



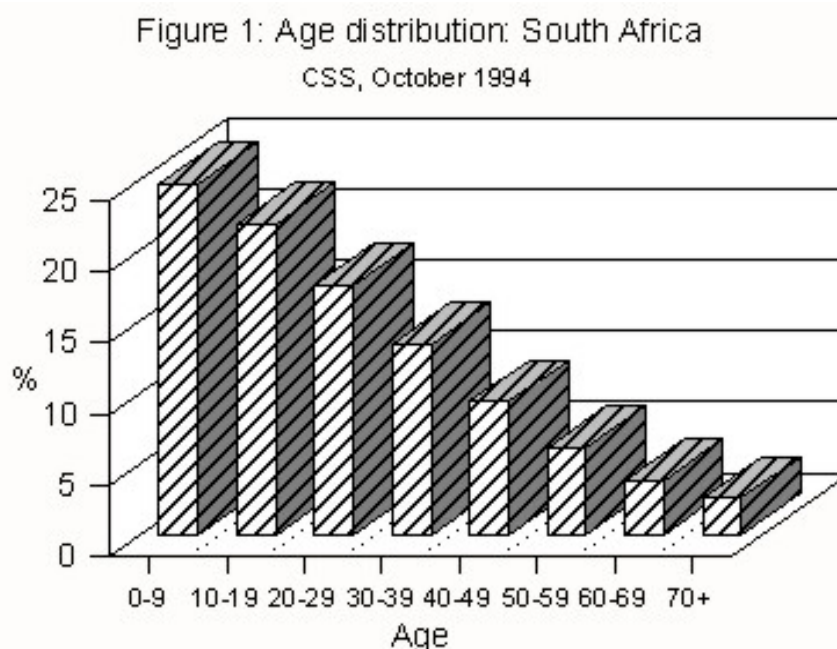
SUBSTANCE ABUSE IN SOUTH AFRICA:  
COUNTRY REPORT  
FOCUSSING ON YOUNG PERSONS

**Prepared for the WHO/UNDCP Regional Consultation - Global Initiative on  
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## 1. INTRODUCTION

South Africa is the southern most country in Africa and has a population of approximately 38 million persons, distributed over nine provinces ranging in population from 746 000 (Northern Cape) to 7 672 000 (KwaZulu-Natal). It is estimated that 55.4% of the population reside in urban areas (Central Statistical Services, 1997). Table 1 gives an indication of the percentage of the population falling in different age bands. There has been considerable controversy in South Africa with regard to what constitutes a young person, with the Youth League of the African National Congress for example, allowing into membership persons up to 35 years of age. Regardless of ones definition of what constitutes a young person it is clear from Figure 1 that at least half the population of South Africa can probably be categorised as young people .



Law enforcement authorities, service providers and substance abuse researchers are in agreement that the nature and extent of illicit drug trafficking, consumption and associated problems have all increased dramatically during the 1990s as the country has gone through a major political and social transformation and as trade and other links have open up with other African countries and the rest of the world. The change with regard to substances such as alcohol and tobacco has been less dramatic, but due to the enormous burden to society caused by the use of these substances, prevention efforts should not only be directed towards illicit substances. This report, in particular, focuses on alcohol and other drugs (AODs), and gives special attention to young persons.

## **2. SUBSTANCE ABUSE AND RELATED HEALTH AND SOCIAL PROBLEMS IN SOUTH AFRICA**

### **2.1 Systems/mechanisms to collect substance abuse information**

Historically South Africa has not had very reliable systems in place to facilitate the collection of data relating to substance use. To date, much of the available information has come from *ad hoc* cross-sectional research studies often conducted in a single location and from information on police arrests and seizures. This has been supplemented by occasional national surveys. Apart from the police arrest and seizure data, which is greatly influenced by factors such as resources available and particular policing policies and initiatives, there has been no longitudinal information available on trends in illicit drug use. With regard to alcohol, the only national trend data available are (i) information on adult, per capita annual absolute alcohol consumption from 1985, (ii) information on the results of annual testing of alcohol levels among drivers and pedestrians from 1975, and (iii) a single study comparing consumption of absolute alcohol among different populations in 1982 and 1985 (Rocha-Silva, 1989).

As stated, the predominant way in which information on AOD use has been collected in South Africa has been via *ad hoc* research undertaken by researchers from one of the science councils (the Medical Research Council (MRC), the Human Sciences Research Council (HSRC) or the Council for Scientific and Industrial Research (CSIR)), or from universities (e.g. Cape Town, Stellenbosch and Durban-Westville) or from NGOs (e.g. the Centre for Alcohol & Drug Studies, the South African National Council on Alcoholism and Drug Dependence (SANCA), the Institute for Health Training and Development (IHTD) and the South African Brain Research Institute (SABRI)). Funding has largely come from the Centre for Science Development, the MRC, the Department of Welfare and individual universities.

Several new systems have been initiated which should lead to more valid and reliable information on AOD use in future. These include:

The South African Community Epidemiology Network on Drug Use (SACENDU)  
SACENDU is a network of persons from a variety of different sectors (e.g. law enforcement, health and welfare treatment services, and public health research) that meets biannually to present and discuss information about existing and emerging AOD abuse patterns and trends. The network, currently comprising over 50 organisations in four sentinel sites, was established by the MRC in collaboration with the University of Durban-Westville in 1996 with the technical assistance of the World Health Organization's Programme on Substance Abuse (WHO/PSA) and the US National Institute on Drug Abuse (NIDA). Start up funds for SACENDU were provided by WHO/the United Nations Development Programme (UNDP) and the MRC. It now comprises three port cities (Cape Town, Durban and Port Elizabeth) and Gauteng Province (which includes Johannesburg and Pretoria). Indicators used in Phase I of the SACENDU Project, together with the type of data (primary or secondary), the data source and frequency of data collection are listed in Table 1.

Data sources have included specialised treatment centres, acute psychiatric admissions units, the police, and mortuaries. Here the focus has been on collecting secondary data. Primary data have also been collected via qualitative research (involving sex workers, persons attending rave parties, street children and pharmacists), school surveys, and trauma unit studies (Parry, Bhana, & Bayley, 1997).

#### The Crime Information Management Centre (CIMC)

This centre was established in 1996 and is tasked with the coordination, processing, analysis and interpretation of crime information and intelligence in order to facilitate the combatting of crime by means of effective and holistic crime information management (CIMC, 1997). On a quarterly basis CIMC releases national, provincial, and district -level statistics by 32 crime categories, including drug related crime and driving under the influence of alcohol or drugs . Unfortunately data are not yet broken down by the age of the offender.

