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Illicit Drug Use and Treatment in South Africa:

a review

Karl Peltzer[1,2], **Shandir Ramlagan**[1], **Bruce D. Johnson**[3], and **Nancy Phaswana-Mafuya**[1,4]

[1]Human Sciences Research Council, Pretoria, South Africa

[2]University of the Free State, Bloemfontein, South Africa

[3]National Development and Research Institutes, Inc., New York, USA

[4]University of the Western Cape, Cape Town, South Africa

Abstract

This review synthesizes available epidemiological data on current drug use and substance abuse treatment admissions in south africa since 1994, and how changes in the political, economic and social structures within south africa both before and after apartheid make the country more vulnerable to drug use. based on national surveys current use of cannabis ranged among adolescents from 2% to 9% and among adults 2%, cocaine/crack (0.3%), mandrax/sedatives (0.3%), club drugs/amphetamine-type stimulants (0.2%), opiates (0.1%) and hallucinogens (0.1%). The primary illicit substance at admission to South African drug treatment centers was cannabis 16.9%, methamphetamine (Tik) 12.8%, crack/cocaine 9.6%, cannabis and mandrax 3.4%, heroin/opiates 9.2%, and prescription and OTC 2.6%. An increase in substance abuse treatment admissions has occurred. While the prevalence of illicit drug use in South Africa is relatively low compared to the USA and Australia, prevention and intervention policies need to be designed to reduce these levels by targeting the more risky subpopulations identified from this review.

Keywords

South Africa; epidemiology; substance abuse treatment; cannabis; mandrax; cocaine; crack; heroin; methamphetamine; tik

Introduction

At the end of the apartheid era, Rocha-Silva (1992) wrote that South African research relating to the nature and extent of use of drugs other than alcohol and tobacco among the general adult population in South Africa was virtually non-existent. In South Africa alcohol and drug abuse was signaled by former President Nelson Mandela in his opening address to Parliament in 1994 as a problem among social pathologies that needed to be combated. By February 1999, the South African Drug Advisory Board hailed an unacceptable increase in substance abuse and its associated problems. This problem has been identified by the National Drug Master Plan, as a fuel for crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability the escalation of chronic diseases, such as AIDS and TB, injury and premature death (Drug Advisory Board, 1999).

Address correspondence to Prof Karl Peltzer, Social Aspects of HIV/AIDS and Health, Human Sciences Research Council, P/Bag X41, Pretoria 0001, South Africa. E-mail: KPeltzer@hsrc.ac.za .

Historically, as a direct result of the Apartheid government, the (native black) African population was segregated into the least desirable areas and kept out of many areas where the dominant whites lived and worked. The apartheid governments built the strongest economic system in Africa, with seaports, transportation road systems, mining, agriculture, and several resource recovery industries. They also established a range of other health, social, and government services, primarily for whites. The vast majority of black Africans were segregated into remote areas called Bantustans (like American Indian reservations) and townships (near urban areas) in South Africa. Few South African government resources supported housing, education, health, or social services in black communities. Police and law enforcement resources were employed almost exclusively to maintain controls over the blacks and were thoroughly supported after the National Party electoral victory (Wikipedia, 2007a). Black on black crimes and illegal drug use/sale were rarely investigated nor prosecuted by the Apartheid officials. Although South Africa followed international treaties and instituted statutes that made the use of heroin, cocaine, and cannabis criminal offenses, few resources were devoted to enforcement of such laws. Until 1991, South African law divided the population and labeled persons into four major South African defined racial categories: Blacks, Whites, Coloureds, and Asians. These racial divisions remain deeply entrenched in South African society. According to Statistics South Africa (2006), the 2006 estimated population (42 million) figures are: Black African at 79.5%, White at 9.2%, Coloured at 8.9%, and Indian or Asian at 2.5%. (Wikipedia, 2007b).

Even with the end of apartheid in 1992, and election of Nelson Mandela in 1994, whites (and to a lesser extent the Coloreds and Asians), continue to occupy a privileged position in South Africa. Many black Africans are now beginning to occupy middle class positions since 1994. Sizable portions of the growing middle class population (regardless of ethnicity) now live in “gated communities” primarily located in suburban zones around the major cities. They can afford western style housing, usually have car(s), and have stable employment in business, academia, industry, and government. South Africa is a society in transition. Changes in the political, economic and social structures within South Africa both before and after Apartheid make the country more vulnerable to drug use. Drug availability and use likely correlate with the pressures placed upon social capital by rapid modernization and a decline in traditional social relationships and forms of family structures. Difficulties of social transformation in South African society are exemplified by the somewhat slower than the hoped for pace of the redistribution of economic power throughout the society. This has a number of implications for illicit drug availability, use, and treatment. The factors that reflect increased or changed patterns of use and what society factors would account for facilitating these changes include: availability and easy accessibility within a tolerant or limited enforcement of drug laws within society, age at first use and diversity of available drugs, growing wealth among new populations particularly within the middle class, better infrastructures for transportation, less policing, more tolerance for new ideas and behaviours. This will be discussed under (1) Availability and diversity of illicit drugs, (2) Political change (weak border control, participation in the world economic system), (3) Enforcement policies and debates about decriminalization of cannabis, 4) Economic and social change, (5) Epidemiology of illicit drug use (including age at first use), and (6) Illicit drug use treatment demand.

The aim of this review is to delineate how political, economic and social changes may be linked to illicit drug use and treatment in South Africa.

Methods

The authors of this paper conducted a search for published and unpublished material (research reports, articles and conference presentations) pertaining to illicit drugs in South

Africa using online searches (including electronic databases such as EBSCO, Medline and Science Direct), Google star. Search terms included illicit drug markets, drug related crimes, drug abuse and treatment, illegal drug prices, illegal; drugs in South Africa and drugs and crime. The authors found that agencies and organizations such as the Institute for Security Studies (ISS), the South African Police Services (SAPS), the South African Medical Research Council (MRC), the South African Community Epidemiology Network on Drug Use (SACENDU) provided major sources of information on drugs. International organizations including the United Nations Office on Drugs and Crime (UNODC), and Interpol, and the US Drug Enforcement Administration also provided international reports that included South Africa. In general, however, the ISS and SACENDU had information about the epidemiology of drugs, while information from the UNDOC provides more regional data with limited statistics. The MRC contributed information on treatment demand while the SAPS would contribute information on the justice system, number of arrestees and the police system in general with regards to drug-related crimes.

