Improvement Plan for the implementation evaluation of the National Drug Master Plan Improvement Plan

Title of Evaluation	The implementation evaluation of the National Drug Master Plan 2013-2018	**Date of Approval of Evaluation Report**	22 February 2016
Name of Lead Department	Department of Social Development	**Date of Approval of Improvement Plan**	
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1 Comprehensive review the NDMP

Recommendation 2	**R2: There is a need for a comprehensive review of the NDMP to be aligned with the MTSF 2014-2019 and to provide much clearer roles and responsibilities for the departments, Specific issues to be covered include:** R2.1 A stronger and clearer policy position on harm reduction R2.2 The revision must have an implementation plan with a clear M&E framework and plan for indicators at national, provincial and local level including clear guidance on how to prioritise, apply and align or pool resources for their efficient use R2.3 The process should also include awareness raising and lobbying of parliamentarians around harm reduction, and a high-level political dialogue about South Africa's position of the International Drug Control Paradigm must be held, preferably before the special session of the Commission on Narcotic Drugs in 2016 (this could be driven by the CDA and DIRCO).
Recommendation 1	R1: The CDA should advocate for a review and harmonisation of legislation, addressing the inconsistencies identified in the evaluation, and advocate for bills and policies that have been in draft form for some time to go through Cabinet. The Minister of Social Development needs to lead on this and perhaps engage the IMC if necessary. R1.1 Review legislation, including the Drug Trafficking Act, so that it does not conflict with the harm reduction approach in the NDMP and other national legislation so that it harmonises with liquor by-laws of municipalities. R1.2 Amend the Substance Abuse Act to include the need for a Provincial Substance Abuse profile to ensure that an evidence based approach for planning is used by PSAFs and LDACs. The process must provide an indication of the need for intervention and where services are located, and then identify the gaps.

	R1.3 Fast track tabling of The Control of Marketing of Alcoholic Beverages Bill, National Road Traffic Amendment Bill, amendments to the Schools Act (to allow random testing for doping in sports), Substance Abuse Act and the Liquor Act.							
Recommendation 14	R14: To avoid misunderstanding, the CDA has to ensure terminological preciseness in all material it produces and disseminates. Moreover, the reasons behind the preference for particular terms should be articulated. Special care must also be taken to avoid terminology that may be perceived as pejorative.							
Intervention Objective 1 (improvement area)	**Revise NDMP and harmonise legislation in different government departments**							
Outputs to achieve the objective	**Priority L/M/H**	**Activity to achieve output**	**Person/institution responsible**	**By when? (Deadline)**	**Target**	**Embedded where**	**Budget available**	**Current situation**
1.1. National Drug Master Plan 2018-2022	H	1.1.1. Consult provinces and departments on the draft NDMP 2018-2022	DSD (CDA)	July 2017	NDMP 2018-2022	DSD APP		The CDA is currently reviewing the NDMP 2013-2017. A draft NDMP 2018-2022 has been completed. The NDMP 2018-2022 is informed by the evaluation findings and recommendations. DoH has raised concerns about the use of the term Harm Reduction, a new concept in used in the reviewed NDMP 2018-2022. The review also aligns NDMP with thinking in the NDP and MTSF
	H	1.1.2. Finalise the NDMP 2018-2022 which propose a paradigm shift in line with the UNGASS 2016 which recognises substance use disorder as a medical and behavioural condition that require management and not criminalisation	CDA	August 2017		DSD APP		
	H	1.1.3. Submission of the NDMP to cabinet for approval	CDA	March 2018		DSD APP		

		1.1.4. Consult IMC on (Combating) substance abuse to raise awareness about the changes in the approach to deal with substance use.	CDA	Jan 2018		CDA reports		
1.2. Approved and costed implementation plan (activity plan) for the NDMP 2018-2022)		1.2.1. Develop an implementation plan (activity plan) for the NDMP translating how the change in thinking introduced in the NDMP 2018-2022. NT to provide technical support.	DSD	Dec 2019	Approved and costed implementation plan	CDA plans		
		1.2.2. Cost the implementation plan (activity plan) for the NDMP to understand the costs implication of the paradigm shift suggested in the NDMP 2018-2022	CDA	March 2020		CDA Plans		
1.3. Departmental DMPs	H	1.3.1. Formally communicate with heads of national departments with instructions and guidance on how to develop the DMPs and what each of the departments need to address based on the changes in the NDMP 2018-22 and in the context.	CDA	March 2018	Departmental DMP	CDA reports	n/a	