#### The South African Alliance for the Prevention of Substance Abuse (SAAPSA)

SAAPSA was established in 1995 with the assistance of WHO/PSA, the International Council on Alcohol and Addictions (ICAA), and the International Organisation of Good Templars (IOGT) and includes members from over 70 organisations. Its goal is to facilitate networking amongst all organisations, government and civil society, concerned with drug and alcohol abuse in South Africa with the view to optimise cooperation in the prevention and treatment of alcohol and drug abuse in order to improve the quality of life and to promote peace and development for all South Africans (Turner, 1996, p. 7).

#### The South African Researcher-Practitioner Association (SARPA)

SARPA comprises over 50 government departments, private institutions as well as CBOs. Its vision is to sustain an inclusive multi-sectoral forum of researchers and practitioners that facilitates community-driven research based policy formation and service provision regarding drug-related prevention and treatment in South Africa (Drug Advisory Board, 1997, p. 22). The HSRC is one of the driving forces behind SARPA.

#### National Information System for Social Welfare (NISWEL)

For several years now there has been some discussion by the Department of Welfare with regard to the development of a National Information System for Social Welfare which among other things would include national level indicators on substance abuse treatment demand and prevention services. This system is not yet fully operational.

**TABLE 1**  
**SACENDU: Indicators, data sources and frequency of data collection**

INDICATOR	TYPE	SOURCE	FREQUENCY
<b>NATURE AND EXTENT OF AOD USE/ABUSE</b>			
Primary substance of abuse (as well as secondary drugs used, mode of administration, referral source, type of treatment, severity, monthly spending on AODs)	2°ary	All specialist treatment centres	Continuous-6 months
<u>ATOD use</u>	1°ary 1°ary 2°ary	-School surveys (representative sample Grades 8 and 11) -Interviews with drug users (street children, rave party attenders, commercial sex workers) & pharmacists Alcohol testing drivers/pedestrians (from CSIR)	1 X per year 2 X per year 1 X per year
<b>CONSEQUENCES OF AOD USE</b>			
<u>AOD-related deaths</u>	2°ary	Mortuary surveillance: blood alcohol & drug OD mentions (from UCT/U Stellenbosch Forensic Medicine)	Continuous-12 months
AOD arrests/seizures -Drunk driving (collision/no collision) -Dealing in drugs (arrests, units seized, price, purity) -AOD use among arrestees	2°ary 2°ary 1°ary	Crime Information Management Centre Crime Information Management Centre, SANAB MRC/SANCA/Institute for Security Studies: using blood/urine analyses	Continuous-6 months Continuous-6 months TBA
<u>AOD-related trauma mentions</u>	1°ary	Study of patients 1 public hospital - 2 idealized weeks over 2 months: breath (alcohol), urine/sweat (drugs)	1 X per yr
<u>AOD-related psychiatric conditions</u>	2°ary	Review intake/discharge information from public psychiatric facilities (alcohol/drug-related diagnoses as proportion of other diagnoses)	Continuous-6 mo.

Continuous -- 12 mo. means the data is collected continuously, but only reported once every 12 months

1°ary = primary; 2°ary = secondary

## 2.2 Nature and extent of substance use in South Africa

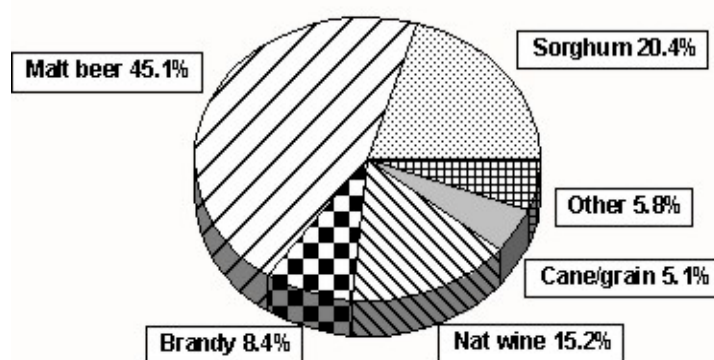
### 2.2.1 Overview

#### 2.2.1.1 Range of substance used

AODs used and abused in South Africa can be roughly divided into three categories, those which are extensively used, those which are moderately used, and those which are less frequently used. In the first category, alcohol remains the most commonly abused drug in South Africa, followed by dagga (cannabis) and the dagga/Mandrax (white pipe) combination. Mandrax (Methaqualone) is sometimes also used on its own. There is also considerable abuse of over-the-counter and prescription medicines (e.g. pain relievers, tranquillizers (including benzodiazepines), cough mixtures (containing codeine), and slimming tablets), as well as solvents (especially glue)). In the second category one finds drugs such as crack cocaine, cocaine (powder), heroin, Speed, LSD, hashish and Ecstasy (MDMA). Crack cocaine may well need to be placed in the first category in the near future. In the latter category are drugs such as opium, Rohypnol (Flunitrazepam), Ketamine, and Wellconal. Many substance users in South Africa are poly-substance users (e.g. using various drugs in combination with alcohol as well as other combinations, such as cocaine and heroin). In terms of pharmacological properties, the substances most abused in South Africa are depressants (e.g. alcohol, white pipes, Mandrax, benzodiazepines) followed by hallucinogens (dagga, LSD, Speed and Ecstasy).

South Africans consume well over 5 billion litres of alcoholic beverage per year. The figure could be nearer to 6 billion litres, depending on one's estimate of the amount of sorghum beer consumed. Roughly two-thirds of the absolute alcohol consumed in South Africa is malt or sorghum beer. In terms of alcoholic beverage this translates to roughly 4.2 billion litres or roughly 90% of the alcoholic beverage consumed. Roughly 15% of the absolute alcohol consumed is wine. See Figure 2.

