

**Social workers' perspectives on barriers
to substance abuse treatment for
women in Limpopo province**

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DECLARATION

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ABSTRACT

The prevalence rate of substance abuse is escalating in women and little is known about their access to the available treatment services. Previous studies on barriers faced by women in accessing substance abuse treatment did not explore the perspectives of social workers, who are experts in helping women with substance abuse problems, but rather focused on service users. Therefore, the goal of this study was to explore the perspectives of social workers coordinating substance abuse programmes regarding the barriers women face in accessing treatment for substance abuse.

The nature of the study is qualitative. An exploratory and descriptive research designs were adopted in the study. The findings of the study were derived from an empirical investigation conducted with 20 social workers employed by the Department of Social Development in Limpopo province. Data were collected from the participants through telephonic interviews using a semi-structured interview guide, and thematic content analysis was used to analyse the data.

The findings of the study show that social workers observe a lot of women in local communities who are abusing substances, but they are not seeking help. The findings also reveal that women encounter different types of barriers when seeking treatment services for substance abuse. Internal barriers, such as a lack of motivation to change their behaviour and denial were identified, while external barriers such as a shortage of treatment facilities were also found. It was also found that the available treatment facilities and outpatient treatment services are not accessible to people, who live far from the centralised treatment facilities. These barriers contribute to women not receiving treatment and not seeking help. In order to eliminate these barriers, there is a serious need for additional treatment, whether these be inpatient or outpatient treatment services, to cater for the needs of women, including childcare. Furthermore, the study recommends that government must relook at legislation and policies on substance abuse services in order to address substance abuse problems for women, instead of the current primary focus on men.

It is anticipated that the findings of this study will contribute to an understanding of barriers that women are facing in accessing substance abuse treatment. The study will also help in developing strategies to address factors to consider when admitting

women to a treatment facility, such as their fear of leaving their children and family behind, which could hinder their decision to initiate treatment. Thus, the study advocates for the establishment of treatment centres for women and the development of treatment services that will minimise the barriers that women face in accessing substance abuse treatment centres. Lastly, the study will assist those in social work practice and other professionals in the field of substance abuse to enhance service delivery to women.

OPSOMMING

Die voorkomssyfer van middelmisbruik onder vroue neem toe en daar is min bekend oor vroue se toegang tot die beskikbare behandelingsdienste. Vorige studies oor die struikelblokke vir vroue ten opsigte van toegang tot behandeling vir middelmisbruik het nie die perspektief van maatskaplike werkers met kennis oor hulpverlening aan vroue met middelmisbruikprobleme verken nie, maar het eerder op die diensgebruikers gefokus. Die doel van hierdie studie was dus om die perspektief van maatskaplike werkers, wat middelmisbruikprogramme koördineer, op die struikelblokke vir vroue ten opsigte van toegang tot behandeling vir middelmisbruik te verken.

Die studie is van kwalitatiewe aard en 'n verkennende en beskrywende navorsingsontwerpe is aangewend. Die bevindings van die studie is gegrond op 'n empiriese ondersoek onder 20 maatskaplike werkers in diens van die Departement van Maatskaplike Ontwikkeling in die Limpopo-provinsie. Data is ingesamel met behulp van 'n semigestruktureerde onderhoudshandleiding om telefoniese onderhoude met deelnemers te voer, en data is met behulp van tematiese inhoudsontleding ontleed.

Die bevindings van die studie toon dat maatskaplike werkers baie vroue wat middels misbruik in plaaslike gemeenskappe waarneem, maar dat hierdie vroue nie hulp soek nie. Die bevindings toon ook dat vroue verskillende soorte struikelblokke teëkom wanneer hulle van behandelingsdienste vir middelmisbruik gebruik wil maak. Interne struikelblokke, soos 'n gebrek aan motivering om te verander en ontkenning, is geïdentifiseer. Daar is ook eksterne struikelblokke, soos 'n tekort aan behandelingsgeriewe, geïdentifiseer. Daar is bevind dat beskikbare behandelingsgeriewe en buitepasiëntbehandelingsdienste nie vir diegene wat ver van die behandelingsgeriewe woon, toeganklik is nie, omdat hierdie geriewe gesentraliseerd is. Hierdie struikelblokke dra daartoe by dat vroue nie behandeling ontvang en nie hulp soek nie. Daar is 'n ernstige behoefte aan bykomende behandelingsgeriewe (binnepasiënt- of buitepasiëntbehandelingsdienste) wat aan die behoeftes van vroue, soos kindersorg, voldoen.

Voorts beveel die studie aan dat die regering wetgewing en beleid vir middelmisbruikdienste hersien, om die middelmisbruikprobleme van vroue op te los, in plaas van die huidige primêre fokus op mans.

Daar word voorsien dat die bevindings van die studie tot begrip van die struikelblokke vir vroue ten opsigte van toegang tot behandeling vir middelmisbruik sal bydra. Die studie sal ook help met die ontwikkeling van strategieë vir die faktore wat oorweeg moet word wanneer vroue in 'n behandelingsinstelling opgeneem moet word, soos die vrees om hulle kinders en gesinne te moet agterlaat, wat hulle besluit om met behandeling te begin, kan belemmer. Die studie bepleit die vestiging van behandelingsentrums vir vroue en die ontwikkeling van behandelingsdienste wat die struikelblokke vir vroue ten opsigte van toegang tot middelmisbruikbehandelingsentrums tot die minimum sal beperk. Die studie kan ook maatskaplikewerkspraktyk verbeter en ander beroepslui op die gebied van middelmisbruik help om dienslewering aan vroue te verbeter.

DEDICATION

ANDZANI NTSUMI KHOSA

All things are possible, break all the barriers and realise your potential because you are born limitless.

This thesis is dedicated to my daughter, for understanding that I spent most of my time studying and had to sacrifice our quality time. You always said, “Mom, are you going to play with me today?” and most of the time the answer was “No, I have to study” – but you respected that. To my mom, who always prayed for me and kept reminding me to study in all our conversations – your love, care and support motivated me to press on.

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CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 PRELIMINARY STUDY AND RATIONALE

Substance abuse is one of the most prominent social problems globally. The United Nations Office on Drugs and Crime (UNODC, 2018) reported that an estimated number of 247 million people between the ages of 15 and 64 years used at least one drug in 2014. The figures are in addition to the 39 million users identified in 2006, 12% of whom were diagnosed with a substance use disorder. The report further outlined that, in 2010, 183 million people had used cannabis, 34 million had used methamphetamine and three million had used opioids.

In South Africa, statistics captured from the inpatient and outpatient treatment centres across the nine provinces between July and December 2017 revealed that 9 501 people received treatment for substance abuse (South African Community Epidemiology Network on Drug Use [SACENDU], 2018). It was found that the most used drugs were alcohol, heroin, methamphetamine, methcathinone and cocaine. The report also shows that most people who received treatment were men rather than women, and that this came through self-referral, family and friends. However, in a study conducted in the Western Cape, Dada, Burnhams, Laubscher, Parry and Myers (2018) discovered that the number of women seeking treatment had increased by 7% from 2000 to 2013. This corresponds with an earlier study by Myers (2007), who found that 28% of females in the Cape Town Metropole were abusing alcohol and methamphetamine daily compared to 22% of males. Dada *et al.* (2018) also reported that most women accessed treatment services for over the counter and prescription medicines. Thus, the authors saw a great need for further research on substance use among women due to limited research on the topic in South Africa, including on women who seek and access treatment services.

A research study by Isobell, Kamalwoodien and Savahl (2015:2) discusses barriers to access treatment for women, such as “absence of a structured referral pathway, the need for formal referrals from social workers, long referral processes, mandatory detox or mental health treatment services prior to admission and the waiting period”. These barriers were identified by service users, but the study neglected the perspectives of

the referring social workers. Other personal barriers covered in the same study include a lack of motivation for change, stigma towards women, pregnant women, children's needs/childcare, labelling and fulfilling motherly tasks. Little is known about the perspectives of social workers who are providing the prevention services, early intervention and treatment on the barriers women face in accessing or seeking treatment services. Therefore, this study seeks to close the gap. The available research, by Muusha (2012), Ndou (2019) and Ovens and Prinsloo (2018), mainly covers factors that lead to the different causes of substance abuse by women and men, as well as access to substance abuse treatment by men and women.

The report by UNODC (2018) remarks that factors that contribute to substance abuse differ for men and women. Women are reported to use substances to self-medicate their internalised problems, such as depression and anxiety, whereas men use substances to deal with their externalised behaviours, such as conduct disorders and anti-social personality disorders. Greenfield, Back, Lawson and Brady (2010) and the United Nations Interregional Crime Research Institute (2015) are of the view that men start using substances from a younger age due to peer pressure, whereas women begin using substances at a later stage, largely after being introduced by their intimate partners. Greenfield *et al.* (2010) also highlighted that most of these women are suffering from posttraumatic stress disorder due to their vulnerability to physical abuse, rape and domestic violence, which lead to the quick progression to substance abuse disorder.

The study conducted by Ramlagan, Peltzer and Matseke (2010) emphasises that males dominate treatment centres compared to females. Pretorius, Naidoo and Reddy (2009) point out that men have the advantage of being referred for substance abuse treatment by the criminal justice system, the employer or through volunteering. Meanwhile women are less likely to be referred for treatment by the criminal justice system because they often do not commit crimes to sustain their substance abuse. Pretorius *et al.* (2009) claim that women are not likely to admit their substance use due to their fear of stigma, labelling and discrimination; instead, they choose to consult mental health professionals for depression, anxiety, insomnia and stress, in which cases substance abuse is not likely to be diagnosed. They also hide their substance-use problems from their families, employers and society at large, and it becomes difficult to identify them. Karoll (2010) and Nelson-Zlupko, Kauffman and Dore (1995)

concur that social workers can play a very critical role in the identification of women abusing substances, as they provide a holistic intervention for women seeking assistance with different social problems.

However, this may not be feasible if social workers do not identify barriers to accessing substance abuse treatment for women. MacMaster (2005) and Tuchman (2010) describe different kinds of barriers to treatment for women, including treatment that does not cater for pregnant women, fear of losing custody of their children, fear of prosecution, and their experiences of sexual harassment.

The factors outlined are an indication that women are underprivileged in accessing treatment when compared to men. They suffer from normative stigma, societal expectations, their roles in the families and limited opportunities to enter treatment (Stringer & Baker, 2018; Taylor, 2010; UNODC, 2018). There are limited studies on access to treatment by women abusing substances. The low rates of entry into substance abuse treatment among women may reflect the specific barriers they face. In this regard, social workers play a vital role in identifying, assessing and referring women in need of treatment according to the Prevention of and Treatment for Substance Abuse Act 70 of 2008 (Republic of South Africa [RSA], 2008). They also have a responsibility to provide prevention, early intervention, treatment, aftercare and reintegration services. Isobell *et al.* (2015) outline that access to relevant and holistic treatment and proper referrals are essential elements to ensure a continuum of care. Social services have been identified as one of the critical referral sources for treatment of substance use for women. It therefore is essential to explore the perspectives of social workers on barriers faced by women in accessing treatment for substance abuse.

The focus of this study was on barriers to substance abuse treatment for women based on the perspectives of social workers in Limpopo province. Substance abuse has become a global and local scourge, affecting every province in the country (SACENDU, 2018), including Limpopo province, though the extent and characteristics vary per province. For instance, a research study conducted by the Limpopo Department of Social Development ([DSD], 2013) in partnership with the University of Limpopo shows that the commonly used drugs in the province are alcohol, cannabis and opiates. A total number of 400 youth between the ages of 14 and 35 from 25

municipalities in the province were interviewed, and 49% had used cannabis, 39% had used inhalants, 32% had used bottled wine and 54.8% had used commercially brewed beer. Out of 400 respondents who had used substances before, 67.3% were males and 31.8% were females. This may support the assumption that males indulge in substances more than females. Although the statistics above reveal that the use of drugs in the province is growing, there is only one inpatient and one outpatient treatment centre available in the entire Limpopo province. The inpatient centre has limited bed capacity and has allocated more beds for male adult service users, whereas women have few beds. Social workers end up referring some women to other provinces, such as Gauteng and Mpumalanga, which have more capacity for females, although their priority should lie with women from their own province.

The Limpopo Department of Social Development realised that substance abuse has escalated within the province. As a result, the department developed a strategy to alleviate this problem by appointing social workers to serve as substance abuse coordinators within local municipalities in the province. Substance abuse coordinators are expected to dedicate their work solely to the substance abuse programme in their respective local municipalities (Ramogopa, 2013). These social workers, often referred to as coordinators, are regarded as experts in the field of substance abuse after receiving training offered by the South African National Council on Alcoholism and Drug Dependency (SANCA), which focuses on but is not limited to treatment services, aftercare services, chemical dependency, treatment models and the integrated service delivery model (ISDM) (DSD, 2006). The coordinators are responsible for rendering prevention and early intervention care, doing referrals, and providing after-care and reintegration services for service users in the province. Based on the key role the coordinators play at different local municipalities in the province, they are better positioned to provide their perspectives on the barriers women encounter while seeking treatment within the province.

1.2 PROBLEM STATEMENT

There has been an increase in the number of women who use, misuse and abuse substances (Dada *et al.*, 2018). However, the increasing number of women who abuse substances is not reflective of access to substance abuse treatment amongst women. The SACENDU (2018) report shows that the number of women who accessed

outpatient and inpatient services in the private and government centre in South Africa between July and December 2017 ranged between 12% and 29%. Research conducted by Dada *et al.* (2018) found that fewer women relative to men accessed specialist substance abuse treatment facilities, but there had been a gradual increase in the proportion of women utilising these services in the Western Cape. Dada *et al.* (2018) also suggest that there is a need to expand access to alcohol treatment for women by identifying women with problematic patterns of substance use in communities and healthcare facilities through screening. Moreover, Ramlagan *et al.* (2010) highlight that the effect of substance abuse on women has been overlooked and that the focus has been more on men, as it is generally regarded that men are more susceptible to substance abuse disorder. Meanwhile, women present with different challenges than those raised by men abusing substances. A convergence of evidence suggests that women with substance use disorders are more likely than men to face multiple barriers affecting access and entry to substance abuse treatment (Tuchman, 2010; Konzelman, 2020).

Despite an increased number of women abusing substances, it is alarming that limited research has been conducted on this topic, especially from the perspective of social workers referring service users for treatment. Very few studies have focused on the barriers to accessing substance abuse treatment for women in Canada (Konzelman, 2020) and in Mississippi (Pacher, 2019). However, in South Africa there are no studies that have focused on this research area, including in Limpopo province. For instance, Moyana (2019) focused on the utilisation of the continuum of care for the treatment of persons with substance use disorder, namely the experiences and perceptions of service providers and service users. Meanwhile, Langeveld (2020) conducted a study exploring the perceptions of staff regarding the services offered at a substance abuse treatment centre for women in Cape Town. Without sufficient research, it will be difficult, if not impossible, to find solutions that will address the barriers that women face in accessing substance abuse treatment. Based on the research conducted by Moyana (2019) and Langeveld (2020), there is still a gap, which this research study intends to fill by exploring the barriers women face in accessing treatment for substance abuse from the perspective of social workers.

1.3 RESEARCH QUESTION

The research question that the study set out to answer is: What are social workers' perspectives on barriers to accessing substance abuse treatment for women in Limpopo province?

1.4 AIM AND OBJECTIVES

1.4.1 The aim of the study

The aim of this study was to gain an understanding of social workers' perspectives on the barriers to accessing treatment for women abusing substances in Limpopo province.

1.4.2 The objectives to achieve the aim

- Discuss the prevalence and effects of substance abuse among women, and to explore the relevant policies and legislation regarding substance abuse.
- Examine the barriers to accessing substance abuse treatment for women from within a feminist theory.
- Empirically investigate social workers' perspectives on barriers to accessing substance abuse treatment for women in Limpopo province.
- Recommend strategies that can be employed to facilitate substance abuse treatment for women abusing substances in Limpopo province.

1.5 THEORETICAL POINT OF DEPARTURE

The study was guided by feminist theory, which outlines that gender inequality is a social problem and is rooted in capitalism, which needs urgent consideration to deal with gaps observed between men and women in accessing substance abuse treatment services. According to Hossain, Ahmad and Siraj (2016:13) gender stratification reflects the "unequal distribution of wealth, power, and privilege between men and women". Although nobody can overlook the biological differences between men and women, society also imposes several distinctions that are practised. These distinctions in social practices ultimately result in discrimination and inequality.

Delaney (2005:202, cited in Hossain *et al.*, 2016:13) states that feminist theory is an outgrowth of the general movement to empower women worldwide. It is a broad-based theoretical perspective that attempts to demonstrate the importance of women, to reveal the historical reality that women have been subordinate to men (beginning with the sexual division of labour), and to bring about gender equality. Studies by Dada *et al.* (2018) and Isobell *et al.* (2015) suggest that specific treatment for women should be developed to attend to the special needs of women, such as centres that care for children, and address women's issues such as prostitution, pregnancy and domestic violence.

The relevance of feminist theory in this study is that it serves to advocate for women's empowerment and to voice their concerns. It also seeks to challenge the policies and legislation that set the standard for treatment services and their accessibility in order to ensure that women benefit as much as men. The study strives to demonstrate that there are unique barriers to women's access to treatment when compared to men. The study will further assist in identifying the barriers and making recommendations that will help provide accessible treatment services for women.

In addition to feminist theory, the study is also guided by legislation, such as the National Drug Master Plan (RSA, 2013) and the Prevention of and Treatment for Substance Abuse Act 70 of 2008 (RSA, 2008), which guide the provision of substance abuse treatment services. The National Drug Master Plan (RSA, 2013) highlights that there should be coordination between all government departments and other stakeholders in making efforts to reduce demand, supply and harm caused by substance abuse. In terms of section 4(h) of the Act (RSA, 2008), the services provided to people must be available and accessible to all service users, including women, children, older persons and persons with disabilities. The Act further promotes the provision of accessible, effective and affordable substance abuse treatment to all service users, irrespective of gender. This study identifies barriers to substance abuse treatment for women from the perspectives of social workers, who provide prevention, early intervention, aftercare and reintegration and referral for treatment in Limpopo province.

1.6 CONCEPTS AND DEFINITIONS

1.6.1 Barriers

In this study, the term barriers refer to the impediments and obstacles that prevent women from accessing and entering the available substance abuse treatment services, such as inpatient and outpatient treatment services (Taylor, 2010).

1.6.2 Perspective

In this study, perspective refers to the broader understanding or personal point of view of social workers who coordinate substance abuse services in the local municipalities in Limpopo province on barriers women face when accessing substance abuse treatment services (Hornby, 2010).

1.6.3 Social worker

The Social Service Professions Act, No 110 of 1978 (RSA, 1978) defines a social worker as a person registered with the South African Council for Social Service Professions under section 17, which states that the person must hold prescribed qualifications and satisfy the prescribed conditions, and satisfy the Council that they are fit and proper to be allowed to practise the profession of social work.

1.6.4 Substance abuse

The World Health Organization (WHO, 2000) defines substance abuse as the ongoing use of a substance, despite awareness of the serious implications of its use.

1.6.5 Treatment

The Prevention of and Treatment for Substance Abuse Act, No 70 of 2008 (RSA, 2008) defines treatment as the provision of specialised social, psychological and medical services to service users and to persons affected by substance abuse with a view to addressing the social and health consequences associated therewith.

1.7 RESEARCH METHODOLOGY

This section briefly outlines the research design, research approach, sampling, data collection and data analysis.

1.7.1 Research approach

A qualitative approach was viewed as appropriate for this study because it explored the perspectives of participants regarding barriers women face when accessing substance abuse treatment. Creswell (2014) states that a qualitative research approach is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. This research followed both inductive and deductive reasoning. Deductive reasoning was applied to the in-depth literature study in order to develop an interview schedule for data collection. Inductive reasoning was used to interpret the research findings pertaining to facts, evidence and observations presented in Chapter 4 (Teddlie & Tashakkori, 2009).

1.7.2 Research design

The research design allows a researcher to come to new insight derived from integrating findings from the participants with existing knowledge from the literature and theory. This study used a descriptive research design, as it enables the researcher to describe the essence of the participants' experiences by focusing on the interpretation of the meaning of their experiential world (Schurink, Schurink & Fouché, 2021). It is also more likely to refer to more intense examination of the social worker's perspectives on the barriers to accessing substance abuse treatment for women and their deeper meanings, thus leading to a thicker description of the phenomena under study. The study was also exploratory, since little was known about the perspectives of social workers on barriers to accessing substance abuse treatment for women.

1.7.3 Sampling

The sample of the study comprised 20 participants. Non-probability purposive sampling was used to recruit participants who could best represent the topic of the study. The sampling method focused on the participants with the most characteristic, representative or typical attributes of the population that served the purpose of the study so as to collect the richest data. This sampling method was suitable, since the participants were experts in the field of substance abuse and came from all the local

municipalities in Limpopo province (Strydom, 2021). The researcher requested permission from the Limpopo Department of Social Development to conduct this study with social workers who coordinate substance abuse treatment in different local municipalities of Limpopo province (See Annexure C). Once permission was granted, the researcher contacted the district substance abuse coordinators to request the official contact numbers of social workers coordinating substance abuse treatment in the municipalities in order to recruit them to participate in the study. The following criteria for inclusion were applied. Participants had to be:

- ❖ Social workers registered with the South African Council for Social Service Professions.
- ❖ A coordinator of a substance abuse programme for at least one year in any of the local municipalities in Limpopo province.
- ❖ Proficient in English.

The researcher called each substance abuse coordinator to recruit them to participate in the study. The researcher presented the purpose of the study, its rationale and the ethical considerations of the study when recruiting participants telephonically. Social workers coordinating substance abuse treatment were given an opportunity to volunteer to participate in the study. The pre-interview telephonic conversation was done to address the participants' concerns, build rapport and create interest, and to explain the interview (Farooq & De Villiers, 2017). A consent form (Annexure B) was emailed to all volunteering participants to complete. Thereafter, the researcher and the participant agreed on the date and time to conduct the interview telephonically that was suitable to the participant.

1.7.4 Instrument for data collection

Semi-structured interviews were used for data collection. Semi-structured interviews are defined as interviews organised around an area of particular interest, while still allowing considerable flexibility in scope and depth (De Vos, Strydom, Fouché & Delport, 2011). Semi-structured telephone interviews were used, since they provide a more balanced distribution of power between the interview participants and allow them to express themselves freely when answering to interview questions (Farooq & De Villiers, 2017). Telephone interviews were suitable for this study since the country was

under lockdown due to COVID-19 and social distance was recommended to ensure participants' safety when conducting interviews. The interview process was flexible and guided by the interview schedule, rather than dictated by it (De Vos *et al.*, 2011). Open- and closed-ended questions were used to allow probing and to get a narrative description of the participant's perspectives on the barriers to accessing substance abuse treatment by women. All participants were interviewed by the researcher using the same semi-structured interview schedule to achieve the intended goal and objectives. The semi-structured interview was conducted in English. Attached as Annexure A is the semi-structured interview schedule used as the data collection tool.

1.7.5 Pilot study

According to Strydom (2021), a pilot study is used to test the relevance of the data collected from the respondents and allows an evaluation of the interview schedule in order to modify it for the enhancement of the quality of the main enquiry. The pilot study moreover assists in estimating the time and costs that may be involved, as well as pre-empting the problems that may arise during the actual qualitative interviews (Strydom, 2021). A pilot study was conducted to test the interview schedule. The researcher conducted one telephone interview with a social worker who met the criteria for inclusion in order to be familiar with the possible challenges when collecting data, establishing relationships and practising effective communication with potential participants (Strydom, 2021). The researcher made a few changes to the interview schedule and the terminology after the pilot study to help gain more insight into the content of the study. The pilot study does not form part of the empirical findings.

1.7.6 Data analysis

Schurink *et al.* (2021:391) define data analysis "as the process of bringing order, structure and meaning to the data collected". Data analysis involves reducing the volume of raw information by shifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveals. Qualitative analysis focuses mainly on the presentation of key themes, supported by quotations from the participants, as the primary form of analysis and reports on the data. The main goal of data analysis was to ensure that the findings are logical and can be interpreted so that the relationships between research problems can be tested and studied and so that it allows for conclusions to be drawn.

The researcher used thematic analysis, as it is considered a foundational method in qualitative data analysis in order to organise and report analytic data. Thematic analysis strives to reduce the raw data collected into manageable pieces by breaking it up and reconstructing it to find meanings. The researcher managed to get a clear understanding of the participants' perspectives by identifying, analysing and portraying themes found in the data. Thematic analysis was used to report the experiences, meanings and reality of the participants (Braun & Clarke, 2006). Data were transcribed and converted into words from audio in sufficient detail. The researcher familiarised herself with the data collected by prudently evaluating the words spoken by the participants in order to find real meanings. The data were then categorised, allocated to themes and sub-themes, classified in patterns and organised in a systematic and coherent manner (Babbie, 2010). The researcher interpreted the findings based on her perspectives and existing literature to demonstrate an understanding of the empirical data presented in Chapter 4.

1.7.7 Method of data verification

The researcher verified the qualitative data according to Guba and Lincoln's (1994) model for qualitative data verification, as adapted by Schurink *et al.* (2021) based on the following constructs.

1.7.7.1 Credibility

Credibility is used to ensure that the research participants are accurately identified and described (Schurink *et al.*, 2021). The researcher ensured credibility by collecting thick data from the participants through probing and seeking clarity from them. Credibility was also ensured through member checking, whereby the participants were given an opportunity to ask questions and seek clarity on the information they provided to ensure that the information was captured correctly and was a true reflection of what they meant.

