Mental Health
Determinants
and Populations

UNDCP/WHO GLOBAL INITIATIVE ON PRIMARY PREVENTION OF SUBSTANCE ABUSE

Report of the regional training of trainers workshop on primary prevention of substance abuse

Harare, Zimbabwe, 6-8- December 1999
UNDCP/WHO GLOBAL INITIATIVE
ON PRIMARY PREVENTION OF SUBSTANCE ABUSE:

REPORT OF THE REGIONAL TRAINING OF TRAINERS
WORKSHOP ON PRIMARY PREVENTION OF SUBSTANCE ABUSE

Harare, Zimbabwe, 6-8 December 1999

Abstract

With financial support from the Norwegian government, The World Health Organization (WHO) and the United Nations International Drug Control Programme (UNDCP) began implementing the revised project "The Global Initiative on Primary Prevention of Substance Abuse" in July 1999. The project aims at preventing and reducing the use and abuse of psychoactive substances among young people through mobilisation of communities and the development of good practices in the area of primary prevention.

The importance of human resources development and the contribution of the human resource in this undertaking cannot be overemphasised. Acquiring adequate knowledge and skills on the changing patterns of psychoactive substance use, expanding scientific knowledge and implementing effective projects on primary prevention are important considerations in this project. In recognition of these facts, development of training materials for project operators was the initial step. The second step was to expose these materials to potential users in order to solicit their input for the finalisation of these materials.

In December 1999, the first regional training of trainers workshop was held, involving key players in the three selected countries in Southern Africa. The workshop served as a medium for participants to review the materials and provide input, share country experiences and acquire additional knowledge and skills on primary prevention of psychoactive substance use and project development and management. This report summarises the proceedings of this workshop.
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Purpose</td>
<td>2</td>
</tr>
<tr>
<td>1.2 Objectives</td>
<td>2</td>
</tr>
<tr>
<td>1.3 Methodology</td>
<td>2</td>
</tr>
<tr>
<td>2. Proceedings of Day 1</td>
<td>3</td>
</tr>
<tr>
<td>2.1 Opening remarks</td>
<td>3</td>
</tr>
<tr>
<td>2.2 Key note address</td>
<td>3</td>
</tr>
<tr>
<td>2.3 Overview of the Global Initiative</td>
<td>4</td>
</tr>
<tr>
<td>2.4 Expectation of participants</td>
<td>5</td>
</tr>
<tr>
<td>2.5 Rules</td>
<td>5</td>
</tr>
<tr>
<td>2.6 Primary prevention of substance abuse: overview of the workshop</td>
<td>6</td>
</tr>
<tr>
<td>2.6.1 Objectives</td>
<td>6</td>
</tr>
<tr>
<td>2.6.2 Introduction to documents</td>
<td>6</td>
</tr>
<tr>
<td>2.6.3 Summary of country presentations</td>
<td>7</td>
</tr>
<tr>
<td>2.6.3.1 South Africa</td>
<td>7</td>
</tr>
<tr>
<td>2.6.4 Tanzania</td>
<td>9</td>
</tr>
<tr>
<td>2.6.5 Zambia</td>
<td>10</td>
</tr>
<tr>
<td>2.6.6 Zimbabwe</td>
<td>12</td>
</tr>
<tr>
<td>2.7 Discussion of country experiences</td>
<td>13</td>
</tr>
<tr>
<td>2.8 Introduction to training concepts: the workbook</td>
<td>14</td>
</tr>
<tr>
<td>2.9 Training and review of Workbook Modules</td>
<td>15</td>
</tr>
<tr>
<td>2.9.1 Module 1: Psychoactive substances</td>
<td>15</td>
</tr>
</tbody>
</table>
2.9.2 Training and review of Workbook Module 2: Psychoactive substance use among young people ........................................ 17

2.9.3 Training and review of Workbook Module 3: Ways of preventing psychoactive substance abuse ........................................ 18

2.10 Discussions .............................................................................................................................................................................. 21

3. Proceedings of Day 2 ........................................................................................................................................................................... 22

3.1 Lessons learned on Day 1 ......................................................................................................................................................... 22

3.1.1 Feedback on evaluation of Day one ......................................................................................................................................... 22

3.2 Training and review of Workbook Module 4: Project development and management ......................................................... 23

3.3 Training and review of Workbook Module 5: Baseline assessment ....................................................................................... 23

3.4 Training and review of Workbook Module 6: Monitoring and impact evaluation ................................................................. 25

3.5 Training and overview of Workbook Module 7: Project capacity building ........................................................................ 26

4. Proceedings of Day 3 ........................................................................................................................................................................... 28

4.1 Lessons learned on Day 2 ......................................................................................................................................................... 28

4.1.1 Evaluation of Day 2 ................................................................................................................................................................. 28

4.2 Micro teaching .................................................................................................................................................................................... 29

4.3 Field visit ......................................................................................................................................................................................... 29

4.3.1 Purpose ...................................................................................................................................................................................... 29

4.3.2 Specific objectives ................................................................................................................................................................. 29

4.3.3 Issues considered during the visit ....................................................................................................................................... 30

4.4 Presentation of national action plans ....................................................................................................................................... 32

4.5 Final evaluation of the workshop ............................................................................................................................................ 32

4.6 Closing remarks ................................................................................................................................................................................ 32

4.7 Recommendations .......................................................................................................................................................................... 33

4.7.1 Recommendations from participants .................................................................................................................................... 33

4.7.2 Recommendations for WHO/AFRO ....................................................................................................................................... 33
1. INTRODUCTION

The World Health Organization (WHO) and United Nations International Drug Control Programme (UNDCP) are jointly carrying out the Global Initiative Project on Primary Prevention of Substance Abuse Among Young People\textsuperscript{1}. The project aims at prevention and reduction of use and abuse of psychoactive substances among young people. Essential to the project is the mobilization of communities, a crucial factor being active participation of the intended beneficiaries of the projects themselves, and the young people. Another fundamental factor is the development of good practices.

The Global Initiative is being implemented in three regions, namely, Central and Eastern Europe, Southeast Asia and Southern Africa. The work is being instituted in close cooperation with WHO and UNDCP Regional Offices.

The initial regional training of trainers (TOT) workshop was held in Harare from 6 to 8 December 1999. WHO headquarters and the African Regional Office (AFRO) in collaboration with UNDCP mutually organized the meeting.

In Southern Africa, three countries were selected to participate in the Global Initiative (Tanzania, Zambia and South Africa), but four countries were invited to take part in the TOT workshop. Participants from Zimbabwe attended as observers. The criteria for selecting participants included most of the following:

a) They had to be from the three countries where the Global Initiative will be implemented.

b) They had to be involved in the prevention of psychoactive substance use.

c) They had to be working with a non-governmental organization, or government department involved in substance abuse or related fields such as mental health or social welfare.

\textsuperscript{1} The Global Initiative
1.1 Purpose

The purpose of the workshop was to develop a core group of trainers in Primary Prevention of Substance Abuse in the three selected countries in Southern Africa and to test learning materials developed for project operators who are to participate in a variety of project activities in the Global Initiative.

1.2 Objectives

Specific objectives of the workshop were as follows:

1. To train trainers for the WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse.
2. To field-test the draft workbook for the project operators, and the facilitator guide and compile comments and recommendations to incorporate into the draft workbook for its improvement.
3. To develop proposals of Action Plans for national training workshops and other project activities on Primary Prevention of Psychoactive Substance Abuse.

1.3 Methodology

Facilitators of the workshop were drawn from the two executing agencies, WHO and UNDCP. Methods of work included plenary sessions, small group discussions, lecture discussions, presentations, exercises, micro-teaching and a field visit.
2. PROCEEDINGS OF DAY 1

2.1 Opening remarks

Dr M Belhocine, Director of Non-Communicable Diseases on behalf of the Regional Director, opened the workshop. In his opening remarks he emphasized that primary prevention of substance abuse is a major concern in the region and psychoactive substance abuse was not an isolated phenomenon. It was occurring in a volatile environment, with rapid economical and social changes. In such an environment, transformation from transit to consumer status was inevitable. Countries in the region are struggling with AIDS, refugees and famine. Therefore, it was critical to address the problem before it reached crisis proportions. More evidence is needed on the prevalence and relationship to crime and so on. This knowledge would enable action, as the more that is known, the better policy makers are prepared. The aim is to support countries, especially in relation to women and young people. Partnership is essential for success. An important step towards partnership is the promotion of community-based interventions. For sustainable results, action should be integrated to include all stakeholders. Monitoring and evaluation are critical. It is important to develop a culture of monitoring and evaluation. Evaluation is the strongest tool for advocacy as it provides evidence for success. Description and dissemination of practices will be required. If this is not done, efforts would not be sustainable.

2.2 Key note address

Mr Ketil Bentzen, representing the Norwegian Government, the donor agency, delivered the keynote address. He pointed out that medical professionals are limited in what they could do in terms of primary prevention of substance abuse. Regarding how to mobilise resources, especially community resources, he stressed that one cannot go out to teach the community, one has to be prepared to listen when doing prevention work. Primary prevention is partly a responsibility of the government with laws and regulations to restrict use. The general population needs to be informed about the dangers of substance abuse. Prevention activities should serve to meet the needs of young people at risk. There are some initiatives in the communities. The challenge is how to organise the initiatives in a meaningful way. The purpose of the project is to strengthen partnership with non-governmental organizations (NGOs). NGOs may have a problem by themselves as they are formed by a certain fixed idea. There is therefore need to open up to young people who are not usually reached adequately through most services that are provided.
2.3 Overview of the Global Initiative

Dr R Abdool of UNDCP, noted that the number *three* was special with the Global Initiative. Not only were there three partners, the Norwegian Government, UNDCP and WHO, but there were also *three* continents, Africa, Asia and Europe, and three participating countries, South Africa, Tanzania and Zambia. In addition, there were the *three* specific objectives for the workshop, training of trainers, review of draft workbook and the development of action plans. He pointed out that UNDCP Regional Office for Eastern and Central Africa operates under Southern African Office in Pretoria. Substance abuse was reaching near crisis proportions in several countries of the region.

Ms A Nkowane of WHO headquarters stressed the importance of cooperating with the ministries of health and local partners. Outcomes of the project included the following:

- Reduction in the number of young people abusing substances.
- Improved awareness of adverse effects of psychoactive substance abuse in the communities.
- A pool of trainers in the community to train others.
- Networking.
- Feasible, tested models for primary prevention.
- Public awareness towards prevention programmes.

**Intended beneficiaries**

The primary beneficiaries for the intervention activities are:

- adolescents and pre-adolescents;
- people who play a significant role in young people's lives such as parents and teachers.

Dr C Mandlhate, Regional Advisor for Mental Health and Substance Abuse (WHO, AFRO) indicated that the issue of coordinating different actors in communities was still weak. The project was starting in selected countries. It was therefore important to show evidence that what was being done is good. The African Region of WHO is composed of forty-six countries. The challenge to the three selected countries was to prove that they are able to do the work.

The regional committee held a meeting in Windhoek, Namibia in 1999 that was attended by ministers of health. At this meeting a resolution making mental health and substance abuse prevention a priority was passed. The challenge to the workshop participants was to make the political resolution a reality.
The principles guiding the resolution include the following:
- integration of mental health and substance use issues
- targeting special vulnerable groups such as refugees, high-risk groups and young people
- helping countries on policy development and resource mobilization.

Partnership will therefore be important.

2.4 Expectations of participants

As community work involves the community, it is crucial to encourage this aspect during the workshop. To ensure that the objectives of the workshop were compatible with those of the participants, it was necessary to find out what participants expected to gain from the workshop. Expectations of the participants are listed below:

- To be equipped with requisite knowledge and impart it to others.
- Learn how to utilize resources.
- Learn effective approaches and teaching prevention at community level.
- To share experiences.
- Organizers to put in place support mechanisms for sustaining projects.
- To acquire skills for integrating substance abuse into Primary Health Care.
- To come up with a common approach in teaching substance abuse prevention.
- To have the opportunity to join the Global Village.
- Learn how to involve young people to ensure sustainability.

2.5 Rules

In addition, to ascertain the participants' expectations, it was also important to determine rules to abide by. The participants felt that it was important to:

- Keep to time.
- Respect individual ideas.
- Challenge constructively (each) individual ideas.
- Stay focused on objectives.
- Refrain from smoking in the workshop room.
- Switch off cellular telephones during session.
Another way that was used to foster an atmosphere of cooperation was to ask the participants to offer to take up certain social responsibilities or nominate some members for specific social responsibilities. Four specific responsibilities were identified, and these were health, social affairs, time management during workshops, and food.

2.6 Primary prevention of substance abuse: Overview of the workshop

2.6.1 Objectives

The general and specific objectives of the workshop were reiterated. The general objective was to develop a core group of trainers in selected countries of implementation.

The specific objectives were expanded upon as follows:

- To conduct training of trainers.
- To field-test the Global Initiative material.
- To compile suggestions and comments on the Global Initiative learning materials.
- To evaluate daily workshop activities.
- To evaluate the entire workshop.
- To evaluate micro teaching conducted by participants.

2.6.2 Introduction to documents – operator’s workbook and facilitator guide

Participants were expected to carry out a critical review of the workbook and present a synthesis individually. It was reiterated that the development of training materials had to take into account relevance and cultural appropriateness to the target group. Drafting of learning materials signifies accomplishment of the initial step in this process. As the learners are usually examined or tested to determine whether they have attained the required knowledge, skills and attitudes, the same process applies to the development of learning/training materials. The process adopted is highly participatory. A format on the process for the review was provided for each participant. Suggestions from this exercise are to be utilized to modify the workbook making it appropriate for the users.
2.6.3 Summary of country presentations

South Africa

Ms A Moleko (South African Alliance for Prevention of Substance Abuse - see full presentation in the annex)

The problem in South Africa results from "substance abuse" occurring in an economy currently at a fair level of development. The burden of substance abuse varies across and within the various provinces. There is increasing population pressure, homeless people, number of informal settlements, income inequalities, poverty, unemployment, crime and violence including rape. In addition, there is the increasing burden of HIV/AIDS.

There is need for understanding the causes. Government organizations, non-governmental organizations and community organizations have established the South African Alliance for Prevention of Substance Abuse. There is no integration among these organizations, therefore there is need to contextualize substance abuse prevention. A prevention strategy focusing on research, risk reduction and Primary Health Care has been developed using a multi-method and multi-disciplinary approach.

