Journal of Addiction Research & Therapy
ISSN: 2155-6105
Khumalo, et al., J Addict Res Ther 2019, 10:4
Review Article
Open Access

Ecological and Recovery Approaches to Curbing Whoonga Addiction in South Africa: A Critical Hermeneutical Review of Literature

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Received date: June 18, 2019; **Accepted date:** August 12, 2019; **Published date:** August 20, 2019

Abstract

In dealing with a wave of addiction to whoonga, a heroin variant drug beleaguering mainly Black African youth in South African townships and informal settlements, harm reduction measures take their cue from successes around the world. They call for community-based approaches that include availing opioid substitution therapy, and complementing professional expertise. This non-judgmental approach, compared with the preceding, moral and medical models on drug addiction, is concerned with alleviating negative psychological and social effects associated with addiction to drugs. This paper reviews literature on whoonga addiction in South Africa. The study theorises on the adoption of ecological and recovery approaches to drug addiction as appropriate to a whoonga situation, complementing harm reduction measures at local and community levels of intervention. The study adopted recovery as an organizing concept to give the face, the voice, the vision, choice, and hope that whoonga addiction can be overcome. The dislocation theory is revisited. This theory is consonant with a recovery movement at local level. It advances the idea of eradicating addictions: both interventions involve engaging the community agency.

Keywords: Addiction; Whoonga/nyaope; Recovery; Dislocation theory; Ecological approach

Introduction

An unintended consequence of democracy in South Africa, when 1994 ended its pariah status, signalling admission to the global community, is that the country had exposure to an influx of illicit drugs [1,2]. The most popular and enduring opioid that took hold of Black African youths in townships and informal settlements in the early 2000s is whoonga or nyaope [3,4]. This drug is described as a white powder, comprising low-grade heroin, and a multitude of cutting agents [3,5]. Its availability in third-world settings is associated with the increased production of opium in the Middle East that dropped in demand on original markets [6-8]. In seeking new markets, South Africa became an attractive 'emerging market' for the drug underworld. A large number of drugs in the Southern African Development Community (SADC) region were destined for the country [7-9].

As with the rest of African countries, South Africa moved from being a footnote in the drug story, a 'transit' or 'transhipment hub' for drugs destined for other continents, to becoming a destination [3,10,11]. Compared with drugs that have always been available among these communities, for example, dagga (cannabis), Mandrax (methaqualone), glue, and other inhalants, etc., whoonga is a hard drug. Whoonga created dedicated users in large numbers over a relatively short time. Other than elevating levels of crime and other social ills like prostitution, dropping out of school, interpersonal violence, etc., whoonga created homelessness. This was characterised by now dissolved whoonga parks or colonies in major cities [12-15]. The drug has spread nationwide; with evidence of its use in rural areas, as well as in neighbouring countries [16-19].

Method

This review of literature is from a study on interpretative phenomenological analysis (IPA) of addiction and recovery from whoonga. It draws from the critical hermeneutical analysis, an element that IPA balances with the hermeneutics of empathy [20]. Critical hermeneutics on the life of participants focuses on the analysis of the context; and how it shapes the everyday lives of participants. For Smith [21], the researcher critiques historical bases of dominant ideologies. Smith describes how these ideologies shape and organize the daily lives of study participants. Since socially accepted views about a phenomenon are usually those of the privileged, in giving addicts a voice, " … they may plan social and political actions that can help remedy some of the historical and environmental conditions that affect their health and well-being" [21]. The paper draws from ecological approaches. The recovery paradigm and the dislocation theory are used to theorize on group or community support at harm-reduction level. Dislocation theory further theorises on the elimination of drug addiction through removing alienation and supporting social integration [22,23].

In discussing literature on whoonga addiction, pioneering and authoritative studies in the field will point to what has been a priority, giving a background of what has been done. Owing to its newness as a drug that creates dedicated users, and the speed at which whoonga addicts grew, the need to know what the drug was took precedence. The taxonomy of the drug therefore fuelled a number of studies on addiction to whoonga. The profile of whoonga addicts was delineated, together with the context in which these addictions thrive [24,25]. The effects it has on individuals experiencing addictions, the effect it has on families and communities, as well as its withdrawal signs were outlined [25-27]. The paper discusses ecological theories and how the recovery model as a harm-reduction measure is essential in engaging the community. Therapeutic or engaged communities consider addictions

as threatening their survival; and a need to curb them a socio-political and economic necessity [28].

