

SOCIAL WORKERS' PERCEPTIONS ON THE IMPLEMENTATION
OF THE COALITION ON RESPONSIBLE DRINKING (CORD) PROGRAMME IN
NAMIBIA

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

MASTER OF ARTS IN SOCIAL WORK

OF

THE UNIVERSITY OF NAMIBIA

BY

MANFRIEDINE KANDJII

(9014535)

February 2016

MAIN SUPERVISOR: Prof. J. D. Matthews

ABSTRACT

The purpose of the study was to assess the perception of social workers on the implementation of the coalition on responsible drinking (CORD) programme in Namibia. The study investigated the achievements and challenges social workers at the Ministry of Health and Social Services (MoHSS) experience in the implementation of the CORD programme. The study also obtained detailed information about the inputs, activities, and processes of the programme in order to uncover the achievements and challenges experienced during the programme implementation, the adequacy of resource allocation, and the availability and transparency of programme documentation.

The main aim of the study was to collect data to assess the implementation of the CORD programme in preventing and mitigating alcohol abuse in Namibia by evaluating the opinions and perceptions of social workers who work directly with it. A quantitative research approach using a descriptive research design was adopted. A pilot study was conducted with ten (10) respondents in order to identify shortcomings and to correct the questionnaire. Data were collected through a structured questionnaire that involved closed ended and open-ended questions in order to gather more detailed and complex information from the respondents. Sixty-four respondents were identified as the sample population. The questionnaire was mailed to the respondents. Fifty-five respondents returned a completed questionnaire.

The study found that the CORD programme implementation is very important for the Ministry of Health and Social Services, the community and the stakeholders involved in its implementation. The study also found that there is a shortage of social workers to implement the programme. Furthermore there is a lack of necessary resources, as well as a monitoring and evaluation tool. The study also established that individual counselling is mainly used to help people with alcohol problems, whilst there is a low referral of people who are addicted to alcohol to rehabilitation centers.

Based on the findings of the study, it is suggested that more social workers be recruited and stakeholder involvement be strengthened. There is also a need to avail the necessary resources, such as funds and transport that can enhance the implementation of the planned activities. A monitoring and evaluation tool needs to be developed to monitor the progress of the implementation of activities. There is a need to operationalise and establish alcohol and drug rehabilitation services for treatment of people with alcohol addiction problems and aftercare services to ensure sobriety of rehabilitated clients.

TABLE OF CONTENTS

TABLE OF CONTENTS.....	iii
LIST OF TABLE.....	viii
LIST OF FIGURES.....	xi
ACKNOWLEDGEMENT.....	xii
DEDICATION.....	xiii
DECLARATION.....	xiv
CHAPTER 1.....	1
1. INTRODUCTION.....	1
1.1 Orientation of the study.....	1
1.2 Statement of the problem.....	3
1.3 Study objectives.....	5
1.4 Research questions for the study.....	6
1.5 Significance of the study.....	6
1.6 Summary.....	7
CHAPTER 2.....	9
2. LITERATURE REVIEW.....	9
2.1 Introduction.....	9
2.2 Definition of terms.....	9
2.3 CORD programme and its purpose.....	12
2.4 Three key interventions strategies on which the CORD programme focuses.....	15
2.4.1 Prevention.....	15
2.4.1.1 Processes and structures of the substance (alcohol) prevention programme.....	17

2.4.1.2 Record keeping and communication during the implementation of the programme...	22
2.4.2 Legislation enforcement	27
2.4.3 Treatment	27
2.4.3.1 Different Treatment models/programmes for substances addicts.....	29
2.4.3.1.1 The Trans- theoretical ‘Wheel of change’ model	29
(i) Pre-contemplation stage	29
(ii) Contemplation stage	30
(iii) Preparation stage	31
(iv) Action stage.....	31
(v) Maintenance stage	32
(vi) Relapse stage	32
2.4.3.1.2 Individual counselling/ Outpatient individual therapy	32
2.4.3.1.3 Disease model	33
2.4.3.1.4 Motivational interviewing.....	34
2.4.3.1.5 Self-help/ Support groups	36
2.5 Stakeholders’ involvement in the implementation of the CORD programme.....	38
2.6 Alcohol effects	40
2.6.1 Alcohol and health	40
2.6.2 Alcohol abuse and HIV and AIDS.....	41
2.6.3 Alcohol and mental health	43
2.6.4 Alcohol and poverty.....	44
2.6.5 Alcohol and disability	45
2.6.6 The consequences of alcohol on the family and society.....	46
2.6.6.1 Generational changes in drinking attitudes.....	47

2.6.6.2 The influence of parents on the child drinking behaviour	49
2.6.7 Alcohol and gender	50
2.6.8 Alcohol abuse and accidents	52
2.6.9 Alcohol abuse and its effect at the workplace.....	52
2.7 Alcohol legislation and policies that enhance alcohol prevention in Namibia	54
2.7.1 Government control as a measure of controlling availability of alcohol.....	55
2.7.2 Licensing.....	56
2.7.3 Restriction of legal age on purchasing and use of alcohol beverages.....	57
2.8 Summary	59
CHAPTER 3	61
3. RESEARCH METHODOLOGY.....	61
3.1 Introduction.....	61
3.2 Rationale for the methodology.....	61
3.3 Research approach	62
3.4 Type of research.....	63
3.5 Research design	64
3.6 Description of the research population, sample and sampling method.....	64
3.6.1 Target population	64
3.6.2 Sampling methods.....	65
3.7 Research instrument.....	66
3.7.1 Questionnaire construction	66
3.7.2 Questionnaire items	67
3.8 Pilot study	67
3.9 Administration of questionnaires.....	68

3.10	Collection of questionnaires	68
3.11	Data processing and analysis	68
3.12	Validity and reliability	69
3.13	Eliminations of bias	71
3.14	Ethical considerations	71
3.14.1	Informed consent	71
3.14.2	Voluntary participation	72
3.14.3	Confidentiality	72
3.14.4	Avoidance of harm	72
3.15	Summary	73
	CHAPTER 4	74
	4. PRESENTATION AND INTERPRETATIONS OF RESULTS	74
4.1	Introduction	74
4.2	Presentation and interpretation of results	75
4.2.1	Respondents' information	75
4.2.2	Alcohol prevention and education	77
4.2.3	Enforcement of alcohol-related legislation	91
4.2.4	Treatment of people addicted to alcohol	96
4.2.5	Availability of resources	99
4.2.6	Monitoring and evaluation of CORD activities	105
4.3	Summary	111
	CHAPTER 5	112
	5. RECOMMENDATIONS AND CONCLUSIONS	112
5.1	Introduction	112

5.2 Conclusions.....	112
5.3 Recommendations.....	115
5.3.1 Directorate of Social Welfare Services:.....	115
5.3.2 Social Workers.....	116
5.4 Limitations of the study.....	118
5.5 Future research.....	118
5.6 Summary.....	119
REFERENCES.....	122
APPENDIX 1.....	131
QUESTIONNAIRE No:.....	131
APPENDIX 2.....	144
LETTER OF APPROVAL FROM MINISTRY OF HEALTH AND SOCIAL SERVICES	144
APPENDIX 3.....	145
LETTER OF APPROVAL FROM UNIVERSITY OF NAMIBIA.....	145

LIST OF TABLES

Table 1: Logic Plan Model	24
Table 2: Respondents by job title	75
Table 3: Respondents by job title and experience in social work and involvement in the CORD programme by job title	75
Table 4: Respondents' perception on importance of the CORD programme implementation for MoHSS, stakeholders and community	77
Table 5: Respondents' perception on importance of the CORD programme implementation for MoHSS, stakeholders and community by job title	78
Table 6: Respondents by reasons why CORD programme is important in the region/health district	79
Table 7: Main stakeholders that are aware of the CORD programme	80
Table 8: Main stakeholders by involvement in the implementation of CORD programme	80
Table 9: Main reasons for stakeholders' lack of involvement in the implementation of CORD programme	81
Table 10: Suggestions to improve stakeholder's involvement in the implementation of CORD programme	82
Table 11: Respondents by training received on alcohol prevention, treatment and counselling	84

Table 12: Respondents by training received on alcohol prevention, treatment and counselling and job title	85
Table 13: Number of outreach sessions conducted in the past one year on alcohol prevention	88
Table 14: Stakeholders' awareness of the CORD programme	88
Table 15: Stakeholders implementing the CORD programme	90
Table 16: Type of legislation available to carry out awareness campaigns in the community	92
Table 17: Type of legislation used to carry out awareness campaigns in the community	92
Table 18: Type of policies/manuals available to carry out awareness campaigns in the community	93
Table 19: Type of policies/manuals used to carry out awareness campaigns in the community	94
Table 20: Type of interventions available to help patients with alcohol problems	96
Table 21: Type of interventions used to help patients with alcohol problems	97
Table 22: Number of referrals.....	98
Table 23: Reasons for none or low referrals.....	98
Table 24: Suggestions to address insufficient human resources.....	100
Table 25: Reasons why CORD programme is not funded by MoHSS.....	101
Table 26: List of other funding sources for CORD programme.....	103
Table 27: Major transport challenges	104

Table 28: Possible solutions to address transport problems	105
Table 29: Record sharing methods	108
Table 30: Suggestion on implementation of monitoring and evaluation (M&E) tool... 109	
Table 31: General comments on the implementation of the CORD programme	110

LIST OF FIGURES

Figure 1: Organogram.....	14
Figure 2: Respondents by possession of programme management training or qualification	76
Figure 3: Respondents by type of programme management training or qualification	76
Figure 4: Comfortable to advice clients on alcohol drinking problems.....	86
Figure 5: Availability of IEC materials	86
Figure 6: Usage of IEC materials.....	87
Figure 7: Number of stakeholders involved.....	89
Figure 8: Respondents by type of policies/laws	91
Figure 9: Respondents by sufficient human resources	99
Figure 10: Respondents by funding of CORD programme	101
Figure 11: Respondents by other funding sources for CORD programme.....	102
Figure 12: Respondents by availability of transport.....	103
Figure 13: Respondents by record keeping of CORD activities.....	106
Figure 14: Respondents by format of record keeping of CORD activities.....	106
Figure 15: Respondents sharing CORD activities with other stakeholders.....	107
Figure 16: Existence of monitoring and evaluation tool for the CORD programme.....	109

ACKNOWLEDGEMENTS

I would like to thank my supervisor, Professor John Matthews for his support and guidance during this study. Without him, this could never have been realized.

I would also like to thank the following people who contributed to the success of my studies:

- My husband Mr. M. U. Kandjii, and my sister Faye Tjaheya Kandjeo, for the support they provided me to complete my study.
- My supervisor Mrs. R. A. Adams, for moral and professional support during my studies.
- Mrs. H.U.L. Mouton, for valuable assistance and support during my studies.
- Mr. J. J. Swartz, Statistician who assisted with the entering and processing of data.
- Ms. L. Munro who assisted me with the editing of the thesis.
- Namibia Students Financial Assistance Fund for granting me financial assistance to complete this study.

DEDICATION

This work is dedicated to my late parents.

DECLARATION

I, Manfredine Kandjii, declare that this study is a true reflection of my own research, and that this work, or part thereof has not been submitted for a degree in any other institution of higher education.

No part of this thesis may be reproduced, stored in any retrieval system, or transmitted in any form, or by means (e.g. electronic, mechanical, photocopying, recording or otherwise) without the prior permission of the author or the University of Namibia.

I, Manfredine Kandjii, grant The University of Namibia the right to reproduce this thesis in whole or in part, in any manner or format, which The University of Namibia may deem fit, for any person or institution requiring it for study and research; providing that The University of Namibia shall waive this right if the whole thesis has been or is being published in a manner satisfactory to the University.

.....

[Signature]

Date.....

[Student's name]

CHAPTER 1

1. INTRODUCTION

1.1 Orientation of the study

The production and sale of alcoholic beverages is an important economic activity in many countries (Babor et al., 2010). According to the above mentioned authors, alcohol generates profits for the producers, advertisers, provides employment opportunities, generates tax revenues for governments, and brings in foreign currency for exported beverages. As a result, there are many interests that support the continuation and growth of alcohol production (Babor et al., 2010).

However, sustained heavy drinking may cause tissue damage and dependence, and even relatively low frequency of drinking together with consumption of high number of drinks per occasion can lead to a variety of medical and social problems, such as accidents, injuries, and interpersonal violence (Babor et al., 2010).

Furthermore, alcohol and drug addiction has been recognized as drivers of the HIV and AIDS epidemic as there is a link between alcohol consumption and risky sexual behaviour (Howe, 2009). This phenomenon guided several presentations and discussions on the implications of drug and alcohol dependence in HIV prevention and treatment at the 5th International AIDS Society (IAS) Conference. Namibia has the fourth highest HIV prevalence rate in the world and alcohol and drug addiction is among the main

causes of the spread of sexually transmitted infections (STIs), including HIV and AIDS (Ministry of Health and Social Services [MoHSS], 2009).

The (World Health Organization [WHO], 2006) stated that, in Sub-Saharan Africa drinkers have a 70% higher risk of contracting HIV, compared to non - drinkers. Similarly, Eastern Europe and Central Asia have experienced an epidemic in terms of drug abuse since the 1990's, resulting in intravenous drug users now making up 85% of people living with HIV and AIDS.

In a brief study of alcohol consumption patterns conducted in Katutura residential area, Windhoek, by the MoHSS during 2009 revealed that 48% of men and 26% of women meet the World Health Organization's (WHO) criteria for hazardous and harmful drinking behavior.

According to the nationwide knowledge, attitude and practice (KAP) baseline survey on alcohol and drug use in Namibia (2002), over fifty-five percent of the Namibian adult population consume alcohol, and 53% of youth have ingested alcohol. Due to this high incident of alcohol consumption in the country, the Ministry of Health and Social Services (MoHSS) initiated the coalition on responsible drinking (CORD) programme in 2004 to prevent the abuse of alcohol.

This programme has since been implemented by social workers of MoHSS in collaboration with line ministries, such as the Ministry of Gender Equality and Child Welfare, the Ministry of Safety and Security and the Ministry of Education. It focuses on three intervention strategies: (i) prevention and education focusing on alcohol related harm, such as risky sexual activities and other health and social problems caused by alcohol abuse; (ii) the enforcement of alcohol-related legislation; and (iii) the treatment of Namibians addicted to alcohol (MoHSS, n.d.).

To date, however, the success of CORD has not been measured and it has not yet been internally or externally evaluated. This study therefore assesses the achievements and challenges in the implementation of the CORD programme in preventing and mitigating alcohol abuse in Namibia by evaluating the opinions and perceptions of social workers who work directly with the CORD programme.

1.2 Statement of the problem

According to De Vos et al, (2011) the statement of the problem suggests the exploration and establishment of the problem leading to the study.

The World Health Organisation (2007) stated that the harmful use of alcohol is a serious public health problem that causes serious health burden and social consequences that affects all individuals on international scale. Wilson and Kolander (2011) also asserted that many people believe that using alcohol is immoral and unacceptable, while other

individuals who have different roots and values believe that drug or alcohol use is an acceptable way to smooth the rough edges of life and bring pleasure to daily existence.

The Coalition on Responsible Drinking (CORD) programme is an alcohol prevention programme that was established with the purpose of educating the community on the harmful effects of alcohol abuse through its three intervention strategies (MoHSS, n.d.). Wilson and Kolander (2011) defined that prevention must be comprehensive, involving many systems, such as educational, medical, law enforcement, religious, and business communities. It is collaborative efforts that involve the school, family and community in planning and implementing multiple strategies. The CORD programme was never evaluated since its inception. Patton (2002) indicates that it is crucial to know the extent to which a programme is effective after its implementation. This study assesses the effectiveness of the implementation of the programme by assessing how social workers, who are directly involved in the implementation of the programme, perceive the CORD programme. The programme does include other stakeholders, but this study is limited to assessment of social workers' perceptions. As the CORD programme is an ongoing programme, a process-evaluation approach is used. Such an approach provides "feedback on how a programme or series of interventions is operating and to what extent intended objectives are being attained" (De Vos et al., 2011, p.457).

De Vos et al. (2011) suggest that process evaluation should be directed at the following four key elements: (1) significant role players, (2) design and population, (3) resources,

and (4) record-keeping of data. The objectives of the study are based on these four key elements.

Problem statement was defined by the researcher as one's knowledge about the proposed area of study. In terms of this study it was the assessment of the perception of social workers on the implementation of the CORD programme based on both self-administered interviews and literature.

1.3 Study objectives

De Vos et al. (2011) define an objective as something that you plan to do or achieve and the steps that you take, one by one to attain the desired goal.

The objectives of the study are:

- (i) To assesses how the social workers see their role and the roles of other stakeholders within the programme.
- (ii) To explore the inputs, processes, structures and the target population being served by the programme.
- (iii) To examine whether resources in terms of funding, human resources and transport are allocated to the CORD programme in order to carry out activities, as well as determining whether the programmes data are kept and shared, during meetings, as well being incorporated into the reports of MoHSS.
- (iv) To investigate whether the programme has a monitoring and evaluation tool to measure progress of implementation of programme activities.

1.4 Research questions for the study

Research questions may act as guidelines on what has to be studied. Adler and Clarck (2011) point out that research questions concentrate on one or more topics that can be answered through research. The questions in this study were the following:

- How do social workers perceive their role and that of other stakeholders in the implementation of the CORD programme?
- What are the processes, structures and activities involved in the implementation of the programme?
- Does the programme have adequate resources for programme implementation?
- How are the programmes activities documented and shared?

1.5 Significance of the study

The study addresses the current knowledge gaps in terms of the implementation of the CORD programme. The achievements and challenges that social workers experience in the implementation of the programme will be underscored. Detailed information about the inputs, activities and processes of the programme will be obtained in order to:

- Uncover the achievements and challenges in the implementation of the programme.
- Determine the adequacy of resource allocation.
- Determine the availability and transparency of programme documentation.

The findings of the study will be available to stakeholders to enable them to improve on the implementation of the programme. Programme evaluation is vital as the data collected for evaluation inform decision-makers how to improve services, in other words to provide more effective and efficient services to clients. Through programme evaluation, we can learn a great deal from practitioners in the field in terms of who they serve, what they do, and which interventions are most effective (Unrau et al., 2007).

1.6 Summary

Alcohol abuse is causing detrimental health and social effects worldwide where over 76 million people worldwide are reported as having alcohol disorder and 3.2 percent of deaths globally are due to alcohol problems (WHO, 2007, as cited in Baggott, 2011). This chapter presented an overview of the alcohol situation worldwide and in Namibia. In response to the alarming alcohol problem in the country, the Namibian government has introduced the CORD programme to mitigate the health and social effects of alcohol abuse.

The three focus area of the programme, namely prevention, law enforcement and treatment were discussed. Relevant literature that focus on prevention services and legislation that influence alcohol consumption were critically analyzed and how they apply within the Namibian context. The trans theoretical model as proposed by Prochasta and Di Clemente (1983, as cited in Straussner, 2004) was a good example of explaining the stages the person will go through in a the way of changing behaviour

which is relating to CORD programme. Motivational interviewing, individual counselling and disease model were also discussed. The health and social effects of substance/alcohol abuse were outlined in this chapter.

Stakeholders' involvement is a vital component to the implementation of the CORD programme. This aspect was clearly discussed in accordance with the available literature that suggested that stakeholders should represent the diversity of the community in many ways, such as race, ethnicity, ability, income, sexual orientation and different professionals (Unrau et al., 2007). The authors went further and stated that stakeholders' involvement means the inclusion of all stakeholders from all segment of society in programme planning and implementation (Unrau et al., 2007).

The significance of the study and its objectives are covered in this chapter. Limitations of the study are also presented. The next chapter covers literature pertinent to the study.

CHAPTER 2

2. LITERATURE REVIEW

2.1 Introduction

This chapter will concentrate on the following: defining the relevant terms that are used in the study, describing the CORD programme and its purpose by looking at the three intervention strategies of the programme and the existing literature on these strategies. As the programme entails the involvement of stakeholders in its implementation, the chapter will further explore available literature on stakeholders on programme implementation. The health and social impact of substance abuse will also be discussed and the chapter is concluded by reviewing literature on the relevant legislation on substance abuse.

2.2 Definition of terms

- **Abstinence:** Nelson (2012) defines abstinence as refraining from the use of all substance.
- **Harm reduction:** Nelson (2012) defines the term as interventions that seek to reduce the harm to people who may choose to continue to use substances.
- **Alcohol use:** It involves drinking beer, wine, or hard liquor, but in a moderate and responsible manner (Miller & Munoz, 2005).

- **Alcohol abuse:** Miller and Munoz (2005) refer to alcohol abuse as “harmful” use of alcohol which is drinking in a way that causes or contributes to harm.
- **Substance abuse:** According to DSM-IV-TR; APA manual (2000, as cited in Straussner, 2004) the term is defined as maladaptive pattern of substance use, such as heroin, amphetamines, and marijuana leading to clinically significant impairment or distress.
- **Alcohol dependence:** Tobbut (2011) stated that for a person to be medically diagnosed with alcohol dependence, they must demonstrate three of the six criteria over a period of 12 months: Increased tolerance to alcohol, repeated withdrawal symptoms, relief of alcohol withdrawal symptoms, drinking becomes central to daily living, drinking is uncontrollable, and reinstatement after abstinence.
- **Relapse:** Hilarski (2005) defines relapse as the process in which an individual who is attempting to change behaviour experiences a set-back leading to the resumption of the target behaviour.
- **HIV:** Kinghorn and Steinberg (1999) define HIV as the Human Immuno- deficiency Virus.

- **AIDS:** Mbuya (2000) defines AIDS as the final and terminal stage of HIV infection.
- **Responsible drinking:** According to MoHSS, responsible drinking refers to allowable drink per day: 2 units for women and 3 units for men per day. The guide further explains responsible drinking as not to drink when pregnant, taking medication for ARV, diabetes, hypertension or any other chronic disease, and when a person is driving (MoHSS, n.d).

