



COLLEGE OF HUMANITIES
SCHOOL OF APPLIED HUMAN SCIENCES

Understanding the Bio-psychosocial effects of whoonga use by youth
in KwaMashu Township, north of Durban

By

Nkululeko Mphumeleli Khumalo
9700575

Supervisors: Professor Kasiram and Mrs Mathe

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DECLARATION OF ORIGINALITY

I, **Nkululeko Mphumeleli Khumalo**, hereby declare that this thesis for the Master of Social Work degree at the University of KwaZulu-Natal, hereby submitted by me has not previously been submitted for a degree at this or any other institution, and that it is my own work in design and execution. All reference materials contained therein have been duly acknowledged.

Signature _____ **Date** _____

Submitted with approval of the Supervisors: **Mrs Sibonisile Mathe**

Professor Rugnath Kasiram

Signature: _____ Date: _____

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DEDICATION

This dissertation is dedicated to my lovely wife, Nolundi and my children, Sibaphiwe Luyolo and Lilitha Sisipho who were so understanding, patient and supportive throughout the study.

ABSTRACT

Drug addiction is a chronic disease with users suffering bio-psycho and social effects. Whoonga is a relatively new addition to the drug market. The devastating effects on the lives of young people using whoonga have not been adequately explored and understood. Although, substance use is a world wide problem, the literature dealing with whoonga use is somewhat out dated or irrelevant. The classification of the substance as dangerous by the media in 2014 suggests that there is a need to establish clear danger levels as well as the effects of its use. This study thus aimed to gain a holistic and multi dimensional understanding of the effects of whoonga use by youth in KwaMashu Township, north of Durban.

A qualitative research methodology and the bio-psychosocial approach were employed to understand whoonga addiction. The participants were purposively selected. Social workers and nurses at the KwaMashu outpatient treatment centre screened and referred those who were interested in participating in the study. Data collection was conducted at the centre by means of semi-structured interviews. Only willing and voluntary research participants participated. Ten male whoonga users were interviewed. All the interviews were audio recorded and transcribed after data collection, and thematic content analysis was employed.

The major findings of the study were that whoonga addiction has no age limit and awareness, prevention and treatment programs should thus target all age groups; whoonga users suffer bio-psychosocial effects and become trapped in bio-psychosocial problems such as addiction, vulnerability to HIV infection, low self-esteem, anger and aggression, isolation by families and communities; they become involved in criminal activities and they have slim chances of being employed. These findings highlight the need for community-based awareness, treatment and supportive programs.

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CHAPTER ONE

CONTEXTUAL AND THEORETICAL FRAMEWORK FOR THE STUDY

1.1. INTRODUCTION

Whoonga use is a topical issue in South Africa and is portrayed in the media as destructive and damaging to young people. This study aimed to gain insight into the bio-psycho and social effects of whoonga use among youth in KwaMashu Township north of Durban. This chapter introduces the study by focusing on the background and rationale for the study, its significance, aims and objectives, and theoretical framework. It also discusses the study location, defines the major concepts and outlines the structure of the dissertation.

1.2. BACKGROUND AND RATIONALE FOR THE STUDY

The South African media has reported on the escalating use of illegal drugs by young people in the country (City Press, 2014). A drug called whoonga was reported to be the new popular drug that is abused by young people. In a bid to increasing awareness of this new drug a television documentary show, “The Cutting Edge” interviewed whoonga users and highlighted concerns over the escalation of its use and its effects in the Durban-Glenwood area (SABC 1:2014). The documentary revealed an alarming increase in the number of young people using whoonga and the rise in prostitution among young adult females who use this drug. This insight prompted my interest in undertaking this study. As a social worker, I felt that it was important to take a closer look at these social problems that were reported to be impacting negatively on the lives of young people.

According to Mokwena and Huma (2014); Moodley, Matjila and Moosa (2012); Zyl (2014); and Nkoma and Bhumura (2014), the use of psychoactive drugs in South Africa, particularly whoonga, has increased drastically in the past nine years. Morojele, Rich, Flisher and Myers (2012) also report that there has been an increase in the range of illegal drugs in South Africa since 1994. It can thus be concluded that substance abuse among young people as well as the availability of illegal drugs in South Africa is increasing.

Grelotte, Closson, Smit, Mabude, Matthews, Saften, Bangsbergan and Mimiaga (2013) and Chinouya's (2014) study in Inkwazi, KwaZulu-Natal found that 24.7% of whoonga users between the ages of 15 and 49 were infected with the Human Immuno deficiency Virus (HIV) through drug use. Zastrow and Kirst-Ashman (2004) concluded that substance abuse was a major contributor to crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability, the escalation of chronic diseases such as HIV/AIDS and Tuberculosis (TB), injury and premature death. The increasing use of whoonga has challenged health and social work professionals. Insight into how whoonga impacts on people's lives and how addiction to whoonga intersects with other social problems is important. This study thus explored the biological, psychological and social effects of whoonga drug use which included understanding the effects associated with addiction.

In response to the emergence of whoonga around the year 2000, the South African Drug and Trafficking Act was amended in March 2014 to declare it an illegal drug (Government Gazette, 2014). This also encouraged the researcher to focus whoonga's effects. The fact that this drug was classified around 2014 as a "dangerous" one prompted my interest in gaining understanding on why this is the case. The National Drug Master Plan (NDMP) 2013-2017 noted that the South African Revenue Service found that drug use in 2005 was estimated to be worth R101 000 million. All of these pronouncements show that substance abuse is a major social problem in South Africa; hence the need for this study and for treatment of substance abuse. The NDMP (2013-2017) also notes the emotional, social and financial implications arising from drug usage that affect the immediate family of abusers. This heightens concerns about the escalation in drug usage since 2005, limited knowledge about the drug's dangers to whoonga users and the struggle of dealing with its effects.

At a personal level, my experience of counseling young offenders that use whoonga encouraged me to conduct the study. The increase in the number of young offenders addicted to whoonga raised the following concerns and questions: what causes young people to use whoonga and how does it affect them during and after usage? I thus sought to gain a broader perspective on the causes and effects of whoonga use. Chapter two discusses this in further detail.

In exploring and understanding the causes and effects of whoonga usage on young people, the study gave young users the opportunity to share their perceptions of the bio-psycho and social effects of addiction. The data gathered were critically analyzed in order to determine the causes of the high rate of drug use and expose misconceptions about whoonga. It is hoped that the study will contribute to the promotion and evaluation of effective treatment programs and improved policies.

1.3. SIGNIFICANT OF THE STUDY

The classification of whoonga as dangerous in 2014 suggested the need to establish clearer danger levels than are noted in the available literature. The current literature focuses on the factors that lead to whoonga use rather than the psycho and socio-emotional impact. The study sought to bridge this gap by sharing young whoonga users' experiences. Its findings will inform substance abuse treatment policy, program planning and intervention programs by the social work profession, nurses, the Department of Health, non-governmental organizations, policy makers and other stakeholders. Research on the bio-psychosocial effects of whoonga use by young people will assist in developing more empathetic approaches to deal with the issues that cause them to use the drug. The study will also encourage other researchers to conduct further studies on the effects of whoonga.

1.4. MAIN AIM OF THE STUDY

The aim of the study was to understand the bio-psychosocial effects of whoonga use by youth in KwaMashu Township.

Objectives and Key questions

The following table summarizes the study's objectives and questions.

Objectives	Questions
1. To explore the common reasons for whoonga usage among young users at a selected drug centre.	What are the common reasons that lead young people to use whoonga?
2. To determine the bio-psychosocial effects of whoonga usage.	What are the bio-psychosocial effects of the drug?
3. To explore available support programs for whoonga addicts.	What support programs are available for whoonga addicts?

1.5. THEORITICAL FRAMEWORK

The bio-psychosocial perspective was adopted as the theoretical framework for this study. This theory was relevant since the research questions focused on the biological, psychological and social effects of whoonga use. According to Johnson (2004), the bio-psychosocial perspective assesses problematic life areas across the spectrum of different experiences as well as acknowledging human motivation. Both these aspects were important for this study because they assisted in understanding the participants' life situation with regard to different experiences, outcomes and support services and enabled the identification of intrinsic motivational factors for the use of whoonga.

The bio-psychosocial perspective has a relationship with various theories of social learning and rational choice theory. This made this perspective appropriate in understanding the complex experiences of whoonga users as the theory is a broad perspective emanating from other well established theories. Griffiths (2005) and Huffman (2004) argue that all three components, biological, psychological and social, need to be present in order to define substance use as addictive. The study used these three components to understand whoonga use as a disease.

Griffiths (2005) identified three factors associated with whoonga effects that are in line with the bio-psychosocial approach.

The biological factor focuses on the physiological effects of whoonga such as physical dependence and medical problems. According to Gibbons, Huang, Iversen, Roth, Setola, and Treble (2013) and Mokwena and Huma (2014), biological effects include toxicity of the nervous system, deteriorating personal hygiene, slow movement, severe cravings and a dazed look. The participants in this study exhibited these effects as well as psychological and social impacts.

The second factor is psychological, which focuses on the mental effects of using a substance. Smith (2014:2) defined “psychological dependence as associated with cravings, loss of control and compulsions which may refer to substance seeking behavior.” Van Wormer and Davis (2008) and Gray (2010) note that psychological dependence involves the thinking and mental processes that lead to drug addiction. Irrational thinking might be related to depression or anxiety and could encourage drug use in order to escape from the psychological ills the person is facing. This study thus aimed to understand the psychological impacts of whoonga use and possible mental influences on such use.

The third factor is the structural or social issues that focus on social or environmental causes. According to Sawyer (2006) and Smith (2014) social factors include crime as a motivation to use whoonga like selling stolen goods and perpetrating its habitual use, absenteeism and disorientation in social functioning. Gray (2010) supports this view by stating that the social aspects of the bio-psychosocial model entail environmental and structural factors that lead to drug use. This study interpreted environmental factors to mean drug users’ immediate environment. Wechsberg, Luseno, Karg, Young, Rodman, Myers and Parry (2008) argue that the social effects of whoonga are determined by race and geographical differences. Zastrow and Kirst-Ashman (2004) observe that drug usage is influenced by many structural injustices like race, economic status and gender discrimination.

Friends and family may be directly or indirectly involved in a person's drug use. In exploring the social factors, this study sought to understand the role played by factors such as gender, poverty, and the social or environmental effects of whoonga use and the structures promoting the abuse of drugs.

The three components of the bio-psycho-social model are thus the key in understanding the effects of whoonga. Taken together, biological, psychological and social factors create the conditions for addiction. Gray (2010) notes, that, the systems theory influenced the integration of these factors into the bio-psycho-social model. The current study also explored the support structure available to whoonga users.

1.6. LOCATION OF THE STUDY

The study was conducted at the KwaMashu outpatient treatment centre, which is located in KwaMashu Township, north of Durban. Recovering whoonga addicts receive multi-treatment programs during week days at the centre, including medical treatment and counseling. The centre was selected as it accommodates recovering whoonga users from the area. It has well-structured offices that offered a suitable environment to interview the participants and maintain their anonymity. Management at the centre sanctioned and approved the study.

The centre is well-resourced with a multi-disciplinary professional team consisting of social workers and nurses, offering an opportunity to gather rich data to explore the research problem. Gatekeeper's permission was obtained from the director to conduct the study at the centre. Ethical clearance was subsequently secured from the University of KwaZulu-Natal.

1.7 DEFINITION OF MAJOR CONCEPTS

1.7.1. Addiction

Doweiko (2006:3) states that addiction is "a progressive, chronic, primary, relapsing disorder that involves features such as compulsion to use a chemical, loss of control over the use of a substance, and continued use of a drug in spite of adverse consequences caused by its use."

1.7.2. Drugs

“Refers to psychoactive or dependence-producing substances and often, more specifically, to those that are illicit” (NDMP, 2013-2017: 17).

1.7.3. Drug Abuse

“The use of a drug in such a manner or in situations such that the drug uses causes problems or greatly increases the chance of problems occurring.” (Ray and Ksir, 2004).

1.7.4. Substance Abuse

“The misuse and abuse of legal or illicit substances such as nicotine, alcohol, over-the-counter and prescription medication, alcohol concoctions, indigenous plants, solvents and inhalants, as well as the use of illegal or illicit substances” (National Drug Master Plan-NDMP, 2013-2017: 19).

1.7.5. Whoonga

Mokwena and Huma (2014:353) defined whoonga as a “new cocktail substance which contains illegal substances like Cannabis, Methamphetamine, Heroin, house hold products like detergent, rat poison (strychnine), Antiretroviral (ARV) medication and sugar which produce hypnotic effects.” The Oxford Dictionary (2016) defines whoonga as a combination of nasty chemicals including detergent powder, rat poison and sometimes crushed antiretroviral drugs. Thomas and Velaphi (2014) define it as a new addictive drug created from combining ARV pills, detergent powder and rat poison.

1.7.6. Youth

According to the National Youth Policy youth are young people between the ages of fourteen (14) and thirty five (35) (National Youth Commission, 2002). The Oxford Advanced Learner’s Dictionary defines youth as the time when a person is young, especially the time before a child becomes an adult. The South African Concise Oxford Dictionary defines youth as the period between childhood and adulthood.

1.7.7. Human Immunodeficiency Virus (HIV)

The Centre for Disease Control (2001) defines HIV as a virus that enters the body from outside and attacks the immune system which protects it. Van Dyk (2008) defined HIV as a virus that enters and weakens the immune system so that it can no longer fight it.

1.7.8. Acquired Immune Deficiency Syndrome (AIDS)

Van Dyk (2008) defines AIDS as a disease that is acquired and that weakens the immune system so that it can no longer defend itself against passing infections. Nefale (2004) defined AIDS as the disease that causes severe loss of the body's cellular immunity, greatly lowering resistance to infection and tumours.

1.7.9. Rehabilitation

Van Heerden (2005) defines this as the act of starting to consider that somebody is good or acceptable after a long period during which they were considered bad or unacceptable.

1.8. STRUCTURE OF THE DISSERTATION

Chapter 1: Introduction and Background of the Study

This chapter presents an introduction, and the background and rationale for the study. It discusses the problem statement, the study's aims and objectives and the theoretical framework employed. The chapter concludes by examining the location of the study, defining the major concepts and outlining the structure of the dissertation.

Chapter 2: Literature Review. Whoonga's effects and support programs

This chapter reviews the literature on substance abuse and support programs. It examines the nature of whoonga, substance use globally and in South Africa, the availability of whoonga in KwaZulu-Natal and Durban, rehabilitation resources, bio-psychosocial factors, and the effects of drug use as well as HIV/AIDS.

Chapter 3: Research Methodology

The chapter focuses on the research methodology used in the study. It discusses the research approach and research design, briefly describes the research site, and highlights the sampling method and process, data collection methods and instruments, data analysis, trustworthiness, ethical considerations and the study's limitations. The chapter thus describes how the research was conducted and the rationale for the methodology adopted based on the literature reviewed.

Chapter 4: Presentation and Discussion of the Results

Chapter 4 systematically presents and analyzes the data collected for this study. It presents a profile of the participants, the factors contributing to whoonga use, whoonga usage, bio-psychosocial factors, recovery and rehabilitation, the roles of the family, community and government, participants' suggestions and a chapter summary. The data provided by the participants is discussed in relation to the existing literature on specific topics.

Chapter 5: Summary of Study Findings and Recommendations

The final chapter presents a brief interpretation of the findings and the linkages with the reviewed literature. It discusses the major conclusions arising from the analyses of the findings in chapter 4. The implications of the findings are also discussed and recommendations are presented.

1.9. SUMMARY OF CHAPTER 1

Chapter 1 outlined the background and rationale for the study, its significance, main aim, objectives and key research questions. The theoretical framework employed was briefly outlined as well as the location of the study. Major concepts were defined and the chapter ended with the structure of the dissertation. The following chapter presents a review of the literature relevant to this study.

CHAPTER TWO

LITERATURE REVIEW

2.1. INTRODUCTION

This chapter presents a review of the relevant literature as a background to the study. In keeping with the study's objectives, the key issues that relate to bio-psychosocial factors and support programs are explored. It is recognized that while the study focuses on whoonga use, whoonga is always used in relation to other drugs or is used as an alternative to another addictive substance. Thus the literature on drug use in general is reviewed in order to broaden our understanding of substance abuse (Miller and Carroll, 2006; Wills, 2005).

Although the focus of this study is youth that use whoonga in KwaMashu, the review is not confined to this age category as the youth are members of wider social systems and their challenges are the result of the intersection of multi-dimensional factors. Therefore a broader approach is adopted which reflects the factors that contribute to whoonga use and its bio-psychosocial effects. The review thus seeks to understand the nature of whoonga, use globally and in South Africa, the availability of whoonga in KwaZulu-Natal and Durban, rehabilitation resources, bio-psychosocial factors, the effects of whoonga, and HIV/AIDS. These foci are consistent with the choice of the bio-psychosocial model as the study's theoretical framework. The model enables the systematic ordering of the chapter with a focus on the biological, psychological and social elements in relation to a new drug, whoonga.

2.2. UNDERSTANDING WHOONGA

The photograph below depicts a spliff where the powder form whoonga is mixed with dagga. It illustrates that whoonga is mixed with other illegal drugs.



Photograph 1: Bryson in Associated Press (2010).

Whoonga is known as ‘Nyaope’ or ‘Kataza’ in Gauteng, ‘Whoonga’ or ‘sugar’ in KwaZulu-Natal, ‘Ungah’ in the Western Cape and ‘Pinch’ in Limpopo and Mpumalanga. It is defined by Mokwena and Huma (2014:353) as a “new cocktail drug which contains illegal substances like Cannabis, Methamphetamine, Heroin, house hold products like detergent, rat poison (strychnine), Antiretroviral medication (Efavirenz) and sugar which produce hypnotic effects.” Similarly, Grelotte et al. (2013) define whoonga as a cocktail of drugs with a mixture of Cannabis, Heroin, rat poison, soap powder, antiretroviral medication and white powder.

Davis & Steslow (2014); Grelotti, Closson, Smit, Mabude, Matthews & Safren (2014) and Thomas & Velaphi (2014) note that the precise composition of whoonga is generally not known, although most agree that heroin is the main ingredient, and rumours of the inclusion of ARVs have been documented. Venter (2014) differs from this view by indicating that rat poison is the only whoonga ingredient that circulates in many townships and this has appeared in several media publications.