Two major national surveys included in the analysis were the 2002 Youth Risk Behaviour Survey (YRBS) among school adolescents (Reddy et al., 2002), and a national population-based survey in 2005 (SABSSM II) (Shisana et al., 2005), in which current cannabis use was defined as cannabis use in the past 3 months. The YRBS was a cross-sectional national prevalence study among secondary school learners in South Africa where 23 Government schools per province were chosen; 14,766 students in grades 8, 9, 10 and 11 were sampled and 10,699 completed a self-administered questionnaire. This survey was planned using a two-stage cluster sample design so as to ensure nationally and provincially representative data.

SABSSM II is a national household study of HIV/AIDS which gathered data on HIV prevalence, behaviour, and communication; measures of drug use were included. The survey design applied a multi-stage disproportionate, stratified sampling approach which yielded 23,275 respondents of which, 16,395 people were 15 years and older. This nationally and provincially representative sample was collected through interviewer-administered questionnaires.

Results

(1) Availability and diversity of illicit drugs

South Africa has a sophisticated and diversified economy—including a first world infrastructure existing along widespread and severe poverty; the country offers the most attractive consumer market in the subcontinent. South Africa is by far the largest market for illicit drugs within sub-Saharan Africa (Nel, 2003). Its relative affluence in Africa makes it a tempting ‘emerging market’ in its own right. The influx of new international cultural trends among the more affluent segments of the population, are all associated with the increase in drug use and abuse as well as increases in violent and organized crime. The political and economic isolation of the country under the apartheid regime in combination with a strong population growth resulted in an actual 0.6% decline in GDP per capita during the period 1975-97. By 2001, GDP growth was at 2.2%. This has occurred despite the high level of crime (drug-driven) and violence, perceived, among broad sections of the population, as being out of control (UNOCD, 2002).

Table 1 summarizes the major illicit drugs commonly used in South Africa and provides a brief history for each substance, the typical names and common use practices, and retail unit prices in the nation. The South African names are relatively unique—*Dagga* for marijuana (dried herbal cannabis), *Tik* for methamphetamine, and *Mandrax* for methaquaqlone.

Likewise, the *White Pipe* (combining tobacco, cannabis, and methaqualone smoked through a broken bottleneck) is largely unknown among drug users in other societies.

Price trends for illicit drugs in SA have demonstrated some changes since the mid-1990s, contributing to the general availability and increased demand for the less customary drugs of choice. While the SAR price remained somewhat stable, if expressed in US$, the price of both heroin and cocaine fell by more than 75% between 1992 and 2001. This meant that a much wider range of consumers were able to afford these illicit drugs previously out of their price range. This price drop has negative implications, as a much wider range of consumers was able to afford drugs previously out of their price range, and the potential for increasing drug use among lower-income and youth markets (UNODC, 2002,2006).

(2) Political change (weak border control, participation in the world economic system)

In the 1960s and 1970s, the widespread abuse of psychotropic substances emerged in South Africa. Globalization has facilitated the introduction of potent addictive drugs such as heroin, cocaine and ecstasy in South Africa. Legett (2004) noted that prior to 1994, cocaine and heroin were not readily available in the society. South Africa's re-integration into the world-wide community in the 1990s and its developed transportation, communications systems, and advanced banking structure can be used for the purpose of illicit trafficking of many commodities, including drugs (UNOCD, 2002). The end of Apartheid has increased vulnerability to illicit drug trafficking and consumption between source countries in Asia and South America and the major consumer markets in Western Europe and North America. While not the most direct route between these areas, South Africa may be used for transshipments of illegal drugs. The quality of air and sea travel connections via South Africa to many parts of the world offers drug traffickers opportunities that did not exist earlier. The country's geography, porous borders and expanding international trade links with Asia, Western Europe, and North America have made it an attractive drug transit country. Drug trafficking and abuse have escalated. The point of escalation is traceable to the fall of apartheid and the liberalization of most aspects of society in the years following the country's first democratic elections in 1994.

Cocaine from Latin America transits through to Europe, and heroin from the Far East passes through South Africa on to Europe and the US (US Department of State, 1996). South Africa, along with Namibia, Kenya, Swaziland, Angola, Tanzania and Uganda are now on the major cocaine trafficking routes. Colombian cocaine drug lords are reported to be moving their operations into South Africa which allows them easier access to Europe. More recently, the cartels have established contacts with Asian and Far Eastern producers to use South Africa as a conduit for smuggling hash, heroin, and opium to Europe and the US (Hawthorne, 1996).

Long, porous borders and weak border control, including undermanned ports and numerous secondary airports, give traffickers nearly unlimited access to South Africa. The growing presence of illicit drugs in South Africa is indirectly a result of the dramatic increase in the number of international flights to the country, relaxed visa requirements for South Africans to travel overseas, movement of large numbers of legal and illegal people across the borders, poorly monitored borders, and ill-equipped customs. All of these create a highly attractive market for influx of drugs (SAPA, 1995), and a growing reputation as a 'paradise' emerging market and transit point for illicit drugs (Steyn, 1996; Ryan, 1997). Although little available evidence to substantiate it, the growth of organised crime and lack of adequate resources to deal with it, contribute among others, to an increase in accessibility and availability of illicit drugs in South Africa, a corresponding increase in consumption is probable.