1.7.7.2 Transferability

Transferability is determined by the extent to which the findings of the research can be applied in other contexts and studies (Schurink *et al.*, 2021). The researcher's findings in this study could be transferred to other research on barriers experienced by women in accessing substance abuse treatment, and the recommendations will

assist in making treatment for women accessible. In order to ensure transferability, the researcher interviewed participants from different municipalities in both rural, semi-rural and semi-urban areas of Limpopo province, the data collected were the same in all areas of the study.

1.7.7.3 Dependability

Dependability is achieved through examining evidence of the research process, which should be logical, well-documented and audited (Schurink *et al.*, 2021). The researcher ensured that all interviews were transcribed accurately, and that the findings were well documented, organised and presented logically and systematically using themes (see Chapter 4). Furthermore, the researcher used both international and national research articles in the study to allow for a dependable research study.

1.7.7.4 Confirmability

Confirmability is concerned with the objectivity and ability to compare the findings of the study with other literature. Confirmability implies that other researchers can confirm the origins of the findings in order to conclude that, if they follow the same steps, they are likely to come to the same conclusions (Schurink *et al.* 2021). The researcher ensured that objectivity was maintained during the research process by comparing the findings with existing literature and citing direct quotes from participants to demonstrate that findings emerged from the data.

1.7.7.5 Reflexivity

Finlay (2016) suggests that reflexivity is the ability of the researcher to be consciously aware of self in order to be subjective throughout the research process. As a registered social worker working in the treatment facility of the Department of Social Development, the researcher shared some similarities with the participants, and thus recognises that previous experience in social work intervention has resulted in personal opinions and feelings regarding the needs, strengths, weaknesses and objectives of rendering treatment services to women abusing substances. Reflexivity aided the researcher to be cognisant of her own views during data analysis process to avoid overshadowing the experiences of the participants. The researcher ensured that all opinions and biases were set aside in order to receive the participants' qualitative data without predetermined judgements or assumptions from existing

knowledge (Schurink *et al.*, 2021). The researcher also ensured that ethical considerations were adhered to during the study.

1.8 ETHICAL CONSIDERATIONS

The study explored the perspectives of social workers on barriers to accessing substance abuse treatment for women, so it was considered low risk in terms of the ethical guidelines. The researcher requested permission from the Departmental Ethics Screening Committee (DESC) and the Research Ethical Committee (REC) at Stellenbosch University before the study could be conducted. The researcher was guided by the research ethics guidelines and principles when conducting the research.

The project involved professional social workers employed in the Department of Social Development as substance abuse coordinators in various municipalities in Limpopo province. The researcher was granted permission by the head of the department to conduct the study with the coordinators. The following ethics were considered during the study:

1.8.1 Voluntary participation

Voluntary participation refers to taking part in a research study without being forced to do so and on the understanding of the consequences of participating (Strydom & Roestenburg, 2021). The researcher asked the participants if they would like to be part of the research study on their field of substance abuse, and everyone had the right to choose whether to participate in the study or not. Volunteering participants were allowed to choose the date of the interview and a time convenient to them.

1.8.2 Informed consent

Informed consent refers to the researcher's ability to give the right amount of information to the participant in order for the latter to give informed consent to take part in the study (Strydom & Roestenburg, 2021). The researcher shared the purpose of the study to allow them to familiarise themselves with what the research was about, which allowed them to make an informed decision to consent to taking part in the study. The expected behaviour, type of interview, method of data collection and duration of the interview were discussed with the participants. All participants were given consent forms (Annexure B) to sign via email.

1.8.3 Privacy, anonymity and confidentiality

Privacy focuses on the physical setting in which data were collected. Confidentiality is the agreement between people about who may access their information. Anonymity is about being able to keep people's personal information private in order to protect their identity (Strydom & Roestenburg, 2021). The participants' personal information, including their names and office location, were kept confidential. Interviews were conducted telephonically, and the participants had the leverage to do it at a place convenient for them to protect them from compromising their safety and confidential information. The participants were informed about the limitations of confidentiality for the study, such as sharing the transcript with the supervisor. The interview was protective of the participants' anonymity, as the information required was not personal and their names were not included in the study.

1.8.4. Debriefing

The research was considered carrying low risk, because emotional content was not anticipated during the interview. However, a contingency measure was made for debriefing by way of making referrals to relevant personnel such as psychologists, counsellors and social workers should a need arise.

1.9 LIMITATIONS OF THE STUDY

The study is qualitative; therefore, the findings cannot be generalised. Given that the study aimed to fill the existing gap on barriers women face in accessing substance abuse treatment, some literature cited in this study was dated due to lack of recent literature. Although the researcher only interviewed social workers coordinating substance abuse programmes and not the women experiencing the barriers, she still managed to discover vital information and data. The researcher used telephone interviews due to COVID-19 restrictions, which limited her from gauging the genuineness of the participant's responses, and she was unable to observe the behaviour and body language of the participants. The researcher is employed by the Department of Social Development in Limpopo, was a substance abuse coordinator from 2013 to 2015, and currently is working at the Seshego Treatment Centre, which

can be seen as bias. However, it was advantageous since she is well informed about matters of substance abuse and was able to be objective throughout the study. Participants were allowed to express their perceptions without being judged and intimidated by the researcher. The researcher's knowledge about the substance abuse programme allowed her to interpret the findings within the context of participants.

1.10 PRESENTATION OF THE STUDY

This research study is presented in five chapters. Chapter 1 is the introduction and general orientation to the study, presents the context of the study, its theoretical point of departure, research methodology, ethical considerations as well as the definition of key concepts. Chapter 2 focuses on the first objective of the study, which is to discuss the prevalence and effects of substance abuse among women. Chapter 3 describes barriers to accessing substance abuse treatment services by women from a feminist perspective. Chapter 4 explores the social workers' perspectives on barriers to accessing substance abuse treatment services for women in Limpopo province. Chapter 5 concludes the study and make recommendations for future research based on the implications of the study's findings in the field of substance abuse in South Africa.

CHAPTER 2

PREVALENCE AND EFFECTS OF SUBSTANCE ABUSE AMONG WOMEN

2.1 INTRODUCTION

This chapter focuses on the first objective of the study, which was to explore and discuss the prevalence rate of substance abuse among women in South Africa. The chapter also explores the applicable legislation and policies concerning the use of substances in South Africa. Moreover, the chapter discusses drugs commonly used by women, the contributory factors for using substances and the effects drugs have on women.

2.2 POLICIES AND LEGISLATION REGARDING SUBSTANCE ABUSE IN SOUTH AFRICA

What follows is a discussion of policies and legislation used in South Africa to address issues related to substance abuse. The legislation outlines and guides processes and procedures to address any issues related to substance abuse in the country.

2.2.1 Drugs and Drug Trafficking Act, No. 140 of 1992

The Drugs and Drug Trafficking Act No. 140 of 1992 (RSA, 1992) is aimed at providing guidelines to manage the prohibition of use, possession of and dealing with drugs in South Africa. The Act serves to manage the rules on the manufacturing or supply of certain substances and the acquisition of drugs in the country. It sets out the obligations of residents to report information they have on drug supply to the police and the management of drug trafficking to and from the country.

Harper, Harper and Stockdale (2000) are of the view that women are used to smuggle drugs from one country to another by drug lords and end up being arrested in other countries for drug trafficking. Van Heerden and Minnaar (2016) reported that, from the media articles they analysed, most arrested South African drug mules were women. In Britain, it was found that, out of all women in prison, 20% had been arrested for drug trafficking offences, while only 4% of males in the prison population had been arrested for the same crime.

Giacomello (2017) highlights that the number of women who have been arrested for drug offences were approximately 466,000 inmates in 2000 and 700,000 in 2015. This growing number includes both women sentenced for crimes committed to maintain their substance abuse habits and those who were caught smuggling drugs to get payment to look after their families. It was also reported that the number of women in prison increased by 50% and drug offences represent the second reason for their arrest. Corina (2014) reports that Argentina has more than 60% of the cases of female imprisonment for drug-related offences, while 68% of women's imprisonment in Chile was linked to drugs compared to the 26% of men.

Most women found in prison for drug-related offences were reported to be single parents with one or two children, economically and socially marginalised and victims of sexual violence. They also had a low level of education, which makes it difficult for them to find stable jobs to look after their families (Khajedaluee, Dadgarmoghaddam, Erfanian, Alipourtabrizi & Khadem-Rezaiyan, 2015). Kissin, Tang, Campbell, Claus and Orwin (2013) reported that upwards of 80% of female offenders in Washington State, USA had substance abuse problems, and 50% of them had committed crimes under the influence of substances. Although the Drugs and Drug Trafficking Act clearly highlights that all offenders will be treated equally based on the type of offence committed and not on gender, regardless of the uniqueness of the case, the studies reviewed here clearly show that women, including South African women, are the most likely to be used for drug trafficking. For the purposes of this study, the researcher sought to explore the barriers women face in accessing substance abuse treatment in Limpopo.

2.2.2 Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008

The Prevention of and Treatment for Substance Abuse Act No. 70 of 2008 is aimed at the provision of a comprehensive national response to combat substance abuse in South Africa among all people, including women. It provides strategies to deal with the demand and supply of substances, and to help deal with the harm caused by substances to people. The Act set out guidelines for the provision of prevention, early intervention, and treatment and reintegration services to service users. The Act also sets guidelines for the registration and establishment of treatment centres and halfway houses, and provides guidelines on admission criteria, together with procedures that

must be accessible by all people, including women. It guides the Central Drug Authority and oversees the implementation of the National Drug Master Plan (NDMP, 2019-2024).

The Act is silent about provisions for women with special needs, such as caring for children while undergoing substance abuse treatment. However, section 4 (h) outlines that the Act seeks to ensure that services are available and accessible to all service users, including women, children, older persons and persons with disabilities, without any preference or discrimination. The Act assumes that the provision of treatment services cuts across all genders, age groups and races. However, in October 2019, SACENDU reported that most people accessing substance abuse treatment in South Africa were adult men rather than adult women. In addition, Myers, Carney and Wechsberg (2016) point out that women are not included on the health agenda, which affects the provision of treatments specifically for them. The authors also identified resource constraints, stigma towards women who use alcohol and other drugs and gender inequality, all of which contribute to their absence in treatment facilities.

2.2.3 The National Drug Master Plan (2019-2024)

The National Drug Master Plan ([NDMP] DSD, 2020) seeks to address challenges faced by South Africans related to substance abuse. Illicit and licit drug abuse have a negative effect on the users, their families and the community at large. Non-communicable diseases such as HIV and AIDS, cancer, heart disease and psychological diseases were mostly found to be associated with drug abuse. Substance abuse was also reported to increase the rate of crime, domestic violence, unemployment, school dropout and foetal alcohol syndrome. Excessive abuse of substances also leads to premature death due to ill health, car accidents and suicide (Cormier, Dell & Poole, 2004). The NDMP (2019-2024) is designed to address all the aforementioned issues by ensuring that there is an integration of services between government departments and other stakeholders in the field of substance abuse to combat the use and abuse of substances. The NDMP (2019-2024) sets out the types of contribution and roles each government department, from the national to provincial level, should play in fighting the scourge of substance abuse. It also acknowledges the need for collaboration with external stakeholders in the country, such as faith-based organisations, traditional leaders and business entities.

The overall objectives of the NDMP (DSD, 2020) are, firstly, to reduce the demand for drugs for non-medicinal use, increase approaches to harm-reduction treatment, control of drug use for medical use and prevent new forms of drugs from entering the country in a coordinated manner. Secondly, it is to ensure effective and efficient services by combating substance abuse through the elimination of drug trafficking and related crimes. Lastly, it should enable the sharing of current good practices in reducing harm, including social ills related to substance abuse. The NDMP was developed after a review of the previous version (2013-2017). The Central Drug Authority (CDA) identified several challenges and impediments that needed to be addressed and were incorporated in the NDMP (DSD, 2020). In the review and in the amendments made, it was noted that there was a need to put more effort into dealing with women and pregnant women with substance abuse problems in a coordinated and multi-sectorial approach.

The CDA is the statutory body authorised in terms of the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992), as amended, as well as the Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008), as amended, to develop a NDMP and to direct, guide and oversee its implementation, as well as to monitor and evaluate the success of the NDMP (DSD, 2020). The CDA comprises representatives of all government departments that mandate the provinces to formulate their provincial substance abuse forums and other stakeholders. The provincial forum ensures the development of local drug action committees in the districts. The committees are responsible for the identification of substance abuse problem areas in the province, reporting on the prevalence rate of substance abuse in the province, developing intervention strategies to deal with the problems and ensuring the implementation of such plans. In 2016, the CDA annual report revealed that the use of substances by women is rising, and initiatives to capacitate local drug action members in terms of the management of Foetal Alcohol Syndrome (FAS) were formulated. However, there was nothing reported about strategies to identify women who use substances and how they can be assisted.

2.3 PREVALENCE OF SUBSTANCE ABUSE AMONG WOMEN

Historically, drugs such as marijuana were used to treat labour pains, uterine haemorrhages, postpartum psychosis and other sicknesses (Stevens, Andrade &

Ruiz, 2009). This generally means that, at some point, women have used substances for medical reasons. Stevens *et al.* (2009) reported that in the United States of America during the 1700s there was an increase in the prevalence rate of the use of opium in women during the revolutionary as it was used to treat wounded soldiers. Drugs such as opium and syringe kits were openly available for sale and became more accessible and accepted for use by women. The doctors used to recommend beer, wine and opium as an alternative furthering the use of opium to people addicted to distilled spirits. Furthermore, there is an increase of alcohol and illicit substance abuse by women in secret places since it was not acknowledged by society especially prior the mid 1960's (Stevens *et al.*, 2009).

In its World Drug Report, the United Nations Office on Drugs and Crime ([UNODC], 2013, 2015) revealed an alarming increase in problems relating to the abuse of legal and illegal drugs in the world. Statistics from UNODC (2013) shows that 180 million people, or 3.9% of the population aged between 15 and 64, abuse dagga, while 1.6 million people inject drugs and, as a result, are infected with HIV. The World Drug Report (UNODC, 2015) outlines that a total of 246 million people used illicit drugs in 2013. The report also shows that the number of people injecting drugs has increased to 12.19 million since 2013, and most of these people are diagnosed with HIV.

Stevens *et al.* (2009) found that an estimated 6.5 million (5.9%) women from age 18 years and older met the diagnostic criteria of substance-use disorder, but 92% of them never received treatment. It was also found that, of all the women mentioned above, an estimated 5.2 million (4.7%) were dependent on alcohol and two million (1.8%) were dependent on illicit drugs. Their study also showed that 15% of women between the ages of 18 and 25 were dependent on alcohol or illicit drugs, compared to 9% of women between the ages of 26 and 34. The study also highlighted that women reduce their level of use as they age. Arpa (2017) states that the number of women who have ever tried using illicit drugs is escalating in different countries.

European Monitoring Centre for Drugs and Drug Addiction (2016) reports that 34.8 million women aged 15 to 64 tried to use illicit drugs compared to 54.3 million men. It also highlights that the lifetime rate of illicit use of drugs among women differs from one country to another. France was reported to have a highest rate of 33%, followed by Denmark with 30%, the United Kingdom with 29%, and the lowest rated country

was Malta, with only 1%. The prevalence rates were equally or slightly different among boys and girls in the Czech Republic, the Faroes, Malta and Iceland. Younger girls were found to have a higher rate of illicit use of drugs compared to older women (Arpa, 2017). In the Islamic Republic of Iran, drug dependence is regarded as a male phenomenon, and it is taboo to see women smoking cigarettes. The Ministry for Health in the country reported that one out of eight Iranian women is dependent on drugs, whereas a study in the United States argues that almost 4.5 million women drink alcohol, 3.5 million abuse prescription drugs and more than three million abuse illicit drugs (Khajedaluae *et al.*, 2015).

A review of the literature done by the UNODC (2014) on drug and substance abuse amongst youth and young women highlights that South Africa is not excluded from the rise in substance and alcohol abuse problems. Substance abuse is seen as a contributory factor to the increase in social ills, health problems and economic crises in the country. In 2014, statistics revealed that drug consumption (cannabis, cocaine and crystal methamphetamine) in South Africa was twice the global average and second to none in Africa (UNODC, 2014), and the country was reported to be among the top 10 narcotics and alcohol abusers in the world. Additionally, a decade ago South Africa was rated amongst the top 10 nations that consume alcohol, and its drug use was regarded as higher than the global average use of substances (Ovens, 2010). More recently, the prevalence of women abusing substances has escalated among women from socio-economically disadvantaged communities (Ovens & Prinsloo, 2018).

The abuse of methamphetamines and heroin is rising in South Africa. The heroin market has grown substantially and has saturated the country since 2015. Moreover, over the counter and prescription medication, such as slimming tablets, analgesics and benzodiazepines (diazepam and flunitrazepam), continue to be a problem in the country and are used as secondary drugs of choice (DSD, 2020). In a study conducted in Cape Town, Van Heerden, Grimsrud, Seedat, Myer, Williams and Stein (2009) found that substance abuse is most prevalent in males, with trends suggesting roughly an 80/20% male/female split across the country. Back, Contini and Brady (2007) observe that there is consistency in the higher rate of drug and alcohol use among men than women. Research has shown that men are twice as likely as women to meet

lifetime Diagnostic Statistical Manual (DSM-IV) criteria for any drug-use disorder which is 13.8% for men and 7.1% of women (Hasin & Grant, 2015).

SACENDU (2016, 2019) reported that alcohol remains the dominant substance abused in KwaZulu-Natal and in the central region, which covers the Free State, Northern Cape and North West. Limpopo and Mpumalanga, also known as the northern region, were reported to have a prevalence rate of cannabis use at 38%, followed by heroin at 34% and alcohol at 17% as the primary substances used reported by treatment centres. There has been an increase of 24% in the use of multiple substances in the northern region. SACENDU (2020) shows that there has been a slight increase in the number of females who reported with substance abuse, at 22%, hence there was a need to investigate the barriers women encounter while seeking treatment services in Limpopo province.

2.4 SUBSTANCES COMMONLY USED BY WOMEN

Historically, women were more likely to receive prescription medication compared to men. Women were generally viewed as people who could be treated with psycho-active drugs for their problems and illnesses (Stevens *et al.*, 2009). There was a perception that women could not become addicted to alcohol and other drugs, hence doctors would treat them openly and prescribe drugs such as cocaine for neurasthenia. These psycho-active drugs used to treat mental problems kept women sedated and numb from their thoughts and emotions. The abuse of such drugs resulted in women losing their ability to understand and resolve issues such as anxiety, depression and self-worth. The United Nations Office on Drugs and Crime ([UNODC], 2018) reports that women commonly use tranquilisers and opioids for non-medicinal purposes and are likely to begin using drugs later in life when compared to men. Stene, Dyb, Tverdal, Jacobsen and Scej (2012) highlight that women commonly use analgesic psychotropic drugs to treat pain, mental distress and insomnia, which develops drug tolerance and decreases its effectiveness. They are likely to acquire more prescriptions from different physicians to maintain their habit.

Greenfield *et al.* (2010) highlight that there are no specific and special drugs used by women; they use the same drugs as men. Both men and women use alcohol but for different of reasons, as women are commonly observed to drink to deal with stress and negative emotions. Greenfield *et al.* (2010) picked up that there has been an

increase in the use of methamphetamine for non-medicinal use among women between 1995 and 2005. They also identified the similarities in the usage of opioids between males and females, but females aged 12 to 17 had a higher rate of use than men of the same age. However, men aged 18 to 25 years had higher rates of opioid use than women of the same age. Women who use heroin are reported to be initiated into its use by their intimate partners. Women use cannabis to deal with moods predisposed by premenstrual dysphoric disorder. Men are at the highest rate of nicotine use compared to women.

The use of tranquilisers by women in western and central Europe is nearly twice that of cannabis use, while the use of other substances such as amphetamine, cocaine and opioids remain at a very low level (UNODC, 2015). It was also reported by Nelson-Zlupko *et al.* (1995) and the Centre for Substance Abuse Treatment (2015) that women exceed their medical and nonmedical use of prescription drugs they obtained legally from medical practitioners such as physicians. Women are also reported to frequently use multiple mood-altering substances, which they use mostly in isolation and in private. The Centre for Substance Abuse Treatment (2015) also confirms that women commonly use prescription drugs with addictive properties. The survey conducted by the National Survey on Drug Use and Health (NSDUH, 2006) in 2003 and 2004 on persons aged 12 years and older with lifetime nonmedical use of pain relievers showed that usage increased from 31.2 million to 31.7 million. The survey also reveals that 55% of new people who used these prescription drugs were female (Wright & Sathe, 2006).

Tobacco is seen as a gateway drug to proceed to alcohol and other drugs. Reddy, Zuma, Shisana, Jonas and Sewpaul (2015) found that the prevalence rate of tobacco use for men was four times higher, at 29.2%, compared to female use, at 7.3%. The province with the highest tobacco smoking prevalence in South Africa was the Western Cape, with 32.9%, followed by the Northern Cape (31.2%) and the Free State (27.4%). Between 2008 and 2011, there was an increase in tobacco use among women in South Africa. The South African National Health and Nutrition Examination Survey (SANHANES, 2012) revealed that there was significantly greater usage of tobacco products by men than women, which they believed was due to tobacco being more socially acceptable among men than women in many communities in the country.

2.5 FACTORS CONTRIBUTING TO SUBSTANCE ABUSE AMONG WOMEN

Substance abuse among women is reported to be predisposed by different contributing factors. Following are the identified contributory factors to women abusing substances.

2.5.1. Traumatic childhood experiences

Several scholars have found that trauma caused by childhood abuse is a contributory factor to initiation into substance abuse by women (Arpa, 2017; Greaves, Chabot, Jategaonkar, Poole & McCullough, 2006; Taylor, 2010). Women who are victims of childhood trauma, incest, sexual and physical abuse perpetrated by people they know, and trust are likely to use substances later in life. Taylor (2010) also highlights that 80% of these women present with symptoms of post-traumatic stress disorder and suffer the co-occurrence of substance use disorder and mental illness.

Cross, Crow, Powers and Bradley (2015) and the UNODC (2018) agree that there is early developmental trauma and Post Traumatic Stress Disorder (PTSD) due to childhood rape that often proceeds to the development of alcohol and substance abuse. As a result, women self-medicate their feelings with substances in order to remove themselves from the symptoms of PTSD. Data from substance abuse treatment centres in Canada highlights that, of the 98 women sampled, 85.7% were victims of child abuse, with childhood sexual abuse sitting at 56.3% and childhood physical abuse at 56.1% (Cormier *et al.*, 2004). The Centre for Substance Abuse Treatment (2015) found that women with a history of child sexual abuse were highly represented in substance abuse samples, with a prevalence ranging from 15% to 25%. All the adversities listed above are reported to have contributed to these women abusing substances.

The Centre for Substance Abuse Treatment (2015) reports that female children taking on adult responsibilities (such as looking after their sick parents, caring for their siblings and doing chores) are also seen to abuse substances later in life. A study by Covington (2002) proves that women with a history of traumatic experiences are at high risk of substance abuse. Her comparative study was done between women who were addicted and those who were not addicted, and the findings show that 74% of the addicted women reported sexual abuse, 52% reported physical abuse and 72% reported emotional abuse. The study also emphasises that the abuse happened

frequently and for a longer period, and the incidents included incest and rape. Kissin *et al.* (2013) point out that there is an association between a history of childhood victimisation and dysfunctional relationships that lead to depression, anxiety, substance abuse and involvement in criminal activities. Dysfunctional relationships can also lead to domestic violence, resulting in women using substances.

2.5.2. History of domestic violence

Women who experienced victimisation and domestic violence at the hands of their intimate partners are likely to initiate substance abuse, which can escalate to substance-use disorder (Arpa, 2017; Back *et al.*, 2007; Cormier *et al.*, 2004; National Institute on Drug Abuse [NIDA], 2018). UNODC (2018) reports that women who use drugs have two to five times higher prevalence of experiencing gender-based violence than women in the general population who do not use drugs. Covington (2002) adds that women in an abusive relationship with partners who lack mutuality and sympathy often use drugs to numb the pain. According to the Centre for Substance Abuse Treatment (2015), women who abuse substances with their partners continue to abuse substances to maintain their relationships.

Cormier *et al.* (2004) also highlight that two third of women who have experienced domestic violence and have substance abuse problems have a concurrent mental health problem, such as traumatic stress disorder, panic disorder and/or eating disorders. Simmons, Knight and Menard (2015) indicate that women who have been victimised through physical abuse and/or battering by their intimate partner are at high risk of developing depression, which leads to the development of dependency on substances to cope with an unhealthy relationship. Some scholars posit that women experiencing intimate partner violence are frequently prescribed potentially addictive drugs to cope with the abuse, which they end up depending on (Greaves *et al.*, 2006; Stene *et al.*, 2012). The domestic violence experienced by women also has a negative effect on the whole family.

2.5.3. Family problems

Women initiate the use of substances due to the burden of family responsibilities, interpersonal conflicts and poor parenting (UNODC, 2015). Research has shown that women who grew up in a chaotic, dysfunctional, argumentative, blame-orientated and violent household are more prone to abuse substances (Ashley, Marsden & Brady,

2003; Centre for Substance Abuse Treatment, 2015; Nelson-Zlupko *et al.*, 1995). The United Nations Drug Control Programme ([UNDCP], 2002) found that married women from Delhi identified marital conflicts and the use of prescription drugs as the initiating factors of their drug abuse. The NIDA (2018) adds that divorce, the loss of child custody or the death of a partner or child can trigger women's substance abuse, or a mental health disorder that can lead to substance abuse. Greaves *et al.* (2006) point out that women who have experienced abuse by their partners fear to separate with their partners to avoid losing custody of their children, going through the process of divorce and experiencing financial problems. As a result, they opt to abuse substances to deal with their stresses.