	M	1.3.2. All departments covered by the Act produce DMPs which the CDA give inputs and policy guidance	Departments articulated in the Prevention and treatment for substance abuse Act.	April 2018		Departments APPs	n/a	
1.4. Harmonised legislation and policy for consistency in how the country is responding to substance use	H	1.4.1. The National Drug Master Plan identify legislation in conflict with each other and with the new developments in the sector globally and the NDMP that require review for consistency in anti-substance abuse sector	DSD	August 2017	Harmonised legislation	CDA plans		The DSD is currently reviewing the NDMP 2013-2017. A draft NDMP 2018-2022 has been completed. The NDMP 2018-2022 is informed by the evaluation findings and recommendations. The DSD recognises that legislation amendments can take a long time and will explore alternatives to dealing with policy inconsistencies/contradictions The Prevention and treatment of substance abuse Act 70 2008 is being reviewed.
	M	1.4.2. Consult with the DoJ and departments about legislation that require amendments	DSD	December 2017		CDA plans		
	M	1.4.3. Explore alternatives to address the inconsistencies in legislation i.e. revise the regulations, use policies, etc.	DSD	June 2018	Solution to address the contradictions in legislation	CDA Plans		
	H	Conclude the following bills: 1.4.4. Amendment to Liquor Act; 1.4.5. Control of marketing of alcohol beverage bill; 1.4.6. Tobacco product control Act amendment bill	DTI DoH DoH	March 2019	Promulgated Acts	Departments APPs		DTI is in the process of submitting amendments to the Liquor Act. The DoH is working on total ban of liquor through the Control of Marketing of alcohol beverages. A SEIAS has already been completed.

		This should be done in line with the new thinking in NDMP 2018-22 1.4.7. Complete the amendment of the Prevention and treatment of substance abuse Act	DSD					
1.5. Reviewed outcome 2, 3 and 13 MTSF has indicators on substance use in line with UNGASS 2017 and NDMP 2018-2022		1.5.1. Consult with outcome facilitators in DPME to influence the review of outcome 2, 3 and 13 MTSF to support the paradigm shift suggested in UNGASS 2017 and NDMP 2018-2022	DSD/CDA	August 2017	Reviewed outcome 2, 3 and 13 MTSF has indicators on substance use that recognise the paradigm shift in definition of the problem as recommended in UNGASS 2017 and NDMP 2018-2022	DPME MTSF	N/A	DPME is currently reviewing the MTSF to improve alignment with the NDP.

2 Strengthen the CDA

Recommendation 3	**R3.1 DSD and CDA could consider ways to increase the autonomy, independence and authority of the CDA and the evaluators are proposing the following two options (and the Substance Abuse Act (No 70 of 2008) must be amended accordingly:** • The CDA should be moved outside of DSD and be completely independent like SASSA, NDA, MCC – a streamlined entity that has a slim operational structure and works in a coordinated manner, and is funded directly be treasury not through another department. As recommended by Deloitte (2010) the CDA could be registered as a 'government component' and hence be a separate institution in the public service. • The CDA should be an independent entity hosted in the Presidency.