(3) Enforcement policies and debates about decriminalization of cannabis

South Africa has a thriving campaign for, and public debate about, decriminalization of cannabis. This is due in part to the widespread perception that illicit drug consumption is expanding and will continue to do so, aided by growing tolerance towards drugs and ineffectual law enforcement. Such perceptions are easily attached to xenophobic views that the "swamping" of the country by illegal drugs compounds - or in extreme cases creates - its economic and social problems, thereby adding to currents of moral panic about drug use as a vehicle of more general fears (UNODCCP, 1999).

Religious values and perspectives have important influences on attitudes to drug abuse and trafficking. Elements within Muslim community predominantly in the Western Cape launched a vigilante movement in 1995 known as People Against Gangsterism And Drugs (PAGAD), out of frustration at the ineffectiveness of the police in dealing with the related problems of violence crime and drug abuse in many townships. South African drug enforcement has primarily been directed against large scale distributors and trafficking syndicates, local police seldom focus upon retail level distributors. Very little police time is dedicated to curbing small time drug exchanges between sellers and buyers of cannabis in public places. Yet South Africa reports approximately 100 drug arrests per 100,000 population (SAPS 2005). Most drug enforcement initiatives in the South African context focus on tackling drug trafficking syndicates and conducting major drug busts and "successful" prosecutions. A newspaper report (Eliseev & Maughan, 2006) on the marijuana market in the streets of Yeoville in Johannesburg notes that police patrols in the area hardly give any attention to drug transactions between dealers and buyers. The report points out that even when the police do give attention, most street dealers and buyers almost always manage to evade arrest. Law enforcement appears to be attuned to current production and seizure trends. There appears to be no clear or official re-prioritization away from cannabis and Mandrax enforcement toward crack, heroin and the club drugs.

According to the Drug Policy Alliance Africa (2005), until recently, drug trade and use in Africa was not of major regional or international concern. Global changes and recurrent internal conflicts have impacted the region in such a way that illicit drugs have now become an issue. Internal economic, social and political instability has created conditions that foster drug use and sales. For example, the fall in the world price of basic commodities in Africa has encouraged the shift to drug (cannabis) production and trafficking in heroin and cocaine (Odejide, 2006). Drug dealing (informal trade in drugs) has become the norm as a result of poverty. This informal trade has aided trafficking in illicit psychoactive drugs such as cocaine, crack cocaine, heroin and ecstasy (MDMA) to different parts of Africa (Odejide, 2006). South Africa is a large producer of cannabis (the world's third largest), most of which is consumed in the Southern African region. Cannabis is cultivated in South Africa, and also imported from neighboring countries (Swaziland, Lesotho, Mozambique, Zimbabwe), and exported to some of the neighboring countries (e.g. Namibia). Some finds its way to Europe (mainly Holland, UK) (UNOCD, 2006).

Cultivation of illicit drugs appears confined to the widespread cultivation of cannabis (but not opium nor coca) in the eastern half of South Africa and in some northern areas. There are large rural areas with good conditions for growing cannabis. The estimated area under drug cultivation has been a controversial matter in recent years, with some unrealistically high figures put forward by the authorities. Current estimates put the amount of land under cultivation at 1,000-1,200 hectares. This estimate still places South Africa among the top four herbal cannabis sources in the world according to Interpol (UNODC, 2003). A considerable effort is dedicated to both eradication of the crop and to seizures, with large quantities discovered by the police annually. The growing cultivation of cannabis, poor

security and lack of intelligence within the police service, have been blamed for increased trafficking of illicit cannabis.

4) Economic and social change

The current South African economy generates enough revenue so that the government can begin to address the enormous inequalities from the Apartheid era that remain, especially for black Africans. Probably a third to half of the SA population live in urban townships and informal settlements, about 90% are black Africans who live in poverty. The vast majority of residents in these impoverished communities lack full time jobs and stable incomes. To supplement income, people in informal settlements and townships rely primarily upon the informal economy. This could be as simple as domestic work in households, selling goods at the roadside, to watching parked cars, to selling illegal drugs. Moreover, these poorest communities exist without, or have few, governmental services (including police, health care facilities, alcohol/drug treatment programs, schools, statistical data, etc.) —an ongoing legacy of apartheid. Such governmental services are more commonly targeted into middle class communities.

Drug use correlates strongly rapid modernization and the decline in traditional social relationships and forms of family structure. Epidemiological surveys in South Africa suggest that high proportions of drug consumers experienced especially difficult family circumstances as children (Frank and Fisher 1998). The expansion of public education is uneven and contributes to anxieties about the loss of control over youth; unfilled expectations and early disillusionment are considered by many as key factors that encourage experimentation with drugs among the young (UNODCCP, 1999).

UNODCCP (1999) suggests that a major sector of South African adults find themselves in a social environment conducive to drug use, i. e., an environment in which there is a fair degree of social support for drug use, exposure to such use and limited discrimination against it. These social factors seem to be generally strengthened by certain psychological factors, namely tolerance towards drug use, a personal need for or attraction to drug intake. Illicit drugs are used in a fairly uncontrolled environment, namely in privacy, i.e. not in the company of other people (when it occurs in company, friends and/or relatives are mostly the company of choice) and at home (in the general population, public use mostly occurs in metropolitan centres and towns bordering these centres, with clubs/discotheques mostly the places of choice; among offenders, the street (in the case of cannabis) and the place of a drug dealer (illicit drugs other than cannabis) are fairly common places of use (UNODCCP, 1999). Particularly common reasons for using illicit drugs (at least among people of African cultural background) seem to be mood-changing and coping; among people admitted to drug-related treatment, matters such as habit, lack of energy and sleeping problems seem to particularly motivate their drug use; solvent users in particular associate their solvent use with getting high and breaking the monotony of their daily life (indeed, the popularity of mood-changing and coping with hardships as reasons for illicit drug use among African groups and indications that African households (especially female-headed households) have the lowest average income in South Africa substantiate the above conclusion that illicit drug use could increase among socio-economically marginalized sectors) (UNODC, 2006).

