THE EFFECTS OF WHOONGA ON THE LEARNING OF AFFECTED YOUTH IN KWA-DABEKA TOWNSHIP

BY

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DECLARATION OF ORIGINALITY
STUDENT NUMBER: 06384870

I declare that The effects of whoonga on the learning of affected youth in Kwa-Dabeka Township is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

.......................................................... ..........................................................
Signature Date

Zamakhosi Thina Shembe
DEDICATION

I dedicate this work to my beloved and late father, J.G. Shembe, who valued education so much, and who I know would have been so proud of me for this postgraduate degree.
ACKNOWLEDGEMENTS

I would like to extend a sincere word of gratitude to the following people for their contribution in making this study a success:

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ABSTRACT

Whoonga is a relatively new addition into the drug market. The need for this study was prompted by the devastating effects this new arrival has had in the lives of young people addicted to it. The purpose of this study was to investigate the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. This study adopted a qualitative method and employed a phenomenological approach to explore the experiences of participants with regard to whoonga use and their learning. Data was collected through purposive sampling. Interviews were conducted, using semi-structured and unstructured questions with the help of an interview guide. Observations were also conducted to collect more data. This was done in the classroom during teaching and learning, as well as outside the classroom during recess. The study employed a social learning theoretical framework on the experiences of participants with regard to the use of whoonga. Four participants from one high school in Kwa-Dabeka Township were involved in the study.

Themes that emerged from the study were that all the participants were totally ignorant of what they were getting themselves into before they started using whoonga. Peer pressure, coupled with curiosity made their decision to use whoonga easy. Challenges that participants face now on daily basis are far beyond their young age. The findings have indicated that learning is a situation of near impossibility for the participants. The findings have also depicted a picture of young people who are trapped in a vicious cycle of one of life’s harshest living conditions in terms of their encounters with parents, school and the communities they come from. Despite their hopes for a brighter future one day, participants see no end in sight for their suffering at the hands of this unforgiving, destructive drug at this point in time.
KEY WORDS

Whoonga, substance abuse, addiction, youth, peer pressure, parent involvement, ignorance, drug awareness, health risk, disillusionment.
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CHAPTER ONE
INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION AND BACKGROUND.

In his opening address in parliament in 1994, the former South African president, Nelson Mandela, singled out alcohol and drug abuse as a social pathology requiring urgent attention (The National Drug Master Plan 2006-2011:4). This observation by the then president prompted the drafting of the National Drug Master Plan in 1998 as an effort on the part of the government to curb the spread of drug abuse in the country. According to the National Drug Master Plan (2006-2011:4), substance abuse is a major contributor to crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability, the escalation of chronic diseases such as AIDS and Tuberculosis (TB), injury and premature death.

In the foreword to Pakkies’ book titled *Dealing in death* (2009), Helen Zille, the premier of the Western Cape writes that over the past ten years, substance abuse has become one of post-apartheid South Africa’s most serious developmental challenges. Zille in Pakkies (2009:xi) further highlights that in the Western Cape, the police estimate that about seventy percent of violent criminal cases in urban centres are related to alcohol or drug abuse. Methamphetamine, locally known as tik, has created serious problems for health and police authorities around the world because of the volatile behaviour it triggers. Schools are not exempted from the ills resulting from drug related incidents as scores of pupils within the school grounds are faced with gang related violence from their own school mates.

South Africa, like many countries, is faced with the alarming increase in substance abuse. The South African Medical Journal (2011:79) cautions that the substances that cause the most damage to the individuals and societies are legal. These substances are alcohol, cigarette smoking and prescription medicine. Young people can easily access these legal drugs at home. These legal drugs initiate young people to move on and experiment with illicit drugs like cannabis and many other types of drugs.

This study will attempt to understand the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. The necessity of this study is prompted by the realisation that whoonga is a relatively new drug, and not much information is available yet on how the
effects of whoonga on users are different, if any, from the effects of other illicit drugs. Parry (2005:34) of the World Psychiatric Journal recognizes that various gaps need to be addressed in South Africa, to further strengthen the research base underpinning substance policy. These gaps will include intervention focused demonstration projects and regular treatment services and prevention programmes. It is against this background that I wish to make a contribution, albeit in a small way, to the multi-facet research that is going on by highlighting the emergence of this new drug called whoonga, and the dangers facing the users. Drug abuse knows no racial, cultural, social, language or religious boundaries. It affects all members of society directly or indirectly.

Bezuidenhout (2008:131) explains that the psycho social climate in South Africa is conducive to use, misuse and abuse of substances. Bezuidenhout (2008:131) further observes that there seems to be an increase in the prevalence of substance-related abuse problems. This observation requires critical prevention strategies. The above acknowledgement by Bezuidenhout applies perfectly to the community I work with. As an educator in a school situated in an informal settlement, I have worked in this community for the past twenty-one years. This community, like many communities in Durban and surrounding areas, has been struggling with drug problems for a long time. But I have noticed that since the emergence of whoonga, many young people get sick and die within a few months of using the drug. Young people leave school as early as grade six or seven to engage in various criminal activities, including robbing HIV positive patients of their much needed treatment, so that these users can mix the ARVs to make the whoonga drug. As a result, their lives are cut short as they are killed or end up in prison.

This study will be useful to teachers in understanding the challenges faced by whoonga users, it may shed light on how to deal with the problem effectively in the school situation. This study will also be helpful to parents as an awareness programme and identification of early signs and symptoms of whoonga use. The study will also help the community leaders who work tirelessly to fight drug abuse in their respective communities, as well as police who also need help in combating drug abuse.
1.2 PROBLEM STATEMENT

In Kwa-Dabeka Township, many people are ravaged by the abuse of whoonga. This has led to ill health, imprisonment and even death of a lot of youth in the area. The National Drug Master Plan (2006-2011:15) acknowledges that young people occupy a dependent position in the family and society; they are more influenced by peers and popular culture and for this reason they are more likely to use drugs.

The United Nations on Drug and Crime (UNODC) (2009) cautions that there is growing trafficking of illicit drugs into and through Eastern Africa. As a result of the frequent commercial flights from Africa and the Middle East, the international airports in Kenya, Addis Ababa and Ethiopia are key entry points for illicit drugs into the region. From the UNODC report, it is evident that the drug problem is not only a South African problem but some of the African countries are also facing the same dilemma as well.

The emergence of whoonga not only puts its users in danger, but also millions of HIV/AIDS patients who are robbed everyday of their treatment. Subashni Naidoo of The Times Newspaper (28 November 2010) warns that there are now syndicates who operate in Kwa-Zulu Natal, Gauteng, Eastern and Western Cape. These syndicates have raided clinics, mugged AIDS patients and attempted to highjack distribution trucks. The Stocrin antiretroviral is the one used by whoonga users. The Stocrin is an antiretroviral drug that prevents HIV from making copies of itself in the body.

When taken as prescribed, Stocrin can cause side effects, including drowsiness and vivid colourful dreams. This may be the reason why addicts prefer Stocrin to other ARVs; they may be seeking the feeling of those vivid colourful dreams. A seventeen-year old addict told BBC News that there was no turning back once you have first started using whoonga. Zinhle Thabethe, an HIV counsellor at Edendale Hospital in South Africa told Scientific America.com that teenagers sometimes steal Stocrin from their ailing parents just to get high. There are many addicts in Kwa-Dabeka Township. The addicts are paying between fifteen and thirty-five rand a dose. The addict can use more than seven Stocrin tablets a day, according to Whoonga Free, a NGO trying to combat the use of whoonga in Kwa-Dabeka Township. The amount being paid per dose may seem small, but it becomes very expensive to the unemployed, sometimes school going youth because they need to use the drug several
times a day, thus resorting to criminal activities to feed their habit. In Kwa-Dabeka Township there are many incidents of house breaking, petty theft and robbery that are linked to whoonga use.

Various attempts have been made to try and curb the spread of substance abuse. Many programmes (governmental and non-governmental), like the National Drug Master Plan and others have been put in place as an attempt to fight drug abuse. Some researchers note that South Africa does not have the infrastructure to control the supply, nor has it sufficient treatment centres and trained manpower to cope with the increasing number of victims. Prevention and education facilities have been inadequate. As a result, many of these carefully planned efforts have not yet worked. Schools with Whoonga addicted learners find themselves at the receiving end of this illicit drug. These learners’ school attendance is inconsistent and they usually arrive very late whenever they come to school. They can hardly focus for a minute on the teacher and tend to be sleepy in class. This creates a lot of problems for the teacher who has to maintain discipline and create conducive environment for effective teaching and learning to take place. The constant misbehaviour of the addicted learner distracts other learners and more time is wasted when the teacher pays attention to him/her. In most cases these learners do not do their homework. This together with all the other problems lead to very poor performance in their schoolwork. As a result most of them they are too old for the grades they are doing. The drug problem has led to violence being visited to the schools at times. No wonder it is not uncommon nowadays to hear of a teacher being molested or attacked by a learner in the classroom. Safety is a very serious issue in South African schools because of drug abuse.

Schools have now been targeted by gangsters as centres for running their illicit business and learners are the right couriers of the drugs because they cannot be easily suspected by the police. This has led to gang wars breaking up at schools fighting for territorial protection of their business. A whoonga addict is like a demon possessed person, helplessly under the control of the drug. Hence in many instances, learners who are addicts eventually run away from home and live in the streets as beggars. This drug has destroyed the lives of very promising young people who were so intelligent in class. They end up in jail because of crime or dead. Something needs to be done to stop this problem or else we are heading for a catastrophe. We cannot be a drug abuser nation.
1.3 MAIN RESEARCH QUESTION.

What are the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township?

1.4 SUB-QUESTIONS

1.4.1 What are the common causes, if any, for young people to use whoonga?
1.4.2 How can a whoonga addict be identified earlier in the addiction process?
1.4.3 How can the youth using whoonga be assisted to do away with the habit?

1.5 AIM OF THE STUDY

This study aims to investigate the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township.

1.6 OBJECTIVES

- To find out the causes for young people to use whoonga.
- To investigate how whoonga affect its users and their learning.
- To find out how the youth using whoonga can be assisted to do away with the habit.

1.7 DEFINITION OF OPERATIONAL CONCEPTS.

1.7.1 Whoonga

The Urban Dictionary defines whoonga as a combination of all sorts of nasty chemicals including detergent powder, rat poison and sometimes crushed antiretroviral drugs. Caaglop.com defines whoonga as a new addictive drug created from combining ARV pills, detergent powder and rat poison. In this study, whoonga refers to the highly addictive drug used by youth in Kwa-Dabeka Township.
1.7.2 Youth

The Oxford Advanced Learner’s Dictionary defines youth as the time when a person is young, especially a time before a child becomes an adult. South African Concise Oxford Dictionary defines youth as a period between childhood and adult age. In this study youth refers to learners at a particular school in Kwa-Dabeka Township.

1.7.3 Addiction

The Oxford Advanced Learner’s Dictionary defines addiction as the condition of being an addict. In this study addiction will be used to refer to the state of being addicted of the youth at a particular school in Kwa-Dabeka Township.

1.8 STRUCTURAL OUTLINE OF THE STUDY.

CHAPTER ONE: STUDY ORIENTATION.

This chapter provides an introduction and background to the study. It also lays out the problem statement, introduces the main question, sub-questions, aim of the study, objectives as well as the definition of concepts.

CHAPTER TWO: THEORETICAL FRAMEWORK AND REVIEWED LITERATURE.

This chapter deals with the theories on which this study is based. A detailed account of the literature on whoonga use is discussed as well.

CHAPTER THREE: RESEARCH DESIGN AND METHODOLGY.

This chapter outlines the method and approach that were employed in the study. It provides information on site selection, data collection method, validity and reliability of the study as well as ethical issues.
CHAPTER FOUR: RESEARCH FINDINGS AND DISCUSSION.

This chapter covers the researcher’s perceptions, the profile of all the participants and their account of events, observation account by the researcher, findings and discussion.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.

In this chapter, a brief summary of the research findings as well as recommendations is given.

1.10 CONCLUSION

In this chapter an introduction and background to the study has been laid out. The reasons that prompted the necessity of the study were given. An introduction of the main question, sub-questions was done. The aims and objectives of the study were also mentioned. This chapter has also provided the definition of concepts as well as the layout of the structural outline of the study. As whoonga is a relatively new addition to the drug world and not much information is available on it yet, it is important for the community members to learn about all the social and health ills that this deadly addition brings in their midst. The physical, emotional and psychological suffering that addicts go through requires that we as a people take note and do whatever we can to curb the spread of whoonga use in our communities.

The subsequent chapter, which is chapter two, covers the theoretical grounding of the study. It addresses the question of why the study takes its position on the deliberations in all issues throughout to chapter five. Finally, an extensive review of related literature on the study is done.
CHAPTER TWO

THE NATURE AND EXTENT OF SUBSTANCE ABUSE AMONG YOUTH IN SOUTH AFRICA WITH A SPECIFIC FOCUS IN KWA-DABEKA TOWNSHIP.

2.1 INTRODUCTION.

According to Obenzinger (2005:1), a literature review provides a meaningful context of a project within the universe of already existing research. Indeed, the drug abuse problem is as old as mankind and the literature dealing with it almost just as old. But the world of drugs is full of ever changing, continuous new inventions by drug dealers to keep their industry alive, as well as keep their customers forever curious to try out the latest inventions. This is true of the new invention called “whoonga”. Even though whoonga is new in the drug market, it belongs to the narcotics family of drugs. The reason for this is that the main ingredient in the concoction of the whoonga cocktail is the cheap form of heroin. Masline (2000:20) asserts that narcotics are a small family of drugs hanging by a common thread, which is to relieve pain. Besides relieving pain, narcotics also reduce anxiety and increase the feeling of euphoria. Masline (2000) notes that since a tolerance to narcotics develops over time, larger and larger doses are required to get high. But dosage is tricky, and overdose can result in death.

To get a better understanding of the composition as well as the ill effects of whoonga, the researcher has made use of a lot of literature. Because of this reason, there is no academic literature yet on the subject. The researcher has to rely mainly on primary sources as well as newspapers for the literature. The researcher has communicated with for example, doctors who tested samples of whoonga, different rehabilitation centres who witness all the side effects, the emotional and psychological toll whoonga takes on abusers. Among these is Dr Anwar Jeewa, who together with his team collected whoonga samples from different townships around Durban for example, from Umlazi, KwaDabeka, Clermont and KwaNdengezi. Dr Jeewa took these samples to a SAPS laboratory for testing. The purpose was to find out the similarities and differences, if any, in the composition of the whoonga cocktail. Another primary source was Carol du Toit of SANCA Durban, who has witnessed the gradual change in the composition of whoonga over the past few years, and seen the devastating effects whoonga
has on young people. Also among these primary sources is a young man called Vumani Gwala, who runs a project which attempts to curb the spread of whoonga, as well as intervene in the process of finding these young people help if they need it in KwaDabeka Township. This project is called Whoonga Free. Gwala witnesses first hand these young people crushing and smoking ARVs or preparing the whoonga concoction for smoking. He has also seen the devastating effects whoonga has had in the lives of these young people, either physically, emotionally, academically or social.

This study focuses on the effect of whoonga on the learning of affected youth in Kwa-Dabeka Township. A few substance dependency theories are going to be discussed, including the disease theories, the psychological theories, the subculture, social and cultural support perspective as well as the adaptation theories.

Kwa-Dabeka community is reeling in the cruel grip of a new drug called whoonga. At this point in time, relatively very little has been done by major role players like community leaders, local and national government in an attempt to find ways and means fight the abuse and spread of drugs, including whoonga among the youth all over the country, including KwaDabeka Township as an effort to find out the causes for the use of this deadly drug, to seek ways and means of assisting the helpless youth to do away with whoonga abuse. The researcher also wishes to highlight the effects of drugs in general on the learning of the youth as whoonga is only but a small part of the broader spectrum of drugs. The problem of drug use does not only affect the South African youth but the youth around the world. For this reason, it is necessary to approach the drug problem in a broader context. Through this research, the researcher hopes to contribute, albeit in a small way, in drawing the attention of all stakeholders by highlighting how dire the whoonga abuse situation is in Kwa-Dabeka Township in the hope of getting all role players to join hands and try to curb the spread of this deadly drug.

Whoonga addiction is devastating, not only to addicts but to addicts’ parents, close family and the community at large. Whoonga has both the physical and psychological aspects that the addict is confronted with. Gwala of Whoonga Free, a project fighting whoonga use in Kwa-Dabeka Township, says the psychological aspect is more difficult and takes longer to deal with, because the mind has to be geared toward quitting whoonga use before the addict can be able to finally stop the abuse, unlike the physical aspect where the treatment takes only a few
days and the withdrawal symptoms are gone, leaving the monumental task of adjusting the mind to find sheer determination to stop.

This study attempts to comprehend the effects whoonga has on the learning of affected youth. In this endeavour, the study has to take cognisance of the fact that the same phenomenon, the same material reality can mean completely different things to different people. Bandura (1977) as quoted by Peele (peele.net) explains in his social learning theory that the addict will continue with his delusional behaviour in the hope of getting the incentives which he calls “reinforcers,” despite the fact that these incentives exist solely in the individual’s mind. The essential insight that reinforcers gain meaning only from a given human context enables us to understand firstly, why different people react differently to the same drugs, secondly, how people can modify these reactions through their own efforts, and thirdly, how people’s relationships with their environments determine drug reactions. This means that whoonga abuse and addiction can have different meaning to different addicts. It can also mean different things to different families and different community members. For this reason, this study attempts to understand the causes of whoonga use and abuse as seen and explained by whoonga addicts themselves. This is done in the hope that these revelations may point to the direction to be taken to help the affected youth in Kwa-Dabeka Township to do away with the habit.

2.2 THEORETICAL FRAMEWORK.

This study will be based on the social learning theory which has its foundations in Vygotsky’s social development theory and Lave’s Situated Learning, which also emphasise the importance of social learning (Learning-Theories.com). According to Boeree (2006), Albert Bandura is one of the leading proponents of the social learning theory and is often considered a “father” of the cognitivist movement. Social learning theory works on the premise that people learn by watching what others do and that human thought processes are central to understanding personality. Ormrod (2003) posits that social leaning theory works on the five main principles. The first one is that people learn by observing others. Secondly, learning is an internal process that may or may not change behaviour. Thirdly, people behave in certain ways to reach goals. The fourth principle is that behaviour is self-directed as opposed to the behaviourist thought that behaviour is determined by the environment. The fifth and last principle is that reinforcement and punishment have unpredictable and indirect effect on both
behaviour and learning. According to Learning Theories Knowledgebase (2007), Bandura believes in “reciprocal determinism,” that is, the world and a person’s behaviour cause each other. Bandura considers personality as an interaction between three components, namely, the environment, behaviour and one’s psychological processes, that is, one’s ability to entertain images and language.

Social learning theory revolves around the process of knowledge acquisition or learning directly correlated to the observation of models. Models are individuals being observed. The models can be live, an actual person demonstrating the behaviour. There can also be a symbolic model, which can be a person or action portrayed in some other medium such as television, videotape or computer programmes. Ormrod (2003) argues that learning will most likely occur if there is a close identification between the observer and the model. Identification allows the observer to feel a one to one connection with the individual being imitated and will be more likely to achieve those imitations if the observer feels that he/she has the ability to follow through with the imitated action. McLeod (2011) informs that a person will take into account what happens to other people when deciding whether or not to copy someone’s actions. This is known as vicarious learning. A good example of vicarious learning would be that of smoking. The initial experience of smoking is unpleasant. This powerful punishment, directly associated with the act of smoking should bring such behaviour to an abrupt end. Vicarious learning asserts that at the same time the individual experiences the first consequences of smoking, they also observed in others that smoking can be an enjoyable and rewarding behaviour, so they persist in the expectation of future enjoyment.

Olson and Scott (2009) mention Bandura’s conditions that are necessary for effective modelling. The first condition is attention. In order to learn one needs to pay attention to the features of the modelled behaviour. Many factors may influence the amount of attention one pays to the modelled activities. If, for example, one is sleepy, groggy, drugged, sick or nervous, one learns less well. The second condition is retention; the ability to store information is an important part of the learning process. Thirdly, there is motor reproduction. Once one has paid attention to the model and retained the information, it is time to actually perform the behaviour. Motivation is the fourth and last condition necessary to imitate behaviour. In order for observational learning to be successful, one has to be motivated to imitate the behaviour that has been modelled. Motivation may come in the form of incentives that the individual envisions. These imagined incentives act as reinforcers.
I have chosen the social learning theory because it emphasizes the importance of observing and modelling the behaviours, attitudes and emotional reactions of others. Drugs, including whoonga, are usually used in a social context among peers. Inexperienced observers are usually initiated by observing their peers modelling how to prepare and smoke whoonga. Later these initiates will have to reproduce the behaviour they have observed in their peers. More practice will probably perfect the observed behaviour.

2.3 THEORIES OF SUBSTANCE ABUSE

Many attempts have been made throughout history to provide a reason as to why some people abuse alcohol and drugs to such an extent that they harm themselves and others. The behaviour of the addicts can really baffle those around them, and the addicts themselves will usually be at a loss to explain their own destructive behaviour. Markwood (2011) observes that typically each person has familiarity with one or two segments of drug abuse, at best, and generalises from their limited experience in conjunction with their overall belief system. There has been more than one reason given as to why people abuse alcohol and drugs and this has led to the development of different theories. Peele (peele.net) notes that in many cases, addiction theorists have now progressed beyond the stereotyped disease conceptions of alcoholism or the idea that narcotics are inherently addictive to anyone who uses them. Kuhn (1962: 5-6) once pointed out:

Sometimes a normal problem; one that ought to be solvable by known rules and procedures resists the reiterated onslaught of ablest members of the group within whose competence it falls. On other occasions, a piece of equipment designed and constructed for the purpose of normal research fails to perform in the anticipated manner revealing an anomaly that cannot, despite repeated effort, be aligned with professional expectation. There are times, now I know, when an important component of the role of research and of researchers ought to go beyond the what is, and extend to the how comes, the whys and the ought to be(s). these together would then locate and link the contemporary with the historical/retrospective, and the normative/prospective.

Due to the complexity of the problem under scrutiny; The effects of whoonga on the learning of its addicts, I have resorted to operating within a tapestry of a framework influenced by Clark (2010), More (2008), and Hanson, Venturelli and Fleckenstein (2009). As it happens
with the formation of the image of an object in the eye, the discourses and debates on whoonga will also need to pass through a multiple variety of lenses and media, being processed and adapted to finally fall on the yellow spot for an upside-down image to fall on the fovea centralis allowing the nerve cells to receive and transmit it to the brain for interpretation. A single cannot assist meaningfully in deconstruction and reconstruction of whoonga leading to a better understanding of the problem. The following three theories serve for the same purpose.