Ovens and Prinsloo (2018) hold the view that women abuse drugs due to their accessibility and availability within their family environment. The WHO (2014) adds that women who were raised in a family with a history of alcohol use disorder are vulnerable to genetic and environmental factors to abuse substances. Nelson-Zlupko *et al.* (1995) point out that most women are introduced to substances by people they are related to and live with, such as spouse, partners, boyfriend and family members or close relatives. Covington (2002) concurs that women who are in an intimate relationship with men supplying drugs or selling drugs are more vulnerable to abusing those substances. Women who have experienced disappointments in relationships mostly find their solace in substances. Myers *et al.* (2016) found in their study that, due to poverty in their families, young women find themselves in intimate relationships with drug suppliers and gangs who support them and their families financially. Furthermore, the study shows that the families of these young people support these relationships and are against them separating from the drug dealers, since they are benefiting financially. Consequently, these women end up using drugs with their partners to sustain and strengthen their relationships.

2.5.4. Psychological distress

Researchers have found that women are commonly susceptible to drug abuse due to suffering from stress, depression, post-traumatic stress disorder, panic disorders, mood and anxiety disorders (Centre for Substance Abuse Treatment, 2015; Cormier *et al.*, 2004; Greenfield *et al.*, 2010; UNODC, 2015). Slabbert, Greene, Womersley, Olatrju, Sobaka and Lemieux (2019) add that women vulnerable to psychological

distress run a high risk of developing substance use disorders since they use substances to cope with these challenges in the absence of effective health care services to remedy the problems.

The Centre for Substance Abuse Treatment (2015) and Greenfield *et al.* (2010) concur that there are numerous factors that influence and perpetuate the initiation of substance abuse by women, such as experiencing negative emotions and relationship problems. Women who abuse substances are more likely to have co-occurring psychiatric disorders that impede efforts to seek treatment. More reasons for perpetuating the abuse of substances by women that were identified by Ashley *et al.* (2003) and Nelson-Zlupko *et al.* (1995) include sudden physical illness, the death of loved ones, accidents and the disruption of family life, which later result in symptoms of PTSD. Ashley *et al.* (2003) adds that women with a poor self-concept, such as low self-esteem, guilt and self-blame, and a high rate of mental problems, such as bipolar disorder, suicidal ideation and psychosexual disorders, are vulnerable to substance abuse. The UNDCP (2002) emphasises that 13% of women from Mumbai initiated drug use after experiencing humiliation, shame, anger and powerlessness in response to dealing with such negative experiences, which can have devastating effects on women.

2.6. EFFECTS OF DRUG USE ON WOMEN

Substance abuse affects both males and females, but the difference is in the severity of the effects it has on the genders (Khajedaluee *et al.*, 2015). According to Back *et al.* (2007), women are reported to be more vulnerable to the adverse consequences of substance abuse, such as advancing more rapidly from the use to the abuse of substances. Perkins (2001) points out that the effects of substance abuse are not clearly outlined based on specific genders due to limited studies that have focused on effects by gender. The severity of substance abuse in women is found to be equivalent to that in males, even though women have abused substances for fewer years and in smaller quantities. The UNDCP (2002) highlights that substance abuse has a wide array of effects on the individual, not only physically, emotionally and financially, but also on the environment and people around them. Daley (2014) also agrees that substance abuse affects families and significant others differently, depending on the severity of abuse by the person abusing the substances. Various problems, such as

psychiatric illness caused by the excessive use of substance, and behaviours displayed towards family members by the person under the influence of substances, may have a negative effect on the family members. Family members are forced to develop coping mechanisms to deal with the substance abuser within the family. The effects of drug use on women are presented as set out below.

2.6.1 Social effects of substance abuse

There are different types of social effects of substance abuse, such as housing instability, unemployment, homelessness, victims and perpetrator of crime, and imprisonment. Women suffer serious long-term incarceration for offences related to drug use and drug-related offences. Many women have been sentenced for drug-related offences than men. Women are commonly incarcerated for drug-related offences in some countries and, upon release, they suffer stigma, discrimination and limited access to health care and social services, along with social isolation and living in circumstances of social and economic disadvantage and inequality (UNODC, 2018). They find difficulty maintaining their jobs and run the risk of losing their jobs due to their substance abuse, and some never got a chance to be employed when they are already dependent on substances (Donohue, 2004).

Women who abuse drugs suffer from stigma, shame and discriminatory responses within families and societies because of their gender (Arpa, 2017). Society believes that women who abuse substances cannot make a good wife, mother or be respected by society. The WHO (2014) confirms that many societies display a more negative attitude towards women who abuse substances than men, which increases women's vulnerability to social harm. These women experience discrimination and disapproving and unsupportive responses from different service providers within the society. Compared to men, women who abuse substances are more likely to have poor or a lack of social support when they attempt to find treatment. Their relationships with children, partners, significant others and the community at large are also affected by their substance abuse. Back *et al.* (2007) identified the family environment as a big influence on women's substance abuse, since they are likely to have role models who are also dependent on substances.

Research has shown that women who abuse substances are vulnerable to domestic and interpersonal violence, social isolation and structural inequalities (Covington,

2002; Nelson-Zlupko *et al.*, 1995; Slabbert *et al.*, 2019). Myers *et al.* (2016) are of the view that alcohol and other drugs predispose women to gender-based violence. There has been an exponentially increasing number of gender-based violence cases in South Africa in which women and children have been raped and murdered. President Cyril Ramaphosa, in a speech on 17 June 2020, expressed his concerns about gender-based violence becoming a second pandemic in South Africa due to alcohol abuse during the nationwide lockdown because of the COVID-19 pandemic (Ellis, 2020).

2.6.2 Health effects of substance abuse

The Centre for Substance Abuse Treatment (2015) highlights that women and men differ in genetics, physiology, anatomy and sociocultural expectations and experiences. Women have unique health problems related to substance abuse and they are at high risk of being diagnosed with co-occurring physical and mental disorders. Several authors agree that women's physical responses to substance abuse entail a quicker progression from initial use to dependence (Centre for Substance Abuse Treatment, 2015; Nelson-Zlupko *et al.*, 1995; Najavits, Rosier, Nolan & Freeman, 2007; Stevens *et al.*, 2009). Women develop alcohol-related physical health problems such as strokes, depression and balance problems at lower doses and over a shorter period than men (Centre for Substance Abuse Treatment, 2015).

From the early onset of substance abuse, women are more likely to suffer from malnutrition, high blood pressure, cancer and some other dangerous diseases, like hepatitis or HIV/AIDS (Greenfield *et al.*, 2010; Khajedaluee *et al.*, 2015). Compared to males, women may be more prone to HIV/AIDS or other sexually transmitted diseases due to their vulnerability. McCabe, Feaster and Mitrani (2014) highlight that women who use multiple drugs are linked to impulsivity and high-risk sexual behaviour, which lead to a high risk of HIV transmission. Greenfield *et al.* (2010) and Myers *et al.* (2016) highlight that women who use substances are at risk of contracting sexually transmitted diseases, since they find it difficult to negotiate for a condom during sex. Men have power and control over the use or not of protection during sex, since they provide drugs for the women. The UNODC (2015) adds that women can also contract HIV infections and hepatitis by sharing syringe needles with their male counterparts.

The NIDA (2018) outlines that women are more sensitive than men to the effects of substance abuse due to fact that their sex hormones have the ability to make them more sensitive to the effects of drugs.

Women who use heroin and methadone at childbearing age are likely to experience amenorrhea, leading them to believe that they are unable to conceive and misreading early signs of pregnancy as withdrawal symptoms (The Centre for Substance Abuse Treatment, 2015). Furthermore, Greenfield *et al.* (2010) highlight that women who smoke are more likely to suffer from heart attacks, experience faster lung deterioration than men and are at increased risk for chronic obstructive pulmonary cancer. Smoking also leads to the earlier commencement of menopause, increased menstrual bleeding, difficulty in becoming pregnant and experiencing of spontaneous abortion. Sreeramareddy, Harper and Ernstsens (2016) report that tobacco smoking has caused the deaths of an estimated 6.1 million people and increased the disability-adjusted life years (DALYs) to 143.5 million. Back *et al.* (2008) say that chronic nicotine use by women affects the hypothalamic-pituitary-adrenal (HPA) axis, which is found to be more sensitive in women.

The Centre for Substance Abuse Treatment (2015) and Cormier *et al.* (2004) state that women are more likely to develop liver cirrhosis and heart muscle and nerve damage with fewer years of heavy drinking. Cormier *et al.* (2004) emphasise that the findings above also apply to brain shrinkage and impairment, breast cancer, gastric ulcers and alcoholic hepatitis. Thompson-Brenner, Eddy, Franko, Dorer, Vashchenko and Herzog (2008) outline that women who abuse substances are also reported to have bad feelings about their bodies and are at risk of eating disorders. Even with small doses of drugs, women are at higher risk of detrimental consequences, such as fatty liver, hypertension, insomnia, anaemia and gastrointestinal disorders. The Centre for Substance Abuse Treatment (2015) confirms that women are reported to encounter more complications and more severe problems due to alcohol abuse, which develop rapidly. In addition, the abuse of stimulants, opioids and some prescription medication and over-the-counter drugs causes an increased risk of lung cancer.

2.6.3 Effects of substance abuse on pregnant women and the unborn child

There are limited chances for pregnant women with substance abuse problems to start with prenatal care until they realise that they are pregnant. Initiation of prenatal care remains a great challenge for women abusing substances, due to their fear of legal implications for abusing drugs while pregnant and the impact drugs have on the unborn child (Centre for Substance Abuse Treatment, 2015). Redgrave, Swartz and Romankosi (2003) confirm that pregnant women with risky drinking patterns enter prenatal care three weeks later than women who do not drink alcohol.

Jackson and Shannon (2012) state that tobacco abuse during pregnancy has negative health effects on the unborn child, such as preterm birth, placental abruption, low birth weight and paediatric asthma, while alcohol abuse can cause foetal alcohol syndrome (FAS), which can affect the child's mental, physical and/or cognitive development. Marijuana abuse during pregnancy is associated with intrauterine growth retardation (IUGR), low birth weight and cognitive impairments. Children born to women who abuse opioids are at increased risk for neonatal abstinence syndrome, which can contribute to developmental or cognitive delays (Daley, 2014). Opiate abuse has been linked to maternal complications involving both the physical and mental health of the child. Neonatal abstinence syndrome causes withdrawal symptoms for the foetus, including fever, sneezing, irritability, trembling, diarrhoea, vomiting, increased sweating and seizure (Jackson & Shannon, 2012). The NIDA (2018) shows that substance abuse during pregnancy is risky to the woman's health and that of the child in the short and long term. Drugs such as stimulants and opioids could potentially harm the unborn child and can increase the risk of miscarriage. They can also cause migraines, seizures or high blood pressure in the mother, which may affect the foetus. Ovens (2010) points out that some unborn children are exposed to psychoactive substances by their pregnant mothers. The unborn children become victims of habitual dependence or overdoses of depressant drugs administered by their mothers. The author further reports that there are limited studies in South Africa on prenatal drug abuse as a form of child abuse.

2.6.4 Effects of substances abuse on families

According to the UNDCP (2002), drug abuse does not only affect the individual who abuses the drugs, but also their family and community at large. There is not much

difference in the effects of substance abuse on the interpersonal relationships of men and women. Daley (2014) and the UNDCP (2002) argue that both men and women often neglect their responsibilities within their families on account of drug abuse, and the whole family suffers resentment, stress and depression. Substance abuse affects the family's financial and emotional status. Women who abuse substances often spend their money on their substances of choice and deceive or manipulate their family members to get more money to feed their substance-abuse habits. Daley (2014) assert that family members often suffer emotional burdens, such as anger, frustration, anxiety, fear, worry, shame and guilt, or embarrassment due to their family member's abuse of substance, and their behaviour while intoxicated or withdrawing. Interpersonal relationships in families are affected and there is dissatisfaction between couples, which may lead to separation, divorce and domestic violence (Greenfield *et al.*, 2010). Lander, Howsare and Byrne (2013) add that women who abuse substances are viewed as a threat to their children and their capabilities to care for the family are doubted.

Children of parents who abuse substances are vulnerable to increased risk of abuse or neglect, physical problems, poor behavioural or impulse control, poor emotional regulation, conduct or oppositional disorders, poorer academic performance, psychiatric problems such as depression or anxiety, and substance abuse. Mothers who abuse substances may be less sensitive and emotionally unavailable to their children, and may leave their children feeling guilty, helpless, frustrated, angry or depressed (Daley, 2014; Ovens & Prinsloo, 2018). Donohue (2004) and Ovens (2010) concur that mothers who abuse substances demonstrate difficulties in supervising their children and often practise inconsistent parenting styles, which contributes to problems in child development. They often neglect providing care for the children, such as dressing, feeding, medical care, hygiene and emotional attention. These children are also at high risk of injuries due to the neglectful parenting behaviour of their mother. The UNDCP (2002) confirms that women who abuse substances suffer from guilt for neglecting their children.

2.6.5 Psychological effects

SACENDU (2018) reports that 14% of service users present with a dual diagnosis during treatment admission. Mental problems were ranked the highest, with 47% of

service users in treatment admission compared to other diseases. A national comorbidity study (Centre for Substance Abuse Treatment, 2015) reported that 72.4% of women abusing alcohol had been diagnosed with co-occurring disorders. Women were found likely to be diagnosed with multiple comorbidities (three or more psychiatric diagnoses), in addition to substance use disorder. Substance abuse was seen as a means of self-medicating to lighten the distressing effects of other psychiatric disorders. It is likely that mental disorders can play a primary role in initiating substance abuse to gain relief, but it must be acknowledged that psychiatric disorders may occur as a consequences of substance abuse or develop independently, yet concurrently, of the current pattern of substance abuse (Centre for Substance Abuse Treatment, 2015).

Numerous studies concur that most women using substances have co-occurring diagnoses of substance abuse and personality disorders when compared to women who do not use substances (Back *et al.*, 2007; Cormier *et al.*, 2004; Cross *et al.*, 2015). The disorders commonly identified in women who abuse substances are anxiety disorders, major depressive disorders, eating disorders, PTSDs, agoraphobia with or without panic attacks, eating disorders and borderline personality disorders. The Centre for Substance Abuse Treatment (2015) and Cormier *et al.* (2004) agree that women with substance use disorders increase their vulnerability to additional trauma, suicidal ideation and attempt, decrease their ability to defend themselves, alter their judgement, and draw themselves closer to unsafe environments.

Women encounter different types of effects of substance abuse, such as psychological, social, health and family effects, which are linked to reasons they are not seeking treatment. It is important to discuss the barriers women are facing to access substance abuse treatment services to help minimise those effects in the future.

2.7 CONCLUSION

In this chapter, several policies and legislation regulating substance abuse in South Africa were explored to understand strategies government has put in place to address issues concerning substance abuse in the country. There is a gap in legislation and policies when it comes to addressing substance abuse by women, since nothing is discussed about treatment strategies to address women's issues. The liberal feminism

theory adopted in this study advocates for women's inclusion in legislation and policies, since women also play an important role in giving inputs and direction to the provision of substance abuse treatment. The prevalence of substance abuse among women, contributory factors to substance abuse and effects of substances on women were also discussed. The literature reveals that men and women use the same substances, but women progress more quickly to dependence. Women are seen to be more severely affected by substance abuse from the onset compared to men. Despite the severe effects of substance abuse, women experience many barriers when accessing treatment. Hence, the next chapter explores the barriers women face when seeking treatment for substance abuse.

CHAPTER 3

BARRIERS TO ACCESSING SUBSTANCE ABUSE TREATMENT FOR WOMEN: A FEMINIST PERSPECTIVE

3.1 INTRODUCTION

This chapter discusses barriers women face in accessing substance abuse treatment from a feminist perspective which responds to the second objective of the study. Liberal feminism as a type of feminist theory was used to explore the accessibility of substance abuse treatment by women. The chapter also discusses substance abuse treatment services for women. Social workers' roles in assisting women to access substance abuse treatment services were explored, along with the processes and procedures for accessing treatment services. This will assist in identifying gaps in the treatment services offered to women and in making recommendations for the betterment of services.

3.2 FEMINIST THEORY

Feminist theory focuses on analysing women's experiences of gender subordination, the roots of women's oppression, and how gender inequality is perpetuated, and offers different solutions to gender inequality (Jones & Budig, 2008; Tong, 2001). This theory is aimed at understanding the position of women when it comes to substance abuse in order to assist policymakers to come up with strategies that will improve access to treatment by women. Feminist theory is classified into four categories, namely liberal feminist, social feminist, radical feminist and multiracial feminist (Rasool, 2019). For the purpose of this study, liberal feminism will be used as a lens to challenge the systems of unfairness, inequality and injustice in the provision of substance abuse services to women.

Liberal feminism is suitable for this study since it strives for social justice. The study seeks to establish whether women are given an equal opportunity to access effective substance abuse treatment services to that given to men. Substance abuse has predominately been regarded as a male problem and women find themselves with their needs unattended, since treatment services are often focused on males (Rakesh, Koushik & Swati, 2015). Women who are abusing substances suffer more

stigma, labelling, discrimination and disrespect from society compared to men, who are praised and supported. Substance abuse treatment facilities have more bed capacity for men than for women. Liberal feminists advocate for women's empowerment and encourage women to fight for their right to be respected in society and to practise their autonomy to seek treatment services. What follows is an overview of substance abuse treatment services for women in order to have a clear understanding of treatment accessibility for women.

3.3 AN OVERVIEW OF SUBSTANCE ABUSE TREATMENT FOR WOMEN

It is important to gain access to substance abuse treatment before receiving treatment services (MacMaster, 2005). Access to treatment is regarded as the greatest opportunity for women to overcome barriers, to promote treatment engagement and to continue using treatment services. For this reason, this section explores how accessible substance abuse treatment services are for women.

3.3.1 Accessibility of substance abuse treatment by women

Joe and Simpson (2002, cited by MacMaster, 2005) developed the treatment process model, which suggests that one can only initiate treatment once the recipients are motivated and have the desire and readiness to change. The model highlights that treatment engagement is a personal, self-introspection process that is linked to positive outcomes. However, UNODC (2015) confirms that, in most societies, substance abuse among women is heavily stigmatised and therefore it becomes difficult for women to acknowledge their substance abuse because it may mean that they must leave their homes and families to undergo treatment. The Centre for Substance Abuse Treatment (2015) posits that gender-specific factors that influence treatment seeking, continuity of care and the retention of women abusing substances are influenced by interpersonal relationships, family, and the role of substance abuse in sexuality. A prevalence and history of trauma and violence, and common patterns of co-occurring disorders, also influence the decision to seek treatment for substance abuse by women.

A convergence of evidence by Pullen and Oser (2014), Jackson and Shannon (2012) and Smith (2017) suggest that women with substance use disorders are less likely, over their lifetime, to enter treatment than their male counterparts, as they are more

likely to face barriers that affect their access to and entry into drug treatment. It is also reported that, globally, one person out of three drug abusers is a woman, but only one out of five drug abusers in treatment is a woman (UNODC, 2018). Several authors agree that women with substance abuse problems are less likely to seek help from relevant treatment settings due to the experience of being stigmatised (Crawford, Sias & Goodwin Jr., 2015; Green, 2006; Jackson & Shannon, 2012). Pretorius *et al.* (2009) also report that women consult health professionals (such as physicians, clinic staff and mental and medical health professionals), self-help groups and pastors for help and, in this regard, their substance abuse problem remain undiagnosed. In a study conducted in East Carolina (USA), Crawford *et al.* (2015) found that only 30% of admissions to substance abuse treatment in 2002 were women, which reflects that most service users who benefit from treatment are men. Similarly, Jackson and Shannon (2012) reported that, in 2005, only 32% of substance abuse treatment admissions in the USA were women. However, South Africa has seen a major decrease in number of service users who access treatment admission, from 9 692 in 2019 to 6 317 in 2020. This has been largely because of the COVID-19 pandemic and lockdown restrictions, which limited the number of admissions to treatment centres (SACENDU, 2020). Despite COVID-19 restrictions, women continue to be less prioritised when it comes to substance abuse treatment even though there are guiding policies and legislation that promote access to services for all people regardless of gender. From a feminist perspective, there is a need for social justice in this field in order to improve women's access to substance abuse treatment.

3.3.2 Processes and procedures for accessing treatment

Before one can be admitted for substance abuse treatment, there are processes and procedures that need to be adhered to. The processes and procedures are vital in order to begin with the substance abuse treatment process and they differ from one facility to the other, depending on country and context. For example, in the USA, the procedure used in accessing the addiction treatment system is through a phone call-scheduling system (Quanbeck, Wheelock, Ford II, Pulvermacher, Capoccia & Gustafson, 2013). Rockhill, Green and Newton-Curtis (2007) highlight that in the state of Oregon (Portland), a person can undergo substance abuse treatment through a court referral after an enquiry has been made on child abuse resulting from substance abuse.

In South Africa, the service user can voluntarily seek help from a social worker or a health and wellness practitioner in the workplace. The service user can also be referred for treatment by a concerned family member, their employer, a concerned community member, alcohol or substance abuse care providers such as community-based centres and healthcare professionals, as well as through the statutory and criminal justice system (Isobell, 2013). Isobell *et al.* (2015) maintain that other referring agents, such as the employer, a concerned community member or relative seeking for inpatient treatment access for their loved ones, are obliged to work with a social worker, since the application process requires assessment and a psychosocial report compiled by a registered social worker. The referral process can be time-consuming, labour-intensive and, at times, demoralising.

The Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008, stipulates the treatment services that one can access, if they follow the processes and procedures, which include prevention, early intervention, and inpatient and outpatient services. Inpatient and outpatient treatment services are rendered in treatment facilities with a multidisciplinary team of professionals, such as social workers, occupational therapists, psychologists, care workers and nurses. According to section 32 of the Act, a service user may voluntarily apply for admission to an inpatient treatment centre with the help of a social worker. This requires the service user to acknowledge their substance abuse problem and to take a decision to seek help. Section 33 refers to an involuntary application made on behalf of the service user on the basis that a sworn statement was made and submitted to a public prosecutor by either a social worker, community leader or person closely associated with the service user. The person who qualifies for involuntary admission must be found to be a danger to themselves or to their immediate environment, or to cause a major public risk. It takes into consideration the service user's harm to his or her own welfare and the welfare of his or her family. Lastly, admission is obtained if the service user commits a criminal act to sustain his or her dependence on substances.

Isobell *et al.* (2015) note that there are processes that follow showing an interest in seeking treatment, such as assessment, applying to treatment facilities, waiting for approval and preparing for treatment services. However, admission can only be done if there is space available in the treatment centre to which one has applied (Isobell, 2013; Myers, Louw & Pasche, 2010). There are multiple challenges women encounter

while following the aforementioned procedures of seeking treatment. The challenges include treatment centres' failure to communicate and give feedback to the referring agent, such as registered counsellors, psychologists and social workers (Isobell *et al.*, 2015). The lack of communication contributes to service users easily changing their minds about treatment when they are not responded to within a reasonable time, leading to a loss of motivation and discouragement.

3.3.3 Role of social workers in assisting women who seek treatment

Social workers are treatment professionals and usually the first point of contact with the service users who may need substance abuse treatment services. Social workers can identify women with substance abuse problems in various service delivery systems, such as child welfare, employee assistance programmes, hospitals, schools, services for elderly people, and community-based services. Social workers often provide key assessments in order to identify intervention strategies suitable to the presenting problem, and do referrals to relevant service providers (Hall, Amodeo, Shaffer & Vander Bilt, 2000). Social workers are the most recognised referring agents for inpatient and outpatient treatment services. They play a vital role in ensuring that the necessary processes and procedures are followed, even though they might take time to finalise the application processes due to high caseloads. Diraditsile and Mabote (2019) point out that social workers have the capacity to identify and assess the needs of their clients beyond the scope of their initial presenting problem, as they can gain insight into the real problem, such as substance abuse, child neglect and domestic violence. The Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008, states clearly that social workers play an important role in the application for admission to substance abuse treatment services in the treatment centre. Social workers determine the treatment needs of the service user based on certain elements found during assessment, such as severity of substance abuse, withdrawal symptoms, effects of substances, family issues that include childcare and employment status, etc.

Social workers play a valuable role in the field of substance abuse treatment processes, such as promoting the available treatment services, advocating for service users' admission to treatment settings, and fighting for vulnerable groups that are ready and willing to access effective services (National Association of Social Workers, 2013). Social workers in healthcare settings and family planning settings have the

privilege of working with pregnant women dependent on substances and are able to effectively refer and link them with the range of treatment services available using a non-judgemental approach. Social workers also have the role and responsibility to identify women abusing substances as they attend to their day-to-day cases, motivate them to change and empower them with relevant information concerning the treatment services available to them. They also play an advocacy role in the development of alternative treatment services that are sensitive to women with special needs, such as caring for children, disability and other unique needs identified during the assessment process.

Social workers are also pivotal in providing therapeutic treatment services in treatment facilities and assist in gathering the pertinent social data used by policymakers to make amendments to legislation to improve services (Straussner, 2001). Social workers collaborate with the service users and their families to determine the type of intervention suitable for the needs of the service user – from prevention, early intervention and treatment – and determine whether inpatient or outpatient services are suitable (National Association of Social Workers, 2013).

According to article (5)(a) of the Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008, social workers are responsible for applying for admission to a treatment centre and for gathering all the admission requirements, such as a psychosocial report regarding the applicant's social circumstances, along with any medical or psychiatric report from the medical doctor that the manager of the treatment centre may consider necessary. After the approval of the application, the social worker is responsible for the transportation of the service user to the treatment centre and for giving support throughout the treatment process. The next section focuses particularly on treatment services for women.

