issues that are not known, not recorded neither recognised by policy makers. Nevertheless, the South African government recognizes the uniqueness of its rural areas realities, hence there is a minister for Rural Development and Land Reforms, honourable Minister Gugile Kwinti. This shows progress by the South African government towards recognition of rural areas as a unique challenge that needs attention however this has not translated to policies as mentioned above. Given this

context of the scarcity of knowledge as identified and generic policies, this study explored and profiled the experiences of rural substance abuse service providers to inform the state of rural service delivery and minimize the knowledge gap about substance abuse in rural areas. This will in turn assist in policy guidelines that can meet the unique needs of the service providers in rural areas of South African.

Murry et al (2011), on the study conducted in rural areas of America concluded that the outcome of disadvantage as a consequence of social, political, and economic marginalization exerts a powerful influence on medical care and access to service, which in turn perpetuates poor health and health disparities. These health disparities exist in the Rural South African context. A study conducted in Cape Town rural areas by Myers et al (2010), pointed to inequitable access to substance abuse treatment services among people from poor South African communities with a number of factors being powerful determinants of substance abuse treatment utilization, especially financial, geographic access and awareness barriers. These findings support the notion that rural areas have more or less the same problems across the board. Therefore it is worth exploring how substance abuse service providers experience and perceive the impact of these determinants or influences when rendering the services in rural areas of UMkhanyakude district of KwaZulu Natal, South Africa.

2.6 Collaboration/inter-sectoral approach to Substance Abuse Service Provision

The Prevention of and Treatment for Substance Abuse Act no 70 of 2008 specify that *'The Minister must, together with the National Youth Commission and the Ministers of Finance, Education, Health, Justice and Constitutional Development, Arts and Culture, Sports and Recreation, Local and Provincial Government, Correctional Services and Safety and Security, develop and implement comprehensive inter-sectoral strategies*

aimed at reducing the demand and harm caused by substance abuse'. According to the National Drug Master Plan of 2012-2016, the Central Drug Authority is mandated to facilitate the integration of the work of different stakeholders including the provincial, departmental and organisation in substance abuse service delivery. The NDMP (2011-2016) calls for the formation of Local Drug Action Committee, The Mayor of each municipality, of which there are at present 238 must establish a Local Drug Action Committee (LDAC) consisting of interested persons and stakeholders who are involved in organisations dealing with the combating of substance abuse in each municipality and to Ensure the effective relevant implementations of the National Drug Master Plan. These are some of the ways that aims to hasten the working together of all stakeholders for substance abuse services. The question is how far has South Africa moved towards this goal? How effective is the LDAC? What are the experiences of those in such committees? These questions have not been answered by literature, hence this study explore the experience of service providers in fulfilling this inter-sectoral collaboration mandate in rural areas in the midst of rural realities.

Although the legislature promotes collaborative effort of all sectors but the service remains fragmented. According to Parry (2005), the substance abuse services in South Africa continues to be insufficient, poorly distributed geographically and disjointed between health and social welfare sectors. The disjointed service results to an uncoordinated service which is likely to yield minimal benefit to the service users as oppose to un-fragmented, inter-sectoral and interdisciplinary effort or approach to service delivery. In addition Primary health care approach recognizes and promotes the inter-sectoral approach/collaboration for an effective health system and service delivery. Myers and Fakier (2007) recommended that Substance abuse service should move towards primary health care approach as oppose to curative. Hence, this study,

explore the experiences and perceptions of substance abuse service providers in terms inter-sectorial or interdisciplinary collaboration in substance abuse service provision of UMkhanyakude (district) population.

2.7 Monitoring and evaluation of Service Delivery

Monitoring and evaluation is part of the strategic plan for any service delivery plan. A qualitative research that explores the meanings and understanding service providers' have of monitoring and evaluation would be valuable (Myers, Harker Burnhams, & Fakier, 2010). In addition, South Africa has not yet developed regional or national monitoring systems for substance abuse services (Myers et al., 2010). These indicate the great need for in monitoring and evaluation systems to be in place. And also improve in the research output of monitoring and evaluation. The National Drug master Plan of 2013-2017 recognizes the need for Ongoing monitoring which will not only 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. This is a gap identified by the NDMP of 2013-2017, in response to this, this study explore the experiences and perceptions of rural substance abuse service providers in order to inform policies and service delivery guidelines. This study partly evaluate the service provision of rural areas through the voices of service providers at a fieldwork and managerial level, of which they are mostly neglected by the South African research which mostly focus on service users.

Awareness of Substance abuse as one of the huge challenge or problem in South Africa has increased, subsequently policies and plans has been developed and

reviewed regularly however there seem to be less or slow implementation. According to (Parry, 2005) the awareness of alcohol problems and the need for action has grown extensively however much more emphasis needs to be given to facilitating policy implementation, ensuring the necessary resources available, ensuring effective leadership and hastening the implementation in general. Rural areas have been characterized by a lack of resources, scarcity of service providers (Eager et al., 2013). These may impede on implementation of policies or they may be behind in these areas therefore exploring the perceptions and experience of substance service providers working in rural areas will be worthwhile and may yield results that can guide how to improve the implementation of policies in rural areas, which will result in an improved service delivery.

2.8 Conclusion

In this chapter, the researcher has provided a background and the context of substance abuse at a global, African, South African, provincial (KwaZulu Natal) and District (UMkhanyakude) level, as well as the challenges within rural areas in general. This was done in the hope of staging the burden of substance abuse in South Africa. In addition, an overview of substance abuse service provision was highlighted with reference to the National Drug Master Plan. The state of South Africa in the monitoring & evaluation and inter-sectoral collaboration of substance abuse service provision enforced by the NDMP was also reviewed. The gap in literature related to rural areas was also highlighted. The next chapter outlines the research design and methodology used in this study.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

A phenomenological qualitative study was undertaken. This chapter chronicles the sequence of events applied in this study. In a phenomenological study design, the research methodology maps out in detail how the researcher studied the phenomenon to answer the research question/s were answered. This chapter will therefore provide details about the study location, study population with recruitment strategy, data collection, data management and analysis. The chapter culminates with describing the trustworthiness of the methods used, study limitations, and the ethical considerations observed throughout the study.

3.2 Research Design

A phenomenological qualitative research design was employed. According to Creswell (2013) a phenomenological study describes the common meaning for several individuals of their lived experience of a concept or phenomenon. Phenomenological research does not necessarily provide definitive explanations but it does raise awareness and increases insight. In addition, phenomenology provides a deep understanding of a common or shared experiences of a phenomenon by a number of people, such data can be valuable, and can inform policy makers, practice, service planning & delivery, and quality improvement strategies (Creswell, 2007, pg.68). Therefore the researcher applied this study design as it a suitable and reliable design to guide the inquiry of the experiences and perceptions of substance abuse service

providers on their service provision in a rural area. Focus group and interviews were used as relevant strategies to explore this phenomenon.

3.3 Location of the Study

The study was conducted at UMkhanyakude District Municipality, which is one of the 11 districts of KwaZulu Natal province of South Africa, located in the northeast corner. This district was named after its famous trees called “UMkhanyakude”, which is an isiZulu name meaning “shine/bright from a distance”. The district demarcation stretches from the UMfolozi River, near Mtubatuba in the south and in the east; it borders the Indian Ocean with about 175km of pristine beaches which is a destination for tourists. The north is bordered by two neighboring countries of the Southern African Development Community (SADC) region, namely, Mozambique and Swaziland. Figure 3.1 below, indicates the location of UMkhanyakude District in relation to South Africa and neighboring countries.



Figure 3.1 South African Map highlighting UMkhanyakude District

UMkhanyakude District Municipality is comprised of the District Management Areas known as DMAs and five local municipalities (see annexure 1 for more details of *UMkhanyakude district* and its five local municipalities). According to the District Health Barometer (2009), UMkhanyakude district is one of the two most deprived rural districts, ranked number 51 out of 52 districts in South Africa, with a total population of 600840 people. According to the Health Systems Trust which produces the District Health Barometer (2009), deprivation is defined as a combination of indicators including unemployment rates, access to piped water and electricity, female-headed households with high numbers of children and low education levels. In addition, the socio-economic quintile of UMkhanyakude district is rated poor according to the deprivation index of the 2007 District Health Barometer. Furthermore the household income of UMkhanyakude District is on average worse off than all other districts in KwaZulu-Natal, with 85% of house hold income of less than R400 per month, based on 2001 statistics (UDM Environmental Management Framework Report, 2012). This indicates the poor standard of living of the population of UMkhanyakude district.

Although UMkhanyakude District is regarded among the poorest, deprived and under-resourced districts, nevertheless, it is a popular tourist destination which is within the region of South Africa's First World Heritage Site, known as iSimangaliso Wetland Park listed since 1999. In addition the district takes pride in hosting the "big five" animals in a number of game reserves. The big five game animals are the African elephant, Cape buffalo, leopard and rhinoceros. The game reserves serve as a source of employment in this district. Moreover agriculture is another economic strength of this district. Other than the subsistence farming by local residents, it has a large

commercial timber and sugarcane plantations that are also the biggest seasonal source of employment for local residents and migrant workers.

The public service resources or infrastructure has made drastic improvement over the past 20 years of democracy dispensation. However, the district does not have a drug or substance abuse rehabilitation facility for inpatient/admissions care services. Therefore clients are referred to Newcastle, Durban and Pietermaritzburg for such services. All these cities are located far from UMkhanyakude district, approximately 360 kilometers or more. Nevertheless, the researcher identified a number of stakeholders contributing directly towards substance abuse services as described in chapter two 2.4 Substance Abuse at UMkhanyakude District.

3.4 Study Population

The population included substance abuse service providers rendering services in the UMkhanyakude district of KwaZulu Natal, South Africa. These included employees that are responsible for substance abuse services at a fieldwork or managerial level within the departments of Health, Social Development and an NGO Ophondweni Youth Development Initiative.

Non-probability purposive heterogeneous sampling was employed to select participants for this study. Furthermore Shi (2008, p. 279) emphasizes that “purposive sampling selects sampling based on expert judgment in terms of the representativeness or typical nature of the population elements and the purpose of the study.” Therefore substance abuse service providers working at a fieldwork and managerial levels for the departments of Social development and Health and the

Ophondweni Youth Development Initiative in UMkhanyakude district of KwaZulu Natal, South Africa were selected for the study.

3.5. Sample/Selection and Recruitment of Participants

The sample comprised 29 participants. Sampling continued until redundancy and saturation were reached. **Tables 3.1 and 3.2** below summarizes the sample in this study.

Table 3.1 Description of the Sample in this Study

STAKEHOLDER DEPARTMENT	NUMBER OF PARTICIPANT/S	DESIGNATION	PROFESSIONAL GROUP	DATA COLLECTION METHOD
Department of Health	11	Mental Health Care Team	3 Social workers 4 Psychiatric Nurses 3 Occupational Therapists 1 Medical Officer	1 focus group (4) 2 triad interviews 1 individual interview
	3	District Managers	Undisclosed to maintain confidentiality	1 Individual Interview 1 Dyad Interview
Department of Social Development	6	Substance Abuse Co-ordinators	Social Workers	4 Individual Interviews 1 Dyad Interview
	5	Managers (Supervisors)	Social Workers	3 Individual Interviews 1 Dyad Interview
Ophondweni Youth Development Initiative	3	Fieldworkers	Undisclosed to maintain confidentiality	1 Triad Interview
	1	Manager	Undisclosed to maintain confidentiality	1 Individual Interview

Table 3.2 Recruitment Process and Inclusion Criteria

STAKEHOLDER DEPARTMENT	PROFESSIONAL GROUP	RECRUITMENT PROCESS	INCLUSION CRITERIA
Department of Health	3 Social workers 4 Psychiatric Nurses 3 OTs 1 Medical Officer	<ul style="list-style-type: none"> • Email to the Medical and Hospital Managers inviting participation (with study details and ethical clearance forms) • Follow-up email and telephonic follow up to determine voluntary participation • Time and logistics discussed and set for data collection and coordinated so as to not compromise service delivery • Voluntary participation stressed and informed consent 	<ul style="list-style-type: none"> • The participant had to be a member of the mental health team within the District hospital • Had to have more than one year of work experience in that particular profession/field. • Had to have a minimum of one year working experience in UMkhanyakude District. • Had to be a full time employee (work at least 40 hours per week)
	3 District Managers		<ul style="list-style-type: none"> • Manager with more than one year of work experience in a management position • Had to be responsible for substance abuse services or mental health services. • Had to have a minimum of one year experience in UMkhanyakude District in the designated position

Department of Social Development	5 Social Workers (Managers)	<ul style="list-style-type: none"> • Email to the District Manager of UMkhanyakude inviting participation (with study details and ethical clearance forms) • The first email did not yield a response. Thus a second email coupled with a telephonic follow up. 	<ul style="list-style-type: none"> • Manager with more than one year of work experience • Had to have a minimum of one year working at UMkhanyakude District in a designated position
	6 Social Workers (Substance Abuse Co-ordinators)	<ul style="list-style-type: none"> • Follow-up email and telephonic with each facility to determine voluntary participation • Time and logistics discussed and set for data collection and co-ordinated so as to not compromise service delivery • Voluntary participation stressed and informed consent 	<ul style="list-style-type: none"> • Assigned social worker for substance abuse services. • Has more than one year of work experience in a particular profession. • Minimum of one year working at UMkhanyakude District in a designated position.
Ophondweni Youth Development Initiative	3 Fieldworkers (Undisclosed to maintain confidentiality)	<ul style="list-style-type: none"> • Email to the Director of OYDI inviting participation (with study details and ethical clearance forms) • Follow-up telephonically to determine voluntary participation 	<ul style="list-style-type: none"> • Has more than one year of work experience in the particular profession/field. • Minimum of one year working at UMkhanyakude District in a designated position/profession.

	<p>1 Manager (Undisclosed to maintain confidentiality)</p>	<ul style="list-style-type: none"> • Time and logistics discussed and set for data collection and co-ordinated so as to not compromise service delivery • Voluntary participation stressed and informed consent 	<ul style="list-style-type: none"> • Has more than one year of work experience in the particular profession/field. • Minimum of one year working at UMkhanyakude District in a designated position/profession.
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3.5.1 Department of Health (DOH)

Following ethical clearance from a human and social sciences research committee and the KZN Health Research Committee, gate keeper permission was sought from UMkhanyakude district (see annexure 2). The district health management team and three Hospitals of UMkhanyakude district were selected for the study with data saturation being reached at a third hospital. Data saturation is described as the point at which or when there is 'no new information of significance obtained with an ongoing thematic development and data collection (Tuckett, 2004). Within each hospital a Mental Health Care Team comprising a social worker, mental health care/psychiatric nurse, occupational therapist, psychologist, and psychiatrist or a doctor responsible for psychiatric services were recruited. None of the hospitals had a full complement of the mental health care team; this was partly due to staff shortage as well as the unavailability of other invited participants. In some districts, there were no psychiatrists working within the district and some of their duties were carried out by other doctors and psychologists. One hospital reported that a psychiatrist visits the facility once in three months. The description/summary of participants is outlined in Table 3.1.

In terms of the inclusion criteria, outlined in Table 3.2 most of the invited participants did not meet the above criteria therefore the criterion of work experience was altered to include those that had more than 6 months of work experience in the district. Participants were also limited due to a high staff turnover within this rural district. This is explained in detail in the study limitations.

3.5.2. Department of Social Development (DSD)

Five managers and six fieldworkers from the department of social development participated in the study. In the DSD one social worker per service facility is assigned as a Substance Abuse Service Coordinator. Each coordinator reports to one supervisor who is responsible for the managerial and supervision aspect of the substance abuse services. In this study, coordinators are categorised within the fieldworker's category as they are involved in fieldwork and co-ordination of the service, whilst supervisors are within the management category. The study participants, recruitment strategy and inclusion criteria are represented in Tables 3.1 and 3.2.

Despite the process followed in recruitment, some participants were unavailable during the data gathering due to a number of reasons, for instance, being on sick leave on the day/s of data collection, some were on maternity leave and others were involved in fieldwork away from the office.

3.5.3. Ophondweni Youth Development Initiative (NGO)

Ophondweni Youth Development Initiative is a non-governmental organization located at Ophondweni area, the nearest town being Jozini. It is responsible for a number of programmes for the youth and the community at large, namely vulnerable populations, youth development and substance abuse etc. A portion of its funding is from the Department of Social Development. The recruitment of both management and fieldworkers was done simultaneously. A description appears in Table 3.2.

3.6. Data Collection Strategies

Two strategies were used in this study, namely, focus groups and semi-structured interviews. The phenomenological qualitative study design relies heavily on these strategies to gain a rich and deeper understanding of the phenomenon experienced by study participants (Creswell, 2007). The focus group was used exclusively with substance abuse service providers in the field whilst interviews were conducted with both fieldworkers and managers of substance abuse services. The overview of the data collection strategies are outlined in Table 3.1 and annexure 5 for questions as well as the following sections for specific details.

3.6 .1 Focus Groups and Triad Semi Structured Interviews

An audiotaped focus group was used to collect data from the substance service providers working at UMkhanyakude district. A focus group is a focused discussion or group interview used as a qualitative data gathering technique that relies upon systemic questioning of several individuals simultaneously in a formal or informal setting (Carpenter and Suto 2008, p. 85). Owing to a number of reasons, only one focus group with four participants was conducted for a duration of 42 minutes. The reasons include, participants not available during data collection period, unforeseen circumstances, incomplete Mental Health Care Teams/Substance Abuse Service Providers Teams in each institution and data saturation reached. The researcher anticipated these possibilities as early as from inception of **this** study, subsequently, the researcher resorted to triad interviews with ease. As a result, three triad interviews were conducted instead of focus groups. A triad interview is a form of a group interview where by a researcher systematically question three individuals simultaneously in a formal or informal setting.

The focus group and two triad interviews were conducted within the workplace of fieldwork participants, two were conducted in the boardroom and one in a nursing college classroom. These venues were suitable to ensure respect, privacy, dignity, confidentiality and good quality tape recording of the discussion for accurate transcription. Moreover, to ensure that participants are comfortable and free to express themselves.

3.6.2 Semi structured Interviews

Twelve semi structured interviews (9 individual and 3 dyad interviews) were conducted with participants who were not part of focus group. Five to 25 audiotaped interviews with participants who have experienced the phenomenon is sufficient to reach saturation for a phenomenological study (Creswell 2007). Mostly, qualitative researchers usually undertake “semi-structured” interviews which involve a number of open ended questions based on the study topic (Hancock et al, 2009). Therefore a 20 to 30 minutes semi-structured in-depth phenomenological face to face individual and dyad Interviews guided by open ended questions were conducted. These were conducted in the participant’s office within their work premises. These venues were quiet, dignified and suitable for good quality recording of the discussion to ensure accurate transcription and the participants were comfortable to share their experiences of working at UMkhanyakude District. These interviews were conducted with six (6) fieldwork and eight (8) management participants from various stakeholders, as outlined in table 3.1 Summary of study participants.

3.7 Data Management

The researcher and research assistant organized the collected data, namely, field notes, informed consent forms and recorded tapes. The recorded tapes of the focus group and interviews were stored in the researcher's password protected computer using pseudonyms for security purposes, and then duplicated to a memory stick for back up reasons. These, with field notes were handed over to the transcriber for transcription. Upon completion of transcriptions, they were handed back to the research assistant to check accuracy of transcription through listening to all audiotapes. The research assistant assured the researcher that verbatim transcriptions were accurate, he then returned them to the researcher to recheck them through listening to them again. The researcher also confirmed the acute transcription. Thereafter these were copied to the rewritable DVDs which is also stored in a lockable storage accessible to the researcher and supervisor only. Transcription scripts, fieldwork notes and informed consent form signed by research participants were stored in a same lockable storage. In addition, all electronic data were given pseudonyms and stored in a password protected computer of the researcher throughout the writing of the thesis. All these sources of data will be destroyed and disposed after five years period of the study through the process of shredding of documents and incineration of audiotapes.

3.8 Data Analysis

The transcribed audiotapes were analysed using content analysis. According to Busch et al (2012), content analysis is a research data analysis tool used to

determine the occurrence of certain words or concepts within texts or sets of data texts. The data was analysed **inductively** using the following procedure:

- **Reduction of Data:** The researcher immersed himself in the data, by reading and re-reading the transcriptions and identifying initial codes.
- **Display of Data:** Similar codes were then grouped together to form a sub-category. Categories were grouped according to their relationships with each other into themes. These are described in chapter 4.
- **Revising and renaming themes:** Themes were revised and renamed to give a clearer meaning and to ensure coherence.
- **Drawing and Verifying Conclusions:** Themes were then presented in discussion as topics for discussion in relation to the literature wherever necessary.