2.3.1 The Addiction Disease Theory

According to Clark (2010), the disease model of addiction claims that it is a chronic, progressive disease similar to other chronic diseases like diabetes. Addiction is considered to fit the definition of a medical ailment, involving an abnormality of structure in, or function of, the brain that result in behavioural impairment.

At the heart of this model or theory is that addiction is characterised by a person’s inability to reliably control his use of alcohol or drugs, and an uncontrollable craving or compulsion to drink alcohol or take drugs. The loss of control can be manifested during either a short or long time span.

This theory is based on the concept that addiction is a physiological deficit that is incurable, progressive and irreversible. It postulates that some people are genetically prone to addiction. The disease theory has been adopted by groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA) as well as the National Institute on Drug Abuse (NIDA). In this model, addiction is viewed as an illness and the addict as someone who is the victim of this disease. This theory holds that there is no known cure but the person can have a lifelong remission if they take certain steps. According to the NA programme, recovery from addiction must be abstinence based. Maybe the observation form my experience with the addicts of whoonga around Kwa-Dabeka supports this theory. There is not a single case of a whoonga addict that has been successfully rehabilitated that I know of.

Beck (2010) mentions certain criteria for addiction to be considered a disease. One must have obsessive thoughts, which lead to compulsive behaviour, that lead to a physical addiction. The illness of addiction must be progressive and predictable, allowing the addict to experience
obsession, negative consequence, denial and lack of control. This theory has been denied by many psychologists due to their belief that addiction is a behaviour that can be controlled, rather than a disease (CASA, 2009).

The disease model can have both negative and positive effects. It advocates that the power to change is outside of an individual’s control, and the “condition” may only be managed rather than cured. This may result in addicts using this as an excuse to relapse over and over again in the hope of receiving more empathy than is required. It can lead to people avoiding self-responsibility, believing that the disease must be attended to by experts, rather than the changes coming from within, albeit with help from others. The positive aspect socially, is that, as with any person suffering from an illness, the approach leads to a more humane and non-judgmental attitude by workers and society at large. The focus is on the disease rather than the person. Peele (peele.net) argues that the disease theories, while seriously misrepresenting the nature and constancy of addictive behaviour and feelings, are based on actual human experiences that must be explained.

The researcher does not believe that the addict is a “helpless victim” of an incurable disease as proposed by the disease theory. The researcher believes that drug abuse can be related to emotional, psychological and social causes. Social and psychological factors that occur in a person’s life can influence their biological tendencies. The researcher also believes that one can make a choice to get help and be cured, if they have the necessary tools to assist them in their recovery. Just as individuals make a choice to take drugs, they can make a choice to get treatment for recovery from drugs as well.

Opponents of the disease theory argue that being labelled as an alcoholic or addict for a lifetime, and spending a lot of time with other alcoholics or addicts, does not help the person attain a fully balanced lifestyle and reintegration into society. What is apparent is that some people can be helped by this theory and the AA or NA, while others do not find it suitable.

2.3.2 The Psychological Theory

More (2008) states that the psychological theory of drug abuse works on the premise that drug abuse begins because of unconscious motivations within all of us. We are not aware of these motivations, not even when they manifest themselves. The theory posits that there are
unconscious conflicts and motivations that reside within us as well as our early reactions to early events in our lives that move a person toward drug use and abuse. The motivations for drug use are within us, and we are not aware of them, nor are we aware that those are the reasons we have chosen to turn to drugs.

The person may be weak or without self-esteem or even see themselves in the opposite manner, as all-important. Drug use then becomes a sort of crutch to make up with all that is wrong with their lives and wrong with themselves. Drug users and abusers in the psychological theory find it extremely difficult to find some sort of balance in their lives. When they struggle to find that balance and that state of really being alright with themselves, it is easy to resort to drugs of any sort to help restore that balance or peace. Drugs become the way of escaping the pain of being unable to find that balance. Drugs become the way they stop feeling badly about themselves. Since the feeling of euphoria lasts for a short while, the user continues to use and abuse drugs, thus begins the cycle of addiction.

Moore (2008) argues that we all have unhealed issues inside us. Some people turn to drugs and others do not, but all of us have crutches and vices that we use when we are feeling negatively about ourselves. For some people these vices may be positive, like exercise, but for others they may be negative, like excessive eating or drinking or drug abuse.

The researcher finds this theory applicable to the drug abuse scenario in Kwa-Dabeka Township. Gwala, who runs a non-profit organisation called “I am Whoonga Free” in Kwa-Dabeka, says many youth find it difficult to cope with the realities of their daily lives namely poverty, unemployment and peer pressure. Drugs then become a temporary escape from reality which consequently results in a vicious cycle of addiction.

2.3.3 The Sub-Culture, Social and Cultural Support Perspective

2.3.3.1 The Subculture Theory

Hanson, Venturelli and Fleckenstein (2009:69) maintain that subculture theory explains drug use as a peer generated activity. The theory speaks of the role of peer pressure and the behaviour resulting from peer group influences. In all groups, there are certain members who are more popular and respected and, as a result, exert more social influence than other peer
members. Often, these more socially endowed members are group leaders, task leaders or emotional leaders who possess greater ability to influence others. Drug abuse that result from peer pressure demonstrate the extent to which these more popular and respected leaders can influence and pressure others to initially use or abuse drugs. Hanson et al (2009:70) further note that in groups where drugs are consumed, the extent of peer influence coupled with the art of persuasion and camaraderie are powerfully persuasive and cause the spread of drug use. The above observation fits in comfortably with the drug abuse reality in Kwa-Dabeka Township. Many young people who are in rehab at Whoonga Free in Kwa-Dabeka Township told BBC News that they are often peer pressured to get involved in drugs, including whoonga. Siphesihle Pakisi, 19, says he was struggling with his parent’s divorce and his friends told him about this drug that made you forget all your problems. He then started smoking whoonga and he tells BBC News that he was stress free for just a while and all problems that go with drug abuse started. When one of his friends threw up his own intestines and died before his eyes, Siphesihle decided to quit.

2.3.3.2 The Social and Cultural Support Perspective.

It is a further extension of subculture theory. It explains drug use and abuse in peer groups as resulting from an attempt by peers to solve problems collectively. Members of certain peer groups are unable to achieve respect within the larger society. Such status conscious youths find that being able to commit delinquent acts and yet evade law enforcement officials is admirable in the eyes of their delinquent peers. Cohen, as quoted by Henson et al (2009:70) believed that delinquent behaviour is a subcultural solution for overcoming feelings of status frustration and low self-esteem largely determined by lower class status. Although the emphasis of Cohen’s perspective is on juvenile delinquency, his notion that delinquent behaviour is a subcultural solution can easily be applied to drug use and abuse primarily in members of lower class peer groups. Underlying drug use and abuse in delinquent gangs, in most cases, results from sharing common feelings of alienation and escape from a society that appears non caring, non-inclusive, distant and hostile.

In Kwa-Dabeka Township poverty is a daily reality to a large number of households due to unemployment. Gwala of Whoonga Free concedes that the majority of whoonga users and sellers among school going age youth come from poverty stricken households. The social and cultural support theory holds true for this poverty stricken community. The poor youth may
feel that smoking and selling drugs give them a particular status and recognition among their peers, albeit in a negative way. Other youth from equally poor background suffering from the same low self-esteem and equally craving the same feeling of importance, may admire these “heroes” and be tempted to emulate their behaviour, as at this age group peers’ opinions and friendships are still far more important than any norms and values placed upon the youth by parents, school and society.

2.3.4 The Adaptation Theory

The adaption theories include the psychological, environmental and social factors that influence addiction. According to Peele, advocates of these theories have analysed how expectations and beliefs about what a drug will do influence the rewards and behaviours associated with its use. The theory recognises that any number of factors such as subjective emotional experiences, as well as internal and external cues, will contribute to potential addictive behaviour. It supports the view that addiction involves emotional and cognitive regulations that are contributed to the past conditioning.

The theory explores the social and psychological functions performed by drug effects. It focuses on the way the drug addict’s experience of the drug effect fits into the person’s psychological and environmental ecology. The addict uses drugs as a way to cope with personal and social needs and changing situational demands. Because the person cannot adapt normally in society, they use drugs to help them adapt and deal with internal and external pressures. The above observation has also broadened the scope of addiction into psychological realms. This theory might help to explain why some people become addicted to drugs and why others do not. Instead of developing healthy coping strategies in development, these addicts might have used the drugs as a coping strategy to run away from stress and social pressures. Advocates of these theories have also implicated ego deficiencies and other psychological deficits, including child-rearing deficits as other factors contributing to drug abuse.

The researcher is in agreement with many of the adaption theories’ views. The researcher believes that individuals can surely become addicted to drugs due to bad events that occur in their life. If a drug user is unable to tolerate bad situations, such as stressful or traumatic experiences, they could repeatedly use drugs, which will result in a regulated process, causing
them to continue and adapt to drug use. These factors play an influential role as to whether or not an individual will become dependent on drugs.

Some experts however, have certain reservations regarding the adaptation theories. Peele (peele.net) argues that adaptation theories have typically had a different limitation than other addiction theories. They do often correctly focus on the way in which the addict’s experience of a drug’s effects fits into the person’s psychological and environmental ecology. In this way drugs are seen as a way to cope, however dysfunctional that is, with personal and social needs and changing situational demands. Yet the adaptation models, while pointing in the right direction, fail because they do not directly explain the pharmacological role the substance plays in addiction, the theory highlights only the psychic dependence. In agreement with Peele’s observation, sparknotes.com points out that despite their importance, these social-psychological theories exist in isolation from the other theories because of their inability to merge concepts with other more substantial models. Adaptation theories also miss the opportunity, readily available at the social-psychological level of analysis, to integrate individual and cultural experiences.

From all the above theories, the researcher chooses the subculture, social and cultural theory for this particular study. The reason is that the subculture theory sees drug abuse as a peer-generated activity. This is more relevant because the age group targeted by this research is the school going age youth where peer pressure is most powerful.

The subculture theory talks about peer group leaders, which is practical and happening among youth in Kwa-Dabeka Township. Most peer groups in schools have members who, for one reason or another, are more popular than others. These members are able to dictate the terms and conditions of membership to the whole group. A member or prospective member will have to do, talk, behave and sometimes dress exactly as the rest of the group in order to be accepted. At this particular age group, acceptance is of primary importance. A youngster will do almost anything, even if it is against his or her better judgement, just to be accepted. If one of the conditions of acceptance is drug taking, the youth will feel they have no choice but to oblige, just to have a sense of belonging. This is precisely what is happening among youth in Kwa-Dabeka Township.
The theory touches on peer group members attempting to solve problems as a collective. The social classes come into focus in this perspective. Most youth who use and abuse drugs come from a poor social background. These youths face the same social problems, namely poverty and having society look down upon them for the sole reason that they are poor. In many social circles, more often than not, people are not respected because of their character, but because they have a lot of money and power. This misguided social attitude applies also in Kwa-Dabeka Township. Since these youths who come from poor households are unable to achieve any respect within their community, drug taking becomes more attractive as a way of sharing the same pain and rejection they feel subjected to by their own community. This behaviour, no matter how negative, will surely attract the more desired attention.

Considering that a large number of the youth in Kwa-Dabeka Township comes from this lower class category, suffering from low self-esteem, it is easy to understand why whoonga has taken epidemic proportions in this area. The youth are somehow trying to collectively overcome their common feeling of emptiness and avoid thinking about a future that looks already bleak to them even at this very young age in their life. For the above reasons, the researcher feels that the subculture, social and cultural theory will be more appropriate for this particular study.

2.4 REVIEWD LITERATURE

2.4.1 The Nature and Extent of Drug Use and Abuse among Youth in South Africa

According to the National Drug Master Plan (2006-2011:5), the level of substance abuse in South Africa continues to rise with the age of experimentation with drugs dropping to ten years. The South African Medical Journal (2011:79) states that the use of psychotropic substances is as old as human history. Some people use drugs as part of religious observations but the majority who take part in illicit drugs do it for recreational purposes. Whatever the reasons, there is an agreement among stakeholders, including parents, teachers, researchers, NGOs and government that drugs prevent people from reaching their full productive potential as adults.

Edmonds and Wilcocks (2000:5) observe that as a nation, South Africans have a tendency to disregard the existence of the drug threat to the young generation. Parents have this attitude of
thinking it is someone else’s problem, it won’t happen to their children. This attitude, they acknowledge, is a characteristic of the apathy that exists in South Africa.

The above observation regarding the drug threat to our youth is true. In Kwa-Dabeka Township, parents and the community at large, have the tendency to turn a blind eye when the neighbour is struggling with their child’s drug problem. This reality confirms the need for research and education programmes aimed at this community. The Challenge is:

*How far are parents willing to go to tackle the drug problem head on and also to set a consistent example in their own behaviour?*

Hanson, Venturelli and Fleckentein (2009:50) mention that humans can develop a very intense relationship with chemicals. Most people have chemically altered their mood at some point in their life; it may be just consuming a cup of coffee or a glass of wine. But for some individuals, chemicals become the centre of their lives, driving their behaviour and determining their priorities even to the point at which catastrophic consequences to their health and social well-being ensue.

Van Niekerk of the South African Journal (SAMJ) (2011) observes that the war on drugs has failed so far, not only in South Africa but all over the world. Van Niekerk (ibid) argues that South Africa needs to rethink its drug policies. He thinks that even though the “get tough” measures sound attractive but they are often counterproductive. Van Niekerk (ibid) further suggests that pragmatism is urgently needed in debates about these issues and our responses to them. Focussing on enforcement and compliance further erodes discretion for those responsible for treating and supervising such offenders. Van Niekerk (2011) points out that the government should legalise drugs, and have them regulated just like alcohol and tobacco. The big question though is: *Is legalisation of drugs really the answer to the on-going drug problem? Or is it going to create an addition of addicts to the large existing number due to alcohol and tobacco?* Whatever view or suggestion is put on the table, it is clear that the drug problem, including whoonga, needs urgent, positive and hands-on approach. This will take a concerted effort from all stakeholders including parents, teachers, community members and government.
Van Niekerk (2011) also maintains that policy should aim to reduce the harm that drugs cause, and not to embroil more people in the criminal justice system. Society should have faith in the capacity of drug-using offenders to change, and actively assist and enable them to achieve this goal. I agree with this observation completely. Putting drug offenders in prison does not help them do away with the habit, but maybe if the government could look into other alternatives like creating more rehabilitation facilities for these offenders.

The community in Kwa-Dabeka Township is not yet certain of how to help the whoonga addicts to get rid of the habit. Maybe some of the answers lie in Van Niekerk’s claim that people with the history of drug problems are often seen as blameworthy and to be feared. As a community, we need to embrace the drug addicts. We should remove the stigma which is often a barrier to their recovery and further prevents them from playing a more positive role in our communities. People’s positive attitudes may play an important role in reintegrating the drug addicts back into society. We can make an effort to make people recovering from drugs be part of the normal society.

The drug abuse situation in Kwa-Dabeka Township is not different from the rest of South Africa. One of the worrying factors is that, apart from easy access to drugs, there are now drug merchants within the schools. The Bureau of Justice reports that eighty five per cent of teenagers say they know where to get marijuana and fifty five per cent know where to get amphetamines.

The knowledge of drugs is similar regardless of race or location. Learners living in rural, urban or suburban areas all reported similar levels of drug availability. Even more frightening is that twenty nine per cent of learners admit that someone has offered, sold or given them an illegal drug on the school property.

The emergence of whoonga into the already bleak picture of drug abuse does not help matters in anyway. The South African Medical Journal (SAMJ) (2011:80) argues that the war on drugs has failed. Van Niekerk, managing director of the SAMJ, notes that prohibition has never kept humans from taking psychoactive substances. Van Niekerk believes that making people criminals for taking psychoactive substances is in itself criminal, he regards the behaviour of taking illicit drugs as a vice but not a crime. Whatever opinion is put on the table, the fact remains that drug abuse, including whoonga, poses all kinds of danger to users.
and non-users alike, in terms of health risks, violence and so on. It is also quite evident that a solution to this problem is urgently needed.

2.5 THE NAME “WHOONGA”

Whoonga addicts told City Press (5 February 2011) that the name whoonga comes from the Zulu term “wukeka”, referring to the excruciating stomach cramps that assail anyone withdrawing from the drug.

Dr Jeewa, a director of a Durban-based drug rehabilitation centre called Minds Alive, says the drug dealers use different names in different places for the same product. Whoonga is the street name used in the East Africa. Anecdotal evidence suggests that the name “Whoonga” is Tanzanian, Tanzania is an entry point for heroin into Africa and whoonga composition includes low grade heroin. Jeewa says that whoonga is called sugars in Chatsworth, Phoenix and Durban, Nyaope in Mpumalanga or Brown Sugar in most of the world. Brown sugar is the international term for low grade heroin. Whatever the name is, whoonga is a deadly cocktail that is killing many youth and requires urgent attention.

Issa, not his real name, a whoonga user in rehabilitation, said he first encountered the drug while living in Cape Town. Tanzanians in the Cape used to bring it into the country and sell it, referring to it as “whoonga”. This may confirm anecdotal evidence that suggests that the name “whoonga” is actually Tanzanian.

2.6 THE PREVALENCE OF WHOONGA

Whoonga first gained popularity in Kwa-Dabeka, a township near Durban in 2008. It soon infiltrated the surrounding taxi ranks and other townships around Durban. According to News 24 (7-2-2011), Kwa-Dabeka and Clermont have been identified as the townships with the highest prevalence of whoonga use and addiction in the country.

From Durban and surroundings, whoonga quickly spread to other places. The Witness (1-12-2010), a Pietermaritzburg- based newspaper, reported the tragic emergence of the drug with equally tragic consequences. A taxi driver who wanted to remain anonymous told The Witness that Market Square taxi rank is now the whoonga –smoking den for young
Pietermaritzburg school children. Zinhle Thabethe, an HIV counsellor at Edendale Hospital in Pietermaritzburg told Scientific American.com that teenagers sometimes steal Efavirenz (Stocrin), an ARV medication from their ailing parents to get high.

Subashni Naidoo of The Times Newspaper (12-11-2010) learnt from the ANC councillors, leaders of community policing forums, the police and AIDS activists that in just one month:

- About seventy five AIDS patients a week have been robbed of their medication in Durban’s Umlazi Township.
- More than twenty five patients a week have been mugged in Kwa-Dabeka/Clermont Township.
- A syndicate attempted to highjack a government vehicle delivering drugs to the Mzamo clinic at St Wendoline near Marriahill outside Durban.
- Gangs, particularly in KwaZulu-Natal have attempted to raid clinics and steal Stocrin.
  Some addicts have even deliberately infected themselves with the HI virus to secure a regular supply of Stocrin from state health services.

Naidoo of The Times (28-11-2010) further warns that there are now syndicates who operate in KwaZulu-Natal, Eastern Cape and Western Cape. These syndicates have raided clinics, mugged AIDS patients and attempted to highjack distribution trucks to get Efavirenz (Stocrin), ARV tablets believed to be one of the ingredients used in the whoonga cocktail.

According to Voxxi.com (2012), experts note that the practice of whoonga has been reported in the United States as well, though primarily in jails and with limited use in nightclubs in Miami.

It is evident that whoonga, by whatever name, has rapidly spread all over the country and is now spreading to other countries as well, in a short period of time. It is equally evident, that more effort needs to be made in terms of highlighting the danger faced by HIV/AIDS patients on daily basis when they collect their life-saving medication from clinics. It also surfaces that ways and means need to be made to educate both whoonga users and non-users about the
dangers of using the drug. Measures need to be put in place to assist those who are already abusing the drug to stop the habit. All community stakeholders need to get involved.

2.7 THE MYSTERY OF WHOONGA COMPOSITION

There has been widespread belief that the main ingredient for the whoonga cocktail is Efavirenz (Stocrin), an antiretroviral tablet. This has put a lot of HIV positive patients in a lot of danger as they are being robbed of their life-saving medication everyday on their way home from the clinics.

Dr Anwar Jeewa, director of Minds Alive, a Durban-based rehabilitation centre, says whoonga is made up of acetyl morphine (heroin) and other impurities like the teething powder, talcum powder and many other impurities just to increase the mass. Jeewa and his team sent the samples to the SAPS forensic department for testing. The tests found no ARV in the samples. Jeewa tested samples from Clermont, Kwa-Dabeka, Umlazi, Shongweni and Central Durban and found that the ingredients were all the same.

Dr Thavendran Govender from the department of chemistry at the University of KwaZulu-Natal tested some whoonga samples as well. He found that it was a mixture of heroin, morphine and strychnine, which is used to kill rats. Dr Govender told Cullinan of Health-e (2011) that whoonga is “a clever mix” that catches the addict in a vicious cycle that keeps them coming back for more. He says it’s a matter of what is available to dilute the sample. He found only small trace amounts of ARV medication in one of the samples. Dr Govender also suspects that claiming to have ARVs in the mixture might be the “dealers’ marketing ploy” of advertising their product as better than what other dealers have.

According to Carol du Toit of the South African Council of Alcohol and Drug Abuse (SANCA), a few years ago whoonga was a mixture between marijuana and Stocrin. Du Toit says as they continue to admit whoonga patients, both at outpatient and inpatient level, the mixture now seems to have progressed more to having a heroin content. An attempt to find the truth from the users themselves, however, may help eliminate some of the “myths” regarding the actual composition of this deadly drug.
Vumani Gwala, coordinator of an organisation called Whoonga Free in Kwa-Dabeka Township, says not only are there no ARV tablets in whoonga, but that most addicts who do crush and smoke ARVs do so because they cannot afford whoonga itself. The ARV medication somehow makes the withdrawal symptoms better while they look for money to purchase whoonga.

Jeewa believes that making people think ARVs are a good high, coupled with a new name for “sugars” may be all part of a game, he likened it with rebranding and repackaging a product in order to boost sales. Shamin Garda, national executive director of the South African Council on Alcoholism and Drug Dependence is also of the view that telling addicts that whoonga contains ARVs is the kind of a marketing ploy that feeds into the minds of addicts. She told IRIN/Plus News that what happens with most addicts is that they think the more they put into their drug, the better the effect they have.

Dr Njabulo Mabaso, an AIDS expert, told the Daily Mail Reporter (21-11-2010) that whoonga smokers may be fooling themselves into believing that AIDS drugs are giving them a high, when it is really some other ingredient, because there is no evidence that any ingredient of the AIDS drug cocktail is addictive or does anything to enhance the marijuana high. Phumza Fihlani of the BBC News said smokers use the ARV Stocrin to lace joints, believing that it increases the hallucinogenic effects of marijuana, though there is no scientific proof of this.

Neuroskptic (2011) asserts that it is always possible that the users are getting high on cannabis and mistakenly thinking that the Efavirenz is making it better through the placebo effect.