On the other hand, responsible drinking theory suggests that drinking norms comes from those who drink to develop their own definition of responsible drinking. This theory represents the normative/ socio-cultural model which is based on the accepted norms of drinking in a given society (Washton & Zweben, 2006).
- **Coalition:** It is a formal, multipurpose and long-term alliance, which bring a variety of human and material resources together to work towards a specific change that would not be able to bring about individually (Butterfoss, 2007).
- **Social Work:** Horner (2012) defines the social work profession as a profession that promotes social change, problem

solving in human relationship and the empowerment and liberation of people to enhance well-being. The social workers are utilizing theories of human behaviour and social systems, intervenes at the points where people interact with their environments. The principles of human rights and social justice are fundamental to social work (Horner, 2012).

- **Stakeholders:** Unrau et al. (2007) defined stakeholders as funders and administrators of a programme, staff, programme participants, family members and the wider community. They should represent the diversity of the community in many ways, such as race, ethnicity, ability, income; and sexual orientation.

2.3 CORD programme and its purpose

The CORD programme was initiated in Namibia in 2004 as a response to the high alcohol consumption in the country among the youth and adult population. It is funded by development partners, such as the United Nation Children Fund (UNICEF), Center for Disease Control and Prevention, under the President's Emergency Fund for AIDS Relief (PEPFAR) and the government of Namibia, specifically the Ministry of Health and Social Services (MoHSS). However the funding by development partners is decreasing. The programme seeks to prevent and mitigate the health and social consequences of

alcohol abuse, by implementing key prevention strategies within society; in order to change people's behaviour towards harmful drinking (MoHSS, n.d.). Wilson and Kolander (2011) indicated that prevention strategies consist of organized prevention activities that may take place in homes, schools, churches or a variety of other community settings. Sloboda and Bukoski (2003) further stated that drug abuse prevention approaches, such as life skills training, can reduce alcohol abuse among different populations, such as the youth, adults and vulnerable groups, for example people with disabilities.

The implementation of the programme is facilitated by the MoHSS (Head Office) Directorate: Social Welfare Services. The Subdivision: Substance Abuse Prevention, Drug Control and Rehabilitation plays the frontline role in the implementation of the programme. Chief social workers of the MoHSS in all the regions are responsible for ensuring the implementation of the programme. They supervise the implementation of programme activities by district social workers. The social workers who are implementing the CORD programme are social workers who do not specialize in substance abuse prevention, addiction or treatment services. The regional directors are the overall managers. Their support in terms of budget allocation and transport for programme activities, amongst others, is important to ensure the effective implementation of programme activities. Figure 1 is an organogram of the staff involved in the implementation of the activities of the CORD programme.

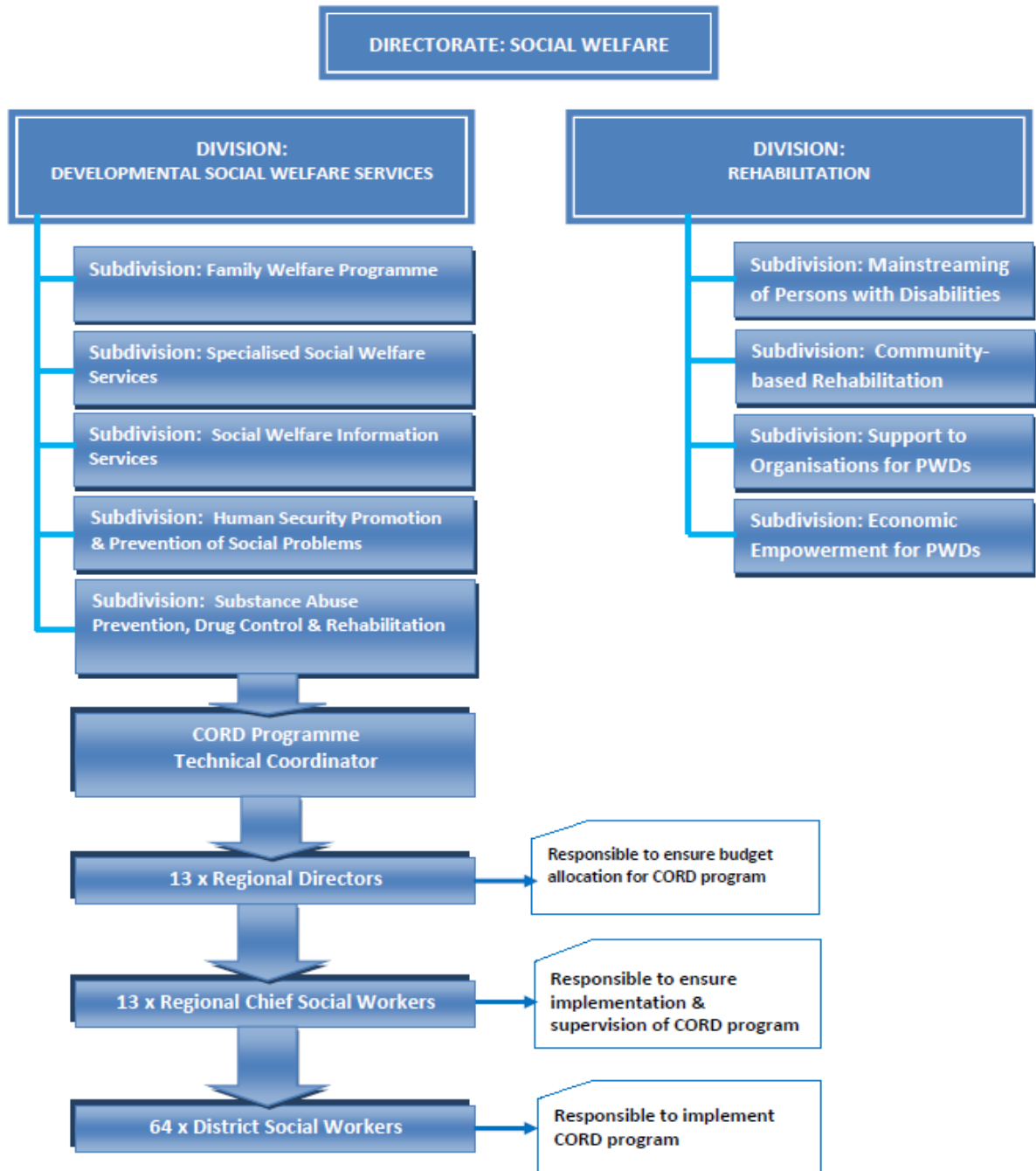


Figure 1: Organogram

2.4 Three key interventions strategies on which the CORD programme focuses

2.4.1 Prevention

This intervention focuses on the following:

- Educating the young people and the community at large on the dangers of alcohol abuse, including the spread of sexually transmitted diseases, such as HIV and AIDS. This can be done through establishing life skills programmes in schools and organizing youth camps, and information sessions for out-of-school youth.
- Advocating the banning of alcohol products from being advertised at sport events, around schools and other places where young people socialize.
- Providing the youth with alternatives to drinking, such as sports and cultural activities.
- Educating and discouraging parents from giving alcohol to children.
- Promoting economic development to eradicate poverty that might lead to alcohol abuse.
- Lobbying for the implementation of alcohol policies in schools and work places.
- Enforcing laws that restrict underage drinking, drunk driving, and alcohol sales (MoHSS, n.d).

Wilson and Kolander (2011) proposed some principles that can guide alcohol community-based prevention programmes which relate to the CORD programme:

- Prevention programmes should be designed to enhance protective factors and move toward reversing or reducing known risk factors.
- Prevention programmes should target all forms of drug abuse, including the use of alcohol, tobacco, marijuana and inhalants.
- Prevention programmes should include skills to resist drugs when offered, strengthen personal commitments against drug use and increase social competency: for example, communications, peer relationships, self-efficacy, and assertiveness.
- Prevention programmes for adolescents should include interactive methods, such as peer discussion groups, rather than didactic teaching techniques alone.
- Programmes should include a parent and/or caregiver component that reinforces what the children are learning, such as factors about drugs and their harmful effects, and that opens opportunities for family discussions about the use of legal and illegal substances.
- Prevention programmes should be long-term, over the school career, with repeat interventions to reinforce the original prevention goals. This will assist children to adapt with critical transitions from primary to high school and alleviate peer pressure that can influence children negatively.
- Family focused prevention efforts have greater impact than strategies that focus on parents or children only.
- Community based prevention programmes that include media campaigns and policy changes, such as new restrictions that restrict access to alcohol, tobacco

and other drugs are more effective when they are accompanied by school and family interventions.

- Community-based prevention programmes need to strengthen norms against drug use in all drug abuse prevention settings, including the family, school, work-places and the community.
- Prevention programmes should be adapted to address the specific nature of the drug abuse problem in the local community.
- The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.
- Prevention programmes must be age specific, developmentally appropriate, and culturally sensitive.
- Effective prevention programmes are cost-effective. For every dollar spent on drug use prevention, communities can save four or more dollars in costs for drug abuse treatment and counselling.

2.4.1.1 Processes and structures of the substance (alcohol) prevention programme

The community cannot establish a substance abuse prevention programme on its own; it needs the cooperation of government, health care professionals and the local community (International Labor Organization [ILO], 2004). Programme implementers/social workers are responsible to form a steering committee to facilitate community involvement in the envisaged prevention programme. As members of a diverse group, they should represent all segments of the

community and devote time to team-building. Social workers should see their role as empowering and facilitating, rather than controlling or directing people. They need to help people to examine their own attitudes and behaviour regarding the use of alcohol and drugs and to clarify their own philosophy of alcoholism. Time should be spent to reach agreement on the coalition ground rules and to build trust among coalition members. According to Bourne (2009) the success in establishing and managing stakeholders' relationships is a long-term commitment to a structured process that focuses on:

- Carefully identifying the right stakeholders for the project/ programme to be undertaken;
- Understanding the expectations of all stakeholders towards the envisage programme and developing a mission that lead to the common vision;
- Managing those expectations through clear plan of actions;
- To develop steps to get from where they are and where they would like to be, i.e. the vision with short and long-term goals with measurable objectives in order to set the first actions for the group; and
- To evaluate, improve and add to the original plan so that they can address those issues that are important and have an impact in the community.

Fertman and Allensworth (2010) stated that planning a health promotion programme, which in this context is an alcohol prevention programme, will reduce the health and social ills, requires that staff, stakeholders and participants

all must know what the programme seeks to accomplish and how it will go about trying to accomplish it. Creating a stakeholders' culture within the main implementing organization and outside the organization, requires a structured approach, skillful management and it further requires understanding and support, or awareness from everyone in the organization ranging from top management to the contracted employees (Bourne, 2009). It is important that programme implementers should be aware that its implementation is not an event, but a process that happens over time. It happens only after programme staff, stakeholders and participants have decided on a programme mission, outcomes, policies and procedures of the programme (Fertman & Allensworth, 2010).

Fixsen et al. (2005, as cited in Fertman & Allensworth, 2010) outlined six stages which are crucial in the process of programme implementation. These stages are presented below.

- **Exploration adoption stage**

This is part of planning which includes needs assessment and decisions about mission, goals, objectives, intervention outcomes, policies and procedures of the programme. This, according to the authors, is an important part of planning to achieve acceptance and support for the programme.

- **Programme installation**

This stage focuses on the structural support which is necessary to initiate a programme. It involves ensuring the availability of funding streams, human resource strategies, supporting policy, creating referral mechanism, reporting frameworks and outcome expectations. Furthermore, programme installation assesses the additional resources that may be needed to realign the current staff and recruit and train new staff members, secure appropriate space, and purchase the necessary technology, such as computers needed for the programme. The authors noted that these activities, and the associated start-up costs, are a necessary first step in beginning a new programme in an organisation, workplace or community. If there is a need for transport for the programme to be implemented, it should be provided to ensure service delivery as the lack of transport may hinder service delivery and the programme implementation will be negatively affected (Ch'ien, 2008).

- **Initial implementation**

During this stage, the staff and stakeholders may experience fear of change and the complex work of implementing something new at a time when the programme is struggling to commence, and when confidence in the decision to implement the programme is being tested. This stage can determine the strength of the programme and whether the participants' needs are being met in terms of the interventions of the programme.

- **Full operation stage**

This stage occurs when the programme has a fully operational staff complement and capacity to address the client's/customer's needs. These indicate the realities of the programme being in place. During this stage, the programme should be fully operational where activities and referrals are carried out. The programme, by this stage should become an accepted practice. The anticipated benefits should have been realized: the programme staff members have become skilful and procedures are routine.

- **Innovation**

This stage happens over time as staff, stakeholders and participants learn what works with the target population in a particular setting. Staff turnover, feedback from evaluators and new conditions should present opportunities to refine and expand the programme.

- **Sustainability**

Skilled staff and other well-trained staff at this stage should be able to leave the programme. They should be able to be replaced with other skilled staff, leaders and other funding streams. New social problems may arise, partners may come and go, external systems may change and political leaders may also change. The authors recommend that despite all these changes, programme staff, stakeholders and participants should adjust to the changes without losing the functional components of the programme or letting the programme die from lack of essential financial and stakeholders' support.

The goal during this stage, according to the authors, is the long-term survival and continued effectiveness of the implementation of the programme in the context of the changing environment.

2.4.1.2 Record keeping and communication during the implementation of the programme

Nicholas et al. (2010) asserted that social work managers should, as part of their administrative tasks, ensure that records are accurate and reflect the services provided. This will ensure that sufficient and timely documentation of records are kept to facilitate the delivery of services and ensure continuity of services provided to clients.

It is best practice that any programme should be supported by a communication plan, which according to Swanepoel and De Beer (2006) is an outline of anticipated communication among programme stakeholders to support the programme's deliverables. A communication plan therefore brings project implementers together with other stakeholders. The required type of communication depends on a project type. As suggested by Swanepoel and De Beer (2006) there is a need to document meetings minutes, progress reports, status reports, challenges/risks and ways of militating against them and financial issues and share this information with all partners involved.

In addition to the communication plan (Erwin et al., 2003; Mckencie et al., 2005, cited in Fertman & Allensworth, 2010) believe that a logic plan is an important tool that illustrates the activities that need to be conducted, resources needed and the outcome of these interventions. According to these authors, the plan will foster ownership and commitment to perform what is expected from each group member. It will help to communicate relationships between programme elements to stakeholders and potential partners, as well as the target population. It shows the relationship between the programme resources (inputs), its planned activities (outputs) and the expected results (outcomes). The logic plan is designed to provide a simple graphic illustration of the relationships assumed between implementation tools, programme staff and budgets (Erwin et al., 2003; Mckencie et al., 2005, cited in Fertman & Allensworth, 2010). Table 1 is an example of a logic plan model, designed by the authors, for preventing the initiation of tobacco use among young people. This model can be applied in the CORD programme.

Table 1: Logic Plan Model

Inputs	Activities	Short-term outcomes	Intermediate outcomes	Long-term outcomes	Goals
<ul style="list-style-type: none"> • Personnel • Funding • Equipment • Supplies • Materials • Partnership • Space • Technology 	Inter-based multi media	Increased media awareness and skills to educate on effects of alcohol on individuals, families and communities	Alcohol usage demoralized among the community members	<ul style="list-style-type: none"> • Improved quality of life for the persons • Reduced initiation of alcohol use among youth 	<ul style="list-style-type: none"> • Reduced alcohol- related morbidity and mortality • Decreased alcohol related health disparities
	Literacy programmes focused on the youth	Change in knowledge, attitudes, behaviour and skills	Schools and communities promoting and supporting alcohol free activities and recreation		
	School-based life skills training and alcohol and other drugs	Decrease access to alcohol in all neighborhoods and			

Inputs	Activities	Short-term outcomes	Intermediate outcomes	Long-term outcomes	Goals
	education	communities			
	Policy and regulatory action to enforce restrictions of sale of alcohol to minors in desperate populations	Increased access to community based youth programmes and activities			
	Community partnership to improve youth community activities and support				

The data in Table 1 cover information generated during the planning process when the goals, objectives and the strategies are developed; and the resources from the public, health department and partners. These resources could include funding and staff from the health department for alcohol use prevention, the programme staff for drug and alcohol prevention and local staff of the local education authorities (school principals, school health councils, school health teams, and school health coordinators). Resources

could be staff, locations to hold programme events, equipment, technology, curriculum, or institutional resources.

The activities column in Table 1 focuses on specific strategies and interventions that were selected during the planning process on the basis of staff and stakeholders' understanding of the underlying problem, its context and the programme's desired outcomes.

The outcomes columns cover the areas on what has to be achieved. The short-term outcome lists the things that are expected to happen as an immediate result of each of the planned activities. For example, the media literacy programme, school based prevention, literacy initiatives, community activities and support should increase students' knowledge, awareness and skills, as well as provide changes in their attitudes. There should be a logical link between the items that are specified in the activities column and what is assumed will happen if these are properly implemented. The intermediate outcomes column refers to results that may not be seen after a single activity, but can be measured or verified in the future. In this example, the planners hope to demoralized tobacco use. This outcome can be assessed by conducting surveys at schools or within the community after the programme has been delivered for several years. The long term outcomes column outlines the ultimate extension of the programme's impact. This can be achieved if both the short-term and the intermediate outcomes are met; i.e. successful reduction in the initiation of tobacco and improvement

in the quality of life of the youth. The ultimate long-term outcomes that are envisioned are the programme goals. In this case, as indicated in the goals column, a reasonable long-term outcome might be a 20% reduction in tobacco-related morbidity and mortality twenty to forty years later when the youth, who received the interventions, are adults. Another long-term goal for the programme is to strive for a decrease in alcohol-related health disparities.

The authors further recommended that programme implementers should work backwards and forward in this model to check and communicate valuable inputs and suggestions that can enhance the programme effectiveness.

2.4.2 Legislation enforcement

This strategy aims at:

- Ensuring restrictions on advertising of alcohol beverages
- Mandating the inscription of health-warning labels on alcohol products
- Lobbying for the implementation of alcohol taxation laws
- Confronting alcoholism as a disease to help those who are addicted to admit their problems and seek help (MoHSS, n.d).

2.4.3 Treatment

The Namibian government encourages the MoHSS to put treatment protocols in place, as well as establishing inpatient treatment facilities and programmes nationwide. In

addition, the introduction of a substance abuse and treatment course at tertiary institutions could serve as an important tool towards the provision of alcohol treatment (MoHSS, n.d).

The Directorate of Social Welfare Services (DSWS) established Etegameno Rehabilitation and Resource Center (ERRC). It is a sixteen bed treatment facility that is situated 25 kilometers north of Windhoek and provides treatment and rehabilitation to alcohol and drug dependent individuals and support to families.

There are four private and one government rehabilitation centers in Namibia. The maximum fee for clients at the government rehabilitation center is N\$ 1 000.00 per person per intake for individuals who are employed; unemployed persons receive free services. At the private rehabilitation centers the cost is not less than N\$ 12 000.00 per person per intake (Adams, 2007).

The treatment programmes in Namibia vary from detoxification, psychiatric treatment to counselling centers. There are six treatment centers: Nova Vita, Okonguarri Psychotherapeutic Center, two “My 24/7 Wellness” centers in Swakopmund, Usakos, the Mental Health Unit, and the Etegameno Rehabilitation and Resource Centre (Adams, 2007).

The social workers who are implementing the CORD programme are responsible to identify people with alcohol/substance addiction in their community or those who are being referred to their offices and provide counselling for their drug addiction or refer them for treatment.

2.4.3.1 Different Treatment models/programmes for substances addicts

The following models and programmes are discussed below:

2.4.3.1.1 The Trans- theoretical ‘Wheel of change’ model

Prochaska and DiClemente (1983, as cited in Straussner, 2004) discussed the following stages in the model to understand the stages that a person will go through on the way to changing behaviour. This is applicable to the phenomena under investigation, which is behaviour change towards alcohol abuse to mitigate harm caused by alcohol abuse. The stages are discussed as follows:

(i) Pre-contemplation stage

This marks the first stage where the client is not considering change and the use of a statement such as, “alcohol is not a problem to me” is often used. A social worker should acknowledge the client’s feelings about the use of alcohol as he/she has not realized the benefits of not drinking. However, the simple benefits attributed to non-drinking, which include reduction of health risks and family problems, could be mentioned. A social worker can also explore certain concerns with the client in terms of his/her drinking behaviour. For example, a

question such as “has your drinking ever caused a problem” could be posed. Social workers are encouraged not to force clients to change during this stage, but rather to thank them for sharing their drinking experiences.

(ii) Contemplation stage

This stage is referred to as ‘sitting on the fence’. The client might say “Yes, alcohol is a problem to me, but I am not willing or able to begin stopping to drink within the next month”. The role of social workers in the second stage is to validate the client’s experience, as well as clarifying the pros and cons of attempting to stop drinking. Validation could include statements such as: “I am hearing that you are thinking about stopping alcohol intake, but you are not yet ready to take action right now”. The client’s control of the situation should be acknowledged. A social worker should also affirm that the client is an adult who knows when to decide to stop drinking. However, the client’s perception of the pros and cons of attempted efforts of stopping alcohol consumption should be clarified by using a worksheet that addresses the benefits and disadvantages of alcohol abuse. A social worker needs to encourage self-exploration by giving the client questions to complete at home regarding drinking behaviour. There should be a follow-up discussion of these questions with the client during the next contact session. If the client is ready to make a change about his/her drinking behaviour, the next stage can be considered.

(iii) Preparation stage

The third stage is referred to as 'testing the waters'. The client admits in this stage to having a drinking problem. For example, "My drinking is a concern for me. I am clear that the benefits of attempting to stop drinking outweigh the disadvantages of not stopping and I am planning to start within the next month". The goal of a social worker in this stage would be to praise the client for deciding to change behaviour. An example of praising the client: "It is great that you feel good about your decision to stop your alcohol intake, you are doing something important to decrease your health and family problems." Priorities of behaviour change opportunities need to be set in order to help the client avoid drinking environments. A social worker's role at this stage is to identify potential obstacles the client may encounter and to assist in problem solving; the client should be assisted to identify problems or obstacles which challenge non-drinking patterns.

