LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF SOCIAL DEVELOPMENT

Substance use, misuse and abuse amongst the youth in Limpopo Province

2013

UNIVERSITY OF LIMPOPO

Turfloop Campus

Well cared for, socially empowered and self-reliant people of Limpopo

ACKNOWLEDGEMENT

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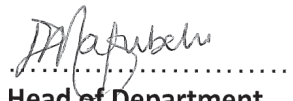
Last but not least, gratitude is extended to the social work coordinators for their efforts in spearheading data collection from the clientele



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Head of Department
Ms. Daisy Mafubelu

FOREWORD BY THE MEC

The Department of Social Development is mandated by the Prevention and Treatment of Substance Abuse Act (No. 70 of 2008) to implement substance abuse prevention programmes for children and the general population of the province. One of the social ills which the department is trying to combat is alcohol and substance abuse amongst the youth, which aggravates socioeconomic challenges in communities. Against this background, the Cabinet has established an Inter-Ministerial Committee on combating substance abuse which is coordinating government efforts to address this scourge.

The Limpopo Department of Social Development in partnership with the University of Limpopo has conducted a study titled “Substance use, misuse and abuse amongst the youth in Limpopo Province”. The main objective of this study was to collect baseline data which will enable government and the private sector to improve treatment, prevention strategies and approaches to reduce substance abuse amongst the youth in Limpopo Province.

Findings from this study show that the youth smoke tobacco, drink alcohol and use hard-core drugs. The most commonly used substances are Cannabis (49%), Inhalants (39%), bottled wine (32%), home-brewed beer (30%), and commercially brewed beer (greater than 4% Alc/Vol) used by 54.8% of the youth. The findings also show limited knowledge about the Foetal Alcohol Syndrome (FAS) among the youth.

The study recommends strengthened collaboration between role associates to promote the implementation of health promotion and public health programmes in schools and communities. The Department of Health should consider intensifying Foetal Alcohol Syndrome (FAS) interventions into the health promotion programmes to reduce its effects to the youth.

The Department of social development needs to strengthen the prevention and protection services targeting the youth through a multi-stakeholder approach.

I therefore urge all stakeholders to make good use of the report.

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Mme Dipuo Letsatsi-Duba

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Acronyms and abbreviations

ARV	: Antiretroviral
NDMP	: National Drug Master Plan
FGD	: Focus Group Discussion
WHO	: World Health Organisation
HSRC	: Human Sciences Research Council
NYDA	: National Youth Development Agency
STI's	: Sexually Transmitted Infections
HIV	: Human Immunodeficiency Virus
AIDS	: Acquired immune deficiency syndrome
UNODC	: United Nations Office on Drugs and Crime
GCIS	: Government Communications and Information System
SAB	: South African Breweries
SANCA	: South African National Council for alcoholism and drug abuse

Glossary

Naturally occurring substances:

Certain plants and animal tissue have psychoactive effects; in some cases, the crude material is used as a drug preparation while in other cases the psychotic substances are extracted and purified. Examples of naturally occurring substances are cannabis (dagga), tobacco and khat.

Semi-synthetic drugs:

Chemical manipulations of psychoactive substances that have been extracted from natural materials may result in drugs with different properties. Examples are cocaine, alcohol and heroin.

Synthetic drugs:

These involve psychoactive agents neither found in nature nor derived from natural psychoactive agents. They are created entirely by the laboratory manipulation of two or more relatively simple chemicals, which are themselves usually psychoactively inert. Examples are methylenedioxymethamphetamine (MDMA) (ecstasy), methaqualone (mandrax), methamphetamine and methcathinone.

Abuse:

Persistent or periodic excessive drug use inconsistent with or unrelated to acceptable medical practice.

Chemical precursors:

Substances frequently used in the illicit manufacturing of narcotic drugs or psychotropic substances as defined in Article 12 of the 1988 UN Convention against Illicit Drugs and Psychotropic Substances mentioned in Table I and Table II annexed to the convention.

Community-based treatment:

Community-based treatment refers to programmes or initiatives that arise from the needs of a particular community (established through a needs assessment) which identify and utilise existing infrastructure to meet these needs.

Demand reduction:

A general term used to describe policies or programmes directed at reducing the consumer demand for psychoactive drugs. It is applied primarily to illicit drugs, particularly with reference to education, treatment and rehabilitation strategies as opposed to law enforcement strategies aimed at preventing the production and distribution of drugs.

Dependence:

A person is dependent on a drug or alcohol when it becomes difficult or even impossible for him or her to refrain from taking the drug/alcohol without help after having taken it regularly for a period of time. The dependence may be physical or psychological or both.

Designer drug:

A novel chemical substance with psychoactive properties synthesised specifically to be sold on the illicit market and to circumvent regulations on controlled substances. These regulations now commonly cover novel and possible analogues of existing psychoactive substances.

Drug:

A term of varied usage. In medicine, it refers to any substance with the potential to prevent or cure disease or enhance physical or mental welfare and, in pharmacology, to any chemical agent that alters the biochemical or physiological processes of tissues or organisms. In common usage, the term refers to psychoactive drugs and often, more specifically, to illicit drugs.

Drug control:

The regulation, by a system of laws and agencies, of the production, distribution, sale and use of specific psychoactive drugs (controlled substances) locally, nationally or internationally; alternatively, as an equivalent to drug policy in the context of psychoactive drugs, the aggregate of policies designed to affect the supply of and/or the demand for illicit drugs, locally or nationally, including education, treatment, control and other programmes and policies.

National Drug master plan:

A master plan is a single document, adopted by government, outlining all national concerns regarding drug control.

Drugs or substances of abuse:

This term encompasses drugs, alcohol, chemical or psychoactive substances.

Drug testing:

The analysis of body fluids (such as blood, urine or saliva), hair or other tissue for the presence of one or more psychoactive substances.

Early intervention:

A therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved. Treatment is offered or provided prior to patients presenting of their own volition and, in many cases, before they become aware that their substance use may cause problems. It is directed particularly at individuals who have not developed a physical dependency or major psychosocial complications.

Harm reduction:

A harm reduction philosophy emphasises the development of policies and programmes that focus directly on reducing the social, economic and health-related harm resulting from the use of alcohol or drugs.

Illicit drug:

A psychoactive substance, the production, sale or use of which is prohibited.

Licit drug:

A drug that is legally available by medical prescription in the jurisdiction in question or, sometimes, a drug legally available without medical prescription.

Prevention:

Prevention is a proactive process that empowers individuals and systems to meet the challenges of life's events and transitions by creating and reinforcing conditions that promote healthy behaviour and lifestyles. It generally requires three levels of action: primary prevention (focuses on altering the individual and the environment in such a way as to reduce the initial risk of substance abuse); secondary prevention (focuses on early identification of persons who are at risk of substance abuse and intervening in such a way as to arrest progress); and tertiary prevention (focuses on treatment of the person who has developed a drug dependency).

Substance abuse:

The term refers to the misuse and abuse of legal substances such as nicotine, alcohol, over-the-counter drugs, prescribed drugs, alcohol concoctions, indigenous plants, solvents and inhalants, as well as the use of illicit drugs.

Supply reduction:

A general term that refers to policies or programmes aimed at stopping the production and distribution of drugs, particularly law enforcement strategies for reducing the supply of illicit drugs.

Treatment:

A process aimed at promoting the quality of life of the drug dependant and his or her system (husband/wife, family members and other significant persons in his or her life) with the help of a multi-professional team.

Youth

In the context and the purpose of this research project, youth means persons between the ages of 14 and 35 as outlined in National Youth Development Agency (NYDA) Act 54 of 2008.

Executive Summary

1.1 Background and Rationale of the study

Substance abuse has become a global scourge affecting virtually every country, not excluding South Africa in general and Limpopo Province specifically, though the extent and characteristics vary. The most commonly used and abused substances are cigarettes, cannabis and alcohol. Alcohol use is increasingly becoming a public health concern. Its misuse of alcohol represents one of the leading causes of preventable death, illness and injury. Other common substances which have emerged recently include *Nyaope*, *Taiwan* and *khilibidi*.

Substance abuse is generally associated with increasing amounts consumed, frequency of use and acquaintances one associates with. The substance abuse problem in Limpopo Province is no different from other provinces though there may be variations in the magnitude of the problem. It is difficult to say when it actually became a problem in Limpopo Province as there is currently no epidemiological surveillance system with specific reference to substance abuse. Currently, use and abuse of drugs have transformed from the traditional custom involving adults, to a stage where the youth are also involved.

Youth drinking, and alcohol-related problems reveal a pattern of widespread use and abuse by underage people. Adolescence is characterised primarily by the transition from childhood to adulthood and the changing demands and expectations from different role players and society at large. All change brings with it stress and instability. Generally, drug abuse research has focused on affluent provinces and metropolis cities with minimum attention being paid to rural provinces. Lack of credible information has skewed the provision of services on substance abuse with regard to prevention and treatment. In its earliest form, prevention was based on opinion rather than evidence. One of the strategies adopted to reinforce the message that drugs are dangerous is the use of scare tactics. With passage of time and development more conventional strategies involving information dissemination and

communication have been adopted. The notion is that once people know the negative consequences of drug use, they would choose not to use drugs.

The central objective of this study was to collect baseline data which will enable government and private sector to improve treatment and prevention strategies and approaches to reduce substance abuse amongst the youth in Limpopo Province.

1.2 Methodology

The cross sectional study employed both quantitative and qualitative data collection methods. An exploratory-descriptive research design was utilised. For purposes of triangulation multiple research instruments were used. These included structured questionnaires and focus group interview guidelines. These instruments enabled the research process to gather information about individual and collective experiences around the issues of substance use, abuse and misuse.

The population for this study was drawn from youth in all five districts of Limpopo Province. Both youth in-school and out-of-school youth were involved. The research study selected youth substance users and non-substance users of both sexes between the ages of 14 – 35 as defined by NYDA Act 54 of 2008.

Quantitative data was collected from 400 users and 100 non-users. Twenty five focus group interviews were conducted in all (25) local municipalities.

1.3 Results

The results of this study show that substance use among the youth is a challenge and the prevalence varies in districts. The most commonly used substances are Cannabis (49%), Inhalants (39%), bottled wine (32%), home-brewed beer (30%), and commercially brewed beer (greater than 4% Alc/Vol) used by 54.8% of the youth sampled in this study. The findings also show limited knowledge about the Fetal Alcohol Syndrome (FAS) among the youth.

The onset of substance use amongst the youth is as low as under 10 years of age with the median age of substance users being 24 years. Substances used by the youth are easily accessible and available which increases the potential for substance misuse, and ultimately abuse.

The study found that academic advancement reduces the likelihood of the youth to indulge in substance use. With regard to age, the likelihood of one using substances is higher amongst teenagers (under 18) as compared to youth above 19 years old. The two findings call for the intensification of substance abuse prevention programmes in the early stages of the youth's life experiences. With regard to the role of the media, there is an element of glorifying substance use, particularly tobacco and alcohol which has a potential for disastrous outcomes when it comes to the youth. The mass media, if used positively, will be an effective tool in preventing tobacco use and reducing alcohol consumption amongst the youth.

Focus Group Discussions conducted with the youth indicated that there is a serious problem of youth indulging in drugs. Substances mentioned to be abused include dagga and alcohol due to their accessibility and affordability. The viewpoint of the youth is that substance abuse is linked to other social problems, namely, child neglect, poverty, peer pressure, traumas, crime and HIV/AIDS. One striking case is a situation wherein the youth are commemorating June16; they do so by indulging in alcohol heavily.

The reasons for substance use as advanced by the youth include puberty, increased independence, curiosity, stress, peer pressure, strictness from parents, and dealing with family problems. Other factors contributing to substance use include substance availability, lack of entertainment facilities, parents as role models, customs and cultural practices as well as the influence of the media.

The study revealed that it is the youth who recently left school that know about prevention programmes such as *Ke moja, No thanks I am fine without drugs.* Other than this programme, the youth are familiar with Love Life and home-based care for HIV and AIDS infected people. Other programmes mentioned include *Learner Support Programme* and Poppets. With regard to *Phuza Wise*, the youth indicated to have heard of it over the television

1.4 Conclusion and Recommendations

The results of this study show that substance use among the youth is a challenge and the prevalence varies in districts. The most commonly used substances are cannabis, Inhalants, bottled wine, home-brewed beer, and commercially brewed beer (greater than 4% Alc/Vol). The findings also show limited knowledge about the Fetal Alcohol Syndrome (FAS) among the youth. The results show that the use of various substances by the youth also varies. The onset of substance use amongst the youth is as low as under 10 years of age with the median age of substance users being 24 years. To reduce substance abuse amongst the youth in Limpopo Province, there is a need to adopt a multi-stakeholder approach which ought to include Government, private sector, communities and civil society organizations. This should involve interventions related to (1) The provision of substance abuse health promotion activities, programmes and services; (2) Constructive media-based public education campaigns; (3) Development and implementation school-based substance abuse programmes; and (4) Provision of recreational facilities.

CHAPTER ONE: INTRODUCTION

1.1 Introduction

Besides the rising prevalence of drug use, there is a growing concern about the deepening problem of socially unacceptable and violent crimes committed by young people (Kachur, Stennies, Powell, et al. 1996; Lowry, Powell, Kann, Collins & Kolbe, 1998; Allan, Roberts, Allan, Pienaar & Stein, 2001; Blumstein, 2002). Drug use is often cited as one of the key factors responsible for undertaking risky behaviour (Brook, Cohen & Brook, 1998; Griffin, Botvin, Scheier, Diaz & Miller, 2000; Lansford, Dodgee, Pettit, Bates, Crozier & Kaplow, 2002). Although, there is no consensus on which of the two factors (i.e. substance use and risky behaviour) precedes the other, some authors have suggested that both of them (referred to as deviancy) are the result of an antecedent history of a dysfunctional social and cultural environment (Galea, Ahern & Vlahov, 2003).

Van der Bijl, (2004) argues that substances are abused not only in affluent societies but also in poor communities; they (substances) consequently impose a very direct and heavy burden on the already overstretched primary health care resources in South Africa. The use and abuse of substances, and their impact on primary health care, are particularly relevant today, particularly in South Africa. Alcohol use during adolescence is thought to elevate the risk of substance abuse later in life (Arata, Stafford, & Tims, 2003; Agrawal, Grant, & Waldron, 2006; King & Chassin, 2007). A study of substance abuse trends found alcohol to be the second most commonly abused substance, preceded by dagga/marijuana, among adolescent patients admitted for rehabilitation in Durban, KwaZulu-Natal (Parry et al., 2004). The 2008 Youth Risk Behaviour Survey (YRBS) conducted among secondary school students reported an increase in the prevalence of having ever used alcohol, alcohol use and binge drinking in the preceding month across gender and age groups from the first YRBS in 2002 (Reddy, et al 2003). The increase of alcohol abuse among female students is especially alarming. White and coloured students were found to be significantly more likely to use alcohol than black and Indian students in both surveys. While similar trends were reported for KwaZulu-Natal in the 2002 and 2009 YRBS reports, the prevalence for alcohol use and binge drinking were higher than the national rates. Binge drinking was reported in

other studies to be common among students of both sexes (Parry, et al., 2004; Reddy, et al., 2010)

In an earlier study involving 1 318 students in grade 10 from 28 high schools in southern KwaZulu-Natal, 53% of males and 25% of females reported ever having used alcohol (Taylor, Jinabhai, Naidoo, et al., 2003). However, adolescent alcohol use should be considered within a developmental framework, as experimentation and risk taking may occur during this stage with increased chances of negative short- and long-term consequences (Miller, Naimai, Brewer, & Everett-Jones, 2006; King & Chassin, 2007)

Peer influence, significant during this stage, has been linked to alcohol misuse (Leteka, 2007; Onya, Madu, & Govender, 2005; Furguson, & Meehan, 2011). However, parents remain influential during the adolescent years as younger adolescents listen to parents' opinions about alcohol, while older adolescents seek guidance from parents' own drinking habits (Leteka, 2007; Payne, & Meyer-Weitz, 2007). Research shows that when parents use alcohol frequently, their adolescents have an increased likelihood of exposure to alcohol and related risk behaviours (Hayes, Smart, Toumbourou, & Sanson, 2004c). Furthermore, adolescents with parents who held permissive attitudes towards alcohol use were found more likely to engage in heavy binge drinking. Parental permissiveness also influences peer associations with a significant relationship between peer influence and alcohol use (Wood, Read, Mitchell, & Brand, 2004). Little attention has been paid to the role of parents in alcohol misuse of or by adolescents in the South African context, particularly in rural provinces such as Limpopo.

Substance abuse among youth continues to be a major problem worldwide, and South Africa and its provinces are not an exception (United Nations Office on Drugs and Crime, 2009). Adolescence is a period of physical and psychological development. It has also been described as a stage of increased curiosity, experimentation and the quest for personal identity (World Health Organisation – WHO, 1997). Substance abuse by adolescents is an enduring public health issue worldwide, including South Africa. The Global Status Report by the WHO points out that many school children experiment with alcohol before the age of 12 years and the WHO therefore encourages member states to implement effective strategies to delay the onset of alcohol use (World Health Organization, 2004c).

In South Africa, 12% of youth experiment with alcohol use before 13 years of age (Reddy et al., 2010). Studies found that the increase of alcohol intake among South African adolescents is a major cause for concern, as it has been linked to other risk behaviours, such as unsafe sex with an increased risk of human immunodeficiency virus (HIV) infection, teenage pregnancy, dropping out of school and delinquent or criminal behaviour (Arata, Stafford, & Tims, 2003; Miller, Naimai, Brewer, & Everett-Jones, 2006; Simbayi, Mwaba, & Kalichman, 2006; Abdool Karim, Meyer-Weitz, & Harrison 2009). South Africa has witnessed many social and political changes in the past decade. The political transition and transformation that occurred in the 1990's have led to rural-urban migration. Alcohol and tobacco have become the most commonly used drugs among teenagers in South Africa while cannabis is the most commonly used illicit drug (Flisher et al., 1993; Rocha –Silver, 1998; Parry, 1998; Visser & Moleko, 1999).

1.2 Statement of the Problem

Youth substance misuse and abuse is a major problem worldwide. Its extent and characteristics however, vary from country to country, but trends among the youth specifically have begun to converge in recent years. The ages of users and abusers range from 09 to 80 years. The early inception of substance use and/or abuse - nine years – indicates the potential danger substances pose to the youth and society at large. Increasing youth indulgence in substance use and abuse is a major threat to family stability, social security and national development.

In the past few years, there has been an increased awareness of the growing trend in substance use among adolescents both in developing and developed countries (Miller & Plant, 1996; Lynskey, White, Hill, Letcher & Hall, 1999; Jernigan, 2001; Parry, Myers, Morojele, *et al*., 2004). Besides the rising prevalence of drug abuse, there is a growing concern about the deepening problem of socially unacceptable and violent crimes committed by young people (Kachur, Stennies, Powell, et al*.,* 1996; Lowry, Powell, Kann, Collins, & Kolbe, 1998; Allan, Roberts, Allan, Pienaar, & Stein, 2001; Blumstein, 2002).

Reliable objective information on substance use and associated effects, particularly from a rural context, is limited. Limpopo province is no exception given its generally rural situation.

There is a dearth of empirical information on substance use particularly among the youth to inform contextualised interventions in terms of prevention and treatment.

Most young people begin to experiment with substances at an early age. The most widely abused substances are alcohol, tobacco and cannabis. The age at first use of alcohol and substance use has been reported as nine years, which is a challenge to both young people and the society. This is supported by findings according to the Department of Health as cited in Baloyi (2006); children are beginning to use and abuse alcohol and other drugs at a much younger age. A national survey indicates that 34% of Grade 6 learners experienced peer pressure to use dagga while 51% experienced pressure to drink alcohol. The Department of Health, as cited in Baloyi (2006), further states that the earlier a young person starts using drugs, the more likely he or she is to experience dependency and go on to other hard drugs. Cigarette smoking is the gateway drug to hard drugs and peer pressure plays a big role in the abuse of drugs by youth.

According to the UNODC (2008), substance abuse is worsened by complex socio-economic challenges such as unemployment, poverty, peer pressure and crime in general. These social ills are devastating many families and communities. Drug pushers are forcing young people into taking substances so that once they are hooked; they can manipulate their friends into taking substances. Many youth seem to think of experimentation with substances as an acceptable part of transition into adulthood. Few youth take seriously the negative consequences of dependence on substances (Madu & Matla, 2003).

Alcohol and substance abuse among the youth are costing the country (South Africa) a substantial amount of money annually. This is evident in large sums of money used in prevention and treatment centres throughout the country (UNODC, 2008). Eventually this affects the whole country as such funds could be put to alternative use in development initiatives like poverty alleviation programmes.

1.3 Aims and Objectives of the Study

The central objective of this study was to collect baseline data which will enable government and private sector to improve treatment and prevention strategies to reduce substance abuse amongst the youth in Limpopo Province.

1.3.1 Objectives

Accomplishing the central objective was premised against the following objectives:

- Ascertain the risk factors associated with substance, use, misuse and abuse amongst the youth;
- Determine the prevalence of substance, use, misuse and abuse amongst the youth;
- Establish the predictors of substance use, misuse and abuse amongst the youth;
- To explore the extent of substance abuse amongst the youth;
- To explore the youth's knowledge of and preference for services related to treatment and prevention of substance abuse;

1.3.2 Research Questions

The following research questions were developed to guide the implementation of the study:

- How prevalent is substance, use, misuse and abuse amongst the youth exist in Limpopo Province;
- What are the risk factors associated with substance, use, misuse and abuse amongst the youth;
- What are the predictors of substance use, misuse and abuse among the youth in Limpopo Province;
- What is the extent of substance abuse amongst the youth in Limpopo Province;
- What is the youth's knowledge of and preference for services related to treatment and prevention of substance abuse.

1.4 Significance of the Study

According to Brennen (1992) significance of the study focuses on the contribution of the study to the particular area of study. In this case, the study's contribution lies in finding answers to the raised questions which in turn would form a basis for improving the programmes addressing substance use and abuse.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Young adulthood is the peak developmental period for the onset of drug problems (Chen, O'Brien, & Anthony, 2005; Fillmore, Johnstone, Leino, & Ager, 1993; Harford, Grant, Yi, & Chen, 2005; Hilton, 1991). Alcohol and other drug use have been associated with violence and crime in South Africa (Peden, van der Spuy, Smith, & Bautz, 2000; Matzopoulos, Seedat, & Cassim, 2003; Parry, Pluddemann, Louw, & Leggett, 2004). There are indications that the use of drugs has progressively increased among adolescents in the country (Parry, Myers et al., 2004; Da Rocha Silva, 2012). The proliferation of drugs and drug use in various communities may heighten adolescents' exposure to and/or involvement in violent activities (Da Rocha Silva, 2004). According to Schonfeldt (2007), South Africa is faced with a growing problem of substance abuse. This has serious implications for millions of citizens because it contributes to crime, domestic violence, family disintegration and other social problems. The problem of drug abuse by the youth is a blight that is a threat to any nation and society.

According to Ondieki and Mokua (2012), the issue of drug use has been in existence for thousands of years. It is as old as human beings and has been an integral part of most societies. Currently, drug abuse is a problem experienced by both young and old, although its impact tends to be particularly intense among the young people. Chesang (2013) indicates that drug abuse is one of the top problems confronting the nation today especially among the youth. Furthermore, drug abuse is not confined to young people in certain geographical areas or from particular social-economic backgrounds. Chesang (2013) and Masilo (2012) note that substance abuse knows no boundaries. It affects people irrespective of race, political and economic standing, gender and sexual orientation, socio-educational standing, age and place of residence.