Young People Characteristics

- age group 10-24 years (31.6% of total population).
- 49% Male and 51% Female.
- KwaZulu Natal has the highest population of young people, followed by the Eastern Cape.
- younger age group and females are concentrated in rural areas.
- there is migration from rural to urban areas especially among older males.
- for the age groups 14 to 35 years, the unemployment rate is 43%.
- for 16 to 35 year age group, 20% are in informal employment.
- there is 33% school drop-out rate.
- 19.3% of those aged 20 years and older have no schooling.
- average age of people committing crime is falling, in 1988 this was 22 years and in 1990 this was 17 years.
- HIV infection in girls aged 14 to 19 years was 12.7% in 1997 and 21% in 1998.
Young people and drug use

A number of studies on drug use have been carried out from the mid-1970s through to the 1990s. Studies have described the nature and extent of drug use among the 10 to 25 year age group. The studies were restrictive in terms of geography, demography and methods used. Geographically, studies tended to concentrate on particular regions or communities and on particular subgroups. School surveys and "unstandardized" self-administered instruments were used. Comparisons and interpretations were complicated.

Findings

Findings indicated that drug use was complex and varied over time. Patterns and trends showed an overall increase in use. In the past, though legal drugs such as alcohol, tobacco and over the counter drugs were used by advantaged older, urban males, presently use has spread to the disadvantaged, very poor rural people including females. In the past, use was restricted to particular groups and special occasions, this has now become an everyday activity. Preference used to be for malt beer for those with a Sintu language background, now commercial alcohol has a wider preference.

The homeless, young people who live on the streets use solvents in order to overcome cold and hunger. Cannabis is the fourth popular drug. Whereas in the past cannabis was used by disadvantaged older males, use has now spread to the advantaged younger age group, including females. There is a wider variety of illicit drugs available and now there is poly-drug use. Broadening of drug use is facilitated by demand (social exposure, social pressure and limited social discrimination) and access (opportunities).

Prevention

Prevention efforts would focus on individuals as well as communities. For individuals this would include life-skills training and provision of education and employment opportunities; whilst for the communities, this would focus on the reduction of socio-economic inequalities, family, community and nation building. It is appropriate to investigate, monitor and evaluate preventive actions through collaboration, using multiple techniques and methods. There is need for periodic household surveys and a general point of reference.
2.6.4 Country presentation: Tanzania

Dr J Mbatia (Ministry of Health)

On the mainland of Tanzania, substance abuse falls under mental health. There is close cooperation with the anti-drug commission. Realizing the magnitude of the drug abuse and trafficking problem, the Government of the United Republic of Tanzania enacted the Drugs and Prevention of Illicit Traffic Act of 1995. It is through this Act that the Inter-ministerial Anti-Drug Commission was formed to reinforce the government’s commitment to eliminating the drug problem in the country. The Anti-Drug Commission is under the chairmanship of the Prime Minister and draws key people from various ministries. The secretariat provides technical support and each key player is supposed to have input in the Commission. The Commission co-ordinates all activities on drug abuse. The UNDCP in Dar-es-Salaam links with the Commission. A multi-sectoral approach is used on issues of policy.

Mr S Chisongela (Education for Youth Project “EMAU”)

EMAU is a non-governmental Organization that was established in 1976 by the Christian Council of Tanzania. They started the project for Responsible Parenthood Education for Youth as a result of concern about youth problems.

Focus

The focus of the project has been on training programmes. They have conducted training programmes through youth leadership and parent outreach seminars. Parent outreach seminars were for leaders of non-governmental organizations and religious sectors involved with youths. There were other special seminars involving working with the Ministry of Education, Ministry of Labour and Youth Development on various areas including substance abuse.

Implementation of activities has been in three-year phases, each with an evaluation. For the literature production project, 21 series of booklets have been written and published on various projects; three of the booklets are on drug abuse, alcoholism and addiction. Other activities include poster designing and public awareness programmes. There is a fifteen-minute radio programme on Saturdays, on drug abuse. There is another programme on BBC.
Mr M Mussa (Islands – Zanzibar)

Drug abuse is a big problem on the island. Zanzibar is used as a transit point for substances. The Department of Substance Abuse links with the Ministry of Health, working on mental health policies. In the last two years, substance abuse has been integrated into mental health. About 20% of hospital admissions involved substance abuse problems. There is a radio programme once a week and a television programme twice per week. Other activities include school health information on substance use and training of trainers with the help of UNDCP.

2.6.5 Country presentation: Zambia

Mr J Mayeya (Central Board of Health)

Country profile

- Population: 10.4 million.
- Growth rate: 3.2%.
- Young population is about 50%.
- Economy not doing well, open market system.
- Unemployment is high.

Health services

In Zambia, the government, church and private organizations run health services. By 1990 Zambia had 82 hospitals and 942 health centres. In line with general policy reform, there were reforms in the health sector in 1992. The aim was to re-align scarce resources to meet changing demands. This resulted in the development of the National Health Strategic Plans (1995-1998, 1998-2000)

Constraints related to mental health in the health reforms

1. Mental health and illness have been missing from the listed priorities. As a result they are still not integrated in the Essential Health Care Packages.
2. There is no national mental health policy in place.
3. The Mental Disorders Act of 1951 is outdated.
Current efforts to streamline mental health services in Zambia

1. A draft Mental Health Policy working document has been developed.
2. The Mental Disorders Act chapter 539 has been reviewed for submission to Ministry of Legal Affairs.
3. Draft guidelines for integrating mental health into Essential Health Care Package have been formulated.

The “missing” link

Over the years, mental health service development has been ad hoc. It has been based on the general health policy, the missing link being the National Mental Health Plan of Action.

Extent of substance abuse

A situation analysis involving nine provinces showed that substance abuse was rising. A study of 2,105 key informants carried out by Boog, et al. (1999) revealed that the common drugs were cannabis, inhalants and valium, respectively. A retrospective study by Okitapoy and Munkombwe (1999) of 9,973 psychiatric cases revealed that the majority (89.50%) of psychiatric attendees were adolescents and young adults aged between 15 and 35 years. In 1996, Chita conducted a case review of substance abuse and use among psychiatric establishments involving 20,726 cases admitted to the main psychiatric hospital and psychiatric units in the country. In this study, it was shown that 7% of admissions were related to drug abuse.

Constraints

Constraints related to substance abuse activities include lack of equipment and transport. There were attempts to foster closer links with different institutions such as the Young Women's Christian Association.
2.6.6  Country presentation: Zimbabwe

Mr A Mataranyika (Anti-drug Abuse Association of Zimbabwe)

A national perspective

Drug related problems are becoming a major public health concern. The Zimbabwean health delivery system is at its lowest delivery of service since independence. The rate of unemployment is constantly rising. Culture is disintegrating. The HIV/AIDS epidemic is a burden with the number of orphans increasing. The prevailing economic environment is harsh. With this background, statistics have shown a sharp increase in drug cultivation, drug seizure by law enforcement agencies and drug-related crime in the country. Studies carried out have shown that the problem of drug abuse is prevalent among young people.

Limited actions have been attempted to minimise the drug problem. In 1986, the government acknowledged the problem of drug abuse and established the Resource Center for Drug and Alcohol Problems through the Ministry of Social Welfare. A drug squad was created within the police force. The Ministry of Health has continued to offer treatment and rehabilitation services to drug-dependent people. The Health Education Unit in the same ministry has developed preventive drug education programmes. The Ministry of Education is also actively involved in preventive efforts in some schools. To date, there is no policy on substance abuse, but a National Drug Control master plan is on the drawing board.

The problem

The major problem is acceptance of the gravity of the situation. The problem is given little priority in terms of resources, despite the indications that use and possession of drugs is increasing. In 1997 there were 1,027 lives lost as a result of drunken driving. For the non-governmental organizations involved in substance abuse, the main focus was on other issues.

Future activities

The drug squad of the police will launch a strategy in 2000. The Anti-Drug Abuse Association has a number of activities scheduled for 2000, including the schools pilot project intended to educate young people on dangers of substance abuse. Other activities would involve assessment of the magnitude of the problem, anti-drug music and an art festival.
Ms C Chasokela (Ministry of Health)

There will be a new Mental Health Act in place in December 1999. There is a three-year plan for mental health and substance abuse as priorities. The Ministry of Health is involved in activities with the International Centre for Alcohol.

2.7 Discussion of country experiences

Discussions relating to the response of programmes from various social strata in South Africa, indicated that the "bottom-up" approach had a positive and good effect. The response was encouraging. However, problems had been noted, not only with high density areas, but also with the informal settlement areas where substances were used as a source of income. The issue of commercial versus traditional use appeared to affect most of the countries. It was also indicated that the first world approach was being adopted in the urban areas. Emphasis in the urban areas is to the detriment of the more rural areas. In assessing the impact of the non-governmental organization youth programme in Tanzania, it was pointed out that results were more positive in urban areas. Non-governmental organizations were not well equipped for the rural population.

Major issues that were brought up during the various country presentations included:

- The need for policy basis was acknowledged.
- The issue of integrating prevention of substance abuse into PHC was acknowledged.
- The issue of equity between rural and urban areas required attention.
- The issue of strengthening of partnership was noted.
- The need for monitoring and evaluation was identified.
- In agreement with regional framework, UNDCP/WHO country office has a focal person in the country or is in process of trying to appoint one.
2.8 Introduction of the training concepts: the workbook

Ms A Nkowane

The concept learning

Learning involves the acquisition of knowledge, skills and attitudes. Learning needs to be enjoyable. In assessing whether learning has taken place, it was important to ensure that change brought about by learning would endure. For this reason, there was need to follow up. Assessing change involves the issue of indicators. Learning outcomes are therefore important. A critical aspect becomes knowing what the person (learner) should do, know or understand, and the type of attitude adopted after training.

Training distinguished from education

In training, one has to deal with a person who has experience. What should be done is to build on that experience. In education, the basic assumption is that the person being educated has none or little knowledge and skills with no experience to build on.

How people can learn

According to the participants, people can learn through various ways such as:
- listening and taking notes
- feedback/question and answer
- problem solving approach/role playing
- use of anecdotes
- doing tasks/demonstrations
- enquiry method
- lecture discussions
- observation
- cultural approach

Methods proposed

1. Question and answer and not lecture
2. Discussions
3. Role plays
4. Song and drama
Important issues in facilitating learning

Learning aids facilitate learning and should be used in conjunction with the selected training method. Learning aids help learners recall what has bee taught. To be effective, the trainer needs to take into consideration the characteristics of good and effective learning aids. Good and effective learning aids should be simple, specific to topic, specific to culture and carry a single message. Apart from adopting appropriate training methods and learning aids, the trainer needs to possess or develop the ability to listen and provide appropriate and timely feedback on evaluation or assessment of the learner.

2.9 Training and review of Workbook Modules

2.9.1 Module 1: Psychoactive substances

Dr R Abdool

Types of abused substances included:

a) Alcohol (including cough syrups)
b) Tobacco/nicotine, cannabis
c) Stimulants (amphetamines, khat, cocaine, crack cocaine, designer drugs)
d) Opioids (heroin, morphine, opium, methadone, buphrenorphine)
e) Depressants
f) Hallucinogens (LSD)
g) Nitrites – popper, volatile inhalants- genkem, grass
h) Other, betel
i) Locally abused (brew) substances

Effects

Effects of substance abuse can be immediate, short or long term. In South Africa, students have been reported to experience cannabis psychosis.

Other effects included:
- malnutrition
- mental problems
- pregnancy – foetal alcohol syndrome due to smoking during pregnancy results in low birth weight, respiratory problems
- congenital abnormalities (spinal-bifida)
Consequences

Consequences were experienced at three levels.
- personal level
- familial level
- community level

In the absence of the drug, the body craves more of the drug. Drug use is no longer pleasurable. In the end, the drug is used to suppress craving.

Population

![Population Pyramid Diagram]

Developing country

Developed country

The challenge

Comparing the population pyramid between developing and developed countries there are notable differences. For developing countries the population pyramid has a wide base and a very narrow apex. On the other hand, the population pyramid of a developed country has a wider base and a fairly wide or flat apex. The challenge for the region is that while the population of young people is much higher than that of developed countries, school enrolment is decreasing while the drop-out rate is increasing. Prostitution is increasing with the added danger of HIV/AIDS. There are rapid socio-economic changes. There is need for training teachers in light of the low age of initiating use of drugs. It is crucial to take on the maximum number of players.

When one implements Primary Health Schemes there will be clients who require secondary or tertiary services, therefore, programmes have to be flexible in considering those in need of referral. It was important to allow the community to drive the programme. Primary prevention of substance abuse involves early intervention, statutory intervention, as well as continuance of care.
Matters concerning child development 7 to 13 years require attention. Parents need to be educated. It was important to consider how best to involve parents. Starting involvement with community leaders bears results.

Following the presentation, there were no major issues raised.

2.9.2 Training and review of Workbook Module 2: Psychoactive substance use among young people

Ms A Nkowane

Objectives of the module were stated. The Public Health Model was used to help participants understand substance use and abuse. After a review of the model, participants worked on various exercises in small groups. This was followed by plenary discussion.

Risk factors

Risk factors for substance abuse included:
- peer pressure;
- exposure to drugs;
- lack of information about the effects and dangers of drugs;
- lack of facilities, e.g. educational, recreational and lack of other resources, drugs used helped the user to withstand cold during the night on the streets or to gain courage when engaging in prostitution;
- age, young people are in the period when they are curious, seeking fun and their behaviours could involve risk taking.

Protective factors

Protective factors identified included:
- skills;
- resources to meet emotional needs (internal—within the young person e.g. ability to make decisions about not taking substance, external—social-cultural support systems and other physical resources);
- policies relating to law enforcement and their enforcement, and educational, community policies; and
- positive attachments e.g. role models, schooling

There were no major issues raised concerning this module.
2.9.3 Training and review of Workbook Module 3: Ways of preventing psychoactive substance abuse

Ms T Butau

The guiding principle in psychoactive substance use prevention is health promotion, which encompasses mental, social and physical well being. Health promotion refers to:
- social action
- educational action
- political action

Principal strategies

- advocacy
- social support
- empowerment
- research

Health promotion action involves

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services

Approaches to health promotion

Health promotion involves change at various levels.