Whoonga: An addiction to heroin

To some, whoonga is considered the repackaging of the drug that has always been available in society prior to 1994 [7,29]. Heroin use changed its face from a White male group, accounting for less than 2% of intake, to about 65% of Black youth admitted for heroin addiction and treatment in 2007 [30,31]. It was the concern with a range of 'other' ingredients allegedly contained in whoonga [32] that obscured the idea that it could be an opioid, mainly heroin and morphine [33-35]. These ingredients offered no proof of enhancing the potency of the drug as adulterants [36]. Many such ingredients serve purely as bulking or cutting agents, to increase the dealer's yield, given that pure heroin is expensive [5,37]. In pursuit of a taxonomy of whoonga as a drug, with clear visual evidence of its effects as a hard drug, the initial concern was the reports claiming use of antiretroviral medication (ARV) – the illicit redirecting of lifesaving medication for recreational use [38-42].

Consumption of whoonga, whose contents include ARVs, has psychiatric effects when these medications are taken as a pill, i.e., orally, and not smoked [42-45]. However, experts argue whether such a transfer of these effects is likely [29,46,47]. A warning of possible pre-treatment exposure to ARV medication through smoking whoonga was made. Pre-treatment exposure was hypothesized to have the potential of causing resistance to the drug upon the initiation of antiretroviral therapy [41,48,49]. Whoonga addiction was presented as complicating the treatment of HIV/Aids, evoking and escalating conditions that are rare for this part of the world [50-52]. Such placed a burden on and stretches meagre health and mental health resources [53]. The epidemic of whoonga addiction showed a potential to deplete the ARV roll-out in South Africa to treat another preceding scourge [54], also predominant among Black African youth HIV/Aids [55].

Proponents of theoretical neuropsychiatric attributes of smoked ARVs in whoonga nevertheless point out that ARVs were used. Redirecting them would affect supply to those who need it, and ultimately their cost [54,56]. Arrests and prosecutions were evidence of health officials selling ARVs for a whoonga mix [57,58]. ARVs featuring in some concoctions of whoonga supports the evidence of their use, albeit not widespread [33]. There is a view that the observed 'high' from smoking ARVs could be a placebo effect [46,59,60]. A chemist in Durban who tested a concoction for both a local television programme and an international documentary did not find ARV medication in six samples of whoonga powder sourced in Durban and surrounding areas, including townships [29]. The chemist suggested that ARV medication would not be sufficient to meet the whoonga demand. The conception that ARVs are an active drug in whoonga is considered a myth in some quarters [61]. However, according to the manufacturer, Sustiva or Efivarenz, is a white crystalline substance that is insoluble in water [62]. While insolubility in water does not imply combustibility, the colour of ARVs advances the conjecture that ingredients in whoonga mimic purer forms of heroin, i.e., white, the injectable type, or brown, the smokable type [63].

Whoonga addiction in South Africa

Problematic drug use pervades all walks of life and social classes, such that both rich and poor are affected [64]. The harshness of a life as a 'druggie' or a dedicated user, whose life centres on acquiring and consuming the drug, often affects the indigent [65]. The purity of the drug one uses can help evade death, or the overdose caused by adulterants. The ability to afford rehabilitation, and lawyers upon arrest for possession, are among other factors that shield affluent addicts [64]. Whoonga addiction is not limited to lower class Black African communities in townships and informal settlements [66-68]. However, this group is affected the most, perhaps through exposure to conditions of poverty [7]. Black African youth in townships lack relevant skills. This leads to high levels of unemployment [69]. In a space where boredom is rife, left with nothing to do, the influence of peers becomes a dominant risk factor that compounds enticement to drug use [70]. Most addicts report that a pull to use drugs arises as an escape from a monotonous and squalid everyday existence in the townships [7], the spaces of alienation [71]. As a highly unequal society, those who enjoy the least privilege and the lingering effects of apartheid could easily suffer the most, the Black Africans [7]. In other instances, peddling, and the subsequent increase in the use of drugs is evident in countries undergoing socio-political transition [72].