According to Jeewa, ARV smokers remain a minority of drug users, he also added that those who can afford whoonga may have been led to believe they were buying ARV-laced heroin by dealers. When addicts buy their drugs from dealers, they are not sure whether they are smoking heroin or ARVs.

It would appear that the drug dealers market their product as if it is different from place to place. Ntobeko Khumalo (22) from Kwa-Ndengezi, near Pinetown, who has been hooked on whoonga since 2007, told City Press (5-2-2011) that the drug sold in the area was mainly a
mix of heroin imported from Tanzania and crack cocaine. He said that at Kwa-Ndengezi they
don’t do cheap whoonga as it is done at Umlazi Township. However, the effects of the two
kinds of whoonga are exactly the same. These effects could confirm Jeewa’s observation that
the drug addicts don’t always know what they are smoking.

Despite the mystery in the composition of whoonga, one thing remains certain, whoonga is
killing young people in numbers and not much attention is being given to the problem as yet.
This is one of the reasons why I would like to try and highlight some of the grey areas
regarding the effect of the drug on users as well as ways and means that stakeholders can
employ to help whoonga users to do away with the habit.

2.7.1 Cannabis in partnership with Whoonga

Cannabis is derived from the cannabis plant. Drug info explains that cannabis is a depressant
drug. Depressant drugs do not necessarily make the user feel depressed. They slow down the
activity of the central nervous system and the messages going between the brain and the body.
The effects of marijuana include problems with memory and learning, distorted perception
(sight, sound, time and touch), trouble with thinking and problem solving. The side effects are
meaningful indicators of how out of touch whoonga users become during learning in the
classroom. After using whoonga, these young people may be as good as confused “visitors”
instead of being active participants among their sober peers in the learning and teaching
environment. This factor contributes tremendously to the dropout and high failure rate that is
prevalent among whoonga users in Kwa-Dabeka Township.

2.7.2 Heroin, another powerful partner to whoonga

Kidshealth reports that pure heroin is a white powder that tastes really bad. Some heroin is
dark brown, and black tar heroin is either sticky or hard and looks a lot like roofing tar.
Heroin belongs to a group of pain-relieving drugs called narcotics. Buddy (2012) warns that
heroin will begin to affect the body’s central nervous system immediately after its use. A
feeling of euphoria will come to the users. They have a warm flushing of the skin, dry mouth
and a feeling of having “heavy” arms and legs. Because the withdrawal symptoms of
whoonga are intense stomach cramps and body pain, Dr Govender explains that the heroin or
morphine initially masks the effects of the strychnine, which causes terrible muscle spasms.
Then the person experiences excruciating body pain and the only way to relieve this body pain is to smoke more whoonga because he wants to take in the heroin and morphine to mask the strychnine. The whoonga addict also experiences “cloudy” mental function because heroin suppresses the central nervous system. Van Zyl (2007:11) refers to heroin as the “source of many evils.” Heroin depresses the activity of the brain’s respiratory centres, thus causing the user to breath at a slower rate. The above effects are a clear indication that whoonga users are more often than not, not feeling well enough to attend classes, hence the prolonged absence rate from school among whoonga users in Kwa-Dabeka Township.

2.7.3 Deadly strychnine in partnership to whoonga

The Center for Disease Control and Prevention (CDC) defines strychnine as a white, odourless, bitter crystalline powder that can be taken by mouth, inhaled or injected directly into the vein. It is a strong poison. Only a small amount is needed to produce severe effects in people. eHow. Com mentions that strychnine causes extreme pain in the various parts of the body, due to intense muscle cramping. Respiratory failure results from muscles that are exhausted by the convulsions and no longer able to move the lungs as required. These muscle spasms also lead to kidney and liver injury, dark urine, agitation and fear.

The addition of strychnine to the whoonga cocktail is baffling. It appears to be the odd piece in the puzzle since the poison doesn’t seem to have additional value to the sought after feeling of euphoria. There is no valid excuse as to why the dealers would add such a deadly agent to the already dangerous cocktail. I fully agree with Dr Govender when he suggests that whoonga dealers should be charged with attempted murder because a lot of young people have died and many are sick from this strychnine which is present in the whoonga cocktail.

2.7.4 Stocrin as a doubtful addition to the mixture

The European Medicine Agency defines Stocrin as a medicine that contains the active substance Efavirenz. Stocrin reduces the amount of HIV in the blood and keeps it at a low level. Stocrin is known to have adverse effects such as nausea, insomnia, depression, dizziness and aggressive behaviour. According to Dr Govender, Stocrin has no proven psychoactive effects and its molecular weight is also so heavy that it doesn’t vaporise easily, making it almost impossible to smoke.
The main reason why I have highlighted the different agents used in the whoonga cocktail is that we need to have a clearer picture of how much the use of whoonga adversely affects the youth of Kwa-Dabeka Township in terms of their learning, to indicate the possible reasons why these whoonga users may have opted for this deadly cocktail, and how we as the community may approach this problem in trying to get our youth get rid of the habit.

2.8 WHOONGA, THE DRUG WITH A DIFFERENCE

Many cheap drugs such as whoonga, reveal themselves from time to time, but the ingredients of this particular drug are what make it such a danger to both smokers and non-smokers alike. Two of the biggest issues facing South African teenagers, namely drugs and HIV, have joined forces.

Not only is the introduction of a new drug never good to improving the economic growth of a community, but the production of whoonga in particular, unlike various types of drugs that have come before it, serves to hurt the current health plans to battle against HIV, with dire consequences for the community. Whoonga is the only drug that has the potential to collapse the government’s carefully planned national ARV roll out programme. The fact that ARVs are implicated in the whoonga cocktail has had devastating consequences in terms of ARV theft, the emergence of ARV black market that sees both HIV positive patience willingly selling their medication and the corrupt health officials removing ARVs from shelves and selling them into the black market.

Even the South African president, Jacob Zuma, at a Biennial Summit on drug abuse, has added his voice to the debate, publicly denying the presence of ARVs in the whoonga cocktail after the results of tests done by Dr Govender and others were revealed. But try telling that to the addicts who are both convinced that ARV is included in whoonga and that it makes their drug stronger. Xolani, not his real name, told Stein of BBC News (24-11-2011) that with ARVs, they take one pill and mix it with marijuana and grind it. When they smoke it they “feel something”, and in his own words “It’s the drug ARV” that is responsible for the “something” they feel. This existing conviction will likely take a long time to turn around, and it is the sole reason why HIV patients are still mugged or are enticed to sell their ARV medication. It is the reason why so many poor HIV patients are still on the waiting list to get
ARV because corrupt health officials are selling them to the booming “industry” of whoonga dealers and users.

It is tragic that this generation of young people is seen as the “lost generation” when in actual fact they are supposed to be the first “free generation”. Why is the youth being held back by drug use? Is it due to home factors like alcohol abuse? Is it because teenagers have no outlets for self-expression? Is it because of the shortage of opportunities for education due to poverty? Whatever the reason is, something has to be urgently done to save the future of Kwa-Dabeka community as well as South Africa as a whole.

2.9 THE PREPARATION OF WHOONGA FOR SMOKING

Cebekhulu and Khumalo, who have been smoking whoonga for years, took the City Press (2011) team into a dark room to demonstrate how they take the drug.

The drug was placed on a tile that had been heated on a hot plate and was then chopped with a razor blade by Cebekhulu until it was fine, while Khumalo removed seeds and stems from the dagga they use as the base from which to smoke it. Khumalo placed the dagga he had mixed with tobacco onto a cigarette paper and sprinkled the whoonga on top. He rolled the mixture into a cigarette filter as a stopper at one end. The two men then shared the high-powered joint. Intervention Organization Drug Addiction help agrees with the City Press team. The organization observes that users heat a plate or piece of tile, and then crash the drug using any plastic material on top of the heated plate or tile. Dagga that was prepared separately is then mixed with tobacco from the cigarette. This is rolled in smoking paper. The whoonga powder is then sprinkled on top of this mixture.

2.10 WHOONGA, THE DRUG THAT BOTH CREATES THE PAIN AND RELIEVES IT

It is a horrible part of human nature that we seem to be attracted to prey on the members of our societies who are suffering the most, and inflict more pain on them while we make money, a punishment for their daring to be poor. Robbing the poor, sick individuals of their medication, as well as enticing them to sell their life-prolonging medication, has got to be an all-time low for human nature.
From what experts say regarding the composition of whoonga, it contains heroin which is a pain reliever and strychnine, which is a well-known rat poison responsible for the crippling stomach cramps on the users. After the pain-healing of heroin wears off, the strychnine sets in, producing painful muscular cramps and digestive tract torment. This acute pain sends whoonga addicts back to the dealers to get the next fix to relieve the pain. In Dr Govender’s words “The patient now has this excruciating body pain”. The only solution, albeit a temporary one, to relieve the pain is to smoke more whoonga. Addicts now want to take in the heroin and the morphine to mark the strychnine. Govender contends that whoonga is “a clever mix” that catches the addict in a vicious cycle that keeps them coming back for more. The cycle goes on and on, withdrawal symptoms are ghastly.

In Kwa-Dabeka Township, this is precisely why the learners, after starting to smoke whoonga, are absent from school for long periods of time, or drop out of school permanently. The struggle to find money to get the next fix and the excruciating pain caused by withdrawal, leave no opportunity for them to even think about school, let alone to have the energy to attend classes. So smoking whoonga takes first priority over everything else and becomes a full time job.

Some recovery centres have begun to offer assistance to help in the treatment. This gives a safe haven for those addicted, but there are very few of these facilities that exist. It is questionable if these centres can make any real headway when it comes to dealing with this type of substance abuse. In third world countries such as South Africa, recovery is not a priority. Survival comes before anything else and it dominates one’s life.

2.11 THE EFFECTS OF WHOONGA ON THE USERS IN GENERAL

- Physical effects.

Masline (2000:12-14) reveals that the physical effects can range from fatigue and irritability to overdose, and death is the worst physical effect. Different drugs cause different effects. Marijuana impairs judgement and motor skills and can cause lung damage. Regular use of stimulants, such as cocaine, can lead to insomnia, appetite loss and depression. Injecting any drug with shared, contaminated needles can cause life-threatening diseases, including AIDS,
and hepatitis (a serious liver disease). Cocaine and crack claim victims from overdose, heart attack and stroke. Hallucinogens cause strange and sometimes violent behaviour. Heroin and other narcotics can slow a user’s breathing and heart rate so much that they simply stop. A street dealer may sell something that appears to be heroin but is actually a synthetic copy ten times more powerful. The risk of overdose from a designer drug like this is very high.

- The psychological effects

Relationships with friends and family are often damaged when a teenager start using drugs. Arguments can be frequent and intense. It is very common for teenagers to hate and turn away from the very people who are trying to render assistance. Overtime, the use of dangerous substances can lead to serious psychological problems such as anxiety, depression and paranoia.

- Problems with school work.

The American Academy of Child & Adolescent Psychiatry notes that when a teenager start using drugs, school work suffers too as loss of interest and lack of motivation causes grade to slip. The teenager begins to develop a negative attitude toward any school-related activity. The teenager begins to be absent from school more often, which results in truancy and a lot of discipline problems. Eventually, as a result of the deterioration of concentration and memory, the teenager may decide to drop out of school altogether.

2.12 THE EFFECTS OF WHOONGA ON THE LEARNING OF THE YOUTH

The whoonga concoction, as explained by experts, comprises cheap heroin, which is highly addictive in nature, and strychnine, which is a well-known rat poison as well as many other impurities. Addicts sprinkle this deadly cocktail on top of cannabis as a base from which to smoke it. The different agents in the mixture have different ill effects on the whoonga users. The presence of all these impurities makes the users more vulnerable to casualties, which might even lead to death.

According to Drug Free Homes, there are many ill effects of whoonga on the physical side, the psychological side as well as the behavioural and social effects. On the physical aspect,
whoonga use leads to lack of sleep, vomiting, watering of the nose, the heart function slows down, insomnia, loss of appetite and weight, breathing is severely slowed. These ill effects all create a picture of a youngster who, because of all the above mentioned side effects, can hardly drag himself to wake up in the morning, eat a healthy breakfast without vomiting and have enough energy to go to school. It is easy to comprehend that these youth are just feeling too sick to go anywhere, except perhaps to go back to the drug dealers to get the next fix, hence the prolonged absences from school among whoonga users in Kwa-Dabeka Township.

On the psychological side, whoonga smoking leads to irritability, lack of concentration, depression and frustration. The heroin which is present in the whoonga concoction is a nervous system depressant. It depresses the activity of the brain’s respiratory centres. The user experiences “cloudy” mental function because heroin depresses the central nervous system. The Drug Guide refers to this cloudy mental state as “on the nod,” where the user alternates between a wakeful and drowsy state. Looking at these side effects, it is not difficult to understand that school is the last place whoonga addicts would like to be. School work requires a great amount of concentration, this will obviously result in addicts getting frustrated and depressed because, on top of not feeling well physically, their mental state is nowhere near able to absorb the large amount of work required to do well in school.

The National Institute on Drug Abuse (NIDA) points out that research has shown that marijuana’s negative effects on attention, memory and learning can last for days or weeks after the acute effects of the drug wear off. These side effects include distorted perception, that is, problems with sight, sound, time and touch. Marijuana users also have trouble with thinking and problem solving. As dagga is used as a base from which to smoke whoonga, addicts are bound to experience all these side effects. According to NIDA, a person who smokes dagga daily may be functioning at a reduced intellectual level most or all of the time. It is not surprising therefore that, compared to their non-smoking peers; whoonga users get lower marks and are more likely to fail at the end of the year. The above revelation leaves no doubt in our mind that whoonga addicts are in no way prepared to deal with a classroom situation. If they have a problem with thinking and solving problems, then clearly the classroom appears to them to be the wrong place to be since the major purpose of attending class is to work hard using their thinking and problem solving skills. Also, the distorted perception and memory loss add to the already confused state of mind in the life of a whoonga addict.
The behavioural and social effects lead to socially deviant behaviour, involvement in criminal activities, violent and aggressive behaviour, compulsive lying and manipulation. The criminal activities by whoonga addicts, more often than not, result in a trip to prison, which in turn result in addicts missing out on a lot of school work due to prolonged absences. The violent and aggressive behaviour also manifest in addicts physically and emotionally terrorising other learners in the school grounds, which result in learners being afraid to attend school because they are being bullied by whoonga addicts. Interpersonal relationship problems also develop between teachers and addicts. Teachers are constantly disappointed by the poor quality of work presented by addicts, and addicts in return regard teachers as their “enemies” because they always want their work, making school further undesirable to addicts.

Although dependence is both physical and psychological, experts say physical dependence is easier to treat than psychological dependence. This makes it very difficult to stop using the drug because the mind has to be ready to quit, even if the body is healed of withdrawal symptoms, before the addict becomes completely free of the deadly grip of whoonga. All the side effects combined are crucial pointers into the hopeless plight of whoonga addicts in regard to their learning, attending classes and even being in the school environment itself. This is because schools have rules to be followed, and in their weakened physical and mental state of mind, addicts may not even remember any of those rules or understand what is being taught in class. This state of feeling out of place in the school environment contributes considerably to long absences as well as school dropout which are prevalent among whoonga users in Kwa-Dabeka Township. At this point in the whoonga addicts’ life, whoonga completely overpowers them. Their thoughts and actions are controlled by it. Finding the money to get the next fix becomes a permanent job, which results in addicts sometimes leaving school early and long absences from school in search of money to buy the next fix, and they sometimes find themselves involved in crime, getting arrested, dropping out of school and even dying. The ultimate destination of a whoonga addict is prison, rehabilitation centres or in a worst case scenario, death. But tragically, many young people do not realise this, for lack of knowledge, until it is too late to turn back the clock.

According to the National Institute of Health (NIH), considerable research has demonstrated a positive association between early marijuana use and low educational attainment as measured by both years of education and high school dropout status. This finding has been frequently
interpreted as evidence that marijuana use interferes with learning by impairing memory, attention or other cognitive functioning and/or motivation, any of which could translate into poor schooling outcomes. As cannabis is used as a base from which to smoke whoonga, it is inevitable that addicts will perform poorly in schoolwork and ultimately fail at the end of the year. The constant poor show of academic results will put the whoonga user in a lot of pressure from both the parents and the teachers. Thus many addicts decide to finally drop out of school as a result. This reality is also applicable to other illicit drugs like heroin, which is the main ingredient for the whoonga concoction.

According to the National Income Dynamics Study Survey database (NIDS) (2008), the dropout rate in South Africa differs from grade to grade. The study discovered that the school dropout rate per year in grade eight is 3.8%, grade nine, 6.5%, grade ten, 11.5% and grade eleven, 11.8%. Statistics South Africa (2009) adds that the dropout rate for grade twelve is 6.9%. Statistics South Africa further estimates that the actual level of repetition in grade twelve is likely to be much higher, since large numbers of learners enrol in FET colleges and Adult Education Centres to have a second chance at passing grade twelve.

From the above statistics we note that the dropout rate is lower from grade eight and escalates up until grade eleven and drops down again in grade twelve. This may have to do with the difference in their ages as well as an indication of how peer pressure affects the different age groups. In Kwa-Dabeka Township, the dropout rate is the same as the above mentioned statistics. Some age groups are more vulnerable than others. The most vulnerable groups are between the ages of fourteen and sixteen.

2.13 THE NATURE OF WHOONGA ADDICTION

Since whoonga contains a lot of heroin in it, the effects are the same. The reason that addicts choose whoonga, apart from it being cheaper than most street drugs, may be that heroin is a pain reliever.

2.13.1 The psychological price addicts pay

Some drug addicts rationalise their dependence on drugs by using various excuses or explanations. There are varying experiences when taking whoonga. People who use it say
they feel like the best people ever. Others say they feel at peace and some reported it helps them sleep. Some addicts say that whoonga gives them a heavenly experience. But the psychological effects experienced by an addict, if the drug is not consumed for twelve hours are so painful that there can’t be any hell worse than it.

While all the above “wonderful” experiences may be the initial reasons to begin taking the drug, the withdrawal seems so severe that the unpleasantness is what keeps them using again and again. An addict told Mchome of The Citizen (22-10-2011), that if he stays without using whoonga, he feels like he is sick, and the whole system inside him is dead, so whoonga brings him back to life. Vukani Mahlase, a recovering addict and HIV patient, told Phumza Fihlani of the BBC News (28-2-2011) that when he suffers from cravings and there is no money to buy the next fix, he is prepared to do anything.

There is also a shift in values and priorities due to the fact that the thought of where and how to get the next fix has taken first priority. Addicts start to feel that the only way they can enjoy life is to smoke the drug. The long term use becomes a miserable cycle of relapse, pain and the feeling of pure hopelessness. Whoonga use leads to irritability, lack of concentration, depression and frustration, as well as suicidal thoughts. The severe dependence and fear of painful withdrawal symptoms can lead many addicts to avoid the addiction treatment, but without treatment and detox, many whoonga addicts never recover and may face even death.

2.13.2 The physical effects

Whoonga is highly addictive and cause severe dependence and intense withdrawal symptoms. Most drug addicts find it difficult to withstand the pain and would rather continue taking the drug to make themselves comfortable, not for any pleasurable feelings but in order to avoid the excruciating pain of withdrawal symptoms. Because the heroin in whoonga suppresses the central nervous system, the user experiences “cloudy” mental function. Users will begin to breathe at a slower rate and their breathing can reach a point of respiratory failure (NIDA). According to Drugs.com, whoonga interferes with the brain’s ability to perceive pain, which could lead to injury. The presence of many impurities makes the users more vulnerable to casualties, which might lead to death. Many youth have died from crippling stomach cramps in Kwa-Dabeka Township. Other side effects include liver disease, kidney disease, heart
infection as well as lung infection. If taken in overdose heart and lung function reduction becomes fatal.

Looking at both the psychological and physical effects of whoonga, it is difficult to envisage many of our youth reaching adulthood. Without the urgent intervention of stakeholders including government and NGOs, South Africa faces a bleak future in terms of having would be fully productive adults who will be able to contribute meaningfully to all spheres of life, turn to drug-dependent and burdensome citizens who are at the mercy of relatives and state welfare grants to survive.

2.14 THE IMPLICATIONS OF WHOONGA EXISTENCE

According to Kikkawa of Caaglop.com (2012), cheap and potent street drugs are always dangerous to the user’s health due to the unsafe ingredients that are used to cut the drugs as well as the risk of overdosing. Cheap drugs that provide a stimulus like crack, the cheap alternative to cocaine, are very popular due to their strong kick. Crack is only cheap because there are unknown ingredients mixed into the drug to boost its volume and lower costs.

Whoonga fits in comfortably in this category of cheap drugs as its base is a cheap form of heroin that is mixed with additional impurities like rat poison and detergent to increase its volume. These impurities are a strong cause of death due to the fact that drug dealers mix almost anything they can get their hands on to lower costs, resulting in users consuming ingredients the human body was never supposed to consume. If the impurities don’t kill the user, then overdose will do the job, while the low prices and addictive quality encourage individuals to consume greater amounts to meet their previous levels of high as their resistance to the drug increases.

In addition to the basic damages however, whoonga adds another danger in that it mixes an unknown drug into the mix. The continued use increases the tolerance of the user to the drug, including ARV. The increased tolerance to ARV means that if the user ever gets infected with HIV, the user will need a greater dose of ARV to control their HIV.

Regardless of how much or how little ARV drugs contribute to the creation of whoonga, the current prominence of whoonga in recent analysis is due to the implications the alternate use
of ARV drugs have on the South African community. Due the popularity of whoonga because of its relatively low prices and potency, there is a significant demand for whoonga which therefore creates a significant demand for the ingredients to create whoonga. This has led to the development of a black market for ARV drugs and ARV muggings by gang members. An article by All Africa reported that civil organisations want to see government adopting a firmer stance against the existence of ARV in the black market. Due to people getting mugged of their ARV medication on their way home from clinics, people are now afraid to collect their treatment. Recently, there have been three men who were arrested for possessing R200,000 worth of ARV medication.

The smuggling of ARV drugs into the black market is devastation to the entire South African community due to the twisted incentives it produces. Regardless of the existence of whoonga, there is a value placed on ARV medication due to the fact that it provides HIV-positive individuals with the ability to regain control of their life from the disease. Thus, there is inherent by wealthy HIV-positive individuals to buy this medication if they cannot access it. There is also an incentive for the poor who must balance between their health and income to provide for their families. The ARV medication is a potential source of income, the selling of ARV medication into the black market sacrifices their health but allows the individual to gain money to provide basic necessities for the family. Regardless of where the demand of ARV drugs comes from, there is a demand for ARV drugs and the existence of a black market to trade these drugs reinforces the social inequalities South Africans are facing.

