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Samkelo Bala

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ADDRESSING COLONIAL-APARTHEID LEGACY AND INFRASTRUCTURAL BARRIERS IN ACCESS TO SUBSTANCE USE DISORDER TREATMENT IN SOUTH AFRICA'S EASTERN CAPE PROVINCE

SAMKELO BALA
University of Witwatersrand, Johannesburg, South Africa

ABSTRACT

Despite the official end of apartheid in 1994, systemic barriers to accessing resources and human rights continue to exist in certain parts of South Africa. One example of this is inadequate access to substance use disorder treatment, which exacerbates the problem. Substance use disorder is recognised globally as a multifactorial health issue, and South Africa's struggle to address this phenomenon is compounded by infrastructural deficits. To gain insight into the problem, a qualitative study was conducted, involving semi-structured interviews and focus group discussions with 15 participants in East London in the Eastern Cape, South Africa. The research findings revealed several problems, including a lack of substance use treatment centres, the impact of colonial and apartheid segregation on access to these centres, inadequate human resources for treating substance use disorder, and insufficient financial support for implementing treatment programmes. Inconsistencies in the treatment of substance use disorder pose a threat to the success of policies. The Eastern Cape is among the most neglected areas in terms of resource allocation and access to substance use treatment centres.

Keywords: Substance use disorder, colonial, apartheid, healthcare, inequality.

INTRODUCTION

The transition from apartheid to the post-1994 era marked a significant milestone in South Africa's history. With the adoption of a new constitution, the country enshrined the equal rights of all its citizens, which has guided numerous policies. For instance, policies like the White Paper for Social Welfare (1997) and the National Development Plan (2011) have sought to transform the South African public service and redress economic disparities between white and black South Africans. Despite these efforts, a 2022 World Bank report revealed that South Africa remains the most unequal country in the world (World Bank, 2022). Studies suggest that this concern is a legacy of colonial apartheid, which socially engineered inequality (Shackleton & Gwedla, 2021).

Access to constitutional rights is still a significant challenge for most black South Africans. This is primarily due to the daily struggle to access services and the lack of resources in poor communities. Historically, colonial and apartheid governments confined black people to specific areas, denying them access to natural resources and services

Corresponding author: Dr. Samkelo Bala, Department of Social Work/Social Development, School of Human and Community Development, University of Witwatersrand, 1 Jan Smuts Avenue, Braamfontein 200, Johannesburg, South Africa. Email: samkelo.bala@wits.ac.za No: 0786657721 ORCiD id: 0000-0003-1874-2531

(Ngcukaitobi, 2018). Similarly, people of colour were segregated into separate townships, far from central business areas. The purpose and systematic barriers associated with these policies are still felt today and have been inherited by the post-1994 ANC government (Sithole, 2020). In the healthcare sector, inequities are prevalent in rural settings, where there is a lack of facilities and support resources (Gaede & Versteeg, 2011). Brauns and Stanton (2016) explain that the post-1994 government inherited the implications of the structures set up under apartheid, which resulted in an unequal provision of public healthcare.

Referring to substance use disorder, extensive research from the humanities and neurologists confirm it to be a mental health problem, comparable to other mental illnesses. The developed world has responded through robust health methods based on its understanding of how substance use disorder alters the brain's dopamine production in the ventral tegmental area (Volkow et al., 2019). Industrialised countries have taken into account the recommendations in the Outcome Document of the 2016 United Nations General Assembly Special Session on Drugs (Bewley-Taylor & Jelsma, 2016) by embracing concurrent pharmaceutical and cognitive-behavioural models. However, Africa is still struggling to respond adequately to substance use disorder (Bala & Kang'ethe, 2022). This could be because of the stigma attached to substance use disorder in Africa, weak health systems and embedded inequalities (Harris et al., 2011). In South Africa, although the call to address substance use disorder has been recognised, the implementation remains dubious. Additionally, South Africa's anti-substance use response system is overwhelmed and reflects inequality in most parts of the country.