**Figure 2: Market for alcoholic beverages  
1996, based on AA (KVV, 1997)**

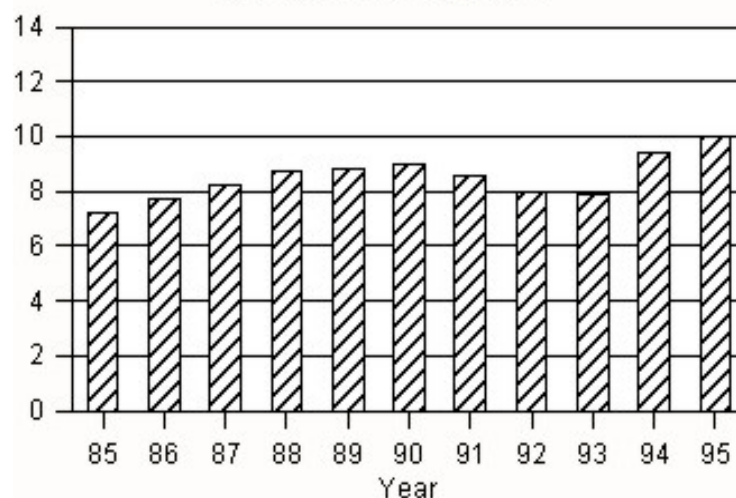


### 2.2.1.2 **Prevalence of AOD use**

The overall prevalence of alcohol misuse is likely to be as much as 30% among certain groups and as low as about 5% in others, and is dependent on factors such as age, gender, socio-economic status and degree of urbanisation. Binge drinking among young people, especially males is high (in excess of 25% in many communities). High levels of alcohol misuse have been reported among persons involved in certain occupations (e.g. farming and mining) and among residents of disadvantaged communities where there is easy access to alcohol (Parry & Bennetts, in press). Adult per capita consumption of absolute alcohol in South Africa is between 9 and 10 litres per year which places the country among the higher alcohol consuming nations. Since 1993 the level of per capita adult absolute alcohol consumption appears to be rising, after a decrease in 1990 and 1991 (see Figure 3).

**Figure 3: Per capita adult AA cons.**

**Source: D. of Welfare**



Accurate national statistics on the prevalence of the use of illicit drugs and on the inappropriate use of over-the-counter or prescription medicines ( lifetime use, use in last 12 months , and use in last 30 days ) are currently not available. Use of illicit drugs in the last 30 days may well be as high as 20% in certain communities, particularly considering rates of dagga and dagga/Mandrax use. There is clearly a need for regular household surveys to be conducted to assess illicit drug use, preferably at a national level or else in selected sentinel surveillance sites. A national household health survey will be held in early 1988, but it only asks about alcohol and tobacco use.

### 2.2.1.3 **Frequency of use**

Weekend drinking is particularly prevalent. Table 2 provides an indication of the proportion of *current users* who use various substances at least once a week :

**Table 2: Percentage of current users who reported consumption of various substances of at least once a week : Africans** (Rocha-Silva et al., 1996)

		Malt beer	Sorghu m beer	Wine	Distilled spirits	Dagga
Metros*	Male	79	77	60	51	13
	Female	71	46	38	43	-
Towns*	Male	87	69	44	54	75
	Female	75	-	50	56	-
Squatters *	Male	85	70	72	66	17
	Female	74	-	56	52	-
Urban**	Male	44	9***	33	46	67
	Female	35	5***	23	50	-
Rural**	Male	69	35***	45	49	-
	Female	43	18***	29	-	-

\* - Persons 14+, \*\* - young persons 10-21 years old, \*\*\* - home made liquor (not just beer)

### 2.2.1.4 **Mode of ingestion**

Excluding alcohol and prescription and over-the-counter medicines, the most common means of ingestion of drugs in South Africa is smoking (sometimes referred to as *batting* ). Rates of drug injection are low at present. Drugs such as Speed are being snorted ( *snarfig* ) and swallowed.

### 2.2.1.5 **Characteristics of substance users**

In terms of AOD use patterns, difference have been noted with regard to age, social class, occupation, school-status, gender and geographic location. This is demonstrated, for example, by the following information/research findings:

**AGE:** Treatment demand statistics suggest that use of drugs such as Ecstasy, LSD and Speed are more common among younger persons than among older persons. Solvent use is also higher among young persons. Patients in specialised treatment centres whose primary substance of abuse is alcohol tend to be older than those whose primary substance of abuse is the dagga/Mandrax ( *white pipe* ) combination who in tum tend to be older than persons whose primary substance of abuse is dagga on its own. (Parry et al., 1997). Among school going youth alcohol use appears to increase with age for both males and females (Flisher, Ziervogel, Chalton & Robertson, 1993a).



**Gender:** AOD use is more prevalent among males than females (Parry et al., 1997, Tibbs, 1996). Gender differences, however, appear to be less marked for drugs such as heroin and cocaine (Parry et al., 1997).

**Socio-economic status:** Use of drugs such as dagga/Mandrax and solvents (e.g. glue) are more common among persons from less advantaged communities, whereas use of drugs such as cocaine and Ecstasy is more prevalent among persons from middle- and upper-class communities. Drugs such as Ecstasy and LSD, and to some extent Speed and hashish, are used at rave parties (Parry et al., 1997).

**Occupation :** Drugs such as alcohol, dagga, crack and Mandrax are frequently used by sex workers (Parry et al., 1997). High levels of alcohol use and misuse have been reported among workers in the mine industry and among workers in the fruit and wine farming industries. Higher levels of binge drinking have been reported among high school drop-outs than among students of similar age who are still attending school (Fisher & Chalton, 1995).

**Geographic location:** The highest use of the white pipe combination occurs in the Western Cape. Crack cocaine and heroin use are likely to be used more frequently in urban as compared to rural areas. In comparison to Cape Town and Port Elizabeth, the most frequent cases of Rohypnol use and use of cocaine/heroin in combination have been reported by persons attending treatment centres in Durban (Parry et al., 1997). With regard to alcohol, research among Africans 14 years and older has found greater levels of risky drinking among residents of squatter settlements, metropolitan areas and towns than among the more rural populations in the previously designated homelands (Rocha-Silva 1991a/b). Conversely, research among African young persons aged 10-21 years reported the highest levels of risky drinking among rural as compared to urban populations.

Various studies (e.g. Rocha-Silva, 1989; Rocha-Silva et al., 1996) suggest that clear differences exist between different age, gender and race groupings with regard to the types of alcoholic beverages consumed and to the proportions of current drinkers (Table 3). The proportion of current drinkers is indicated in brackets for each group. Clearly the proportion of current drinkers (and conversely abstainers and past drinkers) differs among the various groups.