Furthermore, the ARV black market encourages improper ARV use. If an individual uses ARV drugs to both maintain their health and earn some income on the side, the random use of ARV will cause the Individual to develop a tolerance to the drug, harming their health in the future. The more people who get involved in the black market and trade their drugs away for money, the fewer the number of people who are able to manage their health with HIV which would make the government programme a failure due to the existence of economic inequality. This failure is only magnified with the gangs who steal ARV medication from citizens who intend to use them, the drugs going into the black market meaning that the poor are unable to get the care they need and resulting in a failed national health programme despite its good intentions.
The ARV black market is a disease created from corruption and greed that feeds off the health of the poor to fund the wicked and should not be tolerated. The only beneficiaries are the gang members who profit from selling whoonga to users at the expense of poor HIV-positive individuals who need ARV drugs to survive and the government who wants to show a successful national health programme.

For the country that is rated as containing the highest number of HIV-positive people in the world, the emergence of whoonga and its devastating implications is a terrible blow to the national roll out of the ARV programme.

2.15 HIV AND THE STATUS QUO IN RELATION TO WHOONGA

South Africa has the highest burden of HIV than any other country in the world. As it finally begins to make meaningful progress against the disease, whoonga could not have come at a worse time. As the government responsible for the world’s biggest population of HIV infected people prepares to make anti-retroviral drugs more widely available, authorities are trying to stamp out the illegal trade, tighten security for ARV supplies and make patients aware of the risks of theft.

The biggest question that may be baffling is why, despite the risks of death from HIV, South Africans choose to sell their medication into the black market. If life is the most precious thing we have, shouldn’t the fear of death be enough to discourage us to reduce our risk of HIV infection? But the tragic reality is that HIV/AIDS is closely related to poverty, the choice between selling their heavily-subsidised ARVs for food is not an option at all to those HIV positive individuals staring starvation in the face.

In a study conducted by HIV activist Winston Zulu on why people choose to reject ARV medication, Zulu found that people who are HIV positive can apply for disability grants from the government, which allows them to earn an income to support their families. Taking medication to address HIV would reduce their applicability for disability grants and thus would cause families to lose the very money they need to support their families. Given the lack of alternative means of income that would generate as much money as the disability grant, it would be in the interest of infected parents to retain their HIV positive status and reject medicine in favour of the disability grant money. Whoonga dealers are acutely aware of
this status quo. They then take full advantage of the situation by enticing poor HIV patients to sell their medication.

The emergence of whoonga and its connection to HIV medication put the South African economic situation into sharper focus. The issue no longer depends on the availability of services to reduce HIV but on the South African economy itself. Due to the sparse job opportunities that are well-paid, individuals are forced to balance between their income and their health, sacrificing their health for income. If there are other jobs for mothers which allow them to earn a greater amount of money than from the disability grants and possibly provides child care, mothers will have the incentive to take the ARV treatments to control their HIV. The unfortunate part is that the South African Police Service is underequipped to address the spread of whoonga, the ARV black market connected to whoonga as well as the crime rates that accompany the demand for the drug.

The researcher touches on the country’s economic state of affairs in an attempt to accentuate the fact that, as long as the economic status quo remains unchanged, poor HIV positive patients will continue to sacrifice their life for income, and whoonga dealers will continue to have their “business” flourish at the expense of poor citizens. This is also true of the circumstances in Kwa-Dabeka Township. Some parents keep loads of ARVs acquired through illegal connections with corrupt health officials and earmarked for the black market. But unfortunately, more often than not, these ARVs land in the hands of youth, including young school children, who for lack of money to buy whoonga, crush and smoke them.

This equation makes it very difficult to find ways to help the youth affected by whoonga to do away with the habit. Whoonga Free’s initiative to rehabilitate and integrate youth addicted to whoonga in Kwa-Dabeka Township is necessary and praiseworthy, but it is not enough on a larger scale. This is clearly an issue of public health and safety.
2.16 WHOONGA, THE TRAGIC MENACE

2.16.1 On the health front

In addition to the usual violent stomach cramps that more often than not result in the trip to the hospitals to have the whoonga addicts’ young tummies operated upon, vomiting their own intestines as well as dying, there is now a new and far deadlier twist to the whoonga tail.

Voxxi.com reports that a concerning drug resistance is developing with two common HIV drugs namely, Efavirenz and Ritonavir, though the reason for the resistance is not solely the result of improper dosing or prescribing as it is with many other disease treatments.

Dr David Grelotti, a Harvard School of Public Health researcher, told npr.org (2012) that one large study showed that three to five per cent of people with HIV were coming in with pre-treatment resistance to antiretroviral drugs in South Africa. This can happen in two ways. People with HIV who smoke whoonga can develop mutant strains of the virus resistance to the medication. So when they need treatment, it doesn’t work. Or people can become infected with a strain of HIV that came from someone who used whoonga. This may explain why some HIV patients are resistant to this front line medicines even if they have never been in treatment before.

Dr Grelotti believes that street use of Efavirenz (Stocrin), sold as Sustiva in the U.S., may exploit HIV drug’s well-known tendency to cause especially vivid and colourful dreams and other central nervous system effects. Hypothetically, that could enhance the effects of marijuana, methamphetamine, heroin and other illicit drugs,

Dr Grelotti admits that very little is known about the extent of recreational use of these drugs, outside of anecdotes and media reports. His group decided to call attention to this issue so that doctors would think about possible recreational use in prescribing Efavirenz and Ritonavir. They may need to use other alternatives. The sad and tragic reality though, is that while other medications choices do exist for the treatment of symptoms of HIV, alternatives are not always available in poorer countries, including South Africa. As more and more people use Efavirenz and Ritonavir for recreational use, the drug’s ability to combat symptoms of HIV becomes diminished and patients begin to show signs of resistance.
The meaning of the above revelation is devastating. On top of the threat of the normal HIV which is controllable with the use of affordable Efavirenz and Ritonavir, now comes a situation where these mainstay drugs are rendered ineffective and useless by whoonga dealers and smokers. The biggest threat is to those people who may get infected with the HIV and not get help due to the fact that they were infected by someone who smokes whoonga and is already resistant to ARV medication.

What makes whoonga particularly insidious and difficult to combat is lack of information. Many young people experiment with it without realising what they are getting themselves into. The cruel irony is that there is no evidence to suggest that the HIV medication actually enhance the feeling of euphoria.

Equally tragic, is that some whoonga addicts intentionally infect themselves with the HI virus so that they can access a regular supply of HIV drugs. As if this is not tragic enough, there are corrupt health officials who are selling ARV medication to the black market. This implies that legitimate beneficiaries of this medication are getting robbed of the opportunity to improve their health by the very system which is supposed to look after their health. This corruption renders the earnest effort of the government to improve the lives of those living with HIV useless. In the long run, the effect of this selfish and thoughtless activity by corrupt officials is going to be devastating to South Africa as a whole, including Kwa-Dabeka Township.

In resource limited settings like South Africa, sophisticated drug resistance testing is often not available, further complicating the ability to identify patients who have acquired resistance through recreational HIV drug use. This means that South Africa is a long way from being able to gauge the number of HIV resistant individuals and plan accordingly for the next move.

2.16.2 On the social standing front

On top of the devastating health problems related to whoonga use, the social reality of Kwa-Dabeka community regarding the existence of whoonga in the area is equally devastating.

Parents of whoonga addicts live in constant fear of vigilantism. On many occasions, people in Kwa-Dabeka Township have gone on a rampage, targeting houses of whoonga users, looking
for their stolen goods. When they find these addicts they beat them up and unfortunately for their parents, they are always caught in the middle of things. In desperation, vigilantes try to get rid of whoonga use by employing violent tactics and some families have gotten their homes burned down. This however, has not stopped whoonga use spreading through the entire township. The sad reality is that addicts would do anything to get the next fix. Vumani Gwala of Whoonga Free says that to addicts, it is a matter of life and death, and not about committing a crime. Parents of whoonga addicts are more often than not treated like pariahs by members of the community as the entire community struggles to deal with the whoonga problem. This has resulted in neighbour turning against neighbour, which makes the social life in the community extremely difficult because of the hostilities and lack of trust between “them and us”.

Parents of non-users also live in constant fear of a different kind. Vumani Gwala of Whoonga Free says parents phone him all the time looking for help because gangs are forcing their innocent children to sell whoonga, and threatening them if they don’t. As a result these children live in fear of their own lives and are now reluctant to go to school, as schools are breeding grounds for recruiting new users and dealers alike. So in Kwa-Dabeka township, it does not matter whether your child uses whoonga or not. All parents face the real danger of their children either getting hooked, selling willingly or being forced to sell drugs. These children face the real possibility of death either by whoonga abuse or by being killed by gangs if they refuse to sell the drug. Gwala says whoonga street sellers are often poor youth in the community and the best place for them to do business is schools.

There is another group of Kwa-Dabeka township citizens which is also paying a high price due to the emergence of whoonga in the area. Apart from the health risk when losing their medication through theft and muggings, HIV positive patients face a real possibility of getting stabbed or killed during these violent encounters. Many of them try to walk in groups to and from the local clinic on the day of ARV medication collection, but this is not always possible as some people still hide their status for fear of stigmatisation. As a result, these individuals become isolated from their fellow HIV positive patients and become easy targets for whoonga users and dealers. Police in Kwa-Dabeka told allAfrica.com (2010) that they have seen a rise in housebreaking cases and theft related to whoonga use.
Boys will sometimes go as far as raping HIV positive women in the hope of acquiring the virus themselves and thus qualifying for treatment, just to be able to get their fix, because sometimes they don’t have the money to buy the ARVs from corrupt health officials who are selling them in the black market.

As if corrupt health officials are not bad enough, Mkhize, a Marrianhill policing forum leader, told Sowetan (15-03-2011) that it is disappointing to see police failing to arrest identified dealers. More disturbing is the confession by dealers to Mkhize that they smoke whoonga with “the boys in blue”. This tragic and shocking state of affairs could be applicable to all communities, including Kwa-Dabeka Township. Communities are faced with the dilemma of not knowing who to trust anymore because the police are shown the dealers and the drug hot spots, but for reasons known only to them, fail to make arrests.

Other than the physical threats of whoonga use, Kwa-Dabeka community faces a bleak future in which young peoples’ aspirations, dreams and ambitions for the future are stolen away by whoonga use. If they smoke whoonga, they don’t think of ways to empower themselves and better their lives. All they think about and live for is how to get the next fix. Many young people in the area are unskilled and unemployed. The emergence of whoonga in school grounds adds to the already bleak picture as many teenagers drop out of school after they start using whoonga, adding to the vast number of unskilled youth.

Looking at the above scenario, it is easy to comprehend that young people, especially school children, need urgent help from the cruel grip of whoonga. This may take the effort of all the stakeholders.

2.17 EFFORTS TO CURB THE USE AND SPREAD OF WHOONGA

In Kwa-Dabeka Township, Whoonga Free, a project run by Vumani Gwala, is the only project making a real effort to curb the spread of whoonga use. Gwala’s project is run by a committee made up of people from Kwa-Dabeka community. They help to identify, motivate and rehabilitate users and reintegrate them back into the community. Together they have organised various initiatives, which include producing a movie about whoonga’s negative effects. Their plan is to show the movie at schools and community centres. They sometimes use former whoonga addicts to further highlight the dangers of using the drug. Gwala says his
organisation and the community at large would benefit a lot if the government could join hands with them in terms of awareness campaigns and educating young people about the dangers of the drug, especially those who have not yet started using the drug. But unfortunately for now, the government is standing and watching from the side lines.

According to Carol du Toit of the South African National Council of Alcohol and Drug Abuse (SANCA), not enough is being done to stop whoonga use. She says if the stakeholders can have a properly orchestrated approach, she has no doubt that a dent can be made in this problem but right now the whole approach is very fragmented.

The authorities are very much aware of whoonga. The police and the national addiction council say they are doing what they can. But with whoonga production and supply occurring behind closed doors in the townships that are plagued by high levels of crime, whoonga becomes less of a priority. With limited resources to turn the tide on ignorance among the ill-educated youth, officials admit that efforts to promote awareness are not enough.

The researcher tends to be in agreement with Gwala’s observation that the government needs to get involved in the fight against whoonga use. The government could put measures in place and have a well-planned programme on how to approach this problem. Organisations can only do so much but they really need the support of the government. The government may not be aware of it yet, but its carefully planned ARV roll out programme may fail completely in the long run as a result of the selling and theft of ARV medication connected to whoonga use, not to mention the inevitable ineffectiveness of ARV medication due to virus resistance to medication, which has already been noticed by doctors, caused by smoking of ARVs. Gwala’s efforts give an indication of some ways and means that can be employed to help the affected youth in Kwa-Dabeke Township to do away with whoonga use.

The African culture is centred on “Ubuntu”, which is our values and humanity. Ubuntu, as we Africans understand it, means deep respect for all and looking after one another as one big family in every possible way in a community. African children are brought up to live by this belief. If these values are ignored, it becomes a tragedy for the whole community. It then becomes the sole responsibility of each family, as opposed to the whole community; to teach their young never to allow themselves to be led astray by whatever negative influences that may potentially destroy their lives. This effort is a lot more difficult than it looks. This is
when it is crucial for the government to step in and seriously start focusing on the drug problem and possible measures to be taken to ease the burden on families and communities.

Without more projects geared toward youth and opportunities for education and school building, young people in Kwa-Dabeka Township are likely to continue experimenting with drugs, including whoonga, as a way to pass the time. The future of these young people lies in the hands of community leaders and their attention to the seriousness of the situation.

2.18 IS THE GOVERNMENT DOING ITS SHARE?

2.18.1 The Blame Game

Hendrika Kruger, DA MP in the Gauteng legislature, told the Sowetan (18-01-2011), that the government was to blame in some instances of theft and selling of ARV medication. Kruger says that the government has known for the past few years that ARVs were used to get high but has not done anything about it. She made this statement after three men were arrested in Gauteng for allegedly stealing ARVs worth R200,000. Fidel Hadebe, spokesperson for the health department said the government was “extremely concerned” that people were stealing ARVs to turn them into drugs.

The government itself is blaming the media for reporting that ARVs are implicated in the whoonga concoction. Even though test results revealed that only trace amounts were found in one of the samples, addicts’ perceptions are what count the most. They sincerely believe that ARV is put into the whoonga cocktail and that it makes their drug stronger. In reality, some whoonga addicts actually crush and smoke ARVs either for lack of money to buy whoonga, or because of the belief that it does something for them. So, regardless of what the media said or did not say about the presence of ARVs in the whoonga cocktail, the government cannot afford to turn a blind eye on the issue of ARV medication being stolen or sold into the black market. It is the government’s responsibility to protect its carefully planned ARV roll out programme, to see to it that it is ultimately successful in reducing the spread of HIV and prolonging life to those infected with HIV. In other words, the blame game is not going to solve the whoonga problem. The government needs to do more than point fingers in the hope that the whoonga problem is going to magically disappear.
2.18.2 Loop Holes in the ARV Administration

Kruger, DA MP in the Gauteng legislature, pointed out that it is possible within a twenty five kilometre radius, to access clinics in Limpopo, North West, Mpumalanga and Gauteng, to register in all four provinces and then sell the extra medication at twenty rand or twenty five rand a pill.

Fidel Hadebe, of the Health Department told Sowetan that there was no centralised system in place yet to prevent the same person from registering at clinics in four different provinces. Hadebe added that this would be introduced “later”.

Jay Naicker, SAPS spokesperson in Durban admits to ABC News (24-04-2011) that individuals don’t report cases of ARV muggings or theft to the police. So the police don’t know if the people are actually mugged or selling their ARVs into the black market and go back to the clinics and claim they were robbed. As a result, there is no documented record because people are not coming forward.

The above state of uncertainty regarding who receives the ARV medication where may easily be applicable to the Durban and surrounding areas, including Kwa-Dabeka Township. This confusion presents a perfect opportunity for whoonga dealers and smokers to take full advantage of a fragmented record keeping system by the Health department. Also, those HIV positive breadwinners who have no other income may seize the opportunity at the expense of poor fellow HIV positive individuals who may never receive their share of the life prolonging ARVs due to shortages, not to mention corrupt health officials, who are at a tremendous advantage because they are more aware of these loop holes and how to manipulate the situation far better than even the whoonga dealers and smokers.

2.19 CONCLUSION

The researcher has presented an overview of the nature and extent of drug use and abuse among youth in South Africa with a specific focus in Kwa-Dabeka Township. In the review it has come to light that:

- The age for first experimentation with drugs is becoming younger and younger.
Access to drugs has become easier, and more types of drugs are entering the market, whoonga being one of them.

The youth get involved in drug abuse for a variety of reasons including boredom, curiosity, peer pressure, emotional reasons as well as a way to solve personal problems.

There is an undeniable connection between substance abuse, crime, HIV infections and premature death.

Crime that is rampant in the townships takes priority to the police over drug use problem.

Within the South African context, including Kwa-Dabeka Township, there is a lot of uncertainty regarding the “myth vs. truth” in the whoonga composition, in particular the inclusion or not, of ARVs in the cocktail. The uncontrollable spread of whoonga use and abuse in Kwa-Dabeka Township is caused by ignorance among youth. Many young people have confessed to different media reporters that they did not know how dangerous whoonga use was until it was too late. This reality points to the lack of education among the whole community. Presently, there are no meaningful educating mechanisms put in place which are either directed to young children before they start experimenting with whoonga, addicts who are already hooked or the community at large, as to how to deal with the whoonga use situation facing them on daily basis, as an alternative to vigilantism.

It has emerged that the implications of whoonga existence are far reaching as whoonga is the only drug that threatens to collapse the national ARV roll out programme. It has also come to light that the government is yet to realise the danger of whoonga emergence and get involved in terms of educational campaigns nationwide, stamping out the black market for ARV as well as equipping the police with effective tools to successfully stamp out the production, use and abuse of whoonga.

The government has not yet taken measures to encourage HIV positive patients to take their life-prolonging medication instead of rejecting it so as to have a low CD4 count and thus qualify for the government grant. The government, as the biggest role player, has also not yet taken an initiative to actively:
• Put measures in place to deal with whoonga use and abuse.
• Stamp out the ARV black market that has emerged due to whoonga demand.
• Find measures to punish those corrupt health officials who remove ARVs from clinic and hospital shelves to sell them to the black market.
• Come up with a strategy to close down loop holes that exist in the administration of ARVs in relation to whoonga use.
• Put measures in place to educate communities, more especially the youth, about the dangers of whoonga use, the implications of taking ARVs when the body doesn’t need them yet and the injustice done to poor HIV positive patients who may die for lack of ARVs that are sold in the black market.

The researcher has also presented an overview of theories of substance use and abuse. Some of these theories share the same views, while others have contrasting views regarding substance use and abuse. Some theories make a separate but equally important contribution to the bleak picture of substance abuse.

The psychological theory and the adaptation theory are both of the view that addiction is in part, the result of a person’s past experiences. Both theories see drug abuse as a way to escape or cope with reality, to help addicts adapt or acquire the state of being alright with themselves. There are contrasting views between the psychological theories of drug abuse and the disease model of substance abuse. The addiction disease theory sees addiction as a chronic disease that is incurable and irreversible. The psychological theory, on the other hand, believes that addiction is a behaviour that can be controlled.

The subculture, social and cultural perspective has touched on the aspect of the social classes that exist in a society, in relation to drug use and abuse. More often than not, it is the youth from the lower class of a society that fall victim to drug use and abuse. Common feelings of low self-esteem draw these youngsters together and prompt them to attempt to solve problems as a collective.

In short, the above theories of substance abuse have contributed, albeit using different perspectives, in attempting to explain how most youth get involved in substance abuse, that is, through peer pressure or trying to cope with the realities of their daily life. What is left for
communities to do, including Kwa-Dabeka Township community, is to find ways and means to effectively deal with the presence of drugs, including whoonga, in their communities.

Following this chapter is Chapter three which focuses on the empirical part of the study. It deals with the design and method(s) employed in the collection of data from the population for the study is meant by giving a detailed account of how this process unfolded. Chapter Three also deals with the reliability, validity and the ethical issues in the study.
CHAPTER THREE
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Countless studies have been conducted on drug addiction of different kinds, but none yet on one of the latest drugs to come out of the drug market called whoonga. The focus of this study is the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. The aim of this chapter is to provide answers to the common causes, if any, for young people to use whoonga, the way in which whoonga affects its users and their learning, and measures that can be taken to assist youth using whoonga to do away with the habit.

The lack of knowledge regarding whoonga existence has resulted in the need for an in-depth study of this new addition into the drug world. For this reason, this study illustrates why the method of choice for this particular study is the qualitative method. Since the research question is based on the experiences of whoonga addicts in a learning environment, the effects of whoonga are described from a phenomenological perspective. The rationale behind the choice of the research design and approach are discussed in this chapter, as well as the choice of sample and target population.

3.2 THE RESEARCH DESIGN

3.2.1 Qualitative Method

The researcher has opted to employ a qualitative research design for this particular study. Johnson and Christensen (2012:33) maintain that qualitative research is used when little is known about a topic or phenomenon, and when one wants to discover or learn more about it. Since whoonga is a relatively new drug and very little is known about it, the researcher found the qualitative method more appropriate in order to be able to delve into the everyday lived experiences of the youth affected by the use of whoonga which will enhance my understanding of the drug and its effects on the identified users.

Gay, Mills and Airasian (2009:12) state that a qualitative method seeks to find a deeper understanding “about the way things are,” and the reasons why things are that way as well as
how participants in the context perceive those things. The qualitative research fits perfectly into the main purpose of this study, which is to find out the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. The study looked to discover the reasons why young people decide to use whoonga and how this affected their learning. The selection of a qualitative design in this study was based on the social learning theory as indicated in chapter one where various reasons for embarking on this study were spelled out.

Wiersma and Jurs (2009:232) advise that it is the perception of those being studied that are important, and to the extent possible, these perceptions are to be captured in order to obtain an accurate “measure” of reality. On the next page, the above mentioned authors continue to mention that meaning is perceived or experienced by those being studied; it is not imposed by the researcher. It is precisely for the above mentioned reasons that the researcher selected qualitative research as a method of investigation in this study. Participants were allowed enough space by the very nature of qualitative data collection strategies, namely, semi-structured and unstructured interviews, to explain and expand on their responses regarding how they perceive their life-world regarding being addicted to whoonga. Johnson and Christensen (2012:384) define life-world as an individual’s inner world of immediate experience. The above mentioned authors add that in other words, one’s life-world is in one’s mind. It is a combination of feelings, thoughts and self-awareness at any moment in time. In this way, qualitative research allowed each individual user to express his views as he perceives his life-world. The important reality is that, even though these young people are addicted to the same drug, their perceptions and views regarding their experiences with the drug were different. This discovery is in perfect line with Johnson and Christensen’s definition of life-world.