According to Lutchman (2015), the insufficient access to substance use treatment in South Africa violates section 27 of the Constitution, which guarantees equal access to healthcare services for everyone. The poor provision of free-of-cost substance use treatment is against "constitutional obligations to respect, protect, promote and fulfil the right to access healthcare" (Lutchman, 2015, 65-66). Furthermore, barriers hinder people from disadvantaged communities in South Africa from accessing substance use treatment centres (Myers et al., 2010). Socio-political factors hinder access to substance use treatment services with apartheid and its legacy facilitating continued poor distribution in disadvantaged areas (Meyers & Parry, 2005). Studies reveal that black and coloured people face significant difficulties in accessing treatment for substance use disorder (Myers et al., 2022).

Communities that inherited the historical disadvantages of apartheid in South Africa are facing high levels of substance use problems. However, they lack access to treatment, exacerbating the issue (Myers, Fakier & Louw, 2009). Although the National Drug Master Plan 2019-2024 (NDMP4) recognizes the need for recreational programs in disadvantaged communities to combat substance use among youth, a study by Ndhlovu and Tanga (2021) found a deficiency of such facilities, which leads

to youth idleness and frustration. Additionally, Sedibe and Hendricks (2021) point out that adolescents in previously disadvantaged South African townships lack adequate health responses to substance use disorder. The disparities created by the apartheid government persist in the post-apartheid era, with poor communities lacking access to substance use disorder treatment, and few organizations established to address the issue (Mpanza & Govender, 2017).

Although it is well-known that substance abuse among youth is more prevalent in townships and informal settlements than in urban areas, treatment services are more easily available in urban areas (Mokwena & Setshego, 2021). For instance, the Eastern Cape only has 12 substance use treatment centres, with only 3 of them being cost-free. Moreover, the literature suggests that there is a high rejection rate in cost-free substance use treatment centres due to high demand that exceeds their capacity (Bala, 2016). This lack of access conflicts with the Prevention of and Treatment for Substance Abuse Act 70 of 2008, which mandates the establishment of treatment and rehabilitation centres close to all communities (Shumba & Makura, 2014). In addition, this violation of many rights, including the right to equality and human dignity, is a grave concern.

Problem Statement

Substance use disorder is a major problem in underprivileged areas, such as informal settlements, rural areas and townships in South Africa and around the world. Unfortunately, these communities do not have sufficient access to substance use treatment centres in South Africa, despite being the most affected. This poor service delivery and lack of access to treatment persist even after 29 years of democratic reform, which casts doubt on South Africa's post-1994 transition. Mtapuri and Tinarwo (2021) argue that apartheid's socio-economic and demographic segregation, which forced black people to live in isolated areas, is still evident today.

Blacks and coloured people are the most affected by substance use disorder, yet access to treatment centres is inadequate across all provinces in South Africa (Myers et al., 2022). The Eastern Cape, which has the weakest health system and is the poorest province in the country, is particularly affected. There are few cost-free rehabilitation centres, and private facilities are unaffordable for most people. The Eastern Cape Department of Social Development, which coordinates substance use programmes, has made slow progress in establishing treatment centres. In addition, other agencies that coordinate substance use, such as the Eastern Cape Department of Health, have been criticised for incompetence (Ewing, et al., 2020). Moreover, many people in these areas have limited access to hospitals, clinics and social support organisations, making it challenging to access both pharmaceutical and cognitive-behavioural interventions for substance use disorder.

Therefore, this study seeks to explore the existence of social policy and infrastructural disparities relevant to the study subject. Therefore, this study's

main question is, What infrastructural and colonial-apartheid barriers affect access to treatment for substance use disorder in the Eastern Cape?