2.2 Global Picture of Substance Abuse

The 2013 Youth Month Campaign's key messages issued by the Limpopo Government Communications Information Services (GCIS) indicated that alcohol and substance abuse and illicit drug trafficking are global phenomena, and South Africa is no exception. This has serious implications for millions of South Africans because alcohol and substance abuse contribute to crime, gangsterism, domestic violence, family dysfunctions and other social problems. The Limpopo GCIS continues to indicate that it has been reported that drug abuse in South Africa is twice the world norm in some cases. A matter of particular concern is the recent emergence of local drugs such as *nyaope* and *kubar*.

According to the 2008 World Drug Report (UNODC, 2008), globally, illicit drugs are used by slightly less than 5% of the world's population in the age group 15-64 years. (In the latter report drug use refers to the use of an illicit drug at least once in the past 12 months). The percentage of people severely dependent on drugs is limited to 0.6% of the world population – approximately 26 million people.

According to James, as cited in Mazibuko (2000), a major concern is that children seem to be targeted as the new market for the drug industry globally. In economic terms, both licit and illicit drugs are viewed as consumer goods that are traded in a competitive global market. Illegal drugs account for at least US $400 billion of world trade making it larger than the global iron and steel industries. In support of this, the Minister of Police in South Africa, Mr. Nathi Mthethwa, during the 16th June 2013 Future Leaders Annual Youth Conference in Durban reported that about 230 million people, or 5% of the world's adult population, are estimated to have used an illicit drug at least once in 2010. There are also about 27 million people internationally who use drugs in a manner that exposes them to severe health problems. Kalpana and Kavya (2013) assert that the number of youths continuing to abuse drugs remains a major public health problem worldwide. This issues needs to be addressed.

2.3 Drug Use in Africa

According to UNODC (2011) cannabis, methaqualone, and khat are substances of abuse that are entrenched in the African region. Cannabis is the drug that dominates treatment demand, accounting for 64% of the drug-using population in Africa. The estimated numbers of past-year users aged 15–64 years in East Africa ranged between 21,630,000 and 59,140,000 for cannabis, from 150,000 to 1,790,000 for opioids, and from 140,000 to 1,300,000 for opiates, with minimal or no use for cocaine, amphetamines, and ecstasy. In Southern Africa, the estimated numbers of past-year users are 3,130,000–7,810,000 for cannabis, 240,000–320,000 for opioids, 210,000–230,000 for opiates, 270,000–730,000 for cocaine, 280,000–780,000 for amphetamines, and 180,000–300,000 for ecstasy. Although the numbers of amphetamines users in Africa are estimated at 1,180,000–8,150,000, most of these numbers are reflected from Southern Africa (Degenhardt & Hall, 2012).

The UNODC also estimates the annual cannabis use prevalence rates to be 2.9% for Comoros, 2.1% for Kenya, 9.1% for Madagascar, 3.9% for Mauritius, 2.5% for Somalia, 3.9% for Namibia, 4.3% for South Africa, 9.5% for Zambia, and 6.9% for Zimbabwe. With regard to East Africa specifically, the overall prevalence rate of cannabis is estimated to be between 1.7 and 6.5% of the population. The annual drug use prevalence rate and the estimated number of opiate users for East Africa are 0.1–1.0% for the population aged 15–64 years. More specifically, for this region, the annual prevalence rate of the use of opiates in Kenya is 0.73%. In Mauritius, it is 1.9% for opiates and the corresponding figures are 0.14% for Rwanda, 0.16% for Somalia, and 0.06% for Uganda. Mauritius has a prevalence rate of 1.04% for non-medical use of prescription opiates. Kenya is the main country in East Africa where cocaine features with a prevalence rate of 1.2% (UNODC, 2011).

For most countries in Southern Africa, cannabis is the primary drug of abuse (with the prevalence rate estimated at 3.9–9.8%) (UNODC, 2011). However, relatively little is known about the use of drugs that have the potential to be injected such as opiates, cocaine, and Amphetamine-Type Stimulants (ATS). While the regional prevalence rate for opiate use is

estimated to be 0.1% for the population, amphetamine-related problems have been reported in South Africa, Zambia, and Zimbabwe (UNODC, 2011; World Health Organization, 2011).

In South Africa, which arguably has one of the most entrenched drug economies in the region, illicit drug use is subject to continuous monitoring and investigation. Since South Africa's transition to democracy in 1994 and subsequent opening of the country's borders, there has been an influx of and a growing burden of harm associated with illicit drug use.

In terms of population-level prevalence for illicit drug use, the prevalence rate of opiate use is estimated at 0.1%, cocaine use at 0.3%, ATS at 0.2%, and opiates such as heroin at 0.1% for the population aged 15–49 years (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, et al., 2005). In addition, a recent nationally representative survey reported that at least 13% of the general population met Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for a lifetime substance use disorder (Herman, Stein, Seedat, Heeringa, Moomal & Williams, 2009). As this survey only included South African citizens and, did not include refugees and other undocumented persons, it is possible that these estimates under-represent the true prevalence of substance use disorders in the country. However, when regional patterns of illicit drug use are considered, a more disturbing picture emerges. Illicit drug use appears to be concentrated in the large urban centres of the country, with many of the rural provinces still largely unaffected by the use of illicit drugs that have the potential to be injected (Dada, Pluddemann, Parry, Bhana, Vawda & Fourie, 2011; Herman et al., 2009; Reddy et al., 2010). Notably within the large urban centers of the country, the use of illicit drugs that have the potential to be injected (such as cocaine, heroin, and ATS) appears to be on the rise (Dada et al., 2011; Parry, Pluddemann & Myers, 2007).

2.4 South African Picture of Substance Use

Ndetei et al., (2008) state that in South Africa the health, social and economic consequences associated with problematic substance use have been documented as the burden of harm. Deveau (2008) articulates that the spread of HIV amongst youth substance users, as a high-risk group, is a significant problem in Africa and South Africa in particular, as in other parts of the world. He further contends that drug use is reported to be most commonly abused by young people, with an estimated national abuse rate of 36.3% and that drug use plays a significant role in the spread of HIV. This – in conjunction with the points made in earlier paragraphs – underlines that the problem of drug use/abuse is not only cramped within a certain border, but is a global phenomenon that causes health and social pathologies amongst the youth and population at large.

Muncie et al. (2002:97) and McLoyd, as cited in Manm and Reynolds (2006), articulate that family risk factors, such as domestic violence, drug use, criminal behaviour on the part of a parent, marital conflict and child maltreatment, disrupt parent-child relationships, family structures and impact negatively on the development of young people. Youth from dysfunctional families are most likely to engage in drug use and perform poorly at school, workplace and in other contexts. Dysfunctional families facing problems of drug use turn to focus more on addiction rather than on the needs of the children. Young people, whose family members experience drug use challenges, suffer from neglect, economic hardship and even abuse.

McNichol and Tash (2001) explain that youth that are exposed to parental illegal drug use are at a disproportionate risk of experiencing developmental and behavioural problems. These behavioural problems may range from drug use activities, criminal behaviour, and absconding from classes, tests and examinations and eventually failing or dropping out of school.

The effects of drug use on adolescents and young people inter alia revolve around the family environment. The parental home, as generally the first institution responsible for socialising children appropriately, plays a decisive role in molding and instilling appropriate

attitudes and behaviour patterns. Parents should bond, create and maintain an affectionate relationship with their young.

Cheng and Lo (2011) maintain that positive affection towards a parent may leave adolescents and young people less prone to engage in drug use. A decision made by one family member always influences the choices and actions of other family members; hence situations and events happening within young people's home environments could have an influence on their behaviour and extend to secondary environments such as the school, work place and eventually the community and society at large. The prevalence of drug-based social opportunities in South Africa and peer pressure can be expected to contribute to the spreading of drug abuse among young people. Moreover, a study conducted by Battin et al. (2006) compared youth who had four or more siblings with those who had fewer siblings and found that the former group were twice as likely to offend, regardless of the parents' socio-economic status. These associations may be related to diminished supervision in larger families.

In short, a review of patterns and trends in drug use in South Africa over the period 1960 to 2010 concluded as follows regarding such use among young people (Da Rocha Silva, 2012:74): "[F]air to substantial proportions of young South Africans (±10-24 years) generally admit that they (1) have used some drug or other at some time in their life, and that they (2) have done so fairly intensely, i.e. in terms of frequency and the amount of intake. Drug consumption also mostly comprises the use of alcohol and tobacco, the non-medical use of medicine and the use of cannabis. However, and as in the case of their adult counterparts, young people report the use of a variety of drugs other than alcohol, tobacco and cannabis. There are also indications that drug use is increasing among young people, although unevenly across drug types."

2.5 Specific Drugs and their Effects

Maithya (2009) points out that it is important to note that all drugs are dangerous and that the deliberate ingestion of drugs is harmful to the individual, the family, the community and society as a whole. The following specific drugs will be discussed, especially those that tend to be (fairly) commonly used in South Africa:

- **Alcohol**

Alcohol is easily accessed by consumers, even the youth. Masilo (2012) contends that alcohol is the most readily available drug on the market and is not illegal to use or to possess. According to the 2013-2017 National Drug Master Plan (Department of Social Development, 2013), alcohol remains the primary abused drug in South Africa. Indications are that between 7.5% and 31.5% of South Africans have an alcohol problem or are at risk of having such a problem. Chesang (2013) indicates that alcohol is contained in drinks such as beer, wine, brandy, spirit and whisky. It is an extremely potent drug. It acts on the body primarily as a depressant and lowers brain activity. However, in low doses it can be a stimulant. Chesang further notes that if used in excess, it will damage or even kill body tissues including muscles and brain cells. Its consumption causes a number of marked changes in behaviour. In some instances the consumer of alcohol will act violently when he is under the influence. There are different street names given to alcohol by consumers. These names are listed by Chesang (2013) as booze, pints, slaush, brew and jolly juice. According to Makhubele (2013), in the Mopani District of Limpopo Province in South Africa, homebrewed alcohol is inter alia referred to as *Ndzi ta ku nyisa*, meaning "I will beat you up". Other brewers call it *Skopdonorr.* One of the respondents in Makhubele's (2013:440) study explained the danger of homebrewed alcohol as follows: "It is not supposed to be drunk by weak and sick people. Basically with this alcohol, one should come having had a meal, preferably porridge to avoid vomiting and dizziness. Consumers are unable to walk after drinking and they become very weak."

- **Tobacco**

According to Yuji (2001), smoking is an established cause of a significant number of diseases, disabilities and deaths worldwide. Mlongo (2005) is of the view that it is not only harmful to the individuals who smoke but also to those who are exposed to tobacco smoke. Tobacco contains thousands of substances and nicotine is the one most frequently associated with dependence because it is the component that is psychoactive. Observable behavioural effects, such as mood changes, stress reduction and enhancement of performance, are common. Hodge, McLellan and Cerbone (2001) emphasise that the

problem of tobacco use should be viewed and addressed “as an individual, social, economic and environmental burden at the family, community, national, regional and global levels”.

- **Dagga (cannabis/marijuana)**

Cannabis or marijuana is an addictive hallucinogenic drug, which tends to be smoked. It causes “an unnatural thirst or hunger, uncontrolled mood swings, talkativeness, impaired perception, disturbed judgement, mind disorders, a feeling of well-being and euphoria (pleasant feeling of excitement and of escaping reality) and it alleviates anxiety” (Rehn, Jenkins & Cristal, 2001:112). Akinade (2001) indicates that marijuana makes its users intoxicated, disoriented, euphoric and relaxed. Some users claim that its use can act as a depressant but the drug may induce sensory distortions of vision, hearing or body balance. According to Coombs in Ondieki and Mokua (2012), because of the effects of sensory distortions young people on occasion use it, specifically in order to experience something extraordinary.

- **Cocaine**

Cocaine is one of the drugs known to particularly produce addiction. Its continuous use leads to rapid deterioration of the body, especially of the nervous system with permanent and irreversible injuries. The street names for cocaine include coke, snow, flake, snowbirds, blow, hardy and nose candy. It is normally in the form of white sparkling powder and often diluted with other ingredients (Ondieki and Mokua, 2012). According to Mottran (1996), cocaine has therapeutic effects of relieving pain, euphoria effects and a feeling of reduced fatigue. It is also used as a recreational drug. Cocaine provokes marked excitation, with an increase in intellectual activity, talkativeness, euphoria and increase muscular strength. When the dose is increased, shivers, nervousness and even convulsion may occur (Ondieko and Mokua, 2012). According to Mhlongo (2005) cocaine is an extremely addictive drug and is illegal to possess or deal with.

- **Nyaope**

According to the Daily Maverick newspaper, dated 3 May 2013, and the 2nd Biennial Anti-substance Abuse Summit Report (Department of Social Development, 2013), nyaope (also called whoonga) is made from a cocktail of ingredients such as rat poison, heroin and antiretroviral drugs. It is destroying the future of youth. Nyaope is a white powder that sometimes takes on a creamy tint. It's usually sold in small parcels at R30 a portion. Boys in Johannesburg will tell you that it all began in Pretoria, with Nigerians responsible for the supply.

2.6 Factors which contribute to Drug Abuse among Youth (Risk Factors)

Knowledge of the kinds of drugs being used and the role they play in particular individuals, communities, sub-cultures or groups is vital for any prevention programme. Prevention work should therefore begin with an analysis of these elements in a particular target group of concern. Often one feels safer consulting books or listening to "qualified' adults rather than going to the source and listening to adolescents themselves in order to come to an understanding about why drugs are used.

Drug related risk factors are those which increase the possibility of an individual' engaging in drug use/abuse. As a general rule, the greater the number of risks the child or young person experiences, the greater the likelihood of drug use problems occurring. Research has pointed to the existence of certain factors that increase people's risk of using drugs as well as factors which act to protect them from doing so (Plant & Plant, 1992; World Health Organization, 2002a, 2002b, 2003).

- **Peer pressure**

Masese et al. (2012) note that it seems that relatively few people start using drugs on their own. The interest and expectations of their peer groups have an important bearing on whether or not a person will try a dependence producing drug. A friend or peer group is likely to be the source of information for drug users about the availability of drugs and their allegeable effects. According to the United Nations (1992), drug users, like other people seek approval for their behaviour from their peers by attempting to convince them to join them in their habit. When an individual associates himself/herself with a group of people that

abuse drugs, the chances are high that he/she will be lured into engaging in drug use. For Sempe (2007), adolescents tend to emulate peer behaviour and seek reinforcement from their peers.

- **Availability of drugs**

According to scholars such as Craig (2004) as well as Merton in Masese, Joseph and Ngesu (2012), people use (illegal) drugs because of their availability and such availability is facilitated by those who benefit financially from drug sales. The findings of a study done by Masilo (2012) revealed that the environment in which learners go to in school can contribute to their engagement in drug use – there were many taverns or, for that matter, shebeens within reach of the school premises. Furthermore, learners were not only able to access alcohol but also dagga as some used breaks to smoke dagga in the school toilets. In Kisumu, Kenya, the Big Issue (a magazine in the Wednesday Standard) team identified shops at the Kisumu bus stop and schools within the town centre as the best known dens in which drug trafficking occurred (Masese et al., 2012).

- **Curiosity**

Curiosity is one of man's outstanding characteristics. It appears in life and leads to extensive exploratory behaviour. It is not surprising then that many young people will wish to try some drugs in order to determine the effects for themselves (WHO in Masese et al., 2012). In substantiating this, Masilo (2012) indicates that young people always want to explore adult ways of behaving and satisfying needs and the challenges and the risk these adult ways.

- **Family environment**

Pudo (1998) noted that children from homes where parents take drugs tend to imitate the behaviour of their parents by taking (illegal) drugs. According to Midigo (2002) attitudes of parents towards tobacco, alcohol and other drugs play a major role in children's behaviour. Young people learn from what they see by imitating what their parents and other people in the community do. In this respect it is important to bear in mind the process of socialisation. Tlhoaele (2003) defines socialisation as a process by which one acquires social skills to participate effectively in the society in which one lives and through which one feels accepted and special. The way in which children relate to other socialising agencies is partly influenced by the family of which the child is part. Bezuidenhout (2004) indicates that adolescents with substance abusing parents experience a higher rate of parent and/or family problems than adolescents whose parents do not abuse substances. In line with the National Drug Master Plan (2006-2011:8), Schaefer (1996) adds that youths with poor parental support at home tend to seek support and understanding elsewhere and may turn to drugs to cope with their circumstances. Some young people find affection, understanding and support in the lifestyle of a subgroup whose members are drug abusers. Moreover, children of poverty stricken families may easily be lured by drug traders to sell drugs in schools and the wider community.

2.7 General Challenges faced by Youth

Heather, Taussig, Robert, Clyman, and Lansverk (2001) articulate that longitudinal research on youth drug use suggests that young people who engage in drug use are at risk of presenting with various problems, including poor school performance, incarceration and chronic problems with employment and housing. Cheng and Lo (2011) add that socio-economic disadvantages such as poverty and single parenthood can increase drug use among young people. Cheng and Lo (2011) also note that parental drug use places a young person at risk of also engaging in drug use, while positive parent-child bonding and a lack of substance use in the parental home protect against such use. Moreover, as children grow older, they spend less time with their parents and more time with their friends or peers, resulting in less opportunity for parental oversight or control and more opportunity to be lured into drug use by their friends (Coie *et al.,* 2002 as cited in Bagwell *et al.,* 2000). In

addition, Taiwo and Goldstein (2006) as well as Cheng and Lo (2011) contend that drug use tends to be associated with a variety of socially unacceptable behaviour such as absenteeism, bullying, weapon carrying and conflict with teachers and other persons in their lives.

Young people or adolescents from broken families, single parent families, and dysfunctional families are usually the ones to be confronted with improper behaviours such as early indulgence in drug use and other related social pathologies and school or work related problems. Youth and adolescents who are from families that abuse drugs are likely to display a series of dysfunctional behaviours learnt within the family environment, peers or significant others. Bartol and Bartol (2005), Pearson et al. (2000), Vaden-Kiernan et al. (1999), and McLanahan and Booth (2004) share the same sentiment, namely that delinquent young people and adolescents are more likely than non-delinquents to come from homes where parents are single, divorced or separated. Furthermore, the authors found that youth from single-mother households are at increased risk for poor behavioural outcomes based on the assumption that these households on average have fewer economic resources and other resources to monitor their children's activities and whereabouts.

Farrington (2004) states that having antisocial siblings or peers also increases a youth's likelihood of antisocial behaviour and, that the influence of siblings and peers are stronger when the siblings or peers are close in age. Cheng and Lo (2011), however, emphasise that parents' positive influence on young people's behaviour may diminish the possibility of the latter yielding to negative influences within the contexts within which daily lives such as the workplace, school and tertiary educational institutions and indulge in drug use.

2.8 Consequences of Drug Use amongst the Youth

The impact of drug use on adolescents and youth is not only associated with or confined to anti-social behaviour or risky behavior, poor school and work performances, absenteeism and other forms of volatile behavior. The impact and effects can also extend to the health conditions such as HIV/AIDS. Various scholars (e.g. Bisika, Konyani, Chamangwana & Khanyizira, 2008; Olisah, Adekeye, Sheikh & Yusuf, 2009) contend that risky behaviours associated with drug use are among the main contributors to the spread of HIV/AIDS. They further indicate that drugs can change the way the brain operates through disrupting the parts of the brain that people use to weigh risks and benefits when making decisions. They further note that drug use by any route, not just injection, can put a person at risk of contracting HIV. Drug intoxication affects a person's judgment and can consequently contribute to the drug user engaging in unsafe sexual practices and contracting or transmitting HIV. Indeed, comparatively heavy drug use among young people has been correlated with a tendency towards engagement in high-risk sexual behaviours such as having multiple sex partners and (unprotected) intercourse with high-risk partners (e.g. injection drug users, prostitutes). Olisah, Adekeye, Sheikh, and Yusuf (2009) consequently contend that as drug users are more likely than the general population to contract HIV, and educing (youth) drug use would reduce the spread of HIV and diseases associated with it. Finally, it is important to bear in mind that drug use exposes young people to various sorts of abuse ranging from rape, physical abuse, abduction, human trafficking and other forms of abuse.

2.9 Key Policy Frameworks and Programmes related to Drug Use

Given the comparatively high prevalence of substance abuse in South Africa (Da Rocha Silva, 2012), including among youth, the South African Government has adopted the National Drug Master Plan (Department of Social Development, 2013) as their strategy to fight the blight of substance abuse. It has been designed to serve as the basis for holistic and cost-effective strategies to reduce the demand for and supply of drugs and the harm associated with their use and abuse. Ultimately the plan is intended to help realise the vision

of a substance abuse free society so that more attention can be focused on raising the quality of life of the poor and vulnerable in the country.

More particularly, the National Drug Master Plan (NDMP) 2013-2017 of South Africa is the plan formulated by the Central Drug Authority in terms of the Prevention and Treatment of Drug Dependence Act (Act 20 of 1992 as amended) as well as the Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008), approved by the Parliament to meet the requirements of relevant international bodies while simultaneously addressing specific needs of the South African communities, needs which at times differ from those of other countries (Department of Social Development, 2013).

To counter youth drug abuse, prevention programmes are needed that focus on not only adolescents and young people, but also on the latter's immediate families and the wider community (World Health Organization, 2003). The focus should, furthermore, be on not only changing people's behaviour but also their attitudes, indeed instilling norms that are conducive to avoiding drug use. Leteka (2003) adds that early intervention can reduce future health and social problems since drug use tends to contribute to such problems. Even moderate youth drug use has been shown to be associated with a decrease in physical and social "health" in adulthood. Prevention programmes are a means of assisting a community, group or an individual to comprehend and understand an existing or potential problem that requires attention and then assisting them to deal with the problem. The 2013-2017 National Drug Master Plan (NDMP) calls upon service providers to act on the guidance of policy makers in the development and implementation of prevention programmes.

Van Wyk, Kleintjies Ramlagan and Peltzer (2007) state that in South Africa drug abuse prevention programmes are reportedly predominantly school-based. School-based programmes tend to rely primarily on giving information about drugs, and ever so often use fear arousal and scare tactics as means to discourage drug use. It is a matter of concern to note that drug related prevention programmes such as Ke Moja and Poppets are not necessarily effective, and the emphasis is ever so often on rendering quantity rather than quality services.

Burnhams, Myers and Parry (2009) articulate that various concerns have been raised about the quality and effectiveness of prevention services in South Africa. If these prevention programmes were effective youth drug abuse would have decreased which apparently is not the case. As pointed out by Van Wyk, Kleintjies Ramlagan and Peltzer (2007) and by the World Health Organization (2003), and as has to some extent been noted earlier, prevention programmes should be comprehensive, have multiple components, and be directed at individuals, families and the wider community in a variety of settings, not only in schools. The Ke Moja and Poppets prevention programmes tend to target children and school-going young people. Moreover, Van Wyk, Kleintjies Ramlagan and Peltzer (2007) contend that it seems that young people do not necessarily understand the messages conveyed by the materials used in the Ke Moja awareness campaigns such as posters, radio clips, video clips for television and drama. These scholars also suggest, as do the World Health Organization (2002a, 2002b, 2003), that it may be more appropriate to focus on promoting a "healthy lifestyle", arguing that if behaviours that are known to strengthen health such as exercise and proper nutrition are initiated or enhanced, health-compromising behaviour such as drug use may be reduced.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Theoretical Framework

In conducting this research, the eco-system theory was used to describe and explain circumstances and conditions relating to the risk factors associated with substance, use, misuse and abuse amongst the youth; prevalence patterns and predictors of substance use, misuse and abuse among the youth; extent of substance abuse amongst the youth; and association between substance abuse and deviant behaviours. The researchers explored and described youth substance use, misuse and abuse within a predominantly rural setting. The eco-system theory is more relevant and appropriate in explaining the relationship between substance abuse and the environmental systems in which people interact. The abuse of substances by youth is in one way or another influenced and impacted upon by both the environment and its inhabitants.