- individual level
- organizational level
- community level

Importance of primary prevention in adolescence

This is a key period for problems that emerge later in adulthood in respect to learning and consolidating health-related values, attitudes, behaviours and lifestyle. Causes of substance use during adolescence include: lack of information and skills, poor access to education and health services, unsafe and unsupportive environment. The underlying factors are poverty, rapid social change and urbanization, gender, social values and norms.

For this module participants also worked on various exercises in small groups. Some of the responses are noted below:
Exercise 2:
The list below comprises of people who could be contacted for policy development:
- members of parliament
- local government leaders
- legal experts
- religious leaders
- key local community leaders
- youth leaders

Examples of country policies related to psychoactive substances:
- age limitation laws
- restriction of drinking hours
- commercial alcohol production, distribution and sale regulations
- parental responsibility for under age drinking
- restriction on location of sale
- children under 18 not allowed to enter drinking premises
- young people under 18 not involved in production, distribution and sale of alcohol
- prohibition of local alcohol production in residential areas
- alcohol companies not permitted to sponsor youth activities
- alcohol and other drugs not permitted in schools
- no use of tobacco in health/school/premises or public transport

Enforcement of laws can be achieved through:
- government commitment to enforce them
- well established enforcement mechanisms
- penalties for non-compliance
- good community leadership
- community militancy
- use of community members, police and local magistrates

In small groups participants reviewed the following scenario presented in the workbook in:

Exercise 3:
“*It has become apparent in your community that, the number of people dealing in psychoactive substance has increased. Children walking to and from schools are usually approached to sale psychoactive substances on behalf of these dealers. The community is concerned about this problem and wants to make the environment safe for young people*”.

What options exist in your community that can be used to ensure that the environment is safe for young people?
Below was the response:
- to involve the Law Enforcement Officers to use existing laws to protect young people.
- lobby for advocacy with political leadership for awareness campaigns
- use gate keepers in the community to address the issue of concern
- community based organizations should conduct awareness campaigns about dangers of psychoactive substance use

Types of recreational activities identified were:
- popular sports such as soccer
- music
- drama
- radio and television talk shows
- “nsolo” (equivalent to drafts)

**Exercise 4:**
Strengthening community action approach would entail:
- a bottom up approach
- activities initiated from the grassroots
- information
- encouraging ownership

Community actions would included:
Participation in activities such as International day Against Drug Abuse, school activities, essay poster competition, marches, seminars and TV/radio spots

**Exercise 5:**
Developing personal skills
- industrial theatre and facilitated workshops in the school and community
- Role play
- use of media, print and electronic
- use of information centers such as primary health care centers, churches
- Involvement of the youth in developing posters and information leaflets

Vocational skills:
- micro and small business enterprise
- youth community radio stations
- computer training to develop intervention programmes
- art, music and drama
Exercise 6:
Reorienting services
- orientation of key people in a variety of settings 8 primary health care centres, educational establishments, family health care centres, mental health centres and law enforcers such as “Interpol”

To orient services to meet the needs and demands of young people services should be:
- youth friendly to encourage the youth to accept to use them
- involve youth in dissemination of information and management of services

Other services that may be offered could relate to:
- sports and recreation facilities
- drop in centres
- employment creation and vocational centres
- income generation activities

2.10 Discussions

Issues were raised concerning the role of the community in policy development. Regarding subtopic Building Healthy Public Policies it was suggested that the phrase “an action plan” should be replaced by the word document For the title of exercise 2 it was suggested that this be amended to read Community contribution towards building healthy policies. For item (a) 1. The word “development” to be replaced by the phrase facilitate development of Item (a) 5. To read “Draft a sample policy guideline”. Item (a) 4. To read “Once the policy guideline is developed” and Item 4.ii to be excluded.
3. PROCEEDINGS OF DAY 2

Proceedings on the second day started with reflections on the first day of the workshop.

3.1 Lessons learned on day 1

Reflecting upon the activities of the first day of the workshop, participants indicated that they learned the following:

- Participatory approaches to training enhance learning.
- Importance of community involvement in community work.
- The importance of comprehensive approaches in substance abuse prevention.
- Importance of collaboration between key partners.
- Gained insight on different services that already exist in the community.
- The consequences and effects of substance abuse in young people and types of substances used.
- Importance of evaluation as it brings up evidence of what has been achieved.
- Importance of information sharing in helping countries learn from each other’s experiences.
- The three factors influencing use, the person, substance and environment.
- Importance of modifying approaches to suit cultural context.

3.1.1 Feedback on evaluation of day one

To evaluate each day training/field-testing activities, participants responded to the statements below using the scale of 1-5.
1) Strongly agree 2) Agree 3) No opinion 4) Disagree and Strongly disagree. Total number of people responding = 14. Only comments are documented in annex 3.
3.2 Training and review of Workbook Module 4: Project development and management

*Dr R Abdool*

Participants were introduced to the cycle of project development. This was followed by a review of the different components of a strategic project plan. No issues were raised following review of module 4.

3.3 Training and review of Workbook Module 5: Baseline assessment

*Dr R Abdool*

Baseline assessment involves use of primary and secondary data. Secondary data were useful in making preliminary recommendations. Analysis of secondary data gives a partial picture of the situation. Analysis helps to identify gaps and gives an idea of areas to focus on for primary data collection. After collection of primary data, these should be merged with secondary data and analysed. Quantitative data help to understand what influences the figures. There is need to reach an improved understanding of:
- nature
- extent
- trends
- patterns
- related problems

It is important to assess structures and services that are available or unavailable. Response to problems should be done in a culturally appropriate, sensitive and cost-effective manner. The idea is not to have an absolute picture, but to have a composite picture sufficiently accurate to sensitize policy makers and to develop action.

**Characteristics of Rapid Assessment Methods**

- quick
- flexible
- cost-effective
- mixture of epidemiology and ethnographic
- lack specialised research capabilities
Primary data

I. Sampling
   - opportunistic sampling
   - snowball sampling
   - quota sampling
   - population surveys

II. Technique for data collection
    Focus groups, Key informant, Mapping and others

III. Field notes
    To include, contextual, structural, social and economic, drug abuse, resource and intervention policy assessment

IV. Principles of field work
    - safety
    - image management
    - ethical considerations
    - advocacy
    - not to engage in buying/accepting gifts
    - building partnerships and networking

Following the review of module 5 no major issues were brought up.
3.4 Training and review of Workbook Module 6: Monitoring and impact evaluation

Dr C Mandhate

Participants were introduced to the module 6. Definition of objectives is crucial to monitoring and evaluation. It is important to consider how objectives are to be measured. It is important to select the right activities to achieve set objectives. Monitoring takes place all the time.

Monitoring

Monitoring is the process of checking activities that are being implemented. It is a continuous checking of progress and putting corrective measures in place. It is important to clearly define indicators for monitoring. In addition, responsibilities need to be outlined out clearly.
Monitoring involves:
- review of routine reports
- supervisory/site visits
- review of expenditure
- use of indicators

Evaluation

Evaluation is an extension of monitoring. Evaluation is performed at specific times. Evaluation should involve internal and external people. Evaluation helps to assess progress, achievements, what has/has not been done and what is to be done next.

Following discussion of the module no major issues were raised.
3.5 Training and review of Workbook Module 7: Project capacity building

Ms A Nkowane

The module was introduced and then participants worked on the exercises in small groups. Importance of community mobilization:

- facilitates mobilization of resources
- promotes project sustainability
- enhances response from community

How to motivate the community

- encourage participation at all levels
- establish a community advisory committee
- avoid prejudice
- follow and respect cultural values
- give community members responsibilities
- involve the community from the beginning

It was important to identify local resources, involve young people and ensure networking.

Exercise 1:

Establishing a good relationship with the community should involve:

- giving them information about yourself, what you do and where you are from
- organising mini-seminars or talk shows to stimulate them into participating in activities within the community
- sharing the benefits, objectives and aspirations of the project
- demonstrate tolerance about the community culture, values, virtues as well as to include other activities related to their culture within the project.

Discussions on the case study of Jama in the workbook yielded the following:

- as soon as Jama began his work, he went ahead to implement project activities without a needs assessment, no initial community involvement or ownership
- policy makers had not been part of the process, he developed a list of policies that had been found to work elsewhere
- did not motivate the community properly
- did not attempt to adapt the materials developed by international organization to the local context
To be effective Jama could:
- have ensured that the needs assessment was done
- involve the community from the grassroots in the project
- consult policy formulators to engineer their own policies with particular relevance to their situation
- involve community leaders in the planning stage and develop a mutual understanding, community leaders already have influence in the community and it is easier for them to take on leadership roles
- be flexible in dealing with the youth
- gate keepers should be involved because they can give people a negative picture of the project and bar people from participating

No major issues were raised during the plenary session.

The proceedings of the day ended after participants were briefly introduced to micro-teaching and action planning.
4. PROCEEDINGS OF DAY 3

As during the second day of the workshop, proceedings for the third day began with reflections on the previous day’s activities.

4.1 Lessons learned on Day 2

Participants indicated the following in the box as lessons learned.

- Realized the importance of monitoring and evaluation.
- Learned more about methods and approaches of data collection.
- Learned about rapid assessment methods to use.
- Learned about the relevance of capacity building in project development.
- Aspects of culture need to be taken into consideration when planning and implementing preventive activities.
- To share tasks when there is too much pressure.
- The distinction between policy making and contribution to policy development.
- Resources are readily available in the community if one knows how to access these.
- How to formulate a project proposal.
- The various stages in planning research.

4.1.1 Evaluation of Day 2

The proceedings of day two were guided by the evaluations of the preceding days. In particular, day three proceedings were guided by the participants’ evaluation of the second day as presented in annex 3b.
4.2 Micro teaching

Three groups performed micro-teaching. Teaching activities were videotaped. Each group presentation was followed by a discussion. A copy of the video recordings was provided to each participating country. Participants were given time to self-critique on the training performed and peer evaluation followed by trainers' evaluation was also done. All participants expressed their desire to improve on their training skills for the future and that the exercise was a good one.

A preliminary evaluation was conducted on the participants ability and effectiveness to train others on the material developed based on their performance during the microteaching exercise. The evaluation criteria used was as noted below:
- depth of content
- fluency and lesson delivery
- appropriateness and engaging of participants
- audience impact

All participants scored more than 50% with Mayeya, Moleko, Mbatia, Kaliminwa and Viviers scoring 75%.

4.3 Field visit

Participants were offered the opportunity to visit the Information, Education and Communication (IEC) Department of the Zimbabwe National Family Planning Association. The Zimbabwe Family National Family Planning Council has a department that deals specifically with information, education and communication (IEC). The activities of this department include development, designing and implementation of primary prevention programmes related not only to sexual behaviour of young people, but also to other risk behaviours such as substance abuse.

4.3.1 Purpose

The purpose of the visit was to enable participants to share experiences in integrating substance abuse programmes with existing ones.

4.3.2 Specific Objective

The specific objective of the visit was to assess the feasibility of integrating a substance abuse programme with a reproductive health programme.
4.3.3 Issues considered during the visit

**Type of activities**
- Description of ongoing and past interventions implemented by organizations.
- Youth involvement.
- Coverage of youth population.
- Community involvement.
- Implementation.
- Outcomes.
- Future plans related to substance use.
- Any at-risk groups.

**Networking**
- Type of networking.
- Other agencies involved.

**Resources**
- Sources of resources.
- Local resources.
- External resources if any and how these were acquired.
- Type of human resources/Use of volunteers.

**Services**
- Services required by the youth.
- Existing services that can be used in the prevention of substance use.

**Integration of substance use with other programmes**
- Motivation for integration of prevention of substance use with reproductive health.
- Strengths and weaknesses.
- Problems encountered and measures taken to overcome them.
- Outcomes.

**Radio / television spots**
- Benefit of radio spots.
- Benefit of television spots.
- Who developed the material.
- Outcome.
**Television talk show**

- Benefit of talk show to prevention.
- Who developed the material.
- Outcome.

The visit involved a discussion with the Director of the unit regarding the activities of the department. Participants toured the various production units. A summary of the field visit experiences is documented in the box below:

**Feedback from the field**

<table>
<thead>
<tr>
<th>Summary of field visit findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance abuse prevention has been integrated in the IEC programme.</td>
</tr>
<tr>
<td>2. Adopted approach is information sharing only.</td>
</tr>
<tr>
<td>3. Information may only be relevant to urban settings.</td>
</tr>
<tr>
<td>4. The programme possesses recording equipment and maintenance could be problematic as it is not sustainable.</td>
</tr>
<tr>
<td>5. Some messages had not been carefully developed and could be misinterpreted by the target group.</td>
</tr>
<tr>
<td>6. Integration of substance abuse in the programme did not make use of people working in the substance abuse area.</td>
</tr>
<tr>
<td>7. There was inadequate planning for the integration of substance abuse as only messages and activities prepared four years ago exist.</td>
</tr>
</tbody>
</table>

**What participants learnt**

1. It is important not to respond to a need before fully understanding it and its implications on the programme.
2. Careful planning can yield better results.
3. Cost effectiveness of any project must be carefully taken into consideration before project implementation.
4. Language used to disseminate information must take into account those who are at minimal literacy level.
5. Maintenance of expensive equipment can be a problem and may take away essential financial resources from other more useful project activities.
4.4 Presentation of national action plans

Each of the three countries that were selected to implement the Global Initiative presented draft action plans (see in the annex). The plans signify their efforts in trying to make things happen in their respective countries in preparation for the full implementation of the project in the selected countries.

4.5 Final evaluation of the workshop

Participants responded to the statements outlined in the evaluation form using the scale of 1-5 as for the daily evaluation. The aim was to use the comments to make improvement in subsequent similar workshops at regional and country levels. Thirteen participants responded to the questionnaire. The workshop was well-received. Information about this is presented in annex 5.