3.9 Trustworthiness of the Study

Research is a unique form of enquiry or expedition to a desirable destiny therefore the vehicle of reaching such a destiny must be trustworthy. The trustworthiness of a study is based on meeting a criteria of dependability, transferability, credibility, and confirmability (Shenton, 2004). This criteria can be achieved through a number of methods/strategies namely member checking, rich/thick description of research, data triangulation, peer reviewing, clarification of bias, prolonged engagement, and bracketing. Creswell (2007) recommended that qualitative research should use at least two strategies at a particular study to ensure trustworthiness. As a result, in this study, the researcher used three (3) strategies, namely rich, thick descriptions in the study, bracketing/clarification of bias as well as peer review and debriefing. These strategies are explained below.

3.9.1 Bracketing and Clarification of bias

Bracketing refers to the deliberate putting aside of one's preconceived ideas and experiences about a particular phenomenon under investigation so that the researcher does not influence participant's understanding of a phenomenon (Chan et al, 2013). The researcher was working in the study location for four years therefore this strategy was applied throughout the study (proposal, data collection, data analysis and report writing) as recommended by Groenewald (2004). More details on the reflexive statement below. Having this in mind the researcher consciously avoided to bring his own experience and views throughout the study. Moreover, the researcher used a range of strategies to reduce bias such as using open ended questions (refer to annexure 5 data collection questions) with less probes because probes deemed risky of swaying the direction of interview towards the researcher's views and experience in this particular district.

The researcher also used paraphrasing and summarizing during interviews and the focus group. In all occasions the participants confirmed the summary or paraphrases of the researcher and others added more to it. In this way, participants' experiences and perceptions were accurately captured.

3.9.1.1 Reflexive Statements of the Researcher

The researcher was born and raised at UMhlabuyalingana Local Municipality which is a deep rural local municipality within the UMkhanyakude District, the study site. In addition, he had worked in this district for four years (2009-2012) as an Occupational Therapist, in a post at Bethesda Hospital. During that period, the researcher observed and experienced a number of dynamics around substance abuse service provision which raised a number of questions. The researcher found

that neither literature nor legislature assisted in answering these questions. With this passion for his rural community, the researcher was inspired to conduct a study in an attempt to shed some new light towards answering these questions. The researcher was interested in determining the views and experiences of other service providers working in a marginalized and under-resourced rural district. During his stay within this district, the researcher experienced poor and uncoordinated substance abuse rehabilitation/treatment services that was disjointed from various departments. There was also a lack of support by policy makers and management. In addition, there were no protocols or guidelines or service provision standards that guided practice. The researcher felt that services were neglected and not integrated into primary health care. Furthermore, the researcher experienced difficulties in referring substance abusers in distant rehabilitation facilities such as Madadeni rehabilitation in Newcastle and Newlands Park Centre in Durban. There were mostly issues with long waiting lists and hence clients would remain as inpatients in the hospital for an extended period. Moreover, the researcher noted that the aftercare and community base rehabilitation, was poor to non-existent especially in the reintegration of substance abusers back into their respective communities. As an occupational therapist, the researcher noted that these patients end up being in and out of hospital and rehabilitation facilities (revolving syndrome) with limited or no progress. The researcher had the view that the South African government and research institutions has not given the substance abuse pandemic, the attention it deserves, given the magnitude of the problem, which is not just a health problem but a social ill that is affecting the society in many aspects, namely, increasing crime rate, increased car accidents and decreasing the level of education which worsens the state of poverty in rural areas.

In 2012 the researcher moved to work in Durban, however, without losing his passion for rural health, he returned to conduct this study in 2014. During this time a number of changes had occurred in substance abuse services, including, the new service providers. As a result, only 6% of study participants, which is 5 of 29 participants, were known to the researcher.

As a principle in this phenomenological study design, the researcher bracketed his views and experiences as a means to control bias and undue influence on participants. The researcher was conscious of this throughout the study from proposal development to data collection and analysis as well as in the report writing. In addition, the supervisor assisted by reviewing material and methods of analysis in order to highlight possible personal/emotional involvement rather than presenting participant's experiences and views.

3.9.2 Rich, Thick Description of the study

The researcher has described the setting and context as well as study participants thoroughly. Furthermore, the chronological unfolding of the entire investigation has been recorded systematically in detail because knowing how the data was collected and analysed helps the reader to evaluate the trustworthiness of the results and conclusions that are drawn from them. This accurate detailed step by step account of the study process including the detailed description of the study participants and the setting or context under investigation is recommended by Creswell (2007) and Shenton (2004). Therefore transferability of this study is enhanced as it is possible to duplicate the study in other rural areas.

3.9.3 Peer Review or debriefing

Peer review allows an external check of the research process (Creswell 2007). In this study, the research supervisor and the cohort supervision (group of researchers with a health science background) contributed immensely in the debriefing process and providing scrutiny of the entire research process through asking questions and providing guidance where needed. The researcher presented continually to the cohort supervision panel from the beginning of the study until the end of writing the thesis, in this manner the whole research process was engaged by other researchers. The researcher had regular meetings with the research supervisor and interacted via emails to ensure an external scrutiny of the research process. Furthermore, a transcriber who was not part of the process from the beginning of the study was appointed to do verbatim transcription of the recordings. This was to ensure that the transcriber has no personal influence to the transcription through any preconceived knowledge about the study. In this manner research rigour and credibility of research findings was enhanced resulting to trustworthiness of the study.

3.10 Ethical Considerations

In research, ethics is concerned with the interaction between the researcher and study participant as well as scientific integrity (Carpenter and Suto, 2008, p.50). Therefore, it relies on fundamental issues such as obtaining ethical clearance and gate keeper permission, justice, beneficence, maleficence, autonomy, informed consent and confidentiality. These were considered and followed from the inception of the study until the end. These are summarised in the following subsections.

3.10.1 Ethical Clearance and Gate Keeper Permission

A research proposal was sent to the Human and Social Science Research Committee of the University of KwaZulu Natal (HSSREC). A Provisional Ethics Approval was given by this accredited ethics body with a protocol reference number: HSS/0040/014M. The provisional approval was subject to gate keeper permissions to be obtained prior final approval. The researcher sought gate keeper permission from the following institutions however could not obtain from one of the, as a result, a conditional approval was given to proceed data gathering with the gate keepers who had given the permissions (refer to annexure 3). The process of acquiring the gate keeper permission was as follows:

3.10.1.1 KwaZulu Natal Department of Health

Gate keeper permission was required for UMkhanyakude Health District and its five hospitals. A research proposal, UKZN provisional ethics approval and a letter requesting permission was sent to the District Manager of UMkhanyakude District. Then a letter indicating their willingness was received. As per the guidelines of the KZN Health Research Ethics, the letter from the district, UKZN ethics approval and research proposal was sent to the KZN Health Research Ethics Committee to receive final approval. Thereafter a final approval was received granting permission to conduct the study in all requested institutions (See annexure 3). The entry process/arrangement of visit to each institution is explained in details in section 3.5.1

3.10.1.2 KZN Department of Social Development

As per the procedure of the Department of Social Development, A research proposal, provisional ethics approval and a letter requesting permission was sent to the Research Manager and Population Studies of KwaZulu Natal. The letter requested to conduct a study in 6 facilities of UMkhanyakude District. A letter was

received granting permission to conduct the study (see annexure 2). The entry process/arrangement of visit to each facility is explained in details in section no

3.10.1.3 Ophondweni Youth Development Initiative

A letter requesting permission to conduct the study was sent with the attachment of the provisional ethics approval, to the Director of Ophondweni Youth Development Initiative. The letter granting permission was received (see annexure 2). The entry process/arrangement of visit to this NGO site is explained in details in section no 3.5.3

3.10.2 Justice and Inclusiveness

Justice refers to fairness and equity for all participants in research process. This includes ensuring that no section of the population is unfairly burdened with research demands and no individual or group is neglected or discriminated against. Therefore in this study justice and inclusiveness was guaranteed by ensuring that time allocation to all stakeholders or participants was equitable and they were all treated with equal respect, no discrimination, no stakeholder was prioritized over the other. This also applied to different professionals that were part of the study, they will be treated equal with equitable time allocation to each.

3.10.3 Minimising Harm (Non-Maleficence)

Non-Maleficence refers to the duty to avoid, prevent or minimise harm to others. Therefore, the researcher ensured that safety and welfare of all participants is guaranteed throughout the study by abiding to the prescribed procedure to avoid any actions that might threaten the safety and welfare of the participants. For instance the Ethical clearance was sought from the University of KwaZulu-Natal

Research and Ethics Committee prior to the commencement of this research as per the regulation of the University so that minimum ethical research standard is adhered to. Thereafter a gate keeper permission was sought from all the targeted institutions. The permission of visit/entry was requested prior visiting each institution to ensure workers are granted permission to leave their work stations for the interview or focus groups and service delivery is not compromised. Furthermore the study was non-evasive with no body contact procedure therefore harm/risk was minimized and participants were not exposed to any frustration nor distress.

3.10.4 Maximising Benefits (Beneficence)

The principle of beneficence enacts a duty to benefit others. In research, the researcher has a duty to maximize the benefit, this entails ensuring that study participants and the whole society benefit from the study. As this study aims to generate new knowledge in substance abuse service delivery of Rural areas of UMkhanyakude district, the dissemination will include giving feedback to all the study participants and their facilities or departments thus informing their service delivery. To ensure participants benefit from the study, during data collection, all participants were given an option to enlist their names and contact details (emails and cell numbers) so that a report can be sent directly to them. All participants enlisted their names as they verbalised their interests to study findings and recommendations. Furthermore the knowledge gained will be communicated to the private sector and all levels of governance e.g. local, provincial and national in order to maximize benefit to the society. In addition, an article will be published in an open journal publication to maximize benefit.

3.10.5 Autonomy, Free and Informed Consent

Informed consent entails the process of ensuring that study participants are full informed about the study conducted, so that they make an informed decision as to participate or not. This process was undertaken without coercion but rather with a clear description of the nature of the research, duration of the study and the process involved to all prospective participants. Information document (refer to annexure 4) was given to all participants prior the data collection and reiterated before starting interview or focus group to ensure each participant gives an informed consent freely, after being given enough information to make a decision. In addition, participants were given a chance to ask questions or seek clarity prior any involvement to the study, they were also informed that they have a right to escalate their concerns or queries to the research supervisor or research office administrator or HSSREC representative through the contact details on the information document which will remain with them. Autonomy recognizes the right of an individual to make own decision and judgment to determine their action. In respect of the study participant's autonomy, the researcher also apprised them about their right to decide whether to participate to the study or not. In addition they were informed how confidentiality (see 3.10.6 for more information) is guaranteed and their right to withdraw from the study at any given point without incurring any consequences.

3.10.6 Privacy and Confidentiality

Privacy and confidentiality refers to ensuring that all study participants are protected in terms of their personal/sensitive information and privacy/dignity is guaranteed throughout the study process (data collection, data storage and dissemination). Therefore the study was conducted in either a boardroom, office or class room, which is a safe and private environment where the participants were free to share

their experiences. The data collected is reported in aggregates and participants are classified in to two categories, namely, fieldworkers and management to ensure confidentiality and privacy. Furthermore all participants were given pseudo names to protect their identity throughout the study and the recorded tapes of the focus group and interviews with transcription scripts, informed consent forms were kept in a lockable storage accessible by the researcher and supervisor. Pseudonyms were also used in the in saving electronic data that was saved in a password protected computer of the researcher and a memory stick for backup reasons. These will be copied to the DVD disk once and deleted from the computer, to minimize bridging confidentiality. The disk will be stored in a lockable storage with other documents as explained above. All these sources of data will be destroyed and disposed after five years period of the study through the process of shredding of documents, and incineration of audiotapes. Study participants were informed how confidentiality and privacy will be ensured throughout the study.

3.11 Summary

In conclusion, this chapter has provided an outline of the research design, the study population, study location and the data collection instruments used in the study. The method used and sequential description of how data was collected, analysed, managed, has been thoroughly detailed. The chapter culminates with trustworthiness, limitations of the study and ethical considerations for the entire study. Hence, the methodology of this study has been succinctly mapped out, making it clear how the study aim and objectives were met. The following chapter will discuss the results of the data collected in this study.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results of the study. As set out in details, in the preceding chapter of methodology, data was collected using focus groups, triad, dyad and individual interviews with 28 substance abuse service providers (managers and fieldworkers) of UMkhanyakude District. The findings of the study relates to the two study objectives, where by the main themes of the study findings emanate:

- A. To explore the **experiences and perceptions** of service providers with respect to services offered/provided in the rural district.
- B. To identify **challenges/barriers and strengths** of substance abuse providers in service provision in the rural district

It was noted that the experiences and perceptions of management and fieldworkers substance abuse service providers were relatively the same with minor differences in expression, hence, in this chapter, seven similar themes are presented in no order of priority, those themes are:

Theme 1: Easy access and poor regulation of substances within the district

Theme 2: Impact of Poverty on substance abuse service delivery

Theme 3: Lack of Resources as a barrier to service provision

Theme 4: No prioritization of Mental Health and substance abuse

Theme 5: Prohibiting factors to effective substance abuse services in the district

Theme 6: Enablers or strengths of Substance abuse services in the district

Each theme below is set out with categories, sub-categories, and codes, as recommended by Graneheim and Lundman (2003). A summary of each theme is summarized in a tabulation first, then categories and sub-categories are further supported with participant's quotes and by researcher observations.

4.2 Theme one: Easy access and poor regulation of substances

In response to objective A (perceptions and experiences) and B (barriers and strengths) theme one, the poor regulation of substances represents the collective views (perceptions) and experiences of all substance abuse service providers. Three categories emerged, namely, *culture promotes substance abuse, unclassified or unregistered substances and easy access to Substance/drugs is a challenge to the service providers and service provision.*

Table 4.1 Theme One: Easy access and poor regulation of substances

CODES	SUB-CATEGORY	CATEGORY	THEME
Marula dance festivals It's an acceptable thing where everybody has their cup Umkhosi womuthayi, everyone is allowed to drink They have to if the parliament is coming to celebrate it,	The unregulated Amarula festival	Culture promotes substance abuse	Poor Regulation of Substances
The onset part of getting into drug emcimbini wamadlozi (ancestor worship ceremonies) They are celebrating these ceremonies The unveiling, it's during those ceremonies that all the family members are expected to drink Is the easiest way to introduce them	Ancestral worship ceremonies		
Using alcohol and they Taking it as a culture You have to drugs or you have to take alcohol. So cultural wise, they don't see it as a wrong thing to drink or substance It is the isizulu culture They say khipha ubuthi Usually we don't take it as a drug, we take it as a norm People are addicted but no one thinks it's an addiction If someone smokes dagga it's just dagga, We don't take it as our concern as the health system	Using substance is an norm		

<p>Hey buy from our local shops, they buy them over the counter from Chinese shops and some are just drugs You ask them and they will tell you they get it from the Chinese One gets arrested, If they do they say it's not classified as a drug so you cannot arrest that person It's destroying kids but no one is getting arrested</p>	Chinese shops	Unclassified or unregistered substances	
<p>Not to forget the porosity due to boarders They are facing a lot of challenges like there are cigarettes that are from mozambique that is cheaper than ours Because some of them come from mozambique, We are near the borders</p>	Boarder influence: Unknown Substances Shipped through Boarders of Swaziland and Mozambique)		
<p>They are unregulated by the liquor authority Alcohol is more home brewed wines Home brewed wines are the ones that are very prevalent, Is common here is the homemade brew. They also manufacture the alcohol like injemane</p>	Home brewed substances	Easy access to Substance/ drugs	
<p>Dagga are the easiest substance abuse that everyone can get They do plant around their house I can see it is around their yard Because people they plant it in their home, I think it's very readily available It's very easy to get dagga here</p>	Dagga plantations at home		

4.2.1 Culture promotes substance abuse

There are three sub-categories that relate to culture promoting substance abuse.

These are presented below:

The Unregulated Amarula Annual Festival

Some participants shared their views and frustrations about the celebration of Amarula Fruits which happens every year in the chief's palace. This is the annual event that happens in the Tembe Tribal Authority and is supported by the Government, mainly the department of Arts and Culture as well as the event receiving huge media coverage nationally. Participants reported that, this is the place where most of young people are introduced to drinking alcohol. Reports were as follows:

*“So these **marula dance festivals**, that is one of the things where the children said they experienced that because **it’s an acceptable thing where everybody has their cup and all of that.**” (Manager Mdlalose)*

*“And also during the **Umkhosi womuthayi (Amarula Festival)**, everyone is allowed to drink.” (Fieldworker: Mandla)*

*“I think also culturally there is this thing they call it **UMkhosi Womthayi (Amarula festival)****They have to if the parliament is coming to celebrate it, you see it as a good thing, you just continue.**” (Fieldworker Zondi)*

Ancestral Worship Ceremonies

In addition, to an Unregulated Amarula festival, most participants reported that the ancestral ceremonies pose a challenge and a quick spread of substance abuse. Most young people are introduced to substance abuse during these ceremonial acts.

*“...when were asked when did they start experimenting with drugs and how did it happen that they did maintain the issue of beginning, **the onset part of getting into drug emcimbini wamadlozi (ancestor worship ceremonies)** so it came out that the children experiment about drugs or taste drugs during traditional rituals, so it’s more like they use this thing Kwangwanase when **they are celebrating these ceremonies**” (Manager Mdlalose)*

*“...in this area is a lot of ceremonies like if my father died, then we are expected at the end of the year, **the unveiling, it’s during those ceremonies that all the family members are expected to drink those...** Most of the children say to us that is the **easiest way to introduce them to starting...** (Fieldworker Londiwe)*

Using substances is a norm

Participants reported that it appears to be an acceptable behaviour to use substances. A sense of discouragement was noted. They reflected as follows:

*“What I can say is I’ve experienced that there are many people **using alcohol and they taking it as a culture** that is if you are living in this area, **you have to drugs or you have to take alcohol**. Even in schools, we found young people smoking cigarettes, smoking drugs, marijuana”. (Fieldworker Ngcuka)*

*“**So cultural wise, they don’t see it as a wrong thing to drink or substance**”. (Fieldworker Naledi)*

*“**It is the isiZulu culture** because there is this thing they say, I don’t know how to say it in English but there’s this thing when **they say khipha ubuthi** (meaning remove poison)” (Fieldworker Zibuyile)*

*“..... what I’ve noticed is the most used drug is alcohol, **usually we don’t take it as a drug, we take it as a norm** and you see people drunk as early as 8 in the morning and you can see that **people are addicted but no one thinks it’s an addiction** because we grew up with alcohol, we stay with alcohol and it’s part of our lives so we think it’s not a drug.... But what is a problem is we take this as a norm.if someone is drunk they just drunk, **if someone smokes dagga it’s just dagga, we don’t take it as our concern as the health system**. (Manager Mchunu)*

“...Like a good thing, everyone is doing it so why can’t we?” (Fieldworkers Mandla)

4.2.2 Unclassified or unregistered substances

There are two sub-categories (local and Chinese shops selling substances and unknown substances shipped through the borders of Swaziland and Mozambique) that relates to culture promoting substance abuse. These are presented below:

Local shops and Chinese shops

*“We visited a school and discovered that children are using drugs at school. Some they say they use it for sexual pleasure that **hey buy from our local shops, they buy them over the counter from Chinese shops and some are just drugs, there is a name that they call it, coope, yeah they get that from the Chinese and I think it’s destroying the youth. You ask them and they will tell you they get it from the Chinese but no one gets arrested, even if they do they say it’s not classified as a drug so you cannot arrest that person because we only know cocaine, dagga and all of that...that one is not classified in South Africa as a drug. It’s destroying kids but no one is getting arrested”** (Manager, Mchunu)*

Unknown substances shipped through borders of Swaziland and Mozambique

*“But it is hard, people they open their borders where they can cross Yeah, a lot like those places that are next to the border, **they are facing a lot of challenges like there are cigarettes that are from Mozambique that is cheaper than ours. Because there is an availability of something so you will find that there are many people who are using it because it is available.”** (Fielworker Ngcuka)*

*“And you also do get some other forms of drugs, is it nyawupe? **Because some of them come from Mozambique, across the border when you go to Durban so you do get a bit of that along the way”** (Manager Ngcobo)*

4.2.3 Easy access to substance/drugs

All participants reflected on the easy access of substances or drugs. The most common was the home brewed substances and dagga plantations at home. This was reported as one of the challenges in rendering services at UMkhanyakude District.

