

# **WHO Global Initiative on Primary Prevention of Substance Abuse**

## **Post Assessment survey of South Africa**

<b>Author</b>	Gina Weir-Smith
<b>Contributors</b>	Zakes Langa Zodwa Mvubelo Khangelani Zuma

*Commissioned by the  
WHO/UNDP*

March 2004

## **1. EXECUTIVE SUMMARY**

The WHO/UNDP commissioned a study to be conducted on substance use in a number of countries globally. The study took place over a number of years to firstly identify the situation, then expose the communities to interventions and then lastly to assess the situation after interventions have taken place. In South Africa an urban site, Pretoria, and a rural site, Bela-Bela, was selected.

### **1.1 COMMUNITY PROFILE AND ADULT SURVEY**

The main findings of the adult KAP survey indicated that substances were not widely used in the rural research site. The most popular substances in Bela-Bela were painkillers (89%), cider (39%) and wine (36%). These differ slightly from the baseline findings which indicated painkillers (70%), malt beer (27%) and wine (24%). The focus in substance use among adult respondents has therefore shifted. Besides shifting to different drugs there was a considerable increase in the use of painkillers. This could indicate increased access to painkillers.

In the urban research site respondents had access to a wider variety of substances. Lifetime use of substances was still fairly low, but it included some illicit substances like sedatives (23%) and tranquillisers (11%). The most popular substances among urban adult respondents were painkillers (73%) wine (64%) and cider (52%). This corresponds with findings in the rural site, but is slightly different from the baseline findings where malt beer was more popular and replaced cider. This change could indicate a change in sophistication where a more refined product is preferred. This change in preference was experienced in both the adult communities between the baseline and post-assessment survey.

Dependency and heavy drinking among adult respondents was reported on a limited scale in both research sites. Six percent of Bela-Bela respondents indicated that they had physical fights or arguments with family/relatives or boy/girl friend about the consequences of their substance use monthly or less than monthly. These consequences remained, however, similar to conditions recorded during the baseline study.

In Bela-Bela perceptions on the risk experienced when using substances was higher when the youth were using those substances (except for cigarettes, marihuana and cocaine). This corresponded largely with findings from the baseline. The findings differ, however, significantly from the baseline in terms of the percentage of respondents who perceived risk. The figures for this post-assessment study are considerably higher than in the baseline study. This indicates an increased awareness of the harm related to substance use.

In terms of the community desktop study limited comparison could be made between the baseline and post-assessment study since no update of the data sets used was done between the two

studies. It was therefore accepted that the findings of the baseline study therefore remained the same. These included that the Bela-Bela is a very poor community with limited access to services, infrastructure and job opportunities. It also has high population density figures and high-level access to liquor trading outlets.

In the Pretoria research site there are selected areas of poverty, good access to services, higher employment rates and higher crime density.

## **1.2 YOUTH SURVEY**

Findings from the youth KAP survey indicated that substance use was not widely practised by the youth in Bela-Bela. This corresponds with findings from the baseline survey. There was however a marked increase in the lifetime use of painkillers between the two surveys. Findings in the post-assessment study indicated that the use of painkillers increased dramatically in the 10-14 year old age group – from 23% to 51%. This should raise immediate concern about the accessibility and availability of painkillers. A similar trend was identified in the adult survey and it would therefore seem that the community as a whole is subject to this increased use of painkillers.

The age of onset for the use of wine and cider is younger in Bela-Bela than in Pretoria. This might be attributed to the fact that there is a lack of entertainment for the youth and as a result they resolve to substance use. Local community involvement and leadership should address this issue.

The daily use of cigarettes seems to prevail in the urban site where 60% of respondents indicated daily use.

## **1.3 COMMUNITY RELATED ISSUES**

Attitudes toward heavy drinking in Bela-Bela has swung to the other side in comparison to the baseline survey. A far smaller number, namely 14% - in comparison to 39% before – indicated that it was acceptable to have one or two drinks several times a week. It would seem that the acceptance of heavy drinking is declining and one could therefore expect that the community is ready to start taking action against it.

In Bela-Bela the findings on perception of risk corresponded with that of the baseline survey. For most substances (except cigarettes, marihuana and cocaine) the respondents perceived more risk when the youth are using those psychoactive substances. The findings differ, however, significantly from the baseline in terms of the percentage of respondents who perceived risk. The statistics for the post-assessment survey are considerably higher than in the baseline study. This indicates an increased awareness about the risk related to substance use.

In the urban research site disapproval of young people using substances was clearly higher than for adults use. This applied to all psychoactive substances included in the questionnaire.

Alcohol use was accepted at all public occasions. Respondents from the rural site indicated slightly higher percentages of alcohol use at social events. Slightly higher percentages of alcohol use were recorded in the baseline study as well.

#### **1.4 INTERVENTION PROGRAMMES**

An almost non-existing intervention structure was identified in Bela-Bela during the baseline study. This related to the absence of services and agencies who specialised in countering the harm related to substance use as well as NGOs which deal with social, welfare and health issues. Poor connections also existed between existing service providers. There was however a willingness to mobilise the community.

This willingness seems to have paid off and based on the intervention that took place between the baseline study and this one, there seem to have been success in mobilising the community against substance use. The Life Skills training presented by the Youth for Christ (YFC) organisation in local secondary schools seem to have been effective, embraced by the youth and supported by educators.

The Pretoria community was well serviced in terms of specialised services provided and strong networking existed between service providers. The community was committed to mobilise against substance abuse. There was however strong competition between service providers for turf.

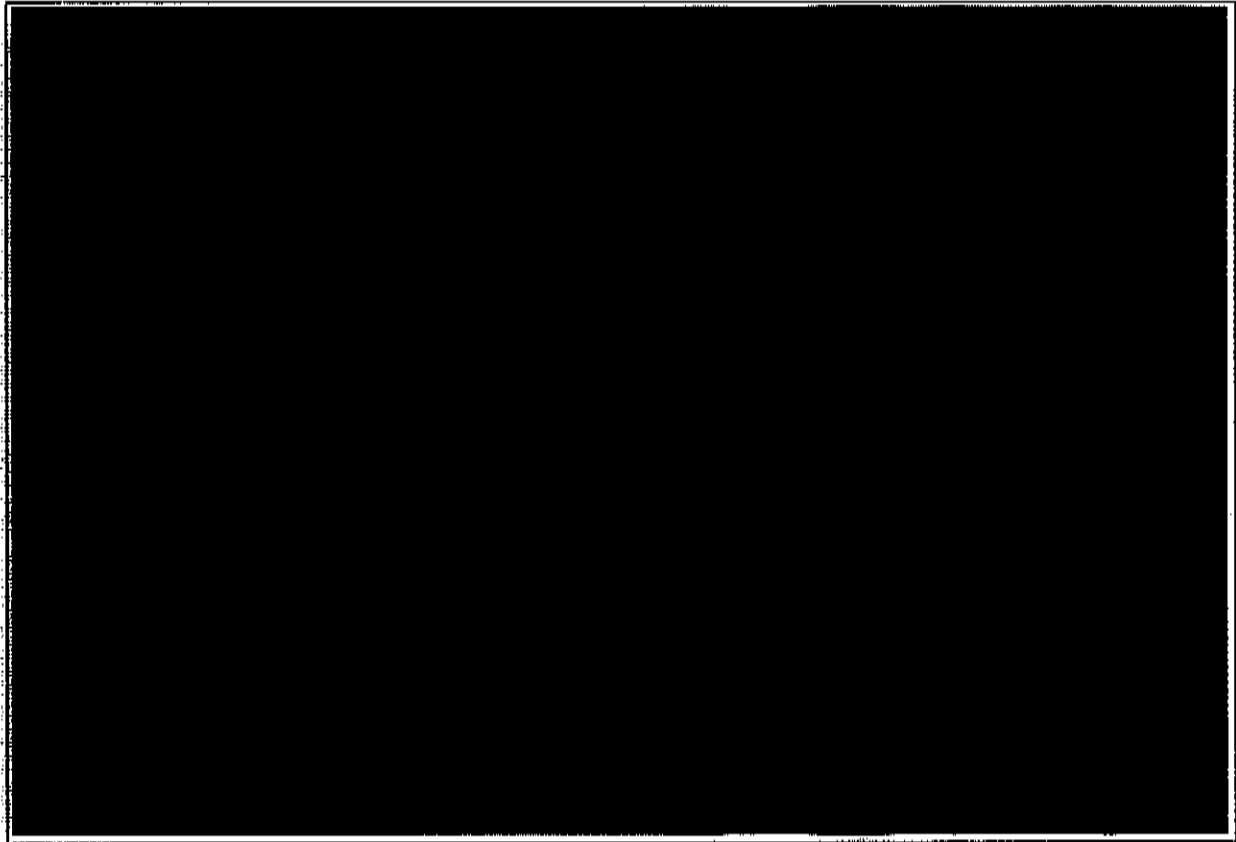
The Life Skills training presented by YFC was successful in the Pretoria research site, but the University of Pretoria peer group intervention was not successful. This failure to succeed can be attributed to the fact that the concept of peer groups was foreign to the learners and the programme was not endorsed by the educators.

## **2. ORIENTATION**

### **2.1 THE GLOBAL INITIATIVE**

The World Health Organisation (WHO) has identified substance abuse among young people as a prime target for global intervention. Several countries are partaking in this initiative, including South Africa. Two sites were selected for the WHO Assessment in South Africa. The first one is an urban site, Pretoria, and the second Bela-Bela – a rural site about 100 km north of Pretoria (see Figure 1 below). The overall aim of the post intervention assessment is to examine the impact of the baseline study on the selected communities. In order to measure this impact selected indicators will be used to compare findings from the different communities. The assessment

comprises four interrelated components namely a community profile, a qualitative study comprising focus groups and key informant interviews, a survey on the knowledge, attitudes and practices (KAP) of young people and adults alike, as well as a case study in one of the sites.



**Figure 1:** Geographic orientation of the research sites in South Africa

## **2.2 RESEARCH SITES**

The motivation for the sites selected in South Africa was firstly based on the availability of statistics about these areas as well as their close proximity to the research house in Pretoria. The close proximity would curb financial expenditure. Secondly, although Bela-Bela is a rural site, it is very accessible because of its close proximity to a very good road network. The N1, a national road between Cape Town in the south and Mussina in the north, runs within 10 kilometres from Bela-Bela. The third motivation for the selection of the two sites is the comparatively high level of drug use (particularly alcohol use) identified from surveys done by the HSRC in the 1990s. The two sites, Pretoria and Bela-Bela, are situated in different provinces, namely Gauteng and Limpopo. Figure 1 presents the geographic context of the two South African research sites

## **2.3 AIM AND OBJECTIVES**

The general aim of the two community profiles is to provide an overview of the broader socio-economic and cultural context in the research sites, including the issue of level of commitment to countering substance use and abuse. The data gathered from post intervention assessment study will be compared with that from the baseline study. The specific objectives are:

- ?? To compare socio-economic conditions in the research sites.
- ?? To compare perceptions in the research sites as to the nature, magnitude and consequences of substance use/abuse in the communities concerned.
- ?? To compare the nature and level of efforts at countering substance related harm in the communities concerned.
- ?? To provide data on the impact of the interventions at the evaluation sites.

## **2.4 METHODOLOGY**

This report for Community Profile 1 and 2 will consider results from various sources, namely from key informant and focus group interviews, available statistical sources and a household sample survey among adults (? 22 years of age) to derive an understanding of the dynamics of the respective sites. The baseline and post intervention assessment results on the two research sites will be analysed comparatively. A qualitative as well as a quantitative approach was used.

Rapid assessment is used in instances where data is needed quickly and where information is required to evaluate intervention programmes. The key principles of RAR (Rapid Assessment and Response), which underpin this study, are rapidity, resource effectiveness, multiple methods, practical adequacy and action oriented. (WHO 2002: 6)

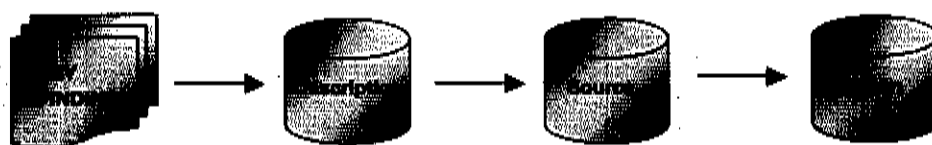
Rapid assessments can inform intervention developments in various ways. These include: identifying interventions, leading the rapid development of interventions, providing persuasive data, strengthening community action and monitoring impact (WHO 2002: 13). Interventions also need to be reflected in changed service delivery. Service delivery has to focus on making contact with target populations, retaining that contact and providing services which meet the health and service need of those target populations (WHO 2002: 17). For the purposes of this assessment no comparative data could be obtained to evaluate the pre and post service delivery.

Individuals and communities operate within the constraints of the wider social and political environment and therefore RAR's should aim to change the structural level (WHO 2002: 19).

This WHO Post Intervention Assessment study was undertaken in a short period of time stretching from June to August 2003. During this time a quantitative survey of 400 respondents were conducted while qualitative work included focus groups and key informants interviews. In terms of

resource effectiveness the study focused on collecting data from various sources which will hopefully maximise the result outputs.

The assessment framework used in this WHO Post Assessment study is reflected in the following figure. Every key finding was also assessed in terms of community, structural and individual level influences. These include among other things socio-economic conditions, substance use norms, risk behaviours and levels of knowledge.



#### **2.4.1 Qualitative data collection**

Focus group discussions should aim at providing detailed data at relative low cost from a number of people at the same time. They tend to provide descriptive data on the nature of substance use, perceptions on meanings attached to substance use and data on contextual factors influencing risk reduction and behaviour change (WHO 2002: 102).

Qualitative research methods link the observer and those being observed. It is designed to improve the comprehension of key elements in a society. It helps to explain the values and judgements people make in their daily lives.

Focus group and key informant interviews were conducted in July 2003. A total of eight focus groups were conducted in the two communities under study. Questions ranged from the type of drugs known, where drugs were used, the reasons for drug use (causes) and the providers of drugs (sources). A total of 55 people were interviewed.