4.6 Closing remarks

Mr A Mataranyika (observer from Zimbabwe)

"On behalf of the participants from all represented countries and facilitators, I would like to first of all express our profound gratitude to the Norwegian Government for providing for this workmanship. I would also like to thank our facilitators, Mwansa, Custodia, Tecla and Reychard for a job well done. I think you should all consider a career in lectureship. We truly believe that the Global Initiative is back and alive. Let me take this opportunity to thank my fellow participants for the three days of sharing, workmanship and respecting one another in the way you did. I certainly and strongly believe that you all have something to take home and a lot of work to do. Now, on behalf of my country Zimbabwe, as the host country and on behalf of my organization, I wish to thank the organisers for allowing us to participate. It really means a lot to us and we have learnt a lot despite that we are not “yet” part of the Initiative, although I have a strong feeling that it will not be long until we join you. It has been an experience, one that will go a long way in primary prevention of substance abuse. Finally, on my behalf, I would like to thank you all. I hope you had a wonderful stay and BON VOYAGE!"
4.7 Recommendations

4.7.1 Recommendations from participants

1. WHO should ensure that the efforts made this far become a reality by June 2000.
2. WHO and UNDCP have the responsibility of making close follow up on this initiative and promote information sharing on the project.
3. The selected countries should ensure total commitment for the delivery of expected outcomes.
4. The updated learning materials should be sent as soon as possible to the selected countries in readiness for the national training activities.
5. The people represented in this workshop must be maintained and supported to ensure continuity and sustainability of the project.
6. Although Zimbabwe attended the workshop as observers, it would be preferred that the project be expanded in future to include them.
7. There is need to stimulate networking among the selected countries as well as other countries doing similar work.
8. Development and circulation of a newsletter about the Global Initiative will ensure that all countries are updated on what is taking place in the project. Its development should be supported.
9. In future, such a workshop should be conducted over a period of 5-6 days to ensure that the objectives are achieved with minimal pressure on the participants and facilitators.
10. The people represented in this workshop should be given attendance certificates.

4.7.2 Recommendations for WHO/AFRO

WHO/AFRO should:

1. strengthen the regional capacity to respond to country needs for support.
2. support the countries on the finalisation of the action plan for the implementation of the project (discussed during the Harare workshop).
3. support the national authorities on the development and implementation of the projects, keeping the proposed deadline.
4. in consultation with countries, propose mechanisms for monitoring and evaluation of the projects.
4.7.3 Recommendations for WHO/Country Offices

WHO Country Offices need to:

1. designate or confirm focal person from the WHO Country support team to respond to substance abuse issues and communicate to AFRO for better co-ordination.

4.7.4 Recommendations for National Co-ordinator for Substance Abuse Programme at the Ministry of Health level

National Co-ordinator for Substance Abuse Programme at the Ministry of Health level should:

1. designate or confirm a Focal Person to co-ordinate the project and liaise with the national key players, UNDCP and WHO country offices.
2. maintain good interaction with the involved partners.
3. finalise within the agreed time frame the project proposals and submit to WHO Country Offices for further follow up action.
4. report regularly to WHO on the progress of the implementation of the activities.
5. keep good interaction with AFRO and report on a regular basis the progress of the implementation of the project.

4.8 Conclusion

The TOT and field-testing of the learning materials was a big success as reflected in the workshop evaluations. All set objectives were realised and both participants and facilitators concluded the workshop with renewed commitment to speed up the implementation of primary prevention of substance abuse activities in the selected countries. Each partner in this process reaffirmed the need to execute the responsibility entrusted to him or her as outlined in this report. Indeed, the enthusiasm shown at this workshop should not be dampened. The financial support of the Norwegian Government has been appreciated. In addition, participation of Mr Bentzen on behalf of the Norwegian Government was a motivating factor to all concerned as it clearly showed the commitment of the Norwegian Government to continue supporting the implementation of this Initiative. The excellent working relationship that was established between WHO and UNDCP during this workshop, is a stepping stone for future collaboration on this project. All key partners WHO, UNDCP and selected countries are committed to begin implementation of projects by June 2000.
Annex 1

FACILITATORS/PARTICIPANTS/OBSERVERS

Participants

Tanzania

Mr Steward N. Chisongela
Executive Director of Responsible Parenthood Education for Youth Project “EMAU”
P.O. Box 297
Dar-es-Salaam, Tanzania
Tel: 255-051-151274/153387
Fax: 255-051-151274

Dr Joseph Mbatia
Co-ordinator
Mental Health Programme
Ministry of Health
Tanzania Mainland
P O Box 9083
Dar-es-Salaam
Tanzania
Tel: 255-51 120261 Ext. 249
255-51 667339 (H)
Cell: 0811 616190
Fax: 255-51 152818
Email: jmbatia@muchs.ac.tz

Mr Mahmoud Mussa
Mental Health Co-ordinator in Zanzibar Zone
Deputy Secretary of SWAZA
P O Box 440
Zanzibar
Tanzania
Tel: 255-0510232257
Home: 235033
South Africa

Ms Cecilia Onica Maphai
Deputy Director: Policy for Substance Abuse
Department of Health, National Office, Pretoria
Private Bag X828
Pretoria, 0001
R1724 Civitas Building
Coss Struberth Andres
or
P.O. Box 242
Denneboom post 0160
Republic of South Africa
Tel: (012) 312-0477/8 or 8017513
Cell: 083 528 0447
Fax: (012) 3231913
Email: maphaco@hltlsa2.pwr.co.za or maphaco@wondline.com

Ms Anne-Gloria Moleko
Chairperson
South African Alliance for Prevention of Substance Abuse
P O Box 41119
MoreletaPark, 0044
Republic of South Africa
Tel: (012)-997-1601 or (011) 6444-2784
Fax: (012) 997-16011

Mr Pierre Viviers
Drug Resource Person
Department of Welfare
Private Bag X901
Pretoria
Republic of South Africa
Tel: (012) 3127783
Fax: (012) 3242648
Zambia

Ms Kawambu Hakachuma
YWCA Child in Crisis Centre- Co-ordinator
P.O. Box 50115
Lusaka
Zambia
Tel: 260-01-252726 / 255204
Fax: 260-01-254751

Mr John Mayeya
Mental Health Specialist
Alcohol and Substance Abuse focal point, including Tobacco Initiative
Central Board of Health
P.O. Box 32588
Lusaka
Zambia
Tel: 253179
Fax: 253173
Email: hritmave@pop3.zamnet.zm

Mr Steve Kaliminwa
Chairman
Substance Abuse Prevention Network (SACN)
P B 671X
Lusaka
Zambia
Tel/Fax: 260-01-236042

Observers/Zimbabwe

Mr Andrew Chapfika
Information and Education Officer
Anti-Drug Abuse Association of Zimbabwe
P O Box 1207 Kopje
11 Connaught Road
Avondale, Harare
Zimbabwe
Tel: 263-4-612437
Email: atchapfika@hotmail.com

Ms Cynthia M. Z. Chasokela
Director of Nursing Services
MOHCW
PO Box CY 1122
Causeway, Harare
Zimbabwe
Tel: 263-04-705967
Fax: 263-04-700960
Cell: 011 723367 /091 236951
Ms Essie Machamire  
Co-ordinator  
Mental Health & Drug Abuse  
Department of Psychiatry  
University of Zimbabwe  
P O Box A 178, Avondale  
Zimbabwe  
Tel:  263-04-791631 Ext. 268

Mr Artwell Mataranyika  
Programme Officer  
Anti-Drug Abuse Association of Zimbabwe  
P O Box 1207, Kopje  
11 Connaught Road  
Avondale, Harare  
Zimbabwe  
Tel:  263-04-302283  
Fax:  263-04-303092

Mr Lamiel BK Phiri  
Schools Programme Manager  
YADAC  
23 Bruce Rd, Midlands II  
Waterfalls, Harare  
Zimbabwe  
Tel:  263-04-610728 (H)  
Cell:  011 718 509  
Email:  lamiel bkp@netscape.net

Ms Dawn Wachenuka  
Youth Advisor, Youth Against Drug Abuse  
Youth Advisor Anti-Drug Abuse Association  
No 1 Ozora Close  
Msasa Park, P O Hatfield  
Harare  
Zimbabwe  
Tel:  263-4-573879

Observers/Norway

Mr Ketil Bentzen  
Deputy Director-General  
Royal Norwegian Ministry of Health and Social affairs  
Grubbegt 10  
P.O. Box 8011 DEP  
N-0030 Oslo  
Norway  
Tel:  047 22 34 8501/03  
Fax:  047 22 342 768
Facilitators/Secretariat

Dr Custodia Mandlhate
Regional Advisor for Mental Health and Substance Abuse, for the Regional Office, WHO, AFRO
Parirenyatwa Hospital
P. O. Box BE773 Belvedere
Harare
Zimbabwe
Tel: 263-04-706951
Fax: 263-04-702177
Email: mandlhatec@server.whoafr.org

Ms Tecla Butau
Technical Officer
WHO, AFRO
Parirenyatwa Hospital
P. O. Box BE773 Belvedere
Harare
Zimbabwe
Tel: 263-4-706951
Fax: 263-4-702177
Email: butaut@whoafr.org

Dr Reychad Abdool
UNDCP, Demand Reduction Advisor for Africa
UNDCP, Gigiti, Room A-200
Nairobi
Kenya
Tel: (254)-(2) 62-30-38
Fax: (254)-(2) 62-36-67
Email: Reychad.Abdool@undcp.unon.org

Ms Mwansa Nkowane
Technical Officer
Mental Health Determinants and Populations (MDP)
World Health Organization
Avenue Apia
1211 Geneva 27
Switzerland
Tel: 0041 22 791 4314
Fax: 0041 22 791 4815
Email: nkowanea@who.ch
Annex 2

WORKSHOP PROGRAMME

Day 1 (Monday, 6 December 1999)

<table>
<thead>
<tr>
<th>TIME</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.30-08.45</td>
<td>Registration</td>
</tr>
<tr>
<td>08.45-09.00</td>
<td>Welcome and introductions by Acting Director, NCD, WHO, AFRO</td>
</tr>
<tr>
<td>09.00-09.15</td>
<td>Key Note Speech Mr Ketil Bentzen (Norwegian government)</td>
</tr>
<tr>
<td>09.15-09.45</td>
<td>Overview of the Global Initiative Project /AFRO Regional Activities/WHO Substance Abuse Structure by UNDCP,WHO AFRO/HQ</td>
</tr>
<tr>
<td>09.45-10.00</td>
<td>Expectations and assigning of responsibilities and norm setting by Project Technical Officer, WHO</td>
</tr>
<tr>
<td>10.00-10.30</td>
<td>Coffee Break</td>
</tr>
<tr>
<td>10.30-10.45</td>
<td>Introduction to the TOT by Project Technical Officer, WHO, HQ</td>
</tr>
<tr>
<td>10.45-11.45</td>
<td>Presentations on experiences from participants by MNH Regional Advisor WHO, AFRO</td>
</tr>
<tr>
<td>11.45-12.00</td>
<td>Introduction to the training concepts and the workbook by Project Technical Officer, WHO, HQ</td>
</tr>
<tr>
<td>12.00-13.00</td>
<td>Training and overview of Module 1 by UNDCP Regional Advisor</td>
</tr>
<tr>
<td>13.00-14.00</td>
<td>Lunch Break</td>
</tr>
<tr>
<td>14.00-14.30</td>
<td>Plenary discussions and clarification of issues by UNDCP Regional Advisor</td>
</tr>
<tr>
<td>14.30-15.00</td>
<td>Training and review of Module 2 by Project Technical Officer, WHO, HQ</td>
</tr>
<tr>
<td>15.00-15.15</td>
<td>Coffee Break</td>
</tr>
<tr>
<td>15.15-15.45</td>
<td>Plenary discussions and clarification of issues by Project Technical Officer, WHO, HQ</td>
</tr>
<tr>
<td>15.45-16.45</td>
<td>Training and review of Module 3 by Project Technical Officer, WHO, AFRO</td>
</tr>
<tr>
<td>16.45-17.00</td>
<td>Introduction to the daily evaluation form and evaluation of day one by MNH Regional Advisor WHO, AFRO</td>
</tr>
<tr>
<td>17.00</td>
<td>END of the DAY</td>
</tr>
</tbody>
</table>
### Day 2 (Tuesday, 7 December 1999)

<table>
<thead>
<tr>
<th>TIME</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.00-08.15</td>
<td>Reflections by Technical Officer, WHO HQ</td>
</tr>
<tr>
<td>08.15-08.45</td>
<td>Plenary discussions and clarification of issues on Module 3 by Technical Officer, WHO, AFRO</td>
</tr>
<tr>
<td>08.45-09.45</td>
<td>Training and review of Module 4 by Technical Officer, WHO HQ</td>
</tr>
<tr>
<td>09.45-10.00</td>
<td>Plenary discussions and clarification of issues by Technical Officer, WHO HQ</td>
</tr>
<tr>
<td>10.00-10.30</td>
<td>Coffee Break</td>
</tr>
<tr>
<td>10.30-11.00</td>
<td>Plenary discussions and clarification of issues by Technical Officer, WHO HQ</td>
</tr>
<tr>
<td>11.00-12.00</td>
<td>Training and review of Module 5 by UNDCP Regional Advisor,</td>
</tr>
<tr>
<td>12.00-13.00</td>
<td>Plenary discussions and clarification of issues by UNDCP Regional Advisor</td>
</tr>
<tr>
<td>13.00-14.00</td>
<td>Lunch Break</td>
</tr>
<tr>
<td>14.00-15.00</td>
<td>Training and review of Module 6 by MNH Regional Advisor WHO, AFRO</td>
</tr>
<tr>
<td>15 00-15.15</td>
<td>Coffee Break</td>
</tr>
<tr>
<td>15.15-15.45</td>
<td>Plenary discussions and clarification of issues by MNH Regional Advisor WHO, AFRO</td>
</tr>
<tr>
<td>15.45-16.45</td>
<td>Training and review of Module 7 by Technical Officer, WHO, HQ</td>
</tr>
<tr>
<td>16.00-16.45</td>
<td>Plenary discussions and clarification of issues by Technical Officer, WHO HQ</td>
</tr>
<tr>
<td>16.45-17.15</td>
<td>Introduction to Micro-teaching by Project Technical Officer, WHO, HQ</td>
</tr>
<tr>
<td>17.15-17.30</td>
<td>Introduction to Action Plan by UNDCP regional Advisor and MNH Regional Advisor WHO, AFRO</td>
</tr>
<tr>
<td>17.30-17.45</td>
<td>Evaluation of the day by participants</td>
</tr>
<tr>
<td>18.00</td>
<td><strong>END of the DAY</strong></td>
</tr>
</tbody>
</table>
### Day 3 (Wednesday, 8 December 1999)

<table>
<thead>
<tr>
<th>TIME</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.00-08.15</td>
<td>Reflections by UNDCP Regional Advisor/Technical Officer, WHO, HQ</td>
</tr>
<tr>
<td>08.15-09.15</td>
<td><strong>Micro-teaching</strong> by Participants (per country)</td>
</tr>
<tr>
<td>09.15-09.30</td>
<td>Discussions and clarification of issues - all facilitators</td>
</tr>
<tr>
<td>09.30-10.30</td>
<td><strong>Micro-teaching</strong> by Participants</td>
</tr>
<tr>
<td>10.00-10.30</td>
<td>Coffee Break</td>
</tr>
<tr>
<td>10.30-11.00</td>
<td><strong>Micro-teaching</strong> by Participants</td>
</tr>
<tr>
<td>11.00-11.30</td>
<td>Discussions and clarification of issues - all Facilitators</td>
</tr>
<tr>
<td>11.30-13.00</td>
<td>Field visit by all Participants and Facilitators</td>
</tr>
<tr>
<td>13.00-14.00</td>
<td>Lunch Break</td>
</tr>
<tr>
<td>14.00-14.30</td>
<td>Feedback on field visit by Project Technical Officer, WHO; AFRO</td>
</tr>
<tr>
<td>14.30-15.30</td>
<td>Presentation of Action Plans, Regional Advisors, UNDCP/WHO</td>
</tr>
<tr>
<td>15.30-16.00</td>
<td><em>Final evaluation of workshop, Project Technical Officer, WHO, HQ</em></td>
</tr>
<tr>
<td>16.30-17.00</td>
<td><strong>Closure</strong>, MNH Regional Advisor WHO, AFRO/Selected participant</td>
</tr>
</tbody>
</table>
Annex 3a
EVALUATION OF DAY 1

- The objectives/activities of today's work were made very clear.
  a) The "Global Initiative" was thoroughly and highly elaborated.
  b) Preparations were superb.
  c) Presentations were well prepared.
  d) I am not at a loss at all, which means all is clear at least for now.
  e) Objectives were met.
  f) Facilitator took time to explain and elaborate objectives of the day's work as well as the whole workshop.
  g) The day was overloaded especially in the afternoon; other discussions were all right.