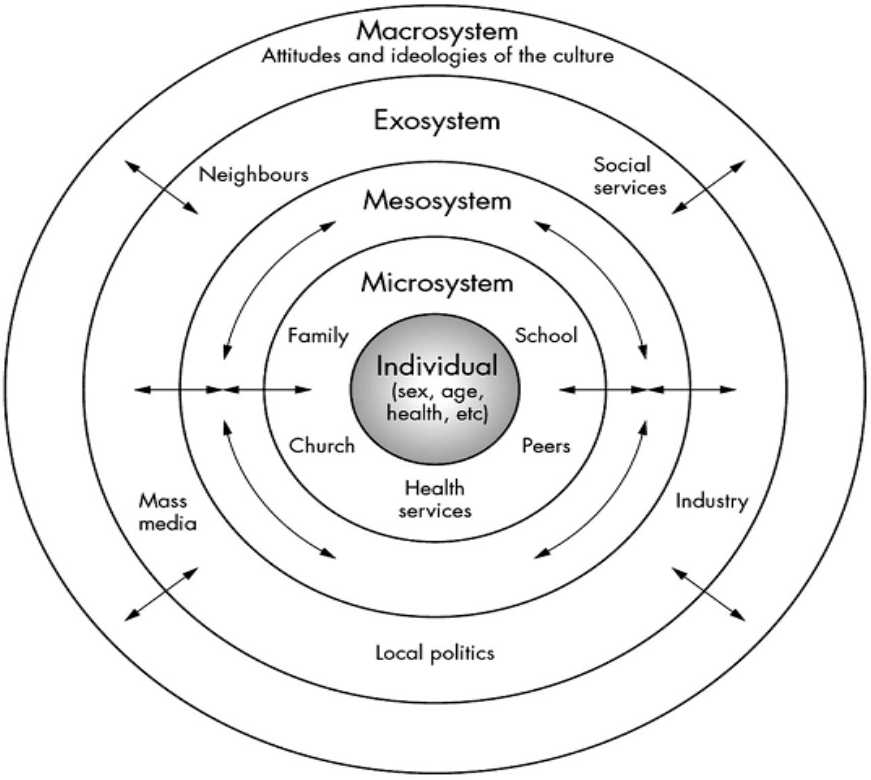
3.1.1 The Eco-systems Theory

The eco-systems theory - also called the life model -, gives the guiding framework for understanding practices (Franklin & Jordan, 1999; Karger, 2000). The eco-system theory asserts that the systems are always sub-systems of the larger systems in an environment, but can, at the same time, be divided into smaller subsystem units. The subsystems influence each other behaviourally (Potgieter, 1998). The eco-system theorists believe that to view substance use, misuse and abuse by youth in isolation from their family and environment is tantamount to ignoring the influence of the home in which they learn to perceive how they fit in the world, as well as the influences others have on their behaviour. Therefore, any risk behaviour an individual may manifest or display, threatens the balance of the family of origin where roles and perceptions are nurtured (Steinglass, 1987).

The theory focuses on the mutual relationship between the person and the environment in which each shapes and influences the other over time. The theory gives an assessment on the negative interactions between people and their physical and social environments. The eco-system theory focuses on the social and cultural factors with regard to behaviour change and learning about the historical traditions, beliefs and values in a particular

environment, and how social and cultural factors influence an individual's behaviour (Keys, MacMahon, Sanchez, London & Abdul-Adil, 2004). It assists in grasping the problem of concern within the situation of the person in context and contributes to the problem intervention process. The following graphical representation presents ecological models according to Bronfenbrenner, (1994).

Figure 1: Bronfenbrenner's Ecological Systems Theory



Adapted from: Bronfenbrenner, (1994).

The eco-systems theory informed the conceptualisation of the study's methodology, design and analysis procedures which are described in the following sub-sections of this chapter (i.e. sub-sections 3.2 – to 3.5).

3.2 Type and approach of the research project

For the purpose of this study, the researchers opted for applied research (empirical study). This approach enabled the researchers to gain valuable knowledge and first-hand experience of the substance abuse problems experienced by young people in Limpopo Province.

The study used both qualitative and quantitative approaches (mixed method). The appropriateness of the qualitative approach stems from the need for the study to gain the understanding, knowledge and insight of the risk factors associated with substance, use, misuse and abuse amongst the youth; prevalence patterns and predictors of substance use, misuse and abuse among the youth; extent of substance abuse amongst the youth; and association between substance abuse and deviant behaviours. This approach was useful as it enabled the researchers to gain first-hand experience from the respondents and/or participants (Creswell, 2003). The focus group technique was used to collect qualitative data. This technique [focus group] enables the researchers to observe, listen to and reflect on what the participants were saying.

The quantitative method is equally appropriate for this study based on the idea that social phenomena can be quantified, measured and expressed numerically. Quantitative data was collected through the use of a structured questionnaire customised from the questionnaire from the Human Sciences Research Council (HSRC). The method enabled the researchers to quantify phenomena and make objective deductions accordingly. The Statistical Package for the Social Science (SPSS) was used to analyse quantitative data.

3.3 Research design

The study applied an exploratory-descriptive research design. The purpose of exploratory research is to gain a broad understanding of a situation or phenomenon (Bless & Higson-Smith, 2000). It addresses the “what” question (Neuman, 2000). The exploratory design enabled the researchers to explore and describe the risk factors associated with substance, use, misuse and abuse amongst the youth contextually; prevalence patterns and predictors

of substance use, misuse and abuse among the youth in Limpopo Province; extent of substance abuse amongst the youth; and association between substance abuse and deviant behaviour in Limpopo Province and also gain a broader understanding of and insight into the phenomena under study.

The descriptive design on the other hand was aimed at describing the risk factors associated with substance, use, misuse and abuse amongst the youth contextually; prevalence patterns and predictors of substance use, misuse and abuse among the youth in Limpopo Province; extent of substance abuse amongst the youth; and association between substance abuse and deviant behaviours in Limpopo province (Bless & Higson-Smith, 2000). It focuses on "how" and "who" questions and enabled the researchers to provide a detailed picture of the background and context of the respondents and/or participants' situation (Neuman, 2000). Thus, the exploratory and descriptive designs greatly enhanced the acquisition of in-depth information on the characteristics of the respondents and/or participants and their experiences concerning substance abuse, misuse and abuse.

3.4 Population

The population for this study was drawn from youth in all five districts of Limpopo Province. Both youth in-school and out-of-school were involved. The research study selected youth substance users and non-substance users of both sexes between the ages of 14 – 35 as defined by NYDA Act 54 of 2008.

3.5 Sampling method

In this study a purposive sampling method was used. A purposive sample, also commonly called a judgmental sample, is one that is selected based on the knowledge of a population and the purpose of the study. The subjects are selected because of some characteristic. According to Census 2011 results, a population of 3 211 667 youth were estimated in Limpopo province (Stats SA, 2011). To determine the ideal sample size for a population, Slovin's formula was used which is:

$$n = \frac{N}{1 + Ne^2}$$
$$= \frac{3211667}{1 + (3211667)0.05^2}$$
$$= 399.95$$
$$\approx 400$$

Where:

n = Sample size

N = Total population (3 211 667)

e = Margin of error (0.05)

In all a total number of 400 users and 100 non-users were selected. Substance non-users were purposively selected given the nature of the study and target population (youth) within a geographical area. As this study was triangulated, 25 focus group discussions were also conducted in the 25 local municipalities. An interview guide was used to collect qualitative data. The substance users were identified by the Substance Abuse Coordinators (Social Workers). The substance users selected in this study are clients sampled from a clientele of substance users benefiting from the substance abuse programme in the Department of Social Development.

3.6 Focus group interviews

Focus group interviews (FGDs) were held with participants (young people: users and non-users, males or females) to uncover information on their perceptions, feelings, opinions, thoughts, and experiences on substance use, misuse and abuse. A Focus group interview is flexible, allowing new questions to be brought up during the interview as a result of what the interviewee says. The interviewer in a focus group discussion generally has a framework of themes to be explored. In this particular study open-ended questions were used to elicit the views and opinions from participants on substance use, misuse and abuse. Data collectors (i.e. facilitators of Focus Group Discussions) together with moderators were trained to ensure that they create an opportunity for participants to freely express themselves, and to

share their [participants] understanding of the issue of substance use, misuse and abuse. The advantage of using open-ended questions is when a variable is relatively unexplored or unknown to the researcher (Fouché, & De Vos, 1998). Each Focus Group Discussion (FGD) had to have a moderator and a scriber who would take notes throughout the discussions, listen to notable quotes, note several key points in response to each question, monitor recording equipment, draw a diagram of the seating arrangements, and give an oral summary and feedback after each discussion. The responses were tape recorded and later transcribed, and translated into themes in English.

3.7 Data analysis

Quantitative data was analysed using SPSS, while qualitative data was analysed thematically using Nvivo software.

3.8 Logistic regression

The use or non-use of substances is influenced by a number of factors, some of which are socio-economic, cultural, demographic and geographic / situational to mention but a few. A number of factors related to the substance user status were included in this study to analyse their influence. The aim was to try and establish what influences some people to use substances while others don't. The proposition is that substance use / non-use is a function of factors (predictors), some of which are included in the data collected for this study.

Such factors include the following;

- Age
- Income
- Gender
- Qualifications
- Geographical location
- Race

Logistic regression was used in this regard. The logistic regression model is as indicated in equations 1 and 2:

$$\pi(x) = \frac{e^{(\beta_0+\beta_x)}}{1+e^{(\beta_0+\beta x)}},\ldots. \quad (1)$$

$$\log it\{\pi(x)\} = \log\frac{\pi(x)}{1+\pi(x)} = \beta_0 + \beta_x,\ldots \quad (2)$$

The choice of Logistic regression as the analytical model for this purpose was based on its flexibility in relation to the problem at hand. In the first place the dependent variable (i.e. user status) is dichotomous, captured as user or non-user. Secondly the explanatory variables differ in terms of the level of measurement, with some - like age and income– being at interval level of analysis, while gender and race are categorical. An individual's qualification is ordinal. According to Tabachnick & Fidel (2001: 517) logistic regression can be applied in a situation where the predictors are a mix of continuous, discrete and dichotomous variables.

Geographical location - urban / rural could be a factor influencing substance use. Data in this regard was collected and analysed. However, this factor was left out in the logistic regression analysis in spite of the model's compatibility. This is mainly because of the relative homogeneity of the geographical areas (Districts) in terms of the level of development. Limpopo province is generally rural. The results are indicated in the chapter which deals with the study's findings.
Race could be a factor influencing substance use/ non-use but it was excluded in the analysis due to the small sample size of certain races in comparison to the African group.

3.9 Ethical Considerations

The fact that human beings are the subjects of study in the social sciences, the researcher in planning research, needs to be aware of the agreements about what is proper and

improper in scientific research. Therefore, ethical concerns are considered as an integral part of the planning and implementation of research. Researchers are responsible for designing and carrying out research both knowledgeably and ethically (Milley, O"Melia & Dubois, 2001). The following ethical considerations were taken into account in this study.

3.9.1 Permission to conduct the study

The Limpopo Department of Social Development in partnership with the Department of Social Work in the University of Limpopo (Turfloop campus) granted permission to conduct the study after the granting of Ethical clearance by the University of Limpopo.

3.9.2 Harm to respondents

Monette et al. (1994) indicates that people should never be exposed to situations that might cause serious or lasting harm. Harm to subjects can be physical or emotional, and emotional harm to respondents and/or participants is often more difficult to predict and to determine than physical discomfort (Motepe, 2006). The study ensured that respondents and/or participants were not exposed to any harm.

3.9.3 Informed consent

Miley et al. (2001) state that this ethical principle (Informed consent) emphasises that, subjects should give their consent to participate only after researchers fully disclose the purpose of the research, what it entails, and its potential effects or consequences. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.

Motepe (2006), states that obtaining informed consent implies that all possible or adequate information on the goal of the investigation, the procedures that will be followed during the investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed, as well as the credibility of the researcher, be rendered to potential subject or their legal representative. In this study, the respondents and/or participants signed a consent form indicating the aim, objectives of the study and the fact that participation was voluntary and that respondents and/or participants may withdraw from the study at any time when they felt so.

3.9.4 Confidentiality and Anonymity

Confidentiality refers to agreements between persons that limit others' access to private information (Mboniswa, 2005). The study adhered to this particular ethical aspect by ensuring that information provided by respondents and/or participants is safely stored and, never shared with other people. According to Mboniswa (2005) anonymity means that no one, including the researcher, should be able to identify any subject afterwards. On this particular aspect the respondents in this study never disclosed their identity on questionnaires while pseudo names were used to disguise their identity in the Focus Groups sessions to ensure that they are not identifiable from the audio-recorded data.

3.9.5 Release or publication of the findings

According to Mboniswa (2005) the researcher must ensure that the investigation proceeds correctly and that no one is deceived by the findings. Researchers should be open with their results, allowing disinterested colleagues to vet the research and its implications. Mboniswa (2005) states that findings should be released in such a manner that utilization by others is encouraged, since, after all that is what the ultimate goal of any research project should be. The research results have been published both in print and electronic formats, providing the respondents and/or participants an opportunity to access them.

3.10 Limitations

This study has traversed one key limitation. The nature of the issue at hand (substance use, misuse and abuse) has got an element of criminality. According to the Prevention and Treatment of Substance Abuse Act (No. 70 of 2008), use of illicit drugs is a criminal offence in South Africa. This intrinsically implies that obtaining or constructing a sampling frame from which a sample of substance users could judiciously be selected is a practically futile exercise. Given this limitation, caution is issued against the use of the results of this study for inferential purposes – neither to the population of substance users nor to the population of youth as operationalised in this study.

3.11 Summary

Chapter three has provided insights into the methodology applied. The focus was mainly on scientific methods utilised to facilitate the achievement of the study aims and objectives. Key methodological aspects including study design, target population, data collection, and research ethics have been fully explained. Chapter four will provide the results of the study.

CHAPTER FOUR: FINDINGS

4.1 Introduction

The previous chapter outlined the research methodology. In this chapter, both qualitative and quantitative data is presented, corroborating each other. Quantitative data was collected from a sample of 500 respondents (400 users and 100 non-users). Qualitative data was collected from 25 focus group sessions. Quantitative data is presented statistically using tables, and graphs whilst qualitative data is presented thematically. This chapter presents the study's findings which emanate from the data analysis process. The results are presented as follows: Substance users, Substance non- users, and qualitative results respectively.

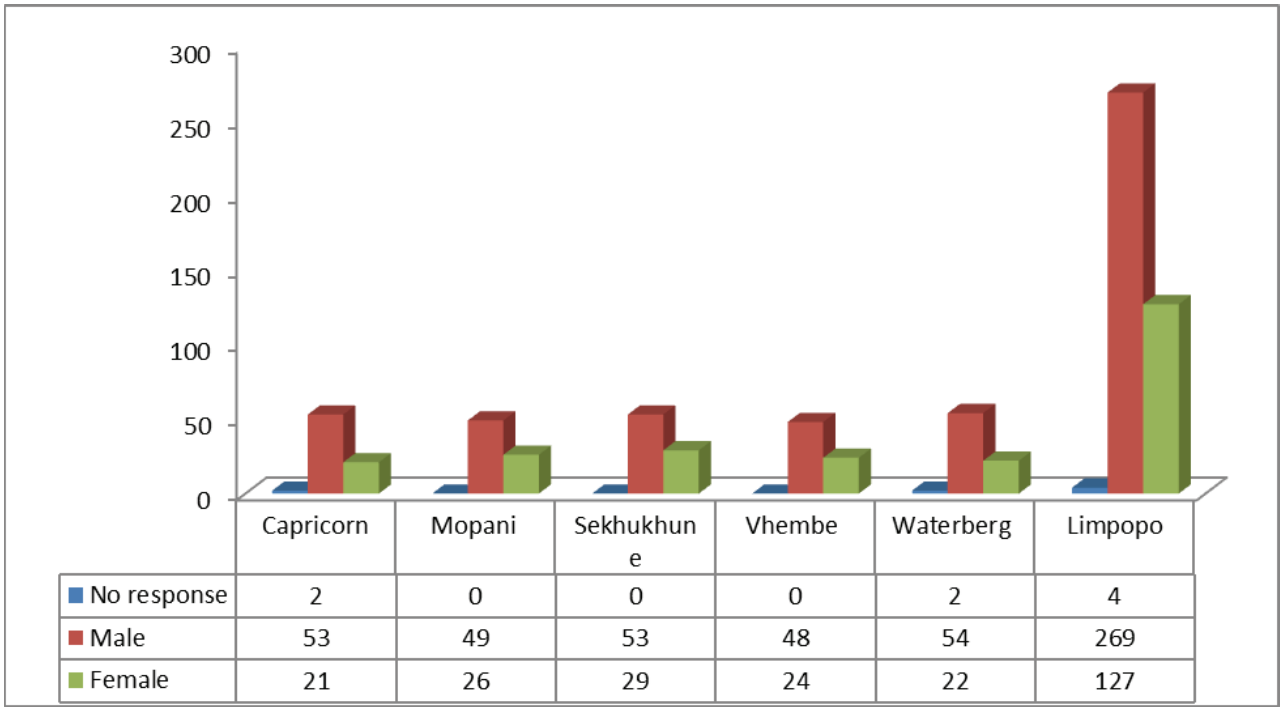
4.2 Background Characteristics of Substance users

The background characteristics of substance users are shown in figure 1 and Table 1 below. The study collected information from 400 substance users in all five districts as follows: Capricorn - 76, Mopani – 75, Sekhukhune - 82, Vhembe – 72 and Waterberg 78. In terms of Gender, Out of 400 respondents, males constituted 67.3% and females 31.8%. This may support the assumption that males indulge in substances more than females. However, this finding and the assumption need to be treated with caution given the methodology (purposive) and fact that female substance users were scarce to come by during the interviews.

Table 1: Distribution of Substance users by gender and district Municipalities

District Municipalities	Gender			Total
	No response	Male	Female	
Capricorn	2	53	21	**76**
Mopani	0	49	26	**75**
Sekhukhune	0	53	29	**82**
Vhembe	0	48	24	**72**
Waterberg	2	54	22	**78**
Total	**4**	**269**	**127**	**400**

Figure 2: Number of Substance Users by gender and district Municipalities



	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Limpopo
No response	2	0	0	0	2	4
Male	53	49	53	48	54	269
Female	21	26	29	24	22	127

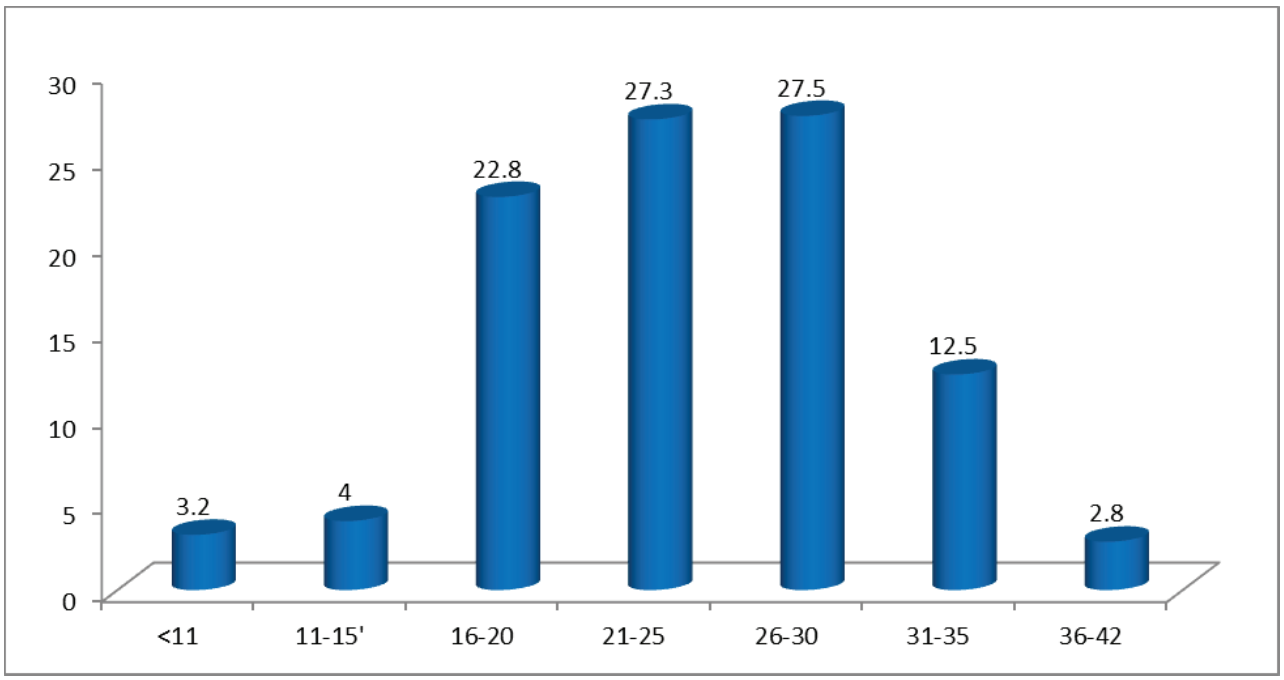
4.2.1: Respondents by age

The figure 3 below provides information regarding the number of respondents by age groups. What is deduced from the figure is that, young people of the age 19 – 30 seem to be the ones indulging in substances more than any other age groups. This can be attributable to Eric Erickson Psychosocial theory that describes the impact of social experience across the whole lifespan. It is vivid that these young persons are straddling with stage of four: industry versus inferiority and stage five: identity versus confusion. Mean Age is 24 years.