**Table 3: Types of beverage consumed and proportion of current drinkers (by race, gender, age)**

	Male	Female
Africans, aged 10-21	Beer (m), spirits, wine, cider, beer (s) [39%-40%]	Wine, beer (m/s), cider [23%-32%]
Africans, aged 14+	Beer (m/s), spirits [77%-80%]	Wine, beer (m/s) [49%-66%]
Coloureds, aged 14+	Wine & beer (m), spirits [59%]	Wine, beer (m) [27%]
Asians, aged 14+	Beer (m) [49%]	[8%]
Whites, aged 14+	Beer (m), wine, spirits [89%]	Wine, beer (m), spirits [77%]
Africans, aged 10-21 (urban)	Beer (m), spirits, wine, cider, home-made liquor [40%]	Beer (m), wine, cider, home-made liquor, spirits [32%]
Africans, aged 10-21 (rural)	Beer (m), spirits, wine, cider, home-made liquor [39%]	Wine, cider, Beer (m), home-made liquor, spirits [23%]

(m) malt, (s) sorghum

#### 2.2.1.6 **Major influences on substance use**

Various factors have been put forward as contributing to substance use and abuse. For alcohol factors are likely to include peer pressure (particularly among young persons) and communal drinking among adults; availability, particularly in more disadvantaged communities; the legacy of the dop system, particularly in the Western Cape; ignorance; the falling price of certain kinds of alcohol products (e.g. malt beer and brandy) relative to the Consumer Price Index; chemical dependence on alcohol; poor social conditions and boredom; a lack of social controls to deal with those misusing substances; and societal attitudes in general (Parry & Bennetts, in press; Rocha-Silva et al., 1996). With regard to availability/access, for example, there are currently almost 23 000 licensed liquor outlets with an estimated 150 000 to 200 000 unlicensed outlets, yielding approximately one liquor outlet for every 190 persons in South Africa (Parry & Bennetts, in press). Research has shown that school-going youth find it easy to purchase alcohol from bottle stores, supermarkets, bars and shebeens (Tibbs & Parry, 1994).

Local research has shown that the most common reasons reported for drug use include habit, to alter mood states, to improve health, to cope with personal, social or interpersonal situations, or for enjoyment/taste (Rocha-Silva et al., 1996). Additional factors supporting the increase in illicit drug use in South Africa are likely to include the falling real price of many drugs; poverty which is likely to have increased the street level trade in drugs; family breakdown and an increase in single

parent households; increased availability as a result of increased trafficking of drugs such as cocaine and heroin through South Africa which in turn may be due to factors such as the decrease in local controls following the collapse of Apartheid, increased travel to South Africa as a result of increasing tourism and trade links, and increased economic and political migration to South Africa -- together with changes in global production, distribution and marketing of drugs in general. The increased use of particular drugs such as crack cocaine, may well be due to increased marketing of cocaine due to a decrease in the US market as well as a (perhaps related) decrease in the quality of local Mandrax. The increase in the use of amphetamine type substances is probably due to the increase in the global production of these substances and increased local marketing.

## 2.2.2 Reference to specific studies focussing on young persons

Several studies undertaken since 1990 have focussed specifically on substance use behaviour among young persons. Given the focus of the Global Initiative, selected findings from these research studies will be provided

### **2.2.2.1 Research on AODs use by street children and persons attending rave parties conducted as part of the SACENDU Project (1996-7)**

As part of the SACENDU Project regular interviews with various groups of young persons have taken place. Such groups have included street children and persons attending rave parties. Focus group interviews with male and female street children in Cape Town at the end of 1996/early 1997 indicated that the main drug of choice for street children appears to be paint thinners, followed by alcohol and cigarettes (Morojele, 1997a).

Research on persons attending rave parties in Cape Town was conducted at the beginning of 1997 and approximately six months later. The research showed that the drugs that continue to be used at raves are Ecstasy and LSD, dagga/hashish to a lesser extent and also Speed, although its use has been on the decrease due to a reduction in its availability. Drugs such as Mandrax and crack cocaine are not used at raves since their effects are largely incompatible with taking part in an environment of high activity dance and high energy music. Among the numerous perceived positive consequences of the use of drugs during such dance events are the drug effects of sociability and connectedness that are brought about through Ecstasy use and the altered consciousness and distorted and greater appreciation of sensations that result from the use of LSD. The major changes noted over the two six month data collection periods were (i) the decrease in the use of Speed and the change in methods of its use by snorting (rather than being swallowed), (ii) a significant decrease in the price of heroin, and (iii) an increase in the variation in the quality of Ecstasy (Morojele, 1997b).

#### **2.2.2.2 Research on binge drinking among adolescents conducted by UCT/MRC (1996-7)**

Since 1995 several studies have been conducted by researchers at the Department of Psychiatry at the University of Cape Town and at the National Urbanisation & Health Research Programme at the MRC. These have included a quantitative study of drinking behaviour of 497 male and female students in Standard 8 (Grade 10) in three high schools from different communities in the Cape Peninsula and a qualitative study involving a group of male binge drinkers and a group of male non-binge drinkers from each of the same three high schools.

In each of the studies the Theory of Planned Behaviour (Ajzen 1991) was used to predict/explain adolescents' behaviour to engage or not to engage in binge drinking behaviour. According to the Theory of Planned Behaviour, the most direct antecedent of a person's behaviour is his or her intention to carry it out. The direct antecedents of the intention to perform a behaviour are attitudes towards the behaviour, subjective norms and perceived behavioural control. Two additional constructs, moral obligation and self-identity were added as antecedents of intention.

In the first study (Morojele, Ziervogel, Parry & Robertson, 1997) found that 39% of males and 18% of females in the school in the middle class, predominately white community (School 1) engaged in binge drinking at least once during the past 14 days as compared to 26% of males and 25% of females in the middle class, predominately Coloured community (School 2), and 36% of males and 4% of females in the lower class, predominately African community (School 3). In all three of the schools attitudes towards binge drinking and perceptions of control around binge drinking were found to be significant and independent predictors of binge drinking intentions. In School 3 motivations to binge drink were also found to be significantly related to students' subjective norms in relation to their behaviour. Self identity was found to be a useful predictor of binge drinking intentions for students in School 3 and for males in general, and moral obligation was a significant negative predictor of females' intentions to engage in binge drinking.

In the second study (Ziervogel, Morojele, Van der Riet, Parry & Robertson, 1997) focus group sessions were held with groups of binge drinkers and non-binge drinkers from each of the three schools referred to earlier. Focus group discussions centred around the concepts of the Theory of Planned Behaviour and the two additional concepts, moral obligation and self-identity. Binge drinkers appeared to focus on the positive outcomes of binge drinking, and while aware of some of the negative outcomes of such behaviour they had little awareness of their own vulnerability. They tended to be more inclined to short-term gratification than the non-binge drinkers and were embedded in a peer group culture which provided normative approval for binge drinking (attitude). They had limited motivation to comply with parental wishes (subjective norms). They had few obstacles to obtaining alcohol (perceived behavioural control) and did not have serious moral objections to binge drinking (moral obligation). For students in the binge drinking group engaging in frequent consumption of alcohol was found to be an important part of their self-identities (self-identity). For the non-binge drinking group, the negative consequences of engaging in binge drinking appeared to outweigh the

positives. They seemed to be more oriented towards achieving longer-term objectives than the other group and many had had bad first experiences with alcohol (attitude). They appeared to be far more motivated to comply with parental wishes (subjective norm) and were more likely to report difficulties in obtaining alcohol (perceived behavioural control). Most felt that it was wrong for persons of their age to binge drink (moral obligation). For these students alcohol and social activities associated with alcohol were found to be much less important to their self-identities (self-identity).