Mokwena and Huma (2014) view whoonga as harmful, but stress that its composition makes it more insidious than other substances and very difficult to deal with, particularly with respect to cravings.

It is generally agreed that whoonga is a mixture of different substances, including drugs and household chemicals that are not intended for human consumption, thus depicting it as a hazardous substance. Whoonga has been categorized as a narcotic substance that relieves pain, and reduces and increases euphoric feelings (Masline, 2000). It is grouped with heroin, methadone, and morphine which are pain killers and highly addictive. It comes in powder form and is sometimes smoked in the belief that it is just Cannabis such as in the photo above. It sells for the relatively cheap price of about R20-R30 per portion or dose.

Whoonga is a relatively new designer drug which is commonly used in many Black townships in South Africa (Conway-Smith, Mbanjwa and Tuwan, 2013). According to several media publications, it emerged in early 2000 in Soshanguve and Mamelodi townships in Pretoria, and over the years many young Black and poor people have become addicted to it. Mokwena and Huma (2014) note that there has been an increase in the use of drugs especially whoonga among impoverished young black people in the townships. In under developed urban townships, it retail for R30. Studies note that whoonga addiction is of serious concern in such areas.

2.3. SUBSTANCE USE AT THE GLOBAL LEVEL

According to Wills (2005), illicit substances have the greatest effect in developed countries. The majority of western societies are current or past users of at least one psychoactive substance. On the other hand, Mokwena and Huma (2014) indicated that illicit substances also have grave effects in developing countries like South Africa, especially in Black townships due to unemployment. The use of illegal substances harms individuals and society at large in a wide range of ways. According to the World Health Organization (WHO) (2014) substance abuse refers to the harmful or hazardous use of a psycho-active substance. It is estimated that, globally, 185 million people consume illicit substances and 80% of the global deaths per year due to illicit drug use are among men (WHO, 2014). The global trafficking and use of psychoactive substances has increased steadily, especially in the past 25 years (Schuckit, 2000).

The Substance Abuse and Mental Health Services Administration (2007) indicated that 20.4 million people use an illicit drug and 125 million use alcohol as a drug. The National Institute of Drug Abuse (2004) found that marijuana is the most widely used illicit substance in the United States of America.

Thus, the use of illicit substances is an increasing problem which negatively affects the lives of millions around the world. Further more, it has been identified as a significant social challenge (Zyl, 2014). Increased use of illicit substances has also encouraged the emergence of new drugs like whoonga (Zyl, 2014).

The WHO (2014) estimates that the effects of substance addiction cost billions of dollars globally and include health care expenses, lost wages, the costs of prevention programs and costs to the criminal justice system. Substance abuse is regarded as a global health problem with the whole population exposed to the problems associated with it (Ray and Ksir, 2004).

On the African continent, Mashele (2005:1) maintains that, “the drug problem has become a serious developmental challenge and continues to undermine collective and individual efforts of African governments.” Combined with high levels of poverty, it increases the continent’s vulnerability to social problems such as crime and HIV and AIDS (Lombard and Wairire, 2010). The African Union (AU) has established portfolio committees and protocols to manage the negative effects of drug abuse and drug-related crimes on the achievement of development goals (Mashele, 2005). The World Drug Report (2014) indicated that East Africa, which includes Kenya, is characterized by growing instability in terms of substance-related crimes (UNODC, 2014).

2.4. SUBSTANCE USE IN SOUTH AFRICA

In the past few years, South Africa has experienced an increase in the amount and types of illicit drug manufacturing, use and distribution. Substance abuse is fast becoming a major problem (Taunyane, 2013). The United Nations World Drug Report (2004) identified South Africa as one of the drug centres of the world. Whoonga was first created and used in South Africa, but has failed to establish a foothold in overseas markets (Miller & Carroll, 2006). According to the South African Depression and Anxiety Group (Health 24, 2014), illegal substance consumption in South Africa is double the world norm. Dr. David Bayever (Conway-Smith, 2013) of the Central Drug Authority (CDA) noted that up to 15% of South Africans abuse substances. Regardless of South African laws, the risks of being caught are slim and there is inadequate infrastructure to deal with whoonga usage, resulting in users contravening the law (Ray and Ksir, 2004).

This has led to an increase in crime rates especially among poor, unemployed South Africans (Mokwena and Huma, 2014). Figures published by the South African Police Service show that substance abuse accounts for 60% of all crimes (Mashele, 2005). This justifies the need for effective substance abuse treatment and thus the relevance of this study.

A study by researchers from the Universities of the Free State University, KwaZulu-Natal, and the North, and the Institute for Special Populations Research found that South Africa has the dubious distinction of having the largest illegal drug market in sub-Saharan Africa (Ellis, Stein, Thomas & Meintjies, 2012). The United Nations World Drug Report (2010) noted that the country is one of the drug centers in the world. It stated that drug consumption in South Africa is twice the world norm, with an estimated 15% of South Africans said to have a drug problem. Expanding trade links with other parts of the world such as Asia, Europe, and the Americas have also made South Africa attractive to drug traffickers. Widely available and abused drugs include heroin, marijuana, methamphetamines, and cocaine. Novel psychoactive substances (NPSs) are an ever-increasing group of compounds, which may be synthetic, semi-synthetic or natural, and are often sold as alternatives to known illicit drugs (Wood, Greene & Dargan). While the detailed effects of many NPS substances are not known, their health effects include toxicity of various systems of the body and brain dysfunction (Wood, Greene & Dargan, 2011; Dawson & Moffat, 2012; Dargan & Wood, 2013).

The WHO (2014) indicated that 270 991 addicts require treatment each year in South Africa and the treatment resources can accommodate only around 21000 per annum. The country is characterized by major health and social challenges relating to substance abuse (Mokwena and Huma, 2014). Thothela, Van der Wath and van Rensburg (2014) indicated that one in twenty South Africans between the ages of 15 and 64 years have used an illicit drug due to health and social challenges. However, substance abuse affects the youth around the world, irrespective of their age, social status, race or creed. Poverty has been identified as a risk factor for substance abuse (Kalichman, Simbayi, Kagee, Toefy, Jooste, Cain & Cherry, 2006). Sawyer, Wechsberg & Myers (2006) and Wechsberg et al. (2008) identified race and geographical differences as determinants of the types of substance use and use patterns, respectively. While these authors differ in terms of the risk factors, they agree on the biopsychosocial risk factors in relation to whoonga use.

Ramlagan, Peltzer & Matseke (2010) and Walton, Blow, Bingham, Chermack (2003) identify unfavourable social conditions like poverty, unemployment and a lack of recreational facilities as health and social issues at community level. Smith (2001) noted that substance use is one of the most significant health and social issues in the community. However, to date major role players such as community leaders, and local and national government have achieved relatively little in finding ways and means to fight the abuse and spread of substance use, including whoonga among South African youth.

As noted earlier, whoonga is a relatively new illicit drug in South Africa. It is highly addictive and is commonly used by the youth (Mokwena and Huma, 2014). Children as young as 14 years old drop out of school to work for drug dealers just to get a free hit (Masombuka, 2013). Furthermore, young girls work as prostitutes to pay for their drugs. The Coalition for Juvenile Justice (2000) indicated that 17 000 drug users under the age of 18 are incarcerated each year.

Bryson (2010) noted that AIDS patients in South Africa are being robbed of their life-saving drugs to make whoonga which can be mixed with marijuana and smoked. According to Vumani Gwala, a drug counsellor, the drug is so addictive that addicts will actively try to contract HIV in order to access to ARVs, which are then crushed and smoked as a substitute for the real stuff. This mixture is called whoonga. Dr. Njabulo Mabaso, an AIDS expert (2010), notes that the AIDS drug cocktail is highly addictive. Some drug dealers are suspected of stretching the whoonga mixture with soap powder and even rat poison to increase their profit. Dr. Thavie Govender and a team of scientists from the University of KwaZulu-Natal analyzed a number of whoonga samples in 2011 and found that it contained heroine and strychnine, a pesticide mainly used to kill rats. They also found that whoonga contained ARVs. This calls for more research on HIV/AIDS and whoonga.

2.5. AVAILABILITY OF WHOONGA IN KWAZULU-NATAL

Vincent Ndunge, a police spokesman in KwaZulu-Natal reported that whoonga was first noticed two or three years ago (Moeng, 2013). Others believe that it is not new and has been available for more than ten years (Ghosh, 2013). It is thought to have first been manufactured in Chatsworth, an Indian area south west of the Durban city centre, and was known as ‘sugars’.

Apparently sugars were rebranded as 'whoonga' sometime around 2010 to confuse the authorities who were trying to crack down on the drug, which was rapidly spreading to the townships and the innercity. Since the use of whoonga has come to light in KwaZulu-Natal, there have been several alarming reports indicating that AIDS patients are being robbed of their ARVs when leaving their local clinic, leading to irregular intake or them going without. Other patients are willing to sell them and corrupt health workers and clinic staff have also reportedly been selling ARVs for the whoonga market (Davis & Steslow, 2014; Rough, Dietrich, Gray & Katz, 2014; Soutto, 2009).

Lihle Dlamini of the Treatment Action Campaign observed that whoonga use is widespread in communities and that drug dealers robbed HIV patients of their medication in order to form the whoonga drug cocktail (Grelotti et al., 2014). Users crush the ARVs and smoke them with a mixture of rat poison, detergent and marijuana to get high; the powder is said to be so addictive that users are hooked within days. In the township of Umlazi, near Durban, officials say that dozens of AIDS patients are being robbed of their antiretroviral drugs every week (Modisane, 2010). This discussion indicates that the usage of whoonga in KwaZulu-Natal has had negative health consequences due to the theft of ARVs.

The Sowetan (03:2015) and Moeng (2013) previously reported that street whoonga was not classified as an illegal substance and police officials and prosecutors were thus struggling to stem the trade and use of the physically and mentally debilitating substance. Furthermore, a large number of drug dealers and users sold and sought it freely without fear of being arrested. Mthunzi Mhaga of the Department of Justice reported that escalating abuse of whoonga was also believed to be the cause of some of the heinous crimes committed around the country, exacerbated by its non-classification as an illegal drug. It was only classified as illegal in March 2014, with the amendment of the Drugs and Trafficking Act (Government Gazette, 2014) with a view to ensuring that those arrested for possession and dealing in the substance referred to as whoonga, are successfully prosecuted. Hopefully, it will also lead to the formulation of treatment strategies and resources for such.

2.6. AVAILABILITY OF WHOONGA IN DURBAN

Whoonga was first reported in Durban before it spread to other parts of the country. According to Mokwena and Huma (2014), whoonga use spread to most Durban townships due to unemployment and poverty.

Drug users did not know what whoonga was when dealers first started offering them the cream-colored powder that smelled of vinegar at R20 a smoke (Mbanjwa, 2014). While whoonga gave users euphoric feelings, Masombuka (2013) noted that most experienced withdrawal symptoms including severe headaches, stomach pains and night sweats. This ensured that they quickly became hooked. Many resorted to crimes like robbery and stealing ARVs to feed their habit or became dealers. Addicts are often absent from work. This underlines the need for more information on the effects of whoonga as an emerging drug and the need to understand its addictive effects.

2.7. REHABILITATION RESOURCES

Myers, Louw, & Fakier (2008) note a lack of public rehabilitation centres for substance abuse, with long waiting lists for those that do exist. High rates of unemployment result in the available private services being unaffordable. This means that most young addicts do not have access to rehabilitation services (Ephraim, 2014; Ho, 2013; Daily News, 2014). This is especially true of those in disadvantaged Black townships (Ghosh, 2013). The required rehabilitation period is long, treatment is expensive and the withdrawal symptoms are harsh. At least a full year of intense rehabilitation and family commitment and support are required to successfully rehabilitate a whoonga addict (SANCA, 2004). The situation has become so desperate that some whoonga users resort to creating their own “rehabilitation” services by locking themselves in a community hall in an effort to separate them from the unfavourable social environment which promotes whoonga use (Stuurman, 2014). Studies note that users cannot be successfully rehabilitated without effective treatment centres.

2.8. BIO-PSYCHOSOCIAL FACTOR ASSOCIATED WITH/CONTRIBUTING TO DRUGS USE IN SOUTH AFRICA

Drugs do not discriminate, respect boundaries or obey laws. They destroy whatever they come into contact with, effectively erasing health, sanity, families, and eventually people’s lives (Colett, 2004). The use of whoonga can impede physiological, psychological and social functioning. Users may have difficulty in establishing their identity, developing relationships or skills, gaining physical and emotional independence and preparing for responsible adulthood. Substance abuse halts the addict’s maturity causing him/her to continue immature behavior into adulthood (Wills, 2005).

The bio-psychosocial frame of reference is used to organize this literature review as differently to the substance and come from different environments which develop different meanings of biological, psychological and sociological factors play a part in drug use. Different whoonga users reacted to whoonga. The biological, psychological and social factors are discussed below.

2.9. BIOLOGICAL FACTORS

The benefits of whoonga use contribute to addiction. Users enjoy physical strength and vitality and capability on the sports field. Comer, Walker & Collins (2005) reported that whoonga users feel euphoric and elated. This “high” is followed by feelings of drowsiness and relaxation which are similar to the effects of heroin. Furthermore, continued use of the substance is associated with the development of tolerance, and addicts therefore resort to using increased and more frequent doses to achieve the same high. Those that have used other substances state that whoonga is the best when it comes to satisfaction which leads addicts to want more. However, the problems associated with substance use have major effects on society at large.

Gavin (2004) notes that whoonga users appear to be normal. Most describe the drug’s effects as calming, peaceful, enjoyable and satisfying. During the early days of use, these effects lure them to use the drug again. They also explained that they felt stress free and that they could sleep at night despite their problems.

2.10. PSYCHOLOGICAL FACTORS

According to Moore (2008), unresolved personal issues or emotional pain as a result of the traumatic loss of a significant person contribute to whoonga usage. Van Wormer and Davis (2008) support this by stating that many users were exposed to victimization when they were still young which affected their self-esteem. They use whoonga to alleviate emotional pain or to forget about the loss.

Weaver, Turner and O’Dell (2000) stated that stress and ineffective coping mechanisms result in whoonga usage. Loneliness, anxiety, moodiness and depression also lead to its use (Stein and Mentjie, 2012). Life challenges and stress expose people to emotional and psychological strain. Furthermore, users struggle to control their moods and emotions.

Young males use substances to prove their independence from adults and their ability to make their own decisions.

2.11. SOCIAL FACTORS

Different social factors are cited by different studies as contributing to substance abuse, particularly whoonga. Mossakowski (2008), Davstad, Leifman, Allebeck and Romelsjö (2013) and Venter (2014) indicated that socio-economic status contributes to the use of drugs in South Africa. Kalichman, Simbayi, Kagee, Toefy, Jooste, Cain and Cherry (2006), Chinouya, Rikhotso, Ngunyulu, Peu, Mataboge, Mulaudzi and Jiyane (2014) and Mokwena and Huma (2014) confirmed that poverty is a risk factor for substance abuse. The Sowetan (2015) indicated that some people turn to drugs due to ‘vices’. This indicates that addicts start using drugs to cope with stress or pain. Sawyer, Wechsberg, Luseno, Young, Rodman, Parry and Myers (2008) identified race, gender and geographical differences as contributing to drug use. Ghosh (2013) and Ho (2013) concurred and indicated that the uniqueness of whoonga lies in its almost exclusive use by Black people. In contrast, Arndt, Clayton & Schultz (2011) concluded that age plays a part in drug abuse patterns. All the above-mentioned factors are explored in this study in relation to the use of whoonga.

Mokwena and Huma’s (2014) study in the Provinces of Gauteng, Mpumalanga and North West found that whoonga use is influenced by the 28.3% unemployment rate among those aged 15 to 64. Other studies have also identified socio-economic status as a factor in drug abuse patterns and noted that there are regional and country variations in drug use (Mossakowski, 2008; Ibrahim, Abdallat, & Hadidi, 2009). All the areas where whoonga was a challenge were noted as socio-economically deprived, with high unemployment rates and pockets of poverty (Ghosh, 2013). Other researchers cite peer pressure and fears among young people of being rejected if they resist drug use as influential factors. Van Heerden (2005), Le Roux (2000), Health 24 (2004), Brown (2004) and Lembersky (2004) support this notion by noting that when a young person’s friends use drugs they fear being rejected if they do not do likewise.

The World Economic Forum (2014) also identifies the increase in unemployment as a cause of drug use in South Africa, noting that it now stands at 50%.

Van Heerden (2005) observes that young people use whoonga to experience euphoric feelings and a sense of adventure, which lead to them losing interest in seeking employment.

Ramagan et al.(2010); Ghosh (2013); and Walton et al. (2003) note that the factors contributing to drug use include unfavourable social conditions like poverty, unemployment and a lack of recreational facilities and these seem to be fuelling the use of whoonga in Black communities. This suggests that in Black townships, whoonga may be the most frequently used drug (Morebudi & Mukhari, (2014). In contrast, Louw (2011) and The Sowetan (2015) indicated that the lack of rehabilitation centres in poor communities and poor health services contribute to whoonga use.

At community level, inadequate support structures and resources, changes in family structure, high levels of uncertainty and unemployment, the lack of personal safety due to crime, and stress are seen as contributors. Drugs serve as an escape mechanism to cope with stress and personal problems. People that cannot handle everyday family or emotional problems are more likely to abuse drugs. These factors are further explored in chapter 4. They include widespread and severe poverty, rapid modernization and a decline in traditional and social relationships, as well as porous borders.