An experienced focus group interviewer conducted ten key informant interviews in the two communities. (See Appendix A for a copy of the interviewer's detailed report.) In Pretoria the key informants included concerned private counsellors, local community centre managers, volunteers and social workers. Bela-Bela interviews included social workers, volunteers, life skills teachers, clergymen and recovered alcoholics. All of these individuals work with young people in some capacity or another.

#### **2.4.2 Quantitative data collection**

Available socio-economic census data was utilised to profile broader socio-economic conditions and the level of commitment to countering substance abuse in the communities concerned. This was used together with existing databases like the Department of Social Development's Resource

Directory on services and facilities for the prevention and treatment of substance abuse, the Liquor Trade's Official Journal, Licence Guardian and the Department of Health's register of health facilities. Unfortunately, most of these resources have not been updated between the baseline and post assessment studies and therefore no conclusion can be made about the difference between the two time frames.

It is important to keep the limited application use of indicators in mind, since it is seen as relative and also an indirect measure (WHO 2000: 50). It is important to keep in mind that existing data is often collected for administrative purposes and it is therefore limited in assessing patterns of substance use.

The second part of the quantitative data consisted of a sample survey conducted among adults in the communities under research. Adults were defined as people aged 22 years and older. One adult was interviewed at every second household in order to reach the target of 100 adult respondents. In total 6 households per Enumerator Area (EA) were interviewed. Enumerator Areas are the smallest spatial unit for which demographic information is available. It usually consists of between 180 and 250 households. EAs were sorted on EA number and a probability sample was drawn based on the total population of each EA. The EAs drawn for the sample is shown in Figures 2 and 3. A Pretoria based fieldwork company, Field Focus, conducted fieldwork. A hundred percent response rate was obtained. The sample realisation is shown in the tables below.

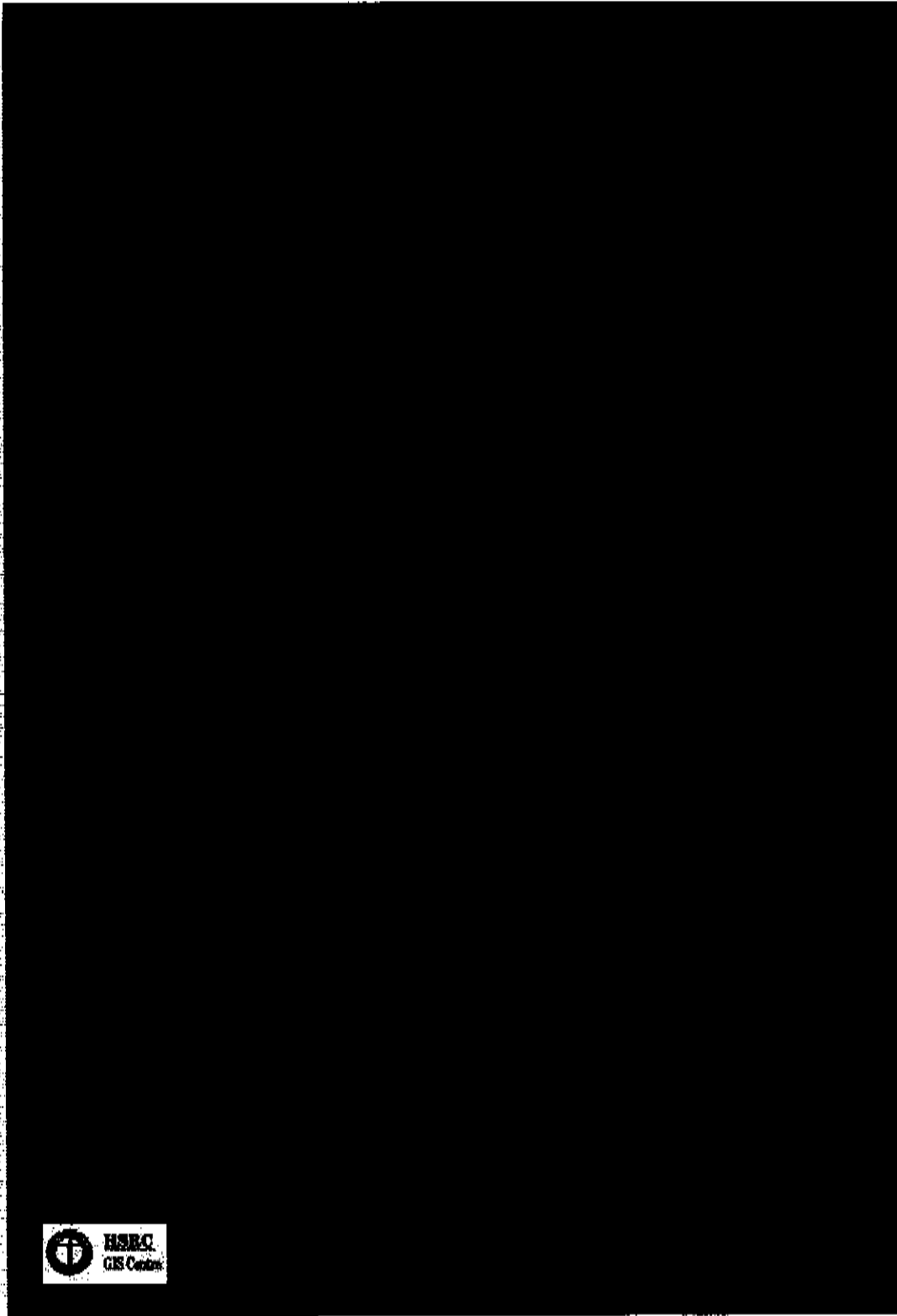




**Figure 2:** Sampled Enumerator Areas in the rural research site Bela-Bela

**Table 1:** Bela-Bela sample realisation

	EA	Adults
Bela-Bela	9100014	3
Bela-Bela	9100044	3
Bela-Bela	9100049	3
Bela-Bela	9100052	3
Bela-Bela	9100022	3
Bela-Bela	9100037	3
Bela-Bela	9100041	3
Bela-Bela	9100017	3
Bela-Bela Leseding	9100027	3
Bela-Bela	9100031	3
Bela-Bela Skirlik & Tambo	9100089	3
Bela-Bela	9100023	3
<b>Sub-total Bela-Bela</b>		<b>33</b>



**Figure 3: Sampled Enumerator Areas in the urban research site Pretoria**

**Table 2: Pretoria sample realisation**

	EA	Adult
Atteridgeville	7010553	3
Atteridgeville	7010655	3
Soshanguve	7020063	3
Soshanguve	7020215	3
Mamelodi	7030122	3
Mamelodi	7030217	3
Mamelodi	7030506	3
Soshanguve	7020345	3
Soshanguve	7020514	3
Erasmia	7011503	3
Mamelodi	7030076	3
Lotus Gardens	7010081	3
Sunnyside	7010374	3
City Centre	7010464	3
Mamelodi North/Baviaanspoort	7030439	3
Pretoria West	7010138	3
Hillcrest	7010528	3
Garsfontein/Menlyn	7010901	3
Silverton	7011087	3
Waterkloof Ridge	7011303	3
Walmer	7030325	3
Theresa Park	7030574	3
<b>Subtotal Pretoria</b>		<b>66</b>

The next section will focus on findings based on the qualitative data.

### **3. RESULTS: QUALITATIVE DATA**

This section will deal with the data accumulated in the focus groups and key informant interviews. This is a summary of the findings for the eight focus group discussions that took place in both Pretoria and Bela-Bela. The detailed analysis can be seen in Addendum A.

The age of the focus group participants ranged from 10 years to 43 years. The average age for most respondents was 18 years. Twenty seven respondents were female and 28 respondents were male and all race groups were represented. The level of education ranged from Grade 5 to 12, though the majority of respondents (N=7) were doing grade 7, closely followed by grade 12 learners (N=5).

### **3.1 PERCEPTIONS REGARDING SUBSTANCE USE/ABUSE**

There seems to be a stark difference in the use of drugs between boys and girls. Boys seem to start taking drugs earlier than girls, who normally start this activity at high school. A lot of the quotations from the focus groups seem to suggest support for this theory. However, there are also a few opposing views (two quotations) which seem to contradict this view which suggest that both boys and girls abuse drugs, as seen by their frequenting of taverns and going to the toilets (school toilets) for a quick smoke or drinking session. In spite of this, the idea that boys take harder drugs than females is still borne out by the different observations.

#### **3.1.1 Types of substances used**

The results showed that different drug types are used at different levels. This means that children start with alcohol, cigarettes and to a limited extent, dagga (cannabis) and then graduate to hard drugs like cocaine and ecstasy. However, most respondents did not use the latter drugs (designer drugs) very frequently, because they were expensive. It therefore seems that children from lower income groups (especially informal settlements) are likely to use cheaper (though more dangerous types of drugs) like dagga and crack (a cheap derivative of cocaine).

Popular substances used by the youth include dagga, alcohol, glue, tobacco and shaba. Shaba is a tablet and according to respondents it is the cheapest substance - about R1.50 each. However, there were some respondents who maintained that there have been selected instances where children have been reported to use cocaine and mandrax ("Some children get cocaine from Eesterust." This refers to the Pretoria site.). In Bela-Bela "High school boys from rich families are said to be taking mandrax". The interviews seem to indicate that the majority of young people prefer to use light substances (e.g. alcohol, shaba, glue, cigarette) in comparison to cocaine and mandrax. This could be because of affordability. It is also important to note is that although dagga is illegal it still easily accessible and available in the communities.

#### **3.1.2 Reasons for use**

Children engage in substance use for different reasons. One of the reasons that kept recurring during the interviews was that children usually do it when they have nothing to do at home or on the streets. This is when their parents are not around and they are maybe alone at home. Some said children take substances just to experiment and to have fun, whilst others said it they use it to help them forget family problems - especially domestic violence.

Some of the responses indicate that children use drugs just because they are available. This was noted earlier - substance are affordable and available. In addition, one of the main reasons why young people use substances is because of 'conformity'. They want to be accepted by others and in the process they try to impress them. Therefore peer pressure is a major contributing factor.

Many respondents also highlighted that children sometimes learn such habits from their parents. One of the respondents referred to situations where "*when parents are drinking kids also take advantage*". This indicates that children assume that this habit is socially acceptable because it is also done at home. Sometimes alcohol is available at home (parents are already using it) and young people make use of this opportunity and gradually succumb to peer pressure.

Other reasons for substance use were based on interpersonal relations like needs for companionship or relationships either with parents or peers. Some respondents indicated that young people end up using drugs because of problems at home. Substances are then used as a means to escape depression. This happens in cases of parents divorcing, domestic violence, feelings of neglect and not being loved.

Psychological reasons that lead to substance use are related to emotional issues like boredom, loneliness, stress and other psychosocial issues. Boredom or the lack of having something to do kept recurring as one of the reasons why young people are using substance. The lack of recreational facilities was also highlighted as one of the problems adding to substance use. Interestingly, some respondents reported that young girls use cigarettes for slimming purposes and boys just engage in such activities for fun or other reasons.

In informal settlements boys are introduced to substance use between the ages of 9 to 12 years. Girls on the other side start smoking tobacco between 11 and 12 years. Both girls and boys from squatter camps together with the street kids start using substances at a very early age - about seven years. Most of the respondents emphasised the fact that boys start engaging in substance abuse earlier than girls. Another interesting fact is that girls usually tend to use tobacco related substances together with alcohol whilst boys use substances such as tobacco and alcohol together with glue and dagga (adding mandrax and cocaine if they are also using heavy substances).

### **3.1.3 Places of use and sources**

In most cases children used substances when they were with friends at school during breaks. It was also mentioned that young people use it in the toilets or in hiding. This shows that they are well aware of the fact that this behaviour is not socially acceptable. They also use such substances during school trips, on weekends, at parties, in nightclubs, during weddings and even at funerals "after tears parties". It seems therefore that children usually engage in such activities as a group.

### **3.1.4 Impact of substance abuse**

The reported effects of substances were the health of children and psychological effects like the lack of concentration in classes.

One respondent in Bela-Bela indicated that "Substance abuse is getting out of control. We all see the evidence. Sexually transmitted diseases must be prevented. School dropouts will increase criminal activities. Child abuse will result."

In Bela-Bela there seems to be "...moral decay. Family values have been sold. Fathers rape their girls because they are not thinking."

### **3.1.5 Solutions to substance abuse**

The establishing of support or peer groups for children with substance problems was mentioned. Similar groups could be established for families of affected children to assist them and provide ideas on how to deal with the situation.

Many respondents indicated that the resources for communities to mobilise against substance abuse are available, but that there are inhibiting factors. These seem to centre around money and unemployment. It also seems that "apathy on the part of the community" are inhibiting efforts.

Even though the electronic media could be seen as a potential solution, it would seem that it has already shown the dangers of drug abuse. From the tone of the quotations in the focus groups, it seems that there need not be any more media education, since children have already been exposed to the message.

Mass media on its own is not an effective means of regulating substance use, but it assists in raising awareness levels and support policy initiatives (WHO 2002: ). It has to be used in combination with community action (like environmental change). It has been found that health warnings on licit psychoactive substances are effective in communicating hazards.

Respondents seemed to be in favour of advocating strong substance censure measures in the community. In Pretoria it was advocated that "Stricter enforcement of age restrictions in the liquor Act should be complied with". "Severe punishment for drug dealers" was also suggested.

## **3.2 EXISTING PRIMARY PREVENTION PROGRAMMES**

The previous section indicated possible solutions to substance use as indicated by the respondents. These solutions did, however, not consider existing programmes. This section will explore existing initiatives as identified by key informants and other existing databases.

A number of initiatives seem to be taking place in Bela-Bela. These include an initiative called 'Light of Africa' which offers life skills programmes to three schools in the area. A church called 'Power House' does biblical counselling, referrals to other organisations and follow-ups of referred cases in Bela-Bela. "Businesses such as Pick 'n Pay support campaigns by providing financial

assistance to buy the necessary equipment and material" for life skills programmes. Radio Thobela FM is allowing a two weekly broadcasting of information on substance use. The Kebophelo Centre is involved in information dissemination.