Based on these findings recommendations were made with regard to possible strategies to reduce binge drinking among young persons. For example it was proposed that:

Interventions should be designed for the particular communities they are meant to reach, that is, generic programmes may not be effective.

Life skills programmes should be designed to address the attitudes of young persons towards binge drinking, specifically attempting to modify adolescents perceptions regarding the positive consequences of binge drinking and to introduce less risky alternative activities which are also likely to lead to positive outcomes.

Strategies need to be formulated to reduce the perceived behavioural control binge drinkers experience, for example, strategies are needed to reduce the availability of alcohol.

Life skills programmes should also take into account the influence of normative factors and self-identity on the intentions of males to engage in binge drinking. This might best be achieved through programmes involving values clarification or training in resistance-skills (refusing pressure to drink or to drink heavily). Young persons also need to be encouraged to have an appreciation of the need to plan ahead and to be equipped with the skills to do so. Peer-led programmes may be an effective mechanism for influencing adolescent norms and self-identity.

#### **2.2.2.3 Research on AOD use among students at one high school in Port Elizabeth conducted by SANCA (PE) (1997)**

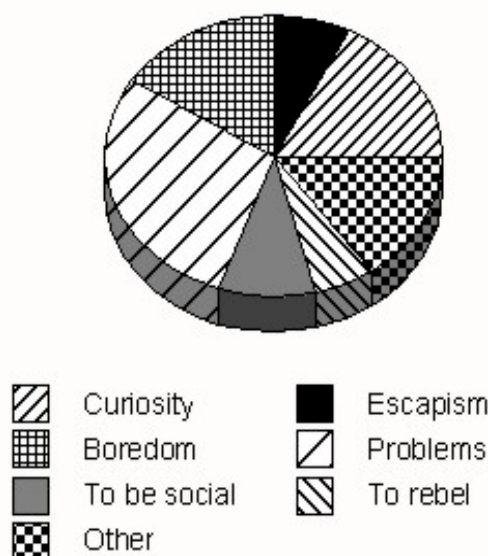
In February 1997 a survey of 328 students in Standards 9 and 10 (Grades 11 and 12) at a high school in the northern areas of Port Elizabeth was undertaken. The school population comprised mainly coloured students as well as a number of African students. The lifetime prevalence of binge drinking (5 or more drinks on any occasion) was high: 45% of males and 40% of females in Standard 9, and 59% of males and 38% of females in Standard Grade 10 (Bayley, 1997). The lifetime prevalence and percentage of current use of dagga and Mandrax is indicated in Table 4. Dagga is predominately used on special occasions, but seven students reported daily use of dagga and a further 6 reported using dagga two to three times per week (out of 27 current users).

**Table 4: Lifetime prevalence and percentage of current use of dagga and Mandrax (School in northern areas of Port Elizabeth, 1997)**

Drug	Standard	Gender	Life time prevalence (%)	% reporting current use
Dagga	10	Male	52	29
		Female	14	3
	9	Male	34	3
		Female	13	4
Mandrax	10	Male	10	8
		Female	0	0
	9	Male	5	4
		Female	2	2

#### 2.2.2.4 Research on AOD use among high school students in Gauteng and in the Cape Peninsula conducted by the Independent Order of True Templars (IOTT) (1996)

In 1996 a study of AOD use was undertaken in 4 schools in the Western Cape and 5 schools in Gauteng Province (Tibbs, 1996). The sample comprised 420 students in Standard 6 (Grade 8). Students were predominantly African or coloured. Twenty-four percent of the students reported having drunk alcohol in the past 7 days, with 21% of the students indicating that they had drunk 5 or more alcoholic drinks on at least one occasion during the past 14 days. Various reasons were given for why alcohol was first used (Figure 4).

**Figure 4: Reasons for first drinking alcohol**

The lifetime prevalence of various drugs was as follows: dagga (10%; 17% - males, 3% females), glue/thinners (4%), injectable drugs (3%), and other drugs excluding tobacco (7%). A large proportion of students indicated that regular use of different substances leads to no harm: dagga (26%), LSD (25%) and binge drinking (31%). A high percentage of the students reported having family members with drinking or drug problems (42%). Forty-five percent of the students reported coming from families that seldom did things together and the same percentage reported that their parents were mostly unaware of where they were or what they were doing. When asked who had first introduced them to alcohol, 58% reported their friends followed by their siblings (25%) and parents (19%). When it came to dagga, parents were ranked first, ahead of friends. Over half (58%) believed that prevention and education programmes about drugs were important for everyone in the community (Tibbs, 1996).

#### **2.2.2.5 Research on AOD use among black youth ages 10-21 years conducted by the HSRC (1994)**

In a survey of 1378 African young persons aged 10-21 from urban and rural areas in South Africa, Rocha-Silva et al. (1996) found that 11.3% of urban males and 19.6% of rural males consumed on average 10cl of absolute alcohol on average per day (equivalent to almost five 340ml beers). The corresponding percentages for females were 6.1% in urban areas and 7.7% in rural areas (see also Tables 2 and 3 above).