Table 2: Distribution of respondents by Age groups

Age groups	Frequency	Percentage
Less than 11	13	3.2
11-15	16	4.0
16-20	91	22.8
21-25	109	27.3
26-30	110	27.5
31-35	50	12.5
36-42	11	2.8
Total	400	100

Figure 3: Percentage distribution of respondents by Age groups



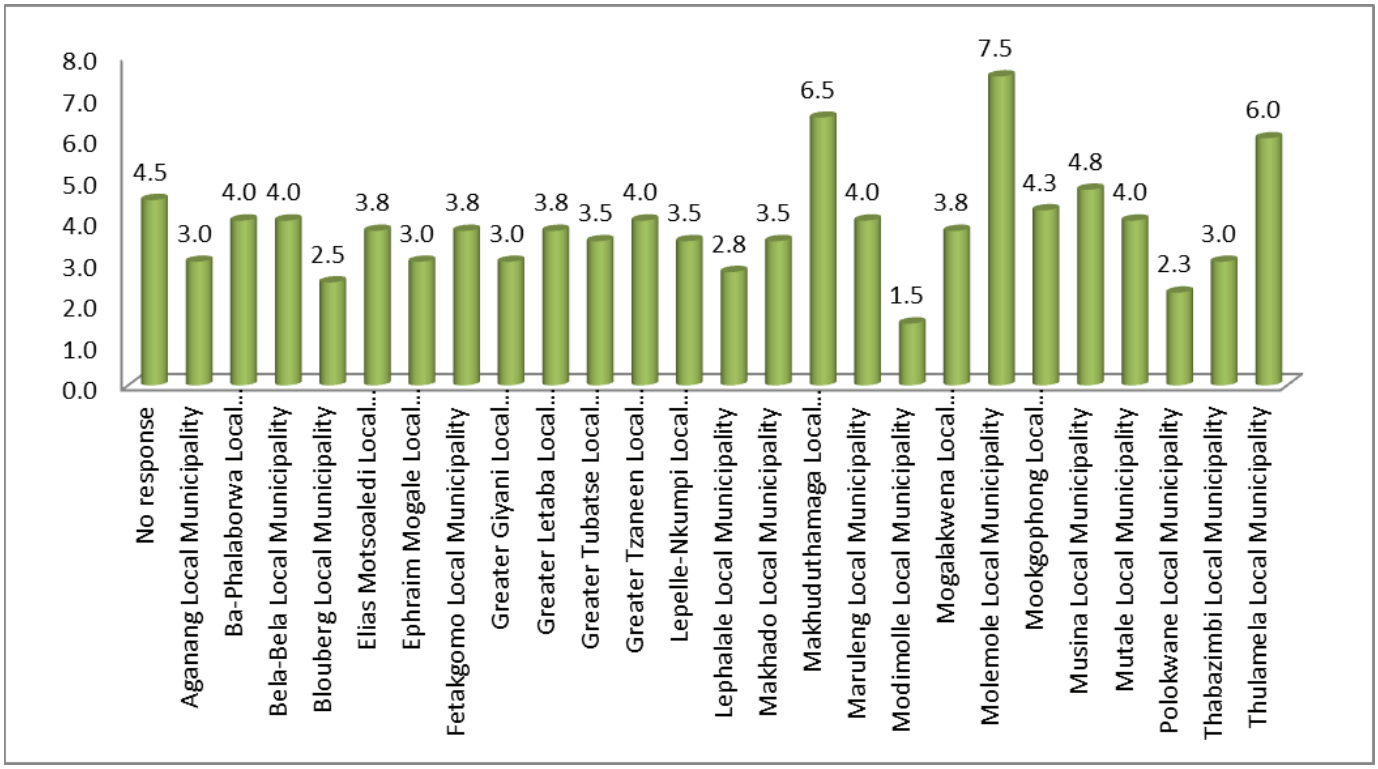
4.2.2 Substance Users by Local municipalities

The findings show that the highest response came from Molemole Local municipality with 7.5% followed by Makhuduthamaga local Municipality with 6.5%. Subsequently followed by Thulamela Local Municipality with 6.0%. The other local municipalities range between 4.8 and 1.5% response rate.

Table 3: Respondents by Local municipalities

Local municipalities	Frequency	Percentages
No response	18	4.5
Aganang Local Municipality	12	3.0
Ba-Phalaborwa Local Municipality	16	4.0
Bela-Bela Local Municipality	16	4.0
Blouberg Local Municipality	10	2.5
Elias Motsoaledi Local Municipality	15	3.8
Ephraim Mogale Local Municipality	12	3.0
Fetakgomo Local Municipality	15	3.8
Greater Giyani Local Municipality	12	3.0
Greater Letaba Local Municipality	15	3.8
Greater Tubatse Local Municipality	14	3.5
Greater Tzaneen Local Municipality	16	4.0
Lepelle-Nkumpi Local Municipality	14	3.5
Lephalale Local Municipality	11	2.8
Makhado Local Municipality	14	3.5
Makhuduthamaga Local Municipality	26	6.5
Maruleng Local Municipality	16	4.0
Modimolle Local Municipality	6	1.5
Mogalakwena Local Municipality	15	3.8
Molemole Local Municipality	30	7.5
Mookgophong Local Municipality	17	4.3
Musina Local Municipality	19	4.8
Mutale Local Municipality	16	4.0
Polokwane Local Municipality	9	2.3
Thabazimbi Local Municipality	12	3.0
Thulamela Local Municipality	24	6.0
Total	400	100.0

Figure 4: Respondents by local municipalities



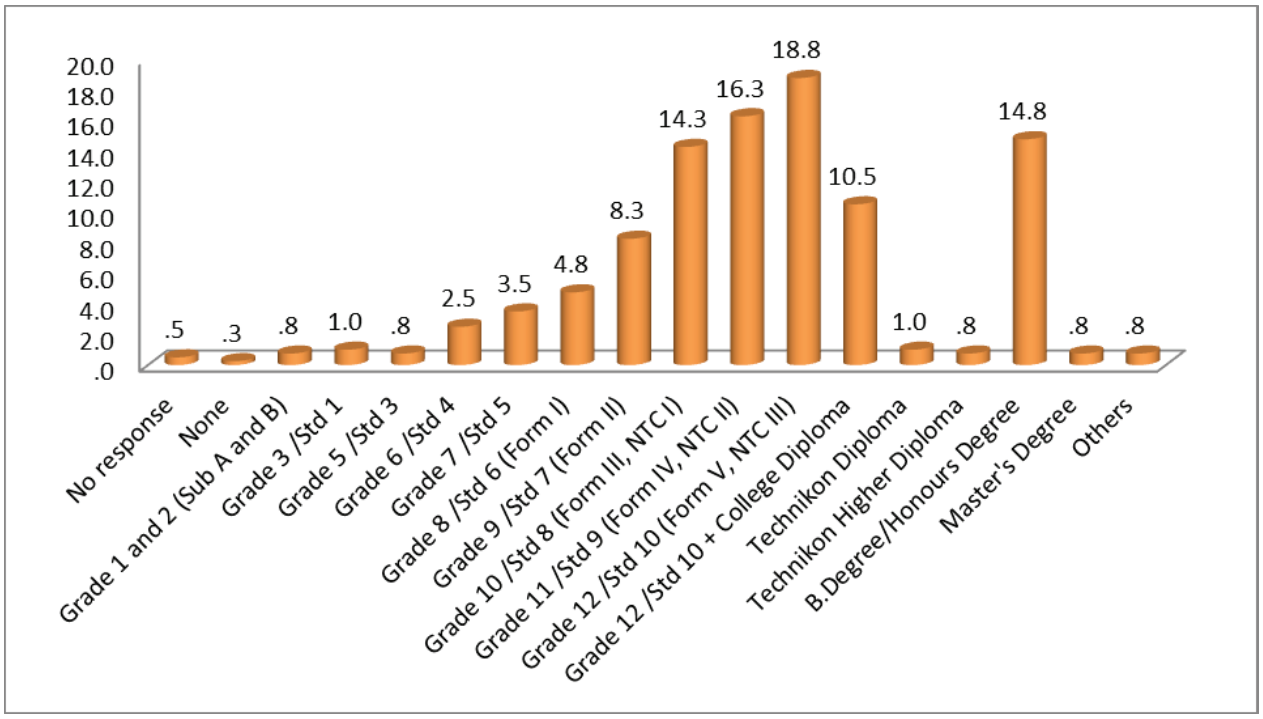
4.2.3: Respondents by Level of Education

The study sought to find out if substance use has anything to do with an individual's qualification. Figure 5 shows the findings regarding this particular aspect. It is evident from the findings that most young people who indulge in substances do possess some qualifications. A substantial percentage of youth (18.8%) have grade 12. Another finding is the fact that 10.5% and 14.8 % have post-matric qualifications, people whom are assumed to have some level of education, but the one to be abusing substances. It can be deduced that there are secondary factors playing a role in influencing them to indulge in substances.

Table 4: Respondents by level of Education and Gender

Qualifications	Gender			Total	
	No response	Male	Female		Percentages
No response	0	2	0	2	0.5
None	0	0	1	1	0.3
Grade 1 and 2 (Sub A and B)	0	2	1	3	0.8
Grade 3 /Std 1	0	0	4	4	1.0
Grade 5 /Std 3	0	3	0	3	0.8
Grade 6 /Std 4	1	8	1	10	2.5
Grade 7 /Std 5	0	10	4	14	3.5
Grade 8 /Std 6 (Form I)	0	13	6	19	4.8
Grade 9 /Std 7 (Form II)	0	17	16	33	8.3
Grade 10 /Std 8 (Form III, NTC I)	1	40	16	57	14.3
Grade 11 /Std 9 (Form IV, NTC II)	0	45	20	65	16.3
Grade 12 /Std 10 (Form V, NTC III)	2	54	19	75	18.8
Grade 12 /Std 10 + College Diploma	0	33	9	42	10.5
Technikon Diploma	0	3	1	4	1.0
Technikon Higher Diploma	0	3	0	3	0.8
B.Degree/Honours Degree	0	34	25	59	14.8
Master's Degree	0	0	3	3	0.8
Others	0	2	1	3	0.8
Total	**4**	**269**	**127**	**400**	100

Figure 5: Respondents by level of Education



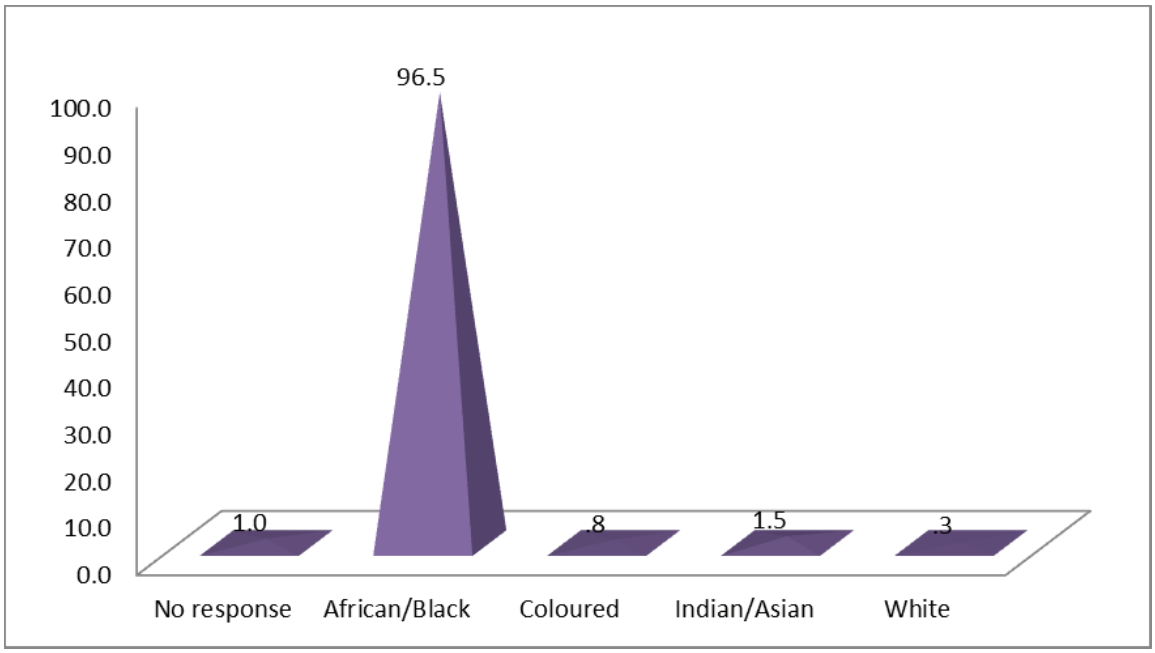
4.2.4: Respondents by Population Group

The findings confirm the statistics by Statistics that Limpopo Province in terms of Population group, blacks constitutes the majority. For the people sampled, 96.5% were black people. This can be attributable to the fact that social workers employed by the Department of Social Development are blacks, the areas they sampled were populated by blacks, hence this picture.

Table 5: Respondents by Population Group

Population groups	Frequency	Percentage
No response	4	1.0
African/Black	386	96.5
Coloured	3	.8
Indian/Asian	6	1.5
White	1	.3
Total	400	100.0

Figure 6: Respondents by Population Group



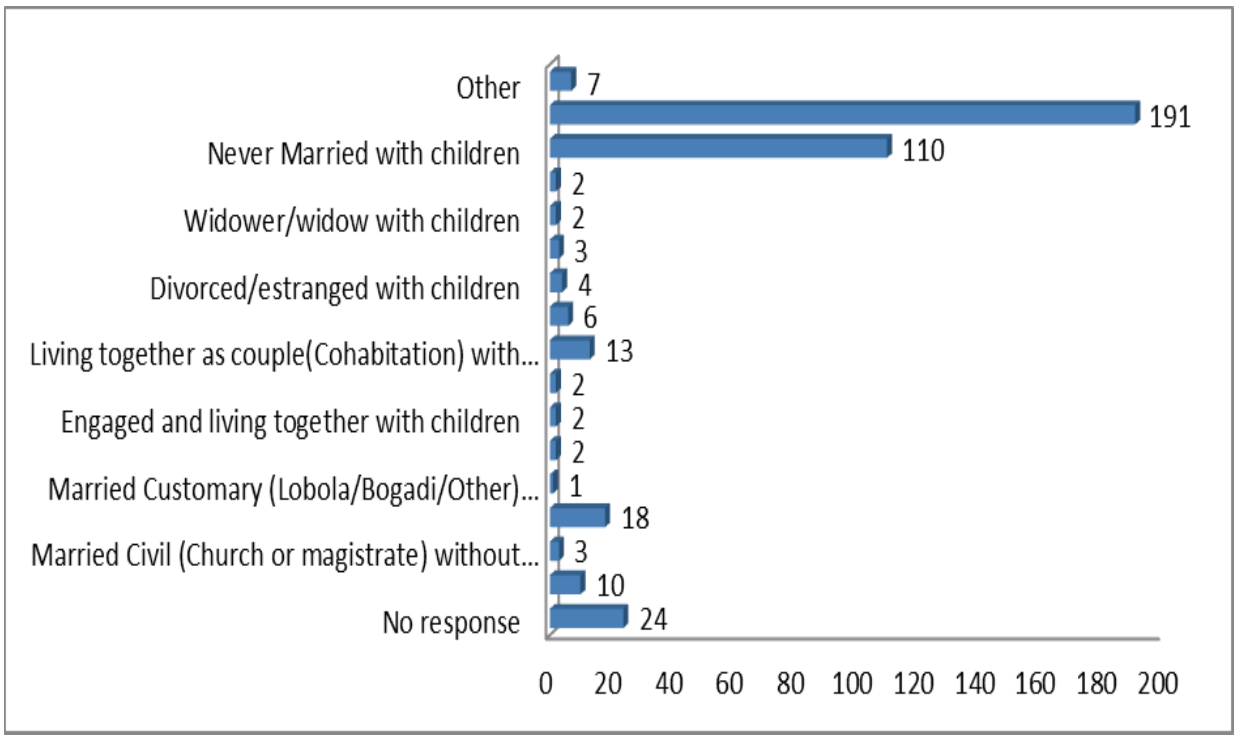
4.2.5: Respondents by marital status

The figure above highlights the true reflection about young people though there are serious challenges wherein 27.5% of youth have children out of wedlock. Never married without children 47.8%

Table 6: Respondents by Marital status

Marital status	Frequency	Percent
No response	24	6.0
Married Civil (Church or magistrate) with children	10	2.5
Married Civil (Church or magistrate) without children	3	.8
Married Customary (Lobola/Bogadi/Other) with children	18	4.5
Married Customary (Lobola/Bogadi/Other) without children	1	.3
Married Civil and Customary with children	2	.5
Engaged and living together with children	2	.5
Engaged and living together without children	2	.5
Living together as couple(Cohabitation) with children	13	3.3
Living together as couple(Cohabitation) without children	6	1.5
Divorced/estranged with children	4	1.0
Divorced/estranged without children	3	.8
Widower/widow with children	2	.5
Widower/widow without children	2	.5
Never Married with children	110	27.5
Never Married without children	191	47.8
Other	7	1.8
Total	400	100.0

Figure 7: Respondents by marital status



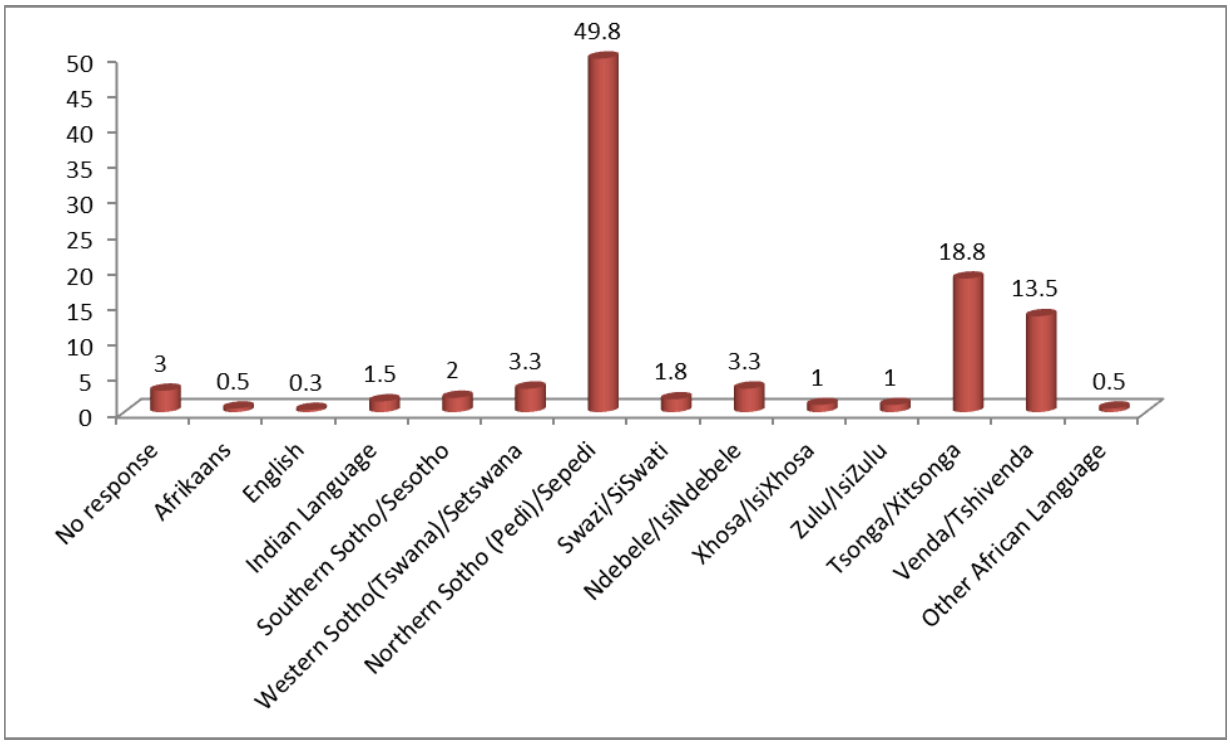
4.2.6: Respondents by language

In terms of the language demographics of the province, it was found that, Northern Sotho constituted 49.8%, followed by the Xitsonga speaking people – 18.8% and the Venda – 13.5%, and Ndebele – 3.3%.

Table 7: Respondents by Language

Language	Frequency	Percentage
No response	12	3.0
Afrikaans	2	.5
English	1	.3
Indian Language	6	1.5
Southern Sotho/Sesotho	8	2.0
Western Sotho(Tswana)/Setswana	13	3.3
Northern Sotho (Pedi)/Sepedi	199	49.8
Swazi/SiSwati	7	1.8
Ndebele/IsiNdebele	13	3.3
Xhosa/IsiXhosa	4	1.0
Zulu/IsiZulu	4	1.0
Tsonga/Xitsonga	75	18.8
Venda/Tshivenda	54	13.5
Other African Language	2	.5
Total	400	100.0

Figure 8: Respondents by Language



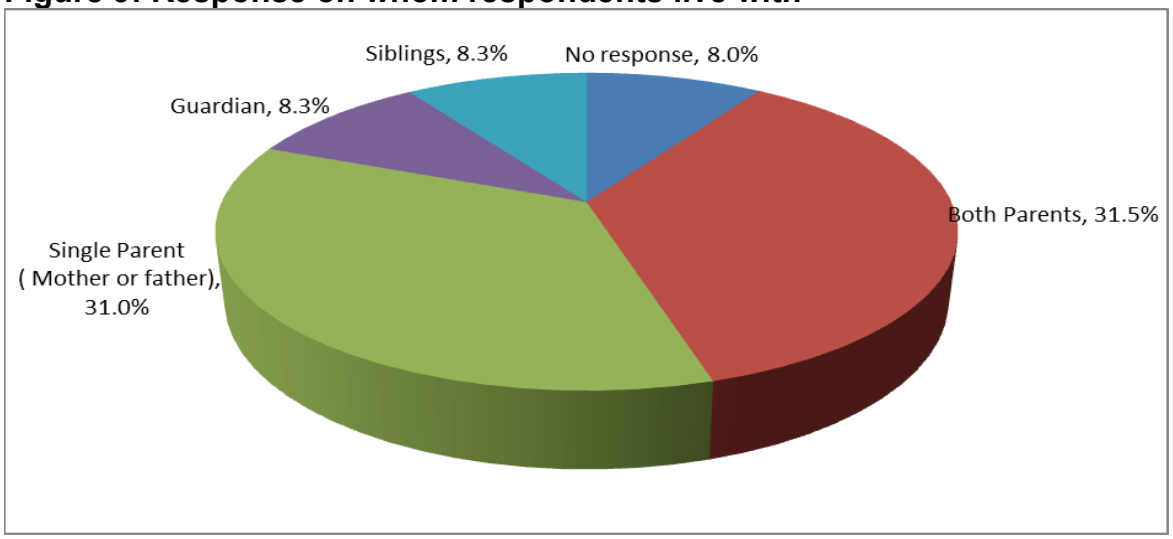
4.2.7: Response on whom respondents live with

From the data above, 31.5% stay with their both parents whilst 31% live either with mother or father. From the general observation, it is more common for mothers to take care of the children than fathers. Nonetheless, a substantial number (8.3%) live with guardians which raises serious issues of where parents passed on or are unknown or their whereabouts could not be established. Another shocking revelation is the percentages of youth living with siblings in the absence of parents. This raises issues of discipline as to who exercises control or discipline in the household. Data from Focus group discussion indicates that parents should be the one to exercise control over children.

Table 8: Response on whom respondents live with

Whom respondents live with	Frequency	Percent
No response	32	8.0
Both Parents	126	31.5
Single Parent (Mother or father)	124	31.0
Guardian	33	8.3
Siblings	33	8.3
Other	52	13.0
Total	400	100.0

Figure 9: Response on whom respondents live with



4.2.8: Respondents by gross income

As indicated above, the majority of participants (26.8%) mentioned that they have no income and when considering those who did not respond to this question, it can be assumed that since Limpopo Province is a rural area, poverty levels are high and unemployment rates are alarming.