Another factor contributing to the increased prominence of illicit drug use in South African society is high unemployment. Among the non-White population, social injustice and the weakened family bonds which resulted from decades of apartheid policies have created an environment in which temporary escape from the harsh reality of everyday life is often sought through the consumption of psychoactive substances. Among the White population, anecdotal evidence also supports a connection between increased substance abuse and both

increased availability of drugs and the psychological consequences of adjusting to life in the "new" South Africa (UNOCD, 2002).

Historically, the controlled use and consumption of cannabis among the African population was ubiquitous throughout Southern Africa. Cannabis was an integral part of the culture of traditional communities. Strict rules and values governed the circumstances under which it could be used. Availability was usually controlled by tribal elders. However, in the context of a modernizing, increasingly urbanized society, where traditional community controls are breaking down, the use of cannabis has now become the domain of the younger user and the poly-drug user. In South Africa, cannabis use is now often associated with alcohol and mandrax use. Over the past few decades cannabis use has also gained in popularity among all ethnic groups (Eide & Acuda, 1997; UNOCD, 2002).

Cannabis consumption has been principally a male practice, though this is starting to change, with consumption now reaching increasingly into different gender, age and religious groups.

One reason for this expansion of consumer groups is due to the rise in "functional" drug use, including:

- Those doing physically demanding or dangerous work—this includes consumption by construction and other labourers, dockers, drivers, farmers and farm labourers, whose "functional" reasons for using cannabis are that it enables them to stay awake, to work longer without eating and that it generally enables them to continue working;
- Those confronting social danger involving transgression of taboos, whether formal (legal) or more widely social and cultural (including sex workers, criminals, street children).
- Those wishing to escape conditions of social and/or personal misery; this includes many sections of the urban underclass in townships and the slums and other poor areas of the cities. In such conditions, use of drugs may be "functional" as it provides a form of release or escape not only for the large numbers of unemployed (especially young men) who may also feel they are unemployable, but for the precariously self-employed of the burgeoning informal sector as well.

A broad base of recreational consumption exists, especially in the higher-income groups. One high-profile category of recreational use/users is musicians and artists, whose rationale is inspiration and creativity and the need to overcome social inhibition when performing publicly. Drug consumption by musicians in this regard demonstrates how functional and recreational uses of cannabis can become blurred and difficult to distinguish (UNODCCP, 1999).

South Africa is the most highly urbanized country in sub-Saharan Africa and the only one with over half its population recorded as urban (55.4% in 1996). Gauteng (96.4%) (Johannesburg/Pretoria) and the Western Cape (Cape Town) are the most highly urbanized provinces and have the highest rates of drug abuse. Cities are characterized by high rates of urbanization, limited employment opportunities, expansive informal sector exchange and, an erosion of so-called traditional values and family cohesion. The proportion of female-headed households in urban areas has been rising steadily, and is now estimated at approximately one-third of all urban household. They are overwhelmingly concentrated in the poorest social and economic communities. Parents often return home late, leaving their latchkey children with inadequate adult supervision for much time each day. The process of urbanization leads to higher rates of unemployment in the cities, which exacerbates the

social and economic pressures that underpin both the illicit supply and demand for drugs, all in an informal environment that state authorities are unable to monitor, let alone effectively control (UNODCCP, 1999).

(5) Epidemiology of illicit drug use

Cannabis—The only school-based Youth Risk and Behaviour Survey (YRBS) conducted in 2002 in South Africa; Reddy, Panday, Swart, Jinabhai, Amosun, James, et al. (2003) found that current (past month) use of cannabis was 9% among students. In a national household survey in 2005 (SABSSM II) (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, et al., 2005) cannabis prevalence was 2% in the past 3 months among 15-19 year-olds and in 1.7% in persons 15 years and above (see Table 2).

Higher current cannabis use rate in South Africa were found in urban (2.3%) than in rural (1.0%) areas in 2005 (SABSSM II) (Shisana et al., 2005). Among school students current cannabis use was found highest in the provinces of Gauteng, Western Cape, Mpumalanga, Free State and Limpopo. The highest rates among adults were in Western Cape, Gauteng and North West Provinces. Among adolescents current cannabis use was highest among Indians or Asians and Coloureds, while among adults it was highest among Coloureds and Whites. Current cannabis use was especially low (about 0.2% or less) among women from black Africans and Indian/Asian backgrounds. Current cannabis use rates seem not to be related to any educational level.

The range of current use of cannabis among adolescents from 2 to 9% in two national samples (YRBS and SABSSM II). These prevalence rates are reflected in various local surveys among youth, and range from 2.6 to 12%. Male youth by far had higher current cannabis use prevalence rates than female youth (see Table 3), two to five times greater depending upon the survey.

Other illicit drugs—Based on three national surveys among adolescents, lifetime illicit drug use was highest for over-the-counter or prescription drugs (16%), followed by inhalants (between 0.2 to 11.1%), club drugs (0.2-7.6%), cocaine (crack) (0.1-6.4%), mandrax/sedatives (0.1-6.4%) and opiates 11.5% (the latter figure from the 2002 YRBS seems unreasonably high). Past three months use appears to be well under 1% for most of these drugs in general population samples. Less than 0.3% of adult females reported past three month use of each non-cannabis drug. There were gender differences: more male than female adolescents took inhalants, mandrax/sedatives, club drugs and cocaine (crack) (see Table 4).

(6) Illicit drug use treatment demand

Drug treatment data provide information about those seeking help. The primary substance(s) of abuse at admission to most government-funded treatment centres (n=60) in 2006 in South Africa was alcohol 51.3%, cannabis 19.9%, methamphetamine (Tik) 5.2%, crack/cocaine 7.8%, cannabis and mandrax 2.6%, heroin/opiates 5.5%, and prescription and OTC 2.8%. Treatment admissions were concentrated in the most populated provinces in South Africa: Gauteng (37.9%), Western Cape (32.3%), Eastern Cape (9.4%), Mpumalanga (6.1%) and KwaZulu-Natal (5.9%). Treatment demand was overrepresented for men (79.3%) as opposed to women (20.3%), Whites (38.7%) and Coloureds (30.8%) were overrepresented compared with Black Africans (27.4%) and Indian or Asians (3.0%). There has also been a steady increase in treatment demand for young people (below 20 or 22 years respectively) who now constitute 26.7% of the treatment demand (see Table 5).