3.3.4 Substance abuse treatment services for women

Treatment facilities have been found to have similar benefits for both men and women, although there is a slight difference in their treatment outcomes and retention rates. Women who enter substance abuse treatment are likely to complete and benefit from the treatment (Back *et al.*, 2007). UNODC (2015) suggests that men have the privilege of being referred for substance abuse treatment by their family, employer and the criminal justice system, whereas women are mostly referred through social welfare

services and mental health care practitioners or enter treatment voluntarily. Furthermore, women enter treatment with a history of physical abuse, domestic violence, rape and incest and have limited support (UNODC, 2018). Green (2006) concurs that gender plays an important role in the identification of substance abuse problems and affects the steps that are taken in reaching out for help. Most women who seek treatment for alcohol problems are single and have experienced serious acute complications due to substance abuse. Most women are discouraged by their families from entering treatment to protect their family name (Green, 2006).

The Centre for Substance Abuse Treatment (2015:84) says that, in

‘treatment engagement, placement, and planning women face many obstacles and challenges engaging in treatment services. There is lack of collaboration among social welfare service systems, limited options for women who are pregnant, lack of culturally congruent services, few resources for women with children, fear of loss of child custody, and the stigma of substance abuse’.

The Centre for Substance Abuse Treatment (2015) further highlights that the types of treatment options available and accessible influence the decisions of women on the type of treatment services they deem suitable for themselves. The severity of substance abuse is another guiding factor to the suitable treatment setting.

Roberts, Jackson and Carlton-LaNey (2000) highlight that the treatment centres that are available are largely male oriented and pay very little attention to the needs of women in treatment. From a liberal feminism perspective, there is a need to review substance abuse policies and legislation in order to cater for the injustices women face in accessing treatment services. This will assist social workers to promote effective treatment services for both males and females. The UNODC (2015) remarks that women who received gender-specific treatment services, including pharmacotherapy and behavioural therapy that address their unique treatment needs such as childcare and employment support, have better treatment outcomes and improvements in important areas of their lives compared to those who attend non-gender-specific treatment services.

However, there is lack of general understanding of the specific needs of women within treatment facilities (UNODC, 2018). This gap is easily identifiable in resource-constrained countries such as South Africa and neighbouring African countries, which have limited evidence-based treatment services tailored to meet the specific needs of women. The UNODC (2015) adds that statistics on women accessing treatment services are limited due to the lack of services tailored to meet the specific needs of women in treatment (e.g. caring for children and pregnancy).

Covington (2002) highlights that, for treatment to be effective, it must consider women's life contexts, such as genetic factors, health consequences, shame and isolation from society as well as the history of abuse. Covington (2002) further claims that the services women receive in the public and private sector were not designed for women in the first place. It is important that treatment services reinforce women towards change, growth and healing from addiction in an environment that fosters empathy and healthy relationships with their counsellors and with one another. Researchers have found that treatment of substance abuse in women must be integrated with treatment of trauma, domestic violence, childcare, parental care and all mental disorders (Covington, 2002; Lafave, Desportes & McBride, 2009; Taylor, 2010). Issues of childcare, pregnant women and child custody must also be considered when developing treatment services for women.

The UNODC (2018) posits that treatment services that include childcare, parenting classes and job training can yield positive results. Several researchers highlight that women need treatment that will attend to their special needs, and advocate for comprehensive, strengths-based, relational, trauma-informed and gender-sensitive treatment (Kissin *et al.*, 2013; Tang, Claus, Orwin, Kissin & Arieira, 2011). Despite the importance of treatment services tailored for women, as discussed in this section, women experience numerous barriers in accessing treatment. The barriers are outlined in detail in the next section.

3.4 BARRIERS TO ACCESSING SUBSTANCE ABUSE TREATMENT FOR WOMEN

Although there has been an improvement in women accessing substance abuse treatment, only a few women enter treatment compared to men because of a multitude

of barriers. These barriers are regarded as the biggest obstacle preventing women from entering treatment services and completing their treatment plan. Some of the barriers are shaped and predisposed by structural inequalities, such as poverty, racism and unemployment among women (Gueta, 2017). Feminist theory advocates for men and women to receive equal treatment (McAfee, 2018). This can be achieved by ensuring that all barriers are eliminated by amending policies, legislation, treatment services and treatment facilities, and equipping service providers with the necessary skills to help women with substance abuse. Gueta (2017) says that there are internal and external barriers associated with women seeking substance abuse treatment discussed next.

3.4.1 External barriers

Women who use, abuse and misuse substances are faced with different external barriers to accessing substance abuse treatment services. Below are some of the external barriers that hinder women from initiating treatment services.

3.4.1.1 Societal expectations concerning women

Referring agents such as registered counsellors, psychologists and social workers believe that cultural beliefs and practices have a negative effect on treatment seeking by women (Isobell *et al.*, 2015). Cultural beliefs, such as that women who use substances lack values, principles and self-discipline, hinder women from acknowledging that they have substance abuse problems. Ashley *et al.* (2003) say that society displays a punitive attitude towards women who use substances, since they believe these women are bad people who defy societal norms and beliefs. Societal expectations hinder women from exercising their constitutional right to access treatment services, and they thus are disadvantaged when compared with men when addressing their substance abuse problem. Consequently, progress in women seeking treatment is disturbed, since they fear being labelled as failures in marriage and raising their children.

Liberal feminists advocate for social change on behalf of women (Tong, 2001). Women are being denied the right to access substance abuse treatment due to their gender and role expectations within their family and society. Feminist theory challenges societal norms and values that oppress women, since they have the right to access substance abuse treatment services. Rasool (2019) shows that the feminist

perspective advocates for women to stand their ground and restore their integrity and self-worth in society by reaching out for help and taking control of their lives, rather than succumbing to societal abuse. This can also be achieved by raising awareness in society on the rights of women to access treatment and the societal roles of supporting these women.

3.4.1.2 Service providers' attitudes towards and beliefs about women

Service providers such as healthcare workers have been reported to have negative views of female drug users and show reluctance to work with them (Au, 2006). This disapproval of and unwillingness to be involved in helping people who abuse drugs has been identified among general practitioners and psychiatrists, through their attitudinal factors, occupational constraints, and a lack of motivation to learn about drug-related issues (Au, 2006). Isobell *et al.* (2015) add that referring professionals, such as registered counsellors, psychologist and social workers, appear to be judgmental towards service users based solely on their substance of choice. They judge the level of service user's motivation for change based on their substance of choice. Their personal beliefs influence and affect the treatment services they offer to the service users (Isobell *et al.*, 2015).

Myers *et al.* (2016) observe that service providers are labelled as being rude to women abusing substances by imposing their own values on these service users. The attitudes displayed to women by service providers are not the same as those towards men, since it is portrayed as normal for men to use substances. This discourages women from seeking treatment. Liberal feminism strives for women's rights to human dignity being upheld. In South Africa, women's rights can be upheld by service providers while rendering treatment services according to the Bill of Rights as stipulated in the Constitution of the Republic of South Africa (RSA, 1996). It is a basic human right for women to access treatment and it needs to be respected and protected. Thus, liberal feminists advocate for non-discrimination in treatment facilities by ensuring that facilities provide services that are inclusive of women and their special needs (Roberts *et al.*, 2000).

3.4.1.3 Service providers who lack skills and knowledge related to substance abuse

Most service providers within the substance abuse treatment field are not specialised in such treatment services and lack skills to treat service users in a proper way (Isobell

et al., 2015). They tend to fail to diagnose substance abuse problems during consultation with the clients and most service users miss the opportunity to be referred to substance abuse treatment services that are suitable for their problems. Isobell *et al.* (2015) further claim that there is a knowledge gap in stakeholders such as physicians, doctors, nurses, psychologists, etc., who lack the insight to identify people with substance abuse problems and do not know how to refer service users for substance abuse treatment. Slabbert *et al.* (2019) highlight that service providers working in treatment and prevention services for substance abuse lack training on how to treat service users in the field. Ashley *et al.* (2003) and Stone (2015) add that women fear to be labelled as substance abusers by medical practitioners, so they do not consult for substance abuse but instead present with a different medical condition to avoid substance detection in the body. Myers and Parry (2005) point out that uninformed service providers limit women from receiving information about the treatment options available to them.

3.4.1.4 Lack of family and social support

Women who abuse substances end up losing support from their families. Families and friends of women who abuse substances stigmatise, discourage and disapprove their decision to seek treatment. Women who use substances with their spouses or partners fear losing their partners if they opt to seek treatment, so they continue to use substances to keep their relationship (Taylor, 2010). Hecksher and Hesse (2009) confirm that families and friends of women who abuse alcohol support women who choose to deal with their substance abuse problem on their own than seeking for professional help for treatment. Women with children at childrearing age often have challenges of lack of support from families and without anyone to look after their children during the period of treatment and these influence their decision to seek for treatment (Hecksher & Hesse, 2009). This is not the case with men, who receive support from their families, friends and society. Women are discriminated against based on their gender and men are given support, since their substance abuse is normalised.

From a liberal feminist perspective, women with substance abuse problems should be acknowledged in families just as is the case with men (Roberts *et al.*, 2000). This can be achieved by empowering families and society with the necessary information about

substance abuse, its effects and the importance of their support in recovery to reduce their worry and for better treatment outcomes. MacMaster (2005) also confirms that women worry about their social support from friends after treatment and the challenges of making new friends. Pretorius *et al.* (2009) concur that significant others and family members may disapprove of women entering residential treatment or assist her with transport to outpatient sessions due to fear of disrupting the family system. In their study, Myers *et al.* (2016) found that there was a lack of family support for women who were attempting to change their lives by seeking treatment in contrast to men.

3.4.1.5 Stigma towards women who use substances

According to Covington (2002), stigma is identified as the main psychosocial issue differentiating substance abuse by men and women. Men drinking alcohol is regarded as normal in society, but the very same act is seen as conflicting with society's view of femininity and the roles of a woman. Women who use substances are labelled negatively and they end up internalising this stigma and feelings of guilt, shame, despair and fear when they are addicted to substances. This stigma and other threats of severe consequences of substance abuse often lead women and their families to minimise the effect of substance abuse by living in denial. Cormier *et al.* (2004) highlight that women experienced negative attitudes from members of society as a result of using substances and are stigmatised and called bad women.

Several authors have observed that, although both men and women have a similar level of substance abuse, women suffer more serious stigma than men since, in many cultures, they are regarded as defying traditional roles and expectations (Myers *et al.*, 2016; Slabbert *et al.*, 2019). Men have more opportunities to change their social circumstances, since their substance abuse is regarded as normal, and they are openly free to seek treatment knowing that they have the full support of society. Liberal feminists challenge the discrimination that exists between men and women, and demand that both are treated equally, as they experience the same problem (Radtke, 2017). Equal treatment is likely to encourage women to stand firm and work on their substance abuse problem without being ashamed of themselves.

Myers *et al.* (2016) found in their study that women who use substances are often mistreated by community members due to their use of alcohol and other drugs, which leads them to be hesitant to seek for treatment services due to fear of being exposed

as substance abusers. Society often imposes several norms and values to be practised, and any form of deviation is punishable. These societal gender inequalities have a negative effect on how women who use substances are treated in communities and in the healthcare system, and they often are excluded from opportunities that enhance their personal development. Thus, women need to learn to challenge stereotypical images portrayed by society by expressing their feelings regarding their substance abuse. However, Pretorius *et al.* (2009) explained that women abusing substances experience societal rebuke and poor support from their family members. The bad treatment they receive at home and within their society also affects their treatment initiation. Women with substance abuse problems often face stigma as a barrier to access treatment. Isobell *et al.* (2015) outline that pregnant women and those with child care needs are stigmatised as they start with their treatment application, since most treatment centres do not cater for their needs. This is a sign of pure discrimination of women based on their gender, and liberal feminism strives to promote services that cater for the needs of women, regardless of their position in the family and society (Roberts *et al.*, 2000).

3.4.1.6 Insufficient treatment centres that accommodate women

Under the apartheid system in South Africa, state-subsidised treatment facilities were unevenly distributed in urban areas and not all of them admitted female service users (Myers & Parry, 2005). People living in rural areas are still suffering the brunt of this setup, since they struggle to access treatment services. People living in rural areas continue to be disproportionately disadvantaged by a lack of basic services and underutilisation of available services when compared to urban contexts. This is exacerbated by the problem of fewer facilities, as clients in rural areas are more geographically dispersed with fewer public transportation options. Isobell *et al.* (2015) point out that treatment facilities (inpatient and outpatient) are often located in places where service users are not able to access them using public transport. This makes it difficult for women with young children to attend such services and they end up quitting due to poor support. Referring agents such as registered counsellors, psychologists and social workers are also located in central places, which limits access by service users and demoralises the service users, since a lot of compromise and effort is required to access treatment services (Isobell *et al.*, 2015). Most women will choose

to prioritise their household duties rather than making sacrifices and compromises to access treatment, since they have more responsibilities in the household.

It has also been highlighted that the available state-funded treatment facilities are not evenly dispersed, and this leads to service users being kept on waiting lists for a long period. Insufficient treatment centres affect everyone; however, it is seen as an added burden for women since they suffer from stigma, poor support and have special needs. Treatment seeking in rural communities may also lead to a lack of anonymity, since there are few facilities and lower probability of support groups (Pullen & Oser, 2014).

Due to insufficient treatment facilities, most service users wait long before admission to treatment facilities. Service users end up being placed on outpatient treatment services in anticipation of finding space in an inpatient centre and, within that period, it becomes difficult for service users to remain motivated and willing to receive treatment. Research has shown that, prior to approval for admission to the inpatient treatment centre, service users still must go through a waiting period for detoxification (Isobell *et al.*, 2015; Jackson & Shannon, 2012). MacMaster (2005) agrees that the time lag between the initial period when an individual decides to enter treatment and when treatment entry gets approved is a barrier to most service users (UNODC, 2018).

Moreover, Pretorius *et al.* (2009) observe that one barrier for women seeking treatment is the lack of treatment services that are sensitive to the special needs of women, such as childcare. The available treatment facilities were designed specifically for men and neglected women with substance abuse problems. However, the number of people using substances, including women, is escalating and the treatment facilities are not able to accommodate everyone in need of treatment. Feminist theory advocates for the inclusion and provision of treatment facilities for women, as they are also affected by substance abuse. When issues of insufficient treatment are addressed, equal allocation of resources for women in rural and urban areas will be safeguarded. This can be achieved by ensuring that treatment facilities maintain and develop the provision of opportunities for women to access treatment, even though there are insufficient facilities (Hossain *et al.*, 2016).

3.4.1.7 Financial barriers

Service users who lack financial resources are compelled to rely on state-funded treatment services, although they must incur travel costs to access referring agents at

outpatient sites (Isobell, 2015). Several scholars agree that many of these women are unemployed and from a poor background, so their financial constraints prevent them from accessing substance abuse treatment as they do not have insurance or medical aid to pay for treatment (Jackson & Shannon, 2012; Macmaster, 2005; Taylor, 2010). Women with insurance and medical aid often must wait for approval from their insurance or medical aid before they can access treatment services. According to Myers *et al.* (2016), many women present with a lack of money for transport to access treatment services as their barrier, since the treatment services offered are not comprehensive and they have to navigate separate departments to get effective treatment.

3.4.1.8 Lack of childcare services within treatment facilities

Single mothers are caught between seeking treatment to achieve sobriety and playing the mother role to their children (Isobell *et al.*, 2015). Green (2006) and Smith (2017) confirm that women are reluctant to leave their children to seek substance abuse treatment. Taylor (2010) and MacMaster (2005) agree that, because women are the primary caregivers of their children compared to men, they live in shame knowing that their substance abuse may lead them into losing custody of their children and therefore shy away from seeking treatment. Hence, women with children are likely to enter and remain in outpatient treatment centres that offer childcare services, since they do not have to worry about the wellbeing of their children while accessing treatment (Brown, Vartivarian & Alderks, 2011).

Moreover, women are more likely to have difficulty attending regular treatment sessions because of family responsibilities, including caring for their children due to the feminine role of motherhood. Ashley *et al.* (2003) argue that women are mainly given the responsibility of child rearing and it becomes difficult for them to seek treatment, since the centres do not cater for children's needs. Thus, mothers are at a disadvantage in receiving treatment due to motherhood. Based on liberal feminist view, treatment facilities should recognise special needs of women and develop treatment services that will be user friendly for women with children and other special needs. The theory assert that treatment centres should become sensitive to the special needs of women with young children, and that policymakers need to close the

gaps when developing policies and legislation to improve substance abuse services for women (McAfee, 2018).

3.4.1.9 Difficulty in accessing treatment centres that cater for pregnant women

Different authors are of the view that most inpatient treatment centres do not cater for pregnant women and their special needs (Hecksher & Hesse, 2009; Isobell *et al.*, 2015; Jackson & Shannon, 2012). Crawford *et al.* (2015) highlight that there are a limited number of treatment facilities that accept pregnant women, and those that accept them have criteria of admission that need to be met. Treatment centres that admit pregnant women firstly check how far the pregnancy is before they can admit these women due to limited resources to treat pregnant women with dependence at their facilities. Often, women do not disclose their substance abuse problem or deny it once confronted about it and may drop out of treatment after confrontation (Crawford *et al.*, 2015). The Centre for Substance Abuse Treatment (2015) adds that there are limited substance abuse treatment facilities that offer special treatment services for pregnant women. Over and above the general limitations imposed on treatment for women, pregnant women and those caring for young children are affected the most by these limitations (Centre for Substance Abuse Treatment, 2015).

According to Hecksher and Hesse (2009), pregnant women abusing substances encounter massive pressure to enter as well as comply with treatment. They live in fear of the continuous uncertainty of the harm they might have caused their unborn child, and pressure from their social environment to cease their use of alcohol and drugs. Most pregnant women who abuse substances deliberately avoid the treatment system and health services due to fear of being discriminated against and stigmatised by service providers such as nurses and social workers. Pretorius *et al.* (2009) highlight that pregnant women were found to be fearful to consult prenatal care to avoid being found to be abusing substances, and this is harmful for the baby. Pregnant women are discriminated against on the basis that they are women and are pregnant. Feminist theory advocates for better services for women regardless of their circumstances (Radtke, 2017). Cormier *et al.* (2004) raised concerns about the scarcity of supportive treatment services that cater for pregnant women. Therefore, there is a need to relook at the treatment facilities and policies to ensure that there are equal opportunities for everyone to get the best treatment services (Tong, 2001).

3.3.1.10 Discrimination against women with comorbidities

Most of the treatment centres' admission criteria are discriminating in nature, since they are strict towards people with different medical conditions, and it therefore is difficult for these people to access substance abuse treatment. Several authors concur that most women with substance abuse problems present with comorbidity of other psychiatric conditions, which impede their access to most treatment facilities because they require specialised expertise and most centres do not have this (Green, 2006; Isobell et al., 2015; Taylor, 2010). Women are required and recommended to consult a psychiatric hospital for treatment of their psychiatric condition and provide a psychiatrist's report to ensure their mental stability and assurance that they will benefit from substance abuse treatment (Isobell et al., 2015). Meanwhile, Green (2006) points out that the prevalence and severity of anxiety or depressive disorders among women who abuse substances prevents them from seeking help from substance abuse treatment facilities.

Taylor (2010) argues that women with PTSD and substance use disorders have poor treatment retention rates and outcomes. When these women enter treatment facilities, it is difficult to engage with them, to treat them successfully and to retain them in treatment, which limit their chances to access treatment. Another barrier identified by Taylor (2010) was that some of the substance abuse facilities are not equipped to deal with the mental disorders with which women commonly present and have little to no knowledge for integrating treatment for service users, which causes them to discriminate when providing services.

3.4.2 Internal barriers

Women have personal challenges that hinder their treatment initiation. Below is a discussion of internal barriers faced by women when seeking treatment. Liberal feminism strives to empower women to exercise their autonomy when dealing with their substance abuse problems (Jones & Budig, 2008).

3.4.2.1 Women's lack of motivation to change

Motivation to change is regarded as an important factor that leads to successful treatment outcomes. Lack of motivation by the service users is regarded as a barrier to treatment, since it is used to measure the seriousness to seek treatment (Isobell, 2015). Isobell (2015) further highlights that, even though the service user has been accepted by the treatment centre and has financial support, a lack of motivation becomes a barrier to effective treatment outcomes. Hecksher and Hesse (2009) point out that women present themselves with poor motivation for change because they attribute their problems to depression or stress, rather than substance abuse.

Moreover, MacMaster (2005) points out that a lack of desire for treatment and to stop using substances is also identified as the greatest barrier to seeking treatment services. Most women are reported to come up with excuses for not stopping to abuse substances, such as denial, not being ready for treatment, lacking motivation and believing that they are in control of their substance abuse. MacMaster (2005) further reports that several women who managed to access treatment services lacked the desire to stop using substances and did not take their treatment seriously.

3.4.2.2 Women denying their substance abuse

Taylor (2010) found denial to be a defence mechanism that protects women from the anxiety that tends to overwhelm them from time to time. It is easier to deny that an addiction problem exists than it is to admit there is a problem. Denying that a substance addiction exists is a natural first step to easing the pain of what life has become to an addicted person. Women who are dependent on drugs may not perceive that they have a substance abuse problem but are more likely than men to blame their substance abuse on issues that they are experiencing, such as stressful, emotional, psychological or physical health conditions.

Covington (2002) says that addiction causes women to tighten their circle, constricting their lives until it completely focuses on drugs. They then hide their substance abuse, protect the supplier and hide their addiction from everyone, and their life revolves around drugs. The process of accepting that they have lost control to drug addiction can be humiliating. Women end up living a double-standard life, which inflicts more shame. Furthermore, society stigmatises men for their addiction, but rarely attacks

their sexuality or competency as parents, which increases women's denial of substance abuse.

3.4.2.3 Fear of seeking treatment

Women with substance abuse problems experience fear of seeking treatment services because they do not know what to expect, and their fear of being judged reduces their chances to enter or accept treatment (Jackson & Shannon, 2012; MacMaster, 2005). Myers *et al.* (2016) argue that women who abuse substances are ashamed and fear that someone they know will see them while accessing treatment. Due to a lack of insight of what treatment is all about, women often assume that they are being institutionalised in a psychiatric hospital and decide not to peruse the application for treatment. Several authors concur that women lack information about treatment options available for substance abuse and the procedures to access such services, which hamper their efforts to seek treatment (Green, 2006; Isobell, 2015).

3.5 CONCLUSION

This chapter has focused on an overview of substance abuse treatment for women, exploring the accessibility of treatment, processes and procedures followed to access treatment, and the role of social workers. The internal and external barriers women face when seeking substance abuse treatment services were explored from a feminist perspective. Feminist theory advocates for women's rights to be treated with respect and dignity when they reach out for help with their substance abuse problems. Feminist theory also strives for equal access to treatment by men and women to eliminate the barriers women encounter when they reach out for help, such as stigma, poor support and negative attitudes. The next chapter focuses on the empirical findings of the study.

CHAPTER 4

AN EMPIRICAL INVESTIGATION OF SOCIAL WORKERS' PERSPECTIVES ON BARRIERS TO ACCESSING SUBSTANCE ABUSE TREATMENT FOR WOMEN IN LIMPOPO PROVINCE

4.1 INTRODUCTION

This chapter focuses on the third objective of the study, which was to investigate social workers' perspectives on barriers to accessing substance abuse treatment by women in Limpopo province. Chapter 2 focused on the prevalence of substance abuse and the effects of drug abuse on women. Chapter 3 focused on the barriers women face when seeking substance abuse treatment. These two chapters guided the researcher towards the empirical study. The findings are discussed in themes, subthemes and categories.

4.2 RESEARCH METHODOLOGY

This section presents a brief overview of the methodology used in this study. It focuses on the research sample, research approach and design, as well as the data collection and analysis. The in-depth information on the methodology used in the study is found in Chapter 1.

4.2.1 Research sample

The sample of the research comprised of 20 participants. Participants were all social workers employed by the Department of Social Development in Limpopo province as coordinators of substance abuse programmes in various local municipalities in the province. All participants had a minimum of one year in the field of substances and had coordinated the substance abuse programme for a year. Non-probability purposive sampling was used to recruit the participants. The sampling method focused on the participants with the most characteristic, representative or typical attributes of the population that served the purpose of the study best (Strydom, 2021).

4.2.2 Research approach and design

The researcher employed a qualitative research approach with an exploratory and descriptive research design. Creswell (2014) argues that a qualitative research

approach seeks to explore and understand the meaning individuals or groups ascribe to a social or human problem. A qualitative research approach with an exploratory and descriptive research design was used since it was helpful in obtaining the data that answered the research question effectively. The perspectives of social workers on the barriers women face in accessing substance abuse treatment in Limpopo province were explored and described in this study.

4.2.3 Data collection and analysis

A semi-structured interview guide was used to collect data. Schurink *et al.* (2021) maintain that semi-structured interviews allow considerable flexibility in scope and depth. Telephone interviews were suitable for this study, since the country was under lockdown due to COVID-19 and social distance was recommended to ensure participants' safety when conducting interviews. Participants were given an opportunity to choose the date and time convenient for them to do the telephonic interview. The researcher conducted the interviews to ensure the authenticity and effectiveness of the data collection process. Even though the researcher was familiar with the context under discussion, as she had coordinated substance abuse programmes before, she was able to withhold her perceptions and beliefs on the matters discussed and avoided interfering with the participants' views.

