

A content analysis of the National Drug Master Plan 2006-2011 from a social development perspective

by

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“For the Lord is good;
his mercy is everlasting;
and his truth *endureth* to all generations.”
Psalm 100:5

LS GEYER

Pretoria, April 2012

Dedicated to my godparents, Billy and Christa Vorster

Abstract

A content analysis of the National Drug Master Plan 2006-2011 from a social development perspective

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The goal of this study was to analyse and describe the content of the National Drug Master Plan 2006-2011 (NDMP2) from a social development perspective. In order to achieve this goal, a quantitative research approach was adopted to determine objectively whether indicators of social development are encapsulated in the manifest content of the NDMP2. To this end a cross-sectional survey research design guided the study. A checklist, as a data collection instrument, was developed and utilised to collect data. The validity, that is face and content validity, and reliability ($r = 0.98$) of the checklist, was confirmed. From the raw data, descriptive statistics, specifically frequencies and percentages, were calculated.

Three different genres of policy analysis were undertaken to answer the following research question: “*Is the content of the NDMP2 in accordance with a social development perspective?*” The key finding of the study was that, holistically interpreted, the NDMP2 is in accordance with a social development perspective because all ten the identified dimensions of a social development theoretical framework, i.e. capital development, innovation, integrated service delivery strategy, intervention by social service professionals, levels of service delivery, mandate, partnerships, principles, a rights-based approach and target groups, are captured in the content of the policy, albeit with different prominence. In addition, it was found that the NDMP2 has specific limitations due to the exclusion of several indicators of social development.

It was concluded that the content of the NDMP2 has both strengths and limitations, when interpreted from a social development perspective. Amongst the *strengths* of the NDMP2 are the following: a multi-sectoral approach; bridging of the micro-macro divide; and provision for vulnerable groups, with the emphasis on the youth and children. The *limitations* of the NDMP2 are that its strategic framework fails to give equal weight to harm reduction strategies, alongside demand and supply reduction strategies; economic capital development

is totally omitted; clear indicators for the monitoring and evaluating of policy are absent; treatment, as a level of service delivery, receives the most attention at the expense of prevention, early intervention and aftercare and reintegration services; a human-rights approach towards service delivery is not adequately emphasised; and, lastly, the NDMP2 does not make provision for gay, lesbian, bisexual and transgender people as a vulnerable group.

To align future National Drug Master Plans (i.e. NDMP 2012-2016) with a social development approach, the recommendations are, amongst others, to ensure equal attention is given to demand, supply and harm reduction strategies; to include economic capital development in the service delivery framework; to illuminate clear indicators for policy evaluation purposes; to provide equal weight to all levels of service delivery; and to ensure a human-rights approach to service delivery is clearly delineated.

Future research could compare the content of all the National Drug Master Plans in South Africa as valuable insights could be obtained about the development of such policies and the alignment of these plans with a social development approach.

Keywords:

- Alcohol and drug abuse
- Content analysis
- Developmental approach
- Dimensions of social development
- Indicators
- National Drug Master Plan
- Social development
- Social development indicators
- Substance abuse

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Chapter 1: General introduction

1.1 INTRODUCTION AND CONTEXTUALISATION

Worldwide the numbers of people who abuse alcohol and other drugs (AOD¹), and who are involved in drug-related crimes, are increasing. The *World Drug Report 2011* indicates that every year approximately 210 million people worldwide consume *illicit drugs*, of whom about 200 000 die each year as a consequence of drug abuse (United Nations Office on Drugs and Crime [UNODC], 2011:8). Cannabis is the drug most often used, with between 125 and 205 million users, followed by amphetamine-type stimulants (ATS) and opioids (UNODC, 2011:13). Drug trafficking costs “hundreds of billions of dollars” and puts the stability and security of nations at risk (UNODC, 2011:8). The *Global Status Report on Alcohol and Health 2011* reports that alcohol, a *licit drug*, results in 2.5 million deaths per annum due to alcohol-related diseases (World Health Organization [WHO], 2011:x). The consequences of alcohol abuse are numerous: 29.6% of deaths around the world are associated with unintended injuries (for example violence and self-inflicted injuries), followed by 21.6% of the world population being diagnosed with alcohol-related cancers and 16.6% presenting with liver cirrhosis (WHO, 2011:22, 26). Globally, alcohol use is estimated to be 6.13 litres of pure alcohol per capita per annum (WHO, 2011:4). Despite the absence of exact figure, it is evident that alcohol abuse poses a threat to the economic development of countries (WHO, 2011:33).

The African continent has not escaped the negative effects of AOD abuse and drug-related crimes. Approximations are that 59.14 million Africans² use cannabis per annum, followed by 8.1 million ATS and 4.4 million cocaine users (UNODC, 2011:24). Indications are that between 13 000 and 41 700 Africans die per annum as a result of drug abuse (UNODC, 2011:41). With the potential of the drug industry to result in substantial incomes, Africa, together with the numerous poor living on the continent, is often involved in the illegal production of cannabis, opium and ATS (UNDOC, 2011:40). Cannabis is the drug most often trafficked between African countries, while cocaine is smuggled from South America to

¹ Within the context of this study the concepts ‘AOD abuse’, ‘drug abuse’ and ‘substance abuse’ will be used interchangeably. These concepts refer to both legal and illicit drugs.

² The term ‘Africans’ refers to people living on the African continent. It has no racial connotation.

Europe via Africa (UNODC, 2011:40). In addition, the WHO (2011:5) estimates that Africans consume around 31.4 litres of pure alcohol per capita per annum.

South Africa has an estimated 50.59 million citizens (Statistics South Africa, 2011). Of these, approximately 270 991 citizens are problem drug users who primarily use cannabis and ATS and a further 1.97 million citizens are problem alcohol users³ (Department of Social Development [DSD], 2008a:25, 31) who, on average, consume 34.9 litres of pure alcohol per capita per annum (WHO, 2011:276). In South Africa the direct costs involved in alcohol and illicit drug abuse are calculated to be R104.8 billion and R101 000 million per annum, respectively (DSD, 2010a:15-17). It is thus evident that AOD abuse is causing numerous bio-psychosocial and economic problems around the globe.

A worldwide problem such as AOD abuse needs to be addressed by universal declarations and conventions. The United Nations takes the lead in this regard, and a first attempt to mitigate the problems associated with drug abuse and illicit drug trafficking came about through the *Single Convention on Narcotic Drugs, 1961* as amended in 1972 (UN, 1972). Thereafter the *Convention on Psychotropic Substances, 1971* (UN, 1971) and the *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988* (UN, 1988) followed. In addition, the ten principal commitments adopted at the *World Summit for Social Development, Copenhagen* make provision for the eradication of substance abuse (International Council on Social Welfare [ICSW], 1995). In 2001 the ten principal commitments were streamlined with the formulation of eight targeted Millennium Development Goals (MDGs) which are envisaged to be achieved by 2015 (Zammit, 2003:3-4).

The African continent has established initiatives to deal with drug abuse. The *Social Affairs Portfolio* of the African Union (AU) manages drug control amongst its responsibilities (Republic of South Africa [RSA], Department of Foreign Affairs, 2004:1). The southern region of the African continent has, as the Southern African Development Community (SADC), drafted a *Protocol on Combating Illicit Drugs* (1996) and has established a *Regional Drug Control Programme* (1998) (Franzern, 1999:2). This protocol and programme are specifically applicable to member states of the SADC. These initiatives are clearly an indication that the African continent is aware of the negative impact that drug abuse has on achieving development goals, such as the Millennium Development Goals.

³ Problem alcohol users are males who consume five or more, or females who consume three or more units of alcohol per day (cf. DSD, 2008a:31).

In South Africa, as a member state of the SADC, the *Reconstruction and Development Programme* (hereafter referred to as the RDP) has paved the way for the social welfare sector to respond to people's basic needs and to adapt social welfare services according to a developmental paradigm with the aim "... to promote social justice ... build human capabilities and enhance livelihoods and social functioning ..." (Patel, 2005:208). With the adoption of the *White Paper for Social Welfare* (hereafter referred to as the White Paper) the social welfare sector responded towards the realisation of South Africa's socio-economic goals through the adoption of social development as a welfare approach (Midgley, 2001:272). The White Paper created the framework for all social ills, including AOD abuse, to be dealt with from a social development perspective. Since the adoption of the White Paper, the first social policy to deal with AOD abuse and drug-related crimes has been the *National Drug Master Plan 1999-2004*. The *National Drug Master Plan 1999-2004* (hereafter referred to as the NDMP1) was drafted and implemented under the leadership of a former Minister of Welfare, Ms Geraldine Fraser-Moleketi, with the rationale of the policy being: "[the] South African Government is ... committed to reducing both the supply of illegal drugs and the demand for them through a wide range of actions and programmes" (Department of Welfare, 1999:3). It is clearly stated in the NDMP1 that "establishing a National Drug Master Plan should not be seen as the end of a process, but rather the beginning"; therefore the policy is revised to adjust to current "... socio-economic problems facing the country ..." (Department of Welfare, 1999:46).

With the current *National Drug Master Plan 2006-2011*⁴ (hereafter referred to as the NDMP2), efforts were made to design a policy "[that] reflects the country's [South Africa] responses to the substance abuse problem as set out by UN Conventions and other international bodies" (DSD, 2007a:4). Dr Zola Skweyiya, the Minister of Social Development at the time, elucidated the necessity for the NDMP2 with the following remark in his foreword to the policy: "[the] scourge of substance abuse continues to ravage our communities, families and, particularly, our youth; the more so, as it goes hand in hand with poverty, crime, reduced productivity, unemployment, dysfunctional family life, escalation of chronic diseases and premature death" (DSD, 2007a:1). Hence, to manage the negative implications of drug abuse and drug-related crimes, the NDMP2 calls for "[a] concerted effort ... from the government and the different sectors of society to make South Africa a drug-free country" (DSD, 2007a:5).

⁴ The *Central Drug Authority Annual Report 2009/10* reported that the following National Drug Master Plan will cover the period April 2012 to March 2016 (DSD, 2010a:22).

Parry (1998:62) criticised the NDMP1 when he stated that “... one of the things that is missing from the Master Plan is a clear articulation of the way in which alcohol and other drugs impact on other national priorities, e.g. development ...” As South Africa has adopted social development as a priority for its development agenda, this study intended to analyse and describe the content of the NDMP2 in order to determine whether this policy has been drafted in accordance with a social development perspective. An analysis and a description of the NDMP2 from a social development approach⁵ were considered appropriate, since this approach is based on normative theory which enables social researchers to formulate criteria and principles for research endeavours in order to inform social policy, research and practice (Patel & Hochfeld, 2008:197). A National Drug Master Plan which is formulated from a social development perspective could furnish social service providers with a mandate to deal with AOD abuse and drug-related crimes by investing in people’s human, social and economic capital and as a result contribute towards the achievement of South Africa’s social developmental goals (cf. Lombard, 2005:224-225; Midgley & Tang, 2001:247-251).

1.2 PROBLEM STATEMENT AND RATIONALE

The increase in substance abuse is a worldwide phenomenon, and the impact thereof on social development is a huge concern, also in South Africa (Da Rocha Silva & Malaka, 2008:44; Mashele, 2005:1). International initiatives, including the ten principal commitments adopted at Copenhagen (ICSW, 1995) and the MDGs (Zammit, 2003:3-4), to which South Africa is a signatory, are instrumental in promoting and achieving social development goals, including the eradication of substance abuse and drug-related crimes.

The role of the social welfare sector in social development is mandated by the White Paper (RSA, Ministry for Welfare and Population Development, 1997). In accordance with the social development focus in social welfare, it is essential that all social policies explicitly sanction role players to contribute towards the country’s social development goals in conjunction with specific social challenges, such as drug abuse, to which it aims to respond (Patel, 2008:73). Within the context of this study, the NDMP2 should not only mandate social service providers to implement various initiatives, strategies and programmes in order to achieve a “drug-free society” (DSD, 2007a:13), but should also enable and call upon all role players to contribute towards the realisation of South Africa’s social development goals by fulfilling their services in accordance with a developmental approach. As such, the premise of this research is that if the NDMP2 is drafted according to a social development perspective, the concerted effort of

⁵ In this study the concepts **social development perspective** and **social development approach** are used interchangeably.

stakeholders who implement the NDMP2, could contribute towards the achievement of the country's social development goals, which envisage a country in which every citizen's basic needs are met, human resources are developed, the economy is growing, and democracy prevails (RSA, 1994:9). If social development goals are achieved, this will further be evident through several development indicators, including: an improved Human Development Index (HDI); a Gini-coefficient reflecting a balance between the rich and poor; a decline in poverty rates; and an increased Gross Domestic Product (GDP) (cf. Green, 2008:175-179; Patel, 2005:49-51; United Nations Development Programme [UNDP], 2003:xv-xxii).

It was confirmed through Sabinet, the South African Research Database, that no study, or accredited article, exists which has analysed the content of the NDMP2. Within the context of this study, the challenge, therefore, was to address this limitation from a social development perspective. In this regard Da Rocha Silva and Malaka (2007:17) made the following appeal:

... the recruitment and training of drug-related researchers who are orientated towards policy, service delivery and socioeconomic development has to be ensured. The social work departments at universities could be useful in this respect, considering their current emphasis on a social development approach to social work and social work's concern with individuals as well as the environment in which they live.

This study intended to take up this challenge. Both Da Rocha Silva (2009/01/15) and Malaka (2009/02/07) have confirmed that the researcher's intention to analyse and describe the content of the NDMP2 from a social development perspective will make a valuable contribution to the field of substance abuse. Commenting as both a social work scholar and member of the Central Drug Authority (CDA), Malaka (2009/02/07) responded as follows on the suspect of the envisaged study: "I hope your study is carried out immediately, as the CDA will have to submit a revised document ... and your study is not only relevant but very important as it might serve to guide the CDA." To this end, the following research question had to be answered: "*Is the content of the NDMP2 in accordance with a social development perspective?*"

1.3 GOAL AND OBJECTIVES OF THE RESEARCH STUDY

The **goal** of the study was to analyse and describe the content of the National Drug Master Plan 2006-2011 from a social development perspective.

The **objectives** of the study were as follows:

- to describe both the *historical development* of drug policy and legislation in South Africa, and the *content* of the NDMP2 by means of a historical and descriptive policy analysis;
- to develop a checklist consisting of indicators for social development to guide the analysis of the NDMP2;
- to analyse the content of the NDMP2 from a social development perspective, and draw conclusions on its strengths and limitations; and
- based on the research findings and conclusions, to make recommendations on the formulation of the *National Drug Master Plan 2012-2016*⁶ from a social development perspective.

1.4 RESEARCH METHODOLOGY

This study was rooted in a post-positivist paradigm with its intention to analyse and describe the manifest content of the NDMP2 from a social development perspective (Rubin & Babbie, 2010:15). Manifest content refers to items in a document that are “directly visible [and] objectively identifiable ...” (Rubin & Babbie, 2010:244-245). Consequently, a quantitative research approach was adopted to determine objectively whether indicators of social development are encapsulated in the manifest content of the NDMP2 (Neuman, 2006:323). Studies, which aspire to discover and describe the content of documents, such as the NDMP2, are mostly undertaken with a descriptive research purpose (Neuman, 2006:44). This study could therefore be considered descriptive.

As it was the aim of this study to obtain results which could be used to address a problem or issue in the ‘real world’, such as drug abuse, this study was applied in nature (Newton, 2006:8-9). The intention of this study is, amongst other things, to inform policy formulation in order to deal with acute social problems, namely drug abuse and drug-related crime in South Africa (Monette, Sullivan & DeJong, 2002:5). Since this study was quantitative in nature, and aimed at analysing and describing the content of a policy, a cross-sectional survey research design was considered to be the most appropriate research strategy (Babbie, 2007:102; Fouché, Delport & De Vos, 2011:146,156; Rubin & Babbie, 2010:43). Following three consecutive steps, the data collection instrument, a checklist (see Addendum 1), which consists of indicators of social development for drug policy in South Africa, was developed (cf. Babbie, 2007:125-127; Baster, 1972:15; Hong & Hodge, 2009:214-215; Neuman, 1997:133-

⁶ Hereafter referred to as the NDMP3.

138). The credibility of the checklist was ensured through both face and content validity, as well as with the calculation of the Pearson correlation coefficient (r), to determine its reliability (Krippendorff, 2004:315; Neuendorf, 2002:116; Rubin & Babbie, 2010:83). With $r = 0.98$, the reliability of the checklist was confirmed (Fouché & Bartley, 2011:274; Pietersen & Maree, 2007a:236). The content analysis process of Leedy and Ormrod (2005:142) was followed to analyse and describe the NDMP2. To comply with the required rigour analysing manifest content, two different software packages, i.e. WordSmith Tools 6 and Microsoft Word 2010, were utilised during the content analysis process. From the raw data, descriptive statistics, specifically frequencies and percentages, were calculated (Babbie & Mouton, 2001:52; Sapsford, 2006:185-192). Before the empirical study was undertaken, its feasibility was ensured through, amongst others, ethical clearance from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (see Addendum 2). For a more detailed discussion of the research methodology and ethical considerations applicable to this study, see Chapter 3, Section 1.

1.5 DEFINITION OF KEY CONCEPTS

The key concepts relevant to this study are presented below.

1.5.1 Content analysis

According to Neuman (2006:44), “[C]ontent analysis is a technique for examining the content, or information and symbols, contained in written documents or other communication medium (e.g., photographs, movies, song lyrics, advertisements).”

Welman, Kruger and Mitchell (2005:221) define content analysis as “[a] quantitative analysis of qualitative data.”

The researcher defines the concept as follows: Content analysis is the quantitative analysis of the content of a written document, or another medium, to determine the frequency of specific themes and features encapsulated within the source.

1.5.2 Indicator

The *New Dictionary of Social Work* (1995:32) defines an indicator as an “[o]bjective numerical value indicating the actual or ideal state in respect of social phenomena.”

Ferriss (1988:615) adds a policy dimension to the definition when he postulates that “... it must relate to public policy ...” This dimension is of particular concern in this study as it relates directly to policy.

The researcher defines the concept as follows: An indicator is an operational definition which is utilised to quantify and measure either features of a (theoretical) concept, or to analyse specific elements of social phenomena within the context of policy.

1.5.3 National Drug Master Plan

The Prevention of and Treatment for Substance Abuse Act 70 of 2008 defines the National Drug Master Plan as “[the plan] containing the national strategy and setting out measures to control and manage the supply of and demand for drugs in the Republic.”

1.5.4 Policy

Policies “... provide the overall framework or plan of action drawn up by governments to guide public officials on how to address specific social issues” (Patel & Selipsky, 2010:50). Policy is also considered “a mechanism employed to realise societal goals and to allocate resources” (Baker et al., 1975 in De Coning, 2006:14).

Within the context of this study, policy is used as an overarching concept which refers to public, social and social welfare policy, as well as governmental strategies and programmes, amongst others, to promote social development or mitigate AOD abuse and drug-related crime.

1.5.5 Social development

Lombard (2007:299) offers the following conceptualisation which was also adopted for this study: “Social development needs to be clearly distinguished as (1) an ultimate (end) goal of development activities; and (2) as an appropriate approach to social welfare and thus an intervention strategy that incorporates social and economic processes to achieve social development as its ultimate goal.”

1.5.6 Substance abuse

The Prevention of and Treatment for Substance Abuse Act 70 of 2008 defines substance abuse as "... sustained or sporadic excessive use of substances and includes any use of illicit substances and the unlawful use of substances."

Fisher and Harrison (2009:14-15) define substance abuse as "[t]he continued use of alcohol and/or other drugs in spite of adverse consequences in one or more areas of an individual's life (e.g. family, job, legal, financial)."

This researcher defines substance abuse as the act whereby a legal or illegal drug is continuously or sporadically used and, as a result, the bio-psychosocial and economic well-being of the user, and that of significant others, and the country's citizens in general, are negatively affected.

1.6 CONTENTS OF THE RESEARCH REPORT

The structure of the research report is set out below.

Chapter 1: General introduction

In this chapter the reader is generally oriented and introduced to the study and the problem statement is outlined. Furthermore, the goal and objectives of the study are indicated followed by a synopsis of the research methodology. Finally the various key concepts on which this study is founded are defined.

Chapter 2: The National Drug Master Plan 2006-2011: a historical and descriptive analysis

Based on a thorough study of the literature, the first section of the chapter describes the development of South African drug-related policy and legislation by means of a historical policy analysis. The second section of the chapter provides a description of the content of the NDMP2 by means of a descriptive policy analysis.

Chapter 3: Research methodology, empirical study and research findings

This chapter consists of three sections. Section 1 outlines the research methodology which was followed in this study, namely the research question; the research paradigm, approach and purpose; the type of research; the research design; research methods; and the ethical considerations. Based on an in-depth literature review, the dimensions, themes and features of a social development perspective for drug policy in South Africa, are discussed in Section 2. The chapter concludes with Section 3 which presents and interprets the research findings, followed by an illumination of the limitations of the study.

Chapter 4: Conclusions and recommendations

The concluding chapter discusses whether the goal and various objectives of the study have been reached. Subsequently, the key findings and concomitant conclusions that could be drawn from this study are presented. Lastly, recommendations emanating from the study are made.

Chapter 2: The National Drug Master Plan 2006-2011: a historical and descriptive analysis

2.1 INTRODUCTION

Due to the negative consequences of Apartheid, which includes poverty and inequality, the *Reconstruction and Development Programme* (RDP) proposed, amongst other things, that South Africa embark on social development as a welfare approach (Patel & Selipsky, 2010:57; RSA, 1994) with the intention "... to mobilise the country's human and economic resources to strengthen its *young* democracy ..." (Binza, 2006:493). The RDP paved the way for the welfare sector to respond to people's basic rights such as social welfare services. To be in line with the country's adoption of a social development approach, social welfare services were expected to be adapted to developmental social welfare services with the aim "... to promote social justice ... build human capabilities ... and enhance ... social functioning ..." (Patel, 2005:208). The *White Paper for Social Welfare* (hereafter referred to as the White Paper) was adopted in 1997 and restructured the social welfare system in South Africa from a residual model to a developmental model (RSA, Ministry of Welfare and Population Development, 1997) "to address poverty and inequity and promote social development by integrating social interventions with economic development" (Lombard, 2009:296). Complementary to the White Paper, and to fast track service delivery, the *Integrated Service Delivery Model towards improved social services* (hereafter referred to as the ISDM) was launched in 2006 with the desired outcome to "[implement] ... a comprehensive, efficient, effective quality service delivery system that contributes to a self-reliant society" (DSD, 2006:9).