Overall the number of treatment admissions has significantly increased over the past 10 years. The percentage of admissions for cannabis, heroin, and methamphetamine increased between 1996 and 2005, while the admission percentages decreased for alcohol. Cannabis abuse alone increased from 14% in 1999 to 17% in 2005 of all treatment demand. Cannabis mixed with mandrax has remained stable from 7% in 1999 to 7% in 2005 (see Figure 1).

There has been an increase in demand for drug treatment by young persons, under 20 years of age, e.g., from January 1997 to December 2001, treatment demand for heroin-related problems increased from 2.1% to 9.1% and ranged between 4.7% and ranged between 0.0% and 14.3% of the total number of adolescents in substance abuse treatment in Gauteng, Cape Town, and Durban, respectively (Parry et al., 2004). In Cape Town the proportion of black African patients having cocaine as a primary drug of abuse has been consistently low (under 7%) whereas there has been an increase in the proportion of cocaine patients who are Coloured from 3.6% in 1997 to 31.1% in 2006. The latter has resulted from a decline in the proportion of cocaine patients who are white (Parry, Plüddemann, & Myers, 2007). In Gauteng between 1999 and 2006 roughly 60% or more patients having cocaine as a primary drug of abuse were white. The proportion of patients treated for cocaine related problem who were black African in Gauteng increased significantly from 4.8% in the second half of 1999 to 12.5% in the second half of 2006. Similarly, there was a significant increase in the proportion of cocaine patients who were Coloured, from 8.8% to 18.7% (Parry et al., 2007). In Gauteng between 1998 and 2003 consistently almost 90% of heroin patients were white, and in Cape Town the corresponding percentage was about 80%; the range for blacks was 0-7% in Gauteng and 0-6% in Cape Town, and for Coloureds was 0-2% in Gauteng and 2-32% in Cape Town (Parry, Plüddemann, & Myers, 2005).

Discussion

The prevalence rates of illicit drug use in South Africa (Table 6) seem considerably lower than that in some other countries such as the USA and Australia, though it is difficult to compare different surveys and different populations. Current cannabis use among South African men (3.9%) and women (0.4%) is about half the American rates--8.2% among men and 6.1% among women 12 years and above (Department of Health and Human Services, 2005). In Australia, current cannabis use is 8.9% among men and 4.6% among women 14 years and above (Australian Institute of Health & Welfare, 2005). Annual cannabis prevalence rates are lower in South America (2.6%), Asia (2.1%) and higher in West and Central Europe (7.4%), Africa (8.1%), and North America (10.3%), USA (31%) (UNODC, 2006). Likewise, current prevalence of other illegal drugs (sedatives, cocaine/crack, heroin, club drugs) is about twice as high in the USA and Australia as in South Africa.

After 1994 South Africa has seen increase in the market for illicit drugs. The country's permeable borders, particularly with neighbouring states, the comparatively high levels of income, as well as long-standing and worsening income disparities have all combined to make South Africa attractive to both local and international drug trafficking syndicates. Compared to other countries in sub-Saharan Africa, South Africa represents the largest market in illicit drugs. A rapidly changing social and economic climate, coupled with increased availability and promotion of drugs and the demand for them, have contributed to the increasing magnitude of the national drug abuse problem. The complexity of the problem has been compounded by changing patterns of drug abuse, supply and distribution. There has been an increase in social and economic factors which make people, especially the young, more vulnerable and likely to engage in drug use and drug-related risk-taking behaviour. South Africa is experiencing the consequences of drug abuse and illicit trafficking: adverse effects on health; an upsurge in crime, and violence and corruption.

Two optimistic findings are worthy of special mention. First, South Africa's largest population, black Africans, appear to have among the lowest prevalence rates of illegal drugs other than cannabis. Even for dagga, however, prevalence rates of cannabis use among black African are lower than among whites and coloured. Second, the self-reported use of every illegal drug in epidemiological surveys cited above appears to be lower and often substantially lower (often by half) than the prevalence rates reported in comparable population surveys in the USA and Australia. Whether these two important findings persist in the future remains to be documented.

Of increasing concern is that the age of initiation for drug use appears to be decreasing. Apart from cannabis and mandrax, other reported popular drugs of choice among young people in South Africa are ecstasy and methamphetamine or tik. Methamphetamine is most common among the coloured population in Cape Town; whether its consumption spreads to other races and major cities remains to be studied. Heroin is reported to have become more attractive to the youth due to its intense physical effects and reducing price. However, heroin use is still more prevalent among males and among the white English and Afrikaans speaking populations.

Despite the data reviewed above, much additional information would be needed to more systematically monitor the long range trends, and especially to provide improved data at the local level. One long-term ongoing monitoring study is conducted by SACENDU, which publishes two reports a year. SACENDU started monitoring substance abuse treatment centers in 1997 initially starting with Cape Town and by 1999, Western Cape, Eastern Cape, KwaZulu-Natal, Gauteng and Eastern Cape were reporting treatment demand data to the SACENDU project. At present, a further three provinces, namely Free State, Northern Cape and North West have been added. The ninth province in South Africa, Limpopo, has not been added to the projects data set, as only one out-patient facility exists in the province. Although this project provides arguably the best data on treatment demand in South Africa at present, the major shortcoming is that the data is only based on those that visit treatment centers, with no information about retention and outcomes of those who enter. Those seeking treatment at psychiatric hospitals and private institutions are not included. Also those that do not seek treatment, which are the majority of substance abusers, are not included.