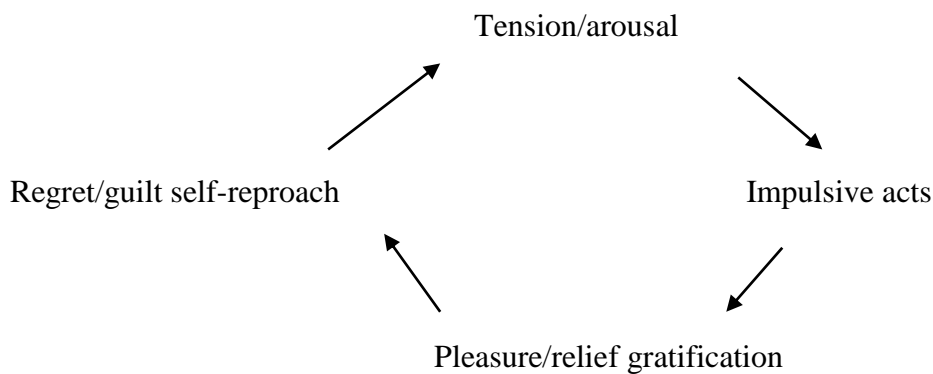
Unhealthy marital relationships and weak maternal and paternal figures can predispose a person to substance use (Caudill & Kong, 2001). Furthermore, the lack of a parental figure and family support contribute to substance use. On the other hand, Schukit (2000) notes that whoonga users with a negative self-image feel inferior and seek recognition. Therefore, they may want to feel in control. Using whoonga gives them a temporary feeling of independence and power and improved self-image.

The use of whoonga and its consequences for users' social lives have been reported by the media, including television documentaries and almost all newspapers in South Africa. Health 24 (2014); Hull (2010) noted that it might well be the country's worst drug ever. Concerns have been voiced about the negative effects this street drug has had on communities (Conway-Smith, 2013). Ho (2013) indicated that some townships families in South Africa claimed to have been ruined by whoonga. In certain areas as much as 80% of households were affected by whoonga addiction in one way or another. Family support and parental figures are thus important in fighting whoonga use.

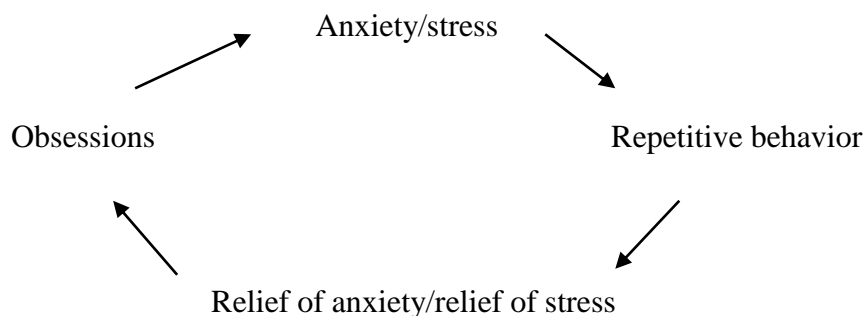
2.12. WHOONGA USE

Substance use is not isolated behavior but is intimately intertwined with a range of common, long standing human issues and social problems. Miller and Carroll (2006) perceive drug addiction as a disorder that progresses from impulsivity to compulsivity. The impulse disorder involves using substances as positive reinforcement in relation to personal challenges or social tensions and later develops into a compulsive disorder which has negative reinforcement. Miller and Carroll (2006) used the diagram below to further elaborate the disorders:

Impulse control disorder



Compulsive disorder



Human behaviour leads to devastating consequences and tension among biological and social selves. A whoonga addict experiences physical, psychological and social effects. Those around the addict, like family members, are also affected. While the effects of addiction might be somewhat hidden, the different physiological, psychological and social effects of drug use are discussed here under.

2.12.1. Physiological effects

The following photograph shows the sores that develop as a physiological effect of whoonga use.



Photograph 2: Ephraim (2014)

Pienaar (2012) describes whoonga as a chemical or other substance that alters the function of an organism and changes the human body. This is evident in the above photograph.

Drugs have harmful effects on organs such as the brain, liver, lungs, heart and the gastrointestinal system (Van Wormer & Davis, 2008). All addicts care about is the next dose. They are not interested in taking in liquid and lose their appetites, leading to weight loss. They also experience psychological effects. While whoonga has similar effects to heroin (Modisane, 2010; Moodley, Matjila and Moosa, 2012), it is perceived as more addictive as it contains ARVs which have hallucinogenic effects (Chinouya, et al. 2014). Mokwena and Huma (2014), Tuwani (2013), Ephraim (2014) and the National Institute of Drug Abuse (2004) note that whoonga's physical effects include stomach cramps, joint pain, sweating, insomnia and other physiological changes when the user is craving a fix. It also damages the heart, brain, liver and esophagus, leading to cancer of the mouth (dry mouth and throat), as well as of the bladder, pancreas, bronchitis, larynx and kidneys. Ninety per cent of liver disease is related to substance abuse and it causes cancer of the head and neck, 72% of cases of pancreatitis, 41% of seizure disorders and 13% of breast cancer (Venter, 2014). Addicts develop tolerance, resulting in increased dosages. These health and physical challenges require treatment and rehabilitation.

Cravings for whoonga cause extreme body pain, which pushes addicts to increase both the amount and frequency of use. Health 24 (2014) notes, that, the use of whoonga aggravates asthma, cause difficulty in breathing, and causes skin disorders such as psoriasis. Some users experience difficulty in running, kicking, throwing, catching, cycling and swimming. The physical consequences of drug addiction include HIV infection, hepatitis and other illnesses, heart rate irregularities, heart attacks, respiratory problems such as lung cancer, emphysema and breathing problems, diabetes, abdominal pain, vomiting, constipation, diarrhoea, kidney and liver damage, seizures, strokes, brain damage, and changes in appetite, body temperature and sleeping patterns. A study by Izenberg and Lyness (2002) indicated that prolonged usage of whoonga can lead to the breakdown of lung tissue and clogged air sacs. This results in lung problems and inhibits performance in sport and daily duties.

The Sunday Times (2016:6) quoted an addict by the name of Jomo (31 years): *"If I don't smoke it, I get pains and I can't sleep until I get some more," whose eyes became red and glazed after a few deep drags on a "joint", as saying. He and his fellow whoonga addicts smoke up to 30 "packets" of whoonga substance every day at a cost of almost R600 a day. "I just rob people to get the money. I don't have a job, this is all I do,"* Jomo added as he rolled another joint.

This extract illustrates that whoonga usage has negative health and financial consequences.

2.12.2. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

Whoonga use is perceived as contributing to the spread of HIV through unprotected sex, as well as hepatitis and TB (Thomas and Velaphi, 2014). A researcher at the Harvard School of Public Health (Sowetan, 2015) expressed concern that people with HIV who smoke whoonga may develop mutant strains of the virus which are resistant to medication. Users seem to not care about adhering to treatment and a good diet as they replace this with drugs, which leads to health challenges. Mashele (2005); Fihlani (2011); Knox (2012) noted that the greatest health threats associated with substance abuse are risky social behavior and the concomitant increase in HIV infection and AIDS-related deaths. The WHO (2014) indicated that there is a causal relationship between the use of whoonga and illnesses like TB, cancer and so forth. Furthermore, many young users are hospitalized due to substance use and compromised health (Van Heerden, 2005).

Whoonga is seen as destroying whatever it comes into contact with, threatening health, sanity, families, and eventually people's lives (Colett, 2004). Bezuidenhout (2004) observed that the use of substances leads to physical tolerance, resulting in uncontrolled and prolonged use. Whoonga users suffer withdrawal symptoms like diarrhea and delirium tremens (trembling). Once addicts are dependent on the drug, they will experience physical pain if they attempt to stop. They also develop chronic illnesses. Young people leave school as early as grade six or seven to engage in various criminal activities, including robbing HIV positive patients of their much-needed ARVs to make whoonga. There have been reports of gangs robbing HIV/AIDS clinics in Soweto to obtain ARVs as well as addicts mugging patients to obtain the drugs for themselves (Sowetan, 2015).

2.12.3. Physiological Appearance and Care

Whoonga users are easily identified by their poor personal hygiene, their slowness of movement and their half-dazed looks. Gouws & Kruger (2003) report that physical development concerns the growth of the body, changes in the proportions between different parts of the body and changes in its internal structure and functioning. Ray and Ksir (2004) observe that whoonga users neglect their hygiene, leading to dental problems, skin diseases and other health problems. They experience an increase in height and mass together with an increase in appetite. They also appear to be older than they are. According to Van Heerden (2005), whoonga causes a decrease in appetite and a changed personality. The long term effects are a loss of interest in life, convulsions, coma and physical dependence. Withdrawal symptoms include pain, anxiety, muscle cramps, severe vomiting and abdominal pain.

Many users suffer from inadequate nutrition, unsuitable living conditions and deficient personal hygiene. They also contract chest infections, coughs and colds, TB and urinary tract infections (Tuwan, 2013). The brain of the user reaches adult size and mass. Breathing becomes slower and deeper whilst blood pressure rises but the heart beat decelerates. Whoonga use thus has severe negative health challenges that can result in death.

Whoonga robs the body of essential vitamins and minerals and interferes with digestion. Young users may suffer from malnutrition due to a lack of vitamins and calcium (Ephraim, 2014).

An addict residing in Whoonga Park going by the pseudonym of Lucky shared that in his seven years, he had experienced sweating and vomiting. He added that he survived by begging on the street (Sowetan, 2015). The most significant challenge in trying to quit whoonga is the physical pain, which contributes to addicts' consistent relapse. Because smoking whoonga temporarily relieves the pain, it is the easy option, leading to a cycle of abuse. It is for this reason that users acknowledge that they need help. Effective management of the pain is likely to increase the potential for successful rehabilitation (Mokwena and Huma, 2014).

2.12.4. Psychological effects

Berg (2015), Van Heerden (2005) and Brown (2004) noted that the psychological effects of whoonga include low self-esteem, elation, depression, alienation, anxiety, inability to express feelings and mood disorders. Other psychological effects of drug addiction include wild mood swings, paranoia, violence, and decreased pleasure in everyday life, complication of mental illnesses, hallucinations, confusion, psychological tolerance of the drug's effects creating a desire to consume ever-increasing amounts, and risky behaviour.

Gouws & Kruger (2003) concur and note that whoonga is a mood altering substance that is part of the package of psycho-active drugs. These drugs cause roller coaster emotions like anger, happiness, sadness, fear and anxiety. Griffiths (2002) and Mokwena and Huma (2014) agree that the psychological effects include mental tolerance which increases the frequency and amount of whoonga usage.

SANCA (2004) notes that, whoonga use leads to volatile behaviour, staggering, and loss of balance, and generally affects motor co-ordination. Furthermore, motor dysfunction especially dysfunction in terms of fine motor co-ordination such as required for articulation, writing and eye movement may cause secondary school learners to experience speaking, writing and reading difficulties. Wood, Greene and Dargan (2011) and Dawson and Moffat (2012) associate whoonga with toxicity and brain dysfunction. The National Institute of Drugs Abuse (2004) stated that substance use blocks messages to the brain and alters the user's perceptions, emotions, vision, hearing and coordination. It was recently found that, 1,023 patients admitted to a trauma unit in Durban had cannabis and whoonga in their blood stream (Health 24, 2014).

Drugs may intensify or dull the senses; alter one's sense of alertness and sometimes decrease physical pain. The psychological effects of drug addiction stem from the reason the user is addicted to drugs, as well as the changes that take place in the brain once they become a drug addict. Mokwena (2015) linked the psychological effects of whoonga to mental illness. Modisane (2010) concurs and notes that the long-term effects of cannabis and whoonga include a variety of psychiatric disorders. On the other hand, authors such as Davis and Steslow (2014) and Lembersky (2004) claim that whoonga use has not been linked to mental functions which involve concentration, reasoning and productivity. However, it affects academic development and leads to possible failure. These psychological effects are further discussed in chapter 4.

2.12.5. Withdrawal Symptoms

Whoonga is highly addictive, even after only one hit, and has severe side-effects such as anxiety, aggression, stomach cramps, and slowing of the heart rate and lungs (Venter, 2014). Furthermore, if taken in overdose, heart and lung function reduction becomes fatal. Reported withdrawal symptoms include extreme craving and pain, which are only temporarily relieved by fresh doses of the drug. A few users have allegedly died from crippling stomach cramps and acute pain (Tuwan, 2013). One of the psychological effects of addiction is the belief that the addict cannot function or handle life without using the drug.

Brown (2004) observed that whoonga use affects cognitive development by contributing to the loss of short-term memory and a person's ability to learn, resolve their problems and reproduce information at a later stage. Users experience a lack of initiative, motivation and concern about the future. Long term effects include diminished sexual pleasure, enhanced risk of cancer, a lower sperm count which limits the chances of having children and psychological dependence.

2.12.6. Psychological Dependence

Psychological dependence is a major issue; with 90% of users experience some degree of relapse (Bezuidenhout, 2004). This factor is complicated and takes longer to deal with, because the mind has to be geared toward quitting whoonga before the addict is able to stop the abuse.

An addict continues with his/her delusional behavior in the hopes of getting incentives known as “reinforces,” despite the fact that these only exist in the individual’s mind. Users also develop emotional dependence which increases the desire to continue consuming the substance and their thoughts become centered on whoonga. This may lead to dishonesty in all areas of their lives. The psychological effects of whoonga use mean that even though a person might wish to stop, they will not know how to because they rely on substance abuse to resolve their problems and escape from reality. They become less co-operative; friendly and sensitive to others who want to assist them.

2.12.7. Social effects

Whoonga addiction is devastating, not only to addicts but for their parents, immediate family and the community at large. Whoonga has a negative influence on users’ acquaintances and family. It also increases the financial burden, crime, violence, and ill health of society at large. The social cost paid by users, and their families and communities is very high due to the severity of the addiction and the intensity of the withdrawal symptoms (Masombuka, 2013). The subtopics are discussed below.

2.12.8. Family and Social breakdown

The breakdown of the family and society, that should inculcate morals in the young, has contributed to whoonga abuse (Nasibi, 2003). Pretorius, Van den Berg and Louw (2003); Mokwena and Morojelo (2014); Ghosh (2013); and Smit (2014) indicated that the intense negative social effects of whoonga include users being shunned by their communities and families because of the criminal element, dropping out of school, losing their jobs due to losing track of time and poor future prospects. Young users may also experience decreased motivation, concentration, and overall achievement, and a lack of interest in sport and extra-mural activities (Donald, Lolwana & Lazarus, 2002). Hu (2013) and Parry (2005) note that addicts turn to crime to finance their habit. Whoonga use also contributes significantly to violence within the family and society.

In the townships, addicts are often referred to as “whoonga boys” that are known to resort to theft in order to sustain their habit (Mbanjwa, 2014). Addicts' lives are cut short as they are killed or end up in prison. Whoonga use increases violence, theft and robbery among the youth. Families live in fear of their own children (Thomas and Velaphi, 2014).

Substance abuse also reduces opportunities as people who use whoonga excessively tend to be unreliable and are often marginalized from mainstream society (CSIR 2006).

2.12.9. Social Consequences

Whoonga dependence also lowers self-esteem and causes negative attitudes as well as social inhibitions. The different social consequences identified in the literature point to the need for further research on this issue. It has been reported that users have problems in their interpersonal relationships and have a reputation for damaging property (Van Heerden, 2005). Izenberg & Lyness, (2002) and Lembersky (2004) note that young users tend to withdraw from all relationships with other people. Whoonga use also decreases the user's chances of experiencing feelings and developing relationships with their parents and peers as well as adult relationships that have a positive effect in becoming a responsible and socially accepted adult. The addict finds it difficult to simultaneously maintain and satisfy the need for the drug and intra- and extra-familial relationships. The literature notes that, users lose their sense of reality which leads to withdrawal from others and the loss of the ability to function. Since "birds of a feather flock together" users will most likely have friends with similar habits in their peer group. The greater the user's involvement with friends that consume whoonga; the more likely the chances of becoming addicted.

2.12.10. Crime and Violence

Boomgaard (2010) cites the case of a person interviewed in Chatsworth, Durban using the pseudonym of Rafick, who related that he used to support his drug habit by stealing from his home and selling everything, even pots. The Fish Hoek Drug Crisis Centre (2004) states that whoonga users tell lies, keep secrets, steal or borrow money or engage in sneaky and suspicious behavior. They might also be found in the company of suspicious individuals. Bezuidenhout & Joubert (2003) observe that some substance abusers exhibit unacceptable behavior such as mugging, stealing, snatching handbags and violence to acquire money to satisfy and maintain their habit whilst others may resort to prostitution. Some whoonga users form their own community. This is the case in Albert Park in Durban, where users have formed "families" that they feel comfortable with. They commit crime in order to feed themselves and their targets include both the rich and the poor.

2.13. CONCLUSION

This chapter reviewed the relevant literature in order to understand the factors that may play a part in whoonga use. The bio-psychosocial model was employed to examine the bio-psychosocial effects of whoonga use and available support programs. Furthermore, the review enabled a better understanding of the factors that contribute to whoonga usage. The following chapter presents the research methodology employed to conduct this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

The research methodology is defined as the plan, structure and strategies to obtain answers to research questions or problems (Kumar, 2011; Bereska, 2003; Selebalo, 2010; Sarantakes, 2005). Payne & Payne (2004) state, that, research methodology is a procedure; practice and set of techniques used to identify and explore research questions and a means by which to collect, analyse and present the findings. It also sets out the processes and strategies to collect and organize the data and translate it into findings. This study explored the reasons for and effects of whoonga use by young people in KwaMashu Township. This chapter presents the research approach, study design, location of the study, sampling approach, data collection method, and data analysis procedures. It also discusses the trustworthiness of the study, ethical considerations and the study's limitations.

3.2. RESEARCH APPROACH

This study was framed within the qualitative research approach. This approach was selected because whoonga is a relatively new substance and very little is known about it. The qualitative approach was appropriate to explore the every day lived experiences of the youth that use whoonga, in order to enhance our understanding of the drug and its effects on the identified users. Johnson and Christensen (2012:33) maintain that “qualitative research is used when little is known about a topic or phenomenon, and when one wants to discover or learn more about it.” A qualitative research approach allows a researcher to explore, discover and clarify situations through researching feelings, perceptions, attitudes, values, experiences and beliefs. It also enables the researcher to study selected issues in depth, openly and in detail in order to understand the information that emerges from the data (Terre Blanche, Durrheim & Painter, 2006; Hancock, 2002). Mitchell, Kruger and Welman (2005); Flick, von Kordorff and Steinke (2000); Henning, Rensburg and Smit (2003) and Gray (2010) concur that this approach seeks to describe, decode, translate and otherwise come to terms with the meaning of naturally occurring phenomena in the social world. This study sought to explore the effects of whoonga use by young users through describing, interpreting and finding meaning for this social problem.