Youth addiction to whoonga is associated with crime, especially theft; despite that a number of addicts hustle (phanta) [73]. They provide cheap labour, collect and sell plastic and scrap metal, wash vehicles, among other menial jobs, to sustain their addiction and inadvertently enrich drug dealers [73]. To ward off withdrawal from whoonga, some people are prepared to do whatever it takes [61]. This includes prostitution [5,73] housebreaking, mugging, inter alia [1,74]. Communities from which whoonga addicts hail, and those who dwell in peri-urban areas, including business people and the public, have in various ways voiced concerns to government officials. These concerns have ranged from seeking help for their own children [75], fear of squalor [73], personal and property safety, as well the spread of whoonga addictions [76]. Owing to the crimes that youth addicted to whoonga commit, if they do not suffer mob justice [77-79], they are often arrested. Arrests gain them criminal records that further dim chances of gainful employment.

The government has amended legislation to discourage the peddling and possession of whoonga [80]. This has helped the prosecution and the police who had previously struggled to arrest and successfully prosecute those in possession of a white powder with unknown contents. This new legislation was welcomed in limiting supplies of this drug [81]. There are those who oppose the prosecution of an addict who is otherwise a patient in need of treatment and rehabilitation [82]. These proponents advocate for the decriminalization of the drug, citing success of this model in European countries [83]. They further endorse the roll-out of opioid substitution therapy (OST) [84]. As a health issue, whoonga addiction intersects with other existing health concerns such as its intravenous use, HIV/AIDS, Hepatitis B and C as well as tuberculosis [85-87].

The conception is that whoonga should warrant urgent intervention accorded to conditions it intersects with [88]. Therefore, to legalize the drug, and even to tax its sales would remove the drug as a currency of addiction controlled by the underworld [61,88]. Regulated, the drug could be cleaner, and revenue generated could be directed to health and other relevant needs [89]. The criminal justice system was perceived as being less capable of rehabilitating whoonga addicts. A suggestion for collaboration between the Department of Justice and Correctional Services and the Department of Health was made [90]. The idea is to redirect youth addicted to whoonga to rehabilitation. This assists in avoiding dry detoxification weaning oneself off drugs without medical or professional help, tantamount to suffering the full

blow of withdrawal symptoms. Whoonga addicts avoid such at all costs, hence they often relapse [90]. Dry detoxification is illustrated vividly in the movie Basketball Diaries [the character played by a young Leonardo DiCaprio] [74]. For whoonga, in a local documentary, coming clean overcoming Nyaope Addiction [91], there are negative effects associated with dry detoxification. The negative implication of dry detoxification hinders long-term recovery [90].

The need for collaborative efforts against the wave of whoonga addictions is not limited to the treatment of youth addicts per se. There is a need to support families who are adversely affected by having a family member addicted to drugs. In addiction literature, mothers deal with a range of emotions that begin with knowing that a child is addicted, to fear for the safety of their children as mob justice may befall them [26,92]. Interventions in drug addiction focus on the addicted person. There is little evidence, if it exists at all, of family members also receiving the attention and treatment they need [93].

Mothers of children addicted to whoonga often become highly stressed [94]. They also report feelings of shame, finding it difficult to approach extended family members who may also shun them. Such parents receive hardly any support [26,95]. The relationship with their child could be difficult and may not exist while the estranged child is in rehabilitation. The relationship has to be resumed with great difficulty upon discharge [96]. Youth addicted to whoonga are difficult to live with because they are irritable and unpredictable, having anger outbursts. Before they steal from the community, most start within their household: devices, appliances, and money disappear [25,74,96].

Seeking intervention

In the context of a drug that affects lower-class communities, and given the increasing number of youths addicted to whoonga (which, although it is unknown, is estimated to be in hundreds of thousands), the concern has been how to avail medical treatment en masse. The concern is on limited access to public rehabilitation centres [53,97], and that private rehabilitation institutions are expensive for most of these communities [25]. The suggestion has been to avail OST in the form of a mobile community clinic [98,99]. What this means is that recovering youth will remain in their original community and receive their prescription of methadone syrup from professionals visiting the community [84,100,101]. The use of substitution drugs to manage withdrawal from addiction ideally features in early recovery, in an institution, monitored, and tapered by professionals [102]. The substitute drug is similar to an original drug and there are fears of addiction to it also, as well as the possibility of overdose [100].

Institutions are considered capable of removing the recovering individual from the pressures of the daily grind, so that these individuals can focus on recovery [103,104]. A concern with lack of after-care facilities once these individuals have left the institution [105] is in availing OST to the communities. This is balanced by the idea that the end goal of recovering from addiction involves reintroduction to the original community. The concern with accommodation is addressed, among other needs, such as employment and the treatment of health problems, that a recovering individual would require when discharged [106,107]. This perspective adopts the view that communities would support treatment and recovery from addiction [108].