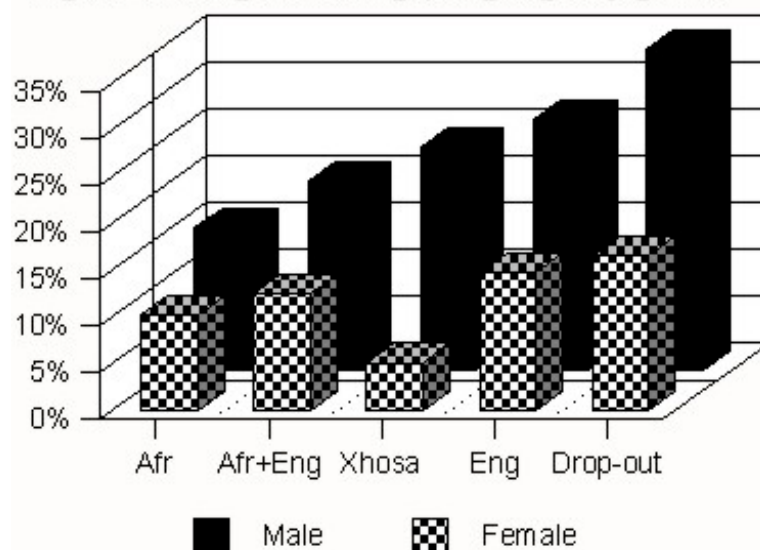
Besides dagga use by urban males (5.5%), very little current use of illicit drugs was reported by males or females in either the urban or rural samples. Within the combined sample, self-reported lifetime use of various substances was as follows: LSD (1.9%), Mandrax (1.7%), cocaine (0.9%), heroin (0.9%), Ecstasy (0.1%), non-prescriptive narcotics other than heroin (2.1%), and steroids (2.0%). Self-reported use of these substances in the last 12 months was as follows: LSD (1.5%), Mandrax (1.7%), cocaine (0.8%), heroin (0.9%), non-prescriptive narcotics other than heroin (2.1%), and steroids (2.9%).

Over half of the urban males started using dagga between 14 and 17 years of age. For young persons in urban and rural areas, both males and females, the use of solvents generally started between the ages of 10 and 13. These substances were generally first obtained through friends. The most common context within which alcohol is consumed for urban and rural males was at a shebeen, tavern or home where they have to pay for their drink. For urban females it was at the home of friends where they either bring their own drink or get it for free. For rural females it was at home/the place where they live.

### 2.2.2.6 **Research on adolescent risk behaviour based on surveys of high school youth and high school drop-outs in the Cape Peninsula conducted by UCT/MRC (1990-91)**

Flisher, Ziervogel, Chalton, Leger & Robertson (1993a/b) reported on a 1990 survey of AOD use in a sample of 7340 high school students in 16 schools in the Cape Peninsula. The sample comprised students from all race groups in the area. Findings were reported by descriptive variables such as language, gender and standard. They later reported on a similar survey of 68 coloured high school drop-outs (Flisher & Chalton, 1995). The proportions indicating that they had engaged in binge drinking (five or more drinks on at least one occasion during the past 14 days) are shown in Figure 5.

**Figure 5: Binge drinking (language by gender)**



Levels of binge drinking are clearly higher in the drop-out sample than in the school going sample (but this could be due to the drop-out sample being older). Amongst the school-going sample binge drinking was higher in males than females. It was particularly high in English and Xhosa-speaking males and particularly low in the Xhosa-speaking females. In general the prevalence of binge drinking appeared to increase with standard (age).

Among the school-going sample the lifetime prevalence of dagga use was 7.5%, and 2.4% reported using dagga at least once in the past 7 days. More males than females for each standard and language group had smoked dagga and there was a trend of increased lifetime use with standard. The proportion of Xhosa-speaking females who had used dagga was particularly small. More males than females reported recent use for each standard and language group. For both genders the variation between standards was not marked. A relatively large proportion (10%) of Xhosa-speaking males reported recent dagga use. Of Xhosa-speaking males, 2.3% reported using dagga and Mandrax together.



Reported lifetime use of injectable drugs was 0.5%, and 0.2% had used them at least once in the past 7 days. Reported use of drugs such as cocaine, heroin, LSD and opium was rare. Lifetime use (sniffing) of solvents such as glue, petrol or thinners was 10.9%. Less than 3% of the sample reported sniffing solvents at least once in the past 7 days.

Data (collected in 1997) from two further studies are currently being analysed and findings should be available by the middle of 1998. Both have been conducted by researchers from UCT and the MRC. The one involves a study of ATOD use in approximately 3000 high school students in Standards 6 and 9 (Grades 8 and 11) in Cape Town and the other is an 18 month follow up of drinking behaviour among 400+ students in three schools in Cape Town comprising students from widely differing backgrounds.

### 2.3 Health and social problems arising from AOD use by young persons in South Africa

Research in the area of AOD use and young people in South Africa has tended to focus on issues such as the assessment of the nature and extent of substance use, risk factors associated with substance use, and reasons for substance use/abuse. There has been very little research into social and health consequences associated with AOD use by young people in this country (Parry, 1997). Data from the SACENDU Project (Parry & Bhana, 1997), however, support the view that young persons in South Africa and the country are burdened as a result of the use of AODs by young persons. For example:

26% of persons arrested by the South African Narcotics Bureau (SANAB) for dealing in illicit substances in Cape Town the second half of 1996 were juveniles, up from 8% in the previous six months.

Analysis of statistics provided by specialist treatment centres in Cape Town in the second half of 1996 and in the first half of 1997 reveals that approximately 6% of all admissions are for persons under 20 years of age.

Investigations of AOD use among cases seen at trauma units and the mortuaries are likely to support the view that the use of these products can have serious and even fatal consequences for young persons and place a heavy burden economically and in other ways upon society. One topic which has been very little studied in South Africa is the effect of substance use on school performance. Yamada, Kendix & Yamada (1996) in a study using data from the US National Longitudinal Survey of Youth found that increases in the incidence of frequent drinking, liquor and wine consumption, and frequent cannabis (dagga) use significantly reduce the probability of high school graduation.

### **3. CURRENT PREVENTION WORK IN SOUTH AFRICA WITH YOUNG PEOPLE**

There are a range of initiatives directed towards preventing substance abuse among young persons in South Africa. I presume this section will be covered at length by the delegates from the South African (national) Departments of Health and Welfare and from the National Office of SANCA. The ones that I am particularly familiar with are listed below (by the agencies most responsible for their design and implementation):

#### **3.1 Department of Welfare**

The national and provincial Department of Welfare embarked upon a national school-based education initiative, *I m addicted to life* . It was launched in May 1995 and was aimed at teenagers between the ages of 11 and 20. The television series involved 13x9 minute episodes and 13x2 minute endorsements which were flighted in the afternoons and evenings. 13x3 minute radio spots in 11 languages were also produced. In addition, 13x30 second personality endorsements were produced and flighted. Anti-drug posters were produced and distributed to every school in the country and an anti-drug pledge campaign initiated. Information leaflets were also produced and distributed to the schools. The campaign has also been expanded to include a video and teacher s manual.

An independent evaluation of the campaign was undertaken by market research company. Ninety-six percent of the 265 young persons interviewed from around the country had heard of the campaign, with the percentage being highest among respondents in Standard 10 (Grade 12) and students in tertiary education (100%), and lowest among respondents in Standards 6 and 7 (93%). Respondents were asked whether they felt that the campaign was a good idea and whether it would influence young people not to take drugs. According to the evaluation report there was complete consensus that the campaign is a good idea. On reflection it is clear that this was a very soft evaluation. A more rigorous evaluation would require a pre- and post-intervention evaluation of changes in knowledge, attitudes, intentions and preferably behaviour.