### **3.2.1 Key informant interviews**

Many respondents mentioned that there is a major need for community actions. It is important to note is that several respondents indicated that for such a programme to be successful, all concerned stakeholders should unite and take part in the war against drug abuse. There are existing initiatives in some communities such as the group called 'Light of Africa' in Bela Bela. This programme offers life skills programmes to different schools in the area. Many mentioned the importance of establishing support or peer groups for children with such problems and also for the affected families to help them and give them ideas on how to deal with such problems.

Many respondents mentioned that the resources for communities to mobilise against drug abuse are available. There are, however, still some factors that are hindering the whole process. This includes parents who are not eager to talk openly about substance use problems and families who are selling alcohol. The latter issue indicates that alcohol is seen as something acceptable in these households and therefore children from these households will not be willing to join programmes against substance abuse. Besides the fact that these children see nothing wrong with substance abuse, they are sometimes ashamed about their relationship with these households and therefore do not want to talk about it.

### **3.2.2 Existing databases**

A review of firstly, the Department of Social Development's most recent Resource Directory on Services and Facilities for the Prevention and Treatment of Substance Abuse (1997) and secondly, the list of registered Non-Government Organisations as identified in the Prodder<sup>1</sup> directory, revealed the following. No update of the data has been done since the baseline study and it is therefore not possible to indicate whether these services have changed, increased or improved. These facilities indicated in the Resource Directory did include agencies focussing on outpatient and inpatient services, support, after care or primary preventive services, but not necessarily focusing on substance use only. No such services were recorded for Bela-Bela. The NGOs focus on various issues that might not necessarily include substance use. No registered NGOs were active in Bela-Bela.

## **4. RESULTS: SOCIO-ECONOMIC CONDITIONS (DESK REVIEW)**

A desk review was conducted using available statistical sources to gather demographic and socio-economic information about the two communities. In the following sections the Pretoria and Bela-

---

<sup>1</sup> Prodder 2000. Terreblance, Y (ed.). The Southern African Development Directory. Johannesburg: Dictum

Bela communities will be assessed according to the guidelines set out by the WHO. Appendix B contains complete socio-economic statistics. The most prominent findings will be discussed in this section. The South African population census formed the base of most of the following sections. However, the latest census data (2001) has not been released at a small area level. This means that the current format of data which is at a municipal level, does not allow for it to be broken down into smaller areas and it is therefore not possible to identify any data for Bela-Bela or Pretoria at the same level as in the baseline survey. This means that detailed differences will not be identified, especially in Bela-Bela where all the surrounding farms are included in the municipal area. The small area level statistics is scheduled to be released in October 2003.

#### **4.1 POPULATION AND HOUSING MEASURE**

The variables for this section will stay unchanged, because no comparison between the previous and the present data can be made. No comparison can be made on population, household income, population density, poverty gap and access to services between the baseline and post intervention assessment.

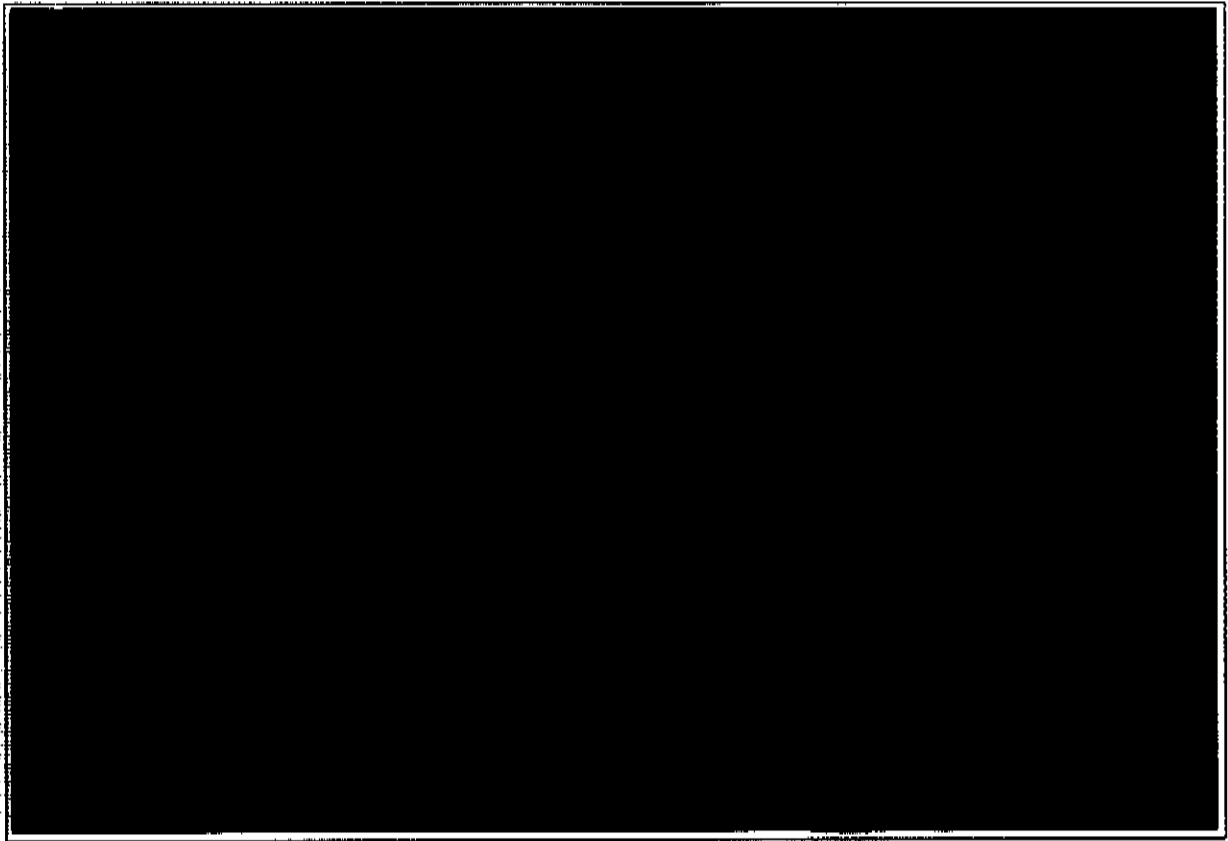
#### **4.2 EDUCATIONAL, HEALTH AND WELFARE SERVICES**

The 1998 health databases from the Department of Health was obtained. According to this data set there are eight clinics and two hospitals in Warmbaths, close to Bela-Bela. None of these are however in Bela-Bela. One could therefore assume that the Bela-Bela community is still very dependent on Warmbaths for services. In the Pretoria research site there were still 116 clinics and hospitals. Figure 4 and 5 below displays the geographic distribution of facilities and services provided in the two communities.

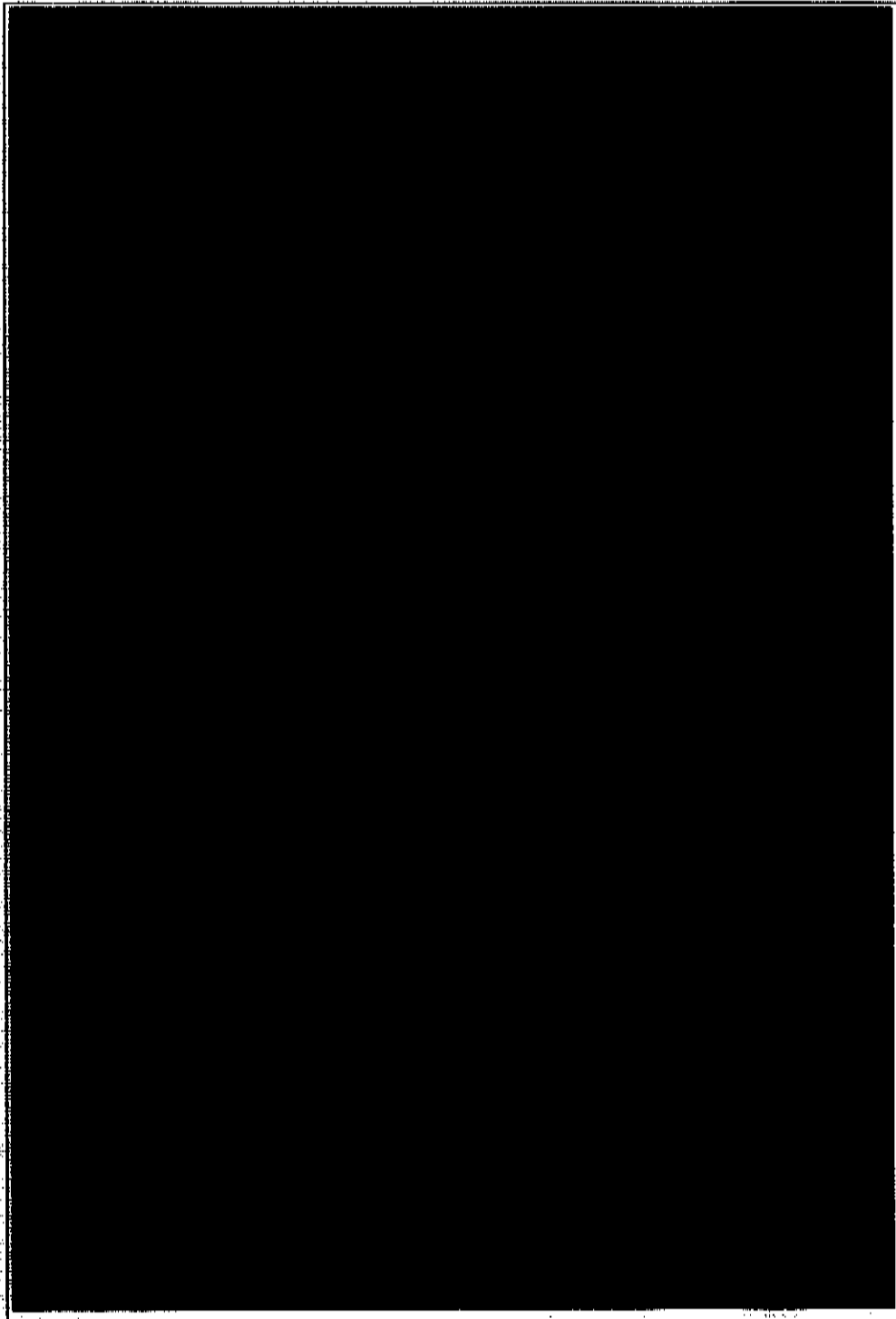
In terms of educational services there is no data set more recent than the School Register of Needs (SRN) 2000 used in the baseline survey. The reference to school services therefore stays the same. The level of education of the population might have changed, but it is not possible to assess this, because the 2001 Census data is not available at a small area level yet.

Overall, Pretoria seems to be well served in terms of public services, but in some cases the historically disadvantaged area of Soshanguve lack services. Bela-Bela seems to be worse off than Pretoria and is in many instances dependent on Warmbaths for services.





**Figure 4:** Geographic distribution of various facilities in the rural research site Bela-Bela



**Figure 5: Geographic distribution of various facilities in the urban research site Pretoria**

### **4.3 ECONOMIC STRUCTURE AND ACTIVITIES**

The 2001 census is not available at a small area level, it is therefore not possible to analyse the two communities in terms of economic activities. For purposes of comparison, the municipal areas will be briefly described. This will provide some indication as to changes in the local economy between the 1996 and 2001 census.

The major industries of employment in Bela-Bela municipality were: agriculture (23%), community and social services (19%) and wholesale and retail (18%). In comparison the municipality in which Pretoria is situated recorded community and social services (25%), wholesale and retail (16%) and financial (14%) as the largest industries of employment.

In comparison to the baseline survey, the dominant industries in the two research sites remained the same. Agriculture seems to be the major industry in the Bela-Bela municipality, but this refers to the whole municipality and not just the research site.

The density of liquor outlets in the two communities has stayed the same since the data was not updated between the baseline and the post assessment survey.

In terms of advertising of alcohol and tobacco the following was noted. Due to legal restrictions tobacco is not advertised at all. Alcohol is advertised on TV and is mostly aimed at males older than 18 years. The advertising on weekends is more extensive than on weekdays.

#### **4.4 LEGAL CONDITIONS**

The structure of the legal system and crime is discussed in this section. Although crime statistics for 1999 was released by the South African Police Service, the statistics was released only on an aggregated level and can therefore not be analyzed in comparison to the baseline study. No update was made in terms of the data referring to courts.

Based on literature the regulation of the physical and economic availability of alcohol has the following impact. An increase in consumption takes place if: the age of availability gets lowered, the actual costs decrease and the number of outlets increase (WHO 2002 (a): ). In the South African context the age of availability did not change during the two surveys. The actual cost of alcohol did increase. Updated data about the number of outlets was not available and it is therefore difficult to assess whether there was any change in this regard.

Literature studies also indicates that alcohol related problems were reduced in cases where (WHO 2002 (a): ):

- ?? Random breath testing took place.
- ?? Liquor licensing laws were strictly enforced.
- ?? Responsible serving practices were adopted.
- ?? Increasing the real cost of alcohol.

Random breath testing does take place in South Africa, but the frequency of these tests is not known. As was indicated in the focus group interviews, it was suggested that liquor outlets should have stricter enforcement of age restrictions. This comment suggests that currently these laws are

not adhered to. The real cost of alcohol did increase between the two surveys. Conditions for reducing alcohol were therefore favourable.

In terms of the regulation of physical and economic availability of illicit substances findings indicated that the regulation of the industry produces no direct reduction in eradicating the use (WHO 2002 (a): ). It has the following effects, though:

?? Shaping the market.

?? Affecting purity of substances.

?? Affecting price.

These conditions do not apply to the South African context.

#### **4.5 CIVIL INSTITUTIONS AND ACTIVITIES**

There was no update made to the existing data on Non-Governmental Organisations (NGOs) and therefore no comparison could be made with the baseline study.

The following section will consider data collected during the KAP survey of adults.