Gay, Mills and Airasian (2009:12) note that the “qualitative method seeks to allow a deeper understanding about the way things are and the reasons why things are that way as well as how participants in the context perceive those things.” Babbie and Mouton (2011) and Mason (2002) observe that such an approach offers insights into the population under study. The current study sought to promote a profound understanding of people’s behaviour and developed attitudes about the world in relation to whoonga’s effects. The views and meanings of those being studied are important, and to the greatest extent possible, these views are captured in order to obtain an accurate “measure” of reality (Wiersma and Jurs, 2009). The important reality is that, even though these young people are addicted to the same drug, their views on their experiences of it were different.

The qualitative research approach was well suited to this study, as it enabled the researcher to explore the bio-psychosocial issues that influence young whoonga users. Using interviews as an instrument for data collection was of great benefit as this enabled the researcher to interpret what the participants shared about their feelings and experience of whoonga use. Using a qualitative approach, the researcher explored, discovered and clarified the effects of whoonga use by young people in KwaMashu Township.

3.3. RESEARCH DESIGN

Shahajan (2004:43) defined a research design as a “proper planning and execution of a study as it specifies methods and procedures for acquiring the information needed to solve the problem.” Mouton cited in De Vos, Strydom, Fouche and Delpont (2011) defined a research design as a “plan or blueprint of how the researcher intends to conduct the research.” Both authors stress planning in order to execute a study. This study employed an exploratory research design.

Alpaslan, Du Plooy, Gelderblom, Van Eeden and Wigston (2010:93) describe the aim of an exploratory design as follows: “to explore and familiarise the researcher with basic facts, about people and problems that need to be addressed and also to determine what further research can be done about the topic.” Rubin and Babbie (2013) stated that exploratory studies are typically used to research a new interest or relatively new subjects.

They emphasized that an exploratory design is used to research unexplored topics. Whoonga is a relatively a new substance and its level of danger has been largely unexplored in the

locale under study. The study also aimed to explore young whoonga users' experiences in order to interpret them and find meaning. The explorative design allowed the researcher to interact with the participants in a non-threatening manner and at a level where participants felt and experienced the research process as experts.

3.4. BRIEF DESCRIPTION OF THE RESEARCH SITE

The study was conducted at the KwaMashu outpatient treatment centre, which is located in KwaMashu Township, north of Durban. McMillan and Schumacher (2006:319) posit that researchers need to choose a site that will enable them to “locate people involved in a particular event.” The area of study was the KwaMashu community health centre, where recovering whoonga addicts attend multi-treatment programs on week days. The centre is located in township 26 km from the Durban city centre. The treatment program involves medical treatment and counseling services. The KwaMashu outpatient treatment centre was selected as it accommodates recovering whoonga users from the area. The centre was considered suitable because it has well-structured offices that provided a suitable environment for interviews that assisted in maintaining participants' anonymity. Management of the centre sanctioned and approved the study. The centre is well-resourced with a multi-disciplinary professional team consisting of Doctors, social workers and nurses, offering an opportunity to obtain rich data to explore the research problem.

The map (Map data, 2014) below shows the location of KwaMashu Township (north of Durban) where the study was conducted.



Map data (2014)

3.5. SAMPLING METHOD AND PROCESS

Purposive sampling was used to select the participants. Donalek and Soldwisch 2004 cited in Apalsan et al. (2010:21) defined purposive sampling as “a form of non-probability sampling where cases are selected based on the researcher’s judgment about information-rich participants based on their first-hand knowledge and ability to describe the experiences, challenges and coping strategies of going through a particular situation.” According to Rubin and Babbie (2013), purposive sampling entails selecting a sample based on the nature of the research aims and knowledge of the population and its elements. Morse and Richards (2002) agree that purposive sampling involves choosing participants based on characteristics they possess that fit the study. McMillan and Schumacher (2006) observe that the power and logic of purposeful sampling is that a few cases that are studied in depth generate many insights into the topic. All these authors emphasize the need to select the sample based on characteristics that fit the study’s aims and knowledge of the population. Ten participants were selected. These were willing participants who were selected, not simply because they were easily accessible, but based on the research aims and knowledge of the KwaMashu population.

The criteria for participating in the study were:

- Male recovering whoonga users between the ages of 20 and 35 as per the definition of youth in the South African youth policy (National Youth Policy, 2015; Mokwena and Huma, 2014). According to these authors, young people in the townships are mostly affected by whoonga; hence the choice of location and age group. According to the social workers at the KwaMashu outpatient treatment centre (23/09/2015), most recovering whoonga users that receive treatment are males between the ages of 20 and 35. The ten male participants were referred by social workers and nurses at the centre.
- Recovering whoonga users that had attended the first two counseling sessions in the institutional treatment centre and were continuing with the program in order for social workers to refer them based on risk assessment. This assisted in securing participants that had been screened by social workers in order to minimize potential discomfort during the study. Nonetheless, every effort was made to offer onsite assistance or referral should discomfort arise.

The study was first introduced to the Medical Director of the centre by explaining its nature, purpose, procedures, and anticipated value, and the fundamental role the centre was requested to play in assisting. Written permission was secured from the Medical Director and the provincial Department of Health. The researcher engaged social workers and nurses prior to data collection so as to build rapport and trust; this facilitated the referral of recovering users to participate in the study.

Participation in the study was on a strictly voluntary basis. Once the procedures had been sufficiently clarified and agreed upon, the social workers and nurses started screening and referring those who were interested in participating. Only ten willing and screened participants made contact with the researcher. Davies (2007) states that a small sample allows the participants to talk at length, suggesting that the information obtained will be closer to their reality. Thus, the data yielded the participants' perceptions and experiences based on their lived reality.

The researcher started by interviewing two male whoonga users who were screened and referred by social workers. He was then requested to put his interviews on hold as the Medical Director who was aware of the study was on suspension leave.

The researcher had to re-submit all the relevant documents which included a brief proposal and the University's Ethics Committee's approval letters as well as letters from the provincial Department of Health. He also had to request a meeting with the current acting director to outline the study's purpose, nature and procedures. He was granted verbal permission to continue with the study after a month. The researcher then contacted the social workers and nurses and re-arranged the referral process. This was a slow process as the participants did not honour most of the social workers and nurses' appointments due to a variety of reasons, one of which was the cold weather.

3.6. DATA COLLECTION AND INSTRUMENTS

Data was collected once the gate keeper's permission letter and the ethical approval from University of KwaZulu-Natal's Ethics Committee were received. Data was collected through semi-structured interviews, which offered maximum efficiency and minimum bias. May (2010:123) advocates, that, "semi-structured interviews allow people to answer more on their own terms." McMillan and Schumacher (2006:204) note that "semi-structured questions have no choices from which the respondent selects an answer." Kumar (2011) observes that this kind of interview enables the researcher to probe when gaps become apparent in order to acquire relevant information. Probing assisted me to better understand the effects of whoonga on users as it is a complex phenomenon. The semi-structured interview established a one-on-one relationship between the researcher and the participants which promoted positive information disclosure.

The researcher prepared an interview schedule to guide the interviews and this was translated into the participants' home language (IsiZulu). According to Kumar (2011), an interview guide promotes freedom of expression. It offers flexibility with respect to the participants' accounts by not restricting them in any way (Babbie and Mouton, 2001). Such freedom was important because it allowed the participants to be flexible and spontaneous in the content and structure of our interaction. The researcher used open-ended questions, with no set order. Once the participants had given their permission, an audio recorder was used to record the responses, supplemented by field notes. Recording the interviews ensured that the information was not lost after the interview process.

The field notes recorded key information and were also used for those participants that were not comfortable with the interview being recorded. It was found that this type of design enabled the participants to recreate and relive their experiences when they used whoonga. This open, flexible and inductive approach was the key to obtain fresh insights into recovering users. Each participant was given an opportunity to express and explain the effects of whoonga use in terms of his own reality and perceptions. This promoted the free flow of the interview and freedom to explore the topic in depth as the interview was not too technical. The researcher ensured that the interviews were evenly balanced between the research aims and the participants' free expression.

The researcher also provided constant counseling support when in-depth and sensitive issues were ventured into. Where necessary, he was able to request that they share more information. This ensured a thorough exploration of the participants' experiences without being forced to take any particular direction. The questions were clear and easily understood by the participants. The researcher rephrased and paraphrased where they were not clear and took note of non-verbal cues. Data saturation was reached after ten interviews. Kumar (2011) states, that, data saturation is achieved when one is no longer obtaining new information or the new data is negligible. Corbin and Strauss (2008) describe data saturation as the point where all concepts are well-defined and explained. Each interview took approximately 69 minutes. The interviews were transcribed immediately in order to safe guard the data. The researcher clarified all aspects that were unclear with each participant. This assisted in reaching common understanding.

The semi-structured interviews captured the participants' shared experiences as well as those that were not common to all (Babbie & Mouton, 2001; Terre Blanche & Durrheim, 2002). The researcher adhered to the ethics of social work in refraining from being judgemental and treating the individuals as unique. All the interviews were conducted in IsiZulu and translated into English by the researcher using a bilingual assistant. The social workers' consulting room was used in order to ensure privacy and confidentiality. The participants felt comfortable and relaxed due to the privacy which allowed the interviews to flow unhindered. The interviews were conducted in June 2016, as verbal re-permission was given at the beginning of that month.

3.7. DATA ANALYSIS

Mayan (2001,21) defined data analysis as “a process of observing patterns in the data, asking questions of those patterns, constructing conjectures, deliberate collecting data from selected individuals on the topic, confirming and analyzing the data through sorting, thinking, constructing and testing conjectures.” According to Mitchell et al. (2005), “this involves reducing the volume of raw information, sifting significant from trivia, identifying significant patterns and constructing patterns and a constructing framework for communicating the essence of what the data reveal.” Concurring with Mitchell et al. (2005) De Vos et al. (2011) state, that, data analysis is the process of bringing order, structure and meaning to a mass of collected data as it involves making sense of and interpreting and theorizing the data.

Thematic data analysis was used in this study. This is defined by Carey (2009) as a common type of data analysis used in social work qualitative research. Furthermore, it is more convenient with a small sample and the themes are carefully explored. It offers an accessible and theoretically flexible approach to analyzing qualitative data. The analysis consisted of five phases. The researcher started by familiarizing himself with the data through consistently listening and understanding the recorded audio interviews. The collected data was transcribed verbatim. According to Cresswell (2009), transcribing has to do with gaining some understanding of the data. During analysis, it was translated from isiZulu into English in order to be easy to group into codes.

The second phase was the creation of codes. The researcher used YP1, YP2, YP3 up to the tenth participant as codes. Labelling or coding every item of information shared during the interview enabled the researcher to recognize differences and similarities between the whoonga users’ experiences and perceptions of this substance. It also involved picking up verbal and non-verbal items from each participant’s interview transcripts, labelling them and identifying differences and similarities with other transcripts (Hancock, 2002). The coding of data assisted in narrowing the information and focused on relevant information for the study. It also assisted in gaining an understanding of the young participants’ thoughts, views and experiences of the bio-psychosocial effects of using whoonga.

The third phase focused on grouping the codes into themes. The researcher looked at recurring thoughts, experiences, ideas and feelings that were shared by the young whoonga users during the interviews. Codes that contained similar ideas were grouped together in themes. The relationships between codes were identified and themes were developed (Potjo, 2012). This assisted the researcher in developing a thematic map in order to produce the report. In the fourth phase, data was reviewed in themes by reading all the extracts from the transcripts and also examining the data extracts from each theme. Finally, the researcher wrote the research report, aiming to be coherent and convincing and to provide an interesting account of the story the data told (Whittaker, 2012). These phases of analysis ensured that the data collected was interpreted correctly and coded accordingly. The data will be kept for five years in a lockable, safe place.

3.8. TRUSTWORTHINESS

According to Lincoln and Guba (cited in De Vos, 2002), trustworthiness in qualitative research can be assessed using the dimensions of credibility, transferability, dependability and confirmability. Trustworthiness is defined by Lincoln and Guba (2003:64) as the “way in which the researcher is able to convince an audience that the findings are worth paying attention to and that the research is of high quality.” The researcher ensured trustworthiness according to the following dimensions:

3.8.1. Credibility (Trust value)

Credibility involves establishing if the results of the study are believable or credible (Trochim & Donnelly, 2007; Mayan, 2001). I ensured credibility by exploring the participants’ perceptions, experiences, feelings, and beliefs in the study’s findings. This was done after prolonged engagement with the participants until data saturation was reached and taking the findings of the study back to the participants to determine if they accurately reflected their feelings and opinions. I engaged them from May to end of June 2016 with the aim of reaching data saturation. I also ensured persistent observation by viewing interpretations in alternate ways in the process of analysis. The high levels of confirmation and approval of the results/outcomes by participants indicated the high credibility level of the study.

3.8.2. Transferability (Applicability)

Durrheim and Wassenaar (2002) described transferability as the degree to which generalizations can be made from the data and the context of the research study to the wider population and settings. De Vos (2002) stated that too much generalization can weaken a qualitative research study. He concurred with Durrheim and Wassenaar (2002) that the researcher should provide thick descriptions of what the participants said as well the theoretical approaches used to formulate generalizations. Transferability was achieved to some extent as the researcher extensively and thoroughly described the process that was used so that other researchers can follow it for replication.

The study offers a rich, thick description of the participants and context, and a clear and detailed research process. The time of data collection was also stipulated so that other researchers can understand when the results were applicable. The data was collected during the month of June 2016 at KwaMashu outpatient treatment centre. All this would be helpful in replicating the study in different contexts or using different research methodologies. Transferability was ensured by compiling detailed and descriptive information about the young whoonga users who participated in the study. Furthermore, the literature relating to the effects of whoonga usage by young people was reviewed in order to enable future researchers to refer to other studies on this subject.

3.8.3. Dependability (Consistency)

Dependability entails obtaining the same results if a study is observed twice (Trochim & Donnelly, 2007; Durrheim & Wassenaar, 2002). Sinkovics, Penz & Ghauri (2008) define dependability as a criterion that is considered equivalent to reliability and is similarly concerned with the stability of the results over time. Babbie and Mouton (2006) note, that, credibility relies on dependability and that demonstration of credibility is sufficient to show the existence of dependability. I established dependability by identifying accurate and dependable themes from the data obtained from the participants through following rigorous processes of qualitative data collation. Dependability was achieved by providing a thick description of the method and setting of my study in order for other researchers to obtain accurate information about it. I also ensured dependability by working with my supervisor in order to ensure consistency in the research plan and its implementation.

3.8.4. Confirmability (neutrality)

This refers to the degree to which a study's findings could be confirmed by others (Trochim & Donnelly, 2007). Confirmability was ensured by reducing researcher bias. The methods and materials like articles and audio data were interpreted objectively under the guidance of my University supervisors. My research was examined through the University of KwaZulu-Natal, thus enhancing confirmability. To enhance neutrality and data authenticity, I recorded all the research processes in a diary in order to avoid relying on human memory. The research interviews were recorded in this diary as well as meetings with social workers.

3.9. ETHICAL CONSIDERATIONS

Research ethics are rules of morally good conduct which should be grounded in moral and political beliefs (Gomm, 2003). De Vos et al. (2011) define ethics as a set of moral principles which are suggested by an individual or group and are widely accepted. In my study, I considered the ethics of honesty and integrity, utility and futility, the right to know versus the right to withdraw, informed consent and confidentiality and anonymity. These ethics promoted accountability when disseminating the findings and ensured honesty.

3.9.1 Honesty and Integrity

Hugman (2009) states that honesty and integrity is the truthfulness of research which includes both the process and product. The researcher was transparent with the participants and thoroughly explained the research process and procedures. I ensured the truthfulness of my research product through honest and value free interviews with recovering whoonga addicts. Furthermore, as a registered social worker, I was guided by the social work code of ethics when conducting interviews. I recorded the interviews after securing signed consent from the participants. I also availed the recorded interviews to my University supervisors as proof of the honesty and integrity of my research.

3.9.2. Utility and Futility

According to Hugman (2009), utility and futility include using and relying on a relevant methodology to acquire the desired findings. As noted previously, the study was established as useful and worth conducting in relation to existing knowledge and research on the subject. Thus, a thorough literature review was conducted before refining the topic and before choosing the most appropriate and relevant methodology.

My research supervisors also provided guidance on the selection of a sound research methodology. A proper rationale was provided for the research methodology chosen.

3.9.3. The right to know versus the right to withdraw or withhold information

The intention of the study was explained to the participants. The researcher did not put the interests of the study above the interests of the research participants or organizations under study (Hugman, 2009). The research participants are human beings and had a right to withhold confidential information. The researcher treated each participant as a unique person and further respected their recorded experiences and perceptions. The use of whoonga brought to the fore negative life consequences and they discussed sensitive issues with me. I respected this by not forcing them to divulge information that they were not comfortable to share in order to meet my research interests. There was no penalty for withdrawing from the study or not wishing to divulge details during an interview. In this way, I valued the worth, dignity and decisions of the participants during the research process. The participants had no problem disclosing information.

3.9.4. Informed consent

Informed consent involves making the participants fully aware of the type of information required, the nature of the research, the purpose of the information and the consequences of participating in the study (Kumar, 2011; Rubin & Babbie, 2013). The selected participants were fully informed of the nature of the study prior to seeking consent and were also notified that their participation was voluntary. I informed them that I would respect their decision should they wish to withdraw or refuse to participate and assured them that there would be no negative consequences. No participants withdrew and all were interested in taking part in the study. The participants signed consent forms showing that they were participating voluntarily. The study was properly explained in isiZulu and the consent forms were also provided in that language.

3.9.5. Confidentiality and Anonymity

Kumar (2011) defines confidentiality and anonymity as protecting information from being accessed by someone with no research intentions and also protecting the participants' identity. I protected the information collected from participants during the research process by not using their names or other identifying details in my report. Pseudonyms were used to maintain confidentiality and anonymity.

My supervisor, who had access to recorded information, had no access to their real identity. I was also guided by the South African social work profession ethics in maintaining the confidentiality and uniqueness of participants. The recorded information is stored in a safe, lockable cabinet in a safe place and no one will have access to the recordings. The Centre Manager provided written permission for the use of a secure office at the centre, in order to ensure confidentiality and privacy during interviews. The social workers ensured that this office was available for the interviews.