The demand for drug-related treatment in Cape Town, Gauteng and Mpumalanga is reported to be on the increase. As in all other societies, males make up the largest percentage of drug users presenting at treatment centers. Contrary to what was the situation prior to 1994, increasing numbers of women and non-white populations are presenting at treatment facilities for heroin abuse. As long as methadone maintenance is effectively prohibited by government policy, detoxification from heroin will remain expensive. Another drug reported to be on the increase in South Africa is crack. South Africa (16.9%) appears similar to other countries in terms of admissions for primary cannabis use among treatment populations (e.g. Denmark 27%, Greece 7%, Netherlands 17%, UK 10% (UNOCD, 2006).

The need to reduce both the supply of illegal drugs and the demand would need to be informed by empirical evidence for wide range of actions and programs. But like most African societies, significant funding for research on drug-related issues is limited by many competing priorities face by the South Africa government (housing, education, health care, etc). This means a substantial lack of information about illicit drugs and treatment success. The limited research that studied drug use trends post 1994 has concentrated mainly on adolescents and their use of alcohol. The South African government has no agency, like the American NIDA, that provides sustained funding to specifically support research projects studying illegal drug use. The duplication of certain services and the non existence of others

(like funding for innovative research), has led, in effect, to the mismanagement of meagre resources available and the failure to secure others. The lack of a single strategic response to the drug problem, based on empirical evidence, has meant that the war against drugs has been waged neither effectively nor on all fronts. Public concern and pressure for action in respect of illicit drugs have been increasing. Law enforcement authorities, substance abuse researchers and service providers all concur that the nature and scale of illicit drug trafficking, consumption and related problems appear to be increasing in South Africa largely due to political, economic and social changes that have taken place in the country. In the light of the foregoing discussion and in its vision of building a drug-free society and to make a contribution to the global problem of substance abuse, this paper suggests in that South Africa needs to:

- Pledge a sustained political, social, health and educational commitment to investing in demand reduction programmes that will contribute towards reducing public health problems, improving individual health and well-being, promoting social and economic integration, reinforcing family systems and making communities safer;
- Improve living conditions and community safety through a combination of more effective policing, infrastructural upgrading and encouragement to participatory approaches like community policing for other community based organisations
- Ensure effective liaison and complementarity among various donor agencies (e.g. UNDCP, EU, DFID, USAID) providing material, technical and financial assistance to the country in respect of drugs policy, policing and treatment.
- Establish and maintain a substance-abuse information system which will support the implementation, evaluation and ongoing development of substance abuse interventions.

Demand reduction programmes should be based on a regular assessment of the nature and magnitude of drug use and abuse and drug-related problems in the population. Assessments should be undertaken by the South African States in a comprehensive, systematic and periodic manner. Demand reduction strategies should be built on knowledge acquired from research as well as lessons derived from past programmes.

Limitations

Historically South Africa has not had reliable systems in place to facilitate the collection of data relating to substance abuse. To date, much of the available information has come from ad hoc cross-sectional research studies often conducted in a single location and easily accessible populations (e.g. students). The best national survey (Shisana et al 2005) of the households population was designed to measure HIV/AIDS, but included several questions about illicit drug use. Most other data come from police arrests and seizures. Such data are greatly influenced by factors such as resources available and particular police policies and initiatives. To date, no longitudinal information is available about the drug user life histories. Several new systems have been initiated with the aim of developing more valid and reliable information on illicit drug use. These initiatives have provided valuable information on drug abuse in South Africa upon which this paper is based, but important gaps about illicit drug remain to be addressed.

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Biography

Karl Peltzer is Research Director in the research programme Social Aspects of HIV/AIDS and Health, Human Sciences Research Council, and an extraordinary professor of psychology at Free State University, South Africa. He is a prevention researcher and evaluator with over 20 years of experience in the study of health promotion, risk behaviour and disease prevention, and socio-behavioural interventions. Dr Peltzer has published extensively on health behaviour and health interventions (13 books and 300 articles). He has worked extensively on public health subject areas of substance use, cancer, tuberculosis and HIV control; nutrition, physical activity, hypertension, mental health, injury and violence prevention and health systems.

Shandir Ramlagan is a senior researcher in the Social Aspects of HIV/AIDS and Health research programme. He obtained his master's in development studies from the University of Natal and is currently studying towards his doctoral degree. Mr Ramlagan has experience in social science research, especially in the areas of qualitative research design and methodology, planning and management of surveys, and design of research instruments. His project experience includes work for organizations such as the W.K. Kellogg Foundation, Nelson Mandela Children's Fund, the World Bank, Population Council, and various government departments. His publication record spans progress reports, co-authored chapters for SIDA and the World Bank, literature reviews, co-authored peer-reviewed journal articles, conference presentations, conceptual and epidemiological models, and design questionnaires.

Bruce D. Johnson (Ph.D. 1971 Columbia University) is an American authority on the criminality and illicit marketing of drugs in the street economy and among arrestees and minority populations. He directs the Institute for Special Populations Research at the National Development and Research Institutes. He is a professional researcher with five books and over 130 articles based upon findings emerging from over 30 different research and prevention projects funded by the National Institute on Drug Abuse and National Institutes of Justice. He also directs the nation's largest pre- and postdoctoral training program in the U.S. He visited South Africa in 2006 and collaborated in submitting proposals with the other authors in 2007.

Professor Nancy Phaswana-Mafuya holds a PhD (Health Social Work) from the University of the North in South Africa. She is currently a Research Director at the Human Sciences Research Council based in the Social Aspects of HIV/AIDS and Health Research Programme and an Extraordinary Visiting Professor at the Social Work Department of the University of the Western Cape. Research interests: Social aspects of public health, HIV/AIDS, injury prevention, substance use and misuse, environmental health and social work applied to health.