### **5. RESULTS: ADULT KNOWLEDGE, ATTITUDES AND PRACTICES REGARDING SUBSTANCE USE (SURVEY)**

This section deals with the results from the sample survey of adults in the research communities. Appendix C contains the questionnaire with frequencies per section for both sites. Findings from the sites will be discussed separately before recommendations will be done.

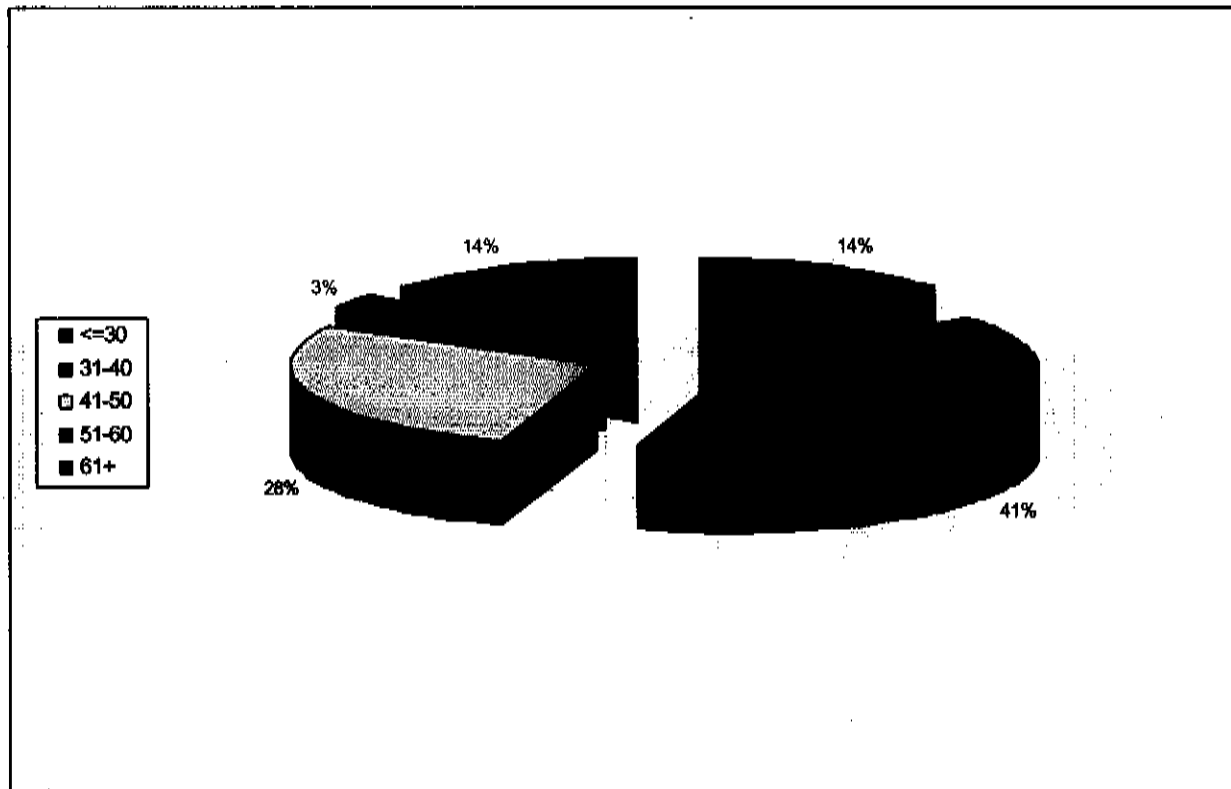
The small sample size of the survey needs to be taken into consideration. The survey data merely compliments the data gathering, validates the data gathered from the focus group interviews and the desktop study as well as provides baseline data for future evaluation of interventions in the two communities.

#### **5.1 BELA-BELA**

##### **5.1.1 Biographics**

The majority of the interviewees (75%) were women. Most of the respondents (57%) did not work on a paid job during most of the last 12 months. Only 29% worked on a full-time paid job during the previous 12 months. The number of unemployed (46%) were slightly higher than the employed (40%). By far the greatest majority of the respondents (91%) were of the Christian faith. They also seem to be active Christians since 58% attends religious or church meetings once or more a week. Eighty five percent of the respondents viewed religion as very important in their lives.

In comparison to the baseline survey, the number of people who were employed seemed to have decrease (from 55% to 40%). This figure corresponds with national trends of a decrease in formal employment (from x% to X%) between 1996 and 2001 censuses. Religion still seems to play an important role in the community. The age breakdown seemed to be slightly different from the baseline survey, with more respondents from the 31-40 year and 41-50 year old age groups.



**Figure 4:** Age breakdown of adult respondents in Bela-Bela

Figure 4 above shows the age breakdown of the respondents. The mean age of respondents were 41.9 years.

In terms of education 18% of respondents had completed 1-7 years of training (this refers to primary school training) and 65% had completed between 8 and 12 years of schooling. These figures are basically the same as that of the baseline study.

### 5.1.2 Availability of psychoactive substances

Cigarettes and alcohol in general were very easy to obtain (81 and 78% respectively). Hard liquor (58%), malt beer (66%), wine (53%) and home made liquor (66%) were all very easy to obtain. An illicit substance like marijuana (55%) was very easy to obtain while cocaine/crack was very difficult to obtain (58%). Substances that were "probably impossible" to obtain were heroin (14%), hallucinogens, amphetamines and sedatives (all 11%). These figures are significantly lower than the findings from the baseline survey where figures of between 67-79% were recorded for the

same substances. The availability of other substances remained the same between the time of the baseline and this study.

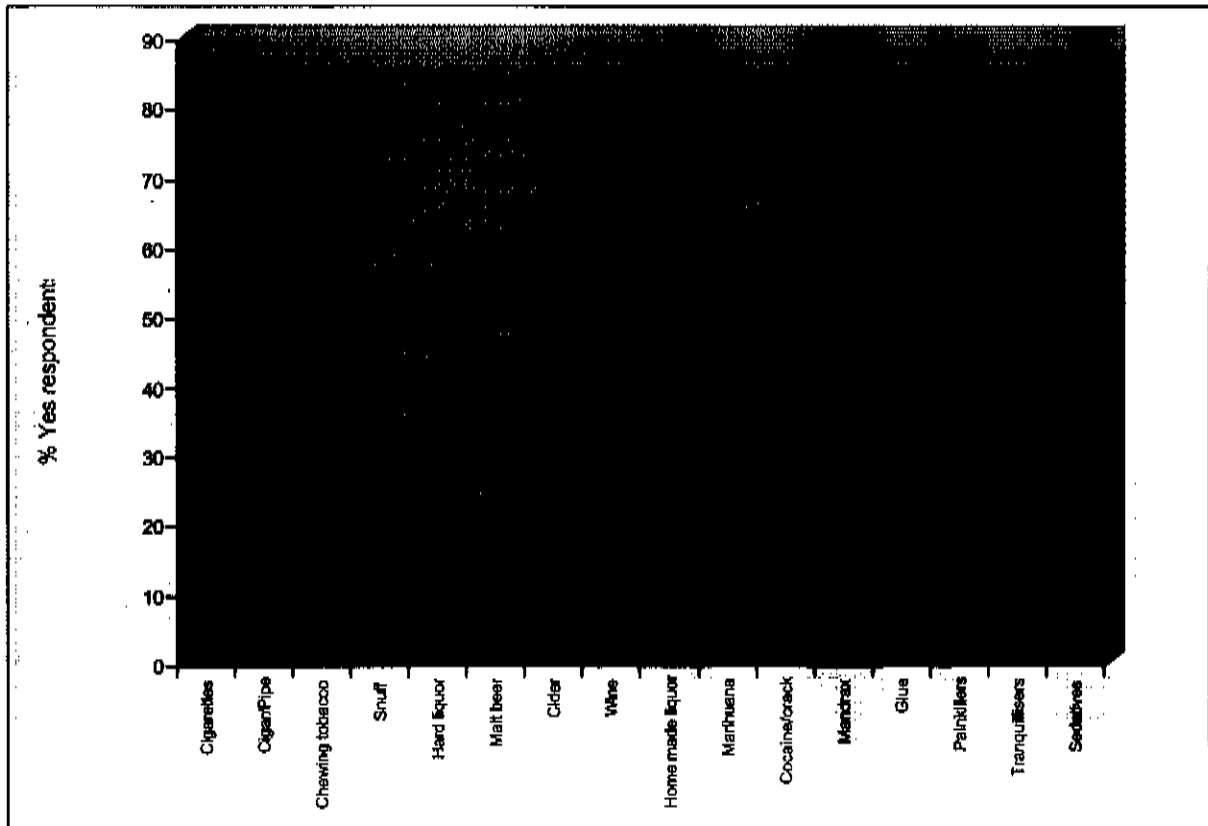
### **5.1.3 Substance use**

Low percentages of lifetime substances use were recorded for most substances. In the case of only four substances (licit) more than 30% of respondents reported lifetime. These were in order of popularity: over the counter painkillers, cider and wine (see Figure 5 below). According to the survey, no respondents indicated lifetime use of heroin, amphetamines, mandrax and marihuana mix or hallucinogens. These findings correspond with the baseline study.

Most respondents did not use cigarettes either in their lifetime (81%), past twelve months (74%) or in the past 30 days (78%). However, of those respondents that used cigarettes in the past twelve, 9% indicated that they used it daily. Another 6% of respondents used cigarettes 3-4 times a week. Cigars or pipe smoking was not very popular with lifetime use being restricted to 3% of respondents. Chewing tobacco was also not popular – only 1 respondent had done it in their lifetime. The minority of respondents had taken snuff in their lifetime (25%), the past year (22%) or past 30 days (22%).

Although many respondents (44%) had taken alcohol in their lifetime, only 32% took it in the past 30 days. Of those respondents who had used alcohol in the past month, 14% used it 2 – 3 days during that time while 8% used it 1 – 2 days a week. A high level of intake was reported among 18% of respondents who had five or more drinks in a row in the last two weeks. Signs of dependence (e.g. requiring a drink first thing in the morning) were, however, not common. Some responses included, people who failed to do what was normally expected from them because of drinking (6%) and people who had a feeling of guilt or remorse after drinking (3%).

Hard liquor was consumed by 11% of respondents in their lifetime. Only 6% of those respondents who used hard liquor in the past month, used it once during the past month.



**Figure 5:** Lifetime use of substances among adults in the rural research site Bela-Bela

Eleven percent of respondents consumed malt beer during their lifetime. Of those respondents who consumed it in the past month, 4% consumed it on 2 – 3 days in the month and 7% once during the month.

Although cider was consumed by 39% of respondents during their lifetime, only 25% of respondents used it during the past 30 days. The majority of respondents (21%) used cider 2 – 3 days during the past month. Seven percent of the respondents used it once a month.

In terms of wine, 36% of respondents consumed it during their lifetime. Twenty eight percent consumed it in the past year while only 20% consumed it in the past thirty days. Ten percent of the respondent consumed wine only once a month while 3% consumed it once in the previous 12 months. Homemade liquor was consumed by 28% or respondents during their lifetime. Six percent of the respondents used homemade liquor 2-3 times a month and another 6% used it once a month, but the majority (85%) did not use it at all during the previous year.

In terms of other (illicit) substances the results can be viewed in the questionnaire which forms part of Appendix C. Low percentages of lifetime use of illicit substances were reported. This ranged between 8% for sniffing glue, etc. to 3% for mandrax and cocaine/crack use.

The vast majority of respondents (89%) had used over-the-counter painkillers without the instruction of a doctor or a health worker (see Figure 5 above). The majority of the respondents (32%) who used over-the-counter painkillers without instruction used it 2-3 days a month. Another 23% of respondents used it once a month.

In terms of substances that help people to relax and tranquillisers, 6% of the respondents had used these during their lifetime without the instruction of a doctor or a health worker. Three percent of respondents used these substances almost daily in the past 12 months.

Three percent of respondents indicated lifetime use of substances that help people to sleep and sedatives. Seven percent had used it 2 – 3 days in the past 12 months.

The most popular substances identified during this study varied from those in the baseline study. In the baseline study the most popular psychoactive substances were painkillers, snuff and malt beer. The post intervention assessment study identified painkillers, cider and wine. There has therefore been a change in substance use patterns and also in order of priority.

**5.1.4 Health and social consequences of substance use**

Low responses were recorded for negative experiences related to substance use in the twelve months before the survey. Three percent of respondents indicated that they were “arrested” for disorderly conduct due to substance abuse. Six percent indicated that they had physical fights or arguments with family/relatives or boy/girl friend about consequences of your substance use monthly or less than monthly. These consequences remained similar to conditions recorded during the baseline study.

**5.1.5 Attitudes and local customs**

Minor proportions of the adult respondents in the Bela-Bela community approved the following behaviour patterns. Although respondents were still divided about heavy drinking, the attitude had swung to the other side in comparison to the baseline survey. A far smaller number, namely 14% - in comparison to 39% before – indicated that it was acceptable to have one or two drinks several times a week.

**Table 3: Attitude: Approval towards “people in general” using the following substances**

Having one or two drinks several times a week	14



Strong disapproval was indicated towards the use of the following substances. Disapproval includes "people in general" as well as young people. Illicit substance use was mostly disapproved as shown in Table 4 below.

**Table 4: Attitude: Disapproval towards using the following substances**

Smoking 10 or more cigarettes a day	60	83
Smoking marijuana or hashish regularly	83	80
Taking cocaine occasionally	82	80
Having five or more drinks once or twice each weekend	47	61
Taking amphetamines occasionally	69	78
Taking heroin occasionally	78	78
Taking mandrax occasionally	78	78
Taking hallucinogens occasionally	78	78

The negative attitude towards illicit substance use was stronger when the youth were using these. This applied to selected substances only – smoking cigarettes, the use of alcohol, amphetamines and heroin. The trend of attaching a higher negative value to youthful substance use remained.