3.9.6. No Harm

No harm ethics ensures that the research participants are protected from any direct and indirect consequences of the research (Terre Blanche, Durrheim & Painter, 2006). I ensured no harm by monitoring the participants during the semi-structured interviews and determining that they were not experiencing any “vulnerability” due to the process. I used my skills as a social worker to assist them in minimizing vulnerability. I also offered on-site professional help and/or referred them for ongoing assistance at the Centre whose service staff was appraised in advance of the research. The participants were referred back to social workers to address any outstanding emotions. The semi-structured interviews were conducted in a manner that avoided and minimized harm. The researcher utilised his social work skills to probe the participants and ensure minimal harm. The participants were informed and guided against possible discomfort during the researcher’s questioning in order to be well prepared. During the interviews, the participants displayed minimal discomfort as the process was user friendly. Thus iterative consent (Hugman, 2009) was secured throughout the interview in order to address discomfort that might emerge. I ensured that before resuming the interviews, consent forms were signed to authorise the process. Finally, as noted above, pseudonyms were used to protect the participants.

3.9.7. Reciprocity

The researcher provided feedback to the participants from time to time. He took extra care that reciprocity occurred within the constraints of research and personal ethics. The researcher always maintained his role as an investigator.

3.10. LIMITATIONS

The study experienced the following limitations:

- Whoonga was only legally recognized as an illegal substance in 2014 (Government Gazette, 2014); thus the literature on whoonga use and abuse is still relatively limited. This was not problematic as the study was considered a pioneering one that would contribute to knowledge in this important field.
- Due to the small sample and since the study was limited to one organization, transferability was minimal. This was not problematic as this was a qualitative study that intended to offer rich detail on the subject using a small sample.
- Whoonga use is a relatively sensitive issue and initially users did not always feel free to discuss their experiences with the researcher. I addressed this by making very clear arrangements to obtain the sample and explaining the purpose of the study. I ensured anonymity and confidentiality by conducting interviews in professional offices.
- It was expected that obtaining a sample might be challenging as some whoonga users might not be willing to participate in the study. To reduce the impact of most of these limitations on the quality of my study, I used my social work skills and experience to develop rapport and a professional relationship with the respondents. I also had a larger participant base from which to secure additional participants should some fall away.
- The researcher acknowledges that, like any data collection tools, interviews are not free from limitations. One of the disadvantages is that respondents might try to impress the researcher by responding in a way they think will please him. I minimized this possibility by facilitating an environment where the respondents felt accepted and respected. I listened actively to their responses, and was sympathetic and non-judgmental. The interviews began with the least sensitive questions and proceeded to the most sensitive.
- This study was conducted in one township located in Durban. The sample did not represent all socio-economic backgrounds. However, since the researcher was not planning to generalize the findings, this limitation did not impact the value of the study. The study reports on the findings in a specific context.
- Whoonga is a very sensitive topic and is illegal. This negatively affected participation in the study. It took the researcher some time to find willing respondents. This

limitation was minimized by consistently working closely with the social workers. To ensure that the researcher did not violate privacy and social worker-client confidentiality, all participants were first approached by social workers.

3.11. CHAPTER SUMMARY

This chapter discussed the methodology employed by this study. It noted that the research study was qualitative in nature and that the approach was exploratory. The sample comprised of ten participants who are whoonga users. The process by which data was collected was described, i.e., in-depth interviews, as well as the use of an audio recorder with the participants' permission. The process of consultation and consent was also detailed, as was data analysis. The chapter also briefly described the research site. The limitations and challenges of the study and how these were minimized were discussed. Finally, the chapter outlined the ethical principles that the study adhered to. The following chapter presents and discusses the study's findings.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

4.1. INTRODUCTION

This chapter presents, discusses and interprets the participants' responses on the effects of whoonga use by young people from a township in Durban. Through interviews and observation, the researcher captured data on ten participants' experiences. Pseudonyms are used for ethical reasons. The participants' responses were analysed using thematic content analysis. Carey (2009) notes, that this type of data analysis is commonly used in social work qualitative research. Furthermore, it works best in exploring a small sample. Blanche, Durrheim and Painter (2006) concur that thematic analysis is suited to qualitative research. Using the bio-psychosocial theory frame of reference to explore the bio-psychosocial effects of whoonga use on young people, this chapter comprises of the following key themes identified by the researcher:

- Profile of participants
- Factors that contribute to whoonga use
- Whoonga usage
- Bio-psychosocial factors
 - Social factors
 - Biological factors
 - Psychological factors
- Recovery and rehabilitation centres
- Support programs
- Roles of families, community and government
- Participants' suggestions
- Chapter summary

4.2. PROFILE OF PARTICIPANTS

Table 1 below presents the research participants' demographic information. The study sample was not representative of all races and socio-economic groups in Durban because of the geographical location of the research site. The site is located in a township where only Africans and predominantly isiZulu-speaking people reside. Ten isiZulu speaking, African males from a township north of Durban participated in the study. The names used in the table are pseudonyms in order to ensure confidentiality and anonymity.

Table 1: Age, Gender, Employment status and Family composition

<u>Name</u>	<u>Age</u>	<u>Gender</u>	<u>Employment Status</u>	<u>Family composition</u>	<u>Years of use</u>	<u>Previous substance</u>
Bheki	30	male	Temporary employment	3 siblings and 2 nephews	10	Dagga
Qaphela	32	male	Self-employed	Grandmother and sister	09	None
Bongani	24	male	Unemployed	Mother, 2 maternal Uncles and 2 siblings	16	None
Thami	32	male	Temporary employment	Mother, 2 maternal Uncles, 1 sibling and two nephews	03	Dagga
Sfiso	30	male	Temporary employment	Parents and 7 siblings	16	Alcohol
Lovemore	25	male	Temporary employment	3 maternal Uncles, maternal Aunt and 3 siblings	02	Dagga
Nkosinathi	21	male	Unemployed	Mother and 3 siblings	01	Dagga
Lungelo	35	male	Unemployed	Parents and 2 siblings	08	Dagga

Mandla	29	male	Self-employed	Maternal grandmother, maternal Aunt and 4 cousins	07	Dagga ecstasy	&
Thulani	30	male	Self-employed	Parents and 3 siblings	16	Dagga	

4.2.1. Participants' ages

Table 1 above indicates that all the participants in this study were youth between the ages of twenty (20) and thirty-five (35). According to the National Youth Policy (2003) youth in South Africa are between the ages of twenty (20) and thirty-five (35). Six participants were between the ages of 30 and 35, three fell into the 20-25 age group and only one participant was between 26 and 29 years. Although not quantitatively significant, this indicates that most whoonga users in the study were aged between 30 and 35. Numerous media reports (Sowetan, 2015; Sunday Times, 2016) have indicated that whoonga is mainly used by teenagers who are still confused and escaping life responsibilities. However, in this study, the majority of participants were aged 30 years and above. These are mature ages and the participants would be expected to have families and jobs and be productive community members. The high number of participants in this age group that use whoonga suggests the much bigger problem of whoonga use.

4.2.2. Participants' Employment status

Table 1 above highlights that four participants were in temporary/casual employment, three were self-employed as hawkers and three were unemployed. The Sunday Times (2016) and World Economic Forum (2014) reported that most whoonga users used the substance due to unemployment. Mokwena and Huma (2014) concur that whoonga use is influenced by unemployment. This indicates that employment and thus financial status as one of the important factors that play a part in young people's decision to use whoonga. The participants were all not permanently employed and had more time to use whoonga.

4.2.3. Period of whoonga use and other related substances

The research participants purposefully selected to participate in this study were those with in-depth experience of using whoonga. As such, they had all used the substance for more than a year. Furthermore, table 1 above highlights that whoonga was not the substance that most participants started with. Seven used dagga before using whoonga and one participant started off on alcohol. Only two participants started with whoonga. This finding highlights the interaction of whoonga and other drugs. It is likely that people who are exposed to one type of substance, get exposed or graduate to using more dangerous substances.

The extracts below capture some of the discussion with the research participants that indicates that whoonga was not the first substance they started with and that when one uses other substances, there is a greater chance of being introduced to whoonga.

“I used to smoke dagga and had no interest on whoonga. My friend introduced it through mixing dagga with it without me knowing about it. The first time I used it, I felt the different, and the dagga was stronger than usual. I asked my friend about it and he admitted that dagga was mixed with whoonga and informed me about the whoonga supplier. After the first test, I tried to use dagga several times without whoonga and it couldn't reach the whoonga cravings, which made me interested in using the whoonga substance in order to satisfy its craving.” Bheki

“I was using dagga substance before and heard from my friends that whoonga substance can eradicate my anxiety. I started using it in order to deal with my anxiety.” Lovemore

4.3. FACTORS CONTRIBUTING TO WHOONGA USE

4.3.1. Peer pressure

The data reflects that peer pressure was the main reason for using whoonga. Five participants reported being introduced to whoonga by friends/peers through deceit, involuntary or voluntary. Hanson, Venturelli and Fleckenstein (2009:70) “stated that in groups where drugs are consumed, the extent of peer influence coupled with the art of persuasion and camaraderie are powerfully persuasive and cause the spread of drug use.” The Sunday Times (05:2016) reported that users formed cliques that easily influence one other. The extracts below highlight the role of peer pressure in whoonga use by some of the participants:

“I had fears that I will die soon due to my aggressive behaviour when drunk and needed a drug that will replace alcohol. My friend informed me that whoonga substance clash with alcohol which led me to start using the substance.” Sfiso

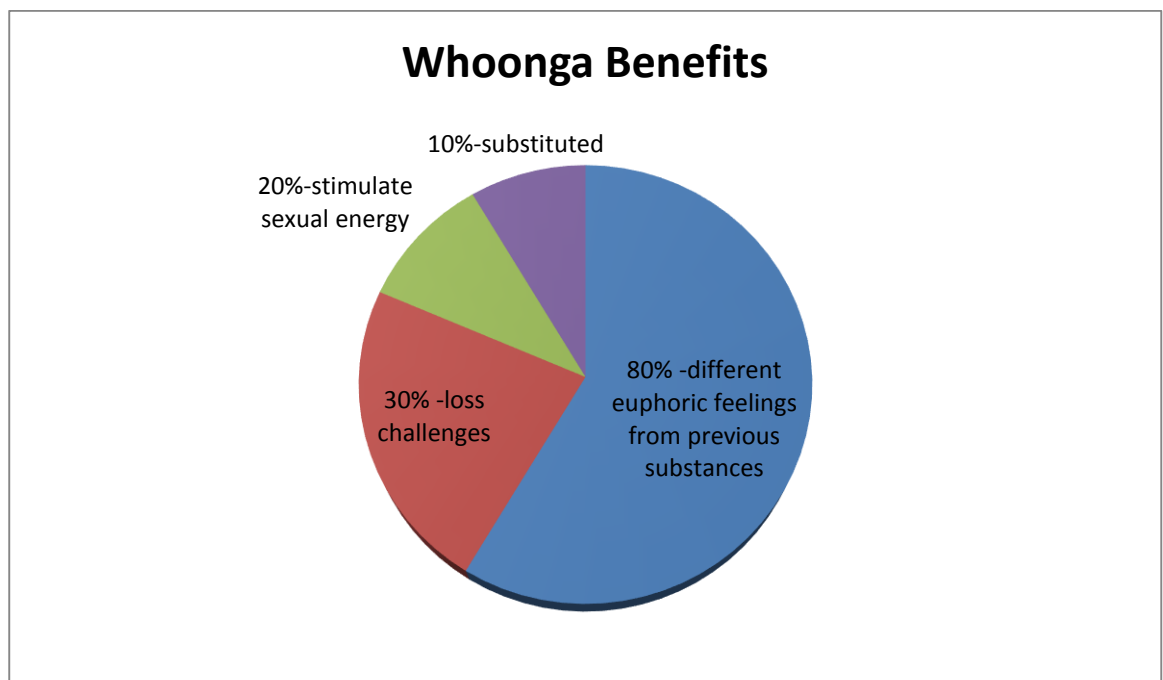
“I was using dagga and ecstasy prior to whoonga and needed a drug with strong gooft. My friends told me about the gooft of whoonga substance. I became interested as the two drugs had not much gooft (euphoric feelings). I started testing the substance and got hooked.”

Mandla

This indicates that most participants were influenced to start using whoonga and were further advised to continue with it if they felt withdrawal symptoms. It is also clear that all the participants had no knowledge of the substance and relied on information from friends and others to obtain whoonga.

4.3.2. Whoonga benefits

Chart 1: the following figures depict the benefits of using whoonga highlighted by the research participants. These benefits are further discussed under the sub-headings below:



4.3.3. Dealing with loss or challenges

The data show that whoonga was seen as a reliever of emotional pain due to the death or loss of loved ones. Three (30%) participants started to use the substance due to personal challenges. According to Moore (2008), all substance users have unhealed issues. The Sowetan (2015) indicated that some people turn to whoonga due to ‘vices’ that they have in life, which further affect them negatively. This indicates that the loss of loved ones contributed to whoonga use with the aim of dealing with emotional pain.

The extracts below highlight this factor:

“I had nightmares and flashbacks due to the traumatic death of my friend through gunshot whilst walking together. I started using the substance in order to forget the incidence and find later struggle to quit. I felt relax after using the substance and will have no flashbacks of my friend’s death. I grew up in a warm and stable family. My life was positive and had everything was going well until I started using whoonga substance.” Qaphela

“I lost my mother who was very close to me and later started experiencing poor treatment from her sisters and brothers. The mother’s absence led being defenceless and worthless. I wanted to quit using whoonga substance but couldn’t due to thoughts about mother’s death and the ill-treatment.” Lovemore

“My father was supportive and furthers a breadwinner. His death affected my life. I was afraid that people will see me as a loser. Due to bereavement emotions, I was exposed to whoonga substance thinking it will relieve the emotions.” Bongani

The loss of their loved ones exposed these participants to whoonga as they couldn’t cope with the painful bereavement/trauma. They turned to whoonga to relieve the painful loss and had no knowledge that it is strongly addictive. SANCA Vaal (2015) defines addiction as experimental use that develops into social use. A person starts using drugs occasionally because they enjoyed the experience the first time. Later, it becomes harmful use and abuse of drugs leads to problems such as relationship issues and health challenges.

4.3.4. Whoonga use in substituting other drugs

Some of the participants used whoonga to replace/overcome another addictive substance. One (10%) participant that did so did not know that whoonga is also very addictive. The participant highlighted using whoonga as a substitute for past problematic substances like alcohol. He mentioned that alcohol triggered aggressive behaviour towards other people and that he also had fears of death. He felt that he did not have the skills to control his alcohol intake and needed a substitute. His peers put pressure on him to choose whoonga due to information that it clashes with alcohol. The Sunday Times (05:2016) indicated that most young users substituted their previous substances with whoonga. This was due to various motives like wanting strong euphoric feelings and replacing a problematic substance.

The extracts below highlight some of the participants' use of whoonga as a substitute for other addictive substances:

"I had fears that I will die soon due to my aggressive behaviour when drunk and needed a drug that will replace alcohol. My friend informed me that whoonga substance clash with alcohol which led me to start using the substance." Sfiso

"I was experiencing less gooft from the dagga and ecstasy. I started to use whoonga in order to experience the high gooft. The dagga and ecstasy was replaced by whoonga drug."
Mandla

These extracts indicate that some participants use whoonga to deal with other addictive substances like alcohol which were starting to be a problem in their lives.

4.3.5. Whoonga as a source of euphoric feelings

All of the participants (100%) felt that whoonga was stronger than their previous substances, which were dagga, ecstasy and alcohol.

They all indicated strong euphoric feelings, deep contentment and relaxation. It energised them to perform work duties and do piece jobs like gardening. They also reported that it made them sexually active. The Sunday Times (05:2016) reported that whoonga users in Goud Street in Johannesburg said that whoonga use led to euphoric feelings, deep contentment and a relaxed mood.

The extracts below highlight the euphoric feelings experienced by the participants:

"Whoonga's gooft was very strong from what I am used to. I felt gooft in a different way from my previous drug and also will have feeling of being sleepy." Bheki

"The whoonga gooft made me decide to quit dagga and upgrade to whoonga substance."
Mandla

"The whoonga gooft made me decide to continue using it. I was not aware of its withdrawal symptoms." Lovemore

These extracts indicate that the euphoric feelings experienced contribute to on-going whoonga use.

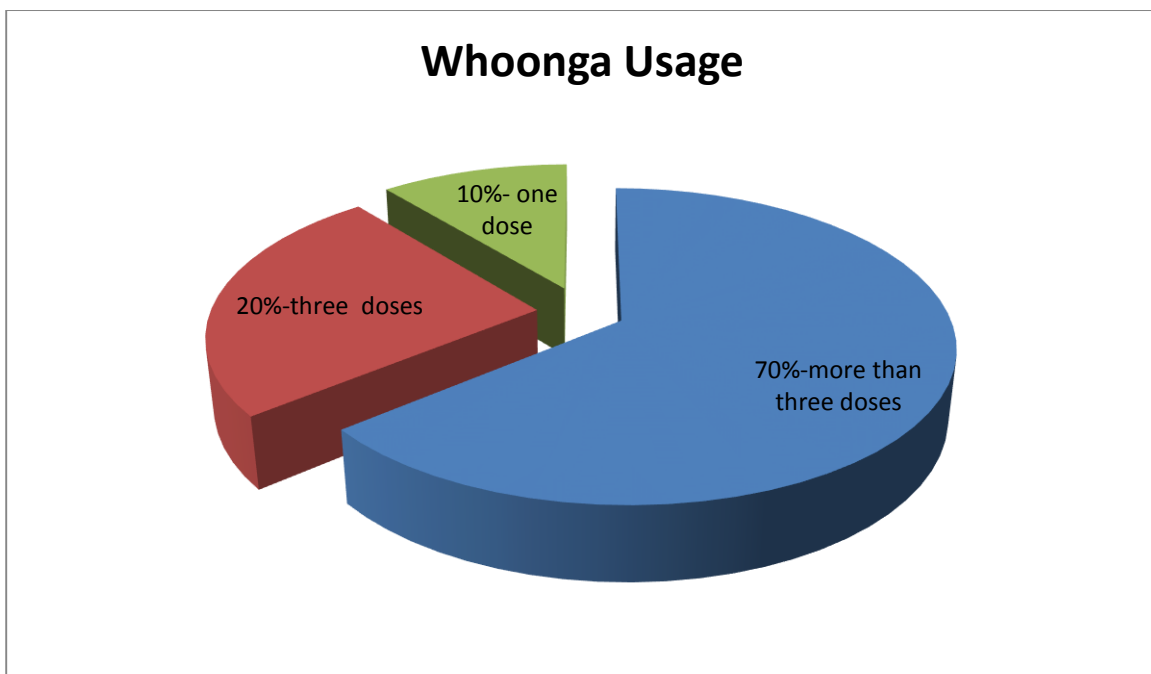
4.3.6. Whoonga usage

Most participants (N=7) reported using more than three doses of whoonga per day in order to experience euphoric feeling and sleepiness. They also indicated that it depends on their daily income; if they have more cash, they continue until it is exhausted. The participants added that whoonga can be used the whole day due to cravings. The extracts below capture the participants' experience of using whoonga and the number of doses used to feel euphoric:

“If I want to be well gooft, three doses per day are enough.” Bheki and Mandla

“It depends on my cash for the day and can use more than three doses. If I have enough cash, I will use five or more doses of whoonga substance.” Bongani, Sfiso, Lovemore, Nkosinathi, Lungelo and Thulani

Chart 2: The following figures shows the doses used per day in order to experience euphoric feelings.