- The level of participation and contribution in today's sessions was optimal.
  a) People seemed hesitant to participate; I would call it warming up. They were given a chance to participate though.
  b) Participants had knowledge of substance abuse prior to workshop.
  c) Presentations were well prepared. Participants should give others a chance to participate.
  d) More emphasis on sharing after group discussions.
  e) Some participants were hesitant to participate fully.
  f) Contributions were positive.

- The subject matter of the day was relevant to the objectives of this workshop.
  a) We start early at 08:00 hours and finish at 12:30 before we get very tired.
  b) It was well focused.
  c) Preparation on the part of the resource person was excellent.
  d) Presenters were well prepared and objectives and subject matter correlated.
  e) All well except for time factor.

- The day's sessions were presented and facilitated well.
  a) Facilitation allowed equal participation at individual level, hence a conducive / comfortable atmosphere was maintained.
  b) Facilitators were well-prepared and motivated participants.
  c) Facilitators were well prepared but pressured. Time ran out.
  d) Module 3 was rushed.
  e) Preparations satisfactory but not all participants contributed.
  f) We should continue with the same spirit.

- Other comments:
  a) I look forward to tomorrow.
  b) Need summary of the Tanzanian copy in English if possible.
  c) Workshop was very educative, easy to understand concepts. It was done in a very basic manner.
  d) The high level of professional interaction must be maintained.
  e) Started late and somehow this had implications on presentation of country experiences.
  f) The room was hot in the morning session, air conditioning started working in the afternoon session.
  g) Time management to be closely watched in order to avoid tracking behind time.
  h) We need to note input regarding the content of the workbook (questions) and discuss it accordingly.
  i) Time management needs attention.
Annex 3b
EVALUATION OF DAY 2

Total number of people responding = 13

- The objectives/activities of today's work were made very clear.
  a) Indeed they were made clear.
  b) I did not understand some of the things.

- The level of participation and contribution in today's sessions was optimal.
  a) It was excellent.
  b) Report back was quite vibrant and since it formed the core of yesterday's business, it was quite participatory and stimulating.
  c) I think people are getting the hang of it and participation has never been better.
  d) Was encouraged in all lectures (facilitation).
  e) Stronger than day one.

- The subject matter in today's sessions was relevant to the objectives of this workshop.
  a) True, they were.
  b) The constant reflection on past activities was very helpful.
  c) More time was required to exhaust the subject.
  d) Facilitators are focused, well done.

- Sessions were presented and facilitated well.
  a) Individual time keeping was above expectation and must be mentioned.
  b) Did not feel that time was long.
  c) There was an improvement in facilitation.

- Other comments:
  a) Time was better managed. However, housekeeping problems disturbed the flow of the workshop.
  b) In general, everything was quite ok.
  c) May we continue to improve and cultivate on aspect of networking and solidarity as a region?
  d) Excellent planning.
  e) Congratulations to the time Minister, he was very good.
  f) Enjoyed the learning.
  g) Yesterday was so busy and yet enjoyable. Great distance was covered.
  h) Just one more day to go. I hope the spirit of constructive communication and collective planning persists.
  i) Time management has improved.
  j) Programme was very packed but enjoyable.
# Annex 4

## ACTION PLANS (Tanzania)

*Focal Person: Dr Joseph Mbatia*

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Activities</th>
<th>Time Frame</th>
<th>Outcome</th>
<th>Responsible person (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To identify key partners (NGOs)</td>
<td>Introduction of the Global Initiative selection Criteria of Local partners Identification of at least two more local partners.</td>
<td>January 2000</td>
<td>Finalized list of key partners to implement the Global Initiative Project</td>
<td>Dr. Joseph Mbatia Mr. Steward Chisongela Mr. Mahmoud Mussa</td>
</tr>
<tr>
<td>To establish a Management Committee for the Global Initiative Project</td>
<td>Hold consultative meetings with key partners (Ministries of Health, Social-Welfare, Youth, Social development women and Children, Responsible Parenthood, Mental Health Association, AMREF, WHO, project reps). Develop of responsibilities for committee members</td>
<td>February 2000</td>
<td>A core group of people to oversee the running of the Global Initiative Project</td>
<td>Dr. Joseph Mbatia Mr. Steward Chisongela Mr. Mahmoud Mussa</td>
</tr>
<tr>
<td>To identify communities for the implementation of the Global Initiative project</td>
<td>Confirmation of the three sites Zanzibar, Dar es Salaam and a rural setting</td>
<td>February 2000</td>
<td>Selected communities for the implementation of the Global Initiative Project</td>
<td>Dr. Joseph Mbatia Mr. Steward Chisongela Mr. Mahmoud Mussa</td>
</tr>
<tr>
<td>Train communities using the materials developed for the Global Initiative Project</td>
<td>Hold a national workshop for selected communities</td>
<td>March 2000</td>
<td>Trained community members ready to implement activities on primary prevention of substance abuse among young people</td>
<td>Dr. Joseph Mbatia Mr. Steward Chisongela Mr. Mahmoud Mussa</td>
</tr>
<tr>
<td>To conduct a baseline assessment in selected communities</td>
<td>- Conducting planning meetings - Mobilization of resources - Conducting of baseline assessment - Data analysis</td>
<td>April 2000</td>
<td>Determined needs and problems in the selected communities of implementation</td>
<td>Dr. Joseph Mbatia Mr. Steward Chisongela Mr. Mahmoud Mussa</td>
</tr>
<tr>
<td>To develop an Implementation Action Plan</td>
<td>- Consultative meetings - Development of a Action Plan</td>
<td>May 2000</td>
<td>Strategic Action Plan for the Implementation of the projects</td>
<td>Dr. Joseph Mbatia Mr. Steward Chisongela Mr. Mahmoud Mussa</td>
</tr>
<tr>
<td>To formulate project proposals</td>
<td>- Consultative meetings - Writing of the project proposals</td>
<td>May 2000</td>
<td>Proposal for submission to WHO for funding</td>
<td>Dr. Joseph Mbatia Mr. Steward Chisongela Mr. Mahmoud Mussa</td>
</tr>
<tr>
<td>Implement projects at least in three sites Zanzibar (1), Dar-es-Salaam (1) and Rural community (19)</td>
<td>- Involvement of community members and other stake holders - Networking, monitoring and evaluation</td>
<td>July 2000- onwards</td>
<td>Community based activities on primary prevention of substance abuse among young people</td>
<td>Dr. Joseph Mbatia Mr. Steward Chisongela Mr. Mahmoud Mussa</td>
</tr>
<tr>
<td>Time Frame</td>
<td>Activities</td>
<td>Responsible Person(s)</td>
<td>Outcome</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
<td>-----------------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>January 2000</td>
<td>Hold consultative meetings with key partners</td>
<td>Mr. John Mwaya, Ms. Kahumba Hakachuma, Mr. Steve Kalimwawa</td>
<td>A core group of people to oversee the running of the Global Initiative Project</td>
<td></td>
</tr>
<tr>
<td>January 2000</td>
<td>Development of roles and responsibilities of the committee</td>
<td>Mr. John Mwaya, Ms. Kahumba Hakachuma, Mr. Steve Kalimwawa</td>
<td>Finalized list of key partners to implement the Global Initiative project</td>
<td></td>
</tr>
<tr>
<td>February-March 2000</td>
<td>Review existing information to determine other relevant information</td>
<td>Mr. John Mwaya, Ms. Kahumba Hakachuma, Mr. Steve Kalimwawa</td>
<td>Selected communities for the implementation of the Global Initiative Project</td>
<td></td>
</tr>
<tr>
<td>April 2000</td>
<td>Conduct community visits to at least 4 communities</td>
<td>Mr. John Mwaya, Ms. Kahumba Hakachuma, Mr. Steve Kalimwawa</td>
<td>Trained community members ready to implement activities on primary prevention of substance abuse among young people</td>
<td></td>
</tr>
<tr>
<td>April 2000</td>
<td>Hold a national workshop for selected communities</td>
<td>Mr. John Mwaya, Ms. Kahumba Hakachuma, Mr. Steve Kalimwawa</td>
<td>Determined needs and problems in the selected communities</td>
<td></td>
</tr>
<tr>
<td>May 2000</td>
<td>Conducting planning meetings</td>
<td>Mr. John Mwaya, Ms. Kahumba Hakachuma, Mr. Steve Kalimwawa</td>
<td>Strategic Action Plan for the implementation of the projects</td>
<td></td>
</tr>
<tr>
<td>June 2000</td>
<td>Data analysis</td>
<td>Mr. John Mwaya, Ms. Kahumba Hakachuma, Mr. Steve Kalimwawa</td>
<td>Projects proposal for submission to WHO for funding</td>
<td></td>
</tr>
<tr>
<td>July 2000 onwards</td>
<td>Networking, monitoring and evaluation</td>
<td>Mr. John Mwaya, Ms. Kahumba Hakachuma, Mr. Steve Kalimwawa</td>
<td>Community based activities on primary prevention of substance abuse among young people</td>
<td></td>
</tr>
</tbody>
</table>

**Zambia**

<table>
<thead>
<tr>
<th>Focal Person: Mr. John Mwaya</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Objectives**

- To establish a Management Committee for the Global Initiative Project
- To select the criteria of local partners and share relevant information
- To finalize the selection of key partners (NGOs)
- To identify communities for the implementation project
- To conduct a baseline assessment in selected communities
- To develop an Action Plan
- To formulate project proposals
- Implement projects

**Activities**

- Hold consultative meetings with key partners
- Development of roles and responsibilities of the committee
- Review existing information to determine other relevant information
- Conduct community visits to at least 4 communities
- Hold a national workshop for selected communities
- Conducting planning meetings
- Data analysis
- Networking, monitoring and evaluation
**South Africa**

* Focal person Ms Moleko (to be confirmed)

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Activities</th>
<th>Time Frame</th>
<th>Outcome</th>
<th>Responsible person(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To identify key partners (NGOs)</td>
<td>Finalization of identification of local partners (SAAPSA and others) criteria for the Global Initiative was used.</td>
<td>January 2000</td>
<td>Confirmation of local partners to implement community based projects</td>
<td>Ms Anne-Gloria Moleko</td>
</tr>
<tr>
<td></td>
<td>A management committee on primary prevention of substance abuse exists</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Ms Cecilia Onica Maphai</td>
</tr>
<tr>
<td>To establish a Management Committee For the Global Initiative Project</td>
<td></td>
<td></td>
<td></td>
<td>Mr Pierre Viviers</td>
</tr>
<tr>
<td>To identify communities for the implementation of the Global Initiative Project</td>
<td>Already identified (Pretoria schools, Themba Trust Rural) Criteria for the Global Initiative were used.</td>
<td>Achieved</td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td>Train communities using the materials developed for the Global Initiative project</td>
<td>Hold a national workshop for selected communities</td>
<td>March /April 2000</td>
<td>Trained community members ready to implement activities on primary prevention of substance abuse among young people</td>
<td>Ms Anne-Gloria Moleko</td>
</tr>
<tr>
<td></td>
<td>Conducting planning meetings</td>
<td></td>
<td></td>
<td>Ms Cecilia Onica Maphai</td>
</tr>
<tr>
<td></td>
<td>Mobilization of resources</td>
<td></td>
<td></td>
<td>Mr Pierre Viviers</td>
</tr>
<tr>
<td></td>
<td>Conducting baseline assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To conduct a baseline assessment in selected communities</td>
<td>Consultative meetings</td>
<td>April 2000</td>
<td>Determined needs and problems in the selected communities of implementation</td>
<td>Ms Anne-Gloria Moleko</td>
</tr>
<tr>
<td></td>
<td>Development of an Action plan</td>
<td></td>
<td></td>
<td>Ms Cecilia Onica Maphai</td>
</tr>
<tr>
<td>To develop an Implementation Action Plan</td>
<td>Consultative meetings</td>
<td>April/May 2000</td>
<td>Strategic Action Plan for the Implementation of the projects</td>
<td>Mr Pierre Viviers</td>
</tr>
<tr>
<td>To facilitate communication to formulate project proposals</td>
<td>Consultative meetings</td>
<td>May 2000</td>
<td>Project proposal for submission to WHO for funding</td>
<td>Ms Anne-Gloria Moleko</td>
</tr>
<tr>
<td>Implement projects</td>
<td>Involvement of community members and other stake holders</td>
<td>July 2000-Onwards</td>
<td>Community based activities on primary prevention of substance abuse among young people</td>
<td>Ms Cecilia Onica Maphai</td>
</tr>
<tr>
<td></td>
<td>Networking, monitoring and evaluation</td>
<td></td>
<td></td>
<td>Mr Pierre Viviers</td>
</tr>
</tbody>
</table>
Annex 5

FINAL WORKSHOP EVALUATION

Comments

A. Preparations
- Workshop preparations were adequate
  1. Although at short notice and disjointed in the beginning, preparations were adequate.
  2. More time should have made it possible to provide more information on training methods.
  3. Handouts provided were appreciated.
- Enough information was provided before the workshop
  1. We knew exactly what to expect.
  2. Additional information provided was appreciated.
- Travel arrangements to the workshop were adequate/appropriate
  1. WHO local office was excellent for making travel plans.
  2. Too short notice.
  3. Planning was excellent given the short notice.