(iv) Action stage

In this fourth stage the client practices new behaviour for about three to six months. The client focuses on restructuring life and identifying social support, as well as strengthening self-efficacy in dealing with obstacles/challenges that may occur.

(v) Maintenance stage

During this stage a social worker is encouraged to strengthen the client's commitment to sustain new behaviour over six months to five years. To prevent possible relapse it is important in this stage to follow-up and provide psycho-social support to the client.

(vi) Relapse stage

This is the stage where the client resumes previous drinking behaviour. It is also known as the 'fall from grace' stage. A social worker is advised to counsel the client on the possible relapse indicators (triggers). This is done to encourage and support the client to resume positive behaviour of recovery.

2.4.3.1.2 Individual counselling/ Outpatient individual therapy

Chronic substance abusers usually substitute a chemical for human contact, hence, a crucial part of treatment is the establishment of a non-threatening relationship with a caring and consistently reliable individual (Straussner, 2004). As a result, the goal of individual treatment/counselling is to enhance patients' self-image and provide needed ego support so that they can begin to examine their use of chemicals and their current feelings and behaviour (Straussner, 2004).

The above mentioned author further asserted that outpatient psychotherapy is not usually recommended until the person is secure in his/her abstinence from chemicals,

because the anxiety aroused during treatment may lead to the resumption of alcohol or drug use. The author stated that conducting individual counselling or therapy with an active substance abuser is questionable due to the impact of the chemicals on the brain and the possibility of blackouts. However, if a client has stopped using the substance or is making serious efforts to diminish their drug and alcohol use, ego-supportive counselling may be applied Goldstein (1995, as cited in Straussner, 2004).

This sentiment was supported by Heller and Gitterman (2011) who maintained that outpatient care or counselling is most appropriate when clients are ready to make changes in their lives, minimal risks exist for symptoms of withdrawal, they have a supportive environment and they have adequate coping mechanisms for handling pressures to use drugs.

2.4.3.1.3 Disease model

Goodman (2007) explained that in this model, alcohol dependence is seen as a disease whereby the addicts have to understand that they have a disease that prevents them from controlling their drinking or drug problem. As a consequence the addicts have to avoid their former drinking friends/partners and situations. The programme focuses on a biological dimension that explain that the drug is having a possibility to make the person ill, but perversely they need to take the drug to avoid withdrawal, such as ‘shakes’ if they stop the drug without the medical help, whereby the drug user would go through what has been called ‘cold turkey’.

It is believed that the substances affect the functioning of the brain and are depressive. As a result, the mood of the user is affected which cause psychological disturbance and a general feeling of negativity. Personal relationships with the partner, children, relatives, and friends might be affected. Their careers, finances and other social aspects of their lives can be under strain or getting out of control (Goodman, 2007).

2.4.3.1.4 Motivational interviewing

According to Goodman (2007) the approach of this model emphasizes on the empowerment of the client and seeks to involve the client in the work of changing his/her behavior. The approach is there to help people to recognize and do something about their present or potential problems. It is useful with people who are reluctant to change and ambivalent about changing. This approach creates openness to change, which paves the way for further important therapeutic work.

During motivational interviewing, the counsellor does not assume an authoritarian role and avoids the message that he/she is an expert and does not tell the clients on how to run their life. The clients are always free to take advice or not. The strategies in this approach are more persuasive than coercive, more supportive than argumentative (Goodman, 2007).

The author further elaborated on the five principles of motivational interviewing as discussed below:

(i) Express empathy

- Acceptance is prerequisite to starting the process of change
- Reflective listening is essential response
- Expect to be met with ambivalence
- The client should be seen as capable of changing

(ii) Develop discrepancy that client lifestyle and future goals of the client do not match

- Awareness of consequences of no change is important
- The counsellor need to be directive
- A discrepancy between present behaviour and important goals will motivate change
- The client should put forward the arguments for change

(iii) Avoid argument

- Arguments are counterproductive
- Defending breeds defensiveness
- Resistance is a signal to change strategies
- Labelling is unnecessary

(iv) Roll with resistance (means essentially move on and try other strategies)

- Momentum can be used to good advantage
- Perceptions can be shifted
- New perspectives are invited from the client
- The counsellor does not put forward solutions for the client

- The client should provide the solutions to problems

(v) Support self- efficacy

- The client will be motivated if they have a belief in the possibility of change
- The client is responsible for choosing how they will change
- The clients need to carry their changes so that they are in the driving force
- There is hope in the range of alternative approaches available
- The counsellor needs to believe in the client's ability to change

2.4.3.1.5 Self-help/ Support groups

Self-help groups offer support to develop strong relationship amongst its members to nourish values of cooperation and mutual concerns. The roles of these groups are made by the members themselves who help members overcome problems with authority and discipline. Most substance abusers do not easily submit to non-addicts' authority figures or even a counsellor. As members identify more strongly with the group experience and the benefits of discipline, they tend to internalize its authority and acquire self-discipline (Rosenberg, 2001).

A well-developed self-help or support group could make its intimate membership network available to each other on a 24 hour basis, like some professional services would do.

Adams (2007) further suggested the following key findings and interventions that are necessary on alcohol and drug rehabilitation services:

- The professionals who provide rehabilitation services should have specific counselling and specialized knowledge about alcohol and drug addiction.
- Detoxification is an important requirement in the treatment programme as it reduces the withdrawal symptoms a client experiences.
- Pre-intake assessment is necessary to assess the client's motivation level and to develop a treatment programme plan that is designed for an individual client and this can be done by a motivational group in the community to increase the client's motivational level.
- Individual counselling sessions with clients are necessary to identify triggers, establish a structure for the future and to discuss issues or initiatives that are not well suited for a group discussion.
- Group therapy is important to confront the clients with reality in order to confront their addictions.
- Family therapy helps the clients and their families to understand the painful cycle of confusion and blaming, which is part of the psycho-dynamics of alcoholism and it helps that the clients take responsibility for their own recovery.

Petersen and McBride (2002) highlighted that regular training for practitioners dealing with substances is important to enable them to offer the required services and they should ensure that the treatment they offer are supported by evidence of effectiveness.

The authors recommended that the trainings can be offered by employers through conferences and seminars or where bursaries can be made available to staff to acquire the specific skills needed for the job. The practitioners can also find their own trainings through journals and other accredited agencies and pay by themselves (Petersen & McBride, 2002).

2.5 Stakeholders' involvement in the implementation of the CORD programme

The involvement of stakeholders in the implementation of CORD's key interventions remains imperative. The stakeholders include amongst others, different line ministries, such Ministry of Education, Ministry of Gender Equality and Child Welfare, Ministry of Safety and Security, Local Authority, Religious Organizations, Local businesses, Non-Governmental Organizations, traditional leaders and ordinary community members (MoHSS, n.d.). The main roles of stakeholders in the implementation of the CORD programme are the coordination and collaboration in addressing alcohol abuse in the community through implementation and enforcement of the three intervention strategies of the CORD programme (MoHSS, n.d.).

Stakeholders' involvement is based upon the belief that expertise does not solely lie with the professionals, such as social workers. Stakeholders are an important component of the programme; they are able to provide insight into various needs of the programme. They may be involved in multiple roles and serve various functions. Focus groups could

be conducted to get their initial ideas and reveal community norms, history and different role players in the community (Unrau et al., 2007).

Unrau et al. (2007) further highlighted the inclusion of key leaders from all segments of community as being essential in every phase of community prevention services. It is important to involve the formal leadership within the community, such as appointed leaders, agency heads and ministries. It is also important to involve informal leaders, because they influence others by their words and actions. Service providers should actively seek to involve all the specific groups that represent various agencies, organisations and ethnic groups. These groups should include youth and elders, schools, media, parents, businesses and law enforcement personnel. It is important that the entire community has ownership of the activities planned and implemented by the group. It is further recommended that inclusion should be an ongoing process; new members can be included any time in the group. Different group members can work on different projects of the programme: each person of the coalition brings skills, interests, and perspectives to the shared vision. What is vital is that that each person or group should be informed, feel included and should have a sense of ownership of all projects ((Unrau et al., 2007).

Wilson and Kolander (2011) stressed that for stakeholders to be effective participants of community based prevention programmes, they need to be part of the planning, implementation and continuous evaluation of different activities of the programme. According to these authors, stakeholder's involvement in the programme will give them

a feeling of ownership and commitment towards the programme and they will be part of the benefits that the programme can bring.

Goodman (2007) also believed that communication is equally important for effective programme implementation as he maintain that the way agencies communicate with each other and at what level they communicate is of central importance to good practice and it will enhance service delivery. It is also vital to provide incentives for stakeholders/volunteers in the form of allowance, retreats and trainings in order to increase their motivation (Velleman, 2006).

2.6 Alcohol effects

Alcohol abuse leads to health and social effects that are discussed below.

2.6.1 Alcohol and health

The MoHSS conducted a study regarding alcohol use and abuse in Katutura, Windhoek. This study revealed that 48% of male respondents and 26% of female respondents met the WHO criteria for hazardous and harmful drinking behaviour. These statistics are alarming as various negative social and health consequences have been attributed to alcohol abuse. These consequences include an increased risk for HIV contraction and adverse physical and psychological effects on individuals and families.

Long-term use of alcohol can cause cirrhosis and alcohol poisoning; death can occur if alcohol is consumed in excess, whether in a single instance or over an extended period of time (ILO, 2004). Similar adverse health conditions are presented by Nelson (2012): long-term regular heavy use of alcohol can lead to severe health problems, including cirrhosis of the liver, high blood pressure, damage to the brain and severe vitamin deficiencies. The author went further to state that overdosing on alcohol can lead to vomiting, blackouts, acute poisoning, unconsciousness, coma and death, and alcohol abuse during pregnancy can have a direct impact on the fetus. The use of alcohol and drugs in combination with poor nutrition, poor general health of the mother, experiences of mental health of the mother, and trauma during pregnancy make a pregnant mother vulnerable to miscarriages and puts the unborn child at risk of birth defects, such as fetal alcohol spectrum disorders in the child (Nelson, 2012).

2.6.2 Alcohol abuse and HIV and AIDS

Alcohol and drug addiction are the major drivers of the HIV and AIDS epidemic in many parts of the world (Howe, 2009). The association between alcohol use and high-risk behaviour, such as inconsistent condom use with sexual partners, concurrent of sexual partners, buying and selling of sex, and the experience of violent or coercive sex, are all associated with an increased risk of HIV infection (WHO, 2006).

According to Santelli et al. (2013) young people are more likely to drink alcohol, which increases the HIV risk; therefore there is a huge need to address substance abuse in

prevention activities with young people. Samsa (2006, as cited in Ashford & LeCroy, 2010) mentioned that the high school and college period is one of heightened vulnerability to the pressures associated with alcohol consumption; college students consumed more alcohol than similarly aged non-college students, and they participated in binge drinking and heavy drinking. It was further noted that peer pressure and expectations about sexual arousal and social acceptance could increase the reported amount people drink (Azar, 1995, as cited in Ashford & LeCroy, 2010).

Alcohol use leads to sexual disinhibition and results in lower levels of condom use and earlier sexual debut. Alcohol drinkers have higher risk sex partners, such as multiple concurrent partners, casual partners and more at-risk partners (Sivaram et al., 2008).

Studies have shown that higher HIV and STI prevalence is observed among drinkers in Southern Africa: South Africa, Botswana, Zimbabwe and Zambia; East Africa: Uganda, Tanzania and Kenya. Persons who consume alcohol have higher odds of contracting HIV (Sivaram et al., 2008).

The availability of alcohol at bars and private parties enables people to become intoxicated; the risk of participating in risky sexual behaviour increases (USAID, 2009, as cited in Sivaram et al., 2008). Alcohol also increases the number of cases of HIV and AIDS among the young people, especially girls who sell their bodies for money and alcohol (Nakale, 2012). It is further stated that many young girls in the Omaheke

Region are unemployed and do not attend school. As a result, when they see men with cash at livestock auctions and shebeens, they (the young girls) go and drink with them and sell their bodies (ibid).

Goodmann (2007) stated that women who drink excessively will experience a danger of sexual attack and unsafe sex, especially if this happens late in the night.

2.6.3 Alcohol and mental health

Substance abuse also contributes to mental health problems. Hall (1979, as cited in Straussner, 2004) found that there is a co-existence of substance abuse and severe persistent mental illness. The author stated that 58% of patients admitted to a psychiatric unit reported a history of drug abuse, including alcohol.

Goodman (2007) further stated that mental health and emotional problems result in drug use, because the person with mental health or emotional problems uses drugs to ‘blot out’ painful emotional problems or depression and anxiety. Some people go to their medical practitioner (doctor) for anti-depressants, but others may take illegal substances in addition or as an alternative to these.

Additionally, Nelson (2012) stated that people with mental health problems use substances for several reasons: self-medication to provide relief from symptoms of their mental health problems; to deal with the unpleasant side effects of any medication they

may be taking; and to promote social interaction. Furthermore, a lack of financial resources can also lead to mental health problems, because the individual may not be able to access health care system in order to treat mental health disorder, which in turn may worsen the condition (Heller & Gitterman, 2011).

On the contrary, alcoholism is viewed as a manifestation of a primary disease which is brain and biologically based. Alcoholism is thus regarded as a disease that has a linear progression and loss of control over alcohol use (Heller & Gitterman, 2011). Again, these authors classified substance abuse as a mental disorder and symptom of underlying personality problems whereby substance abuse represents a manifestation of oral-dependency and regression to minimize conflict.

2.6.4 Alcohol and poverty

Goodman (2007) stated that poverty and lifestyle may cause alcohol abuse, for example when there is limited job prospects, it can be depressing and unfulfilling, and taking and dealing in drugs provides money, status and reason to belong. Also, social class, based on employment classification, has a relationship with substance abuse. Factors such as poverty, geography, availability and culture have influence on substance abuse (Petersen & McBride, 2002). The authors further claim that the unemployed have been reported as being more likely to have used or be using illicit drugs, but loss of employment has been shown to reduce alcohol consumption. However, higher income groups are often associated with higher consumption of alcohol and some other drugs.

Alcohol can also directly affect individuals and families, because people who abuse alcohol can cause significant financial problems for their families as they often face unemployment, or a low employment rate, as well as other risky financial behaviour, such as gambling or irresponsible spending that leads to poor living condition (Babor, et al., 2010).

2.6.5 Alcohol and disability

Nelson (2012) asserted that there is an increased likelihood that people with disabilities will experiment, use and develop problems with substances since deinstitutionalization. This refers to the process whereby more people with disabilities are now being cared for in community settings as opposed to in residential centers or in hospitals. Thus, according to the author, will expose people with disabilities to substances more than they had before and it may become an area of concern as the level of problematic substance use can increase.

Additionally, people with disabilities could be seen as more vulnerable to problematic substance use, especially alcohol due to additional stress relating to the disability, the need for pain relief, resultant disability due to substance misuse, and the nature of the disability, for example learning disabilities and mental health. The author indicated that if people with disabilities use and experiment with substances, there is also a potential for them to be more at risk of the adverse effects of substances if they are currently

taking medications; they may become vulnerable to assault or theft from others who may take advantage of them (Nelson, 2012).

2.6.6 The consequences of alcohol on the family and society

Babor et al. (2010) indicated that although the heaviest drinkers have a much higher risk of various alcohol-related harms compared with other drinkers, it was not necessarily the heaviest drinkers who accounted for most of the alcohol burden. The vast majority of people who use alcohol do so without any ill-effect to themselves or others. The small percentages of those who abuse alcohol, however, do cause significant physical, social and psychological problems for themselves, their families and society in general.

Babor et al. (2010) argue that “alcohol can be at the same time a food, a drug, and a highly elaborated cultural artefact with important symbolic meanings. Alcohol products are also used as beverages to serve with meals. The rationale is to facilitate socialization and to demonstrate hospitality. Additionally, Wilson and Kolander (2011) reasoned that many people believe that using alcohol is immoral and unacceptable, while other individuals believe that drugs or alcohol use is an acceptable way to smooth the rough edges of life and to bring pleasure to daily existence.

However, life with substance-abusing family members is typically full of inconsistency and unpredictability, resulting in a chronic state of crisis (Straussner, 2004). The author further stated that legal and financial problems, serious illness, and various accidents are

common occurrences that intrude on family life. When parents are abusing alcohol, the children assume parental roles and responsibilities, violence between parents is common and incest might also occur (Straussner, 2004).

In addition, Ashford and LeCroy (2010) stated that alcohol abuse is present in more than 50% of all incidents of domestic violence, and alcohol-related motor vehicle accidents are the number one killer of teenage children.

Compton (2010) also affirmed that there is a greater risk of family conflict and domestic violence when a parent has an alcohol use disorder. The author further stated that there is a greater chance of separation and divorce in couples when one of them has alcohol dependence. Children are also negatively affected in these families (Compton, 2010). Alcohol abuse by parents contributes to the risk of child abuse, especially when it is combined with other drug abuse, and the effects of child abuse can cause children to suffer psychological effects, including bed-wetting, tantrums, hypersensitivity, low self-esteem and school problems (Ashford & LeCroy, 2010).

2.6.6.1 Generational changes in drinking attitudes

Blocker et al. (2003) are of the opinion that drinking attitudes and habits are a part of culture that changes slowly over generations. This sentiment is supported by Jayne et al. (2011) in their comparative study on changing drinking attitudes in different generations. The results of their study showed that the older generations, 65 years and

older, who were teenagers in the 1950s, grew up in a historical period with significant social prohibition on alcohol consumption. Alcohol consumed at home was not the norm; drinking in a public place was generally a male pursuit. Their findings revealed that males started drinking as early as 15-16 years, but without their parents' knowledge as they were not allowed to consume alcohol in front of them. On the other hand, it was considered socially unacceptable for women to drink alcohol. Their findings recorded a significant change in attitudes and practices towards alcohol consumption in the mid-generation: the adults were children or teenagers in the mid to late 1970 and the 1980s. This generation recalled that alcohol played a big role in their parents' lives. The respondents (middle class) recalled that there was a drinking cabinet at home; alcohol was evident when their parents entertained friends, and working class parents drank more at pubs. For this generation, the majority of them were introduced to alcohol at Christmas or other special family occasions. Compared with the old generation, the younger mid-generation of both sexes commenced alcohol consumption when they were 16 years old; they usually drank without their parents' knowledge at pubs, church yards, parks and youth clubs, amongst others (Jayne et al., 2011).

These authors reported that the majority of the respondents, in the current youth generation of the 1990s to 2000s, recalled being introduced to alcohol at a young age. They experienced consumption of alcohol in a family context. Their parents were more relaxed about experimenting with alcohol compared to the more conservative attitude of the other two generations in the study. Underage drinking was also recorded among

rural youth in areas with limited alternative social and leisure opportunities for young people. This age group also described going to pubs with their parents (Jayne et al., 2011). Another important factor mentioned by these authors, was the difference between the mid and older generations compared to the youth generation on the type of alcohol products they consumed and their motivation to drink. The former generations reported that they began drinking beer and cider and moved to spirits when they were in their adulthood whereas the current youth generation started underage drinking of vodka and other types of shots. It was reported that the latter generation would deliberately go out to get drunk whereas the other two generations did so to meet friends or to have a drink. This sometimes led to excess consumption, drunkenness, but it was not necessarily the motive to socialize.

Additionally, Nelson (2012) stated that that the number of older people who drink may be increasing, and there is evidence that today population of older people may be heavier drinkers than previous generations. This, according to the author is a result of being from a generation in which there was a high availability and social acceptance of alcohol use.

2.6.6.2 The influence of parents on the child drinking behaviour

Compton (2010) stressed that parents are the most important factor influencing an adolescent's decision to drink. Children living in adverse home conditions, such as crowded homes, noisy and disorderly home without rules or religion, are more likely to

develop an alcohol use disorder later in life compared to those in stable, supportive homes. Compton (2010) indicated that even if one parent is dependent on alcohol, a child may have more struggles socializing and may join peer groups in which drinking and other risky behaviour are accepted or even supported. The author further stated that most children of alcohol dependence parents are monitored minimally by their parents. They therefore begin drinking before the age of fifteen years.

Straussner (2004) also noted that the impact of substance abuse on the family has additional intergenerational repercussions as he indicated that the sons of alcoholic fathers are four times more likely to become alcoholics while the daughters of alcoholic parents are three times likely to marry alcoholic men.

Although parents have an influence on the inception of drinking by their children, many drug users, including alcoholics have endured a difficult lifestyle and disadvantaged childhood. They have been immersed in a dehumanizing drug centered lifestyle for most of their adult life and have been subject to considerable prejudice and discrimination that cultivate, foster and sustain drug use (Goodman, 2007).

2.6.7 Alcohol and gender

Goodman (2007) indicated that young women tend to binge drink and the level of women abusing alcohol is increasing, even if it still lags behind men. This, according to the author, is attributed to the pressure of women juggling with work and domestic

responsibilities, coping with life stresses and low self-esteem. Supporting this sentiment is a study that was conducted in Latin America and the Caribbean that focuses on the gender dimension of alcohol consumption during 2002. These findings revealed that as women move into the workplace and gender roles change, the gap between male and female drinking behaviour will narrow (Pyne et al., 2002). The study also asserted that in industrialized countries, where women are entering formal employment outside their homes, women are likely to consume alcohol. As women take on dual roles in family and in the workplace, the new stress in their lives leads to more drinking, and as they break down the social barriers to formal employment, they gain greater freedom to engage in behaviour traditionally associated with men, including drinking (Pyne et al., 2002).