Gray (2011:164) mentions that the role of a qualitative researcher is to gain a deep, intense and holistic overview of the context under study. Qualitative research is a naturalistic approach that seeks to understand phenomena within their own context-specific settings, Gray (2011). The above observation further highlights the reason for the choice of qualitative method for this study. Each participant was given an opportunity through the interview sessions, to express and explain the effects of whoonga use in his learning in terms of his own reality and perceptions. People are unique individuals, including whoonga users. This means that their experiences, whether psychologically, emotionally or physically will be different.
Qualitative research catered for this uniqueness by affording each respondent an opportunity to state his case as he perceives it, as it is real to him.

3.3 THE RESEARCH APPROACH

3.3.1 Phenomenology

Phenomenology was used as the approach of choice for this particular study. Phenomenology asks about the meaning of an experience for the participants, (Gay, Mills and Airasian, 2009:13). According to Johnson and Christensen (2012:383), phenomenology refers to the description of one or more individuals’ consciousness and experience of a phenomenon.

The above statements clearly indicate why phenomenology was selected as the approach of choice for this particular study. The main purpose of this study was to investigate the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. Through conducting this study, the researcher wished to learn how whoonga use affected each user, what the common causes are, if any, for young people to use whoonga, as well as how in their opinion, they can be helped to do away with the habit. Phenomenology as a qualitative approach allowed the subjects to express their views regarding their experience with whoonga use. It allowed both elements of individuality (uniqueness) as well as those of commonality to emerge from their descriptions of their encounters with the use of whoonga. Johnson and Christensen (2012:385) confirm that phenomenological researchers do not generally assume that individuals are completely unique. They generally assume that there is some commonality in human experience, and they seek to understand this commonality. Johnson and Christensen further explain that this commonality of experience is called an essence, or invariant structure, of an experience. Indeed, there was a lot of commonality across the research participants regarding their experiences with whoonga use. There were also a lot of differences. Many of these commonalities emerged during the interview sessions, for example, in terms of how and why these young people use whoonga.

Gray (2011:171) is of the opinion that phenomenology seeks to understand the world from a participant’s point of view. Gray believes that this can only be achieved if the researcher “brackets out” their own perceptions. Johnson and Christensen (2012:384) explain that bracketing is to suspend one’s perceptions or learned feelings about a phenomenon. The
researcher had to keep this reality in mind when entering the field. This allowed the researcher to be free of any preconceived ideas about whoonga and be receptive to the information presented by respondents from their own perspectives regarding the effects of whoonga on their learning. Lodico, Spaulding and Voegtle (2010:38) point out that the role of the phenomenologist is to “give voice” to personal perspectives. Guided by the above observation, the researcher treated each experience of each participant as a separate entity and unique to the participant even though there were commonalities across participants. The reason is that the same phenomenon in the same environment can be perceived quite differently by different individuals, even if occurring at the same time. The reason for the difference in perception is that each individual brings a history of personal experiences, attitudes, behaviours, all of which influence how he/she views the shared experience, (Lodico, Spaulding and Voegtle, 2010:38).

Therefore, phenomenology as an approach suited this particular study to perfection. The researcher did not intend to spread the research to involve large numbers of participants from which to generalise findings. The researcher wished to do an in-depth study and transcribe the verbal accounts of the participants’ experiences as precisely as possible. Snider, as quoted by Suter (2012:344) observes that numbers impress, but unfortunately, also conceal far more than they reveal. For the above mentioned reason, the researcher believed that a few number of information-rich participants would enable the researcher to learn far more about the daily reality of learners who are affected by the use of whoonga, and whose learning is also negatively affected in different ways.

3.4 RESEARCH METHODOLOGY

In this study a number of data collection procedures were engaged in the attempt to find answers as to the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. All procedures the researcher followed in order to acquire the desired outcome are discussed below.

3.4.1 Site selection

This study focused on one high school in the area of Kwa-Dabeka Township. McMillan and Schumacher (2006:319) posit that researchers need to choose a site that will enable them to
“locate people involved in a particular event.” In choosing this particular high school, the researcher was aware that it is one of the schools in which the struggle against drug abuse is rampant. This means that the possibility to “locate” young people whose lives are ravaged by the use of whoonga was good. The researcher was determined to obtain facts about the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. The researcher targeted only one school because Kwa-Dabeka is a small township with only three high schools which are in close proximity to one another and learners from these three schools know one another well and experience the same problems in terms of drug use and abuse. So, from this standpoint, the researcher felt it would be redundant to do more than one school.

3.4.2 Sample and sampling

The centre of the study was to investigate the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. In order to achieve this goal, purposeful sampling was employed in this study. McMillan and Schumacher (2006:319) observe that the power and logic of purposeful sampling is that a few cases that are studied in depth generate many insights about the topic. For the above mentioned observation, purposeful sampling suited this particular study to perfection because only five learners were initially targeted as research participants for this study. On one of the days when an interview was supposed to take place, one of the participants withdrew, citing personal reasons. Since the participant had initially been made aware through a written letter and verbal explanation from the researcher that he was under no obligation to take part in the research process, the researcher had to respect the respondent’s wishes to pull out of the study process; as a result the interview session was cancelled. For this reason, the researcher was left with four participants who went through with all the research processes.

The Principal of the school referred the researcher to different class teachers who have learners with whoonga use problems. Altogether, the teachers gave the researcher eight names to choose from. The researcher picked the participants that met the criteria. These included:

- The voluntary acceptance by learners to participate in the study if they were of age (18 years and above).
- Parents’ or guardians’ permission, if applicable, to allow their child or ward to participate in the study, in the case of minor children.
• Learners who are currently using whoonga.
• Learners using whoonga could be either male or female.
• Learners had to be between the ages of fourteen and twenty two.

Learners who were considered as participants in the study were sampled for the sole reason that they were regarded as a data rich source that will best shed light on the common causes, if any, for young people to use whoonga. The researcher hoped that these key-rich informants would also shed light on how whoonga affect them as users, as well as what they think could be done to help them to do away with the habit. Below are biographical details of the participants.

### Table 1 Personal account of the participants

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Grade</th>
<th>Years of whoonga use</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Jabulani</td>
<td>Male</td>
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<td>10</td>
<td>5</td>
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<tr>
<td>2</td>
<td>Zamani</td>
<td>Male</td>
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<td>9</td>
<td>5</td>
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<td>Lucky</td>
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<td>18</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Sipho</td>
<td>Male</td>
<td>21</td>
<td>11</td>
<td>6</td>
</tr>
</tbody>
</table>

*Pseudonyms.

### 3.5 DATA COLLECTION METHODS

Rossman and Rallis (2012:4) report that data are images, sounds, words and numbers. The above mentioned authors further explain that qualitative researchers look for answers to their questions in the real world. To do this, the researchers gather information on what they see, hear and read. To Rossman and Rallis, qualitative researchers are “learners,” and qualitative inquiry provides the detailed and rich data for this learning process.

The above observation holds true for this particular study as well. The researcher used a combination of data collecting strategies in order to be able to record what the researcher saw, heard and read. The process of employing more than one data collecting method allowed for
triangulation. Denzin and Lincoln (2005) as quoted by Lodico et al (2010:34), mention that triangulation is when researchers engage more than one method of data collection in the same study and compare the results obtained through these multiple methods. They further add that triangulation adds thoroughness, richness and depth of understanding to the study. McMillan and Schumacher (2006:325) are of the opinion that in triangulation, different methods may generate different insights about the topic of interest and increase the credibility of findings. Therefore, bearing the above observation in mind, the researcher decided to employ interviews, using semi-structured and unstructured questions, as well as field observation to collect data from the participants.

Gray (2011:167) asserts that qualitative data are open to multiple interpretations. Flick (2006) as quoted by Gray (2011) points out that these interpretations can include the voices of those being studied as well as that of the researcher. After the collection of data, the researcher had to confer with individual participants to clarify any aspect that was unclear to the researcher. This allowed the researcher and each participant to arrive at the common interpretation of either what was said in the interview or what was observed during observation.

The researcher collected data within the month of June. The reason is that the searcher was given permission by the KwaZulu-Natal Department of Education to conduct the research specifically from the 1st of June 2013 onwards. June was a month of both learning and examinations at the school. This afforded the researcher the opportunity to collect data through observation during the learning periods in class as well as during the examinations.

### 3.5.1 Interviews

The researcher used interviews as one of the data collecting strategies. Rossman and Rallis (2012:176) posit that interviewing is the hallmark of qualitative research. May (2010:120) states that an interview is a method of generating conversations with people on a specific topic. The researcher applied a mixture of semi-structured and unstructured interviews in this study.
3.5.1.1 Semi-structured interviews

May (2010:123) advocates that the semi-structured interviews allow people to answer more on their own terms. McMillan and Schumacher (2006:204) reveal that semi-structured questions have no choices from which the respondent selects an answer. Since the researcher wished to learn about the effects of whoonga on the learning of affected youth through the perspective of the youth who are affected, the researcher felt that semi-structured interviews would allow the respondents to elaborate on particular questions if they wished to, using their own words. Another motivating factor in choosing the semi-structured interview is that the interviewer can seek both clarification and elaboration on the answers given (May 2010:123).

3.5.1.2 Unstructured interviews

The researcher also employed unstructured interviews in this study. McMillan and Schumacher (2006:204) advise that unstructured questions allow the interviewer great latitude in asking broad questions in whatever order that seems appropriate. The researcher was keen to make participants as relaxed as possible during the interview sessions so that they could take their time and ponder each question. This would allow them to answer as holistically as possible from their own perspective. The unstructured questions allowed the researcher that opportunity. Rossman and Rallis (2012:182) observe that the quality of an interview rests on the relevance of the questions and a researcher’s skill in asking follow-up questions. Unstructured questions enabled the researcher to ask for clarification on certain responses to ensure mutual understanding between the researcher and the respondent. May (2010:124) ascertain that an unstructured interview provides “qualitative depth” by enabling respondents to talk about the subject within their own frames of reference. In doing this, the meanings that individuals attribute to events and relationships are comprehended on the interviewee’s own terms. This therefore, provides a greater understanding of the participant’s point of view. For the above reasons, the unstructured questions were preferred by the researcher.

Both semi-structured and unstructured interviews were guided by open-ended questions with the support of an interview schedule. The schedule contained a list of questions seeking answers to the main question as well as the sub-questions as stipulated in chapter one. The questions were based on the learners’ use of whoonga and the overall effects it has on them, that is, socially, emotionally and physically but most importantly, how the use of whoonga
affect their schooling. McMillan and Schumacher (2006:204) note that an open-ended question is phrased to allow for individual responses but is fairly specific in its intent.

The interviews were scheduled for forty five to sixty minutes per session. All four participants who were interviewed were not comfortable with being interviewed in the school premises. This is because they are always at loggerhead with the teachers. The researcher then went to negotiate with a young man at the local municipal offices. The choice of this young man’s office was motivated by the fact that he is trusted by the young whoonga users because he sometimes takes them for counselling on drug use. Furthermore, he is a former learner at the very high school where the participants attend, so most of them know him, either through counselling or the fact that he went to the same school. In this way, they regard him as their trusted friend. This young man agreed to let the researcher use his office to conduct interviews at the local municipal offices. The interviews took place after the learners finished with their school programme from 16h00 to 17h00. It was a small office with a tiny desk and three chairs, one for the interviewer and two on the other side. The small office was full of pictures warning about the dangers of drug abuse.

One big advantage that the researcher later realised was that participants were genuinely more comfortable and relaxed in that particular office than they would have been in the school premises. The researcher could tell from their body language that they visited the office on regular basis and were quite familiar with the surroundings. This atmosphere of relaxation allowed the interview process to flow comfortably without the respondents getting agitated by the appearance of a teacher or fellow learner. Inside the safety of the familiar office, participants were comfortable enough to ask whatever question was on their mind. Their honest questions indicated earlier on to the researcher that most of them had serious problems with the issues of trust in fellow human beings, especially adults. This gave the researcher an opportunity to allay their fears and doubts at least as far as the study and their participation was concerned. The researcher used a tape recorder to record the interviews. This gave the researcher the opportunity to observe the respondents’ behaviour when they responded for example, facial expressions and body language. One of the participants flatly refused to be tape recorded during the interview. This further highlighted the deep-seated mistrust these young people have about adults. Below is a table showing the dates, recurrences as well as the length of the interviews.
Table 2  Date, recurrence and length of interviews

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Recurrence</th>
<th>Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Jabulani</td>
<td>4 June 2013</td>
<td>1</td>
<td>55 minutes</td>
</tr>
<tr>
<td>2 Zamani</td>
<td>10 June 2013</td>
<td>1</td>
<td>65 minutes</td>
</tr>
<tr>
<td>3 Lucky</td>
<td>14 June 2013</td>
<td>1</td>
<td>75 minutes</td>
</tr>
<tr>
<td>4 Sipho</td>
<td>20 June 2013</td>
<td>1</td>
<td>40 minutes</td>
</tr>
</tbody>
</table>

*Pseudonyms

3.5.2 Observation

Observation was another data collection strategy employed by the researcher. Lodico et al (2010:114) affirm that observation requires systematic and careful examination of the phenomena being studied. In this study, the phenomenon being studied was the effect of whoonga on the learning of affected youth in Kwa-Dabeka Township. The researcher used field observation. McMillan and Schumacher (2006:346) note that field observation is the technique that is used by the researcher to observe and record directly without interacting with participants. This type of observation fitted the researcher’s purpose as some of the observation was done in the classrooms during lessons, where the researcher could not disturb lessons by interacting with participants. The researcher also used low-inference observation. McMillan and Schumacher (2006:207) inform that low-inference observation require the observer to record specific behaviours without making judgements. Low-inference observation was in line with the purpose of the study. The researcher went to the field as a student who had come to learn how whoonga affected the learning of those learners using it, not as a knowledgeable person who had come to judge participants. The researcher used field notes from memory to record relevant information. This was done in an attempt not to draw attention to the researcher, which might result in participants changing their behaviour.

The researcher was afforded the opportunity by the school to go into class and observe how the participants coped with learning activities in class. The researcher wished to observe the behaviour of the respondents before and after they used whoonga. In other words, the researcher wanted to find out if the participants learned or concentrated better or worse in class before or after they used whoonga. This means that the researcher wished to observe the effects of withdrawal as well as the effects of whoonga use during the learning process.
The observation process took about two weeks to finish. The reason is that more often than not, participants did not enter the classroom at all. All they did was walk up and down the school corridors. When a teacher appeared, they would then run and hide in the toilets. So, most of the time, the researcher would come to do observation, only to discover that attending class was never in the participants plan during that period for whatever reason. Various teachers had warned the researcher that it was the order of the day for whoonga users not to attend class at all, sometimes from the first period to the last; sometimes they attend certain periods only, depending on what’s on their minds on a particular day.

The researcher had to define precisely what was to be observed as suggested by McMillan and Schumacher (2006:208) This process put the focus squarely on the phenomena to be observed so as to minimise deviation from the intended outcome. Schreiber (2011:11) states that a phenomenon is any discreet experience that can be articulated such as joy, death, friendship etc. In this study, this discreet phenomenon that was the target of investigation and articulation was the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. In this the researcher was guided by the research question which is, “What are the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township?” So the researcher had to observe the following:

1. Class attendance by learners using whoonga, that is, how regularly, how punctual.
2. Coping with classroom activities, that is, if learners are easily distracted or if they are the ones disrupting the learning process, if they are able to concentrate and follow the teacher’s instructions.
3. Physical, mental and emotional state of the participants in and out of a classroom situation.
4. Communication of participants with fellow learners, teachers and among themselves.
5. Non-verbal communication for example, facial expressions, body language and hand gestures.

The purpose of observation was to gather data on how the learners affected by the use of whoonga behaved at school, whether they were inside the classroom or out during break time. Even during the interview sessions, the researcher made observations. These included how long the respondent took to answer certain questions, which might mean hesitation or
reluctance to answer that particular question. Also, facial expressions and body language were observed as well.

### 3.6 DATA ANALYSIS

Below is a discussion of the way in which the data collected from interviews and observation were analysed. The intention of collecting this particular data was to answer the research question, “What are the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township?” McMillan and Schumacher (2006:364) allude that the qualitative data analysis is a systematic coding, categorising and interpreting data to provide explanations of a single phenomenon. Gay et al (2011:465) point out that in qualitative research, data analysis entails summarising data in a dependable and accurate manner, this leads to the presentation of study findings that generate undeniable results.

The researcher employed interim data analysis in this study. Johnson and Christensen (2012:517) refer to interim analysis as the cyclical process of collecting and analysing data during a single research study. The reason behind the selection of interim analysis was that the researcher wished to analyse data from the beginning in order that no important detail was left out at the end of the data collection. McMillan and Schumacher (2006:364) inform that the purpose of interim analysis is to make data collection decisions and also to identify recurring topics. Jonson and Christensen (2012:517) further state that qualitative researchers employ interim analysis in order to develop a successively deeper understanding of their research topic and to guide each round of data collection. Johnson and Christensen see this as strength of qualitative research.

In order to create an effective data analysis, the researcher followed the steps that are recommended by Gay et al (2011:468-469) as well as Johnson and Christensen (2012:520-522). These steps are:

- **Reading/Memoing**, which was to read and write memos about all field notes.
- **Describing**, which involved developing thorough and comprehensive descriptions of the participants, the setting and the phenomenon being studied, to convey the rich complexity of the research.
- **Transcription**, which was the process of transforming data (tape recordings of interviews) into typed text.
- **Segmenting**, which involved dividing data into meaningful, analytical units.
- **Coding**, which means marking segments of data with symbols, descriptive words or category names.
- **Interpretation** of individual instances and identification of patterns.

In this study, four participants were interviewed using the interview schedule. The transcribed data for each interviewee was awarded a code for anonymity purposes. The code appeared on the interview schedule. For instance, the researcher had four different codes representing the four participants and one for the researcher. The codes were LP1, LP2, LP3 and LP4. LP stands for Learner Participant. The researcher used R to represent the researcher. The researcher also used brackets around the segments of data to demarcate where each segment started and ended as recommended by Jonson and Christensen (2012:521).

The field notes that were written during classroom observation as well as during break time were analysed using line by line coding as advocated by Johnson and Christensen (2012:521). This particular strategy afforded the researcher the opportunity to go back and seek clarity from participants by asking questions regarding particular behaviours and actions observed at different settings. Observation schedules were used for both the classroom and playground settings. Data were analysed manually.

As a result of the coding process, the researcher was able to recognise the similarities and differences emanating from individual responses of the participants. This led to the development of new categories. The researcher also took direct quotations from the subjects’ responses. The researcher intended to use these quotations so as to improve the quality of the written report. When the transcription was completed and the codes were awarded to various units of meaning, the related codes were grouped into categories to construct themes. The data that was collected was used to guide the researcher to come to a conclusion as to what name should be given to each category. To give an example, in this particular study, new categories such as “trust issues, survival mechanisms, parent/guardian involvement” developed. These topics were not part of the study focus but emerged from the responses that participants put
forward from their perspective. Participants regard these as either negative contributors to whoonga use or lacking in the effort to curb the spread of whoonga use among young people.

3.7 VALIDITY AND RELIABILITY (TRUSTWORTHINESS)

Guion, Diehl and McDonald (2011) believe that validity, in qualitative research, speaks of whether the findings of a study are true and certain, “true” in the sense that research findings accurately reflect the situation, and “certain” in the sense that research findings are supported by evidence. Cohen and Crabtree (2008:334) reason that understanding the concept of validity requires understanding beliefs about the nature of reality. Reliability refers to the degree to which an assessment consistently measures the phenomenon it is measuring. In other words, reliability refers to the ability of research to replicate observations.

To enhance validity and reliability, the researcher employed multi method strategies, low-inference descriptors, member checking as well as participant review, as recommended by McMillan and Schumacher (2006:326). The multi method strategies, sometimes termed triangulation, helped to yield different insights into the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. It also rendered the research project more credible. Low-inference descriptors means that the researcher used almost literal descriptions and that any important terms were those used and understood by the participants. Member checking allowed the researcher to confirm observations through casual conversations, for example, in the playground during break time. Lastly, the participant review strategy was instrumental in clarifying any misunderstanding that had occurred during in-depth interviews. The researcher asked participants to modify any information from the interview data for accuracy purposes. The researcher employed all the above strategies bearing in mind the observation by Cohen and Crabtree (2008:334) that an important dimension of good qualitative research is plausibility and accuracy.

3.8 ETHICAL CONSIDERATION

This study considered the following considerations as recommended by Taylor (2008).
• Informed consent

The researcher wrote letters seeking permission to conduct research from the KwaZulu-Natal Department of Education, the principal of the school where the researcher intended, to conduct the research, the parents/guardians in cases of minor children, learners (18 years and above), who agreed to participate in the study. The Department of Education responded by writing a letter allowing the researcher to conduct the research. The principal also responded by a written letter. The participants responded by signing the consent forms, to confirm their willingness to participate in the study. All participants were informed about the overall purpose of the study.

• Honesty and truth

The researcher did not deceive participants in anyway. Participants were told the truth about all the activities regarding the research. This was done prior to the commencement of the study.

• Privacy, Confidentiality and Anonymity.

Regarding privacy, the researcher did not give any third party access to sensitive information she had acquired during the research. In terms of confidentiality, the researcher honoured the agreements she had made with the participants regarding what would be done with the data, that is, the data was used solely for the purpose of research. In terms of anonymity, the researcher protected the identities of participants by using pseudonyms instead of their real names.

• Reciprocity

The researcher provided feedback to the participants from time to time. The researcher took extra care that reciprocity occurred within the constraints of research and personal ethics. The researcher always maintained her role as an investigator.
This chapter discussed the research methods and approaches that were employed when embarking on the journey to discover the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. The rationale behind the selection of these methods and approaches was given. The strategies that were employed for data collection, as well as the reasons for using such strategies were explained. The research methodology and design that were selected for this study were significant for the purpose of research in the sense that data that were collected were able to address the research questions of the study. The researcher was able to acquire understanding and experiences of the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township.

In Chapter Four an attempt is made to give meaning to the data collected in Chapter Three. This is important as it allows the researcher to determine whether the problem identified in Chapter One, addressed theoretically in Chapter Two through the reviewed literature and scrutinized further by collecting data form respondents in Chapter Three is indeed genuine, researchable and scientific.
CHAPTER FOUR
RESEARCH FINDINGS AND DISCUSSION

4.1 INTRODUCTION

In this chapter an attempt is made to analyse and interpret the data that was gathered through the use of interviews and observations. The analysis is done in the form of discussions and interpretations of the participants’ responses regarding the effects of whoonga on their learning.

The researcher’s preconceptions are briefly discussed. The profile of the participants as well as their accounts regarding their personal experiences with whoonga, are explained in detail. The observation conducted by the researcher is also discussed. The findings of the research as well as discussion are outlined.

Phenomenology, as the approach of choice for this particular study, allowed the researcher to understand and record the social and psychological perspectives of the participants. Through interviews and observation, the researcher attempted to capture the “essence” of the participants’ experiences by describing with great care, the personal experiences of all four participants in the study (Lodico et al 2010:37).