B. Process
- Workshop objectives have been achieved
  1. It is amazing to have achieved what was planned in three days.
  2. Objectives achieved 110%.
  3. Facilitation commendable.
  4. “You cannot do better”.
- Expectations of participants were met
  1. Expectations met more than anticipated.
  2. Hard work pays dividends.
  3. This is an important step forward and should be sustained.
- Workshop methodologies were appropriate
  1. The approach allowed active and equal participation.
  2. Reinforced practice and the concept of participatory approach.
  3. Excellent and very educative.

Comments continued on next page....
C. Venue & facilities
   1. Were appropriate.
   2. Accessible and central.
   3. Alternative accommodation should be provided close to the workshop venue.
   4. Needed two extra rooms for group discussions.
   5. The urinal in the men’s toilet was in bad condition.
   - Facilities for the workshop were comfortable and conducive
     1. The facilities were excellent.
   - Time management was efficient
     1. Excellent despite time constraints.
     2. More time was needed to do difficult tasks.
     3. The “Minister of Time” did an excellent job.

D. Support Services
   - Administrative services were adequate
     1. Very efficient and accommodated the preparations on micro-teaching.

E. Outcome
   - Quality of training was satisfactory
     1. The training was stimulating and helped to get a good grasp on training skills.
     2. The micro-teaching conducted is a “success story”.
   - Learning of subjects offered has taken place
     1. This was proved by the good teaching conducted.
     2. The TOT helped to build on existing knowledge.
     3. The TOT improved the knowledge base and is a “success story”.
   - Instructions for the Action Plans were clear and realistic
     1. “The results tell the story”.
     2. Clear and simple.

What I can do differently next time when I hold a similar workshop
   1. The duration of such a workshop would be extended from 3 to 5-7 days.
   2. A filed visit to the target group would also be made.
   3. Participants would be given more time for micro-teaching.
Annex 6

FIELD TESTING OF WORKBOOK (INPUT)

Participants responded to the statement outlined in the field testing form using a scale of 1 to 5 and commented where necessary. The aim was to use the comments for modifying the workbook.

A. Testing scale
   a) Excellent
   b) Good
   c) Fair
   d) Poor
   e) Very Poor

B. Explanation of terms for the field-testing
   • Comprehensiveness
     a) Are the contents of these documents sufficient to address the training needs of project operators of the Global Initiative project?
     b) Does the summary of each module capture the salient learning messages addressed in the module
   • Clarity
     a) Is the information provided in the section/module clear?
     b) Are the learning outcomes in each module clear?
     c) Are the contents understandable and arranged in a meaningful order that facilitates learning (simple to complex-known to unknown)?
     d) Are the content areas in each topic clear?
     e) Are the training methods and learning experiences (exercised easy to interpret and adapt in any given environment)?
     f) Is the language used in these documents easy, simple and readable?
     g) Are there terms used in these documents that need simplification?
   • Appropriateness
     a) Do the contents of these learning materials reflect the learning needs (knowledge, skills) and problems related to psychoactive substance abuse of local communities?
   • Illustrations
     a) Are the illustrations appropriate for the content addressed?
     b) Do the illustrations add a good visual impression to enhance the learning and user friendliness of the document?
   • Adaptability/applicability
     a) Are these training materials applicable in your country situation?
     b) Can they easily be adapted to country/cultural orientations?
     c) Do the training methods/learning aids and exercises conform to the local training needs of project operators?
     d) Are the illustrations cultural sensitive?
     e) Can they be adapted for local learning needs?

Number of participants responding = 10
COMMENTS AND SUGGESTIONS

A. Introduction

- Comprehensiveness
  a) Heading missing i.e. Introduction on page 7.
  b) Gives a comprehensive bird’s eye view of the project. Could make
  c) Reference to ½ specific studies other than broad study reference.
  d) Good language arrangement.

- Clarity
  a) Is it not possible to have module 5 as 4 and 4 as 5 Baseline Project
     development on page 9?
  b) Clearly spells out who the project operator is.
  c) The language is understandable at local level.
  d) Matters were ably clarified.

- Appropriateness
  a) Very appropriate for project operators.

- Adaptability/Applicability
  a) Very applicable and adaptable to the Zimbabwean situation. Adaptability
     is very high throughout the document.

B. Glossary

- Comprehensiveness
  a) A comprehensive glossary. Definition of health to include spiritual as
     abuse in Africa is used to communicate with the ancestral spirits and higher
     powers.

- Clarity
  a) Need to broaden definition of abuse to include ‘binge’ drinkers and crisis
     abusers. Suggest including harmful and hazardous use. The term abuse is
     inadequately explained. Wrongful use, one can use a drug properly and still
     face a hazard depending on the individual.
  b) Definitions are clear and simplified, but use the additional glossary as
     supplement when teaching the more educated.
  c) Solvent glossary simple and straightforward. Adequate for communities
     and not technical students.

- Adaptability/Applicability
  a) Could be more concise. Review descriptions of community based action
     and community development.
  b) Omit word “Young people”.

Module 1: Psychoactive Substances

- Comprehensiveness
  a) Could we have an extra package of teaching aids in colour to show those substances e.g. pamphlets, posters, charts. Youths learn more by seeing the product’s picture.
  b) The exercises/activities are a little too simplistic.
  c) I think it covers all sectors of interest.

- Clarity
  a) Street names such as ganja do not denote a type, therefore are mere repetition if given as examples.
  b) Illustrations added clarity.
  c) Except for the part on cannabis, I think more clarification is needed to present the ‘types’ of cannabis or common names of cannabis. It needs revising.

- Appropriateness
  a) Very appropriate. It is essential to know about psychoactive substances before one can address them.
  b) The illustrations make the module very appropriate.
  c) The document should at least go a bit further and explain some of the effects e.g. extent of the psychoactive substances.

- Adaptability/Applicability
  a) Highlight glue sniffing and cannabis

Module 2: What May Contribute to Psychoactive Substance Abuse Among Young People?

- Comprehensiveness
  a) Very comprehensive. Gives a broad and simple overview. The gender section is good, needs examples of possible interventions.
  b) Covers most psychoactive substances that are known.
  c) Well covered. I think it was also necessary to cover the issue of gender. It really is an important factor and needs even more elaboration.

- Clarity
  a) Exercise 1b, the case study needs to be more clear on who really Joseph and John are i.e. age. There are many risk factors behind their story. They can be separated into two, each story concentrating on separate related risk factors.
  b) The module is very clear and interesting to read.

- Appropriateness
  a) Excellent. Addresses issues seen at home:

- Adaptability/Applicability
  a) Question 1c needs to be restructured. Is it asking for consequences or risk factors or both?
  b) Exercises can be adapted to the Zimbabwean situation easily.
  c) The exercise questions were directed at the situation in one’s community and thus promote relevancy and adaptability to any given country/community.
  d) Need to shed some light on the age and mental state of the two boys in the exercises.
Module 3: Ways of Preventing Psychoactive Substance Use

- **Comprehensiveness**
  a) The use of situational examples is most helpful as it allows the participant to experience dealing with the problem.
  b) Comprehensive and very interesting. Can easily stimulate interest.
  c) Comprehensive enough, but the module could also be a bit more encompassing by taking into account consideration of the youths such that the topic which says (settings where primary prevention should take place) could give room for out-of-homes.

- **Clarity**
  a) The way the term ‘policy’ is presented and the idea that is intended to be put across differs since a policy document is something big, developed and approved by government. More clarity or simplification is needed.
  b) Exercise 1 needs to be clearer. Section on Building Policy is ambiguous.
  c) This module convincingly met its learning outcomes; therefore it was very educational.

- ** Appropriateness**
  a) Trainers should refer to examples closer to Africa as opposed to USA and Bangladesh.
  b) Goes beyond substance abuse can be applied to management of services.
  c) Examples should be relevant to the particular country.

- **Adaptability/Applicability**
  a) Well explored, but the term ‘Youth Friendly’ could be adopted when describing the approach given by health institutions e.g. page 56.
  b) Highly adaptable/applicable to the project and day-to-day use.
  c) The module gave emphasis to networking and collaborated action as part of the solution and this is a good aspect in drug demand reduction.
  d) Need to give examples from own country.

Module 4: Project Development and Management

- **Comprehensiveness**
  a) Propose as module 5.
  b) This module started at grassroots level irrespective of the experiences vested in the individual and thus helps make the INITIATIVE uniform, i.e. running on the same guidelines. The information is quite helpful.
  c) Comprehensive and interesting to read.
  d) Covers the most important stages of project development.
  e) Is this not supposed to come after module 5?
  f) Cycle necessary although the arrows and starting point should be added otherwise it is simple enough to understand.

- **Clarity**
  a) The strategic plan table is clear, but an explanation of contents is needed before or after a section i.e. objective, strategy, activity etc., as this could be misread.
  b) Made in an easy to follow format.
  c) By giving the process in phases the clarity of the document improved and this also helps in understanding each single stage as it comes. Use of acronyms such as SMART improves memory.
- Appropriateness
  a) Appropriate to any project development activity.
  b) The information given can lead to a comprehensive project proposal.
- Adaptability/Applicability
  a) The issue of time management could be included in project development as it plays an important part.
  b) Good, but local examples should be given.

Module 5: Baseline Assessment
- Comprehensiveness
  a) Module is comprehensive. The expansion in the lecture discussion added to the information.
  b) It is important to incorporate the illustration given by Reychad Abool on baseline assessment (Rapid situation assessment).
- Clarity
  a) Clear enough.
  b) Very clear. Additional information by facilitator improved clarity.
- Appropriateness
  a) Very appropriate to substance abuse and other areas of work.
  b) The module has been very helpful in explaining this important part of the proposal.
- Adaptability/Applicability
  a) The techniques are easily adaptable to any given community.
  b) Very useful and applicable as it is.

Module 6: Monitoring and Evaluation
- Comprehensiveness
  a) A comprehensive module.
- Clarity
  a) Distinction between monitoring and evaluation necessary.
  b) Clear but needs additional practical examples.
- Appropriateness
  a) Highly appropriate.
- Adaptability/Applicability
  a) Adaptable to situation at hand.
  b) This is standard and anyone can go out and implement it without problems. Procedures are well laid out.
Module 7: Project Capacity Building

- Comprehensiveness
  a) More examples on community motivation required.
  b) Touches on all pertinent issues.
  c) Should include subheadings on sustainability.
  d) Sustainability should have been stressed as it is the most important.
  e) Emphasize the main reason why the community should be involved in the project.

- Clarity
  a) Phrase ‘Give them responsibility’ needs revisiting. State what kind of responsibilities they should get.
  b) A pleasure to read and easily imparted.

- Appropriateness
  a) Very appropriate.

- Adaptability/Applicability
  a) Some of the material could be incorporated in the first modules i.e. networking.
  b) Good as it is.

ILLUSTRATIONS

A. Cover page

- Appropriateness
  a) Should be made more realistic.
  b) User friendly because of the illustration. It is very appropriate and necessary, but suggest a change in font for the cover page only.
  c) Appears too crowded. Too many themes reflected.
  d) OK.

- Adaptability/Applicability
  a) Few can be adapted others can not.
  b) Illustrations should portray the African child with kinky hair and with shorts.
  c) Can be adapted to local situations if resources allow.

Module 1: Psychoactive Substances

- Appropriateness
  a) Fair
  b) Improve on size and number of illustrations. This helps enhance memory especially for the youth. Add a bit of colour.
  c) Appropriate except for one on ‘constant demand for money …’ page 24. This can be redesigned to really bring out the constant demand for money. If it is from family begging, it would be appropriate.
  d) Needs to reflect local drugs e.g. cannabis plant?
  e) Good.

- Adaptability/Applicability
  a) Adaptable.
  b) Need to supplement with colour posters of the substances for use by the trainer.
  c) Could be improved during fieldwork.
Module 2: What May Contribute to Psychoactive Substance Abuse Among Young People?

- Appropriateness
  a) Fair.
  b) The first illustration could be enhanced with the addition of substances being abused/used by young people e.g. smoking, drinking. All the others are appropriate.
  c) These reflect the situation.
  d) Good.

- Adaptability/applicability
  a) Adaptable.
  b) Can include cannabis plant and glue sniffing.
  c) Fairly OK.

Module 3: Ways of Preventing Psychoactive Substance Abuse

- Appropriateness
  a) Excellent. Depicts and clarifies points.
  b) ‘All fun fetes too’ could be enhanced by showing uniforms to show that we are referring to a school environment (page 39). All others are appropriate.
  c) Illustrations should as much as possible cover all possible settings e.g. rural, urban.
  d) Good.

- Adaptability/applicability
  a) Adaptable.
  b) Good.

Module 4: Project Development and Management

- Appropriateness
  a) A bit too few.
  b) Appropriate.
  c) Excellent.
  d) Good.

- Adaptability/applicability
  a) Good.
  b) Adaptable.

Module 5: Baseline Assessment

- Appropriateness
  a) The illustration is showing an observer taking notes. If the observer is made more significant, it would not cause any harm. All others are appropriate.
  b) Good.

- Adaptability/applicability
  a) Adaptable.
  b) Good.
  c) Excellent.
Module 6: Monitoring and Impact Evaluation

- Appropriateness
  a) Excellent.
  b) The first page, 93, is more of a focus group discussion than that showing monitoring and evaluation. Could have either a desk monitoring/evaluation or people out with the respondents monitoring and evaluating.
  c) Fair.
  d) Excellent.