Table 9: Distribution of Respondents Gross income

Gross Income	Frequency	Percentage
No response	43	10.8
No income	107	26.8
R1 - R99	12	3.0
R100 - R299	14	3.5
R300 - R499	14	3.5
R500 - R799	16	4.0
R800 - R999	15	3.8
R1000 - R2399	42	10.5
R2400 - R4999	37	9.3
R5000 - R9999	39	9.8
R10 000 - R15 999	39	9.8
R16 000 - R19 999	3	.8
R20 000 - R24 999	6	1.5
R25 000 - R29 999	1	.3
Uncertain/don't know	12	3.0
Total	400	100.0

Figure 10: Distribution of Respondents Gross income

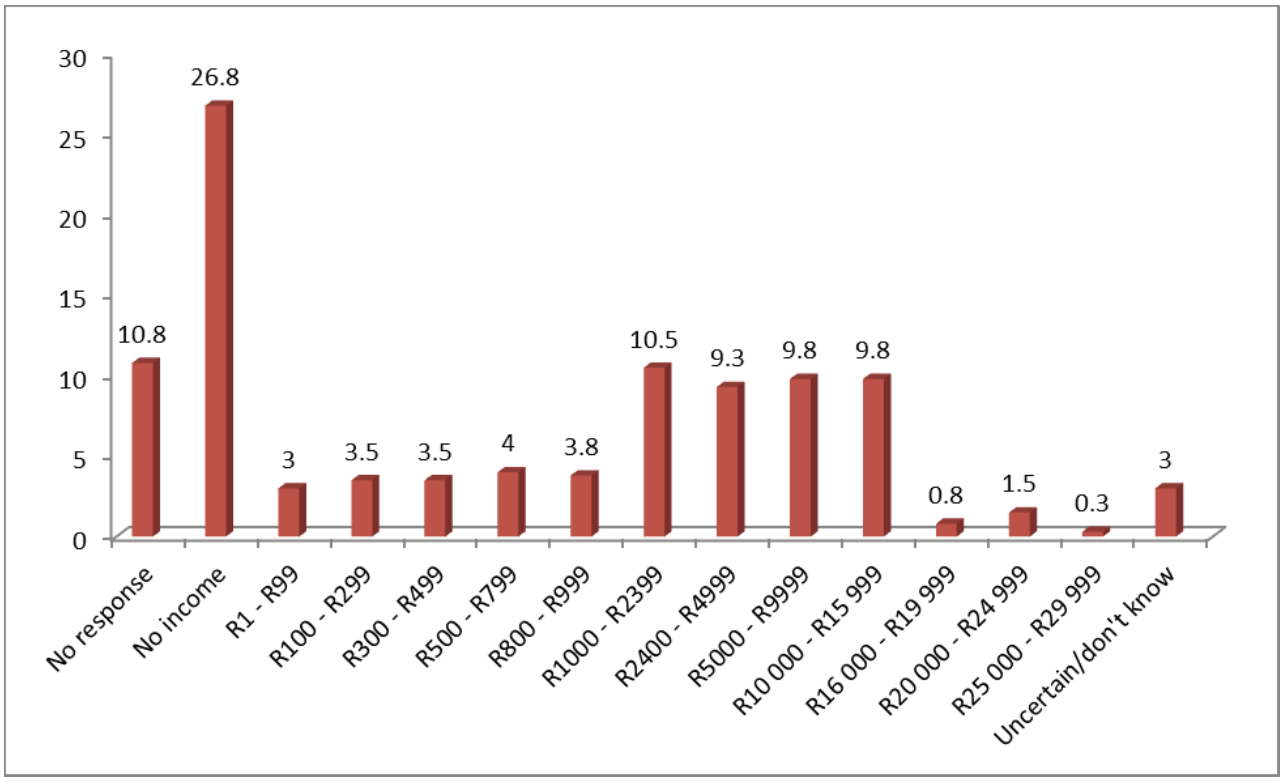
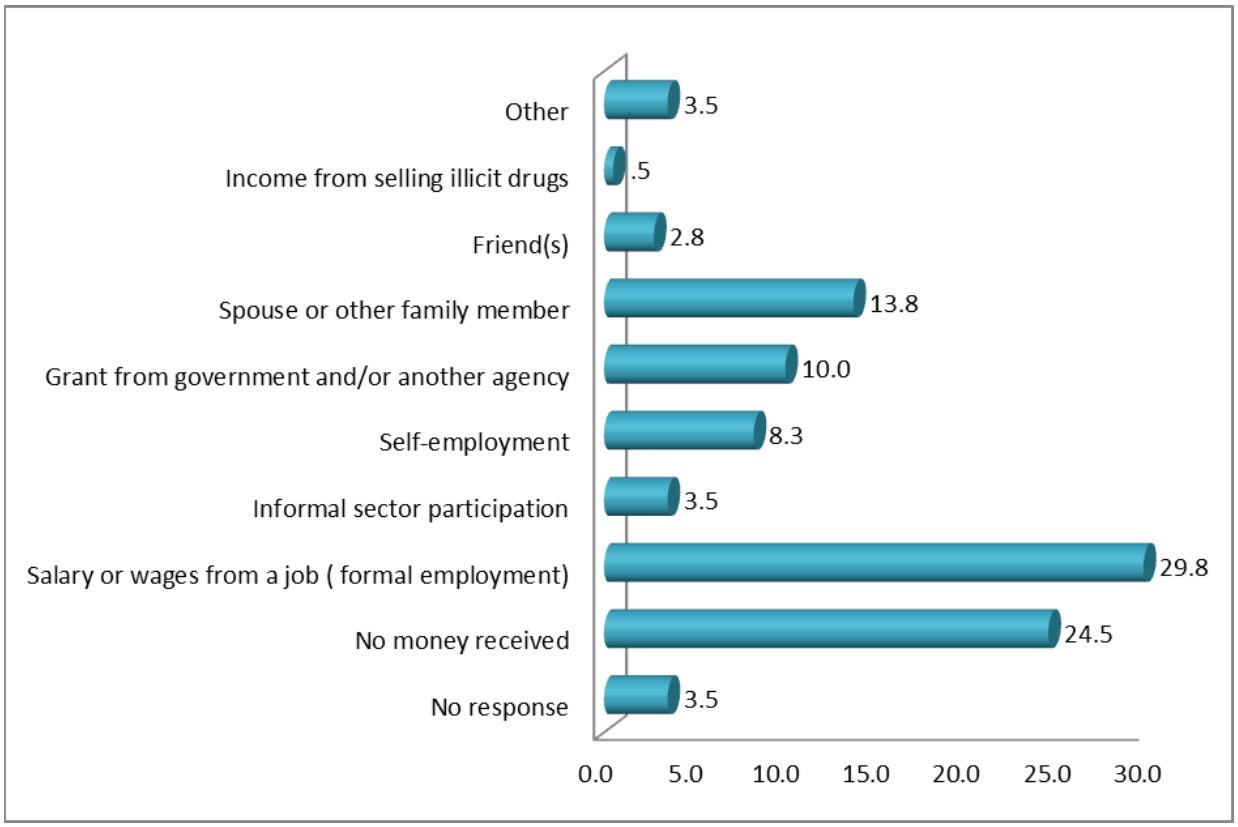


Table 10: Respondents' source of income

Source of income	Frequency	Percentage
No response	14	3.5
No money received	98	24.5
Salary or wages from a job (formal employment)	119	29.8
Informal sector participation	14	3.5
Self-employment	33	8.3
Grant from government and/or another agency	40	10.0
Spouse or other family member	55	13.8
Friend(s)	11	2.8
Income from selling illicit drugs	2	.5
Other	14	3.5
Total	400	100.0

Figure 11: Respondents' source of income



4.3 Background characteristics of Non-Substance –users

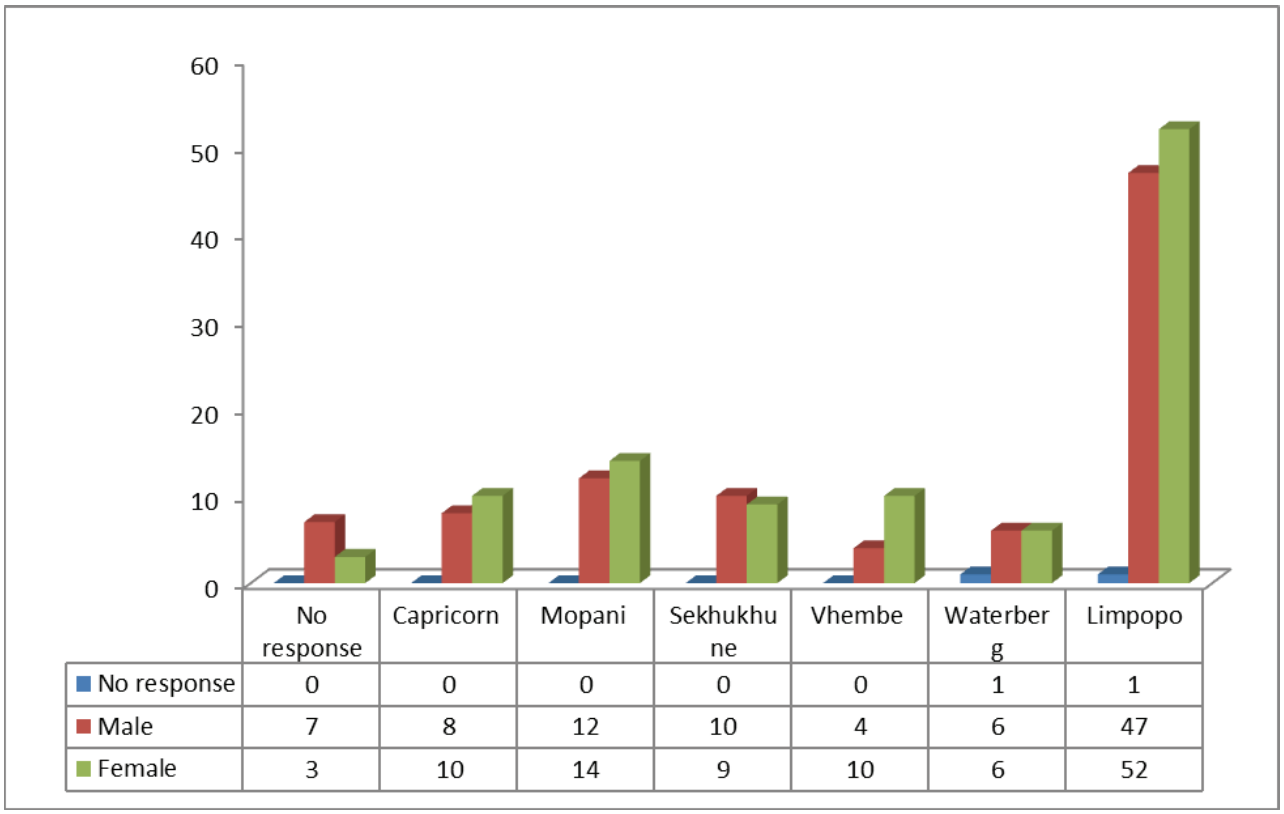
4.3.1 Respondents by district

The table below shows that the study also collected information from 100 substance non-users. Mopani district constituted 26%, Sekhukhune district with 19%, Capricorn district with 18%, Vhembe district with 14%, Waterberg district with 13% and finally 10% accounted for those who did not respond. In terms of gender, males constituted 47% and females 52%. This again confirms the assumption that males use substances than females.

Table 11: Respondents by District and Gender

District	No response	Male	Female	Total	Percentages
No response	0	7	3	10	10.0
Capricorn	0	8	10	18	18.0
Mopani	0	12	14	26	26.0
Sekhukhune	0	10	9	19	19.0
Vhembe	0	4	10	14	14.0
Waterberg	1	6	6	13	13.0
Total	1	47	52	100	100.0

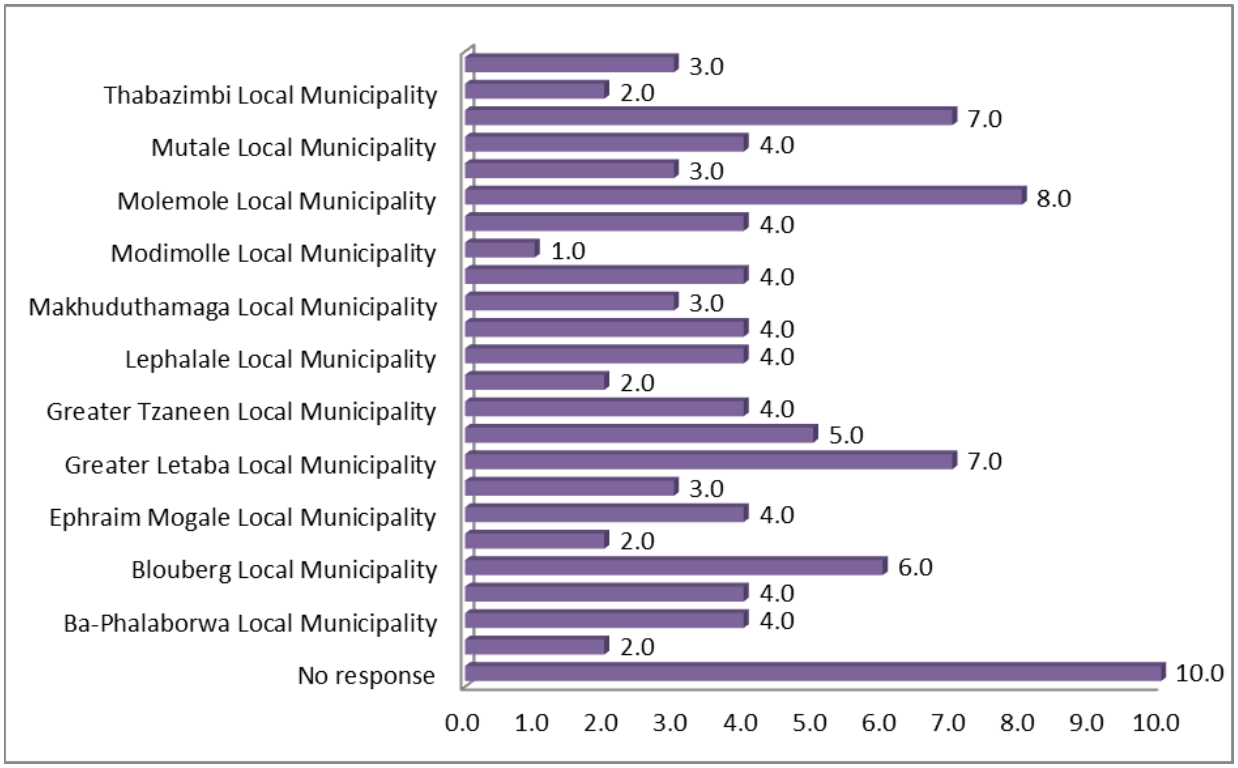
Figure 12: Respondents by Districts and Gender



4.3.2 Respondents by local municipalities

The local municipality with the highest Respondents was Molemole with 8% followed by Greater Letaba and Musina Local Municipality with 7%. The lowest response came from Modimolle Local municipality with 1%.

Figure 13: Respondents by local municipality



4.2.4 Respondents by age

In this category of non-users, the findings highlight that at least 10% are in the age of 24. What is eye catching too, is the age group ranging between 25 -29 constituting between 6 – 9%.

Table 12: Respondents by age

Age	Frequency	Percent
14	3	3.0
18	5	5.0
19	4	4.0
20	4	4.0
21	5	5.0
22	3	3.0
23	6	6.0
24	10	10.0
25	6	6.0
26	8	8.0
27	5	5.0
28	9	9.0
29	7	7.0
30	6	6.0
31	7	7.0
32	2	2.0
33	2	2.0
34	2	2.0
35	6	6.0
Total	100	100.0

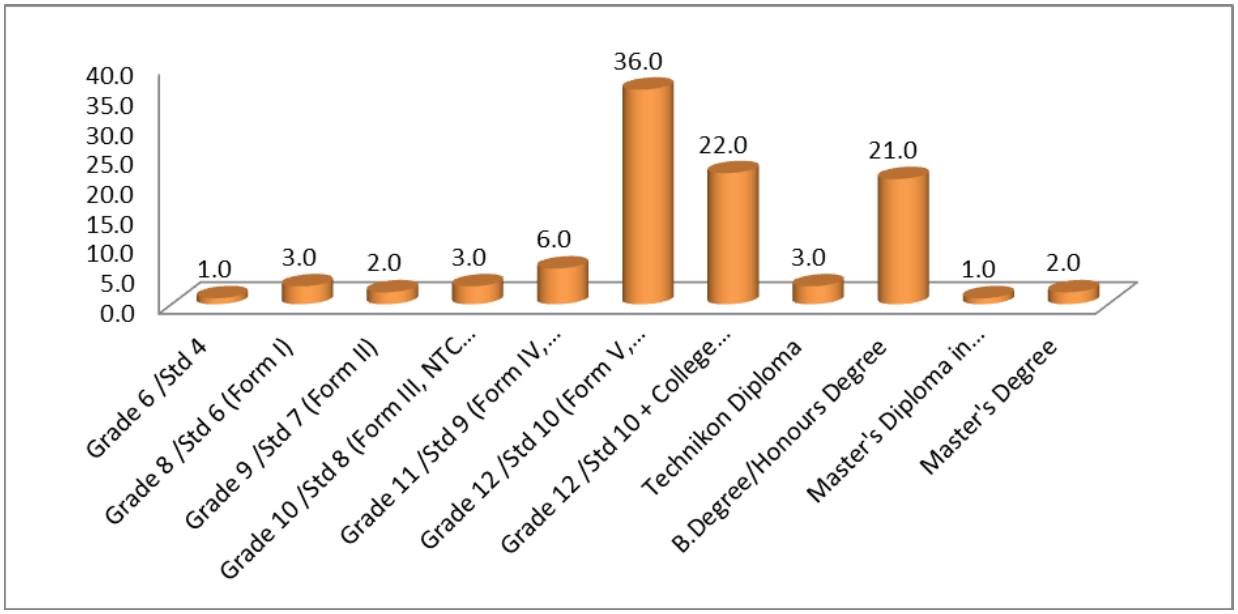
4.2.5 Respondents by educational qualifications

The findings indicate that out of 100 participants, 36% of the respondents had grade 12 and significantly, 21% had post-matric qualification, preferably honours.

Table 13: Respondents by qualification

Qualifications	Frequency	Percent
Grade 6 /Std 4	1	1.0
Grade 8 /Std 6 (Form I)	3	3.0
Grade 9 /Std 7 (Form II)	2	2.0
Grade 10 /Std 8 (Form III, NTC I)	3	3.0
Grade 11 /Std 9 (Form IV, NTC II)	6	6.0
Grade 12 /Std 10 (Form V, NTC III)	36	36.0
Grade 12 /Std 10 + College Diploma	22	22.0
Technikon Diploma	3	3.0
B.Degree/Honours Degree	21	21.0
Master's Diploma in Technology	1	1.0
Master's Degree	2	2.0
Total	100	100.0

Figure 14: Respondents by qualification



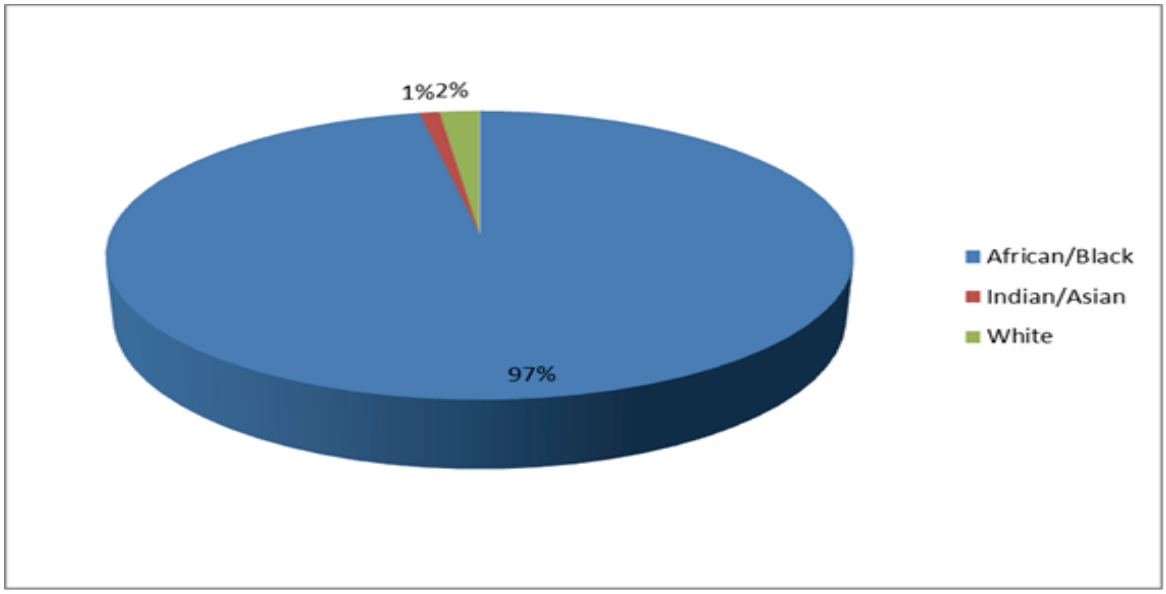
4.2.6 Respondents by Population group

From above, it can be deduced that 97% constituted by African/Black and 2% by white and finally 1% constituted by Asian

Table 14: Respondents by Population group

Population group	Frequency	Percent
African/Black	97	97.0
Indian/Asian	1	1.0
White	2	2.0
Total	100	100.0

Figure 15: Respondents by Population group



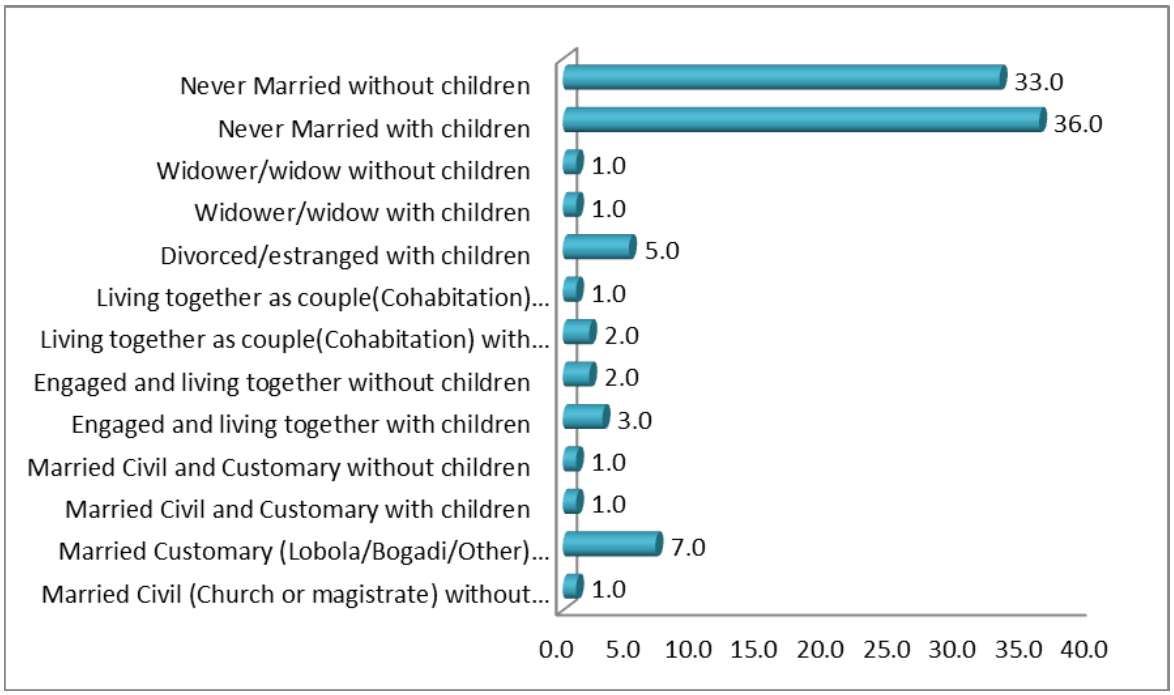
4.2.7 Respondents by marital status

From the figure above, those were not married without children constituted 33% and those with children constituted 36%

Table 15: Respondents by marital status

Marital status	Frequency	Percent
Married Civil (Church or magistrate) without children	1	1.0
Married Customary (Lobola/Bogadi/Other) with children	7	7.0
Married Civil and Customary with children	1	1.0
Married Civil and Customary without children	1	1.0
Engaged and living together with children	3	3.0
Engaged and living together without children	2	2.0
Living together as couple(Cohabitation) with children	2	2.0
Living together as couple(Cohabitation) without children	1	1.0
Divorced/estranged with children	5	5.0
Widower/widow with children	1	1.0
Widower/widow without children	1	1.0
Never Married with children	36	36.0
Never Married without children	33	33.0
Other	6	6.0
Total	100	100.0

Figure 16: Respondents by marital status



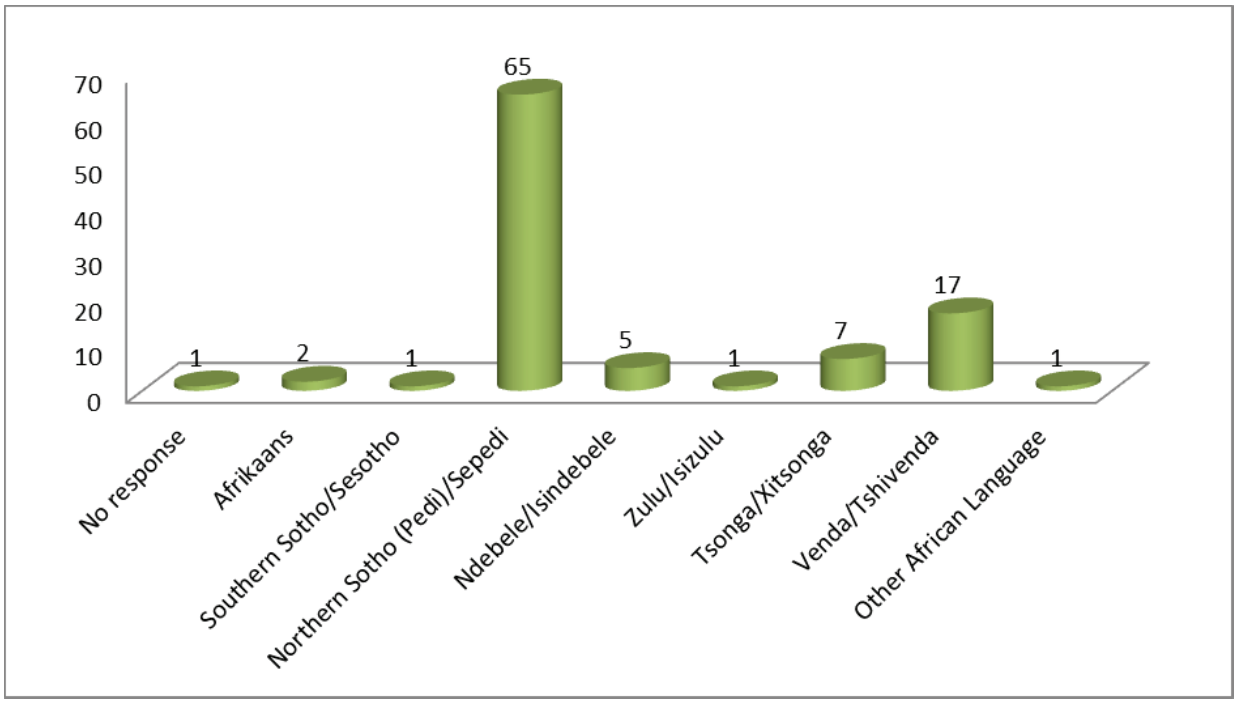
4.2.8 Respondents by Language

The figure above indicates that 65% were the Northern Sotho speaking people, while 17% were the Venda speaking people and Tsonga speaking constituted 7%. This is followed by the Ndebele with 5% and Afrikaans with 2%.