4.2 THE RESEARCHER’S PERCEPTIONS AND VIEWS REGARDING THE USE OF WHOONGA

The researcher has consulted various theoretical explanations, perceptions and views with regard to drug addiction, including the addiction disease theory, the psychological theory as well as the subculture, social and cultural support perspective. This was done in the hope to acquire clarity in terms of drug addiction.

From the above theories, the researcher could not find sufficient explanation with regard to drug addiction, that is, why do so many people choose to use drugs and sometimes never stop until it kills them.
The researcher believed that drug addiction was the same for every user, as long as addicts were hooked on the same drug. In other words, whoonga users, according to the researcher’s beliefs, perceived the experience of addiction in exactly the same way.

The researcher was also of the opinion that whoonga killed its users within a few months of use. The researcher regarded whoonga use as a form of committing suicide.

The researcher saw the solution to stop whoonga use as lying in the hands of users themselves who, according to the researcher’s views, could wake up one morning and decide to call it a day, and then move on with their lives as if nothing has happened.

It was difficult for the researcher to comprehend a situation where the addicts could not be able to make a “simple” decision to find alternative ways to cope with their whoonga addiction. According to the researcher’s perception, whoonga addicts had an easy option to stop using whoonga as soon as they wanted, even after getting hooked.

The researcher was always baffled by the fact that whoonga addicts would continue to use it even after they had witnessed their friends die before their very own eyes. The researcher marvelled at the determination of whoonga addicts to destroy their lives, when, in the eyes of the researcher, they could choose the safety of a drug-free life.

The researcher saw the selfish and uncaring nature which she regarded as inherent among whoonga users. This view was prompted by the fact that whoonga addicts must surely realise how they were hurting their own families in the process but chose to selfishly indulge in whoonga use in the pursuit of the famous euphoria. Many of the addicts have lost the valued trust and relationships of friends and family, yet selfishly they persist in using whoonga.

To allow the research to proceed without the interference of the researcher’s perceptions, all the existing preconceptions that the researcher had were suspended (or bracketed) as Johnson and Christensen (2012: 384) suggest. The phenomenological approach that was employed in the study afforded the researcher the opportunity to obtain a view into the participants’ life-worlds and to understand their personal meanings constructed from their lived experiences (Johnson and Christensen 2012:384).
Throughout the interviews and observations, the researcher was aware of the preconceived ideas, but never, at any point of conducting the study, allowed these views to affect the procedure and direction which the interviews and observation would take. The interviews were transcribed exactly as the participants had relayed them to the researcher, with the help of a tape recorder. The behaviour that was recorded from observations was recorded as it was observed; it was never interpreted in any way. The researcher had to consult with individual participants from time to time, to clarify any behaviour or response by participants.

4.3 THE PROFILE OF THE PARTICIPANTS

The participants in this study were four learners from a particular high school in Kwa-Dabeka Township. The participants’ ages ranged from 18-21. The participants were in different grades, ranging from grade 9-11. All participants are currently hooked on whoonga. The research was conducted in June 2013. The identities of the participants were not revealed throughout the research process to maintain anonymity as required by the research ethics. For this reason, the researcher used pseudonyms for all participants.

The following paragraphs and sections discuss the process and interaction during the interviews with different participants. Interview responses, class and playground observations are also discussed and interpreted. The verbatim accounts of the respondents are presented in italics to differentiate between the respondents’ and the researcher’s accounts.

4.3.1 Jabulani.

4.3.1.1 Process and interaction during the interview

Jabulani is twenty years old and in grade ten. He lives with his father and stepmother. He has been to rehabilitation clinics twice in his five years of whoonga use. Jabulani is very soft spoken and a little bit shy.

Jabulani was willing to share his experiences with whoonga in the hope that it might help shed light on the reality of whoonga use. In sharing his story, Jabulani also hoped to deter the young children who have not yet started using whoonga not to even think about using it.
4.3.1.2 Jabulani’s account of events

Jabulani was introduced to whoonga by a schoolmate. At the tender age of fifteen, Jabulani realised that he was becoming a heavy alcohol drinker and he wanted to stop the habit. He decided to substitute alcohol with a drug, any drug because he thought that would be better than alcohol, so a friend introduced him to whoonga.

- **Ignorance**

  “When I first started using whoonga, I didn’t know anything about the ill effects and how difficult it would be to stop.”

Jabulani felt at the beginning of his smoking that it was heavenly; whoonga took away all his pain, both physically and emotionally. He really believed he had found the answer to all his problems.

  “When I started getting stomach cramps, I told my friends, they advised me to take more whoonga to stop or numb the pain thus began the cycle of addiction.”

To feed his habit, Jabulani has to steal items from home. He also does shoplifting. Jabulani, like many other addicts, has sold all his belongings, especially clothes. As he comes from a well-to-do family, he has sold his expensive cell phones and laptops as well. He still has dreams for the future, so he doesn’t want to do heavy crime that will spoil his name and jeopardise any opportunity for him to become someone in the future. The desperation to get the next fix pushes him to lie and cheat.

- **Paranoia.**

  “If I don’t smoke, I feel like someone is going to come after me with a gun and shoot me for not smoking. I feel very anxious, as if I’m in big trouble.”

He also gets terrible stomach cramps which send him running back to whoonga dealers for the next fix.
Jabulani uses whoonga in one day as many times as his money will allow him. As long as there is still money in his pocket, he will go and buy more whoonga. The average amount he spends per day is one hundred and fifty rand, but if he has more money, he will buy whoonga until all the money is finished. Whoonga sells for twenty five rand or thirty rand a dose. He uses whoonga five times a day on average. There is no time of the day when he could say “no” to whoonga use.

**Effects**

Whoonga has affected Jabulani’s learning in a negative way. He simply cannot concentrate on his schoolwork, whether he is high or not. When he suffers from cravings, he cannot concentrate because the only thing he can think about is getting the next dose of whoonga. In this way, he finds himself not listening to anything the teacher is saying. Similarly, when he is high, his mind is very cloudy, and he feels very sleepy, and in fact sleeps right through the lessons most of the time. As a result he finds it extremely difficult to concentrate because his ability to focus on anything is being hampered by whoonga use. For this reason, many a times he finds himself not being able to go to school because school is the last thing on his mind anyway. He can’t remember anything he learned the previous day, let alone the previous week. As a result, he gets very frustrated and angry at everyone.

**Challenges**

As a result of his whoonga use, Jabulani has encountered a number of difficulties at home, school and the community at large. Due to stealing in order to feed his habit, he has been sent away from home on several occasions. He has sometimes found himself living with relatives, from whom he ended up stealing their belongings as well and got chased away. He sometimes goes to stay with his friends’ families, and gets sent away as well because he can’t stop stealing to feed his habit. Sometimes he finds that he has to run away from home because he has stolen from so many people and now people want him to pay back whatever he has stolen.

**The biggest loss ever.**

Jabulani feels that the worst part of it all is the loss of trust from his loved ones.
“The worst feeling for me is the loss of trust. My parents, my friends, the teachers and the community at large don’t trust me anymore, and with good reason. This is very hard for me because sometimes I do want to communicate with them, but they want nothing to do with me.”

He feels he has lost what he terms “true friends” because of using whoonga. Jabulani doesn’t see how he could ever get his friends’ and parents’ trust back. To him that is the biggest price he has paid for using whoonga.

• School performance

Jabulani describes himself as an intelligent individual. Before he started using whoonga, he used to get seventy to eighty five percent in most of his tests and exams. Now his performance is very low at school. He usually gets very low marks and many a times, fails the term or year. This is the reason why he is twenty years old and still in grade ten. He realises that other young people his age are at a tertiary level, which also adds to his loss of hope for a brighter future. Jabulani attributes the low marks to the fact that he is unable to concentrate on what is being learned in class, whether he is high or not. He can hardly remember what was said on that very morning, let alone the work for the whole term. He admits that assignments and projects are the most difficult because he just sits and stares at whatever topic is in front of him without the slightest idea of what he needs to do. This has resulted in him not handing in most of his work for assessment, resulting in him getting low marks or failure at the end of the year.

• Parents involvement

Jabulani believes that parents should play a more active role in the lives of their children.

“My stepmother realised very early on that I was using drugs but she never said or did anything about it. My father discovered very late about my drug habit. He then tried to talk to me but by then it was already too late because I was already hooked.”
Jabulani believes that the best way to try and help the youth to do away with the habit is by involving them in sport as well as creating jobs for them.

“I once found a summer job at a supermarket. I found my mind occupied by the job and the colleagues who were always talking about constructive things. During that period I smoked far less and whoonga did not occupy my mind from morning to sunset.”

Jabulani also believes that prevention campaigns targeting the young children who have not yet started using whoonga would go a long way in preventing the youth from the fate he suffered as a result of ignorance.

“If anyone had informed me of the dangers and consequences of using whoonga before I started using it, I would not be in the situation I find myself in right now.”

Jabulani believes that whoonga is a disease that spreads quicker than any virus. He has seen parks full of people who smoke whoonga. In his opinion, no other drug is like that. He has observed that some of these parks are full of Tanzanians. These Tanzanians tell them that whoonga is legal in Tanzania, many people smoke it, just like many people smoke dagga in South Africa. Jabulani believes that whoonga is going to spread HIV/AIDS like wildfire. This is because he sees young girls who are fellow whoonga addicts prostitute themselves in order to acquire money to buy whoonga. He wants to stop and start a new life but finds it extremely difficult. He also realises that the company one keeps has a huge influence on whether one recovers or relapses several times.

4.3.2 Zamani

4.3.2.1 Process and interaction during the interview

Zamani is nineteen years old and in grade nine. At home he lives with his father and stepmother. He was eager to tell his story.
“I want to hear myself talking about myself, maybe I will get a better understanding of what my life really is.”

He then laughed briefly and told the researcher the reason why he had just made the above statement.

“As a drug addict, there is never time for me to stop and think about my life, or put things into perspective. Now that you have given me this opportunity, I want to release the emotional pressure by saying it all aloud.”

Then he began his description of his life.

4.3.2.2 Zamani’s account of events

Zamani first learned about whoonga when he was fourteen years of age.

“I used to scold my friends who were using whoonga, telling them to stop the bad habit. As time went on, I found myself getting more curious than ever to find out what it was that made my friends so carefree after using whoonga.”

Then a friend introduced him to it, telling that all his worries and problems would disappear after he used whoonga. Zamani had been using marijuana since he was ten years old and it no longer had much effect on him. The reason why he decided to try whoonga was that he wanted to experience more high than he was presently getting from dagga. Zamani was not aware of the side effects of using whoonga at the time he started using it, but soon discovered the hard way. He suffered crippling stomach cramps, but by then it was too late to stop.

Zamani uses whoonga five or six times a day on average, depending on the availability of the money in his possession. The more money he has, the more doses he gets per day. The dose amount varies from twenty five rand to fifty rand in the area where he lives. To feed his habit, Zamani resorts to stealing, shoplifting and robbing people. This has landed him in jail more than once in his young life. But going to jail has not stopped him from using whoonga. To him, the need to use whoonga is greater than the fear to go to jail. Zamani has stolen and sold
many items from his household, as well as selling his own clothes to feed his habit. He admits that if he doesn’t smoke, he becomes extremely miserable with the crippling stomach cramps. Most of the time, he does not even feel well enough to attend classes, whether he has used whoonga or not.

- **Effects**

Zamani acknowledges that whoonga has affected his ability to learn in many different ways, all negative. Physically, he is never fit enough to enjoy a normal day at school. This is because there are many activities at school that require physical strength like sport.

> “I can hardly drag myself out of bed in the morning, my body is so tired and aching that all I think about is how to get money for the next fix. The very last thing on my mind is school and school projects.”

Academically, the biggest problem he encounters is lack of concentration. No matter how he tries, he simply cannot focus on what is being learned in class. No matter how hard he desperately he tries, he cannot remember what was learned in the morning or the day before, let alone a week before. This result in him losing interest in school and everything that comes with it. As a result, he is absent from school most of the time, and misses a lot of lessons. Inevitably, he lags behind, does poorly in tests and exams and fails at the end of the year. If he is present at school, more often than not, he will leave school early in pursuit of whoonga or money to buy it. Sometimes he goes to school with the sole purpose of smoking whoonga with his friends and never attends a single lesson from morning until the end of the school hours. All he thinks about all day is whoonga and how to acquire money to buy more whoonga. Like many of his fellow addicts, school is the last thing on his mind.

- **Low self-esteem.**

Zamani admits he no longer enjoys school because most of the time he is paranoid.

> “I feel like everybody is looking at me and judging me because of my habit. I know that this is probably not true but I can’t help feeling this way.”
This attitude has isolated him from many fellow learners. The feeling of isolation is just as painful as the feeling of trying to get together with fellow learners. This leaves him feeling extremely frustrated and emotionally lost. He does not know what to do about the whole situation, and his solution, he stays home many a times and not attend school.

**Challenges.**

Zamani has faced many challenges at school, home and with the community at large. At school he feels like he is being treated like a pariah because of his habit. Teachers don’t trust him and neither do his fellow learners. He feels like an outcast each time he sets foot in the school. At the home front, his parents have chased him away from home on many occasions. He does not have many relatives or friends. The few he has, he has stolen from them and got chased out of their houses as well.

Zamani has lived on the street more than once in young life.

“When you live on the street, you have to be street smart.”

When the researcher enquired what he meant by “street smart,” Zamani explained:

“On the street, one has to be very careful not to step on anyone’s toes by sleeping or occupying someone else’s territory. If one does that by mistake, a huge fight can ensue and that’s not what one needs on the street. One needs to make friends so that one is looked after by fellow street dwellers.”

Regarding his standing in the community, Zamani admits the community has sent him to prison on several occasions for housebreakings and petty theft. Instead of learning from his mistakes after being arrested, in jail he learns how he should have done whatever he did better so as not to get arrested. In other words, he learns how to commit crime better. On a personal note, Zamani has lost many friends because of his addiction to whoonga. He admits though, that the most painful and difficult loss of all is that of trust between him and the people he loves, top of that list is his family and friends.


- **School performance.**

Describing his performance at school, Zamani admits that since using whoonga, he has repeated each and every grade he has done and this has resulted in him getting left behind by his peers, so many of whom are at a tertiary level by now. Most of the time his marks are among the lowest in class, obviously due to his inability to concentrate in class as well as his constant absence from school. He also admits that more often than not, he does not give his report to his parents because he is ashamed of his poor performance in school.

Responding to what he thinks would help him to do away with the habit, Zamani confessed that he would like to be far away from his present friends. He hopes that by moving away he will get an opportunity to start a new life with different people who lead a healthy lifestyle.

> “I believe the best place to start is a rehabilitation centre. That will give me an opportunity to clear my mind and body of whoonga and be able to really focus on a new beginning. If I ever get an opportunity like that, I promise I will never look back.”

The most unfortunate part of the above confession though, is that rehabilitation centres are extremely expensive, Zamani’s parents are poor and cannot afford the exorbitant fees charged at rehab centres. This means that he is stuck where he is right now with his uncomfortable drug habit devouring him physically and emotionally. Zamani believes that parents should start at an early age to talk to their children about drugs and drug use. He laments the fact that neither his father nor stepmother ever said anything to him about drugs.

> “If my parents had said something to me about the dangers of drugs and drug use earlier on in my life, I would have been more aware of what was going on around and thus would have responded differently to peer pressure.”

Zamani also believes that if he can involve himself in sport of whatever nature, he can gradually kick the habit of whoonga use, as his mind would be more occupied with sport and less anxious about how to get the next fix.
• **A bitter experience on the street**

Zamani wanted to share a piece of information with the researcher, the incident when he was admitted to hospital for two weeks.

> “I felt the stomach cramps one day. I never thought much of it, believing that it was only the withdrawal symptom as usual. I then went to my usual hangout place and bought a dose of whoonga.”

He then smoked it with the hope of numbing whatever physical pain he was experiencing. To his surprise, the pain did not go away this time, instead it became worse.

> “The worst part of it is that it was during one of the times when I lived on the street. I lay on the street for hours with the excruciating pain until one fellow street dweller realised that something was wrong with me and took me to hospital. The doctors told me that my intestines were blocked and twisted.”

He was immediately taken to surgery to perform an emergency operation, and he survived. Zamani is one of the lucky few. Many of these whoonga users do not survive the twisted intestine ordeal, and pass on. Zamani has seen many of his fellow whoonga addicts die right in front of his very own eyes. The sad reality though, is that Zamani is still using whoonga even today.

4.3.3 **Lucky**

4.3.3.1 Process and interaction during the interview

Lucky is a talkative young fellow. He is eighteen years old and in grade ten. He was very happy to share his experiences with the researcher. He told the researcher that he regarded the office that was used for the interview as his second home because he spent a lot of time in it, during counselling sessions.
Lucky has lived with his father ever since he was a year old, after his mother passed away. His father got married just three years ago. Now he lives with his father and stepmother. Lucky considers himself as having had a good upbringing. His father did everything for him. He felt really loved and cared for as a young child. Then things fell apart.

4.3.3.2 Lucy’s account of events

Lucky first learned about whoonga at age fourteen. By that age he was already smoking cannabis. Lucky went to visit his maternal grandmother during one of the school holidays. When he arrived, he joined a group of friends. Lucky refers to his new found friends as a mixed group. When the researcher enquired what he meant by a “mixed group,” Lucky explained:

“I mean people smoked many different kinds of drugs, including whoonga”

Lucky continued to buy marijuana from a merchant who was also part of the group. The merchant befriended him and all was well in his world. It so happened that the merchant ran out of marijuana and had to buy it in bulk somewhere, but it took a few days for the merchant to return.

“I waited patiently for the merchant to return because I had no serious cravings at the time.”

The merchant then came back and Lucky continued to enjoy his daily dose of dagga. When the holidays drew to an end, most of cannabis smokers went back to wherever they had come from. Lucky was now left with only whoonga, heroin and crack cocaine users.

“One of the whoonga smokers urged me to try it and see how I felt. I guess peer pressure set in because I agreed to try it. I took two drags with the other smokers but didn’t feel anything.”

Lucky continued to smoke whoonga and within a week he was hooked. He was then surprised to find that when he smoked marijuana, it no longer made him high. He was then suffering from withdrawals. That was four years ago and he has not been able to break the habit.
Lucky uses whoonga seven or eight times a day on average. He supports his habit by stealing from home, neighbours as well as shoplifting. At home he began by stealing those items that are not in everyday use, like tools. He also lies a lot to the neighbours, like telling a neighbour one day that his grandmother was in hospital and he needed money to go visit her. He also steals from his friends.

- **Effects.**

Lucky admits that the use of whoonga has affected his learning very badly. He acknowledges that it is very difficult for him to balance school, friend and smoking. He hardly ever goes to school, and when he does, he attends only morning classes and after break he is gone in search of the next fix.

“The reason I wake up at all in the morning is because of the cravings and not because of any desire to go to school.”

Sometimes when he goes to school, his sole purpose is to sell some of his clothes to those learners who can afford them. He is usually seen on the school premises but not in class. When exams come, sometimes he sits for exams, and other times he time he just runs away because he has nothing to write. As a result, he is in a lower grade than his age group. To make matters worse, whoonga merchants are fellow learners at school, which makes easily accessible at school at any hour of the school day.

- **Challenges.**

Regarding the challenges he has encountered since he started smoking whoonga, Lucky admits it has destroyed many things and opportunities for him. He has lost the trust of his parents. His father has sent him away on more than one occasion. Sometimes he went to live at a friend’s house. The trouble is that his friend is also a drug addict, and together they stole things from the house and he got sent away as well.

“I have spent some nights on the street. One night I went to school to ask permission from the night guard to spend the night on the school veranda or
corridor, so that I could feel safe, but knowing my drug problem, the guard chased me away.”

Lucky has lost many friends to whoonga use. He has also had a traumatic experience of witnessing some of his friends die right before his very eyes due to whoonga use. Lucky regards whoonga as the worst drug of all. He observes that a whoonga addict is unable to bath or even brush his teeth, let alone clean the place where he lives.

- **School performance.**

Lucky describes his performance at school as very disappointing. Usually, he performs better during the first term of each year. The reason behind this performance is that he vows to himself to attend school and do better at the beginning of each year. So, he tries hard and usually gets good marks. As the merchants on the school grounds continue to sell whoonga and peer pressure overcomes him, school marks begin to get lower and lower until he fails at the end of the year. By then, he usually attends class three or four times a month, because then school is the last thing on his mind.

“Factions don’t allow me to attend classes. When they see me going to class, they tempt me by telling me where they are going right then to get the next fix. I then feel like I am going to lose out on a lot, and finally give in and join them.”

Lucky believes what may help him do away with the habit is if he can develop trust in himself that he can do it.

“The biggest enemy to many drug addicts, including me, is that we lie to ourselves. I need to stop lying to myself.”

He admits he would like to teach himself to stop. He believes all he needs is willpower. Lucky does not trust rehabilitation centres. He believes they are full of lies and corruption. He claims he has seen people who work at rehab centres selling drugs to addicts right inside these centres. He does believe in medication though.
Lucky would like to associate himself with friends who do not use whoonga as he believes that would encourage him to stop. Loneliness is also one of his biggest enemies.

“I would like to avoid a situation where I’m alone most of the time. That is the worst time where my mind start playing games with me. I start thinking about a lot of dangerous activities to embark on.”

On a general note, Lucky wishes he could go on awareness campaigns to try and save those youngsters who have not yet started using whoonga from the fate he suffered due to his ignorance and peer pressure.

4.3.4 Sipho

4.3.4.1 Process and interaction during the interview.

Sipho has a profound distrust of people, especially adults. He sincerely believes they are fundamentally dishonest and unreliable. Sipho flatly refused to be tape recorded during the interview session. He told the researcher that he simply did not believe the story about using the information for the purpose of research only. The researcher had to respect Sipho’s wishes to be interviewed without a tape recorder. Then Sipho explained to the researcher why he finds it very difficult to trust people, especially adults. As far as he is concerned, he has experienced nothing but betrayal at the hands of adults, and suffered severely, and worst of all, the people who hurt him most were the ones who were supposed to protect him.

Sipho feels he was abandoned by his own mother during the early years of his life. This caused him to be brought up by his father and paternal grandmother. Asked by the researcher to elaborate on his “abandonment” perspective that he was referring to, Sipho explained:

“My mother had me when she was nineteen and not married. She then left me with my father when I was a year old so that she could go to university to study. When she came back from the university, having completed her studies and working, she never bothered to take me back so that I could live with her, to me, that is pure abandonment.”
Despite his disappointing encounters with adults, Sipho was willing to share his experiences of whoonga use with the researcher. He wanted other young people to know and avoid doing the same mistakes he did.

4.3.4.2 Sipho’s account of events.

Sipho grew up with his father as mentioned above. He only came to live with his mother when he was fifteen years of age. Since his parents were not married, he left his father behind, and missed him and his paternal grandmother terribly.