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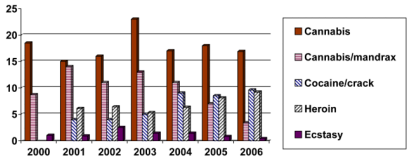

Figure 1. Percent of all treatment demand for illicit primary drugs in South Africa
SACENDU and SANCA [2000-2005 SACENDU: five provinces; 2006 SACENDU & SANCA: all nine provinces]

Table 1
Overview of illicit drugs commonly used in South Africa

Illicit drug	Introduced/production	Use practices	Price *
Cannabis/Dagga	**16/17th century;** Cultivation of illicit drugs appears confined to the widespread cultivation of cannabis (but not opium nor coca) in the eastern half of South Africa and in some northern areas. SA generates a surplus cannabis crop, some of which is exported to Europe and other countries, but most is consumed in SA.	Smoking, eating	R1 per one gram (Drugaware, 2006) [14 US cents.] A kilogram of cannabis can be bought on the streets of South Africa for about $20, but in the US, the same kilogram is worth about $2 300, and the UK, $3,400. (Drugaware, 2006)
Mandrax/Methaqualone	**Late 1980s** During the late 1980s and early 1990s, apartheid agents reportedly produced one thousand kilograms of both mandrax and MDMA (henceforth ecstasy) Now produced and sold illegally in South Africa	The most serious form of abuse occurs when Mandrax is combined with diazepam. These pills are often crushed and smoked with a mixture of tobacco and 'magat' (low grade cannabis, often dried with a volatile solvent), usually smoked from a broken bottleneck - this form of use is called *white pipe* (Leggett, 2002)	R25 - R65 (per tablet, Drugaware, 2006).
Cocaine/Crack	Cocaine HCL not commonly available in South Africa prior to 1994 and the first arrest for it occurred in 1995 (Leggett, 2002). All is illegally imported.	Crack is cheaper than cocaine powder. (Drugaware, 2006).	R150 - R250 per gram, but is available on street level at R50 for a "Snatch" (Drugaware, 2006).
Heroin	During the 80's, heroin was a relatively unknown drug in South Africa. All is illegal imported.	Heroin was first introduced in South Africa as a brown substance. SA heroin users preferred to smoke heroin with cannabis or inhale the vapours ("chasing the dragon"). In the mid 2000s, heroin has come to be mainly injected and snorted. Injection use appears to be growing in South African consumers (Pluddemann & Perry, 2004)	Currently heroin sells in clubs and on the streets at anything between R130 and R300 for a gram (Erasmus, 2006).
Methamphetamine (known as ***tik*** in South Africa.	This is a white, odourless, bitter-tasting crystalline powder that readily dissolves in water or alcohol. The drug can easily be made in clandestine laboratories (Plüddemann, Parry, Bhana, Harker, Potgieter, Gerber, et al., 2005)	Tik is typically smoked by placing the powder/crystal in a light bulb from which the metal threading has been removed. A lighter is used to heat the bulb and the fumes are smoked (Plüddemann et al., 2005).	Low cost (about R20-R30/'straw') (Plüddemann et al., 2005)
Ecstasy	Effectively it started only in 1994 following the opening up of South Africa to the outside world from the UK in 1980s.	Ecstasy has made the biggest impact of all illicit drugs in South Africa since the early 1990's. It is widely associated with the rave scene (Drugaware, 2006)	Retailing at around R60 per tablet and for most people one tablet is enough to create the desired effect. (Erasmus, 2006).

* In 2007, the South African Rand (SAR or R) had an exchange rate of about 7R~1US$ or 10R~1 Euro.

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Table 2

Cannabis use in South Africa by gender and demographics

	2002 YRBS (13-19 yrs) N=10699 (Reddy et al., 2002)		2005 SABSSM II (15 years and above) N=23236 (Shisana et al., 2005)		
	Men	**Women**	**Men**	**Women**	**Total**
Current use					
Age group			15-19 years		
13-19	13.7	5.5	2.5[1]	1.1	
	9.1		1.7		
20 and above			4.4	0.3	1.7
Urban			4.7	0.7	2.3
Rural			2.7	0.0	1.0
Province			15 years and above		
Western Cape (WC)	17.0	6.7	6.8	1.5	3.6
Eastern Cape (EC)	11.3	2.7	2.5	0.2	1.0
Northern Cape (NC)	10.0	2.6	3.1	0.3	1.3
Free State (FS)	15.6	4.0	3.3	0.2	1.4
KwaZulu-Natal (KZN)	13.6	4.4	3.3	0.1	1.2
North West (NW)	11.1	5.0	4.3	0.0	1.7
Gauteng (GP)	18.3	6.2	5.5	0.8	2.9
Mpumalanga (MP)	14.1	7.7	2.1	0.3	1.1
Limpopo (LP)	10.2	8.7	2.0	0.0	0.7
Race					
Black African	13.4	5.3	3.5	0.1	1.4
Coloured*	16.2	8.3	5.8	1.3	3.1
White	10.2	5.3	4.9	1.3	2.8
Indian/Asian	25.3	7.4	1.1	0.1	0.6
Education					
No education			4.1	0.0	1.2
Less Gr 6			4.7	0.1	1.8

	2002 YRBS (13-19 yrs) N=10699 (Reddy et al., 2002)		2005 SABSSM II (15 years and above) N=23236 (Shisana et al., 2005)		
	Men	**Women**	**Men**	**Women**	**Total**
Gr 6-7			4.3	0.2	1.7
Gr 8-11	13.7	5.5	3.7	0.4	1.7
Gr 12			4.8	0.9	2.3
Higher			2.2	0.2	1.1
Total			3.9	0.4	1.7

[1] Past 3 months use among 15-19 year olds

[*] Coloured are persons of mixed racial ancestry, but who had privileges during Apartheid that were denied to black Africans. They are treated as a distinctive ethnic group in South Africa.