Home brewed substances: A number of home brewed substances were considered as the most prevalent and challenging substances at UMkhanyakude District as they are poorly controlled. These include ¹injemane (palm wine), ²isiqatha, ³isistambetame, ⁴amaganu (amarula wine), ⁵bhomane, ⁶mbamba, ⁷qo, ⁸isiZulu, ⁹umqombothi, the composition and names varies from community to community. These makes it difficult to control especial when trying to rehabilitate someone within their environment.

“They are unregulated by the liquor authority, they are also prevalent without being like guided by those who regulate. Alcohol is more home brewed wines so the home brewed wines are the ones that are very prevalent, it varies from community to another and the composition also varies, you’ll find that the palm wine is very prevalent and March/April , you’ll find that Marula wine is very prevalent”.
(Manager Mdlalose)

“The most common drug or substance abuse that is common here is the homemade brew.” (Fieldworker Cindy)

“You see...and people they also manufacture the alcohol like Injemane (palm wine)...so this is the most common used substance” (Fieldworker Ngcuka)

¹ Injemane: Palm wine (cut the palm tree to obtain its juice)

² isiqatha: mixture of the left overs of isiZulu, maize meal, bread, sugar, etc

³isitambetambe: mixture of pumpkins pineapple, sugar

⁴ Amaganu: mixture of Amarula wine (squiz amarula fruits)

⁵ lbhomane: mixture of glue, battery, pineapple

⁶ Mbamba: suger, pumkins, sugarcane, amarula etc

⁷ Qo: unknown substance bought from chineese sshops and mixed

⁸ IsiZulu: mixture of maize, umthombo, sorghum, yeast and bread, sugar

⁹ Umqombothi: mixture of soghum, pineapple and bread

Dagga plantations at home

Dagga was reported to be second most prevalent substance used because it is readily available in most areas of UMkhanyakude district including homes.

“...dagga are the easiest substance abuse that everyone can get, like dagga, some people they do plant around their house. I as a social worker, sometimes when I am doing the home visits, I can see it is around their yard”. (Fieldworker Majuba)

“So the common used substance or drug in this area is Marijuana because people they plant it in their home, it means Marijuana is available in their garden, home” (Fieldworker Ngcuka)

“Patients in male ward particularly that have drug induced psychosis due to dagga and I think it’s very readily available in Ingwavuma particularly. A lot of people seem to grow it, it’s very easy to get dagga here.” (Fieldworker Londiwe)

4.3 Theme Two: Impact of poverty on substance abuse service provision

In response to objective A (perceptions and experiences) and aspect of objective B (barriers and strengths) the high rate of poverty in this district was reflected by most participants as a huge challenge in rendering substance abuse services at a prevention and treatment level. The theme has three categories, namely, lack of occupational choices, low education level and breaking down of families. The summary is presented on the table 4.2.below.

Table 4.2 Theme two: The impact of poverty in substance abuse service provision

CODES	SUB-CATEGORY	CATEGORY	THEME
We need to give them some occupational Something that they have to do... He's not working, he's going to go back to alcohol There is nothing that is occupying them.	Unemployment		

It's also not a very industrial area High rate of unemployment.			Impact of Poverty on Service Provision
The elders most of them are in poverty Sustainable program of poverty alleviation So many of them are selling those concoctions (home brewed) because what else am i going to do, it's the way they live The ones that are brewing this illegal liquor So you cannot touch those people if they are protected by the izinduna,	Sustainable livelihood through selling Illegal Substances		
Young people need to be diverted by being in educational or recreational programs. Let them come and have fun, but who can fund that? Diversion programs, alternatives, interventions to drugs. Limited leisure activities outlets As well as there aren't many activities or projects that are aimed at keeping the youth off the streets or being busy Don't have the infrastructure and we don't have much resources meaningful leisure activities	Lack of recreation	Occupational deprivation	
Lack of meaningful occupations in which to engage. People are bored, Homes is people gathered, drinking alcohol It's very closely related with boredom, now work, Because the opportunities within this community to engage in healthy occupations,	Boredom		
You find out that other children drop out of school but they are continuing using drugs Youth from that area, they drop out of school Even the child has been to school, they do drop out Leads to the drop out in schools Like they don't even finish matric	School drop out Poor performance	Low education level	
The prevalence of this drug abuse is due to the breakdown in families Children, they end up not getting proper guidance in where growing up is concerned Proper family structure because you'll find that the mother is here and the father...they have broken down in their relationships. This motherly-fatherly love that they long for makes them engage themselves in whatever can divert their focus Because of family situations, stressful life events happen A child grows up in a family which is affected by poverty, Maybe it's a wife and the husband, when they get drunk they used to fight together Chasing, maybe the children in their homes, Parents have dismally failed to control their children.	Lack Parental Involvement in Children	Family Break down	
So parent themselves are the ones who start drinking, so even their children start drinking so they The elder people are doing it, so it is going to be very difficult to assist. It has to start with like a granny. Your parents are unemployed or a lot of the people in the community are unemployed, it kind of narrows your idea of what you can achieve It's also lack of possibly role models People older than them are abusing substances, Almost like few good examples to guide them Yeah but they do have the role models, Their role models are the ones that are abusing dagga	Lack of role models within homes and community		

<p>There is no one that is achieving in life that are not abusing that they can look up to But teachers as well, they are using drugs in school in front of the children,</p>			
<p>Their family fail to go there Usually the family members don't even come to pick them up, If parents can work hand in hand with the government institutions There is usually lack of support from the home sid They need someone who is going to be on their side routing for them and encouraging them to keep their appointments Hardly a family member that's there so there's never really a good follow up</p>	<p>Poor Family Support</p>		

4.3.1 Lack of occupational choices

Most participants reflected on the lack of occupational choices as their major challenge mainly during the intervention phase because the substance abusers are unemployed and has limited recreational facilities that can keep them occupied, so they are mostly bored. Three sub-categories, namely, unemployment, lack of Leisure/recreational Activities and boredom that perpetuates substance abuse are presented below:

Unemployment

“We really sitting with a problem because we need to give them some occupational, something that they have to do...like when we rehabilitate that person and he's not working, he's going to go back to alcohol and there is nothing that is occupying them.” (Manager Mnguni)

“it's also not a very industrial area so there is also a high rate of unemployment.” (Fieldworker Hlengiwe)

Sustainable livelihood through selling illicit substances

A challenge that was reported was that a number of community members resort to sell illegal substances to make a living, especially the home brewed alcohol,

because of poverty (unemployment) and limited occupational choices. This was frustrating to the service providers because they have no means to assist patients with more occupational choices or social relief of distress.

*“So...the elders most of them are in poverty but if you are to move them away from alcohol abuse and the traditional ones, you’ve got to have program, a sustainable **program of poverty alleviation**.....So many of them are selling those concoctions (home brewed) because what else am I going to do, it’s the way they live” (Manager Mdlalose)*

*“Most of the people here are **very poor and since they are poor they make home breweries (alcohol)** and they sell it to others. And then if you tell them to stop selling alcohol, they say earning a living.... I cannot give the person the **Social Relief of the Stress**, the Social Relief..., I cannot give him/her every month if I stop her to sell alcohol.....I have to like substitute, **if they stop selling alcohol I have to give them a way of living**” (Fieldworker Sibongile)*

It was expressed with frustrations that sometimes traditional leaders protects the home brewers:

*“And this thing of the traditional leaders, that one is another problem when working in the rural areas because ...the ones that are **brewing this illegal liquor**, they are being protected by this Izinduna (Traditional leaders) and all those people so you cannot touch those people if they are protected by the Izinduna, and then that’s a problem because you’ll find that this person is a relative of whoever, a well-known person in the area... so that’s another challenge we are having here, these traditional leaders” (Fieldworker Pinky)*

Lack of leisure/recreational activities makes it difficult to prevent and rehabilitate substance abuse

The perceptions of participants were that, owing to limited leisure facilities for meaningful leisure pursuits at UMkhanyakude, people resort to substance abuse to occupy themselves, especially the young people. This poses a challenge to them as service providers as they are limited in terms of resources

“Young people need to be diverted by being in educational or recreational programmes. *It could be we are bringing like the libraries or like the ICT centres, in fact that is the direction we are going to with Ophondweni but we need to have computers and internet so that other than having the drugs, let them come and have fun , but who can fund that? we really have a challenge with that. There is a serious need for us to have diversion programs, alternatives, interventions to drugs. So if we could have that, we will draw a lot of young people from experimenting with drugs to be committed into something else.”* (Manager Mdlaose)

“Hlabisa has got like very limited leisure activities outlets, it’s also not a very industrial area so there is also a high rate of unemployment, as well as there aren’t many activities or projects that are aimed at keeping the youth off the streets or being busy because most of the abusers haven’t been adults, it’s mostly like when they come here it’s the young people so I think that’s one of the main areas we don’t have the infrastructure and we don’t have much resources when it comes to meaningful leisure activities.” (Fieldworker Hlengiwe)

Boredom perpetuates substance abuse

Participants reported that patients’ boredom exacerbates the use of substances.

“...Lack of meaningful occupations in which to engage. I think that the people are bored, they aren’t going to school, they aren’t working so it’s linked to what my colleagues are saying...” (Fieldworkers Londiwe)

*“...what we often find when we arrive at peoples’ homes is people gathered, drinking alcohol, especially men and I think from an occupational perspective it’s very closely **related with boredom, no work**, so what do you do during the day...you gather with your friends, you sit and drink, you sit and smoke. Because the opportunities within this community to engage in healthy occupations, you get a job to work which are limited which makes it difficult.” (Fieldworker Beauty)*

4.3.2 Substance abuse contributes to low level of education

The UMkhanyakude District as a rural area has a very low level of education, and the substance abuse worsens the situation through a high number of school drop outs which in turn keeps the people in the vicious cycle of poverty. The participants reflected as follows:

*“This substance abuse also results to school problems, **you find out that other children drop out of school but they are continuing using drugs** because like if I can take an example, there is an area here in UMhlabuyalingana located in Ward 9, we had other events or awareness joint with other stakeholders where we wanted to engage them with regards to that area because most of the **youth from that area, they drop out of school.**” (Manager Zungu)*

*“I think it differs but there are more cases whereby you find that **even the child has been to school, they do drop out**, there are high cases where they do drop out of schools.” (Manager Nsibande)*

*“The issues of the substance because this is our main problem as compared to...because it **leads to the drop out in schools**, it leads to the family disengagement.” (Fieldworker Naledi)*

*“It is true...and most of them **like they don’t even finish Matric** and most of them are already introduced to drugs at early ages.” (Manager Ngcobo)*

4.3.3 Family breakdown is challenge in dealing with youth substance abusers

Participants expressed that due to high rate of poverty resulting unemployment, there is a number of family breakdowns. Some attributed this to parents not being at home because they are in cities looking for a job, with children being cared for by grandparents. There is a lack of role models within homes because elders are also said to abuse substances. These factors perpetuates substance abuse and makes it difficult to prevent the youth from abusing substances as well as assisting those who need rehabilitation as there is poor familial support.

Lack parental involvement in children

“....his drug abuse is the breakdown in families because most of the children here are staying with the grandparents only to find that the mother or father is working in towns in Durban far away so these children, they end up not getting proper guidance in where growing up is concerned. So I think one of them finding themselves and engaging in drugs is not getting the proper family structure because you’ll find that the mother is here and the father...they have broken down in their relationships.”

(Fieldwork Beauty)

“Working in this area is very hard because....lot of cases where they bring their cases here, maybe it’s a wife and the husband, when they get drunk they used to fight together, chasing, maybe the children in their homes, so something like that.”

(Fieldworker sibongile)

Lack of good role models at homes/parents and community

“Parents have dismally failed to control their children, so parent themselves are the ones who start drinking, so even their children start drinking so they, so they drink because their parents drink as well, yes that is a challenge.” (Fieldworker Noxolo)

“And the worst part of it is that if a family does not have maybe rules that nobody is allowed in this family to abuse alcohol, whereas the elder people are doing it, so it is going to be very difficult to assist. It has to start with the elder so if we say that I am not allowed to get involved with any people who are abusing alcohol or to indulge in alcohol so it will be easy to assist that particular family, it has to start with like a granny.” (Manager Nsibande)

Most youth is exposed to bad role models within community this worsen the situation and poses a challenge to service providers

*“Another challenge is based in schools, yes we are preaching that children must quit from drugs...but teachers as well, they are **using drugs in school in front of the children**, I’m not too sure whether it’s a challenge...Young people, like if you say there is no future in drugs, they will say there is a future in taking drugs because A, B and C are using drugs and now they are rich so those are the challenges we are facing so far.” (Fieldworker Londiwe)*

“And I think that it’s also lack of possibly role models, people older than them are abusing substances, there’s almost like few good examples to guide them. (Fieldworker Triad Inter 3: Cindy). Then Siwela added Yeah but they do have the role models, their role models are the ones that are abusing daggaYes so what she is trying to saying there is no one that is achieving in life that are not abusing that they can look up to” (Fieldworker Siwela).

Poor family support

*“And we have a challenge when it comes to discharging them because usually the family members don’t even come to pick them up...(Fieldworker Malembe) then Londiwe added, Like there is one case...you know if they are going to do maybe a function at home, they used to take that patient to the hospital because that person was diagnosed to be a mental healthcare patient. **They just take them and dump***

them here and finish their things and then they even forget about them, they are just neglected” (Fieldworker Londiwe)

“I think what happens when someone is a substance abuser, there is usually lack of support from the home side so when they come here they need taxi fare, they need resources to come to the hospital and they need someone who is going to be on their side routing for them and encouraging them to keep their appointments”
(Fieldworker Hlengiwe)

4.4 Theme three: Lack of resources is a barrier to service provision

In response to objective A (perceptions and experiences) and B (barriers and strengths), participants voiced out the difficulties posed by the area being underdeveloped/underprivileged and marginalised from resources as well as the lack of resources within their work places. They regarded this as a hindrance in rendering the effective and quality substance abuse services at UMkhanyakude District.

*“But coming to this site it was a bit of a challenge because there **are limited resources** when it comes to providing such services to the substance abuse participants. **So it’s like we are trying to create something out of nothing to assist that particular person** and in a way kind of like failing to provide a sustainable service because of those limited resources”. (Fieldworkers Focus Group: Naledi)*

“There are a lot of challenges that we are faced with. The first one is we have a shortage of resources, it is our major challenge which also maybe contributes to us not rendering that effective” (Manager Zungu).

Two categories emerged, namely, lack of resources in the work place and lack of infrastructure within UMkhanyakude District. Refer to the summary in table 4.4 below:

Table 4.4 Theme three: The lack of resources as a barrier to substance abuse service provision

CODES	SUB-CATEGORY	CATEGORY	THEME
<p>But the thing is we've got a lot of work It will maybe be attended to after a long time A very limited number of staff members that are involved Since 2009 until now, there's only been one permanent one It's very hard to actually like to cover substance abuse</p>	Human resources: Staff-shortage	Lack of resources in the work place	
<p>So it becomes difficult to conduct a program, in fact I didn't conduct it It needs those resources Expecting us to conduct it while we don't have anything that we can use In terms of resources like cars but also working material as well We are working here in rural areas, shortage of resources</p>	Material and equipment		
<p>There is money to transport these people There must be food Even our petty cash cannot go and cover that so that is just the taste of the problems It's very skewed... Like I said, funding is not enough,</p>	Funding		Lack of Resources
<p>No transport...really that one He lack of resources is really a struggle We fail to do that because there is no transport But then you cannot go because you don't have a car It's very challenging to get the transport Challenge with transport, transport is very limited So the coordinators normally walk</p>	Transport/cars		
<p>you have to drive maybe an hour to get to that area there are times you are not able to locate the house easily it's in deep rural you get stuck, there's sand There are areas which are difficult to reach here in UMkhanyakude Enkovukeni, we use a boat, not that boat maybe the one you thinking of we cross by feet approximately to 1500m</p>	Hard to reach areas	infrastructure	

<p>No there is no rehabilitation centre around here We don't have the facilities Rehab centres so when we have to refer a person To achieve that we need to have a centre Madadeni is the most nearest whereas it looks geographically far from here With the resources that we have, it's so limited.</p>	<p>No treatment facility at UMkhanyakude</p>		
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4.4.1 Lack of resources within work place

The lack of resources within the work place is presented with three sub-categories, namely, staff shortage, shortage of equipment/material and lack of Funding.

“But the resources, they do not tie with these programmes” (Fieldworker Pinky, said with frustration)

Staff shortage

*“We are working like them **but the thing is we’ve got a lot of work**, other things that we are doing so we have to look on them. Sometimes you’ll find that the case will be reported maybe today and **it will maybe be attended to after a long time** so there is a lot of work.”(Manager Thwala)*

*“The hospital regarding substance abuse because the problem is when it comes to mental health there is usually **a very limited number of staff members that are involved** because at one time there was no psychologists and then when the psychologists came, we are usually bombarded by other cases....**Since 2009 until now, there’s only been one permanent OT**, and then when it comes to comm-service, there’s always been like one comm serv or no comm serv at all, so **it’s very hard to actually like to cover substance abuse**” (Fieldworker Hlengiwe)*

Shortage of equipment/material

*“Still on the resources, I think Kemoja is one of our prevention programs which contain many different modules like there is a **puppet show program** which is designed for school children **so it becomes difficult to conduct a program, in fact I didn’t conduct it because it needs those resources that will accommodate young children...Yes we don’t have that but the department is expecting us to conduct it while we don’t have anything that we can use.**”(Fieldworkers Pinky)*

*“And other challenges, it might not be necessarily in terms of resources like cars **but also working material as well.** One of the challenges we are having working here in a rural area, we talk of computers and also access to internet, as much as we might be having it but it’s something that we didn’t have before so that becomes a huge challenge so it’s one of the challenges we are facing as **we are working here in rural areas, shortage of resources.**” (Manager Zungu)*

“Cars...there are few and the other thing is not in good condition.” (Fieldworker Siwela).

Lack of funding

Programmes are not congruent with funding allocation.

*“Grow it’s a very long program because you guiding the recovery of women, that’s a very long therapeutic program. I must make sure that there are crèches to take care of these children, **there is money to transport these people to where we going to meet, there is food because I cannot talk to people with an empty stomach, there must be food, if it’s cold I must have jerseys and other things so that they will feel warm. There must be that element from me, like in black and white there must be that from me. But I cannot provide that for them because there is no such...even our petty cash cannot go and cover that so that is just the taste***

of the problems we are having in terms of resources tying up with the programs”(Fieldworker Rose)

“I think for instance, we have a challenge with funding from Social Development, **it’s very skewed...**for us to work better, you’ve got to do your children’s house planning correctly, and they need to be trained, the training part is very weak with the organisation, we don’t have much service providers that do training on drug and substance abuse. **Like I said, funding is not enough,** it has to come together and it must be done generously.” (Manager Mdlalose)

Issues surrounding transport

Transport issues were raised as one of the aspects that discourages participants on a day to day basis.

“Maybe I can say the challenges we are facing is a lack of resources, example maybe if I want to conduct a home visit...**no transport...really that one, even if in the morning I wake up, if I’m thinking about what I’m going to visit, I become discouraged. The lack of resources is really a struggle** because as we are here in the hospital, we are working hand in hand, sometimes my colleague can refer them or refer the case to me if I’m supposed to intervene through a home visit to see the home circumstances, **we fail to do that because there is no transport.**” (Fieldworker Majuba)

Transport problems were emphasized by most participants that it is a challenge that affects their ability to render services:

“Yes, because like there is a need for me to go out there and trace and there is a need for me to go out there and do the home visit and to see how is he or she is taking the treatment and so on **but then you cannot go because you don’t have a car.** Sometimes they combine you with the other team and ending up not reaching

*your target...so we end up not reaching there and by past two we need to come back so you waste the whole day there. So it's affecting us and other programs that end up not going out, they know that if I'm combining with this one I won't reach there so it's very challenging in this institution. Let's talk about this institution, **it's very challenging to get the transport.**" (Fieldworker Siwela)*

*"We also have a **challenge with transport, transport is very limited**, limited transport that is provided per month so Social Development should provide money for transport.....The rurality and the vastness of it. **So the coordinators normally walk**, I'm sure you must have heard that those are the challenges." (Manger Mdlalose)*

4.4.2 Lack of infrastructure

Participants expressed their frustrations about the lack of infrastructure at UMkhanyakude District. Three sub-categories emerged, namely, hard to reach areas, no treatment Facility within UMkhanyakude District.