When Sipho arrived to live with his mother, he found that his uncle on his mother’s side was also living there. Sipho was initially happy at the thought of living with a male figure, in the hope that somehow his uncle would represent the father he had left behind. But soon that hope was bitterly dashed. Not only was his uncle not going to represent a father figure to Sipho, but his uncle was a drug dealer, selling drugs to the local people.

At this point in time, Sipho did not know much about drugs, he had only heard about them, and actually had never seen them before. When the schools re-opened, Sipho’s uncle gave him some drugs, taught him which drug was which, and instructed him to sell these drugs at school. Sipho was too stunned and afraid to report the matter to his mother, who was not aware of what had happened. Sipho didn’t know how to refuse, so he took the drugs to school to sell. He kept quiet about it for fear it would cause a huge family fight and break up.

Sipho did not immediately smoke whoonga, he just sold it as he was instructed by his uncle. Being a newcomer at school, he quickly gained popularity among drug users. He was regarded as one of the “clever guys” in school and was “respected” by many because of the crowd he mixed with at school. Flattered by the attention he received, and eager to fit in with the crowd, peer pressure set in and he tried whoonga for the first time three months later.

“The main reason I tried whoonga was curiosity and peer pressure. I initially smoked whoonga twice a day. I did not experience bad withdrawals at the time, just mild discomfort now and then.”
As he increased the dose of whoonga, then real pains and stomach cramps set in. He now uses whoonga more than six times a day

- **More abandonment.**

When he was seventeen years of age, Sipho’s father passed away. Sipho took his father’s passing as another form of abandonment, a confirmation of the “untrustworthiness” of the adult population. Sipho began to seriously wonder why people closest to him were “determined” to hurt him so badly. At this point in his life, Sipho is still very angry at his father for passing away. His father has now “abandoned” him, just like his mother did earlier on in his life. His uncle destroyed his life by introducing him to drugs, including whoonga. As far as he sees things, nothing lasts in his life. This makes it hard for him even to form long lasting friendships. As a result, Sipho is a very bitter young man.

“What is it that is so disgusting in me that no one wants to be around me? Why would anyone want to be with me when my own parents won’t anyway?”

He asked, with tears welling up in his eyes, the question directed more to himself than to the researcher.

Sipho reveals he supports his habit by using bus fare money to buy whoonga. He hides from his parents and neighbours during the day so that they don’t realise that he never took the bus to school. He also sacrifices his lunch money so that he and his friends can put together the right amount to buy the next dose of whoonga. During weekends there is no bus fare and lunch money from parents, so he goes around stealing whatever he can lay his hands on, including robbing the vulnerable elderly people. If he happens to come to school on a particular day, Sipho bullies younger learners and takes away their lunch money. They don’t report him to teachers because they are terrified of him. This situation allows him to bully them over and over again without any fear of getting punished himself.

- **Effects.**

Sipho admits that whoonga has had a very negative effect on his learning.
“I no longer feel comfortable in the company of other learners, especially those who don’t use drugs. I hate the way they look normal and seem not to have a care in the world. I resent the fact that I can’t keep up with them regarding school work.”

This reality makes him want to run away from school, and he does, hence the long absences from school.

“With whoonga, there is no time to feel better. When I’m in class and haven’t smoked, I’m so restless and can’t concentrate on what is being learned.”

This feeling makes him leave the lesson in search of the next dose of whoonga.

“When I have smoked, I come back to class to continue with my lessons, only to discover that now I’m too drowsy to understand anything the teacher says. So all I do is sleep right through the lessons.”

The realisation of this “no win” situation he finds himself in, forces Sipho to face the fact that he no longer belongs in the classroom, whether he is sober or not.

- Challenges.

The most painful challenge Sipho has encountered, is the loss of trust from loved ones. He admits no one believes a word that comes out of his mouth. Although he knows that his family and friends are justified in feeling the way they do about his habit, he accepts that it is still painful. He has no idea how to rebuild their trust back again at this present moment. He is grateful that his mother still sends him on errands sometimes, and gives him money to pay for those errands.

“I usually try very hard to bring the change back to my mom, but sometimes it’s really hard, especially when I’m suffering from withdrawals, so I don’t always bring back the change, betraying the little trust that still exist in my mother, and that is really painful.”
Sipho admits he has a lot of debt in his neighbourhood because he borrows money almost from every neighbour, using his mother’s name as the person who sent him to borrow money.

- **School performance.**

Describing his performance at school, Sipho admits it is far below his capabilities. He describes himself as a naturally very intelligent person. He used to get As and Bs before he used whoonga, but now he fails dismally most of the time. The main reason for his failure is his inability to concentrate in class, coupled with long absences from school, thus missing a lot of schoolwork.

“Whoonga has changed even my personality. I was once a happy and carefree person, and now I have mood swings.”

Sipho is aware that he has no control over his mood swings at all, which makes it further difficult for any class mate who wishes to help him out with school work to stand those mood swings. He reveals that sometimes he can’t remember his own name, let alone what he learned at school.

“Sometimes when I look in the mirror, I don’t recognise myself because I can’t remember what I look like. In the mirror I just see someone else.”

Responding to what he believes would help him to stop the habit of using whoonga, Sipho says the most important thing would be the will to stop. He admits that without the will to stop, no amount of help from anyone could ever work. He believes the key to stop lies with the individual addict. He also believes the support from family and friends can go a long way in encouraging the drug user to find the courage within himself to stop. He would like to move away from his old friends and find new friends and new environment. He believes that friends with healthy habits may help him develop healthy habits as well and stop using whoonga. Sipho believes he needs something to do to occupy his mind, like sport, so that he has little or no time to think about whoonga.
4.4 OBSERVATION

The main purpose of observation was to observe the behaviour of the participants before and after they used whoonga. In other words, the researcher wanted to observe the effects of withdrawal symptoms as well as the effects of whoonga use in the classroom learning situation as well as out during break time. The researcher wanted to observe how the participants behaved in and out of the classroom, how they communicated with fellow learners in and out of the classroom.

Observations were conducted by the researcher during the month of June 2013. June was a month of both learning and examinations. This afforded the researcher an opportunity to observe the participants in their classrooms during lessons, in the school yard during breaks, as well as during the serious period of writing examinations.

- In the classroom:
- Before break

All participants showed signs of restlessness in the morning before break time. They used to stand and move around the classroom regularly. They would finally move in and out of the classroom frequently, which resulted in them missing out on a lot of what was being learnt in class. Most of the participants were very short tempered in the morning. The researcher observed that many fellow learners stayed clear of the participants when they were suffering from withdrawal symptoms in order to avoid any encounter with them.

The researcher observed that there was a lot of bullying going around in the classroom. Most of the time, participants didn’t ask or borrow things from fellow learners, they just took them, used them, and when they were through, gave them back without even thanking the rightful owners of those items. These were items such as calculators, mathematical instruments and even pens. In a one hour lesson, Jabulani attended for only fifteen minutes. The rest of the time he was walking up and down the corridors, getting in and out of the classroom, disturbing the lesson because the teacher had to stop the lesson and call him to order on more than one occasion. Outside in the corridor, when a teacher appeared, Jabulani would run and hide in the toilets.
One of the days during classroom observation, a student teacher was in class, teaching. When she was through with her lesson, she gave learners the class work to do. This was Lucky’s class. He had been very agitated throughout the whole lesson and not listening to a single word the teacher was saying. So, when the work was given, he had no idea what was required. He kept on copying the work from his desk mate. The teacher saw him and then went to tell him to stop copying and do his own work. Lucky became very angry, stood up and hit the young student teacher right on her face with a fist, and then left the classroom. This happened in full view of other learners who ran out to call other teachers to come and help the student teacher, who was not only injured, but humiliated beyond belief. By that time, Lucky had long gone out and jumped over the high wall that is the school fence. The lesson sourly ended there and then, and the researcher closed her books and left.

- **Outside during break**

The researcher observed that when the bell went to signal break time, the participants would be the first ones out the door. They would go straight and gather near the concrete fence of the school. There, they would meet with whoonga merchants, and the researcher could see the exchange of money and the “goods,” in this case whoonga. The participants then went to the back of the toilets to prepare the dose of the morning. They smoked, sharing it until it was finished. After a few drags, their eyes immediately turned red. The researcher also observed a drastic change in their mood, and the fact that they became less aggressive toward fellow learners.

The researcher observed that whoonga users kept to themselves most of the time, and non-users try to be as far away as possible from whoonga smokers, for fear of being bullied or pick pocketed, or any unpleasant experience that emanates from getting into close contact with whoonga users.

Some of the merchants who sell whoonga are learners at the school. Some of the merchants are outsiders. Some of these outsiders wear school uniform to disguise themselves during break time so that no one recognises them and chases them away during the “business hour” which is the break time. On more than one occasion, the researcher observed the school guard chasing these intruders out of the school premises. These intruders in uniform don’t come through the gate, but jump over a high concrete wall to get into the school grounds.
• Back into the classroom:

• After break

When the bell goes to indicate the end of the recess, the participants’ reaction is the opposite of their reaction to the bell indicating the start of the break. Whereas the participants were the first ones out the door to go to recess, they were usually the last ones to come back to class after break, that is, if they come back at all. Most of the time they remained behind and continued to do whatever they had been doing during normal break time, like gambling, or just walked up and down the corridors and never get back to class. On many occasions, the researcher would come to class, with the intention of conducting some observation, only to discover that the participants had never returned to class after recess.

On the occasions when the participants decided to come to class after break, the researcher would notice that their eyes were red, their noses were running and they kept using the back of their hands to wipe them. They were then extremely drowsy and sleepy. In fact, they slept right through the lessons. They would stand up now and again to go and spit through the window, even in the presence of a teacher, or they would sometimes go outside and spit. They seemed to have this strong, uncontrollable urge to spit everywhere. To them, it wasn’t even a matter of bad manners or lack of consciousness regarding hygiene, they simply had to spit, it wasn’t a choice of whether to spit or not to spit.

When they were not dosing off in class, they were walking up and down the corridors. During a geography lesson one afternoon, the teacher conducting the lesson attempted to wake up Sipho on several occasions to no avail. No matter how hard he tried to wake up and concentrate on what was being learned, he simply could not. The teacher finally asked Sipho to go and stand at the back of the class and listen. Sipho went and stood there like a zombie, trying to focus his attention on the teacher and the lesson, and failing dismally. What the researcher observed was that Sipho never grumbled or complained, he just stood there and genuinely attempted to do the best he could to learn.

• During examinations.

It was interesting to note that all participants came to sit for examinations in their respective grades when the examinations started. Although most of them displayed signs of restlessness,
especially during the morning sessions of the examinations due to the fact that they were suffering from cravings, they persevered and went through with the examinations.

- **Further observation**

The researcher noticed that when the learners asked for permission to go and use the toilet during lessons, they took their school bags with them. During break time, many learners walk around the school grounds with their school bags on their backs. Interestingly, the participants never carried their school bags around.

The researcher then asked Jabulani as to the reason why learners walked everywhere with their school bags. This was outside during break time. Jabulani smiled briefly and told the researcher that if learners left their school bags unattended anywhere, they disappeared, including all the “valuables” that might be in them. The researcher then asked Jabulani to elaborate on this particular statement. Jabulani then explained that drug users, including whoonga users, stole school bags and sold them in order to get money to buy whoonga. This is done within the school premises. They steal items from grade eight classrooms, go and sell them to grade twelve learners and vice versa. This is easily possible because there are different blocks for different grades, the grade eight learners never go to the grade twelve block and vice versa. The prices of the “goods” are as follows:

- **The school bag sells for ten rand.**
- **The calculator sells for fifty rand.**

The researcher also observed that more often than not, the participants ask for money from learners who do not use whoonga. Sometimes the researcher would observe a learner putting his/her hand in the pocket, coming out with a few cents, like ten or twenty cents, and giving the money to the participants. The participants appeared to be grateful for whatever amount of money they received, which would add to the amount of the next dose of whoonga. Sometimes the researcher would observe participants talking briefly to fellow learners in an undertone, and then the participants would put their hands into the learners’ pockets without permission. The researcher noticed from the learners’ facial expressions that they were afraid of the participants, and never went to report these incidents to their teachers.
The teachers are by no means exempted from theft. They also walk around carrying their bags, especially female teachers. They wouldn’t dare leave their bags on the tables in their classrooms. If a teacher accidentally forgets his/her cell phone anywhere within the school premises, it disappears within a few minutes. On one of the days during observation, a female teacher left in a rush to attend to some urgent matter. She forgot her bag on the table in the classroom full of learners. When she remembered and rushed back to the classroom, her purse which had been inside her hand bag was gone, it was later found in the boys’ toilets, and all the money gone. The learners were too scared to tell the teacher who stole the purse, for fear of being beaten up, or even stabbed by whoonga users.

The above observation was an interesting revelation to the researcher, because during the interviews, with the exception of Sipho, none of the participants ever mentioned the stealing of learners’ possessions, the pick pocketing and the severe bullying that they put fellow learners through around the school premises. Many of the participants mentioned the stealing at home and shoplifting, but not the reign of terror that went around the school grounds, perpetrated by the participants in a desperate attempt to find money to get the next fix.

Bullying is rampant in the school premises, more especially in the boys’ toilets. This is a hunting ground for whoonga users. They stay in the toilets and wait for learners to come and use the toilets during lessons, usually alone. They then threaten and frighten them, sometimes using knives, into giving them their lunch money and whatever possessions they have with them, even ball pens. The researcher walked around the school veranda towards the boys’ toilets one morning. Then a boy, of about fifteen years, came out of the toilet with his school tie askew around his neck, and tears in his eyes. Before the researcher could ask the boy what was wrong, Zamani came out of the same toilet, looking extremely agitated and angry, and then explained to the researcher that he had to bully the boy because he desperately needed the money to buy the next fix. Zamani looked as though he felt really justified to bully these young boys into surrendering whatever items they possess, to enable him and his fellow whoonga users to get the next dose. The researcher discovered from the participants that some learners never ever use the school toilets because of the bullying that goes on inside those toilets.
4.5 THE RESEARCH FINDINGS

The purpose of conducting this study was to learn about the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. The data is presented in accordance with the participants’ accounts in terms of whoonga effects as they perceive and experience them. Data is also presented with regard to the observations conducted by the researcher. The researcher discovered a number of similar experiences as well as different ones among the participants. All the findings are discussed below.

- **Ignorance**

  Most of the participants were completely ignorant of the effects and consequences of using whoonga. No one, not even their parents, had ever explained to them the dangers involved in using whoonga. They had no knowledge of how difficult it would be to stop or quit the habit. They knew nothing of the crippling stomach cramps that would attack them only a few days after their initiation to whoonga.

- **Peer pressure coupled with curiosity.**

  Many of the participants cite peer pressure as one of the contributing factors to their initiation to the use of whoonga. Most participants were urged by friends to “try” whoonga. One of the participants recalls:

  
  “I guess peer pressure set in because I agreed to try it.”

  The above admission is a clear indication that peer pressure played a major role in the decision by the participants to smoke whoonga. Curiosity was another major contributing factor for participants to use whoonga. They watched their peers using whoonga and always wondered what it would be to try it, as one participant confirms:

  
  “I found myself getting more curious that ever to find out what it was that made my friends so carefree after using whoonga.”
• **Effects.**

All participants discovered that their learning had been negatively affected by the use of whoonga in many ways. First and foremost on the list is the general inability to concentrate on what is being learned, which is common among all participants, at any time of the school day, and whether the participants are high on not. Their memory is hampered by this lack of concentration. Physically, the participants are not well enough to attend classes, due to the cravings and withdrawal symptoms that assail them throughout the day. Prolonged absences do not help the already hopeless situation regarding school work in the lives of the participants, as one of the participants acknowledges:

“The only reason I wake up at all in the morning is because of the cravings, and not because of any desire to go to school.”

• **Challenges**

There are a lot of similarities with regard to the challenges encountered by respondents as fellow whoonga users. Many of them have been chased away from home on many occasions, because of stealing. Since all the participants were learners in this study, their only source of income to feed their habit, is by stealing whatever comes their way everywhere possible, lying and cheating their families and neighbours, friends and relatives. All participants have sold their belongings as well in the desperation to get the next fix. Some of the participants have even lived on the streets after being chased away by family, friends and relatives. One of the participants has been arrested more than once in his young life, due to criminal activities driven by the desperation to get money to buy whoonga. Most of the participants feel like they are being treated like pariahs by the teachers, fellow learners and the community at large. One of the participants admits:

“I no longer feel comfortable in the company of other learners, especially those who don’t do drugs.”
• **Loss of something most valuable.**

Of all the participants, none of them has lamented the loss of their possessions, no matter how expensive these items were, but all of them regret deeply the loss of trust of their families and friends. To all the respondents, this is the biggest and most painful of all losses. They wish to regain the trust of their loved ones, but have no idea how to do it, and where to start, since their families and friends no longer believe a single word that comes out of the participants’ mouth. Some of the participants confess that they sometimes wish to get close to their families and friends again, but the loss of trust makes it really difficult as most family members and friends are tired of lies.

• **Parent/guardian involvement.**

Most, if not all participants see parental involvement as crucial in the teaching of their children about the dangers of drugs and drug abuse at a very early age, long before the children start using them, long before they reach the age of peer pressure. Participants believe that if parents can play an active role in warning their children about the dangers of drugs, and getting involved in their children’s lives, the children would know long before hand of what might come later in their lives and be better prepared to deal with the challenges of drug abuse and peer pressure. One of the participants laments:

> “If my parents had said something to me about the dangers of drugs and drug abuse earlier on in my life, I would have been more aware of what was going on around me and would have responded differently to peer pressure.”

The above sentiment is shared by a fellow participant:

> “My stepmother realised very early on that I was using drugs, but she never said or did anything. My father discovered very late about my drug habit. He then tried to talk to me but by then it was already too late because I was already hooked.”
**Whoonga dictates terms of their lives.**

The participants’ lives are now controlled by whoonga. The need for whoonga tells them when to get up in the morning to go whoonga hunting, how long to remain in class in an attempt to learn something, how much it allows them to understand or not understand during lessons, how much physical and emotional energy it allows them to have on a particular day. Their life is a constant cycle of the miserable withdrawal symptoms, whoonga hunting and using whoonga to numb the physical and emotional pain and loss.

### 4.6 DISCUSSION

The purpose of this study was to investigate the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. The three primary questions were:

- What are the common causes, if any, for young people to use whoonga?
- How does whoonga affect its users and their learning?
- How can the youth using whoonga be assisted to do away with the habit?

Different data collection strategies were employed in this study, such as interviews and observation. Four participants were interviewed. They were also observed in their natural setting, in this particular instance, the school premises. The observations were conducted inside the classrooms during lessons, as well as outside during break times. The objective was to obtain the empirical data from the participants. Findings were made, the study results are discussed below in detail.

**Ignorance.**

It has emerged that the youth using whoonga have paid a heavy price for their ignorance. One of the leading causes for them to use whoonga, the researcher discovered, is total ignorance of the dangers and consequences of using whoonga. Blindly, the participants follow in the footsteps of their peers in smoking whoonga, looking only at the supposedly “brighter” side of experiencing the feeling of euphoria, only to discover very soon, that the feeling of euphoria was not worth the feeling of hell that would become their life. The admission of
ignorance by the participants puts into sharper focus the implications of the lack of awareness of education aimed at young people in an attempt to save them from the devastating consequences of whoonga use. The lack of education seems to be from all angles. The parents don’t appear to breathe a word about the dangers of drugs to their children. The government doesn’t seem to have any measures in place for the driving of awareness programmes, at any level of government, that is, locally, provincially and nationally. For the moment, whoonga users continue to blindly join their peers in getting into the deadly grip of whoonga, where there doesn’t appear to be any escape.

- **Peer pressure and curiosity.**

Many participants found that peer pressure, coupled with their curiosity, was a major let down in terms of getting initiated to whoonga use. The average age on which the participants were initiated didn’t help matters. Most of the participants were first initiated to whoonga use at the age of fourteen or fifteen. During this age, most of these youngsters have just entered high school, and they are desperate to fit in with the crowd.

At this young age, the most important thing in their life is not the parents, the school work or their communities. The most important thing is what their friends and peers say and think, from the language of that particular group up to the dress code. Since many of these youth crave acceptance, the pressure to be counted as one of the group drives them to do whatever it takes to be accepted, no matter what the cost will eventually be, just like it happened to the participants. Most of them have discovered very late in the game, that the way back to a life without whoonga, is just so difficult that many of the whoonga users believe they don’t have the strength to swim against the whoonga tide. For many of them, even at this very young age, the fight is over. The way back to life, as they once knew it, looks to them like a distant, faint dream.

- **Effects.**

This was the main question regarding the use of whoonga by the participants. The study aimed to discover the effects of whoonga on the learning of the users. All four participants were in agreement that the saddest discovery they made was how negatively whoonga would affect their learning. Blinded by their curiosity, pushed by their desperate need to fit in, and
misled by their own ignorance, the participants believed that they could use whoonga and still continue with their normal learning, even after they were hooked.

Another huge misconception on the participants’ part was the thought that they could treat whoonga as a hobby, that is, they believed they could use it only when they wanted to, just like they had been doing with dagga. But the effects of whoonga soon brought the reality home, albeit the hard way.

Not being able to concentrate in class, no matter how desperately hard they try, participants admit, is the most frustrating of all effects with regard to their learning. The worst part of it is that there is no time of the school day when they get maximum benefit out of a learning situation. When they suffer from cravings, they can’t concentrate, similarly, when they have used whoonga, they simply can’t concentrate either.

This frustration, as all the participants confessed, has led to anger and resentment. The unfortunate part is that this anger is usually taken out on innocent fellow learners as well as teachers, whom the participants view as always nagging about school work and general good behaviour or lack of it. This display of anger and violence is what leads learners to avoid any interaction with the participants, and participants, in return, feel like they are being treated like pariahs.

The physical and emotional effects of whoonga use, participants discovered, make it very difficult or near impossible for them to attend school and actively participate and enjoy the daily routine of a normal school day. This has resulted in their self-imposed isolation and resentment of the school and everything in it, as one participant admits:

“I resent the way they look normal.”

The above reality does not leave much room for participants to progress with their studies, hence a large number of school dropouts among whoonga users.
Challenges.

The challenges these young whoonga users have faced are far beyond their age. At this point in their young life, participants should be enjoying their school life with their friends, and not having a care in the world.

The reality is, the participants have known hardships like living on the streets, going to prison and getting chased around by their own communities. This sad statement of fact highlights the loss of direction and purpose from the very people who are supposed to protect these youth, namely, parents, communities and government. In the middle of all the antagonism directed at the young whoonga users, someone has to take the responsibility to rectify the situation. The young people cannot do it on their own.