- Adaptability/applicability
  a) Needs to be improved.
  b) Good.
  c) Excellent.

Module 7: Project Capacity Building

- Appropriateness
  a) Suggest that we totally change because it is the same with the one on the front of the page and it would seem that this is now what the front page referred to.
  b) Front cover and resources in community – a bit too crowded.
  c) Excellent.

- Adaptability/applicability
  a) Adaptable.
FACILITATOR GUIDE

A. Helping project operators learn
   - Comprehensiveness
     a) Relates comprehensively to workbook.

Module 1: Psychoactive Substances
   - Comprehensiveness
     a) Very comprehensive, clear. Content is wide.
   - Clarity
     a) Clear

Module 2: What May Contribute to Psychoactive Substance Abuse Among Young People?
   - Comprehensiveness
     a) For the answers to questions in the workbook it could be indicated that these are only examples and leave room for other contributions. Answers suggested at this workshop could be included.
   - Clarity
     a) Very clear

Module 3: Ways of Preventing Psychoactive Substance Abuse
   - Comprehensiveness
     a) An introduction is necessary, to state what role a facilitator plays in this module.
     b) Excellent, especially on examples of control policies.

Module 4: Project Development and Management
   - Comprehensiveness
     a) Introduction would be necessary.
   - Appropriateness
     a) Very appropriate.
     b) Add a little more on (a) and (b).

Module 5: Baseline Assessment
   - Comprehensiveness
     a) Introductory/opening sentence needed.
   - Appropriateness
     a) Questions for collecting data are quite appropriate. It should be indicated that provision for addition or subtraction is open.

Module 6: Monitoring and Evaluation
   - Comprehensiveness
     a) More could be added especially on methods and procedures of evaluation.

Module 7: Project Capacity Building
   - Comprehensiveness
     a) An introduction is needed.
   - Clarity
     a) Clear enough
   - Adaptability/applicability
     a) Check spelling on page 62.
Annex 7

DETAILED INFORMATION ON THE PRESENTATIONS
SOUTH AFRICA

SUBSTANCE ABUSE PREVENTION STRATEGY IN SOUTH AFRICA

A PRESENTATION AT THE REGIONAL TRAINING OF TRAINEES WORKSHOP ON PRIMARY PREVENTION OF SUBSTANCE ABUSE
6-8 DECEMBER 1999, HARARE, ZIMBABWE

BY: ANNE-GLORIA MOLEKO, SOUTH AFRICAN ALLIANCE FOR THE PREVENTION OF SUBSTANCE ABUSE (SAAPSA)

1. INTRODUCTION

Before tackling the complexities of substance abuse, the question must be asked as to why the focus should be on this area of intervention. Substance abuse is not an isolated activity, bearing only consequences in and of it, but relates to a myriad of other factors and areas. "Data consistently confirm that offending behaviour in adolescents often occurs together with, or as an expression of substance abuse..." (Kaliski, 1998 p. 107).

In the discussion that follows, the background of The South African Alliance for the Prevention of Substance Abuse (SAAPSA) information will be explicated. An outline of the situational assessment as well as some of the available services and facilities is given. The National Strategic Action Plan is described.

2. WHAT IS SAAPSA?

In early 1994 in South Africa, there was recognition by many organizations concerned with the prevention of substance abuse that they could not deal with the problem alone, and that they needed to work together if effective prevention was to be achieved. There had been attempts in the past to bring organizations together, but they had not been successful in the long term. In 1994 and early 1995, three factors facilitated the establishment of SAAPSA.

First, President Mandela had placed substance abuse high on the agenda as a threat to the peaceful transition and the development of South Africa. Second, the Reconstruction and Development Plan gave a high priority to the prevention of substance abuse as a precondition for the success of the plan. Third, the WHO was developing the Global Initiative on the Primary Prevention of Substance abuse focused on the four regions of the world experiencing rapid social change. Southern Africa was one of the regions.

With the desire of the organizations to co-ordinate their activities and work together; and the commitment to substance abuse prevention, South Africa provided all the ingredients required for a concerted action to promote substance abuse prevention. In March 1995, the representatives from the governmental and non-governmental organizations held a Strategic Planning Workshop at which SAAPSA was established. The international representatives of the World Health Organization (WHO), the International Council on Alcohol and Addictions (ICAA), and the International Organization of Good Templars (IOGT) attended the above-stated workshop.
2.1. Membership of SAAPSA

The membership of SAAPSA includes a broad range of individuals and organizations from the community-based organizations, non-governmental organizations and the government sectors.

2.2. The Mission Statement of SAAPSA

The Alliance is established for the purpose of networking together all organizations, government and civil society, concerned with drug and alcohol abuse in South Africa with a view to optimise cooperation in the prevention and treatment of alcohol and drug abuse in order to improve the quality of life and to promote peace and development for all South Africans.

2.3. The role of SAAPSA is:

- To facilitate the development of networks (enabling systems) for the prevention of substance abuse and related health and social problems amongst the young people and the general population in a range of different geographical, cultural, social and economic settings.
- To raise public awareness about issues related to the prevention and reduction of substance abuse and related health and social problems among the youth.
- To encourage mobilization of resources at a community level which will address these prevention issues.
- To ensure the development of appropriate mechanisms for encouraging the active participation of all South Africans, especially the young people, in the identification of prevention issues and the development of interventions.
- To co-ordinate the substance abuse prevention projects of its members.
- To promote collaborative projects.
- To promote constructive educational and other preventive projects.
- To develop a National Strategic Action Plan.
- To oversee and guide the planning and implementation of a range of priority activities and projects which flow from the National Strategic Action Plan in the area of primary prevention.
- To emphasise national capacity building and the empowerment of local communities.
- To strive to promote affordable treatment services.
- To be accountable to open evaluation of activities undertaken in the name of the Alliance.
- To develop a model(s) for the prevention of substance abuses, and related health and social problems.
- To facilitate sharing of information and experience.
- To provide information and assistance to national, provincial, regional and community prevention projects.

2.4. The structure of SAAPSA

The structure of SAAPSA consists of the following:
- The Board of Trustees,
- Management committee
- Research/project committee, and the Secretariat
3. SITUATIONAL ASSESSMENT

South Africa has undergone a major political transformation, and with winds of change in politics there are dramatic changes to social and economic areas. The level of development within the country is fair, although there are social burdens, which vary across and within the provinces. The burdens are population pressure, income inequality, poverty, unemployment, crime and HIV/AIDS (Rocha-Silva, 1999).

In the context of South Africa, various factors have been put forward as contributing to substance use and abuse. Factors are likely to include peer pressure, particularly among young people, and the communal drinking among adults. The availability, the legacy of the “dop” system, particularly in the Western Cape, ignorance, the falling price of certain kinds of alcohol products relative to the Consumer Price Index, chemical dependency on alcohol, poor social conditions and boredom.

Local research has shown that the most common reasons reported for substance abuse include habit, to alter mood states, to improve health, to cope with personal, social or interpersonal situations, and enjoyment (Parry, 1997)

3.1 Young people in South Africa

Statistics South Africa, 1998, indicate that the young people between the ages 10-24 years form 31.6% of the total population, 49% being males and 51% females. The highest proportion is found in KwaZulu-Natal whilst the Eastern Cape is the second highest. The younger age groups and females are found in the rural areas. Older males from the rural areas moved to the urban areas for employment. The unemployment rate of the young people between the ages of 14-35 years is 43%. Persons between the ages of 16-30 residing in informal settlements form 20%; 33% dropped out of school, and 19.3% of 20 years and older black females have no schooling (cited in Rocha-Silva, 1999).

3.2 South African youth and substance abuse

A review of research conducted between the mid-1970s and the mid-1990s has been conducted at the Human Science Research Council for SAAPSA. The purpose of the review was to establish the nature and extent of substance abuse among the young people in South Africa. The research information was scrutinized for regularity patterns and trends in use (Rocha-Silva, 1998, Mokoko & Van Niekerk, 1999).

As indicated by Rocha-Silva, 1998, 1999 and Mokoko & Van Niekerk 1999, the findings of the research are that the drug use is complex, dynamic and varies over time. (Example: differ across groups, type of substances, dimensions and links between types of drugs). The patterns and trends are that overall level of use has increased and is summarized as follows:
3.2.1 Licit drugs (alcohol, tobacco and over-the-counter medicine),
In the past they were used by the advantaged older male group; and presently they are used by advantaged and disadvantaged rural females and males. Total absolute alcohol intake was particularly high in males. Previously, the preference was for malt beer and homebrew. Presently, commercial alcohol is widely preferred. Cider drinks have infiltrated the homebrew occasions. The use of alcohol was restricted in the past (example, particular groups and occasion). Currently it is used every day.

3.2.2 Solvents
The “homeless” and the “street children” to overcome cold and hunger use these.

3.2.3 Cannabis
Disadvantaged older male group used it in the past. Presently is used by the advantaged and disadvantaged male, female, and younger group.

3.2.4 Other drugs that were used are of a wider variety; prescription drugs: sedatives, tranquillisers, amphetamines, “club” drugs (ecstasy); illicit drugs:

3.2.5 LSD, cocaine/crack, heroin injection (older females). It was also found that demand and social access facilitated the broadening of drug use. Demand resulted from social exposure and pressure as well as limited social discrimination. Most had the opportunity to access the drugs of their choice.

4. NATIONAL STRATEGIC ACTION PLAN (NSAP)

The National Strategic Action Plan was developed by SAAPSA by means of a consultative process at a national forum supported by World Health Organization, and United Nations Development Programme (Mokoko and Van Niekerk, 1999). The Mentor Foundation is one of the international organizations that has supported the development of NSAP.

4.1 What is national strategic action plan?

It is a document that has to serve as a framework for the implementation of projects and activities aimed at the prevention of substance abuse and related health and social problems.

4.2 Problems and needs to address

Various risk factors and protective factors were identified from the workshop discussions and the research data. Specific and general needs were identified, as these will always differ according to the areas.

The identified target group is the youth. The strategies to be adopted were said to be comprehensive, inclusive of policy, educational and community-based issues.
5. PREVENTION PROJECTS

Prevention should be planned not only on an individual level but using potential resources of the entire community. One of the basic principles of prevention programmes is that a holistic and a multi-disciplinary approach should be followed, taking into consideration the research-based intervention.

The focus of prevention in South Africa is on reduction of supply and demand with emphasis on the person in context (individual and the environment). With some of the projects following a public health model as an intervention framework. The Alliance support substance abuse prevention projects that are geared towards the programmes affecting change with respect to:

- Knowledge
- Attitudes change
- Behaviour modification or change
- Capacity building.

Currently there are three primary prevention projects that are being funded by WHO.

References


ZAMBIA

COUNTRY EXPERIENCES, ACTIVITIES AND APPROACHES RELATED TO PREVENTION OF SUBSTANCE ABUSE: THE CASE OF ZAMBIA

A PRESENTATION AT THE REGIONAL TRAINING OF TRainers
WORKSHOP ON PRIMARY PREVENTION OF SUBSTANCE ABUSE
6-8 DECEMBER 1999, HARARE ZIMBABWE

COMPILED BY: J.MAYEYA, S. KALIMINWA, K. HAKACHIMA and A. MWEEMBA

1. BACKGROUND AND INTRODUCTION

Zambia lies in Southern Central Africa. It is a landlocked country and shares borders with eight countries: Democratic Republic of Congo and Tanzania in the north, Malawi and Mozambique in the east, Zimbabwe and Botswana in the south, Namibia in the Southwest, and Angola in the west. The country is administratively divided into nine provinces with 72 districts and has an area of 752,612 square kilometres.

The population of Zambia for 1999 is estimated to be at 10.4 million, with an annual population growth rate of 3.2 percent. Close to 50% of the population is comprised of young people below the age of 15 years. There is also a huge concentration of people along the line of rail and the Copperbelt towns.

Copper mining is Zambia's foreign exchange earner since independence. Unfortunately, unfavourable copper prices since the oil crisis of 1975 saw export earnings declining. The situation was rendered worse by the nationalisation of industry which took place in 1972. The Gross Domestic Product for Zambia has been declining from US$ 290 in 1992 (GRZ and UNICEF, 1996) to US$245 in 1998 (Central Statistical Office, 1999).

From independence in 1964, there was a multiparty system of governance under the United Nations Independence Party (UNIP). In 1972, there was a shift to one party rule, still under UNIP. However, in the late 80s pressure for political reform increased resulting to change in constitutional clause barring political parties and in the 1991 multiparty elections held, a new party-the Movement for Multiparty Democracy (MMD) assumed political authority in a 150 seat Parliament.

With inspiration from the World Bank, the Government embarked on an aggressive reform of the economy based on private sector initiative. The role of the government under the rule is that of facilitator.

However, these policy reforms, started in earnest in 1992 have had a lot of impact on the economy, including health and social services. A number of companies have been privatized and down sized. The implications are that many people have lost jobs through retrenchments.
2. HEALTH SERVICES

The Zambian health services, under the primary health care concept, are structured around health centres and hospitals run by the government and churches. Additional health services are provided by the industrial sector and individual private enterprises. By 1990 Zambia had 82 hospitals (42 were government-run) and 942 health centres (796 government-run); Seven hundred and thirty four (734) of the health centres were in rural areas and two hundred and eighty (280) were in urban areas (GRZ and UNICEF, 1996).

The 10 year evaluation of the implementation of Primary Health Care in Zambia, carried between, 1990-1991 illustrated a decline in quantity and quality of health services. This resulted in the erosion of infrastructure, an increase in the morbidity and mortality index including infant and child mortality, shortage of drugs, crisis of finance, loss of public confidence and low staff morale. In line with the general policy reform, government decided to pursue radical reforms in the health sector in 1992.

To this end, the desire to re-align scarce resources to meet the changing demands and meaning of health care provision was paramount and this resulted in the development of National Health Strategic Plans (1995-1998; 1998-2000). In the first plan, the Disability Adjusted Life Years (DALYS) method of arriving at the burden of disease was used to arrive at health care priorities while the second plan is a combination of findings based on DALYS and other studies. Key health priorities listed in the second plan (1998-2000) are:

1. Malaria
2. Acute Respiratory Infection
3. Acquired Immune Deficiency Syndrome (AIDS)
4. Diarrhoea
5. Perinatal ill health
6. Malnutrition
7. Gastrointestinal Diseases
8. Maternal and Child Health
9. Anaemia

Based on these priorities, an Essential Health Care Package was developed.