Hard to reach areas due to lack of infrastructure

*"I will say it's the huge number, the people that we seeing and the distance, **you have to drive maybe an hour to get to that area** after you have done your ward rounds, maybe you leave here at 11 o' clock, get there by 12, half past 12 and **there are times you are not able to locate the house easily**, if it's in deep rural you get stuck, **there's sand**, not enough transport, those are just the challenges." (Fieldworkers Naledi)*

*"**There are areas which are difficult to reach here in UMkhanyakude** as a whole, there are difficult areas, for example there is an area that is 35km away from this office, called Enkovukeni, it's difficult to get to that area but at the end we have to give service to them. I tell you what, when we go to **Enkovukeni, we use a boat, not that boat***

maybe the one you thinking of, we cross by feet approximately to 1500m which is 1km and 500m to get to” (Manager Zungu)

No rehabilitation facility within UMkhanyakude district

The district does not have a rehabilitation facility. Participants raised this a huge challenge as it is difficult to isolate substance abusers from their homes and families to distant rehabilitation facilities for example Newlands Park Centre in Durban and Madadeni Rehabilitation in Newcastle. Both these facilities are approximately 350km away from UMkhanyakude District.

“No there is no rehabilitation centre around here. *We only provide counselling which not helping really” (Fieldworker Sibongile)*

*“I think on the limitation as well **we don’t have the facilities, rehab centres so when we have to refer a person,** looking at the distance, we have to refer a person to Durban or Madadeni.....and the waiting list is long, if they do have an access or maybe they accepted to transport a person to that centre, it means now you are isolating that person from their family, they won’t be able to...like it’s putting him/her into prison for 6 months or whatever so that is the issue” (Manager Ngcobo)*

“To achieve that we need to have a centre. *Because if you are to service a client holistically, you have to remove the client and bring him back to a Newlands Park Centre in Durban and the relocating from an environment that is where he is, it might even compromise that because bringing that person to a new environment, it also complicates the situation of the person and the recovery process at later.” (Manager Mdlalose)*

*“Just a follow up on that limited resources that the social worker has talked about, since we are here we say **Madadeni is the most nearest whereas it looks geographically far from here,** it’s the only place that we have and they’ve got their*

*own requirements as she said, as well as their restrictions, let's say they are designed if you may look for the people around Newcastle, they have to serve us also here so with that we can say **with the resources that we have, it's so limited.**" (Fieldworker Zondi)*

4.5 Theme four: No prioritisation of mental health and substance abuse services

In response to objective A (perceptions and experiences) and B (barriers and strengths) a number of participants exclusively from department of health shared their experiences and perceptions about the Substance Abuse services at UMkhanyakude. Their view, was that it is not given priority as compare to other programs instead neglected and given less focus.

*"I think just the priority I'm a bit worried about, the priority of the program because you'll find that our top managers will say oh you talking about that, okay let's shift that one, let's talk about HIV..... Yes it's neglected, a healthy lifestyle, it's there, MDG, it's there, long and healthy lifestyle but we not looking at the real lifestyle, we are only looking at the infectious conditions which TB, HIV and the others. **So I think it's the priority of the programs**" (Manager Mchunu).*

Two categories emerged, mental health and substance abuse not a focus/not important and no integration of mental health and substance abuse to Primary Health Care. The theme and its categories, subcategories and codes are summarised on the table 4.4 below:

Table 4.4 Theme four: No prioritisation of mental health and substance abuse

CODES	SUB-CATEGORY	CATEGORY	THEME
Here every day for mental health treatment and the person is also taking arvs but they don't know,	Integration to day to day running of the PHC facility		

there's no integration even of the dates But it's not documented anywhere. Integration of mental health to other PHC conditions We need to do this reintegration of the mental health into the PHC, that		No integration of mental health and substance abuse to Primary Health Care	No prioritisation of Mental Health and Substance Abuse
personnel can be retrained on this reintegration of mental health where especially at the PSC level person is not fully screened in terms of their substance until it is too late training of nurses o training it shouldn't be waiting until someone goes to do mental health, should be integrated in the basic training	Staff training on Substance abuse and mental health integration to PHC		
Even the allocation you will find that there's a TB car but we don't have mental health team vehicle Provinces that got cars for HIV team But if somebody else whose job is perceived more important than yours, Mental Health I never saw any program that is supporting	No resource allocation	Mental health and substance abuse not a focus and not important.	
Mental health so we mainly focus on the physical side So substance abuse and psych conditions have taken a backseat. We have thee priority programs We only think of hiv, tb There is no integration. I think just the priority i'm a bit worried about, the priority You talking about that, okay let's shift that one, let's talk about hiv So i think it's the priority	Not given time for planning platform for discussion on meetings		

4.5.1 No integration of mental health and substance abuse to Primary Health Care

The perceptions of participants were that mental health and substance abuse are not integrated to primary health care. Two categories emerged, namely, integration to day to day running of the health facility and staff training.

Integration to day to day running of the PHC facility

“Because even at hospitals you come to a mental clinic and then you’ll ask is so and so taking ARVs, they don’t know...you’ll find that it’s a client that comes here every day for mental health treatment and the person is also taking ARVs but

they don't know, there's no integration even of the dates because if you know so and so is taking ARVs and mental health treatment, you will integrate the date of coming. But I won't say they don't care but they don't know any other condition that the person is suffering from except mental health and the ARV part, they'll just know so and so takes ARVs, even when you ask, they'll say oh we've seen him sometimes going to ARV, I think he/she is taking **but it's not documented anywhere**. So the **integration of mental health to other PHC conditions is vital**, I think it's very vital because it's also a PHC program." (Manager Mchunu)

"So that's my main worry that we need to do this reintegration of the mental health into **the PHC that is a big, big challenge**" (Manager Mnguni)

Staff training on substance abuse and mental health integration to PHC

"Firstly if the health staff or **personnel can be retrained on this reintegration of mental health** because it's where especially at the PSC level, it's where the client they go and report so some of them, they are being like missed because there is no proper screening in terms of their abuse when it comes to addiction so you find that **the person is not fully screened in terms of their substance until it is too late....** . Right now there are plans that are on, we are trying to retrain the staff." (Manager Mnguni)

"A challenge is also training when we do training of nurses or even with the CCGs from the community, it's rare that we talk about the substance abuse...So I think even in training it shouldn't be waiting until someone goes to do mental health, it should be integrated in the basic training." (Manager Mchunu)

4.5.2 Mental health and substance abuse not a focus and not important (neglected)

The perceptions of participants were that mental health and substance abuse is neglected or seen as less important, hence, resource allocation neglect/ignore Mental health and Substance Abuse Program and program planning neglect substance abuse. These were expressed with frustrations:

Resource allocation neglect/ignore mental health and substance abuse program

*“In that part it will be transport, **even the allocation you will find that there’s a TB car but we don’t have mental health team vehicle** so it goes back to priority and integration...Because even with the allocation you can go to **provinces that got cars for HIV team**, they got cars for TB team but you’ll never hear a car for mental health.” (Manager Mchunu)*

*“Because we can try to book transport and you’ll get transport **but if somebody else whose job is perceived more important than yours**, needs transport but they didn’t book the transport, they will get the transport” (Fieldworker Cindy)*

*“And there’s another thing, the other programs like HIV/Aids, there is Africa Centre but in **Mental Health I never saw any program that is supporting**...Yes, it’s like it’s been neglected.” (Fieldworkers Londiwe)*

Programme planning neglect substance abuse

*“So it’s very hard to actually like to cover substance abuse or **mental health so we mainly focus on the physical side** and then as well as community outreach, that’s been our main priority and then promoting OT as well, **so substance abuse and psych conditions have taken a backseat**” (Fieldworker Hlengiwe)*

*“The challenge is priority, **we have thee priority programs, we only think of HIV, TB**...when someone comes in we check HIV, we see if that person is positive then we’ll say you know this is infectious, here are program to prevent it but let someone*

come in smelling of alcohol in the morning, you don't care about the alcohol, if he says he's got an headache, you give him Panado and he goes, you don't talk about the alcohol because you think it's none of your business or else you think it's social work business, it's police business, there is no integration.” (Manager Mchunu)

4.6 Theme Five: Prohibiting factors to effective substance abuse services in the district

In response to objective A (perceptions and experiences) and B (barriers and strengths) participants expressed their perceptions and experiences about the Substance abuse services that it is difficult to render the service due fragmented treatment/rehabilitation services and poor monitoring and evaluation. Therefore, two categories emerged, namely, no measuring of impact and poor treatment services due to no monitoring and evaluation of the service. The theme and its categories, sub-categories and codes are summarised on the table 4.5 below:

Table 4.5 Theme Five: Prohibiting factors to effective substance abuse services in the district

CODES	SUB-CATEGORY	CATEGORY	THEME
Need to have indicators and monitoring systems of our program We are unable to measure other things We don't have means of measuring whether it worked or not	No Monitoring and evaluation tools of Substance Abuse Services	Poor monitoring and evaluation of treatment services	
The quality of data is not good the report we get is not the details that has been provided you still find some gaps information is not as accurate and it doesn't give us a clear picture so that we can plan properly It cannot account really so the data is questionable Who are the most affected group	Poor collection of statistics for Substance Abuse Services		
I think we need to do our base line from time to time and to research institutions, Issues that need to be researched Do the research	Lack of Research in Rural Areas		

<p>So this study, will it come up with some recommendations Thank you for coming and considering us in your study</p>			<p>Prohibitors of UMkhanyakude district substance abuse services</p>
<p>That the person is having a problem, what do you do? Program that we are having here are not exactly tailor made to answer to those problems The framework, a systematic framework was not there and it is still not there We don't have a system to service the service users of drugs So the service provision is very broken It's fragmented, let me put it that way, there is no system.... And how do you monitor the perfection of that?</p>	<p>No treatment/rehabilitation protocols nor proper systems in place</p>	<p>Fragmented/ Treatment Rehabilitation Services.</p>	
<p>I supported him even though we don't have aftercare programs I supported him in many ways, The government should provide the capacity at a community Based interventions are out based Outpatient community services They report it to us, they are coming back now, what are we going to do?</p>	<p>No aftercare and community based rehabilitation program</p>		
<p>Here you have to think of Madadeni procedure How long will that person take to get such services. Rehab services but they've got their own requirements A non-payable organisation so they've got this long waiting list, That the person needs to wait for six months in order to get to the rehab To be in that long waiting list It difficult really because of the waiting list is long, Are isolating that person from their family, t They've got their own requirements as she said, as well as their restrictions. Geographically far from here</p>	<p>Long waiting list and Difficult referral systems to a faraway rehab facility</p>		
<p>you have to have basically committed a crime so that the judge will force you to go to rehab you have to be psychotic you have to have another problem Like the earlier milder cases, you can't really at the beginning stages where there's maybe more hope for him, there's nowhere to send him so even if you manage to become rehabilitated, the damage has already been done if there was something for milder cases in the state</p>	<p>Poor/no early treatment/rehabilitation intervention</p>		

4.6.1. Poor monitoring and evaluation of services

Most participants raised that there is poor monitoring and evaluation of substance abuse services, as a result they are unable to see if their service is making a difference or not. Three sub-categories emerged no monitoring and evaluation tools

of Substance Abuse Services, poor collection of statistics for Substance Abuse Services and lack of rural research on Substance Abuse.

No monitoring and evaluation tools for substance abuse services

*‘So again, another, we don’t have a proper systematic framework for our programs. Like, we **need to have indicators and monitoring systems of our program**, so it troubles me as a decision maker, so we work around but we don’t have a clear program we still need assistance as an organisation. It’s not a nice thing present especially when you present it for lots of people but I would want you to raise it. **We need capacity building around those issues.**’ (Manager Mdlalose)*

*“**And we are unable to measure other things** because when we render the prevention to schools, **we don’t have means of measuring whether it worked or not**, yeah that’s a problem we have.” (Fieldworkers Pinky)*

Poor collection of statistics for substance abuse services

*“There is no proper tracing mechanism, they don’t have a proper tracing mechanism that is at hand that this client has got a problem, maybe now he’s on a substance the monitoring, so they don’t have a proper system, if it’s there it’s broken or if it’s there **it cannot account really so the data is questionable**”. (Manager Ngcobo)*

*“Now we still need to also understand, **who are the most affected group**, is it youth, is it females, is it males, and why... So if at all we could be assisted as organisations” (Manager Mdlalose)*

Lack of rural research on substance abuse

*“**I think we need to do our base line from time to time and to research institutions**, be able to work with them, giving them **issues that need to be***

researched, you delegate the students to come and work with us and do the research from time to time because drug trends change.” (Manager Mdlalose)

This study was seen as a way of monitoring and evaluation:

“So this study, will it come up with some recommendations, like helping us to...how we can start up with those early intervention” (Fieldworker Naledi)

“Thank you for coming and considering us in your study...Sometimes we feel like what we are doing is just a drop in the ocean but we know that lives are being helped, even though sometimes we don’t know how like as I said, the ability of measuring the impacts of our services so we are looking forward to your report.” (Fieldworker Pinky)

4.6.2 Fragmented/treatment rehabilitation services

The perceptions of most participants reflected that the rehabilitation/treatment services at UMkhanyakude are fragmented; this poses a challenge in their service provision. These were reflected with four Sub-categories, namely, no treatment protocols nor proper systems in place, no aftercare and community based rehabilitation program and long waiting list and difficult referral systems to faraway rehab facilities. It was however noted that with the department of Social development they have a treatment/rehabilitation program, namely, GROW (guiding the recovery of women) which is for woman only however it is also difficult to implement due to lack of resources, as illustrated in 4.4.1 lack of resources within the work place. These categories are summarised on the table below:

No treatment/rehabilitation protocols nor proper systems in place

“And then number two, a person comes to the office, approaching the office and you’ll see that the person is having a problem, what do you do? The program

that we are having here are not exactly tailor made to answer to those problems the people are having. Yes, we do have Kemoja for prevention, we do have Wake Up Call also for prevention we've been trained" (Fieldworker Pinky)

"When it comes to service provision, the framework, a systematic framework was not there and it is still not there. For instance in the case of HIV, you will get somebody attending you at the clinic, from the clinic he will be referred to the hospital, and from hospital back to the NGOs. So although we have a drug problem, a serious problem in this community, we don't have a system to service the service users of drugs...so the service provision is very broken, it's fragmented, let me put it that way, there is no system.... and how do you monitor the perfection of that? So the services are very fragmented, the service providers are far and wide, they are scattered and as a result it compromises the services that we should be rendering." (Manager Mdlalose)

No aftercare and community based rehabilitation programme

"When he came back (From rehab facility) then I supported him even though we don't have aftercare programs but I supported him in many ways, made sure that he stays clean and until now I am happy he is still clean" (Fieldworker Pinky)
Rose was in agreement and as sense of frustration noted.

"The government should provide the capacity at a community, that one I think the community based interventions or out based, they call it outpatient community services." (Manager Mdlalose)

"So we are facing that problem so we don't have any rehab and also the aftercare.... Right now we do have two guys, the cases that are here...the social worker, they report it to us, they are coming back now, what are we going to do? Because this is not for the first time this guy went there, this is the third time but now, what are we doing as UMkhanyakude? We really sitting with a problem because we

need to give them some occupational, something that they have to do.” (Manager Mnguni) Ngcobo nodded in agreement to the statement.

Long waiting list and difficult referral systems to a faraway rehabilitation facility

These concerns were expressed with frustrations by a number of participants.

*“Here you have to think of Madadeni procedure and how long will that person take to get such services. Madadeni is partly our psych referral hospital and also for rehab services but they’ve **got their own requirements** that what have we done as a hospital because they take it as a last resort to refer those people there. And since it’s also a non-payable **organisation so they’ve got this long waiting list**, we might find that the person needs to **wait for six months** in order to get to the rehab for such services so maybe by that time the person has gone... there is **Newlands one** which is with the state, the one that ... maybe you have to be in that **long waiting list**” (Fieldwork Naledi)*

*“It is difficult. Firstly the referral is being done by the social worker so they are finding it difficult really because of the **waiting list is long**, if they do have an access or maybe they accepted to transport a person to that centre (madadeni), it means now you **are isolating that person from their family**, they won’t be able to...like it’s putting him/her into prison for 6 months or whatever so that is the issue.” (Manager Mnguni)*

*“it’s the only place that we have and they’ve got their **own requirements as she said, as well as their restrictions**”.(Fieldwork Zondi)*

Poor/no early treatment/rehabilitation intervention

Most participants expressed their frustration in failing to provide early treatment interventions and only send patient to rehab facilities when they are psychotic or committed crime, where at that stage the damage is worse.

“My experience is that you have to have basically committed a crime so that the judge will force you to go to rehab or you have to be psychotic so that we can send you to Madadeni, like you have to have another problem. Like the earlier milder cases, you can’t really...patient cannot afford....it’s out of your reach so all that we have...for me if I have a patient I refer to Occupational Therapy or Social Work to see if they can do counselling and that kind of thing which is not drug rehab really and then encourage the family if the patient has committed any crimes to report him because so the judge can force him and then those ones are paid for. For somebody who’s sort of at the beginning stages where there’s maybe more hope for him, there’s nowhere to send him...so by the time you’re committing crimes as a drug addict, your brain is very badly damaged, the rest of your body is also very badly damaged so even if you manage to become rehabilitated, the damage has already been done. It would be really nice if there was something for milder cases in the state”. (Fieldworker Stacey)

“I think with Department of Health, because they enter at a very advanced stage, so when the damage is worse. So those early interventions then, they need to be engaged or to be attended at the earliest stage before people get into dependency or clinical dependency of some sort. So that says then, so that says then I am worried about the people who come here already dependent on drugs..... Yes. If we can strengthen our intervention from prevention as well as early interventions, it will reduce the number of people that get into dependency, chemical dependency.” (Manager Mdlalose)

“So this study, will it come up with some recommendations, like helping us to...how we can start up with those early intervention and we need manpower to do that... so it’s limited stuff as compared to the huge number of the ones that are starting, the ones that are addicted and the ones that are dependent on the substances, so we are not able to reach out to those. So as much as we would like to do the

early intervention and even the awareness early on, we will be glad *but it's just that we are out of the resources to do that.*" (Fieldworker Naledi)

4.7 Theme Six: Enablers or strengths of substance abuse services in the district

In response to objective A (perceptions and experiences) and B (barriers and strengths), participant's perceptions about the strengths of their service provision were very negative. They find it difficult to answer the direct question about strengths (What are the strengths or advantages of your Substance Abuse Services):

*"I am just **thinking about what I can appreciate you**" (Fieldworker Majuba)*
Laughing

*"Sometimes **we feel like what we are doing is just a drop in the ocean** but we know that lives are being helped, even though sometimes we don't know how like I said". (Fieldworker Pinky)*

*"It can **be a drop in the ocean** but it's something better than no services at all"*
(Fieldworker Naledi)

Nevertheless, the researcher noted the strengths of the service and this was indirectly reflected by most participants. Three categories noted, namely Good inter-sectoral collaboration on Prevention Program, Civil Societies support action against substance abuse and resilience of substance abuse service providers. These are summarised on the table below and then quotes and sub-categories:

Table 4.7 Theme six: Enablers or strengths of substance abuse services in the district

CODES	SUB-CATEGORY	CATEGORY	THEME
Relationship is good The drug master plan stipulate the formation of LDAC. Its in the substance abuse act no70 of 2008 Working here in rural is that there is huge partnerships Relationship is good	Drug master plan through ldac promotes good inter-sectoral collaboration	4.8.1 Good inter-sectoral collaboration on prevention program	Strength of Substance abuse services at UMkhanyakude District
The chairperson will report department who not participating I think its OSS kinder enforces it War-rooms Its premiers program	Operational sukuma sakhe (oss) through war-rooms promotes inter-sectoral collaboration		
Ophondweni are the forerunners Given mandate by municipality to facilitate LDAC As NGOs we face who are you attitude So we use the center of influence like regional	Ngo lead local drug committee	4.8.2 Civil Societies Support Action Against Substance Abuse	
Education during traditional leadership meeting Izinduna (traditional leaders) are still valued Izinduna are resepected by community People go to church when they distress Faith base organization are part of local drug committee The advantage I can say, it's the traditional leaders here they allow us to do awareness campaigns	Traditional leadership and faith based organization supports substance abuse services		
Crossing the river with a boat. Climbing hills Getting stark on the road Walking long distances Vast area and Rurality of the area	Motivated against rural challenges	4.8.3 Resilient Rural Substance Abuse Service Provide	
Making deals with Shebeen Owners Educating During Traditional Leaders Routine Meetings Monitoring the consumpsion of elderly substance abusers	Innovative Strategies on Substance Abuse Service Deliveries		

4.7.1 Good Inter-sectoral collaboration on prevention programme

The perceptions of most participants were that they have a very good relationship with relevant stakeholders, however, others expressed that there are some that are not yet on board. They appraised the Drug Master Plan through the Local Drug Action Committee (LDAC), Operational Sukuma Sakhe (OSS) through War-r.ooms as a very important supporting structures that promotes Substance Abuse Service Providers Inter-sectoral Collaboration at UMkhanyakude District. They say this helped them to avoid working in silos and repetition of services.