In Bela-Bela the adult use of alcohol was customary (between 94% and 83% use recorded) especially at parties, on weekends, at other public festivals, at sporting events, on weddings and with visitors. It was used to a lesser extent at funerals (56%). In terms of other substances marijuana was mostly used at social events like sporting events (47%), other public festivals (47%), on weekends (47%), at parties (47%), with visitors (39%), at work (25%) and at weddings (25%). At other public festivals amphetamines (6%) and cocaine (14%) was used. Cocaine (14%) was also used at parties. The use of substances other than alcohol at social events has expanded since the baseline survey. This is indicated in the use of marijuana, amphetamines and cocaine which was not previously indicated.

The adult survey respondents perceived risk when the following psychoactive substances were used (Table 6 below). In most instances (except cigarettes, marihuana and cocaine) the respondents perceived that more risk is experienced when the youth are using psychoactive substances. This corresponds largely with findings from the baseline. The findings differ, however, significantly from the baseline in terms of the percentage of respondents who perceived risk. The figures for this survey are considerably higher than in the baseline study.

**Table 5: Perceptions: Risk when using psychoactive substances**

Smoking 10 or more cigarettes a day	100	100
Smoking marijuana or hashish regularly	100	100
Taking cocaine occasionally	100	100
Having five or more drinks once or twice each weekend	97	100
Taking amphetamines occasionally	95	97
Taking heroin occasionally	97	100
Taking inhalants occasionally	97	100
Taking mandrax occasionally	97	100
Taking hallucinogens occasionally	95	97

Perceptions on the current legal status of the non-medical use of psychoactive substances, indicated that adults regarded most substances (e.g. marihuana, mandrax, heroin, amphetamines, cocaine and hallucinogens) as illegal. A large proportion (27%) of the respondents did, however, indicate that painkillers are legal. Another 8% of respondents regarded tranquillisers and sedatives respectively as legal.

In terms of the future legal status of psychoactive substances, respondents indicated that painkillers (31%), sedatives (7%) and tranquillisers (8%) should be legalised. For the remainder of substances, the indication was that the current status should prevail. In the baseline study a significant number of respondents (33%) indicated that the non-medical status of marihuana was

legal. In this post assessment survey there is no indication of this nature. In fact, it seems that adults now attached this non-medical legal status to painkillers.

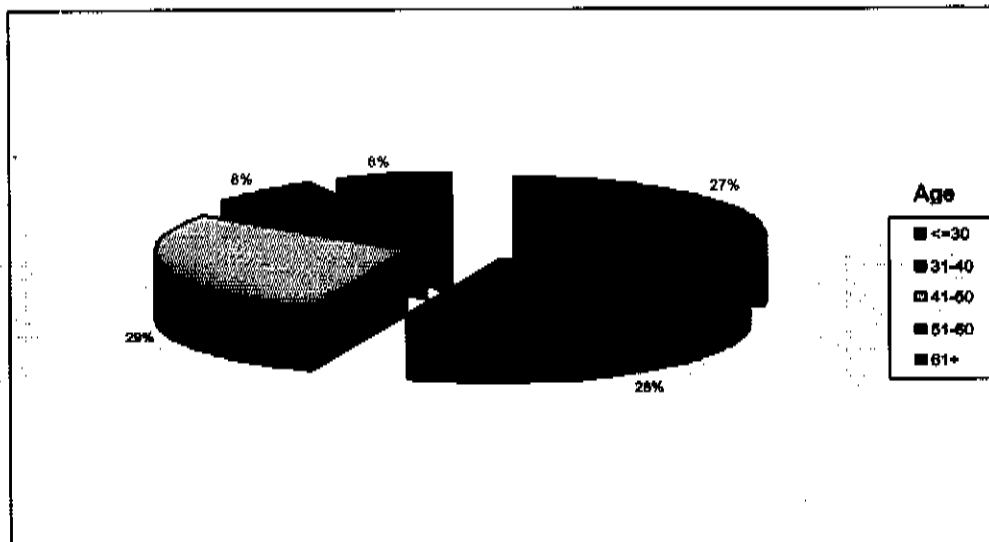
Forty nine percent of respondents were living with a spouse or co-habitant. Cigarettes (52%) and alcohol (56%) were the substances mostly used by co-habitants. There was also an indication that respondents' co-habitants were getting drunk at least once a week (36%). The latter experience was not indicated in the baseline survey.

## 5.2 PRETORIA

### 5.2.1 Biographics

The respondents in the urban research site were predominantly female (73%). Seventy one percent of the respondents had between 8-12 years of schooling. Forty two percent were employed. The greatest majority (92%) of the respondents were of the Christian faith. Respondents also indicated that they attended religious meetings once a week or more. Most respondents (72%) viewed religion as very important in their lives.

The age structure of the respondents is shown in Figure 6 below. The age groups were evenly represented. The mean age of respondents was 39.6 years.



**Figure 6:** Age breakdown of adult respondents in Pretoria

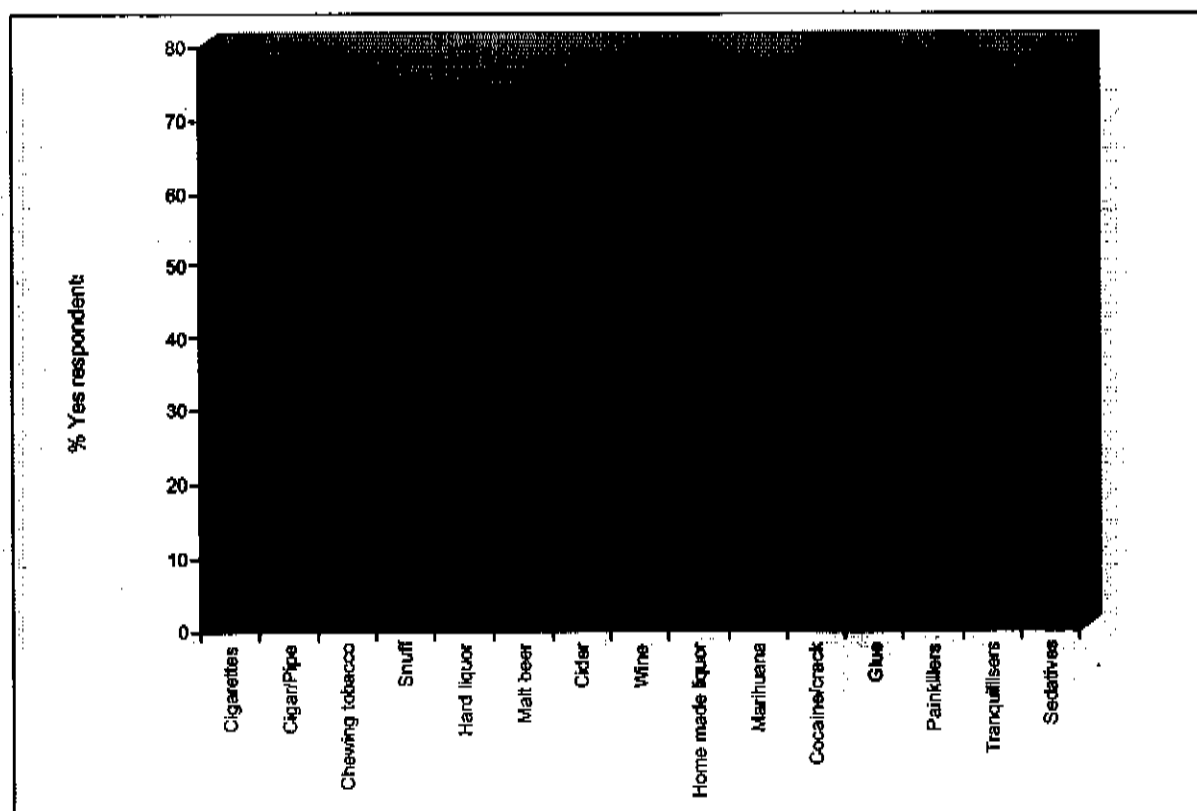
The employment status of respondents is lower than during the baseline survey (42% compared to 63%). The post assessment survey is characterised by the dominance of female respondents (73%). The other biographical features of the respondents have remained largely the same.

## 5.2.2 Availability of psychoactive substances

Substances that were the easiest to obtain were cigarettes, other kinds of tobacco, hard liquor, malt beer and wine. Marihuana, heroin, crack/cocaine, hallucinogens, amphetamines, sedatives and tranquillisers were "probably impossible" to obtain. Substantial proportions of respondents indicated that marihuana (40%), cocaine/crack (26%), sedatives (21%) and tranquillisers (20%) were very easy to obtain.

## 5.2.3 Substance use

Lifetime use of substances like painkillers (73%), wine (64%), cider (52%) and cigarettes (33%) were recorded most among the respondents. No lifetime use of heroin, hallucinogens, amphetamines, mandrax as well as mandrax and marihuana mix was recorded.



**Figure 7:** Lifetime use of substances among adults in the urban research site Pretoria

Painkillers seem to have a more prominent use in the rural site where lifetime use amounted to 89% in comparison to the 73% recorded in the urban site. However, in terms of other popular psychoactive substances like wine, cigarettes and cider the consumption in the urban area was higher. These trends correspond with findings in the baseline survey.

Thirteen percent of the past twelve months' users of alcohol used it one to two days a week while 27% of past twelve month tobacco users indicated daily use. Daily cigarette smoking was higher in

the urban area than the rural. "Heavy" drinking (five or more drinks in a row) was not very common - five percent of respondents indicated this happened in the two weeks preceding the survey. Signs of substance dependence were restricted to weekly or daily feelings of guilt (6%) and being unable to stop drinking once having started (6%). These figures are higher than those reported in the rural site, but seem to be lower than those reported during the baseline study.

#### 5.2.4 Social and health consequences

Virtually no negative effect of substance use was recorded during the twelve months preceding the survey (see Addendum C for details). This is lower than the statistics recorded during the baseline survey and lower than that of the rural site.

#### 5.2.5 Attitudes regarding local customs

Approval was accepted for "people in general" having one or two drinks several times a week (22%) or having five or more drinks once or twice each weekend (21%). The same activities were however disapproved by respectively 66% and 68% of the respondents. Respondents disapproved (including "strongly disapproved") the taking of illicit substances (amphetamines, hallucinogens, etc.) and responses ranged between 85 and 96%.

Disapproval if young people use substances was clearly higher than for adults use. This applied to all psychoactive substances included in the question. Table 6 below indicates these findings. The findings discussed here, broadly corresponds with findings from the baseline study. In comparison to the rural site where selected substances were disapproved for youthful use, all substances were disapproved more for youthful than adult use.

**Table 6: Attitude: Disapproval towards people using the following substances**

Smoking 10 or more cigarettes a day	51	82
Smoking marijuana or hashish regularly	71	91
Taking cocaine occasionally	73	89
Having five or more drinks once or twice each weekend	42	70
Taking amphetamines occasionally	68	88

Taking heroin occasionally	71	89
Taking mandrax occasionally	71	92
Taking hallucinogens occasionally	71	92

In terms of local customs it was customary to take alcohol on the following occasions: other public festivals (82%), sporting events (80%), weddings (86%), weekends (86%), parties (91%), with visitors (77%). It was used to a lesser extent at work (38%), funerals (42%) and religious festivals (24%). Other psychoactive substances tend to be used at other public festivals, weekends, parties and with visitors. These substances included marihuana as well as heroin and cocaine to a limited extent. Respondents from the rural site indicated slightly higher percentages of alcohol use at social events. Slightly higher percentages of alcohol use were recorded in the baseline study as well.

Young people tended to use alcohol at other public festivals (80%), sporting events (79%), weddings (79%), on weekends (79%) and at parties (89%). Illicit substances that were used included marihuana and cocaine. During the baseline study amphetamines and heroin were reported as being used by the youth at social events.

**Table 7: Perceptions: Risk when using psychoactive substances**

Smoking 10 or more cigarettes a day	99	99
Smoking marijuana or hashish regularly	100	100
Taking cocaine occasionally	100	100
Having five or more drinks once or twice each weekend	97	100
Taking amphetamines occasionally	100	100
Taking heroin occasionally	100	100

Taking inhalants occasionally	100	100
Taking mandrax occasionally	100	100
Taking hallucinogens occasionally	100	100

Pretoria respondents seem to be unanimous in the risk posed by substance use. This risk applies to both adults and youth according to the respondents. The respondents indicated that all psychoactive substances, except alcohol, posed a 100% risk to users. These figures are consistently higher than that of the rural site and the baseline study.

In terms of respondents' knowledge about the prevailing status of the non-medical use of substances, the following was found. Most respondents indicated that the prevailing medical status was illegal. However, a significant proportion indicated that sedatives (21%), tranquillisers (25%) and painkillers (61%) were legal. The non-medical use of painkillers was also seen as legal in the rural site, but not to the same extent (27%). The urban findings correspond largely with findings from the baseline survey where high numbers of respondents indicated that the non-medical use of painkillers, tranquillisers and sedatives was legal.

A reasonable number of respondents also indicated that the status for the non-medical use of painkillers (49%), tranquillisers (16%) and sedatives (11%) should be legal. Although these numbers are lower than the baseline study, the trend remained the same. The number of respondents in the rural site who indicated the status of these substances should be legal, were lower than those of the urban.

## 6. RESULTS: YOUTH KNOWLEDGE, ATTITUDES AND PRACTICES REGARDING SUBSTANCE USE (SURVEY)

This section will discuss results from the two research sites for the KAP youth survey. The sample realisation for the youth survey is displayed in the two tables below.