The first democratic South African President, Mr Nelson Mandela, emphasised during his first opening of Parliament in 1994, that alcohol and drug abuse are among the social pathologies that needed to be eradicated (Department of Welfare, 1999:1). It is therefore inevitable that both the White Paper and ISDM identify substance abuse as one of the social ills that prevent South Africa from achieving social development as it impacts negatively on

the quality of life of citizens. In order to attend to this social problem South Africa had initially adopted the *National Drug Master Plan 1999-2004* (hereafter referred to as the NDMP1) with the vision "... to build a drug-free society together and to make a contribution to the global problem of substance abuse" (Department of Welfare, 1999:5). In 2006 the *National Drug Master Plan 2006-2011* (hereafter referred to as the NDMP2) was adopted, as a review of the NDMP1 (Mabuza-Mokoko, 2011), "... to serve as the basis for holistic and cost-effective strategies to reduce the supply and consumption of drugs and limit the harm they cause" (DSD, 2007a:1). As indicated in Chapter 1, the NDMP2 positions South Africa's dedication to attend to drug abuse and drug-related crimes within the context of its international obligations and regional commitments, as well as national policy and legislation with the vision to reach a drug-free society. The President of the Republic of South Africa, Mr Jacob Zuma, reiterated government's commitment to eradicating substance abuse and drug trafficking in his *State of the Nation Address 2011* (RSA, State of the National Address, 2011:10).

Against this background, the adoption of social development as a welfare approach can address the social problem of substance abuse in conjunction with economic development. Policies were adopted and legislation promulgated in order to guide stakeholders in their endeavours to deal with social problems. The NDMP2 is an example of a social policy that has been adopted to attend to specific social problems, namely drug abuse and drug-related crimes. It is the aim of this chapter to describe both the historical development of drug policy and legislation in South Africa, and the content of the NDMP2 by means of a historical and descriptive policy analysis. In order to achieve this objective, this chapter will combine two genres of policy analysis. These are a *historical analysis* (cf. Popple & Leighninger, 2008:56) where the evolution of drug-related policy and legislation in South Africa will be described; and a *descriptive analysis* (cf. Popple & Leighninger, 2008:45-55) where the content of the NDMP2 will be described. Apart from the conclusions drawn regarding the strengths and limitations of the NDMP2 from the historical and descriptive analysis, these conclusions will further inform the formulation of *indicators* for social development, as a theoretical framework, for drug policy in South Africa. The indicators form the basis on which the empirical results, as presented in Chapter 3, is founded.

As a point of departure the first *section* of this chapter will present a historical analysis of drug-related policy and legislation in South Africa because it is imperative to understand the historical development of drug policy and legislation in South Africa, in order to describe the current master plan addressing drug abuse and drug-related crime, i.e. NDMP2, effectively.

2.2 HISTORICAL ANALYSIS OF DRUG POLICY AND LEGISLATION IN SOUTH AFRICA

In this chapter the premise of Patel and Selipsky (2010:50) is adopted, namely that “policies ... provide the overall framework or plan of action drawn up by governments to guide public officials on how to address specific social issues. Legislation ... is a set of rules, laws and regulations to prescribe behaviour ...”

The historical development of drug policy and legislation in South Africa will be outlined briefly by distinguishing three systemic periods in South African history, viz. South Africa prior to Apartheid (1652-1948); South Africa during Apartheid (1948-1994); and Democratic South Africa (1994 -). Historical analyses of drug-related policy and legislation concerning the restriction on drug advertising, the regulation of retail sales of alcohol, taxation, the criminalisation of substance abuse and to combat illicit drug trafficking have already been undertaken by Haefele (2000), Parry (2010) and Steinberg (2005). In the outline that follows the focus will predominantly be on policy and legislation related to substance abuse treatment. Furthermore, this historical analysis of drug-related policy and legislation will be contextualised within the broader social welfare context of the respective eras of South African history, since social problems, such as substance abuse, cannot be examined in isolation from the context in which they occur.

2.2.1 South Africa prior to Apartheid

In 1652 Jan van Riebeeck, an employee of the Dutch East India Company, established a commercial colony in the Cape of Good Hope (Nicholas, 2010:40). Soon the number of Dutch colonists grew and the first Dutch Reformed Church of Holland was founded in 1665 (McKendrick, 1990:6-8). Poor soil and changing weather patterns led to poverty, and associated social ills such as substance abuse. The Dutch colony followed a residual welfare model whereby “the keystone of welfare was the family and kinship group” (McKendrick, 1990:7).

Although the residual model prevailed, it had also become imperative for the Parliament of the Cape of Good Hope to promulgate legislation to govern society and attend to, amongst other things, welfare problems. As a result, organised social welfare services, including institutions, were established to deal with social ills, i.e. the first orphanage in 1814 in Cape Town attended to the needs of orphaned and vulnerable children. The first act to deal with, amongst other things, the institutionalisation of youth with delinquent behaviour, which

included substance abuse, came about in the form of the Reformatory Institutions Act 7 of 1879 (Potgieter, 1973:27). This Act was replaced by the Reformatory Institutions Act 4 of 1892. Together with the development of the mining industry, involving diamonds in Kimberley (± 1866) and gold in the Witwatersrand (± 1785), independent republics, cities and industries were mushrooming (Van Niekerk, 2003:363). These developments exacerbated social ills such as substance abuse and consequently quite a number of laws came into existence. For example, outside the borders of the Cape of Good Hope an independent Boer Republic, namely the *Zuid-Afrikaanse Republiek*, promulgated an Ordinance which was the Prisons and Reformatories Ordinance 6 of 1906, similar to Act 4 of 1892 of the Cape. The spread of substance abuse also resulted in the first lodge for people dependant on alcohol, established by the *International Order of Good Templars*, in 1889 in Cape Town (Potgieter, 1973:83).

Apart from making provision for the incarceration of people involved with drug-related crimes, the Prisons and Reformatories Act 13 of 1911 also catered for the establishment of institutions, both state and privately owned, where alcohol-dependent people (referred to as “chronic sick”) could be institutionalised following a court order (Potgieter, 1973:84). As such, this Act represents both a criminal (incarceration of drug offenders) and medical model (treatment of the chronic sick) towards drug policy (cf. MacGregor, 1999:121). The *Natal Retreat* in Pietermaritzburg, the first treatment centre, was set up in 1914 in line with Act 13 of 1911. This Act was extended with the Prisons and Reformatories Act 46 of 1920 by specifically making provision for the detention of juvenile offenders in certified hostels. During Apartheid, thus after 1948, the Correctional Services Act 8 of 1959 repealed both Act 13 of 1911 and Act 46 of 1920.

It became apparent that some people were suffering from chronic substance dependency and needed to be removed from society. The Work Colonies Act 20 of 1927 made provision for working colonies, under the auspice of the Department of Labour, where these people were placed (Potgieter, 1973:84). After 1938 two working colonies were established, namely *Northlea for men* and *Mount Collins for women* under the management of the *Rand Aid Association* (Potgieter, 1973:84). The mentioned Act was repealed by the Work Colonies Act 25 of 1949 during the years of Apartheid. Apart from the strong focus on the rehabilitation of alcohol-dependent people in treatment centres, community-based rehabilitation services were also initiated in the country. For example, the first group of *Alcoholics Anonymous* (AA) was founded in Johannesburg during 1946 (Potgieter, 1973:84).

It goes without saying that all policies and legislation pertaining to alcohol abuse were directed at the white population of South Africa, while ignoring those of the indigenous tribes.

It was also characteristic of both a criminal and medical model towards drug policy (MacGregor, 1999:121), whereby alcohol-dependent people were either incarcerated or admitted to treatment centres. However, self-help groups, such as AA, were not mandated and regulated through drug policy and legislation.

2.2.2 South Africa during Apartheid

In 1948 the National Party came into power with their policy of Apartheid (Nicholas, 2010:41). The government's welfare model was characterised by institutionalism for the white population and residualism for the 'black' citizens (Patel, 2008:72). In terms of drug policy, it was a time in history characterised by numerous developments to the advantage of the white population, while black people (including coloureds and Asians) were either denied access to treatment centres, or had only limited access to such services (Myers, Louw & Fakier, 2008:157-158).

With the promulgation of the Work Colonies Act 25 of 1949, the treatment of alcohol-dependent people was not limited to working colonies, but retreats (similar as current treatment centres) and hostels (similar to half-way houses) were added.

In 1951 a national conference on alcoholism was held in Pretoria. One outcome of this conference was the establishment of the *South African National Council on Alcoholism* (SANCA) in 1956. Only during 1969 did the council's mandate expand to include drugs other than alcohol (Potgieter, 1973:96). Till this day it is one of the leading private initiatives concerned with the treatment and prevention of drug dependency (DSD, 2010b).

Act 25 of 1949 was repealed and replaced by the Retreats and Rehabilitation Centres Act 86 of 1963. Amongst others, this Act made provision for the establishment of treatment centres dedicated to the treatment of alcoholism, a state subsidy for rehabilitation services, the involuntary and voluntary treatment of people addicted to alcohol, as well as the establishment of the *National Alcoholism Advisory Board* (Potgieter, 1973:86-88). This board was later renamed the *National Board on Rehabilitation Matters* (McKendrick, 1990:27) and its mandate was expanded to include attention to the abuse of all dependence-producing substances. As will be seen later in this historical outline (see paragraph 2.2.3), the functions of this council, i.e. to advise the Minister on any issues related to alcoholism and to institute measures to curb the spread of drug abuse and attend to its treatment, effectively correspond with the responsibilities of the current advisory board in South Africa, the Central Drug Authority (CDA). Overall, these developments support an observation by McKendrick

(1990:15) that “... social welfare services became increasingly oriented towards the rehabilitation of persons in social need, rather than being centred on palliative measures.” Accordingly, this era was characterised by partnerships between state and private welfare services as long as the latter agreed to adhere to apartheid policy as reflected in, for example, Circular 29/1966 and Circular 66/1966 (Lombard, 2000:129; McKendrick, 1990:15; Patel, 2005:73). The social work profession, in particular, provided organised welfare services in accordance with apartheid policy for approximately 40 years (Gray & Lombard, 2008:132).

Act 86 of 1963 was expanded with the Abuse of Dependence-producing Substances and Rehabilitation Centres Act 41 of 1971. This Act marked a distinct point of development as it was the first legislation to deal unequivocally with the prevention and treatment of the abuse of alcohol and other drugs (AODs). In addition, this Act also outlined measures to prohibit the dealing in, and the use or possession of, dependence-producing drugs. Both Act 86 of 1963 and Act 41 of 1971 were replaced by two sets of legislation, namely the Drug and Drug Trafficking Act 140 of 1992 and the Prevention and Treatment of Drug Dependency Act 20 of 1992. As such, the government embarked on a process aimed at attending to drug trafficking and the treatment of substance dependence through separate legislation, namely Act 140 of 1992 dealt exclusively with drug trafficking, and Act 20 of 1992 only dealt with the treatment of substance-dependency. In relation to Act 20 of 1992, a former Minister of Social Development, Dr Zola Skweyiya, made the following announcement:

[Act 20 of 1992] has become outdated and is not responsive to current challenges. Amongst other things, the Act focuses primarily on institutional treatment, provides very little provision for prevention, community based and out-patient services; and treatment services are not equally available and accessible to all citizens (DSD, 2008b).

In addition, Myers et al. (2008:157-158) expose the evils of Apartheid drug policy when they indicate that treatment for black and coloured people was limited and socio-political factors excluded them from access to these services; national, provincial and local inter-sectoral collaboration was weak, coupled with disparities between the then two government departments responsible for substance abuse matters, namely the Departments of Health and Welfare; and lastly services were fragmented due to racial segregation.

Apart from the legislation mentioned, with its primary focus on the treatment of substance abuse through institutionalisation, various pieces of legislation had been promulgated to regulate the registration and use of substances and to attend to people who committed drug-

related crimes such as the Medicine and Related Substance Control Act 101 of 1965 and the Liquor Act 27 of 1989, which was later replaced with Act 59 of 2003.

2.2.3 Democratic South Africa

After South Africa became a democracy, various policies and pieces of legislation were introduced to address, amongst others, substance abuse. Not only did the democracy necessitate a redress of imbalances left by Apartheid, but the country's acceptance into the global and regional arena opened South African borders to the trafficking and abuse of illicit drugs (DSD, 2007a:10; Magubane, 2002; Patel, 2005:55; Patel & Selipsky, 2010:48-49; Singer, 2008:468-469; Steinberg, 2005).

In line with the adoption of social development as a welfare approach, which is characterised by multi-sectoral strategies (Patel, 2005:107-109), the Prevention and Treatment of Drug Dependency Amendment Act 14 of 1999 made provision for the institution of the CDA. This is a multi-sectoral forum whose main function is to develop, monitor and review the National Drug Master Plan, as well as providing authoritative advice to the South African government on issues with regards to policy and programmes about drug abuse and trafficking (Department of Welfare, 1999:9-10). Apart from the drug-related legislation referred to, two National Drug Master Plans, as drug-related policy, have been introduced since 1994. The NDMP1 was for the period 1999-2004, while the NDMP2, the current plan, is in operation for the period 2006-2011. The NDMP1 aspired towards a drug-free society and the NDMP2 has adopted the same vision (Department of Welfare, 1999:5; DSD, 2007a:13). Furthermore, the NDMP2 outlines South Africa's partnerships, on both the international and regional level, to attend to the social ill of drug abuse.

Complementary to the NDMP2, the Prevention and Treatment of Substance Abuse Act 70 of 2008 was formulated and is expected to repeal Act 20 of 1992 as soon as the regulations are gazetted and the Act officially promulgated (DSD, 2010b). Act 70 of 2008 aims to accomplish the following:

To provide for a comprehensive national response for the combating of substance abuse; to provide for mechanisms aimed at demand and harm reduction in relation to substance abuse through prevention, early intervention, treatment and re-integration programmes; to provide for the registration and establishment of treatment centres and halfway houses; to provide for the committal of persons to and from treatment centres and for their treatment, rehabilitation and skills development in such treatment centres; to provide for the establishment of the Central Drug Authority; and to provide for matters connected therewith.

From the definition of this Act, it becomes evident that the South African government is attending to the criticisms raised against Act 20 of 1992, as amended. For example, Act 70 of 2008 makes provision for the establishment of community-based, in-patient and out-patient services, specifically targeted at rural areas irrespective of racial grouping.

In addition to the legislation promulgated and the policy adopted to deal with the treatment of substance abuse, a number of legislation came into existence to regulate drug-related matters, for example the South African Institute for Drug-Free Sport Act 14 of 1997, the Medicine and Related Substances Control Act 59 of 2002, the Tobacco Products Control Amendment Act 63 of 2008, and the Medicines and Related Substances Amendment Act 72 of 2008.

From the historical outline pertaining to the period after democratisation, it can be argued that South African drug policy and legislation has deviated from predominantly the criminal and medical models by adding a public health model (cf. MacGregor, 1999:121). Prior to democratisation, and in line with government's residual welfare model, the legislation dealing with drug-related matters was predominantly characterised by the issues described below.

- The white population's substance abuse was regarded problematic and therefore government made provision for state-subsidised treatment, while neglecting similar problems amongst the other racial groupings in the country.
- From 1652 up to 1971, legislation neglected the regulation and treatment of drugs other than alcohol.
- To curb the spread of substance abuse, the focus was predominantly on the treatment of substance-dependent people in private or state-owned treatment centres. Prevention and community-based rehabilitation were largely neglected.
- Criminal and medical models were followed to cope with substance abuse because substance-dependent people were institutionalised in treatment centres, and people involved with drug-related crimes were incarcerated in correctional centres. The government relied on managing the substance abuse problem in South Africa by means of models which focused on the symptoms of social problems instead of its causes (cf. Hawk, 1994).

After democratisation, and with the adoption of social development as a welfare approach, policy, such as the NDMP2, and legislation, such as Act 70 of 2008, introduced various changes in terms of dealing with substance abuse, and these are indicated below.

- All racial groupings, in line with the Constitution of the Republic of South Africa, 1996, are entitled to services related to AODs.
- The criminal and medical models concerning drug policy were extended with a public health model. This emphasised the prevention of substance abuse and community-based rehabilitation, as well as the adoption of an integrated strategy against drug abuse which include demand, supply and harm reduction (DSD, 2007b:32-39).
- Although drug-related matters remain the primary responsibility of the Department of Social Development, where the CDA is also situated, other government departments, such as the Department of Health and Justice, as well as the South African Police Service, also became stakeholders in the country's fight against substance abuse and drug-related crimes. In this way a multi-sectoral approach was introduced.

This synoptic overview of drug legislation and policy in South Africa provided the context for a descriptive analysis of the NDMP2.

2.3 DESCRIPTIVE ANALYSIS OF THE NDMP2

In order to provide a descriptive analysis of the NDMP2, this section of the chapter will *firstly* deliberate why the NDMP2 is considered to be a policy and what types of policy it represents. *Secondly* it will focus on the current socio-economic and political context of South Africa to describe the environment and context within which the NDMP2 is being implemented, and *thirdly* it will describe the core content of the NDMP2. This description will be elaborated on with information from CDA Annual Reports, which are published each year, and which report on drug abuse trends, achievements and challenges faced by the CDA in implementing the NDMP2. Furthermore, where possible, the information will be supplemented with documentation of the World Health Organization (WHO) and United Nations Office on Drugs and Crime (UNODC).

2.3.1 The NDMP2 as policy

The NDMP2 is not an Act of Parliament but a policy, specifically a Green Paper (Mabuza-Mokoko, 2011), which was adopted after democratisation to outline South Africa's commitment and plan to achieve a "drug-free society" (DSD, 2007a:13) and in this way to contribute to the achievement of South Africa's socio-economic development goals through various social development strategies. The NDMP2 had been approved by Cabinet in October 2006 (DSD, 2010b:8; RSA, Government Communication and Information System

[GCIS], 2006) and it was thereafter introduced into Parliament (RSA, Budget Vote Speech, 2008).

The NDMP2 fits the criteria for being regarded as public, social and social welfare policy. It is a *public policy* because it was primarily developed by DSD as the specific government department responsible for monitoring and evaluating drug-related services in South Africa, after consultation with stakeholders in government (18 different government departments, institutions and organisations), the private sector (e.g. SANCA) and communities (e.g. Local Drug Action Committees (LDACs)) (Anderson, 2006:7; Mabuza-Mokoko, 2011). It is stated that “[the] National Drug Master Plan (NDMP) was drafted in accordance with the stipulations of the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992)” and “[it] reflects the country’s responses to the substance abuse problem as set out by UN Conventions and other international bodies” (DSD, 2007a:4). Furthermore, as a public policy the researcher believes that the NDMP2 fits the criteria to be considered a social policy, as a specific type of public policy. In terms of various definitions of social policy (cf. Alcock, Payne & Sullivan, 2004:1; Patel & Selipsky, 2010:49-50), the NDMP2 could be regarded a *social policy* as it was launched, amongst other things, to establish services with “the quest to build a drug-free society and to fight substance abuse” (DSD, 2007a:5) and to improve the quality of life of all citizens through attention to a specific social problem, namely substance abuse (Mamburu, 2004:108). Furthermore, it could also be regarded as a *social welfare policy*, as a specific type of social policy, because it targets people who are vulnerable, and often marginalised, due to drug-related problems (cf. Ellis, 2003:14; Mazibuko, 1996:150). For example, the NDMP2 has identified nine priority areas which specifically target vulnerable and marginalised groups in society, namely the children on and off the streets, youth, women, people with disabilities, older persons, unemployed persons, and persons affected by HIV and Aids (DSD, 2007a:14). These priority areas correlate with most of the vulnerable groups prioritised in the White Paper and the ISDM (DSD, 2006; RSA, Ministry of Welfare and Population Development, 1997). These groups need to be targeted in order to achieve the country’s socio-economic goals.

2.3.2 Socio-economic and political context

To understand the NDMP2 better, it is important to take cognisance of the socio-economical and political context within which it is implemented.

2.3.2.1 *Socio-economic context*

When the African National Congress (ANC) came into power in 1994 it inherited various socio-economic challenges from the Apartheid government such as high levels of unemployment and sharp inequalities in opportunities (Schoeman, 2001:323-324; Terreblanche, 2002:4). Various South African scholars, such as Green (2008:175-179), Leahy (2009:173-175), Patel (2003:1-4), Triegaardt (2005:251; 2002:328-331) and Van der Berg (2005:214-216), refer to some aspects of the burdensome socio-economic context of South Africa. These aspects include a high poverty rate (approximately 50%), a low Human Development Index (HDI), and a Gini-coefficient which reflects severe income inequality. Although these findings are alarming, it reflects tendencies about the socio-economic context in South Africa in general. The researcher will illustrate that substance abuse contributes to this troubling picture.

The conservative economic cost of alcohol abuse for South Africa is estimated to be R104.8 billion per annum (DSD, 2010a:17), while the direct cost of illicit drugs (that is the amount spent by drug users) is estimated at R101 000 million (DSD, 2010a:15). The social costs associated with alcohol and drug abuse are an estimated R136 380 million per annum. This translates to between 17.2 and 19.8 million citizens being affected both emotionally and financially by people in their midst who are dependent on AODs (DSD, 2010a:15-17). Furthermore, an estimated 25 000 smoking-related deaths occur annually, while tobacco smoking results in 2.5 million workdays lost due to tobacco-related illnesses (DSD, 2007a:7-8).

