

Rural realities in service provision for substance abuse: a qualitative study in uMkhanyakude district, KwaZulu-Natal, South Africa

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Background: Substance abuse is recognised as a worldwide concern, contributing significantly to morbidity and mortality in South Africa. There is minimal research that has considered influences in mental health care service delivery in rural and disadvantaged communities in South Africa.

Methods: A qualitative study with substance abuse service providers in uMkhanyakude rural district of KwaZulu-Natal was undertaken to gain insight into the experiences and challenges in service delivery. Focus groups and semi-structured interviews were conducted with various stakeholders ($n = 29$) in the rural district.

Results: The findings of the study suggest that service providers experience challenges in service delivery in this rural area. The effects of culture (amarula festival and ancestral worship) exacerbate the use of substances; the high rate of unemployment and poverty lead to the produce of home-brewed substances for sustainable living; a lack of resources poses threats to service delivery; the poor prioritisation of mental health care services and a lack of monitoring and evaluation of services in the district were highlighted.

Conclusions: Despite this being a single district study, findings reflect the need for a district, provincial and national standard for substance abuse rehabilitation services in addition to the improvement of monitoring and evaluation for quality improvement. There is also a need to respond to the gaps that exist in after-care and community-based or decentralised substance abuse services that are essential in such areas, which are under-resourced despite the high prevalence of substance users.

Keywords: community occupational therapy, rural, service delivery, service providers, substance abuse

Background

There is an increasing global burden of substance abuse. In light of this increasing burden in South Africa (SA), there has been a drastic increase in the establishment of private treatment services (both licensed and unlicensed) in the post-apartheid era, but these are still not widely accessible to the poorer communities.¹ Additionally education and treatment services of the South African National Council on Alcoholism and Drug Dependence (SANCA) are limited, and there remains minimal extension of treatment services to the majority previously underserved, disadvantaged population.²

In SA, mental health and substance abuse constitute a huge burden of disease among disadvantaged communities.³ One such district is that of uMkhanyakude, located in the province of KwaZulu-Natal (KZN). This district is listed amongst the most disadvantaged, poor and isolated areas in SA.⁴ It appears as though most of the research on substance abuse in SA has focused on service users with a lesser focus on service providers. In this study there was thus a shift of attention towards service providers within a rural district.

Methods

A qualitative descriptive phenomenological study was employed which aimed at exploring the experiences of service provision by service providers working within the uMkhanyakude district of KZN, SA. Non-probability purposive heterogeneous sampling was used to select 29 participants (interviewed individually, in dyads, triads and focus groups). These participants included the mental health care team (social workers, psychiatric nurses, occupational therapists, medical officers); fieldworkers (social workers), service coordinators and district management personnel from the

departments of social development and health, as well as a non-governmental youth development initiative. Recruitment continued until both redundancy and saturation were reached. The study was granted ethical approval by a human and social sciences committee (HSS/0040/014 M). Ethical principles including gatekeeper permissions, informed consent, right to withdraw from the study and confidentiality were observed in the study in addition to upholding principles of justice, beneficence and scientific integrity throughout the research process. Data were analysed using inductive reasoning with reflexivity and strategies for reducing bias being implemented.

Results and discussion

There were a number of shared opinions and experiences of participants in this study that explored service provision for clients with substance abuse disorders within the uMkhanyakude district of KZN. This paper will highlight the key emergent themes, skewed towards the challenges experienced. Under the two broad themes of easy access and poor regulation of substances and poor prioritisation and integration of mental health care services, there are a number of categories that are discussed with supporting verbatim quotations of participants. This section is concluded with a brief overview of what is currently effective in the district.