METHOD

Study Site

The study was conducted in East London, which is located in the Eastern Cape, South Africa. The province has a population of 6.6 million, representing 13% of the South African population. The majority of the province's population speaks IsiXhosa, while Afrikaans and English are spoken by 11% and 6% of the population, respectively (Statistics South Africa, 2016). The Eastern Cape is the third most populous and second-largest province by landmass, covering 169,580 square kilometres (13.9% of South Africa's total landmass). East London is the second-largest industrial zone in the Eastern Cape, and its population is largely composed of people who were forced to move from different parts of the province during apartheid to seek employment opportunities, resulting in the city currently being dominated by townships and informal settlements. In addition, the city is overwhelmed by burgeoning substance use across ages different groups and gender.

Research Design and Procedure

The qualitative study utilised an exploratory and descriptive research design (Brannen, 2016). In addition, 9 participants from government organisations were recruited through purposive sampling, while 6 community members were recruited through referral. Ethical approval for the study was granted by the University Research Ethics Committee (UREC) with reference/project number KANO41SBAL01. Permission to conduct the study was obtained from the leaders of the involved organisations, and individual participation consent forms were signed by all participants.

Semi-structured interviews were conducted with a total of 15 participants, 7 of whom identified as female and 8 as male. The participants came from diverse professional backgrounds, including 4 social workers, 2 secondary school principals, 2 senior education specialists from the Department of Education, 1 nurse, 2 community liaison officers from the Buffalo City Municipality, 1 ward councillor, 1 sergeant from the South African Police Service, and 2 counselling psychologists from a rehabilitation centre. The semi-structured interviews were approximately 45 minutes in length.

Data Analysis

After the interviews were recorded and transcribed, with the IsiXhisa verbatims translated into English, the analysis followed Braun and Clarke's (2019) six-step process for thematic analysis, which involves familiarising oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing a report. In other words, the researchers reviewed the transcripts and audio recordings to identify patterns and categories through coding, resulting in the identification of themes and subthemes (Rubin & Babbie, 2016). Thus, the researchers organised

the raw data in an orderly manner, eliminating unnecessary information to produce relevant patterns. To validate the themes, the researchers captured relevant quotations from the transcripts.

Ethical Considerations

Creswell and Clark (2011) emphasise the importance of protecting the privacy and freedom of participants by treating their information confidentially and anonymously. To uphold these principles, the researchers did not collect any personal data from the participants. They used pseudonyms and code names, which is a common method to protect and maintain anonymity in research. In some instances, they even codenamed organisations or companies. However, the literature suggests that ensuring total anonymity in qualitative research can be challenging since some participants' stories are unique and identifiable. To address this issue, the researchers modified certain parts of the data without compromising ethical principles.

THEMATIC FINDINGS

The following section explains the four themes generated by the data analysis.

Scarcity of Treatment Centres

The study aimed to explore the state of substance use treatment centres, and the findings revealed that the participants perceived a scarcity of such facilities. Almost all of the participants reported that substance use treatment organisations were insufficient to deal with the rapidly increasing substance use problem in the Eastern Cape. Participants who were social workers highlighted the challenges they face in placing patients due to the limited number of inpatient substance use treatment centres, which are consistently at capacity. The following quotations extracted from the transcript support these findings:

> **KP3:** I am working as a probation social worker dealing with substance, let me be honest with you, the treatment centres are a drop in the ocean and I think it would make sense to put it in Xhosa *"Lithontsana"(it is a drop)*.
>
> **KP6:** We have a little number of cost-free substance use treatment centres in the province and because of that we have struggled to place patients.
>
> **BEP10:** If my memory serves me well for the entire Eastern Cape, we have less than four free accessible substance use treatment centres and many are private. Because of that there is always a huge backlog where clients wait for 6 months and above to get the space.