Schurink *et al.* (2021:391) define data analysis "as the process of bringing order, structure and meaning to the data collected". Data analysis involves reducing large volumes of raw information, sifting significant from irrelevant information, identifying significant patterns and subsequently constructing a framework that allows for communicating the core of the key findings. The researcher used thematic analysis to identify, analyse and report patterns within the data. Thematic analysis was used to report the experiences, meanings and reality of the participants (Braun & Clarke, 2006). The data were then categorised, allocated to themes and sub-themes, classified into patterns and organised in a systematic and coherent manner, with key findings being compared to the existing literature (Babbie, 2010).

4.3 PARTICIPANTS' DEMOGRAPHIC INFORMATION

The table below illustrates the profile of the participants, followed by the data analysis and interpretation. These biographic profiles of the social workers include years of

experience as a social worker, their gender, number of years as a substance abuse coordinator and the municipality they work in.

Table 4.3: Participants' demographic information

Name	Years of experience as a social worker	Local municipality	Years of coordinating substance abuse programme	Gender
Participant 1	10	Mokgalakwena	5	Female
Participant 2	12	Thulamela	5	Female
Participant 3	12	Lephalale	7	Female
Participant 4	9	Maruleng	1	Female
Participant 5	7	Polokwane	1	Female
Participant 6	12	Mokgalakwena	7	Male
Participant 7	10	Belabela	2	Female
Participant 8	12	Tubatse	4	Female
Participant 9	9	Maruleng	3	Male
Participant 10	10	Polokwane	5	Female
Participant 11	10	Giyani	7	Female
Participant 12	13	Letaba	6	Female
Participant 13	10	Musina	6	Male
Participant 14	10	Polokwane	3	Male
Participant 15	13	Polokwane	6	Female
Participant 16	8	Tubatse	3	Male
Participant 17	9	Tzaneen	5	Male
Participant 18	10	Thulamela	6	Female
Participant 19	15	Tzaneen	15	Female
Participant 20	7	Fetakgomo	6	Female

The demographic information shows that 20 registered social workers participated in the study. The study also shows that most of the participants were females, because social work is a female-dominant profession (Van der Westhuizen, 2010). All participants had more than five years working experience as social workers, and most

of them had been coordinating substance abuse programmes for more than five years, which shows that they are experts in the field and their cumulative years of experience provided depth in the study. The findings also show that participants had sufficient experience as social workers to work with cases of substance abuse. Through their practicing experience, participants had broad knowledge and skills in the field of substance abuse, as they were assigned specifically to focus on substance abuse prevention, early intervention, referral to treatment centres and the rendering of aftercare and reintegration.

The Limpopo province comprises 22 municipalities, of which 13 were represented in this study. The researcher planned to interview participants from 20 municipalities, but some of the substance abuse coordinators no longer worked in the same place in the district, some did not consent to participate, some focused on other programmes in the department, while others were no longer working for the department. The researcher used participants from various municipalities in Limpopo to allow the study findings to be relatable to other municipalities with a similar context. The participants were from 13 municipalities across Limpopo, viz. Mkgalakwena, Tubatse, Mankweng, Polokwane, Tzaneen, Giyani, Letaba, Maruleng, Lephalale, Musina, Fetakgomo, Belabela and Thulamela. The municipalities are situated in rural, semi-rural and semi-urban areas. Different social workers' perspectives from the municipalities were gathered based on their context to add credibility to the study.

4.4 PRESENTATION OF THE EMPIRICAL FINDINGS

This section focuses on a discussion of the empirical findings of the study. A total of six themes emerged, namely prevalence of substance abuse among women (Theme 1), effects of substance abuse on women (Theme 2), nature of treatment services available for women with substance abuse problems (Theme 3), accessibility of treatment services (Theme 4), the role social workers play in assisting women to access substance abuse treatment services (Theme 5) and, lastly, barriers women face in accessing substance abuse treatment services (Theme 6). The themes, sub-themes and categories are discussed as shown in Table 4.4.

Table 4.4: Schematic presentation of the themes, sub-themes and categories

THEMES	SUB-THEMES	CATEGORIES
1. Prevalence of substance abuse among women	Types of substances women commonly use	
	Reasons women use substances	<ul style="list-style-type: none"> • Domestic violence • Peer pressure and a need for belonging • Frequent social gathering • Substances easily accessible and affordable • Relief of stress and depression • Unresolved childhood trauma • Boredom
2. Effects of substance on women	Effects of substance abuse on children	
	Health effects	
	Psychological effects	
	Financial effects	
	Interpersonal relationship problems	
3. Nature of treatment services available to women with	Prevention services	

substance abuse problems		
	Early intervention	
	Inpatient treatment services	
	Outpatient treatment services	
	Aftercare and reintegration services	
4. Accessibility of treatment services	Processes and procedures that women need to follow to access treatment	
	Opportunities between men and women in accessing substance abuse treatment	
5. The role social workers play in assisting women to access substance abuse treatment services	Identification of women with substance abuse problems	
	Challenges faced by social workers when identifying women with substance abuse problems	
6. Barriers women face in accessing substance abuse treatment services	Internal barriers	<ul style="list-style-type: none"> • Lack of motivation to seek treatment • Fear of being stereotyped by society • Fear of losing custody of children • Poor support from family and significant others
	External barriers	<ul style="list-style-type: none"> • Lack of collaboration between stakeholders

		<ul style="list-style-type: none"> • Strict admission criteria • Insufficient treatment centres in Limpopo province • Lack of resources • Limited substance abuse training for service providers • Financial constraints
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4.4.1 Theme 1: Prevalence of substance abuse among women

Under this theme, two sub-themes emerged, namely the types of substances women commonly use and the effects of substance abuse on women. Participants were asked about their perspective on the prevalence of women abusing substances in their municipalities. The participants stated that they had observed a high prevalence of women who used substances in the municipalities. The participants argued that, despite the high number of women abusing substances, only a low number of cases were reported of women with substance abuse problems. Some participants pointed out that they had never assisted women with substance abuse-related problems, and they had never seen one consult their office. Women often become victims of the fear of stigmatisation and labelling and therefore do not want to admit their substance abuse problem, and some women join society in judging and stigmatising others. Stevens *et al.* (2009) concur that women increasingly use substances secretly, since society disapproves of their use. The above is supported by the quotes below:

To tell you the honest fact I haven't received any single case for a woman who come to my office seeking for help with problem of substance abuse (Participant 11).

Since I have been coordinating, I have worked with one woman in 2015 and two women that I have treatment centre recently in the past 3 months (Participant 15).

The participants' observations of low numbers of cases being reported to their offices do not necessarily mean that women do not have substance abuse problems but can also mean that women have normalised the use of substances and do not see a problem. The participants observed that cases of women who abuse substances are most likely to be reported in the form of cases for child neglect, misuse of grants and marital problems, which need social workers to probe in order to identify the real problem. This is reflected in the following quote:

Almost on our daily basis we encounter such challenges but it doesn't come directly to our offices as reported that women are abusing substances there are a lot of family problems that are reported in the families and when we make follow ups trying to find out the causes of the problem, sometimes we happen to find out that the mothers or wives at home for certain husbands use those substances that's where a lot of family problems start most of the time (Participant 17).

The participants strongly believed that women are shy to admit their substance abuse problems due to the stigma around them. The participants remarked that women are trained to suppress their feelings due to the societal belief that women are strong, and that substance abuse is for men, so they hide their addiction to appear to be good women. The participants also pointed out that women were ashamed of their substance abuse and, as a result, they feared being labelled barbarians by the community members, who view it as taboo for women to use substances. The participants' views below correlate with the findings of Khajedaluee *et al.* (2015), that it is taboo for women in the Islamic Republic of Iran to use substances, hence they hide their use.

Women actually are not supposed to be drinking alcohol and using drugs, so it seems like you are a loose woman, you are not taking care of yourself, you are the kind of woman who don't have dignity so that is why they do it secretly (Participant 11).

Like I said those women think issues of substance abuse is a male problem they don't see themselves with substance abuse problem or as a problem that needs professional help (Participant 7).

Stevens *et al.* (2009) state that most women who were identified with substance abuse problems never received treatment, since they never sought help. This was also demonstrated by the participants' views that, in the communities they serve, a lot of women abuse substances but do not seek help, hence they hardly have records of women in their offices. A study conducted by Dada *et al.* (2018) in Cape Town, South Africa supports the participant's observation that there is an increase in the prevalence rate of women using substances. However, the same study proves that there has been an increase in the number of women accessing treatment services in Cape Town. The study also revealed that most of the cases were identified by social workers during their intervention in cases such as poor care for children, disorganised family, uncontrollable children, children dropping out of school, misuse of grants and having loan debts, which are reported regularly by concerned family members, teachers and other stakeholders. The UNODC (2014) supports the findings that, when women abuse substances, it results in symptoms such as an increased number of social ills, health problems and economic crises, which are identified through the cases reported by their loved ones. Thus, the findings of this study correlate with existing research which show an increase in the prevalence of women abusing substance, as observed by the participants, and the types of substances commonly used by women are discussed next.

4.4.1.1 Types of substances women commonly use

The study found that the choice of substance use differs in each municipality, as it depends on the availability, accessibility and affordability of that substance in the area. All participants confirmed that the substance used most by women in their municipality is alcohol, including home-brewed alcohol called "Umqomboti" and "Thothotho". A study conducted by Makhubele (2011) confirms that there is over-consumption of homemade alcohol in Limpopo province. Greenfield *et al.* (2010) concur with the participants that women commonly use alcohol to self-medicate their problems. Moreover, Greenfield *et al.* (2010) show that there is increased use of methamphetamine and heroine by women. This was remarked by some of the participants. Some of the substances the participants identified as commonly used by women were snuff, nyaope, cannabis, nicotine, stilpane, heroin, crystal meth, ngoma (mixture of dagga and cough syrup), over-the-counter medication, glue and painkillers.

The Centre for Substance Abuse Treatment (2015) confirms that women commonly use prescription drugs with addictive properties.

They mostly use alcohol, dagga, pain killers and nyaope (Participant 5).

We have assisted most women who drink alcohol, using snuff and those who engage in nyaope (Participant 1).

They mostly engage themselves in alcohol and dagga sometimes, those are the two common types that I am aware of (Participant 14).

Although participants identified alcohol as the substance of choice for most women due to easy access and affordability, a study done by Dada *et al.* (2018) shows that women commonly use more than one substance. The study further outlines that home-brewed alcohol is easily accessible, readily available, socially acceptable and affordable, especially for selling, sociocultural activities and religious purposes. This was confirmed by Manganyi (2015) who indicates that home-brewed alcohol is commonly made by older women for sale in order to sustain their families, which makes it more accessible as it is brewed frequently. Therefore, it can be deduced that alcohol is commonly used by women due to its low cost and easy access.

4.4.1.2 Reasons women use substances

The participants were asked to share their views on the reasons why women use substances.

a) Domestic violence

The participants hold the view that most women who are victims of domestic violence end up using substances to deal with the effects of violence in their lives. According to the participants, women use substances to deal and cope with their experience of traumatic events such as rape, assault, intimate partner violence and incest.

They use alcohol for pleasure, because they are from domestic violence relationship, stress, divorce or separation and some for status (most expensive and current beverages) (Participant 1).

Another contributory factor could be marital and family problems at home, domestic issues and the issue of not being where they want to be in life as they compare themselves with their peers (Participant 5).

Most of the time it's stress and curiosity because most of women we have interviewed are from abusive relationships and domestic violence relationships (Participant 1).

The participants' views reveal that women experiencing abuse in intimate relationships find comfort in the use of substances. Even though only few participants identified domestic violence as one of the reasons women use substances, a study by Levenson and Grady (2016) proves that children who were unable to deal with domestic violence that caused them to be anxious and experience painful emotions found comfort in substance abuse later in life. Arpa (2017) and NIDA (2018) add that women who are victims of domestic violence perpetuated by their intimate partners are seen to suffer from substance use disorder. The UNODC (2018) also says that women who abuse substances report a high rate of domestic violence. The findings show that women who experience domestic violence fail to find better ways to deal with the bad experience and end up self-medicating their feelings with substances to numb the pain. This is reflected in the following quotes:

Women being in an abusive relationship instead of getting out of that issue and relationship seeking help they find comfort in using substances to suppress the pain of the experience of what they are going through (Participant 4).

Family problems, some are always fighting with their husbands, some dysfunctional families so some if they don't get professional assistance, they end up eventually doing this kind of things (Participant 9).

Covington (2002) concurs with the participants' views that women who stick around in abusive relationships use substances to numb the pain they endure. Participants also confirmed that staying in an unhappy and unhealthy relationship where there is infidelity also contributes to substance use initiation for women. The findings show that women who feel threatened, unsafe and unimportant in a relationship becomes vulnerable, so they use substances to make themselves feel better.

b) Peer pressure and a need for belonging

The participants' view was that women use substances because they are easily influenced by their peers and friends, and to feel a sense of belonging and have a

social circle to which they can relate. It was also highlighted that women use substances to boost their self-esteem and be part of the trends.

Peer pressure, the kind of friends you socialise with also contribute to using substances (Participant 4).

I'll say some of them it's for pleasure and peer pressure (Participant 7).

Other issues for young women would be peer pressure, seeking to belong to a certain group, nowadays we have slay queens so they want to belong to the category of slay queens, and they use certain drugs so that they belong to those groups (Participant 15).

The findings show that women succumb to peer pressure and want to appear relevant to their peers. They end up forming affiliations with social groups that have a common goal to fulfil and have certain standards to be maintained, some of which require using certain kinds of substances to be accepted (Namadi & Haruna, 2019).

c) Frequent social gatherings

The participants pointed out that there were an increasing number of social gatherings in communities frequented by women where there was easy access to free alcohol. Women use substances in order to be seen relevant within their social circles, such as “Xiseveseve”, which is a social gathering of women with their friends characterised by traditional dances, the exchange of gifts and excessive alcohol intake to celebrate certain events.

The issue of stokvel in our community we have prevalence of stokvel such as Xiseveseve, so they spend their leisure time doing those things so there is too much alcohol available in those gatherings (Participant 19).

There is also a tendency of too much parties in this community like you find that there is unveiling of tombstones, baby showers, birthday parties, weddings actually there is an event every weekend and alcohol is available in those they even have stokvel of buying alcohol for one another during those events, you find that each person have to buy 24 when there is a particular event so you find that alcohol is very much available and too much for a particular event

which takes place in each and every weekend so that's why there is this peer pressure for wanting to belong to those groups (Participant 19).

I think social clubs contribute, this gathering (in Xitsonga Xisevese) they drink there when they gather (Participant 6).

These findings agree with the study conducted by Makhubele (2013), which shows that homemade alcohol is used mainly for social and religious occasions by elders. Although there has been a decrease of social gatherings due to COVID-19 restrictions, given that family members were allowed to gather at a limited number in accordance with the regulations, women still got access to alcohol.

d) Substances easily accessible and affordable

The participants highlighted that women socialise in places where they can easily access their substance of choice and with people who are able to provide substances for them. One participant confirmed that in Tubatse Municipality, they have a lot of mining industries where most employees are men who do not mind buying substances for the women they socialise with. Another participant pointed out that dagga is very accessible, as it can grow easily when planted in the backyard and women can brew homemade alcohol by themselves. They also emphasised that traditional beer and snuff are affordable, as these are sold for lower prices. Participants claimed that snuff is cheap and easy to make.

It's normal for a woman to go to a pharmacy and complain of pains and they give them pain killers so it easy to access them (Participant 5).

What I have noticed is that in Maruleng each and every village has more than two to five beer lounges where they sell alcohol, the availability of this alcohol, thothotho and cigarettes are the reasons women use these substances (Participant 9).

The traditional beer everybody can make it and it's the most accessible one because it's cheap everybody can access it even when you have R10 you can buy it. You can drink and get your marijuana from the back of your house, so their day gets to be very well because it seems they spend it very well with those two substances (Participant 17).

The findings show that both licit and illicit substances are easily accessible by women. It was also found that women are more likely to consult pharmacies to purchase over-the-counter medication, which they use without diagnosis and prescription and can result in dependence. Substances such as home-brewed alcohol and dagga are deemed accessible and affordable within municipalities, and they either plant, brew or purchase these at a reasonable price (Manganyi, 2015).

e) *Relief of stress and depression*

The participants' point of view was that women use substances to cope with stressful and depressive experiences.

Women use substances as a way of suppressing their hidden emotions of what they go through daily for instance you find a woman being in an abusive relationship instead of getting out of that issue and relationship seeking help they find comfort in using substances to suppress the pain of the experience of what they are going through (Participant 4).

I think stress is one of the common causes of family disorganisation (Participant 20).

They were trying to manage the stress using substances (Participant 20).

Kissin *et al.* (2013) confirm that women use substances to deal with stressors and their depressed mood. Slabbert *et al.* (2019) add that women are at a high risk of developing substance use disorders, as they use substances to cope rather than visiting healthcare services. Women are reported to often self-medicate with substances when they are faced with psychological problems, hoping these will go away rather than seeking professional help. Lee and Boeri (2017) confirm that most women who suffer from emotional and psychological difficulties such as depression and social stress self-medicate with drugs.

f) *Unresolved childhood trauma*

The participants identify that women who have experienced rape in the past indulge in substances due to poor support and failing to get over the experience.

We have a lot of people who have been abused sexually especially females, the case was never reported in some communities they all think that if a person

has raped a person and give them R200 its fine but it's damaging the mind of a person who has been abused because that person has never visited the social worker's office for counselling (Participant 2).

Some they experience traumatic experiences like rape, so they use substances to comfort themselves (Participant 15).

Arpa (2017), Greaves *et al.* (2006) and Taylor (2010) concur that women who have suffered from traumatic experiences such as incest, sexual and physical abuse tend to resort to substance use. The findings show that women go through a lot of traumatic experiences but do not receive professional help, since no one encourages them to seek help. Society has normalised rape to such an extent that women fear to seek help and resort to substance abuse to escape the feelings of being violated.

g) Boredom

Participants stated that women who drop out of school and are unemployed have more time to themselves to do nothing. They therefore end up being bored and entertain themselves by using substances to socialise and pass time.

I can say boredom is one of the contributory factors because when they are bored, they call somebody to say let's do this and that and majority of households in Musina are child headed families it means they have space to do these things privately (Participant 13).

Sometimes boredom, people just want to keep themselves busy and they think using substances is the other way to keep yourself busy (Participant 17).

The participants highlighted that most women find themselves bored due to limited job opportunities which contribute to substance abuse. The findings show that some women who have more time to themselves resort to using substances when they are bored. Existing research has also found that boredom is one of the contributory factors for women to abuse substances and it leads to long-term consequences, such as dependence and focusing on less important things in their lives (Myers *et al.*, 2016; Taylor, 2010).

4.4.2 Theme 2: Effects of substance abuse on women

Participants were asked to identify the effects of substance abuse on women. Five subthemes are discussed under this theme.

4.4.2.1 The effects of substance abuse on children

The participants were of the view that the abuse of substances by women contributes to social ills, such as neglecting and abusing their children, and they are at increased risk of being raped and trafficked. They end up being violent to their children and are reported to the social worker's office for the neglect and abuse of their children.

You may find out that they go to parties and taverns leaving the children alone and when they come back you may find out that those children got raped and some get killed because their parent were not even available (Participant 11).

It affects them in many ways because some of them end up neglecting their kids some of them end up abusing their kids (Participant 3).

Their children go to school dirty, there is always complaints from teachers that the children are not well taken care of, the reason are the same as the above that I have mentioned that the children are uncontrollable, they are involved in behaviour that lead them to be in conflict with the law at the young age because they want food and to survive, they drop out from school (Participant 19).

Those whom we have observed are being declared as unfit mothers, they abuse their children physically, emotionally and financially (Participant 8).

Daley (2014) and Ovens and Prinsloo (2018) support the participants' views that many women fail to fulfil their roles as mothers to their children due to substance abuse. The participants also say that most women who do not admit their substance abuse problem get reported to the social worker for neglecting their children, and some children end up being placed in the Child and Youth Care Centre, as they would be declared in need of care and protection. Donohue (2004) and Ovens (2010) confirm that women who abuse substances practise inconsistent parenting styles, which disturb the developmental stages of the child and hence these mothers end up being declared unfit mothers. This is a result of mothers abusing their children physically, emotionally and financially, and constantly being absent from their lives to provide for

their basic needs. These women are reported to be unable to care for their children and fail to notice when their children have problems as they focus on their personal needs of feeding their cravings (Gruber & Taylor, 2006).

The participants also observed that children perform poorly at school due to poor support and lack of guidance, and some end up being street kids because they feel that no one cares. Children lose respect for their mothers due to the disrespectful behaviour displayed while they are intoxicated. As a result, children are forced to mature fast and take care of their mothers, who cannot take care of themselves and their siblings. Having said that, feminism strives for equality and balance between men and women by challenging societal norms and expectations in terms of gender roles. This is important to protect children whose mothers are seeking treatment services and to encourage fathers to step in to look after their children (Baehr, 2017).

4.4.2.2 Health effects

Women are vulnerable to different kinds of STIs and unplanned pregnancy because of the risk of engaging in unprotected sex while under the influence of substances. Women who abuse substances while they are pregnant expose their unborn child to foetal alcohol syndrome, which can also lead to miscarriage (Gunasekara, 2012).

“Women who are using substances have got children and some use it while pregnant and the children end up developing foetal alcohol syndrome (FAS) (Participant 6).

Some of them have protected sex and some unprotected sex the results could be teenage pregnancy and HIV/AIDS to some of them (Participant 17).

They are at high risk of health issues such as contacting STIs, for those who are pregnant end up giving birth to children with foetal alcohol syndrome, stillborn, having unwanted pregnancies, miscarriage, changes in menstrual cycle (high or low volume), when its high it causes more health risk especially for those using dagga and snuff usually their menstrual cycle changes so they will report such cases, having suicidal thoughts since they are coming out of broken/dysfunctional relationships wherein they lose partners through divorce and custody of their children (Participant 1).

According to Jackson and Shannon (2012), pregnant women who use substances expose themselves and the unborn child to health risks. Daley (2014) adds that children born from women who abuse substances are at high risk of developing neonatal abstinence syndrome. Greenfield *et al.* (2010), McCabe *et al.* (2014) and Myers *et al.* (2016) concur with the participants' views that women who abuse substances are vulnerable to contracting sexually transmitted diseases due to their engagement in risky sexual behaviours under the influence of substances.

The participants' remarked that women with substance abuse problems find it difficult to maintain their physical appearance, have poor hygiene and develop "phuza" face. Phuza face is when the skin develops defect especially on the face caused by alcohol and dehydration from low water intake. They also highlighted that their speech gets affected when they are intoxicated.

Some they end up not looking very well, you find that their age is young, but the appearance is like an old lady born in 1920 (Participant 6).

They at times find it difficult to maintain their personal hygiene, again changes in behaviour patterns and they also experience slurred speech when under the influence (Participant 14).

Gunasekara (2012) show that excessive use of alcohol by women increases their risk of breast cancer, reduced fertility, unplanned pregnancy, sexually transmitted diseases, heavy or irregular periods and cessation of periods, and during pregnancy increases the risk of miscarriage, stillbirth, low birth weight and premature birth. The findings show that women with substance abuse problems run a high risk of medical conditions that will require intense treatment. Thus, women who abuse substances are more vulnerable to health effects compared to women who do not abuse substances.

4.4.2.3 Psychological effects

Women who abuse substances to cope with life stressors are vulnerable to suicidal thoughts and attempts while intoxicated. They suffer from low self-esteem due to the stigma around their abuse of substances. They also suffer depression and unstable moods, as they abuse substance as a coping mechanism (Greenfield *et al.*, 2010; UNODC, 2018). Participants shared the following views.

It makes them to be at high risk of suicidal thoughts since substance makes them not to think clearly, low self-esteem (Participant 1).

Psychological wellbeing, they are emotionally unstable, brain damage which lead to mood changes and those are the effects I believe substances have on women (Participant 9).

The Centre for Substance Abuse Treatment (2015) and Cormier *et al.* (2004) also assert that the use of substances by women contributes to their inability to defend themselves against the strong urges of suicidal ideation and attempts. However, studies by Back *et al.* (2007), Cross *et al.* (2015) and UNODC (2018) show that women with substance use disorders suffer from personality disorders more so than women who do not use substances. The findings show that women with psychological problems are not receiving professional help and are vulnerable to self-medicating with substances to feel better. The use of substances does more harm to them than their intended goal of treating the psychological problems.

4.4.2.4 Financial effects

Women with substance abuse problems are more likely to have financial problems in providing for their families and maintaining their substance abuse habits. As a result, they misuse the child support grant that was meant to look after the children. Khosa and Kaseke (2017) also prove that many women who are recipients of the child support grant misuse the grant by gambling and purchasing alcohol. This was confirmed by participants' perspectives.

High risk of economic effects since most clients are receiving social grant and use the money to support their habits, children suffer and end up with more depts. Since their SASSA cards are taken by the loan sharks (Participant 1).

Some of them might even lose their jobs (Participant 2).

Another effect is, it has caused especially young women to engage in gambling (playing cards) (Participant 4).

Donohue (2004) concurs with the participants' views that women who abuse substances run a risk of losing their jobs and struggling to maintain their families and substance abuse habits. The participants observed that women find themselves

borrowing money from a loan shark to provide for their families and end up failing to repay the loan. Khosa and Kaseke (2017) also found that to redeem themselves from their debt, women end up gambling with the little they get, hoping to make more to maintain their substance abuse habit and their families. The findings show that families of women abusing substances suffer financially due to their mismanagement of the money that was meant to look after the family, such as the child support grant.