“My colleague is right, when the committee started it stopped this thing of repetition, then you find that a person is doing and the other department goes to the same area and does the same thing...so there is this thing called merging of services, now that you are together I know that you SANCA what you are planning then we go together to the community and it makes our services meaningful because now we are together.... other departments still work in isolation, you’ll find that others are excluding themselves.”(Fieldworker Pinky) Rose in agreement.

Drug Master Plan through LDAC Promotes good inter-sectoral collaboration

“The relationship is good...and the drug committee that we have that is led by the municipality, I think it’s a big strength because we meet there at the SANCA and these guys from South African Liquor Services... I think that collaboration with the stakeholders, it gives us even more strength as the Department of Health to address the issues.” (Manager Ngcobo) They both agreed.

“Our relationship is good like we have Local Drug Action Committee who includes the stakeholders to combat substance abuse...so Local Drug Action Committee, it’s made up by different stakeholders, departments, I’m a secretary to that structure. So we use to have meetings, after that we have awareness campaigns at schools or to the communities...In the schools we go there as Local Drug Action Committee, then we do awareness campaigns.” (Fieldworker Ngcuka)

Operational Sukuma Sakhe (OSS) through war-rooms promotes inter-sectoral collaboration

“I think it’s the issue of the Speration Sukuma Sakhe (OSS), where every department was aware that we have to meet, we have to sit here because it’s a premier program... Yes. If that department does not show up, then the chairperson of OSS has to report that department did not participate whatsoever, yes they know very well because these OSS from the ward, we call it the war-rooms.” (Fieldworker Londiwe)

“Yes, even the introduction of OSS (Operations Sukuma Sakhe), making it very easy for us to work with all departments around local and districts.” (Manager Nsibande)

4.7.2 Civil Societies support action against substance abuse

The perceptions of the participants were that one of their strengths is the strong support from the civil society within UMkhanyakude District. This goes to the extent whereby they take a lead in Local Drug Committee, in particular the Ophondweni Youth Development Initiative (NGO). In addition, the Faith Based Organizations and Traditional Leaders supports Substance Abuse Services of which they are the most valued and respected entity in the rural community. These two sub-categories are presented below.

NGO lead Local Drug Committee

“There is Ophondweni Youth Development, which I think was their initiative of this whole committee, the UMhlabuyalingana, because the four runners of UMhlabuyalingana Local Drug Action Committee. Since we are stuck in the government institutions like I have to be here at quarter to seven and at four o'clock I go home, they are the ones that are always there in the community.” (Fieldworker Zondi)

“...we still have a problem of non-attendance, worse that it's being driven by Ophondweni as an organisation. If the department is called by NGOs because we are there to facilitate that, so you face a challenge of who is he attitude, but we are trying to bridge that gap...let's make sure that they come in but also use the center of influence like the Regional Office to make sure each government stakeholder becomes part and parcel of that. So all the local drug action committees have been

launched in four local municipalities where we've been working" (Manager Mdlalose)

Traditional Leadership and Faith Based Organization supports substance abuse services

*"I was very impressed when the guys from the **traditional leader**...that they are on board because people from our village, they tend to respect these guys so I think that going forward we going to have a very important impact in addressing the issues that we are facing in the district in terms of substance abuse" (Manager dyad interview 1: Ngcobo). Mnguni in agreement, she added, "...then it represents all the stakeholders because we also have the people from the **Faith Organisation**, yes we've got representatives" (Manager Ngcobo).*

"We target those places that are ruled by Izinduna (traditional Leaders), we use these gatherings to go there and advise people about substance. In the schools we go there as Local Drug Action Committee, then we do awareness campaigns." (Fieldworker Ngcuka)

"The advantage I can say, it's the traditional leaders here they allow us to do awareness campaigns" (Fieldworker Sibongile)

4.7.3 Resilience of substance abuse service providers

The researcher observed that most substance abuse service providers are motivated, resilient rural workers in spite all odds they still do they best to provide the service even to the hard to reach areas where their lives are at risk.

Motivated against rural challenges

Difficult areas to reach but participants reach them

“it’s difficult to get to that area but at the end we have to give service to them..., we normally go when it’s low tide, when it’s high tide it’s difficult to go to Enkovukeni, you can’t go there. There are mostly risks involved but because we want to get the service to the people, we go....so after you have crossed the river (Enkovukeni river-connected to the sea), you have to **climb a high hill to reach to that school....**but you have to still walk..., there’s only one primary school called Enkovukeni, there is no high school there...Kids cross everyday” (Manager Zungu)

“Maybe you leave here at 11 o’ clock, get there by 12, half past 12 and there are times you are not able to locate the house easily, if it’s in deep rural you get stuck, there’s sand, not enough transport, those are just the challenges.” (Fieldworkers Naledi)

Vast area-long distances-long walks to Substance Abusers

“The rurality and the vastness of it. So the coordinators normally walk, I’m sure you must have heard that those are the challenges. (Manager Mdlaose)

It’s a rural area so it’s large places, it’s not for small one or this Hlabisa it’s a huge area to cover so it looks so difficult sometimes... Yes, sometimes they were going to Hlabisa to Hluhluwe to attend the service users.” (Fieldworker Noxolo)

Innovative strategies on substance abuse service deliveries

Making deals with Shebeen Owners-to monitor the drinking of the elderly

“clients who are getting a grant, maybe like a psych patient or any gogo who is getting a grant but then all monies are going to that particular Sheeben so we have to go to that household to say you must restrict this old person.” (Fieldworker Naledi)

“So we are going to have shebeen interventions together with KwaZulu Natal Liquor Authority, where we’ll be empowering, taking all these concoction mothers and bringing them together to learn from them, to have a discussion, to hold a dialogue with them so

that we understand why they do that, do they understand the damage they cause in the community” (Manager Mdlaose).

Educating during traditional leaders routine meetings

“..We have awareness campaigns at schools or to the communities, we target those places that are ruled by Izinduna (traditional leaders), we use these gatherings to go there and advise people about substance. In the schools we go there as Local Drug Action Committee, then we do awareness campaigns” (Fieldworker Ngcuka).

4.8. Summary

The findings presented in this chapter has outlined the perceptions and experiences of substance abuse service providers in service provision at UMkhanyakude district. The data was then classified in to six themes that emerged in relation to study objectives during data analysis, namely, easy access and poor regulation of substances, impact of poverty on substance abuse service delivery, lack of resources as a barrier to substance abuse service provision, no prioritization of mental health and substance abuse, prohibiting factors to effective substance abuse services and enablers or strengths of Substance abuse services at UMkhanyakude district. These findings will be discussed in relation to literature and a district context in the next chapter.

CHAPTER FIVE

DISCUSSION

5.1 Overview

In this chapter, the researcher will describe the findings outlined in the previous section (chapter 4) within the context of available literature and make assertions as to some of the findings. This study which sought to present the experiences and perceptions of rural substance abuse service providers culminated in six emergent themes, namely,

1. Easy access and poor regulation of substances within the district
2. Impact of poverty on substance abuse service delivery
3. Lack of resources as a barrier to substance abuse service delivery
4. No prioritization of Mental Health and substance abuse in the district
5. Prohibiting factors to effective substance abuse services in the district
6. Enablers or strengths of the substance abuse services in the district

5.2 Easy access and poor Regulation of Substances/drugs

The service provider's reflections were that substances/drugs at UMkhanyakude district are poorly regulated and this poses a challenge and unique experience to the service delivery in the rural areas of this district. The poor regulation of substances appeared to be perpetrated by three factors, namely, some cultural aspects that promotes substance abuse, unclassified or unregistered substances and the easy access to substances. These are described in more detail.

Each community is constructed within a particular cultural belief, and this influences the behaviour of people who subscribe to that particular culture, this is evident at UMkhanyakude where by some people subscribe to ancestral worships. Ancestral worship ceremonies were reflected as a huge challenge to the service providers because it works against them in combating the spread of substance abuse. For instance, young people experience alcohol for the first time during the cultural rituals, where everyone in the family is expected to have a sip of alcohol to be part of the ritual and be recognised by the ancestors. This is difficult to control as it a respectable culture of the area. In addition, at UMhlabuyalingana Municipality within UMkhanyakude district, service providers experience a challenge with the spread of substance abuse which is worsened by the Amarula Annual Festival. The difficulty is that, in this event, everyone is allowed to drink in celebration of the amarula fruit and the age restriction is not adhered to. Since the homemade amarula wine is not registered as an alcoholic drink. The adherence to the age restriction poses a serious issue as the event is supported by a number of governmental departments including the provincial legislature. In both events, many young people get introduced to alcohol and this continues in the consumption of other alcoholic drinks, compounded by the use of illicit substances. The service providers were of the opinion that there must be greater control with the age restrictions being adhered to.

The service providers experienced difficulties with unclassified and/or unregistered substances. It was expressed that that when perpetrators or drug dealers have been apprehended with these substances, they cannot be prosecuted as these substances are not registered as illicit substances. The Liquor Act 59 of 2003 has made a provision for the regulation of micro manufactures of substances to be

regulated by Provincial Liquor Authorities (www.thedti.gov.za), however this doesn't seem to happen effectively in rural areas. This cripples the combat and prevention of the spread of substances within UMkhanyakude district. This situation is worsened by the porosity of UMkhanyakude, as it is bordered by Mozambique and Swaziland. As a result a number of unknown substances are brought in across these borders.

An additional challenge to service providers in the district related to the easy accessibility of substance/ drugs especially cannabis (dagga) which is exacerbated by the home dagga plantations. A number of home brewed substances are also easily accessed, namely, isitambetambe, isiqatha, ibhomane, injemane (palm wine), amaganu (Amarula wine), qo, imbamba, isiZulu etc. This is a challenge during rehabilitation as clients can easily access these substances. The availability of these substances contributes to alcohol and cannabis being the leading substances used in South Africa and more specifically KZN (SACENDU, 2010). The availability of dagga in KZN especially in rural areas, plays a huge role in exacerbating the burden of substance abuse and the prevalence of the homemade substances is not well documented. Notwithstanding this, whilst the magnitude of the problem of substance abuse is known with regular reviews by the South African Centre for Epidemiology in Drug Use (SACENDU), there is limited evidence from the rural areas and details around the home made substances which has affected many people (NMDP, 2014).

In summary, there is easy access and poor regulation of substances at UMkhanyakude district, which is contradictory to the aim of the National Drug Master Plan of South Africa 2013-2017, which stipulates the strengthening of the combat against substances (NMDP 2013-2017). . This resonates with much of the

research in South Africa which has mostly focused on commercial/prescription substances and has overlooked the impact of indigenous substances that has affected mainly the rural and disadvantaged communities. (NMDP 2013-2017) If rural areas of South Africa are well researched, these indigenous substances would be better documented with its impact on overall health and well-being. This may in turn assist in the application of legislation in the registration and control of such substances, towards the greater goal of reducing the burden of substance abuse in the country.

5.3. The impact of poverty on substance abuse service provision

The high rate of poverty was reported by all participants as a challenging factor in their service provision. The district of UMkhanyakude, is rated the second poorest district in South Africa, ranking 51 out of 52 districts (District Health Barometer 2009). In addition, the socio-economic quintile of UMkhanyakude district is regarded as most deprived (District Health Barometer Deprivation index 2007), meaning that it contains people with the lowest socio-economic status. Service providers expressed that lack of occupations including jobs, low education level and the family breakdown caused by high rate of poverty in this district, makes it difficult to render the efficient and quality substance abuse services.

There is a high rate of unemployment and the district is less industrious as a result some people resort to sustainable livelihoods through the selling of illegal substances (home brewed). In addition, there is lack of recreational facilities which results in boredom and then people begin to occupy themselves with substances. Service providers found this very challenging as it is difficult to have diversional intervention programmes to keep the youth “off the streets”. This impacts negatively

on the service delivery within the UMkhanyakude District. The NDMP of 2013-2017 however recognises this problem, and it stipulates that recreational facilities and diversion programmes should be made available to prevent vulnerable populations from becoming substance abusers/dependents (NDMP, 2013-2017). Although, there is this provision at a policy level, the situation at the ground level differs in UMkhanyakude district.

The Department of Sport and Recreation is required to develop and implement prevention programmes against substance abuse in 57 sporting disciplines at regional, national and international level. Hence the South African Institute for Drug-Free Sport (SAIDS) was established in terms of the Drug-Free Sport Act (14 of 1997) to promote participation in sport that is free from the use of prohibited substances or methods intended to enhance performance artificially. The NDMP and Drug-Free Sport Act (14 of 1997) has neglected the deprivation that exists in rural areas. Often there would be one sporting code that is poorly resourced, and due to this lack of resources and recreational facilities, other sporting codes are impossible. This act and NDMP has focused mainly on controlling and ensuring that South Africa has drug free sport in its 57 sporting codes/discipline through SAIDS, but SAIDS doesn't exist in rural sport which appears neglected for instance it was reported that youth uses dagga to enhance their sports performance. There is nothing done about it. Although these are unprofessional sports but SAIDS should extend their services to rural community too.

UMkhanyakude district has been noted to have individuals with very low levels of education due to a number of factors, with poverty having the strongest influence. The situation in this district resonates with Jiloha (2009) that people with low socioeconomic status and educational level have high rate of substance abuse.

This could be a vicious cycle as substance abuse was found to also worsen the situation. The reflections of the participants were that substance abuse exacerbated the high rate of school drop outs and poor school performance. These reflections were in line with findings by Jiloha (2009). Most parents in this area are living in poverty due to poor educational levels (Deprivation Index, 2007), this seems to worsen the vicious cycle of poverty in this area. This was expressed as a challenge and a barrier to effective service delivery as many factors are beyond the control of the service providers.

It was reflected by the service providers that substance abuse in this district leads to family breakdowns. This negatively impacts on their intervention as many service users have poor support by family which decrease compliance to rehabilitation. Some families were said to want to support the substance abuser but cannot afford the costs involved. Other than rehabilitation, this perpetuates substance abuse within families because mostly children of parents who abuse substance lack parental role models so they end up abusing substances too. It was reflected with frustrations that the role models they have are those who abuse substances anyway, so it is difficult for the service providers to divert them, because they see them succeeding through abusing and peddling substances. Although family based intervention is enshrined on the NMDP of 2013-2017, these interventions are limited in this district due to a number of factors including poverty and rurality, as more parents live in cities for work purposes.

In summary the issue around the impact of poverty on service provision is clear in the literature. Murry et al (2011), stated that the quality of one's health is influenced by many factors, including income, education, and area of residence. One can see that this area of rural residence (UMkhanyakude District), as rural poses a unique

challenge to its residents which further impact the service providers and service provision. Given the magnitude and complexities of this issues, a joint effort is required as intervention. This resonates with the National drug Master Plan (2013-2017) as it stipulates that all government, private sector and civil society should play their role in combatting substance abuse. In this regard the department of sports and recreation, economic development and the ministry of Rural Development and Land reforms has a responsibility to look closely at this rural district to minimize the external factors impacting on the burden of substance abuse.

5.4 Lack of resources is a barrier to substance abuse service delivery

The NDMP of 2013-2017, states that “The success of the NDMP depends on the continued support of the government, the provision of the necessary resources and the ability of the CDA, its supporting infrastructure and civil society to deliver the outcomes, outputs and activities needed to meet the needs of the people” however, the rural areas are mainly defined by a lack of resources. According to Eager and Versteeg (2013), rural populations are mostly poor with limited access to social and economic resources to improve their conditions and this results in worse health outcomes. UMkhanyakude district is no different but among the worse off in South Africa (Barometer, 2009). As a result, the service providers experience difficulties in rendering the service due lack of resources within the work place and UMkhanyakude District, in particular lack of infrastructure.

In this district, most government institution and NGOs experience severe staff shortage, shortage/unavailability of equipment/material and lack of funding as their major challenge and barrier to the substance abuse service provision. The lack of resources include the staff shortage. This resonate with Dookie and Singh (2012) that the important barrier in the provision, implementation and sustainability of

district health services is the shortage of key health personnel. Shortage of critical health care personnel continue to prevent nearly 40% of South Africa's population living in rural areas from having full access to good quality health care (Eager et al, 2014). This seems to be worse in rural areas of UMkhanyakude due to a number of strong influences such as lack of funding and resources as expressed strongly by the participants. Such difficult working conditions result to limited service providers interested in working in these rural areas. This is supported by the findings by Zondi (2004) that the challenge of UMkhanyakude District is the shortage of human resources, and overstretching to the existing staff, aggravated by the high staff turnover and failing to recruit new staff.. Other than these difficulties, the public sector continues to be under-resourced and over-used whilst the private sector is increasing in numbers and attracts most health personnel in South Africa (Sibiya and Gwele, 2013).

Their perceptions were that the expected services by policies is incongruent with the resource allocation within the work place. Owing to this, some programmes or services are difficult or impossible to implement, as there is no equipment nor material, such as Kemoja and GROW, to mention a few. This frustrate the service providers as they fail to provide the quality service they intended and expected to. This resonate with Parry (2005), that there is a lack of resources for substance abuse services therefore, there is a need for policy implementation and providing necessary resources to hasten the implementation. The resource allocation should be in line with policies and service standard. Although, in South Africa there is no service standard for substance abuse services, but guidelines by the National Drug Master Plan.

Lack of infrastructure such roads and bridges in this district as whole is barrier to quality substance abuse service provision. The experiences of substance abuse service providers were that at UMkhanyakude District, there are areas that are very hard to reach and the access to services is difficult for both substance abusers and service providers as outlined in 4.4. These are congruent with findings by Zondi (2004), that the main challenge at UMkhanyakude district is the infrastructure backlogs which limit access to certain PHC facilities. This is discussed further in 5.6 There is no rehabilitation facility (private or state funded) within UMkhanyakude District. The nearest government inpatient rehabilitation facilities being Madadeni Rehab in Newcastle and Newlands Park Centre in Durban as well private facilities. All these facilities are more than 350 kilometres away from this district, however are the only option they have for inpatient rehabilitation in spite difficulties as outlined in 5.7. (Fragmented treatment/rehabilitation services. This geographically isolated rural areas of UMkhanyakude District resulted in limited access to quality health care services which is a deprivation of their constitutional right.

In addition to the geographic isolation, service users from this district cannot afford private rehab and the distance to government facilities is difficult. This poses a challenge to the service providers as most families and service users refuse to go to these facilities. This indicate how the lack of resources affect service provision, and highlight the geographical marginalization of rural community. This in line with the study findings in America, which found that social disadvantage and geographic isolation is linked with heightened mental and physical health complications among rural African Americans (Murry et al, 2007). In addition, a study conducted in Cape Town rural areas by Myers et al (2010), indicated the geographic isolation and

financial access as a strong determinants of substance abuse treatment utilization and this results to inequitable access by poor rural South African communities This affects the rural service provision and it is a challenge to the service providers.