People dependent on substances need to be rehabilitated in order to become economically active citizens who contribute to the country's economic growth so that social development goals can be achieved. Social services are needed to assist people who abuse substances. Unfortunately, one consequence of South Africa's neo-liberal macro-economic policy, *Growth, Employment and Redistribution* (GEAR), is that the greatest share of the welfare budget is allocated to social grants, resulting in reduced funding for service providers (Hölscher, 2008:116-117; Lombard, 2007:295-296). As a result, citizens are experiencing deepening poverty and an increase in social pathologies (Lombard, 2009:300). Furthermore, of the estimated 270 991 problem drug users and the 1.97 million problem alcohol drinkers in South Africa, only about 17 500 can be treated annually at approximately 73 treatment centres (DSD, 2009:15; DSD, 2008a:25, 31). Meanwhile crime, the HIV and Aids pandemic, and a high percentage of traffic accidents are closely linked to the country's substance abuse problem (DSD, 2010b; DSD, 2007a:14-20). It thus becomes clear that the NDMP2 is

implemented in a country whose social fabric and economic growth is compromised due to substance abuse.

2.3.2.2 *Political context*

Although South Africa is a democratic country, the implementation of social policy is complicated due to the existence of two opposite political ideologies dominating South Africa's political arena, namely social democracy and neo-liberalism. Regarding the *social democracy ideology*, it is stipulated in the RDP that government takes responsibility for making services available to citizens to achieve a state of equity, equality and social justice in order to eradicate the legacy of Apartheid (Hölscher, 2008:116-117; Midgley, 2001:268-270; Patel, 2008:71-72). However, due to the RDP's failure to enhance economic growth, this policy was expanded with a macro-economic policy based on *neo-liberal* ideology, namely GEAR, as "a structural adjustment programme", amongst other things, to improve economic growth (Triegaardt, 2005:251).

Through the adoption of GEAR, the ANC government deviated from its initial promise in the RDP. "[I]nstead of empowering the people ... it exacerbated the dire economic conditions facing the poor ..." (Mueni wa Muiu, 2004:280). As a result, poverty alleviation became a secondary consideration which impacted negatively on social policy and the circumstances of the poor and marginalised (Triegaardt, 2005:251). According to a neo-liberal view it is believed that the needs of the poor will be attended to through the "trickle down" effect of the market (Alcock et al., 2004:125-126; Pratt, 2006:9-10, 20). The increase of poverty, and associated social ills such as substance abuse, illustrates that no trickle down has yet been achieved for the country's polarised citizens.

The draft *National Development Plan* (NDP), which sets out South Africa's vision for 2030, namely "[a country which is] just, prosperous and equitable ... [and which] each and every South African can proudly call home", was introduced on the 11th of November 2011 (RSA, The Presidency, 2011:27). The NDP highlights the combating of smoking and substance abuse as being among other key priority areas, such as creating an economy that promotes employment and building safer communities, in order to achieve holistic development in the country (RSA, The Presidency, 2011:19). Although promising, only the future will learn whether the NDP will manage to bring about change in the country's socio-economic circumstances wherein millions of people are trapped in substance abuse and drug-related crimes.

The ideology of neo-liberalism, as encapsulated in GEAR, is not in line with a social development approach towards welfare (Sewpaul, 2001:311). A social development approach is pro-poor and universally available to all people, because it promotes human rights where all people are equal and imbalances of the past are redressed through social grants and anti-poverty programmes; government creates an enabling environment for all citizens to become active in the economy to promote their ultimate social welfare (Midgley, 1995:25-28; Patel, 2005:203-206).

Although the payment of social grants is a plausible attempt of government to deal with poverty alleviation and it is congruent with a human rights culture, it does not succeed in breaking the vicious cycle of poverty and enabling people ultimately to achieve sustainable social development. This same sentiment was confirmed by government as Mr Jacob Zuma indicated in his *State of the Nation Address 2011* that "... we are building a developmental and not a welfare state, the social grants will be linked to economic activity and community development ..." (RSA, State of the Nation Address, 2011:3). The same message was reiterated in the *State of the Nation Address 2012* (RSA, State of the Nation Address, 2012:3). In summary, the socio-economic and political contexts of South Africa do not create an environment which enables the implementation of the NDMP2 aimed at curbing substance abuse and drug-related crimes, and, as a result, the realisation of the country's social development goals is obstructed.

2.3.3 Key components of the NDMP2

The content of the NDMP2 will be outlined by describing its key components, which are the background and rationale for a NDMP2; its vision, mission and goals; the national priority areas identified in the framework for action; strategic interventions proposed to curb both drug abuse and drug-related crime; the institutional framework demarcating the responsibilities of various stakeholders who ought to implement the NDMP2; and lastly the proposed strategy for the monitoring and evaluation of the NDMP2.

2.3.3.1 Background and rationale

The rationale for the NMPD2 is to have a policy that (a) reflects South Africa's response to substance abuse as set out by UN conventions and other international bodies concerned with drug abuse; (b) to demarcate the role and responsibilities of the CDA as an administrative unit within DSD; and (c) to enable co-operation and specify the roles of government departments and other stakeholders involved in the field of drug abuse (DSD,

2007a:4-5). Furthermore, the necessity for a social policy addressing substance abuse is outlined by referring to the commitment of the first democratic president, Mr Nelson Mandela, to address social pathologies, such as substance abuse. In the preamble to the NDMP2 this sentiment is reiterated by the statement that “It [substance abuse] reaches across social, racial, cultural, language, religious and gender boundaries and affects everyone directly or indirectly” (DSD, 2007a:4).

The mandate for the NDMP2 originates from the legal framework of South Africa in the form of Act 20 of 1992, Act 140 of 1992, and the Constitution of the Republic of South Africa, 1996, as well as international, regional and national protocols and conventions to which South Africa is a signatory (DSD, 2007a:12). The rationale for the NDMP2 is further motivated through reference to different types of drugs, their use, and the cost to the South African economy, as well as the health and socio-economic consequences thereof (DSD, 2007a:5-10). The NDMP2 mainly reports on trends with regards to the abuse and consequences of alcohol, cannabis (“dagga”), cocaine, ecstasy and methamphetamine (“Tik”). According to the NDMP2, alcohol is “the primary drug of abuse in South Africa” followed by cannabis (DSD, 2007a:7) and this situation has remained unchanged since the adoption of the NDMP2 (DSD, 2010a:12). The costs involved in these forms of drug abuse have already been alluded to in paragraph 2.3.2.1. The NDMP2 quotes outdated statistics, namely the *South African Demographic and Health Survey (1998)* of the Department of Health (DoH) (DSD, 2007a:8-9). However, the policy writers of the NDMP2 acknowledged this limitation when they wrote that “Accurate, up-to-date statistical data on the use and abuse of alcohol and illicit drugs in South Africa are difficult to obtain ...” (DSD, 2007a:6). In order to eliminate this limitation, the CDA established baselines of alcohol and drug abuse trends, respectively, with the publication of the *CDA Annual Report 2006/2007* – the first annual report after the adoption of the NDMP2 (DSD, 2007b:5-6). These baselines are primarily based on the following data: *World Drug Report 2006* and the research data (2003-2004) of the SA Medical Research Council for illicit drug abuse trends; the *World Health Organization’s Global Status Report on Alcohol (2004)* for alcohol abuse trends as well as continuous research conducted by the South African Community Epidemiology Network on Drug Use (SACENDU). Ever since then the CDA has been comparing drug and alcohol abuse trends against these figures when publishing annual reports. In order to establish comprehensive nationwide baselines of the substance abuse situation in South Africa, the CDA has identified the need for a research project to obtain data on the nature, extent and impact of substance abuse. The motivation behind this research project is to prevent the situation where there is an over reliance on approximations and extrapolations of obtaining a

baseline for drug abuse in South Africa. Unfortunately the survey has yet to be undertaken (DSD, 2010a:20).

According to the *Global Status Report on Alcohol and Health 2011* (WHO, 2011), the *World Drug Report 2011* (UNODC, 2011), the *CDA Annual Report for the year ended 31 March 2008* (DSD, 2008a:20-35) and the *CDA Annual Report 2009/10* (DSD, 2010a:11-17), the alcohol and drug abuse trends in South Africa can be summarised as follows:

◆ **Drug abuse trends**

- 270 991 citizens are problem drug users.
- Cannabis is the drug most used, with 3.2 million users and therefore it is the primary drug of abuse in treatment demand. This is followed by 0.32 million people who use amphetamine-type stimulants (including Ecstasy, methamphetamine, methcathinone, “Tik”).
- 17.2 million members of families are affected by drug abuse.

◆ **Alcohol abuse trends**

- South Africa is classified as a country with risky drinking patterns. 1.97 million citizens are problem alcohol users. This places South Africa in the 47th position of recorded alcohol consumption amongst 189 countries.
- On the one hand DSD (2010a:16-17) reports that an estimated 20.1 litres of pure alcohol are consumed per capita per annum. This translates into 196 six pack of regular beer in 340 ml cans, or 62 bottles of spirits in 750 ml bottles, or 220 bottles of wine in 750 ml bottles, or 666 cartons of sorghum beer in 500 ml containers (DSD, 2008a:20-35). On the other hand, the WHO (2011:276) reports an even more alarming figure, namely that South Africans consume on average 34.9 litres of pure alcohol per capita per annum.
- The most frequently consumed drink is beer, followed by African traditional beer, wine, brandy, alcohol fruit beverages, whisky, fortified wine and sparkling wine.

Unfortunately the NDMP2 has only one paragraph which describes drug-related crime and this is also quite superficial. The paragraph merely states that South Africa’s “international air links, porous borders and modern telecommunication and banking systems” enable drug trafficking (DSD, 2007a:10). Therefore, role players such as the South African Police Service (SAPS) and South African Revenue Service (SARS), consistently strive to reduce the supply of drugs. For example, between 2009 and 2010 twenty five clandestine drug laboratories

were identified and closed down, 567 hectares of cannabis plantations (estimated value R397 million) were destroyed, 165 drug couriers and 265 consignments of drugs were seized (estimated value R437 million), and 48kg amphetamine-type stimulants seized (DSD, 2010a:30-35; UNODC, 2011:162).

The background and rationale of the NDMP2 serve as the foundation to formulate a specific vision, mission and concomitant goals for the policy.

2.3.3.2 Vision, Mission and Goals

The vision of the NDMP2 is that of a ‘drug-free society’ (DSD, 2007a:13). The vision is refined through a mission that reads as follows: “... to implement holistic and cost-effective strategies to reduce the supply and consumption of drugs and to limit the harm associated with substance use, abuse and dependency in South Africa” (DSD, 2007a:13). The strategies that are proposed in the NDMP2 consist of eight goals. The goals of the NDMP2 are as follows:

- To ensure the coordination of efforts to reduce the supply of and demand for drugs/substances of abuse;
- To strengthen efforts aimed at the elimination of drug trafficking and related crimes;
- To strengthen the legal and institutional framework for combating the illicit supply and abuse of substances;
- To promote the integration of substance abuse issues into the mainstream of socioeconomic development programmes;
- To ensure appropriate intervention strategies through awareness raising, education, prevention, early intervention and treatment programmes;
- To promote family and community based intervention approaches in order to facilitate the social reintegration of abusers;
- To promote partnerships and the participation of all stakeholders at local and provincial level in the fights against illicit substances and abuse;
- To promote regional, national and international cooperation in the management of the illicit supply of drugs and substances of abuse (DSD, 2007a:13).

From the goals above it becomes evident that the NDMP2 prioritises equal attention to drug-related crime and the prevention of and rehabilitation of substance abuse. In addition, an integrated approach, that promotes national, regional and international co-operation, is emphasised to manage substance abuse in the country. Chapter 3 (see Section 3) will deliberate to what extent these policy goals are attended to through a content analysis of the NDMP2.

For the vision, mission and goals of the NDMP2 to be reached, the policy should indicate, amongst other things, national priority areas to curb the spread of substance abuse and drug-related crime.

2.3.3.3 National priority areas

The NDMP2 singles out nine priority areas, which include crime, youth, other vulnerable groups (e.g. children on and off the streets, women, people with disabilities, older persons, persons affected by HIV and Aids, and road users), community health, research and information dissemination, international involvements, communication, capacity building and occupational groups at risk (e.g. artists, musicians, farm workers, and truck drivers) (DSD, 2007a:14-21). The nine priority areas were identified through consultation with stakeholders in the private sector (e.g. NGOs) and government departments, as well as best practices that were proposed by South African social services providers and the country's counterparts (SADC countries, UK, USA, Germany, Sweden and Australia) (Mabuza-Mokoko, 2011). The NDMP2 motivates why each of these priority areas are considered vital in the fight against drugs. The nine priority areas are listed below.

➤ Crime

The NDMP2 distinguishes between three categories of drug-related crimes and these are: crime due to drug use, crime due to the need to pay for expensive drug use habits, and crime associated with involvement in drugs and/or drug trafficking (DSD, 2007a:14). The objectives that are proposed to deal with drug-related crimes cut across various government departments in order to ensure effective law enforcement, crime reduction, the establishment of diversion programmes and proactive policing (DSD, 2007a:14). Neale (2006:7) echoes the importance of this priority area, as drug addiction often serves as a trigger for crime activities in order to sustain the habit.

➤ Youth

The South African government prioritises the needs of children and youth to ensure a better life for generations to come. The NDMP2 emphasises that specific treatment services (especially in rural areas), aftercare programmes and multipurpose centres for unemployed youth are of importance, because “coordinating structures for the youth exist, [but] their effectiveness in relation to substance abuse has to be improved” (DSD, 2007a:15). Increasingly more children and young people are abusing drugs (DSD, 2010a:5; WHO,

2011:10) and the situation is being aggravated by unemployment which is accompanied by limited funding to access training institutions (Melrose, 2006:38). Therefore, not surprisingly, the objectives for this priority area focus on the holistic development of the youth (such as empowerment, life skills and recreational programmes), appropriate drug education programmes, and the application of restorative justice in countering drug-related crime (DSD, 2007a:15).

➤ Poor and vulnerable groups

The NDMP2 categorically declares that the use and abuse of substances by poor and vulnerable groups “places an enormous health and socioeconomic burden on South African society” (DSD, 2007a:16). For example, drug abuse amongst women, as a vulnerable group, continuously increases and the number of babies born with foetal alcohol syndrome is escalating (DSD, 2010a:5). Accordingly, a number of objectives are formulated for this priority area, such as ensuring prevention, treatment, rehabilitation, and aftercare services for all vulnerable groups. Furthermore, the poor and vulnerable are to be empowered with knowledge about their rights and how to claim these as a preventative measure for victimisation (DSD, 2007a:16; Harding, 2006:27).

➤ Health

This priority area is predominantly the responsibility of the DoH who should focus on the following problem areas from a harm reduction strategy (i.e. a strategy that aims to reduce and prevent the harmful effects of drug use): teenage pregnancy and substance abusing mothers, foetal alcohol syndrome, sexually transmitted infections (including HIV and Aids), and hepatitis-infection as a result of non-sterile injection equipment usage (DSD, 2007a:16; Neale, 2006:6; UNODC, 2011:8). In addition this Department is responsible for detoxification services to all substance-dependent persons as this forms an integral part of the treatment process. As a consequence the following objectives are forwarded: to minimise harm associated with substance abuse and “to ensure that persons suffering from mental illness and substance abuse morbidity (dual diagnosis) receive appropriate and accredited treatment” (DSD, 2007a:17).

➤ Research and dissemination of information

It is acknowledged in the NDMP2 that appropriate knowledge about drug-related issues, for instance the profile of drug abusers, is needed to develop appropriate policies (DSD,

2007a:17). The NDMP2 identifies the following research gaps (DSD, 2007a:17-18): the impact of indigenous substances, the evaluation of existing services, up to date figures on the economic costs of substance abuse and the relationship between substance abuse and national health problems (e.g. HIV and Aids). Objectives for this priority area include that research in the field of substance abuse should be conducted, promoted and coordinated (DSD, 2007a:18).

➤ International liaison

A detailed account is provided of the various international, regional and national protocols and conventions to which South Africa is a signatory and which aim to curb the spread of substance abuse and drug-related crimes. The following objectives, in line with South Africa's signature to UNODC protocols and conventions, guide this priority area (DSD, 2007a:19): to monitor developments with regards to drug abuse and illicit drug trafficking, to advise government when entering into international agreements and to prioritise specific actions to manage drug abuse, as well as "to facilitate the achievement of international benchmarks on the prevention and treatment of substance abuse." Nonetheless, it should be noted that the UN-based protocols and treaties, to which South Africa is a signatory, are criticised for (a) being predominantly in favour of the developed world, i.e. the USA, and subsequently at the expense of the developing world (Bewley-Taylor, 2003:178), and (b) denying the drug-dependent person's human rights (Barrett, 2010:13).

➤ Communication

The essence of this priority area is captured in the following quote: "Communication should take into account South Africa's eleven official languages, other cultural and socioeconomic differences, and disabilities such as visual impairment and illiteracy" (DSD, 2007a:19). Objectives related to this priority area are to ensure that all educational material and information communicated to the public is factually correct and that this is available in all official languages, including Braille for blind persons (DSD, 2007a:20). An example of an objective that was reached is that on 25 June 2008 a national helpline was established for drug-related matters (DSD, 2008a:80).

➤ Capacity building

The NDMP2 emphasises that, in order for South Africa to deal effectively with its drug problem, various professional groups require accredited training, and that service providers

should be professionally licensed (DSD, 2007a:20). Therefore, the objectives of this priority area highlight the following: to provide for a national accreditation system which include the monitoring and evaluation of service providers, and to establish “a training programme that builds the capacity of law enforcement officers to enforce South Africa’s drug laws” (DSD, 2007a:20).

➤ Occupational groups at risk

Although the NDMP2 identifies a number of occupational groups at risk, artists and musicians are prioritised for urgent support (DSD, 2007a:21). With regards to this priority area, the following objectives are specified: awareness campaigns for occupational groups at risk, and provision for their treatment, rehabilitation and aftercare (DSD, 2007a:21).

To attend effectively to the nine priority areas specific strategic interventions need to be executed. Therefore, strategic interventions are discussed as the next key component of the NDMP2.

2.3.3.4 Strategic interventions

The NDMP2 outlines the strategic interventions for drug abuse that are aimed at “actions that reduce the demand for drugs (prevention, treatment and rehabilitation)” (DSD, 2007a:22). According to Mabuza-Mokoko (2011), the strategic interventions that are specified in the NDMP2 are to be implemented according to an integrated strategy consisting of supply reduction (strategies to curb the supply of drugs), demand reduction (strategies to reduce the demand for drugs among the general public and those susceptible to addiction, and the reduction of conditions that lead to experimentation) and harm reduction (strategies to reduce the harm caused to and by people who take drugs and to reduce harm in society at large) in order to meet the requirements of the UNODC (DSD, 2008a:39).

The NDMP2 proposes that strategic interventions target individuals, groups and communities with an explicit stance that primary prevention as “... attempts to curb the supply and to prevent the new use of illicit drugs” represents “the most appropriate and preferred intervention ...” (DSD, 2007a:22). Furthermore, the NDMP2 distinguishes between *secondary prevention* which can be described as “[services] ... aimed at persons who display the early stages of problem behaviour associated with the use of AODs” as well as *tertiary prevention* which “... strives to end compulsive use of AODs and to ameliorate their negative effects through treatment and rehabilitation” (DSD, 2007a:22-23).

In addition, the NDMP2 refines the three types of prevention with a proposal for seven specific forms of intervention. It prioritises preventative and community-based services through different levels of intervention, namely prevention, early intervention, statutory intervention and rehabilitation and reconstruction and aftercare services. Furthermore, strategic interventions make provision for human and social capital development. For example there are provision for educational programmes (human capital development) and an emphasis on the utilisation of protective factors to unite communities and people at large (social capital development) (cf. Midgley & Tang, 2001:249-248). The interventions, which effectively link with proposals by the UNODC (DSD, 2010a:10, 16) are prioritised by the NDMP2 to address the drug abuse problem and these are discussed below.

➤ Reduction in the supply of drugs (law enforcement)

The NDMP2 states: “A zero tolerance attitude towards drugs should be inculcated in communities” (DSD, 2007a:23). As a result, various government departments are involved in curbing the supply of illicit drugs and enforcing the law where needed. These are the SAPS, DoH, Justice and Home Affairs, the SARS and the postal services (DSD, 2007a:23). This strategy is also emphasised by the UNODC (2011:8-9).

➤ Prevention of drug abuse (including education and awareness)

The Departments of Education, Health and Social Development are identified as the government departments that should be instrumental in the prevention of drug abuse, as well as in raising awareness and educating people (DSD, 2007a:23). It is further highlighted in the NDMP2 that all services should be in line with international protocol, as well as national policies (DSD, 2007a:23). This strategy is highlighted as being of special importance for South Africa to win the fight against drug abuse (Mashele, 2005:8).

➤ Risk factors and protective factors in drug abuse prevention

The NDMP2 specifies that all prevention programmes should *promote protective factors* which are factors associated with reducing the potential for drug use. These are strong family bonds and parents involvement in their children’s lives, and *counter risk factors* that make drug use more likely, such as poor social coping skills or failure in school performance (DSD, 2007a:24-25).

➤ Community-based substance abuse prevention

According to the NDMP2, community-based substance abuse prevention should specifically focus on the youth and on ‘gateway’ substances such as tobacco, alcohol and dagga. This intervention should address both the demand for and supply of AODs (DSD, 2007a:25). This strategy links with the target area, community action, as highlighted in the *Global Strategy to Reduce the Harmful Use of Alcohol* (WHO, 2011:41).

➤ Early intervention

The NDMP2 defines early intervention as a form of intervention “... preventing the onset of any substance abuse” (DSD, 2007a:25). The NDMP2 differentiates between two specific types of early intervention, which are *universal prevention* (such as school programmes delivered by educators to all school learners), and *dedicated prevention* (e.g. those aimed at high-risk groups such as youth involved with gangs) (DSD, 2007a:25).

➤ Drug treatment (including rehabilitation and risk reduction)

The DoH and DSD are specifically responsible for this form of intervention with their “... main task ... to provide appropriate services to such persons while maintaining a high standard of care” (DSD, 2007a:26). This form of intervention includes drug courts where substance-dependent people could be committed to treatment centres at government’s expense (DSD, 2007a:26). Although this strategy does not specify strategies for aftercare and reintegration services, Mabuza-Mokoko (2011) indicated that these levels of service delivery are considered to be part of drug treatment in general.