4.4.2.5 Interpersonal relationship problems

Evidence shows that couples who abuse substances together experience marital breakdown, relationship breakdown, family disorganisation and divorce. Gruber and Taylor (2006) add that abuse of substances in families has a negative effect on the family interaction patterns, causes division between family members and leads to loss of respect from extended family members. The family members also suffer stigmatisation by society and lose respect. Family members begin to blame each other for their loved one's use of substances, which causes chaos.

Because I have worked with those with families their use of alcohol and substances made their families to be even more disorganised, because at first, they used substances because there is disorganisation the family, so they were trying to manage the stress through the use of substances but in return the disorganisation even became more worse (Participant 20).

They affect them, there is disorganisation in the family and their families are not happy there is too much instability (Participant 19).

Daley (2014) and the UNDCP (2002) share the same views as the participants that, when women abuse substances, their family suffers a great deal. Women are seen as family builders, so when they abuse substances everyone in the family loses trust in their capabilities to keep the family together. Daley (2014) adds that family members must also deal with shame and guilt perpetuated by substance abuse. The findings show that women are viewed as pillars in their families, so their use of substances affects the perception of their family members and instils doubt in their ability to sustain their roles in the family. However, liberal feminism challenge societal beliefs and practices about the role of women in the family and encourage a balance between partners or family members in relation to family responsibilities. This would give women time to work on their substance abuse problems without carrying the burden

of looking after the family (Hossain *et al.*, 2016). Therefore, social workers need to ensure that both men and women receive support should they enter treatment to create a balance between the genders.

4.4.3 Theme 3: Nature of treatment services available for women with substance abuse problems

The participants were asked about the kind of intervention programmes and treatment services available for women within their municipalities. The participants pointed out that there were no standardised treatment services for women. However, social workers make use of available treatment services and intervention programmes such as prevention, early intervention, referral to inpatient or outpatient treatment services and aftercare and reintegration services depending on the severity of the problem. The participants also believe that there are no formulas of rendering substance abuse services to women, but that it is important to identify the stage of substance abuse a woman is in to determine suitable treatment services. They demonstrated that service users receive treatment based on their level of substance abuse, whether experimentation, social use, regular use or addiction.

We don't have specific programmes that this are specific for women who are abusing alcohol, we just juggle around and see what can come out and put them together (Participant 8).

I don't know any programme that is targeting only women or that is gender based but we have programmes such as outpatient and aftercare, but I don't know of the one that are designed specifically for women, I'm not aware of any (Participant 13).

Some of the participants remarked that the Department of Social Development (DSD) does not have programmes for women because women are not seeking help.

Women are not coming out to seek help, so I think even the department (DSD) do not see a need to implement or develop a programme which is specifically designed for women to utilise as they are not actively coming to our offices to seek for help (Participant 11).

In my municipality we don't have programmes per se but in the department (DSD) I would say we have individual outpatient sessions; life skills

programmes can be done if a woman is identified to be using substances but honestly it doesn't work (Participant 4).

Except for one-on-one therapy or counselling I don't think we have specific programmes designed for women (Participant 18).

From participants' views, it can be inferred that due to the accessibility of generic services rendered by social workers daily, social workers focus mainly on what they can offer, such as behaviour modification, family preservation and social support, and neglect issues of substance abuse. The findings show that a holistic intervention that addresses substance abuse among women will help a great deal to assist women to deal with their problem. In contrary, the UNODC (2015) claims that gender-specific treatment services help improve the treatment outcomes for women.

Although the Department of Social Development does not have specific treatment services designed for women, the following services, which are in accordance with the Integrated Service Delivery Model (DSD, 2006), are generally offered to all service users who seek help.

4.4.3.1 Prevention services

The participants indicated that they rendered prevention services as stipulated in the IDSM. The purpose of rendering prevention services is to strengthen and build the capacity and self-reliance of the service users and minimise future risky behaviours (DSD, 2006). The participants argue that prevention services are rendered to all age groups, including youths and adults, and the main purpose is to raise awareness of the dangerous effects of substance abuse.

The participants also highlighted that they present awareness campaigns, imbizos and mass meetings targeting communities to conscientise women about the danger of substance abuse. Social workers also facilitate anti-substance abuse awareness campaigns in places such as shopping centres where a lot of people can be reached.

Up to so far, I cannot say we are having programmes in order because we are just doing prevention for eighteen and above where we talk about substances but there are no specific programmes meant for women its generalisation (Participant 8).

The participants emphasised that they use media platforms to raise awareness and share information on the available services for people with substance abuse problems. During these prevention services, women are educated about the effects of substance abuse, where to get help and how to get help.

Prevention programmes in most cases that's what we do, we do render campaigns around substance abuse, we do give pamphlet's when they are available, they are not always available but when they are available that's how we do send messages about substance abuse (Participant 12).

Actually, women are the ones who mostly attend our campaigns or events whenever we call them unlike men (Participant 19).

The findings reveal that awareness campaigns are conducted in schools and community meetings. Although the campaigns target every person who attends the event, women are mostly reached in these campaigns. However, due to COVID-19 regulations and restrictions in 2020, social workers were unable to do prevention services in schools and communities.

4.4.3.2 Early intervention

The ISDM (DSD, 2006) defines early intervention as services that are rendered after one is identified to be at risk and entails developmental and therapeutic treatment services before the problem escalates and requires statutory services. The participants pointed out that they offer counselling sessions to women with substance abuse problems and address issues that may have contributed to substance abuse, such as family problems and domestic violence. The therapeutic sessions are conducted in the form of family therapy, individual sessions, support group sessions, and psychosocial and psycho-educational assistance to empower women.

What we normally do in our side, we provide support services by means of providing counselling and family preservation to their respective families (Participant 14).

...we provide counselling, parenting programmes and family preservation services (Participant 10).

The findings show that early intervention is done by social workers after the substance abuse problem is identified, and therapeutic treatment services are implemented to remedy the problem in its early stages (DSD, 2006). Early intervention involves therapeutically integrated social work services that address all issues identified by the social worker, such as substance abuse and its contributory factors, in a holistic manner to prevent escalation to addiction. Thus, early intervention allows social workers to assist women who are still in control of their substance abuse to educate them about the effects of substance abuse and the possible risk of addiction.

4.4.3.3 Inpatient treatment services

Inpatient treatment services are designed for people who are unable to function adequately in society due to the abuse of substances and who are then removed either voluntarily or involuntarily by a court order to inpatient treatment facilities (DSD, 2006). The participants reported that their responsibility is to refer women for inpatient treatment services at the Seshego Treatment Centre in Limpopo province, which is the only centre in the province. The centre was built in response to the mandate of the Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008, that states that the Minister must establish and manage at least one public treatment centre per province in consultation with the Member of the Executive Council (MEC) for the reception, treatment, rehabilitation and skills development of service users with substance abuse problems (RSA, 2008). The centre officially opened in 2019, with male service users being prioritised for admission, but in 2020 the centre started to admit females. The participants pointed out that, before the centre was opened and admitting women, they referred women to treatment centres in Mpumalanga and Gauteng provinces due to the lack of facilities in the province catering for women.

Roberts *et al.* (2000) assert that there are limited treatment centres that admit women and also pay attention to the needs of women. This is also seen in the case of treatment facilities in Limpopo, which were initially focused on men. A major drawback to advocating for increased services is the lack of epidemiological data on the prevalence of alcohol and other drugs and related treatment needs (Myers, Louw & Fakier, 2008). The participants asserted that the centre caters for all municipalities in Limpopo province, although the capacity is very small.

Besides referring them to Seshego treatment centre for the programmes there in none the department we don't have any (Participant 5).

We have one treatment centre which accommodate men and women, so it's still difficult for all these genders to access these services because the centre doesn't accommodate enough number of applicants, it's not easily accessible, the waiting list is forever long, and I cannot say it's not accessible for women but both these genders (Participant 20).

The findings show that the inpatient treatment centre in Limpopo is not sufficient for the demand that arises from women in need of treatment services, and social workers are struggling to get help from other treatment centres. Given the findings, it is evident that both men and women struggle to get admission, since the centre has little bed capacity and the situation is worse for women, who are allocated even fewer beds.

4.4.3.4 Outpatient treatment services

Outpatient services are defined as non-residential services provided by a treatment centre or halfway house to persons who abuse substances and to persons affected by substance abuse; they are managed for the purposes of providing a holistic treatment service (RSA, 2008). The participants pointed out that the Department of Social Development outsourced outpatient treatment services to SANCA, who visit each district to render the services. The participants also pointed out that they referred female service users to SANCA for outpatient services, whereby the social worker allocated to the district visits the outpatient site twice in a month to provide services.

Some of the participants said that the outpatient services are not reachable for women and referring social workers, since they are not allocated per municipality.

We don't have outpatient services in our municipality we normally do sessions with our client's maybe we schedule 5-7 sessions depending on the problem of that service user (Participant 11).

We offer this life skills programmes, individual sessions but to say this is outpatient treatment centre no we don't have but we just do individual sessions with the women and try to help them look at life differently that's how it's done (Participant 4).

SANCA Limpopo is responsible for outpatient treatment services in the province. The findings show that outpatient services are not accessible to women in the communities due to insufficient outpatient sites. Dos Santos, Rataemane, Fourie and Trathen (2010) claim that SANCA has limited outpatient sites due to limited funding and subsidies from their donors, which has also led them to close some of their sites because of limited financial resources to render services to the people. This clarifies the issue of allocating one professional social worker to each district to render outpatient treatment services, as it is almost impossible for them to reach out to everyone who requires their services. The participants pointed out that they must transport the service user to the service point where outpatient treatment services are rendered each time the service user has an appointment, but it becomes difficult with limited resources and the high case load. Financial problems and geographic access have been identified as barriers to accessing substance abuse treatment services (Myers *et al.*, 2010). Based on the information presented, women are unable to benefit from outpatient treatment services due to their geographical location and the need to have financial support to travel to the site.

4.4.3.5 Aftercare and reintegration services

The participants pointed out that every social worker who refers a service user for inpatient and outpatient treatment services is obliged to render aftercare and reintegration services. The latter services are aimed at giving support to enhance self-reliance and optimal functioning by service users as they exit either inpatient or outpatient treatment or return to their families or community (DSD, 2006).

I don't know any programmes that is targeting only women or that is gender based but we have programmes such as outpatient and aftercare, but I don't know of the one that are designed specifically for women, I'm not aware of any
(Participant 13).

Setlalentoa, Ryke and Strydom (2015) emphasise the importance of aftercare services as a continuum of care rendered by social workers to service users and their families to assist in maintaining sobriety, encouraging making amends and providing family support. Aftercare and reintegration services require a good working relationship between social workers and community organisations to be effective.

4.4.4 Theme 4: Accessibility of treatment services

The participants were asked how accessible treatment services are for women in their municipality. The participants pointed out that the accessibility of substance abuse treatment services differ from person to person, depending on the level of substance abuse. The participants confirmed that the social workers' offices are accessible because they are a point of entry for treatment services and are found in all local areas. However, participants noted that they are underutilised for the purpose of substance abuse treatment access or initiation. Treatment services such as prevention services, early intervention, outpatient services in partnership with SANCA Limpopo, and aftercare services and support are rendered from the social workers' local offices.

... they come to our social development office, so we only have one NGO (non-governmental organisation) in the municipality which does what we do, they conscientise the community about the substance abuse" (Participant 6).

Although social work services are available within local communities, the United Nations Office on Drugs and Crime (UNODC, 2015) contends that women do not use the services that are available and accessible, such as social workers for their substance abuse problems due to the stigma that is experienced in society.

However, the participants said that inpatient treatment services for women are not easily accessible, since the social workers depend on one treatment centre in Limpopo that is situated in the capital city of the province, and they also seek help from other centres in Gauteng and Mpumalanga, which prioritise their own residents.

If you have a client who is a woman, you have to exhaust other provinces and most of them are private and people need to pay (Participant 4).

For starters in the province, we have one treatment centre which accommodate men and women, so it's still difficult for all these genders to access these services because the centre doesn't accommodate enough number of applicants, it's not easily accessible, the waiting list is forever long, I cannot say it's not accessible for women but both these genders (Participant 20).

Based on the participants' experiences, inpatient treatment services for women are not easily accessible since Limpopo province has only one inpatient treatment facility that caters for both men and women. According to the participants' observations, the

centre prioritises male service users since it admitted only male service users after the official opening and only recently started admitting women. The capacity of the centre is generally low. The participants pointed out that the inpatient treatment centre is in the centre of Polokwane Municipality, which is far from other municipalities. Isobell *et al.* (2015) concur with the findings that inpatient and outpatient services are mostly located in places where service users are not able to access them using public transport.

The participants also highlighted that, before the erection of the centre, social workers struggled to get space in other inpatient facilities outside the province, as these prioritised women from their own provinces. However, some participants claimed that the number of women seeking treatment was very low, hence the low number of beds allocated to women in inpatient treatment centres. The participants pointed out that the province lacked community-based organisations that offer outpatient services in their local areas. The private organisations that offer such services are centralised in the capital city of the province, which is not accessible to the public at large. However, participants working in the Polokwane Municipality and surrounding areas agreed that treatment facilities were accessible because inpatient and outpatient treatment facilities were accessible in their municipality.

One can normally say it is accessible even though the space might be limited
(Participant 14).

It is accessible now but still has challenges (Participant 5).

Some participants contended that inpatient treatment services were accessible, although women were not seeking for help. Other participants held the view that treatment services were accessible, since they have transport to reach centres such as the Seshego Treatment Centre, Swartfontein in Mpumalanga and Thabong in Gauteng for treatment. The participants also asserted that outpatient services were not easily accessible, since the SANCA was not consistent in visiting their districts.

It is evident that treatment services and facilities are not easily accessible when focusing on inpatient and outpatient treatment services. Outpatient treatment services are not rendered in each municipality, which makes it difficult for women and social workers to access, since it requires transportation to access on a weekly basis. The province is dependent on one inpatient treatment facility, viz. Seshego. The treatment

centre is not accessible in terms of where it is situated in relation to most of the municipalities, and because of the limited number of beds for women. Substance abuse treatment services for women are not well marketed, since they hardly use the services compared to men. The UNODC (2018) reports that, globally, there are only a few women in treatment facilities. This results in women feeling discouraged to reach out for help, knowing that there is a limited chance for them to get admission to inpatient treatment facilities. Outpatient sites are also not accessible to women in the villages, which also makes it difficult for them to try to get the service, since it will require planning, enough time, transportation and support from the referring social workers.

4.4.4.1 Processes and procedures that women need to follow to access treatment services

The participants were asked what procedures women follow to access substance abuse treatment services. The participants highlighted that the case must be reported by the service user or referred by either a family member or a concerned community member to the area social worker for them to intervene. After the case is reported, assessment is done by the social worker, who can continue with the helping process – depending on the nature of the problem or refer it to the municipal substance abuse coordinator to continue with the services based on the seriousness of the case.

The client needs to come out and talk about it because as a social worker I cannot manage everyone in the community that is using substances the client must just come out to us and say we have this problem I need help then we take it from there, we do the necessary procedures (Participant 3).

The procedure is very simple, if they come to the social workers office or our offices in particular, we take them through an intake and they make an assessment (Participant 6).

They have to come to our office and we intake them, have sessions with them, do assessment and do application for them so they will go through all the processes as men do (Participant 20).

The participants pointed out that the process of applying for inpatient substance abuse treatment services is lengthy, as it requires a lot of administration before the

application is complete. They further emphasised that, after the case has been reported or identified, the social worker motivates service users to change through therapy sessions, family preservation, home visits, and processes the application documents and sends them to the treatment centre for feedback. The treatment centre will also require blood tests, a medical report and psychological report, which may take time to be attended to in hospital, so through the journey service users blame social workers and lose hope. Isobell *et al.* (2015) add that treatment centres often delay giving feedback to the applicant, which make the process take even longer. The participants added that, even though social workers take a lead in administering the helping process, they also integrate their services with different professionals, such as doctors, nurses, psychologists, occupational therapists, NGOs etc. from different institutions to play certain roles in the admission process.

The participants demonstrate that there is a need for integration of services involving health professionals, Department of Justice, South African Police Services, Department of Social Development and other stakeholders for the smooth running of inpatient and outpatient treatment services. The participants highlighted that they are responsible for compiling a psychosocial report, which involves gathering information pertaining to the background of the service user, her financial situation, health and environmental factors, and physical and psychological elements that will assist in identifying what causes the substance abuse and helps suitable treatment services to be implemented. The participants confirmed that social workers work hand in hand with the families to identify suitable treatment services for women to deal with substance abuse. In line with the principle of self-determination, Isobell *et al.* (2015) assert that all the processes can only be done once a woman shows interest in going for treatment.

The social worker does an assessment to determine the appropriate treatment services for women, such as early intervention, outpatient or inpatient services. There are three categories to access substance abuse treatment services, namely voluntary, involuntary and committal applications for treatment services, as guided by the Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008. The social worker provides early intervention treatment services or refers the woman to inpatient or outpatient services as stated by one participant.

We take the client directly to the treatment centre but if the client is refusing and we see that the client is dangerous to himself and other people we take the matter to court, we present to the magistrate that this person is living under circumstances where in he is putting other people in danger because of substance abuse then the magistrate issue us an order the he becomes and involuntarily client, he has to go there in terms of the order of which we have to write compliance reports back to court to tell the court that the person is complying or not complying (Participant 19).

The participants hold the view that the process of seeking for substance abuse treatment services is strenuous for women and social workers, as they also must go through a panel which decides to approve or disapprove the application for treatment or put the service user on a waiting list. Isobell *et al.* (2015) concur with the participants that the processes and procedures to access treatment services require patience, as they take long and are demoralising. The participants highlighted that treatment facilities operate differently, and their requirements are not the same, as some require the person to have gone through detoxification prior to admission, whereas others provide the service within their facility. The social worker will therefore facilitate the treatment process of referring to the relevant treatment agreed upon. Isobell (2013) and Myers *et al.* (2010) show that, even after the long processes and procedures have been done to the fullest, admission can only happen when there is space in a particular treatment facility. The findings show that women go through a lengthy process before accessing substance abuse treatment services, and most women are lost in the process while trying to consolidate application requirements. Some women are reluctant to continue with the process after the social worker has explained the procedures for the application to be accepted.

4.4.4.2 Differences in opportunities between men and women accessing substance abuse treatment services

The participants were asked whether men and women have an equal opportunity to access treatment services. The participants shared different views and observations concerning the opportunities of men and women to access substance abuse treatment based on their experiences. Some participants had never assisted women with substance abuse problems, so they had never experienced processing an application

for admission to treatment facilities. However, other participants said that there were equal opportunities to access substance abuse treatment services by men and women, but that women were not using their opportunities.

Yes, there is equal opportunity depending on the willingness of the person, if the person is willing to be assisted, they will all receive the assistance (Participant 19).

Yes, they do have the same opportunity but in most cases men are the ones who will submit themselves to get help but with women they don't (Participant 12).

Yes, I think they have it's just that women are not using it, as South Africa is a democratic country and as I know our department people are equal regardless of their gender (Participant 8).

The participants pointed out that women have the same opportunities as men to apply for treatment, but they are not using the services. However, some participants observed that, since the opening of the treatment centre in Limpopo, there had not been an equal opportunity for women and men to access inpatient treatment services, since men were admitted from the beginning whereas it took the centre a year to admit women. From a feminist perspective, the imbalance in the administration systems need to be amended to equally and fairly benefit both men and women as shared by some of the participants.

Currently they have the same opportunity, in the past they didn't have. The treatment centre in Limpopo was admitting males only but now they also admit females, so they have the equal opportunity to receive treatment (Participant 15).

Based on the previous experience I can say no because before our own treatment centre they were not admitting women but only men, so I don't think they have equal opportunity but as for now because they say they admit women I don't know but before they had no equal opportunity because they were not admitting women (Participant 18).

The participants stated that men were at an advantage in receiving treatment services compared to women, since their abuse of substances was acceptable, and more

centres are accommodative to their applications for admission. They further said that most treatment centres that admit female service users have little bed capacity for women compared to that for men.

The challenge is that the space of women is more limited than that of men for the capacity in most of the treatment centres. I think substance abuse most of the services are for men (Participant 6).

Crawford *et al.* (2015) concur that men are more likely to benefit from substance abuse treatment facilities. The participants are of the view that the Department of Social Development is focused more on males than on women, as the latter do not come out for help. They remarked that this makes it difficult for social workers to evaluate and advocate for women's access to treatment. For example, the opening of the Seshego Treatment Centre gave the people of Limpopo hope for access to treatment services. The centre started admitting men only for a period of more than a year, which instilled doubt and discouragement in female applicants, who were eagerly waiting for the centre to open in order to get help. This resulted in most referring social workers losing female clients who had waited for so long on the waiting list for admission, as their hope was taken away from them. The participants further stated that some women were not accessing substance abuse treatment due to lack of information and knowledge about treatment services for women. Stone (2015) highlights that a lot of women feel confused and vulnerable because of the lack of information related to substance abuse treatment options available to them.

The findings show that women have an equal opportunity to access treatment services as men, but that they are not informed of such services and treatment facilities limit women by offering few beds for them. Due to women often viewed as subordinate to men, feminist theory advocates for better and efficient treatment services for women, in which they access treatment without barriers (Radtke, 2017).

4.4.5 Theme 5: The role social workers play in assisting women to access substance abuse treatment services

The participants were asked about the roles they play in helping women with substance abuse problems. The participants stated that they had a responsibility to do intake and assessment, and to provide the relevant services based on the intensity of the substance abuse. They also highlighted that they were the custodians of the

Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008, which states clearly that social workers play a vital role in the identification and administering of the helping process. Smith, Whitaker and Weismiller (2006) concur that social workers play a vital role in identifying women with substance abuse problems, since they operate from a variety of settings that service women with substance abuse problems. Furthermore, they are responsible for assessing and referring women to relevant treatment facilities. The participants maintained that they processed applications for admission for women to inpatient and outpatient treatment services and rendered aftercare and reintegration treatment services. What follows are different roles played by social workers in the provision of substance abuse treatment services for women.

4.4.5.1 Identification of women with substance abuse problems

Nelson-Zlupko *et al.* (1995) state that social workers can identify substance abuse problems concerning women from cases that are reported daily. The participants were asked to share ways in which they identified women with substance abuse problems. The participants emphasised that they could identify when there are substance abuse-related problems using the psychosocial assessment tool. Assessment is regarded as the most important tool used by social workers daily as they render services. It assists the social workers in defining the problem and analysing it and guiding them on the type of services they require. The participants' remarked that women mostly visit social workers in their local areas to report their loved ones who abuse substances, but they fail to acknowledge their substance abuse problem. Assessment assists in identifying the real problem that perpetuates the presenting problem. The participants also indicated that assessment plays a vital role in the identification of women with substance abuse problems, as it is used to uncover the historical background of a person after a case of any kind is reported. Assessment allows the social worker to investigate and interview the significant others to determine where the problem lies. The participants asserted that probing plays a vital role during assessment, as it assists social workers to have a better understanding of the case reported.

...assessment is holistically, it's using a holistic approach we are able to assess each and every aspect even if there is one family member who came to the office, even if it was a child who came to the office referred from school we are able to reach a point where we know that this child is from a troubled family

which has substance abuse problem because it also concentrate on the family issues, the genogram of the family, who is in the family, how are they living, how are they surviving, check their mental status... (Participant 19).

The assessment tool that we use it reveals a lot, you might find the case let's say maybe of child having been raped and then when you assess the case you come across issues related to rape occurring, so the assessment tool makes the social worker to be able to unfold a lot of issues emerging when you are doing your assessment and substance abuse will be one of them on the list of social issues to be identified (Participant 4).

When assessment is conducted thoroughly, social workers can find the root of the problem and the extent of its effects in order to develop a proper, integrated treatment plan. Moreover, the participants stated that they used a generic assessment tool to identify the abuse of substances, but once it is suspected, the Diagnostic Statistical Manual assessment tool is used to measure the severity of the substance abuse and as a guide for the suitable substance abuse treatment services for intervention. However, the participants maintained that it is rare for women to report their substance abuse, which makes it difficult for them to identify substance abuse in women.

Women who are abusing substances are not easily identifiable as opposed to men (Participant 14).

I have never had a case where a women would come to the office and say I am using this and this except for the family that come to report that we are having this lady is having a substance abuse problem maybe you can intervene and help her but by themselves I have never had a case where a women come by herself to seek for help (Participant 18).

Although the Prevention of and Treatment of Substance Abuse Act, No. 70 of 2008 states that social workers' role is to identify women with substance abuse problems, the participants reported that they do not go out to look for women with substance abuse problems; instead, they wait for them to voluntarily seek help or receive referrals from different stakeholders working with women. The UNODC (2015) adds that women who abuse substances are mostly identified by social welfare services and mental healthcare practitioners when consulting for something different. In addition, concerned family members and community members who observe substance abuse

problems also refer women to social workers for intervention. The participants asserted that most women pretend to be fine, whereas they are going through a lot and abuse substances to cope with their problems, which makes it very difficult for people around them to identify their substance abuse problem. The participants also pointed out that most women are identified by probation officers during investigations of child neglect and abuse.

A women will only admit when they are in conflict with the law because of child abuse cases or whatever that is affecting them at a particular moment (Participant 5).

Some cases come as a child abusing substances and when you assess and dig deeper you find out that even the mother has been doing that and has never reported that kind of behaviour but they themselves is rare that they can approach our office by their own (Participant 8).

They were referred out of this three one was just coming in voluntarily and the two were referred by their family members (Participant 20).