**Table 8: Bela-Bela youth sample realisation**

	EA	10-14	15-21
Bela-Bela	9100014	3	6
Bela-Bela	9100044	4	5
Bela-Bela	9100049	3	6
Bela-Bela	9100052	4	5
Bela-Bela	9100022	6	3
Bela-Bela	9100037	4	5
Bela-Bela	9100041	4	5
Bela-Bela	9100017	4	6
Bela-Bela	9100027	5	4
Bela-Bela	9100031	3	6
Bela-Bela	9100089	6	3
Bela-Bela	9100023	3	6
<b>Total Bela-Bela</b>			

**Table 9: Pretoria youth sample realisation**

	EA	10-14	15-21
Atteridgeville	7010553	5	4
Atteridgeville	7010655	6	3
Soshanguve	7020063	3	6
Soshanguve	7020215	4	5
Mamelodi	7030122	3	6
Mamelodi	7030217	5	4
Mamelodi	7030506	4	5
Soshanguve	7020345	6	3
Soshanguve	7020514	4	5
Erasmia	7011503	6	3
Mamelodi	7030076	5	4
Lotus Gardens	7010081	4	5
Sunnyside	7010374	7	2
City Centre	7010464	5	4

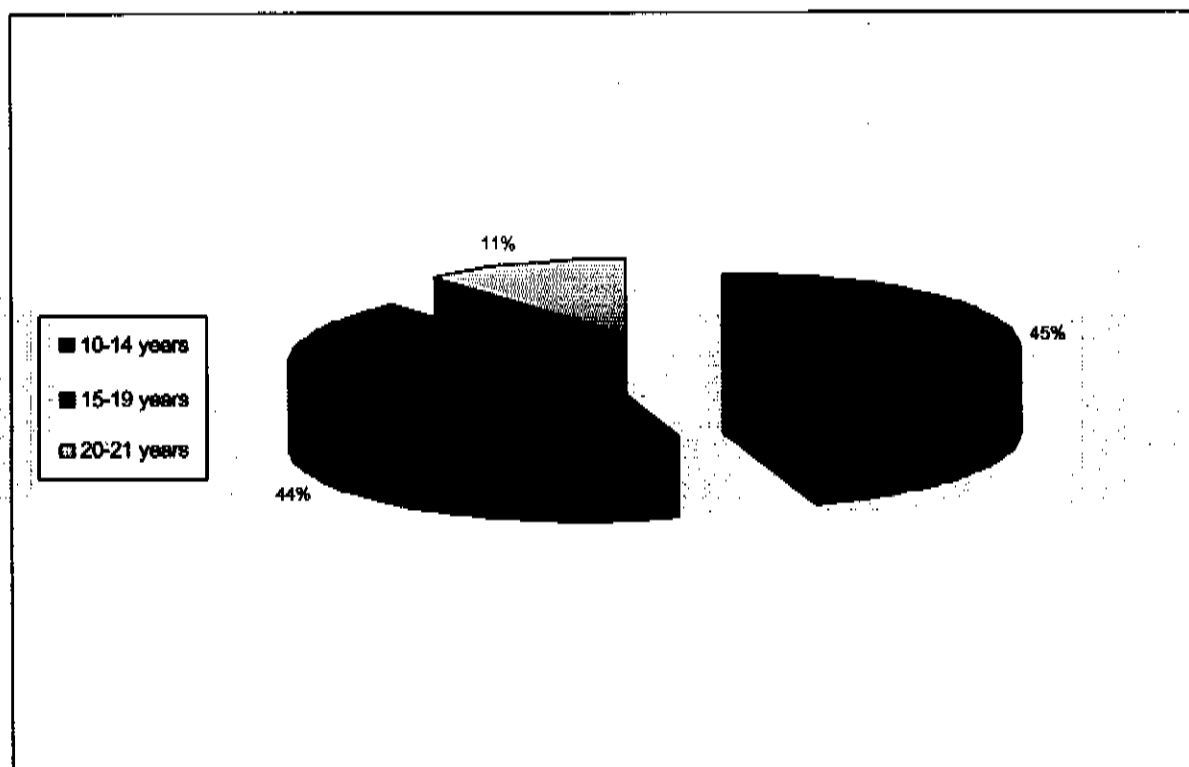


Ward/CPM/TA	EA	Youth (10-14)	Youth (15-21)
Mamelodi North/Baviaanspoort	7030439	4	5
Pretoria West	7010138	5	4
Hillcrest	7010528	3	6
Garsfontein/Menlyn	7010901	5	4
Silverton	7011087	4	5
Waterkloof Ridge	7011303	6	3
Walmer	7030325	5	4
Theresa Park	7030574	3	6
Sub-total Pretoria		42	42

## 6.1 BELA-BELA

### 6.1.1 Biographics

The majority of respondents in Bela-Bela were females (528%). The age groups presented in the survey were 10-14 year olds (45%), 15-19 year olds (44%) and 20-21 year olds (11%). Forty two percent of the respondents had between one and seven years of schooling, while the majority (57%) had between eight and twelve years of schooling.



**Figure 8:** Age breakdown of youth respondents in Bela-Bela

Eighty nine percent of the respondents were full time scholars during the twelve months preceding the survey. Fifty four percent of respondents live with a father/stepfather while 90% have a mother/stepmother in their living environment. Siblings were present in the case of 77% of respondents, while other relatives were present in 22% of respondents' household.

Most respondents indicated that their father's (38%) and mother's (41%) highest school qualification was of secondary nature. Ninety four percent of respondents indicated they belonged to the Christian faith. Religious meeting were attended on a weekly basis by most of the respondents (64%). Respondents also viewed religion as very important in their lives (89%).

### 6.1.2 Availability of psychoactive substances

Cigarettes (76%), hard liquor (60%), malt beer (55%), wine (46%), home made liquor (67%) and painkillers (48%) were very easy to obtain. It would also seem that marihuana (cannabis) was very easy to obtain (53%). Substances that were "probably impossible" to get hold of were, amphetamines (22%), hallucinogens (22%), heroin (21%), cocaine or crack (20%) and mandrax (20%).

During the baseline survey there was no indication that an illicit substance like cannabis was very easy to obtain. It would therefore seem that it has become more freely available since the baseline survey. The percentages for substances that were "probably impossible" to obtain were significantly lower than during the baseline study.

### 6.1.3 Substance use

Substance use is reported in this section. It will be done by age groups, gender, lifetime, past year and past month use per substance. Results will also be compared with baseline findings.

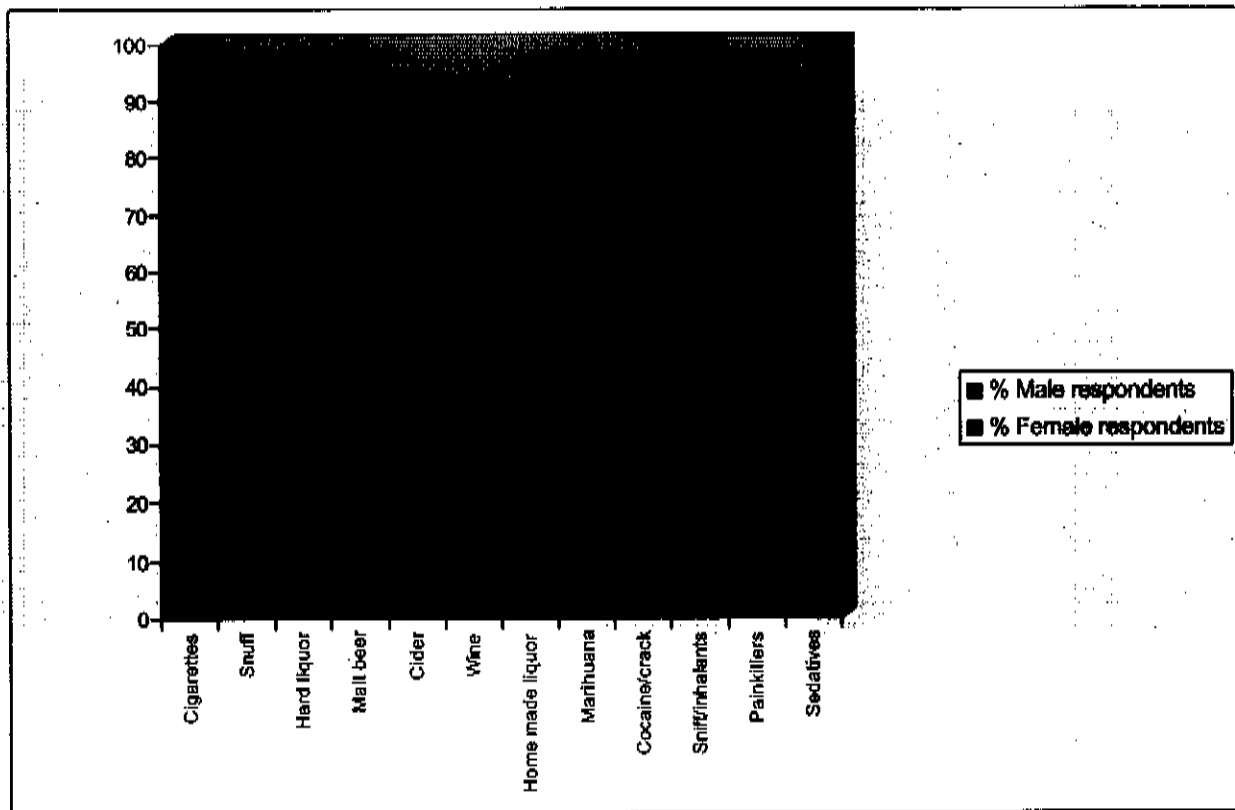
**Table 10: Lifetime use of psychoactive substances by gender in Bela-Bela**

Substance	% MALE RESPONDENTS	% FEMALE RESPONDENTS	% TOTAL
	80	20	10
	100	0	1
	75	25	4
	100	0	2
	54	46	28
	64	36	11
	60	40	5
	100	0	3
	100	0	3

SUBSTANCE	% MALE RESPONDENTS	% FEMALE RESPONDENTS	TOTAL N
	100	0	3
	50	50	82*
	100	0	3

\* 2 respondents did not indicate gender

As has been traditionally the case in South Africa, male respondents are the highest consumers of psychoactive substances (see Table 10 and Figure 9). Females tend to use cider, wine and homemade liquor. Both genders seem to be equal users of over the counter painkillers. Very low responses were recorded for lifetime use of most substances. The exceptions were over the counter painkillers and cider. The same two substances were also the most recorded during the baseline study.



**Figure 9:** Lifetime use of psychoactive substances by gender in Bela-Bela

In terms of substance use by age group, the age group with the highest recorded substance use seem to be the 15-19 year olds. These substances included cigarettes, hard liquor, cider and over the counter painkillers. A high proportion of 10-14 year olds indicated the use of cider, wine and over the counter painkillers. Twenty to twenty-one year olds tend to use wine and home made liquor. No lifetime use of substances like cocaine, mandrax, ecstasy, heroin etc. was recorded.

**Table 11: Lifetime use of psychoactive substances by age group in Bela-Bela**

	% 10-14 years	% 15-19 years	% 20-29 years	TOTAL
	20	60	20	10
	100	0	0	1
	0	75	25	4
	0	100	0	2
	36	46	18	28
	18	36	48	11
	40	20	40	5
	0	67	33	3
	0	67	33	3
	0	67	33	3
	43	44	13	84
	67	33	0	3

**Table 12: Past year use of psychoactive substances by gender in Bela-Bela**

	% MALE RESPONDENTS	% FEMALE RESPONDENTS	TOTAL
	100	0	8
	75	25	4
	100	0	1
	75	25	16
	100	0	3
	100	0	1
	100	0	3
	53	47	73
	100	0	1

Cider and over the counter painkillers seem to be the most popular among past year substance users. Male respondents were the most dominant users. Many substances have not been used in the past year even though lifetime use was admitted – these included snuff, cocaine and inhalants.

**Table 13: Past year of psychoactive substances by age group in Bela-Bela**

	% 10-14 years	% 15-19 years	% 20-24 years	TOTAL N
	12	63	25	8
	0	75	25	4
	0	100	0	1
	31	63	6	16
	0	100	0	3
	0	100	0	1
	0	67	33	3
	44	41	15	75
	0	100	0	1

Cider, cigarettes and painkillers were the substances used by most respondents during the year preceding the survey (Table 13 above). The 15-19 year olds were the highest percentage of users. A high percentage (44%) of 10-14 year olds indicated the use of painkillers in the past year.

No malt beer and homemade liquor use was recorded in past month (see Table 14). Over the counter painkillers had the highest number of users in the past month. Females made up a substantial proportion (41%) of these users. The recorded number of past month users were low for most substances.

**Table 14: Past month use of psychoactive substances by gender in Bela-Bela**

	% MALE RESPONDENTS	% FEMALE RESPONDENTS	TOTAL N
	100	0	8
	75	25	4
	100	0	6
	100	0	3
	100	0	3
	59	41	39
	100	0	1

**Table 15: Past month use of psychoactive substances by age group in Bela-Bela**

Substance	% 10-14 years	% 15-19 years	% 20-21 years	TOTAL N
Painkillers	13	62	25	8
Cigarettes	0	75	25	4
Wine	0	83	17	6
Hard liquor	0	100	0	3
Cider	0	67	33	3
Marijuana	51	33	16	39
Homemade liquor	0	100	0	1

According to Table 15 above, the 10-14 year olds are the highest consumers (51%) of painkillers in the past month. Besides the use of cigarettes and painkillers, this age group did not register the use of any other psychoactive substance in the past month. The 15-19 year olds tend to be the age group with the highest recorded substance use over the past month. The number of users were however, very low. The 20-21 year olds tend to use marijuana, cigarettes, hard liquor, cider and painkillers.

In comparison to the baseline study, it would seem that the use of painkillers have increased in the 10-14 year old age group. Cider remained the most popular alcohol product among respondents while painkillers remained the most popular of all substances. No past month use of homemade liquor was indicated.

Regarding the first age of use, most respondents started using cigarettes and cider between 13 and 14 years. In the case of wine the onset age was slightly older, namely 17-18 years. In all instances males were the majority.

**6.1.4 Social and health consequences**

Heavy drinking seems not to be prevailing, since only 9% of male respondents respectively indicated taking five or more drinks in a row once or twice during the two weeks preceding the survey. Two percent of male respondents reported a feeling of guilt or remorse almost weekly after drinking. Two percent of male respondents reported that someone was injured because of their drinking or concerned about their drinking in the past year.

In terms of frequency of use 50% male respondents (n=8) indicated the almost daily use of cigarettes over the previous month. Fifty percent of these respondents were in the age group 15-19 years. Twenty five percent each were in the age groups 10-14 years and 20-21 years. According to the survey no other substances were used on a daily or almost daily basis and no such use was recorded for females.