The above excerpts are in agreement and confirming scarcity of treatment centres within their local spaces in the Eastern Cape. Consequently, the scarcity of treatment centers is a significant part of infrastructural barriers in healthcare which limit target population from accessing adequately the services. The

paucity of the treatment centers in rural settings like Eastern Cape often lead to disparities in healthcare access based on geographic or socio-economic factors. This nature of barrier gives rise to overburdence with the few existing treatment centers likely to become overcrowded, leading to longer wait times and reduced quality of care. Therefore, the delayed treatment can result in adverse effects on the patient and the society. The scarcity of substance use treatment centres spells that the first goal of the National Drug Master Plan (NDMP) 2019-2024, which is to reduce demand through the prevention and treatment of drug use, misuse, and abuse is theoretical. Similar to the later, the pledge reflecting on the Prevention of and Treatment for Substance Abuse Act No 70 of 2008 on "establishment of all programmes and services, including community based services and those provided intreatment centres and halfway houses" is in vein.

Impact of Colonial and Apartheid Segregation

The participants strongly expressed their belief that the impact of colonialism is still present in society today, specifically in the way that black people are separated from other communities and forced to live in remote and isolated areas. This segregation has contributed to the current difficulties in accessing substance use treatment centres. The majority of Eastern Cape is made up of rural areas that are distant from the towns where substance use treatment organisations are located. Sukeri and Emsley's (2014) study supports this view, highlighting how limited access to health services in the Eastern Cape is intertwined with colonial and apartheid policies. Willie (2011) suggests that the ongoing lack of development of infrastructure such as roads perpetuates the historical challenges of accessing healthcare services. The following comments from the participants reinforce this analysis:

> **KIP2:** Since our people were pushed away and denied access to health during colonial times, nothing has changed because it is still difficult for them to access social support organisations like substance use treatment centres which are far.
>
> **KIP12:** in rural areas and townships there are no substance use treatment centres but there are plenty of them in suburban and this is a historical problem that is still felt today.
>
> **KIP9:** The current government failed to address colonial imbalances and build enough substance use treatment centres in townships.
>
> Analytically, the participants' narratives reasonates with Lephakga (2017) that colonial-apartheid legacies remain strong affecting accessing social services among black people who were pushed live in isolated contextual

areas. The Group Areas Act of 1950 designated specific areas for different racial groups, resulting in forced removals and the creation of isolated homelands for black South Africans remains visible in rural parts of South Africa. The colonial-apartheid segregation and remoteness of rural areas has had long-lasting infrastructural barriers due to their distance from urban centers or services. The former and the latter, do not excuse the ANC's 29 years of governance on the failure to address social, economic, and apartheid political impacts on the affected communities with poor roads that hinder transportation and other technological resources remaing foreign. This colonial-apartheid legacy can be best expressed through the work of Madlingozi (2017) describing the similar situation as neo-apartheid that has survived the transition from apartheid to post-apartheid. Mandlingozi further accentuates that the black people who are experiencing colonial-apartheid legacies are "left behind from the proverbial bridge to the new South Africa".

Insufficient Human Resources

Substance use treatment and management require specialised skills, and the participants noted that there is a shortage of professionals with adequate training in this field. The current number of substance use treatment practitioners is insufficient to address the high prevalence of substance use disorder in the Eastern Cape. The participants suggested that similar to the recruitment and training of human resources during the HIV/AIDS outbreak, a concerted effort is needed to recruit and train professionals in substance use treatment and management to solve this problem. Participants expressed the following sentiments:

> **KIP14:** Eastern Cape is always lacking when it comes to adequate human resources for all fields, similar situations with the treatment of substance use disorder there are few professionals trained.
>
> **KIP8:** The assumption that all social workers are trained to deal with substance use disorder needs to be corrected and trained because substance use disorder is a specialised field.
>
> **KIP13:** I have worked in the field of substance abuse for more than two decades, believe me when I say there are few people trained to curb substance use disorder National and

worse in the Eastern Cape.