Both the extracts and the figures indicate that the participants used more than three doses per day in order to feel euphoric, content and relaxed. The doses varied according to their daily income.

4.4. BIO-PSYCHOSOCIAL FACTORS

4.4.1. BIOLOGICAL FACTORS

Photograph 4 below indicates a user suffering from biological withdrawal symptoms and is discussed below:



Mbanjwa in City Press (2014)

The photograph shows that whoonga has physical effects. All the participants indicated that they experience euphoric feelings, deep contentment and relaxation after using whoonga. Mokwena and Huma (2014), Tuwani (2013) and Ephraim (2014) identified the physical effects when a user is in a state of craving as stomach cramps, joint pain, and other violent physiological changes, which leads them to want more. They also experience the energy to perform any duties and to induce sleep. According to Gibbons et al. (2013) and Mokwena and Huma (2014) the biological effects include toxicity of the nervous system, deteriorating personal hygiene, slow movement, severe cravings and a dazed look.

The following extracts indicate the biological factors experienced by whoonga users:

“I can sleep the whole day after three or more doses. The substance makes me sleepy and relaxed.” Qaphela

“I normally enjoyed the feeling of being gooft, when I use the whoonga substance. It normally takes about an hour in the body. I also feel sleepy.” Thulani and Bheki

“I have lost the sexual interest towards women and do not have time in women.” Thami

The biological effects of whoonga use are discussed below:

4.4.1.1. Health challenges

All the participants related losing weight due to whoonga use and said that they were in good health prior to usage. I observed that they were suffering from weight loss and that their health appeared to be deteriorating due to loss of appetite. A few participants indicated that they were suffering from TB and chest problems due to substance use. One participant experienced abdominal pain. Skin rashes and itching were also highlighted. All the participants said that they had itching bodies as well as rashes, pimples and sores.

They were also observed to be untidy during the interviews. They concurred that they become ignorant of or neglected themselves in terms of being clean or tidy. Some said that they struggled to bath themselves due to whoonga withdrawal symptoms and experienced low moods and exhaustion prior to usage. These are consistent with withdrawal symptoms.

The following extracts indicate the health impact of whoonga use:

“The whoonga substance has caused me to lose weight. I also have no time to be clean myself due to cravings.” Thami and Lungelo

“I have become dark in skin and have suffered from Tuberculosis due to whoonga use.”
Sfiso

“I can sleep the whole day and further ask my friend to wake me up if I have to go somewhere.” Bheki

4.4.1.2. Physical changes

All the participants highlighted physical changes and that they hardly ever bathed or wore clean clothes. During the interviews they were observed to lack cleanliness. The participants reported having no time to clean themselves due to spending most of their time using whoonga. They mentioned being unhappy about neglecting themselves.

Nine participants were also observed to be very thin which concurs with their statements that they had lost weight through whoonga use. All reported developing skin rashes which changed their lives and appearance.

The following extracts indicate the participants’ physiological changes and neglect due to whoonga use:

“I use to love myself and ensure cleanliness. Currently I just woke up, ignore my cleanliness and search for the whoonga substance.” Mandla

“It has burnt my fats in a strange way and feels tired to work in most instances.” Sfiso

The following extract from City Press (2014) indicates a user’s physical changes.

Nyaope (whoonga) boys talk

“I am like a dead man walking,” said Mandla Nkosi. Mandla is one of five nyaope boys from Extension 3 in Mhluzi who spoke out about the agony of drug addiction.”

(City Press, 2014)

4.4.1.3. Withdrawal symptoms

The participants reported agonising withdrawal symptoms including severe abdominal pain, back ache, sweating, chills, nausea, anxiety, diarrhoea, depression, yawning and restlessness. They also cited short tempers, uncontrollable tears, tiredness and sleepiness and mood swings. Mokwena and Huma (2014), Tuwani (2013) and Ephraim (2014) identified the physical effects of stomach cramps, joint pain, and other severe physiological changes when the user is in a state of craving. An addict told Mchome of The Citizen (22-10-2011), that if he stays without using whoonga, he feels like he is sick and his whole system is dead; whoonga brings him back to life. Withdrawal symptoms contribute to continued drug use (Pienaar, 2012).

The extract below highlights the participants' withdrawal symptoms:

“An arosta (withdrawal symptoms) is very painful. I will also feel sick, nausea, hungry with no appetite and .yawning.” All participants

4.4.2. PSYCHOLOGICAL FACTORS

Psychological dependence, also known as behavioural dependence entails the frequency of using a drug or the amount of time the drug addict squanders on drug-seeking behaviour (Ray and Ksir, 2004). All the participants indicated feelings of worthlessness, being unloved and suffering low moods during whoonga use. They used whoonga to enhance their feelings of worth and being loved and to improve their mood. The other challenge mentioned was the lack of daily activities in their lives which were overridden by whoonga thoughts. Substance use may lead to negative emotions such as loneliness, depression and anxiety (Van Wormer and Davis, 2008). The participants said that whoonga dominates their thoughts. They had no thoughts about future plans. Furthermore, they neglected their loved ones. They related waking up each day and thinking only of searching for a dose.

The following extracts indicate the psychological effects of whoonga use:

“The drug has possessed me to always think about it and cannot think about my life due to cravings. The whoonga substance has made me forget about thinking about my child's care and further seeking for another employment.” Mandla

“I always thought of my friend’s death and couldn’t sleep at night. I had traumatic emotions due to the way he died and had consistent thoughts. I started using whoonga with an intention to flush the thoughts away. I was not aware that whoonga is dangerous and only found after experiencing ‘arosta’. I always had thoughts on whoonga due to sickness if I hadn’t used it.” Qaphela

“I feel that the thoughts of whoonga substance are increased by spending most of my time doing nothing. I am not working which give me more time to think on the substance.”
Lungelo

4.4.2.1. Psychological effects

All the participants indicated developing psychological dependence on whoonga. They all felt ‘normal’ after using the substance which indicates psychological dependence. Some relied on whoonga for the energy to perform duties and for sexual activity. They also noted that they struggled to concentrate due to their euphoric mood and lazy feelings before use. The participants said that they had lost their social conscience. They indicated being selfish and corrupt in their thoughts. All displayed low self-esteem by relying on whoonga to boost such self-esteem. Berg (2015) noted that whoonga use is associated with low self-esteem, reactive depression, alienation, anxiety, inability to express feelings and mood disorders. Griffiths (2002) and Mokwena and Huma (2014) agree that the psychological effects involve mental tolerance which maximizes the frequency and amount of whoonga usage. The participants reported feeling self-confident towards challenges and daily duties. Some indicated that whoonga causes them to act in an inappropriate manner like committing a crime to buy the drug. They were sad and angry prior to usage and used the substance to make them happy and calm.

The following extract indicates the psychological effects of using whoonga:

“If I haven’t used the substance, I become irritated and down. I struggle to communicate to others even to open my mouth due to cravings. After the usage, I feel normal and calm to perform the daily duties.” Thulani

The psychological effects indicated by the participants include feelings of worthlessness, low self-esteem, poor support from their family and laziness. Their thoughts were dominated by

the craving for whoonga which made them unsatisfied and unhappy. They also felt lonely which caused them to use the substance.

4.4.3. SOCIAL FACTORS

4.4.3.1. Whoonga changed my life

All the participants indicated that they spent most of their time in isolated, hidden zones when using whoonga and hardly focused on their life. They woke up every day and walked to their zones to search for income by selling or casual jobs in order to have the first dose. This highlights that they have changed their lives as a result of whoonga use and started a different life in their zone. They have also formed new associations with friends with similar interests and spend less time on healthy life interests. It was highlighted that they avoid areas with non-users due to the stigma attached to using the substance and that too changes their self-image. They do not have time to seek permanent employment or follow their dreams.

The following photograph shows the isolated railway hidden zone used by whoonga users in Durban. This impact negatively on the following themes:



Picture 5: Tuwan in Daily News (2013)

4.4.3.2. Poor family relations

Four participants mentioned their family's poor support during whoonga use. They also experience accusations every time something goes missing from the house. This has created a poor relationship with their family members. The breakdown of social and family structures that should inculcate morals in the young has contributed to whoonga abuse (Nasibi, 2003). Users' concerns and suggestions are ignored. The participants indicated that their family members had rejected them due to their abuse of whoonga. They felt unsupported and ill-treated by their family. Zastrow and Kirst-Ashman (2004) state that substance use may lead to deterioration in health, relationship problems, child and spouse abuse, the loss of a job, low self-esteem, loss of social status, financial disaster, divorce, and arrests and convictions.

The following extracts illustrate the accusations experienced by the participants due to whoonga usage:

“The brothers and nephews always pinpoint at me when things went missing in the house, whereas it was my nephew. I then decided to move out to the street in order to avoid being blamed. I also went out to the street when everybody is awake and moving to their work in order to avoid being suspected of stealing.” Bheki

“I have both parents whom I regard them as absent due to their poor supportive role. I have requested things from them which they haven't done.” Mandla

4.4.3.3. Struggle to take responsibility for children

Three participants indicated struggling to support and care for their children. Because they spent all their time using the substance and very little on looking for work, they were not able to support their children materially or emotionally. They mentioned that they always procrastinate due to whoonga cravings. Most experience laziness. The Sunday Times (2016) interviewed a whoonga user with the pseudonym of Jomo, who indicated that after being retrenched, he lost hope and started using whoonga. He said that he stopped supporting his family in Mpumalanga and lost hope of finding another job.

The following extracts illustrate the participants' poor support of their children due to whoonga use:

"I spend most of time on the street smoking the drug and cannot focus on constructing my life and further support my children. My children were taken away due to my poor care towards them as a result of substance use. They stay in Gauteng with their grandmother. I miss them sometime but struggle to see them due to cravings." Bheki

"My child was taken away by her mother due to not being supportive towards him. I still do not get time to visit him due to whoonga substance." Qaphela

4.4.3.4 Relationship challenges

All the participants indicated that their relationships and communication changed due to whoonga usage. They developed more negative emotions like a short temper when suffering from withdrawal symptoms. They also indicated relationship challenges with partners. Some of the participants' relationships broke down due to a lack of care and time with their partner. One participant indicated having no relationship from the start as most of his life had been committed to the substance. Lembersky (2004) also reported that relationships are negatively impacted by substance use.

The following extracts indicate the challenges experienced by the participants in their relationships with their partners and society at large:

"I started spending less time with the child's mother due to whoonga substance which led to relationship challenges. She begged me several times to quit the substance and couldn't due to withdrawal symptoms. I then overheard that she is seeing another person and we end up separating." Qaphela

"When I am using whoonga, I had no time towards relationships. It makes me focus only on it." Thulani

This indicates that users struggle to maintain their social relationships with their family and community and also their intimate relationships with their partners due to whoonga usage.

4.4.3.5. Criminal personality

Three participants reported that they were unemployed because of their tendency to engage in criminal activities in order to support their habit. According to the National Drug Master Plan (2006-2011:4), substance abuse is a major contributor to crime, poverty, reduced productivity, unemployment, a dysfunctional family life, political instability, an escalation in chronic diseases such as AIDS and TB, injury and premature death. Furthermore, some substance users exhibit unacceptable behaviour such as mugging, stealing, snatching handbags and violence to acquire the money to satisfy and maintain their habit whilst others may resort to prostitution (Bezuidenhout & Joubert, 2003). The participants related that they were working but had been fired due to whoonga use or retrenched because of company challenges. Retrenchment led to the need for more whoonga doses. They sold their belongings and stole from their family to finance their craving. The data revealed that the participants were part of gangs that committed criminal offences to finance their habit. The participants said that whoonga had changed them personally by losing their social conscience and becoming corrupt and selfish. They have ceased to care for and love others.

The following extracts capture the participants' feelings about their criminal behavior:

“After losing my job, I started stealing from myself and my family in order to smoke whoonga drug. I saw myself losing my guilty conscience and changing to a corrupt person due to whoonga. I was part of the Gang that commits robberies and thefts within the shops and Trucks that load goods.” Lungelo

“I was stealing from my family and myself. I started stealing in my community and was nearly beaten to death several times. I got arrested three times due to thefts and robberies. That how whoonga changed me.” Lovemore

4.4.3.6. Trust and Values

Trust and values were also highlighted as life changing issues by all the participants. They said that they had lost the trust of the community which lowered their image. They dissociated themselves from non-user friends and join the users which changed their personality completely. Friends and neighbours no longer trusted them. While they were once popular in their community, after using whoonga they became fearful and isolated themselves. They focused on whoonga rather than improving their lives. They also lost their values and adopted negative values. They started behaving badly due to losing respect. All the participants indicated that their community distrusts them and suspects their motives.

All participants, especially those that are unemployed, mentioned that they have lost respect in their community. Their neighbours and community isolate them and are vigilant about their whereabouts. Some participants indicated that their community and neighbours expressed disappointment when they heard about their whoonga usage. The extracts capture these experiences:

“The substance destroyed my personality, dreams and furthers my partner. People lost trust on me and fear to associate with me.” Qaphela

“When I enter a gate in one of my neighbours, I will hear them saying that they must watch their cell phones and other belongings.” Nkosinathi

4.4.3.7. Employment circumstances

Two participants related losing their jobs due to using whoonga. They overslept and were consistently late for work. They said they were given a chance to improve their performance but it deteriorated. They mentioned that losing their job led to low self-esteem and feelings of worthlessness. The World Economic Forum (2014) noted that unemployment is a contributing factor to substance use in South Africa and further indicated that the rate had increased to 50%. Some participants indicated that lack of employment had created more time on their hands or being bored which developed the whoonga habit.

The extracts indicate the impact of whoonga use on the participants’ employment:

“I felt not confidence after losing my job and felt lonely as well. I then saw the whoonga substance as an option towards relieving my problems.” Lungelo

“If I was employed, I would have been busy working and ignore the substance.” Thulani

4.4.3.8. Social Rejection

All the participants reported being perceived of as a thug or parasite, which promoted social rejection and hopelessness. The community suspected them of theft or planning to steal. They disregard them and treat them like animals. They intensified security measures if they saw them and did not allow them into their homes. They even avoided walking at night because the neighbours and community would suspect them if something went missing. Mokwena and Huma (2014) identify social rejection as another contributor to whoonga use. The following extracts capture the rejection felt by the participants due to their use of whoonga:

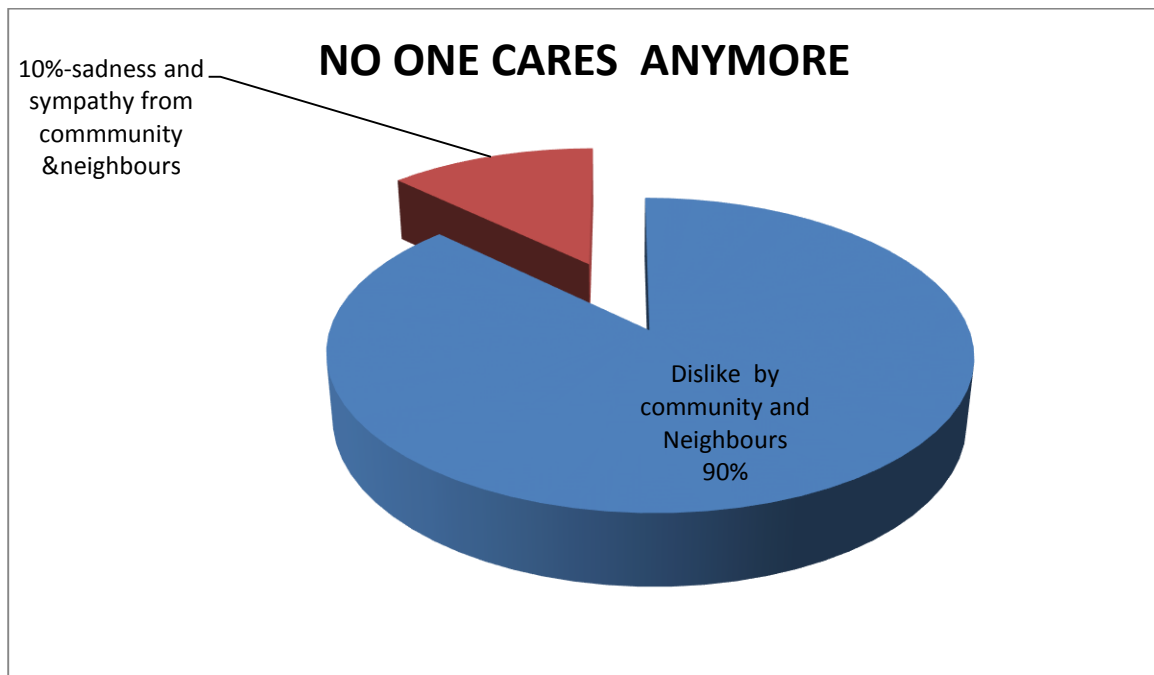
“The friends and neighbours called me ‘Skhotheni’ (thug) or ‘parah’ (parasites) which does not settle well. It made me distance away from them and move to stay with other users in our zone.” Bheki

“They isolate us during the social gathering/party in the community and will sit in groups of non-whoonga use and whoonga use. It does not feel well to be rejected.” Lovemore

4.4.3.9. No one cares anymore

The participants indicated that the community and neighbours resented whoonga users. Only one participant felt that the community reacts by being sad and sympathetic. They have shown no respect towards them especially after they were retrenched from work or unemployed. The Sunday Times (05:2016) reported that whoonga users had lost hope that their neighbours and community would care about them and felt that they did not want them.