Despite the increasing high level of alcohol consumption among females in Latin America and the Caribbean (LAC), the study indicated that men in LAC are more likely to consume and abuse alcohol and women are more likely to abstain from alcohol. This is a result of cultural norms that support and in many cases encourage drinking among men, whereas they impose conditions and restrictions on drinking among women. In Mexico, for example, young unmarried women are discouraged from drinking in public, particularly in company of men (Pyne et al., 2002).

In another study, it was found that women from physically abusive homes are twice more likely to abuse alcohol than those who are not abused (Schuck & Wisdom 2001, as cited in Compton, 2010).

2.6.8 Alcohol abuse and accidents

In addition to the health consequences of alcohol abuse, social consequences include drunkenness, violence and motor vehicle accidents (Howe, 2009). It was further reported that seventy to eighty percent of acute incidents, such as car accidents, violence, and crime, do not occur among heavy drinkers. They occur among moderate and light drinkers, usually as a result of heavy consumption in a session (ILO, 2004).

Babor et al. (2010) stated that in 2002, as many as 1.1 million people died worldwide from traffic injuries where alcohol is a major risk factor of traffic fatalities and injuries. In- high income countries about 20% of fatally injured drivers have a blood alcohol concentration above legal limits while studies in low-income and middle-income countries have shown that between 33% and 69% of fatally injured drivers and between 8% and 29% of non-fatally injured drivers had consumed alcohol (Babor et al., 2010).

2.6.9 Alcohol abuse and its effect at the workplace

Alcohol abuse affects all people and it occurs in the majority of organizations at all levels, from top management to the lowest rank of the organization (ILO, 2004). The following effects of alcohol abuse at the workplace were highlighted:

- **Accidents:** Up to forty percent of accidents at work involve or are related to alcohol use. Drug using or heavy drinking workers are more likely to be involved in an accident at work than workers who do not use drugs or alcohol.
- **Absenteeism:** Drug using or heavy drinking workers are more likely than other workers to be absent from work without permission. They are also more likely to have an absence of eight days per month more than other workers, especially on Mondays.
- **Strains on co-workers:** There is an increased workload on the teetotalers to compensate for a drug using or heavy drinking worker. There is a high safety risks due to intoxication, negligence and impaired judgment of a drug using or heavy drinking workers. They tend to be involved in disputes and grievances at the workplace as well as violence and theft. Intimidation and drug trafficking can easily occur at the workplace.
- **Replacement costs:** Drug using or heavy drinking workers are more likely than other workers to have worked for three or more employers in the past year. They are further likely than other workers to have voluntary left an employer in the past year or been fired by an employer in the past two years.
- **Work output:** Intoxication and post use impairment (hang over) impact the following functions that are relevant to work performance: the reaction time get slower, blurred vision, the mood as the person experience more aggression or depression, learning and memory is affected as the person experience a loss of concentration and there is impairment of logical thinking.

Due to this health, social, familial and individual problems associated with excessive alcohol use, the Namibian government introduced various pieces of legislation to regulate alcohol sales and consumption.

2.7 Alcohol legislation and policies that enhance alcohol prevention in Namibia

The Namibian Liquor Act, 1998 (Act 6 of 1998) is important to ensure the effective implementation of the CORD programme as it regulates the production, supply and use of alcohol beverages in Namibia. Although the Liquor Act is supposed to regulate the supply, demand and use of liquor in the country, there seems to be no standard criteria set for issuing of liquor licenses and no strict enforcing measures in terms of the underage children purchasing and consuming alcohol in the shebeens or bars or purchasing alcohol and consuming it elsewhere. Alcohol policies that address the sale, use and health and social problems associated with it, will be reduced when addressing the following:

- **Alcohol availability and accessibility**

Petersen and McBride (2002) assert that when substances, such as alcohol become easily available and cheap it is more likely to be misused. According to Pyne at al. (2002), regulating the availability of alcohol and its condition of use may reduce the consumption of alcohol and harm related to it. The authors stated that availability of alcohol is affected by restricting production, requiring licensing of sales outlets, restricting days and hours of sales, limiting the number

of places of sales, setting a minimum age limit for those already intoxicated and regulating the advertising of alcohol beverages by private companies.

Wagner and Anthony (2002, as cited in Strausnner, 2004) supported the fact that increasing availability of substances contributes to substance abuse. The statement was further supported by (Babor et al., 2010) who asserted that when alcohol is readily available through commercial or social sources, consumption and associated problems increase.

2.7.1 Government control as a measure of controlling availability of alcohol

Alcohol availability may reduce if government holds monopoly on production and sale, special taxes on alcohol beverages, minimum age limit, sale restrictions set by licensing outlets, and limit times of sale (Pyne et al., 2002).

In Namibia, the government through the established Liquor Licensing Boards in all thirteen regions, is only responsible for issuing liquor licenses and determining the hours of operations according to the type of license issued, but the license owners (shebeen and bar owners) are in control of the management of their businesses, and the production of beer and other alcoholic beverages is left with private companies (Liquor Act, 1998). The situation of shebeens in the Namibia was recently criticized by a local town councillor who blamed the Okakarara Town Council for issuing fitness certificates left

and right' without proper precautions; resulting in mushrooming of shebeens and abuse of alcohol (Nakale, 2012).

In contrast, other countries, such as Costa Rica, the government holds monopoly over the production and sale of alcoholic beverages. In Paraguay the state agency maintains a monopoly on purchasing, distilling, and quality control of alcohol products. In Finland, the Finish state agency, ALCO, was crucial part of the alcohol control machinery until 1995 when Finland join the European Union (EU). ALCO had a monopoly on the production, import, export, wholesale and retail sale of alcohol beverages. Furthermore, this agency also controlled very tightly private activities in the alcohol field, and legally all licensed private alcohol retailers were ALCO agents (Pyne at al., 2002).

2.7.2 Licensing

Liquor Licensing Boards are established at all local municipalities in different towns in Namibia. They are responsible for issuing liquor licenses to prospective shebeen and bar applicants (Namibian Liquor Act, 6, 1998). The licenses specify the type of alcohol to be sold, the hours of operations according to the type of alcohol outlet as well as the age restrictions that need to be adhered to.

Similarly, alcohol outlets in some European countries where governments do not have the monopoly on production and sale alcohol, such as in Greece, the alcohol producers

need licenses, but once issued, these licenses are permanent and they include specific rules and regulations that have to be enforced (Pyne et al., 2002).

However, licensed drinking environment does not reduce alcohol consumption and problems associated with drinking as they are associated with drunkenness, drink-driving and aggressive behaviour. Therefore, interventions in drinking environments can be important in averting problems that often harm people who are not drinking (WHO, 2009, as cited in Pyne et al., 2002).

In an effort to curb the effects of alcohol abuse, the Namibian police in the Khomas Region advocated that (i) unlicensed shebeens should be closed down; and (ii) the licensed ones should operate according to their license specifications in terms of the type of alcohol they sell, trading hours and reducing noise pollution (Nakale, 2012).

2.7.3 Restriction of legal age on purchasing and use of alcohol beverages

Babor et al. (2010) indicated that increasing the legal minimum drinking age has shown to reduce the prevalence of alcohol consumption among the adolescents, but at the same time it has been associated with mild increase in the prevalence of marijuana use in this age group.

According to the provision in the Namibian Liquor Act, No. 6 of 1998 the legal age of using alcohol is eighteen (18) years. There seems to be a problem in the enforcement of

this provision as there is a big public outcry on alcohol availability, accessibility to underage children and noise pollution. This led to the National Council to refer a motion on shebeens to the Standing Committee on Security, Constitutional and Legal Affairs to review the relevant provisions and regulations of the Liquor Act, No. 6 of 1998 (Nakale, 2012). The provisions that were recommended for review entail the licensing of shebeens, the proximity of shebeens to residential areas, and the rationale for different operating hours of shebeens, and the selling of liquor to under-age children at shebeens. This motion was supported by the Okakarara councilor who called on the country law-makers to review and amend the said legislation to prevent more alcohol-related deaths. This call was due to two incidents: a person was hit by a car after leaving a bar to return home at 04:00, and a young man (17 years old) from the same town was stabbed to death allegedly as a result of fighting that erupted due to alcohol (Muraranganda, 2013).

Babor et al. (2010) mentioned that restricting the days and times of alcohol sale reduces opportunities and availability for purchasing alcohol whereby alcohol-related problems are then reduced. World Health Organisation (2009, as cited in Babor et al., 2010) mentioned that drinking environments are associated with drunkenness, drunk-driving, aggressive and violent behaviour. Interventions in drinking environments can be important in terms of averting problems, such as alcohol-related violence, that often harm people who are not drinking.

The draft Namibian Demand Reduction Policy on Alcohol Use and Misuse (2009) is another legislation that aims to develop alcohol-related services and to guide associated health, education, social care and criminal justice agencies in terms of the availability of alcohol and the prevention of substance abuse. It also supports programmes that focus on harm reduction, alcohol addiction treatment and intervention. The International Labour Organisation (2004) indicated that there should be a policy framework at a national level which addresses the use and abuse of alcohol and drugs. This should support the development of prevention and treatment programmes in workplaces and at the community level. The lack of such framework will makes it difficult for employers and workers to address substance abuse.

2.8 Summary

This chapter defined the relevant terms applicable to the study. The chapter further described the CORD programme and its three intervention strategies, namely prevention, law enforcement and treatment. Different prevention strategies were discussed. The structure and record keeping components as part of the prevention programme were also included. Substance abuse is a learned behaviour from observation in a drinking environment and media, and socializing with peers, therefore, the Trans Theoretical (wheel of change) Model, as one treatment model was discussed to illustrate the stages the person will pass on their way to changing behaviour. Other treatment models, such as individual counselling, motivational interviewing, and the disease model were also discussed.

The CORD programme entails the involvement of other stakeholders, such as other line ministries, partners, donors and community members; hence the available literature on stakeholders' involvement was consulted. It is important to include all key stakeholders, key leaders in the community, and informal leaders in the initial implementation of community based prevention programme (Unrau et al., 2007).

Substance abuse cause harm, not only to the user, but also to the non-user in form of violence, accidents and other health and social problems. The health and social effects of substance abuse were thus discussed through the application of relevant literature.

Relevant legislations pertaining to substance abuse were discussed while critically looking at the available literature on the legislation in different countries. The Liquor Act (No. 6 of 1998) formed the basis of the key legislation in Namibia that controls the availability, accessibility, use and supply of alcohol beverages, hence the discussion thereof.

CHAPTER 3

3. RESEARCH METHODOLOGY

3.1 Introduction

The assessment explored the achievements and challenges that social workers experience in the implementation of the coalition on responsible drinking (CORD) programme at MoHSS. The assessment gathered detailed information about the inputs, activities and processes of the programme in order to uncover the achievements and challenges experience during programme implementation, the adequacy of resource allocation and the availability and transparency of programme documentation.

This chapter presents an overview of the important areas that need to be considered when undertaking research. Types of research, as well as the rationale for choosing the methodology, are outlined. The following are defined and described: target population, research design, strategy, research instruments, pilot study, administration and collection of the questionnaires, data processing, data analysis, validity and reliability, limitations and ethical considerations.

3. 2 Rationale for the methodology

The research project utilizes a quantitative methodology approach. A quantitative approach is more appropriate to determine the extent of the problem, issue or phenomenon by quantifying the variations, whereas a qualitative approach is more

appropriate to explore the nature of the problem, issue or phenomenon without quantifying it. The main objective is to describe the variations in a phenomenon, situation or attitude, for example, a description of an observed situation, the historical enumeration of event and an account of different opinion that different people have about an issue, description of working conditions in a particular working environment.

In this study the purpose was to gain insight on how all social workers responsible for implementing the CORD programme perceive the process, investigate possible challenges which hamper the successful implementation of CORD and to develop recommendations that could enhance the programme implementation.

3.3 Research approach

Fouche (2002) indicates that a research approach refers to quantitative or qualitative or combined quantitative-qualitative approach. In this study a quantitative approach was adopted. The researcher opted for this approach, because the study focused on knowledge of the respondents about the implementation of the CORD programme in their regions. This involved examining the relationship among variables of interest. For example, perceptions of different categories, the views of different levels of social workers, and regional comparisons.

3.4 Type of research

The study was an applied type of research. Bless and Higson-Smith (2000) refer to applied research as social research that has the primary aim of finding solutions to specific concerns or problems facing particular groups of people by applying models or theories developed through basic research. On the other hand, Adler and Clarck (2011) refer to applied research as being designed to provide information that is immediately useful to those participating in institutions or programmes.

The authors stated that applied research is intended to provide information that is useful in the immediate future and to suggest actions or increase effectiveness in some areas of the programme. This type of research is a means for testing objective theories by examining the relationship among variables. These variables, in turn, can be measured, typically on instruments, so that numbered data can be analysed using statistical procedures. The final written report has a set structure consisting of introduction, literature and theory, methods, results and discussion (Creswell, 2006).

For this study, a quantitative method approach was used with closed and some open-ended questions. The main reason for including open ended questions was to obtain answers to complex issues, self-expression, and to obtain more ideas of possible responses on the implementation of the CORD programme.

3.5 Research design

Creswell (2006) indicated that research designs are plans and procedures for research that span the decision from broad assumptions to detailed methods of data collection and analysis. Furthermore, the author added that the selection of a research design is also based on: (i) the nature of the research problem or issue being addressed; (ii) the researcher's personal experiences; and (iii) the audience for the study.

Descriptive research is social research with the primary aim of describing, rather than explaining, a particular phenomenon (Bless & Higson-Smith, 2000). Newman (2000) emphasizes that descriptive research presents a picture of the specific details of a situation, social setting or relationship. It is the researcher's view that the previous definition was more relevant to the topic under study as it focused on describing the situation on the implementation of the CORD programme. When using a descriptive design, the main purpose is to describe situations and events.

3.6 Description of the research population, sample and sampling method

3.6.1 Target population

A population represents the entire group of people, events or things of interest (Creswell, 2006). According to Adler and Clarck (2011) a population is a group of elements from which a researcher samples and to which he or she might like to generalize.

For this study, the target population comprised female and male social workers, employed at MoHSS in the thirteen regions of Namibia and who were involved in CORD programme implementation. The researcher contacted the regional chief social workers to identify the number of social workers who were involved in the implementation of the CORD programme. The researcher was informed that there were 64 social workers involved country-wide. Therefore, the researcher defined the target population to be all social workers who were involved in the implementation of the CORD programme.

3.6.2 Sampling methods

De Vos et al. (2011) refer to sampling as a smaller number of a population that is considered to be a representation or having particular characteristics of that total population. The sample selected represents the larger population and it is used to draw inferences about that population. Sampling is a research technique widely used in the social sciences as a way to gather information about a population, without having to measure the entire population. According to the above-mentioned authors, there are two sampling techniques: non-probability and probability sampling, respectively. The former is a sampling technique where the samples are gathered in a process that does not give all the individuals in the population equal chances of being selected. It includes: reliance on available subjects; purposive or judgmental sample, snowball sample, quota sampling and respondent driven. On the other hand, probability sampling is a sampling technique where the samples are gathered in a process that gives all the individuals in

the population an equal chance of being selected. Such sampling includes: simple random sampling, systematic sampling, stratified sampling and cluster sampling. For the purpose of this study, the entire population has been selected for the study as it is relatively small.

3.7 Research instrument

A structured self-administered questionnaire was developed and distributed via postal mail and self-delivery to the respondents to gather a broad spectrum of information. This research instrument is more advantageous than others for data collection. It is less time consuming and is cost-effective. The completed questionnaires were mailed back via postal services to the researcher. In this study follow ups were made telephonically and through e-mails to ensure a high response rate.

3.7.1 Questionnaire construction

Closed-ended and open-ended questions were included in the research instrument to allow the researcher to discover the participants' perception on how the CORD programme is implemented in the regions. The questions were compiled to assess the CORD project management and implementation measures that are in place at the MoHSS in terms of effectiveness, and to recommend strategies towards improved CORD project management systems. In other words the questions were related to the objectives in 1.3 (See Appendix 1).

3.7.2 Questionnaire items

The closed and open ended questions covered the following main areas (see Appendix 1):

- Respondent information
- Alcohol prevention and education
- Enforcement of alcohol-related legislation
- Treatment of people addicted to alcohol
- Availability of resources
- Record keeping and sharing of CORD activities

3.8 Pilot study

Creswell (2006) stated that a pilot study refers to: (i) the feasibility or small-scale versions of studies conducted in preparation for the main study; and (ii) the pretesting of a particular research instrument. They add that a good pilot study increase the likelihood of success in the main study and should warn of possible project failures, deviations from protocols or problems with proposed methods or instruments. Adler and Clark (2011) provide a simple definition of a pilot study as being “a preliminary set of questions that is tested before the actual data collection”.

Before embarking on the full-scale study, questionnaires were distributed to 10 social workers in the MoHSS in the Khomas Region and these respondents were not included

in the main study. The shortcomings were identified and incorporated in the questions and a revised questionnaire was used for the main study.

3.9 Administration of questionnaires

Firstly, permission was requested (Appendix 2) and obtained from the MoHSS as the study would allow for an indication of how the CORD programme is implemented at the MoHSS and to recommend strategies towards improved CORD programme implementation.

3.10 Collection of questionnaires

The potential respondents were given 10 working days to complete the questionnaires and to return to the researcher. The researcher did follow-ups via telephone and e-mail to remind them of the deadline.

3.11 Data processing and analysis

A data entry application was developed in EpiInfo programme. A data clerk entered the data. The MS Access data file in EpiInfo was then imported into Statistical Package for the Social Sciences (SPSS), where data cleaning and validation were done. Illogical values were corrected by comparing the respondent's data with the corresponding hardcopy questionnaire. Responses to open-ended questions were coded and new variables were created in the SPSS file for these questions. Frequency and cross

tabulation tables were generated using SPSS. Graphs and tables were created in Microsoft Excel.

3.12 Validity and reliability

According to De Vos et al. (2011) reliability means that the measuring instruments must produce compatible results in the same or similar circumstances using the same or similar research groups. Validity means that the measuring instruments must measure what they are supposed to measure.

The researcher ensured validity and reliability of the results of the study by developing a structured self-administered questionnaire in consultation with the supervisor and conducted a pilot study. The questionnaire for the pilot study was distributed and completed by the Khomas Region social workers who were not part of the main study in order to detect possible flaws in conducting the study, such as inadequate time.

Trustworthiness should also be seen in terms of its validity and reliability and can be evaluated according to credibility, conformability, and dependability (Newman, 2000). These concepts were used to provide evidence of the validity and reliability of the research study:

3.12.1 Credibility

The credibility of the research can be established through conducting a pilot study, flexibility and peer de- briefing (Newman, 2000). In this research the pilot study was

conducted prior to the main study to affirm whether the main participants of the study will understand and respond effectively to the questions.

3.12.2 Confirmability

Confirmability refers to the degree to which the findings of the research study were the product of the inquiry and not the biases of the researcher involved in the study (Streubert & Carpenter, 2003). Reflexive analysis and auditing as approaches of confirmability was applied to increase the neutrality of this research.

In terms of reflexive analysis, Newman (2000) asserted that the researcher should be aware of his/ her own effect on the process and outcomes of research, understanding that knowledge cannot be separated from what the researcher already knows as he/ she is part of the phenomenon under study. The researcher was therefore constantly aware of personal feelings and experiences that might influence the study and integrated her understanding in the study to ensure objectivity.

Auditing of the research process is another approach to ensure confirmability of the research study. Auditing is a systematic collection of materials and documents so that dependant or external auditors have comparable conclusions about the data. The purpose is to demonstrate that the evidence and the understood processes give different researchers the same conclusions about the collected data (Streubert & Carpenter, 2003).

Mr. Jan Swartz, a Statistician, served as the auditor and assisted with entering and processing of data using the Statistical Package for the Social Sciences (SPSS), where data was analysed.

3.12.3 Dependability

Streubert and Carpenter (2003) refer to dependability as the level of consistency of the findings; which means that the findings of the study should be consistent if the study is repeated with the same participants within the same context. In this research, the research protocol was discussed with other social workers and the supervisor to ensure the applicability of the research design and the research plan.

3.13 Eliminations of bias

The language used in the questionnaire was simple, clear and understandable. Moreover, part of the reason for choosing quantitative approach was to reduce possible bias as it required the researcher to maintain a critical distance from the respondents.

3.14 Ethical considerations

The researcher believes that it is important that anyone who is conducting research should comply with professional ethics. De Vos et al. (2011) define ethics as principles that influence behaviour in human relations: a code of conduct. The following research issues were considered:

3.14.1 Informed consent

This implies that respondents are informed about the purpose of a study and the advantages of conducting such a study. In this study the respondents were informed of

the aim of the study, namely, to evaluate the CORD programme by assessing the social workers' perception on its implementation. The instructions on the research instrument clearly indicated what was expected of the respondents.

3.14.2 Voluntary participation

The consent form covered the principles of voluntary participation. It ensured that the respondents were informed of their rights. Voluntary participation implies that respondents must not be coerced to participate in a study. They must do so voluntarily, and should be allowed to freely withdraw from a study at any time.

3.14.3 Confidentiality

The principle of confidentiality refers to an agreement between persons that limits other people to have access to specific information. De Vos et al. (2011) stated that researchers must keep the nature and quality of participants' performance strictly confidential. To adhere to this principle the respondents were not required to write their name on the data collection tools. The questionnaires were self-administered with e-mail and telephonic support from the researcher. The respondents were informed that their responses would be kept confidential.

3.14.4 Avoidance of harm

De Vos et al. (2011) stated that researchers should not expose research participants to unnecessary physical or psychological harm. This study did not expose the respondents

to any harm. They were informed that the information collected would only be used for the study and not for any personal issues.

3.15 Summary

This chapter discussed the research methods used in the study. The methods conform to a quantitative research approach using a descriptive study design. The study also outlined the study population that focused on the entire population of social workers in all the thirteen regions who are involved in the implementation of the CORD programme.