There are two concerns about the above approach. One is the medical position it focuses on, and the other is the idea that both professional and non-professional agents will help communities deal with addiction. The mainstream approach to drug addiction based on animal models conducted in the 1960s and 1970s sheds light on the neurobiology of addiction to hard drugs. The approach focuses on its irreversible nature, as well as loss of control over a disease [109]. Drug addiction is not only a physical disease. It has social, psychological, and cultural causes and effects, as acknowledged by the adoption of the biopsychosocial approach that all are integral and interactively involved in physical health and illness [110-113].

The disappointment with the bio-psychosocial approach is that it has not expanded application outside the original model, i.e., beyond careful history taking by Western trained health-care professionals [110]. Neither has a call for collaboration with other health sectors, disciplines, departments or ministries delivered [113,114]. In situations such as whoonga addiction, where it can no longer be business as usual, or the continuation of the obviously dysfunctional approach [115,116], this study adopted recovery, revisiting ecological approaches to drug addiction. Kolker [116] believes that it is an ethical obligation for addiction professionals to seek an alternative model because a 3-5% success is close to a 100% failure rate [116]. Although these ecological models grew differently, they both focus on the environment, with the former as a platform for healing [23], and the latter as the source of, and the means to stamp out addictions [117].

The proposal that addiction is a chronic relapse disease [118] has been criticized mainly because of the focus on addiction as a disease or a health problem [119]. This position downplays the social and psychological reasons that drive drug use [120]. Rat-park experiments were conducted around the same time as the animal models, using the positivist tradition of the times that continues today to help understand the neurobiology of addiction [121]. These experiments led researchers to conclude that caged rats died of overdose resulting from addiction to a drug [122]. Upon reviewing these experiments, Alexander and his colleagues confirmed that, when caged rats are introduced to a drug, they would take in continuous, subsequently increasing doses, eventually dying of drug overdose [123].

Alexander [124] concluded that this was not because of the drug; rather, because of the cages. In subsequent experiments, Alexander [124] created a rat park or rat haven, where rats had access to companionship that comes with relationships, and sex, play toys, enough food and water, sawdust in the floor, going on to mimic the natural environment of the rats, by painting a forest. In another experiment, rats that had spent time in cages (57 days) and were addicted to drugs were moved to rat parks [125]. These researchers observed that the environment contributed immensely to drug addiction/recovery. The dislocation theory of addictions ensuing from these experiments proposed that it was alienation that was the root cause of addiction. None of the addicted rats died when moved to the rat park environment [125].

Alexander [124] did not use the word recovery to describe laboratory rats that were moved after some time in cages and addicted to a drug, thereafter being placed in a rat park setting, going on to wean themselves off drugs [125,126]. Notions of recovery that brought hope to drug addiction as a retractable disease were stimulated by research conducted using urinalysis on Vietnam war veterans soon after they had returned. In a follow-up testing conducted a year afterwards, the majority of veterans had successfully recovered [127]. To further cement the context argument, an example is made of a surgery patient who receives high doses of morphine above the street level, and who, upon discharge, does not return home as a junkie [128]. Such an exposure to a drug, in the way most people would be

exposed to them, does not lead to addiction [129-131]. In similar ways as the recovery model, researchers on the Vietnam War veterans' study further questioned the sustainability of instantaneous remission or recovery from drugs [132].

The recovery paradigm

The focus on recovery is conceptually departing from a common position that drug addiction is a chronic relapse disease [118]. This idea is consistent with the mainstream approach to drug addiction in proposing that people have the capacity to stop taking drugs. However, because of a potential to relapse, long-term remission is difficult [133]. Therefore, the focus should be on supporting recovering addicts to remain sober as a movement of peers that put a face on recovery; and on the idea that drug addiction can be overcome [134]. The acute-care approach does not support the notion that drug addiction is a chronic disease that requires long term intervention [135]. This view proposes that it is not oppositional to the disease model, in celebrating recovery [23]. There is a focus on the positive aspect in an addiction story that has been narrated as never-ending and gloomy [136]. Addiction was considered a lifelong affliction difficult to recover from, given the irreversible neurochemical changes in the brain that the drug causes [137,138]. For the recovery model, the individual can do whatever it takes to stop, but they will need support to maintain sobriety at the individual and community levels [23]. This is called recovery capital [139]. Other than financial, employment and other requirements, recovery capital describes a sense of belonging within a community of peers and supportive relationships with caring others [28]. The recovery model would be appropriate and practical at local and community levels [23]. Together with the notion of therapeutic communities [140-142], it partially addresses what is theorized to cause addiction, which is alienation, a feeling of estrangement and of 'not belonging' that current geopolitical and economic forces cause [131,143]. However, alienation enforced by the moralist and prohibitionists culminating in the 'war on drugs' persecutes addicts [82,144]. This could exacerbate original feelings of alienation and consequently addictions. This makes recovery difficult.