	R3.2 A CEO should be appointed to provide dedicated and permanent leadership. A more streamlined structure is needed for the CDA with a core group of departments whose mandates align most closely to the NDMP (such as DSD, DBE, DOH, DOJCD, NPA, DTI, SAPS, DOSR's Institute for Drug Free Sport). Other departments should be part of the broader CDA consultative forum and part of the extended meetings. Only the core departments should be required to have DMPs. Sub-committees lead by experts should be formed according to the three pillars of supply, demand and harm reduction. R3.3 As the CDA and the IMC are pursuing the same goals and are complementing each other it is recommended that they clarify the roles and responsibilities of each structure and formalise their interaction.
Recommendation 4	**R4: Improve current functioning of the CDA to provide more direct guidance for and monitoring of the implementation of the NDMP by national departments, provinces and local authorities. In order to achieve this, the CDA needs to do the following at a national level:** R4.1 Ensure that each core department has its own DMP which has outputs that speaks to the outcomes of the NDMP. Heads of departments should engage with the NDMP to assist in departmental planning. This will assist them to make sure that their outputs talk to the outcomes of the NDMP. The CDA must provide guidance on how departments are supposed to fund their DMPs. Specifically the CDA must send a letter to the HODs of each national and provincial department setting out exactly the department's role in substance abuse and request that a DMP be developed, attaching the reporting guidelines. R4.2 In order to facilitate functioning of the PSAFs, the CDA chairperson, CDA members and experts in the CDA should **prioritise visits to provincial Premiers' Offices to gain their buy-in and support for PSAFs, and assist with holding non-compliant departments accountable.** The functionality of the PSAFs needs to be properly monitored so that adequate guidance in the interpretation and implementation of the NDMP and DMP can be provided. The CDA Secretariat should support and guide PSAFs in developing a strategy for securing the support from the sector, including the business sector. The problem of poorly functioning PSAFs, such as that in KwaZulu-Natal, needs to be addressed immediately. R4.3 The CDA must **strengthen its monitoring, evaluation and reporting** and provide more support and onsite monitoring visits to departments and PSAFs, using simple assessment checklists or tools to track functionality. R4.4 **Data collected by the CDA support structures needs to be analysed and interpreted** more comprehensively, and it should also be shared with everyone who needs it. The reporting should not only be about what departments are doing (activity level) but about what changes are happening as a result of the activities and outputs (outcome and impact level). R4.5 **The CDA needs budget to implement the recommendations contained in this document**, and to implement joint programmes and to initiate its own projects such as the research clearing house or to run (or sub-contract) an information portal, or coordinate and support a research agenda. The new structure should allow budget to be directly allocated to the CDA (not through the DSD), and the CDA should be able to raise its own funds. For example given the enormous profits made by the liquor industry there is a need and obligation for this industry to be substantively more involved in harm reduction efforts. (CDA, 2015)

Intervention Objective 2 (improvement area)	**Independent CDA able to guide implementation of the NDMP is established**

Outputs to achieve the objective	Priority L/M/H	Activity to achieve output	Person/institution responsible	By when? (Deadline)	Target	Embedded where	Budget available	Current situation/ Progress Report
1.6. Develop protocols and guidelines to guide departments and CSOs	M	1.6.1. Develop SOP (in line with the rules of the CDA) to guide the development, costing, implementation, management and monitoring and evaluation of the NDMP, DMPs and PDMPs. This should align the DMP planning to existing government planning system and cycle.	CDA	March 2018	Work of the CDA is regularised	CDA plans		
	M	1.6.2. Develop a set of simplified guides for the implementation of substance abuse programmes to be used by PSAFs and LDACs	CDA	March 2018		CDA Plans/reports		
	M	1.6.3. Develop a guideline on how the CDA will advise the country to respond to emerging trends in substance use	CDA	March 2018		CDA Plans/reports		UNGASS 2016 recommended that countries develop systems to track substance trends as they develop in society

Outputs to achieve the objective	Priority L/M/H	Activity to achieve output	Person/institution responsible	By when? (Deadline)	Target	Embedded where	Budget available	Current situation/ Progress Report
1.7. Improved M&E and reporting system	H	1.7.1. Develop a performance management system with technical indicator definition, data collection and reporting protocols for the NDMP 2018-22. DPME should work with CDA to develop the plan and the system.	CDA, DSD M&E and DPME	March 2018	M&E system that is operational, detects trends in society, and effective reporting to parliament	CDA report/DSD APP		This will be developed as part of the revision of the NDMP.
	M	1.7.2. Monitor trends in the sector and to analyse data and reports and develop CDA reports to parliament.	CDA with DSD and other CDA members M&E	March 2018		CDA strategic Plan		
	H	1.7.3. Prepare a report biannually on implementation of the NDMP	CDA secretariat	April 2018		CDA Strategic Plan		
	H	1.7.4. Submit the report to social and justice cluster twice a year to inform cluster on progress in implementing substance abuse programmes	CDA secretariat	April 2018		CDA Strategic Plan		
1.8. A new CDA operational model		The new entity will be unaffordable and therefore work will be done to strengthen the current CDA.						