The manner in which the data was collected was explained in this chapter, as well as the validity and reliability of the data collection instrument. Ethical consideration was also highlighted.

Chapter 4 presents and analyses the findings. The results are linked to the literature review.

CHAPTER 4

4. PRESENTATION AND INTERPRETATIONS OF RESULTS

4.1 Introduction

This chapter provides interpretation of the empirical data. Data are presented in the sequence in which questions were asked in the data collection instrument. The researcher used closed-ended and open-ended questions in the questionnaire; they allow the researcher to discover each participant's perception on how the CORD programme is implemented in the regions. The questions were compiled to assess the CORD project management and implementation measures that are in place at the MoHSS in terms of effectiveness, and to recommend strategies towards improved CORD project implementation. The semi-structured interview consisted of six (6) sections:

- Respondent information
- Alcohol prevention and education
- Enforcement of alcohol-related legislation
- Treatment of people addicted to alcohol
- Availability of resources
- Monitoring and evaluation of CORD activities

4.2 Presentation and interpretation of results

The results of the six sections of the questionnaire are presented below.

4.2.1 Respondents' information

Table 2: Respondents by job title (n = 55)

Job Title			
Chief Social Worker	Principal Social Worker	District Social Worker	Total
Percent	Percent	Percent	Percent
7	15	78	100

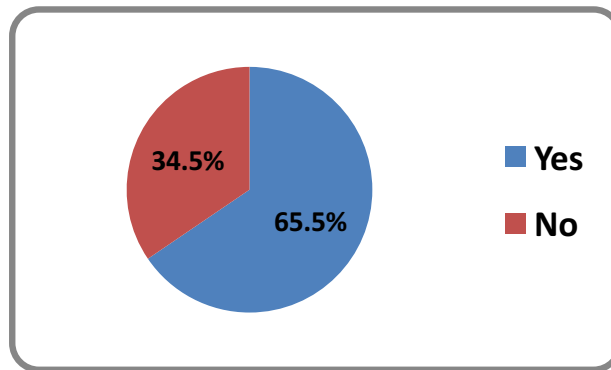
Table 2 shows that most respondents, namely 78 % (43 out of the total of 55 respondents), who completed the questionnaire were district social workers, with 8 (15% (8 out of a total of 55 respondents) principal social workers and 4 (7%) were chief social workers.

Table 3: Respondents by job title and experience in social work and involvement in the CORD programme by job title (n = 55)

Job Title	Number of years' experience in social work	Number of years' involved in implementation of CORD programme
	Average Years	Average Years
Chief Social Worker	21	6
Principal Social Worker	19	5
District Social Worker	7	3
Total Average	16	5

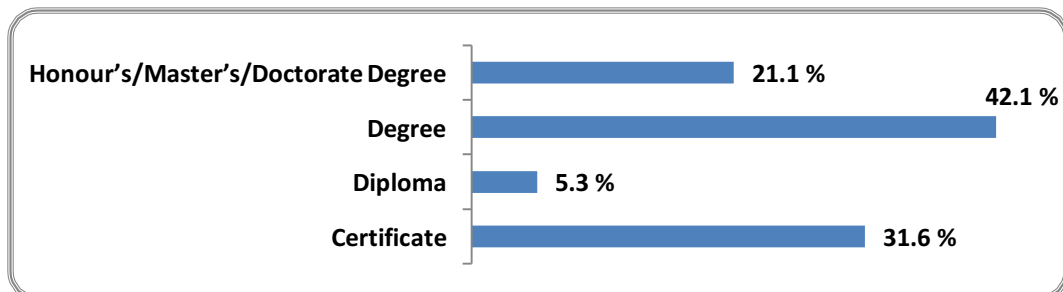
The average years of work experience listed in Table 3 were 21 years for chief social workers; 19 years for principal social workers and 7 years for district social workers.

Figure 2: Respondents by possession of programme management training or qualification (n = 55)



As evident in Figure 2 only 36 (65.5 %) of the respondents possessed qualification in project management and 19 (34.5%) did not have training in project management.

Figure 3: Respondents by type of programme management training or qualification (n = 55)



As shown in Figure 3, the respondents' qualifications were as follows: 12 (21.1 %) have post-graduate qualifications, e.g. honours/masters/doctorate degrees; 22 (42.1%) have a

degree in project management, 3 (5.3%) have a diploma in project management and 18 (31.6 %) a certificate. Goodmann (2007) highlighted that an adequate complement of trained staff is necessary to manage programmes and to deal with problems relating to drug and alcohol abuse in the stakeholders.

4.2.2 Alcohol prevention and education

Table 4: Respondents' perception on importance of the CORD programme implementation for MoHSS, stakeholders and community (n = 55)

Importance of CORD for	Somewhat	Important	Very Important	Total
	Percent	Percent	Percent	Percent
Ministry of Health and Social Services	3.6	21.8	74.5	100.0
Stakeholders	10.9	40.0	49.1	100.0
Community	7.3	18.2	74.5	100.0

It can be observed from Table 4 that 41 (74.5%) of the respondents felt that the CORD programme implementation is very important for the MoHSS and the community; while 27 (49.1%) reported that the programme is very important for stakeholders. Fertman and Allensworth (2010) stated that staff, stakeholders and participants should all know what a programme seeks to accomplish and how it will go about trying to accomplish alcohol abuse reduction. All should therefore be involved in the planning and implementation of the programme.

Table 5: Respondents' perception on importance of the CORD programme implementation for MoHSS, stakeholders and community by job title (n = 55)

Importance of CORD programme for		Chief Social Worker	Principal Social Worker	District Social Worker
		Percent	Percent	Percent
Ministry of Health and Social Services	Somewhat	0	0	5
	Important	25	13	16
	Very Important	75	88	79
	Total	100	100	100
Stakeholder	Somewhat	0	13	12
	Important	50	63	30
	Very Important	50	25	58
	Total	100	100	100
Community	Somewhat	0	0	9
	Important	25	38	14
	Very Important	75	63	77
	Total	100	100	100

Table 5 shows that 48 (88%) of the principal social workers felt that that the CORD programme implementation is very important for MoHSS and 43 (79%) of district social workers felt that CORD programme implementation is very important for the MoHSS. In terms of the importance of the programme for stakeholders the results were: 35 (63%) of principal social workers were in agreement that the implementation of the CORD programme is important whereas only (32) 58% of district social workers were of this opinion. On the other hand 41 (75%) of principal social workers felt the importance of CORD programme implementation for the community compared 42 (77%) of the district

social workers.

Table 6: Respondents by reasons why CORD programme is important in the region/health district (n = 55)

Reasons why CORD programme is important in the Region/Health District	Number	Percent
Reduce alcohol problems	2	3.6
Education and alcohol abuse Prevention programme	22	40.0
Addresses the challenges the community have on alcohol	8	14.5
Awareness raising on alcohol abuse	3	5.5
CORD members to assist the community in absence of social workers	4	7.3
Promote responsible drinking and to help those who want to quit drinking	5	9.1
Monitoring tool for alcohol outlets	3	5.5
To promote stakeholders and community involvement in CORD	5	9.1
Not stated	3	5.5
Total	55	100.0

As shown in Table 6 22 (40%) respondents felt that the CORD programme is important in the region/district as an education and alcohol abuse prevention programme, whilst the lowest percentage of 2 (3.6%) indicated that the CORD programme is important for reduction of alcohol problems.

Table 7: Main stakeholders that are aware of the CORD programme (n = 55)

Main stakeholders that are aware of CORD	Number	Percent
GRN Ministries	52	94.5
Donors, Partners, NGO's	33	60.0
Private Industry	21	38.2
Community	49	89.1

As evident in Table 7, 52 (94.5%) of respondents indicated that GRN ministries are the main stakeholders that are aware of the CORD programme; while 49 (89.1%) indicated that the community is aware of the CORD programme.

Table 8: Main stakeholders by involvement in the implementation of CORD programme

Main stakeholders	Fully involvement of stakeholders		
	Yes	No	Total
	Percent	Percent	Percent
GRN Ministries	48.1	51.9	100.0
Donors, Partners, NGO's	57.6	42.4	100.0
Private Industry	38.1	61.9	100.0
Community	49.0	51.0	100.0

Thirty-two of the respondents (57.6%) indicated that donors, partners and NGO's are fully involved in the implementation of the CORD programme and 27 (49%) of the community is involved in the programme, while 26 (48.1%) of the GRN ministries are

fully involved in the implementation of the CORD programme. (ILO, 2004) suggested that Programme implementers/social workers are responsible to form a steering committee to facilitate community involvement in the envisaged prevention programme. As members of a diverse group, they should represent all segments of the community and devote time to team-building. Bourne (2009) stated that a shared vision, and a common framework for action, can connect all energies and focus the coalition steering committee toward common goals which is an important step in moving a community beyond fragmentation toward an effective, coordinated prevention system where all will feel their importance in the involvement of the programme.

Table 9: Main reasons for stakeholders' lack of involvement in the implementation of CORD programme

Reasons for lack of involvement	Number	Percent
They experience challenges with the Liquor Act , the Act is having loop holes	1	4%
Lack of motivation, low morale of stakeholders	4	14%
Lack of incentives for stakeholders	9	32%
Other reasons, such as their political leader not elected in leadership position	2	7%
If social workers are not fully involved, other stakeholders won't be involved	1	4%
No proper orientation or education for stakeholders on the CORD programme	4	14%
Conflict of interest as they also have alcohol outlets	1	4%
Stakeholders are employed full time and have no time for CORD programme	2	7%
Stakeholders see CORD as a Social Workers programme and not theirs	2	7%
The Head office of the other ministries are not involved in the programme, than the regions would not be fully involved	2	7%
Total respondents who indicated reasons why there is a lack of stakeholder involvement:	28	51%

Reasons for lack of involvement	Number	Percent
Total respondents who indicated that stakeholders are fully involved:	26	47%
Total respondents who did not state any reasons for lack of involvement by stakeholders:	1	2%
Total number of respondents:	55	100%

Fifty-one percent of the respondents indicated that the main stakeholders are not fully involved in the implementation of the CORD programme. Of the 28 (51%) respondents who indicated that the main stakeholders are not fully involved, Table 9 indicates that 9 (32%) were of the opinion that lack of incentives is the main reason for the lack of involvement of stakeholders in the implementation of the CORD programme. Velleman (2006) stated that it is important to provide incentives for stakeholders/volunteers in the form of allowance, retreats and trainings in order to increase their motivation.

Table 10: Suggestions to improve stakeholder's involvement in the implementation of CORD programme

Suggestions to improve involvement	Number	Percent
More funding and technical support is needed	3	5.5
Provide incentives for stakeholders, even caps and t-shirts	6	10.9
Involve the respective ministries from managerial level	5	9.1
Amend the Liquor Act and enforcement of the law	2	3.6
Conduct regular motivational and educational meetings	3	5.5
Formulate clear roles for regional CORD committees	2	3.6
Invite stakeholders to conferences and cluster cord review meetings	13	23.6
Coordinate CORD activities with stakeholders	1	1.8
Train more staff and stakeholders on CORD to sustain the programme	2	3.6

Suggestions to improve involvement	Number	Percent
Recruit more social workers in the regions	1	1.8
Conduct more meetings to educate, motivate and encourage stakeholders	2	3.6
Involve more private partners and media coverage	1	1.8
Introduce CORD as workplace programme at various ministries	2	3.6
Provide resources, such as transport	1	1.8
Total number of respondents who did not provide any suggestions on how to improve stakeholder involvement:	11	20.0
Total:	55	100.0

The main suggestion to improve stakeholders' involvement, according to the 13 respondents, is to invite them to conferences and CORD review meetings (23.6%). Unrau et al. (2007) indicated that stakeholders' involvement is based upon the belief that expertise does not solely lie with the professionals; stakeholders are an important component of the programme as they are able to provide insight into various needs of the programme. Wilson and Kolander (2011) stressed that in order for stakeholders to be effective participants of community based programmes, they need to know the important lessons learned from successful, as well as unsuccessful community based prevention programmes through review meetings to evaluate progress of activities and show new skills and knowledge.

Table 11: Respondents by training received on alcohol prevention, treatment and counselling

Received training on	Yes	No	Not stated	Total
	Percent	Percent	Percent	Percent
Alcohol prevention, treatment and counselling in degree	47.3	50.9	1.8	100.0
Alcohol prevention, treatment and counselling in specialization programmes	21.8	76.4	1.8	100.0
Alcohol prevention, treatment and counselling during workshops	92.7	5.5	1.8	100.0

As evident in Table 11 training on alcohol prevention, treatment and counselling was received by 51 (92.7%) of the respondents during workshops; 26 (47.3%) of the respondents obtained such knowledge during the degree training; only 12 (21.8%) obtained such knowledge as a specialization area. Goodman (2007) acknowledged that pre-qualification and in-service training on the potential harm to children and parents on alcohol abuse should be provided to service providers.

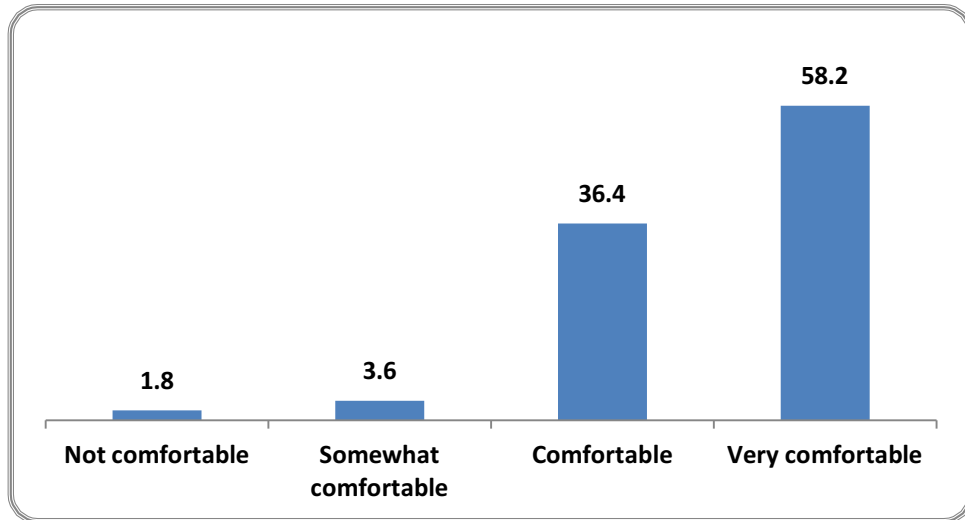
Table 12: Respondents by training received on alcohol prevention, treatment and counselling and job title

Received training on		Job Title			Total
		Chief Social Worker	Principal Social Worker	District Social Worker	
		Percent	Percent	Percent	
Alcohol prevention, treatment and counselling in degree	No	50.0	75.0	46.5	50.9
	Yes	50.0	12.5	53.5	47.3
	Not stated	0.0	12.5	0.0	1.8
	Total	100.0	100.0	100.0	100.0
Alcohol prevention, treatment and counselling in specialization programmes	No	100.0	62.5	76.7	76.4
	Yes	0.0	25.0	23.3	21.8
	Not stated	0.0	12.5	0.0	1.8
	Total	100.0	100.0	100.0	100.0
Alcohol prevention, treatment and counselling during workshops	No	0.0	0.0	7.0	5.5
	Yes	100.0	87.5	93.0	92.7
	Not stated	0.0	12.5	0.0	1.8
	Total	100.0	100.0	100.0	100.0

Furthermore, 100% of chief social workers, 87.5 % of the principal social workers, and 93% of the district social workers confirmed that they had received training on alcohol abuse prevention, treatment and counselling during workshops as evident in Table 12.

This effort was supported by (Petersen and McBride, 2002) who stated that regular training for practitioners dealing with substances is important to enable them to offer the required services and ensure the provision of evidence based interventions.

Figure 4: Comfortable to advise clients on alcohol drinking problems



The results in Figure 4 indicate that 32 (58.2%) of the respondents are very comfortable to advise clients on alcohol drinking problems.

Figure 5: Availability of IEC materials

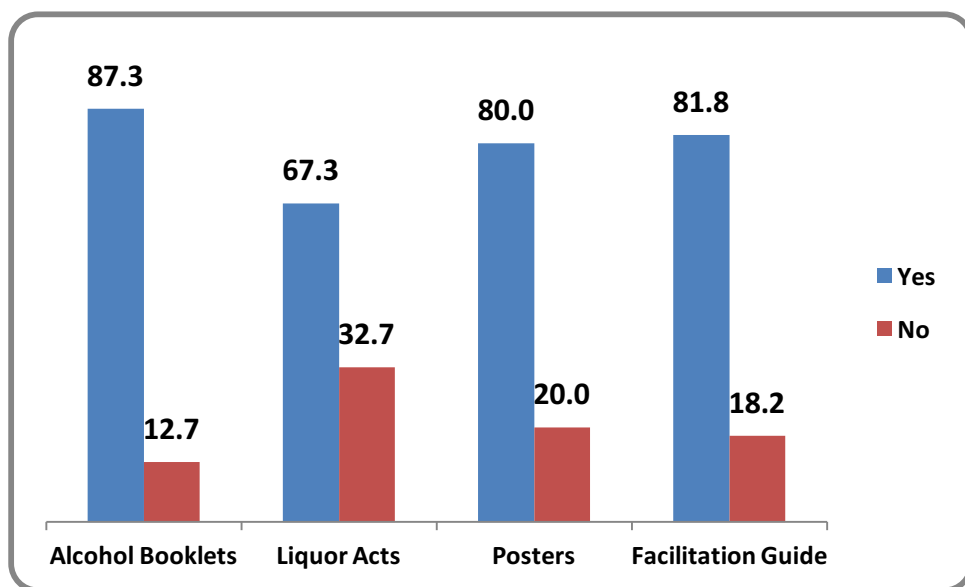
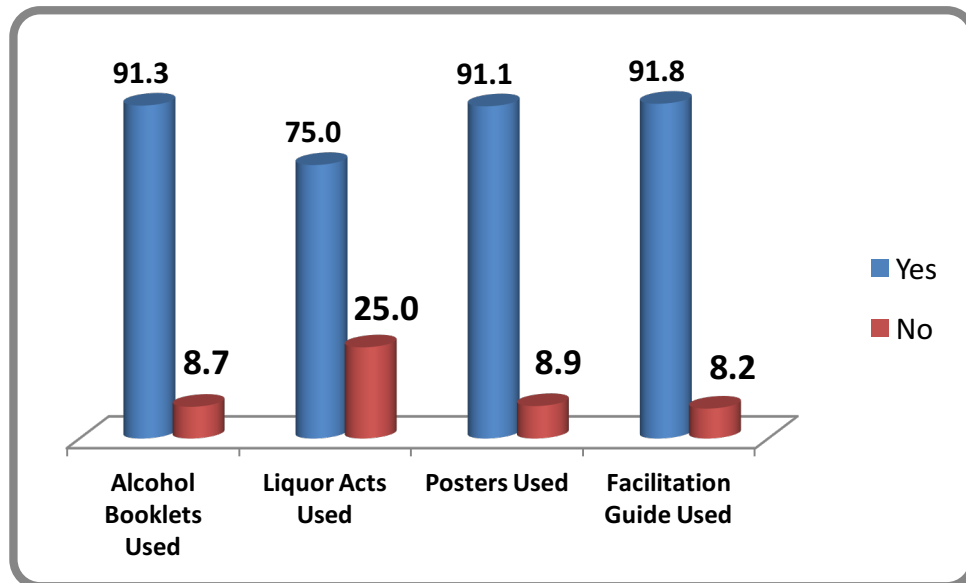


Figure 5 shows that there is a high availability of IEC material on alcohol education and prevention: 48 (87.3%) respondents indicated that the alcohol prevention booklets are available, while 37 (67.3%) of the respondents indicated that material on the Liquor Act are available.

Figure 6: Usage of IEC materials



Fifty (91%) of the respondents reported usage of the available IEC material. The lowest usage rate was 41 (75%) of the Liquor Act. The ILO (2004) highlighted that health promotion activities on substance abuse should include written material, for example leaflets delivered in pay envelopes, and brochures placed in break areas and cafeterias.

Table 13: Number of outreach sessions conducted in the past one year on alcohol prevention

Type Community Outreach	Total Number of Sessions
Youth camps	12
Schools	120
Drinking Places	92
CORD Committee Meeting	166
Media	22
Line Ministers	45
Churches	57
Health Facilities	81
Old Age Homes	11
Community Meetings	146
Other Places	22

The results in Table 13 show that CORD Committee meetings (166) and community meetings (146) were the highest numbers of outreach services conducted.

Table 14: Stakeholders' awareness of the CORD programme

Stakeholders	Awareness of the CORD programme		
	Yes	No	Total
	Percent	Percent	Percent
Police	45.5	54.5	100.0
Ministry of Education	58.2	41.8	100.0
Ministry of Health and Social Services	16.4	83.6	100.0
Youth Centre	20.0	80.0	100.0
Ministry of Gender Equality and Child Welfare	52.7	47.3	100.0
Catholic Aids Action	7.3	92.7	100.0
Ministry of Home Affairs	7.3	92.7	100.0
Red Cross	9.1	90.9	100.0
Ministry of Justice	12.7	87.3	100.0
Town Council	38.2	61.8	100.0
Ministry of Safety and Security	25.5	74.5	100.0

Stakeholders	Awareness of the CORD programme		
	Yes	No	Total
	Percent	Percent	Percent
Traditional Authority	9.1	90.9	100.0
Ministry of Lands, Resettlement and Rehabilitation	3.6	96.4	100.0
Ministry of Agriculture Water and Forestry	5.5	94.5	100.0
Regional Authority	3.6	96.4	100.0
Churches	41.8	58.2	100.0
Life Line Child Line	10.9	89.1	100.0

The results in Table 14 show that most stakeholders were not aware of the CORD programme, including MoHSS (83.6%) were the implementing social workers are employed.