The provision of opportunities for the training of staff as enshrined in the Prevention of and Treatment for Substance Abuse Act No 70 of 2008 remains a theoretical promise. The inadequate number of human resources available for the treatment of substance use disorder could potentially lead to the continuous failure of policy frameworks aimed at addressing this problem. Consequently, the lack of adequate human resources significantly impedes the smooth functioning of the organization which forms part of infrastructural barriers. The subject matter hinders the progress and limits the capacity to meet demands of service delivery efficiently. On the same note, the shortage and lack of skilled personnel compromises the overall infrastructure's performance. Irrefutably, the matter has social implications because of its adversity to societal well-being. This also suggests a lack of emergency from government in response to this societal ravaging problem. Perhaps, this reveals that the substance use problem is not prioritised equally with other health diseases. This is the condescension of different policy levels as United Nations Office on Drugs and Crime (UNODC) and World Health Organization emphasized the need for adequate trained personel and professionals to tackle substance use disorder.

Weak Financial Support

In response to a question on the challenges associated with the implementation of treatment for substance use disorder, participants highlighted poor resource allocation as a major issue. Specifically, participants reported that non-governmental organisations providing inpatient substance use treatment services often deny patients owing to financial constraints. The following verbatim responses provide support for these findings:

> **KIP11:** Unlike other health programmes, there is little financial support for anti-substance use programmes from both government and corporate social investment.
>
> **KIP4:** I have worked with different health programmes as a nurse and in the past five years joined the anti-substance use programme in schools. Therefore, in comparison to other programmes, the delay against substance use is also facilitated by poor allocation and support to get different needed equipment.
>
> **KIP15:** We struggle to expand the large inpatient environment because we don't get enough funding from the government which is affecting the progress against substance use disorder in Eastern Cape.

The isufficient financial support from government is the major infrastructural barrier for the majority of black South Africans who cannot afford access to private treatment centres due

to the high costs and thus leaving them without proper care. The underfunding affects accessibility to holistic treatments such as residential programs or long-term care which tend to be expensive. Once again, the sufficient funding promises made by the Prevention of and Treatment for Substance Abuse Act No 70 of 2008 remains imaginary. Therefore, this theoretical commitment to address these issues results in the lack of implementation and operationalisation. The South African government responded to the HIV/AIDS epidemic with significant financial investments in various programs and initiatives aimed at prevention, treatment, and awareness. This included widespread campaigns to educate the public about the disease, providing access to medications, and supporting healthcare infrastructure to manage the epidemic more effectively. The former and the later have not been strong in response to substance use while it continues to wreak havoc in the country. The investment in prevention, treatment, and support services is crucial to address this multifaceted issue effectively.

DISCUSSION

Antithetically, there is a dearth of substance use treatment centres in South African communities heavily affected by related problems (Peltzer et al., 2010). The study conducted by Myers et al. (2010) revealed a significant shortage of substance use treatment centres in townships and informal settlements, despite the pressing need. Pasche and Myers (2012) emphasise that despite the increasing cases of substance use disorder, South Africa has an inadequate number of treatment centres, especially in underprivileged communities. The Eastern Cape is the most neglected province in South Africa with few to no substance use treatment facilities (Bala, 2016).

Ad hoc literature shows that there are only three public substance use treatment centres in the Eastern Cape, while the majority are private. The scarcity of substance use treatment facilities in impoverished communities exacerbates unequal access to healthcare services (Lutchman, 2015). Mpanza (2014) highlights the urgent need to develop rehabilitation services in South African rural communities. Parr et al. (2017) note that the only provinces with public substance use treatment facilities are Western Cape, Gauteng, Mpumalanga, KwaZulu-Natal, and Limpopo, with the Eastern Cape being left out.

The legacy of colonialism in South Africa has resulted in persistent barriers to accessing healthcare services, including substance use treatment centres. Research indicates that demographic segregation and historical racial disparities are still prevalent in the country (Harris et al., 2011; McLaren et al., 2013; Myers et al., 2008). For example, black individuals were often forced to live in isolated areas during apartheid, which continues to affect their ability to access substance use treatment centres, particularly in rural areas (Myers et al., 2010). Additionally, underprivileged provinces such as the Eastern Cape have fewer public treatment centres, and private ones are

often unaffordable (Myers et al., 2008).