3 Strengthen governance mechanism

Recommendation 5	R5: Institutional strengthening of the PSAFs by ensuring appropriate and adequate human, technical and financial resources for the PSAFs. This would also include ensuring continued support by the Premier. It is furthermore recommended that the CDA develop a standardised TOR and guideline document for PSAFs.
Recommendation 6	R6: The PSAFs should ensure that programmes are well allocated across the continuum of care throughout the province, based on evidence of need, with equity in service provision as a key consideration. This should include ensuring effective distribution of resources across the continuum of care so that prevention and early intervention are better linked, and that rehabilitation, and aftercare and reintegration are better integrated. This will facilitate availability of services for those who need them the most. R6.1 A Provincial Substance Abuse profile should be developed to ensure that an evidence-based approach for planning is used by PSAFs and LDACs. In order to support this, the CDA, together with DSD, must develop a process and tool for determining a substance abuse profile for the province and at local level, which could be updated every three years. It must provide an indication of the need for intervention, and where services are located, and then identify the gaps. An example is the provincial profile tool used for the Children's Act monitoring. This must be written into the Substance Abuse Act (No 70 of 2008) as a requirement.
Recommendation 7	R7: A support programme aimed at strengthening the capacity of LDACs be developed and piloted. The Expanded Partnership Programme implemented by the Western Cape government, Department of Community Safety in order to strengthen Community Policing Forums is an example of the type of model which could be piloted here. As part of this pilot (or as a stand-alone activity), in order to improve the functioning of LDACs it is recommended that the CDA develop a standardised TOR and Guideline document for LDACs. National and provincial departments should assist to define the roles and responsibilities of the local structures in LDACs and ensure that provision is made in budgets, operational plans and performance management tools for such functions. If all this is done, and the pilots find that the LDACs are not able to achieve positive outcomes, then the suitability of the structures themselves can be questioned.
Recommendation 8	R8: **Develop and implement a capacity building strategy for CDA, PSAF, LDAC including the relevant competencies (skills and knowledge) to guide selection of members for each structure (CDA, PSAF, LDAC)** and addressing the specific functions of these structures as laid out in in Section 56 (d) and Section 58 (d) of the Substance Abuse Act (70 of 2008). In order to maximise impact of this strategy the following should be included: R8.1 Developing standardised training materials and guidelines for each of the structures. The training of master trainers for training of PSAF and LDAC members and the use of a train-the-trainer approach should be considered as a cost-effective way of reaching large

	numbers of committee members. If implemented, this approach should include a strategy for selecting suitable participants as master trainers and a strong, well-planned mentoring component for master trainers. R8.2 An operational plan and adequate budget allocation by the CDA to each province to ensure that capacity building of structures will take place on a regular basis rather than being once-off in nature.

Intervention Objective 3 (improvement area)	Strengthened institutional mechanisms to support the implementation of the NDMP

Outputs to achieve the objective	Priority L/M/H	Activity to achieve output	Person/institution responsible	By when? (Deadline)	Embedded where	Budget available	Current situation/ Progress Report
3.1. Improve political support for the work of the NDMP at provincial and local government	H	3.1.1. Consult with the provincial premiers on the NDMP to get political support for the provincial PSAFs and DMP	CDA	Dec 2017	CDA strat plan	CDA	The CDA is in the process of planning meetings with the premiers and mayors. Challenges have been experienced.
	H	3.1.2. Consult Mayors on the NDMP to improve support for the LDAC	CDA	Dec 2017	CDA strat Plan	CDA	
3.2. Capacity building strategy	M	3.2.1. Establish the CDA as a QFA under the Health and Welfare SETA. This will be done in consultation with the DHET.	CDA	March 2018	CDA strat Plan	CDA	Consultation with the Health and Welfare SETA has already commenced. DoH is in conversation with DHET to develop specialised training on Substance Use Disorder
	M	3.2.2. Develop a capacity development strategy (including	DSD	March 2019	CDA strat plan	CDA	