Table 3

Current cannabis use in local surveys of youth

				Current cannabis use		
Author/s	**Year of study/Study location**	**Grade/Age in yrs**	**N**	**Male**	**Female**	**Total**
Flisher et al. (1993)	1990/Secondary schools, Cape Town	Gr 8-12	7340	9.1	2.4	7.0
Flisher et al. (2003)	1997/Secondary schools, Cape Town	Gr 8-11	2779	7.3	3.0	6.1
Visser & Moleko (1999)	1998/Primary schools, Pretoria	12-14	460	6.2	1.7	3.7
Terblanche & Venter (1999)	1998/Seconday schools, Port Elizabeth	Gr 8-12	382			2.8
Peltzer et al. (1999b)	1998/Urban secondary schools, Polokwane, Limpopo Province	M=19.1	191	15.1	9.5	12.0
Peltzer et al. (1999a)	1998/Rural secondary schools, Limpopo Province	M=19.4	209	11.2	2.6	6.2
Mwansa et al. (2004)	2002/Bela Bela & Pretoria	10-21	303			4.0
Peltzer et al. (2006)	2004/Community survey (Limpopo Province, Johannesburg, Cape Town, East London, Pretoria)	16-17	800	12.4	1.3	6.9
Peltzer et al. (2002)	2000/University students, Turflop, Limpopo Province	M=20.1	799	10.7	2.9	6.6
Peltzer et al. (2005)	2005/National, 25 Higher education 3rd/4th year students, South Africa	18-24 (47.9%) 25-29 (22.9%) 30+ (10.9%)	1056	3.6	2.2	2.6

Table 4

Other illicit drugs status by age and gender among youths in South Africa

	1994 HSRC African Blacks (10-21 yrs)	2002 YRBS (13-19 yrs)		2005 SABSSM II 15-19 (20 above)	
Usage	**Ever used**	**Ever used**		**Past 3 months**	
		Men	**Women**	**Men**	**Women**
Inhalants (glue, petrol, paint thinner, etc.)		13.1	9.5	0.4 (0.2)	0.0 (0.0)
Total		11.1		0.2 (01)	
Mandrax, sedatives		7.6	4.8	0.2 (0.6)	0.1 (0.1)
Total	1.9	6.0		0.1 (0.3)	
Cocaine (crack)		7.3	5.6	0.2 (0.5)	0.0 (0.2)
Total	0.9	6.4		0.1 (0.3)	
Opiates (Heroin, morphine, Welconal, etc.)		11.8	11.3	0.0 (0.2)	0.0 (0.0)
Total	3.0	11.5		0.0 (0.1)	
Club drugs/*amphetamine-type stimulants* (speed, ecstasy, tic, etc.)		7.6	4.4	0.2 (0.4)	0.2 (0.1)
Total	2.0	5.8		0.2 (0.2)	
Hallucinogens (LSD, acid, etc.)				0.0 (0.3)	0.2 (0.0)
Total	1.9			0.1 (0.1)	
Over-the-counter or prescription drugs		16.4	14.8		
Total		15.5			

Table 5

Treatment demand by province and by gender, race, age and primary drug of abuse, in percent (2006)

In/out-patients	EC	KZN	WC	GP	MP	LP	FS	NC	NW	Total
Number	1395	1428	5458	6414	1040	74	544	342	291	16986
Male	84.0	84.5	74.5	80.5	83.5	78	81.5	84.5	77.5	80.9
Black African	35.5	39	6.5	35	50.5	46	33.5	30	28	33.8
Coloured	32.5	10.5	68	10	4	4	13	55.5	4	22.4
White	29.25	25.5	24	52	22.5	50	52.5	12.5	67.5	37.3
Indian/Asian	2.75	25	1	3	23	0	<1	1.5	1	6.4
<20 *<22	17	25	27	23	18.5	26*	20.5*	40*	11*	23.1
20-34 #22-35	44.7	35.5	46.5	38	42	24*	33#	27#	37.5#	36.5
35-49	29.0	29.5	21	27.5	29	0	19	10.5	18	20.4
50-64 **50+	7.0	10**	6	10.5	9.5	*45*	*9*	*5*	*10*	12.4
65+	<1	0	1	<1	<1	*5*	*<1*	*1*	*3*	1.1
Alcohol	46.5	43	28	48	51	57	61	57.5	69.5	51.3
Cannabis	18.3	26	9	21	29.5	23	22	22	8.5	19.9
Cannabis/mandrax	5.75	2	3	2	<1	0	1.5	5	4	2.6
Crack/cocaine	15.3	11.5	4.5	11	6	1	8.5	1.5	10.5	7.8
Heroin/opiates	3.8	5	12	9	10	3	2	2	3	5.5
Prescription/OTC	2.5	7	1.5	3	2	3	4	1	1.5	2.8
Methamphetamine	2.5	0	39.5	<1	0	0	0.2	0.5	4.5	5.2

EC to MP Jan - Dec 2006 (Source: SACENDU); FS to NC Apr-Sept 2006 (Source: SANCA) and July to Dec 2006 (Source: SACENDU); Italic data July to Dec 2006 (Source: SACENDU)

Table 6

Comparisons of illicit drug use epidemiology: South Africa, USA and Australia

Type of drug	South Africa, 2005) (15 yrs +)[1]		USA, 2005 (12 yrs+)[2]		Australia, 2004 (14 yrs +)[3]	
Current Use of:	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
Cannabis (past month=USA/AUS, Past 3 mos SA)	3.9	0.4	8.2	6.1	8.9	4.6
Inhalants	0.2	0.0	0.3	0.2	0.4	0.1
Mandrax, sedative, pain reliever, tranquilizers	0.5	0.1	3.0	2.6	1.9	2.2
Cocaine (crack)	0.4	0.2	1.3 (0.4)	0.7 (0.2)	0.4	0.3
Opiates, heroin	0.2	0.0	0.1	0.2	3.1	1.7
Club drugs/ amphetamine type stimulants	0.3	0.1	0.6	0.6	1.6	1.0
Hallucinogens (LSD)	0.2	0.1	06	03	0.3	0.1

[1] SABSSM II (Shisana et al., 2006)

[2] National Survey on Drug Use and Health (NSDUH) (Australian Institute of Health and Welfare. 2005)

[3] National Drug Strategy Household Survey (U.S. Department of Health and Human Services, 2006)