Instead of isolating the participants by chasing them away from homes and communities, maybe some measures need to be taken to make an earnest effort to help them do away with the use of whoonga. It has come to light that sending the participants to jail was not a solution to the problem of whoonga use, because, instead of realising what they have done wrong, in jail they find “teachers and coaches” who teach them how to be better criminals. This is not what the parents, the communities and the government need.

Parent/guardian involvement.

A large number of participants found that they were severely disadvantaged by their own parents by keeping silent on the dangers and consequences of drugs. Many a times, parents are reluctant to talk about issues they regard as sensitive to their children, including drug abuse.

Most of the time, parents attempt to shift this responsibility to teachers, and usually by the time teachers talk to the youngsters, it is already too late, the damage has already been done. Most participants lament the fact that they were kept ignorant by their parents as to the dangers of drug use, as one of the participants regretfully commented:
“If my parents had said something to me about the dangers of drug use earlier on in my life, I would have been more aware of what was going on around me and would have responded differently to peer pressure.”

The researcher repeats the above quote over and over again in an attempt to bring to attention that, much as whoonga addicts are now regarded as the scum of any household and community, parents in those households are not entirely without blame. Community members and leaders are also not without blame. The drug merchants are community members, and sometimes, even community leaders.

By keeping quiet about the “sensitive” topics due to the unfounded fear that the topic might prompt children to go and experiment with whatever was discussed, has had a negative effect and devastating consequences. Young people, it appears, would like to be informed about the dangers that lie ahead of them, so that they may be better equipped to deal with those challenges when the time comes. Contrary to the belief that silence is safer, the opposite is actually true, as the participants have discovered the hard way.

All in all, the findings illuminate many gaps in the whole approach or lack of it, regarding the steps that need to be taken in order to deal effectively with the presence of whoonga in the lives of young people. At the present moment, it would appear that no one would like to assume responsibility to ascertain that young people are taken out and kept away from the cruel grip of whoonga.

Parents are reluctant, or lack awareness, that as primary educators of their children, they need to take the initiative to talk to their children about ways and means of taking care of themselves, even in the face of peer pressure. This may save the young people a lot of pain, suffering and uncertainty regarding their future, as it is the case right now with the participants.

Challenges that face the youth using whoonga need to be shared by the whole community in the form of fighting, as a collective, the selling of whoonga in their communities. It is also evident that young people need urgent help in their daily struggle to cope with the hopeless situation whoonga has put them in.
If the reality of the presence of whoonga among the youth is ignored, the youth, both users and non-users are going to be forced to live with the dangers posed by whoonga on daily basis. These dangers include the violence in schools, sickness and death of young whoonga users as well as the possibility of the whole generation lacking in skills due to school dropouts.

4.7 CONCLUSION

This chapter discussed the findings of the study. It has come to light from the research findings that learners are really not coping well with school work due to the presence of whoonga in their young lives. Their lives are constantly being disrupted in terms of always thinking about where and how to get money for the next fix. It has emerged that ignorance and peer pressure are among the main causes of why young people use whoonga and then discover with utter surprise and frustration, that there is practically no way out of the situation they find themselves in, as they finally realise the strong grip whoonga addiction has on them. The challenges that these young addicts face, both socially and academically, depict a picture of emotional and physical pain, torture and misery. An equally important discovery, is the lack of parent involvement in the life of their children. According to the participants’ perspective, parents need to play a more active role in the lives of their offspring in terms of talking and discussing important issues like drug abuse, at an early age before it is too late for the information to have any meaningful impact.
CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS.

5.1 INTRODUCTION

This chapter provides a summary of the study as laid out in the previous chapters. This chapter also highlights the key findings of the study, offer proposed recommendations that might help the youth of Kwa-Dabeka Township cope or deal with the plight of whoonga use. It provides the conclusions drawn from the study, brings to the fore the strengths and limitations of the study, and accentuates some aspects for further research.

5.2 SUMMARY OF THE RESEARCH.

The main purpose of this study was to investigate the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. This study probed the experiences participants encountered with regard to the use of whoonga in relation to their learning as they perceive them.

- Socio-demographic details of the participants

Four respondents participated in this study. Their ages ranged from 18-21. Their grades ranged from 9-11. Three of the participants live with their biological fathers and stepmothers. One participant lives with a single mother. Regarding their economic standing, one participant comes from a well-to-do family, two come from working class families and the last one comes from a non-working, poor family.

- Methodology

The qualitative method of enquiry was employed in this study, and phenomenology was the approach of choice. Purposeful sampling was used to select the most suitable participants for the study. Four participants were interviewed, using semi-structured and unstructured questions. Observations were also conducted at the school, that is, participants were observed in their respective classrooms during learning periods as well as outside of the classroom.
during break times. The interviews, together with observations lasted for a period of three weeks. This was done during the month of June 2013.

The findings of the study have indicated that the learning of the participants has been negatively affected by the use of whoonga. Findings have also suggested the need for assistance to these learners who are in desperate need of it. A few themes emerged in this study from the data that was collected from participants. These themes include ignorance, undesirable peer influence as well as attachment to parents. Below is a summary of the key findings according to the themes that emerged from the study.

5.3 SUMMARY OF THE KEY RESEARCH FINDINGS

This study looked to address the following questions:

The main question

What are the effects of whoonga on the learning of affected youth in Kwa-Dabeka Township?

Sub-questions

- What are the common causes, if any, for young people to use whoonga?
- How does whoonga affect its users and their learning?
- How can the youth using whoonga be assisted to do away with the habit?

As stated in 5.2, themes that emerged from data collection were ignorance, undesirable peer pressure as well as attachment to parents.

5.3.1 Ignorance

The findings of the study highlighted that ignorance was among the major causes of young participants choosing to use whoonga. All the participants admitted that prior to using whoonga, they did not have the slightest idea of the effects of whoonga and how difficult it would be for them to do away with the habit of using whoonga. The socio-economic background of the participants is different, but the experience with ignorance is exactly the
same among all the participants. All the participants were even more ignorant about how negatively the use of whoonga would affect their learning. They naively expected to continue normally with their learning, and that whoonga would play no disturbing part in their school life. The findings have revealed that the participants’ learning has been deeply affected in a negative way. In fact, the findings have depicted a near impossible situation for participants to even present themselves in class, let alone be able to mentally concentrate and absorb what is being learned in class, not to mention the impossibility to remember what was learned in class.

### 5.3.2 Undesirable peer influence

The findings of this study have shown that the undesirable peer influence was another key deciding factor for most, if not all participants to start using drugs. Their own curiosity was also part of the problem. Even if some of the participants initially realised that using whoonga was not a good habit, and even scolded their friends for doing so, their curiosity got the better of them and they finally found themselves using whoonga as well.

Regarding what they believe may help them to do away with the habit, the evidence suggests that participants have different views on the topic. Some believe in rehabilitation centres, some are totally opposed to the idea. Some believe they only need a will to stop, because without it, no amount of outside help would ever succeed, while some think that if they believe in themselves, that is, if they have a belief that they can do it, that may ultimately push them or help them to stop the habit. Some see the support of parents and family members as invaluable in encouraging them to do away with the habit.

### 5.3.3 Attachment to parents

The findings reveal that most participants are profoundly unhappy with the lack parent-child bond that should exist between them and their parents. The participants feel that the lack of communication between them and their parents was a major cause for their ignorance. Among all four participants, not one of them was ever warned by his parents about the dangers of drug abuse. Even when some of these parents became aware of the drug problem in their children, they never said or did anything about it. This has widened the emotional gap between participants and their parents. The data reveal that the lack or complete absence of
attachment to their parents, in some instances, has led to complete distrust of the entire adult population by some of the participants.

**Contributing factors and risk factors to drug abuse.**

Below are some of the factors that contributed to the use of whoonga among the participants. There are also factors that put the participants at high risk for the use of whoonga.

- **Contributing factors.**
  
i) **Unstable family situation.**

This refers to single parenthood, poor attachment with parents, ineffective communication between participants and their parents.

From the evidence it could be argued that the above mentioned factors contributed in one way or another, to the choice by participants to use whoonga. Some of the participants come from single parent households. Some participants consider their attachment to parents as poor, and some consider the communication as poor or non-existent, that is, in regard to topics that really matter, like drug abuse.

ii) **Access.**

This refers to easy access within immediate neighbourhood and cheap cost. All participants have easy access to whoonga. When they are at home, there are many merchants of whoonga in the neighbourhood. When they are at school, merchants are some of their fellow learners. The participants are surrounded by whoonga everywhere they go. Compared to other drugs, whoonga is relatively cheaper due to the unknown impurities that are added to increase the mass. The cheap prices make whoonga accessible to these young and unemployed participants.

- **Risk factors.**

This refers to parents’ divorce, separation as well as passing away.
The above mentioned factors are potential risk situations that may prompt young people to engage in drug use, including whoonga use. One of the participants admitted that he regarded his father’s passing away as a sign of rejection. This perceived rejection has amounted to anger that the participant is still struggling to deal with on daily basis. Some participants said that their mothers passed away, so they had to be looked after by stepmothers, which in their opinion, is not the same as having your own mother. One participant pointed out that his parents were not married. This resulted in them living separately, which affected him negatively as he yearned to live with both of his parents like other children. The evidence suggests that these risk factors helped to propel the participants’ inner drives towards the use of whoonga.

5.4 PROPOSED RECOMMENDATIONS

The evidence gathered from data collection revealed that participants have paid a high price for ignorance, curiosity and lack of parental involvement in their lives. The researcher proposes the following to help learners deal with the plight of whoonga use.

- A holistic support system need to be put in place in schools for drug addicts, non-using learners as well as teachers who have to deal with addicts on daily basis. This could reduce stigmatisation, alienation as well as frustration among all parties concerned.

- Focusing attention on the drug addict or victim when dealing with drug abuse problem is not sufficient by itself. The only challenge with this approach is that it fails to understand that the recruitment process into drug abuse continues unabated, today’s non drug abuser is possibly tomorrow’s drug addict. Drug abuse is not simply an individual problem, but is both a socio-political and economic issue. It is borne out of the multiple social structural factors at play in the individual’s life at the time of addiction. There need to be education programmes directed at young children before they start using whoonga. These programmes could be at national, regional as well as local level. These campaigns could go a long way in alerting young children about the dangers of drugs and give them practical skills on how to avoid situations where they could find themselves using drugs. This will prevent vulnerable and prospective drug addicts from entering into the system. I believe it is easy and costs
less to prevent a person from being a victim of this evil than to cure him/her out of the system: prevention is better than cure.

- The majority of parents are at a loss as to how to talk to their offspring regarding the use of drugs. As parents are the primary educators of their children, the researcher recommends programmes that will enlighten them on the issue of drug abuse. The acquired new knowledge may equip them with skills to talk effectively to their children about the drug problem as early as possible, and be able to practically deal with it if their child has already started using drugs. Parents may also be taught about the warning signs of drug abuse, including whoonga.

- Teachers need the support of government in terms of how to deal with whoonga users on daily basis. As things stand right now, teachers have to juggle their limited teaching time between disciplining whoonga users who are always disrupting learning in class, and actual teaching. Most of these teachers find it really difficult to succeed in both attempts. Teachers also need to be educated on the nature of drug addiction in order to better understand the addicts and be in a better position to deal with them.

- It is recommended that the government employ more social workers or counsellors who are better trained to give emotional and psychological support to the learners at school. This may give learners the opportunity to voice their fears, anger and anxieties to someone who is neutral. In this way an opportunity may arise to deal with these fears and anger long before they culminate into disastrous behaviour like drug abuse.

- It is proposed that government considers the establishment of more rehabilitation centres for the addicted youth because private rehab centres are highly expensive and the majority of parents cannot afford them. The government rehabilitation centres need to be free and accessible to all young people everywhere in the country.

- The government need to look at another alternative to prison. The evidence confirmed that young whoonga users do not benefit anything from going to prison,
instead, they get training on how to become better criminals. It would be in the best interest of all parties concerned, including government, communities, parents and teachers, to have these young people put into homes designed for them to afford them the opportunity of rehabilitation and the learning of skills of how to deal with life on life’s terms. South Africa has the capacity to fight and win the war against the circulation of drugs hence abuse. China has got one of the world’s best security systems in place. It is known that trafficking drugs into China is impossible than taking them from China to another country. Usually the drug peddler lives in the same community and is known to it. With the kind of resources that we have in South Africa; the intelligent systems; police; defence force, tightly controlled boarders and other points of entry into South Africa; and strong Community Policing Forums, there is no reason why drugs cannot be eliminated from our communities. Cutting off the supply of drugs will be more effective and less costly for our country than to arrest the victims and putting them to jail while the supply chain runs undisturbed.

5.5 CONCLUSIONS

The findings of the study revealed that the common causes for young people to use whoonga are ignorance, curiosity as well as peer pressure. All participants were completely ignorant of the ill effects of whoonga. All of them had no idea how difficult it would be to stop the habit. Many participants admitted that curiosity was another driving force behind their decision to use whoonga. Watching their friends use resulted in their curiosity getting the better of them. The results also indicated that many participants were not able to resist peer pressure when their friends urged them to try whoonga.

The findings also show that all participants have been negatively affected by the use of whoonga with regard to their school work. It has emerged that participants are never fit, that is physically, emotionally and psychologically, to participate actively in many school activities. Lack of concentration is the primary cause for them not to do well in school, and to find themselves repeating almost all the grades they go through. The above observation is confirmed by their ages in relation to the grades they are doing at school. Not one of the participants is in the grade which is appropriate for his age. All of their ages indicate that they
should be at a tertiary level by now. Prolonged absences from school are also a matter of concern as this result in participants missing out on a lot of school work.

The study results determine that there is a difference of opinion with regard to what participants believe might help them to do away with the habit of using whoonga. Some of them are totally opposed to the idea of rehabilitation centres since they view them as corrupt places with people who are full of lies. Some participants however, embrace the idea of a rehabilitation centre. They view it as a starting point in the effort to stop the habit of whoonga use. Some of the participants argue that they need something meaningful to occupy them, like a job or sport. Other participants believe that they need to have a will to stop, as without it, no amount of outside help can be successful.

What was discovered by the study findings is that participants are confronted by many challenges which make their young lives very difficult. To give a few examples, some participants have been chased away from home, some have lived on the street, and some have been arrested more than once. All participants have lost the trust of their parents, teachers and community members.

The results showed that participants are not satisfied with the lack of parental involvement in their lives. They feel that parents need to engage their children actively in all matters that involve challenges or encounters that children may come across as they weave their way through to adulthood. The silence on the part of parents is viewed as apathy by participants.

The researcher concluded in this study that ignorance plays a key role in young people choosing to use whoonga. Undesirable peer influence is another negative contributor, due to the desperation in young people to fit in or to be accepted by their peers. Challenges that are encountered by the participants are far beyond their age. Normal learning is almost impossible for participants due to physical and emotional effects they experience before and after whoonga use. Parents do not involve themselves in the lives of their offspring in terms of educating them about drugs, and practically dealing with the drug problem when their child is already addicted.
### 5.6 STRENGTHS AND LIMITATIONS OF THE STUDY

#### 5.6.1 Strengths of the study

- During the interviews, participants were able to view their addiction from different perspectives. In this way, they were able to contribute invaluable insight into their daily lives and experiences of whoonga use.
- This study provides one of the rare glimpses into the life-world of whoonga users and improves our conception of this particular addiction.
- This study may offer the foundation on which existing misconceptions about whoonga can be attended to and be dealt with.

#### 5.6.2 Limitations of the study

- This study focused only on whoonga, so the research findings may not be applicable to other types of drugs, like crack cocaine, Chrystal meth and other types.
- This study was conducted in one school in a small area called Kwa-Dabeka Township. It is not known whether the results are applicable to other places.
- The participants were all from one race, black. This is because of the area the research was conducted. The results may not be applicable to other races.
- The research focused only on the participants who are still hooked on whoonga, and not those who have stopped using whoonga.
- The study focused on the effects of whoonga on the youth using it and not on how their siblings are affected as well.
- There was no focus either, on how teachers and fellow learners experience the presence of whoonga addicts in their midst.

### 5.7 RECOMMENDATIONS FOR FURTHER RESEARCH

In spite of the limitations of this small-scale qualitative study, a few observations may generate further research. The recommendations are as follows:
As this study focused on one school in a small area of Kwa-Dabeka Township, a study can be conducted in other areas to find out if the experiences of whoonga are the same as in Kwa-Dabeka Township.

A study may also be conducted on those young people who have successfully stopped the habit of whoonga use, as all participants in this study were still hooked on whoonga. The youngsters who have done away with the habit of whoonga use may shed light on their perspective and coping skills.

A study may be conducted on how fellow learners perceive and experience the presence of whoonga addicts in their midst.

Another study may be directed at teachers to investigate their daily struggles in dealing with whoonga addicts. This may shed light on the extent of disruption of learning on daily basis.
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APPENDIX A

LETTER SEEKING PERMISSION FROM THE KZN DEPARTMENT OF EDUCATION

4 Morgan Hall
5 Morgan Road
Pinetown
3610
20 April 2013

Head of Department: Education
KZN Department of Education
Private Bag X913
Pietermaritzburg
3201

DATA GATHERING FOR Med (SOCIO-EDUCATION).

TO WHOM IT MAY CONCERN.

I am a student at the University of South Africa. I am currently doing a Master’s degree in Socio-Education. The title of my research is: The effect of whoonga on the learning of affected youth in Kwa-Dabeka Township. I believe this study will be useful to parents, police and the community at large, who are all at a loss as to how to deal with the rampant use of this deadly drug.

I now have to embark on the most important aspect of my research termed data collection, which is the practical part where I need to interview learners using whoonga. For this to be successful, I will have to conduct my research in one of the high schools in Kwa-Dabeka Township. I am therefore hereby humbly asking for your help by giving me permission to conduct this research.

Your kind assistance is highly appreciated.

Yours faithfully

Z.T. Shembe (Ms)
Contact details:
Cell: 083 965 9825
Email: thinashembe@gmail.com
APPENDIX B
LETTER SEEKING PERMISSION FROM THE PRINCIPAL

4 Morgan Hall
5 Morgan Hall
Pinetown
3610
20 April 2013

The Principal

DATA GATHERING FOR Med (SOCIO-EDUCATION)

Sir/Madam

I am currently doing my Master’s degree in Socio-Education with the University of South Africa (UNISA). The title of my dissertation is: The effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. The purpose of the study is to find causes for young people to use whoonga, to describe the effects of whoonga to users’ school work and to try and find ways and means to help the affected youth to do away with the habit.

I am now at a stage where I need to collect data from the willing participants in order to be able to successfully complete my degree successfully. To do this I have to interview those learners who are a whoonga users. Participation from participants is voluntary. Participants may withdraw from taking part in the study at any given time without penalty. I am hereby asking for your permission to conduct my research at your school.

Your kind assistance will be highly appreciated.

Yours faithfully
Z.T. Shembe (Ms)

Researcher’s contact details:
Cell: 083 965 9825
Email: thinashembe@gmail.com
APPENDIX C

LETTER SEEKING CONSENT FROM PARENT/GUARDIAN IN CASE OF A MINOR PRACTICAL WORK FOR Med (SOCIO-EDUCATION)

Dear Parent/Guardian

I am a student at the University of South Africa (UNISA). I am currently doing my Master’s degree in Socio-Education. The title of my dissertation is: The effects of whoonga on the learning of affected youth in Kwa-Dabeka Township. In order to complete the requirements for my degree, I have to do research on the topic. This means that I have to talk to the youth who are affected by the use of whoonga.

Kindly allow your child/ward to participate in my research. Participants will be interviewed by the researcher and the responses will be recorded. The recording will be done for the purpose of the study only and nothing else. The interview will last for about 45 minutes to one hour. I will not use real names in the study in order to protect your child/ward’s identity. Please note that participation is voluntary. Participants may withdraw from participation at any given time without penalty.

If you are willing to give consent for your child/ward to participate in this study, I will appreciate it if you sign a consent form.

Thank you very much for helping me to reach my goal.

Yours faithfully

Z.T. Shembe (Ms)

Researcher’s contact details:
Cell: 083 965 9825
Email: thinashembe@gmail.com
APPENDIX D
LETTER OF CONSENT SIGNED BY PARENT/GUARDIAN IN CASE OF A MINOR

I ..............................................................................................................................................................................

have understood the contents of the letter seeking my permission to allow my child/ward to participate in the research. I therefore hereby give my permission for my child/ward to take part in the study conducted by Ms Z.T. Shembe.

Signed: Parent/Guardian: .................................................................................................................................
Researcher: ...........................................................................................................................................................
Date: ....................................................................................................................................................................
APPENDIX E
LETTER SEEKING PARTICIPATION FROM PROSPECTIVE SUBJECTS
.

Dear

I am currently doing my Master’s degree in (Socio-Education) at the University of South Africa (UNISA). The title of my dissertation is: The effect of whoonga on the learning of affected youth in Kwa-Dabeka Township. I wish to describe the causes for whoonga use, the effect of whoonga on users’ school work, and ways to help affected youth to do away with the habit. I wish to do this from the participants’ point of view. I will do this by conducting an interview with participants. I would like to tape record the interview. This will be done for the purpose of research only and nothing else. This will enable me to transcribe and analyse the results of the interview. I will not use real names in the study to maintain anonymity and confidentiality. Participants will participate on voluntary basis. Participants may withdraw participation at any given moment without penalty. Participants are free to ask any questions relating to the study. I will also not disclose the contents of the interview to a third party to maintain confidentiality. Participants will also be given an opportunity to view the results.

If you are willing to participate in this study, I would appreciate it if you sign a written consent.

Your compassionate help is highly appreciated.

Yours faithfully
Z.T. Shembe. (Ms)

Researcher’s contact details:
Cell: 038 965 9825
APPENDIX F

LETTER OF CONSENT SIGNED BY THE SUBJECTS

I………………………………………………………………………………………………………………………………………………………………………………

hereby agree to participate in the research on whoonga addiction, conducted by Ms Z.T. Shembe.

I give consent for the tape recording of interviews and the publication of the research findings.

Signed:

Participant: …………………………………………………………………………………………………………………………………………………

Researcher: …………………………………………………………………………………………………………………………………………………

Date: …………………………………………………………………………………………………………………………………………………
APPENDIX G
POSSIBLE INTERVIEW QUESTIONS

1. How did you first learn about whoonga?
2. What made you choose to use whoonga?
3. How often do you use a day and how do you pay for your drugs?
4. How has whoonga affected your learning?
5. What challenges have you encountered since you started using whoonga? (home, school, community)
6. How would you describe your performance at school?
7. In your opinion, what would help you to do away with whoonga?
8. Is there anything else you feel you need to discuss with me?
APPENDIX H

OBSERVATION RECORD

Name: ........................................................................................................................................

Date and Time: ...........................................................................................................................

Observer: ....................................................................................................................................

Site/Project: ................................................................................................................................

Observation of events and behaviours:
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Comments/Summary:
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