Family members and significant others play an important role in assisting their loved ones to get help by reporting women who display unusual behaviour that calls for concern. Social workers can assess the circumstances and identify if the problems are related to substance abuse, depression or financial problems. The findings show that social workers use a generic assessment tool for every case reported daily and, when the assessment tool is used thoroughly, the social worker can identify the real problem from the presented problem, since women never seek help for substance abuse. Thus, social workers need to be vigilant when attending to social issues reported in their offices daily and sharpen their probing skills to get to the root of the cases they are investigating. The findings further demonstrate that social workers are required to have a good working relationship and integrate services with other stakeholders that will assist with the identification and referral of women with substance abuse problems.

4.4.5.2 Challenges faced by social workers when identifying women with substance abuse problems

The participants were asked about challenges they face when identifying women with substance abuse problems. The participants highlighted that women with substance abuse problems are often aggressive and, as a result, they insult the service provider when they identify their substance abuse problem. They also asserted that women often threaten social workers who offer to assist with the substance abuse services, which makes social workers fear home visits to implement treatment services after cases are reported by families.

Remember with substance abuse you start with acceptance that I have a problem for treatment to work so mostly are in denial that is the problem for them. Once they are in denial it is difficult to continue with the process and most of them feel insulted when you try to show them that this is a problem and it contribute to your marital problems, lack or failure to parenting (Participant 5).

The participants said that it is very difficult to work with women who are not ready to or interested in disclosing their problem. It is important to respect the autonomy of the service user who is not willing to receive the services offered, and to ensure that one does not infringe on their human rights. Social workers find themselves ceasing their intervention and waiting until the service user has made up her mind before continuing with the intervention. The participants stated that some women are in denial of their substance abuse problem, which makes it difficult to intervene.

Most of them don't want to admit they come with a certain problem when you intervene you find that the substance is one of the underlying matters but when you want to confront the problem, they do not admit the problem, or it can be the cause of the problem that they are seeking help for (Participant 5).

It is very difficult for a woman to come out when they have a problem, women are those kinds of people who pretend like everything is under control they only realise it when they are in conflict with the law, that's when one will admit that I have a problem and I need help (Participant 5).

The findings show that social workers encounter great challenges when working with women who are not motivated and who use defence mechanisms when confronted

about their substance abuse problem. This makes it difficult for social workers to intervene and continue offering services due to the denial of the problem and the negative attitude the service user displays to social workers.

4.4.6 Theme 6: Barriers women face in accessing substance abuse treatment services

The participants were asked what the barriers are that women encounter in accessing treatment services. The barriers are categorised as internal and external barriers.

4.4.6.1 Internal barriers

The findings reveal that women face personal barriers that are within their control as discussed below.

a) Lack of motivation to seek treatment

The participants pointed out that women lack motivation to seek treatment and are easily influenced by the opinions of their partners and significant others before they decide to go for treatment, which affect their decisions. They also said that women who accessed outpatient treatment service were not motivated enough to respect the services offered to them, as they were not honouring appointments and did not show interest in participating in the required activities.

Service user just come once or twice and never come back again so that is the challenge, they are not complying with our sessions (Participant 11).

The participants said that most cases of women with substance abuse problems are referred by their significant others, so they do not see a problem with themselves and end up going to the social worker's office once or twice for compliance, which in the end is not effective. Isobell *et al.* (2015) assert that, without motivation, a person can never benefit from treatment services rendered, no matter how effective they are proven to be for others. For treatment services to work for the women, they need to admit their problem and take the first step to access the services.

It's a challenge because sometimes they end up not honouring the appointment (Participant 13).

You might try to talk to them then you try to set up an appointment with them so that they come so you can continue they might not pitch (Participant 12).

Hecksher and Hesse (2009) agree with the participants' point of view that women often minimise their substance abuse problem by being dishonest and pretend that everything is under control. A study by the Centre for Substance Abuse Treatment (2015) also shows that women who are not motivated do not seek help and, even if they do seek help, they do not benefit due to lack of motivation. Miller and Rollnick (2013) argue that social workers can use motivational interviewing techniques to evoke change in women with substance abuse problems. Motivational interviewing is defined as a "collaborative conversation style for strengthening a person's own motivation and commitment to change" (Miller & Rollnick, 2013:12). This can be achieved by creating ambivalence in the mind of the service user for them to realise the need for change and decide to seek help.

b) Fear of being stereotyped by society

The participants pointed out that there are a lot of cultural expectations of an ideal, good woman and a woman who abuses substances does not fall into this category. Rather, they are labelled as prostitutes, junkies, loose and not worthy of marriage. The participants asserted that most women worry more about societal beliefs and misconceptions that substance abuse, which is regarded as being for men, which makes them fear looking for help to avoid being labelled.

I have worked with them (women), they are older people so they fear what the community would say: "if they heard that I went to rehab because of substances so I would rather just stop before even going there" (Participant 20).

The societal expectations are the ones that are oppressing them not to be able to come out, there are lot of women that are using substances in our community, but they are afraid to come out, they are afraid to seek for help because they fear being stigmatized or labelled and all that, so they choose not to get help they rather just die (Participant 20).

Isobell *et al.* (2015) concur with the participants' view that the societal perception of women who abuse substances contributes to women's fear of seeking treatment. Ashley *et al.* (2003) assert that women who are identified with substance use disorders

suffer shame and humiliation in society and lack support from society, as they are seen as bad people, and no one wants to associate with them. Society's lack of insight into substance-related issues has a negative effect on women's initiation of treatment. Women end up hiding their substance abuse problems to protect themselves from the pain society might inflict on them, rather than seeking help. Feminist theory challenges these misconceptions and advocates for equal treatment of women and men with substance abuse problems (Radtke, 2017).

Based on participants' view, it can be inferred that women fear prejudice and discrimination by society when they admit their substance abuse problem, which prevents them from seeking help. Hence, they opt to deal with their substance abuse problems on their own to avoid being labelled and dragging their families along. The participants also asserted that women do not seek treatment because they need to maintain their pride and dignity in the family and society, so they choose to hide their problems.

c) Fear of losing custody of children

The participants confirmed that some women have an excessive fear of losing custody of their children, as they believe that, if they go for treatment, they render themselves unfit parents. The Centre for Substance Abuse Treatment (2015) argues that treatment facilities admitting women with substance abuse problems have limited resources to cater for women with children and, as a result, women deny their use of substances to protect the custodianship of their children and the child support grant. Women also worry about who will care for their children when they are placed in a treatment centre before they make up their minds to seek help.

Who is going to look after your kids when you went to look for help? (Participant 7).

Like last week I have placed a service user who is having a one-year-old child, you could see that the child is still very young and still needs the mother (Participant 10).

It is when a social issue such as child neglect maybe misuse of SASSA grant... (Participant 9).

The participants stated that women deny their substance due to fear of being investigated and charged with child neglect and losing custody of their children, which may lead to them being forced into involuntarily treatment as stipulated by the Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008. They also believe that, by accepting their substance abuse problem, it will be evident to their children and loved ones that they deserve to be labelled and stigmatised by society. The participants realised that it is difficult for women to access treatment services because they need assurance that their children will be taken care well of when they choose to go for treatment, since they are the primary caregivers of their children. The placement of children in child and youth centres or in foster care will assist women to benefit from treatment, knowing that their children are take care of well.

The above findings prove that women have poor insight into the placement of children in need of care and protection and assume that their children will not be reintegrated with them post-treatment. The UNODC (2018) maintains that treatment services that cater for children, and offer parenting classes and job training, can yield positive results in the provision of treatment services. In contrast, a study by Dada *et al.* (2018) notes that treatment services in Cape Town lack childcare services, although therapeutic family preservation services are rendered in most treatment centres. The findings reveal that women have several considerations before making the decision to enter treatment, such as care for their children; meanwhile, their decision to stay at home for the children's sake also has a negative effect on the children. The participants pointed out that women become motivated for treatment when they are sure of support from their loved ones.

d) Poor support from family and significant others

The participants found that women who shared their substance abuse problem with their families did not receive support; instead, the family threatened to disown them as they felt humiliated. The participants pointed out that men were failing to step in to care for the children when their mother decide to attend inpatient treatment. It was also observed that, due to the lack of support from spouses, boyfriends and intimate partners, women were afraid to take the initiative to go for treatment due to fear of losing the relationship. Women choose not to seek help for their substance abuse to sustain their marriages and intimate relationships.

They lack support from the family members or the partners (participant 8).

The problem lies with the clients themselves, if their significant others does not give them support it becomes a problem for them to undergo the process of detox that's where lies the problem (Participant 9).

Several authors believe that women are discouraged by their families from entering treatment and advised to deal with it on their own in order to prevent shaming the family (Green, 2006; Hecksher & Hesse, 2009; Taylor, 2010). However, Daley (2013) posits that family support has a positive influence on women entering treatment and encourages the family to deal with the effects of substance abuse on their family. The findings demonstrate that women who are loved and supported by their families develop motivation to seek substance abuse treatment voluntarily.

4.4.6.2 External barriers

The participants identified different external barriers that women face in accessing substance abuse treatment services. These are discussed below.

a) Lack of collaboration between stakeholders

The participants demonstrated that a lack of collaboration between stakeholders negatively affects the helping process of women with substance abuse problems, therefore the helping process requires an integrated approach to be effective. Participants confirmed that they lose a lot of cases in the process of gathering relevant information to process the application for admission to treatment facilities. They also pointed out that the process is prolonged due stakeholders' lack of insight of their roles and expectations in the helping process of substance abuse treatment services.

Participants further mentioned that due to the bad treatment women receive from hospitals when they go for blood tests or are sent to do mental assessments, women end up changing their minds about going to a treatment centre. Lack of collaboration between the Department of Health and the Department of Social Development when rendering substance abuse treatment services was also identified as a contributing factor. There is a poor working relationship between provinces, treatment centres and the national Department of Social Development, as they do not allow referrals from treatment centres in other provinces since the opening of the Seshego Treatment

Centre in Limpopo. This has a negative effect on service delivery to the service users, as they end up with a negative experience of the services rendered by social workers.

I don't want to speak bad about our department (DSD), but we have lost that working relationship (no collaboration and integration) whereby you find back then we used to have these campaigns where you will find social workers, doctors, Department of Health, NGOs and SAPS (Participant 4).

Hospital doctors and nurses currently they seem to be reluctant when you send your client usually, they attend them when we have accompanied them that's when they give them pleasant services... (Participant 20).

The Centre for Substance Abuse Treatment (2015) remarks that the lack of collaboration among social welfare service systems has a negative effect on women's decisions to enter treatment and to continue with their treatment services, as they identify a loophole in the helping process. A study conducted by Myers *et al.* (2008) shows that there is poor intersectoral collaboration and limited consultation with service providers, which hinders service delivery. The participants pointed out that there is confusion on the roles of different professionals and the implementation of the Act when addressing issues of substance abuse. Professionals who play a vital role in administering applications for treatment services, such as health professionals, prosecutors and the South African Police Services, are inactive in their roles of providing effective services for the service user to receive admission to treatment facilities. The Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008, clearly states that the prosecutor is responsible for issuing a court order for involuntary treatment services, and police officials must assist with enforcing and implementing the court order, whereas the health professionals need to assist with medical reports and blood tests as required by the treatment facilities. However, the findings demonstrate that there is poor implementation of the Act by the departments, which affects women in need of services. The lack of proper procedures in place to guide the professionals involved in the substance abuse helping process negatively affects women in need of accessing treatment centres.

b) Strict admission criteria

The participants remarked that the admissions criteria differed from one treatment facility to another, as some required people to access detoxification services at a local

hospital before admission to the facility, while others provided detoxification on site. The participants highlighted that women with comorbidities or other diagnoses, such as tuberculosis and other infectious diseases, were required to go through medical treatment before admission at a substance abuse treatment facility to protect fellow service users and staff. Furthermore, pregnant women must be screened prior to the approval of their application. A lot of things are considered before they can be admitted, and this discourages women from seeking help.

The requirements from the centre is making the whole process difficult because they are forever going in and out of hospital for blood test (Participant 20).

Six months pregnant and above cannot be admitted, when you have tuberculosis, it must be treated first before application can be approved, if you have mental illness, it should be stabilised before you are treated (Participant 15).

Isobell *et al.* (2015) agree with participants' views that women with substance abuse problems suffer different types of comorbidities that limit their chances to be admitted to treatment centres due to admission criteria that require those comorbidities to be treated prior to approval for admission. Taylor (2010) adds that most treatment centres do not have professionals equipped to deal with mental disorders, so treatment is rarely integrated, and it forces the centre to have a difficult admission criterion.

c) Insufficient treatment centres in Limpopo province

The participants indicated that there is only one inpatient treatment centre in Limpopo (Seshego Treatment Centre) that caters for both men and women. They further highlighted that the centre was not operating to its full capacity, as it admitted a limited number of service users due to insufficient staff members, which contribute to the low number of admissions of women. The participants pointed out that they had to depend on the only treatment facility, since treatment centres outside the province prioritise women from their own provinces. Furthermore, they indicated that, although the centre admitted women, the bed capacity was low compared to that for men and this demotivated referring social workers from starting with the application for admission to the inpatient treatment centres, only to find no space.

The challenge was that we have one centre and that centre cannot accommodate all our clients at the same time, it means it's going to take time that is why if we see that the problem is in too deep and the person have gone too far to the last stages if I can say that and that person cannot wait for too long it means we can easily opt to send that person to other provinces instead of waiting for 6 months, 3 months and damage will be too much (Participant 2).

In line with the findings of this study, Myers and Parry (2005) note that there is poor distribution of state-subsidised treatment facilities in South Africa, with Limpopo being one of the provinces that operated for very long without a single inpatient treatment centre. In summary, the state's limited allocation of financial resources to services for the abuse of alcohol and other drugs restricts the availability of affordable treatment facilities, which directly hamper timely access to care for persons from historically disadvantaged communities (Myers *et al.*, 2008).

The participants asserted that the lack of treatment facilities contributes to social workers who are demotivated and creates a backlog of women with substance abuse problems. They also maintain that they struggle to find space for women in treatment centres, which prolongs the helping process. Feminist theory advocates for women to also benefit equally from the few treatment facilities and limited resources available to deal with substance abuse problems (Hossain *et al.*, 2016). The findings show that one treatment centre is not able to cater for the needs of the people of Limpopo province, which leads to a lot of pressure on the social workers providing services, as they are burnt out and without alternatives to assist their clients. Social workers are also vulnerable to threats and disrespectful comments from clients, who are dissatisfied with the service they receive regarding their substance abuse problems.

The participants also posited that, due to a lack of sufficient treatment facilities that admit women in Limpopo province, women wait very long to access to treatment. During the waiting period, some change their minds, lose hope and interest, and give up on themselves.

You find that some take three to four months on the waiting list waiting for admission (Participant 9).

The challenges include being put on the waiting list by the time the client is about to go in they would have given up, they would have lost hope so the waiting period is chaotic (Participant 4).

Research done by Isobell *et al.* (2015) and Jackson and Shannon (2012) confirm that service users struggle to get space in the inpatient treatment centre and spend more time on the waiting list, even after their application has been approved. Andrews, Shin, Marsh and Cao (2012) state that women wait twice as long as men for treatment due to reasons such as a lack of childcare, pregnancy and fear of losing custody of their children – all issues that need to be attended to before they enter into treatment. MacMaster (2005) agrees with the participants that the period between treatment initiation and admission is too long and negatively affects the decision of service users. An unintended consequence of these lengthy waiting periods for affordable treatment is diminished motivation for treatment (Myers *et al.*, 2008). The study demonstrates that the period in which women must wait before they get accepted for treatment does not encourage them to start with the helping process.

d) Lack of resources

The participants hinted that they did not have sufficient resources to provide services to people, such as transport, internet and promotional material. The shortage of transport also results in the delay of processing the application for inpatient treatment services and the rest of the helping process. The lack of internet access hinders the delivery service since it is not easy to send through the application and communicate with other stakeholders.

The transport challenge, that's the biggest challenge it's not easy to transport the person to other province because we don't have enough cars (Participant 2).

The issue of sending the documents in the era where people believe in sending information through the emails and our department doesn't have internet services which means that if you want to send documents you have to travel far to the district office or even if you find that the district office is too far you might end up using your own money to print and send all these documents (Participant 2).

The participants highlighted that each municipality was assigned one social work coordinator to attend to substance abuse cases, which led to backlogs and a high case load. Limited human resources and a sense of being overburdened were significant contributors to poor staff retention and poor services (Myers *et al.*, 2008).

We don't do follow ups because of the issues of lack of transport in our service point so instead of going and doing monitoring the service we have rendered to the community are as effectiveness as they must be we end up not doing follow ups because of the constraints that we are having regarding the issues of transport (Participant 16).

The participants revealed that they had no alternatives for women who are uncomfortable to visit their office for help to access substance abuse treatment services, and even the treatment centres do not assist walk-in users; they refer them back to the local social workers to start the helping process. The findings demonstrate that there is a shortage of social workers dedicated to providing substance abuse services in the province, which slows down service delivery to the people. Radtke (2017) posit that feminism strives for the allocation of resources and human resources equally for women in rural and urban areas to access substance abuse treatment services. The shortage of resources such as access to the internet in the era of COVID-19 also hinders service delivery to the people because social workers are unable to process applications for admission electronically. It can be inferred that the shortage of human resources, internet connection and transport contribute to long waiting lists, backlogs and losing clients along the way who were supposed to access substance abuse treatment services from all levels of interventions.

e) Limited substance abuse training for service providers

The participants highlighted that some social workers are not trained about substance abuse treatment services, which makes it difficult for them to work with women who have a substance abuse problem.

The people who are doing those campaigns I think they are not capacitated enough because you might find that the person has not gone through a training where he/she has done basic substance abuse they just heard somebody saying that there is a programme of substance abuse then you need to address

it. They just go with an ordinary knowledge which I think cannot solve our problem (Participant 2).

Slabbert *et al.* (2019) concur with the participants' views that service providers have a knowledge gap regarding treatment services and implementation, and there is a need for them to be capacitated in order to improve the services.

Our hospitals were not informed about the issue of detoxifying the service users that was the challenge that we were encountering (Participant 10).

Isobell *et al.* (2015) concur with the participants' point of view that service providers in the field of substance abuse are not capacitated, skilled or informed of the available resources available for their service users. Ndou (2019) adds that service users encounter challenges of medical practitioners not knowing what they are expected to do with the service user seeking detoxification and the lack of hospital beds for admission. Some of the participants said that they were not aware of the treatment facilities and treatment services to be rendered when they receive cases of women with substance abuse, since they have no exposure to such cases. This shows that some social workers are not informed of the available treatment services that service users can benefit from and this results in poor service delivery.

I don't know how accessible because I have never dealt with an outpatient case, I don't know where they meet and how often and what need to be done. I just heard that there is patient who can be treated out they don't go to treatment centre, but I have never come across that patient, I don't know what's expected, experience, the challenges, I have never encountered that in my services (Participant 8).

The participants confirmed that social workers have the authority to place women in the treatment facility involuntarily in terms of section 33 of the Act (RSA, 2008), if they can prove to the court that the woman is a danger to herself, her family and society, but this option is seldom implemented. Some participants were not aware that the treatment facility in Limpopo province admitted women for treatment, which disadvantaged the community they serve.

The findings show that professionals from different departments working in the substance abuse field, such as social workers, health professionals, the Department

of Justice and the South African Police Services, lack training to deal with substance abuse cases. They are not informed of the services that they should render to the people in order for women with substance abuse to receive treatment and are unaware of their roles when it comes to the implementation the Act. This can create a barrier for women receiving treatment services.

f) Financial constraints

The participants confirmed that outpatient treatment services were rendered by SANCA officials who are allocated to serve in the districts. The central service point where social workers render outpatient services was found to be far for women who are living at the periphery and require transport to access the services, since the social workers are unable to transport them to every appointment. The participants confirmed that this discourages women from initiating treatment or continuing with treatment if they managed to start. The participants maintained that some women are breadwinners, so they think about financial implications before they consider treatment. Women fail to access private treatment centres, because these are expensive, and most women cannot afford to pay.

From NGO SANCA and mind you they pay each and every session not once off. You could see that financially it has a negative impact on the family especially for those parents who are not working (Participant 10).

In Tzaneen we have four local areas but we only receive one therapist who come to Naphuno so I think we need to have one therapist in each local... (Participant 19).

The participants confirmed that women are struggling to pay for services by non-governmental organisations and that the outpatient services provided are not within their reach. The findings reveal that each district has one outpatient social worker who cannot accommodate everyone in terms of their geographic location, which makes it hard for service users to travel to the site since they cannot afford to do so. As a result, service users are dependent on social workers to transport them every time they have an appointment, which is almost impossible with lack of transport. Isobell *et al.* (2015) agree with the participants' view that, due to limited treatment facilities in Limpopo province, women without financial resources are unable to access services from private inpatient and outpatient treatment centres. Several scholars remark that most

women with substance abuse problems are unemployed and lack financial support from family, which prevents them from accessing treatment (Jackson & Shannon, 2012; Taylor, 2010).

The findings demonstrate that outpatient services are not easily accessible, as each district has one site, which requires everyone who needs the service to travel in the absence of a government car to transport them. Social workers are responsible for transporting women to the outpatient site for outpatient services, but this is not easy due to limited access to transport. Therefore, women end up not being able to attend their appointments. Attending outpatient services far from home also requires a high level of commitment, time management and strong support to achieve the goals of recovery, so women who have a lot of responsibilities at home choose to abandon treatment to focus on their household chores. Most women cannot afford private inpatient treatment facilities due to unemployment and low income, and as a result they do not initiate treatment.

4.5 CONCLUSION

This chapter focused on the perceptions and experiences of twenty social workers on the barriers women face in accessing substance abuse treatment services. These social workers coordinate the substance abuse programme in Limpopo province. The social workers indicated that it is rare for women to reach out for help with their substance abuse problems voluntarily. They also highlighted that, in most of the cases they attended to, women were either referred or reported by their significant others for help. Several internal and external barriers were explored in this chapter. Based on the findings, there is a need for strategies to identify women with substance abuse problems, to undertake awareness campaigns, and to market substance abuse services available for women, along with treatment options and how to access them. It also seems that society is not educated enough about women abusing substances and the treatment services available for women.

The next chapter concludes the study and presents recommendations based on the findings of the study.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The rate of substance abuse among women is escalating in South Africa. In the past, substance abuse was perceived as a male problem, however it does not discriminate between age and gender. It does not only affect the women who use it, but also their loved ones. This chapter presents the conclusions and recommendations from the findings of the empirical study. Conclusions and recommendations on the profiles of the participants will be presented first, followed by conclusions and recommendations on the themes that emerged during the study. These recommendations will potentially improve service delivery for women with substance abuse problems. Recommendation for further research will also be made in relation to the findings in the previous chapter and related to the findings and conclusions of this research study.

5.2 CONCLUSIONS AND RECOMMENDATIONS

The conclusions and recommendations were made based on the themes that emerged during the empirical study.

5.2.1 Profiles of participants

The participants' profiles included their gender, years of experience as a social worker, years of experience coordinating a substance abuse programme, and the municipality they worked in during the empirical study. The diversity in the participants' profiles helped capture their different perspectives, which contributed to the strength of the study. The findings reveal that most social workers coordinating substance abuse programmes are females, and this is a clear indication that the social work profession is dominated by females. The findings show that all 20 participants had six or more years' working experience as social workers. Most of the participants had been coordinating a substance abuse programme for more than five years. This study also covered many municipalities in Limpopo province. Based on the profile of the participants, they were the ideal candidates to provide knowledge and perspectives of the barriers women are facing in accessing substance abuse treatment in Limpopo province.

Recommendations

Working with service users with substance use disorders requires a passionate, motivated and informed social worker. It requires coordinators who are willing to improve their knowledge and skills often. This could become possible with support from the Department of Social Development, which could create a platform for personal development, such as developing capacity building workshops, financing social workers' studies, and ensuring all necessary resources such as transport and internet are available to render substance abuse services.

5.2.2 Prevalence of substance abuse among women

The findings of the study show that, although there has been an escalation in the number of women abusing substances, some of the participants had not worked directly with women who abuse substances within the communities they serve in their respective municipalities. This is because women rarely reach out to access substance abuse treatment services due to shame and fear of being labelled by society, as their abuse of substances is not acknowledged to the same extent as that of men.

The study revealed that alcohol is the most abused substance among women because it is easily accessible at social gatherings and easy to brew in the form of "Umqomboti". The study shows that women abuse substances for different reasons, such as failure to cope with the effects of domestic violence experienced in intimate relationships. Peer pressure, boredom, and frequent social gatherings were identified as some of the contributory factors why women use substances. It was also found that women who were unable to deal effectively with stress and depression were found to be self-medicating with over the counter and prescription medication. Unresolved childhood trauma experienced by the women was also identified as a contributory factor to abusing substances to hide their vulnerabilities. It can be concluded that some women are vulnerable to substance abuse due to their inability to find better ways to deal with certain challenges they face in life, and therefore find comfort in the abuse of substances.

Recommendations

Based on the findings, it is recommended that the Department of Social Development should invest in establishing intervention strategies designed to address issues women face that lead them to abuse substances. This can be achieved by first developing a screening tool to assist in the early identification of predisposing and perpetuating factors for substance abuse before it creates dependence. The screening tool can be used by social workers, nurses, police officers and other stakeholders who work with women with social problems daily.

5.2.3 Effects of substance abuse on women

The findings show that substance abuse affects women in different ways. It was found that the effects go beyond just the women, but also affects their loved ones. For example, children suffer from child neglect and abuse or end up dropping out of school due to the unavailability of their mothers in their lives. It was also found that the families of women who abuse substances end up being dysfunctional and disorganised lot of problems, which leads to interpersonal relationships breaking down. This is because women are burdened with a lot of responsibilities in the family compared to men and, when things go wrong, women are blamed. For example, it was reported that some of the women who use substances lose custody of their children and their family support. Based on the feminist perspective, it is argued that societal norms and beliefs that women should be the pillar of strength of their families and advocates for responsibilities to be shared equally between men and women to sustain their families.