Outputs to achieve the objective	Priority L/M/H	Activity to achieve output	Person/institution responsible	By when? (Deadline)	Embedded where	Budget available	Current situation/ Progress Report
		training and education framework and guidelines and a training framework for sector, CDA, PSAFs and LDACs. This must be linked to Colombo plan.					
	M	3.2.3. Develop a competency framework linked to training and skills development plan to promote upward mobility and continuity (succession plan) in the CDA structures.	CDA	March 2019			
	M	3.2.4. Develop a skills/qualification/experience criteria for selecting members of CDA, PSAFs and LDACs	CDA	Dec 2017			

4 Improve implementation

Recommendation 11	R11: Development and implementation of guidelines and protocols for substance abuse programmes, including for prevention and early intervention programmes, multi-disciplinary and multi-modal protocols and practices for integrated diagnosis and treatment of substance dependence and co-occurring disorders and for funding such diagnosis and treatment. Guidelines for a referral system at local level should be piloted through a few LDACs to see how it can work. The guidelines must include a process and tool for asset and stakeholder mapping, which can be used to build the referral system. These guidelines must take the integration of services in account at all times.
Recommendation 15	R15: The DBE must make sure that the National Strategy for the Prevention and Management of Alcohol and Drug use amongst learners in schools is widely known and that schools are assisted to establish the support systems envisaged in the strategy.
Recommendation 10	R10. A quick response strategy must be urgently developed to curb the spread of heroin including increased awareness about the dangers of nyaope (woonga) that it is in fact heroin and what this means, and prepare for an influx of heroin addicts and needle users in

	Mpumalanga, KZN and Limpopo. These provinces must be prepared to implement needle supply and OST. This strategy must be informed by research and it needs a high level driver such as the CDA or a national department. The Western Cape had MINMAC drive a similar response when methamphetamine became a problem. The response needs to be linked to harm reduction.
Recommendation 9	R9: The DOH must play a greater role in providing the human infrastructure and other resources for providing medication as part of treatment regimes, including intervention services in hospital settings. Improving the skills in the sector is critical as addiction treatment is a highly specialised field. For the medical model to work more doctors who specialise in medication treatment of addiction and addiction psychiatrists are needed. To further address the gap in specialist skills amongst the workforce, the CDA should continue its efforts to oversee the **development of an accredited training course on substance abuse for targeting social workers, auxiliary social workers, nurses, lay counsellors and other mental health professionals as defined in the Mental Health Care Act (Act no 18 of 1973**). While pursuing the long term goal of getting approval from the College of Medicine to having a specialisation being developed in addiction medicine, the CDA should in the interim also start with developing programmes that can be Continuing Professional Development (CPD) accredited. (Likewise, shorter certificate and diploma courses could be developed). This should draw on work already done by CSOs and treatment centres and on the Colombo Plan, which was mentioned as a good resource for intensive, internationally recognised training and has already been specified in the CDA Business Plan 2014/2015. Once this course is developed, each department should develop a capacity building strategy which targets departmental officials working in the substance abuse sector.

Intervention Objective 3 (improvement area)		Improve delivery of treatment services to users to reduce relapse and break the cycle of substance abuse.						
Outputs to achieve the objective	**Priority L/M/H**	**Activity to achieve output**	**Person/institution responsible**	**By when? (Deadline)**	**Target**	**Embedded where**	**Budget available**	**Current situation/ Progress Report**
4.1. All provinces provide treatment and after care services	H	4.1.1. Finalise the construction and operationalization of the public treatment centres in all provinces	DSD substance abuse unit	March 2018	Public treatment centre in each province	DSD APPs		Conditional grant from national DSD has been established to fulfil this function. Construction is underway in most provinces.
	H	4.1.2. Monitor the registration and compliance of treatment centres and	DSD substance abuse			DSD APPs		

		those providing after care services						
4.2. Improve funding for Substance abuse programmes	H	4.2.1. Develop a protocol to increase funding for substance abuse programme.	DSD	March 2020	Protocols developed	CDA Plans		IMC proposed that 2% of the liquor industry profit be reinvested back to fund Harm reduction. This is included in the Liquor Act amendments.
4.3. Implementation plan for school based substance abuse management interventions	M	4.3.1. DBE to roll out implementation of the Strategy to all schools	DBE	March 2018	School based substance abuse interventions implemented	DBE APP		DBE developed the strategy and are now developing a costed implementation plan. This will include the development of a training manual for government and for the schools (educators).