Social consequences following from substance use was not common in Bela-Bela. Only one male respondent aged 15-19 years old reported absence, suspension or being expelled from school or have poor school performance due to substance use and driving under the influence of alcohol or other substances. Two male respondents aged 15-19 years old reported to have physical fights or arguments with their parents or girl/boy friend about consequences of their substance use.

In terms of the prevailing legal status of the non-medical use of substances, most respondents answers were consequent with the legal status. A few respondents (n=4) indicated that tranquillisers were legal. These were mostly female (75%) and equally distributed in the age groups between 10-14 and 15-19 years. Thirty three percent of respondents indicated that the current non-medical use of painkillers is legal. These respondents were mostly female (59%) and predominantly in the age groups 10-14 years (35%) and 15-19 years (47%).

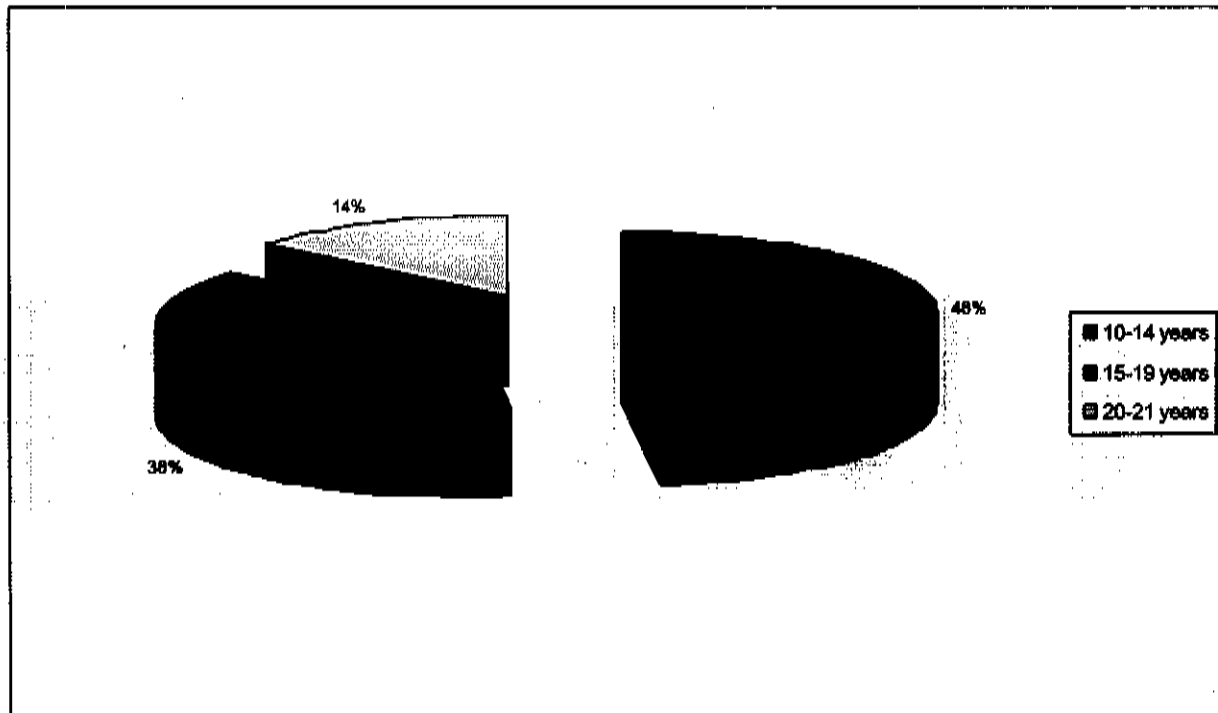
A small number of respondents (N=2 or N=1) indicated that the future legal status of all substances questioned should be legal. A larger proportion of respondents (29%) indicated that the future non-medical use of painkillers should be legal. Of these respondents 60% were female while 48% were between 10-14 years and 36% between 15-19 years. This figure of 29% is lower than that recorded in the baseline study (84%).

## **6.2 PRETORIA**

The results from the youth KAP survey will be discussed here. It will be compared with the baseline findings as well as that of the rural site.

### **6.2.1 Biographics**

Fifty four percent of the respondents were female. The dominant age group was the 10-14 year olds (48%). The breakdown of respondents by age group is displayed in Figure 10 below.



**Figure 10: Age breakdown of youth respondents in Pretoria**

Fifty five percent of respondents had between 8 – 12 years of schooling (i.e. secondary school training). Ninety percent were full-time students. Most respondents (59%) indicated that they live with a father/stepfather, mother/stepmother (76%) and siblings (72%). Forty four percent of respondents indicated that their father and mother (55%) completed secondary or high school training. Nine one percent of respondents belonged to the Christian faith. Religious meetings were attended more than once a week (56%). Eighty percent of respondents indicated that religion is very important in their lives.

The 10-14 year old age group makes up a larger component (48%) of the survey in this post assessment study than in the baseline. Although the gender distribution was fairly equal, there were slightly more females (54%) in the post assessment KAP survey. The level of schooling of the respondents' father was higher than during the baseline survey – 44% indicated secondary school training in comparison to 38% having a primary education (baseline).

### **6.2.2 Availability of psychoactive substances**

Substances that were very easy to obtain were cigarettes (69%), other tobacco products (62%), alcohol (64%), hard liquor (58%), malt beer (56%), wine (54%) and painkillers (62%). Cannabis (marihuana) was reported by 28% of respondents to be "very easy" to obtain. Substances that were "probably impossible" to obtain included mandrax (23%), cocaine (23%), heroin (27%), hallucinogens (26%) and amphetamines (26%).



In comparison to the baseline study the number of respondents who regard substances as "easily obtainable" are comparatively lower – e.g. the perception that painkillers are "easily obtainable" is lower by 20%. The same applies to most other substances mentioned. While the rural site recorded homemade liquor and cannabis as easily available, these substances were not as easily obtainable in the urban site.

### 6.2.3 Substance use

This section looks at substance use among the youth based on lifetime, past year and past month use. It will be broken down by gender and age.

**Table 16: Lifetime use of psychoactive substances by gender in Pretoria**

	MALE RESPONDENTS	FEMALE RESPONDENTS	TOTAL
	62	38	39
	78	22	9
	50	50	2
	50	50	8
	67	33	33
	71	29	21
	54	46	69
	52	48	52
	53	47	15
	76	24	21
	100	0	1
	100	0	2
	100	0	2
	75	25	8
	100	0	3
	67	33	3
	60	40	5
	50	50	2
	100	0	1
	79	21	14
	43	57	93
	60	40	5
	50	50	10

Although the number of respondents who indicated lifetime use was not high for all substances, a high number of substances were recorded. This indicative of the wide variety of substances

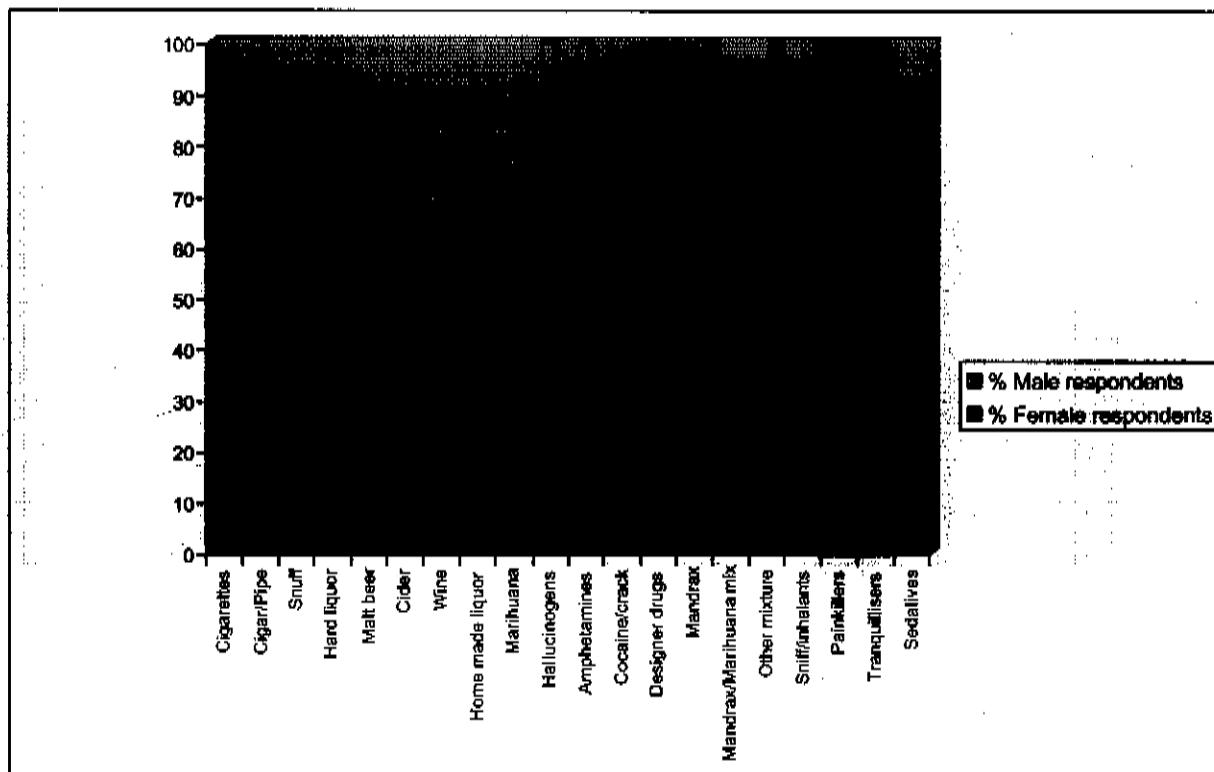
available in the urban research site. Cigarettes, hard liquor, malt beer, cider, wine, cannabis (marihuana) and painkillers were the most popular. Male respondents tended to be the higher number of users, except for over the counter painkillers (see Table 16 and Figure 11).

The lifetime use included more substances in the urban site than in the rural site. The following substances were not recorded in the rural site: cigar/pipe, chewing tobacco, heroin, hallucinogens, amphetamines, designer drugs, mandrax, white pipe, substances taken by needle and tranquillisers. It would therefore seem that a wider variety of substances are available in the urban research site. The substances recorded as lifetime use, corresponds with those recorded during the baseline study.

Table 17 below shows lifetime substance use by age group.

**Table 17: Lifetime use of psychoactive substances by age group in Pretoria**

	% 10-14 years	% 15-19 years	% 20-29 years	% 30-39 years
	33	41	26	39
	22	56	22	9
	50	0	50	2
	50	38	12	8
	27	46	27	33
	33	48	19	21
	30	44	28	69
	27	44	29	52
	20	60	20	15
	27	38	33	21
	0	0	100	1
	0	50	50	2
	0	50	50	2
	25	25	50	8
	0	33	67	3
	33	33	34	3
	40	20	40	5
	50	0	50	2
	0	0	100	1
	43	28	29	14
	33	48	18	93
	40	40	20	5
	40	50	10	10



**Figure 11: Lifetime use of psychoactive substances by gender in Pretoria**

The 15-19 year old age group tend to be the age group with the highest number of substance users. Exceptions occur in terms of snuff, mandrax and marihuana mixture (white pipe) and inhalants where the age group 10-14 years tend to have more lifetime users. The 20-21 year olds tend to use mandrax, cocaine, designer drugs and heroin. The reported numbers for the latter substances are however low and care should therefore be taken to accept these as the norm.

According to Table 18 the past year use of substances was mostly by males. Females tend to use over the counter painkillers and sedatives. Very low responses were recorded for hallucinogens, amphetamines, cocaine, designer drugs, mandrax and other substance mixtures. The most popular substance for past year use seemed to be (in order of popularity) painkillers, cider, wine, cigarettes, hard liquor, malt beer and marihuana.

**Table 18: Past year use of psychoactive substances by gender in Pretoria**

	% MALE RESPONDENTS	% FEMALE RESPONDENTS	%
	68	32	31
	100	0	5
	50	50	4
	73	27	28

	% MALE RESPONDENTS	% FEMALE RESPONDENTS	TOTAL
	67	33	18
	57	43	56
	51	49	39
	60	40	5
	78	22	18
	100	0	2
	100	0	1
	33	67	2
	100	0	1
	50	50	2
	50	50	4
	0	100	1
	80	20	5
	39	61	76
	75	25	4
	25	75	4

Table 19: Past year use of psychoactive substances by age group in Pretoria

	% 10-14 years	% 15-19 years	% 20-24 years	TOTAL
	32	36	32	31
	20	40	40	5
	75	25	0	4
	27	42	31	26
	22	56	22	18
	32	41	27	56
	23	46	31	39
	20	40	40	5
	28	33	39	18
	0	50	50	2
	0	100	0	1
	67	33	0	3
	0	100	0	1
	50	50	0	2
	50	25	25	4
	100	0	0	1
	20	80	0	5
	36	46	18	76

SUBSTANCE	% 10-14 years	% 15-19 years	% 20-21 years	TOTAL
	25	50	25	4
	25	50	25	4

Based on the table above it can be seen that the very young age group (10-14 year olds) prefer snuff. The 15-19 year olds were the highest users of substances in the past year. They tend to use cigarettes, hard liquor, malt beer, cider, wine and painkillers. The older age group (20-21 year olds) preferred cannabis.

**Table 20: Past month use of psychoactive substances by gender in Pretoria**

SUBSTANCE	% MALE RESPONDENTS	% FEMALE RESPONDENTS	TOTAL
	67	33	30
	100	0	1
	100	0	1
	68	32	22
	71	29	17
	53	47	40
	53	47	30
	50	50	4
	69	31	13
	100	0	1
	100	0	1
	0	100	1
	75	25	4
	39	61	51
	75	25	4
	33	67	3

Table 20 above indicates that male respondents were the dominant substance users in the month preceding the survey. The most popular substances were painkillers, cider, wine, cigarettes and hard liquor. Females tend to use painkillers and sedatives. In comparison to the baseline study, females are no more the dominant user group of cider in the past month.