The government's failure to address the inequities in accessing health services is considered a breach of section 27 of the current South African Constitution (Lutchman, 2015, South Africa, 1996). Pullen and Oser (2014) note that there are differences between substance use treatment centres located in urban and rural areas, with urban centres often being better. However, regardless of the region or province they live in, black individuals who are poor in South Africa encounter difficulties when trying to access substance use treatment (Parry et al., 2017).

Substance use treatment and management require specialised knowledge and skills, but there is a shortage of adequately trained personnel in Africa. According to the World Health Organisation (2003), the lack of trained personnel is a significant constraint to the treatment and prevention of substance use. Pasche and Myers (2012) support this assertion, stating that substance use disorder treatment is hindered by a small and inadequately trained workforce. Therefore, Mpanza (2014) suggests that personnel should be trained in substance use treatment and integrated with mental health services.

Pullen and Oser (2014) indicate that there is a limited number of professionals trained to treat substance use disorders adequately, especially in rural environments and that the available workforce is overwhelmed by caseloads, which impacts the effectiveness of treatment. Moreover, some treatment providers are unfamiliar with new approaches to using the diverse range of drugs currently available (Parry et al., 2017) and lack the skills to administer them (Smook et al., 2018), thereby still using unfeasible approaches to substance use treatment are still being used. Furthermore, Mokwena et al. (2020) highlight that some training professionals lack sufficient training in the interpretation of substance use policies.

Substance use treatment and prevention in rural settings are hindered by poor resource allocation, as confirmed by several studies. Geographical segregation is one of the reasons for the lack of resources to address substance use disorder in rural areas (Mpanza, 2014). The problem is further compounded by rock-bottom funding that depresses progress in preventing and treating substance use (Pullen & Oser, 2014). Poor allocation of resources also affects aftercare and monitoring, which are critical components of substance use treatment.

A 2016 report by the Department of Social Development, the Department of Planning Monitoring and Evaluation, which falls under the Presidency and other experts revealed that the Central Drug Authority (CDA) did not receive adequate resources to manage and facilitate the implementation of the National Drug Master Plan 2013-2017. A lack of funding jeopardizes the success of policies aimed at addressing substance use treatment (Mpanza & Govender, 2017).

Conclusion

The qualitative study aimed to

investigate the challenges in implementing substance use treatment in East London, Eastern Cape, South Africa. The findings highlighted several paradoxes that impede the success of substance use policies, including inequalities that delay progress against substance use disorder. The Eastern Cape is particularly affected by a lack of resources and trained personnel to address substance use disorder comprehensively. The Department of Planning, Monitoring and Evaluation should collaborate with the Departments of Social Development and Health to address the discrepancies in service delivery and bridge the gaps in resource allocation and workforce training.

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Author contribution

Both authors contributed equally throughout the entire article, which was supported by the National Institute for the Humanities and Social Sciences under Grant SDS17/1285.

Data Availability

We guarantee the accuracy of the data reported in this article and confirm that they originate from legitimate sources.

Declaration

We hereby declare that this article titled " Addressing Colonial-Apartheid Legacy and Infrastructural Barriers in Access to Substance Use Disorder Treatment in South Africa's Eastern Cape Province has not been previously submitted to any other journal for publication. If it is submitted to another journal, we will obtain prior consent from the editor.

Conflict of Interest

The study has not raised any conflicts of interest. Moreover, the Department of Social Work/Social Development and the Faculty of Social Sciences and Humanities' Higher Degrees Committee has approved the quality assurance of the study. The data collection instruments and study highlights underwent the necessary ethical review and clearance by an ethics committee. As a result, the Govan Mbeki Research and Development Centre (GMRDC) at the University of Fort Hare has granted ethical clearance certification for the data collection process.

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