As outlined how under-resourced is UMkhanyakude district, like many rural areas of South Africa. Although the South African constitution of 1996, state that all South Africans have a right to the full access to quality, comprehensive health care (Section 27, SA Constitution 1996) but inequalities still exists even after 20 years of democracy. This is also noted by Sibiya and Gwele (2013), that there is huge inequalities in health service distribution and related enabling factors such as staff adequacy and infrastructure. This is worse in rural areas and frustrate service providers, this is supported by Eager et al (2014), stated that, the public health care system in rural areas is mostly under-resourced and access to quality healthcare is severely limited in the marginalised rural communities.

5.5 No prioritization of mental health and substance abuse is a barrier to service provision in rural areas.

The collective perceptions of the service providers exclusively from the department of health, were that substance abuse and mental health programmes are not prioritised as compared to other programmes. These are discussed under two categories, namely, no integration of mental health and substance abuse to primary health care and mental health and substance abuse is regarded as not a focus and not important (neglected). In the department of health substance abuse falls within the programmes of mental health. The neglected was reflected by participants as a

barrier to the quality service and this was noted to exist at low level and up to a provincial level as reflected in 4.5.

The perceptions were that the mental health and substance abuse is treated as a separate programme such that even the basic nursing training does not integrated mental health very well but treated as a specialty after a professional degree. They felt that the training should integrate mental health very early and intensively in the nursing training so that every nurse can implement mental health care like any other programme. It is possible that due to this specialty training in nursing, nursing attitude becomes is that this is a problem for those who specialize on it. As a result it is not my day to day problem. Although, the vision of KZN DOH Substance Abuse and Mental Health is “Mental well-being for all people in KwaZulu-Natal through an appropriate mental health and substance abuse programmes within the primary health care approach” (www.kznhealth.gov.za) but this is not translating to action on the ground level. There is poor integration of mental health and substance abuse in the day to day running of the health facilities. It was reflected by service providers that even simple things like dates of collecting chronic treatment was not integrated, same person will come on different dates to collect mental health treatment and another may be for ARVs etc. In addition, it was reflected that many mental health concerns are overlooked by other health professionals. Their perceptions were that there is a need for in house staff training including the community care givers at a grass root level. This could hasten the integration of mental health to primary health care.

These perceptions concur with Meyers and Fakier (2007) views that South Africa should move towards primary health care approach rather than curative. In addition, these emphasize the need for integration of mental health to primary health care.

Other than this, South Africa is undergoing a strong review of its health services through the preparation for the introduction of the National Health Insurance (NHI) and Primary Health Care Re-engineering. These reviews are aimed at strengthening the health system to increase access to quality care in South Africa's most vulnerable people, especial in PHC (Dookie and Singh, 2012). These should not exclude the mental health

The perceptions of the substance abuse service providers were that the mental health is not given focus neither seen as important programme. This translate to no resource allocation for Mental health and Substance Abuse Programmes this exist from the low level and all the way to the provincial government for instance there are TB, School health Cars allocated at a provincial level and institution level, but there is nothing allocated to mental health services, as reflected in 4.5. This poses a huge challenge in service provision, as in some institution, they fail to do home and clinic visits because there are no cars for mental health, this goes to the extent whereby, even when they have booked the transport but if someone else who didn't book the transport but his/her job perceived more important than mental health they will be given their transport at their expense. So they will have to cancel their trip. These were reflected with frustrations and demoralizing to the service providers. These findings concur with the notion that mental health services in South Africa is neglected by government, although it is a third contributor to disease burden but it is allocate 4% budget (Mokallik, 2013). However, it was noted that the experiences about transport were not the same within it varies from institution to institutions. Some institution had a good running mental health care team that render services at a primary health care level including home visits with minimal challenges with regards to transport. These inconsistencies among institutions resonate with Dookie

and Singh (2012) that the process of implementing and integrating the health system at district level has been slow and inconsistent, as a result some areas are well functioning whilst others are poorly coordinated. This also reflects on the leadership and prioritization of programme during general planning and strategic goals. As it was reflected by a number of participants that mental health and substance abuse is not neglected that it is not given a proper platform for discussion during meetings. This was mostly experienced by the department of health managers, they felt that mental health and substance abuse was in the bottom in the list of priorities for this department health this translate to programme planning where by Mental Health and substance abuse is not given a platform to be discussed or pushed to the end of the agenda by senior managers. These are reflected in 4.5. The managers perceive this a major challenge and a barrier to service provision. It can be argued that this is not done internationally by the senior managers but it is due to the mandate and pressure exerted by the health priority programmes such as HIV, TB, reduce child mortality and maternal health. Other than these factors but the districts in South Africa are not the same so as their challenges. According to Dookie and Singh (2012), the inequalities in the coverage and quality of health services, inequities in resource allocation, with the historical burden of disease shows differences among districts and provinces in level of health care service delivery which is worsened by the burden of the HIV/AIDS pandemic. This disease burden is visible at UMkhanyakude District, the HIV/AIDS and TB are the primary cause of morbidity and mortality (Zondi, 2004). This could be the other reason that the focus is primarily on HIV/AIDS at the expense of other programmes like Mental Health and substance abuse.

5.6 Prohibiting factors to effective substance abuse service provision in the district

The service providers' perceptions are summarized in to two categories, namely, the fragmented treatment/rehabilitation services and poor monitoring and evaluation of services. The perceptions of service providers were that there is poor monitoring and evaluation of substance abuse services at UMkhanyakude District, this is a weakness/disadvantage to their service provision. As a result, there have no monitoring and evaluation tools and there is poor collection of statistics for Substance Abuse Services, such that it is difficult to understand the extent of the substance abuse problem in this district. This was further emphasized by the service providers as one of their challenge in service provision. These experiences are in line with fact that South Africa doesn't have a monitoring and evaluation system for substance abuse services in all levels, national and provincially (Myers et al., 2010). However, there is progress about this, the National Drug Master Plan of 2013-2017 has realised this gap, that the reporting in substance abuse is based on activity conducted as oppose to monitoring and evaluation format. In addition, there is a need for ongoing monitoring which should not only explore the extent of the demand for the service and prevention programmes but in addition should determine trends, patterns and types of drug used by different communities (NMDP, 2013-2017)

This is not only a problem of monitoring and evaluation but indicates, the lack of research in South Africa for substance abuse. Furthermore, the minimal research done so far on substance abuse has neglected the indigenous substances and combination of substances which has affected mainly the rural and marginalized communities of South Africa, the focus has been on commercial and prescription

substances (NDMP, 2012-2016). This research gap and its inequitable focus poses a challenge to the substance abuse service providers in rural areas. This was expressed by a number of participants, that the lack of research on substance abuse rural areas make their work so difficult. Reason being, they don't know the extent of the problem and there is no research to show if their intervention works or not, they cannot even link it to crime statistic in the area. Even though we know that the most leading substance in South Africa is Alcohol followed by Cannabis as indicated by the data produced by the South African Community Epidemiology Network on Drug Use (SACENDU), but there is lack of specific details especial at a district level and rural areas. The perceptions and experiences were shared with requests from the participants that research institution such as UKZN, where the researcher was from must intervene. Research is a good monitoring and evaluation method, this should be strengthened in rural areas. Myers et al (2010) recommended a qualitative research that should explore the meanings and understanding of service providers have of monitoring and evaluation would be important. The findings of the study refute these recommendation, because most participants had a clear understand and meaning of monitoring and evaluation however struggled with putting in to practice. They most emphasize the need to be assisted in this so that they can see the impact of their services. Therefore the findings of this study emphasize the need to explore how the service providers implement monitoring and evaluation of their services in spite of no framework or guide from the policy.

The service providers perceive treatment/rehabilitation services to be fragmented. They regard this as a weakness to their service delivery. As presented in 4.5, this weakness is caused by a number of factors such as there is no

treatment/rehabilitation protocols nor proper systems in place, no aftercare and community based rehabilitation programme and poor/no early treatment/rehabilitation intervention. These fragment the service delivery at UMkhanyakude district which is in line with the substance abuse specialist statement, Dr Parry, that substance abuse service in South Africa continues to be insufficient and poorly distributed geographically, disjointed between department of health and social development (Parry, 2005). Although, the department of health is mandated to reduce the drug demand and harm caused by psychoactive drugs, including alcohol and tobacco, through the formulation of legislation and policy guidelines for early identification and treatment (NDMP, 2013-2017). This was indicated to be problematic because treatment or rehabilitation intervention perceived uncoordinated among different stakeholders however collaboration was stronger in prevention programmes due to a number of enabling factors. This is discussed further in 4.7. The department of social development has mandated SANCA to render treatment, but their services are still limited and extensively smaller and there is minimal and slow extension of treatment services to the previously underserved, disadvantaged majority population (Maiden, 2001). This is evident at UMkhanyakude District, whereby the part of this district was service by SANCA at Nongoma or Empangeni, they both located at Zululand District, which is far from this district, only in 2013 where they have open a satellite office in Jozini. The coverage of the whole district is impossible (as reflected by service providers) such that a number of service providers in other parts of the district were not aware of the existence of SANCA within their district. Some of them reflected the difficulties in referring to this district due to the distance and transport issues. Again, this indicates the inequalities in health care access by South Africans whereby rural

communities are in disparities. This show how resource allocation and policies have been formulated with no considerations of the rural realities.

This is a reality to substance abuse service providers of this particular rural district, they experience insufficient services and geographical isolation from treatment facilities as outlined earlier in 5.4. This frustrate them, and cripples the quality service they intend to provide. In addition to the marginalization, there is long waiting list for admission in Rehab facilities such as Madadeni and Newlands Park Center, which are more than 350 km away. Not only the waiting list and distance was reflected as an issue but these facilities have their own restrictions and prioritise their nearby population. These experiences and weakness are concur with Mayers and Fakier (2007) that the length of waiting lists in KZN remains very long at non-profit and state facilities. This is a challenge of service provider and they perceive this as weakness of their service provision. However, there has been a steady increase in outpatient pattern overtime in KwaZulu Natal, whereby in 2006 it was 65% and 2009 was 82% (SACENDU, 2010). This shows that the province is moving swiftly to relying on outpatient treatment programme. Although there is this move but difficult geographic accessibility continues to marginalise the rural community (Eager et al, 2014). Furthermore, at UMkhanyakude District, there is no community based rehabilitation and after-care program for substance abuse services. This was expressed as another challenge and a weakness to the service delivery. Even after service users have been placed at rehab institution but there is no follow up and community re-integration. This decreases the success rate of substance abuse services and it indicates that the weakness of the service within this district which can be strengthen through refocusing on community based approach intervention. Occupational therapists are the core-members of

community based rehabilitation. In addition, the profession of Occupational Therapy is expanding outside the rehabilitative approach and becoming more proactive in addressing health needs that arise for instance preventative programme, such shift occurs mainly in the community settings (Dorne and Kurferst, 2008). However in the district of UMkhanyakude, they have taken a back seat with regards to substance abuse services due to staff shortage and transport problems. This was expressed by most occupational therapist as a challenge and a weakness to the service provision. Some hospitals in this districts, relies on community service therapist and some with one permanent OT. As a result of staff shortage, they are over-burdened by other cases that takes priority over substance abuse. Although there is a need for Occupational therapy practitioners in community settings to be able to interact with an inter-professional team that includes both professionals and valued community members (Miller and Nelson, 2004), but this is difficult or weak at UMkhanyakude district, nevertheless, there are variations from hospital to hospital. This perceived weakness/barrier by Occupational Therapists concurs with Eager et al (2014) that shortage of critical health care personnel is a barrier that continue to prevent nearly 40% of South Africa's population who live in rural areas from having full access to good quality health care. This indicate the urgent attention by policy makers and senior managers of substance abuse services to find solutions such as recruitment and retention strategies for rural areas.

5.7 Enablers or strengths of the substance abuse services in the district

Even though some of the service providers struggled to reflect on any strengths or advantages but they were identified by many service providers such as good inter-sectoral collaboration and civil society support. In addition, the researcher noted more strengths as well, such as the resilience of a many Substance Abuse Service

providers in this district. As outlined in 4.7, these are discussed in the same sequence below.

The relationship among stakeholders were perceived by the service providers to be good and strong among different stakeholders/sectors, although some are not yet on board. There were two enablers that were identified by the service providers that accelerates the strong relationship, namely, National Drug Master Plan (NDMP) through Local Drug Action Committee (LDAC) and Operational Sukuma Sakhe (OSS) through War-rooms. These were very strong enablers highly praised by almost all study participants. The LDAC, is a committee endorsed by the National Drug Master Plan of South Africa which is a constitutional document for substance abuse by Central Drug Authority (CDA). The LDACs is comprised of each respective municipal departments, NGOs, Community Based Organizations (CBOs), Faith Based Organizations (FBOs) and any other local stakeholders in each municipality (NMDP, 2013-2017). The strength of this rural district is supported by Dookies and Singh (2012), that an effective district health system requires strong leadership and dedication in inter-sectoral collaboration and community participation and empowerment. The inter-sectoral collaboration is an identifiable strength in this district and there is a notable progress in prevention program, however weak on treatment programs and monitoring of services.

The experiences of service providers were that the civil society supports substance abuse service provision of UMkhanyakude District. In addition, the NGO leads the Local Drug Action Committee, mandated by the local municipality. Although, this is contrary to the guidelines by the NMDP of 2013-2017, but seem to have positive results. The success and implementation of NDMP in meeting its goals and activities depends on a number of factors including the civil society support (NMDP,

2012-20117). In addition, community participation and empowerment can be best achieved through equitable resource allocation that respond to specific community needs/challenges and priorities (Dookie and Shenuka, 2012). In spite of the lack of resources, in this district there is very strong community participation in a particular traditional leadership and faith based organizations, as reflected in 4.6. This strengthen the messages sent out to the community during the awareness campaigns as it is collective message with the significant leaders of the community. In rural areas, traditional and faith based leaders are highly respected and valued. As a result, the prevention program is stronger. This is supported by the NDMP of 2013-2017, that community prevention programmes reaching populations in multiple settings (schools, clubs, faith-based organisations and the media) are most effective when presented consistently and collectively in each setting.

As reflected in 4.7 most service providers at UMkhanyakude District are dedicated and motivated against rural challenges, these include lack of infrastructure which result to hard to reach areas such as crossing river with a homemade boat and walking long distances, getting stark in the in sandy road, difficult to locate the homes during home visits etc. Other than their motivation, it is worth noting the innovative approach to the unique challenges of this district, such as making deals with shebeen (places or home selling alcohol) owners. They reported they mostly make deals with shebeen owners to monitor the consumption of alcohol for their old substance abusers so that there is money for the family and the other reason is that they cannot send these old people to a faraway rehab facility who are mostly responsible for a number of grandchildren. This leaves them with no option but to find a way out, although these are crippled by staff shortage as it limit their presence in community. This relate to unique challenges of rural areas of UMkhanyakude

which require unique approach which is not written anywhere neither recognised by policy makers nor legislature. These must be recognised and further for evidence based research so that it can inform policies and legislature. This is in line with the newly reviewed National Drug Master Plan of 2013-17 which emphasize that strategies and solutions must be devised from the bottom up rather than from the top down. In addition, this should include the shift from a national to a community approach which will promote community specific solutions rather than the one size fits all, which is what mostly like is our legislature and policies at the moment.

5.8 Summary

The researcher has discussed the findings that describes the overall experiences and perceptions of substance abuse service providers in relation to literature. These includes the easy access and poor regulation of substances within the district which perpetuate substance abuse, the Impact of poverty on substance abuse service delivery, the lack of resources as a barrier to substance abuse service delivery and no prioritization of Mental Health and substance abuse in the district weakens the service delivery. In addition, some prohibiting factors to effective substance abuse services in the district were noted as well as the enablers or strengths of the substance abuse services in the district. The next chapter will discuss the conclusions and recommendations.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

The study explored the experiences of substance abuse service providers in their service provision at UMkhanyakude District. This chapter will outline conclusions and recommendations from this study. The findings has provided valuable insight about the state of substance abuse service provision in this rural district, as illustrated in the previous chapters.

The findings suggest that challenges were experienced in overall substance abuse service delivery in the rural areas of UMkhanyakude District. These challenges include, culture that exacerbates the use of substance abuse (amarula festival and ancestral worship), high rate of poverty (unemployment and resort to home brewed substance for sustainable living), lack of resources within the respective work places (staff shortage and equipment/cars) and the absence of a treatment or rehabilitation facility within the district. The lack of resources is compounded by the geographical isolation of this district which impacts service provision. In addition, perceptions were that the substance abuse services is poor in treatment or rehabilitation intervention and disjointed among stakeholders, however they perceived their service in preventative programmes as being a strength. Although the non-existence of the rehabilitation facility seemed to be the major stumbling block, there appears to also be no aftercare or community based rehabilitation/community reintegration even when clients return from rehabilitation facilities. Although community reintegration/community based rehabilitation is a huge role of Occupational Therapists (OTs). Perceptions were that it is impossible to provide these services due to inadequate resource allocation, severe shortage

of OTs worsened by being burdened by many other programmes that takes priority over substance abuse. This was in line with the overall experiences and perceptions of department of health service providers that substance abuse and mental health services are neglected and priority is given to other programmes. However, discrepancies in resource allocation and OT staff shortages were noted from institution to institution within the district.

These weaknesses or barriers were worsened by poor monitoring and evaluation of services coupled with lack of research in rural substance abuse, as a result, the magnitude of substance abuse is unknown in this district and rural areas in general. Although there are weakness or barriers there were also strengths or enablers/advantages of substance abuse services at UMkhanyakude District. These included, good inter-sectoral collaboration approach to prevention of substance abuse services, strong support from civil societies and resilient substance abuse service providers against rural realities. The perceptions of service providers were that there were a number of enablers for these strengths such as National Drug Master Plan through Local Drug Action Committee, Operation Sukuma Sakhe (OSS) through war-rooms, and strong support by civil societies such as NGOs, traditional leadership/tribal authorities and Faith Based Organisations (FBOs). Beyond all, the resilience and innovation of a number of substance abuse service providers could not be missed neither ignored. There are some rural substance abuse service providers in some institutions that are motivated and dedicated to deliver the best and relevant service against all odds of UMkhanyakude district. These were noted within their experiences and perceptions, such as crossing the river during low tide with a homemade boat or by feet and walking long distances in hard to reach areas, getting “stuck” in sand roads

and making deals with shebeen owners to restrict alcohol as most substance abusers use all their money there which leaves families in destitute and family breakdowns especially with the elderly. These approaches are responding to unique community needs, which may have a positive impact on service delivery.

6.1 Limitations of the Study

6.1.1 Gate keepers or stakeholders

In spite of numerous efforts in communicating with all gate keepers, the researcher was unable to obtain formal gate keeper permission from SANCA, only verbal permission was given and no formal permission until data collection was completed. As a result, the stakeholder group was excluded from this study. However this may not have impacted the study as four other groups of stakeholders responsible for substance abuse services within UMkhanyakude District were accessed, and due to the qualitative nature of the study as well as that redundancy and saturation was reached.

6.1.2 Study Participants

There were few Psychologists within this district, not all hospitals had a psychologist. In one hospital the psychologist was unable to attend the focus group due to service provision possibly being compromised. A subsequent follow up was also not possible due to an emergency referral for the psychologist. The researcher had planned to have one focus group in each hospital however this was impossible due to understaffed mental health care team and some of participants were not available as data collection was done during work hours. There were no psychiatrist

in this district. Most of their duties are covered by medical officers and psychologists.

6.1.3 Criteria lowered

The criteria of at least one year working experience was lowered because most participants of the department of health, in particular Occupational Therapist did not meet this minimum criteria. Therefore it was lowered to six (6) months. The researcher noted that most of these staff member were employed as community service therapists for one year. Those who had a long stay were not available during the data collection. Therefore, an individual interview with an Occupational Therapist who has five years of working experience at UMkhanyakude. This was to minimize the gap/limitations noted by the researcher.

6.1.4 Generalisation

The results cannot be generalised to the all rural areas of South Africa since there are variations on different rural areas. The facility or resources of substance abuse service providers in this particular rural district many not be the same as in other areas. It is described as one of the two most deprived districts in South Africa according to the District health Barometers of 2007. Furthermore, it is noted that this district may have unique dynamics compare to other rural district as it borders Mozambique and Swaziland, and this may have a different impact in certain areas of UMkhanyakude District. In spite of these limitations, the study findings will contribute in giving baseline evidence of the experiences and substance abuse service provision in a rural South African context. The researcher also did a thick and detailed description of the study location and participants so that the study is replicable in other rural districts that may share the same characteristics.