Easy access and poor regulation of substances

Overall, there appears to be easy access and poor regulation of substances within uMkhanyakude district, which works in contradiction to the aim of the National Drug Master Plan (NDMP) of South Africa 2013–2017,⁵ which is aimed at strengthening the combat against substance abuse. This resonates with much of the research in South Africa, which has mostly focused on commercial/prescription substances and has

overlooked the impact of indigenous substances that has affected mainly the rural and disadvantaged communities.⁶

Cultural influences that support access to substances

We understand each community to be constructed within a particular cultural belief, and this influences the behaviour of people who subscribe to that particular culture, in this case, some residents of uMkhanyakude attach meanings to ancestral worship. Ancestral worship ceremonies, which are an accepted and respected cultural practice, may be viewed as counteracting the preventative programmes aimed at combating the spread of substance abuse within the district:

'... in this area is a lot of ceremonies like if my father died, then we are expected at the end of the year, the unveiling, it's during those ceremonies that all the family members are expected to drink those.... Most of the children say to us that is the easiest way to introduce them to starting....' (Fieldworker)

Adolescents and young adults experience alcohol for the first time during cultural rituals, in which every member of the family is expected to take 'a sip of alcohol' to be part of the ritual and be recognised by the ancestors:

'... when were asked when did they start experimenting with drugs and how did it happen that they did maintain the issue of beginning, the onset part of getting into drug emcimbini wamadlozi (ancestor worship ceremonies) so it came out that the children experiment about drugs or taste drugs during traditional rituals, so it's more like they use this thing Kwangwanase when they are celebrating these ceremonies.' (Manager)

The Amarula Annual Festival, held within one of the local municipalities of the district, is a festival in which everyone is allowed to drink in celebration of the amarula fruit. There is, however, poor adherence to age restrictions, as the home-made amarula wine is not registered as an alcoholic drink. The non-adherence to the age restriction poses a serious issue as the event is supported by a number of governmental departments including the provincial legislature. In these cultural events, many young people are introduced to alcohol and this continues with consumption of other alcoholic drinks, compounded by the use of illicit substances:

'So these marula dance festivals, that is one of the things where the children said they experienced that because it's an acceptable thing where everybody has their cup and all of that.' (Manager)

'I think also culturally there is this thing they call it uMkho-si Womthayi (Amarula festival).... They have to if the parliament is coming to celebrate it, you see it as a good thing, you just continue.' (Fieldworker)

The use and abuse of substances is seen as a cultural norm; it is seen as an acceptable cultural behaviour as expressed by some participants in this study:

'What I can say is I've experienced that there are many people using alcohol and they taking it as a culture that is if you are living in this area, you have to do drugs or you have to take alcohol. Even in schools, we found young people smoking cigarettes, smoking drugs, marijuana.' (Fieldworker)

'So cultural wise, they don't see it as a wrong thing to drink or substance.' (Fieldworker)

'... what I've noticed is the most used drug is alcohol, usually we don't take it as a drug, we take it as a norm and you see people drunk as early as eight in the morning and you can see that people are addicted but no one thinks it's an addiction because we grew up with alcohol, we stay with alcohol and it's part of our lives so we think it's not a drug.... But what is a problem is we take this as a norm ... if someone is drunk they just drunk, if someone smokes dagga it's just dagga, we don't take it as our concern as the health system.' (Manager)

Unclassified or unregistered substances

The Liquor Act 59 of 2003⁷ has made provision for the regulation of micro-manufacturing of substances to be regulated by Provincial Liquor Authorities; however, this does not seem to happen effectively in rural areas. It was expressed that when perpetrators have been apprehended with these substances, they cannot be prosecuted as these substances are not registered as illicit substances. The situation is exacerbated by the porosity of uMkhanyakude, as it is bordered by Mozambique and Swaziland. As a result, a number of unknown substances are brought in across these borders and are distributed in the district with no controls.