Figure 7: Number of stakeholders involved

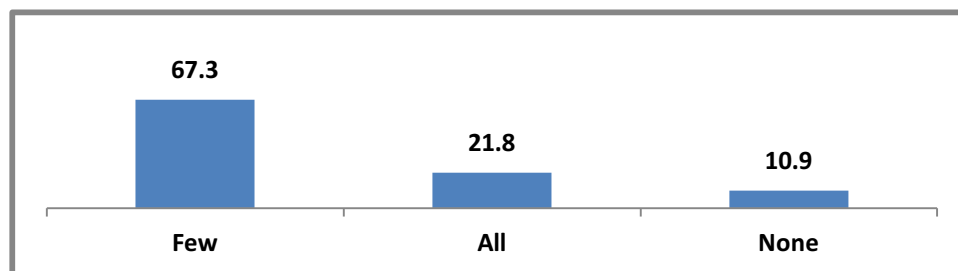


Figure 7 shows that 37 (67.3%) of the respondents stated that only a few stakeholders are involved in the implementation of the CORD programme; 12 (21.8%) of them indicated the involvement of all stakeholders. Bourne (2009) asserted that for stakeholders to be fully involved in the programme, they should be included in the planning of the programme that involves the following steps: identification of the right stakeholders, develop a mission statement to realize the vision of the programme, accurately define

where they are in terms of the alcohol abuse in their community; develop steps to get from where they are and where they would like to be, i.e. the vision with short and long-term goals with measurable objectives in order to set the first actions for the group; evaluate, improve and add to the original plan so that they can address those issues together that are important and have an impact to the community wellbeing.

Table 15: Stakeholders implementing the CORD programme

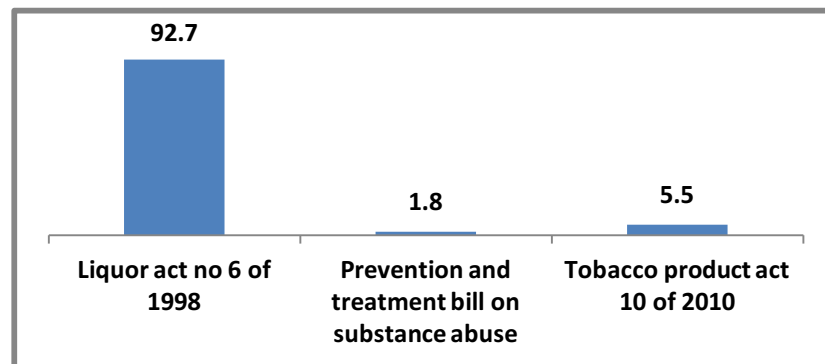
Stakeholders	Implementing the CORD programme		
	Yes	No	Total
	Percent	Percent	Percent
Police	29.1	70.9	100.0
Ministry of Education	30.9	69.1	100.0
Youth Centre	16.4	83.6	100.0
Ministry of Health and Social Services	20.0	80.0	100.0
Ministry of Gender Equality and Child Welfare	16.4	83.6	100.0
Catholic Aids Action	5.5	94.5	100.0
Ministry of Home Affairs	1.8	98.2	100.0
Red Cross	0.0	100.0	100.0
Ministry of Justice	1.8	98.2	100.0
Town Council	14.5	85.5	100.0
Ministry of Safety and Security	16.4	83.6	100.0
Traditional Authority	9.1	90.9	100.0
Ministry of Lands, Resettlement and Rehabilitation	5.5	94.5	100.0
Regional Authority	1.8	98.2	100.0
Churches	18.2	81.8	100.0
Life Line Child Line	3.6	96.4	100.0

It can be observed from Table 15 that the stakeholders who mostly implement the alcohol intervention activities are: Ministry of Education (30.9 %); the police (29.15 %) and MoHSS (20%). Santelli et al. (2013) stated that young people were more likely to drink alcohol and this increased their HIV risk there is therefore a huge need to address substance abuse in prevention activities with young people. In this case more programme activities are implemented at schools (Ministry of Education).

4.2.3 Enforcement of alcohol-related legislation

The results for this section are presented below.

Figure 8: Policies/laws regulating alcohol selling and consumption



As evident 51 (92.7%) of respondents reported that the Liquor Act is the more common legislation for law enforcement known by social workers; only 1 (1.8%) of respondents indicated the Prevention and Treatment Bill on substance abuse as shown in Figure 8.

Table 16: Type of legislation available to carry out awareness campaigns in the community

Type of Legislation	Readily available to carry out awareness campaigns in the community				
	Yes	No	Don't know	Not stated	Total
	Percent	Percent	Percent	Percent	Percent
Abuse of Dependence-producing Substances and Rehabilitation Centre Act	10.9	36.4	20.0	32.7	100.0
Prevention and Treatment Bill on substance	21.8	32.7	18.2	27.3	100.0
Liquor Act	80.0	9.1	3.6	7.3	100.0
Customer and Excise Act	3.6	40.0	18.2	38.2	100.0
The Road Traffic and Transport Act	1.8	41.8	18.2	38.2	100.0

The results in Table 16 confirmed that the Liquor Act is readily available and that it has an 80% usage to carry out awareness campaigns.

Table 17: Type of legislation used to carry out awareness campaigns in the community

Type of Legislation	Legislation being used to carry out awareness campaigns in the community				
	Yes	No	Don't know	Not stated	Total
	Percent	Percent	Percent	Percent	Percent
Abuse of Dependence-producing Substances and Rehabilitation Centre Act	3.6	32.7	12.7	50.9	100.0
Prevention and Treatment Bill on	12.7	30.9	12.7	43.6	100.0

Type of Legislation	Legislation being used to carry out awareness campaigns in the community				
	Yes	No	Don't know	Not stated	Total
	Percent	Percent	Percent	Percent	Percent
substance					
Liquor Act	78.2	10.9	1.8	9.1	100.0
Customer and Excise Act	3.6	34.5	12.7	49.1	100.0
The Road Traffic and Transport Act	1.8	32.7	12.7	52.7	100.0

Forty-three (78%) of the respondents reported that they use the Liquor Act to carry out awareness campaigns compared to other legislation, such as the Road Traffic Act which was only used by one (1.8%) respondent as evident in Table 17.

Table 18: Type of policies/manuals available to carry out awareness campaigns in the community

Alcohol Policies/Manuals	Available to carry out awareness campaigns in your community				
	Yes	No	Don't know	Not stated	Total
	Percent	Percent	Percent	Percent	Percent
National Demand Reduction Policy on Alcohol Use and Misuse available	12.7	27.3	18.2	41.8	100.0
Guidelines on the Management of Substance Intoxication and Withdrawal available	47.3	20.0	10.9	21.8	100.0
Prevention and Aftercare	38.2	23.6	12.7	25.5	100.0

Alcohol Policies/Manuals	Available to carry out awareness campaigns in your community				
	Yes	No	Don't know	Not stated	Total
	Percent	Percent	Percent	Percent	Percent
Manual on Substance Abuse available					
Drug Control Master Plan available	1.8	38.2	16.4	43.6	100.0
Guideline on Case Management for Substance Abuse Clients available	25.5	25.5	18.2	30.9	100.0
Operational Manual for Etegameno Rehabilitation and Resource Centre available	23.6	23.6	18.2	34.5	100.0

Table 18 shows that 26 (47.3%) of the respondents were aware of the guidelines on the management of substance abuse intoxication and 21 (38.2%) of them were aware of the prevention and aftercare manual on substance abuse.

Table 19: Type of policies/manuals used to carry out awareness campaigns in the community

Alcohol Policies/Manuals	Policies being used to carry out awareness campaigns in the community				
	Yes	No	Don't know	Not stated	Total
	Percent	Percent	Percent	Percent	Percent
National Demand Reduction Policy on Alcohol Use and Misuse used	12.7	34.5	18.2	34.5	100.0

Alcohol Policies/Manuals	Policies being used to carry out awareness campaigns in the community				
	Yes	No	Don't know	Not stated	Total
	Percent	Percent	Percent	Percent	Percent
Guidelines on the Management of Substance Intoxication and Withdrawal used	36.4	25.5	9.1	29.1	100.0
Prevention and Aftercare Manual on Substance Abuse used	27.3	27.3	10.9	34.5	100.0
Drug Control Master Plan used	1.8	36.4	14.5	47.3	100.0
Guideline on Case Management for Substance Abuse Clients used	14.5	27.3	12.7	45.5	100.0
Operational Manual for Etegameno Rehabilitation and Resource Centre used	25.5	27.3	10.9	36.4	100.0

Table 19 indicates that the respondents used the following manuals to carry out awareness campaigns: the guideline on management of substance abuse: 36.4% (20 respondents); the prevention and aftercare manual on substance abuse: 27.3% (15 respondents); and the operational manual for Etegameno Rehabilitation and Resource Centre: 25.5% (14 respondents).

4.2.4 Treatment of people addicted to alcohol

Table 20: Type of interventions available to help patients with alcohol problems

Interventions	Interventions available to help patients with alcohol problems		
	Yes	No	Total
	Percent	Percent	Percent
Medication	45.5	54.5	100.0
Individual or group counselling	90.9	9.1	100.0
Traditional Remedies	20.0	80.0	100.0
Referral to another health care professional	67.3	32.7	100.0
Referral to a community-based organization that address the problem	40.0	60.0	100.0
Exercising/social club	21.8	78.2	100.0
Referral to a rehabilitation centre	72.7	27.3	100.0

Table 20 indicates that 50 (90.9%) of respondents reported that individual and group counselling is available to help with alcohol problems; while only 11 (20%) of respondents reported that traditional remedies are available to assist people with alcohol problems.

Table 21: Type of interventions used to help patients with alcohol problems

Interventions	Interventions used to help patients with alcohol problems		
	Yes	No	Total
	Percent	Percent	Percent
Medication	25.5	74.5	100.0
Individual or group counselling	83.6	16.4	100.0
Traditional Remedies	9.1	90.9	100.0
Referral to another health care professional	52.7	47.3	100.0
Referral to a community-based organization that address the problem	29.1	70.9	100.0
Exercising/social club	16.4	83.6	100.0
Referral to a rehabilitation centre	65.5	34.5	100.0

Table 21 indicates that 46 (83.6 %) of the respondents indicated that individual or group counselling is used to help clients with alcohol problems; while only 5 (9.1%) of respondents indicated that traditional remedies are used to assist people with alcohol problems. Straussner (2004) believes that the goal of individual treatment/counselling is to enhance patients' self-image and provide needed ego support so that they can begin to examine their use of chemicals and their current feelings and behaviour. Heller and Gitterman (2011) also maintained that outpatient care or counselling is most appropriate when clients are ready to make changes in their lives, minimal risks exist for symptoms of withdrawal, they have a supportive environment and they have adequate coping mechanisms for handling pressures to use drugs.

Table 22: Number of referrals

	Number
Clients counselled	22
Clients referred to rehabilitation	1
Clients referred to after care	4

Table 22 indicates that 22 people were counselled; four were referred to an aftercare group; and only one person was referred to a rehabilitation centre.

Table 23: Reasons for none or low referrals

Reasons for none or low referral	Number	Percent
Etegameno Rehabilitation Centre is not operational for three years	20	36.4
Clients are not motivated to go for rehabilitation	4	7.3
Aftercare groups not functional	7	12.7
Private rehabilitation centres are expensive	6	10.9
Clients refused to go to Psychiatric hospital for detoxification or rehabilitation	3	5.5
Lack of commitment from Social Workers to motivate clients to attend aftercare groups	1	1.8
Clients don't want to go far from home for rehabilitation , prefer local counselling	3	5.5
No orientation of new Social Workers on the referral of alcohol addicted clients and treatment of alcohol clients	3	5.5
Not stated	8	14.5
Total	55	100.0

As evident in Table 23 the highest number of respondents (20) indicated that the reason for none or low referral of people for rehabilitation services was due to the closure of Etegameno Rehabilitation Centre. There is only one government rehabilitation centre in Namibia (Adams, 2007). Therefore, the researcher believes that there will be low referrals if the centre is closed.

4.2.5 Availability of resources

Figure 9: Respondents by sufficient human resources

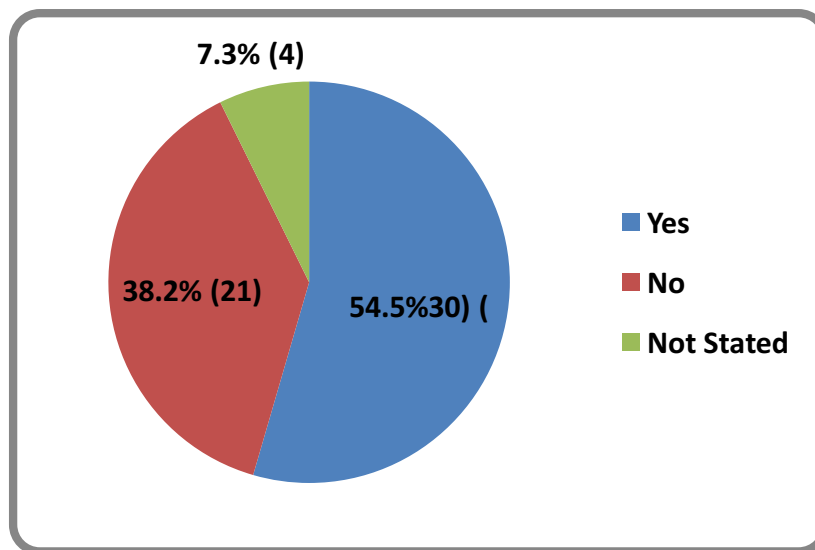


Figure 9 shows that 54.5% of the respondents indicated there are sufficient human resources for implementation of the CORD programme, and 38.2% indicated that there are not sufficient human resources. Fixsen et al. (2005, as cited in Fertman & Allensworth, 2010) stated that the availability of funding streams, human resource

strategies, supporting policy, creating referral mechanism, reporting frameworks, and outcome expectations are important for successful programme implementation.

Table 24: Suggestions to address insufficient human resources

Suggestions to address insufficient human resources	Total	Percent
Usage of health extension workers	1	4%
Appoint Social Worker working exclusively with CORD Program	2	8%
Appoint more Social Workers	12	48%
Train/empower more CORD members/line Ministries	5	20%
Provide incentives to CORD members	2	8%
Employ auxiliary workers	1	4%
Increased funding	1	4%
More Guiding documents (manuals)	1	4%
Total Respondents who indicated that human resources are not sufficient:	25	45%
Total Respondents who indicated that human resources are sufficient:	30	55%

Table 24 shows that 55% of the respondents indicated that human resources are sufficient to implement CORD programme in their respective districts, while 45% felt that the human resources are not sufficient. Of the 45% who felt that human resources are not sufficient, 48 % suggested that more social workers are needed to be recruited in order to address the insufficient human resources. Goodmann (2007) also supported this suggestion and indicated that adequate and trained staff is necessary to deal with problems relating to drug and alcohol abuse in a community.

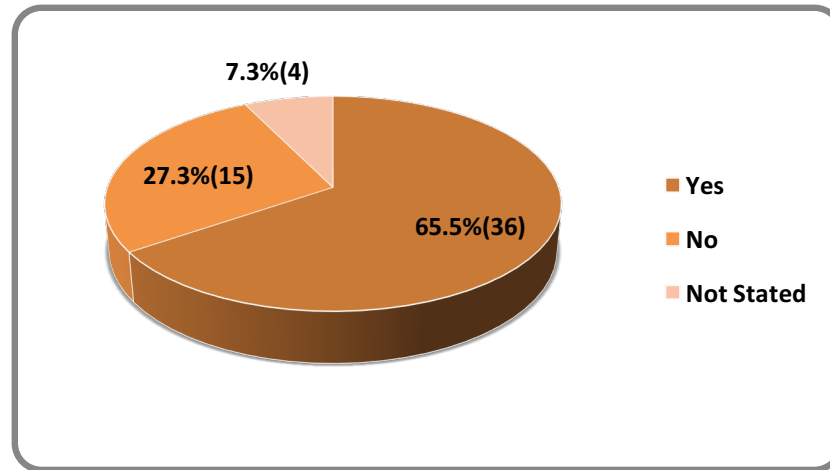
Figure 10: Respondents by funding of CORD programme

Figure 10 shows that 65.5 % of the respondents indicated that the CORD programme is being funded whereas 27.3% stated that the programme is not being funded. Fertman & Allensworth (2010) stated that during programme installation or implementation, the aim is to focus on the structural support which is necessary to initiate a programme. It involves ensuring the availability of funding streams. However, the CORD programme was mainly supported by donor funding during its implementation (MoHSS, n.d).

Table 25: Reasons why CORD programme is not funded by MoHSS

Reasons for not funded	Total	Percent
Budget for CORD activities not approved	8	50%
Programme was inactive in the district	2	13%
Programme not yet recognized in the district	2	13%
Ministry need more donor funding to support the CORD programme	2	13%
Only commemoration of the International Day Against Drug Abuse and Illicit Trafficking is being funded by MoHSS	2	13%

Reasons for not funded	Total	Percent
Total who stated that CORD is not funded:	16	29%
Total who indicated that funding is sufficient:	36	65%
Not stated	3	5%

Table 25 shows that of the respondents who indicated that the CORD programme is not funded, 50% indicated that the budget for CORD activities was not approved by the region.

Figure 11: Respondents by other funding sources for CORD programme

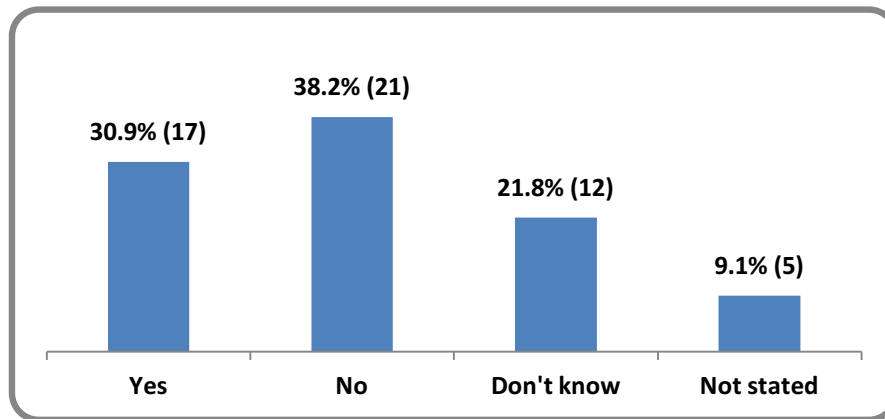


Figure 11 shows that 38.2 % of the respondents reported that there are no other funding sources for the programme, and 30.9% respondents said that there are other funding sources for the programme.

Table 26: List of other funding sources for CORD programme

List of other funding sources	Number	Percent
Blue Cross	1	6%
CDC	10	56%
Local business people sponsor events	2	11%
MVA fund	1	6%
NGO's	1	6%
Regional Councilors	2	11%
USAID	1	6%
Total respondents who listed other sources of funding:	18	33%
Total respondents who indicated that they do not receive other sources of funding:	33	60%
Not stated:	4	7%

A total of 33% of the total respondents indicated that there are other funding sources for the CORD programme. Of those respondents who indicated that there are other sources of funding, 56% indicated that the funding for the programme comes from the Centre for Disease Control and Prevention (CDC) programme (Table 26).

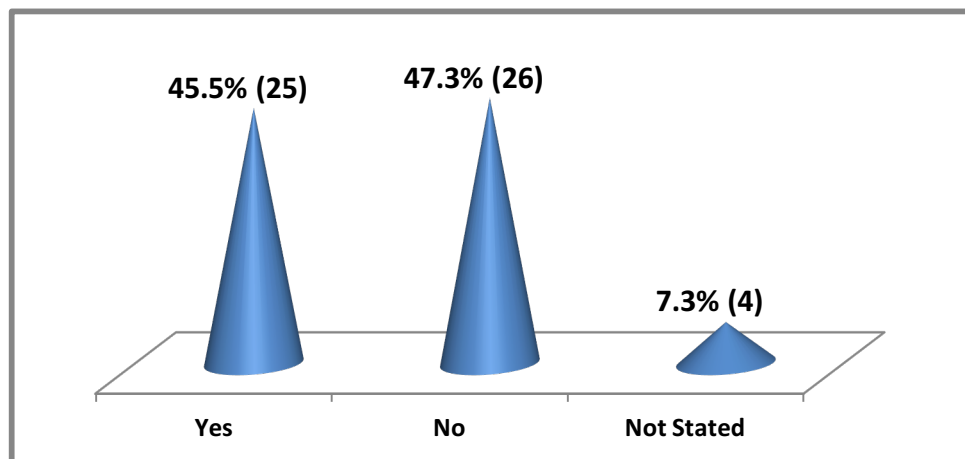
Figure 12: Respondents by availability of transport

Figure 12 shows that 47.3% of the respondents indicated that transport is available for the programme and 45.5% of the respondents indicated that they do not have transport for execution of CORD activities.

Table 27: Major transport challenges

Major Transport challenges	Number	Percent
Vehicles are only there for emergencies	2	8%
No vehicles are allocated to social welfare services	7	29%
Shortage of vehicles in the district	5	21%
Preferences is given to health services	2	8%
Activities need to be planned in advance in order to get transport	1	4%
There are not enough drivers	6	25%
Social workers do not have authorisation to drive government vehicles	1	4%
Total respondents who indicated the major transport challenges:	24	44%
Total respondents who indicated that they do not experience transport challenges:	25	45%
Not stated:	6	11%

As shown in Table 27, the highest percentage of respondents (29%) stated that the major challenge for lack of transport is that there are no vehicles allocated to social welfare services to execute CORD programme activities. Ch'ien (2008) indicated that transport services are essential for service delivery and it should be provided to ensure programme implementation.