In conclusion, the researcher made all effort to minimize study limitations where possible. This was achieved through constant communication with the supervisor and cohort supervision so that proper guidance and supervision was received for this research project to be rigorous.

6.2 Dissemination of Findings

The findings of the study will be published in a form of an article in an accredited journal to maximise benefit to the society. A thesis will be submitted for fulfilment of the requirements for a Master degree in Occupational therapy, after the examination process, the thesis will be submitted to the UKZN Library, this will be available online and as hard copy. The completed research report will be made available through presentation in the Local Drug Committee and district forum of UMkhanyakude District and the KZN Substance Abuse Forum. These are the structures where most of the participants and other service providers can be found. In addition, a written short version report and a publication will be emailed to the study participants and all sectors responsible for substance abuse in private sectors and all levels of governance i.e. local, provincial and national (Central Drug Authority) in order to maximize benefit to the society and access to information by relevant stakeholders. Other than these future plans, the researcher has presented the preliminary findings of the study in the Rural Health Annual Conference in Cape Town, September 2014. In addition, the Mercury newspaper has covered an article about this research twice (25th September and 28th October 2014, see annexure 6). Furthermore, the UKZN Indaba online news has covered the study in greater details, see annexure 6, for more information. Moreover, the researcher is hoping to present at an international conference in order to share learnings from a South African perspective.

6.3 Significance of the Study

6.3.1 Improvement of policies for substance abuse services

There remains limited studies on the experiences of substance abuse service providers in South Africa. This study thus intends to work towards bridging this gap, by this exposition in order to provide information that may assist in informing policies, practice and service delivery in rural areas.

6.3.2 Significance to the profession: Occupational Therapy

The findings of this study may contribute to the understanding of the rural and community context where Occupational Therapists render services. This may assist Occupational Therapists in understanding factors that impact on their service provision positively or negatively. In addition, the study fulfils the advocacy role of OT for service delivery (Harzberg and Finlayson, 2001). Furthermore, the findings explore the inter-sectoral collaboration approach to service delivery which is required by Community Occupational Therapists, especially for Community Based Rehabilitation. Moreover, this contributes as preliminary evidence for further research in OT and substance abuse rural services of South Africa.

6.3.3 Improve monitoring and evaluation of Substance abuse services

There is a need to improve research efforts to explore monitoring and evaluation of South African substance abuse services (Myers et al., 2010). Although this study is not distinctly focusing on monitoring and evaluation, however at some level it contributes towards evaluation of the substance abuse services at UMkhanyakude District. This will assist service guidelines reforms.

6.4 Recommendations

6.4.1 Recommendations for Occupational Therapy Services

6.4.1.1 OT Services at a Provincial level

The provincial leadership should strengthen the recruitment and retention strategy for Occupational Therapists in rural areas especial at UMkhanyakude District whereby the substance abuse service is severely affected by the shortage of OTs. In addition, they should develop protocol and service standard for Substance Abuse Occupational Therapy services for after care and community based rehabilitation towards the development of monitoring and evaluation tools for quality improvement rehabilitation services. Moreover, the Provincial Rehabilitation Leadership should consider prioritising OT substance abuse services, and should possibly be part of monthly indicators and statistic reports.

6.4.1.2 OT services at a District and Hospital level

Although there is no provincial or national standard for Substance Abuse Occupational Therapy services; it is recommended that the District Rehab services should develop their own service standard that is relevant and unique to the needs and challenges of UMkhanyakude District Rehabilitation Services. This standard should respond to gaps identified such as after-care and community integration of substance abusers. It is recommended that the focus about substance abuse rehabilitation should shift from hospital based intervention to community based as it was noted that due to compliance to 72 hours of the Mental Health Care Act, most substance abusers do not stay long in hospital, they either referred to rehabilitation facilities or discharged to home. This will also ensure that service users are treated

in their own environment as oppose to institution, which is likely to give better results. In addition, OT vocational rehabilitation programs should be established to improve vocational skills as a measure to expand the adolescent's skills as well as to reduce boredom and poverty within this district.

6.4.2 Recommendations to stakeholders at UMkhanyakude District

6.4.2.1 Recommendations to LDAC and District Substance Abuse Forum

As the study findings has revealed the strength of LDAC and Forum to be on prevention and more limiting on treatment or rehabilitation, .it is recommended that this gap is bridged to improve on assisting those that require interventions as opposed to prevention only. This committee should develop a Substance Abuse Service standard for UMkhanyakude District. The committee should advocate for the establishment of a treatment/rehabilitation facility with this district

6.4.2.2 Recommendations to Civil Societies

NGO: Ophondweni Youth Development Initiative (OYDI)

OYDI should extend service to all areas of UMkhanyakude such as Hlabisa and big five Municipality. Furthermore, perhaps the initiative should advocate for more funding to strengthen its human resource and address the transport issues that limit their services.

NGO: South African National Council on Alcoholism and Drug Dependence (SANCA)

SANCA should extend their service to all areas of UMkhanyakude as they are currently restricted to only one municipality, viz. Jozini Local Municipality.

Faith Based Organization (FBO):

The Faith Based Organisations should strengthen their support and participation to the LDAC.

Traditional leadership/Tribal Authorities:

The traditional leadership should strengthen their support for substance abuse as in some areas there appeared to be poor support. Additionally, they should also strengthen and ensure full participation in LDAC. At UMhlabuyalingana (Tembe Tribal Authority), they must ensure the age restriction in access to alcohol during the Amarula Festival. In addition, education to communities about age restriction during the collection of amarula fruits and brewing its wine is essential to limit access and introduction to alcohol at early age.

6.4.2.3 Recommendations to Government Departments

Department of arts and culture

The department of arts and culture should look at the culture of UMkhanyakude and the impact it has on substance abuse then help to educate especially during the amarula festival where their support is valued by the community.

Department of Sports and Recreation

The department of sports and recreation should increase access to different sporting codes in rural areas and ensure the integration of rural community to sports in general. In addition, they should advocate for construction of sport facilities in rural areas. The South African Institute for Drug-Free Sport (SAIDS) should extend their services to all rural areas of South Africa to ensure drug free sport in rural

areas too than to focus in cities and professional sports only. The indigenous games that are mostly played in rural areas should perhaps be promoted coupled with funding and facilities.

UMkhanyakude District and Local Municipalities

UMkhanyakude District Municipality should ensure adequate sports facilities and increase sporting codes in all its rural areas. In addition, it should provide more support (funds) to sport initiatives, as sport according to the NDMP plays a huge role in keeping youth off the streets. This may contribute to preventing the spread of substance abuse among the youth through constructive activities.

Department of Health (DOH)

The DOH should hasten the integration of Mental Health to Primary Health Care (PHC). DOH should have equitable resource distribution to limit the neglect of mental health programmes. This translates to vehicle allocation at a provincial level and to some institutions for provision of services outside institutions and PHC facilities. The management should strengthen the management as well as the monitoring and evaluation of mental health care programmes. In addition, the development of a substance abuse service standard to improve and move towards quality substance abuse services is needed.

Department of Social Development (DSD)

DSD should allocate more funding to the NGOs (SANCA and OYDI and any other substance abuse services) and strengthen their human resource with skilled substance abuse service providers. This should include advocacy for establishing

a treatment/rehabilitation facility within UMkhanyakude District or nearby area to decrease geographical marginalization.

South African Police Services (SAPS)

The SAPS should strengthen the border control to prevent drug trafficking from nearby countries such as Mozambique and Swaziland. They should additionally address the issue around dagga plantations at home to decrease access to dagga.

The Department of Trade and Industry (DTI)

The DTI through the South African Liquor Authority should hasten the registration and control of home brewed and unclassified substances that is prevalent in most rural areas.

Central Drug Authority (CDA)

In addition to the NDMP, the CDA should develop a National Substance Abuse Service Standard so that the expected standard of service is clear and measurable so that this can be easily monitored and evaluated to accelerate quality service provision to all South Africans.

6.4.3 Recommendations to Rural Health Association of South Africa

The Rural Health Association, such as Rural Doctors Association (RuDASA) and Rural Rehab South Africa (RuReSA) has since launched a campaign addressing mental health, drug and alcohol addictions. It is therefore recommended that the campaign must be strengthened throughout the country and all relevant departments. In addition, Mental Health and Substance Abuse should be given more support by the Rural Advocacy Project (RAPH) which is focusing on advocating for

the alignment of government policies with rural community needs to improve rural health system and ensure equitable access to health services.

6.4.4 Recommendations for further research

The following studies are recommended:

- A longitudinal study is required to explore the home brewed substances impact on health of the abusers at UMkhanyakude District.
- An epidemiological study is required to understand the prevalence of the substance abuse in rural areas of South Africa.
- A study is required to explore the impact of Culture (ancestral worships and amarula festival) in the spread of Substance Abuse at UMkhanyakude District.
- A policy study is required, that will focus in greater details on the implementation of National Drug Master Plan of South Africa in rural areas.
- Research is needed to explore the factors (enablers and barriers) impacting on the service utilisation and access by substance abuser of UMkhanyakude district. This study can be mixed methods study to look at patterns of utilisation and access then qualitative to explore their experiences and perceptions about the service.

6.5 Conclusion

This study has answered its research question about the experiences and perceptions of the substance abuse service providers working in a rural area of KZN, South Africa. Subsequently, it's the aim of exploring their experiences and perceptions in order to identify potential challenges/barriers and strengths so as to

provide information that may inform policies, practices and guidelines for service delivery in rural areas has been addressed. It is evident from the findings that substance abuse service at UMkhanyakude District is stronger on prevention programmes but requires a review and re-focus especially with regards to treatment/rehabilitation, community based and aftercare programmes. In addition, a rehabilitation/treatment facility within the district or nearby is needed rather than relying on cities that are far away which has geographically deprived many people in this rural district. Other than the weaknesses of the service, the strengths that can be used as a benchmark include, innovative interventions like shebeen interventions, in addition to strong inter-sectoral collaboration and strong civil society support. Moreover, the study provided a clear context of the uniqueness of the rural areas of UMkhanyakude District and these must be considered during policy making and service guidelines. Evidently, the rural context has been neglected by policies and service standards for a long time. This will be in line with the National Drug Master Plan of 2013-2017 which encourages the community specific approach than one size fit all and the bottom up approach than a top down approach in policy making and service guidelines.

REFERENCES

1. American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Substance-Related and Addictive Disorder*. Retrieved from <http://www.psychiatry.org/dsm5>
2. Busch C., Maret P. D., Flynn T., Kellum R., Le S., Meyers B., Saunders M., White R., and Palmquist M. (1994 - 2012). Content Analysis. Writing@CSU. Colorado State University. Available at <http://writing.colostate.edu/guides/guide.cfm?guideid=61>.
3. Carpenter C., and Suto M. (2008). *Qualitative Research for Occupational and Physical Therapists: A Practical Guide*. Oxford UK: Blackwell Publishing
4. Creswell, J.W. (2007) *Qualitative Enquiry and Research Design: Choosing Among Five Approaches*. 2nd Ed. London, UK: Sage Publications
5. Chan, Z. C. Y., Fung, Y. L., & Chien, W. T. (2013). *Bracketing in phenomenology: only undertaken in the data collection and analysis process?* *The Qualitative Report*, 18(59), 1-9. Retrieved from <http://www.nova.edu/ssss/QR/QR18/chan59.pdf>
6. Central Drug Authority Statistics (CDA), Statistics 2009, Retrieved on 06 June 2013 from <http://www.timeslive.co.za/local/2011/08/07/don-t-mess-with-cape-town-s-own-dirty-harry>
7. Dookie S., and Singh S., 2012: Primary health services at district level in South Africa: a critique of the primary health care approach. *BMC Family Practice* 2012 13:67. <http://www.biomedcentral.com/1471-2296/13/67>
8. Dorne, R, and Kurfuerst S. (2008) *Productive aging and Occupational Therapy: A look Ahead*. *Special Interest Section Quarterly: Gerontology*, 31(1), 1-4
8. Eagar D., Versteeg M., and Cooke R., 2014, *RHAP Discussion Document*. Retrieved by 21 November 2014 on <http://www.rhap.org.za/rhap-discussion-document-defining-rurality-within-context-health-policy-planning-resourcing-service-delivery/>
9. Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods*, 3(1). Article 4. Retrieved on 10

November 2014 from
http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.pdf

10. Graneheim U.H. and Lundman, B. 2003, Qualitative content analysis in nursing research concepts, procedure and measures to achieve trustworthiness. *Nurse Education Today*, Umea University, Sweden, Umea 90187, retrieved on 10 October 2014 from intl.elsevierhealth.com/journals/nedt
11. Jiloha R.C., (2009) *Social and Cultural Aspects of Drug Abuse in Adolescents*, Department of Psychiatry, MAMC & GB Pant Hospital, New Delhi 110002 DELHI PSYCHIATRY JOURNAL Vol. 12 No.2 OCTOBER 2009 Delhi Psychiatry Journal 2009; 12:(2) Delhi Psychiatric Society
12. Hancock, B. (2002). *Trent Focus for Research and Development in Primary Health Care: An Introduction to Qualitative Research*. Trent Focus. Retrieved on 10 July 2013 from http://www.cbu.ca/pmacintyre/course_pages/.../IntroQualitativeResearch.pdf
13. Hancock B., Windridge K., and Ockleford E. (2009). *An Introduction to Qualitative Research*. The NIHR RDS for the East Midlands / Yorkshire & the Humber
14. Herzberg, G., & Finlayson, M. (2001). Development of occupational therapy in a homeless shelter. *Occupational Therapy in Healthcare*, 13(3/4), 131–144.
15. Havenaar M.j, Geerlings M.I, Vivian L, Collinson M, Robertson B, (2008) *Common mental health problems in historically disadvantaged urban and rural communities in South Africa: prevalence and risk factors*. *Soc Psychiatry Psychiatry Epidemiol* (2008) 43:209–215
16. KwaZulu Natal Department of Health, *Vision and Mission of Mental Health and Substance Abuse Services* retrieved on 03 December 2014 <http://www.kznhealth.gov.za/mentalhealth.htm>
17. Maiden P.L. (2001) *Substance Abuse in the New South Africa, Employee Assistance Quarterly*. Employee Assistance Quarterly, Vol. 16(3) The Haworth Press Florida, reserved Retrieved from http://dx.doi.org/10.1300/J022v16n03_06

18. Meyers, B and Fakier, N. (2007) *Audit of substance abuse treatment facilities in Gauteng and Kwazulu-Natal (2006-2007)*: Technical Report MRC. Retrieved 27 March 2013 from <http://www.mrc.ac.za/adarg/audit.pdf>
19. Myers, B., Harker Burnhams, N., & Fakier, N. (2010). *Monitoring and Evaluation of Substance Abuse Services in South Africa*: Implications for Policy and Practice. *International Journal of Mental Health & Addiction*, 8(4), 557-565. doi: 10.1007/s11469-009-9232-2
20. Myers, B. J., Louw, J., & Pasche, S. C. (2010). *Inequitable access to substance abuse treatment services in Cape Town, South Africa*. *Substance Abuse Treatment, Prevention & Policy*, 5, 28-38. doi: 10.1186/1747-597X-5- 28
21. Mokallik M., (2013) *Mental illnesses neglected by government* retrieved on 03 December 2014 on <http://www.enca.com/south-africa/mental-illnesses-neglected-government>
22. Miller, B., K and Nelson, D. (2004). *Constructing a program development proposal for community based practice: A valuable learning experience for occupational therapy students*. *Occupational Therapy in Health Care*, 18, 137-150.
23. Murry, V., Heflinger, C., Suiter, S., & Brody, G. (2011). *Examining Perceptions About Mental Health Care and Help-Seeking Among Rural African American Families of Adolescents*. *Journal of Youth & Adolescence*, 40(9), 1118-1131. doi: 10.1007/s10964-010-9627-1
24. National Liquor Authority retrieved on 03 December 2014 from http://www.thedti.gov.za/business_regulation/nla_act.jsp
25. National Drug Master Plan 1999, South Africa Central Drug Authority and Department of Social Development 03 June 2013 from www.dsd.gov.za
26. National Drug Master Plan 2013-2017, South Africa Central Drug Authority and Department of Social Development Retrieved on 10 September 2014 from www.dsd.gov.za
27. NEMAI Consulting. (2012). *Umkhanyakude District Municipality (UDM). Environmental Management Framework Report. Socio-economic Assessment Draft, Africa*

28. Parry, C. D. H. (2005). South Africa: *alcohol today*. *Addiction*, 100(4), 426-429. doi: 10.1111/j.1360-0443.2005.01015.x
29. Provincial description KZN 2009 *report of District health barometers* retrieved on 09 June 2013 from http://www.hst.org.za/sites/default/files/dhb0809_kzn.pdf
30. Rice N and Smith P.C, 2001, *Ethics and geographical equity in health care*, , Journal for medical ethics, University of York, pp.256-261.issn06-6800 retrieved on 28 November 2014 from <http://eprints.whiterose.ac.uk/204/>
31. Shi, L. (2008) *Health Services Research Methods* (2nd ed.). United States of America, Delmar Cengage Learning
32. Shenton K.A., (2004) *Strategies for ensuring trustworthiness in qualitative research* *Division of Information and Communication Studies*, School of Informatics, Lipman Building, Northumbria University, Newcastle upon Tyne, NE1 8ST, UK ,IOS Press and the authors
33. Sibiyi N.M and Gwele N. S. (2014) *A model for the integration of primary health-care services in the province of KwaZulu-Natal*, South Africa, Journal of Nursing Management, 2013 Durban University of Technology, Durban, South Africa
34. Sinclair, K. (2014). *World Federation of Occupational Therapy, WFOT Bulletin* Volume 70 November 2014, Yokohama, WFOT Council and Congress retrieved on 2 December 2014 from www.wfot.org
35. South African Community Epidemiology Network on Drug Use (SACENDU) Monitoring Alcohol and Drug Abuse Treatment admission in South Africa 2010 June Update Alcohol & Drug Abuse Research Group Medical Research Council, South Africa, Cape Town
36. *South African Community Epidemiology Network on Drug Use (SACENDU)* Monitoring Alcohol and Drug Abuse Treatment admission in South Africa 2014 February Update, Alcohol & Drug Abuse Research Group Medical Research Council, South Africa, Cape Town
37. Substance abuse act No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, 2008, South African Act retrieved on July 2013 from www.dsd.gov.za

38. Tuckett, A. (2004). Qualitative research sampling-the very real complexities. *Nurse Researcher*. 12(1): 47-61. Ipswich Queensland 4102 retrieved on 11 November 22014 from http://digilib.library.uq.edu.au/eserv/UQ:114279/UQ_AV_114279.pdf
39. Ophondweni Youth Development Initiative (2009) *A drugs and substance abuse incidences, response and impact assessment for the UMkhanyakude District Municipality*, Unpublished document
40. United Nations Office on Drug and Crime UNODC. (2012). *World Drug Report 2012*(United Nations publication, Sales No. E.12.XI.1). Vienna, Australia, retrieved on July 2013 from www.unodc.org
41. United Nations Office on Drug and Crime UNODC. (2014). *World Drug Report 2014* (United Nations publication, Sales No. E.14.XI.7). Vienna, Australia retrieved on October 2014 from www.unodc.org
42. World Bank (2011). *World Bank Development Indicators: South Africa 2011*. Mata data available at http://data.worldbank.org/country/south-africa#cp_wdi.
43. Zondi, T. 2004, Initiative For Sub-District (Isds) Exit Report for Umkhanyakude *District Municipality Kwazulu-Natal Province March 2002 –September 2004 report*, ISDS-facilitator August 2004