➤ Drug abuse by drivers

The NDMP2 proposes that “The Department of Transport should consider mandatory testing of drivers in all accidents involving alcohol and substance abuse” (DSD, 2007a:26).

For these strategic interventions to materialise there need to be several role players involved. The institutional framework of the NDMP2 deals comprehensively with this aspect.

2.3.3.5 Institutional framework

Dealing with both substance abuse and drug-related crimes is a huge task which requires the collaboration of various role players. This is echoed in the NDMP2 with the following quote: “Action to combat illicit trade in and the use of substances requires broad participation by all spheres of government, organisations, the business sector and civil society” (DSD, 2007a:27).

The NDMP2 has a broad impact on a vast number of stakeholders. The following stakeholders are acknowledged in the NDMP2: numerous government departments, including Arts and Culture, Correctional Services, Education, Financial Intelligence Centre (FIC), Foreign Affairs, Health, Home Affairs, Justice and Constitutional Development, Labour, the Medicine Control Council, the National Youth Commission, Safety and Security, Social Development, SAPS, SARS, Sports and Recreation, Trade and Industry and Transport; civil society, such as non-governmental organisations (NGOs) (e.g. SANCA and Business against Crime), community-based organisations (CBOs) and faith-based organisations (FBOs); Provincial Substance Abuse Forums (PSAFs); municipalities who should establish Local Drug Action Committees (LDACs); and the CDA (DSD, 2007a:27-38). Mabuza-Mokoko (2011) is of the opinion that the extrapolation of the roles and responsibilities of all the stakeholders is a unique feature of the NDMP2, as the NDMP1 failed to explicitly emphasise partnerships. Partnerships ensure that, apart from the treatment of substance abuse by social workers and other psycho-social professionals, other professionals, such as medicine and security, also cope with the widespread consequences of substance abuse, i.e. health problems (e.g. HIV-infection due to shared needles) and drug-related crime (e.g. drug gang violence) (cf. Charles & Britto, 2001:472-473; Mashele, 2005:3-6; UNODC, 2011:9; Singer, 2010:472-475).

From the discussion above, it is clear that the institutional framework of the NDMP2 attempts to create an environment in which multiple sectors are involved.

In an attempt to streamline the description of the institutional framework of the NDMP2, the researcher will describe the CDA, two government departments involved with substance abuse treatment (i.e. DSD and DoH), two government departments dealing with drug-related crimes (i.e. Justice and Constitutional Development and SAPS), as well as the provincial (PSAFs) and local structures (LDACs) who are responsible for attending to substance abuse matters on a provincial and grass roots level.

2.3.3.5.1 Central Drug Authority (CDA)

The CDA, with its “primary function ... to monitor the implementation of the NDMP” consists of various stakeholders from government departments and non-governmental organisations who are appointed by the Minister of Social Development in accordance with Act 20 of 1992 (DSD, 2007a:28). The functions of the CDA are as follows:

- Overseeing and monitoring the implementation of the NDMP
- Facilitating the coordination of a limited number of strategic projects
- Facilitating the rationalisation of existing resources and monitoring their effective use
- Encouraging government departments and the private sector to draw up plans to address drug abuse in line with the goals of the NDMP
- Introducing performance indicators whereby the effectiveness and progress of action plans can be monitored and evaluated at all levels
- Facilitating the initiation and promotion of measures, including legislation, to combat the supply of and reduce the demand for drugs
- Reviewing and commenting on psychoactive substance-related policies and programmes developed locally and internationally
- Establishing and maintaining information systems to support the implementation, evaluation and ongoing development of the NDMP
- Submitting an annual report to parliament that described the national effort in solving the drug problem
- Ensuring the development of effective drug education strategies
- Liaising with the Justice, Crime Prevention and Security Cluster (JCPS) Ministers’ Committee where necessary
- Advising the government on policies and programmes on drug abuse and trafficking
- Reviewing the NDMP on a five-yearly basis and introducing changes where necessary
- Organising a biannual summit on substance abuse to enable role players involved in combating substance abuse to share information (DSD, 2007a:28).

The CDA is supported by the CDA Secretariat, located in the National DSD with its “... core role ... to drive the day-to-day work of the CDA ensuring that decisions taken at CDA meetings are carried out, especially with regard to the implementation of the NDMP” (DSD, 2007a:28).

2.3.3.5.2 Government departments responsible for substance abuse treatment

The DSD and the DoH are working in collaboration and are primarily responsible for the treatment of substance dependency. These two departments are taking the lead in providing treatment centres where substance-dependent people can be treated (DSD, 2007a:33). Yet, there are also unique programmes run by each department as will be indicated in the discussion that follows.

◆ *Department of Social Development (DSD)*

The DSD is the lead government department responsible for the management of substance abuse-related matters and to provide technical and financial support to the CDA. In addition it is responsible for developing policies, such as the NDMP2, dealing with substance abuse (DSD, 2007a:32).

◆ *Department of Health (DoH)*

The DoH plays a vital role in terms of national awareness campaigns, support to treatment centres and through advice and the implementation of detoxification programmes (DSD, 2007a:30). Furthermore, the DoH "... is responsible for reducing drug demand and harm caused by psychoactive drugs, including alcohol and tobacco, through the promulgation of legislation and policy guidelines for early identification and treatment" (DSD, 2007a:30).

2.3.3.5.3 Government departments responsible for managing drug-related crimes

The DSD and the DoH work in collaboration and are also partnering with other government departments to embark on various strategies to ensure an integrated strategy to combat drug-related crimes, i.e. demand and supply reduction.

◆ *Department of Justice and Constitutional Development*

Reducing the demand for illicit drugs and the supply of such drugs on the street is the main concern of this department (DSD, 2007a:31). In terms of the Department's mandate to reduce the demand for drugs, it is responsible for committing involuntary substance-dependent people to treatment centres (DSD, 2007a:31). With regards to its mandate to reduce the supply of drugs, the department "... deals with organised crime involving drugs through forfeiture of the gains/property (asset forfeiture) ensuing from crime as well as through deterrent sentences in the courts" (DSD, 2007a:31).

◆ *South African Police Service (SAPS)*

All five programmes of the SAPS, i.e. Administration, Visible Policing, Detective Services, Crime Intelligence, and Protection and Security Services, include specific attention to drug demand and supply reduction strategies (DSD, 2007a:33). An example of a strategy in the crime intelligence programme, includes "... [to provide] intelligence on precursor chemical

movements nationally and internationally” (DSD, 2007a:33). In addition the SAPS “promotes international cooperation and acts as a competent authority under the United Nations (UN) Convention on the Law of the Sea (FFG)”, as well as the international conventions referred to in Chapter 1 (see paragraph 1.1).

2.3.3.5.4 Provincial Substance Abuse Forums (PSAF)

The NDMP2 stipulates that each of the nine provinces in South Africa must establish a PSAF with stakeholders from education, community action, legislation, law enforcement, policymaking, research and treatment (DSD, 2007a:37). These forums are supported by the human and material resources of the DSD (DSD, 2007a:37). Members of the PSAF should be assigned to focus on specific portfolios, which include treatment and aftercare, prevention and education, community development as well as research and information dissemination (DSD, 2007a:37). Since the 2007/2008 financial year, all nine provinces have had a PSAF (DSD, 2008a:80).

2.3.3.5.5 Local Drug Action Committees (LDAC)

The LDACs are essentially forums to ensure that the voices of the people on grass root levels are heard and their concerns are considered when dealing with substance-related matters. This forum consists of representatives, on the municipal level, from the Department of Justice and Constitutional Development, SAPS, and the Department of Correctional Services, schools, as well as officials from the local DoH and DSD (DSD, 2007a:38). In order to ensure that the views of local people are considered at higher levels, the LDAC liaises with the provincial coordinator for LDACs situated in the DSD (DSD, 2007a:38). Local governments are supposed to “... contribute towards the financial, human and material resources of the LDAC” (DSD, 2007a:38). The main function of the LDAC is encapsulated in the following quote:

Local authorities develop and maintain integrated drug policies in collaboration with all stakeholders in order to prevent drug-related crime and ensure quality of life for residents at the community level. The LDACs ensure that local action is taken in terms of the NDMP in each community (DSD, 2007a:38).

There are approximately 153 LDACs established across the country, although 238 are required (DSD, 2010a:23).

Based on the description of the three components of the NDMP2, i.e. nine priority areas, strategic interventions and institutional framework, the researcher is of the opinion that the NDMP2 fits the criteria of at least three categories of social policy. *Firstly*, it is a *distributive policy* (Booyesen & Erasmus, 1998:224) as it “typically involves using public funds to assist particular groups ...” (Anderson, 2006:111). The NDMP2 is primarily targeting the poor and vulnerable groups who are affected by substance abuse (DSD, 2007a:1). *Secondly*, the NDMP2 could be regarded a *liberal policy* because it is an attempt by government to bring about social change (Anderson, 1997:22) with its aim to promote social justice by targeting marginalised groups previously neglected in service delivery, such as substance-dependent people in rural areas (DSD, 2007a:14-21). *Thirdly*, it is a *procedural policy* (Anderson, 2006:10) because it explains how the various government departments and other stakeholders should render services within the field of substance abuse; and it provides a classification of levels of intervention, as well as particulars pertaining to the monitoring and evaluation of policy (DSD, 2007a).

The last key component of the NDMP2, monitoring and evaluation, is outlined next.

2.3.3.6 Monitoring and evaluation

Monitoring and evaluation are, amongst others, highlighted as a target area to address substance abuse across the globe. As such, the NDMP2 is in line with the specification of the *Global Strategy to Reduce the Harmful Use of Alcohol* (WHO, 2011:41), as well as other UNODC protocols and conventions, for example the *UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988*, to which South Africa is a signatory. Subsequently, Mabuza-Mokoko (2011) has been of the opinion that the section in the NDMP2 dealing with monitoring and evaluation is an improvement, as the NDMP1 failed to explicitly deal with this critical aspect of policy evaluation. The NDMP2 procures that “Ongoing monitoring and evaluation are required to measure progress and achievements in respect of set objectives and the implementation of the NDMP[2] by all stakeholders” (DSD, 2007a:39). Monitoring and evaluation are the responsibility of the CDA and should specifically focus on the following:

- The extent of coordination in dealing with the supply and demand for substances;
- The extent to which substance abuse issues have been effectively incorporated into the socioeconomic programmes of all stakeholders;
- The extent and effect of service integration at local, provincial and national level;

- The effectiveness of national, regional, and international collaboration in combating drug trafficking and enforcing law and order;
- The extent to which individuals, groups (including families) and communities have access to all interventions necessary to address problems associated with substance abuse;
- The extent and impact of information, education and communication as a means of preventing substance abuse;
- The extent of research into the supply of and demand for drugs and the impact of drug abuse on society (DSD, 2007a:39).

In addition to the specific issues that the NDMP2 identifies for monitoring and evaluation, it stipulates that the outcomes of these endeavours will be utilised to make proposals for reviewing policies and legislation on the one hand, and facilitate “the development of systems that will enhance the capacity of monitoring and evaluation” on the other hand (DSD, 2007a:39).

In line with a bottom-up approach, the NDMP2 proposes a multi-level approach towards monitoring and evaluation consisting of the LDACs (at grass root levels), PSAFs (“middle” level) and the national level (at the top). The responsibilities of the LDAC are as follows: to prevent substance abuse at the local level; each municipal area should develop operation plans to deal with drugs abuse on a local level; and the LDACs should “liaise with the provincial coordinator and are represented in the provincial forums” (DSD, 2007a:40-41). Monitoring, on the provincial level, is overseen by the PSAFs and they are responsible for the implementation of the NDMP2 in each province (DSD, 2007a:40). The referred to forum “consists of representatives of core departments involved in the substance abuse field” (DSD, 2007a:40). Furthermore, each forum is supposed to have a coordinator who is appointed by DSD and who works in close collaboration with the secretariat of the CDA. The coordinator “submits two reports annually outlining progress in the implementation of the provincial mini-drug master plan” (DSD, 2007a:40). The CDA secretariat monitors the process of report submission. Non-compliance is clearly published by being revealed in the CDA Annual Reports. Monitoring and evaluation at the national level is executed by the following role players (DSD, 2007a:39-40):

- Cabinet and cabinet committees are responsible for the approval and implementation of legislation dealing with substance abuse.
- The National Council of Provinces ensures that provincial-specific issues related to substance abuse are addressed and it monitors national departments responsible for the implementation of the NDMP2.
- The National assembly is responsible for the monitoring of government departments, especially in terms of their respective mandates.

- Ministers and Members of Executive Councils monitor, *inter alia*, the functioning and progress made by the CDA.
- The Director-General of DSD monitors the CDA and deals with problems if other core departments involved do not fulfil their responsibilities as prescribed in the NDMP2.
- The CDA has various responsibilities as identified in the following quote:

... the coordination of national and provincial departments in respect of substance abuse ... monitors national departments to ensure delivery of services to prevent and combat substance abuse on the basis of mini-drug master plans and reports. It formulates plans annually to demonstrate how it intends achieving its goals (DSD, 2007a:40).

Based on the above historical and descriptive analysis of the NDMP2, strengths and limitations of the NDMP2 are identified as outlined in the next section.

2.4 STRENGTHS AND LIMITATIONS OF THE NDMP2

Although beyond the scope of this study, as it is not a policy evaluation study, some strengths and limitations of the NDMP2 come to the fore based on the historical and descriptive analysis presented in this chapter.

2.4.1 Strengths

Based on the historical and descriptive analysis, the strengths of the NDMP2 are as follows:

- All racial groupings are, in line with the Constitution of the Republic of South Africa, 1996 entitled to services related to substance abuse.
- The NDMP2 prioritises a micro-macro divide by depicting the scope of intervention ranging from individuals, the micro level, to the community, the macro level (DSD, 2007a:22-26).
- Integrated service delivery is prioritised in the NDMP2 with reference to prevention (from primary to tertiary level), and early intervention and treatment (including reintegration services) (DSD, 2007a:22-26).
- Inter- and intra-sectoral collaboration is promoted through the section pertaining to the *Institutional Framework* which refers to the role of the different government departments to implement policy. The roles of government and civil society are also outlined (DSD, 2007a:27-38).

- To acknowledge the impact of globalisation on drug trafficking and the spread of substance abuse, the NDMP2 refers to national, continental (regional) and global initiatives and agreements to eliminate drug abuse and drug-related crimes (DSD, 2007a:12).
- The CDA, representative of various stakeholders and policy actors, reflects a multi-sectoral approach towards substance abuse (DSD, 2007a:27) which is in accordance with the development approach as adopted by the South African government (Lombard, 2007:299; Patel & Hochfeld, 2008:195).
- Several of the constitutional, legal and broader policy mandates with respect to the different service providers and target groups involved with policy implementation are clarified (DSD, 2007a:10-12), e.g. the South African Institute for Drug-Free Sport Act 14 of 1997 which is implemented by the Department of Sport and Recreation.
- The NDMP2 provides a framework within which various role players can locate their required contribution (DSD, 2007a:27-38).
- The process with regards to monitoring and evaluation is stipulated in the NDMP2 (DSD, 2007a:39-41).
- The NDMP2 improves on previous drug-related policy by adding a public health model in addition to criminal and medical models. For example, a harm reduction strategy is prescribed for treatment programmes (DSD, 2007a:16).

2.4.2 Limitations

Based on the historical and descriptive analysis of the NDMP2, the following limitations of the NDMP2, albeit on an operational level, are identified.

- Although the NDMP2 has a monitoring and evaluation framework, clear *indicators* are not provided. This makes reliable policy evaluation difficult (cf. Cloete, 2006:261-265). This limitation was only corrected, after the NDMP2 had been in operation for a year, with the publication of the *Central Drug Authority Annual Report 2006/07* when “a result-based reporting format” was adopted and all stakeholders were expected to report on measurable results which assess the success of the NDMP in combating the drug problem (DSD, 2007b:6). Yet, each of the CDA Annual Reports published since 2006, has failed to report on these results.
- The NDMP2 is predominantly based on research findings originating from the 1998 *South African Demographic and Health Survey*. Those findings were already outdated when the survey was used to write the NDMP2. This limitation was only partially corrected when

baselines for both alcohol and drug use trends were established by adopting UN data (DSD, 2007b:5-6), as South African baselines are still awaited (DSD, 2010a:20).

These strengths and limitations are based solely on the historical and descriptive policy analysis, and information from CDA Annual Reports. Further, strengths and limitations pertaining to the content of the NDMP2, based on a content analysis of indicators for a social development perspective for drug policy in South Africa, will follow in Chapter 3.

2.5 SUMMARY

This chapter provided a historical and descriptive analysis of the NDMP2. The historical analysis outlined the development of drug-related policy and legislation in South Africa since 1652. It highlighted various features such as how the democratisation of the country led to redress in service delivery to substance-dependent people in the form of community-based rehabilitation and services to all racial groupings. In addition the descriptive analysis attempted to outline the NDMP2 by means of its core components and to contextualise the policy within the current socio-economic and political climate of South Africa.

The historical and descriptive analysis provided in this chapter form the basis of the content analysis that follows in the next chapter. Subsequently, in Chapter 3 the manifest content of the NDMP2 will be analysed and described from a social development perspective. As such, the content analysis of the NDMP2 could be considered a *logical policy analysis* (cf. Popple & Leighninger, 2008:57) which "... is similar to content analysis in looking at the content of social welfare policy in detail ... by assessing a policy's internal rigor and consistency."

Chapter 3: Research methodology, empirical study and research findings

3.1 INTRODUCTION

The goal of this study was to analyse and describe the content of the *National Drug Master Plan 2006-2011* from a social development perspective. In Chapter 2 the *National Drug Master Plan 2006-2011* (NDMP2) was described in terms of its historical development and content by means of a historical and descriptive policy analysis. Chapter 3 focuses on the following two objectives of this study, which are “to develop a checklist consisting of indicators for social development to guide the analysis of the NDMP2”, and “to analyse the content of the NDMP2 from a social development perspective, and draw conclusions on its strengths and limitations.”

This chapter will consist of three sections. *Firstly*, the research methodology that guided the empirical study will be discussed. *Next*, a short overview of the literature that informed the development of the checklist - what consists of indicators for social development as a theoretical framework - is outlined. *Finally*, the chapter will present and interpret the research findings, and ultimately outline the limitations of the study.

SECTION 1: RESEARCH METHODOLOGY

3.2 RESEARCH METHODOLOGY

The research methodology will be discussed with reference to the research question, research paradigm, approach and purpose, type of research, research design and methods, pilot study, and ethical considerations.

3.2.1 Research question

Descriptive studies, which could be either quantitative or qualitative in nature, describe the features of a unit of analysis, for instance a policy which is the case in this study (Fouché & De Vos, 2011:96; Rubin & Babbie, 2010:41). The 'features' that had to be described in this quantitative descriptive study were the presence or absence of indicators for social development in the NDMP2. The following research question, which guided this study, was drafted in a format that ensured that it directly relates to the goal of the study, that it is self-explanatory and clear to outside readers (Vithal & Jansen in Maree & Van der Westhuizen, 2007:30):

- Is the content of the NDMP2 in accordance with a social development perspective?

3.2.2 Research paradigm, approach and purpose

From an epistemological point of view, this study was rooted in a post-positivist paradigm having as its purpose to analyse and describe the manifest content of the NDMP2 from a social development perspective in an objective and precise manner (Rubin & Babbie, 2010:15). Additionally, as a new data collection instrument was developed by the researcher to guide the empirical study, while the study sample was of a limited scope (i.e. one policy, the NDMP2) (De Vos, Strydom, Schulze, Patel, 2011:7), the post-positivist paradigm of this study is further emphasised.

The researcher adopted a quantitative research approach as he aimed to determine objectively whether indicators of social development are encapsulated in the content of the

NDMP2. Simultaneously this study was guided by a specific research question, while the data collection was applied in a standardised manner in order to avoid adding subjective impressions or interpretations (Fouché & Delport, 2011:66). Various scholars postulate that research studies which analyse manifest content, as was the case in the present study, are quantitative in nature (cf. Dantzker & Hunter, 2006:88-89; Hong & Hodge, 2009:217; Neuman, 2006:323; Scott, 2006:40).

In line with this study's quantitative approach, numerical data were gathered during the empirical study in order to analyse and describe the content of the NDMP2 by means of descriptive statistical techniques (Pietersen & Maree, 2007b:184). The data collection procedure was consistently followed in this study as the researcher analysed the content of the NDMP2 using a quantitative data collection instrument which took the form of a checklist (Delport & Roestenburg, 2011:202-204). Based on the features of social development, indicators for a social development perspective were formulated and subsequently formed the foundation of the quantitative content analysis.

Neuman (2006:44) contends that content analysis enables the researcher to discover and describe the content of documents, such as the NDMP2, and that it is mostly undertaken with a descriptive research purpose. Survey methods are often used in descriptive studies; therefore, this study adopted a cross-sectional survey design to reach an answer to the research question (Creswell, 2009:17; Rubin & Babbie, 2010:43).

3.2.3 Type of research

As is often the case in the applied professional sciences, such as social work, this study was applied in nature, with its focus on undertaking research where the results could be used to address a problem or issue in the 'real world' (Newton, 2006:8-9). The findings of this study could directly translate into answers regarding the direction of the content of the NDMP2 in relation to a social development perspective. Furthermore, this study indicated the possible limitations of the policy which should be taken into consideration when revising it. By implementing applied research the researcher intended to reach specific solutions to inform policy formulation in order to deal with acute social problems, namely drug abuse and drug-related crime in South Africa (Monette, Sullivan & DeJong 2002:5).

3.2.4 Research design

A research design refers to the strategy a researcher follows to investigate adequately, economically and swiftly a phenomenon to reach an answer to the research question (Babbie, 2007:87; Bless, Higson-Smith & Kagee, 2006:21). Since this research was quantitative in nature, and aimed at analysing and describing the content of a policy, a cross-sectional survey design was considered to be the most appropriate research strategy (Babbie, 2007:102; Fouché, Delpont & De Vos, 2011:146,156; Rubin & Babbie, 2010:43). Gravetter and Forzano (2003:168) support the researcher's argument when they postulate that a survey is useful when the researcher simply aims to obtain a description of a specific unit of analysis, such as the NDMP2. The advantage of the research design was that it enabled the researcher to analyse and describe the content of the NDMP2, as the second National Drug Master Plan in South African history, from a social development perspective.