Table 28: Possible solutions to address transport problems

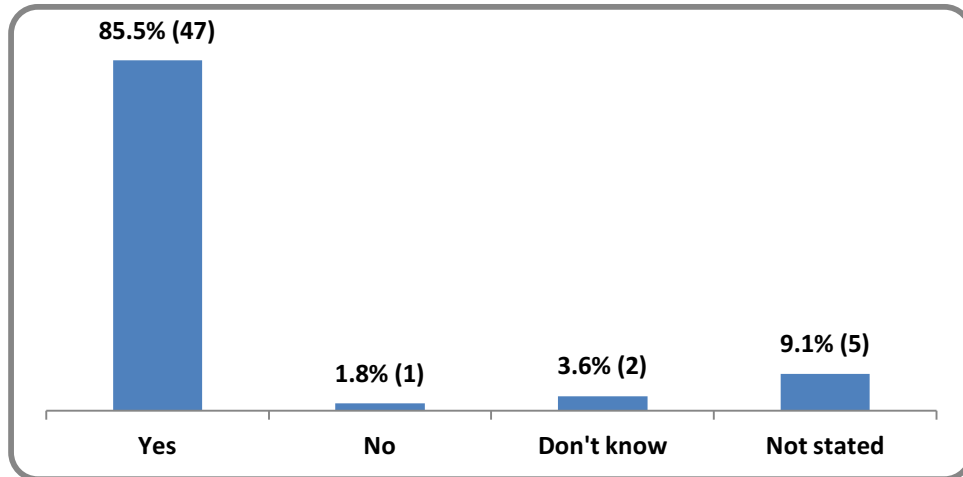
Possible solutions to Transport Problems	Number	Percent
Put up proper budget for transport	1	3%
Plan activities with transport budget	3	10%
Social Services to be regarded as a priority service at the district	8	28%
Allocate vehicle to be specifically used by the social work department	10	34%
Coordinate CORD activities with other stakeholders and ministries	2	7%
Employ more drivers	2	7%
Social workers to get driving licenses	3	10%
Total provided solutions for transport problems:	29	53%
Not stated:	5	9%
Total not experiencing transport problem:	21	38%
Total:	55	100%

As shown in Table 28, the two possible solutions to address the transport problems as reported by respondents were: allocation of vehicles to be specifically used by the social work department (34%), and social services to be regarded as a priority service at the district (28%).

4.2.6 Monitoring and evaluation of CORD activities

Figure 13 shows that 85.5 % of the respondents stated they kept records of CORD activities, and only 1.8% indicated that they do not keep records of CORD activities.

Figure 13: Respondents by record keeping of CORD activities



Nicholas et al. (2010) asserted that social work managers should, as part of their administrative tasks, ensure that records are accurate and reflect the services provided. Sufficient and timely documentation of records should be kept to facilitate the delivery of services and ensure continuity of services provided to clients (Nicholas et al., 2010).

Figure 14: Respondents by format of record keeping of CORD activities

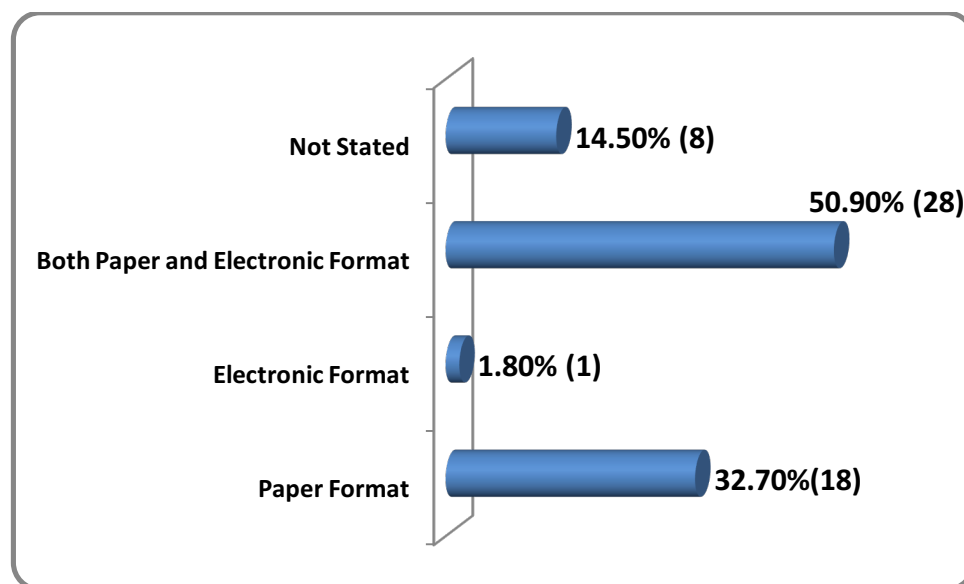


Figure 14 shows that 50.9% of respondents indicated that records are kept in both paper and electronic format whereas 32.7% indicated that kept records are only kept in paper format.

Figure 15: Respondents sharing CORD activities with other stakeholders

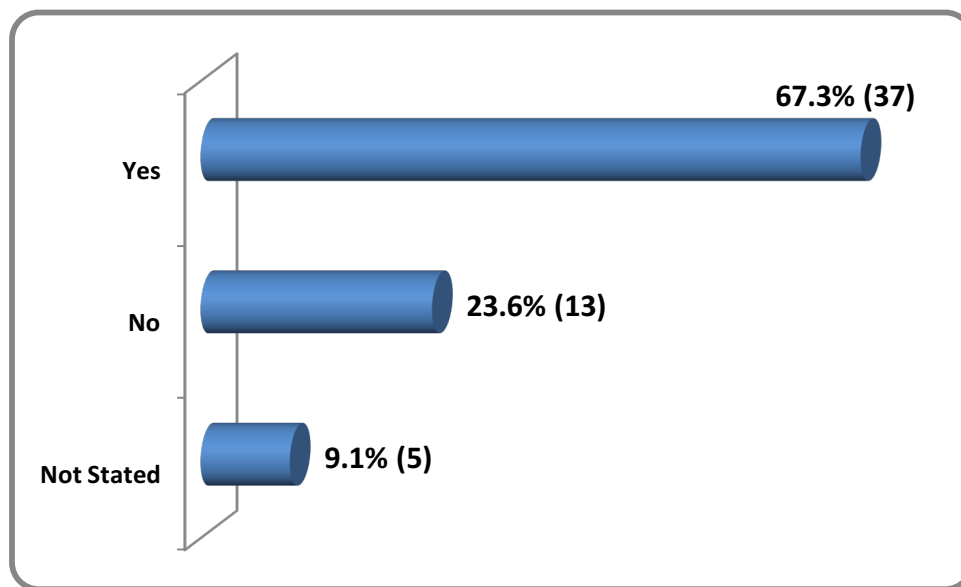


Figure 15 shows that 67.3 % of the respondents reported they share CORD activities with other stakeholders at workshops and meetings; only 23.6% reported that they do not share activities with other stakeholders. It is vital is that each person or group who is part of the programme should be informed, feel included, and should have a sense of ownership of all projects (Bourne, 2009).

Table 29: Record sharing methods

Elaborate on record sharing	Number	Percent
CORD members are provided with plans for the CORD programme	1	3%
Minutes and feedback are provided at workshops and meetings	15	42%
Information is shared during community meetings	5	14%
Information is shared during quarterly meetings with stakeholders	6	17%
Don't have enough records in the office on previous CORD activities in the district	1	3%
Share information through Ministry of information and Broadcasting	2	6%
TADA information is shared with the principals at schools	1	3%
Information is shared during Constituency AIDS Development Committees (CACOC'S)	1	3%
Other Stakeholders don't play an active role in the programme	1	3%
Provide the reports to the Senior Social Worker	1	3%
Stakeholders don't turn up for meetings	1	3%
No CORD committees are yet established	1	3%
Total who share records:	36	65%
Total who do not share records:	19	35%
Total	55	100%

Table 29 shows that 42% of respondents indicated they share information of CORD activities with other stakeholders during meetings and workshops; 17% shared information during quarterly meetings with stakeholders; and 14% shared information during community meetings. As suggested by Swanepoel and de Beer (2006) there is a need to document meetings minutes, progress reports, status reports, challenges/risks and ways of militating against them and financial issues and share this information with all partners involved.

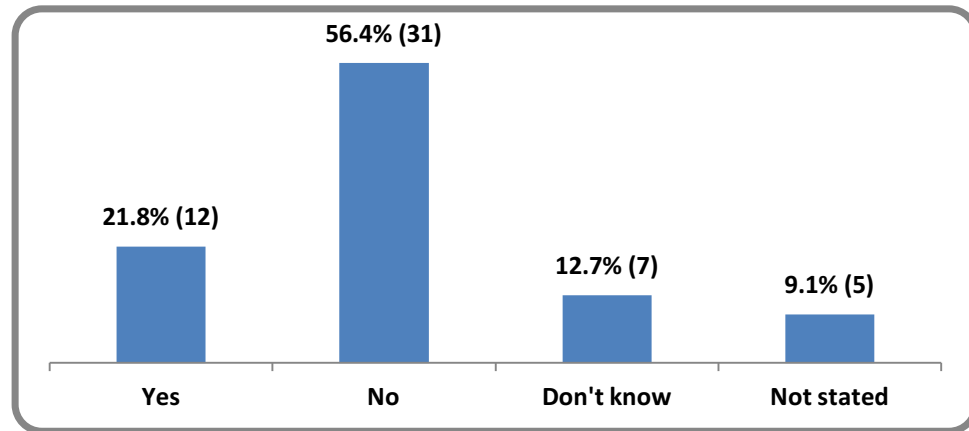
Figure 16: Existence of monitoring and evaluation tool for the CORD programme

Figure 16 illustrates that 56.4% of the respondents stated that there is no monitoring and evaluation tool for the CORD programme; 21.8% indicated the existence of a CORD monitoring and evaluation tool.

Table 30: Suggestion on implementation of monitoring and evaluation (M&E) tool

Suggestion on M&E tools	Number	Percent
National Level to develop an M&E tool for the CORD programme	22	79%
Guideline is needed for regions to develop M & E tool	2	7%
Develop pre and post questionnaire to be used before alcohol abuse prevention information sessions	1	4%
Encourage small research on the incidents of alcohol abuse in the community	1	4%
Conduct review meetings and keep records	1	4%
Keep attendance registers for events	1	4%
Total who provide suggestions on M&E tools	28	51%
Total who indicated that they do not have suggestions on M&E tools:	16	29%
Not stated	11	20%
Total	55	100%

Table 30 shows that 79 % of the respondents suggested that national level should develop a monitoring and evaluation (M&E) tool for the CORD programme. Erwin at al. (2003) and McKencie et al. (2005, cited in Fertman & Allernworth, 2010) suggested the implementation of a logic plan model for community based prevention programme. Such a plan, according to the authors, could be used to measure the outcome of the community based programmes. It is described as a valuable tool that helps to communicate relationships between programme elements to stakeholders and potential partners as well as the target population. It shows the relationship between the programme resources (inputs), its planned activities (outputs) and the expected results (outcomes).

Table 31: General comments on the implementation of the CORD programme

General comments	Number	Percent
CORD is a good programme and it should continue in all regions	8	24%
The programme need political power, involvement of political leaders	4	12%
Programme need stakeholders involvement	4	12%
The programme should be referred to as Coalition on Reduction of Harmful Drinking and not Responsible Drinking	3	9%
IEC material should be translated in local languages	1	3%
Programme should be reviewed to strengthen implementation of the programme	1	3%
Health professionals and management at district and regional level need to support the programme	1	3%
Strengthen support, supervision and training from national level to the regions	6	18%
CORD members to be provided with identification cards and t-shirts	2	6%

General comments	Number	Percent
CORD programme need to be integrated with other programmes at district and regional level	1	3%
Referrals of clients to the rehabilitation centres need to be encouraged	1	3%
Invite regions to conferences and include them in programme planning	1	3%
Total who provided comments on the implementation of CORD:	33	60%
Total who did not provided comments on the implementation of CORD:	22	40%
Total:	55	100%

Table 31 shows the main comments listed by the respondents on the CORD programme: the CORD programme is a valuable programme and needs to continue (24%); the CORD programme needs political power and political involvement (12%); and it also needs stakeholders involvement (12%).

4.3 Summary

The data from the questionnaires were presented in tables and figures. The interpretation of results was presented in this chapter. The semi- structured questionnaire were based on six categories namely, the respondents information, alcohol prevention and education training received by programme implementers , enforcement of alcohol-related legislation, treatment programmes available for people addicted to alcohol, availability of resources for the programme , and the monitoring and evaluation for CORD activities. Conclusions and recommendations are presented in the next chapter.

CHAPTER 5

5. RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

This chapter presents conclusions and recommendations. The main aim of this study was to assess the achievements and challenges in the implementation of the CORD programme by evaluating the opinions and perceptions of social workers who work directly with the programme in the regions of Namibia. In addition the aim of the study was to come up with recommendations for consideration by the Directorate of Social Welfare Services, and more specifically for social workers who work closely with the CORD programme.

5.2 Conclusions

The following conclusions were made according to the set objectives and relevant literature was aligned to the findings.

5.2.1 Objective 1: To assesses how the social workers see their role and the roles of other stakeholders within the programme.

In terms of the above-mentioned objective, social workers perceived themselves as the main implementers of the CORD programme. They further expressed that the donors and community members (volunteers) are one of the main stakeholders of the CORD programme especially, through the funding of the programme by donors. Social workers

also felt that other stakeholders are not fully involved in the implementation of the programme due to the lack of incentives.

Stakeholders need to be part of the planning and implementation of the programme in order to increase their involvement (Unrau et al., 2007). Incentives in the form of trainings, retreats and allowances can further increase the stakeholders' involvement in the implementation of the programme (Vellerman, 2006).

5.2.2 Objective 2: To explore the inputs, processes, structures and the target population being served by the programme

In terms of this objective there were several findings that came out. Social workers mainly receive their training for the alcohol prevention and treatment through in- service trainings that are offered by the employer during workshops and conferences. Although social workers indicated that they received training and are very comfortable to advice clients on alcohol problems, regular trainings are found to be essential to enhance service delivery and provide evidence based treatment (Petersen and McBride, 2002).

Another finding is that the main activities that are conducted for the programme are outreach visits to schools, CORD committee meetings and community meetings.

The findings further revealed that the provision of IEC material in form of posters, alcohol information booklet and facilitation guide are used to expand the provision of substance abuse prevention information in the community.

Individual counselling was found to be the main method used to provide help to people with alcohol problems whilst referral to aftercare groups and treatment centers were use minimal. However, Heller and Gitterman (2011) advised that outpatient care or counselling is most appropriate when clients are ready to make changes in their lives, minimal risks exist for symptoms of withdrawal, they have a supportive environment and they have adequate coping mechanisms for handling pressures to use drugs.

5.2.3 Objective 3: To examine whether resources in terms of funding, human resources, transport are allocated to the CORD programme in order to carry out activities, as well as determining whether the programmes data are kept and shared at meetings as well being incorporated into the reports of MoHSS

The study revealed that the main funding for the CORD programme is coming from donors; hence they also regard the donors and partners as the main stakeholders of the programme implementation. Human resources, in terms of social workers were found to be sufficient while an equal percentage said that human resources, in terms of social workers is not sufficient for the for the implementation of the CORD programme.

Transport was found to be equally available to conduct activities while others felt that transport was not available. The reason for non-availability was stated that there are no vehicles specifically assigned to social workers to conduct their activities.

The study also found that the data for the programme activities is stored in both paper and electronic format and it shared with others during meetings and workshops.

5.2.4 Objective 4: To investigate whether the programme has a monitoring and evaluation tool to monitor the progress of implementation of programme activities.

The study found that there is no monitoring tool for the CORD programme to evaluate the strength and challenges in the implementation of the programme.

The study revealed that there is no short-term or long-term monitoring tool that illustrate the expected inputs, outputs, and expected outcomes that will measure the progress of the implementation of the planned activities in order to address the main objectives of the programme.

5.3 Recommendations

The following recommendations were made based on the findings of the study:

5.3.1 Directorate of Social Welfare Services:

- Create awareness among the political and other leaders at national and regional level on the importance of the CORD programme in reducing the harm caused by alcohol abuse.

- Lobby regional management to budget and provide other necessary resources, such as transport for CORD programme in order to ensure the implementation and sustainability of the programme activities.
- Provide and facilitate continuous training for social workers and stakeholders in the management of substance/alcohol abuse to build capacity in the management of alcohol related problems.
- Operationalise the Etegameno Rehabilitation Centre in Khomas Region, and develop and establish other treatment modalities for people with alcohol and drug addiction problems.
- Recruit more social workers to implement and sustain the programme.
- Involve the other stakeholders at management level in the planning and budgeting of the CORD programme in order to strengthen the coordination of the programme from management to operational level.
- Encourage the provision of incentives for stakeholders to enhance their involvement in the programme.
- Develop and implement a standardized monitoring and evaluation tool for the CORD programme.

5.3.2 Social Workers

- Plan and budget for the activities of the programme at regional and district levels.

- Strengthen stakeholder's involvement in the planning, budgeting and implementation of CORD activities and coordinate activities with other stakeholders and partners.
- Refer people with alcohol problems to rehabilitation centers and sustain aftercare services to prevent rehabilitated clients from relapse.
- Implement the standardized monitoring and evaluation tool at regional and districts levels to ease effective reporting and data sharing.
- It is essential to involve other stakeholders, such as other government ministries, donors, NGO's, community based organizations, business people, local leaders, churches and ordinary community members in the planning, implementation and continuous monitoring of the implementation of the programme activities so that they can develop ownership of the programme.

5.3.3 Stakeholders

- It is vital for the stakeholders to be involved in the planning, implementation and continuous monitoring of implementation of programme activities.
- Stakeholders who are involved in the programme should plan and budget for the activities of the programme in order to ensure ownership and implementation of the programme.
- Stakeholders should identify their training needs according to the programme objectives so that necessary training can be arranged to enhance their skills in the implementation of programme activities.

5.4 Limitations of the study

The scope of the study was limited to the assessment of social workers' perception of the implementation of the CORD programme. The study did not include other stakeholders who are involved in the programme, nor did it include the beneficiaries of the programme.

This study was also the researcher's first attempt to conduct a programme evaluation, therefore the study was only limited to the main programme implementers. Both time and financial resource restraints meant that the study could not focus on other stakeholders who are involved in the CORD programme implementation.

Another limitation is that the study could not be generalized to the wider context of alcohol abuse prevention programmes. It is based on the CORD programme which is an alcohol abuse prevention programme in Namibia.

5.5 Future research

The current study focused on how the social workers employed at the Ministry of Health and Social Services perceived the implementation of the CORD programme. However, the CORD programme implementation involved other stakeholders. As a result, future research needs to be conducted on how other stakeholders perceive the implementation of the CORD programme.

5.6 Summary

The government of Namibia was concerned about the level of alcohol consumption in the country. The Coalition on Responsible Drinking (CORD) programme was introduced during 2004 to mitigate the health and social consequences attributed to alcohol abuse.

It focuses on three intervention strategies: prevention and education, the enforcement of alcohol-related legislation, and the treatment of Namibians addicted to alcohol. Further, the programme aims to reduce the contraction of HIV and AIDS due to risky sexual behaviour related to alcohol abuse. To date, however, the success of CORD has not been measured and it has not yet been internally or externally evaluated. Thus, the researcher saw the need to assess the challenges and achievements of the implementation of the programme by evaluating the opinions and perceptions of social workers who work directly with the CORD programme.

The study established that the CORD programme is valuable alcohol abuse prevention programme that needs to be established in all regions. The findings concluded that there is a need to allocate the needed resources, such as human resources, funding and transport that will ensure effective implementation of the programme activities. The programme, if implemented in all regions and strengthen the involvement of stakeholders will ensure that people will have information on the harmful consequences

of alcohol abuse that can discourage them from abusing alcohol, and people will be aware of available treatment and aftercare services.

The study also revealed that stakeholders are not fully involved in the implementation of the programme, hence the need to lobby for more stakeholders involvement.

The study further established that records of activities were being kept and that information is shared with stakeholders during meetings and workshops. This, according to the researcher need to be strengthened in order for the new appointed social workers to have information on what was achieved and challenges pertaining to the programme. It will also ease the locating of the stakeholders involved in the programme and pending planned activities to be implemented. A monitoring and evaluation tool need to be developed and implemented that will communicate the planned activities and available resources to all stakeholders who are involved in the planning and implementation of the programme. It will also enhance the monitoring of progress in the implementation of planned activities.

The researcher is therefore of the opinion that the CORD programme can make a difference in the life of ordinary Namibians if programme implementers are committed towards the implementation of the programme objectives if the necessary support is provided from the management levels to regional levels, and when local and political leadership realized that alcohol availability and accessibility lead to alcohol abuse which

can hinders development. Thus, collective efforts are needed to fight against the detrimental effects of alcohol abuse.

REFERENCES

- Adams, R. A. (2007). *A social work evaluation of the Etegameno Rehabilitation and Resource Center for substance abusers in Namibia*. Unpublished master's thesis, University of Namibia, Windhoek.
- Adler, E. S., & Clarck R. (2011). *An invitation to social research. How it is done*. (4th ed.). Belmont, USA: Wadsworth Cengage Learning.
- Ashford, J. B., & LeCroy, G. W. (2010). *Human behaviour in the social environment. A Multi-dimensional Perspective*. (4th ed.). Belmont, USA: Cengage Learning.
- Babor, T., Caetano, R., Caswell, S., Edward, G., Gresbrecht N., Graham, K., & Holder, H. (2010). *Alcohol, no ordinary commodity. Research and public policy*. (2nd ed.). New York, NY: Oxford University Press.
- Baggott, R. (2011). *Public health policy & politics*. (2nd ed.). New York, NY: Palgrave Macmillan.
- Bless, C., & Higson-Smith, C. (2000). *Fundamentals of social research at grass roots for the social sciences and human service professionals*. (3rd ed.). Pretoria, South Africa: J.L. Van Schaik publishers.