#### **3.2 The Department of Education**

The national Department of Education is currently involved in implementing its "Curriculum 2005" initiative, which amongst other things is supposed to include a life skills education component which will also seek to prevent substance use/abuse. The International Center for Alcohol Policies (ICAP), based in Washington is also working with the provincial Department of Education in Northwest Province (and in Botswana) to design a life skills education programme aimed at primary school age children. The project specifically involves (i) developing life skills materials for use in five schools, (ii) training teachers in the use of these materials, and (iii) testing these materials in the teacher s classroom for one academic year.

### 3.3 Soul City 3

*Soul City* is a multi-media health education/counter-advertising initiative seeking to address a range of risk behaviours including alcohol and smoking through a very popular prime-time sitcom aired on TV as well as on radio (in the vernacular), and via the print media (a handbook serialised in newspapers). The series on alcohol included 14 prime time TV episodes run over three months. Focus groups involving young persons and adults (separately) were run as part of the pre-testing of material to be used in *Soul City 3*. It is currently being evaluated by CASE (Community Agency for Social Enquiry).

As a result of the evaluation of the second series of *Soul City* on tobacco, AIDS, TB and housing, it was noted that:

the TV series was rated 2<sup>nd</sup> among the total adult population

51% of Africans watched it regularly

61% of persons sampled saw/read or listened to *Soul City*

70% of 16-24 years olds sampled saw/read or listened to *Soul City*

51% of persons with no formal education sampled saw/read or listened to *Soul City*.

### 3.4 Industry Association for Responsible Alcohol (ARA)

ARA has been involved in running the *Buddy Campaign* for almost a decade on university and technikon campuses. The objective is to focus the minds of youth on the dangers of alcohol misuse and abuse. ARA members have also supported life skills education programmes around the country. These programmes reach some 1 000 schools. The *Buddy Campaign* was evaluated by the HSRC in 1993 and it was noted that there was an increase in the awareness of the dangers of alcohol misuse among young persons as a result of the programme.

### 3.5 SANCA s TADA and POPPETS initiatives

The POPPETS (Programmes of Primary Prevention through Stories) programme is aimed at the pre-primary and early primary school child (primarily 5-9 years old). Puppets, stories and games are used to educate the child. Information on alcohol and drugs is provided as well as skills training to address issues such as self-image and peer pressure. The TADA (Teenagers Against Drug Abuse) programme involves the setting up of youth action groups in high schools or youth groups (after hours). It aims to prevent substance abuse among peers and promotes exciting alternatives. SANCA acts as the facilitator providing groups with training and support. Young persons are encouraged to take an increasingly greater responsibility for running the TADA groups. These programmes are thought to be very successful, but have not been formally evaluated as far as I am aware.

### 3.6 CTDCC Schools Drug Education and Prevention Programme

A new and potentially very exciting initiative has been started in Cape Town and should involve approximately 50 schools. The programme is being implemented by the Cape Town Drug Counselling Centre (CTDCC) with funding from USAID, the Royal Netherlands Embassy, and the Transitional

National Development Trust (TNDT). The key components of this programme comprise:

- Initial briefing sessions to all teaching and guidance staff in each school
- Drug education and prevention workshops delivered to school students
- A six week course for guidance teachers at CTDCC
- An educational video on drug prevention to be provided to each school
- A teacher's manual, information leaflets and posters to be provided for each school.

The primary strengths of this initiative are:

- The six month involvement with each school
- The comprehensive training of one guidance teacher from each school at CTDCC
- The development of rapid referral arrangements from schools for drug dependant pupils
- The provision of library resources to each school, i.e. life skills videos, teachers manuals, and reference literature.

### 3.7 Lions International (*Lions Quest Skills for Adolescents Programme*)

This project runs in various parts of the country. In the Western Cape Province alone this programme is currently running in over 45 schools. The *Lions Quest Skills for Adolescents Programme* is designed to combat alcohol and drug abuse among young persons by teaching them social life skills. The focus of the programme is not on the substance abuse problem alone but rather on the proposed causes of the problem; issues such as poor self image, inability to resist peer pressure, poor family relationships, lack of decision making skills and poor communication ability. The main objective is therefore to teach adolescent youth pro-social life skills thereby giving them the opportunity to be who and what they themselves want to be.

Evaluation was undertaken to see whether the programme was suitable for the South African situation (Crous, Lessing, Schultze, & Sonnekus, 1993). The design used was a pre-test/post-test control group design. Six private schools took part in the study. One class from each school formed an experimental group (N=171) and a second class formed a control group (N=176). The 120-item social attributes questionnaire was administered both pre- and post-test. This questionnaire was developed to assess six life skills: self confidence, coping with emotions, resisting peer pressure, improving family relationships, decision making skills and goal setting. In addition, the interpersonal relationship questionnaire was also developed. The results showed that the average score on the social attitudes questionnaire was significantly higher at post-test for the experimental than the control group. For the interpersonal relationship questionnaire, contrary to expectations, the results of the post-test showed that the control group showed more improvement than the experimental group.

### 3.8 Other education initiatives

Many other school-based and after-school initiatives have been established by various governmental organisations and NGOs. Many involve one-off lectures. Some include evaluation forms which are filled in the students, and which assess the quality of the programme in terms of whether the students found the input useful. A number of programmes are listed below by the agency providing the programmes in the schools:

1. **Bridges** - a school-based programme in the Western Cape run by recovering addicts.
2. **Young Caring Community** - aimed at pre-primary, primary, secondary school going students and church-going youth. It is based in the Western Cape. Information is provided through talks, video presentations and workshops/presentations. Youth clubs are also being launched.
3. **South African Police Services (SAPS)** members give talks in schools (national).
4. **Narcotics Anonymous (NA)** runs peer education programmes in various schools nationally. The *Drug Free Marshals Programme* is sponsored by the Church of Scientology. Marshals are drawn from the ranks of primary and high schools. They are expected to follow a drug-free lifestyle, which involves showing their friends how much more fun a drug-free lifestyle can be. They are also charged with learning more about drugs, their harmful effects, and how to get information across in an exciting format. More than 30 schools across South Africa have signed up marshals.
5. **DrugWise Counsellors** gives talks in the schools and prepares educational materials (national)
6. **Horizon Programme** -- This programme is run as a Christian ministry. It has 215 branches and approximately 6 200 members.
7. **Alcohol Drug Concerns (ADC).**
8. **International Order of True Templars (IOTT).**
9. **Youth for Christ** (national).