3.2.5 Research methods

The research methods that guided the execution of this study will be outlined by focusing on the applicable data collection instrument, the data processing and analysis, as well as the pilot study.

3.2.5.1 Data collection instrument

In order to analyse and describe the content of the NDMP2 the researcher made use of a checklist. Delpont and Roestenburg (2011:202) suggest that a checklist is "... a certain type of questionnaire consisting of a series of items ... that indicate whether a characteristic or attribute ... is present or not." Because no previous study attempted to analyse the content of the NDMP2, including a content analysis from a social development perspective, there was no previously developed or standardised checklist available. Therefore, the researcher had to follow a specific procedure to develop, pilot test and implement the checklist which consisted of indicators of social development as a theoretical framework. Based on the features of social development, the researcher developed the indicators as outlined in Addendum 1. Most authors (cf. Babbie, 2007:125-127; Baster, 1972:15; Hong & Hodge, 2009:214-215; Neuman, 1997:133-138) concur that indicator development consists of at least three consecutive steps, which are (1) an in-depth analysis of the concept (i.e. 'social development') in order to identify all the dimensions associated with the concept; (2) a literature study to isolate the themes (also referred to as 'constructs') associated with each dimension; and (3) delineate every theme through the identification of features (also referred

to as 'attributes' or 'characteristics') which are ultimately individually operationally defined to serve as an indicator of the concept that is to be analysed. In this particular study, the process unfolded as described below.

As a point of departure the researcher analysed and clarified the **concept** of 'social development' based on an in-depth literature study. This endeavour resulted in the identification of **ten dimensions** of the concept of 'social development'. For each of the dimensions **associated themes**¹ were identified in the literature (cf. Rubin & Babbie, 2010:66). Consequently, the researcher identified the **features** of each theme and **operationally defined** each feature to become an **indicator** of social development as a perspective (Baster, 1972:15). This process ensured that each indicator serves as a significant descriptor of the concept of social development, and that it is quantifiable, and actually measurable (Greenwood, 2008:55). The result of this process was consolidated into a checklist (see Addendum 1) and subsequently provided the researcher with the data collection instrument with which to analyse and describe the content of the NDMP2 from a social development perspective.

To ensure the credibility of the checklist, the researcher had to determine its validity and reliability as it was a newly developed data collection instrument.

- **Validity**

Within the context of this study, the checklist could be regarded as valid if it, on the one hand, enabled the content analyst to obtain an authentic description and analysis of the concept in question, i.e. social development, and on the other hand, if it made provision for a comprehensive list of indicators for social development as a theoretical framework and thus contributed to an accurate analysis of the concept (Delpont & Roestenburg, 2011:173; Neuendorf, 2002:112). In content analysis studies a data collection instrument is considered valid "if the inferences drawn from the available texts withstand the test of independently available evidence, of new observations, of competing theories or interpretations, or of being able to inform successful actions" (Krippendorff, 2004:313). The validity of the checklist was assured by means of both face and content validity. Face validity is the simplest form of validity, as it is merely concerned with the question of whether the checklist appears to enable a coder to analyse and describe the NDMP2 from a social development perspective (Delpont & Roestenburg, 2011:173-174). Yet it was very informative as it enabled the

¹ Some authors prefer the term 'construct' instead of themes.

researcher to submit the checklist to his research supervisor (a social development expert) and another academic (a specialist in indicator development) to determine whether the data collection instrument could be considered valid on face value (Bless et al., 2006:160; Krippendorff, 2004:314; Rubin & Babbie, 2010:83). Face validity enabled the researcher to assess content validity. In order to determine the content validity of the checklist the question was whether the checklist, based on a theoretical analysis of the concept 'social development' made provision for the analysis and description of a comprehensive list of the indicators that could be associated with a social development perspective (Babbie, 2007:147; Krippendorff, 2004:315; Neuendorf, 2002:116). Based on the outcome of this procedure, and after consultation with a statistician, the researcher judged the checklist to be a valid data collection instrument for the present study. However, validity is not the only criterion for sound quantitative research as the researcher also needs to provide evidence that the data collection instrument is reliable.

- **Reliability**

A quantitative data collection instrument is considered reliable if it produces the same numerical results when it is repeatedly used under the same circumstances (Delpont & Roestenburg, 2011:177; Rubin & Babbie, 2010:82). In other words, within the context of this study, reliability would mean that, if the checklist is used, as a guide, with different content analysing software packages, the same conclusions regarding the content of the NDMP2 are reached. As this study adopted content analysis as the data collection strategy, the researcher had to determine the reliability of the checklist by means of two strategies specifically applicable to content analysis studies, i.e. manifest coding and calculating a correlation coefficient. In order to advance the reliability of the study, the researcher coded only the manifest content, namely those indicators which were "directly visible [and] objectively identifiable ..." (Rubin & Babbie, 2010:244-245). Furthermore, instead of undertaking the content analysis manually, the researcher utilised two different software packages, which were Microsoft Word 2010 and WordSmith Tools 6, to analyse, and ultimately compare the outcomes, regarding the content of the NDMP2. Consequently, a statistician from the University of Pretoria was requested to determine the reliability of the checklist, based on the data obtained from the content analysis with two software packages. The *Pearson correlation coefficient* was calculated to determine whether the two sets of data demonstrate a positive correlation. The checklist was found to be reliable with $r = 0.98$. Fouché and Bartley (2011:274) and Pietersen and Maree (2007a:236) are in agreement that r between 0.6 and 1 represents a very strong and positive association. It thus means that, irrespective of which software package was used, the results correlate in 98% of the cases.

3.2.5.2 Data processing and analysis

The content of the NDMP2 was firstly analysed in order to be described (see 3.3). Content analysis, as a data analysis technique, could either be qualitative or quantitative in nature (Dantzker & Hunter, 2006:88-89; George, 2009:144-155; Krippendorff, 2004:18-19; Maschi, Baer & Turner, 2011:237; Rubin & Babbie, 2010:241). This study is quantitative in nature and therefore adopted Scott's (2006:40) definition of content analysis which states that it is "[a] method of analysing the contents of documents that uses quantitative measures of the frequency of appearance of particular elements in the text."

Within the context of this study the document that had been studied was a policy, namely the NDMP2, while the 'elements' which had to be analysed were indicators of social development. The motivation of the researcher to analyse the NDMP2 utilising the method of content analysis is encapsulated in the following quote by Scott (2006:41):

Content analysis discloses, at best, the 'internal' meaning of a document: it discloses the meaning that the text would convey to a reader who employed reading techniques similar to those used by the researcher ... [c]ontent analysis, therefore, is a useful and important tool of documentary analysis, providing objective and rigorous methods for investigating social meanings.

In this study the content analysis was undertaken according to the method outlined by Leedy and Ormrod (2005:142) as discussed below.

- **Step 1**

Leedy and Ormrod (2005:142) suggest that, if the body of material is relatively small, it should be studied in its entirety; therefore, this study focused on the entire NDMP2.

- **Step 2**

The researcher should outline the characteristics according to which the document will be analysed in precise and concrete terms. As a result, before the NDMP2 was analysed, a checklist had to be developed, in accordance with the process outlined in paragraph 3.2.5.1, in order to guide the analysis.

- **Step 3**

Leedy and Ormrod (2005:142) propose that lengthy or complex documents should be separated into small and manageable segments. As only one policy document had to be analysed, and software packages were used to do so, the results of the entire policy document were captured on one checklist.

- **Step 4**

Lastly, the “researcher scrutinizes the material for instances of each characteristic or quality defined in step 2” (Leedy & Ormrod, 2005:142). During this stage the researcher analysed the manifest content of the entire policy with two different software packages: WordSmith Tools 6 and Microsoft Word 2010, and scored the frequency of the indicators of social development on the checklist which was developed, after which descriptive statistics were derived from it. In line with the suggestion of contemporary content analysis texts (cf. Krippendorff, 2004:192-194; Neuman, 2006:325; Scott, 2006:40-41; Welman, Kruger & Mithcell, 2005:221), the researcher calculated descriptive statistics and used Microsoft Excel 2010 for the task. As only one policy document was involved in this study, it was foreseen from the start that descriptive statistics, and not inferential statistics, could be obtained from the content analysis. Descriptive statistics is a “... collective name for a number of statistical methods that are used to organise and summarise data in a meaningful way” (Pietersen & Maree, 2007b:183). The descriptive statistics, specifically frequencies as a form of univariate analysis, enabled the researcher to report on the presence or absence of social development indicators in the NDMP2 by means of numeric frequencies, tables, pie charts and bar graphs (Babbie & Mouton, 2001:52; Krippendorff, 2004:192; Neuendorf, 2002:172; Sapsford, 2006:185-192). Although frequencies are the most basic form of statistic, frequencies were deemed adequate for this study as the research question merely asked the question “Is the content of the NDMP2 in accordance with a social development perspective?” Therefore, more sophisticated statistical techniques, for example to determine the direction of indicators, or to calculate the space occupied by specific indicators in the policy document were not relevant for this study.

Although not included in the methodological outline of Leedy and Ormrod (2005:142), the researcher added the following step to conclude the process.

- **Step 5**

The outcome of the content analysis needs to be transformed into a research report that is both clear and precise. The data collection method and the process of data analysis, as well as the findings, such as strengths and limitations of the policy, need to be reported in order to guide policy writers in their efforts to revise policy.

3.2.5.3 *Pilot study*

A pilot study should always be part of the research process, because the researcher thus ensures that the proposed study is practically executable. A pilot study could be regarded as a dress rehearsal of the main investigation, which adds value to the study in terms of determining “[whether] the methodology, sampling, instruments and analysis are adequate and appropriate” (Bless et al., 2006:184). For the purpose of this study, the researcher tested the data collection instrument and determined the feasibility of the study during the pilot study in preparation for the main study.

- **Pilot testing of the data collection instrument**

Strydom (2011a:240) suggests that the pilot testing of the data collection instrument basically entails the researcher exposing a number of cases to a process similar to the main investigation in order to identify its strengths and limitations before the actual empirical study commences. Therefore, the researcher developed the checklist, and ensured both its face and content validity, before it was piloted by analysing a chapter from the *National Drug Master Plan 1999-2004* (NDMP1) to determine the checklist’s suitability and usability (cf. Mitchell & Jolley, 2010:216; Neuendorf, 2002:133). By piloting the checklist with the NDMP1, the researcher ensured that a specific section of NDMP2 would not be contaminated before the main study. Furthermore, utilising the NDMP1 was regarded a “valid dress rehearsal” since it was similar to NDMP2, promulgated after South Africa had adopted social development as an approach towards social welfare and also after the *White Paper for Social Welfare* (RSA, Ministry of Welfare and Population Development, 1997) had been adopted in Parliament. The checklist was found to be effective. However, synonyms for indicators were included in the checklist to make provision for the precision of analysing manifest content.

- **Feasibility of the study**

Various advantages are attributed to content analysis, such as the fact that no research staff is required, because the researcher could analyse the documents him/herself; no special equipment is needed, since it is a rather “simple” analytical process; and the study could be undertaken provided that the material to be analysed is available (Babbie, 2007:330). At the onset of the study its feasibility was foreseen due to the fact that the NDMP2 is easily accessible and in the public domain. Additionally, the researcher was the only person involved in the analysis of the policy and could also undertake it without unique equipment. From the preliminary literature review, it was confirmed that literature relating to the NDMP2 is almost non-existent, although literature pertaining to social development, drug-related policy, and theory of social policy was relatively easily accessible. Furthermore, during the study when the need arose to confirm aspects about the policy development process, public officials from the National Department of Social Development (NDSD) were keen to allow the researcher access to documents, specifically the Central Drug Authority (CDA) Annual Reports. In the light of the above, and with the ethical clearance from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (see Addendum 2), the researcher concluded that the study was indeed feasible.

3.2.6 Ethical considerations

Social researchers are reminded that they do not perform their studies in a social vacuum and therefore need to pay special attention to the code of ethics which guides their professional behaviour. The *Policy Guidelines for Course of Conduct, Code of Ethics and the Rules for Social Workers* clearly state that “[social] workers should monitor, evaluate and research policies ... and promote and facilitate evaluation and research to contribute to the development of knowledge” (South African Council for Social Service Profession [SACSSP], n.d.:9). Although no respondents were involved in this study, there were, however, a number of ethical considerations that needed to be taken into account while performing this research study. The researcher is of the opinion that the ethical considerations discussed below were relevant to this study.

3.2.6.1 Deception

No deception, whereby the researcher purposefully withheld information from respondents, or mislead them with regard to the goal of the study (Fisher & Anushko, 2008:101; Gravetter & Forzano, 2003:69), was applied during this study. When the need arose to clarify aspects

regarding the policy development process of the NDMP2, the researcher informed the public official at the NDSD, from whom the information was requested, in writing about the goal and objectives of the study, and that the information would be published. However, no official permission was applicable, since the researcher only obtained access to the information, which is in the public domain, through the assistance of the government employee.

3.2.6.2 Quality of research

The researcher adhered to the ethical obligation to ensure that the best methodology would be followed, to ascertain that any research project is well-executed and eventually adds valuable information to the base of knowledge (Bless et al., 2006:145), as subsequently described. The researcher is primarily, in terms of the Code of Conduct of his profession, obliged to ensure that all social work actions are of good quality and advance the social functioning of humanity. To this end, the research proposal was subjected to a vigorous review process. Firstly, three peer reviewers of a Departmental Research Panel reviewed it to ensure the quality of the proposed study even during the planning stage. In a second phase of quality assurance, the research proposal was scrutinised during a review process by the Faculty Research Ethics Committees who had to determine whether the proposed study upheld ethical and internationally competitive academic standards. It is thus clear that various mechanisms are in place at the University of Pretoria to ensure that research of good quality is undertaken. Furthermore, during the study the researcher was guided by a research supervisor who is both a research methodology and subject-specific expert.

3.2.6.3 Analysing and reporting of research findings

This ethical consideration is explained within a broader scientific context when Babbie (2007:69) maintains that “Researchers can best serve their peers – and scientific discovery as a whole - by telling the truth.” Within the context of this research, the research report is clear and coherent. Amongst others, the methodological constraints which the researcher encountered are reported in Chapter 3, paragraph 3.5 (Bless et al., 2006:145).

3.2.6.4 Publication

The most effective way for a researcher to communicate his/her research findings is through publication. However, when it comes to publication there are several considerations to be taken in account, namely that all persons who have contributed to the research, should be credited, and authors should ensure that they acknowledge the sources in the text in order to

avoid plagiarism (Bless et al., 2007:146; SACSSP, n.d.:9-12). The researcher intends to publish at least one peer-reviewed article originating from this study. The article will be drafted in collaboration with the supervisor as the co-author in order to acknowledge the efforts and guidance of the supervisor in facilitating the researcher through the research process (McLaughlin, 2007:68-69). Furthermore, the outcome of the study will be presented at an international conference, the International Association of Schools for Social Work bi-annual conference, hosted in Stockholm, Sweden during July 2012. The University of Pretoria will be credited with ownership of the intellectual property contained in the research outcomes. Additionally, in line with the policy of the University of Pretoria, all the raw data need to be safeguarded by the Department of Social Work and Criminology for 15 years.

3.2.6.5 Competence of researcher

The essence of this ethical aspect is that researchers have an ethical obligation to ensure that they are competent and adequately skilled to undertake the study (Strydom, 2011b:123-124). The researcher views himself as being competent to have undertaken this study, as he had gained valuable research expertise while studying towards a PhD (SW) and passed a fundamental course in research methodology in partial fulfilment of the requirements for the current MSW (Social Development & Policy) programme.

Section 1 outlined the research methodology and explained the process that was followed to identify the dimensions, themes and features of social development which will next be discussed in Section 2 of this chapter.

SECTION 2: LITERATURE FOUNDATION OF CHECKLIST

3.3 LITERATURE FOUNDATION OF INDICATORS OF A SOCIAL DEVELOPMENT PERSPECTIVE FOR DRUG POLICY IN SOUTH AFRICA

This section of the chapter will outline the dimensions, themes and features of social development. It is not the intention of this section to analyse the content of the NDMP2 from a social development perspective, as this will be dealt with in Section 3 of this chapter.

The process that was followed to identify the dimensions, themes, features and subsequent indicators of social development was explained in detail in Section 1 of this chapter (see paragraph 3.2.5.1). Based on an in-depth literature review of the theoretical concept 'social development' (cf. Burke & Harrison, 2009; Dalrymple & Burke, 2006; DSD, 2006, 2008a; Gray, 2002; Green & Nieman, 2003; Ife, 2001; Lombard, 2009, 2008, 2005, 2003; MacGregor, 1999; Mayadas & Elliott, 2001; Midgley, 2010b, 1995; Midgley & Tang, 2001; Noyoo, 2005; Patel, 2005; Patel & Hochfeld, 2008; Patel, Hochfeld, Graham & Selipsky, 2008; Patel & Selipsky, 2010; Payne, Adams & Dominelli, 2009; Reynecke, 2006; RSA, GCIS, 2012; RSA, Ministry of Welfare and Population Development, 1997; Sherraden, 2009), as well as the conclusions drawn from the historical and descriptive analysis of the NDMP2 in Chapter 2, **Table 1** delineates the dimensions, themes and features² of a social development perspective for drug policy in South Africa.

TABLE 1: DIMENSIONS, THEMES AND FEATURES OF A SOCIAL DEVELOPMENT PERSPECTIVE FOR DRUG POLICY IN SOUTH AFRICA

DIMENSIONS	THEMES	FEATURES
1. Capital development	1.1 Economic capital	<ul style="list-style-type: none"> • Black Economic Empowerment (BEE) • Community economic development (CED) • Cooperatives • Entrepreneurship (e.g. income generation projects)

² The features were operationally defined in the checklist in order to become **indicators** of social development as a theoretical framework with regards to drug policy in South Africa.

		<ul style="list-style-type: none"> • Expanded Public Work Programme (EPWP) • Micro-enterprises • Small Business Development • Social grants
	1.2 Human capital	<ul style="list-style-type: none"> • Personal/interpersonal empowerment (incl. Role modelling, peer and lay counselling, helpline, awareness campaigns/programmes) • Self-knowledge development (incl. Self-determination, self-esteem) • Skills training/Capacity building (incl. Business skills)
	1.3 Social capital	<ul style="list-style-type: none"> • Community mobilisation and advocacy (incl. Community participation in policy formulation) • Building mutual respect • Promoting solidarity (incl. community campaigns against drug-stricken locations and facilities)
2. Innovation	2.1 Research	<ul style="list-style-type: none"> • Community-based interventions • Economic costs of substance abuse • Foetal alcohol syndrome • Indigenous substances • Participatory action research methods (PAR) • Prevalence of substance abuse • Relationship between substance abuse and HIV and Aids, TB, crime, youth development and poverty
	2.2 Monitoring and evaluation	<ul style="list-style-type: none"> • Ex-post evaluation • Final project evaluation • Impact evaluation • Interim evaluation (e.g. twice per annum) • Ongoing evaluation

		<ul style="list-style-type: none"> • Participatory evaluation • Rapid appraisals • Surveys
3. Integrated service delivery strategy ³	3.1 Harm reduction	<ul style="list-style-type: none"> • Early detection • Detoxification and rehabilitation • Aftercare and reintegration services • Medical treatment • Substitution therapy • Controlled access and distribution of drugs
	3.2 Supply reduction	<ul style="list-style-type: none"> • Legal action /law enforcement • Prevention of drug production, manufacturing, trade and trafficking • Seizing and destroying precursor materials, raw materials and products
4. Intervention by social service professionals	4.1 Bridging micro-macro divide	<ul style="list-style-type: none"> • Case work/Therapy • Group work/Group counselling • Community work/development
	4.2 Features of intervention	<ul style="list-style-type: none"> • Anti-oppressive • Asset-based • Critical • Emancipatory • Empowerment • Human potential development (e.g. Max Neef) • Human rights • Social justice • Strengths-based/Strengths perspective
5. Levels of service delivery	5.1 Four levels of service delivery	<ul style="list-style-type: none"> • Prevention (i.e. primary, secondary, tertiary) • Early intervention • Statutory intervention/Rehabilitation/Institutionalisation

³ Although the *CDA Annual Report for 2006/2007* (DSD, 2007b) isolates 'demand reduction' as a separate strategy, it is not isolated as such in this study, as the researcher regards it as integrated in all the dimensions associated with a social development perspective. The checklist was developed accordingly.