Chart 3 below indicates reaction from the community and neighbours with regard to whoonga use.



The chart indicates that the reaction from community and neighbours is overwhelmingly negative, with only a few feeling sad and sympathetic.

4.5. REHABILITATION SUPPORT TREATMENT CENTRES

4.5.1 Abstinence

Eight participants said that they had attempted to quit on their own several times but had relapsed. One participant that had been using whoonga for three years had not previously tried to quit and another said that he had not used whoonga for a month. This shows that most participants find it difficult to quit on their own due to unbearable withdrawal symptoms.

The participants said that they had tried different methods like traditional medicine, methadone treatment, self-medication by pain killers and spiritual support to deal with whoonga cravings. However, they still had cravings.

They all indicated relapsing and re-developed cravings. The following extracts indicate that the participants relapsed due to withdrawal symptoms:

“I have tried several times to quit using the drug and failed due to cravings. I have even tried to use traditional medicine to stop using the whoonga drug and it did not help.” Bheki

“My friend gave me some of his methadone, which lasted for two days. In those two days, I was able to stop using whoonga substance and relapse there after due to lack of methadone.”
Qaphela

“I used the painkillers medication thinking it will end and it was stronger than medication.”
Lovemore

*“I have tried twice to stop on my own and failed due to painful cravings. I was sent to Stanger area where there is a Sterkile spiritual centre and it did not help me.”*Thulani

“I have not tried to stop due to painful withdrawals.” Thami

*“I came to a decision to stop without medication or support. I saw it wasting my future and my time.”*Lungelo

The extracts indicate that the methods utilised by the participants to abstain were unsuccessful due to withdrawal symptoms. A few were afraid to try to stop due to uncomfortable withdrawal symptoms.

4.5.2 Influences on quitting

The findings indicate that families, neighbours and friends played a vital role in influencing the participants to stop using whoonga. Most indicated being encouraged to quit by family members, close neighbours and friends.

“My female friend and neighbours always advises me to stop smoking whoonga and follow my dream.” Bheki

“My family and partner disapprove my whoonga usage whilst friends support it.” Nkosinathi

“My family, neighbours and friends always advise me to quit the substance and did not understand that it is not easy.” Thulani, Lovemore, Lungelo and Mandla

4.5.3 Rehabilitation treatment centres

Nine participants indicated that there are limited treatment centres in the area and that they are not well-resourced to fight whoonga use. Bradshaw (2007) and The Sowetan (2015) indicated that a lack of rehabilitation centres in poor communities and poor health services contribute to whoonga use. Temmingh and Myers (2012) note that the highest number of treatment centres in South Africa are located in Gauteng and the Western Cape. KwaZulu-Natal thus has a limited number. The participants highlighted that of the three commonly known centres, Newlands rehabilitation centre (in-patient treatment centre), KwaMashu community health centre (outpatient centre) and Sterkile spiritual centre (Stanger area-in-patient centre); the two inpatient ones are outside KwaMashu and have limited space. Most of the participants said that they were on the waiting list for admission to the Newlands rehabilitation centre.

The extracts below illustrate that there are few treatment centres in the area and the impact on treating whoonga addiction:

“There is no rehabilitation centre in my community except the Newlands centre.” Bongani, Lungelo, Mandla and Nkosinathi

“I haven’t seen any rehabilitation centre in the area.” Thami and Thulani

“I only know about the Newlands rehabilitation centre which is outside the area.” Qaphela

“Some who quitted were assisted by Sterkile centre which is not situated at KwaMashu area.” Sfiso

“The KwaMashu health centre is the treatment centre that I am receiving help from and is accessible to us.” Lungelo

Most of the participants showed interest in being admitted to the centre and are still on the waiting list.

4.5.4 Support programs

Seven participants related receiving support from community organizations like Reverend Mthakathi's non-profit organization. They also reported that it is the only one that is accessible in the community. However, they indicated that it has limited services and refers people to the social workers in the health treatment clinic for further treatment. The Sowetan (08:2015) highlighted the challenge of limited support programs to deal with whoonga use.

The extracts below indicate the support received from one organization in the area:

“People like Reverend Mthakathi help us by referring to the social workers at the clinic.”
Bheki, Thulani

“Reverend helps us a lot and we sometime run away from him. He shows support even though he has no resources to treat the substance.” Lovemore, Mandla

Three participants said that they were unaware of any support programs in the area. They added that they spent most of their time in their isolated zone using whoonga.

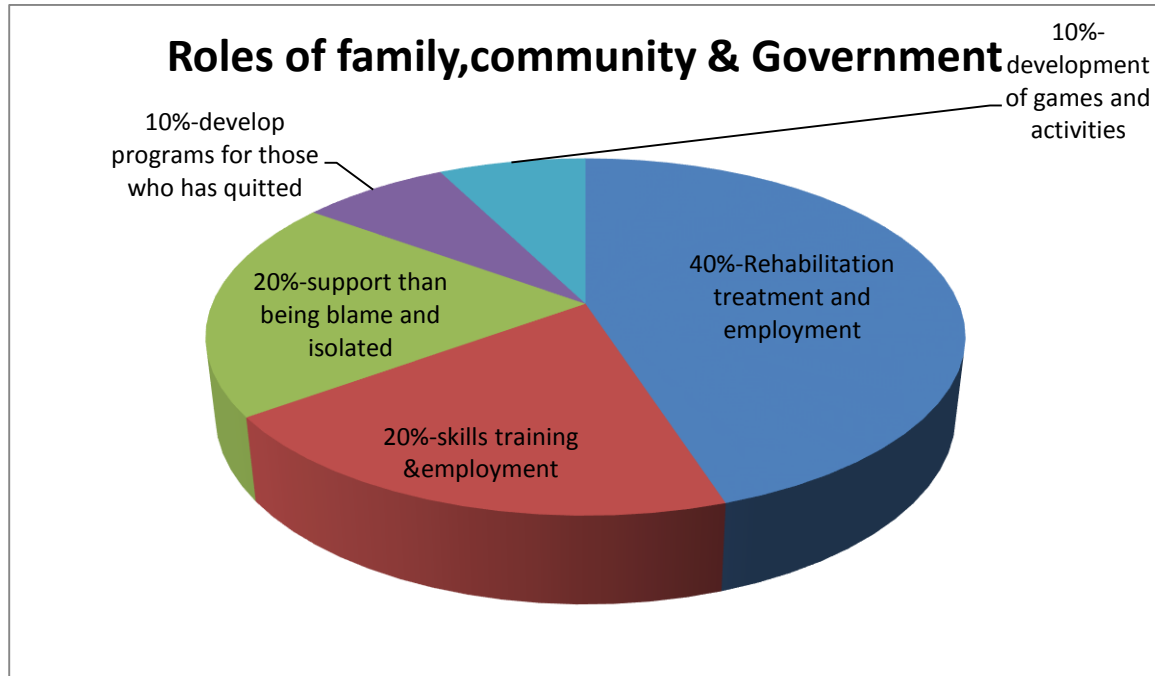
“I am not sure since I do not spend much time in the area.” Qaphela

“There is no support from the community and has tried on my own to quit.” Bongani, Thami, Nkosinathi

These extracts suggest that there are insufficient support programs in the community for whoonga users and that more programs are required.

4.6 ROLES OF FAMILY, COMMUNITY AND GOVERNMENT

Chart 4 figures below indicate the roles identified by the participants for families, the community and government and identify the programs they could support:



4.6.1 Skills training and employment

The participants said that families, the community and government could assist with skills training and job placement.

The following extracts indicate the roles that could be played by families, the community and government in dealing with whoonga use:

“The methadone treatment drug has helped some of us towards whoonga craving.” Bheki, Nkosinathi

4.6.2 Rehabilitation and employment

Some participants (N=4) mentioned that families, the community and government should support them by sending them to rehabilitation centres and create employment opportunities in order to avoid them returning to the smoking zone. As outlined below, this would also assist to keep them busy and occupy their thoughts:

“If they can send us to the rehabilitation centre and create jobs to avoid going to the same area to relapse.” Qaphela, Bongani, Mandla

4.6.3 Genuine Support services

Two participants felt that there is a need for families, communities and the government to assist in providing genuine services or treatment in order for them to quit whoonga rather than isolating or blaming them.

“People must not play with us when they want to help so that we will quit.” Sfiso

“If they can help us in stopping the whoonga substance unlike now where they blame us or isolate us.” Lovemore

4.6.4 Games and activities

One participant also suggested the implementation of games and activities to motivate them to continue to abstain.

“Government should put games and activities to keep us busy especially in school holidays.”
Thulani

The participants thus suggested rehabilitation programs, activities, skills training and employment to address whoonga use among the youth. These should be supported by families, the community and government.

4.7 PARTICIPANTS’ SUGGESTIONS

Most participants suggested the need for rehabilitation programs and thereafter job placement in order to avoid relapse. Some participants saw the supply of Methadone as the solution as well as commitment by whoonga users to quit. These issues are discussed below:

4.7.1 Rehabilitation and Employment

As the following extracts show, most participants indicated that if they could receive rehabilitation at treatment centres as well as jobs, they would avoid using whoonga in the future.

“If we can be admitted to the rehabilitation centre and be employed thereafter, few people can use the drug.” Bheki, Sfiso

“We need to be cleaned from the substance by rehabilitation centres. I am also seen a social worker and still in the waiting list.” Qaphela

“If I can be employed, there will be slim chances to use whoonga substance.” Bongani

4.7.2 Methadone Medication

Some participants suggested the provision of Methadone as the solution to deal with cravings:

“Methadone is the medication that can stop the painful symptoms and is expensive.”
Nkosinathi and Mandla

4.7.3 Positive decisions and Activities

Two participants suggested that the decision to quit should start with the whoonga user and then an appropriate program should be implemented to support them. They noted that whoonga users must be willing to attend the program. Increased activities and awareness could save more people.

The extracts below indicate that decision making skills play a part in treating whoonga addiction:

“The activities can build us and keep us busy to think about whoonga substance.” Lungelo

“People can attend all the rehabilitation centres and continue using the whoonga substance. Before being admitted at the rehabilitation centre, a decision to quit should come from the person.” Thulani

This indicates the importance of linking rehabilitation, employment, and medical treatment as well as addicts’ commitment through positive decisions.

4.8 CHAPTER SUMMARY

This chapter presented a comprehensive analysis of the study participants’ different perceptions of the effects of whoonga use among youth in KwaMashu. It discussed the bio-psychosocial effects, causes and programs available to support whoonga users. The discussion was guided by the study’s objectives and theoretical framework, that is, the bio-psychosocial model. The results of the study varied due to the different perceptions of the ten whoonga users. Overall, they indicate that users are not coping well due to withdrawal symptoms. The main causes were identified as peer pressure, personal emotional challenges and upgrading from smaller doses of other substances to whoonga. It can be concluded that these bio-psychosocial effects have severe consequences for the participants’ personal lives. It was also noted that whoonga users face different challenges in accessing rehabilitation and community support programs due to the limited number of service providers.

CHAPTER FIVE

SUMMARY OF THE STUDY FINDINGS AND RECOMMENDATIONS

5.1. INTRODUCTION

This study explored the factors that influence whoonga usage among young people in KwaMashu Township and the bio-psychosocial effects of the substance. It adopted the bio-psychosocial theory which enabled an understanding of the effects of whoonga and the role played by programs in supporting users. A qualitative research approach was deemed appropriate due to whoonga being a relatively new substance. Furthermore, this approach enabled the researcher to explore, discover and clarify situations through examining feelings, perceptions, attitudes, values, experiences and beliefs. It also allowed the researcher to study selected issues in depth, openly and in detail to understand the information that emerged from the data.

The literature shows that substance abuse is causing major health and social challenges in South Africa (Mokwena and Huma, 2014). According to the United Nations World Drug report (2010), South Africa is one of the leading substance abuse centres in the world. Substance consumption in South Africa is twice the world norm, with an estimated 15% of South Africans said to have a substance problem. Mokwena and Huma (2014) note that substance use, especially whoonga, has increased among impoverished young Black people in the townships since 2000. Bradshaw (2007) and The Sowetan (2015) observe that the lack of rehabilitation centres in poor communities and poor health services are contributing factors to whoonga use. Given this background, the study's objectives were:

- To explore the common reasons for whoonga usage by young users at a selected drug centre.
- To determine the bio-psychosocial effects of whoonga usage.
- To explore available support programs for whoonga addicts.

Using a purposive sampling technique, a sample of ten willing young males between the ages of 20 and 35 who fitted with the research aims and knowledge were selected. The data was collected using semi-structured interviews guided by an interview schedule that enabled

freedom of expression. The questions in the schedule had no set order. It was translated into IsiZulu in order to enhance communication. The participants agreed to the use of an audio recorder to record the interviews. After transcription, the data was analysed using thematic content analysis. The study adhered to the ethical principles outlined in chapter 3. This chapter presents the study's findings and summarizes its main conclusions. Recommendations are also offered based on these findings and conclusions.

5.2. MAJOR CONCLUSIONS

Based on the study's findings, its major conclusions are synthesized and presented under the following headings:

5.2.1. Conclusion regarding the profile of participants

Although the study focused on participants aged between 20 and 35, it was found that addiction is a problem for all ages. The majority of the participants were aged 30 years and above. This is generally regarded as a mature age group and people in this group are expected to be stable members of society that have families and jobs and are productive community members. The findings of the study show that drug addiction has no age limit. Thus, substance abuse awareness and prevention services should be extended to all and not only target teenagers.

Another important finding was the employment status of whoonga users. None of the participants were permanently employed, which contributed to whoonga use. A study conducted by the World Economic Forum (2014) stated that the increasing unemployment rate in South Africa contributed to the high rate of drug abuse, particularly whoonga. Most unemployed participants indicated that they had time on their hands and alleviated boredom by using whoonga, leading to a lack of interest in seeking employment.

Some participants, who had previously been employed, indicated that whoonga use led to them losing their job. They added that while they had been given the opportunity to mend their ways, they had failed due to on-going use of whoonga. While unemployment has been cited as a factor contributing to whoonga use, its physical and the medical effects also limit a user's chances of obtaining a job.

5.2.2. Conclusion regarding the factors contributing to whoonga use

5.2.2.1. Peer pressure

Peer pressure was identified as a major reason for whoonga use by young participants. Participants who had no previous knowledge of whoonga reported, that, friends influenced them to use it. Similarly, Hanson, Venturelli and Fleckenstein (2009) and the Sunday Times (2016) reported that most participants were influenced by friends to use whoonga. The study participants also reported that their friends not only introduced them to whoonga, but encouraged them to remain addicted. When they wanted to quit their friends advised them that there was no way out and they should continue to smoke in order to avoid becoming ill.

5.2.2.2. Death of a significant person

The loss of a significant other was also cited as one of the main contributors to whoonga use. Some participants hoped to alleviate bereavement or trauma by using whoonga. Similarly, Moore (2008) reported that unhealed personal issues or emotions as a result of the loss of a significant person contribute to whoonga usage. The participants said that they were introduced to whoonga due to emotional challenges as a result of the death of family members and friends. They ended up addicted to the drug. Some reported that they had tried to quit several times but were unsuccessful due to withdrawal symptoms.

5.2.2.3. Substituting a problematic substance with whoonga

Another factor that was identified as contributing to whoonga usage is graduating from a less euphoric drug to whoonga. All the participants had used other substances before turning to whoonga. Most were using dagga or alcohol.

They said that when they discovered the euphoric feelings whoonga offered, they decided to graduate to the drug. The participants indicated having no knowledge of how addictive whoonga is until they started using it. The Sunday Times (2016) reported that replacing a problematic drug with another addictive drug leads to re-addiction. Furthermore, users graduated from dagga to whoonga. The participants said that while they had been able to cease using alcohol, they developed an addiction to whoonga. This suggests that users graduate from one drug to another addictive drug due to dissatisfaction with the previous substance.

5.2.2.4. Whoonga as a source of euphoric feelings, contentment and relaxation

All the participants indicated that whoonga use led to euphoric feelings, contentment and relaxation. Furthermore, they had more energy to perform their duties and be sexually active. Comer, Walker and Collins (2005) reported that whoonga users feel euphoric and elated; this 'high' is followed by feelings of drowsiness and relaxation which are similar to the effects of heroin. Continued whoonga use leads to higher tolerance levels and addicts therefore resort to using larger and more frequent amounts of the substance to achieve the same high. The participants indicated that whoonga is the best when it comes to satisfaction which leads them to crave more of the substance. They also said that they enjoyed the physical strength and vitality produced by whoonga. Most participants described the effects of whoonga as calming, peaceful, enjoyable and satisfying which led to them wanting more. They also explained that they felt stress free and that they could sleep at night despite their problems. They had tried to quit but were unsuccessful due to severe withdrawal symptoms.

5.2.3. Conclusions regarding the Bio-psychosocial effects

Most participants indicated that they experienced stomach cramps, joint pain and deteriorating personal hygiene which drove them to seek more of the drug. Mokwena and Huma (2014); Tuwani (2013) and Ephraim (2014) cited stomach aches, painful joints and physiological changes like losing weight as the physical effects of whoonga. The participants said that the withdrawal symptoms were severe and unbearable during the early stages of addiction.

The participants suffered health challenges as a result of using whoonga. All mentioned losing weight and their appetite. They were also exposed to chronic diseases such as AIDS and TB, abdominal pains, chest problems and premature death. The participants developed skin rashes, pimples and sores which itched consistently. I also observed that they were untidy. A study conducted by Van Wormer and Davis (2008) confirmed that whoonga destroys the body's organs, and causes poor nutrition and poor personal hygiene.

All the participants were identified as having developed behavioural dependence on whoonga. They depended on the substance to enhance their low self-esteem, love and worth. The participants reported that whoonga usage has psychological effects. Berg (2015), Griffiths (2002) and Mokwena and Huma (2014) reported that the psychological effects are associated with low self-esteem, poor mental tolerance, mood disorders and the inability to

express feelings. The participants noted that they felt 'abnormal' due to whoonga usage which indicates psychological dependence. However, they felt 'normal' once they used whoonga. They were unable to work or even engage in sexual activity and were found to suffer concentration challenges due to euphoria, short tempers, laziness, sadness, withdrawal symptoms and self-destruction. It was noted that the participants' thoughts revolved around the substance, causing poor self-development and planning for the future. This indicates poor life development due to whoonga use. All the participants also indicated losing their conscience and becoming corrupt due to their addiction. This indicates that the participants are psychologically dependent on whoonga.