5 Improve evidence generation and use to respond to substance use

Recommendation 12	R12: The evidence base for **prevention and treatment programmes needs to improve**. In particular, prevention models that work for different target groups need to be identified and Ke Moja must be evaluated for effectiveness related to behaviour change; the effectiveness of the Matrix Model must be evaluated for efficacy in the South African context, or a local model developed for community-based treatment. The City of Cape Town is implementing this model and could thus be a good site for evaluation.
Recommendation 15	R13: The CDA can play a very important role in facilitating evidence-based effective substance use intervention in South Africa by initiating and stimulating relevant research and information sharing on condition that adequate funding is provided for relevant initiatives. There are three main initiatives needed, namely the setting and coordination of the implementation of a national research agenda, information sharing and communication. These are elaborated on below. R13.1 The CDA must set and coordinate the implementation of a **national research agenda on substance use related issues**. This agenda

	should provide for the initiation and stimulation of primary research as well as for the collation of secondary data. Special attention should be given to the following initiatives: 1. In terms of primary research, the CDA must commission a comprehensive national population household survey on substance use, preferably before drafting of the follow-up to the NDMP 2013-2017. This survey should be regarded as a baseline for related periodic surveys, the value of which is well documented in the NDMP 2013-2017 (page 62 of the NDMP 20130-2017). Regarding substance use related treatment; the CDA should commission a national protocol-effectiveness study (for an example of such a study see https://www.ncjrs.gov/ondcppubs/publications/treat/trmtprot.html). More evaluations of intervention programmes are also needed to identify evidence-based programmes across the continuum of care. 2. In terms of **secondary data, a CDA substance use "clearing house" should be set-up, either by the CDA or a third party**. Generally, in line with the specifications in the NDMP 2013-2017 (see page 62), the focus of this service should be on collating completed research and other data on the nature, extent and consequences of substance use in South Africa. The CDA clearing house role should include the integration and re-analysis of collated data to identify and predict substance use patterns and underlying causes and consequences, and thus direct required research and intervention based upon underlying causes and not visible symptoms only. R13.2 The **CDA must facilitate improved information sharing and communication around substance use** and abuse through the establishment of the mentioned CDA clearing house. The clearing house should thus have an online portal, providing a dynamic space for sharing information on the nature, extent and consequences of substance use as well as on intervention services (including how to register services and ideas for programmes). It should include a communications platform and directories of intervention services for people who need support with regard to substance use. In addition, the portal can host policy briefs, information updates, and a newsletter. R 13.3 The **CDA must develop and implement a communication strategy** for the NDMP and produce a user friendly version of the revised NDMP which can communicate the plan to people at all levels.
Intervention Objective 4 (improvement area)	Evidence developed and used to inform substance use prevention and response programmes

Outputs to achieve the objective	Priority L/M/H	Activity to achieve output	Person/institution responsible	By when? (Deadline)	Target	Embedded where	Budget available	Current situation/ Progress Report
4.4. Evidence based interventions	H	4.4.1. Develop a 5 year national research agenda for the substance use in the country including what works for prevention and early intervention. DST can provide technical support.	CDA	March 2018	Five year national research agenda	CDA plan		
	M	4.4.2. Establish data baseline on substance use and substance disorder in the country. Work with Stats SA.	CDA	2020	Baseline on substance use disorder established	NDMP		
	H	4.4.3. Commission research to explore cost effective evidence based alternative models to provide services to substance users providing for those who require inpatient, outpatient and aftercare services	DoH DSD	Dec 2018	Research commissioned	NDMP		
4.5. Communication and advocacy plan for the NDMP 2018-22		4.5.1. Develop a communication plan for the NDMP 2018-22	GCIS	March 2018	Communication strategy developed	CDA plan		
		4.5.2. Conduct awareness raising campaign with other departments to influence their substance abuse programmes to align with the NDMP and new thinking about alcohol and tobacco and other drugs.	DBE DSD DoH DTI SAPS	March 2018	Awareness campaign developed	CDA plan		

Activities in this plan that will not be completed by March 2018 when the term of the current CDA ends will have to be included in the goal oriented plan to be handed over to the new CDA which is to commence work April 2018.

Endorsed by

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Ms Nelisiwe Vilakazi

Acting Director-General: DSD

Date: ……