<p>6. Mandate</p>	<p>6.1 International</p>	<ul style="list-style-type: none"> • Aftercare and reintegration • Millennium Development Goals (2001) • UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances , 1988 • UN Convention on Psychotropic Substances, 1971 • UN Convention on Transnational Organised Crime, 2000 • UN Protocol on Narcotic Drugs, 1972 • UN Single Convention on Narcotic Drugs, 1961 • UN Summit for Social Development, Copenhagen (1995)
	<p>6.2 African/Regional</p>	<ul style="list-style-type: none"> • African Union (AU): <ul style="list-style-type: none"> ○ Drug Control Protocol • New Partnership for Africa's Development (NEPAD) (2001) • Southern African Development Community (SADC) <ul style="list-style-type: none"> ○ Protocol on Combating Illicit Drugs (1996) ○ Regional Drug Control Programme (1998)
	<p>6.3 National</p>	<ul style="list-style-type: none"> • Accelerated Shared Growth Initiative (AsgiSA) (2006) • Constitution of the Republic of South Africa, 1996 • Drug and Drug Trafficking Act 140 of 1992 • Growth Employment and Redistribution Strategy (GEAR) (1996) • Integrated Service Delivery Model (ISDM) (2006) • Liquor Act 59 of 2003

		<ul style="list-style-type: none"> • Medicine and Related Substances Control Act 59 of 2002 • Prevention and Treatment of Drug Dependency Act 20 of 1992 & 14 of 1999 • Prevention of Organised Crime Act 121 of 1998 • Road Traffic Amendment Act 21 of 1998 • South African Institute for Drug-Free Sport Act 14 of 1997 • Tobacco Products Control Amendment Act 12 of 1999 • White Paper for Reconstruction and Development (1994) • White Paper for Social Welfare (1997)
<p>7. Partnerships/Welfare pluralism</p>	<p>7.1 Government sector</p>	<ul style="list-style-type: none"> • Agriculture, Forestry and Fisheries • Arts and Culture • Communications • Cooperative Governance and Traditional Affairs • Correctional Services • Education (Basic Education and Higher Education & Training) • Financial Intelligence Centre • Foreign Affairs • Health • Home Affairs • International Relations and Cooperation • Justice and Constitutional Development • Labour • National Intelligence Agency • National Treasury • National Youth Commission • Research Councils <ul style="list-style-type: none"> ○ Human Sciences Research Council ○ Medical Research

		<p style="text-align: center;">Council</p> <ul style="list-style-type: none"> • Social Development • SA National Academy of Intelligence • SA Police Service • SA Revenue Service • Sport and Recreation SA • Statistics South Africa • Tourism • Trade and Industry • Transport
	7.2 Private sector ⁴	<ul style="list-style-type: none"> • Community-based organisations • Employee Wellness Programmes/Employee Assistance Services • Faith-based organisations • Non-governmental organisations • Private SA universities
	7.3 Business sector	<ul style="list-style-type: none"> • Business Against Crime
	7.4 Interest groups	<ul style="list-style-type: none"> • Alcoholics Anonymous • Narcotics Anonymous • Christelike Afhanklikheidsdiens (“<i>Christian Dependency Services</i>”) • Christelike Afhanklikheidsbond (“<i>Christian Dependency Association</i>”)
8. Principles	8.1 Social Development Principles	<ul style="list-style-type: none"> • Accessibility • Appropriateness • Democracy • Diversity • Equity • Non-discrimination • People-centred • Redress • Self-reliance • Social justice • Sustainability

⁴ Within the context of this study CBOs, FBOs and NGOs are referred to as **private initiatives** to distinguish them from the efforts by the government and the business sector. However, the researcher is aware that these organisations rely on government subsidy to operate.

		<ul style="list-style-type: none"> • Transparency • Ubuntu
9. Rights-based approach	9.1 International measures	<ul style="list-style-type: none"> • Convention on the Elimination of all forms of Racial Discrimination against Women, 1979 • Convention on the Rights of the Child, 1989 • Universal Declaration of Human Rights, 1948
	9.2 African/Regional measures	<ul style="list-style-type: none"> • African Charter on Human and People Rights (1981) • African Charter on the Rights and Welfare of the Child (1990)
	9.3 National measures	<ul style="list-style-type: none"> • Bill of Rights, Constitution of the Republic of South Africa, 1996
10. Target groups	10.1 Vulnerable and marginalised groups	<ul style="list-style-type: none"> • Children (incl. Children living/working on the streets) • Families (e.g. Family preservation) • Gay, lesbian, bisexual and transgender people • Older persons/Elderly • People infected/affected by HIV and Aids • People with disabilities/Disabled • Poverty stricken people/Poor • Women • Youth

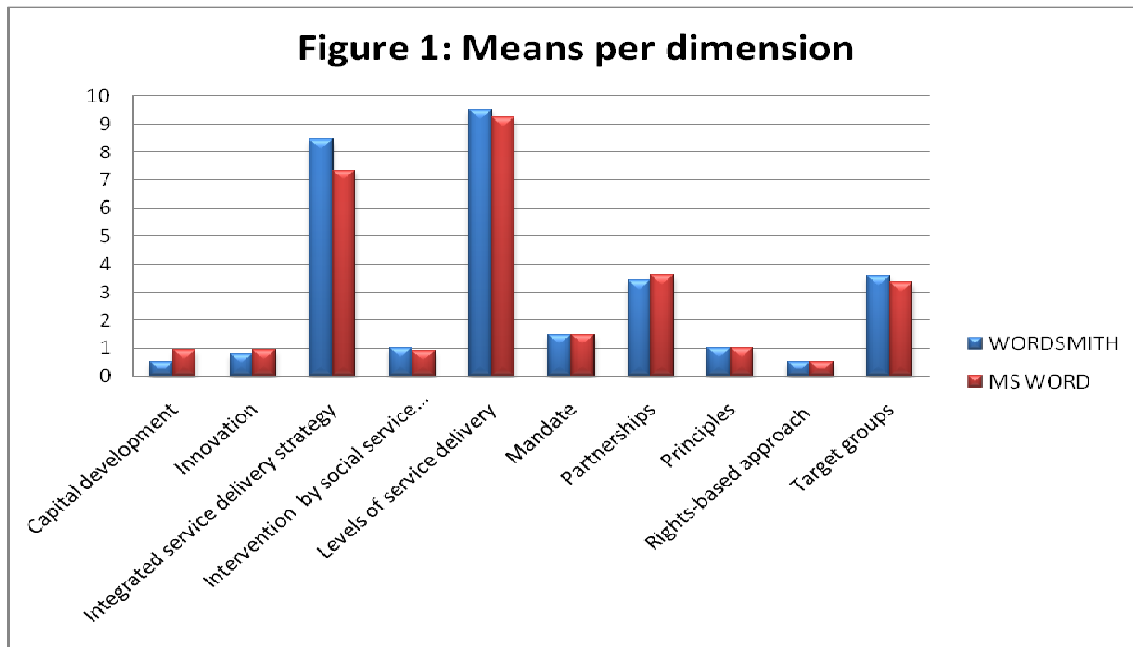
From **Table 1** it is evident that ten dimensions were identified for the concept 'social development' in relation to drug policy in South Africa. The dimensions were elaborated on with numerous themes. The themes were subsequently elucidated with specific features. Each feature was operationally defined in order to become an indicator of social development. Embedded in the literature foundation of the checklist (see Addendum 1), the next section of this chapter focuses on the research findings emanating from the content analysis of the NDMP2 and provides an interpretation thereof.

SECTION 3: RESEARCH FINDINGS AND INTERPRETATION

3.4 RESEARCH FINDINGS AND INTERPRETATION

In Section 3 of this chapter, the research findings of the content analysis process will be presented, and an interpretation thereof will be offered. As a point of departure, an overview of the *weighted mean scores* per dimension will be provided, based on the outcome of the content analysis process with two different software packages: WordSmith Tools 6 (WS) and Microsoft Word 2010 (MsW). **Figure 1** provides an overview of the spread of the various dimensions within the NDMP2. It should be noted that, because the results obtained from the two software packages have shown a 98% agreement correlation (see paragraph 3.2.5.1), the researcher will only discuss the results obtained through the content analysis with WordSmith Tools 6 during the detailed discussion of each dimension respectively.

Figure 1 outlines the weighted mean scores per dimension as per content analyses through the utilisation of both WS and MsW.



From **Figure 1** it is evident that there are dimensions that are strongly emphasised in the content of NDMP2, while others are merely touched on. Those dimensions that received considerable emphasis in the policy content are: **Levels of service delivery** (WS=9.5⁵; MsW=9.25) where the NDMP2 highlights the importance of service delivery to focus on prevention, early intervention, statutory intervention/rehabilitation/institutionalisation, as well as aftercare and reintegration services (DSD, 2007a:22-26). Closely linked to service delivery, the second most emphasised dimension is **integrated service delivery strategy** (WS=8.44; MsW=7.33). This dimension deals with a description of how a harm reduction and supply reduction model, in line with the prescriptions of the United Nations Office on Drugs and Crime (UNODC) (DSD, 2008a:39), should be implemented in the South African context. Next is the dimension about **target groups** (WS=3.56; MsW=3.33). The attention of service providers is drawn to the fact that services must be provided to various target/marginalised groups affected by drug abuse, e.g. the youth, women, and children (DSD, 2007a:14). However, from the mean scores it is also evident that several of the dimensions are barely addressed. For example, dimensions such as a **rights-based approach** (WS=0.5; MsW=0.5) and **capital development** (WS=0.5; MsW 0.93) (e.g. economic, human and social capital) took up much less space in the content of the NDMP2. The discussions that follow will focus on the specific research findings of the ten dimensions respectively.

3.4.1 Capital development

Social development scholars (cf. Lombard, 2005:211; Midgley & Sherraden, 2000:438-444; Patel, 2005:203-206) are in agreement that a social development perspective is characterised by the capital development of welfare service users. This includes economic, human and social capital development. As a result, the first dimension to be analysed in this study, was capital development (see **Table 2**).

⁵ Weighted mean scores.

TABLE 2: CAPITAL DEVELOPMENT

DIMENSION 1: CAPITAL DEVELOPMENT	f	%
1.1 Economic capital		
Black Economic Empowerment	0	0
Community economic development	0	0
Cooperatives	0	0
Entrepreneurship	0	0
Expanded Public Works Programme	0	0
Micro-enterprises	0	0
Small Business Development	0	0
Social grants	0	0
1.2 Human capital		
Personal/intrapersonal empowerment	4	57.14
Self-knowledge development	0	0
Skills training	2	28.57
1.3 Social capital		
Community mobilisation and advocacy	1	14.29
Building mutual respect	0	0
Promoting solidarity	0	0
TOTAL	7	100
MEAN	0.5	

A unique feature of a social development perspective is its emphasis on both the social and economic development of welfare service users (Midgley, 1995:25; 2010b:8-10). The economic development of welfare service users with a substance abuse problem is equally important as they often find it difficult to find employment, for example, after they have been discharged from treatment centres. As indicated in **Table 2**, economic development is totally ignored in the content of the NDMP2. This implies that the NDMP2 includes no directives to service providers to incorporate economic development in programmes for substance-dependent persons. Empirical studies amongst NGOs in general, and statutory social work in particular, revealed similar results, as the researchers found that economic development receives little attention, if any, in practice (Hölscher, 2008:118; Lombard & Kleijn, 2006:220-224; Patel & Hochfeld, 2008:205).

On the contrary, the NDMP2 does make provision for the human capital development of people affected by substance abuse. In particular, personal/intrapersonal development ($f=4$; 57.14%) and skills training ($f=2$; 28.57%) feature in the content of the NDMP2. From the frequencies of these indicators it is concluded that service providers are informed about the necessity of investing time in, amongst other things, the life skills training and building self-esteem and self-reliance (Lombard, 2005:218) of people affected by substance abuse.

The indicators pertaining to social capital development received little attention in the NDMP2. For example, measures to build social capital, i.e. mutual respect and promoting solidarity, are not addressed in the content of the NDMP2. Only one indicator, namely community mobilisation and advocacy ($f=1$; 14.29%), is mentioned in the policy. Thin (2002:87) postulates that strong social capital in communities promotes the realisation of social development goals, while the absence of social capital amongst community members often results in increased drug use (McKee, 2002:456). As indicated in Chapter 2, paragraph 2.3.3.1, South Africa's drug and alcohol abuse rates are extremely high. Clearly the NDMP2 reflects a gap in combating substance abuse and drug-related crime without a strong emphasis on social capital.

3.4.2 Innovation

Green and Nieman (2003:168) regard innovation as an important dimension of a social development perspective. Within the context of this study, innovation is categorised as research as well as monitoring and evaluation. **Table 3** depicts the content of the NDMP2 with relation to these two themes and their associated indicators.

TABLE 3: INNOVATION

DIMENSION 2: INNOVATION	f	%
2.1 Research		
Community-based interventions	1	7.69
Economic costs of substance abuse	1	7.69
Foetal alcohol syndrome	0	0
Impact of policies	0	0
Indigenous substances	4	30.77
Participatory action research methods	0	0
Prevalence of substance abuse	1	7.69
Relationship between substance abuse and HIV and Aids, TB, crime, youth development and poverty	1	7.69
2.2 Monitoring and Evaluation		
Ex-post evaluation	0	0
Final project evaluation	0	0
Impact evaluation	0	0
Interim evaluation	0	0
Ongoing evaluation	5	38.46
Participatory evaluation	0	0
Rapid appraisals	0	0
Surveys	0	0
TOTAL	13	100
MEAN	0.81	

Based on **Table 3**, the NDMP2 emphasises the need for research on indigenous substances ($f=4$; 30.77%) and how these substances affect people's substance use behaviour. Furthermore, indicators such as community-based interventions, the economic costs of substance abuse, the prevalence of substance abuse, and the relationship between substance abuse and HIV and Aids, TB, crime, youth development and poverty featured only once in the content of the NDMP2 ($f=1$; 7.69%). Although Gray (2002:13) is of the opinion that a social development perspective is complemented by participatory action research methods, and the DSD (2007a:16) and Parry (2005:426) allude to the fact that South Africa has the highest occurrence of foetal alcohol syndrome in the world, neither of these

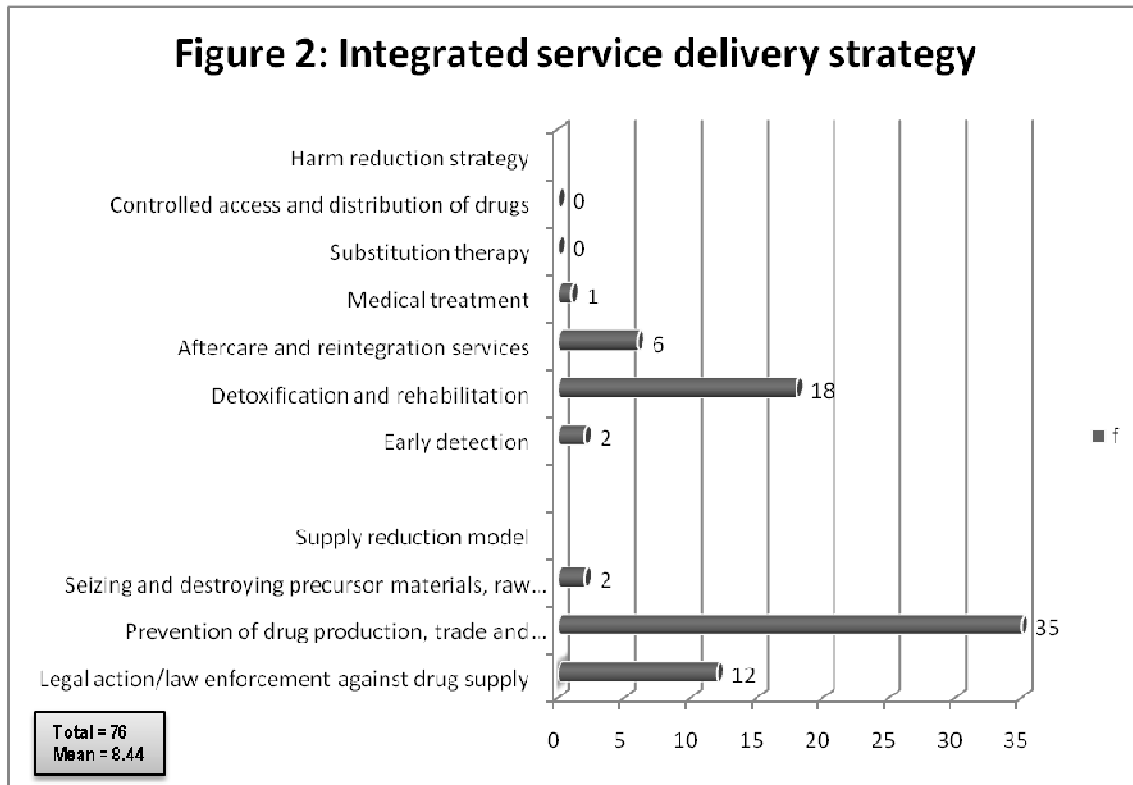
indicators is accounted for in the content of the NDMP2. Furthermore, the content analysis revealed that there is no direct reference to the need to research the impact of the NDMP2 in achieving a drug-free society. This situation still prevails, as the *Central Drug Authority Annual Report 2009/10* (DSD, 2010a:11) reports that "... accurate data on the nature and extent of the problem of alcohol and/or other drugs in South Africa is not available ..."

Closely linked to research, is the monitoring and evaluation of policies. Social policy literature (cf. Cloete, 2006; Noyoo, 2005; Noyoo & Mamphiswana, 2003) describes numerous policy monitoring and evaluation methods, such as ex-post evaluation, impact evaluation and participatory evaluation. The content analysis has shown that only the indicator 'ongoing evaluation' is indicated in the policy. However, from the *Central Drug Authority Annual Report 2009/10* (DSD, 2010a:11) it is clear that this practice has not come into being for either the NDMP1 or the NDMP2. It is therefore assumed that South Africa is at the point to introduce its third National Drug Master Plan (i.e. NDMP 2012-2016), without any research findings to indicate the successes, or failures, of the previous two master plans.

3.4.3 Integrated service delivery strategy

As South Africa is a signatory of the UNODC guidelines (DSD, 2008a:39), the NDMP2 is supposed to make provision for an integrated service delivery strategy that is executed through, *inter alia*, two models: harm reduction and supply reduction model. Consequently, this study analysed whether the content of the NDMP2 makes provision for these models. **Figure 2** outlines the strategies for both harm reduction and supply reduction and how these indicators are accounted for in the content of the NDMP2.

Figure 2: Integrated service delivery strategy



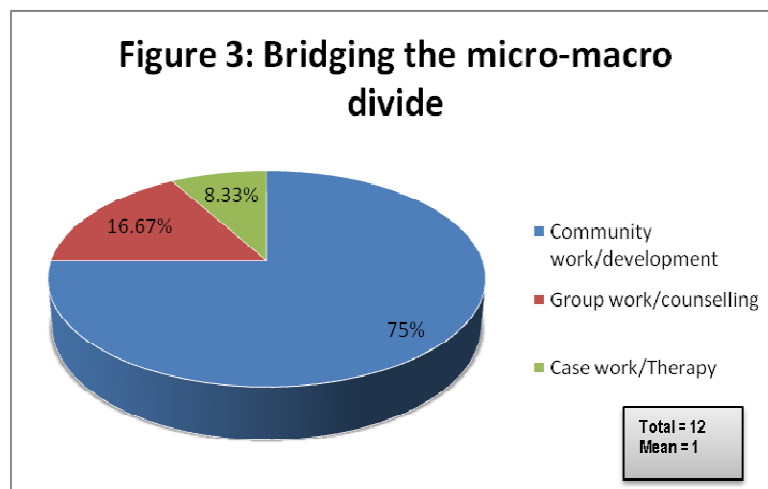
From **Figure 2** the NDMP2 accentuates detoxification and rehabilitation ($f=18$; 23.68%), aftercare and reintegration services ($f=6$; 7.89%) and early detection ($f=2$; 2.63%) as strategies to reduce the harm associated with drug abuse. Not surprisingly strategies such as “substitution therapy” and “controlled access and distribution of drugs” are not outlined in the NDMP2, because, as the first annual report after the introduction of this master plan, namely the *Central Drug Authority Annual Report 2006/07* (DSD, 2007b:35) clearly articulates, “In the South African context, several of the harm reduction interventions practised in other countries are as yet unacceptable for reasons associated with the peculiar culture and the specific religious beliefs of South Africans.” This particular model is attracting considerable attention in the media currently, as the CDA plans to incorporate more harm reduction strategies, such as substitution treatment for heroin dependence and needle syringe programmes, into the NDMP 2012-2016 (Ndaliso, 2011). Ndaliso (2011) reported in *The Witness* of the 6th of October 2011 that various interest groups, such as Doctors for Life, are opposing the inclusion as they believe in the termination of drug use, and not its support “[through] policies and programmes aimed primarily at reducing the health, social and economic costs of ... drugs without *necessarily* reducing drug consumption” (Wodak, 2009:343). Nonetheless, international organisations, such as the UNODC, are of the opinion that “[a]ny sensible drug policy will always combine elements of supply reduction, demand reduction and harm reduction” (Wodak, 2009:344).

Contrary to harm reduction strategies, the findings in **Figure 2** show that the content of the NDMP2 consists of numerous referrals to supply reduction strategies. The prevention of the production, manufacturing, trade and trafficking of drugs received the most attention ($f=35$; 46.05%), followed by law enforcement against drug supply activities ($f=12$; 15.79%) and the seizure and destruction of precursor materials, raw materials and products ($f=2$; 2.63%).

From the prominence that these two models receive in the NDMP2, it is, holistically seen, concluded that South Africa takes the recommendations from the UNODC seriously and therefore incorporates them in the NDMP2.

3.4.4 Intervention by social service professionals

Social policy, such as the *Integrated Service Delivery Model towards improved social services* (ISDM) (DSD, 2006:14-15) and the NDMP2 (DSD, 2007a:22-26), proposes that social service professionals provide services on the micro, meso and macro level, while aspiring towards, amongst others, the empowerment of welfare service users. Patel and Hochfeld (2008:204) found that NGOs, in general, tend to focus their attention on micro and macro practice at the expense of meso practice. As NGOs are one of the dominant sectors involved in services to people who abuse substances (DSD, 2007a:36), it was essential to explore whether the content of the NDMP2 highlights the three primary methods of service delivery as this could provide an idea of how service providers ultimately execute their services. **Figure 3** depicts how the manifest content of the NDMP2 provides direction towards the bridging of the micro-macro divide for intervention by social service professionals.