Most participants indicated that their use of whoonga led to a lack of family support and being accused when items went missing from the house. Their poor relationships with their families led to mistrust in family related matters. The participants reported being exposed to family rejection and ill-treatment. Most of those that had children struggled to support them financially and emotionally. They hardly spend any time with them and did not provide support during their upbringing. Furthermore, they did not offer love and care to their families and partners. Nasibi (2003) also reported that whoonga usage leads to the breakdown of family and social relationships. Furthermore, the participants indicated being feared, mistrusted and isolated from their families and community.

They feel rejected by their families, old friends and partners. Most indicated that there is no time to spare for their families, friends and partners due to withdrawal symptoms and always being in their smoking zone. They also indicated spending less time at home which affected their relationships. The participants noted that they had lost most of their relationships due to being unavailable.

The participants reported that they had created a new set of friends who are also whoonga users, which affected their old relationships. Their loved ones do not trust them as they do not understand them due to a lack of communication and there was constant tension in their families. Zastrow and Kirst-Ashman (2004) and Lembersky (2004) note that substance use may lead to health deterioration, relationship problems, child and spouse abuse, the loss of one's job and social status, financial disaster, divorce, and arrests and convictions.

All the participants indicated that their lives had changed due to whoonga use. When they lost their jobs due to whoonga, they had no income. The need to satisfy their craving led to criminal behavior against both their family members and society at large. Bezuidenhout and Joubert (2003) report, that, whoonga use is a major contributor to crime, poverty, reduced productivity, unemployment and dysfunctional family life.

Due to whoonga use, the participants changed their values and adopted corrupt ones, losing respect from their families and community. They noted that they were suspected of criminal activity and the community felt uneasy around them; this resulted in social rejection. Similarly, Mokwena and Huma (2014) report, that, social rejection is another effect of whoonga use.

5.2.4. Conclusion regarding Rehabilitation Treatment programs

The participants indicated several unsuccessful attempts to quit on their own. Unbearable withdrawal symptoms were cited as the main reason. Various methods including traditional medicine and changing their place of residence were used. The participants also noted a lack of support programs to help them to quit.

5.2.4.1. Rehabilitation centres

Most participants indicated that there are insufficient rehabilitation centres in their area. Bradshaw (2007); The Sowetan (2015); and Temmingh and Myers (2012) found that KwaZulu-Natal is one of the provinces with limited rehabilitation resources to support poor communities and also suffers from poor health services. The study found that the KwaMashu outpatient centre is the only centre providing rehabilitation programs in KwaMashu. The participants noted that nearby centres like Newlands Inpatient and Sterkile spiritual centre are full.

5.2.4.2. Support centres in KwaMashu Township

The majority of the participants indicated that there are limited support programs to assist addicts to combat withdrawal symptoms. Organizations that do offer assistance refer people to the KwaMashu outpatient treatment centre for further support. According to The Sowetan (2015) there are limited support programs in communities to deal with whoonga addiction.

5.2.5. Conclusion regarding the Roles of families, the community and government

The participants felt that families, the community and government are not playing a genuine and effective role in supporting whoonga users. They indicated that these structures reject them or blame them which led to their isolation. The participants felt that they could assist in various ways like introducing games and activities in communities, referring them to centres, and creating skills centres and organizing job placements. This suggests that the participants have not received sufficient support from families, the community and government.

5.3. PARTICIPANTS' SUGGESTIONS

The participants offered different suggestions to combat whoonga use. Most suggested admission to a rehabilitation centre and employment opportunities once they are discharged. Others said that users should be supplied with methadone to deal with withdrawal symptoms. Others indicated the importance of taking positive decisions and engaging in activities.

They stated that rehabilitation alone cannot deal with substance use. This highlights the importance of a multi-treatment approach incorporating rehabilitation, methadone, positive decisions and activities. It is thus recommended that a holistic treatment approach be adopted to address the whoonga problem.

5.4. RECOMMENDATIONS FOR FUTURE RESEARCH

In view of the fact that this study was not representative of all the population groups in the Durban area, it is recommended that a follow-up study be conducted using a sample of black, white, Indian and coloured whoonga users residing in the Durban area. This research study focused on the contributory factors and the bio-psychosocial effects of whoonga use among young people in KwaMashu. The findings from the interviews confirmed the bio-psychosocial effects. However, a scientific study in the field of the natural sciences might be required to confirm the biological and psychological effects of whoonga use. Furthermore, the study focused on whoonga users. It is recommended that future studies focus on families' perceptions and experiences. There could also be a need for further scientific studies on cravings as the findings of this study were not conclusive. The study also found that whoonga is easily available in communities. This suggests the need for research on the laws and policies on the use of whoonga.

5.5. CONCLUSION

In conclusion, this study provided insight into the bio-psychosocial effects of whoonga use among young people in KwaMashu. It also focused on the important factors that contribute to whoonga usage. It is hoped that its findings will contribute to an understanding of the growing problem of whoonga addiction and offer guidelines on improving treatment programs. The participants identified whoonga addiction as a disease which exposed them to withdrawal symptoms and different illnesses. The rehabilitation centre and support programs were found to be insufficient to deal with the problem. The participants also highlighted that families, the community and government play a minimal role in supporting them in recovering and instead blame them. They offered suggestions to combat whoonga use. It is thus concluded that the study's objectives were achieved and that it satisfied the researcher's quest for knowledge on the bio-psychosocial effects of whoonga use among young users in KwaMashu.

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APPENDIX 1: FULL ETHICAL CLEARANCE LETTER



9 March 2016

Mr Nkululeko M Khumalo 9700575
School of Applied Human Sciences
Howard College Campus

Dear Mr Khumalo

Protocol reference number: HSS/1698/015M

Project Title: Understanding the effects of whoonga use on youth in KwaMashu Township, North of Durban

Full Approval – Full Committee Reviewed Protocol

In response to your application received 19 November 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

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 Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Professor M Kasiram & Ms Mathe
Cc Academic Leader Research: Dr Jean Steyn
Cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee



Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbao@ukzn.ac.za / anjmanm@ukzn.ac.za / mohunp@ukzn.ac.za

Website: www.ukzn.ac.za

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APPENDIX 2: REQUEST FOR PERMISSION TO CONDUCT THE MY STUDY



School of Applied Human Sciences
College of Humanities,
University of KwaZulu-Natal,
Howard College Campus,
29 September 2015

Dr Mthethwa
Medical Manager
KwaMashu Health care centre
KwaMashu

Dear Director

RE: PERMISSION TO CONDUCT RESEARCH AT YOUR CENTRE.

My name is Nkululeko Mphumeleli Khumalo. I am a Master of Social Work student studying at the University of KwaZulu-Natal, Howard College campus, South Africa. For my research project, I am interested in understanding the bio-psychosocial effects of whoonga substance use on young adult Addicts in the Durban, KwaMashu area. I intend to interview ten participants from the KwaMashu Health care centre to gather information.

I believe that the study will be useful to your centre in attaining more insight on the problem and in implementing a treatment program that takes cognizance of my study results.

I shall adhere to the strictest ethical code of conduct. In particular, I shall consider the following:

- The participants' anonymity will be guaranteed as their inputs will not be attributed to them in person, but reported only as a population member opinion.
- The interview may last for about 1 hour and may be split depending on your and respondent preference.
- Any information given by the participants will not be used against them, and the collected data will be used for purposes of this research study only.
- Should painful or difficult issues arise during the interview, I shall employ my social work skills to address them and/or refer the respondent for ongoing services.
- Data will be stored in secure storage and destroyed after 5 years.
- Participants have a choice to participate, not participate or stop participating in the research. They will **not** be penalized for taking such an action.
- The participants' involvement is purely for academic purposes only, and there are no financial benefits involved.
- If they are willing to be interviewed, they will be audio recorded upon receipt of their permission.

I can be contacted at:
Email: nkululekomphumeleli1@gmail.com
Cell: 0843015598

Ms Cindy Naicker
School of Applied Human Sciences

Postal Address: Durban, 4041, South Africa

Telephone: +27 (0)31 260 2391 Facsimile: +27 (0)31 260 2618 Email: naickerc@ukzn.ac.za Website: www.ukzn.ac.za
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

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1



My supervisors are Professor M. Kasiram and Mrs Mathe from the Department of Social Work at the University of KwaZulu-Natal. They can be contacted on 031 260 7443/1216 respectively.

You may also contact the Research Office through:
P. Mohun
HSSREC Research Office,
Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za

Thank you for your contribution to this research.

Yours Sincerely



Nkululeko Mphumeleli Khumalo
Master's student



Professor M. Kasiram
Supervisor



Ms Mathe
Supervisor

APPENDIX 3: PROVISIONAL GATEKEEPER's CONSENT LETTER



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

KWAMASHU COMMUNITY HEALTH CENTRE
Private Bag X 013 Kwa-Mashu 4360
P61 Mkhwane Road Kwa Mashu 4359
Tel.:031 504 9100, Fax. 031 504 9111
www.kznhealth.gov.za

Enquiries: Dr J. Mthethwa
Extension: 504 9102
Date: 01 October 2015

Attention: Mr N.M. Khumalo
University of KwaZulu Natal

Dear Sir

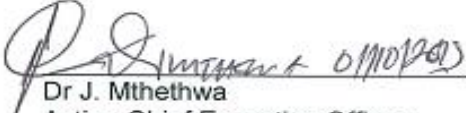
**RE: PROVISIONAL PERMISSION TO CONDUCT RESEARCH –
KWAMASHU CHC**

Please note that provisional permission has been granted for you to do Research at KwaMashu CHC on the research proposal title: **Bio- psychosocial effects of whoonga substance abuse.**

However, you are kindly advised to liaise with Mr V. Hadebe (Social Worker) to facilitate your research.

Wishing you all the best on your research study.

Thank you


Dr J. Mthethwa
Acting Chief Executive Officer

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX 4 : ETHEKWINI DISTRICT GATEKEPPER'S CONSENT LETTER



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address : 83 King Cetshwayo Highway, Mayville, Durban, 4001
Postal Address: P Bag X54318, Durban 4000
Tel: 031 - 2405308 Fax: 031 2405555 Email: somaroo@ukzn.ac.za

DIRECTORATE:

eThekweni District Office

5 February 2016

Dear Mr Khumalo

Re: Understanding the Bio-psycho and social effects of whoonga use by youth in KwaMashu Township

I have pleasure in informing you that your application to conduct research in EtheKwini district has been approved at KwaMashu Community Health centre.

Please note the following:

- i. All research activities must be conducted in a manner that does not interrupt clinical care at the health care facility,
- ii. logistical details must be arranged with the social worker (Mr V Hadebe) of the facility,
- iii. this research project should only commence after final approval by the KwaZulu-Natal Health Research and Knowledge Unit, and full ethical approval, has been granted, and
- iv. a report of your findings should be forwarded to the EtheKwini district office on completion of your project.

Yours sincerely

H Somaroo (Dr)
Medical Officer- Public Health Medicine

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX 5: FULL GATEKEEPER'S CONSENT LETTER



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3169/ 3123 Fax: 033 394 3782
Email:
www.kznhealth.gov.za

Health Research & Knowledge
Management

Reference: 53/16
KZ_2015RP41_712

Date: 4 March 2016
Dear Mr N. Khumalo

Approval of research

1. The research proposal titled 'Understanding the Bio-psycho and social effects of whoonga use by youth in KwaMashu Township, North of Durban' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at kwaMashu Community Health Centre.

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 hrkm@kznhealth.gov.za**

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 07/03/16

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APPENDIX 6: INTERVIEW SCHEDULE

NKULULEKO MPHUMELELI KHUMALO

9700575

Understanding the bio-psycho and social effects of whoonga substance use by youth in
KwaMashu Township, North of Durban.

SECTION A: IDENTIFYING PARTICULARS

- Age, sex, financial status, family composition

SECTION B: CONFIRMATION QUESTIONS

- Did you use the whoonga drug before?
- How did you first learn about the whoonga drug?
- How long did you use a drug?
- What is your perception about whoonga drug?

SECTION C: CAUSES ON USAGE

- What motivated you to choose to use a whoonga drug?
- How often do you use a whoonga drug?
- How do you finance your whoonga usage?
- How did your life challenges contribute to whoonga use?
- How has your life changed as a result of whoonga use?

SOCIAL FACTORS

- How does your family circumstances contribute to your use of whoonga?
- What about friends and neighbours' influences in your whoonga use?
- Describe your experiences when/after using the drug?
- How does your immediate community/neighbourhood react to the whoonga drug use?
- Tell me if there are any gangs' in the area that contribute to your drug and if so, how

PSYCHOLOGICAL FACTORS

- What usually make you think of using whoonga?
- What feelings do you experiences when/after using whoonga drug?
- What are the psychological effects when using the whoonga drug?

BIOLOGICAL FACTORS

- How does the drug affect you physically immediately and after a short time period?
- How do you handle these reactions?
- Have you had withdrawals symptoms of whoonga drug and if so, describe?

RECOVERY, REHABILITATION, RECOMMENDATION

- What attempts have you made in trying to stop taking the drug and what was the result?
- Who influences you to stop or continue with using this drug?
- What are the rehabilitation programmes that are available in your community to assist in recovering from whoonga use?
- What are the challenges in accessing the supportive programs in your community?
- What are your suggestions for drug users to help them stop taking it or getting addicted in the first place?
- What should the family, community, government do to help?

APPENDIX 7: INFORMED CONSENT FORM IN ISIZULU

Ukuthakasela ukwazi ngomthelela wesidakamizwa esibizwa nge woonga kwintsha ekwaMashu eseningizimu yeTheku.

School of Applied Human Sciences
College of Humanities,
University of KwaZulu-Natal,
Howard College Campus.

Mhlanganyeli othandekayo

Incwadi eyazisa ngenvumo

Igama lami ngingu Nkululeko Mphumeleli Khumalo, ngingumfundi wezifundo zobungcweti kwezenhlalakahle kwisikhungo senyuvesi yakwaZulu-Natali, eyikolishi elibizwa ngokuthi uHoward. Nginokuthakasela ukwazi ngomthelela wesidakamizwa esibizwa nge woonga kwintsha ekwaMashu eseningizimu yeTheku. Ngihlosa ukuqasha umhlanganyeli kwindawo eyisikhungo sokwelapha abezindakamizwa kwaMashu ukuze kuhlangukane ulwazi.

Ngicela wazi okulandelayo:

- Imfihlo yakho iphephile njengoba imibono yakho ingeke ibonakale ukuthi eyakho, njengoba izobikwa ngemibono yabantu
- Ingxoxo ingathatha ihora elilodwa noma ihlukaniswe phakathi uma ufuna.
- Noma uluphi ulwazi osipha lona, ngeke lusebenziswe ngokuphambene nawe, futhi luzosetshenziswa inhloso yalophenyo kuphela.
- Ulwazi olutholakalayo luzobekwa endaweni ephephile bese lushabalaliswa emva kweminyaka eyisihlanu.
- Unako ukukhetha ukuhlanganyela, ukungahlangukane noma ume ukuhlanganyela kuphenyo. Ngeke ugwetshe ngokuthatha lesosinyathelo.
- Uphenyo luhlose ukuthola ulwazi olujulile ngomthelela wesidakamizwa sewoonga kwintsha esisebenzisayo elokishini lwaMashu.

- Ukuzibandakanya kakho kuhlose imfundo kuphela, ngeke kubekhona inzuzo yezimali efakwayo.
- Uma unesifiso sokuba kwingxoxo, ngicela ukhethhe (ngokufaka uphawu) ukuthi uyafisa noma awufisi ukuqoshwa ingxoxo ngalezinhlobo ezilandelayo:

	Uyafisa	Awufisi
Umshini wokuqopha amazwi		

Ungangithinta lapha:

Email: nkululekomphumeleli1@gmail.com

Cell: 0843015598

Abangiphethe u Professor M. Kasiram (PhD in Social Work) no Mrs Mathe kuyona indawo yosonhlalakahle kwiNyuvesi yakwaZulu-Natali. Ungabafonela kulenombolo 031 260 7443/1216.

Ungaphinda ufonele kwihhovisi lophenyo ku:

P. Mohun

HSSREC Research Office,

1. Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za

Ngiyabonga ngomnikelo watho kuloluphenyo.

IZWI LOK Mina (amagama aphelele omhlanganyelwa, ngila uku qinisekisa ukuthi ngiyaqonda okungaphakathi kulo mqulo kanye nesimo sopenyo. Ngiyangunyaza ukuhlanganyela kuloluphenyo lwenhloso.

Ngiyaqonda ukuthi nginenkululeko okulokuyeka kwinhloso nomangabe yisiphi isikhathi

SAYINA MHLANGANYELWA USUKU

.....
UFAKAZELA

APPENDIX 8: INFORMED CONSENT FORM IN ENGLISH

School of Applied Human Sciences
College of Humanities,
University of KwaZulu-Natal,
Howard College Campus.

Dear Participant

INFORMED CONSENT LETTER

My name is Nkululeko Mphumeleli Khumalo. I am a Master of Social Work student studying at the University of KwaZulu-Natal, Howard College campus, South Africa. I am interested in learning about the effects of whoonga substance use by youth in KwaMashu, North of Durban central area. I intend to employ participants from.....To gather information, I am interested in asking you some questions.

Please note that:

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 1 hour and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.
- You have a choice to participate, not participate or stop participating in the research. You will **not** be penalized for taking such an action.
- The research aims at gaining insight on the effects of whoonga substance use on young adult Addicts in the Durban central area.
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not willing
Audio Equipment		

I can be contacted at:

Email: nkululekomphumeleli1@gmail.com

Cell: 0843015598

My supervisors are Professor M. Kasiram (PhD in Social Work) and Mrs Mathe from the Department of Social Work at the University of KwaZulu-Natal. They can be contacted on 031 260 7443/1216.

You may also contact the Research Office through:
P. Mohun
HSSREC Research Office,
Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za

Thank you for your contribution to this research.

DECLARATION

I..... (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT

DATE

.....