A number of home-brewed substances are also easily accessed, namely, isitambetambe (mixture of pumpkins, pineapple, sugar), isiqatha (mixture of the leftovers of isiZulu, maize meal, bread, sugar), ibhomane (mixture of glue, battery acid, pineapple), injemane (palm wine (cut from a palm tree to obtain its juice), amaganu (amarula wine made by squeezing amarula fruit), qo (unknown substance bought from Chinese shops and mixed), imbamba (sugar, pumpkins, sugar-cane, amarula), isiZulu (mixture of maize, umthombo, sorghum, yeast and bread, sugar) etc. An additional challenge to service providers in the district was related to the easy accessibility of substances, especially cannabis (colloquially known as dagga), which is exacerbated by the numerous home plantations. The availability of these substances is evidenced by the fact that alcohol and cannabis are the leading substances used in SA and more specifically in KZN.⁸ The availability of dagga in KZN, especially in rural areas, plays a huge role in exacerbating the burden of substance abuse and the prevalence of the home-made substances is not well documented. Notwithstanding this, whilst the magnitude of the burden of substance abuse is known with regular reviews by the South African Community Epidemiology Network on Drug Use (SACENDU), there is limited evidence from the rural areas and details regarding the home-made substances, which has affected many people.⁶

Poor prioritisation and integration of mental health services

The process of implementing and integrating the health system at district level has been slow and inconsistent; as a result some areas are well functioning whilst others are poorly coordinated.⁹ A number of participants indicated that senior management may be pressured by the mandate of health priority programmes such as HIV, TB, and reducing child mortality and maternal health, with a lesser focus on mental health care services. Consequently the collective perceptions of the service providers exclusively from the Department of Health (DOH) were that substance abuse and mental health programmes are not prioritised as compared with other programmes within the district health system:

'I think just the priority I'm a bit worried about, the priority of the programme because you'll find that our top managers will say oh you talking about that, okay let's shift that one, let's talk about HIV.... Yes it's neglected.... So I think it's the priority of the programmes.' (Manager)

In a study on challenges and constraints at district management level in South Africa,¹⁰ the authors found inconsistent and ineffective use of data for evidence-based decision-making by managers, with gaps in adequate resource allocation being noted as one of the systemic problems when considering health systems strengthening.

Within the DOH, substance abuse services fall within the domain of mental health programmes. The perceptions were that mental health and substance abuse services are treated as separate programmes.

Poor resource allocation for service delivery

The perceptions of participants were that mental health and substance abuse is neglected or seen as less important; hence, resource allocation is impacted. The following frustrations were noted:

'In that part it will be transport, even the allocation you will find that there's a TB car but we don't have mental health team vehicle so it goes back to priority and integration.... Because even with the allocation you can go to provinces that got cars for HIV team, they got cars for TB team but you'll never hear a car for mental health.' (Manager)

'Because we can try to book transport and you'll get transport but if somebody else whose job is perceived more important than yours needs transport but they didn't book the transport, they will get the transport.' (Fieldworker)

'And there's another thing, the other programmes like HIV/Aids, there is Africa Centre but in Mental Health I never saw any programme that is supporting.... Yes, it's like it's been neglected.' (Fieldworkers)

Given that mental health care services are not seen as a priority, resource allocation is consequently negatively impacted. These findings are in keeping with the notion that mental health services in South Africa are neglected, and although it is a third contributor to the disease burden, services are allocated only a 4% budget¹¹ and there remains a lack of resources for service provision.¹

An important aspect to note also is that there exists no public or private substance abuse treatment facility within the district. The nearest public facilities are approximately 350 km away in Durban and Newcastle. This geographically isolates uMkhanyakude district. A confounding factor too is that these facilities have long waiting lists. The following was expressed by participants in this study around the absence of a treatment facility: 'No, there is no rehabilitation centre around here. We only provide counselling which (is) not helping really' (Fieldworker).