Table 16: Respondents by Language

Language	Frequency	Percent
No response	1	1.0
Afrikaans	2	2.0
Southern Sotho/Sesotho	1	1.0
Northern Sotho (Pedi)/Sepedi	65	65.0
Ndebele/IsiNdebele	5	5.0
Zulu/IsiZulu	1	1.0
Tsonga/Xitsonga	7	7.0
Venda/Tshivenda	17	17.0
Other African Language	1	1.0
Total	100	100.0

Figure 17: Respondents by Language



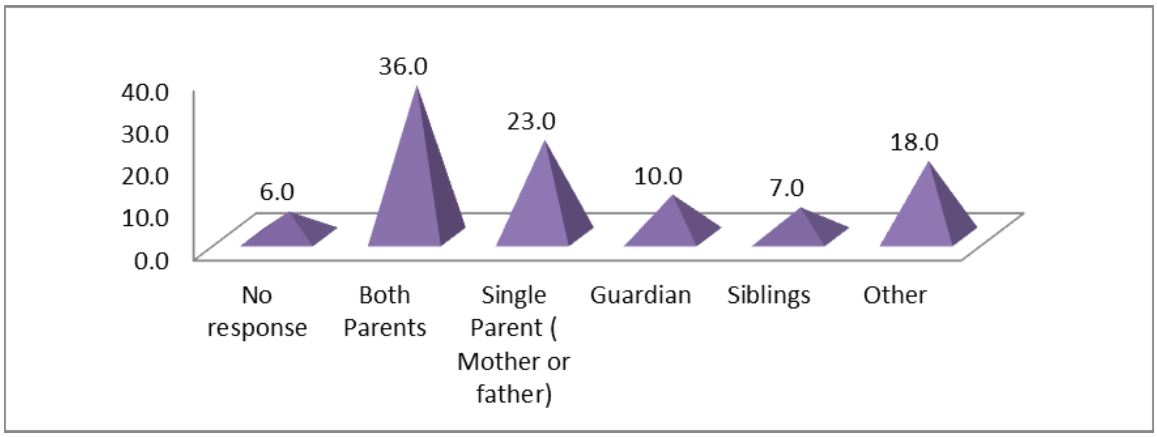
4.2.9 Respondents: people youth live with

It has been found that 36% live with both parents, 23% stay in single parent families (either father or mother headed-household) whilst 10% stay with guardians and those who stay with siblings constituted 7%.

Table 17: Respondents: people youth live with

Respondents by Live with	Frequency	Percent
No response	6	6.0
Both Parents	36	36.0
Single Parent (Mother or father)	23	23.0
Guardian	10	10.0
Siblings	7	7.0
Other	18	18.0
Total	100	100.0

Figure 18: Respondents: people youth live with



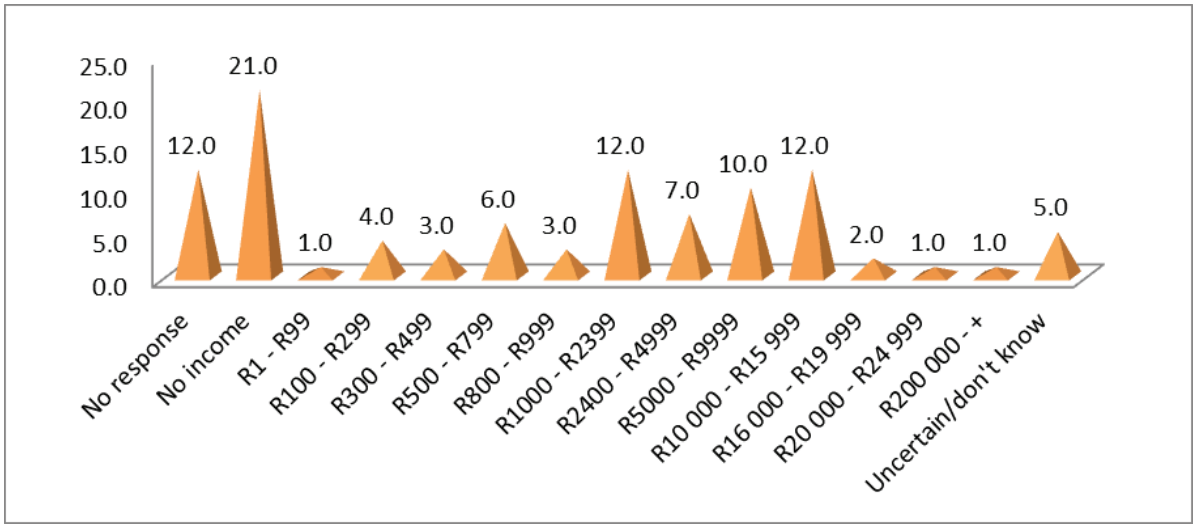
4.2.12 Respondents by gross income

The findings are shocking as youth in spite of 21% who mentioned that they do not have income, 12% received money between the range of R1000 – R2399 and R10 000 – 15 999 respectively.

Table 18: Respondents by gross income

Gross income	Frequency	Percent
No response	12	12.0
No income	21	21.0
R1 - R99	1	1.0
R100 - R299	4	4.0
R300 - R499	3	3.0
R500 - R799	6	6.0
R800 - R999	3	3.0
R1000 - R2399	12	12.0
R2400 - R4999	7	7.0
R5000 - R9999	10	10.0
R10 000 - R15 999	12	12.0
R16 000 - R19 999	2	2.0
R20 000 - R24 999	1	1.0
R200 000 - +	1	1.0
Uncertain/don't know	5	5.0
Total	100	100.0

Figure 19: Respondents by gross income



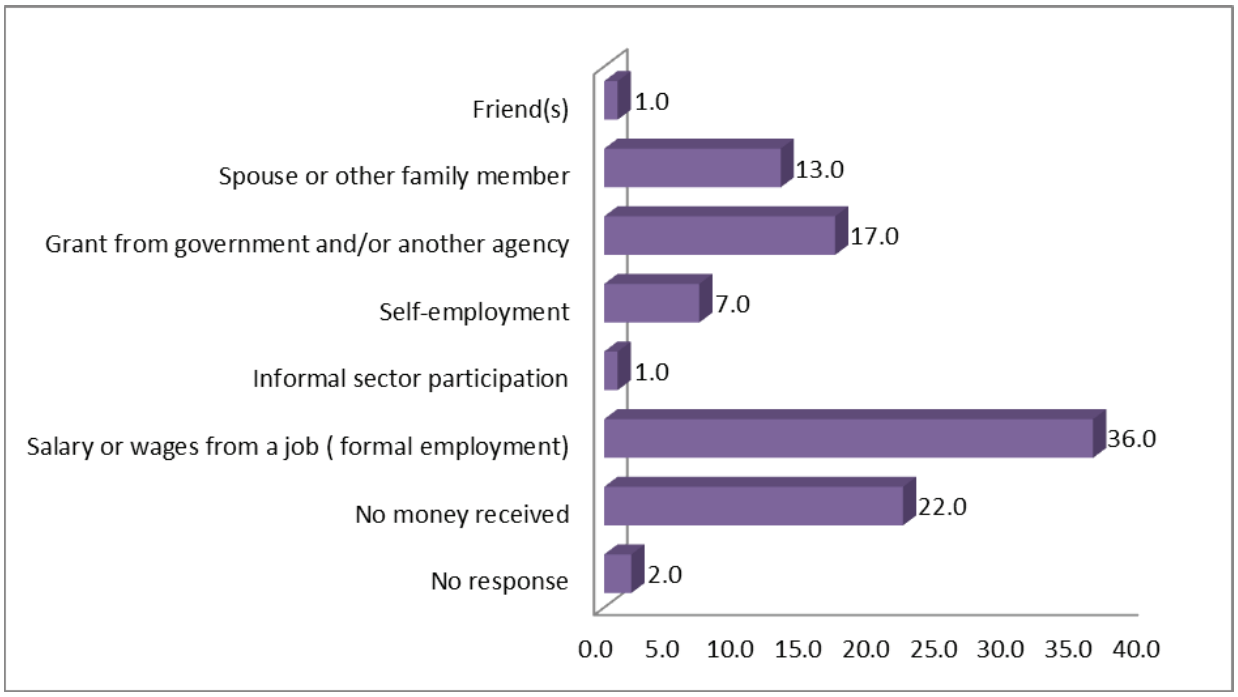
4.2.13 Respondents by sources of income

The figure above indicates at least 36% received money from their jobs whereas 22% indicated they do not have income. Another shocking indication is that 17% received money from government grants and 7% are self-employed and only 1% earned their money from informal sector participation.

Table 19: Respondents by sources of income

Source of income	Frequency	Percent
No response	2	2.0
No money received	22	22.0
Salary or wages from a job (formal employment)	36	36.0
Informal sector participation	1	1.0
Self-employment	7	7.0
Grant from government and/or another agency	17	17.0
Spouse or other family member	13	13.0
Friend(s)	1	1.0
Other	1	1.0
Total	100	100.0

Figure 20: Respondents by money earned



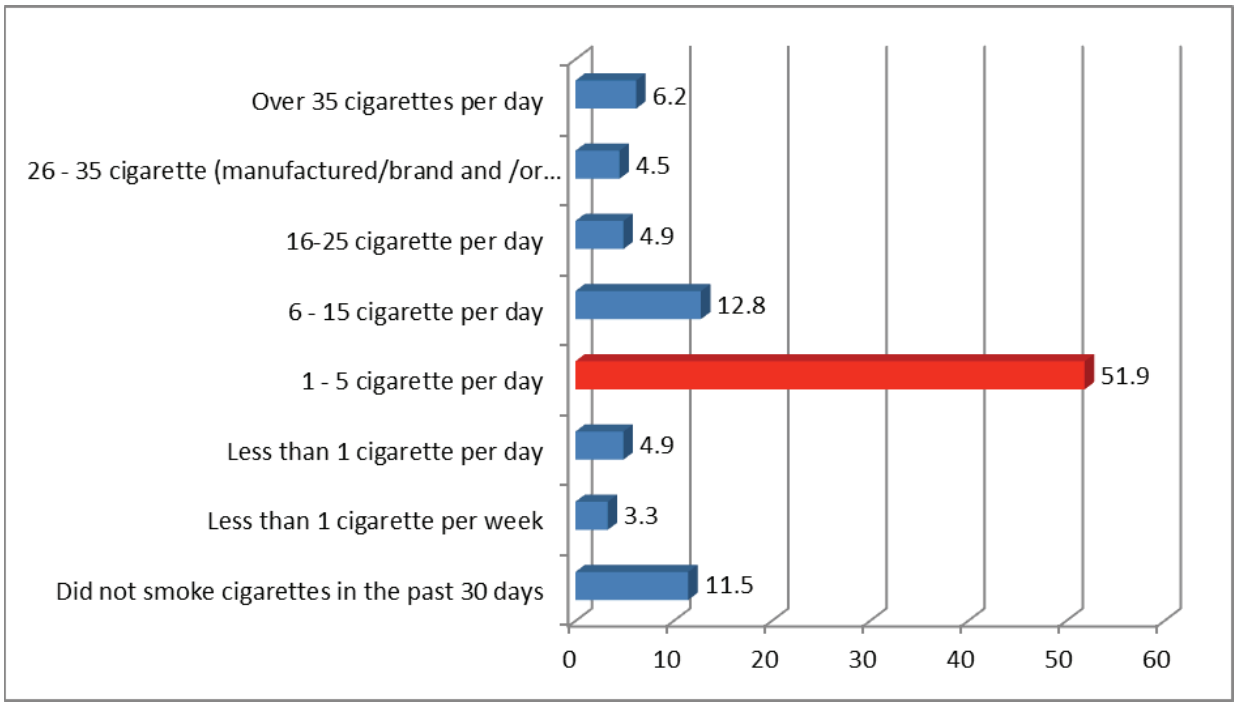
4.3 Tobacco use

The figure below depicts the prevalence of tobacco (cigarette) use in Limpopo province in the past 30 days before the survey. A significant number (51.9%) of those who reported smoking cigarettes in the past 30 days, reported to have smoked 1-5 cigarettes per day. There is also a small proportion (6.2 %) of smokers who reportedly smoked over 35 cigarettes per day in the past 30 days before the survey.

Table 20: Frequency of smoking tobacco in the past 30 days

Frequency of smoking cigarettes	Frequency	Percent
Did not smoke cigarettes in the past 30 days	28	11.5
Less than 1 cigarette per week	8	3.3
Less than 1 cigarette per day	12	4.9
1 - 5 cigarette per day	126	51.9
6 - 15 cigarette per day	31	12.8
16-25 cigarette per day	12	4.9
26 - 35 cigarette (manufactured/brand and /or hand-rolled)per day	11	4.5
Over 35 cigarettes per day	15	6.2
Total	**243**	**100.0**

Figure 21: Frequency of smoking cigarettes in the past 30 days



Types of tobacco used in the Province

Different types of cigarettes which the respondents reported to be smoking are presented in figure 22 and table 7 below. The most commonly smoked cigaterrets in the province is Tobacco, Cigar followed by a pinch of snuff and Quid of chew respectively. The provincial picture follows the same pattern as in the district municipalities.

Table 21: Number of respondents by district and type of tobacco

District	Tobacco	Cigar	Pinch of snuff	Quid of chew/tobacco	Total
No response	7	10	6	6	**29**
Capricorn	39	35	36	37	**147**
Mopani	30	31	30	30	**121**
Sekhukhune	23	18	23	16	**80**
Vhembe	34	31	22	23	**110**
Waterberg	35	34	31	30	**130**
Total	**168**	**159**	**148**	**142**	**617**

4.4 Alcohol use

Table 22 provides information in respect of alcohol use. The most commonly used alcohol includes commercially brewed beer (greater than 4% Alc/Vol) 54.8%, bottled wine (32%), and home-brewed beer (29.8%). According to the results, Waterberg district generally experiences alcohol use more than the other districts in the province while Vhembe district has the least usage.

Table 22: Alcohol use

Districts	Home-brewed beer	Regular strength Beer (greater than 4% Alc/Vol) - commercially brewed and bought over the counter	Light strength beer (3% to 3.9% Alc/Vol) - commercially brewed and bought over the counter	Bottled wine	Premixed spirits in bottles e.g. Brutal Fruit, Breezers, Smirnoff Spin	Ciders (commercially brewed and bought over the counter e.g. Savanna, Hunters)	Home-made hard liquor (e.g. Witblitz, Mampoer or Marula)	Bottled spirits and liqueurs (e.g. Gin, Vodka, Rum, Kahlua)
No response	7	9	1	5	3	1	0	3
Capricorn	13	35	10	21	11	18	14	16
Mopani	23	53	11	24	17	30	17	11
Sekhukhune	16	36	13	18	15	14	15	14
Vhembe	10	20	11	8	8	12	7	5
Waterberg	50	66	51	52	26	29	55	55
Total	119	219	97	128	80	104	108	104
Percent	29.8%	54.8%	24.3%	32%	20%	26%	27%	26%

Table 22 continued

Districts	Fortified wine, port, vermouth, sherry, etc	Other home-brews / concoctions (e.g. Mbhambha and Pynappel)	Other types
No response	4	0	0
Capricorn District Municipality	13	12	6
Mopani	8	9	6
Sekhukhune	11	11	11
Vhembe	5	5	5
Waterberg	60	60	60
Total	101	97	88
Percent	25.3%	24.3%	22%

N.B Percentage Calculated (out of a sample of 400 substance users)

4.5 Use of substances

Table 23 provides information in respect of substances. The most commonly used substances are Cannabis (49%), Inhalants (39.3%). According to the results, Waterberg district generally experiences drug use the most in the province while Vhembe and Capricorn districts have the least usage.

Table 23: Use of substances

	Inhalants	%	Cannabis	%	Khat	%	Cocaine	%	Ecstasy	%
No response	7	4.46	9	4.59	4	3.10	5	3.79	5	3.82
Capricorn	29	18.47	30	15.31	22	17.05	22	16.67	22	16.79
Mopani	32	20.38	37	18.88	27	20.93	27	20.45	27	20.61
Sekhukhune	25	15.92	33	16.84	22	17.05	23	17.42	22	16.79
Vhembe	25	15.92	41	20.92	20	15.50	21	15.91	21	16.03
Waterberg	39	24.84	46	23.47	34	26.36	34	25.76	34	25.95
Total	**157**	100	**196**	100	**129**	100	**132**	100	**131**	100
Percent	**39.3%**		**49.00%**		**32.3%**		**33%**		**32.8%**	

Table 23 continued

	Heroin	%	Hallucinogens	%	Relevin	%	Amphetamines	%	Mandrax	%	Tik	%
No response	5	3.73	5	3.846	5	3.85	5	3.82	5	3.76	5	3.82
Capricorn	22	16.42	21	16.154	21	16.15	21	16.03	22	16.54	21	16.03
Mopani	27	20.15	27	20.769	27	20.77	27	20.61	27	20.30	27	20.61
Sekhukhune	22	16.42	22	16.923	21	16.15	22	16.79	23	17.29	22	16.79
Vhembe	21	15.67	21	16.154	21	16.15	21	16.03	21	15.79	21	16.03
Waterberg	37	27.61	34	26.154	35	26.92	35	26.72	35	26.32	35	26.72
Total	**134**	100	**130**	100	**130**	100	**131**	100	**133**	100	**131**	100
	33.5		32.5		32.5		32.75		33.25		32.75	

N.B Percentage Calculated (out of a sample of 400 substance users)

Table 23 continued

	Mixtures of mandrax	%	Mixtures of alcohol and pills (medicaments)	%	Other mixtures	%	Anabolic steroids	%	Other	%
No response	7	5.00	5	3.759398	3	2.5	4	3.2	2	2.38
Capricorn	24	17.14	21	15.78947	20	16.67	20	16	16	19.05
Mopani	27	19.29	26	19.54887	25	20.83	27	21.6	10	11.90
Sekhukhune	23	16.43	22	16.54135	20	16.67	21	16.8	17	20.24
Vhembe	23	16.43	21	15.78947	19	15.83	19	15.2	17	20.24
Waterberg	36	25.71	38	28.57143	33	27.5	34	27.2	22	26.19
Total	**140**	100	**133**	100	**120**	100	**125**	100	**84**	100
	35.00		33.25		30.00		31.25		21.00	

Table 24: Age of the first use of substances (first sniffed /used or took)

How old were you when you first sniffed /used or took it?	10 years old or less	11-12 years old	13-14 years old	15-16 years old	17-18 years old	19 years or older	*Can't remember/Don't Know*	No response
Inhalants (e.g. glue, petrol, paints thinner, pritt, aerosol sprays, etc.)	6	11	19	24	4	3	90	243
Cannabis (dagga, marijuana, pot, grass, hashish)	4	10	23	58	26	27	48	204
Khat	0	3	1	4	1	2	118	271
Cocaine (coke, snow, powder, flake and/or crack, rock)	0	0	1	3	4	6	118	268
Ecstasy (E, X, XTC, doves, Adam & Eve, fido-dido, snowballs, apples, domes, MDMA)	0	0	0	4	2	6	119	269
Heroin (junk, smack, ska, H, sugars, nyaope)	0	1	2	9	8	8	106	266
Hallucinogens (e.g. LSD (acid), salvia, mescaline, peyote, PCP, psilocybin, mushrooms, special K, etc.)	0	0	1	1	0	2	126	270
Relevin	0	0	1	1	0	2	126	270
Amphetamines (e.g. speed, pep, dexies, bennies, CAT)	0	1	2	0	0	4	124	269
Mandrax (buttons, mandies, mx, whites, pilisi)	2	0	0	1	1	3	126	267
Tik (Methamphetamine) (ice, meth, crystal)	0	0	1	0	0	3	127	269
Mixtures of mandrax (buttons, mandies, mx, whites, pilisi) and cannabis (dagga, marijuana, pot, grass, hashish) (white pipe)	0	5	0	3	4	5	123	260
Mixtures of alcohol and pills (medicaments)	0	0	2	2	5	2	122	267
Anabolic steroids	0	0	1	0	0	2	122	175
Other Specify	1	0	0	2	0	3	144	280