Constraints Related to Provision of Mental Health in the Health Reform Process

1. Mental health and mental illness is missing among the prioritised conditions. As such it is still not integrated into the Essential Health Care Package.
2. There is no national mental health policy in place despite the fact that mental health services in Zambia have a history before and after 1962 when Chainama Hospital for the mentally ill was opened. This has had a lot of implications on service delivery in terms of human resource, infrastructure, information services, clinical care and links with relevant organisations, just to mention a few.
3. The Mental Disorders Act is as outdated as 1951, negatively impacting on the human rights of patients and their families.
Current Efforts to Streamline Mental Health Services in Zambia

1. The first draft Mental Health Policy working document has been developed and is awaiting subjection to the policy development process.
2. The Mental Disorders Act Cap. 5 3 9 of the laws of Zambia has been reviewed for onward submission to Ministry of Legal Affairs.
3. Draft Guidelines concerning Integration of Mental Health into the Essential Package of Care have been formulated for further development.
4. A Situational Analysis of In-Service Training Needs in Mental Health for frontline workers has been done.

The "Missing" Link

There is no vehicle to use for delivery of mental health services in Zambia. Over the years, mental health service development had been adhoc and based on what the general health policy dictated. Mental health policy initiatives and priorities have not been matched with concrete plans to address them. The draft National Mental Health Strategic Plan (2000-2010) for Zambia is designed for use in this direction. In this document, Substance Abuse issues are also being given attention.

3. EXTENT OF SUBSTANCE (AB)USE IN ZAMBIA

It has been observed that substance abuse is rising in Zambia, especially in urban areas. In a recent national study, Boog et al (1999) interviewed 2,105 key informants on the extent of drug (ab)use problem. It was found that more urban than rural residents thought that there was a drug problem in Zambia and the commonest drug of use and abuse is cannabis, followed by inhalants and valium, in that order. In the same vein, health workers cited valium second drug of use and abuse, followed by inhalants. However, this study did not take into account, alcohol and tobacco use and abuse. The other problem was that percentage figures given especially on perceived extent of the drug use and abuse were all in ranges, making it difficult to accurately pinpoint issues raised. Okitapoy and Munkombwe (1999) have done a retrospective study of psychoactive use disorders among 9,973 Psychiatric attendances at Chainama College Hospital in Lusaka, from January 1994-December, 1998. They reveal the following:

1. 2,579 (26.39%) of the attendees suffered from psychoactive use disorders and among the most commonly used psychoactive substance was alcohol. Other dependence forming drugs accounted for (3.24%), with cannabis being the leading Substance. Abuse of non-dependence drugs was associated in (0.57%), Heroine was reported in (0.22%) and Cocaine in (0.86%).
2. The majority of psychiatric attendees were adolescents and young adults aged between 15-35 years (89.50%).
3. Men were in the majority of psychiatry attendees (74.37%).


He realised that out of the 20, 726 cases admitted to psychiatry institutions, 1, 369 had alcohol and drug related problems, representing 7% of total admissions.
In this study, it was observed that there was a variance in clinical diagnostic skills among clinicians, making it difficult to comfortably rely on the diagnoses arrived at. The other constraint was use of non-standardized reporting forms and format.

In an earlier article on drug dependence, Haworth (1 9 8 8), indicated that although Zambia did not have any major drug dependence problems, it was desirable to develop preventive measures and establish a treatment service. He cautioned against complacency in the fight against drug abuse.

The Drug Enforcement Commission of Zambia has been equally worried. They say something drastic needs to be done to discourage people from taking drugs (Zambia Daily Mail, 1999). They also say cannabis is the most commonly abused drug in Zambia by both boys and girls aged between 9-16 years. In other cases, valium is combined with alcohol and is used and abused by various groups for various reasons, especially young boys who add it to the drink with the motive of knocking them out, so as to sexually abuse them.

4. COUNTRY EXPERIENCES, ACTIVITIES AND APPROACHES

a) Central Level

- The main mental hospital opened an Alcohol and Substance Abuse Clinic in 1995, with one qualified member of staff. Services provided include clinical care and counselling both extensive and minimal. Our main constraint is lack of resources such breathalysers, Blood Alcohol Content Analysis (BACA) equipment, transport for outreach activities, computers for creation of an easily accessible data base, and trained personnel. One person cannot take all cases into consideration.

- Closer links are being encouraged in Primary Prevention of Alcohol and Substance Abuse between the Central Board of Health, Progranune Against Substance Abuse (PASA), Zambia Anti-Smoking Society, Mental Health Association of Zambia, Young Womens Christian Association (YWCA) and the Drug Enforcement Commission (DEC).

b) Non-Governmental Organisations

1. Young Women's Christian Association (YWCA)

The YWCA is a non-profit non-governmental organization affiliated to the world YWCA office in Geneva. As a movement and organization, it was started in London in 1855 and is considered to be the oldest youth and women group in the world with members world wide. The major program done by YWCA is the women human rights program under which there are decentralised drop-in centres for battered women, youth and children in crisis.
Most of the YWCA activities are based on the philosophy that all people are equal in God's eyes, regardless of race, nationality, class or age. Under the Youth Department, YWCA has various projects managed by different project coordinators as follows:

- **Youth**: where young people with problems can drop in for information, advice, support and counselling.

- **Adolescent Reproductive Health**: where YWCA trains peer educators in reproductive health issues, such as dating and relationships, adolescence sexuality, drug use and abuse, sexually transmitted diseases and life skills and psychosocial counselling.

- **School and Job Placements for HIV/AIDS Orphans**: this is the response to the impact of HIV/AIDS that has turned a lot of our young people into destitutes.

- **Child in Crisis**: this is a newly opened centre to look into issues of child abuse. The centre carries out public awareness campaigns in the community on the dangers of child abuse. It promotes networking and conducts training for other agencies. Other activities include offer of psychosocial counselling to abused children and their families. Additional work includes collaboration with the Victim Support Unit of the Zambia Police Service.

- **Loans**: YWCA provides loans to deserving street kids under the Youth Skills Enterprise Initiative. This basically is to empower vulnerable young people economically.

- **Experiences**
  - The youth drop-in centre managed to acquire school sponsorship for a number of orphans
  - YWCA advocated for a policy for teenage mothers to get back to school
  - Witnessed change of behaviour for the better in some youths
  - A number of youths received training funded by YWCA
  - One hundred and sixty seven (167) peer educators have been trained from 1996-1999.
  - Managed to train parent elders in Adolescent Reproductive Health issues
  - Disseminated information to about 4,000 peers in the communities
  - The Child in Crisis Centre managed to hold consultations with relevant agencies on Children Human Rights with a view of promoting networking.
  - A successful fund raising party was held for the crisis centre.
  - A number of street children received loans from the Youth Skills Enterprise Initiative (YSEI).

We believe this project will go far in assisting positive response to the problem of substance use and abuse by young people. However, the poor state of the economy is perceived as a major constraint as it somehow pushes many young people into substance abuse.
2. Programme Against Substance Abuse (PASA)

The Programme Against Substance Abuse (PASA) is a non-governmental, non-profit making organisation formed in 1995, with the sole aim of creating, public awareness on the dangers of alcohol and substance abuse including tobacco. It has a membership of about 215. The organisation mainly targets youths with a view of promoting their knowledge attitudes and skills in handling social behavioural problems viz-a-viz use and abuse of illicit substances such cannabis, glue, petrol and Jenkim (sewer bio-gas).

The Programme Against Substance Abuse (PASA) facilitates life skills activities in formal and informal settings for youths. Key activities of the organisation include non-formal education for youths, holding of seminars and workshops.

Within the school system, PASA focal points are available to give on the spot assistance. The central level of the organisation sometimes provide learning materials to the youthclubs. There is also an activity monitoring and reporting system in place to keep track of outputs.

- **Activities**

  - In its endeavour to minimise alcohol and substance abuse, PASA has over the years established partnerships and coalitions with various government and non-governmental organisations who at times provide material and financial resources. Where technical skills are lacking, the organisation contracts various professional organisations for assistance.

  - Support methodologies for youth peer education

  - Development of counselling and support for youth group weaning programmes

- **Expectations**

  - To train youth groups
  - To reduce incidence of substance abuse
  - To develop reservoir of resource materials
  - Acquire self and evaluation skills to promote assertiveness and self esteem to address substance abuse
  - Increase in knowledge of substance abuse issues among youth groups
  - Active participation in anti-drug and alcohol programs and a reduction in behaviours precipitating risky sexual indulgence
  - Increase in quality and quantity of peer education activities as a follow up to the youth workshops
  - Capacity building in youth training among program organisers

3. Mental Health Association of Zambia (MHAZ)

The Mental Health Association of Zambia is a charitable, non-profit, non-governmental organisation founded in 1968 with branches in all the nine provinces of Zambia. The main aim of MHAZ is to create public awareness on mental health issues.
• Activities

Its activities are mainly centred on referral of mental health related cases (substance abuse inclusive) to professional staff. The association is also involved in Community Based Rehabilitation (CBR) in collaboration with the Catholic Church in one township of Lusaka. At the moment, the association is working on a programme to bring together consumers of mental health services.

• Failures

- Sustainability of programmes once cooperate partners leave.
- Inability to support full time staff.

4. Anti-Zambia smoking Society

The Zambia Anti-Smoking, Society (ZAS) operates on similar lines as PASA with the only difference being, that of focus. While PASA concentrates on general substance abuse, ZAS works very closely with Government through the Central Board of Health. At the moment, ZAS dominates membership to the National Tobacco Campaign Committee of the Central Board of Health.

• Activities

- Prints posters and stickers and carries out sticking campaigns on office doors and other public utilities
- Carries out media advertisements on dangers of smoking tobacco
- Spearheads the World No Tobacco Days
- Exhibits in Agriculture and Commercial Shows in Lusaka and the Copperbelt

• Failures

- Inability to organise programmes on underage smoking
- Development of sustainable fund raising projects
- Technical support

ZAS will be happy to be included in the project on primary prevention of substance abuse especially those related to antismoking activities.

5. CONCLUSION

Zambia is quite happy to note that the Global Initiative on Primary Prevention of Substance Abuse is taking shape. We believe it is a vital catalyst to our desire to take health as close as possible to the individual community. The other important fact is that the project is very much in line with the recently adopted WHO Regional Strategy for Mental Health and Prevention and Control of Substance Abuse.
EMAU'S 20 YEARS OF SERVICE TO THE YOUTH

HISTORICAL PERSPECTIVE SHARED IN THE HARARE TRAINING OF TRAINERS
WORKSHOP ON PRIMARY PREVENTION OF SUBSTANCE ABUSE
6-8 December 1999

The Responsible Parenthood Education for Youth Project EMAU is commemorating 20 years of service to Youths in Tanzania. In this special report, the Director of EMAU Mr. Stewart Chisongela, describes the mission of the project, its performance and future plans.

The idea of starting this project for Responsible Parenthood Education for Youth arose in early 70s'. The importance of this idea was recognised by the government on one side, and by religious institutions and Non Governmental Organisations. The Christian Council of Tanzania (CCT) and UMATI became increasingly concerned as a result of reports and remarks about youth problems by religious leaders at almost every meeting.

The Tanzanian youth was in need of counselling and family life education to fill the gap created by the disintegration of traditional tribal education. It was further realised that urbanisation and industrialisation were rapidly promoting interaction between people of different ethnic groups, nationalities and even religious affiliations. This in addition to adulteration of cultural values had precipitated other problems including rural urban migration, high rate of school dropouts, early pregnancies, drug abuse and other undesirable behaviours.

EMAU has therefore endeavoured to assist/produce responsible youths through education that is designed to bring about desirable changes in their attitude, knowledge and behaviour. These changes need to be compatible with the aspirations of parents and in conformity with accepted Tanzania cultural morals and values.

There are short-term objectives and long term objectives

- The short term objectives

1. To advise and participate in the organisation of zonal and regional seminars on Responsible Parenthood to teachers of religious studies in schools, and church leaders.

2. To conduct at national level short courses for key youth leaders who will be instrumental in organising and supervising the preparation of youth leaders in their respective regions.

3. To produce reading materials suitable for youths so as to supplement formal education and the training which they receive through seminars and short courses.

4. To monitor the progress of youth counselling activities in zones and regions and advise accordingly, and

5. To stimulate interest and cooperation with other agencies in promoting Responsible Parenthood Education for youths.
• The long term objectives

1. To contribute to the social, economic and cultural development of youths so as to enable them to function responsibly as members of families and eventually as parents.
2. To produce desirable changes in attitude, knowledge and behaviour related to sexual and family matters which are compatible with the aspirations of Tanzanians and in consonance with their cultural values and norms.
3. To establish sufficient youth leaders in the regions in order to be able to organise and run counselling seminars in their areas, and
4. To integrate EMAU’s activities with those of the Ministries of Education and Culture, Community Development, Women and Children, Labour and Youth Development, Health and Agriculture.

Implementation of project activities

Since EMAU was established in 1976, the project has carried out its activities in three yearly phases. At the end of each phase an evaluation is undertaken. To date, EMAU has completed six phases and is now in its seventh phase. EMAU’s operational phases have been as follows:

**Phase I (1976-1979)**

This phase concentrated mainly on the training of youth leaders and teachers in order to prepare them for teaching Family Life, Education in schools, teachers colleges, churches, youth organisations, youth clubs, the armed forces, etc. Among the notable achievements during this phase were the training of 385 youth leaders; production of Kiswahili publications and a comprehensive evaluation of phase I in 1979.

**Phase II (1980-1982)**

The following activities were executed; six leadership seminars with a total of 194 youth leaders participating; training of 445 youth leaders at zonal level; two annual youth colloquium held under the auspices of CCT and attracting 348 youth participants; the publication of eight supplementary readers and the evaluation of the phase II.

**Phase III (1983-1986)**

It took 4 years to accomplish this phase because one year (1, 983) was reserved for evaluation. There was notable expansion of EMAU’s activities during this phase to foster cooperation between EMAU and other organisations interested in the Family Life Education Programme. During this phase EMAU:

2. Conducted a national seminar for youth leaders and refresher courses or those who participated in the previous phases, seminars.