'I think on [of]) the limitation as well we don't have the facilities, rehab centres so when we have to refer a person, looking at the distance, we have to refer a person to Durban or Madadeni ... and the waiting list is long, if they do have an access or maybe they accepted to transport a person to that centre, it means now you are isolating that person from their family, they won't be able to ... like it's putting him/her into prison for six months or whatever so that is the issue.' (Manager)

This geographical isolation of the district from access to what we can consider to be basic services may be seen as a contradiction to the constitutional rights of those individuals. Under section 27 of the SA Constitution, access to healthcare is a recognised right and the principle of justice and distributive justice is essential in resource allocation with the onus being on the state, and therefore staff employed by the state, to ensure that steps are taken to realise these rights.¹² However, these provisions of the rights depend on whether resources are available.

Rural populations are mostly poor with limited access to social and economic resources to improve their conditions and these result in worse health outcomes.¹³ The public health care system in rural areas is also considered to be mostly under-resourced and access to quality healthcare is severely limited in the marginalised rural communities.¹³ In a study in rural areas of Cape Town, geographic isolation and financial access were indicated as strong determinants of substance abuse treatment utilisation, reinforcing the inequitable access to services by poor rural South African communities.¹⁴

Fractured integration of mental health care services within PHC

Although the vision of KZN DOH Substance Abuse and Mental Health¹⁵ is 'Mental well-being for all people in KwaZulu-Natal through an appropriate mental health and substance abuse programme within the primary health care (PHC) approach', this is not translated on the ground level. There is poor integration of mental health and substance abuse services in the daily running of the health facilities. Service providers highlighted that even simple tasks such as coordinating collection dates of medication was not considered:

'Because even at hospitals you come to a mental clinic and then you'll ask is so and so taking ARVs, they don't know ... you'll find that it's a client that comes here every day for mental health treatment and the person is also taking ARVs but they don't know, there's no integration even of the dates ... even when you ask, they'll say 'oh we've seen him sometimes going to ARV, I think he/she is taking' but it's not documented anywhere. So the integration of mental health to other PHC services is vital, I think it's very vital because it's also a PHC programme.' (Manager)

'So that's my main worry that we need to do this reintegration of the mental health into the PHC that is a big, big challenge.' (Manager)

In addition, it was reflected that many mental health concerns are overlooked by other health professionals. Their perceptions were that there is a need for in-house staff training including the community care givers (CCGs) at a grass-roots level. This could hasten the integration of mental health to primary health care:

'Firstly if the health staff or personnel can be retrained on this reintegration of mental health because it's where especially at the PHC level ... the person is not fully screened in terms of their substance until it is too late.... Right now there are plans that are on, we are trying to retrain the staff.' (Manager)

'A challenge is also training when we do training of nurses or even with the CCGs from the community, it's rare that we talk about the substance abuse.... So I think even in training it shouldn't be waiting until someone goes to do mental health, it should be integrated in the basic training.' (Manager)

These perceptions are aligned to another study¹⁴ which indicated that SA should move towards a primary health care rather than a curative approach. In addition, these perceptions emphasise the need for the effective integration of mental health care services within primary health care. Notably, South Africa is undergoing a review of its health services through the preparations for the introduction of the National Health Insurance (NHI) and Primary Health Care Re-engineering in order to strengthen the health system to increase access to quality care in South Africa, including that of rural districts such as uMkhanyakude. This study thus provides support for such initiatives.

Absence of aftercare and minimal community-based interventions

The NDMP of 2013–2017⁶ and the Prevention of and Treatment for Substance Abuse (Act 70 of 2008)¹⁶ sanctioned the minister of social development in SA to build one treatment facility in each province. Fortunately, KZN has two public substance abuse service facilities; however, the burden of substance abuse in the province and the long waiting lists prevent a number of people from accessing these. There is thus a need for alternative solutions such as effective community-based interventions. Sadly, there is minimal community-based interventions and no aftercare present at uMkhanyakude District. Most participants expressed their frustration in failing to provide early treatment interventions and expressed that patients are referred to the rehabilitation facilities mostly when they present with psychotic symptoms or if they have committed an offence:

'My experience is that you have to have basically committed a crime so that the judge will force you to go to rehab or you have to be psychotic so that we can send you to Madadeni, like you have to have another problem. Like the earlier milder cases, you can't really ... patient cannot afford ... it's out of your reach so all that we have.... For somebody who's sort of at the beginning stages where there's maybe more hope for him, there's nowhere to send him ... so by the time you're committing crimes as a drug addict, your brain is very badly damaged, the rest of your body is also very badly damaged so even if you manage to become rehabilitated, the damage has already been done. It would be really nice if there was something for milder cases in the state.' (Fieldworker)

'If we can strengthen our intervention from prevention as well as early interventions, it will reduce the number of people that get into dependency, chemical dependency.' (Manager)

Regrettably, there are no aftercare programmes when these individuals return to the district:

'When he came back [from rehab facility] then I supported him even though we don't have aftercare programmes but I supported him in many ways, made sure that he stays clean and until now I am happy he is still clean.' (Fieldworker)

'The government should provide the capacity at a community, that one I think the community-based interventions or out based, they call it outpatient community services.' (Manager)

'So we are facing that problem so we don't have any rehab and also the aftercare.... Right now we do have two guys, the cases that are here ... the social worker, they report it to us, they are coming back now, what are we going to do? Because this is not for the first time this guy went there, this is the third time but now, what are we doing as uMkhanyakude? We really sitting with a problem because we need to give them some occupational, something that they have to do.' (Manager)

Although 40% of South Africa's population live in rural areas,¹³ there seems to be less focus on decentralised or community-based interventions and, rather, a reliance on centralised, institutionalised substance abuse treatment services. This compromises the access to quality health care in rural communities like that of uMkhanyakude District. Notwithstanding this, the legislature is not silent about this gap, as the Prevention of and Treatment for Substance Abuse (Act no. 70 of 2008),¹⁶ states that 'the minister must prescribe integrated aftercare and reintegration services aimed at the successful reintegration of a service user into society, the workforce and family and community life'. The need for a community-based intervention approach is also noted by the NDMP 2013–2017⁶ but implementation at ground level appears still to be challenging.

Poor monitoring and evaluation of substance abuse services

Concerns were raised over the monitoring and evaluation of substance abuse services, given that there are no monitoring and evaluation service standards, a paucity of rural research and limited statistics on the burden of substance abuse in rural districts.

The poor monitoring and evaluation of services was emphasised by the service providers as one of their challenges in service provision. Myers *et al.*¹⁷ have reiterated that South Africa does not have a monitoring and evaluation system for substance abuse services at all levels, national and provincially. This is acknowledged in the National Drug Master Plan of 2013–2017,⁶ which highlights that the reporting in substance abuse is based on activities conducted, as opposed to monitoring and evaluation formats. In addition, there is a need for ongoing monitoring, which should not only explore the extent of the demand for the service and prevention programmes but determine trends, patterns and types of drugs used by different communities.⁶

'... the framework, a systematic framework was not there and it is still not there.... So again, another, we don't have a proper systematic framework for our programmes. Like, we need to have indicators and monitoring systems of our programme, so it troubles me as a decision-maker, so we work around but we don't have a clear programme we still need assistance as an organisation. It's not a nice thing, especially when you present it for lots of people, but I would want you to raise it. We need capacity building around those issues.' (Manager)

'There is no proper tracing mechanism, they don't have a proper tracing mechanism that is at hand that this client has got a problem, maybe now he's on a substance the monitoring, so they don't have a proper system, if it's there it's broken or if it's there it cannot account really so the data is questionable.' (Manager)

Strengths within the district

Despite the many challenges, the roll-out of preventative programmes, as well as inter-sectoral collaboration in respect of prevention promulgated by initiatives of the National Drug Master Plan⁶ through enforcing the formation of a Local Drug Action Committee (LDAC), is noted. Additionally, Operation Sukuma Sakhe (OSS)¹⁸ through war-rooms, an initiative of the premier of the province to address service delivery inequalities, and strong support by civil societies such as NGOs, traditional leadership/tribal authorities and faith-based organisations (FBOs) have begun to contribute positively to service delivery and collaboration — in particular, prevention programmes. As a result, the district appears to have more effective awareness campaigns and educational initiatives than intervention/treatment programmes:

'When the committee [LDAC] started it stopped this thing of repetition, then you find that a person is doing and the other department goes to the same area and does the same thing ... so there is this thing called merging of services, now that you are together I know that you SANCA what you are planning then we go together to the community and it makes our services meaningful because now we are together ... other departments still work in isolation, you'll find that others are excluding themselves.' (Fieldworker)

Despite the challenges experienced by service providers at uMkhanyakude District, the resilience and innovation of the service providers is conspicuous. These include walking long distances, where there are no access roads, and crossing rivers with home-made boats or by foot to reach deep rural/hard-to-reach areas, in addition to contracting with shebeen (illicit bar) owners to monitor their clients so that they save money for family needs as well as addressing groups where cultural leaders are present:

'... it's difficult to get to that area but at the end we have to give service to them ... we normally go when it's low tide, when it's high tide it's difficult to go to Enkovukeni, you can't go there. There are mostly risks involved but because we want to get the service to the people, we go ... so after you have crossed the river [Enkovukeni river, connected to the sea], you have to climb a high hill to reach to that school ... but you have to still walk ... there's only one primary school called Enkovukeni, there is no high school there.... Kids cross every day.' (Manager)

'... clients who are getting a grant, maybe like a psych patient or any gogo who is getting a grant but then all monies are going to that particular shebeen so we have to go to that household to say you must restrict this old person.' (Fieldworker)

'We have awareness campaigns at schools or to the communities, we target those places that are ruled by Izinduna [traditional leaders], we use these gatherings to go there and advise people about substance.' (Fieldworker)

The study yielded some important findings that may be translated into recommendations for service provision by mental health care teams in rural contexts of South Africa, as well as used towards policy review and implementation, whilst being cautious in noting that this was a single district study. There appears to be a need for a provincial or national standard for substance abuse rehabilitation services, one that is relevant and responds to the needs and challenges of rural districts. This standard should respond to gaps identified such as the need for after-care and community integration of substance abuse clients. Perhaps there is a need for services to be decentralised from hospital-based intervention to community-based interventions, in terms of compliance with the Mental Health Care Act that specifies 72 hours of observation followed by discharge or referral. As a result, most clients who abuse substances do not stay long in hospital: they are either referred to rehabilitation facilities or discharged home.

A number of recommendations may be made to specific government departments. For example, the cultural influences and the impact these have on substance abuse should be used as a platform for education to the community especially during events such as the Amarula Festival, by the Department of Arts and Culture, whose support is valued by the community. The health ministry should hasten the integration of mental health to primary health care. Some of the challenges that could be addressed relate to the equitable distribution of resources to mental health care programmes as well as monitoring and evaluation of these programmes. The Social Development Ministry should consider strengthening its human resources with skilled substance abuse service providers.

Conclusions

This study following a phenomenological approach was used to gain greater insight into the experiences of service providers in substance abuse service delivery in a rural district of KZN, SA. These findings may not be generalizable; however, they may be used as a starting point in identifying some rural realities and challenges in mental health care service delivery. This paper was written with a focus on the challenges experienced, and included the cultural influences that exacerbate the use of substances, such as ancestral worship ceremonies, the Amarula Festival and the sense of substance abuse as being a cultural norm; poor regulation of home-brewed and home-grown substances; a lack of resources for effective service provision; the absence of a treatment or rehabilitation facility within the district; and no aftercare or community-based reintegration/rehabilitation to name but a few. These challenges, compounded by the geographical isolation of the district, inevitably negatively impact on service provision. Notwithstanding this, a strong inter-sectoral preventative approach to substance abuse is evident in uMkhanyakude district but the poor monitoring and evaluation of substance abuse services leaves the impact of these initiatives unmeasurable.

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