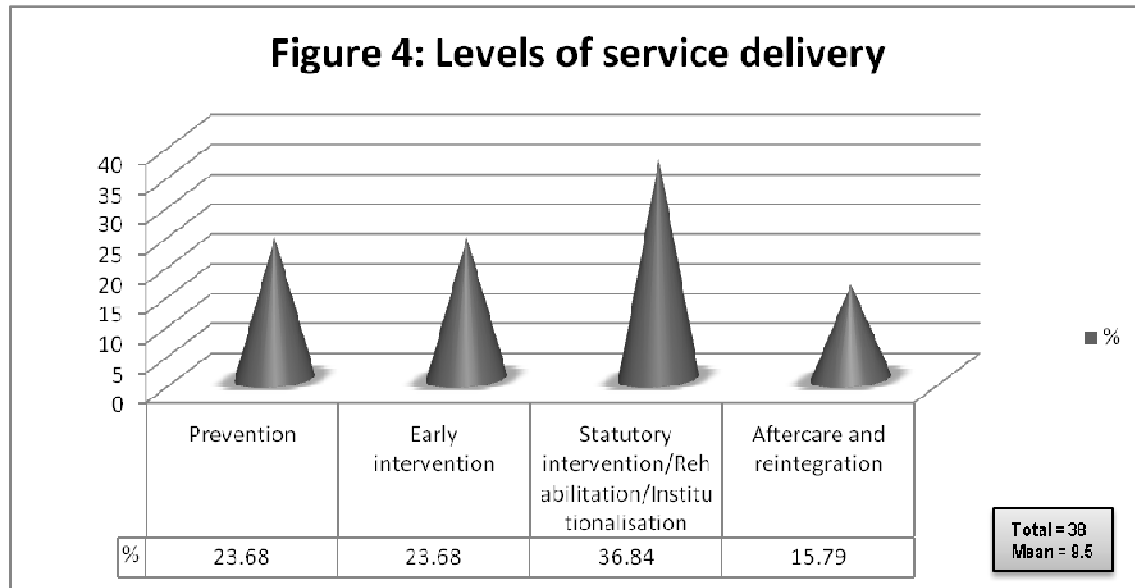
Based on **Figure 3**, it is clear that the content of the NDMP2 predominantly emphasises community work/development ($f=9$; 75%), followed by group work/counselling ($f=2$; 16.67%) and case work/therapy ($f=1$; 8.33%). Within a social development perspective, the bridging of the micro-macro divide is accentuated (Patel, 2005:206). As a result, it could be concluded that, at least from a content point of view, the NDMP2 propagates a micro-macro divide, where macro practice receives the most attention, followed by meso and micro practice. This finding is corroborated by the results relating to capital development (see paragraph 3.4.1). Although to a different degree, both human and social capital development are featured in the content of the NDMP2. Whether service providers implement their services accordingly, could be a worthwhile investigation. For example, Myers et al. (2008:164) found that treatment centres in Cape Town mainly render services on the micro level.

Nevertheless, intervention by social service professionals need not only demonstrate a micro-macro divide. Service delivery should be executed by means of **practice approaches that contributes towards the social development** (i.e. human, social and economic capital development) of welfare service users. Midgley (2010a:10) postulates that social development is often “driven by pragmatic consideration” and therefore its “theoretical content remains weak”. Consequently, numerous scholars, such as Geyer (2010:65), Gray (2002:9), Lombard (2007:300), Mayadas and Elliott (2001:11), Midgley (2010b:13-17), O’Brien and Mazibuko (1998:146-149), and Patel (2005:207), have argued that there are practice approaches reconcilable with the aspirations of social development. For example, empowerment practice, the strengths perspective and asset-based approaches. Unfortunately, none of these practice approaches feature in the content of the NDMP2. Thus it is hypothesised that, although services are to be implemented from a social development perspective (DSD, 2007b:33), the NDMP2 fails to guide stakeholders on the “what” and “how” of service delivery. Such uncertainty hampers the realisation of social development goals, and it contributes towards critique against a social development perspective for not having a ‘solid’ theoretical underpinning (cf. Lombard, 2007:298; 2008:158).

3.4.5 Levels of service delivery

Closely linked to intervention by social service professionals, the dimension “levels of service delivery” is in line with the features of a social development perspective that proclaims that all social services should be rendered on a continuum, namely prevention, early intervention, and statutory intervention/rehabilitation/institutionalisation, as well as aftercare and reintegration (cf. DSD, 2006:18-19). Consequently, the study determined whether the content of the NDMP2 makes provision for these different levels of service delivery as the master

plan ultimately guides the service delivery of stakeholders targeting people affected by substance abuse. **Figure 4** outlines to what extent the NDMP2 proposes different levels of service delivery.



The content of the NDMP2, as reflected in **Figure 4**, accentuates statutory intervention/rehabilitation/institutionalisation ($f=14$; 36.84%). Although prevention is outlined as “the most appropriate and preferred intervention” (DSD, 2007a:22) in the strategic intervention framework of the NDMP2, it is not accordingly reflected in the content of the policy. Furthermore, it should be noted that statutory intervention/rehabilitation/institutionalisation is often associated with a residual welfare model, and not with social development (Lombard & Kleijn, 2006:215). Although the researcher shares the opinion of Lombard and Kleijn (2006) that this level of service delivery could be implemented according to a developmental approach, the fact is that service providers often resort to statutory intervention and institutionalisation in a residual manner. In the study by Patel and Hochfeld (2008:204) they found that statutory intervention and institutionalisation, according to a residual perspective, prevails as the dominant level of service delivery within the South African social welfare service delivery system, especially within the NGO sector. These findings are echoed in the work of Myers et al. (2008:157-158) who argue that rehabilitation remains the service delivery option of choice in treatment centres in the Cape Town area. The content of the NDMP2 therefore concurs with the practical realities.

Prevention and early intervention (both $f=9$; 23.68%) are in joint second place in terms of prominence in the content of the NDMP2. From a social development perspective this aspect

is positive as developmental practices are supposed to prioritise prevention and early intervention services in order to enable citizens to remain productive in the economy (cf. Hall & Midgley, 2004:30-31). The content of the NDMP2 gives the least attention to aftercare and reintegration services ($f=6$; 15.79%). Within a social development perspective, aftercare and reintegration services should form an essential component of the service delivery framework in order to enable people either to become, or to remain active in the economy, after the completion of treatment. Aftercare and reintegration services are often non-existent in South Africa. Hence, substance abuse scholars are putting effort into developing aftercare and reintegration services in order to prevent relapses (cf. Van der Westhuizen, Alpaslan, De Jager, 2011:350).

3.4.6 Mandate

Since democratisation South Africa has become a signatory of numerous international and regional treaties and commitments in order to deal with substance abuse and minimise drug-related crimes (DSD, 2007a:10-12). Consequently, the country has promulgated legislation and adopted policies (see Chapter 2, paragraph 2.2.3) to mitigate the numerous social ills. This study subsequently analysed the content of the NDMP2 to determine whether international, regional and national mandates are recorded, as indicated in **Table 4**.

TABLE 4: MANDATE

DIMENSION 6: MANDATE	<i>f</i>	%
6.1 International mandate		
Millennium Development Goals (2001)	0	0
UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988	1	2.50
UN Convention on Psychotropic Substances, 1971	2	5
UN Convention on Transnational Organised Crime, 2000	1	2.50
UN Protocol on Narcotic Drugs, 1972	2	5
UN Single Convention on Narcotic Drugs, 1961	4	10
UN Summit for Social Development (1995)	0	0

6.2 African/regional mandate		
African Union: Drug Control Protocol	2	5
New Partnership for Africa's Development (2001)	1	2.50
South African Development Community: <ul style="list-style-type: none"> • Protocol on Combating Illicit Drugs (1996) • Regional Drug Control Programme (1998) 	0	0
6.3 National mandate		
Accelerated Shared Growth Initiative (2006)	0	0
Constitution of the Republic of South Africa, 1996	5	12.50
Drug and Drug Trafficking Act 140 of 1992	2	5
Growth Employment and Redistribution Strategy (1996)	0	0
Integrated Service Delivery Model (2006)	0	0
Liquor Act 59 of 2003	2	5
Medicine and Related Substances Control Act 59 of 2002	1	2.50
Prevention and Treatment of Drug Dependency Act 14 of 1999	2	5
Prevention and Treatment of Drug Dependency Act 20 of 1992	6	15
Prevention of Organised Crime Act 121 of 1998	1	2.50
Road Traffic Amendment Act 21 of 1998	2	5
South African Institute for Drug-Free Sport Act 14 of 1997	2	5
Tobacco Products Control Amendment Act 12 of 1999	3	7.50
White Paper for Reconstruction and Development (1994)	0	0
White Paper for Social Welfare (1997)	1	2.50

TOTAL	40	100
MEAN	1.48	

In terms of international mandates, **Table 6** indicates that the *UN Single Convention on Narcotic Drugs, 1961* ($f=4$; 10%) received the most attention in the NDMP2, followed by the *UN Convention on Psychotropic Substances, 1971* and the *UN Protocol on Narcotic Drugs, 1972*, both with ($f=2$; 5%). Thereafter the *UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988* and the *UN Convention on Transnational Organised Crime, 2000* follow with each ($f=1$; 2.50%). However, neither the ten principal commitments adopted at the *UN Summit for Social Development (1995)*, or the *Millennium Development Goals (2001)* features in the NDMP2. Both the principals and the MDGs guide countries in the implementation of social development strategies in order to achieve social development goals (Midgley, 2010b:11-13; Singer, 2008:472-475; UNDP, 2003:2-5).

South Africa is a member of both the African Union (AU) and the Southern African Development Community (SADC). Both these institutions have developed protocols and programmes to deal with substance abuse and drug-related crime (Mashele, 2005:7). The content analysis of NDMP2 revealed that efforts for the African continent, such as the *AU Drug Control Protocol* ($f=2$; 5%) as well as the *New Partnership for Africa's Development (NEPAD)* ($f=1$; 2.5%) are covered. However, sub-regional strategies for southern Africa, such as the *SACD Protocol on Combating Illicit Drugs (1996)*, are omitted. The latter is a serious omission as, from a practical point of view, strengthened efforts at borders could limit, amongst other things, the trafficking of illicit drugs (Haefele, 2000:113; Mashele, 2005:2-3; Patel, 2005:55; Steinberg, 2005:1-13).

As the historical analysis indicated (see Chapter 2, paragraph 2.2.3), South Africa has promulgated numerous laws and adopted policies to rehabilitate people affected by substance abuse and to criminalise drug-related crimes. As the NDMP2 is the master plan that is supposed to guide stakeholders in service delivery, this study analysed whether the content of this policy reflects these laws and policies. The Prevention and Treatment of Drug Dependency Act 20 of 1992 ($f=6$; 15%) and the Constitution of the Republic of South Africa, 1996 ($f=5$; 12.5%) feature most frequently in the NDMP2. These findings could have been anticipated as Act 20 of 1992 is pivotal to the regulation of all substance abuse-related services, while the Constitution is the supreme law influencing all legislation and policy. Contrary to these findings, there are quite a few policies, which specifically sanction social development, which are not alluded to in the NDMP2, i.e. the *Accelerated Shared Growth Initiative (AsgiSA)*, *Growth Employment and Redistribution Strategy (GEAR)*, *Integrated*

Service Delivery Model towards improved social services (ISDM), and the White Paper for Reconstruction and Development (RDP). These findings correlate with the findings of Dimension 1 (see paragraph 3.4.1), as economic capital development is totally ignored in the content of the NDMP2. Likewise, those policies that emphasise socio-economic development are omitted.

3.4.7 Partnerships/Welfare pluralism

Welfare pluralism indicates that a social development perspective is to be adopted and implemented by stakeholders in the government, private and business sector, as well as interest groups, in order to achieve the social development goals of South Africa (Patel, 2005:205). Subsequently, as depicted in **Table 5**, an analysis was undertaken to determine whether these different stakeholders are sanctioned in the NDMP2.

TABLE 5: PARTNERSHIPS/WELFARE PLURALISM

DIMENSION 7: PARTNERSHIPS/ WELFARE PLURALISM	f	%
7.1 Government sector		
Agriculture, Forestry and Fisheries	1	0.81
Arts and Culture	4	3.25
Communications	0	0
Cooperative Governance and Traditional Affairs	0	0
Correctional Services	4	3.25
Education (incl. Basic and Higher Education and Training)	4	3.25
Financial Intelligence Centre	5	4.07
Foreign Affairs	3	2.44
Health	14	11.38
Home Affairs	4	3.25
International Relations and Cooperation	0	0
Justice and Constitutional Development	3	2.44
Labour	2	1.63
National Intelligence Agency	0	0
National Treasury	0	0
National Youth Commission	3	2.44
Research Councils	2	1.63
Social Development	27	21.95

South African National Academy of Intelligence	0	0
South African Police Service	17	13.82
South African Revenue Service	8	6.50
South African Secret Service	0	0
Sport and Recreation South Africa	4	3.25
Statistics South Africa	0	0
Tourism	0	0
Trade and Industry	3	2.44
Transport	5	4.07
7.2 Private sector		
Community-based organisations	2	1.63
Employee Wellness Programmes/Employee Assistance Services	1	0.81
Faith-based organisations	2	1.63
Non-government organisations	1	0.81
Private South African Universities	1	0.81
7.3 Business sector	3	2.44
7.4 Interest groups	0	0
TOTAL	123	100
MEAN		3.42

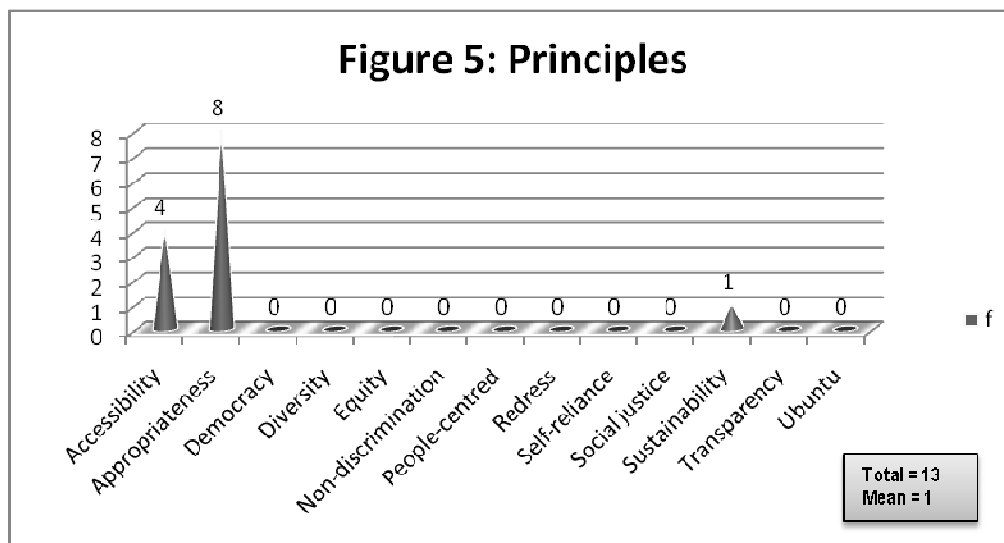
The Departments of Social Development (DSD) and Health (DoH) are pivotal in rendering services to people affected by substance abuse. On the other hand, the South African Police Service (SAPS) is important in curbing drug-related crimes (cf. DSD, 2007a:28-36). Likewise, as seen from **Table 5**, these government departments and services received prominence in the NDMP2, i.e. DSD ($f=27$; 21.95%), SAPS ($f=17$; 13.82%) and DoH ($f=14$; 11.38%). As numerous government departments are not accounted for in the content of the NDMP2, it seems that substance abuse matters are selectively linked to a few departments dealing with welfare and health-related issues.

When attention shifts to the private sector, it is clear from the content of the NDMP2 that this sector is acknowledged in the fight against substance abuse. For example, both the contributions of community-based organisations and faith-based organisations are highlighted in the NDMP2 ($f=2$; 1.63%). Similarly, the NDMP2 indicates that the business sector plays an important role in the field of substance abuse ($f=3$; 2.44%). In contrast to the

acknowledgement of numerous stakeholders from the government, private and business sector, the NDMP2 does not accentuate “interest groups”, such as Alcoholics Anonymous, in its content.

3.4.8 Principles

When South Africa adopted social development, the *White Paper for Social Welfare* (RSA, Ministry for Welfare and Population Development, 1997:16-17) has outlined a number of principles that guide developmental social welfare, which also informs social development practice. This study analysed whether these principles feature as indicators in the NDMP2 in guiding service delivery, as indicated in **Figure 5**.



As depicted in **Figure 5**, only three of the listed principles of a social development perspective, are outlined in the NDMP2, namely appropriateness ($f=8$; 61.54%), accessibility ($f=4$; 30.77%) and sustainability ($f=1$; 7.69%). Because the NDMP2 is supposed to be the policy guiding service delivery in the field of substance abuse, it should quite clearly outline all the guiding principles in line with a social development perspective. A rights-based approach is a principle of social development (Patel & Hochfeld, 2008:195; Sherraden, 2009:6). However, in order to accentuate its necessity in transforming South Africa after years of an Apartheid welfare system, which was characterised by human rights violations (Gray & Lombard, 2008:139; Patel, 2005:98-102), it is subsequently discussed separately.

3.4.9 Rights-based approach

Within the substance abuse field the protection of human rights is vital, especially when working with minority groups such as people with a homosexual orientation or children living on the street (Barret, 2010:141). This study determined whether the content of the NDMP2 acknowledges international, regional and national measures that make provision for the protection of human rights (see **Table 6**).

TABLE 6: RIGHTS-BASED APPROACH

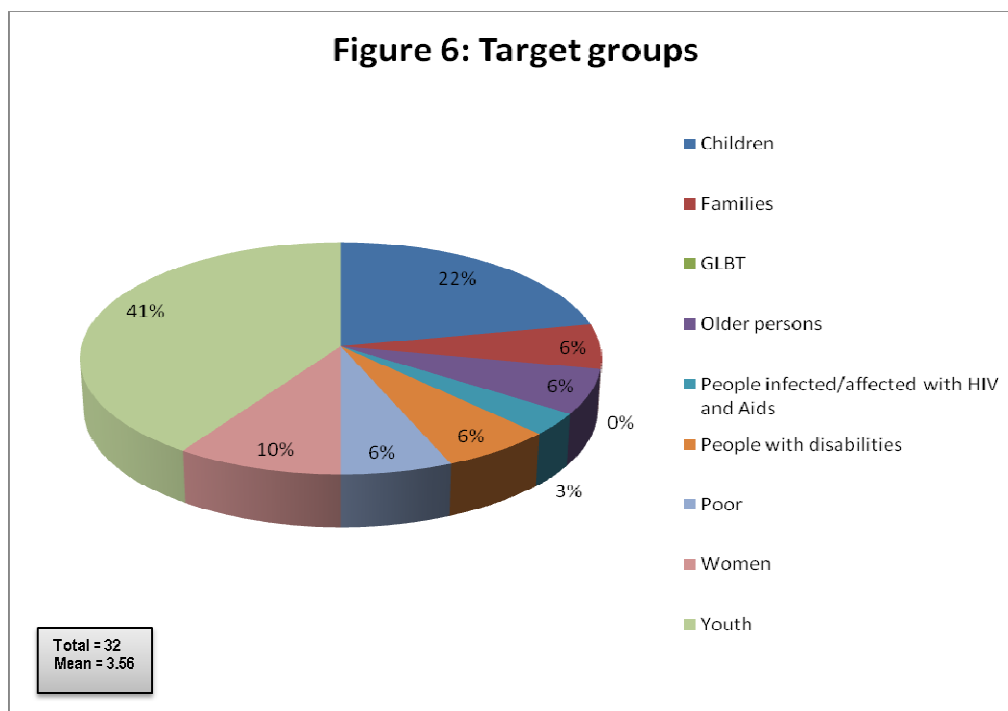
DIMENSION 9: RIGHTS-BASED APPROACH	f	%
9.1 International measures		
Convention on the Elimination of all Forms of Racial Discrimination against Women, 1979	0	0
Convention on the Rights of the Child, 1989	1	33.33
Universal Declaration of Human Rights, 1948	0	0
9.2 African/regional measures		
African Charter on Human and People Rights (1981)	0	0
African Charter on the Rights and Welfare of the Child (1990)	0	0
9.3 National measures		
Bill of Rights, Constitution of the Republic of South Africa, 1996	2	66.67
TOTAL	3	100
MEAN	0.5	

From an international point of view, as outlined in **Table 6**, the content of the NDMP2 only refers to the *Convention on the Rights of the Child, 1989* ($f=1$; 33.33%). The seminal *Universal Declaration of Human Rights, 1948* is not included in the policy. Furthermore, specific international measures to protect the rights of women, namely the *Convention on the Elimination of all Forms of Racial Discrimination against Women, 1979*, does not feature in

the NDMP2, although women are acknowledged as a vulnerable group in substance abuse who deserve special attention (see paragraph 3.4.10). The absence of these international measures is unfortunate, because people who abuse substances, or are involved in drug-related crime, are therefore not overtly protected, although this might be considered to be implied, as South Africa is a signatory to UNODC protocol. In the same vein, none of the regional measures dealing with the protection of human rights are captured in the content of the NDMP2. Nonetheless, from a national point of view, the Bill of Rights, Constitution of the Republic of South Africa, 1996, ($f=2$; 66.67%) is included in the content of the NDMP2.

3.4.10 Target groups

As is the case with every social ill, substance abuse affects vulnerable groups who require specific attention. Generally, social policy in South Africa recognises the following target groups (cf. DSD, 2006:27): children, youth, families, women and older people. These target groups are also acknowledged in the NDMP2 (DSD, 2007a:16). Subsequently, this analysis, as reflected in **Figure 6**, determined whether the content of NDMP2 specifically emphasises target/marginalised groups who require specific attention within the field of substance abuse.



Based on **Figure 6**, the youth ($f=13$; 40.63%) received the most attention in the content of the NDMP2. Thereafter, children (incl. children living/working on the streets) follow ($f=7$;

21.88%). In addition, numerous other vulnerable groups are acknowledged in the NDMP2, i.e. women ($f=3$; 9.38%), families ($f=2$; 6.25%), older persons ($f=2$; 6.25%), people with disabilities ($f=2$; 6.25%) and poverty stricken people/the poor ($f=2$; 6.25%). Although important, it is beyond the scope of this study to determine the finer nuances of the provisions of the NDMP2, e.g. whether the poor are equipped to negotiate entrance into non-drug using social networks (Higate, 2006:129), or whether women are empowered to overcome structural barriers that keep them trapped in the cycle of substance abuse. As Harding (2006:26) postulates, attention needs to be given to "... the links between their [women] drug use and their health, education, social (including recreational), financial, housing, legal and employment needs ... problem drug use cannot be tackled in isolation from women's other needs." Gay, lesbian, bisexual and transgender people, who are prone to substance abuse and drug-related crimes (Cheng, 2003:324-327; Van Wormer & Davis, 2008:472-480), are not specifically referred to in the NDMP2. This omission is unclear seeing that South Africa has a Bill of Rights, as enshrined in the Constitution of the Republic of South Africa 1996, which protects the sexual rights of all people.