Annexure 1: MAPS (PICTURES) OF UMKHANYAKUDE DISTRICT



Figure 1: South Africa Map with UMKhanyakude District highlighted in Red colour

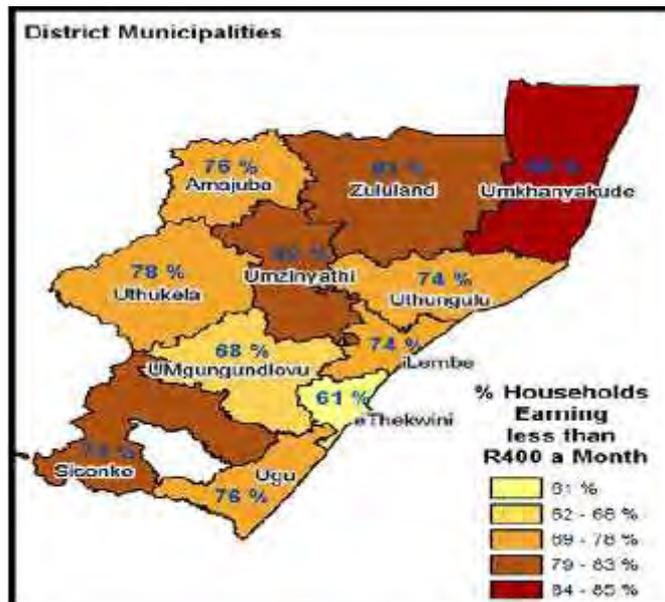


Figure 2: Percentage Household Income less than R400 a month for KwaZulu-Natal District in 2001

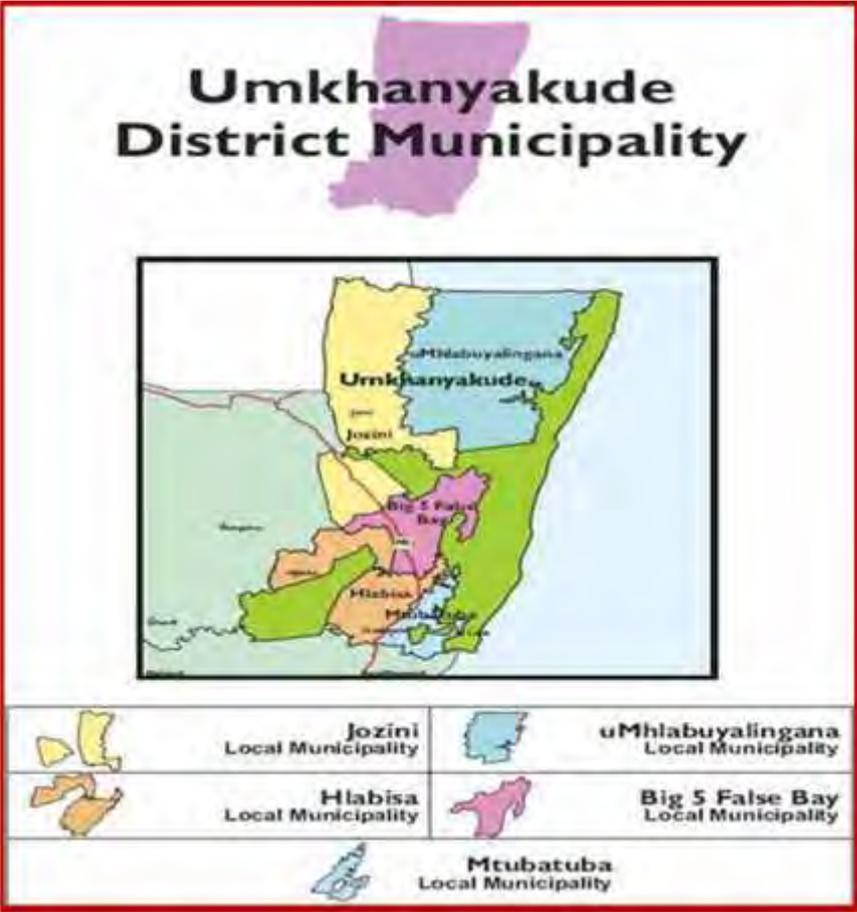


Figure 3: UMkhanyakude District with its five local municipalities.

Annexure 2: GATEKEEPER PERMISSION LETTERS

1. Department of Health:



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel: 033 – 3953189
Fax: 033 – 394 3782
Email: hkrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM79/14
Enquiries : Mrs G Khumalo
Telephone : 033 – 395 3189

Dear Mr D M Mpanza

Subject: Approval of a Research Proposal

1. The research proposal titled '**A study to explore the experiences and perceptions of service providers in provision of substance abuse services for rural areas, South Africa**' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at Umkhanyakude Health District.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hkrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-395 3189.

Yours Sincerely

Dr. E Lutge

Chairperson, KwaZulu-Natal Health Research Committee

Date: 05/07/2014

uMnyango Wezemphilo, Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

2. Department of Social development



social development

Department
Social Development
PROVINCE OF KWAZULU-NATAL

FAX	: 0865965343	208 Hoosen Haffjee, Private Bag X9144
Telephone/ Ucingo /Telefoon	: (033) 264 2178	Pietermaritzburg
Enquiries / Imbuzo / Navree	: Ms. Nolwazi Dlamini	3200
E-mail	: nolwazi.dlamini@kznsocdev.gov.za	

20/03/2014

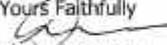
Dr. S Singh
Chair: Humanities & Social Research Ethics Committee
University of KwaZulu-Natal
Govan Mbeki Building
Westville Campus

Dear Sir/Madam

Re: Granting permission for Mr. December M Mpanza to collect data on this study titled: To explore the experiences and perceptions of service providers in provision of substance abuse services for rural areas in South Africa. - Protocol Reference number HSS/0040/014M

1. The above matter bears the reference
2. This letter serves to support the above mentioned study.
3. Mr Mpanza has approached the Department of Social Development requesting the permission to conduct the interviews with NPO/NGOs and Social Workers
4. The District & Offices are as follows:
 - uMkhanyakude :
 - Manguzi Office
 - Mbazwana Office
 - Mboza one stop centre
 - Ngwavuma Office
 - Obonjeni Office
 - Kwamsane Office
5. In a summary, Department Social Development has the authority to oversee and work with NGOs/NPOs in the Province.
6. Your cooperation will be highly appreciated.

Yours Faithfully


Nolwazi Dlamini

3. Ophondweni youth Development Initiative



Follow the light

**Ophondweni Youth
Development Initiative**

P.O. Box 77446, Jozini 3969 **Tel/Fax: (035) 572 5082 TWP/No: 044-074
E-mail: gsco@oynidv.co.za



To: University of Kwa-Zulu Natal (December Mpanza)
From: Ophondweni Youth Development Initiative;
Subject: Re-acceptance of Research Project.
Sir

Kindly accept the letter of acceptance of the drugs and substance abuse research project as it was planned. But note that there are other elements of your research that I think would add value to the current responses and assist Ophondweni Youth Development to increase its impact in the fight against drugs and substances. One of the challenges the area is facing is the prevalence of home brewed wines like Marula, Palm wine and concoctions which brews cocktail of beers made of different substances. This result to poor health more especial to women, youth and children who seem to be the victims of this practice. Let alone the role of legislative enforcement Agencies who seem to be failing stop or arrest such community practices.

Drugs trafficking from Swaziland and Mozambique and local produce dagga further accelerate risk of teens and youth to experiment with these substances. I therefore which to request that your research tools should assist in extracting some of these issues needed to assist service providers with information necessary enough to understand the drugs dynamics of our community. We would be grateful to share this with Anti-Substance abuse forum at the District Level of our community. Your research project is appreciated

Thanking in advance

Sihambiso Mponshane
Centre Manager

Annexure 3: ETHICAL CLEARANCE CERTIFICATES

1. Provisional Ethical Clearance



28 January 2014

Mr December M Mpanza (205502205)
School of Health Sciences
Westville Campus

Dear Mr Mpanza,

Protocol reference number: HSS/0040/014M

Project title: A study to explore the experiences and perceptions of service providers in provision of substance abuse services for rural areas, South Africa

Provisional approval – Expedited

This letter serves to notify you that your application in connection with the above has been provisionally approved, subject to necessary gatekeeper permissions being provided, including the following being addressed and returned to the Research Office:

1. Information Sheet (Annexure E): HSSREC Research Office contact details to be included
2. Information Sheet (Annexure E): Time duration to be indicated
3. Annexure F: HSSREC Research Office contact details to be included

This approval is granted provisionally and the final approval for this project will be given once the above condition has been met. In case you have further queries/correspondence, please quote the above reference number.

Kindly submit your response to the Chair: Dr Shenuka Singh, Research Office as soon as possible

Yours faithfully

Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Ms Pragashnie Naidoo
cc Academic leader Research: Professor JH van Heerden
cc School Administrator: Ms Phindile Nene

2. Conditional Ethical Clearance



14 April 2014

Mr December M Mpanza (205502205)
School of Health Sciences
Westville Campus

Dear Mr Mpanza,

Protocol reference number: HSS/0040/014M

Project title: A study to explore the experiences and perceptions of service providers in provision of substance abuse services for rural areas, South Africa

Conditional Approval - Expedited

I wish to inform you that your application in connection with the above has been conditionally approved, subject to your supervisor overseeing the following:

- Gatekeeper permission letters (SANCA – Nongoma Branch)

Data collection may commence on the following sites:

- Department of Health – Umkhanyakude Health District
- Department of Social Development – Umkhanyakude District
- Ophondweni Youth Development Initiative

Please forward all outstanding documents through to the Research Ethics Office, Westville Campus

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully

Dr S Naidoo (Deputy Chair)

/ms

Cc Supervisor: Ms Pragashnie Naidoo
cc Academic leader Research: Professor JH van Heerden
cc School Administrator: Ms Phindile Nene

3. Full Ethical Approval



05 December 2014

Mr December M Mpanza (205502205)
School of Health Sciences
Westville Campus

Dear Mr Mpanza,

Protocol reference number: HSS/0040/014M

Project title: A study to explore the experiences and perceptions of service providers in provision of substance abuse services for rural areas, South Africa

Full Approval – Expedited Approval

With regards to your response received on 11 November 2014 to our letter of 14 April 2014. The documents submitted have been accepted by the Humanities & Social Sciences Research Ethics Committee and **FULL APPROVAL** for the protocol has been granted.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenika Singh (Chair)

/ms

Cc Supervisor: Ms Pragashnie Naidoo
cc Academic leader Research: Professor JH van Heerden
cc School Administrator: Ms Phindile Nene

Humanities & Social Sciences Research Ethics Committee

Dr Shenika Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Annexure 4: INFORMATION DOCUMENT AND CONSENT FORMS

1. Information Pamphlet

Discipline of Occupational Therapy
School of Health Sciences
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: 031 260 7821



UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

Research Title:

A study to explore the experiences and perceptions of service providers in provision of substance abuse services for rural areas, South Africa.

Purpose of the study

This study aims to explore the experience and perceptions of service providers in the provision of substance abuse services (promotion, prevention and treatment programmes) in a rural area in order to inform police practice for service provision, strategic/service planning and improvement of substance abuse services in rural areas. Furthermore the study is conducted in fulfilment of the requirements for Master of Occupational Therapy for the researcher

Description of the study

This study has been approved by the University Of KwaZulu Natal Ethics Committee and the permission to conduct the study has been obtained from your institution, see attached proof. If you are willing to participate to this study, you have been informed of your rights and responsibilities of the researcher, as well as the

process of the study, thereafter you will be required to sign the Consent Form. In this study you will participate in a focus group and/or individual interview, where you will be requested to answer questions in relation to your experience and perceptions of substance abuse services service delivery in rural areas. The information gathered from this process will be transcribed through verbatim procedure then analysed for the completion of this study. Thereafter a publication will be done and communicated back to you and published for societal benefit and improved service delivery

The following principles are considered:

Benefits

Through your participation in this study, new knowledge and insight to the experience of service providers working in rural areas will be understood in a greater light resulting to improved service delivery of substance abuse services in rural areas.

Participation and Withdrawal

You have a right to choose to participate to the study without any coercion and can withdraw at any given point without incurring any repercussion or any form of victimisation, non what so ever.

Risks

The risk in this study is minimized as there are no procedures that involve body contact with thus will. However should you feel your safety and welfare is threatened in any manner, you have every right to make the researcher aware and decide whether to withdraw or continue with the study.

Confidentiality

Confidentiality will be ensured throughout the study. Your identity will not be disclosed neither published in any form. The information gathered will be used for data analysis in this study only. Furthermore the information will be kept in a lockable storage that is accessible by the researcher and the supervisor.

Transparency and Honesty

The researcher will not withhold any relevant information from you. And will do best to answer questions or give clarity where needed in an honest and transparent manner.

Complains/ concerns or queries channel

As mentioned above the participation is voluntary and you may withdraw at any point without any explanation or incurring consequences. If you are interested in participating on the study please complete the **Consent Form for participation in the Study attached**.

Should you require further information about this research project or any concerns, you may contact the researcher or supervisor of the project (details provided below). In case you are not satisfied with either of them you may escalate your query or concern to the Postgraduate Administrator (details provided below)

Your participation is greatly appreciated.

Yours sincerely,

Mr December M Mpanza, BOT (UKZN)

Researcher/Master Candidate

Ms Phindile Nene

Postgraduate Administrative Officer

Tel: 031 2608375/ Cell: 0828442938

E-mail: Mpanzad@ukzn.ac.za

Tel: 031 2608280

E-mail: nenep1@ukzn.ac.za

Ms Pragashnie Naidoo BOT (UDW);

MOT (UKZN), CAMAG (ABIME)

Research Supervisor

Tel: 031 2608258

E-mail: naidoopg@ukzn.ac.za

Ms Phumelele Ximba

Human Social Science Research

Ethics Administrative Officer

Tel: 031 260 3587/ Fax: 031 260 4609

Email: XIMBAP@ukzn.ac.za

3. Informed Consent Form

Discipline of Occupational Therapy
School of Health Sciences
Postal Address: Private Bag X54001, Durban, 4000, South Africa.
Telephone: 031 260 7821



Research Title

A study to explore the experiences and perceptions of service providers in provision of substance abuse services for rural areas, South Africa.

I, _____ hereby confirm that the study has been clearly explained to me and any concerns or questions has been answered to my satisfaction furthermore any questions arise along the way will be addressed. I'm aware that my participation is voluntary as a result I can withdraw at any given point without any penalties non what so ever. I understand my identity or any information that identifies me will be kept confidential.

I am aware that should I have any questions or concerns, I can raise them directly to the researcher Mr DM Mpanza in person or via email or Mpanzad@ukzn.ac.za Cell no 0828442938/ tell: 0318442938. I understand I have the second option to contact the research supervisor Ms P Naidoo via email Naidoopg@ukzn.ac.za or 0312608258. In addition In case I am not satisfied with either of above mentioned individual, I may escalate my query or concern to the Postgraduate Administrator,

Ms Phindile Nene via email E-mail: nenep1@ukzn.ac.za or Tel: 031 2608280 or to the Human Social Science Research Ethics Administrative Officer, Ms Phumelele Ximba on Tel: 031 260 3587/ Fax: 031 260 4609 or Email: XIMBAP@ukzn.ac.za

I have been apprised of my rights and the researcher responsibility. I have read and understood the information pamphlet and the contents of this form. Therefore I hereby give my consent freely by signing to take part on this study. I am aware that signing this form does not exempt the researcher from ethical responsibility, professional conduct and institutional responsibility as well as my right to withdraw at any given time is not forfeited

I consent to participation in the study

I consent to discussions being digitally-recorded

Signature of Participant

Date

Witness Signature

Date

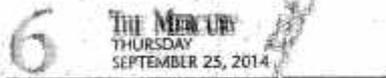
Annexure 5: QUESTIONS FOR INTERVIEWS AND FOCUS GROUP

As a phenomenological study design, six broad questions were asked followed by probes depending on the interview progress:

1. What is your experience as a substance abuse service provider working in rural areas of UMkhanyakude District?
2. What are the strengths/advantages of substance abuse service provision at UMkhanyakude rural areas?
3. What are the challenges/disadvantages of substance abuse service provision at UMkhanyakude rural areas?
4. What is your experience in working with other stake holders in substance abuse service delivery?
5. Any comments about the substance abuse services you provide at UMkhanyakude district?

Annexure 6: MERCURY NEWSPAPER COVERING THIS STUDY

1. Mercury News after conference in Rural health Conference In Cape Town 25 September 2014



Push for improved mental health

Wilma Stassen

HEALTH organisations have launched a new push to address what some have called a "mental health pandemic" fuelled by drug abuse.

The Rural Doctors Association for South Africa, Rural Rehab South Africa and other health organisations launched the Rural Health Advocacy Campaign yesterday at the close of the Rural Health Conference in Worcester in the Western Cape. The campaign aims to advocate for mental health services and addressing drug and alcohol addiction.

"We are facing a mental health pandemic," said Rural Rehab South Africa chairwoman Kate Sherry. "It's everywhere, and the health system is not prepared to deal with it."

Although statistics were inconsistent, it was estimated that 15 percent of South

Africans were affected by drug abuse – double the world average, said University of KwaZulu-Natal researcher and occupational therapist December Mpaza.

Alcohol, cannabis, heroin and mandrax were among the most abused substances, he said.

Mpaza investigated drug abuse in KZN's northern Umkhanyakude district. He found that a range of issues including poverty and a lack of opportunities fuelled abuse.

Mpaza said unregistered stimulants from China were being sold in shops. Illegal substances were also coming in from Mozambique and Zimbabwe.

"Dagga is so common that many parents don't see it as a problem and don't discourage their children from using it," Mpaza said.

"Some cultural practices

promote the use of substances," he said.

Extreme poverty and few job opportunities – coupled with low levels of education – also led people to brew and sell substances, or use substances because "there is just nothing else to do".

However, Mpaza paid tribute to the extraordinary efforts of health-care workers to help patients who had sought help to deal with substance abuse.

In some cases they negotiated with the shebeen owners to limit the amount of money some patrons spent at their bars to help patients regulate their consumption and the amount of money they spend.

"One area is so remote that the health-care workers have to take a boat to get there... When the tide is low, they have to walk more than a kilometre in knee-deep water to reach the community." – Health-e News



Study calls for closer look at substance abuse in rural KZN community

LUNGA MEMELA

A STUDY conducted by a Senior Tutor of Occupational Therapy (OT) at the University of KwaZulu-Natal (UKZN) has raised awareness about the incidence and consequences of substance abuse in the uMkhanyakude District of KwaZulu-Natal.

Mr December Mpanza presented the findings from his masters research at the 18th Rural Health Conference in Cape Town, saying that substance abuse remains a neglected issue in rural areas. Mpanza's study was titled:

"Rural Health Realities Versus Substance Abuse Service Providers in South Africa".

Mpanza grew up in Mbazwana near Sodwana Bay in the uMkhanyakude District of northern KwaZulu-Natal. He studied at UKZN and then worked at Bethesda Hospital in the uMkhanyakude Health District before returning to UKZN to further his studies.

He observed that substance abuse ruined the lives of many youngsters and the people around them, and also placed a huge burden on

health care providers, increasing treatment demands when in fact the problem could be prevented at its roots.

This inspired him to register for a masters degree in Occupational Therapy and to revisit the uMkhanyakude rural district to try to solve some of its ongoing challenges.

Mpanza defines substance (drug) abuse as the sustained or sporadic excessive use of substances, including those considered illicit and unlawful. He said it was a major challenge in the

uMkhanyakude district because substance abuse-induced psychosis was rife, leading to further problems within the community.

Mpanza says mental health is neglected and not integrated to primary health care and this needs urgent attention from the relevant government departments.

He said several factors caused substance abuse in the district, including the fact that youngsters took drugs because of peer pressure, stress and unemployment.

Not only were the common drugs readily available to the

community but local traditions and culture also contributed to the problem as in some instances youngsters were expected to sip traditional brew as a way of respecting the ancestors during traditional ceremonies. In this way, young people were getting exposed to the alcohol, Mpanza explained.

Another concern was that there were local festivals, such as the Amarula Festival, where drinking alcohol is promoted. "It is critical to ensure that the age limit for consuming alcohol is always strictly enforced," he said.

As a way of addressing these challenges and honouring his role as a researcher, he plans to share his findings and disseminate all information with the relevant people and departments, including traditional leadership and the Department of Arts and Culture.

"Research is liberating, therefore it is important that the message is crystal clear to authorities and policy makers so that when they make policies they are sensitive to rural health. It is important to push the agenda of what is

happening in the rural areas and provide solutions," Mpanza explained.

Mpanza, who is a member of Rural Rehab South Africa, said he was grateful that UKZN's OT Discipline and College of Health Sciences granted him time and funding to conduct his research in the uMkhanyakude District.

"It is a challenge to do research in rural areas. Time is a limiting factor and costs can become excessive."

Mpanza intends pursuing his PhD next year and will again focus on rural health as it is his passion and concern.



Rural Health advocate, December Mpanza.