### 3.9 Programmes for street-children

There are various programmes for street children designed to address many problems facing this population including substance abuse, e.g. StreetWise in Johannesburg and the Homestead Programme in Cape Town.

### 3.10 Other

Alcohol Safety Schools have been established in various parts of the country. Talks and video presentations are given to individuals who have been referred by the courts. There are no doubt several other innovative substance abuse prevention programmes in individual communities of which I am not fully aware (e.g. in Shoshanguve and in Mangaung).

Major gaps exist with regard to a comprehensive approach to the prevention of alcohol misuse, for example, programmes directed towards high-school dropouts, and persons living in rural areas.

There are several NGOs which I believe could be invited to become local partners in the Global Initiative:

1. National Progressive Primary Health Care Network (NPPHCN)
2. SANCA (Regional affiliates directly or through National Office)
3. Soul City
4. StreetWise
5. Cape Town Drug Counselling Centre

I am sure that the other colleagues from South Africa will be able to identify CBOs which are doing innovative work in the substance abuse area which could be proposed as suitable partners in the WHO/UNDCP initiative.

#### **4. SUPPORT FOR GLOBAL INITIATIVE ACTIVITIES**

##### **4.1 Regional, national and local bodies which incorporate primary prevention approaches related to young people and substance use issues**

There are several regional, national and local bodies which incorporate primary prevention approaches related to young people and substance use issues (see §3 above).

##### **4.2 Country/regional resources to support youth related primary prevention initiatives**

It is possible that youth related substance abuse primary prevention initiatives could get support from some of the following organisations:

- National and provincial welfare departments
- SANCA Information and Resource Centre (SIRC) based in Johannesburg
- Substance abuse (or Alcohol and Drug Abuse) Prevention Forums in most of the provinces
- DrugWise Pharmacists (national office in Norwood)
- Research Councils (e.g. HSRC, MRC, CSIR)

#### 4.2.1 Grant programmes

**National Youth Commission** may have funding for youth development initiatives

**Reconstruction & Development Programme** -- may have funding for broad development initiatives

**Transitional National Development Trust (TNDT)** - has funding for NGO and NGO projects

**WHO/UNDP Global Initiative for the Prevention of Substance Abuse in South Africa** -- funding was provided for 8 projects (5 of which were primary prevention projects) in 1996/7. Some of the unspent funds from this project may still be available for further prevention projects.

From time to time **other governments** make funds available which could possibly be tapped in to for substance abuse prevention. USAID and the Royal Netherlands Embassy have, for example, provided funding for CTDCC starting 1998 for schools-based substance abuse prevention.

Other international Funding Programmes could perhaps be tapped in to e.g. **EU, UNDP, UNDCP, UNAIDS**.

#### 4.2.2 Materials dealing with primary prevention

Various materials have been developed over the years (posters, booklets, videos, etc) relating to *I m addicted to life programme*, *Soul City*, *TADA/POPPETS programme*, etc. Material have also been produced by Pick n Pay, the Department of Health and Welfare, DrugWise, etc.

#### 4.2.3 National/International experts/consultants active in this area

There are very few national or international consultants working in this area who are working, or who have considered working, in South Africa. Some of those I am aware of are:

Peter Sjorquist (Global Rock Challenge Australia)

Dr Vince Bateman and staff at the Human Resources Development Institute (HDRI) in Chicago

Cornell Taljaard and Ome Louw (Institute for Health Training & Development - Johannesburg)

David Jernigan (Marin Institute - San Rafael, California)

Life Education Australia

Netherlands Institute on Alcohol and Drugs

#### 4.3.4 Training required for NGOs/CBOs

All of the following. Equally important.

Principles of primary prevention

Programmes found to be effective in other countries

Local situation assessment

Project design

Project management

Project monitoring and evaluation.

#### 4.3.5 Access to Internet

There is ready access to the Internet throughout the country (technically speaking), but most NGOs and CBOs do not have the infrastructure or funds to enable Internet access. There are a range of Internet Service Providers (ISPs). Access to computers is a major obstacle, particularly in rural areas. A few of the larger NGOs e.g. SANCA National has access to the Internet. SANCA National has a resource centre (the SANCA Information and Resource Centre) with a full time Information Specialist who would probably be able to assist NGOs and CBOs requiring access to material on the Internet. There are Internet Café s in many of the larger cities where persons/organisations can purchase time on the Internet. Most NGOs and CBOs would have access to a fax machine. Several local agencies working in the substance abuse area (directly or indirectly) have home pages on the World Wide Web:

SANCA s Information & Resource Centre: <http://wn.apc.org/sanca/>  
 The MRC s Mental Health & Substance Abuse Division s home page has links to various local and international prevention resources:

<http://www.mrc.ac.za/urban/hotlinks.htm>

The South African Brain Research Institute:

<http://os2.iafrica.com/sabri/>

The Crime Information Management Centre:

[http://www.saps.co.za/8\\_crimeinfo/8\\_index.htm](http://www.saps.co.za/8_crimeinfo/8_index.htm)

The Institute for Health Training and Development \_\_\_\_

<http://wn.apc.org/sanca/ihtd>

## 5. CONCLUSION

Epidemiologists, service providers, educators, law enforcement authorities and the general public in South Africa and have a strong suspicion that AOD use among young persons is increasing. This is supported, for example, by the finding that many specialist treatment centres are being approached by younger clients and by reports that police in certain locations are arresting younger persons for dealing in or possession of drugs. Such findings could, however, reflect other factors such as police policies or changing admission policies. The findings of research undertaken by the University of Cape Town and the MRC as part of the SACENDU Project on high school students in Cape Town will be released within the next few months. This will allow a determination to be made of changes in the prevalence of substance use over a seven year period (1990-1997) in a comparable group of students. Such information is vital to the planning of preventive interventions targeting young persons and influencing policy at local, provincial and national levels.

It is encouraging that the draft *Framework for a national drug master plan* released by the South African Minister of Welfare in October 1997 identifies motivating our youth to reject illegal drug use and substance abuse by preventive education and by reducing acceptability and availability of drugs to young people as one of its three



priorities (Drug Advisory Board, 1997, p. 25) . The broad agenda has been set. What remains is to identify specific programmes which are likely to be effective. The UNDCP/WHO Global Initiative on Primary Prevention of Substance Abuse through supporting the development, implementation and evaluation of model prevention programmes in different countries in the sub-continent has the potential for greatly assisting our country and others in this process.

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