There is a growing consensus that drug addiction (and other appetitive behaviours) are a means of escape [7], filling the void of not belonging [128,131]. Such are the means with which to deal with dislocation or alienation [145]. This view proposes that to abate addiction, the focus would be on harnessing elements that increase human contact [131]. These 'binding agents' or 'connectors' may be found in a culture that is seen to be able to evoke cemented authentic neighbourliness. These traditional relationships were damaged by the uprooting of people and the individual-orientated kind of life the capitalist model engenders [22,145-147]. Globalisation is harmful to local communities [148]. A side effect of professional help in communities is that it erodes these bonds, taking away support that was originally given by the community. An example is grieving: once, it was the immediate neighbours and the community, rather than the therapy room that supported individuals [146,147].

Treatment of drug addiction requires specialised fields of highly trained professionals [56,63]. Other supporting professional interventions and programmes are treatments rendered to the communities. Conducting needs assessments upon entry into these communities begin as a pathological evaluation [146]. Communities become consumers of professional services guided by resource management and funding, often inspired by top-bottom requirements. Hardly accepted is that this treatment, like any other treatment, has side effects [149]. Consumerism takes away community agency, disempowering communities they intend to empower. The cultural dominance and economic monopoly of these services 'colonise' and 'impose' ideas that are usual distant both culturally and physically to the communities [146]. Models exemplified by the Asset-Based Community Development (ABCD) model have been used to assess community assets that include skills, resources, and talents that can mobilize community engagement and agency [150]. This is a movement from identifying the community as clients, to identifying the community as strengths and assets. These virtues are capable of effecting necessary connections and associations that support long-term recovery management [147,150]. The presence of family and peers has positive effects, and sometimes prove necessary for recovery [23]. There is evidence that recovery is initiated by an individual, but that long-term recovery is supported at individual and community levels [23,151].

Recovery support challenges stigma and exclusion in the community, and presents a therapeutic landscape [146,152]. Further recruitment of assets and strengths when addicts 'in recovery' are in a group of peers further strengthens a community of connections and associations [137,152]. The hope is that recovery is contagious [153]. A therapeutic or welcoming community is support that wards off compensating for the need to connect [145,154]. In establishing a therapeutic community in a South African prison, professionals evaluated the benefits of peer support. In such an environment, they found, among other benefits, that prisoners found a space to confide issues that the prisoners would not be comfortable discussing with a professional [141]. This therapeutic landscape results when recovery connections and existing community assets are further increased by growing attachments or recruitments [23,155]. Communities are best equipped to be therapeutic, not only to stamp out addiction as a sign of becoming well, but also to prevent dabbling with drugs in the first place [156]. An antidote to drug addiction is caring [131,145]. In an African context, the sense of what one is, is defined by refined relationships one has with other selves [157]. A concept of Ubuntu permeates all walks of life [158-162]. It is the gift Africa gives to the world in dealing with drugs.

Conclusion

Kolker considers seeking alternatives to the mainstream approach to drug addiction an ethical responsibility of drug addiction professionals. Such professionals should not accept the level or lack of success in dealing with addictions worldwide. Ensuing harm reduction measures, dubbed the 'third wave' are an incremental ethical improvement compared with the preceding medical and moral approaches in dealing with addictions to whoonga, a heroin variant drug taking hold among Black African youth in South African townships and informal settlements, researchers suggest a roll-out of opioid substitution therapy. To address concomitant social and psychological issues, a systematic availing of professional expertise is further advanced. The view is that communities will assist treatment. Ecological models present a situation in which communities are not only an end-post to recovery, a site for healing but are a medium through which healing happens. Treatment should therefore assist to strengthen individuals and families and to build communities. This suggests that a professional role is facilitative. This role would be to assist the identification and bolstering of strengths essential in building associations or connections for group support. In engaging communities, one must hope to produce caring relationships.

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