Before the chapter is concluded, the limitations of this study are outlined.

3.5 LIMITATIONS OF THE STUDY

The limitations of this study, which are associated with the analysis of *manifest content* (cf. Babbie, 2007:330; Hong & Hodge, 2009:217-218; Horton & Hawkins, 2010:383; Maschi et al., 2011:248), are discussed below.

- The NDMP2 was analysed and described through the utilisation of a checklist, as developed by the researcher (see paragraphs 3.2.5.1 and 3.2.5.2), consisting of indicators for social development. Based on the outcomes of the analysis, strengths and limitations in terms of the content of NDMP2, interpreted from a social development perspective, were identified. It is, however, possible that another scholar might have developed other indicators for social development and consequently reached other research findings.
- This analysis was retrospective in nature. As such, the study could only reach conclusions about the strengths and limitations about the content of the current NDMP. It is, therefore, beyond the reach of this study to influence the *status quo*. Furthermore, it is impossible to predict whether the CDA will take the findings of this study seriously and subsequently attend to the limitations of the NDMP2 when formulating the NDMP 2012-2016.

- The analysis of manifest content, in line with a quantitative research approach, does not make provision for a subjective interpretation (i.e. the *latent content*) of policy content. It may, therefore, be possible that some indicators of social development are implied in the text, but that the objective and precise manner of manifest content analysis did not identify those.

3.6 SUMMARY

In this chapter three sections, all pertaining to the empirical part of the study, were attended to. *Firstly*, the chapter provided a detailed exposition of the research methodology that guided the study. The *second section*, based on a literature review, outlined the dimensions, themes and features of a social development perspective for drug policy in South Africa. Ultimately this outline informed the indicators that were used to analyse and describe the content of the NDMP2 from a social development perspective by using a checklist. The dimensions that were considered descriptive of a social development perspective are the following: capital development; innovation; an integrated service delivery strategy; intervention by social service professionals; levels of service delivery; mandate; partnerships; principles; a rights-based approach and target groups. The *last section* of this chapter presented the research findings and offered an interpretation thereof. The findings revealed that all the dimensions of a social development perspective feature in the content of the NDMP2. The dimensions “levels of service delivery” and “integrated service delivery strategy” receive the most attention in the content of the policy. On the other hand, dimensions such as “capital development” and a “rights-based approach” are given the least coverage in the policy content. In the interpretations that were offered, the strengths and limitations of the NDMP2 were highlighted, as specifically interpreted from a social development perspective. Amongst the strengths of this policy counts the fact that stakeholders are mandated to render services on the prevention, early intervention, statutory intervention/rehabilitation/institutionalisation and aftercare and reintegration levels. However, the content of the NDMP2 revealed a number of limitations. For example, economic development strategies and policies in the fight against substance abuse and drug-related crime are totally omitted. In addition, the limitations of the study were also discussed, such as the retrospective focus of the study.

The next chapter, Chapter 4, concludes this study with a summary of the key findings and conclusions about the strengths and limitations of the content of the NDMP2 as interpreted from a social development perspective. Based on the conclusions, recommendations will also be made.

Chapter 4: Conclusions and recommendations

4.1 INTRODUCTION

This chapter concludes the research report. As a point of departure the researcher will indicate whether the goal and objectives of the study were achieved, and subsequently will answer the research question. Thereafter, the key findings of the study will be presented, from which conclusions and concomitant recommendations will follow.

4.2 RESEARCH GOAL AND OBJECTIVES

The **goal** of this study was to analyse and describe the content of the National Drug Master Plan 2006-2011 from a social development perspective.

This goal was achieved through the realisation of the following **four (4) objectives**.

- ❖ **Objective 1:** To describe both the *historical development* of drug policy and legislation in South Africa, and the *content* of the NDMP2 by means of a historical and descriptive policy analysis.

Based on an in-depth literature review, the historical development of drug policy and legislation in South Africa was described by means of a historical policy analysis in the first section of Chapter 2 (see paragraph 2.2). This part of the objective was specifically attended to by focusing on three systemic periods in South Africa history, *viz.* South Africa prior to Apartheid (1652-1948); South Africa during Apartheid (1948-1994); and Democratic South Africa (1994 -). In addition, the content of the NDMP2 was described using a descriptive policy analysis strategy. The second section of Chapter 2 (see paragraph 2.3) gave effect to the second part of this objective.

- ❖ **Objective 2:** To develop a checklist consisting of indicators for social development to guide the analysis of the NDMP2.

Chapter 3 (see paragraph 3.2.5.1) outlines the procedure that was followed to develop the checklist. The literature foundation on which the checklist is based was presented in Chapter

2 (see paragraph 2.4.1) and Chapter 3 (see paragraph 3.3). The evidence that Objective 2 has been achieved is the checklist (see Addendum 1).

❖ **Objective 3:** To analyse the content of the NDMP2 from a social development perspective, and draw conclusions on its strengths and limitations.

This objective is comprehensively addressed throughout the research process and is dealt with across various chapters in the research report. Firstly, based on the historical and descriptive policy analysis, both the strengths and limitations of the NDMP2 were identified and subsequently discussed in Chapter 2 (see paragraphs 2.4.1 and 2.4.2). Furthermore, following a content analysis process, the presentation and interpretation of the research findings (see Chapter 3, Section 3) highlighted the strengths and limitations of the NDMP2. These findings, interpreted from a social development perspective, culminated in a range of conclusions regarding the strengths and limitations of the NDMP2. These conclusions are presented in this chapter (see paragraph 4.4).

❖ **Objective 4:** Based on the research findings and conclusions, to make recommendations on the formulation of the *National Drug Master Plan 2012-2016* from a social development perspective.

This objective has been achieved as indicated in paragraph 4.5 of this chapter.

The **research question** was as follows: “*Is the content of the NDMP2 in accordance with a social development perspective?*” From a holistic view, the research findings (see Figure 1, Chapter 3), indicated a strong correlation between the content of the NDMP2 and a social development perspective. All ten of the dimensions associated with a social development perspective for drug policy in South Africa, featured in the NDMP2, albeit with different prominence. However, several indicators of a social development perspective are excluded which emerged as limitations of the NDMP2 and these will be discussed below.

4.3 KEY FINDINGS

The key findings that are listed below are the result of three genres of policy analysis, namely a historical and descriptive policy analysis (see Chapter 2), and a logical policy analysis (see Section 3, Chapter 3).

- In accordance with the Constitution of the Republic of South Africa, 1996, drug-related policy and legislation make provision for services to all racial groupings affected by AOD abuse and drug-related crimes.
- Criminal and medical models dominated South African drug policy and legislation up to the adoption of the NDMP2 in 2006. Since then, these models have been extended with a public health model, and as such demand, supply and harm reduction strategies in respect of drug abuse have been introduced in the strategic interventions framework of the NDMP2. Nonetheless, the empirical study revealed that strategies for demand and supply reduction are emphasised, at the expense of harm reduction strategies.
- With the adoption of a social development welfare model in South Africa, a multi-sectoral approach was introduced for drug-related policies. In addition, the sole responsibility for substance abuse services, which originally rested with those government departments concerned with social welfare and health, has been expanded by also mandating other departments to contribute to a drug-free society.
- The NDMP2 prioritises the bridging of the micro-macro divide toward service delivery by depicting the scope of intervention ranging from individuals, the micro level, to the community, the macro level. Community development received the most attention in the NDMP2, followed by group and case work, respectively.
- The NDMP2 makes provision for human capital development and, to a lesser extent, the social capital development of people who abuse AODs. However, indicators for economic capital development, for example community economic development, are totally omitted in the content of the NDMP2.
- Although foetal alcohol syndrome is the highest in South Africa, it is not highlighted as a research need in the NDMP2. Furthermore, the need to research the impact of the NDMP2 in achieving a drug-free society is also not indicated.
- Despite the fact that the NDMP2 has a monitoring and evaluation framework, clear indicators for this framework are not provided and, as such, potentially impede reliable policy evaluation.
- The NDMP2 makes provision for all levels of service delivery, i.e. prevention, early intervention, statutory intervention/rehabilitation/institutionalisation as well as aftercare and reintegration services. However, the accent on statutory intervention/rehabilitation/institutionalisation could be interpreted as an overemphasis of the residual model which, in turn, questions the prioritisation of the intended development outcomes of the policy.
- The developmental mandate for the NDMP2 is only partially reflected in the policy. Relevant policies and legislation providing a mandate for the NDMP2 are outlined in Chapter 1 of the policy. However, UN treaties and commitments, which provide the

conceptual framework for a social development approach, are not explicitly referred to in the NDMP2, i.e. the *Millennium Development Goals* and the commitments captured in the *UN Summit for Social Development*. Although the *New Partnership for Africa's Development* is referred to in the foreword to the NDMP2, sub-regional policies, specifically from the SACD, which promote a social development approach towards drug abuse and drug-related crimes, i.e. the *Protocol on Combating Illicit Drugs* and the *Regional Drug Control Programme*, are not acknowledged in the NDMP2. In addition, South African policies that mandate a social development approach are not particularly mentioned in the NDMP2, for example the *Accelerated shared Growth Initiative*, the *Integrated Service Delivery Model towards improved social services*, and the *White Paper for Social Welfare*.

- The importance of partnerships is reflected in the content of the NDMP2. Nevertheless, some government departments which could contribute towards the fight against drug abuse and drug-related crimes are not specified in the institutional framework, i.e. the Departments of Communications; Cooperative Governance and Traditional Affairs; International Relations and Cooperation; and Tourism. Furthermore, several government institutions, which could support the CDA in their efforts, are excluded from the NDMP2 and these are the National Treasury, the South African Secret Service, and Statistics South Africa. The exclusion of interest groups, e.g. Alcoholics Anonymous, limits the important role of the NDMP2 to link people in need of AOD support services with appropriate resources.
- Numerous principles that underpin a social development perspective are excluded from the content of the NDMP2. Indicators, such as democracy, non-discrimination and *Ubuntu*, do not feature as principles in the NDMP2.
- Several international declarations and regional charters which protect the human rights of people who, amongst other things, abuse substances, or who are involved in drug-related crimes, are not explicitly mentioned in the NDMP2, i.e. the *Convention on the Elimination of all Forms of Racial Discrimination against Women*, the *Universal Declaration of Human Rights*, the *African Charter on Human and People Rights* and the *African Charter on the Rights and Welfare of the Child*.
- The NDMP2 refers to vulnerable groups with specific emphasis on the youth, children and women. Nevertheless, gay, lesbian, bisexual and transgender people (GLBT), who are prone to substance abuse and drug-related crimes, are not distinctively referred to in the NDMP2.

4.4 CONCLUSIONS

Conclusions will be drawn from the key findings of the study in the form of strengths and limitations of the NDMP2 as interpreted from a social development perspective.

4.4.1 Strengths

With regards to the strengths of the NDMP2 it should be noted that this study analysed and described the *content* of the NDMP2; therefore, it cannot be assumed that these strengths are in fact characteristic of those social services being provided by the various service providers.

- A multi-sectoral approach is prescribed by the NDMP2.
- A bridging of the micro-macro divide is proposed in the service delivery framework of the NDMP2.
- Vulnerable groups, in particular the youth, children and women, are highlighted in the policy.

4.4.2 Limitations

The limitations of the NDMP2 are embedded in the exclusion of several indicators of social development and are subsequently listed below.

- Limited attention is given to harm reduction strategies. As such, the limitation of the NDMP2 is not the absence of a harm reduction strategy, but the failure to give it equal weight alongside demand and supply reduction strategies. From a social development perspective it raises the question whether the management of drug abuse and service delivery are focused on a human rights-based approach.
- The nexus of social development, namely equal attention to both social and economic development is not reflected in the NDMP2. This negatively impacts on holistic service delivery with the consequence that service users may not become economically independent.
- Foetal alcohol syndrome is not prioritised as a research need in the NDMP2. Furthermore, the policy does not give a directive for any research into the impact of the NDMP2 in achieving a drug-free society. In the absence of research findings guiding prevention and rehabilitation strategies for foetal alcohol syndrome, the South African

society remains at risk and entrapped within a drug-bound environment. Additionally, both government and international sponsors are entitled to know whether the policy directives of the NDMP2 succeed in establishing a drug-free society.

- The NDMP2 does not illuminate clear indicators according to which the policy is to be monitored and evaluated. The impact and effectiveness of the NDMP2 in achieving its goals can hence not be determined.
- The four levels of service delivery are not equally emphasised in the content of the NDMP2. It impacts negatively on holistic service delivery. Furthermore, the neglect of service delivery on one or more levels could exacerbate the existing AOD abuse problem.
- Some government departments and institutions, which could contribute towards the realisation of the vision of the NDMP2, namely a drug-free society, are not explicitly mandated in the policy. This affects the availability of resources to address substance abuse, and moreover, highlights the absence of a coordinated effort by government towards achieving a drug-free society.
- Interest groups, which could serve as AOD support structures in society, are not acknowledged in the NDMP2. The potential value and possible contributions embedded in these support structures towards achieving a drug-free society are therefore lost.
- Other than, appropriateness, accessibility and sustainability, no other principles of social development are referred to in the content of the NDMP2, or contextualised within the field of substance abuse service delivery. The contribution of the NDMP2 towards achieving social development outcomes is therefore limited.
- In the absence of specific international and regional commitments and charters dealing with the protection of human rights, the NDMP2 fails to emphasise the importance of *human rights* as an indicator of social development. The implication is that service providers could fail to respect and promote the human rights of service users.
- GLBT is not acknowledged as being a vulnerable group in the policy. As a consequence this vulnerable group may not receive the specialised services they require in order to overcome AOD dependency.

4.5 RECOMMENDATIONS

The recommendations from the study are presented in twofold. *Firstly*, recommendations are made to align the envisaged NDMP3 with a social development approach. *Secondly*, some recommendations for future research are proposed.

4.5.1 Recommendations to align the NDMP3 with a social development approach

The following recommendations are forwarded to ensure that the NDMP3 is aligned with a social development approach:

- Strategies pertaining to demand, supply and harm reduction should receive equal attention in the NDMP3. Harm reduction strategies with regard to people who abuse AODs are in line with a human rights approach, and as such, must form part of an NDMP which is implemented within a social development paradigm.
- The preamble of the NDMP3 should capture international treaties and declarations, regional charters and initiatives, as well as national policies in order to provide the conceptual framework for a social development approach that underpins the policy directives of the National Drug Master Plan. It is the premise of this study that social development could, apart from being instrumental in the achievement of the country's development goals, also contribute to the realisation of a drug-free society.
- The NDMP3 must prioritise research in areas of substance abuse which are rampant and which negatively affect the social welfare of South African citizens, for example foetal alcohol syndrome.
- The NDMP3 must outline a monitoring and evaluation framework which illuminates clear indicators for policy evaluation. (The lesson learnt from the NDMP2 is that, unless clear indicators are outlined in the policy, the stakeholders fail to report on outcomes and rather report on the processes they followed [compare paragraph 2.4.2, Chapter 2]).
- Prevention and early intervention must be prioritised as 'first line' levels of service delivery which are complemented by treatment/rehabilitation and aftercare and reintegration services. This 'shift' in service delivery must be clear in the content of the NDMP3 in terms of the *detail* in which prevention and early intervention services are described.
- The institutional framework of the NDMP3 must make provision for a comprehensive list of government departments and institutions, the private and business sector, and interest groups who could play a significant role in achieving a drug-free society. This will unequivocally give voice to a multi-sectoral approach in substance abuse service delivery. A government department which did not exist at the time of the adoption of the NDMP2, and which should be included in the NDMP3, is the Department of Economic Development. This department could play a role in the economic development of AOD-dependent people who are reintegrated into society after their release from treatment centres. To ensure that AOD-dependent people eventually contribute to the economy, this department could establish services where these people are equipped with skills and

subsequently linked to projects with the potential to achieve economic gains, e.g. income generating projects.

- Principles of social development relevant for the implementation of the NDMP3, such as a human rights approach, must be indicated in the policy and should be contextualised within the field of substance abuse.
- The NDMP3 should include GLBT as a vulnerable group in the policy.

4.5.2 Recommendations for future research

- As the content analysis of *manifest content* present with particular limitations (see Chapter 3, paragraph 3.5), a similar study should be undertaken where the *latent content* of the NDMP2 is analysed. The findings of the two content analyses could be compared to obtain a holistic view pertaining to the content of the NDMP2, interpreted from a social development perspective. The findings would be valuable in the sense that a holistic evaluation could be obtained revealing the strengths and limitations of the NDMP2, and these findings could be used to inform the policy writers of the NDMP3 on policy directives to be adopted to align the policy with a social development perspective.
- A comparative analysis of the South African NDMPs should be undertaken, as valuable insights could be obtained about the development of such policies and the alignment of NDMPs with a social development approach.
- The NDMPs of different countries which have adopted social development as a developmental approach could be compared. In this way, best practices and policy directives could be identified, which, in turn, could enrich the further development of the South African NDMPs during policy revisions.

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CHECKLIST:

INDICATORS OF A SOCIAL DEVELOPMENT PERSPECTIVE FOR DRUG POLICY IN SOUTH AFRICA

INSTRUCTIONS:

1. Only manifest content is captured. Should synonyms be captured, these must be recorded on the checklist and consistently applied throughout the content analysis process.
2. No latent content is captured.
3. Record the frequency of an indicator under the column 'manifest content'.

SOFTWARE USED:				DATE:				
NO.	DIMENSIONS	THEMES	INDICATORS	MANIFEST CONTENT				COMPUTER CODE
1.	1.1 Capital development	1.1.1 Economic capital	1.1.1.1 NDMP2 stipulates that the economic capital development of substance-dependent people is realised through strategies such as the following:					1.1
			• Black Economic Empowerment					1.1.1
			• Community economic development					1.1.2
			• Cooperatives					1.1.3
			• Entrepreneurship (e.g. Income generation projects)					1.1.4
			• Expanded Public Works Programme					1.1.5
			• Micro-enterprises					1.1.6

		model	rendered in accordance with a supply reduction model through strategies such as the following:		
			<ul style="list-style-type: none"> • Legal action/law enforcement against drug supply activities 		3.2.1
			<ul style="list-style-type: none"> • Preventing the production, manufacturing, sales/trading and trafficking of drugs 		3.2.2
			<ul style="list-style-type: none"> • Seizing and destroying precursor materials, raw materials and products 		3.2.3
4.	4.1 Intervention by social service professionals	4.1.1 Bridging micro-macro divide	4.1.1.1 NDMP2 regulates that drug-related social services are to be delivered by means of the following methods of service delivery on an equal basis:		4.1
			<ul style="list-style-type: none"> • Case work/Therapy/Micro interventions 		4.1.1
			<ul style="list-style-type: none"> • Group work (incl. Treatment and support groups)/Meso interventions 		4.1.2
			<ul style="list-style-type: none"> • Community work/Community development/Community-based interventions/Macro interventions 		4.1.3
		4.1.2 Features of intervention	4.1.2.1 NDMP2 recommends that all drug-related social interventions are to be delivered according to the following practice approaches:		4.2
			<ul style="list-style-type: none"> • Anti-oppressive 		4.2.1
			<ul style="list-style-type: none"> • Asset-based 		4.2.2
			<ul style="list-style-type: none"> • Critical 		4.2.3
			<ul style="list-style-type: none"> • Emancipatory 		4.2.4
			<ul style="list-style-type: none"> • Empowerment 		4.2.5
			<ul style="list-style-type: none"> • Human potential development (e.g. Max Neef) 		4.2.6
			<ul style="list-style-type: none"> • Human rights 		4.2.7
			<ul style="list-style-type: none"> • Social justice 		4.2.8

			crimes is prescribed/regulated by the following protocols and programmes:		
			<ul style="list-style-type: none"> • African Union (AU): Drug Control Protocol 		6.2.1
			<ul style="list-style-type: none"> • New Partnership for Africa's Development (NEPAD) (2001) 		6.2.2
			<ul style="list-style-type: none"> • Southern African Development Community (SADC): 		6.2.3
			<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Protocol on Combating Illicit Drugs (1996) 		6.2.3.1
			<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Regional Drug Control Programme (1998) 		6.2.3.2
		6.1.3 National mandate	6.1.3.1 The national mandate for services to substance-dependent people and those involved in drug-related crimes is regulated by the following legislation and policies:		6.3
			<ul style="list-style-type: none"> • Accelerated Shared Growth Initiative (AsgiSA) (2006) 		6.3.1
			<ul style="list-style-type: none"> • Constitution of the Republic of South Africa, 1996 (including the Bill of Rights) 		6.3.2
			<ul style="list-style-type: none"> • Drug and Drug Trafficking Act 140 of 1992 		6.3.3
			<ul style="list-style-type: none"> • Growth Employment and Redistribution Strategy (GEAR) (1996) 		6.3.4
			<ul style="list-style-type: none"> • Integrated Service Delivery Model (ISDM) (2006) 		6.3.5
			<ul style="list-style-type: none"> • Liquor Act 59 of 2003 		6.3.6
			<ul style="list-style-type: none"> • Medicine and Related Substances Control Act 59 of 2002 		6.3.7
			<ul style="list-style-type: none"> • Prevention and Treatment of Drug Dependency Act 14 of 1999 		6.3.8
			<ul style="list-style-type: none"> • Prevention and Treatment of Drug Dependency 		6.3.9

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Faculty of Humanities
Research Ethics Committee

Dear Prof Lombard,

Project: A content analysis of the National Drug Master Plan 2006-2011 from a social development perspective.
Researcher: Dr LS Geyer
Supervisor: Prof A Lombard
Department: Social Work and Criminology
Reference number: 28372809

Thank you for the application you submitted to the Research Ethics Committee, Faculty of Humanities.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study on 29 October 2009. The approval is subject to the candidate abiding by the principles and parameters set out in his application and research proposal in the actual execution of the research.

The Committee requests you to convey this approval to Dr Geyer.

We wish you success with the project.

Sincerely

Prof. Elsabé Taljard
Acting Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: elsabe.taljard@up.ac.za