- Blocker, J. S., Fahey, D. M., & Tyrell, I. R. (2003). *Alcohol and temperance in modern history: an international encyclopedia*. Santa Barbara, CA: ABC-CLIO.
- Bourne, L. (2009). *Stakeholders' relationship management: a maturity model for organizational implementation*. Surry, England: Ashgate Publishing Limited.
- Butterfoss, F. D. (2007). *Coalition and partnership in community health*. (1st ed.). San Francisco, CA: Library of congress in publication data.
- Ch'ien, J. (2008). *Principles of effective programming for developing nations*. Geneva: International Labour Office.
- Compton, T. M. (Eds.). (2010). *Clinical manual of prevention in mental health*. (1st ed.). Retrieved from <http://www.googlebooks.com>
- Creswell, J. W. (2006). *Qualitative inquiry and research design: choosing among five approaches*. (2nd ed.). Thousand Oaks, CA: Sage Publications.
- De Vos, A. S., Strydom, H., Fouche, C. B., & Delpont, C. S. L. (2011). *Research at grass roots for the social sciences and human service professions*. (4th Ed.). Pretoria, South Africa: Van Schaik.

Fertman, C. L., & Allensworth, D, P. (Eds.). (2010). *Health promotion programs. From theory to practice*. Retrieved from <http://www.googlebooks.com>

Fouche, B. (2002). *Research strategies for the social sciences and human service professionals*. (2nd ed.). J. L Van Schaik publishers. Pretoria: South Africa.

Goodman, A. (2007). *Social work with drug and substance misusers*. Wiltshire, Great Britain: Cromwell Press Ltd.

Government of Namibia. Office of the Prime Minister. (17 April 1998). Namibia Liquor Act, No 6. Windhoek, Namibia: Government Gazette of the Republic of Namibia. Retrieved from http://www.parliament.gov.na/acts_documents/33_liquor_act_6_of_1998.pdf

Heller, N, R., & Gitterman, A. (Ed). (2011). *Mental health and social problems: A social work perspective*. New York NY: Routledge.

Hilarski, C. (Ed.). (2005). *Addiction, assessment, and treatment with adolescents, adults, and families*. Binghamton, NY: Haworth Press.

Horner, N. (2012). *What is Social Work: Context and perspectives*. (4th ed.). Los Angeles: Sage.

Howe, B. (2009). *Alcohol education: Handbook for health and welfare professionals*. New York, NY: Routledge.

International Labour Organization (2004). *A fair globalization: creating opportunities for all*.

Retrieved from <http://www.ilo.org/public/english/wcsdg/docs/report.pdf>

Jayne, M., Valentine, G., & Holloway, S, L. (2011). *Alcohol, drinking, drunkenness. (Dis) Orderly Spaces*. Surrey, England: Ashgate Publishing Limited.

Kirst-Ashman, K. K. (2012). *Generalist practice with organizations and communities*. (5th ed.). USA: Cengage Learning.

Kinghorn, A., & Steinberg, M. (1999). *HIV/AIDS in South Africa: the impacts and the priorities*. Department of Health.

Le Beau, D., & Yoder, S. (2009). *Alcohol consumption, sexual partners and HIV transmission in Namibia*. USAID. Maryland, DE: ICF Macro.

Martens, M. D., & Wilson, A, T. (2012). *Program evaluation theory& practice: A comprehensive Guide*. Retrieved from <http://www.googlebooks.com>

Mbuya, J. C. (2000). *The AIDS epidemic in South Africa*. Pretoria, South Africa: The Sunny Print.

Miller, W. R., & Munoz, R. F. (2005). *Controlling your drinking*. New York, NY: The Guilford Press.

Ministry of Health and Social Services. Government of Namibia. (n.d). *Guideline on responsible drinking*. [Brochure]. Windhoek, Namibia.

Ministry of Health and Social Services. (2009). *Reducing alcohol- related HIV risk in Katutura, Namibia: A Multi-Level Intervention*. Windhoek, Namibia.

Ministry of Health and Social Services. (2002). *Nationwide KAP baseline survey on alcohol and drug use and abuse in Namibia*. Windhoek, Namibia: Quick Stamps and Printing.

Muraranganda, E. (2013, August 14). *Root of Evil: Shebeens open at all hours contribute to crime and accidents*. The Namibian Sun, p. 4.

Nakale, A. (2012, March, 28). *Shebeens want to do what they like*. New Era, p. 5.

Nakale, A. (2012, October, 11). *San get booze for work*. New Era, p. 2.

- Nelson, A. (2012). *Social work with substance users*. London, UK: SAGE Publications Ltd.
- Newman, W. L. (2000). *Social research methods: Qualitative and Quantitative approaches*. Massachusetts: Allyn and Bacon, Boston.
- Nicholas, L., Reutenbach, J., & Maistry, M. (2010). *Introduction to social work*. Cape Town, South Africa: LTP Printers.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods*. (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Petersen, T., & McBride, A. (Eds). (2002). *Working with substance misusers: A guide to theory and practice*. New York, NY: Routledge.
- Pyne, H. H., Claesen, M., & Correia, M. (2002). *Gender dimensions alcohol consumption and alcohol- related problems in Latin American and the Caribbean*. Washington, USA: Library of Congress Cataloguing in publication data.
- Rosenberg, H. (2001). *Prediction of control drinking by alcoholism and problem drinkers*. New York, NY: Guilford Press.

Santelli, J. S., Edelstein, Z. R., & Mathur, S. (2013). *Journal of Acquired Immune Deficiency Syndroms*. Retrieved from http://www.aidstar-one.com/focus_areas/prevention/resources/prevention_update/July+2013

Sloboda, Z., & Bukoski. (Eds.). (2003). *Handbook of drug prevention, theory, science and practice*. New York, NY: Kluwer Academic.

Siviram, S., Srikrishnan, A. K., Latkin, C., Iriundo-Perez, V. F., Salomon, S., & Celenteno, D. D. (2008). *Male Alcohol Use and unprotected sex with non-regular partners: evidence from wine shops in Chennai, India*. Retrieved from <http://www.thebody.com/content/art46379.html>

Smith, M. J. (2010). *Program evaluation for social work and health professionals*. Retrieved from https://books.google.com.na/books?id=F7ZGLImMysC&source=gbs_navlinks_s

Straussner, S. L. A. (Eds.). (2004). *Clinical work with substance abusing clients*. (2nd ed.). Retrieved from http://books.google.com.na/books/about/Clinical_work_with_substance_abusing_cli.html?id=nr3RgRm6CecC&redir_esc=y

Streubert, H. J., & Carpenter, D. R. (2003). *Qualitative research: Advanced the humanistic imperative*. Philadelphia: Lippincot Williams & Wilkins.

Swanepoel, H., & De Beer, F. (2006). *Community development. Breaking the cycle of poverty.*

Lansdowne, South Africa: Juta and Co Ltd.

The Draft National Demand Reduction Policy on Alcohol Use and Misuse. 2014. Windhoek,

Namibia.

Tobbut, C. (Eds). (2011). *Alcohol at work: Managing alcohol problems and issues in the*

workplace. Surry, England: Gower Publishing LTD.

Unrau, Y. A., Gabor, P, A., & Grinnel, R. M. (2007). *Evaluation in social work. The art and*

science of practice. (4th ed.). Retrieved from

http://books.google.ca/books/about/Evaluation_in_social_work.html?id=KDhHAAAA

MAAJ

Velleman, R. (2006). *Counselling for alcohol problems.* London: SAGE Publication Ltd.

Washton, A, M., & Zweben, J, E. (2006). *Treating alcohol and drug problems in psychotherapy*

practice: Doing what works. New York, NY: The Guilford Press.

Wilson, K., & Kolander, C. (2011). *Drug abuse prevention- a school and community*

partnership. (3rd ed.). New York, NY: Jones & Barlett Publishers.

Winger, G., Fredrick, J. H., & Hofmann, G. (2004). *A handbook on drug and alcohol abuse: the biomedical aspects*. (4th ed.). New York, NY: Oxford University Press.

World Health Organisations Technical Report Series. (2006). *Government makes progress in interpersonal prevention*. Report No 985. Geneva: International Labour Office.

World Health Organisations Technical Report Series. (2007). *WHO Expert Committee on Problems Related to Alcohol Consumption*. Report No. 944. Geneva: World Health Organization. Retrieved from http://.who.int/substance_abuse/expert_committee_alcohol_trs944.pdf

APPENDIX 1**QUESTIONNAIRE No:****Consent and confidentiality clause****“AN ASSESSMENT OF THE SOCIAL WORKERS PERCEPTION ON THE IMPLEMENTATION OF THE COALITION ON RESPONSIBLE DRINKING (CORD) PROGRAMME IN NAMIBIA”**

Dear Respondent,

I am **Manfriedine Kandjii**, currently studying towards my **Master of Arts in Social Work Degree** at the **University of Namibia**, and I am currently undertaking the research **‘An assessment of the social workers perception on the implementation of the Coalition on Responsible Drinking (CORD) programme in Namibia’**.

The assessment will reveal the achievements and challenges that social workers experience in the implementation of the programme. It will also gather detailed information about the inputs, activities and processes of the programme in order to uncover the efficiency of programme implementation, the adequacy of resource allocation and the availability and transparency of programme documentation. The results of the study will fill the gaps in knowledge that exist about the efficacy of the CORD programme as an alcohol abuse prevention programme.

The aim of the distribution of the questionnaire is collect data to assess the CORD programme efficacy in preventing and mitigating alcohol abuse in Namibia by evaluating the opinions and perceptions of social workers who work directly with the CORD programme.

Your participation in the research is entirely voluntary. You may choose to discontinue participation at any time, without prejudice. No direct benefit is due to you for participating in this research. However, what we discover as a result of this study would assist us in developing guidelines for providing effective aftercare services.

I will appreciate it if you take approximately ten minutes of your time to complete the attached questionnaire. To ensure privacy no name or any other identifiable information will be recorded and will be treated as confidential. The data collected will only be used for academic purpose, and the final research document will be available to you after approval.

Thank you for your participation.

Section A: Respondent Information

A1: Job Title	1	2	3	
	Chief Social Worker	Principal Social Worker	District Social Worker	
A2: Region				Code:----- -
A3: District				Code:----- -
A4: Number of years of experience in Social Work	Number of years:-----			
A5: Number of years involved in implementation of CORD	Number of years:-----			
A6: Do you possess any project management training or qualifications	1	2		
	YES	NO		
A7: If Yes in A6, specify Project Management Training or Qualifications	1	2	3	4
	Certificate	Diploma	Degree	Honour's/ Master's/ Doctorate Degree

Section B:
Alcohol Prevention and Education

B1: Is the implementation of the CORD programme important for your ministry, stakeholders and community as a whole?

Item	Not at All	Somewhat	Important	Very Important
Ministry	1	2	3	4
Stakeholders	1	2	3	4
Community	1	2	3	4

B2: Why is the implementation of the CORD programme important in your region/health district?

.....

.....

.....

.....

.....

.....

.....

B3: Who are the main stakeholders in the implementation of the CORD programme?

- 1. Government Ministries
- 2. Donors, Partners, NGOS
- 3. Private industry
- 4. The Community
- 5. None

B4: Are the main stakeholders fully involved in the implementation of the CORD programme?

- 1. Yes
- 2. No
- 3. Not applicable

B5: If not, what do you think are the reasons for their lack of involvement?

.....

.....

.....

B6: What do you suggest can be done to improve their involvement in the implementation of the CORD programme?

.....

B7: Have you received any formal training for alcohol prevention, treatment and counselling during the following times:

	YES	NO
B7.1: While in training for your degree	1	2
B7.2: During specialization programmes	1	2
B7.3: During substances/alcohol conference / workshops	1	2

B8: How comfortable are you to advise clients to address alcohol drinking problem?

- 1. Not comfortable
- 2. Somewhat comfortable
- 3. Comfortable
- 4. Very comfortable

B9: Are the following toolkits (IEC materials) readily **available to you** to carry out awareness campaigns in your community?

	YES	NO
B9.1: Alcohol booklets	1	2
B9.2: Liquor Act	1	2
B9.3: Posters	1	2

B9.4: Facilitation Guides (Picture Codes)	1	2
B9.5: Others, specify.....	1	2

B10: Which of the following toolkit of IEC materials **do you use** to carry out awareness campaigns in your community?

	YES	NO
B10.1: Alcohol booklets	1	2
B10.2: Liquor Act	1	2
B10.3: Posters	1	2
B10.4: Facilitation Guides (Picture Codes)	1	2
B10.5: Others, specify.....	1	2

B11: How many community outreach sessions on alcohol prevention in the **past one year** did you conduct at the following places and how many people attended the sessions. *Enter the number in the space provided, if Not Sure mark appropriate box provided.*

	Number of sessions		Number attending	
	Not sure <input type="checkbox"/> 99	.....	Not sure <input type="checkbox"/> 99
B11.1: Youth camps	Not sure <input type="checkbox"/> 99	.....	Not sure <input type="checkbox"/> 99
B11.2: Schools	Not sure <input type="checkbox"/> 99	.....	Not sure <input type="checkbox"/> 99
B11.3: Drinking places (cuca shops, bars, etc)	Not sure <input type="checkbox"/> 99	.....	Not sure <input type="checkbox"/> 99
B11.4: CORD Committee meetings	Not sure <input type="checkbox"/> 99	.....	Not sure <input type="checkbox"/> 99
B11.5: Media	Not sure <input type="checkbox"/> 99	.....	Not sure <input type="checkbox"/> 99
B11.6: Line ministries	Not sure <input type="checkbox"/> 99	.....	Not sure <input type="checkbox"/> 99
B11.7: Churches	Not sure <input type="checkbox"/> 99	.....	Not sure <input type="checkbox"/> 99
B11.8: Health Facilities	Not sure <input type="checkbox"/> 99	.....	Not sure <input type="checkbox"/> 99
B11.9: Other places	Not sure <input type="checkbox"/> 99	.....	Not sure <input type="checkbox"/> 99

B12: How many stakeholders in your region / district are aware of CORD programme?

1	2	3
Few	All	None

B13: Name the stakeholders in your region / district that are aware of CORD programme.

1.....

2.....

3.....

4.....

5.....

6.....

7.....

8.....

B14: How many stakeholders are involved in the implementation of the CORD programme in your region / district?

1	2	3
Few	All	None

B15: Name the stakeholders in your region / district that are implementing the CORD programme

1.....

2.....

3.....

4.....

5.....

6.....

7.....

8.....

Section C:
Enforcement of alcohol-related legislation

C1: Does Namibia have policies / laws regulating alcohol selling and consumption?

- 1. Yes
- 2. No
- 3. Don't know

C2: If Yes in C1, what are those policies / laws?

- 1.....
- 2.....
- 3.....

C3: Which of the following legislation are readily **available to you** to carry out awareness campaigns in your community?

Alcohol Legislation	YES	NO	Don't know
C3.1: Abuse of Dependence-producing Substances and Rehabilitation Centre Act, 1971	1	2	3
C3.2: The Prevention and Treatment Bill on Substance Abuse	1	2	3
C3.3: The Liquor Act, no. 6 of 1998	1	2	3
C3.4: Customer and Excise Act, 1998	1	2	3
C3.5: The Road Traffic and Transport Act , 1999	1	2	3
C3.6: Others, specify.....	1	2	3

Alcohol Legislation	YES	NO	Don't know
C4.1: Abuse of Dependence-producing Substances and Rehabilitation Centre Act, 1971	1	2	3
C4.2: The Prevention and Treatment Bill on Substance Abuse	1	2	3
C4.3: The Liquor Act, no. 6 of 1998	1	2	3
C4.4: Customer and Excise Act, 1998	1	2	3
C4.5: The Road Traffic and Transport Act , 1999	1	2	3

C4.6: Others, specify.....	1	2	3
-------------------------------	---	---	---

C4: Which of the following legislation **do you use** to carry out awareness campaigns in your community?

C5: Which of the following policies / manuals **are available to you** to carry out awareness campaigns in your community?

Alcohol Policies / Manuals	YES	NO	Don't know
C5.1: National Demand Reduction Policy on Alcohol Use and Misuse	1	2	3
C5.2: Guidelines on the Management of Substance Intoxication and Withdrawal	1	2	3
C5.3: Prevention and Aftercare Manual on Substance Abuse	1	2	3
C5.4: Drug Control Master Plan	1	2	3
C5.5: Guideline on Case Management for Substance Abuse Clients	1	2	3
C5.6: Operational Manual for Etegameno Rehabilitation and Resource Centre	1	2	3
C5.7: Others, specify.....	1	2	3

Alcohol Policies / Manuals	YES	NO	Don't know
C6.1: National Demand Reduction Policy on Alcohol Use and Misuse	1	2	3
C6.2: Guidelines on the Management of Substance Intoxication and Withdrawal	1	2	3
C6.3: Prevention and Aftercare Manual on Substance Abuse	1	2	3

C6.4: Drug Control Master Plan	1	2	3
C6.5: Guideline on Case Management for Substance Abuse Clients	1	2	3
C6.6: Operational Manual for Etegameno Rehabilitation and Resource Centre	1	2	3
C6.7: Others, specify.....	1	2	3

C6: Which of the following policies / manuals **do you use** to carry out awareness campaigns in your community?

Section D:

Treatment of people addicted to alcohol

D1: Which of the following interventions **are available** to you to help patients with alcohol problems? *Mark all that apply*

- 1. Medication
- 2. Individual or group counselling
- 3. Traditional Remedies
- 4. Referral to another health care professional
- 5. Referral to a community-based organization that address the problem
- 6. Exercising / social club
- 7. Other, specify.....

D2: Which of the following interventions **do you use** to help your patients to stop drinking alcohol? *Mark all that apply*

- 1. Medication
- 2. Individual or group counselling
- 3. Traditional Remedies
- 4. Referral to another health care professional
- 5. Referral to a community-based organization that has programmes to address
- 6. Exercising club
- 7. Other, specify.....

D3: How many clients with substance related problems did you council in the past one year?

.....

D4: How many clients with substance related problems did you refer to any rehabilitation centre in the past one year?

.....

**Section E:
Availability of Resources**

E1: Do you have sufficient human resources in your district(s) to implement CORD programme?

- 1. Yes
- 2. No

E2: If not, what do you suggest to address the insufficient human resource problem?

.....
.....
.....
.....
.....
.....
.....
.....

E3: Is the CORD programme being funded by the MoHSS?

- 3. Yes
- 4. No

E4: If not, what are the reasons why the programme is not being funded?

.....
.....
.....

.....
.....
.....
.....

E5: Are there any other funding sources for the implementation of the CORD programme?

- 1. Yes
- 2. No
- 3. Don't know

E6: If yes, list the funding sources.

.....
.....
.....
.....
.....

E7: Is transport readily available to conduct planned activities for the CORD programme?

- 1. Yes
- 2. No

E8: If not, what are the major transport challenges you experience to effectively conduct these activities?

.....
.....
.....
.....
.....

E9: What are the possible solutions to address the transport problems?

.....
.....
.....

.....
.....
.....
.....

Section F:
Monitoring and Evaluation of CORD activities

F1: Do you keep any records of CORD activities implemented in your region?

- 1. Yes
- 2. No
- 3. Don't know

F2: If yes in F1, in what format do you keep records of CORD activities implemented in your region?

- 1. Paper format
- 2. Electronic format
- 3. Both formats

F3: Do you share any records of CORD activities with other stakeholders?

- 1. Yes
- 2. No

F4: Please elaborate on your answer given in F3

.....
.....
.....
.....
.....
.....
.....

F5: Do you have any CORD programmes' standardised monitoring and evaluation tools?

- 1. Yes
- 2. No
- 3. Don't know

F6: If NO in F5, what do you suggest should be done?

.....
.....
.....
.....
.....
.....
.....

F7: Any general comments.

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

THANK YOU FOR YOUR PARTICIPATION!

APPENDIX 2

LETTER OF APPROVAL FROM MINISTRY OF HEALTH AND SOCIAL SERVICES



9 – 0/0001

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2560
Fax: 061 – 222558
E-mail: tkakili@mhss.gov.na

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3

Enquiries: Ms. T. Kakili

Date: 30 June 2014

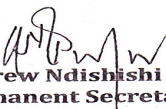
Ms Manfredine Kandjii
P. O. Box 50806
Windhoek

Dear Ms Kandjii

Re: An assessment of the social workers perception on the implementation of the Coalition on Responsible Drinking programme in Namibia.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for the completion of your Master of Arts in Social Work degree;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.4 Preliminary findings to be submitted upon completion of the study;
 - 3.5 Final report to be submitted upon completion of the study;
 - 3.6 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,


Andrew Ndishishi (Mr)
Permanent Secretary

"Health for All"

APPENDIX 3

LETTER OF APPROVAL FROM UNIVERSITY OF NAMIBIA

UNIVERSITY OF NAMIBIA

Private Bag 13301, 340 Mandume Ndemufayo Avenue, Pionerspark, Windhoek, Namibia



The School of Postgraduate Studies
P.Bag13301
Windhoek, Namibia
Tel: 2063523

E-mail: matthewsj@unam.na

Date: 6 December 2013

TO WHOM IT MAY CONCERN

RE: RESEARCH PERMISSION LETTER

1. This letter serves to inform that student: **Ms. Manfredine Kandjeo-Kandjii** (Student number: 9014535) is a registered student in the Department of Human Sciences – Social Work Section at the University of Namibia. His/her research proposal was reviewed and successfully met the University of Namibia requirements.
2. The purpose of this letter is to kindly notify you that the student has been granted permission to carry out postgraduate studies research. The School of Post Graduate Studies has approved the research to be carried out by the student for purposes of fulfilling the requirements of the degree being pursued.
3. The proposal adheres to ethical principles.

Thank you so much in advance and many regards.

Yours truly,

Main Supervisor: Professor JD Matthews, Head of Programme (061 206 3713)

Signed: _____