4.6 Knowledge of programmes on alcohol and other drugs

Table 25 Knowledge of programmes on alcohol and other drugs

Districts	Yes	No	Total
No response	14	2	16
Capricorn	35	36	71
Mopani	58	16	74
Sekhukhune	46	30	76
Vhembe	47	23	70
Waterberg	45	29	74
Total	**245**	**136**	**381**

Knowledge of programmes on alcohol and other drugs
Figure: 22 Knowledge of programmes on alcohol and other drugs

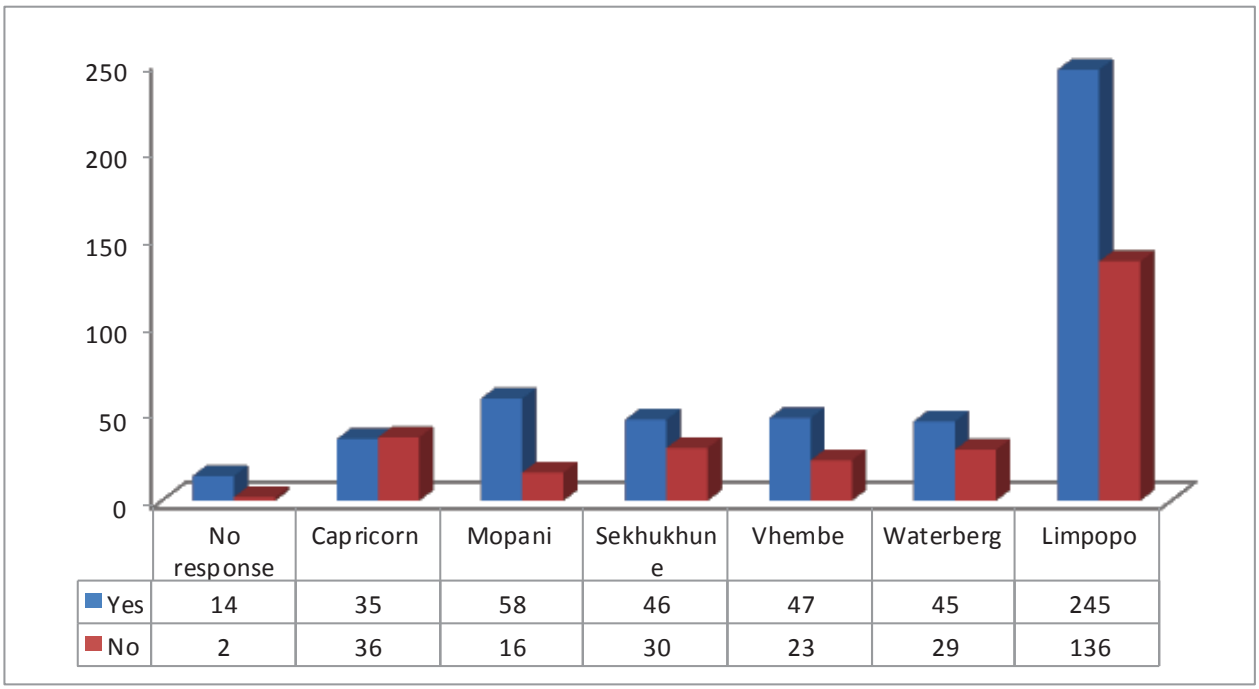


Figure: 22 Knowledge of programmes

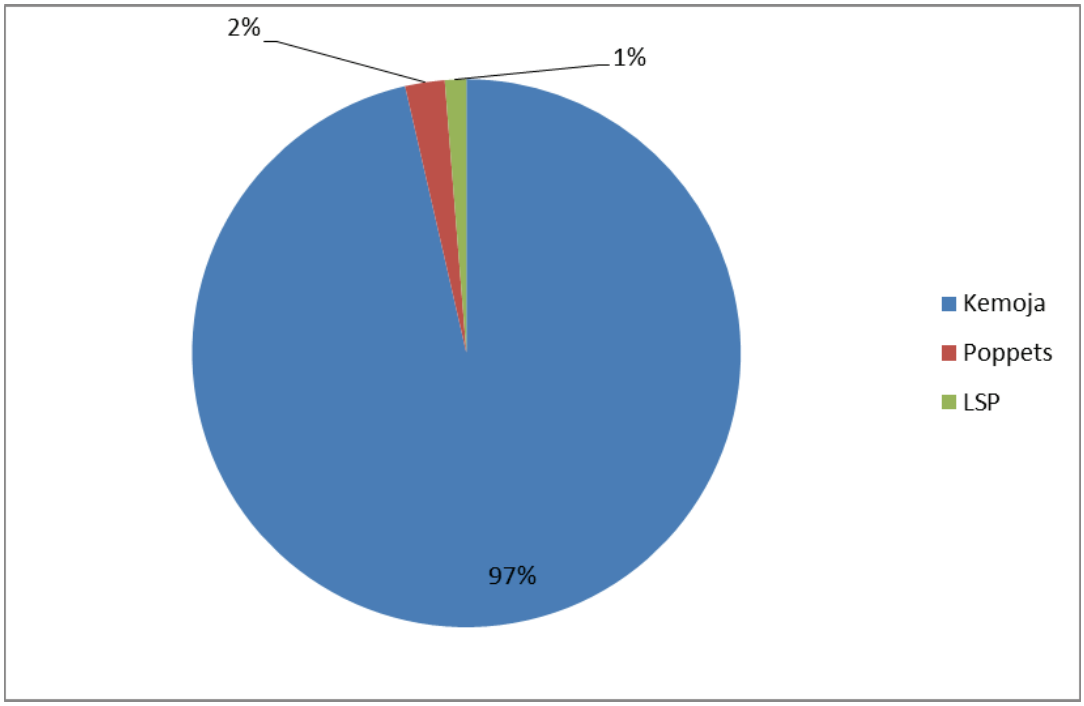
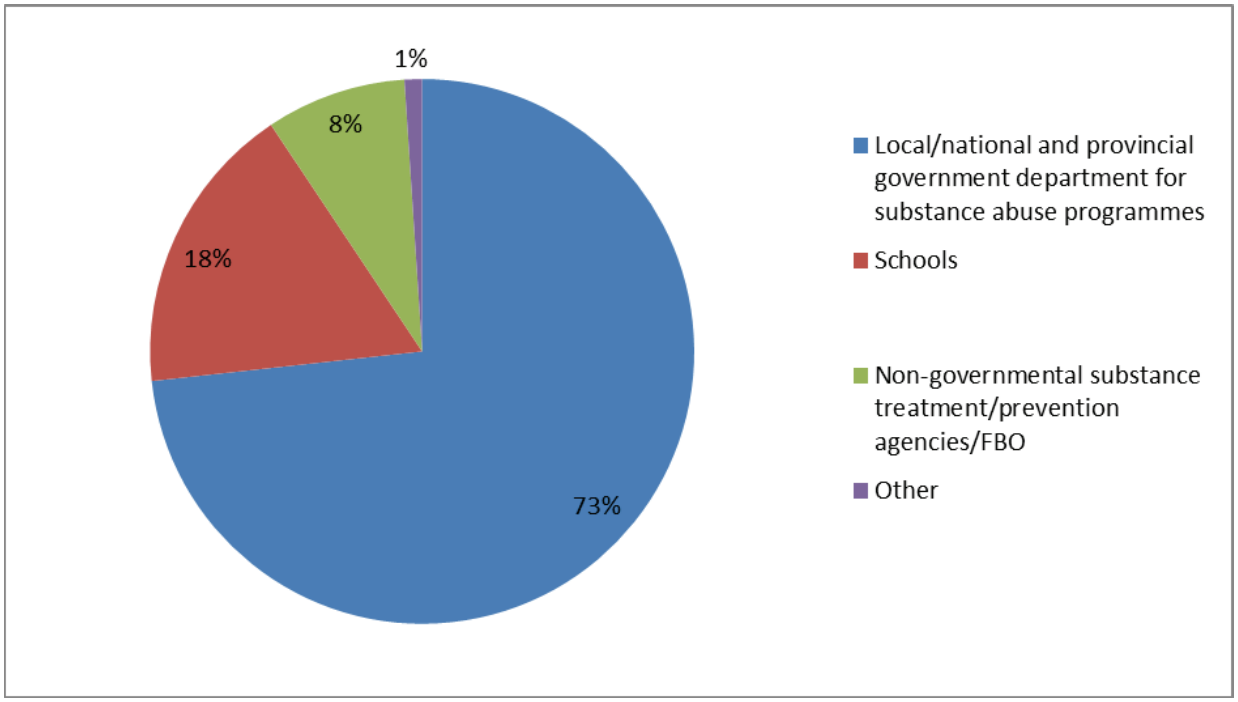


Figure: 23 who in particular should be responsible for providing information on alcohol and substance abuse



4.7: APPLICATION OF STATISTICAL MODELS

Table 26: The t-test

One-Sample Test						
	Test Value = 0					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Substance	67.015	499	.000	1.200	1.16	1.24

A hypothesis was formulated to assess if there is a significant difference around the perceived risks between substance users and non-users? The t-test was then applied in this study to assess whether the means of two groups (user and non-users) are statistically different from each other. The T-test was selected for this study due to the fact that the sample size was small and that the sample size was not balancing properly i.e. 400 substance users and 100 substance non-users.

Table 26 shows that P= 0.000 when t- test is used, this implies that there is a significant difference around the perceived risks between substance users and non-users. This finding is substantiated by the findings relating to the opinions of substance users and non-users on the effects of using the different substances (refer to table 27).

Information in table 27 shows that substance non- users perceive the use of substances to pose a ‘great risk’ to life more than the substance users. Put differently substance users do not perceive the use of substances to pose a great risk to life. This view holds throughout the array of substances included in the study with the exception of having one or two drinks several times a week (62.0% for substance users versus 55.0% for substance non-users). This finding call for a need to intensify programmes aimed at reducing substance use in the case of substance users, while promoting non-substance use among substance non-users.

Table 27: Opinion on the effects of using substances and the perceived risk

Substances	Perceived as Great Risk	
	Percentage Users	Percentage Non-user
Smoke 10 or more cigarettes (manufactured/brand and/or hand-rolled) a day	62.1	78.8
Smoke cannabis (dagga, marijuana, pot, grass, hashish) occasionally	51.6	79
Smoke cannabis (dagga, marijuana, pot, grass, hashish) regularly	66.8	88.8
Taking Khat occasionally	55.9	61.6
Taking Khat regularly	56	66.7
Try cocaine (coke, snow, powder, flake and/or crack, rock) once or twice	56.6	76.8
Take cocaine (coke, snow, powder, flake and/or crack, rock) occasionally	61.5	76.5
Have one or two drinks several times a week	62	55
Have five or more drinks once or twice each weekend	36.9	56.5
Take Amphetamines (e.g. speed, pep, dexies, bennies, CAT) once or twice	57.6	65.7
Take Amphetamines (e.g. speed, pep, dexies, bennies, CAT) occasionally	56.8	71
Try heroin (junk, smack, ska, H, sugars, nyaope) once or twice	62.7	76.8
Take heroin (junk, smack, ska, H, sugars, nyaope) occasionally	61.7	78
Use inhalants (e.g. glue, petrol, paint thinner, pritt, aerosol sprays, etc.) once or twice	72.8	84
Use inhalants (e.g. glue, petrol, paint thinner, pritt, aerosol sprays, etc.) occasionally	73	87
Try mandrax (buttons, mandies, mx, whites, pilisi) once or twice	61.4	73.7
Take mandrax (buttons, mandies, mx, whites, pilisi) occasionally	61.7	76
Try Hallucinogens (e.g. LSD (acid), salvia, mescaline, peyote, PCP, psilocybin, mushrooms, special K, etc.) once or twice	56.9	68
Take Hallucinogens (e.g. LSD (acid), salvia, mescaline, peyote, PCP, psilocybin, mushrooms, special K, etc.) occasionally	57.6	72

Correlation

A hypothesis was formulated to assess if there is an association/correlation between Level of education and Substance use. The study found out that the higher the level of education, the higher exposure to substance use. As learners move to higher grades, they get exposed to substances this could be due to peer pressure; media and affordability due to income (refer to table 28). This finding is also linked to the Ecosystem Theory.

Table 28: Association of Qualification and Substance

			Substance		Total
			Substance user	Substance Non- User	
Qualification	No response	Count	2	0	2
		% within Substance	0.5%	0.0%	0.4%
	None	Count	1	0	1
		% within Substance	0.3%	0.0%	0.2%
	Grade 1 and 2 (Sub A and B)	Count	3	0	3
		% within Substance	0.8%	0.0%	0.6%
	Grade 3 /Std 1	Count	4	0	4
		% within Substance	1.0%	0.0%	0.8%
	Grade 5 /Std 3	Count	3	0	3
		% within Substance	0.8%	0.0%	0.6%
	Grade 6 /Std 4	Count	10	1	11
		% within Substance	2.5%	1.0%	2.2%
	Grade 7 /Std 5	Count	14	0	14
		% within Substance	3.5%	0.0%	2.8%
	Grade 8 /Std 6 (Form I)	Count	19	3	22
		% within Substance	4.8%	3.0%	4.4%
	Grade 9 /Std 7 (Form II)	Count	33	2	35
		% within Substance	8.3%	2.0%	7.0%
	Grade 10 /Std 8 (Form III, NTC I)	Count	57	3	60
		% within Substance	14.3%	3.0%	12.0%
	Grade 11 /Std 9 (Form IV, NTC II)	Count	65	6	71
		% within Substance	16.3%	6.0%	14.2%
	Grade 12 /Std 10 (Form V, NTC III)	Count	75	36	111
		% within Substance	18.8%	36.0%	22.2%
	Grade 12 /Std 10 + College Diploma	Count	42	22	64
		% within Substance	10.5%	22.0%	12.8%
	Technikon Diploma	Count	4	3	7
		% within Substance	1.0%	3.0%	1.4%
	Technikon Higher Diploma	Count	3	0	3
		% within Substance	0.8%	0.0%	0.6%
	B.Degree/Honours Degree	Count	59	21	80
		% within Substance	14.8%	21.0%	16.0%
	Master's Diploma in Technology	Count	0	1	1
		% within Substance	0.0%	1.0%	0.2%
	Master's Degree	Count	3	2	5
		% within Substance	0.8%	2.0%	1.0%
	Others	Count	3	0	3
		% within Substance	0.8%	0.0%	0.6%
Total		Count	400	100	500
		% within Substance	100.0%	100.0%	100.0%

An attempt was made to establish whether the user's level of education is associated with substance use. The Chi-square model is appropriate for this exercise. The results as shown in table 29 shows Chi-square test with a P- value of 0.000 at a 5% significance level implies that qualification has an impact on substance use. The table below shows that there is an association between education and substance use.

Table 29: association between education and substance use

Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	56.923[a]	18	.000
Likelihood Ratio	65.250	18	.000
Linear-by-Linear Association	21.649	1	.000
N of Valid Cases	500		

Table 30: Mean age at first use

A hypothesis was formulated to check if there is an association / correlation between Age and Substance use. The study found out that there is no significant difference in the ages of substance users and non-users. The mean age for substance users was at 24 years and non-users at 26.

Descriptive							
Age							
	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum
					Lower Bound	Upper Bound	
Substance user	400	23.79	7.145	.357	23.09	24.49	0
Substance Non- User	100	25.89	5.803	.580	24.74	27.04	0
Total	500	24.21	6.943	.311	23.60	24.82	0

Table 31: ANOVA

Table 31 shows ANOVA test when P- value is 0.007 which is less than required P-value of 0.05; this implies that gender has impact on the substance use.

ANOVA					
Age					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	351.961	1	351.961	7.395	.007
Within Groups	23703.568	498	47.598		
Total	24055.528	499			

4.8 Logistic Regression

As indicated in chapter three, logistic regression was applied in this study to determine explanatory factors for substance use / non-use in Limpopo province. This section provides results in this respect. The analysis included all the factors highlighted in chapter three viz.

- Age
- Income
- Gender
- Qualifications

It is noted that;

$$Y_i = \beta_0 + \beta_1 X_{n1} + \beta_2 X_{n2} + \ldots + \beta_{p-1} X_{n,p-1} + \varepsilon_n \quad (3)$$

This can be written as follows;

$$Y = X\beta + \varepsilon \quad (4)$$

Where

Y_i is a vector of observations of the dependent variables

β is a vector of parameters

X is a matrix of constants

ε is a vector of independent normal random variables with; $E(\varepsilon) = 0,$ and the variance – covariates with covariates matrix $\sigma^2(\varepsilon) = \sigma^2 I$

Table 32: Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	465.363[a]	.068	.107

a. Estimation terminated at iteration number 5 because parameter estimates changed by less than .001.

Table 33: Omnibus Tests of Model Coefficients

		Chi-square	df	Sig.
Step 1	Step	35.039	4	.000
	Block	35.039	4	.000
	Model	35.039	4	.000

Table 34: Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1[a]	Income	.000	.000	1.410	1	.235	1.000
	Age	-.022	.019	1.312	1	.252	.979
	Qualification	-.145	.043	11.160	1	.001	.865
	Gender	-.685	.231	8.753	1	.003	.504
	Constant	4.715	.676	48.587	1	.000	111.654

a. Variable(s) entered on step 1: Income, Age, Qualification, and Gender.

Table 35: Correlation Matrix

		Constant	Income	Age	Qualification	Gender
Step 1	Constant	1.000	.093	-.467	-.554	-.398
	Income	.093	1.000	-.020	-.215	.015
	Age	-.467	-.020	1.000	-.271	-.053
	Qualification	-.554	-.215	-.271	1.000	-.080
	Gender	-.398	.015	-.053	-.080	1.000

Table 34 above indicates that gender is the most influential factor among the four factors (-.685), followed by qualification (-0.145), and Age (-0.022). With reference to gender and substance use status, the results show that one is likely to use substances by virtue of being a male as opposed to being a female – The data validates that 67% of the substance users are males in this study. Amongst the non-users, males constitute 47%.

Results in respect of qualification show that one is likely not to use substances by virtue of being highly academically qualified as compared to one with a low academic qualification. However the results show that qualification is statistically more significant in influencing substance use / non-use status (p = 0.001) than gender (p = 0.003).

With regard to age the results show that the likelihood of one using substances is higher amongst teenagers (under 18) as compared to youth above 19 years old. The mean and median age of use is at 23.79 and 24.00 respectively; the concentration age of substance use is at 19 years – mode.

Table 36: Substance User status

User status	Male	% Male	Female	% Female	Total
Substance User	269	67	127	33	399
Substance non-User	47	47	52	53	99

N.B *a negative relationship between substance use and the predictors in this study is indicative of a positive outcome which is a reduction in terms of substance use*

The odd ratios in these findings are important in understanding the influence of qualification and gender in substance use / non-use. The data indicates that one is 86.5% certain that a highly academically qualified person is likely not to use substances (Exp(B) = 0.865). The level of certainty is highly compromised with regard to gender where one is 50.4% likely not to use and, 49.6% certain that one uses in this particular dimension (Exp(B) = 0.504).

Table 32 shows the Omnibus Tests of Model Coefficients with a “goodness of fit” value of 465.363 (with p =0.000). The Cox & Snell R Square value of 0.068 in Table 32 indicates that around 7% of the variability in the substance use is explained by the four factors (Age, Income, Gender and Qualification) in the model. This implicitly says that there are a host of other factors other than the four indicated factors that needs to be considered to address substance use holistically.

Income is the least influential factor (0.000). However, from a statistical point of view income is statistically more significant than the age (0.235 versus 0.252 respectively).

In particular,

$$\hat{Y} = 4.717 - .000X_{n1} - 0.145X_{n2} - 0.022X_{n3} - 0.685X_{n4}$$

i.e.

$$\hat{Y} = 4.717 - .000\,Income - 0.145\,Qualification - 0.022\,Age - 0.685\,gender$$

Where the $\hat{Y}$ represents the substance *use status*

4.9 FOCUS GROUP DISCUSSIONS RESULTS

Response as to whether there is a problem of substance abuse in communities

The participants stated in affirmative that there is a serious problem of youth indulging in drugs. Some even mentioned that there are programmes but seemingly, they are not responding to the scourge of substance abuse. Substances mentioned to be abused by the youth include dagga, with alcohol mainly abused due to the fact that they are easily accessed and affordable. They mentioned factors which contributed to the fact that youth end up indulging in alcohol in particular. They mentioned that taverns have mushroomed in every community with most of them in proximity with schools and churches. In Musina, they mentioned a particular tree whose leaves are made use of– they [youth] just chew and get high. Besides alcohol and dagga, they mentioned methylated spirit, glue, and snuff, the reasons advanced for using substances include lack of constructive entertainment facilities such as sporting facilities; they do drugs when they are bored. For youth in-school, they bunk classes to go to taverns and some smoke dagga during school breaks. Some youth mentioned unemployment as the reason for taking drugs. In communities of Waterberg District (Lephalale and Northam) girls are equally indulging in alcohol as they trade in sex work. In some communities (Bela-Bela), there is a problem of *Nyaope*. The community of Belabela, young boys are roaming the streets not knowing what they can do except to smoke *nyaope.* The following are some excerpts in support of the above:

“The youth in our community drinks a lot” (Participants from Mopani)

“They smoke dagga here as they eat porridge because it is easily accessible” (Participants from Vhembe)

“Nyaope has taken the lives of most young people” (Participants from Waterberg)

“It is fashionable for youth to drink, if not in drinking what shall they be doing – no life after all) (Participants from Sekhukhune)

Response on the prevalence and frequency of youth indulging in substance abuse

Alcohol drinking is so prevalent to a point that youth are ever in taverns, and do not go to school. Alcohol use among youth is common and increases with age for both males and females. There is also a tendency to more harmful binge drinking. Reasons for use and misuse of alcohol include peer pressure and a desire to fit in, poor home environments and boredom, ignorance of harm caused by alcohol, and the relative cheapness of alcohol products and their ease of access. The participants alluded to high youth unemployment rates as an exacerbating factor. They stated that alcohol is easily purchased from bottle stores, supermarkets, bars and shebeens as well as other unlicensed liquor outlets, which outnumber licensed ones, particularly in disadvantaged communities.

Unknowingly, in Musina, Northam and Thabazimbi, mention was made of designer drugs and is proliferating at an unprecedented rate and posing unforeseen public health challenges. The use of commonly known drug - Tik-tik, remains widespread in Waterberg and Capricorn districts and appears to be increasing in other districts. Cannabis/dagga remains the most widely used illicit substance. Alcohol remains the dominant substance of abuse across all districts.

“Youth drink alcohol as fish swim in the water” Participant from Waterberg

“They drink as long as they have money – if they have they can drink Monday to Monday 24/7” Participant from Sekhukhune

“Even the 11-12 years old drink alcohol” Capricorn.

Response on substance abuse as a serious problem for the majority of the youth

With special reference to alcohol, participants said that it is the drug of choice among youth, often with devastating consequences. Drinking early in life also is associated with an increased risk of developing an alcohol use disorder at some time during the life span. The majority of FGD participants mentioned that substance abuse is a major problem. Though special focus was on youth, they mentioned that all age groups from younger children as young as 09 years of age to a very old person at 80 years indulge in substance abuse in one way or another. To showcase the seriousness of substance abuse, more criminal cases of rape, murder, assaults, house breaking, and others, FGD participants argue that the cause is substance abuse. Substance abuse is linked to other social problems, namely, child neglect, poverty, social pressures and traumas, crime and HIV/AIDS. One striking case is a situation wherein the youth are commemorate June16; they do so by indulging in alcohol heavily. Similar to that is when youth in school uniform get to the taverns to sit and drink.