**Table 21: Past month use of psychoactive substances by age group in Pretoria**

SUBSTANCE	% 10-14 years	% 15-19 years	% 20-21 years	TOTAL
	30	37	33	30
	100	0	0	1
	0	100	0	1

	% 10-14 years	% 15-19 years	% 20 years	TOTAL
	32	36	32	22
	24	52	24	17
	33	40	27	40
	30	43	27	30
	25	50	25	4
	31	31	38	13
	0	100	0	1
	0	0	100	1
	100	0	0	1
	25	75	0	4
	39	43	18	51
	25	50	25	4
	33	33	34	3

Table 21 above confirms earlier findings that the 15-19 year olds tend to be the dominant substance users. They used substances like painkillers, cider, cigarettes, wine and hard liquor. Even among the past 30 day users, the wider variety of substances used in the urban site is evident.

Regarding the first age of use, most respondents started using cigarettes and wine between 13 – 14 years old and cider between 15 – 16 years old. In the case of hard liquor the age of onset was later between the ages of 17 and 18 years. In all instances males were the majority. In comparison with the rural site, slightly more respondents indicated age of onset for cider at 15-16 years than 13-14 years. The latter was the age of onset for cider use in the rural site. In the case of wine the age of onset was earlier in the urban site (17-18 years vs. 13-14 years).

#### 6.2.4 Social and health consequences

Heavy drinking was not common in the urban site and most respondents (86%) never having five or more drinks in a row in the two weeks preceding the survey. Very few respondents (ranging between n=1 and n=4) recorded harm, because of their substance use patterns. These respondents were predominantly males.

Five percent of respondents (n=8) indicated that they or someone else were injured as a result of their drinking. Seventy five percent of these respondents were male. Another 6% of respondents indicated that a relative or a friend or a doctor or another health worker had been concerned about their drinking or suggested they cut down in the past year. Fifty six percent of these respondents were male.

Sixty percent of respondents indicated that they smoke cigarettes daily or almost daily. These were predominantly males (67%) and of the 10-14 year old age group (39%). Daily use was not recorded among past year respondents using hard liquor, malt beer, cider or wine.

Very few respondents (between 1 and 2%) reported weekly negative social consequences due to substance use. These included being absent from work or having poor work performance, being absent, suspended, or expelled from school or having poor school performance and having physical fights or arguments with your parents or girl/boy friend about consequences of your substance use. Social consequences flowing from substance use seem to be almost non-existent in both research sites.

Significant numbers of respondents indicated that the non-medical use of painkillers (60%), tranquillisers (22%) and sedatives (18%) is legal. These respondents were mostly females in the 10-14 year old age group.

High proportions of respondents indicated that the non-medical use of painkillers (55%), tranquillisers (13%) and sedatives (16%) should be legalised. These respondents were predominantly female and of the 10-14 year old age group. The substances mentioned above correspond with those indicated in the baseline study, but the number of respondents is much lower than in the baseline. The response rate for painkillers are however higher in the urban area (55%) than in the rural (29%).

## **7. DISCUSSION AND RECOMMENDATIONS**

The data accumulated during the various phases of this post assessment survey has lead to the following findings which are discussed below.

### **7.1 QUALITATIVE DATA**

Substance use patterns differ between male and female respondents. This is also reflected in the findings from the KAP survey among adults and young people. Young people tend to start with substances like cigarettes and alcohol which is easy to access. A new tablet, called shaba, was mentioned in the focus groups, but was not identified in the KAP survey. Young people tend to migrate to heavier drugs as they grow older and become used to cigarettes and alcohol.

### **7.2 SUBSTANCE AVAILABILITY**

Licit substance are easy to obtain in both research sites and in some instances there were indications that marihuana/cannabis is freely available. This is different to the findings of the baseline study.

### **7.3 PSYCHOACTIVE SUBSTANCE USE**

#### **BELA-BELA ADULTS**

According to adult respondents the availability of substances remained the same as during the baseline study. There has been a change in substance use patterns and also in order of priority in the rural site. The substances favoured now are painkillers, cider and wine. This is important for intervention purposes.

It seem that attitudes towards approving people using substances have changed, because a considerable smaller number of respondents (14%) indicated that it was acceptable to have one or two drinks several times a week. In the same time attitudes towards the disapproval of using substances seems to have intensified with higher percentages of respondents indicating disapproval for both "people in general" and the youth.

Indications were made that substances other than alcohol were used at social events.

Statistics on the perception of risk are considerably higher than in the baseline study. There seem to be a heightened awareness about the harm related to psychoactive substance use. In comparison reported negative social and health consequences were higher in the rural than in the urban research site. Perceptions on the non-medical legal status of substances also changed in terms of cannabis and painkillers.

Indications were given of co-habitants of respondents getting drunk at least once a week. This was not recorded before. Six percent of respondents indicated that they had physical fights or arguments with family/relatives or boy/girl friend about consequences of their substance use monthly or less than monthly. This figure is higher than that recorded in the urban research site.

#### **BELA-BELA YOUTH**

It would seem that cannabis has become more freely available since the baseline survey. The percentages for substances that were "probably impossible" to obtain were significantly lower than during the baseline study, e.g. amphetamines (22%), hallucinogens (22%), heroin (21%), cocaine or crack (20%) and mandrax (20%).

The large difference between the number of lifetime and past year/ past month users indicates that substance use take place in the short term rather than on a prolonged basis.

The 15-19 year olds are the age group with highest recorded substance use – based on lifetime, past year and past month use. The use of painkillers increased dramatically in the 10-14 year old age group (23% vs. 51%). No indication was made of past month use of homemade liquor in comparison to the baseline study.



Female respondents predominantly (59%) indicated that the current legal status of the non-medical use of painkillers is legal. The number of respondents who indicated the non-medical use of painkillers should be legal was 29% lower than the corresponding figure in the baseline study (84%).

#### **PRETORIA ADULTS**

The reported substance dependence seemed to be lower than that of the baseline study. Slightly lower percentages of alcohol use at social events were recorded. Psychoactive substances used at social events changed from heroin and amphetamines (baseline) to marijuana and cocaine. The percentage of respondents smoking cigarettes daily is higher in the urban research site than the rural (27% vs. 9%).

In general the perception of risk related to substance use, is higher among urban respondents than rural. This percentage is also higher than the recorded baseline figure. The number of respondents that indicated the non-medical status of painkillers (49%), tranquillisers (16%) and sedatives (11%) should be legal were lower than the corresponding baseline figures.

#### **PRETORIA YOUTH**

The 10-14 year old age group makes up a larger component (48%) of the survey in this post assessment study than in the baseline (40%).

The perception that painkillers are "easily obtainable" is lower by 20% (in comparison to the baseline study). Based on lifetime use it seems that a wider variety of substances are available in the urban research site or access to substances is easier.

During the baseline study, female respondents were the dominant users of cider in the past month. Male respondents have now replaced females as this group.

The age of onset for cider seem to be slightly older since more respondents indicated age of onset as 15-16 years. In the rural site this age was indicated as 13-14 years. In the case of wine the age of onset was later in the urban site - 17-18 years vs. 13-14 years in the rural site.

The daily use of cigarettes seem to prevail in both sites with a higher figure recorded for the urban site (60%). The similar figure for the rural site was 50%.

### **7.4 COMMUNITY MOBILISATION**

There seem to be a number of mediating variables which can inhibit or enhance community mobilisation around substance abuse. These will be discussed briefly.

Inhibiting factors like money and unemployment seem to influence community participation around substance use. A clear message was also sent that there should be no more media education on substances since children have already been exposed to the message.

A number of community activities in Bela-Bela were identified and these ranged from NGOs, faith-based to business involvement. It was more difficult to establish this in the urban site since a larger society was interviewed and no comprehensive idea could be formed about it. It is therefore unfair to assume that the Bela-Bela community is more organised against substance abuse than Pretoria even though it might seem like it.

Despite the Tobacco Control Act which aimed to control tobacco consumption, there still seem to be large proportion of the respondents (between 50-60%) smoking cigarettes daily.

Lack of entertainment in the rural centre seems to influence substance use since the age of onset for popular substances like wine and cider is earlier than in the urban site.

"Positive" findings which should be built on is the increased perceptions of risk, the older age of onset for wine and cider among the youth in the urban site, the increased risk awareness among urban adults.

Young female respondents seem to be less informed than their male counterparts about the legal status of non-medical use of substances.

## **7.5 RECOMMENDATIONS**

Despite that fact that low percentages of respondents indicated daily substance use and even low substance use overall, there are factors surrounding these findings that need to be mentioned. These will be discussed briefly in this section.

The most popular substances among the youth were cigarettes, wine, cider and painkillers. These need to be targeted. Although the rate of use for painkillers is lower than in the baseline study it is still higher than acceptable. This indicates that painkillers are freely available. Stricter enforcement of pharmaceutical dispensing should therefore be promulgated.

There was a call for the strict enforcement of liquor licensing laws – this means that alcohol should not be sold to minors. This might require the more active enforcement of this law by civil servants. Liquor advertising is aimed at males of 18 years and older and these groups should be targeted with information and substance awareness programmes. Care should however be taken about how this information is presented, because there seem to be a media-overload on this issue.

Although the Tobacco Control Act aims to control the consumption of tobacco use, it does not seem to be effective. There should either be people who can enforce this law or alternative measures of control should be sought.

The Bela-Bela community seem to be actively involved in the fight against substance abuse. The involvement comes from all sectors of business and includes faith-based organisations, businesses and NGO's. This community involvement should be built on for sustainable anti-drug programmes.

As with the baseline study, socio-economic factors like lack of income or employment seem to inhibit community involvement. This lack of involvement might be interpreted as indifference. If substance awareness programmes can be linked to the creation of employment opportunities, it will add to community building and therefore promote involvement in such programmes.

Young female respondents seem to be less informed about the status of substances. Even though the number of respondents is significantly lower than during the baseline study, it is still too high and they are therefore potentially more vulnerable. Since they also tend to be the highest users of painkillers they need to be informed accordingly. Together with the dramatic increase in the use of painkillers among the 10-14 year olds (Bela-Bela) this seems to be an area where intervention has failed.

The age of onset for wine and cider seem to be younger in the rural research site and since the lack of entertainment was mentioned as a factor which leads to increased substance use, it should be addressed by the specific local authorities together with NGO's.

## **8. CASE STUDY**

It is important to note that this case study is based on two progress reports received from each of the local interventions in South Africa. The final report from each organisation has not been received to date and this case study and its conclusions might therefore be incomplete in some instances.

In instances where community based interventions take place, changes are usually visible in the acceptance of health-orientated policies and an increased knowledge (WHO 2002 (a): . School-based interventions are very popular and should be conducted under the following circumstances.

- ?? It has to be provided at a developmentally appropriate time and when interventions are most likely to have an impact on behaviour.
- ?? Complimentary general health/life skills produce greater change than skill-based education alone.
- ?? Programmes have to be pre-tested with both learners and educators.

## **8.1 BELA-BELA**

The organisation Youth for Christ (YFC) was involved in one high school in Bela-Bela. Their programme is called Active Youth. After conducting a survey among the learners, they selected Active Youth committee members who plan and implement programmes. These committee members were trained over a weekend on issues like goal settings, priorities, planning, communication, leadership skills and balanced lifestyle. An official launch of the programme was done and community members were invited.

Thereafter Life Skills teams presented substance abuse training at the schools. How many people targeted up to date? An Active Youth coach visits each school weekly to assess progress and provide assistance. A weekly progress report was written after each school visit.

This programme seems to be well received by the youth. They are keen to partake and the first acknowledged Active Youth school was established. The learners seem to be keen to promote the message and have taken initiative on several occasions. They seem to understand the message and have taken responsibility for their own living environment.

The training camp seems to be a huge success as well and it was advocated that the camp should take place more often, because there is a need for such training.

Some of their key success factors are the support of the Department of Education, an interactive training programme presented by peers to their peers and the involvement of key community people like teachers and school principals.

In general the Life Skills programme is widely accepted, but concerns have been raised about the real effect it has on changing learner behaviour and with no impact on psychological variables (WHO 2002 (a): 45).

## **8.2 PRETORIA**

Two organisations were involved in this urban research site, they included University of Pretoria and Youth for Christ. Between the two organisations eight schools were targeted.

The programme of the University of Pretoria (UP) aimed at establishing peer support groups in schools. The peer supporters were supervised and thereafter evaluated via focus group discussions and feedback sessions.

It seems that this programme assisted in the personal growth, development of self-esteem and communication skills of the peer supporters. Teachers were positive about the programme, but not really involved. Learners did not use peer supporters many times. It seems as if the system first

need to build credibility. It also need to be marketed among learners so that they can be reminded to use it.

It seem that this intervention failed at delivering appropriate training material and at providing acceptable infrastructure to the target groups. It was therefore not accepted by learners and not supported by educators.

The UP programme might have been unsuccessful, because it seemed not to have empowered teachers efficiently. It might also be that the programme was developed to cater for a wide cultural variety and might not have been specific enough. Results from the formative research might have been interpreted incorrectly and this might have resulted in designing a programme which was not relevant to the needs of the youth (WHO 2002 (a): 42.).

The second initiative, YFC, was discussed in detail under Bela-Bela. This intervention programme seem to be successful, because it has the support of the Department of Education, an interactive training programme presented by peers to their peers and the involvement of key community people like teachers and school principals.

In conclusion it can be said that substance abuse occur in the communities under study. The extent might have been played down, but ample opportunities still exist for targeted intervention programmes. The intervention programmes conducted had mixed success and it should therefore be executed with greater care in future.

## **9. REFERENCES**

Department of Health. 1998. Clinics and Hospitals database.

Prodder. 2000. Terreblance, Y (ed.). The Southern African Development Directory. Johannesburg: Dictum

World Health Organisation. 2000. Guide to Drug Abuse Epidemiology. Geneva: WHO Publishing.

World Health Organisation. 2002 (a). Prevention of psychoactive substance use: A selected review of what works in the area of prevention. Geneva: WHO Publishing.

World Health Organisation. 2002 (b). SEX-RAR Guide. The Rapid Assessment and Response Guide on Psychoactive Substance Use and Sexual Risk Behaviour. Geneva: WHO Publishing.