The study also reveals that women who abuse substances are vulnerable to health conditions such as STIs and HIV and AIDS. Pregnant women are found to be exposing the foetus to substance abuse, which may lead to foetal alcohol syndrome and miscarriage. Based on the findings, it can be concluded that substance abuse has long-term direct effects on women and negatively affects their children and families.

Recommendations

- Social workers should ensure that they develop a recruitment strategy to gather women and educate them through seminars on the effects of substance abuse on them, their families and their children.

- The Department of Social Development should join forces and collaborate with other stakeholders such as Department of Health, Department of Justice, Department of Education and the South African Police Services to raise awareness of the effects of substance abuse on women in communities and places where women are mostly found, such as churches, etc.
- The Department of Health also has a role to play in addressing and rendering harm-reduction services to women affected by substance abuse.

5.2.4 Nature of treatment services available for women with substance abuse problems

The findings reveal that there is no standardised treatment that is followed by social workers, although the participants said that they implemented treatment services such as prevention, early intervention, inpatient, outpatient and aftercare for substance abuse that target both men and women. The findings show that prevention services cover awareness campaigns in society without any targeted gender, but rather aimed at helping anyone with substance abuse problems. These campaigns are done in partnership with stakeholders such as the South African Police Services, health professionals and the Department of Justice. However, due to the COVID-19 pandemic, the social workers were unable to conduct prevention services from March 2020 as social gatherings were prohibited.

The findings also show that early intervention services were rendered to women who had been identified as having substance abuse problems at an early stage, with therapy sessions and psychoeducation. It was further found that the participants initially struggled to cope with women who required inpatient treatment services, since Limpopo was dependant on treatment facilities in other provinces – mostly Gauteng and Mpumalanga – before one was established in Limpopo. The focus of the centre in Limpopo initially was on men rather than women, but it is currently working with both men and women over the age of 18. The findings also show that there are only a few outpatient treatment sites in Limpopo managed by SANCA, which makes it difficult for women to access help in the community. Each district has one outpatient social worker who works twice a month and participants assert that they are not easily accessible to most district beneficiaries due to the geographic location that they work from, since they can only service nearby villages. The findings also show that social workers

employed by the Department of Social Development are not trained to render outpatient services; as a result, women suffer due to a lack of easy access to services.

It was also found that social workers who refer women for treatment services are expected to render aftercare and reintegration services, but they lack insight into these services as there are no guidelines in place to assist in rendering services. This has a negative effect on the retention of women with substance abuse problems. There is a need to market substance abuse treatment services among women for them to reach out for help. Given the findings above, it can be concluded that treatment services available at the Department of Social Development are not easily accessible to most women.

Recommendations

- The Department of Social Development should develop women's substance abuse forums within municipalities that focus on identifying the gaps that exist in the substance abuse treatment services in order to gather inputs that will be used to amend the frameworks and legislation on substance abuse treatment services for women.
- The Department of Social Development should allocate more funds to NGOs rendering outpatient treatment services so that they can expand their services to cover all municipalities. Also, they should train social workers employed by the DSD on the implementation of outpatient treatment services for easy access in all communities where social workers are serving.
- The Department of Social Development should make use of all beds in the Seshego Treatment Centre to close the gaps identified and this can be achieved by hiring more staff as currently there is a shortage of staff that led to minimal functioning of the centre.

5.2.5 Accessibility of treatment services

The study reveals that prevention, early intervention and aftercare and reintegration services are accessible, as these are offered by local social workers. However, inpatient and outpatient treatment services are not easily accessible, since there are limited facilities rendering these services in Limpopo province. The outpatient sites are limited to one social worker in each district office and is only open twice a month. The

Department of Social Development does not have enough transportation for women to be taken to outpatient sites, and the women cannot afford to use public transport for all the sessions scheduled. It was also found that the treatment centre that is operating in the province has low capacity to cater for people with substance abuse problems. As a result, there is a long waiting list for admission. Other treatment centres found in other provinces strictly prioritise women from their own provinces, which leaves women from Limpopo more vulnerable and with no hope.

The findings also reveal that processes and procedures need to be followed to access treatment services. The length of the process seems to be worsened by the admission requirements set by treatment centres, such as mandatory medical reports, blood tests and biopsychosocial information. This process can potentially take time as these require the participation of different stakeholders and facilitated by a social worker. The findings also show that most women change their minds during the process due to impatience. Furthermore, the process differs in terms of the type of service required and the treatment services to be implemented, whether voluntary, involuntary or committal. The study reveals that it is unlikely for women to seek treatment voluntarily and, if they do, they are subjected to a long waiting list that can turn out to be positive or negative, depending on the capacity of the treatment facility.

The findings show that women and men have an equal opportunity to access substance abuse treatment, although women do not take the initiative to look for treatment. The treatment facilities available do not have enough beds for women, which could be due to the low number of applications for admission by women. Women are found to be reluctant to step out and seek treatment, and this can be misinterpreted as men being prioritised because they are often found in large numbers at the treatment facilities. When every service user can access treatment services, it will minimise the effect of substance abuse on women and their families. It can be concluded that administration processes for admission limit women in accessing substance abuse treatment services. Therefore, equal treatment of men and women is important and social workers can advocate for policies in treatment facilities that promote fair sharing of beds between men and women.

Recommendations

- Social workers employed by the Department of Social Development working in local areas should be capacitated to render outpatient services that will be accessible to every woman, which will give women the opportunity to attend treatment and return home daily to fulfil their responsibilities.
- The Department of Social Development should strengthen its working relationship with other stakeholders such as the Department of Health, Department of Justice and the South African Police Services for the betterment of external referral processes between professionals working with women in need of substance abuse treatment services. This will promote the retention of women who seek substance abuse treatment services as they will receive support from all role players.
- The Seshego Treatment Centres should review and reconsider the admission procedures and criteria in order to accommodate women and their needs, and also to give feedback to the applicants on time to promote retention. It should also consider accepting applications for treatment directly from service users, since some women feel uncomfortable reporting their cases to local social workers.
- The treatment facility should balance the genders when it allocates bed capacity for admissions and when processing applications for the admission of service users.
- The Department of Social Development should increase human resources in the centre in order to allow the centre to function to its full capacity and make use of all available beds.

5.2.6 The role social workers play in assisting women to access substance abuse treatment

The findings show that social workers are the custodians of the Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008, as they take control of the helping process. Their role involves the intake, assessment, problem identification and development of individualised treatment plans based on the needs of the client. In executing their roles, social workers use assessment which is the most important tool

used for their day-to-day services to their clients. It is also helpful in determining suitable interventions for the identified problem in order to meet the client's needs holistically.

The findings also show that social workers are at an advantage in identifying women with substance abuse problems through the assessments they do in relation to the cases and referrals they work with daily (including child abuse, domestic violence and family problems). The participants pointed out that it was difficult to identify women with substance abuse problems, since most do not seek help and hide their problems. However, a good working relationship between social workers and other stakeholders is promoted for easy identification by different offices and to foster referral processes. Despite different challenges encountered by social workers when working with women, it can be concluded that social workers are the pillars of substance abuse treatment services and they need to be strengthened in order to provide effective and efficient services.

Recommendations

- The Department of Social Development should develop screening and assessment tools to be used by social workers to determine if there are elements of substance abuse in the cases they work with on a daily basis. The tools can also be used by community development officers when they conduct door-to-door campaigns to identify women with substance abuse problems and refer them to social workers.
- Social workers should raise awareness in communities of information sharing and capacity building regarding processes of helping women with substance abuse problems when they identify them.
- The Department of Social Development should allocate funds to train social workers in the field of substance abuse, such as the courses on addiction care offered by University of Cape Town and Stellenbosch University for the improvement of substance abuse treatment services in the department.

5.2.7 Barriers women face in accessing substance abuse treatment services

The study shows that participants found it difficult to identify barriers women face in accessing substance abuse treatment services, since they hardly have any cases of women seeking these services. The poor experiences of social workers working with women with substance abuse problems have a negative effect on their willingness and eagerness to advocate for the improvement of treatment services for women. Women are found to be in denial of their substance abuse problem, which makes it difficult for social workers to provide substance abuse treatment services. The stigma and stereotypes that surround women play a huge role in preventing them from accessing treatment services. Society also is not informed about substance abuse treatment services for women, which results in a lack of support for women.

The findings show that women do not easily access treatment services because of the waiting list due to limited bed capacity and the need to wait for more female applications to be admitted together. It was also found that a lot of women withdrew during the waiting period because they were impatient and had lost hope. The admission criteria were found to be one reason women were not accessing treatment services, as there are many requirements, and several service providers must be consulted to gather the required documents. The findings show that the limited treatment facilities are also part of the barriers for women to access treatment.

Most women are mothers, so it is a big decision when they must choose between treatment and their children. As a result, they do not initiate treatment and deny substance abuse when identified due to fear of losing custody of their children, the social support grant and support from their families. They fear resentment from their intimate partners and their children, as society will label them unfit to raise their children and look after their families. The findings also suggest that social workers working with limited resources are unable to render effective services to women with substance abuse problems. Women who must attend outpatient treatment services rendered by SANCA require transport, which is already a challenge among social workers. Therefore, lack of treatment services designed for women does not encourage women to initiate help, since they believe help is designed for men. A lot needs to be done to convince women that they are also the beneficiaries of the available treatment services. It can be concluded that women are surrounded by a lot

of barriers to access treatment. However, some barriers can be minimised by empowering women and creating opportunities for them to seek help.

Recommendations

- Social workers and other stakeholders should address issues of stigma in society by capacitating and educating community leaders about substance abuse and treatment services for women to encourage women to seek for help freely and with community support, which will improve the effectiveness of the services. Furthermore, education services should be rendered to the families of women with substance abuse problems for them to have a better understanding of substance abuse and to support their loved one in recovery.
- Social workers need to implement involuntary treatment services in terms of section 33 of the Prevention of and Treatment of Substance Abuse Act, No. 70 of 2008 to women who are declared a danger to themselves, their families and the community at large while abusing substance. They should also ensure that children of women placed involuntarily in treatment have someone to look after them for the period of treatment. The social worker can also consider placing children in child and youth care centres as a last resort if no one is willing to look after them, as this will give their mother assurance that they are well taken care of.
- Treatment centres should make provision for children to visit their mothers often, which could motivate them to complete treatment.
- The Department of Social Development should allocate enough money for resources for social workers, such as an internet connection, transport and other working tools, in order to improve their service delivery to women with substance abuse problems.
- There is a need for interdepartmental collaboration between the Department of Social Development and Department of Health given the need to develop integrated substance abuse treatment services that will address health issues such as pregnant women who seek treatment and women with comorbidities including mental health problems such as unresolved trauma, eating disorders, anxiety and mood disorders in order to retain women in treatment centres until

their intervention programmes are complete. This can be achieved through a multidisciplinary team consisting of medical practitioners, psychologists, psychiatrists and social workers within treatment centres.

5.3 RECOMMENDATIONS FOR FUTURE RESEARCH

In the light of the results of the empirical study regarding social workers' perspectives on barriers to substance abuse treatment for women in Limpopo province, it is recommended that future studies look at the development and improvement of treatment services that address all the barriers that hinder women from accessing substance abuse treatment. Future studies should explore women's needs in a treatment setting, whether inpatient or outpatient. The effectiveness of placing women in treatment as involuntary service users and the effect it has on their families and children is another research area worth investigating.

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ANNEXURES

Annexure A: Interview schedule

1. Biographic information of participants [gender, years of working experience as social worker and municipality they are working in].
2. What is your perspective on the prevalence of women abusing substances in your municipality?
3. What type of drugs do you think women commonly use?
4. What could be the reasons women abuse substances?
5. What are the available treatment services and programmes for women abusing substances?
6. Do you think women have enough knowledge on the available treatment services for substance abuse? Elaborate on your answer.
7. What do you think are barriers faced by women in accessing treatment for substance abuse?
8. What kind of assessment aids do you utilise to determine substance misuse among women?
9. What are the challenges you encounter in identifying women abusing substances?
10. What are your views on the ratio between men versus women in accessing substance abuse treatment?
11. What are your roles as a social worker in ensuring that women access substance abuse treatment?
12. What would you recommend on treatment accessibility for women?

Annexure B: Consent form for participants



UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

DEPARTMENT OF SOCIAL WORK

Social workers' perspectives on barriers to substance abuse treatment for women in Limpopo Province

CONSENT TO PARTICIPATE IN RESEARCH

You are invited to take part in a study conducted by Baloyi D.E., from the Department of Social Work at Stellenbosch University. You were approached as a possible participant because you are working in the field of substance abuse.

1. PURPOSE OF THE STUDY

The research is aimed at gaining an understanding of the perspectives of social workers on the barriers women face in attempt ton accessing substance abuse treatment in Limpopo Province.

2. WHAT WILL BE ASKED OF ME?

If you agree to take part in this study, you will be asked to do the following: to participate in a semi-structured interview that will take approximately sixty minutes. The interview will be conducted at a time and place convenient to you. The interview will be audio-recorded then later transcribed by the researcher. The interview will take the form of a conversation between you and the researcher during which you will be asked to respond to questions about your perspectives on barriers to substance abuse treatment access for women. Should you require further information about the research, please contact the researcher via email at eugineabaloyi@gmail.com.

3. POSSIBLE RISKS AND DISCOMFORTS

There are no anticipated risks associated with participating in this research other than a time inconvenience. Should you, however, feel uncomfortable or distressed during the research process, you can pause or cease the interview. The research is considered low risk in terms of the ethical considerations and no personal information (e.g. names of the participants) will be shared in the narrative of the research.

4. POSSIBLE BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

There are no anticipated benefits to you personally in participating in this research, but you will have the opportunity to share your views and experiences on barriers to substance abuse treatment for women abusing substances. The long-term benefit of your participation could be that the findings of this study might influence laws and policies that have a bearing on social welfare and individual wellbeing of women abusing substances and their families.

5. PAYMENT FOR PARTICIPATION

There will be no payment or compensation for participating in this research study.

6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY AND IDENTITY

Any information you share with me during this study and that could possibly identify you as a participant will be protected. This will be done by securing data in a locked cabinet at the home of the researcher to ensure confidentiality. Any personally identifiable information collected for this research will be kept confidential and will be disclosed only with your consent or as required by law. The researcher and the supervisors are the only people with access to your personally identifiable information. The names of the participants will not be mentioned in the narrative of the research, nor the name of the organisations they work in. Confidentiality will also be maintained by coding the interview transcripts. All interview transcripts will be managed, analysed and processed by the researcher and kept in a code word-protected folder on a computer.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you agree to take part in this study, you may withdraw at any time without consequences. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may withdraw you from this study if you feel unsafe.

8. RESEARCHER'S CONTACT INFORMATION

If you have any questions or concerns about this study, please be free to contact Euginea Baloyi, at eugineabaloyi@gmail.com, or call +27732999847 and/or the supervisor, Mrs Priscalia Khosa, of the Department of Social Work, Stellenbosch University, at priscalia@sun.ac.za or call 0609391655.

9. RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant, I confirm that:

- I have read and understood the above information and it is written in a language that I am comfortable with.
- I have had a chance to ask questions and all my questions have been answered.
- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.

By signing below, I _____ agree to take part in this research study, as conducted by _____

Signature of Participant

Date

DECLARATION BY THE PRINCIPAL INVESTIGATOR
--

As the **principal investigator**, I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition I would like to select the following option:

	The conversation with the participant was conducted in a language in which the participant is fluent.
	The conversation with the participant was conducted with the assistance of a translator (who has signed a non-disclosure agreement), and this consent form is available to the participant in the language in which the participant is fluent.

Signature of principal investigator

Date

Annexure C

P.O. Box 942

Vongani

0930

09 September 2019

The Head of Department

Limpopo Department of Social Development

Private Bag X9710

Polokwane

0700

Attention: Ms. MD Ramokgopa

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am writing to request permission to conduct a study at the Department of Social Development in Limpopo province. I registered for a Masters' Degree in Social Work with the University of Stellenbosch. The title of a Research Proposal is: "*Social workers' perspectives on barriers to substance abuse treatment for women in Limpopo Province*".

As the employee of the Department of Social Development at Seshego Treatment Centre, the researcher observed that the treatment centres have more male service users and a limited number of female service users. This was also evident during the benchmark visit to most treatment centres in the country and confirmed by (South African Community Epidemiology Network on Drug use [SACENDU], 2018) report that shows that female service users who received in-patient services ranges between 12% and 29%. This prompted the researcher – who is also an employee of this

department – to want to establish perspectives of substance abuse coordinators as referring agents to treatment on barriers that women are facing in seeking or accessing treatment services.

Based on the above background, I therefore request for a permission to conduct the research involving the employees of this department as research participants. It is hoped that the study will make a contribution towards the containment of substance abuse in the Limpopo Province.

I trust you will find this request to be consistent with research proposal requirements.

Yours faithfully

Baloyi Dzunisani Euginea

Student no: 20605412

Date

ANNEXURE D

CONFIDENTIAL



OFFICE OF THE PREMIER

Research and Development

Directorate

Private Bag X9483, Polokwane, 0700, South Africa

*Tel: (015) 230 9910, Email:
mokobij@premier.limpopo.gov.za*

LIMPOPO PROVINCIAL RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

Meeting: July 2020

Project Number: LPREC/06/2020: PG

Subject: Social Workers' Perspectives on Barriers to Substance Abuse Treatment for Women in Limpopo Province

Researcher: Baloyi DE

Dr Thembinkosi Mabila

Chairperson: Limpopo Provincial Research Ethics Committee

The Limpopo Provincial Research Ethics Committee (LPREC) is registered with National Health Research Council (NHREC) Registration Number REC-111513-038.

Note:

- i. This study is categorized as a Low Risk Level in accordance with risk level descriptors as enshrined in LPREC Standard Operating Procedures (SOPs)***
- ii. Should there be any amendment to the approved research proposal; the researcher(s) must re-submit the proposal to the ethics committee for review prior data collection.***
- iii. The researcher(s) must provide annual reporting to the committee as well as the relevant department.***

- iv. The ethical clearance certificate is valid for 12 months. Should the need to extend the period for data collection arise then the researcher should renew the certificate through LPREC secretariat. PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRIES.**

ANNEXURE E

CONFIDENTIAL



OFFICE OF THE PREMIER

TO: DR R MOKOBANE

FROM: DR T MABILA

ACTING CHAIRPERSON: LIMPOPO PROVINCIAL RESEARCH COMMITTEE (LPRC)

DATE: JULY 2020

SUBJECT: SOCIAL WORKERS' PERSPECTIVES ON BARRIERS TO SUBSTANCE ABUSE TREATMENT FOR WOMEN IN LIMPOPO PROVINCE

RESEARCHER: BALOYI DE

Dear Colleague

The above researcher's research proposal served at the Limpopo Provincial Research Committee (LPRC). The committee is satisfied with the methodological soundness of the research proposal.

Decision: the research proposal is granted full approval.

Regards

Acting Chairperson: Dr T Mabila

A handwritten signature in black ink, appearing to be "T Mabila".

Secretariat: Ms J Mokobi

Date: 07/08/2020

ANNEXURE F

6 November 2019

Project number: 11746

NOTICE OF APPROVAL*REC: Social, Behavioural and Education Research (SBER) - Initial Application Form**Project Title: Social workers' perspectives on barriers to substance abuse**treatment for women in Limpopo Province Dear Miss Dzunisani Baloyi**Your REC: Social, Behavioural and Education Research (SBER) - Initial Application Form submitted on 2 October 2019 was reviewed and approved by the REC: Humanities.**Please note the following for your approved submission:***Ethics approval period:**

Protocol approval date (Humanities)	Protocol approval date (Humanities)
6 November 2019	05 November 2022

GENERAL COMMENTS:

v. The researcher must please ensure that identities of drug addicts or victims are not revealed in the study. Also, be wary of stereotyping men as different from women. There may be differences but be careful of making broad generalisations.

vi. The researcher is reminded to supply the REC with proof of permission to access data from the DSD. [ACTION REQUIRED]

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: Humanities, the researcher must notify the REC of these changes.

Please use your SU project number (11746) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary)

Included Documents:

Document Type	File Name	Date	Version
Research Protocol/Proposal	Approved by DESC Baloyi RESEARCH PROPOSAL 30.9	01/10/2019	final version
Data collection tool	INTERVIEW GUIDE	01/10/2019	Final
Request for permission	PERMISSION FOR DATA	01/10/2019	Final
Budget	RESEARCH BUDGET	01/10/2019	final
Informed Consent Form	complete informed consent form	01/10/2019	final version
Default	DESC Approval Form Eugenea	01/10/2019	Final

If you have any questions or need further help, please contact the

REC office at cgraham@sun.ac.za. Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Human Research (Humanities)

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.

The Research Ethics Committee: Humanities complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2. Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents/process, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4. Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur**. If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouche within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8. Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9. Final reports. When you have completed (no further participant enrollment, interactions or interventions) or stopped work on your research, you must submit a Final Report to the REC.

10. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.



UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

2 August 2020

Project number: 11746

NOTICE OF APPROVAL

REC: SBER - Amendment Form

Project Title: Social workers' perspectives on barriers to substance abuse treatment for women in Limpopo Province

Dear Miss Dzunisani Baloyi

Co-investigators:

Your REC: SBER - Amendment Form submitted on 14 July 2020 was reviewed and approved by the REC: Social, Behavioural and Education Research (REC: SBE).

Please note below expiration date of this approved submission:

Ethics approval period:

Protocol approval date	Protocol expiration date
6 November 2019	5 November 2022

SUSPENSION OF PHYSICAL CONTACT RESEARCH DURING THE COVID-19 PANDEMIC

Due to the Covid-19 pandemic and resulting lockdown measures, all research activities requiring physical contact or being in undue physical proximity to human participants has been suspended by Stellenbosch University. Please refer to a [formal statement](#) issued by the REC: SBE on 20 March for more information on this.

This suspension will remain in force until such time as the social distancing requirements are relaxed by the national authorities to such an extent that in-person data collection from participants will be allowed. This will be confirmed by a new statement from the REC: SBE on the university's dedicated [Covid-19 webpage](#).

Until such time online or virtual data collection activities, individual or group interviews conducted via online meeting or web conferencing tools, such as Skype or Microsoft Teams are strongly encouraged in all SU research environments.

If you are required to amend your research methods due to this suspension, please submit an amendment to the REC: SBE as soon as possible. The instructions on how to submit an amendment to the REC can be found on this webpage: [[instructions](#)], or you can contact the REC Helpdesk for instructions on how to submit an amendment: applyethics@sun.ac.za.

GENERAL REC COMMENTS PERTAINING TO THIS PROJECT:

INVESTIGATOR RESPONSIBILITIES

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: SBE, the researcher must notify the REC of these changes.

Please use your SU project number (11746) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

You are required to submit a progress report to the REC: SBE before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary).

Once you have completed your research, you are required to submit a final report to the REC: SBE for review.

Included Documents:

Document Type	File Name	Date	Version
Research Protocol/Proposal	EDITED Approved by DESC Baloyi RESEARCH PROPOSAL 30.9 COVID 10	13/07/2020	02
Data collection tool	Annexure A	14/07/2020	02

If you have any questions or need further help, please c

contact the REC office at cgraham@sun.ac.za.

Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Social, Behavioral and Education Research

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Research Ethics Committee: Social, Behavioural and Education Research complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

Principal Investigator Responsibilities

Protection of Human Research Participants

As soon as Research Ethics Committee approval is confirmed by the REC, the principal investigator (PI) is responsible for the following:

Conducting the Research: The PI is responsible for making sure that the research is conducted according to the REC-approved research protocol. The PI is jointly responsible for the conduct of co-investigators and any research staff involved with this research. The PI must ensure that the research is conducted according to the recognised standards of their research field/discipline and according to the principles and standards of ethical research and responsible research conduct.

Participant Enrolment: The PI may not recruit or enrol participants unless the protocol for recruitment is approved by the REC. Recruitment and data collection activities must cease after the expiration date of REC approval. All recruitment materials must be approved by the REC prior to their use.

Informed Consent: The PI is responsible for obtaining and documenting affirmative informed consent using **only** the REC-approved consent documents/process, and for ensuring that no participants are involved in research prior to obtaining their affirmative informed consent. The PI must give all participants copies of the signed informed consent documents, where required. The PI must keep the originals in a secured, REC-approved location for at least five (5) years after the research is complete.

Continuing Review: The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the REC approval of the research expires, **it is the PI's responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur**. Once REC approval of your research lapses, all research activities must cease, and contact must be made with the REC immediately.

Amendments and Changes: Any planned changes to any aspect of the research (such as research design, procedures, participant population, informed consent document, instruments, surveys or recruiting material, etc.), must be submitted to the REC for review and approval before implementation. Amendments may not be initiated without first obtaining written REC approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

Adverse or Unanticipated Events: Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the REC within **five (5) days** of discovery of the incident. The PI must also report any instances of serious or continuing problems,

or non-compliance with the RECs requirements for protecting human research participants.

Research Record Keeping: *The PI must keep the following research-related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence and approvals from the REC.*

Provision of Counselling or emergency support: *When a dedicated counsellor or a psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.*

Final reports: *When the research is completed (no further participant enrolment, interactions or interventions), the PI must submit a Final Report to the REC to close the study.*

On-Site Evaluations, Inspections, or Audits: *If the researcher is notified that the research will be reviewed or audited by the sponsor or any other external agency or any internal group, the PI must inform the REC immediately of the impending audit/evaluation.*