Alcohol also plays a powerful role in risky sexual behavior, including unwanted, unintended, and unprotected sexual activity, and sex with multiple partners. Alcohol is associated with academic failure and drug use. Moreover, while much lower compared to males on account of deviant behaviour, the increasing smoking uptake among young females in both rural and urban areas is of particular concern. The social and cultural constraints that previously prevented black females from smoking are weakening, and traditional constraints can no longer be relied on to maintain the relative low smoking prevalence.
There were instances which were mentioned as triggers of youth to start smoking such as lack of parents as tit leaves children without supervision. The issue of cultural practices was stated, for instance wherein smoking is seen as the rite of passage from teenage-hood to young adulthood. Some youth smoke simply because of misinterpretation of human rights – that it is their right to do as they wish. Some of the youth were cited saying:

“In the next twenty years, the older people would have tripled as substances make young people old” Sekhukhune

“They drink alcohol and end up sleeping with their own sisters – no more respect, they demand sex from their siblings” Waterberg

“The majority are in prisons or have criminal records after smoking dagga and started stealing other people’s valuables” Capricorn

“Due to substance abuse, crime has increased and youth drop out of school” Vhembe

“Female youth who drink alcohol, most of them are HIV positive and have dropped out of school, receiving government social grants” Mopani

Responses on reasons for the youth to engage in substance abuse

The reasons advanced on this issue varied. As children move from adolescence to young adulthood, they encounter dramatic physical, emotional, and lifestyle changes. During the Focus Group Discussions it came out clearly that developmental transitions, such as puberty and increasing independence, have been associated with alcohol use. Thrill-seeking amongst the youth was mentioned, and that included experimenting with alcohol albeit it being risk-taking behavior. What came out was that due to developmental changes, in most cases youth act so impulsively, often not recognising that their actions such as drinking have consequences.

One other reason was the expectations out of drinking alcohol. FGD participants mentioned that how people view alcohol and its effects also influences their drinking behaviour. It was mentioned that an adolescent who expects drinking to be a pleasurable experience is more likely to drink than one who does not. Some indulge in substances for curiosity purposes, to deal with stress, peer pressure, as a way to cope with strictness from parents, and dealing with family problems.

It also emerged that beliefs about alcohol are established very early in life, even before the child begins primary school. This depends on household/family values whereby some

families may generally view alcohol negatively and see drinking as bad, with adverse effects whereas others either ignore or are just careless.

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Some young people drink because of the peers they associate with, or people with whom they share similar personality characteristics. It was mentioned that such groups are disruptive, hyperactive, and aggressive, labeled by the community as antisocial or criminals.

Other factors contributing to substance use include availability, customs and cultural practices. The FGDs indicated that social factors such as the influence of parents and peers, also play a role in substance use and abuse. Parental influence and drinking habits play a strong role in shaping drinking behaviour in young people. For example, parents who drink a great deal and who view drinking favorably are likely to have children who drink in the same manner. An adolescent girl with an older or adult boyfriend is more likely to use alcohol and other drugs as well as engaging in delinquent behavior than an adolescent girl with a boyfriend of her age.

Furthermore, FGD participants mentioned the impact of the media. It was mentioned that alcohol is widely available and aggressively promoted through television, radio, billboards, and the internet.

Another reason advanced is lack of entertainment facilities; in general, young people involved in extracurricular activities are less likely to experience alcohol-related problems. Some youth mentioned domestic violence as a push for them to indulge in substances as a way to cope. Poverty was also mentioned as a contributor to substance abuse. To corroborate these facts, participants from different municipalities stated that:

"If fellow youth drink, as the a young person why not" Waterberg

"How do one withstand a situation wherein the parents are ever fighting in the house" Sekhukhune

"There are no jobs, what do we do" Vhembe

"Home-made alcohol is cheaper and if you need quick pluck, go for it, they mix stuff" Mopani.

Responses on whether is it a tradition for youth to drink alcohol or is it something new

The youth participating in FGD said that alcohol has been there time immemorial, even in biblical times. One of the participants even said:

"Even Jesus Chris changed water to be alcohol for people to drink"

In African cultural practice, alcohol has been reserved for the elderly but of late, it is accessible to the youth. Another exacerbating factor for youth to drink alcohol abusively is peer pressure, pleasing their friends. Some even called it "*Naka la Mosepedi"*. Some indicated that people who played a role in influencing them to use substances, particularly alcohol is their grandparents who encourage them to drink, let alone sending them to buy.

Another compelling factor for youth to drink is alcohol advertising, as opposed to price. They singled out South African Breweries (SAB) competing with a small number of rivals to advertise more than necessary as they advertise on both print and electronic media. They said advertising affects demand and can also explain alcohol advertising effects on knowledge, attitudes and intentions to drink.

With regard to this issue of advertising, they said creation of branded products which consist of distinguishable products with unique packaging or with unique product features encourages youth to drink. Advertising and other marketing techniques are one potential source of information for young people about the costs and perceived benefits of alcohol. Advertising creates the impression that, for a relatively small expenditure, young people can psychologically connect to the positive fantasy of places, lifestyle and personality characteristics that it portrays. Advertising-supplied information can result in inflated positive expectancies about alcohol, which can change actual or intended consumption behaviour.

Responses on what type of substance do the youth typically use and/or abuse

Regardless of location (urban or rural area), most youth drink industry manufactured alcohol. It goes with status. Only in few deep rural areas where unemployment is high do youth drink home-made alcohol. The finding from FGDs also point out that illicit drug use among youth has continued at high rates, largely due to the popularity of marijuana (commonly called dagga or weed). They said that rising marijuana use reflects changing perceptions and attitudes. Young people are showing a lowered perception around the dangers posed by marijuana. The growing perception and attitudes towards marijuana as a drug of choice and pleasure may reflect changes in religious and cultural beliefs, management of stress caused by unemployment and curiosity as indicated by some youth.

The production of *Nyaope* using synthetic marijuana, powder from flat screen TV, rattex and Antiretroviral (ARV) is a new and major concern. These mixtures could be obtained legally. N*yaope* is prevalent around Capricorn district and Waterberg district.

Nonmedical use of prescription and over-the-counter medicines remains a significant part of the drug problem faced by the youth. It has been discovered during FGDs that tablets meant to relieve headache are mixed with snuff and, smoked. In some instances cough mixture is mixed with methylated spirit and drained water from cooked dagga to create concoctions for use by the youth.

Frequency of substance use by youth

Generally, it has been found that youth drink alcohol or any substance as long as they have money to buy alcohol or that substance. Not only are young people drinking alcohol or using substances wrongly but the way they drink it also puts them at such high risk in as far as alcohol-related problems are concerned. They mentioned that young people are especially

likely to binge drinks and drink heavily compared to adults. The following was echoed by participants:

“Even now, if we can go to the tavern, you will find youth there”

“Home-made alcohol is 24/7, with music on around the clock”

‘On weekend it is worse as even those who are working, sleep there until Sunday late”

Smoking by youth

Smoking and smokeless tobacco use are initiated and established primarily during adolescence. Some factors associated with youth tobacco use appear to be similar across different types of tobacco products. The responses given by participants were that the youth start smoking cigarettes as the gateway drug to other drugs. Smoking cigarettes in particular is associated with status in a society. Nonetheless, they said that when youth have graduated from cigarettes, they start smoking dagga and it is not easy to stop. Participants mentioned the following to substantiate their arguments.

“They smoke as God created them with chimneys”

“Jooonaaa, nyaope – they smoke it and they are filthy and stink”

Various factors were mentioned as contributors for youth to smoke. These include social and physical environments including social norms portrayed in tobacco advertising and in movies; these settings promote smoking among young people. Boys and young men are more likely to use certain types of tobacco as it is associated with status. Some stated that small social groups such as family and peer groups contribute towards encouraging someone to smoke. This is so as young people are more likely to use tobacco if their peers use tobacco. Again young people are more likely to use tobacco if they perceive tobacco use as acceptable or normative among their peers. Another trigger is parental smoking which may promote smoking among young people as parents are seen as primary role models.

FGD participants mentioned that they smoke so as to address or deal with depression, anxiety, and stress. Another reason advanced was expectations of positive outcomes from smoking, such as coping with stress and controlling weight. It has been mentioned that youth smoke in order to deal with lack of parental support or involvement. Other factors indicated include accessibility, availability, and the price of tobacco products which is comparably cheaper as compared to the price for hard drugs. Some youth smoke because they have low levels of academic achievement and low self-image or self-esteem. A FGD from Capricorn district specifically mentioned the reason for smoking being exposure to tobacco advertising. The following were echoed by participants:

"…we did have a friend that chewed tobacco and we had two smokers"

"*Some of the parents take alcohol and smoke heavily hence it becomes easy to associate with smoking and alcohol as well, or smoking and drugs so, kind of getting the bigger picture because you know like, they say when people drink they tend to smoke more so, sort of connecting the two…"*

With special focus on hard drugs, such as heroin, mandrax, cocaine, hallucinogens, amphetamines, tik and anabolic steroids, the youth said that these drugs are not easily accessible as they are expensive. They prefer designer drugs such as *Nyaope.* Only in rare cases can one get hold of such stuff as they are used by those who are in Johannesburg, Pretoria and Hammanskraal.

Prevalence of intravenous substances (substance that require using a needle)

Knowledge about intravenous drug users came from Thabazimbi, Lephalale, Belabela, Musina and Polokwane. None of the participants indicated having ever used needles to administer drugs into their bodies. In other words, the use of intravenous substances seems to be a rather rare occurrence.

Programmes addressing substance abuse

Results from this study revealed those who recently left school to be in the know about prevention programmes such as **Ke moja, No thanks I am fine without drugs**. Other than this programme, youth are familiar with Love Life. In Northam, they have a problem of *Opie Kopie* which is a festival organised by farmers and, draws people globally. What was familiar amongst participants is Home-based care for HIV and AIDS infected people. Other programmes mentioned include **Learner Support Programme** and Poppets but little support is being given by the Department of Education. With regard to *Phuza Wise*, the youth indicated to have heard of it over the television. Regarding the usefulness of programmes, the majority do not see these as useful except as a waste of money.

"I cannot comment on their usefulness as they are not in existence in our community"

"We only hear that Ministers were around, just to squander money with food, cheap t-shirts and caps" (Nebo participant).

Availability of elders in the households where the majority of the youth live

The indication from participants was that elders such as parents and grandparents are available. The participants indicated that the structure of the families have changed as elders always indicate. New house-hold phenomena such as single parenting and child-headed households were not there. These new family phenomena bring challenges of discipline and supervision over children in the households. This is what the participants had said:

"I stay with my grandparents as my parents are migrant workers in Gauteng and come home twice a year during long holidays"

"At home I stay with my grandmother and she is very strict, she does not understand the current trends in terms of youth needs"

"My uncle as I stay with him"

“I am responsible for decision making as my parents are all in Gauteng”

The consequences of indulging in substance use, misuse and abuse

Discussion came to a point that whatever it is that leads adolescents to begin drinking, once they start they face a number of potential health risks. They mentioned that those who abuse substances end up mentally disturbed as they [substances] significantly impact on long-term thinking and memory capabilities. For young people, alcohol and drug abuse interferes with their cognitive and emotional development, increases the chance of accidental injury and death, and magnifies the likelihood of drug dependency.

Mentioned was also made that people known to them [participants] who abuse substances, particularly alcohol, suffer from liver cirrhosis. They end up raping and being incarcerated, have *Phuza face*, engage in sexual activities without condom and that how they get HIV and unwanted pregnancies**.** Some end up losing their jobs, committing murder and, in fights unnecessarily. Participants mentioned that some of those who abuse substances end up suffering from brain cancer or cancer of the throat. Those who are still young become street kids. Some develop health problems such as TB, heart attack, and death.

Another challenge discussed was Fetal Alcohol Syndrome (FAS) which is a pattern of mental and physical defect that can develop in a fetus in association with high levels of alcohol consumption during pregnancy. It was indicated that alcohol crosses the placental barrier and can stunt fetal growth or weight, create distinctive facial stigmata, damage neurons and brain structures. This can result in psychological or behavioural problems, and cause other physical damage as well as an array of primary cognitive and functional disabilities (including poor memory, attention deficits, impulsive behaviour, and poor cause-effect reasoning).

Responses regarding drug/substances that require the most urgent attention through prevention, treatment and rehabilitation programmes among youth

The following drugs were mentioned in their order of severity, and prevalence:

Alcohol including home-made alcohol,

- Dagga,
- Nyaope,
- Glue,
- Methylated spirits
- Natural drugs (trees in Musina)

Responses regarding the need for more information on substances (alcohol, tobacco and other drugs and their effects) and the responsible people

It has been an unanimous stance by all FGDs that more information is needed for the youth to make informed decisions. The rationale for such a stance was because they believe there are misunderstandings and lack of knowledge about drugs and their effects. Central to all these is a need to be in a better position to protect one's life and the lives of other people.

The following professionals were mentioned in their order of demand for their services:

i. Social Workers,	**vii. Political Parties, NGO's,**
ii. Teachers/educators,	viii. Traditional Leaders,
iii. Parents,	ix. Mayors,
iv. Nurses,	x. Political Councilors,
v. Police Officers,	xi. and Municipalities.
vi. Home Based Carers,	

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusion

Overall, the central objective of this study was to collect baseline data which will enable government and the private sector to improve treatment and prevention strategies and approaches to reduce substance abuse amongst the youth in Limpopo Province.

The results of this study show that substance use among the youth is a challenge and the prevalence varies in districts. The youth smoke tobacco, drink alcohol and use hard-core drugs. The most commonly used substances are Cannabis (49%), Inhalants (39%), bottled wine (32%), home-brewed beer (30%), and commercially brewed beer (greater than 4% Alc/Vol) used by 54.8% of the youth sampled in this study. From a geographical point of view, substance use is most prevalent in Waterberg and least prevalent in Vhembe district. The findings also show limited knowledge about the Fetal Alcohol Syndrome (FAS) among the youth. The results show that the use of various substances by the youth also varies.

The study also found that the onset of substance use amongst the youth is as low as under 10 years of age with the median age of substance users being 24 years. The majority of substance users (7.5 %) are teenagers aged 19. Substances used by the youth are easily accessible and available which increases the potential for substance misuse, and ultimately abuse. This is the case in spite of school-based prevention programmes, including "*Ke Moja, No thanks I am fine without drugs*" being implemented.

The study found that academic advancement reduces the likelihood of the youth to indulge in substance use. It was also found that that the likelihood of one using substances is higher amongst teenagers (under 18) as compared to youth above 19 years old. The two findings call for the intensification of substance abuse prevention programmes in the early stages of the youth's life experiences – when they are still in the Basic Education phase.

With regard to the role of the media, there is an element of glorifying substance use, particularly tobacco and alcohol which has a potential for disastrous outcomes when it

comes to the youth. The mass media, if used positively, will be an effective tool in preventing tobacco use and reducing alcohol consumption amongst the youth.

5.2 Recommendations

To reduce substance abuse amongst the youth in Limpopo Province, there is a need to adopt a multi-stakeholder approach which will include Government, private sector, communities and civil society organizations. The following recommendations are made:

Recommendation 1: Provision of Substance abuse Health promotion activities, programmes and services

Health promotion activities and advocacy programmes should be geared towards supportive environments to strengthen communities and reorientation of health services with an emphasis on prevention as opposed to treatment and care. Substance abuse health promotion should include inter-sectoral collaboration and inter-organizational partnerships, community participation and engagement.

The Department of Health should consider intensifying Fetal Alcohol Syndrome (FAS) interventions into the health promotion programmes to c*onscientise* the youth on the effects of FAS.

Recommendation 2: Constructive media-based public education campaigns

The media needs to play a constructive role in preventing substance abuse amongst the youth to ensure that appropriate messages are designed and communicated through audience targeting. This should be buttressed by substance abuse control and media policies.

Recomndation3: Development and implementation School-based substance abuse programmes

The Departments of Social Development and Education should consider improving the implementation of school-based prevention programmes with special focus on reinforcing *"Ke Moja, No thanks I am fine without drugs"* programme. This could be achieved through:

- Programmes offering active learning session which create awareness on the influence of substances amongst the youth
- Empowering the youth with skills to resist media temptations and, deconstructing media messages that promote substance use,
- Youth involvement in the implementation of interventions.

Recommendation 4: Provision of recreational facilities

Recreational facilities should be developed in deprived communities needs to keep the youth engaged and as a substitute to focusing on drug-related ventures.

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Appendix A: Substance Types by Local Municipality

Local Municipalities	Inhalants	Cannabis	Khat	Cocaine	Ecstasy	Heroin	Hallucinogens	Relevin	Amphe-tamines	Man-drax	Tik
No response	8	10	5	6	6	6	6	6	6	6	6
Ba-Phalaborwa	9	9	9	9	9	9	9	9	9	9	9
Bela-Bela	15	16	15	15	15	15	15	15	15	15	15
Blouberg	2	3	0	0	0	0	0	0	0	1	0
Ephraim Mogale	2	1	0	1	0	0	0	0	0	1	0
Fetakgomo	12	12	12	12	12	12	12	12	12	12	12
Greater Giyani	6	6	6	6	6	6	6	6	6	6	6
Greater Letaba	10	11	6	6	6	6	6	6	6	6	6
Greater Tubatse	5	7	4	4	4	4	4	3	4	4	4
Greater Tzaneen	7	9	6	6	6	6	6	6	6	6	6
Lepelle-Nkumpi	4	4	2	2	2	2	2	2	2	2	2
Lephalale	2	2	2	2	2	2	2	2	2	2	2
Makhado	2	9	3	3	3	3	3	3	3	3	3
Makhuduthamaga	6	11	6	6	6	6	6	6	6	6	6
Modimolle	1	0	0	0	0	0	0	0	0	0	0
Mogalakwena	13	14	12	12	12	14	12	13	13	13	13
Molemole	16	15	14	13	13	13	13	13	13	13	13
Mookgophong	3	6	3	3	3	4	3	3	3	3	3
Musina	11	12	9	9	9	9	9	9	9	9	9
Mutale	3	8	0	0	0	0	0	0	0	0	0
Polokwane	7	8	6	7	6	7	6	6	6	6	6
Thabazimbi	4	7	1	1	1	1	1	1	1	1	1
Thulamela	9	12	8	9	9	9	9	9	9	9	9
Aganang	0	0	0	0	1	0	0	0	0	0	0
Elias Motsoaledi	0	2	0	0	0	0	0	0	0	0	0
Maruleng	0	2	0	0	0	0	0	0	0	0	0
Total	**157**	**196**	**129**	**132**	**131**	**134**	**130**	**130**	**131**	**133**	**131**

Appendix A: Continued

	Mixtures of Mandrax	Mixtures of alcohol and pills	Other mixtures	Anabolic steroids	Other, specify
No response	8	6	4	5	3
Ba-Phalaborwa	9	9	9	9	3
Bela-Bela	15	15	12	14	5
Blouberg	0	0	0	0	0
Ephraim Mogale	1	0	0	0	0
Fetakgomo	12	12	11	12	9
Greater Giyani	6	6	6	6	4
Greater Letaba	6	5	4	6	3
Greater Tubatse	4	4	3	3	2
Greater Tzaneen	6	6	6	6	0
Lepelle-Nkumpi	2	2	2	2	1
Lephalale	2	2	2	2	1
Makhado	3	3	3	3	3
Makhuduthamaga	6	6	6	6	6
Modimolle	0	0	0	0	0
Mogalakwena	13	13	13	13	13
Molemole	16	13	13	13	11
Mookgophong	4	3	3	3	1
Musina	9	9	9	9	8
Mutale	0	0	0	0	0
Polokwane	6	6	5	5	4
Thabazimbi	1	4	2	1	1
Thulamela	11	9	7	7	6
Aganang	0	0	0	0	0
Elias Motsoaledi	0	0	0	0	0
Maruleng	0	0	0	0	0
Total	**140**	**133**	**120**	**125**	**84**

Appendix B: Alcohol Types by Local Municipality

Local Municipalities	Homebrew	Regular	Light strength	Bottled wine	Ciders
No response	7	9	1	5	1
Ba-Phalaborwa	3	16	25	2	4
Bela-Bela	49	58	27	52	27
Fetakgomo	2	15	13	12	14
Giyani	1	5	2	5	6
Letaba	15	15	4	11	7
Tzaneen	4	11	4	6	4
Makhado	7	7	5	5	6
Makhuduthamaga	2			2	
Molemole	8	15	4	8	5
Thabazimbi	1				
Thulamela	2	4		2	2
Aganang	1	5	1	1	3
Ephraim Mogale	4	2			
Greater Tubatse	1	9			
Polokwane	4	7	4	11	5
Elias Motsoaledi	1	10		2	
Mutale	1	9	5		3
Lepelle Nkumpi	3	4	1	2	4
Lephalale	1	5			1
Maruleng	2	7		1	9
Blouberg		3			1
Mookgophong		3			1
Musina			1	1	1
Modimolle					
	119	219	97	128	104

Appendix B: continued

Local Municipalities	Bottled Spirit	Totalother1	Other2Total	Other types
No response	3	3		
Ba-Phalaborwa				
Bela-Bela	55	48	48	60
Fetakgomo	14	10	10	11
Giyani	2			1
Letaba	8	7	7	5
Tzaneen	1		1	
Makhado	5	4	4	5
Makhuduthamaga				
Molemole	9	4	3	
Thabazimbi				
Thulamela				
Aganang				
Ephraim Mogale				
Greater Tubatse				
Polokwane	5	8	8	6
Elias Motsoaledi				
Mutale				
Lepelle Nkumpi	2			
Lephalale				
Maruleng				
Blouberg				
Mookgophong			1	
Musina				
Modimolle				
Total	104	84	82	88

Appendix C: SMOKING

	Did not smoke cigarettes	Less than 1 cigarette	Less than 1 cigarette	1 - 5 cigarette	6 - 15 cigarette	16-25 cigarette	26 - 35 cigarette	Over 35 cigarettes	Total
No response	0	0	1	11	2	0	0	1	15
Aganang	2	0	0	1	0	3	1	0	7
Ba-Phalaborwa	2	1	0	8	1	0	0	0	12
Bela-Bela	0	0	0	1	5	5	0	1	12
Blouberg	1	0	0	3	2	0	0	1	7
Elias Motsoaledi	2	0	0	2	2	1	0	1	8
Ephraim Mogale	0	0	1	1	1	0	0	1	4
Fetakgomo	1	0	0	7	0	1	0	0	9
Greater Giyani	0	0	0	3	0	0	0	0	3
Greater Letaba	0	0	1	6	3	0	1	2	13
Greater Tubatse	2	1	1	1	0	0	0	2	7
Greater Tzaneen	2	1	0	7	0	0	0	0	10
Lepelle-Nkumpi	0	0	0	4	0	0	0	1	5
Lephalale	0	0	0	1	1	1	1	1	5
Makhado	0	1	1	5	1	0	2	1	11
Makhuduthamaga	0	0	2	6	2	0	3	0	13
Maruleng	3	0	0	1	1	0	0	0	5
Mogala-kwena	0	1	0	6	2	0	0	1	10
Molemole	1	0	0	20	0	0	0	0	21
Mookgo-phong	1	1	0	4	2	0	0	1	9
Musina	5	0	1	3	0	1	0	0	10
Mutale	1	0	2	8	1	0	0	0	12
Polokwane	0	0	0	5	2	0	0	1	8
Thabazimbi	1	2	1	6	1	0	1	0	12
Thulamela	4	0	1	6	2	0	2	0	15
	28	8	12	126	31	12	11	15	243

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